Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 27-Oct-2018 | Report No: PIDISDSC25492

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Congo, Democratic Republic of	P168756		DRC multisectoral child nutrition and health project (P168756)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Dec 03, 2018	Jan 29, 2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Democratic Republic of the Congo	National Nutrition Program (PRONANUT)	

Proposed Development Objective(s)

The development objective of this project is to increase the utilization of nutrition interventions in the project regions.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	400.00
Total Financing	400.00
of which IBRD/IDA	400.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	400.00
IDA Credit	400.00

Environmental and Social Risk Classification	Concept Review Decision
Substantial	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

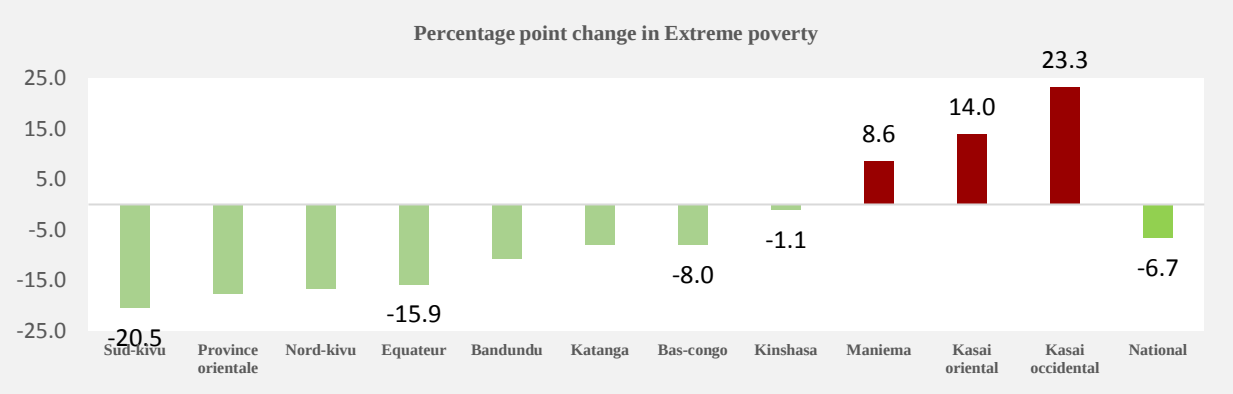
B. Introduction and Context

Country Context

1. Despite its tremendous wealth in natural resources and its potential for economic development, the Democratic Republic of the Congo (DRC) is one of the poorest countries in the world. The per capita gross domestic product (GDP) in 2017 was at 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 Diagnostics, 2018). In 2010-2015, the country has gone through a period of significant growth, with an average GDP growth rate of 7.5 percent. However, the trend has recently slowed down. It is estimated that the slowdown led to a decrease in real per capita GDP, with negative consequences for poverty reduction. Growth has recently picked up again with rising commodity prices and increased activities in the extractive sector, but at a lower rate than previously anticipated.

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 and 14 percent of all people living in extreme poverty in Sub-Saharan Africa live in DRC (DRC Systematic Country Diagnostics, 2018). The pace of poverty reduction is significantly slower than that experienced in other countries in the region (Jobs Diagnostics, World Bank, 2016) and large portions of the population remain trapped in extreme poverty with little hope that their living conditions will improve in the near future (DRC Systematic Country Diagnostics, 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.[1]

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 (in certain areas, membership in armed groups is also seen as an alternative to underemployment; DRC Systematic Country Diagnostics, 2018). Urban areas have been unable to accommodate a growing number of workers— particularly women—into slowly expanding waged jobs and urban dwellers represent an estimated 83 percent of the unemployed. Rapid population increase, insufficient macroeconomic

[1] World Bank. 2013. Congo, Democratic Republic of - Country Assistance Strategy for the period FY13 - FY16 (English). Washington, DC: World Bank.

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 Systematic Country Diagnostics, 2018). DRC ranked 176 among 188 countries on the 2016 Human Development Index and 146 among 157 countries on the 2018 Human Capital Index. Some recent progress has been noted in selected health and education indicators, but considerable challenges remain. DRC has not reached any of the Millennium Development Goals (DRC Systematic Country Diagnostics, 2018). Investments in health and education remain very low. For example, health expenditure in DRC is 10 percent of Sub-Saharan Africa average (DRC Systematic Country Diagnostics, 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. Life expectancy at birth was estimated at 59.6 in 2015 (6 years higher than in 2005). Under 5 child mortality rate of 94.3 per 1,000 live births in 2015 (from 137.4 in 2005) was higher than the Sub-Saharan Africa average of 78.3 per 1,000. Maternal mortality rate increased from 543 per 100,000 live births in 2007 to 850 per 100,000 live births in 2015 and is among the highest in the world.

Table 1: Key Health Indicators

Indicator	Value
Demographic and health indicators	
Infant mortality (deaths per 1,000 births)	72[1]
Child mortality (deaths per 1,000 births)	94.3[1]
Maternal Morality (deaths per 100,000 live births)	850[1]
Life expectancy at birth (years)	59.6[1]
Total fertility rate (children per woman)	6.1
Adolescent fertility rate (% of women 15-19 years of age who have given birth)	12.8%[2]
Stunting prevalence in children 0-5 years of age	42.6%[2]
Health system characteristics	
Total health expenditure per capita (current 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 ante-natal care visits (ANC)	48.0%[2]
Percentage of deliveries assisted by qualified personnel	80.1%[2]
Percentage of deliveries in a health facility	79.9%[2]
Women receiving antenatal iron supplementation	58.9%[2]
Percentage of children 12-23 months of age with complete vaccination	22%-45%[2]
Percentage of infants receiving post-natal care	9.7%[2]

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

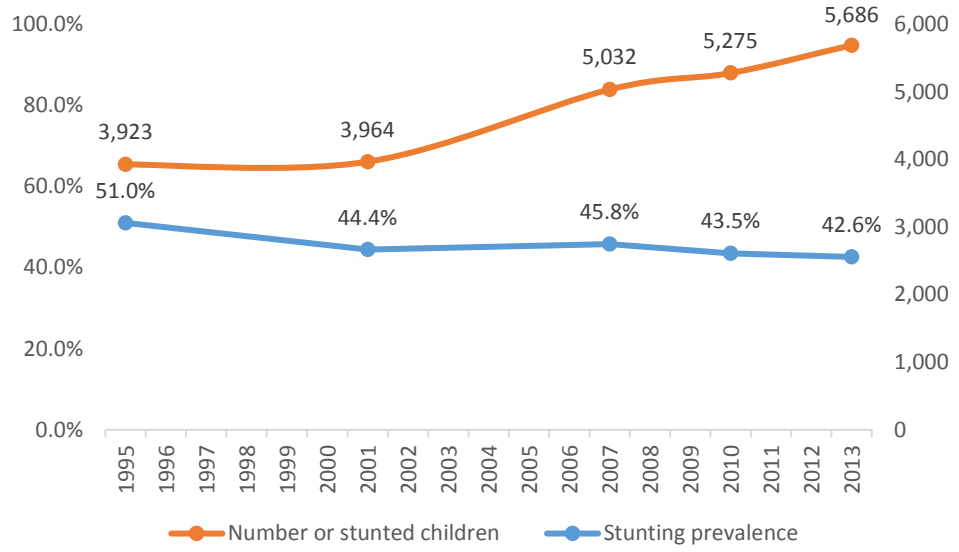
B. Sectoral and Institutional Context

5. 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, and costs countries in Africa and Asia between 4 and 11 percent of GDP annually.

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 five 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 207, 43.5 percent in 2010, and 42.6 percent in 2013), with an annual average decline rate of 0.15 percentage points (see Figure 1 below). Moreover, due to 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.

