



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

Appraisal Stage | Date Prepared/Updated: 04-May-2018 | Report No: PIDISDSA24181



BASIC INFORMATION

A. Basic Project Data

Country Congo, Democratic Republic of	Project ID P166763	Project Name DRC - Gender Based Violence Prevention and Response Project	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 07-May-2018	Estimated Board Date 28-Jun-2018	Practice Area (Lead) Social, Urban, Rural and Resilience Global Practice
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Finance	Implementing Agency Fonds Social Democratic Republic of Congo	

Proposed Development Objective(s)

The objectives of the Project are to increase in targeted Health Zones: (i) the participation in Gender-Based Violence (GBV) prevention programs; (ii) the utilization of multi-sectoral response services for survivors of GBV; and (iii) in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency .

Components

- Gender-Based Violence prevention and integrated support for survivors at community level
- Gender-Based Violence Response
- Support to Policy Development, Project Management and Monitoring and Evaluation
- Contingency Emergency Response Component

The processing of this project is applying the policy requirements exceptions for situations of urgent need of assistance or capacity constraints that are outlined in OP 10.00, paragraph 12.

Yes

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	100.00
Total Financing	100.00
of which IBRD/IDA	100.00
Financing Gap	0.00



DETAILS

World Bank Group Financing

International Development Association (IDA)	100.00
IDA Grant	100.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

- 1. Political instability, poor governance, and weak state institutions are the main factors that explain persistent poverty in the Democratic Republic of Congo (DRC).** DRC is a post-conflict and fragile country with a rapidly growing population. The turbulent history of the country, along with weak governance have limited the ability of successive governments to establish stable institutions and to improve the living standards of the population. Macroeconomic performance improved until mid-2015 and was marked by strong economic growth, ranging from 5.6 to 6.2 percent between 2002 and 2008. However, growth failed to translate into significant reduction in poverty and inequality. While the Gini coefficient improved slightly from 38 in 2005 to 35 in 2012, large portions of the population remain trapped in extreme poverty. High rates of youth unemployment and underemployment in the country are a key indicator that the growth of recent years has not been inclusive. Poverty in the DRC remains pervasive, and above the Sub-Saharan Africa (SSA) average. While the proportion of people living below the poverty line declined from 69.3 percent to 64 percent between 2005 and 2012, the absolute number of poor increased by 7 million during that same period. Almost 14 per cent or one out of six people living in extreme poverty in SSA live in the DRC.¹
- 2. DRC ranked 176th out of 188 countries ² in the 2016 Gender Inequality Index. This index benchmarks national gender gaps using economic, political, education, and health criteria.** Important gains were made in areas such as health and education, and in terms of legislation that addresses gender equality. However, persistent socio-cultural disparities restrict women’s engagement in social and economic life as well as in public decision-making. Women’s participation in politics is limited and they currently occupy about eight percent of parliamentary seats in both the National Assembly and in the Senate (compared with an average of 20.6 percent among low-income countries). The new Family Code (2016) removed several discriminatory provisions in terms of access to land and resources for women and increased the minimum age of marriage for girls from 15 to 18. However, much remains to be done to ensure such legislation is enforced. Women

¹ World Bank (2017), DRC Systematic Country Diagnosis

² With a score of 0.663



continue to face unequal treatment with respect to labor force participation, land tenure and property ownership. The percentage of female workers was reported at 19 percent in the 2013 World Bank Enterprise Survey Results (notably lower than the average 34 percent in surveyed countries).³ While women make up the majority of workers in the agricultural sector (53 percent)⁴ their access to land and credit remains constrained limiting productivity.

3. **Gender-Based Violence prevalence is widespread with significant regional variations.** In 2014, rates of IPV varied from 71 percent in Kasai Occidental to 34 percent in North Kivu. Women with large families are at particular risk of violence⁵. The percentage of women (15-49) reporting having ever experienced physical violence was 60.6 for those with five to six children compared to 37.5 for women with no children. Women with no formal schooling and those who have not completed primary education are similarly at higher risk of experiencing physical violence. Among women having completed secondary education the percentage reporting having ever experienced physical violence was 38.1 compared to 51.5 for those with no formal schooling and 57.3 percent for those who had not completed primary education.⁶
4. **Younger women and adolescent girls constitute a particularly vulnerable group. Overall, younger women are more likely to experience physical violence** (See Figure 2 below) with the exception of those in the 15-19 age group. The national teenage pregnancy rate was 27 percent⁷. Adolescent fertility is nearly three times higher among young women living in the poorest households (42 percent) than among those living in the wealthiest households (15 percent). Overall, 37 percent of women aged 20-24 were married before 18, compared to 6 percent of men in the same age group. Early marriage constitutes an important risk factor for violence with women married before the age of 15 being twice as likely to experience IPV than those married after the age of 25.

Situations of Urgent Need of Assistance

5. **The rationale for processing this operation using the flexibility provided under paragraph 12 of the Investment Project Financing Policy** is that the Democratic Republic of Congo is included in the *Harmonized List of Fragile Situations*. As such, it is deemed by the Bank to experience capacity constraints because of fragility. The proposed project is expected to contribute to the broader goal of reducing vulnerability of women and girls to Gender Based Violence in DRC. Interventions will focus specifically in Provinces where high rates of GBV and high levels of acceptability of GBV have been further exacerbated by ongoing insecurity and violence.
6. **The DRC is emerging from a long period of conflict which has had a devastating impact on institutions, the economy, and the social fabric.** The Congo Wars of 1996-2002 resulted in massive displacement and loss of life⁸. The Sun City Agreement followed by the 2003 transitional government and two rounds of elections placed the country on a path to recovery. However, real GDP per capita in 2016 was only 40 percent of the

³ World Bank website: <https://data.worldbank.org/data-catalog/enterprise-surveys>. World Bank Enterprise Survey Results collect and analyze firm level data from 139 countries.

⁴ 1-2-3 Survey on Employment, the Informal Sector, and Household Living Conditions (2013-2014)

⁵ Overall fertility rates in DRC were 6.6 children per women in 2014 (DHS). Rates vary from from 5.4 in urban areas to 7.3 in rural areas and by province (from 4.2 in Kinshasa to 8.2 in Kasai Occidental).

⁶ Demographic and Health Survey (DHS), 2014.