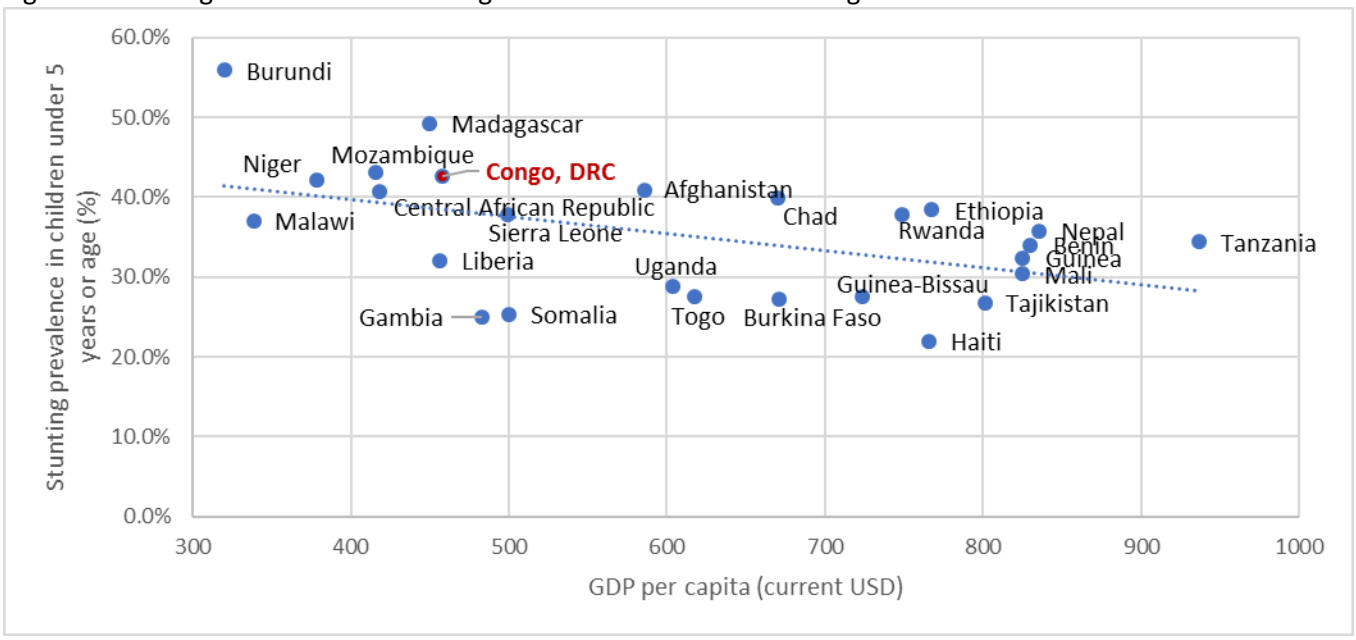


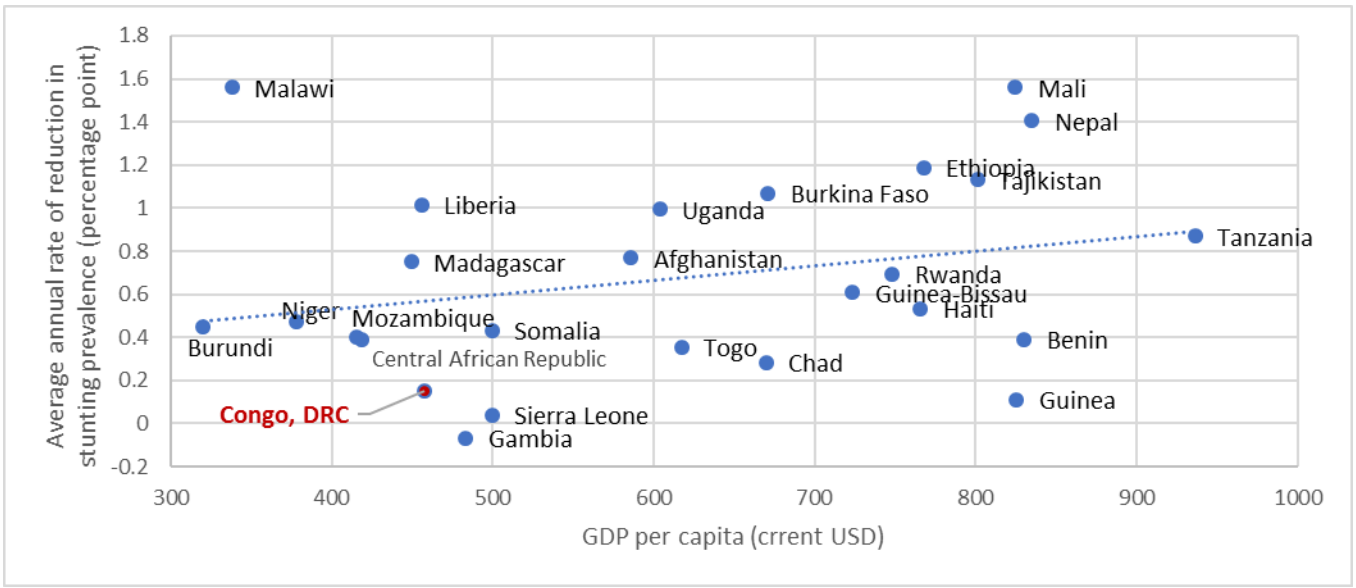
Source: World Development Indicators

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 (WHO) “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.

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 Figure 4, 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 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 Figure 4 Panel 2). This includes other fragility, conflict and violence-affected (FCV) countries such as Somalia, the Central African Republic, and Afghanistan.

Figure 4: Stunting Prevalence and Average Annual Reduction in Stunting Prevalence in Low-Income Countries.





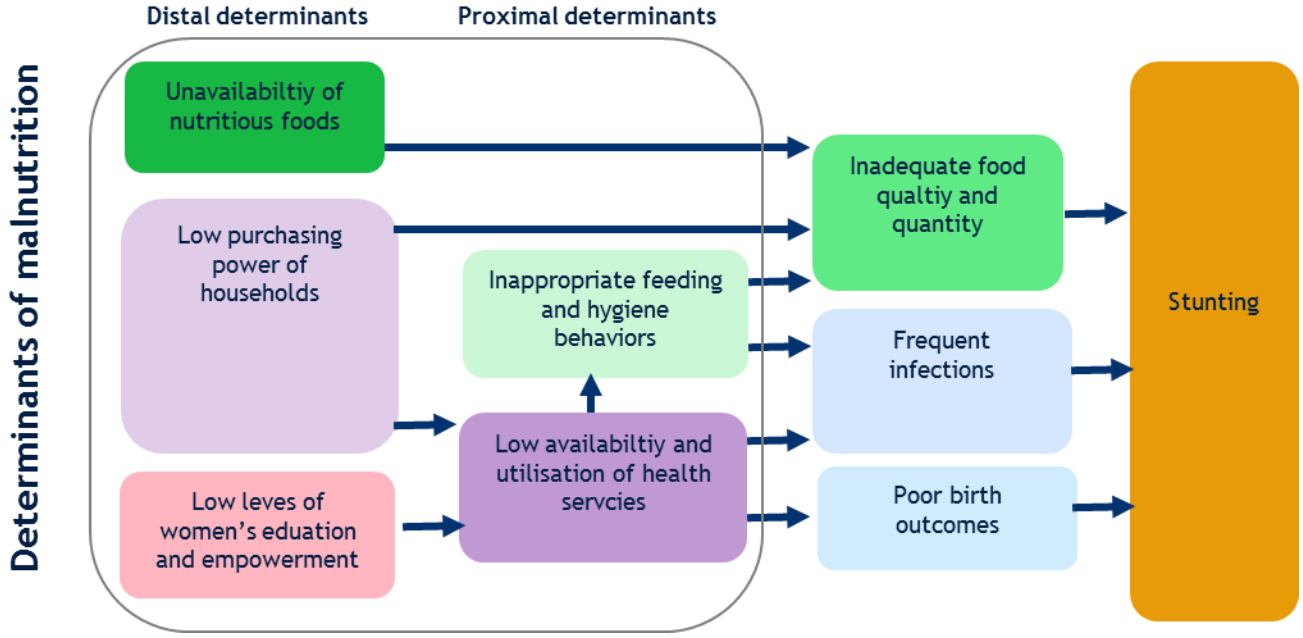
Source: World Development Indicators

9. 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.

Determinants of Chronic Malnutrition in the DRC:

10. Child stunting is a result of inadequate food intake (both in terms of quantity and quality), repeated and untreated infections such as diarrhea, acute respiratory illness, or malaria, and poor birth outcomes, when children are born pre-term or small for gestational age. Those 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 (see Figure 5).

Figure 5: Simplified Conceptual Model of the Determinants of Malnutrition.



11. ***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 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 it 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 form 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[2]). 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 WHO/United Nations International Children's Emergency Fund (UNICEF) infant and young child feeding (IYCF) standards; only 20 percent have adequate food diversity and 35 percent - 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

[2] The PCN 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.

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.

12. ***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 4 ante-natal care 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-natal care. The level of utilization of routine health services for children is even lower: 90.3 percent of new born children do not receive any post-natal care; only 22-45 percent of children 12-23 months of age have complete vaccination (based on vaccination card and mothers' reports, respectively), only 39 percent of children with diarrhea were treated with ORS and only 2.4 percent received zinc. Under-developed 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 the DHS data shows that children 0-23 months of age whose mothers had 4 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[3].

13. ***Suboptimal birth outcomes:*** Poor birth outcomes put newborns at 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 and teenage pregnancy and short intervals between births are the two key factors that increase the risk of negative birth outcomes and the likelihood of child stunting. Recent analyses show that children who were born less than 24 months after a sibling had 40 percent higher odds of being 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, teenage pregnancy and short birth intervals are common. About 13 percent of women aged 15-19 years or age have already given birth. About 27 percent of women report intervals shorter than 24 months between their last two births. Adolescent pregnancy and short inter-birth intervals are closely related. 43 percent of adolescent mothers had the interval between the two most recent births of less than 24 months. Unmet family planning need among adolescents has increased from 26.2 percent to 30.8 percent between 2007 and 2013 (DHS 2013-2014). The two biggest barriers preventing adolescent girls and boys from seeking reproductive health services are stigma and cost.

14. ***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 (Food Balance Sheet, 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 incomes 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 higher price per calorie consumed. Consequently, chronic food insecurity is more prevalent in urban and peri-urban than in rural areas (Adoho et al., 2018). Low incomes also create barriers to the use of health and other key 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).

15. ***Unavailability of foods of high nutritional quality foods:*** Access to adequate quality and quantity of foods is also constrained by the very limited agricultural productivity - one of the lowest in Sub-Saharan Africa (Adoho et al., 2018).

[3] Reanalysis of the DHS data by the project team

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

16. 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.

17. Inappropriate feeding behaviors and practices can be improved through the **infant and young child feeding (IYCF) interventions** 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 e.g. 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 **antenatal care 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, Kakietet, Dayton Eberwien, Walters, 2017). The key determinants of suboptimal birth outcomes which increase the risk of stunting. can be improved by **periconceptual micronutrient supplementation** and by **promotion and provision of family planning and modern contraceptive methods**.

18. **Cash transfers** have been shown to increase household purchasing power and improve household food consumption (Adato and Bassett, 2009). Serval studies form 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, & Peterman, 2013; Miller & Tsoka, 2008; OPM, 2013; Berhane et al., 2015; OPM, 2014; OPM, 2015; Soares & 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, 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, Verhofstadr, 2009), and, critically, when they are provided in context where adequate supply of health services exists (e.g. Manley et al., 2012) .

19. 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 improved growth after growth faltering (Busert et al., 2016).

Table 2: Interventions Shown to Reduce Stunting

Determinants of stunting	Interventions	Common delivery channels
Inappropriate feeding behaviors and practices	• Infant and young child feeding counseling and growth monitoring • Social and behavior change communication campaigns	Community
Low availability and utilization of maternal and child health services:	• Antenatal care for pregnant women • Micronutrient supplementation in pregnancy (iron/folate, multiple micronutrients) • Post-natal care for women and children • Immunization • Micronutrient supplementation for children (vitamin A, multiple micronutrients) • Deworming for children • Zinc and oral rehydration solution (zinc+ORS) for the treatment of diarrhea • Integrated management of childhood illness (IMCI) • Treatment of severe acute malnutrition	Health facilities
Suboptimal birth outcomes	• Promotion and provision of modern contraceptive methods • Micronutrient supplementation • Interventions aimed at delaying marriage and increasing school attainment for girls	Community, health facilities
Low purchasing power of vulnerable households	• Targeted cash transfers	Community, social safety nets programs, health facilities
Unavailability of high nutrition quality foods	• Promotion of biofortified crops • Support for homestead food production	Community, agriculture extension services

Box 1: Recent Evidence on the Impact of Water, Sanitation, and Hygiene (WASH) Intervention on Child Nutrition Outcomes.

The 1990 Nutrition Conceptual Framework[1] identifies poor water and sanitation as some of the underlying causes of malnutrition. This suggests that interventions aimed at improving water, hygiene, and sanitation (WASH) should be considered as part of a comprehensive strategy to reduce malnutrition. However, most of the evidence supporting the link between WASH actions and better nutrition comes from cross-sectional studies (e.g. analysis of household surveys, such as DHS and MICS). Until recently, evidence from more rigorous randomized-controlled trials has been very scant. To address this important evidence gap, two recent large randomized controlled trials (WASH Benefits and SHINE) – the largest conducted to date, examined the impact of a comprehensive WASH intervention on child nutrition, diarrhea incidence, and related outcomes. The studies enrolled nearly 20,000 participants in three countries (WASH Benefits had 5551 participants in Bangladesh and 8246 in Kenya; SHINE had 5280 participants in Zimbabwe). The WASH intervention included building of community latrines, installation of hand washing stations, monthly provision of soap, distribution of WaterGuard for the treatment and purification of water and behavior change communication. The studies showed that this comprehensive WASH intervention had no effects on stunting prevalence, no effects of serum hemoglobin (anemia), and only limited effects no diarrhea (improvements in 7-day diarrhea prevalence recorded in Bangladesh, but not in Kenya and Zimbabwe). Given the size of the study population, the rigor of the studies, the diverse contexts and countries where they were implemented, and the intensity of the WASH interventions, the results of the WASH Benefits and the SHINE studies are particularly disappointing. They indicate that, while improving water, sanitation, and hygiene has many intrinsic benefits (e.g. preventing infectious diseases such as cholera; see Box 2), the current WASH approaches and interventions should not be considered as an effective tool to reduce child malnutrition.

[1]UNICEF, Strategy for Improved Nutrition of Children and Women in Developing Countries, UNICEF, New York, 1990

For more information about the SHINE and WASH Benefits studies and a list of publications see:
http://www.washbenefits.net/

National policy response:

20. Efforts to implement the multisectoral actions including those described above and build a comprehensive nutrition policy agenda in DRC have been under way since the early 2000's. 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.

21. In 2000, the government adopted a National Nutrition Policy and created the National Nutrition Program (PRONANUT) within the Ministry of Public 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 policy, 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 – 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.

22. Recently, the government has adopted a policy and developed operational documents describing a national community nutrition platform (Nutritoin a Assis Communautaire; NAC), anchored in local governance structures and using relais 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 and work as an interface between the community and public service providers. However, to date, the strategy has only been rolled out on a small scale (covering only 36 zones de santé), largely by external donor programs. The utilization of ReCos by different non-governmental organizations (NGOs) and development partners indicates the viability of this 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 points to an urgent need to establish a standardized, cohesive, and coherent national ReCos platform that could be used by the government and the development partners in a coordinated fashion.

23. Nutrition is included in some of the key health sector documents and initiatives. In 2015, the Global Financing Facility in Support of Every Woman and Every Child (GFF) platform was created; it brought together the key government health stakeholders, other line ministries, civil society representatives, and development partners. The platform took the lead in developing the country's reproductive, maternal, neonatal, child and adolescent health and nutrition (RMNCAH-N) investment case which prioritizes the interventions laid out in the National Strategic Development Plan 2016-2020. 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[4]. 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.

24. Several policy documents govern the agriculture sector, but they are not well coordinated and do not address nutrition in a direct manner. The 2013 Programme National d'Investissements Agricoles (PNIA), for 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 agro-business 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 bio-fortified 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.

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

25. 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 (see Table 3). These bottlenecks include: 1) absence of a coordinated response and a service delivery platform at the community level; b) low availability and quality of public services in health and other nutrition-sensitive sectors; c) weak governance and management capacity of state actors at the local, provincial, and central levels.

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

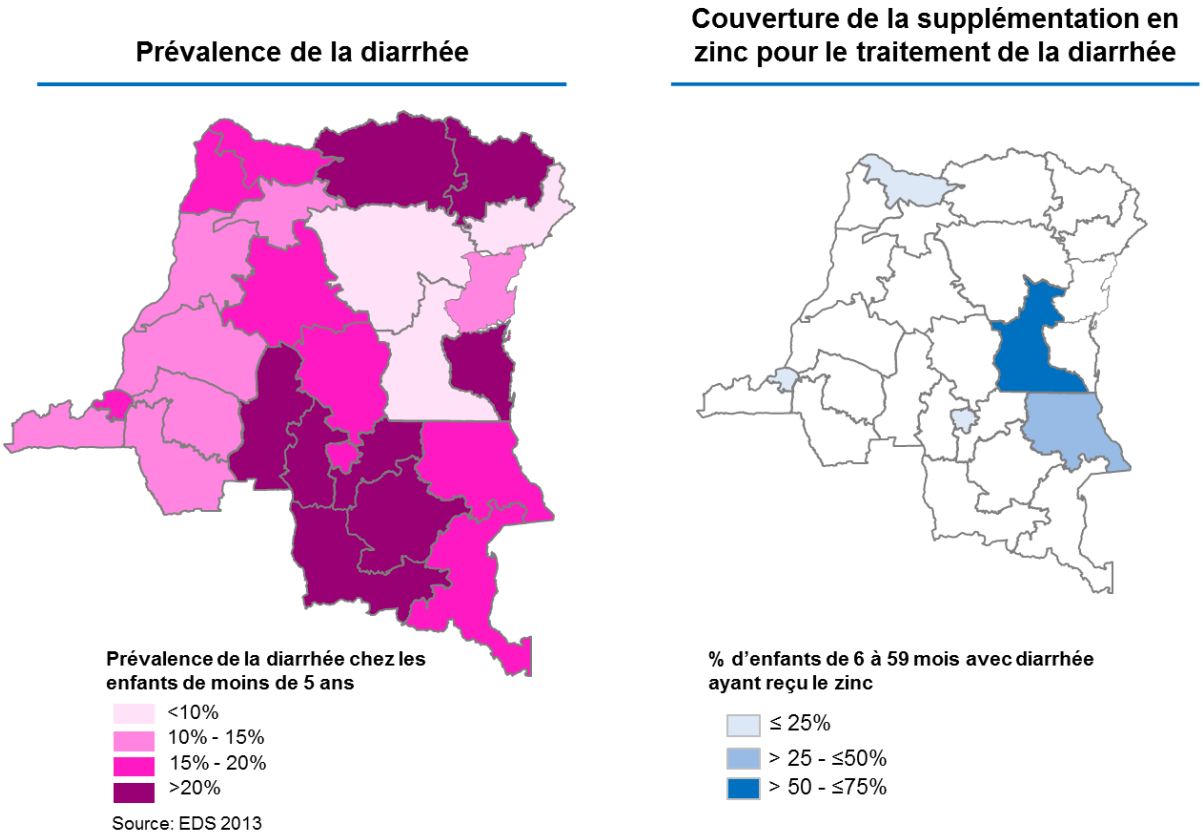
Table 3: Coverage of Selected High-Impact Nutrition-Specific and Nutrition-Sensitive Interventions in DRC

Indicator	Value
Iron supplementation in pregnancy	
Any iron supplementation	59.9%
90 days supplementation	5.0%
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 ante-natal care visits (ANC)	48.0%[2]
Percentage of children 12-23 months of age with complete vaccination	22%-45%[2]
Percentage of infants receiving post-natal care	9.7%[2]
Percentage of women with met demand for modern family planning services	16.3%

Sources: DRC DHS 2013-2014; No data are available regarding the coverage of IYCF, SAM treatment, nutrition-sensitive cash transfers, biofortification, and homestead food production interventions.