⁷ For women aged 15 to 19

⁸ More than 3.5 million people have died since the war began in 1996 with nearly half being children under 5 years of age - World Bank (2017), DRC Systematic Country Diagnosis



1970 level. New elections were expected to take place in 2016. When that did not occur, an agreement was reached to postpone elections. An interim government has been in place since December 2016. The security situation has deteriorated due to the political instability generated by non-recognition of the agreement by part of the opposition and lack of clarity about new elections. The conflict in the east and in the Central Region of the country continues to generate high levels of displacement and humanitarian needs. As of February 2018, the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) estimates that there are more than 4.5 million displaced persons and refugees in the DRC. Over 13 million people are estimated to be in need of humanitarian assistance in 2018. Provinces considered to be the most affected by the humanitarian crisis are Kasai, South Kivu, Maniema, Tanganyika, Haut-Katanga (Pweto Territory) and Haut-Lomami Province (Malemba-Nkulu) territory. The humanitarian situation is also considered of concern in North Kivu⁹. In October 2017, the Inter Agency Standing Committee (IASC)¹⁰ declared system wide Level 3 emergency response (L3) in the Kasai Region, Tanganyika and South Kivu Provinces in DRC.¹¹

- 7. Conflict-related sexual and gender based violence is a pronounced feature of ongoing violence in DRC.** The high prevalence rates of GBV in the DRC are linked to underlying social and cultural norms and values that perpetuate power imbalances between men and women. These are often further exacerbated in the context of conflict.¹² This is especially true in the Eastern Provinces and more recently in Kasai and Tanganyika. Beyond cases of sexual violence linked to conflict, increased food insecurity associated with the humanitarian crisis is also likely to further exacerbate the risk of Sexual Exploitation and Abuse (SEA).¹³¹⁴

⁹ UNOCHA Humanitarian Response Plan, December 2017

¹⁰ Inter Agency Standing Committee (IASC) is the primary mechanism for inter-agency coordination of humanitarian assistance, involving UN and non-UN humanitarian partners.

¹¹ The L3 activation is a tool triggered to ensure that the right capacities are in place to meet needs and save lives, and prompts improved coordination and mobilization of additional funding.

¹² World Bank (2017), Gender inputs to the Country Partnership Framework

¹³ In 2017, over 26 000 new cases of sexual violence were identified in areas of the country affected by the humanitarian crisis (31% of which in Nord-Kivu). UNOCHA Humanitarian Response Plan, December 2017

¹⁴ DRC Sexual and Gender Based Violence Sub-Cluster, August 2017



Sectoral and Institutional Context

- 8. The Government of the DRC recognizes the burden that gender inequality, including GBV, places on social and economic development.** Its commitment to addressing gender inequality and GBV is reflected in the recent progress made in strengthening the legal and policy framework to address GBV as follows:
- a. A Comprehensive Strategy on Combating Sexual Violence in the Democratic Republic of Congo was developed by the Government of the DRC in coordination with the United Nations Organization Stabilization Mission in the DRC (MONUSCO) in April 2009.
 - b. A National Strategy on Combating Gender Based Violence (and related five-year National Action Plan) were subsequently put in place in November 2019 under the leadership of the Ministry of Gender, Family and Children (MGFC). Both the National Strategy and Action Plan are currently being updated with the final version of the approved documents expected to be available before the end of 2018. The National Strategy on Combating Gender Based Violence (NSCGBV) sets out a framework for the implementation of comprehensive GBV prevention measures and provision of multi-sectoral support services for survivors in the context of continued instability and conflict. It also outlines the role of various line agencies, civil society organizations and humanitarian actors at local and national levels. The NSCGBV lays out the following five areas of intervention: (i) protection from and prevention of GBV; (ii) ending impunity; (iii) security sector reform; (iv) assistance for victims of violence; and (v) data collection and mapping. The NSCGBV further highlights the challenges in implementing GBV prevention and response programs in a context of continued insecurity and instability and lays out key gaps in terms of service provision as well as challenges in coordinating the response to GBV.
- 9. The NSCGBV is complemented by a key set of legal instruments including the ratification of major international and regional agreements¹⁵ to promote gender equality.** This includes the Constitution (2006), The Law Against Sexual Violence (2006), and the Child Protection Act (2008). The new Family Code (2016) removed a variety of discriminatory provisions and paved the way for improving gender equality. The new Code allows married women independent access to finance, property rights, and entrepreneurship and expands the working age and professional options among women. It removes earlier requirements that a married woman seek the authorization of her husband to undertake certain business activities such as registering a company, opening a bank account, and seeking a loan. It further increases the minimum age of marriage for girls from 15 to 18.

¹⁵ DRC is party to: (i) The UN Convention on the Elimination of all Forms of Discrimination Against Women; (ii) The UN Convention of the Rights of Child and African Charter on the Rights and Welfare of the Child; (iii) The Declaration on Elimination of Violence Against Women (1993); (iv) UN Security Council Resolution 1325 on Women, Peace and Security (2000) and UN Security Council Resolution 1820 on sexual violence in situations of armed conflict (2008), (v) the African Charter on Human and Peoples' Rights and The Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol) (2003); (vi) The Protocol on the Prevention and Suppression of Sexual Violence against Women and Children of the International Conference on the Great Lakes Region (2006); (vii) the Goma Declaration on Eradicating Sexual violence & ending impunity in the Great Lakes Region (2008); and (viii) the Kampala Declaration on ending impunity (2003).



Table 1 - Mandates of key Governmental institutions and other stakeholders in the implementation of the NSCGBV

Institution	Mandate
Ministry of Gender, Family and Children	Leads a coordinated prevention and response approach to GBV, establishes coordination mechanisms and is responsible for improving data collection and management.
Ministry of Health	Provides appropriate medical services (including emergency services), builds capacity of health sector staff and establishes forensic services.
Ministry of Justice	Establishes mechanisms for procuring justice for survivors of GBV with a focus on putting in place fast-track procedures and is responsible for building capacity of judicial officers to handle GBV cases. The NPAGBV highlights the development of appropriate criminal legislation as important gap/area of focus.
Ministry of Interior and Ministry of Defense	Provides security, establishes mechanisms to ensure perpetrators are apprehended. Responsible for the exclusion of perpetrators from the army. Awareness raising among security forces on GBV
Civil Society Organizations, Development Partners (including UN Agencies)	Play a key role in multi-sectoral service delivery (including in socio-economic reintegration) and in emergency support on GBV

10. National coordination mechanisms with strong participation by development partners and humanitarian actors have been in place to oversee the emergency interventions on GBV prevention and response. These are acknowledged/reflected in the NSCGBV, namely the Inter-Ministerial Working Group on Sexual and Gender Based Violence (SGBV), coordinated by the MGFC. The platform receives financial and technical assistance through the UN Joint Program. Significant challenges in terms of MGFC’s capacity to effectively coordinate GBV programming were identified during the preparation process.