26. ***(1) Absence of a coordinated response and platform at the community level:*** While key policies and guidelines regarding community-level service provision and mobilization have been developed, to date, the strategy has only been rolled out on a small scale, largely by external donor programs, and in an uncoordinated fashion. 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 severe acute malnutrition (SAM), or inputs for family planning. 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 (see Figure 6). 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.

Figure 6: Diarrhea Prevalence and the Coverage of Therapeutic Zinc.



Source: PRONANUT, 2018.

27. ***(2) Low availability and quality of health and other nutrition-sensitive services:*** DRC has 0.09 physicians per 1000 inhabitants – three times fewer than the Sub-Saharan Africa average (0.3) and well below the WHO recommendation of 1 per 1000. 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 Ministry of Health (2017), of the 1,077 health facilities 29 percent were destroyed or looted during the recent crisis; 32 percent experienced increased requirements in 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 family planning services, and the average health facility had only 4 of the 6 essential commodities for the supply of family planning services. Service availability and quality is low also 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 system to provide targeted support to the poorest and most vulnerable (DRC Systematic Country Diagnostics, 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 cost. Consequently, their delivery is fragmented, and varies widely in terms of coverage, generosity and performance.

28. ***(3) Weak governance and management capacity:*** Program management capacity at the central, provincial, and local level in DRC remains weak. At the central level, while very engaged, 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, the provincial health directorates (DPS) do not have capacity to perform their oversight, management, and supervision functions due to lack resources (e.g. lack of basic IT equipment, cars, fuel budgets). Furthermore, while each DPS has a nutrition officer/coordinator, the coordinators lack managerial and technical skills to effectively coordinate activities in their areas. Similarly, the capacity at the local levels (zones des santé aires, de santé) is constrained by insufficient skills and resources.

29. 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 household; and e) address the challenges of reproductive health among adolescent girls and the issues of early motherhood. This effort would need to focus on overcoming three major systemic bottlenecks including: a) absence of a coordinated response and platform at the community level; b) low availability and quality of public services in health and other key nutrition-sensitive sectors; c) weak governance and management capacity of state actors at the local, provincial, and central levels. The proposed project will address the key determinants of stunting listed above and remove the key bottlenecks by: a) strengthening and scaling up the multisectoral community-level service delivery and mobilization platform; b) improving the supply (quality and quantity) of essential nutrition-specific and nutrition-sensitive services in health, agriculture, social protection, and education by investing in essential infrastructure and inputs and scaling up performance-based payment schemes; and 3) building and maintaining nutrition governance capacity at the central, provincial, and local level, through innovative TA mechanisms to incentivize performance and the use of data for program management.

C. Relationship to CPF

30. The proposed project is in line with the World Bank Group's FY13 - FY16 Country Assistance Strategy (CAS) for DRC. The project supports the achievement of the third strategic objective of the CAS: improve social service delivery to raise human development (HD) indicators, and its specific outcomes including a) improved access to health services, b) improved access to basic education and c) strengthened social protection. Through financing of capacity strengthening for local, provincial, and central-level government agencies (e.g. the provincial health directorates) and innovative governance and contracting mechanisms (e.g. Results Based Financing (RBF)) the project will also support the first CAS objective: (i) increase the effectiveness of the state at the center and at decentralized levels and improve good governance while strengthening the development impact of World Bank operations.

31. The project is also aligned with the newly published DRC Systematic Country Diagnostics (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 as well as b) increasing access to good-quality health services to build human capital, c) establishing preconditions for an eventual demographic dividend, 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).

32. Finally, the proposed project is also closely aligned with the WB's strategy on Africa, which calls for investments in human capital.

PROPOSED PDO/RESULTS

A. Proposed Project Development Objective(s)

The development objective of this project is to increase the utilization of nutrition interventions in the project regions.

B. Key Results

Theory of change:

33. This project contributes to the implementation of the National Multisectoral Strategic Nutrition Plan and the National Nutrition Policy and to achieving their objectives, including the reduction of stunting prevalence among children 0-23 months of age by 50 percent over the next 10 years[5].

Project beneficiaries:

34. The key target groups for the project are children 0-23 months, children under the age of 5[6], and pregnant and lactating women. To address the issues of adolescent pregnancy and suboptimal birth outcomes, the project will also target adolescent girls (11-19 years of age).

35. 9 provinces have been identified as priority provinces for the proposed project based on those two criteria, 1) burden of stunting in children 0-23 months of age (combined stunting prevalence and the number of stunted children) and 2) cost-effectiveness of investments in stunting prevention. The criteria and the methods for the selection of the provinces are described in detail in Annex 1. The priority provinces include: Haut Katanga, Kassai, Kassai Central, Kongo Central, Kwilu, Lualaba, Nord Kivu, Sud Kivu and Tanganyika.

36. Based on the available data, scaling up the high impact interventions in the 9 provinces over 5 years from the current coverage level to cover 90% of the population in year 5 would require about US$ 2.1 billion. Over 5 years this investment could prevent over 1.8 million under 5 deaths and prevent over 1.2 million cases of stunting in children 0-23. While such rapid scale up is unlikely given the high resource needs and capacity constraints, this preliminary analysis indicates that substantial improvements could be made in child mortality and nutrition status thanks to investments in high-impact interventions in high-burden provinces.

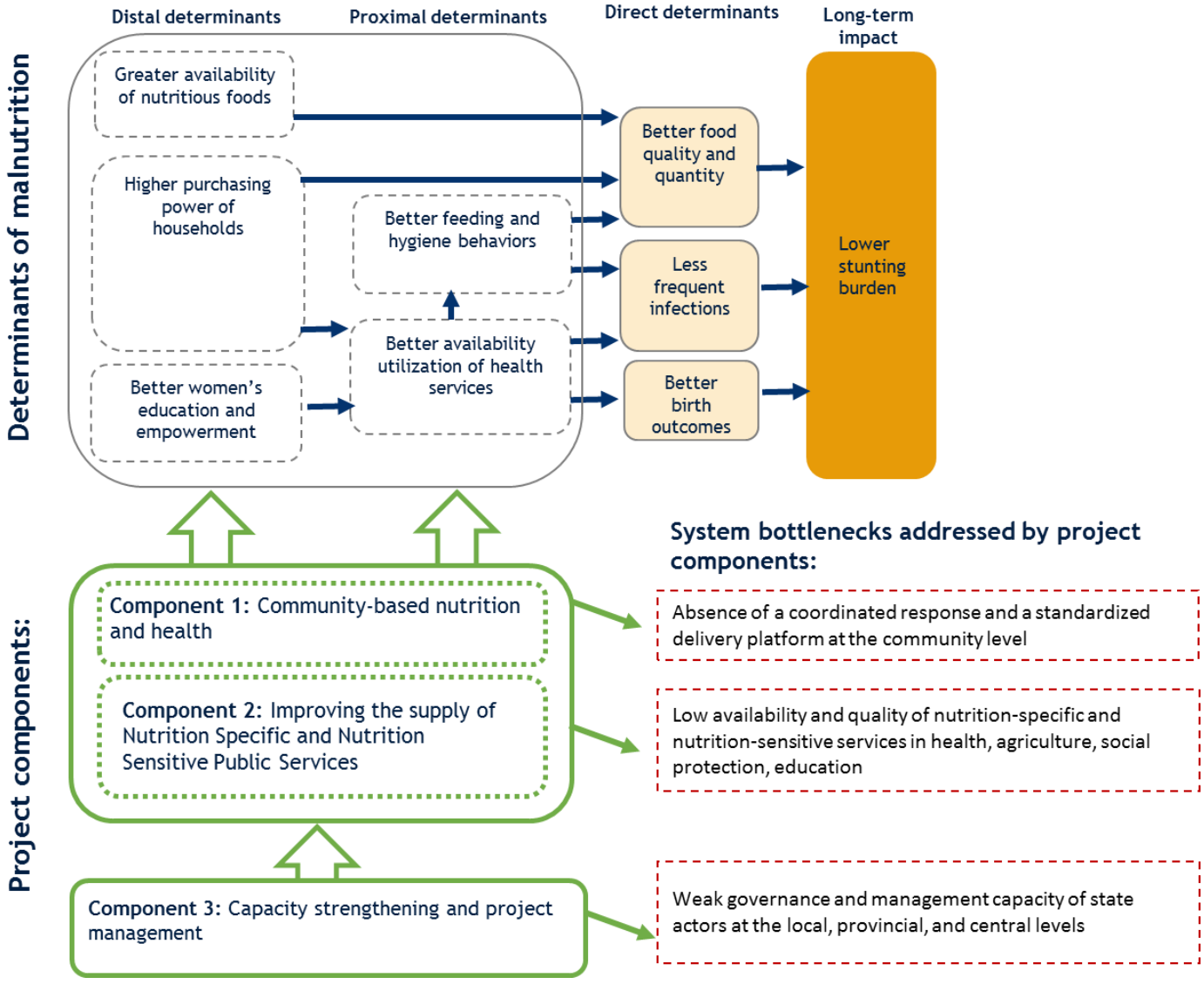
37. It is envisioned that the proposed project will be implemented in a subset of those priority provinces. The remaining priority provinces could be targeted as part of the subsequent projects in the proposed series or projects (SOP; see below). Final selection of the provinces to be targeted will be made early on during project preparation in consultation with the client. Based on the available data, a project envelope of 500 million invested over 5 years would allow to provide nutrition and health services to over 2 million children 0-23 months of age and over 1 million of pregnant women and provide family planning to about 6 million women (including adolescents; for details see Annex 1).