11. Given the context of persistent instability, conflict and weak institutions there are significant gaps in the implementation of legal and policy instruments described above. Access to prevention programs and basic services for survivors remains extremely limited and dependent on external funding. Available service provision is almost exclusively linked to the implementation of humanitarian programs. While additional support has recently been channeled to the Kasai, GBV programming in Eastern DRC has been significantly reduced over the last two years with limited interventions now ongoing in both North and South Kivu as Development Partners (DP) focus shifts to other humanitarian situations.

12. Limited availability and reliability of services, coupled with significant social and cultural barriers to reporting instances of GBV is reflected in service seeking behavior by survivors. Only approximately a third of women who experienced physical or sexual violence seeks support. Women were less likely to seek help if they experienced sexual violence only, with just over a quarter of survivors of sexual violence seeking help. Most women who sought support looked to their own or their partners’ family, or a neighbor or friend for assistance. Only a small percentage of women experiencing violence sought assistance from formal service providers such as the police or medical professionals¹⁶

¹⁶ Help sought disaggregated by violence type and province is presented in the DRC DHS report table A-18.15



C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

13. Gender-Based Violence prevention programs require a sustained investment over a long period of time to achieve impacts in terms of reduction in the incidence of GBV. Social norms and values that may condone GBV change slowly. The project will, therefore contribute to the longer-term goal of reducing GBV prevalence focusing on the following set of intermediate level outcomes.
14. The objectives of the Project are to increase in Targeted Health Zones: (i) the participation in Gender-Based Violence (“GBV”) prevention programs; (ii) the utilization of multi-sectoral response services for survivors of GBV; and (iii) in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

Key Results

15. **Project beneficiaries will primarily include vulnerable women and girls at risk of GBV as well as survivors of GBV. Men and boys in targeted health zones will also benefit from project activities** as survivors of GBV, as family members of survivors and as key opinion leaders and community members promoting behavior change through GBV prevention programs.
16. **The institutional strengthening elements of the program will be national in scope and will target key line ministries and institutions:** Fonds Social DRC, Ministry of Health staff, Ministry of Gender and the Office of the Presidential Representative for Gender-Based Violence. These interventions will focus on the: (i) in service training for front line staff in the health sector, (ii) capacity building in GBV data collection, management and analysis; and (iii) the development of a basic package of community level prevention and response services for GBV.
17. **Project resources funding: (i) community level GBV prevention and integrated support for survivors as well as; (ii) the strengthening of first response services will be concentrated in the health zones outlined in Table 2 below with an overall population of 13.5 million people.** Health Zones were selected in North and South Kivu, Maniema and Tanganyika Provinces. The proposed project will focus its interventions on Provinces where underlying high level of GBV and acceptability of GBV have been exacerbated by growing insecurity¹⁷. The project will therefore focus initially on consolidating the gains made in North and South Kivu, building on the lessons-learned under the Great Lakes Emergency Sexual and Gender Based Violence and Women’s Health Project (P147489 – GL GBV). The project will subsequently expand activities (from Year 2 of project implementation) to Tanganyika and Maniema. Given the rapidly changing security situation in Tanganyika, the project will further validate the selection of Health Zones during Year 1 of project implementation to confirm accessibility of the target areas.
18. **The Kasai Famine Risk Reduction Project (P162517) currently under preparation will include targeted interventions on GBV prevention and response.** The current project will therefore not target the Kasai Province but will include the development of a targeting and roll-strategy for GBV programming in the Kasai.

¹⁷ In line with the 2018 UNOCHA Humanitarian Situation Analysis



Table 2: Target areas for community level prevention and response services

Targeted Health Zones			
South Kivu	North Kivu	Maniema	Tanganyika
1. Fizi	1. Binza	1. Kasongo	1. Kalemie
2. Kaniola	2. Kayna	2. Kibombo	2. Niemba
3. Kimbi/Lulenge	3. Mabalako	3. Kabambare	3. Nyunzu
4. Shabunda	4. Alimbongo	4. Kunda	4. Manono
5. Lulingu	5. Lubero	5. Lusangi	5. Moba
6. Minova	6. Kalunguta	6. Tunda	
7. Lemera	7. Mutwanga	7. Samba	
8. Kalonge	8. Nyirangongo	8. Saramabila	
9. Mulungu	9. Rwanguba		
10. Kitutu	10. Ruthchuru		
11. Kalole	11. Kirotche		
12. Haut plateau	12. Masisi		
	13. Mwesso		

19. Intensive community level GBV prevention and community referral interventions will be undertaken in selected *Aires de Santé* [catchment area for each health center with a population of between 5,000 and 7,000 people]. Based on average population estimates, awareness raising interventions at Health Zone level are expected to reach at least 785,000 people (of which approximately 400,000 women). This will include more intensive gender transformative training with community and opinions leaders as well as life-skills and livelihood interventions targeting women and men. Criteria for selection of benefiting Aires de Santé will be developed and included in the Project’s Operations Manual (POM). A rapid assessment of targeted Health Zones will be undertaken and shall form the basis for selection of the *Aires de Santé*. The final proposed list of *Aires de Santé* will be shared with the World Bank for approval within three months of project effectiveness.

20. Key indicators to measure progress towards the PDO will be as follows:

- Numbers of direct project beneficiaries (percentage of women);
- Percentage reported decrease in accepting attitudes towards GBV in targeted Health Zones;
- Percentage increase in reported cases who receive access to multidisciplinary services, defined as at least two of the following: (medical, psychosocial, security, legal support and livelihoods support);
- Percentage of eligible reported GBV¹⁸ cases who receive Post-Exposure Prophylaxis (PEP) Treatment within 72 hours;
- Percentage of implementing partners providing services to GBV survivors in line with defined quality standards.

¹⁸ Eligible GBV cases for PEP (provision of antiretroviral medicine following potential exposure to HIV) are usually cases of rape that are reported at a service provider within 72 hours of the incident.



D. Project Description

21. In line with global best practices and based on the lessons-learned during the implementation of the GL GBV, the project would focus on:

- i. Preventing GBV and improving the quality of multi-sectoral response services for survivors in targeted Provinces.** Global evidence indicates that effective prevention programs encourage GBV survivors to come forward and seek services. It is therefore important that awareness raising and gender transformative training be accompanied by improvements in the availability and quality of response services. The proposed project would build on the experience of implementing the GL GBV and increase the level of resources allocated to prevention activities as well as livelihood interventions;
- ii. Working primarily through partnerships with civil society organizations for service delivery while including an element of training and capacity building of the health sector for GBV response.** This approach acknowledges the challenges of providing quality services at community level given capacity constraints and growing instability in some of the areas potentially targeted. Challenges include inadequate staffing levels at the level of health facilities, increased difficulties in accessing services giving the worsening security situation, significant case backlog and “systems failures” in the criminal justice system and in terms of the services provided by security forces.