38. Figure 7 (below) presents the project's theory of change. The project will help the government of DRC overcome the key systemic bottlenecks outlined above. It will set up, test, and scale-up a community platform to improve key nutrition behaviors and generate demand for nutrition-specific and nutrition-sensitive public services. It will also increase

[5] In both documents, the reduction in stunting prevalence is envisaged over the 10-year period. The project and the larger program of which this project is part, consistent with the national documents, also assume a 10-year period.
[6] Because the clinical protocols for key child nutrition and health interventions include all children 0-59 months of age children 24-49 months of will also benefit from the project.

the supply and quality of those services to improve access to high nutrition quality foods, the purchasing power of vulnerable households, and health and nutrition status of children 0-23 months of age, pregnant and lactating women and adolescent girls. Finally, it 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.

Figure 7: Theory of Change of the Proposed Project



Long-term vision – a Series of Projects:

39. This project is envisioned as the first in a series of 2-3 projects spanning the next 12 years. The first project will develop and pilot a community nutrition platform in a subset of high-malnutrition-burden provinces of DRC (the selection of the provinces will be finalized early on during project implementation). It will also improve the supply of key nutrition-specific services delivered through the health sector and pilot a limited set of nutrition-sensitive interventions in

agriculture, social protection, and education. The objective of this phase is to demonstrate the effectiveness and feasibility of the platform as the national model to address child malnutrition. For this project, non-governmental actors (e.g. NGOs, United Nations (UN) agencies), where necessary, 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.

40. The second project will expand the community 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 IDA, the second project will seek co-financing from the GFF, 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 this project, the direct involvement of non-state actors in the implementation will be decreasing and they will begin transitioning to providing TA to support government agencies to take over implementation.

41. The third project will scale up the community platform and the expanded set of nutrition-sensitive interventions to new provinces. It will also formalize the resource mobilization and pooling mechanisms so that IDA will contribute but not necessarily constitute the principal source of financing for the platform. For this project, it is envisioned that the implementation will be carried out by the appropriate government agencies and that non-state actors will only provide targeted TA and capacity strengthening[7].

Indicators:

42. The PDO-level indicators will focus on measuring short-term changes that can be attributed to the project (see Table 4):

Table 4: Proposed PDO Indicators.

Impact	Expected results	Proposed indicators
Reducing Prevalence of Stunting	Improving the Delivery of Community Nutrition Interventions	• Number of children 0-23 months of age using community nutrition services • Number of children 6-23 months of age receiving vitamin A supplementation
	Improving the Supply of Nutrition Specific and Nutrition Sensitive Public Services	• Number of children 0-11 months of age completely vaccinated • Number of women using family planning services • Average quarterly quality score in PBF facilities
	Capacity Strengthening and Project Management	• Number of zones de santé with functioning CoDeSa (community health development committees)

43. 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. An end-line population survey will be undertaken with project financing and will provide end-line information for those indicators.

[7] For family planning, it is likely that non-state actors will continue to provider services with the program management and oversight (including contract management) functions fulfilled by the appropriate government entities.

44. End targets for PDO indicators will be set with an appropriate level of ambition taking into account introduction of some novel service delivery mechanisms, low levels of service delivery in the country and the client's absorptive capacity.

PROJECT CONTEXT

A. Concept

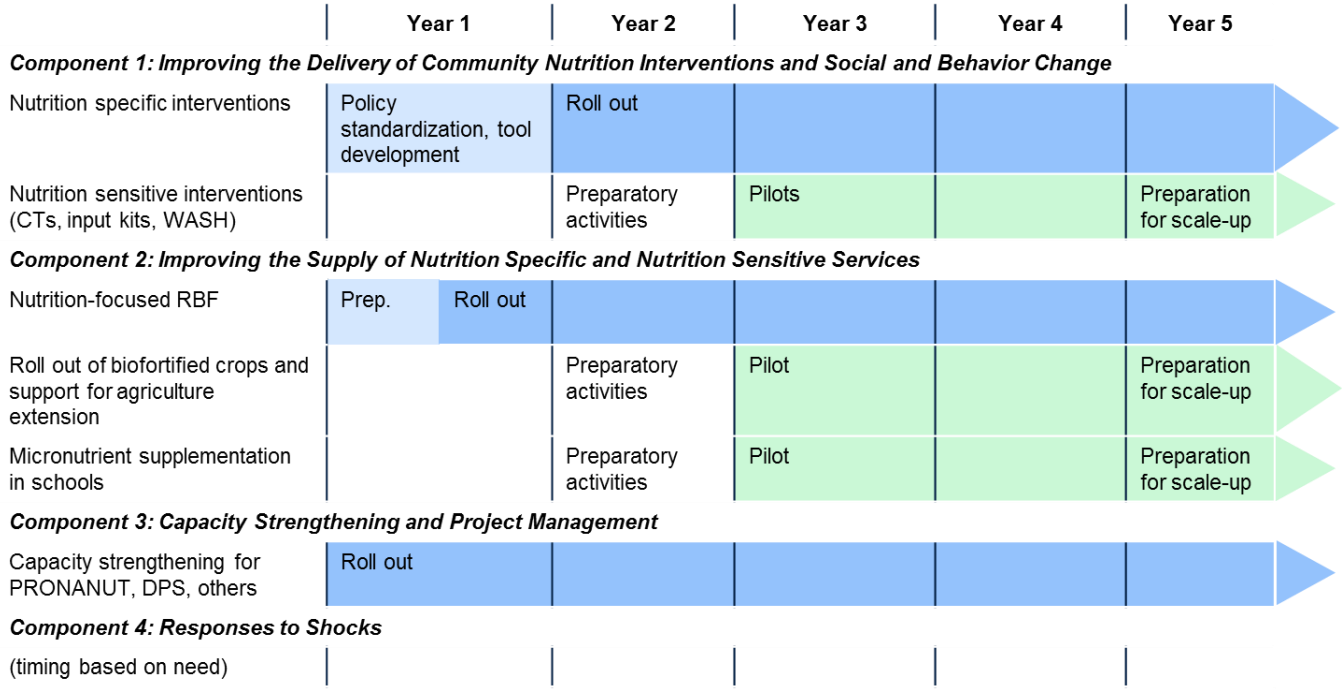
1. Description

45. The proposed project will address the key determinants of child stunting in the targeted regions by focused, evidence based, complementary multisectoral actions in health, social protection, agriculture, and education. It will support the government in establishing and scaling up 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.

46. A coordinated and synergistic approach to stunting reduction – a key element of this project - will be operationalized through: a) vertical coordination between the community and service providers through a system of formal and informal referral-counter-referral and follow-up mechanisms; b) horizontal coordination across different sectors through co-targeting (different interventions targeting the same individuals) and co-location (different interventions located in the same communities) with a complementary package of services in health, social safety nets, agriculture, and education.

47. This first project in a series of projects will focus on the development and scale up of high-impact nutrition-specific interventions at the community and primary health care level and the concurrent piloting of a set of complementary nutrition-sensitive interventions with the strongest evidence of impact. 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 mechanism and systems (see Figure 8). It will also and launch a series of activities to strengthen the capacity of state actors. Starting in year two it will roll out the nutrition-specific services in the targeted provinces. In year 3, the project will gradually start piloting a set of complementary nutrition-sensitive interventions in agriculture, social protection, WASH, and education (see below for details). The focus of the pilots will be to determine effectiveness and, if the pilot results are positive, to identify the best and most efficient way of delivering those services at scale in the subsequent projects within this series of projects (SOP) or as part of WB investments in the respective sectors.