22. Gender-Based Violence prevention programs require a sustained investment over a long period of time to achieve impacts in terms of reduction of GBV incidence. The social norms and values that may condone GBV at community change slowly. By focusing on whole of community awareness raising approaches, gender-transformative training and livelihood interventions aimed at households and individual and combining the prevention approaches with a set of services for survivors who come forward, the project aims to have an impact in terms of changes in attitudes towards GBV, greater decision-making power for women at household level and higher rates of service seeking behavior by survivors of GBV.

Component 1 - Gender-Based Violence prevention and integrated support for survivors at community level (US\$53.8 million)

23. In order to address the underlying causes of GBV and to tackle the social norms and values that may condone GBV, the project will invest significantly in awareness raising and behavior change communication at individual, interpersonal and community level. ¹⁹The approach to prevention will be based on rigorously evaluated models which have shown to be effective in the context of the DRC or in comparable contexts. Particular attention will be paid to taking into account the context of insecurity and instability under which the project will operate.

24. A detailed protocol for individual, interpersonal and community-based prevention and referral activities will be developed by the Fonds Social DRC (FSDRC) by project effectiveness. The protocol will include the

¹⁹ Over 50% of project resources will support the implementation of prevention activities



selection of Aire de Santé to be targeted within the targeted Health Zones. The protocol will be used as the basis for selecting Non-Governmental Organizations (NGOs) who will implement prevention activities as well as community level response interventions and referral to more specialized services. In order to streamline implementation arrangements one Umbrella NGO will be selected per Province for the implementation of Component 1. The umbrella NGO will in turn establish partnerships and sub-contracting arrangements with local NGOs and Community Based Organizations (CBOs) where relevant. The structured transfer of technical expertise to CBOs is expected to contribute to the sustainability of the prevention and community referral approach put in place.

25. The implementation of GBV prevention activities at community level will build on a critical mass of qualified and reputable community activists including para-legals and para-social workers, teachers, religious leaders, mobilizers, community health workers (*relais communautaires*) and members of women's community-based organizations. This pool of activists will receive training on community awareness raising and behavior change interventions as well as on the referral of survivors. Additionally, to ensure that activists will share a core set of knowledge, attitudes and beliefs that promote women's equality, they will undergo in-depth gender transformative training that will provide them with the tools to challenge the social norms that condone violence against women and girls. This is expected to contribute to providing GBV survivors with a set of trusted individuals within the community to whom they can report violence and through whom they can access services. This approach will aim to broaden the current set of community mobilizers and focal points trained under the GL GBV project as first responders to the needs of survivors.

- i. *Community mobilization and promotion of behavior change:* Building on the training and mentoring of the pool of community activists mentioned above, the project will implement a community mobilization intervention targeting opinion leaders, community based organizations as well as older men and women who play a key role in perpetuating accepting attitudes towards GBV. Male engagement in this process will aim to communicate that violence is an issue that needs solving at the community level rather than a private matter or a 'women's issue'.
- ii. *Livelihood interventions:* Building on the experience of the GL GBV Project, the project will support the establishment of Village Savings and Loans Associations (VSLAs). The approach will focus initially on supporting women to build savings. Dedicated technical support will be provided by the Umbrella NGO to group formation. As VSLAs are consolidated, those that have the demonstrated capacity will be further supported with business development skills. Community-based organizations will also be supported to organize small-scale income-generating activities. These activities will be selected through a market analysis of economically viable options in each Health Zone and will provide an opportunity for referral of survivors.
- iii. *Gender transformative training:* Gender transformative training will be conducted to address gender inequality at the household level. This will include a focus on communication and conflict management skills. In addition, community facilitators will be selected among the pool of trained activists to implement behavior change activities with men focusing on positive masculinities.

26. In addition, the project will support the establishment of safe spaces for women and girls at community level: The GL GBV Project has supported a network of CBOs in North and South Kivu. These CBOs provide a key point of entry for survivors of violence in terms of access to psycho-social support and referral to



additional services. The project will broaden the scope of activities by CBOs and focus on the establishment of safe spaces at community level. These spaces will be used for awareness raising and information sessions (including on the availability of services for survivors of GBV), life-skills activities but also informal gatherings and implementation of livelihood activities. Activities implemented in the safe spaces will aim to create an environment of trust around service delivery at community level and encourage service seeking. This will be done by ensuring that services for survivors take place in a space that also offers other activities targeting women and girls more broadly (so that accessing services is not stigmatizing for survivors).

27. Community safe spaces will establish a key link between prevention activities and community referrals and access to services. In addition to the pool of activists highlighted above, focal points selected among CBO members will receive more in-depth training on the provision of psychosocial support and referral to additional services. The basic package of services and referrals provided at community level will be as follows:

- (i) Provision of case management, psychosocial support and mental health care using the Narrative Exposure Therapy (NET) approach provided by trained Focal Points at CBO level;
- (ii) Referral to specialized health services;
- (iii) Provision of initial legal advice by paralegals trained at CBO level (with more complex cases referred to specialized staff at the level of Umbrella NGO);
- (iv) Referral to safety and security services; and
- (v) Referral to livelihood activities.

28. This component will support the provision of mental health care to survivors of GBV through community-based organizations. In coordination with the National Mental Health Program at Ministry of Health (MoH) level, the project will invest in the implementation of a training module for the provision of mental health care at the community level based on the approaches used in the GL GBV project. Training will be provided to selected NGO / CBO staff on the use of NET piloted as part of the GL GBV project. The Fonds Social will contract VIVO International for the provision of these specialized services.

29. Finally, acknowledging the fact that project implementation will take place in a volatile security context, component 1 will include resources to support the implementation of innovative prevention programs. This will allow the project to be flexible and respond to the potential need to target specific groups through its prevention component. This could include: (i) behavior change communication interventions with the armed forces using methodologies tested in Eastern DRC; or (ii) targeted activities focusing on highly vulnerable population groups such as internally displaced communities, or youth.

Component 2 – Response to Gender Based Violence (US\$ 27.5 million)

30. Complementing GBV prevention activities and the immediate support for groups most at risk of GBV, put in place at community level, the project will also strengthen front-line service provision for survivors with a strong focus on improving: (i) multi-sectoral response for the most complex cases and; (ii) the quality of medical services. Building on the experience of the GL GBV project and the challenges in operationalizing activities with the health sector, the project will strengthen service provision through integrated Centers of Excellence (CoE) with a focus on outreach activities and supporting de-centralized One Stop Centers at Health



Zone level. The project will also invest in targeted capacity building of the health sector to bring medical services for survivors of GBV closer to communities.

- 31. Sub-Component 2A – Support for existing integrated Centers of Excellence:** This sub-component will support the specialized referral facilities: (i) Panzi Hospital and Foundation in South Kivu; and (ii) Heal Africa in North Kivu. Services provided by these facilities will include: (a) medical care, including for the most complex cases; (b) forensic evidence collection, analysis and training; (c) legal services; (d) facility based counseling; (e) support services for survivors and their children rejected by families; (f) mobile clinics in remote areas to reach the most vulnerable groups; (g) training and capacity building for health providers on performing complex surgeries, compiling forensic evidence, and providing high quality medical and mental health services; and (h) operational research on GBV (where relevant). Through the training provided by the CoEs the project will also aim to strengthen forensic response capacity among Health Care Providers (HCP). Forensic training will focus on HCP, police and the judiciary with a focus: (i) handling of forensic evidence, (ii) preparing for hearings and; (iii) the filling of police and medico-legal forms.
- 32.** In addition to the activities highlighted above, the project will support the provision of specialized services in decentralized One Stop Centers currently managed by Panzi Foundation and Heal Africa as well as outreach activities in hard to reach Health Zones targeted by the project. Mobile clinics and outreach services will also be supported in Maniema (Heal Africa) and Tanganyika (Panzi Hospital and Foundation). A detailed FM assessment of both centers was carried out during preparation and the summary of key findings is included in Annex 2.
- 33. Sub-Component 2B – Strengthening the Health Sector Response to GBV.** The main objective of this sub-Component will be to strengthen the health sector responsiveness to GBV. Key activities under this sub-component will be as follows:
- 34. *Training of HCPs, including community health workers in targeted health areas, in response to GBV.*** Training will include: (a) GBV case screening, medical case management, including the correct collection of forensic evidence; (b) updating and disseminating management protocols and guidance notes for practitioners (job aides) developed specifically for the health system; and (c) finally, this subcomponent will finance small rehabilitations of health facilities (painting, small internal repairs and provision of screens or partitions as well as secure cabinets) to create adequate conditions of consultation where they currently do not exist. In this context, the project will finance internal repairs and rehabilitation of these facilities where relevant without extending the footprint of existing hospitals or health centers.
- 35. *Support for service provision at hospital and health center level.*** The project will build on the lessons-learned during the implementation of the GL GBV project in terms of the coordination with the Performance Based Financing (PBF) approach currently in place in North and South Kivu²⁰. Considering the challenges observed in the implementation of the GL GBV project in North and South Kivu and the adopt the following approach:

 - i. Lump sum payments to Health Structures and Provincial Directorates of Health (PDH) in North Kivu, South Kivu and Tanganyika for quality services provided to survivors of violence. Such payments will be made against an assessment of the quality of the services provided. Payment

²⁰ with IDA financing through the Health Systems Strengthening Project (PDSS)



will be linked to quality and not the numbers of survivors assisted to avoid creating perverse incentives that may result in an over-reporting of cases;

- j. The assessments of the quality of the services provided by health centers will be carried out by the PDH and Health Zone Supervision teams using the evaluation quality grids put in place by the PBF;
- k. Resources will be allocated to the PDH for the supervision and validation of the quality of the services. This quality assessment will be done with relevant experts from the National Reproductive Health and National Mental Health Programs and in coordination with the Umbrella NGO responsible for the referral of cases (in order to ensure the triangulation of the information);
- l. Resources will be managed directly by the FSDRC and funding allocated will be included in the “Single Contract” currently in place in North and South Kivu to ensure that all amounts for supervision are captured at Provincial level and shared with partners providing funding to the PDH.

36. *In Maniema, the current project will aim align itself with the PBF approach and focus on the same eight Health Zones currently covered by the PDSS.* The quality assessment tools for the PBF will be updated to take into account the medical care of survivors. Certified evaluators among PDH Health Zone supervision teams will be trained on the use of this updated quality assessment grid. Service providers will be oriented on the type and standards of care required by survivors of GBV. An assessment of PBF readiness to include payment for services provided to survivors of GBV will be undertaken during Year 1 of project implementation. Based on the results of this assessment resources will either be programed through the PBF mechanism for service provision or will be allocated following the mechanism also used in the remaining provinces and described in paragraph 38 above.

37. *Procurement of emergency medication for survivors of GBV will be done directly through UNFPA.* This will include Post Exposure Prophylaxis (PEP), emergency contraception and treatment for Sexually Transmitted Diseases (STIs). Distribution will be carried out through the Regional Distribution Centers (CDRs) covering the targeted Provinces where these are functional: Asrames (North Kivu), Cedmeta (Tanganika), Cemema (Maniema), and DCMP / 8th CEPAC (South Kivu). An assessment of the functionality of the CDRs in Maniema and Tanganyika will be carried out within six month of project effectiveness and alternative approaches to distribution of these supplies developed where necessary. The FSRDC will sign contracts with these different CDRs to cover the costs of stock management and drug distribution.

Component 3 – Support to Policy Development, Project Management and Monitoring and Evaluation (US\$18.7 million)

Sub-Component 3 A – Support to Policy Development and Capacity Building

38. The project will aim to strengthen coordination mechanisms for GBV programming. In addition to technical coordination meetings chaired by FSRDC at National, Provincial and Health Zone level, the project will participate regularly in the GBV Inter-Ministerial Coordination group. This will aim to ensure that project activities are aligned with the efforts of other Development Partners and that information on project results are reflected in the GBV national monitoring system managed by the Ministry of Gender, Family and Children.