Figure 8: Phasing of the Proposed Project.



48. The project will consist of the following components:

Component 1. Improving the Delivery of Community Nutrition Interventions and Social and Behavioral Change

49. The long-term programmatic objective of this component will be to support the government in creating 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 (e.g. a multi-donor community health and nutrition trust fund).

Subcomponent 1.1: Improving the Delivery of Community Nutrition Interventions

50. ***Nutrition and health services and referrals for children, adolescent girls, and pregnant and lactating women:*** The proposed project will finance the standardization, piloting, 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 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, and those who work as an interface between the community and public service providers.

51. Annex 2 describes in greater details the package of services provided by the ReCos, the proposed way in which they will be identified, trained, and supervised, as well as the way in which their work and performance will be monitored. In summary, 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 infant and young child feeding (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[8], the ReCos will deliver messages to parents about correct infant and young child care and early stimulation practices. They will conduct growth monitoring and screen children for acute malnutrition. They will also provide referrals and linkages to health facilities for pregnant and lactating women to promote utilization of pre- and post-natal care services, and for children with acute malnutrition and other illnesses. Finally, the ReCos will provide support to health facility staff during vitamin A supplementation, deworming, and vaccination campaigns.

52. To address the impact of adolescent pregnancy and short birth spacing as determinants of stunting, the ReCos will work to create demand and facilitate access to reproductive health and family planning services. The ReCos will work with adolescent girls through youth association (*association des jeunes*) and school-based and out-of-school clubs to 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 family planning and reproductive health. Finally, they will provide referrals to public and non-public family planning providers to increase the utilization of modern family planning methods. The project will also explore the ways to link ReCos with women's association to create demand for family planning and modern contraceptive methods and with local churches to reinforce messages related to adolescent pregnancy prevention.

53. The ReCo guidelines published in 2017 indicate that the local PRONANUT agents (*animateurs communautaires*), in partnership with the local community organizations (CAC) should be responsible for the identification and supervision of the ReCo. However, recognizing the capacity constraints of PRONANUT and the health system more broadly, the current guidelines stipulate that over the next several years the identification and supervision of the ReCo should be done through NGOs. The PIU will conduct a pre-qualification exercise to identify a short list of eligible non-state actors who may bid for this scope of work of identifying, training, and supervising ReCos and providing community-based family planning services (described below). The PIU will then announce a competitive bidding process where applications from offerors will be first evaluated on quality of the technical proposal, and then on a cost basis. The project PIU will contract with the successful NGOs to recruit and support the training and supervision of the ReCos. 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 (see Annex 2), the numbers of supervision meetings convened, and the number of supportive supervision visits carried out.

54. Each ReCo will be assigned to a specific health facility and included in the health zone (HZ) supervision structure. During the proposed project, supervision will be delivered jointly by the NGOs and the staff from the health zone. 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 (e.g., GIS tagging of home visits). The NGOs will develop skill transfer plans and it is

[8] The health and the education GPs 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 FY19, an integrated ECD model adapted to the DRC context of fragility will be available and expandable to various convergence point for safe childcare, early learning, play, and stimulation that prepares them for school. Lessons learned, including associated cost, will contribute to the development of an integrated model of early years' activities and coordination across sectors at national and decentralized level. The model is jointly being implemented by the Ministry of Primary and Secondary Education, the Ministry of Health and the Ministry of Social affairs under the leadership on PRONANUT. The model and the institutional arrangements established will be used by different projects, including 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.

envisioned that, in later phases of the SOP, the identification, training, and supervision responsibilities will be transferred to the appropriate health system agencies.

55. 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 (e.g. Mali, Niger, Madagascar). Initial discussions with the MoH indicate that the MoH recognizes this evidence base and is 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 would provide financial motivation to ReCos. As mentioned above, each ReCo will be attached to a health facility. Through the Performance Based Financing system (PBF; see Component 2), health facilities will be receiving a dedicated budget from which they will provide financial incentives to the ReCos. A similar model is currently being implemented under the PDSS.

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

57. The proposed project will also implement pilots to assess the feasibility of scaling up complementary-nutrition sensitive interventions at the community level. The pilots will be implemented in a subset of communities once the platform for the delivery of nutrition-specific intervention has been set up and tested (e.g. in years two or three of the project). The location, timing, and duration of the pilots will be determined during project implementation. The key nutrition-sensitive interventions piloted under the project will include:

58. ***Pilot of cash transfers for vulnerable children and pregnant and lactating women:*** The project will pilot using 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 Systematic Country Diagnostic (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.

59. To implement the cash transfer component the proposed project will use, to the extent possible, the institutional arrangements of the Productive Inclusion Project (PIP). PIP includes a US$ 20 million cash transfer component targeting health zones 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 Ministry of Social Affairs (MoSA), which in turn will be contracting with payment agencies[9]. The PIU of the proposed project (see below) could contract with the PIP PIU to delivery cash transfers. This arrangement would allow the project to capitalize on the 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 coordinating with other project activities[10].

60. 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, making sure that the transfers are nutrition-sensitive (e.g. 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 (e.g. 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,

[9] The beneficiary targeting mechanisms cash delivery modalities under PIP are still being finalized.
[10] Alternative arrangements using the Social Fund rather than the PIP PIU will also be explored during project preparation.

will deliver small, regular transfers to the beneficiaries to help stabilize consumption. A similar implementation modality is already used by other World Bank investments (e.g. 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 use health services at the same time. As suggested by other cash transfer experiences in DRC, both parents will be encouraged to come on payment day as this facilitates a constructive and consensual use of the cash. The appropriate transfer modality (e.g. conditional vs. non-conditional), targeting mechanisms (e.g. based on poverty, based on acute malnutrition status), and frequency of transfers (e.g. bi-weekly, monthly) will be identified during project preparation based on the experience from DRC and other countries, putting emphasis on coordination and consistency with other World Bank SP operations in DRC, most notably the PIP. It is possible that different modalities will be tested and systematically compared through operational research. 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 scale up by an existing (e.g. through additional financing) or a new World Bank social protection project(s).

61. ***Pilot of 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 project will also pilot complementing the cash transfers with agriculture input kits. The project will contract an experienced technical partner, such as FAO, in delivering agricultural inputs and support in project areas to initially lead this activity by gradually building the capacity of the government (Ministry of Agriculture), through a joint design of a pilot intervention, on-the-job training, and support the Government to evaluate the program and prepare it for scale up and eventual transfer of the task to the government. Lessons from this pilot would capture what is needed in terms of further capacity building of the government to successfully carry out this activity eventually on its own, and scale it up. Vulnerable households (identified through vulnerability targeting jointly with cash transfer interventions) that also have the capacity to engage in homestead food production, will receive a basic package of support, comprising short-cycle nutritious vegetable seeds and tool kit. Based on the information collected during the identification and selection of target areas and households, the project will identify the composition of the agriculture kit and its technical specificities. These inputs will be tested and validated by the relevant services of the Ministry before their distribution to the local communities. Special attention will be paid to varieties that produce their own seeds in order to ensure the sustainability of the intervention over several production cycles without the need to buy new seeds. The distribution will be done with the help of NGO partners who will be selected through a competitive process.

62. The methodology that will be piloted by the FAO and the Government will be as follows: the project will first finance the installation of small animal production/ breeding units and demonstration vegetable gardens that will also serve as seed multiplication sites at community level (this could be at health centers, or another community site). For this, a local supervisor per health center will be trained to coordinate activities, provide support to the center on the installation of the facilities, and train staff at the center and beneficiaries. Through targeting[11] conducted in the health centers, vulnerable women will receive training to set up food production units in their homes and receive joint training by ReCos on the use of recipes with home garden crops and available biofortified crop varieties. At the end of the training, women beneficiaries will receive an agriculture input 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 health/nutrition center to multiply the seeds and small animals through a production contract whereby the project would then purchase 50 percent of that production. Women groups would then be encouraged to invest a portion of the income earned in a village savings and loans association to facilitate income-generating activities for women.

[11] As noted above, targeting will be coordinated and harmonized with the targeting for cash transfers.

63. Like 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 social protection (e.g productive safety nets) or agriculture projects.

64. ***Pilot of WASH interventions in cholera endemic areas:*** While the effectiveness of water, sanitation, and hygiene (WASH) interventions in reducing child stunting is not confirmed by recent large-scale randomized controlled trials (see Box 1), WASH can play an important role in reducing child mortality and morbidity especially in areas where water-borne pathogens are common. This is particularly the case in DRC which continues to experience recurrent cholera outbreaks with eastern provinces classified as cholera-endemic areas. Preventing and controlling cholera outbreaks is critical to ensure child survival and development and the optimal accumulation of human capital. To address the problem of cholera, the project will pilot a WASH intervention in selected communities. The intervention will be based on the existing models successfully implemented in DRC by the government in partnership with UNICEF and other partners - *écoles et villages assainis* – a community-led total sanitation (CLTS) intervention adapted to the local DRC context. The CLTS is an intense behavioral change intervention that also provides communities with skills and tools to build community and household latrines. In addition, the WASH pilot intervention would include the distribution of chlorine tablets for water purification and soap for handwashing – a similar approach is currently being tested under the PDSS project.