39. The project will also support the efforts by the Ministry of Gender, Family and Children and the Office of the Presidential Representative for GBV to safely and ethically map GBV programming interventions. In that regard, the project will conduct an assessment of the design and implementation of the existing national database of GBV incidents compared to global standards of good practice in GBV information management. The results of this assessment will be shared with the development partners network, and will determine the level of support that the project can provide for the national GBV database, with particular emphasis on measures that will further align it with global best practices.
40. This sub-component will fund the dissemination of the 2016 Family Code and Law on Sexual Violence at community level using the CBO and community activist platform put in place under Component 1. The project will further support the dissemination of the Victim Compensation Act (once approved by Parliament). In addition, the project will convene key actors engaged in the revision of National Medico-Legal certificate for the finalization of the certificate and guidelines on its utilization (in coordination with the Development Partners Group on GBV). The establishment of a simplified, user-friendly certificate will play a key role in easing access to forensic services by survivors of GBV.
41. Finally, this sub-component will support the development of a targeting and roll-out strategy for GBV programming for the Kasai and Equateur Provinces. (Additional details are provided in Annex I).

Sub- Component 3 B – Project Management

42. *This sub- component will cover overall project management costs to ensure efficient and effective coordination, fiduciary management at national and local levels. This will be done through dedicated support to the implementing agencies, institutional strengthening and purchase of critical equipment. This component will include support for strengthening existing coordination structures, the sustainability of project activities and the training of critical staff at national and sub-national levels.*
43. Given the substantial fiduciary risk involved in project implementation, component 3 will cover the costs of a third party Financial Management Agent (FMA). The ToRs for the FMA were completed during project preparation and were considered acceptable to the WB. The bidding process is expected to start prior to negotiations. The FMA will allow the project to closely monitor transactions related to Components 1 and 2.2 where fiduciary risk is considered high.

Sub-Component 3C – Monitoring and Evaluation

44. *This sub-component will ensure effective data collection on the implementation of key project activities. The project will fund the upgrading and roll-out of the Management Information System currently being used by the GL GBV project²¹. In addition, the project will include a third-party process evaluation to provide feedback on the quality of services rendered. The use of this methodology is expected to allow the FSDRC to make periodic adjustments to implementation strategies and put in place corrective action as needed.*
45. *In addition, this sub-component will fund an impact evaluation of mental health activities. This will be in line with NET impact assessment, initiated as part of the GL GBV project. This impact evaluation will be conducted by researchers from the World Bank's Africa Gender Innovation Lab. The purpose of this study is*

²¹ Based on the GBV Information Management System.



to evaluate the impact of NET on the mental health, psychosocial well-being, and economic empowerment of SGBV survivors with symptoms of PTSD. (Additional details are provided in Annex I).

Component 4: Contingency Emergency Response Component (CERC) (US\$ 0 million)

46. This component will provide immediate response in the event of an eligible crisis or emergency. This component is a “zero-dollar” Contingency and Emergency Response Component. In the case of an adverse event that causes a major disaster, the Government of DRC may request the Bank for the rapid reallocation of grant proceeds from other components in order to provide preparedness and rapid response support to disaster, emergency and/or catastrophic events, as needed. The funds flow and disbursement arrangements will be determined at the time of activation of the contingency component and will require an amendment to the Project’s Operations Manual (POM).

E. Implementation

Institutional and Implementation Arrangements

- 47. The project will be implemented by the Fonds Social DRC (FSDRC) and in close technical partnership with the Ministry of Health (MoH).** The Fonds Social will be responsible for overall project management and consolidation of Annual Work Programs and Budgets. A single Designated Account (DA) will be established at the level of the FS with Provincial Sub-Accounts in place for all targeted Provinces. The FSDRC will procure specialized service providers for the implementation of Component 1 and engage VIVO International for the provision of mental health services using the NET approach. The FS will further sign contracts with the Integrated Centers of Excellence (Panzi Foundation and Hospital and Heal Africa) for the implementation of Component 2A.
- 48. To streamline implementation arrangements for Component 2B and building on the lessons-learned from implementation in North and South Kivu, the FS DRC will establish Memoranda of Understanding with Provincial Directorates (PDH) of Health.** The Fonds Social will be responsible for payments made to Health Facilities (Hospitals and Health Centers), PDH and Health Zones Supervision teams (HZS) in North Kivu, South Kivu and Tanganyika. In Maniema the project will aim align with the PBF approach and target the same eight HZ currently being supported by the Health Systems Strengthening Project (PDSS). Funds for the provision of services and verification of quality of services may be channeled through the MoH. The FSDRC team will conduct a review of the functionality of the PBF system in Maniema with MoH and agree on whether to follow the approach outlined above for the remaining Provinces or to channel resources through the PBF mechanism (Figures 1 and 2).
- 49. The FS will be responsible for the procurement of emergency supplies through UN Agencies and for establishing contracts with Regional Medication Distribution Centers for the distribution of these supplies in targeted provinces.** The Ministry of Gender and Office of the Presidential Representative for GBV will prepare annual activity plans for the implementation of activities under Component 3A. Payments for supervision and activity costs will be made directly by the FSDRC in line with the agreed activity plans.



Figure 1: Implementation Arrangements (North and South Kivu and Tanganyika)

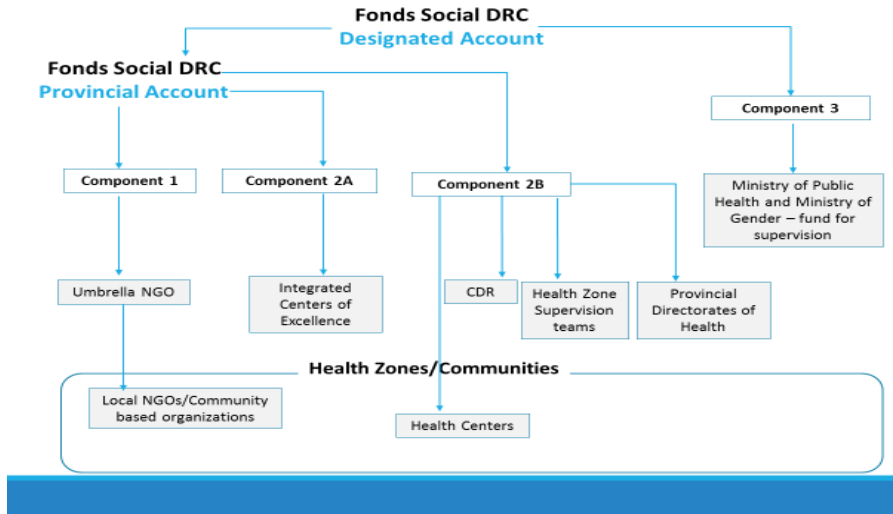
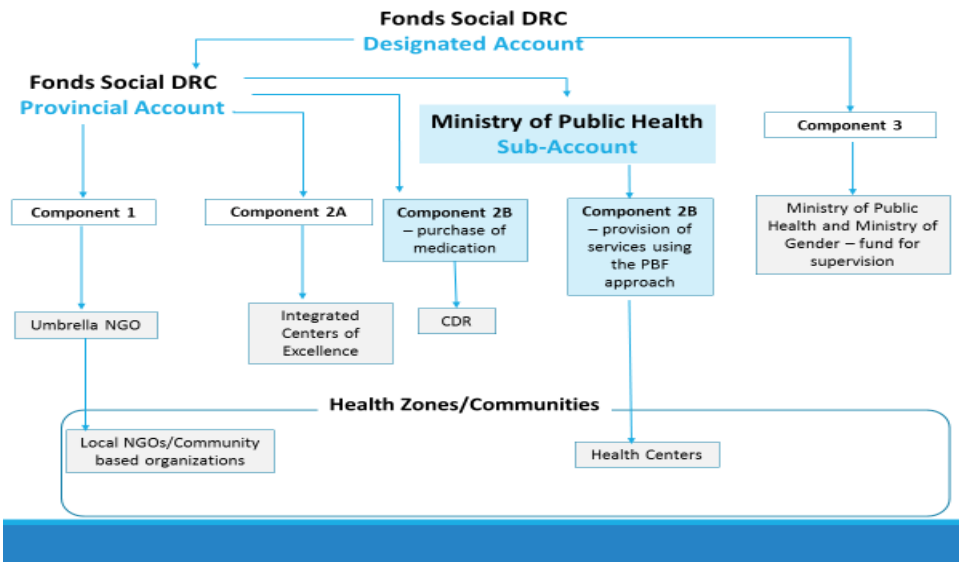


Figure 2: Implementation Arrangements (Maniema)





50. National and Provincial Coordination mechanisms: The project will ensure consistent participation in: (i) the Inter-Ministerial Working Group on GBV chaired by the Ministry of Gender, Family and Children at national level; and (ii) in the Provincial GBV Cluster Coordination meetings. In addition, monthly technical meetings will be held at national and Provincial level with FSDRC, MoH, and specialized service providers. The technical coordination meeting will review critical issues with project implementation and identify concerns/issues with implementation that should be discussed and addressed through the Inter-Ministerial Working Group. The POM will include the detailed description of the functions of participating institutions and local governments.

51. Role of Umbrella NGOs and Integrated Centers of Excellence: The FSDRC shall procure Umbrella NGOs which will be contracted to provide GBV prevention interventions at household and community levels in the areas of: (i) community mobilization, (ii) livelihood support, (iii) establishment of safe spaces; (iv) community based referral and integrated service provision using evidence based GBV prevention and response approaches. VIVO International will be contracted to provide specialized mental health support using the NET approach. The Integrated Centers of Excellence Panzi Foundation and Hospital and Heal Africa will be contracted to provide: (i) medical care, (ii) forensic evidence collection, analysis and training; (iii) legal services; (iv) facility based counseling; (v) support to survivors and their children rejected by families; (vi) mobile clinics; (vii) training and capacity building for health providers; and (ix) conduct operational research on GBV where relevant. Umbrella NGOs and Integrated Centers of Excellence shall submit quarterly progress activity reports to the FSDRC Heads of Field Offices based on their respective work plans and budgets. Umbrella NGOs and Integrated Centers of Excellence shall submit biannual project technical and financial reports to the FSDRC.

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

The project will be implemented in selected "Aires de Santé" to be identified within the following Health Zones (HZ) of North and South Kivu, Maniema and Tanganyika Provinces. The proposed HZ coverage is as follows: 1. North Kivu: Alimbongo, Binza, Kayna, Kirotshe, Mabalako, Nyirangongo, Rwanguba, Rutshuru, Masisi, Lubero, Kalunguta, Mweso, Mutwanga. 2. South Kivu: Fizi, Kaniola, Kimbi Lulenge, Shabunda, Lulingo, Minova, Lemera, Kalonge, Mulungo, Kitutu, Kalole and Haut Plateau. 3. Maniema: Kasongo, Kibombo, Kabambare, Kunda, Lusangi, Tunda, Samba and Saramabila. 4. Tanganyika: Kalemie, Niemba, Nyunzu, Manono and Moba (to be validated during Year 1 of project implementation). While the project has identified target HZ, the "Aires de Santé" have yet to be identified. This will be conducted during the 1st year of implementation. The preparation of the project's IPP will be completed once these "Aires de Santé" have been selected.



G. Environmental and Social Safeguards Specialists on the Team

Lucienne M. M'Baipor, Social Safeguards Specialist
Grace Muhimpundu, Social Safeguards Specialist
Joelle Nkombela Mukungu, Environmental Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project aims to increase participation in Gender-Based Violence (GBV) prevention programs, and utilization of multi-sectoral response services for survivors of GBV in targeted health zones. No major or irreversible environmental or social impacts are expected. The project is classified as a category B, as some activities, mainly those related to livelihood interventions and gender transformative training under component 1, may have potential impacts on the environment. As the exact location is not yet known, a project Environmental and Social Management Framework (ESMF) has been prepared. The ESMF was finalized on April 20, 2018 and cleared by the RSA on April 24, 2018. In country disclose took place by May 3, 2018 and through the World Bank's external website on May 4, 2018. The ESMF includes a section on environmental due diligence for pest management, considering national regulation, as well as health and safety requirements.
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	No project activity will impact Natural Habitats
Forests OP/BP 4.36	No	No project activity will impact Forests
Pest Management OP 4.09	Yes	This policy is triggered as activities under component 1 related to the support for small scale livelihood activities, may potentially also include agricultural and small-scale husbandry. In this case, pesticides or other chemical product may be used by the beneficiary. Therefore, the ESMF includes a section on environmental due diligence for pest



		management, considering national regulation, as well as health and safety requirements.
Physical Cultural Resources OP/BP 4.11	No	No project activity will impact Physical Cultural Resources
Indigenous Peoples OP/BP 4.10	Yes	This policy is triggered as there is a presence of Indigenous Peoples' (IP) in the targeted Provinces: Tanganyika, Maniema as well as North and South Kivu. To ensure social inclusion of the various communities of IPs living in the area, an Indigenous People's Planning Framework (IPPF). The IPPF was finalized on April 20th and cleared by the RSA on April 27, 2018. The IPPF was disclosed in the country (in the various provinces in form and local language understandable by local IP communities) between May 1 and 3rd, as well as through the FSDRC website (May 3rd) and the World Bank's external website (May 4th).
Involuntary Resettlement OP/BP 4.12	No	Activities under this project will not require involuntary resettlement
Safety of Dams OP/BP 4.37	No	This project does not involve dams
Projects on International Waterways OP/BP 7.50	No	This project will not involve international waterways
Projects in Disputed Areas OP/BP 7.60	No	This project will not involve disputed areas