65. In the pilot areas, the contracts of the NGO contracted to support and supervise the ReCos would also include WASH activities. In those communities, the NGOs would procure and distribute inputs (chlorine tablets, soap), train ReCos to provide counselling on cholera prevention (in addition to the routine counseling on hygiene) and, if possible, contribute to community surveillance, help identify potential cholera cases, and provide referrals to cholera treatment centers. The specific intervention package, including implementation tools, training curricula, and monitoring tools, will be developed during the early stages of project implementation, based on the most successful WASH experiences in DRC and globally, particularly those used in other cholera-endemic contexts. The NGO contracts would include performance indicators related to WASH. Like the other pilots under this component, if the WASH pilot proves to be effective in reducing incidence and severity of cholera outbreaks and is scalable, it could then be taken over and scaled up by existing or planned World Bank water project(s).

Box 2: Helping Address Cholera in the Democratic Republic of Congo

The Democratic Republic of Congo is an endemic country for cholera. Sporadic cases and outbreaks are common, particularly in the eastern provinces of the country. Cholera is caused by the ingestion of *Vibrio cholerae*bacteria present in fecally contaminated water or food. It is primarily linked to insufficient access to safe water and adequate sanitation. The primary cholera prevention and management strategies include improvement of access to safe water and sanitation and hygienic practices to prevent cholera transmission, reinforcement of surveillance, particularly at the community level, and improving access to appropriate case management to decrease mortality. The proposed project will contribute to the strengthening of DRC's response to cholera in the following ways:

- Designing and implementing a WASH pilot in cholera-endemic areas aimed at reducing cholera incidence (behavioral WASH, distribution of chlorine tables, soap);
- Training ReCos in recognizing symptoms, making referrals to health facilities, and following up on the referrals;
- Improving the skills of health workers to diagnose, treat, and prevent transmission; providing inputs to health centers/cholera treatment centers; in cholera-endemic areas, paying PBF centers against cholera-related indicators;
- Coordinate surveillance activities with other WBF investments (e.g. EDARDS, PDSS) and other partners (WHO, MSF);
- Coordinate with the water GP on potential future investments in WASH infrastructure.

Subcomponent 1.2 Social and Behavioral Change:

66. 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 amongst a range of stakeholders including the Government, other key donors and 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. It is envisioned that 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; down to the community and household levels with interpersonal communication (IPC).

67. The content, modalities and specific messages of the SBC strategy will be informed through formative research on nutrition and family planning (FP) that will be executed during the project preparation and lead up to effectiveness. The formative research will seek to determine 1) a limited set of key messages that should be promoted; 2) the potential to implement integrated SBC as the same target groups are implicated in the project for nutrition, FP and social protection; and 3) 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 family planning. The formative research will be competitively bid out using the project preparatory advance. 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 quick wins that can be scaled up. A costing of the different components of the SBC strategy will be undertaken to inform scale up. Above all, the SBC strategy seeks to be creative, targeted and evidence-based to effect sustained behavior change across the population.

68. Because several partners are already promoting SBC in DRC around similar topics, coordination will be important to ensure complementary and efficiencies of investments. Coordination may be done through a government-convened steering committee on SBC, or through extensive consultation. The World Bank has engaged in discussion with USAID which has a large SBC effort through its Breakthrough Program, of which the Breakthrough Action project will be implementing in some of the priority provinces listed above, and on much of the same content. The Breakthrough umbrella program also includes another arm, Breakthrough Research, which can also be potentially useful in conducting implementation research on the SBC innovations, measuring the costs and cost effectiveness of the SBC, and course correcting the SBC interventions for improved implementation. Similarly, the Alive and Thrive initiative has had significant success with their behavior change model for nutrition in other countries and could be called upon to adapt their model to DRC.

69. The implementation arrangements for the SBC component of the project will be carried out through a number of modalities. A significant proportion of the SBC will be competitively bid to engage an international implementor or consortia of implementors to bring innovative ideas and global expertise to bear on the challenge of sustainable behavior change. This implementor will test and design mass media campaigns; develop and execute a strategy of nurturing champions for nutrition and family planning, including religious leaders; and develop messaging through IPC to be executed through a number of actors (school based, community based ReCos, facility based). If there is enough overlap with the USAID-supported Breakthrough work, the project may consider sole-sourcing (to Breakthrough) additional complementary components as well as additional coverage to reduce duplication and increase efficiencies of joint investments. It is envisaged that the contract(s) with the SBC non-state actors will be managed by the PIU and perhaps monitored by the provincial and/or district health teams. The consortium may have implementing partners who will cover each of the provinces, while also managing national level multimedia approaches.

Component 2. Improving the Supply of Nutrition Specific and Nutrition Sensitive Services

Sub-component 2.1: Increasing the supply and quality of nutrition-specific and nutrition-sensitive health interventions

70. 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. It will finance the expansion of the existing performance -based financing scheme implemented under the Health System Strengthening 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. PBF incentives will target the following services for pregnant and lactating women, children 0-5 years [12], and adolescent girls: ante-natal care (including iron/folic acid supplementation and intermittent preventive treatment for malaria [IPTp]), routine child health visits for children 0-59 months of age (*consultations prescolaire*), family planning, assisted deliveries, immunization, management of acute malnutrition, and integrated management of child illnesses. In cholera-endemic areas, cholera-related indicators will be included. In addition to providing financial incentives, the project will also finance key inputs and equipment and may support rehabilitations of existing primary health facilities to bring them up to the standard needed to deliver those services. 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.

71. The provision of family planning in health facilities will be strengthened primarily through the expansion of the PDSS' PBF with special emphasis on improving the quality of postpartum services for all women, and especially amongst adolescent girls. Facility utilization rates for delivery are high for both all women and for adolescents (over 80 percent), providing an obvious opportunity to counsel postpartum girls and women on family planning choices. Quality of counseling will be improved through two primary means. First, vignettes to reinforce family planning counseling skills will be used in the PBF scheme by the health zone supervisory team at the facility level as part of the quality scoring and payment. In addition, a system of measuring Method Information Index (MII) through exit interviews of family planning clients will be implemented. The MII consists of a short battery of questions specific to client knowledge of the range of methods, side effects and actions to be taken in the event of side effects. Recent evidence shows a strong positive predictive relationship between the score on the MII and the probability of continuation of the family planning method adopted. While the MII is not currently being used in the PDSS, this system can be piloted in this new project and factored into the quality payment calculation.

72. The expansion of the PDSS will also ensure that all selected facilities will be fully stocked with a full range of family planning 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 for reproductive health and family planning consultations. The project may test different levels of quantity payments for postpartum family planning provision to determine the most optimal price for the service as a further supply side tack.

73. Currentlynly 34 percent of women using contraception receive services from public providers (DHS 2013-2014). During project preparation, supporting non-public providers of family planning services (e.g. NGOs) and strengthening of linkages between health facilities and non-public providers will be explored. Non-state 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 non-state actors would operate under performance-based contracts with the PIU, but with verification and monitoring from the provincial and district health teams. Quality of counseling services may be

[12] The proposed project targets children 0-23 months of age. The clinical protocols for key child nutrition and health interventions include children 0-59 months of age. Because of this, it will not be possible or desirable to exclude children 24-49 months of age from receiving the essential health and nutrition services finance by the project.

measured using the MII methodology on exit interviews for these providers. Depending on their capacity, it is expected that one non-state actor would cover one province, unless there is demonstrated established coverage of more than province.

Sub-component 2.2: Pilots of programs to improve the supply of services aimed at increasing access to foods with high nutritional quality

74. The National Seed Service (SENASEM), and the National Institute for Agricultural Studies and Research (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, which also have higher levels of zinc (see Annex 3) for a summary of the recent biofortification experiences in DRC). HarvestPlus, together with its partner CGIAR centers has, and will continue to build the capacity of INERA, as well as breeders in public universities, to adaptively breed biofortified crop varieties achieving both agronomic[13] and nutrition traits (breeder seeds). Given that the consumption of tubers account for over 40 percent of the total calories consumed by rural households (Adoho et al., 2018) popularization of biofortified cassava and beans in particular has the potential to substantially reduce vitamin A, iron and zinc deficiency and improve related health and nutrition outcomes, including diarrhea incidence and stunting.

75. This project sub-component will be implemented through a contract between the PIU and HarvestPlus to support INERA and SENASEM[14] to roll out of the biofortified crop varieties in a sub-set of communities included in the project (as well as potential integration of biofortified crops into other components of the project[15]). The design of this sub-component, including a detailed work plan will be finalized in year 1. Starting in year 2, the project will finance activities undertaken by HarvestPlus and INERA, backstopped by the CGIAR centers responsible for initial biofortified crop variety development, to select a number of suitable varieties of each biofortified crop.

76. Once sufficient quantities of biofortified planting materials are available for the project areas, HarvestPlus will work with Ministry of Agriculture extension staff, where available, and select and identify other partners, including sub-contracts with NGOs, farmer associations and cooperatives working in the target areas. HarvestPlus will support the Ministry of Agriculture and partners to manage the dissemination, register growers, cultivate demonstration plots, and monitor performance and address issues that may arise. Extension staff in government and partner organizations are trained in dissemination, pest and disease control, and agronomic and nutrition advantages of the biofortified crops. Once training is complete the extension staff, under the supervision of HarvestPlus will work in the targeted communities sensitizing farmers to the biofortified crops, establishing demonstration plots, building farmer capacity through farmer field schools (or other modalities) and training days, and disseminating new planting materials to farmers. HarvestPlus and its partners also use Participatory Varietal Selection (PVS) by farmers, enabling farmers to pick the varieties most suitable for their own needs. This is also a critical gender element given male and female farmers often have different preferences for crop varietal traits based on their uses of the crop. Under the ongoing supervision of HarvestPlus, extension workers are active in the target communities for at least two growing seasons following dissemination and continue to build farmer capacity in terms of pest and disease management, and maximization of their yields. Farmers copy other farmers and as farmers see the agronomic success with the biofortified varieties of other farmers they often ask Ministry of Agriculture extension workers or partner NGOs for access to the new varieties. Given cassava is

[13] For example, the biofortified beans must perform well in acid soils, with low soil fertility and be resistant to angular leaf spot, all common in Eastern DRC where beans are most commonly grown.

[14] Seeds are subject to quality control standards set by SENASEM to ensure farmers now what they are buying. INERA produces the foundation, breeder, and basic seeds for initial dissemination.

[15] Component 1 Pilot of household food production kits for vulnerable children and pregnant and lactating women, and messages around their consumption will be incorporated in community sensitization and information sessions (*causeries*) on infant and young child feeding (IYCF) counseling/messages to all pregnant and lactating women and mothers of children under the age of 5.

disseminated by stems, which have a shorter planting viability, indirect dissemination will also be used. This is a pay-it-forward strategy, where famers are given stems of the biofortified variety and the following year are required to give the same number of stems from their production to three or four additional farmers. A previous survey on this horizontal diffusion method, where initial adopters and the requirement to share planting materials going forward is known in the community, has shown that farmers normally share with 2-3 other farmers. This does not constrain the initial farmer the following season given 10-15 times more cassava will have been grown from the initial stems.

77. 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 maybe done in conjunction with the new community nutrition platforms once established. This method has been successfully used in Uganda using nutrition meetings at community health centers to disseminate Orange Flesh Sweet Potatoes (OFSP). The increased yields of OFSP resulted in men subsequently giving their wives more land to grow the new variety. HarvestPlus will provide messaging in conjunction with PRONANUT for the training of the ReCos in the nutritional advantages of the biofortified varieties, as well as ways to incorporate them in local diets including recipe development and basic processing. The project's monitoring and evaluation system will incorporate the gender disaggregated indicators registering farmer's overall performance that HarvestPlus will establish.

78. HarvestPlus has engaged extensively with PRONANUT, resulting in biofortification's inclusion in the National Nutrition Plan. PRONANUT are invited to HarvestPlus planning and review meetings, where they share their nutrition and health priorities, and participate in all nutrition education and sensitization activities on biofortification[16]. Training activities with PRONANUT, as well as that for ReCos, also focus on other biofortified variety traits that may make them more attractive to women farmers. For example, high iron beans have a much shorter cooking time than the varieties they replace, reducing women's time not only in cooking but also firewood collection, and enabling them to spend more time in child care. Women also control the bean value chain, acting as collectors for excess production from farms, as well as wholesalers and traders across the country. To ensure successful adoption, the project will ensure that work is done with women on basic processing for home and the local market, such as cassava and maize flour and cassava chips, which women both use and sell. This has multiple impacts: 1) it increases nutrient availability locally in commonly purchased products, 2) it increases women's income and potential empowerment, 3) it increases spending on children's goods and more diversified diets.

Sub-component 2.3: Pilots of nutrition-sensitive services for adolescent girls in schools

79. In addition to targeting adolescent girls through community-based services, the education system can be used as a platform to reach them. This sub-component will pilot interventions aimed at improving girls' nutrition status through interventions to reduce anemia prevalence and improve school hygiene in a gender-sensitive fashion. Under this sub-component, 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 pilot will be implemented, the NGOs contracted to identify and monitor the ReCos and support their supervision (see Component 1) will also provide the training for the teaches, procure and deliver commodities, monitor the distribution.

80. The intermittent micronutrient supplementation for adolescent girls will serve as a platform for health and nutrition education sessions. For this pilot, the project will finance the inputs (vitamin A, multiple micronutrients, albendazole/mebendazole for deworming), as well training for teachers.

[16] HarvestPlus is currently establishing its MoU with PRONANUT in South Kivu and Katanga, which will include these activities as well as monitoring

Component 3. Capacity Strengthening and Project Management

Subcomponent 3.1 Capacity Strengthening

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

82. Under the first objective, the project will strengthen frontline health and community workers' capacity to deliver services through pre-service and in-service training and supportive supervision. The project will also finance the capacity of PRONANUT and other relevant programs within the MoH and other relevant line ministries to effectively plan, manage, and monitor programs. Capacity strengthening may include investments in basic equipment, IT infrastructure, additional personnel, as well as in skills training, coaching, and supervision. The project will finance a contract with one or more entities (e.g. large international NGOs) who will provide technical assistance (TA) and delivery training, coaching, and supervision for national staff and 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, procurement and integrity arrangements at different levels of the nutrition service delivery chain, next 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.

83. 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 (e.g., using mobile technology for data collection and reporting at the community and heath facility level) and expanding analytic capacity within national monitoring and evaluation (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 correction. 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.

Subcomponent 3.2 Learning Agenda:

84. Under this sub-component the project will finance will finance a robust learning and innovation agenda. First, the program will include rigorous operational research related to the pilots planned under Components 1 and 2. This will allow to determine whether or not the pilots are effective, scalable, and, if so, what delivery modalities should be used in the subsequent project in the SOP and in other WBG investments and project 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 may include machine learning (e.g. risk-based verification to reduce the cost of RBF[17]), novel methods for child anthropometry, electronic job-aids for facility-based and community-based providers, and other types of innovation. 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 pilots and innovations identified as effective and cost-effective, on in-time course-correction, and on building domestic research capacity in DRC.

85. Third, the project will support as a series of analytical studies which will improve the collective understanding of what 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,

[17] 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.

given that weak governance is identified as one of the three systemic bottlenecks to reducing the burden of stunting. The scope of the study would include: (i) a comprehensive review of the existing legal and institutional framework for service delivery in the sector; (ii) identification of capacity constraints, accountability mechanisms, incentive structures, financial and human resources management of the main actors in the sector; iii) analysis of the nature of accountability relationships between policy makers and service providers; policy makers and service users/citizens; and service providers and users, and how these relationships work in practice; iv) collecting views of service users on the responsiveness of service providers, the quality of services and users' knowledge of their rights and responsibilities; v) analysis of the extent to which service users/citizens have opportunities for participation or expression of voice in service delivery decision that affect them; (vi) review of promising practices in service delivery and opportunities for learning and scaling up such practices. The study will propose a set of actionable recommendations based on the findings which will be used to inform the policy dialogue on how to improve nutrition and reduce stunting.

86. The second study will be informed by the first one and 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.

87. Findings from the analysis of institutional and governance obstacles to improved delivery of nutrition services in DRC will inform also the design of functional reviews of key institutions with a view to optimizing their mandates, organizational structure, HR and performance management for improved service delivery. The functional reviews will be carried out as a collaborative process that engages key internal and external stakeholders in problem definition and the identification of reform options; prioritizes the functions that an agency should provide in line with its mandate and medium-term budget targets; identifies redundancies, overlaps and misalignments in functions, staffing, and the organizational structure; and identifies gains in efficiency and effectiveness from functional and organizational restructuring including cost recovery, contracting in/out and consolidation of services and networks. Recommendations stemming from the functional review and agreed with the Government will be implemented as part of the Subcomponent 3.1 (see above) and as part of the future projects part of the series.

88. 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: i) overall fiscal planning, budget allocation and its execution: comparative analysis between authorized budget provision and funded budget, and funded budget and budget execution; (ii) comparative analysis between allocated budget, its expenditure, and health outcomes/performance by program and geographic location; (iii) budget allocation and expenditure by economic classification: level of detailed recurrent expenditure, in particular the wage bill, and capital expenditure with a comparative analysis with other countries; (iv) financial flows and their management at the central, regional and local levels, including involvement of local structures.

Subcomponent 3.3 Project Management

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

Component 4: Contingent Emergency Response Component (CERC)

90. A no-cost CERC will be included under the proposed project in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

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

Summary of Screening of Environmental and Social Risks and Impacts

A field visit will be conducted during project identification. at this stage, environmental and social risks and impact can be managed during project implementation. However, security issues is some provinces can make the supervision of activities very hard. ESF is new, so Borrower capacity is still very low and will require frequent capacity building session

Note To view the Environmental and Social Risks and Impacts, please refer to the Concept Stage ESRS Document**.**

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