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

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

The Project's geographical coverage includes Tanganyika, Maniema as well as North and South Kivu with presence of the Twa Indigenous Peoples' (IP). To ensure social inclusion of this IP group, the project has triggered safeguard policy OP/BP 4.10. An Indigenous People's Planning Framework (IPPF) was prepared by the borrower and cleared by the Regional Safeguards Advisor on April 27, 2018. An Indigenous People's Plan will subsequently be prepared once:(i) targeted Aires de Santé have been defined for North and South Kivus as well as Maniema Province; and (ii) Health Zone coverage has been validated for Tanganyika Province. Free, prior and informed consultations have been carried out with Twa communities between April 7 and 10, 2018. Some of the identified potential positive effects of project implementation on Indigenous Peoples include increased use of available health care services, delivery of culturally appropriate GBV response services and improved access to health services through outreach activities. The project will promote socio-cultural interaction, coordination and consultation with traditional leaders prior and during implementation. For this, it is essential that civil society partners selected to implement Component 1 employ staff who speak the local dialects and are compliant with local socio-cultural interaction norms and belief systems of IP communities. Through the IPPF consultation process the project has identified potential NGOs and associations in the



four provinces who can act as partners for outreach to IP communities and support project implementation. Feedback sessions with stakeholders on the cleared IPPF were held in North and South Kivu, Tanganyika and Maniema on May 1 to 3, 2018.

The interventions under the project involve improvement in the provision of health services, handling of medical products as well as small scale rehabilitation of health facilities (limited to small internal repairs, painting, installation of screen or partitions for further privacy). Project activities will contribute to improved health services. Given the expected case load (an average of two GBV survivors, per health facility/month) the project is not expected to lead to increased generation of medical waste at health facility level. Small scale rehabilitation works may pose minor health and safety risks, while health care waste may pose health risks to the patients, attendants, health workers and the public in the event of poor management practices. In addition, Component 1 will include support for small scale livelihood activities (potentially also including agricultural and small-scale husbandry). Consequently, the Project triggers the following Environmental Safeguards Policies: Environmental Assessment OP/BP 4.01 and Pest Management OP/BP 4.09. The potential environmental impacts can be adequately managed by integrating environmental due diligence into the Project cycle. Due to the overall limited likelihood of environmental and social impacts, the Project is rated as Environmental Assessment Category B.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area: There are no anticipated long term or irreversible impacts by the project.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts. The project will use a combination of approaches to handle medical waste as per the guidelines issued by the Ministry of Health

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

Environment - An Environmental Management Framework (EMF) was prepared to guide handling of project environmental aspects during implementation and cleared by the Regional Safeguards Advisor on April 24, 2018. The EMF includes the environmental management approaches to be used by the project and provides guidance on measures to be implemented by the project to address potential negative environmental impacts. Environmental compliance will be the responsibility of the Fonds Social of the DRC and the Ministry of Health (MoH). Relevant staff shall undergo refresher training on implementation of Environmental Safeguard requirements for the project, having already received training during the implementation of the GL GBV Project. An Environmental and Social Safeguards Specialist will be hired as part of the Project Support Team (PST) at FSDRC level and will be responsible for overseeing the preparation of the Environmental Management Plans (EMPs). The specialist will receive additional training from the World Bank safeguards team.

Social - The borrower prepared an Indigenous Peoples Planning Framework (IPPF) to address the specific needs of the Twa community in North and South Kivu as well as in Maniema and Tanganyika. For the preparation of the IPPF consultations were held from April 5 to 11, 2018. The IPPF was cleared by the Regional Safeguards Advisor on April 27, 2018. The measures in the IPPF focus on: (i) ensuring that the additional barriers faced by the Twa in accessing prevention and response services on Gender Based Violence (GBV) are effectively addressed; and (ii) putting in place additional measures to mitigate the potential re-victimization of Twa survivors of GBV given the high levels of stigmatization and cultural bias against the Twa on the part of other ethnic groups at health zone level. The IPPF is aligned with the existing project components. It includes additional activities to be carried out in terms of GBV prevention by the civil society organizations to be contracted by Fonds Social DRC (FSDRC) to implementation



community-based GBV prevention activities in North and South Kivu as well as Tanganyika and Maniema. In addition to benefits related to project activities, a number of additional needs were identified, these include: (i) improved access to savings, (ii) additional training of IPs to support their participation in Income Generating Activities (IGA), (iii) establishment of a crisis management committee in areas affected by conflict and; (iv) the sensitization of local communities on the living conditions of IP groups and on expected project interventions that will target IP communities. This last measure will be important to support conflict prevention between IP and non-IP groups. The FSDRC will contract the services of specialized civil society organizations for this purpose. These civil society organizations will be required to bring on board the necessary expertise in terms of community facilitators and mobilizers with extensive expertise of working with IP communities.

The FSDRC will be responsible for the implementation of the development of the project's Indigenous People's Plan (IPP) once Aires de Santé have been identified for project implementation. The GBV Specialist at PMU level will be responsible for overall IPP implementation with the support for the Environmental and Social Safeguards Specialist and will receive additional orientation/training. The FSRDC has experience of implementing social safeguards measures on a number of Bank financed projects, including the Eastern Recovery Project and the Regional Great Lakes Gender Based Violence project under implementation in Eastern DRC.

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

Consultations were held between April 5 and 11 2018 with: (i) local authorities, (ii) civil society organizations working on Gender Based Violence programming and with IP groups; as well as (iii) IP communities across all targeted Provinces. Consultations with Indigenous People were held in: (i) Kibumba, Mudja, Kasumba and Kingarame in North Kivu, (ii) Bukavu with representatives of the IP communities in the Buzi, Nbinga-Nord, Ziralo in Kalehe; (iii) Kindu; and (iv) Kalemie.

In addition, feedback sessions on the IPPF were organized with representatives of IP communities and NGOs in North and South Kivu, Maniema and Tanganyika between May 1 and 3, 2018.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank 03-May-2018	Date of submission for disclosure 04-May-2018	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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"In country" Disclosure

Congo, Democratic Republic of
03-May-2018

Comments

The cleared version of the document was disclosed on May 3, 2018 by the counterpart.



Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank

03-May-2018

Date of submission for disclosure

04-May-2018

"In country" Disclosure

Congo, Democratic Republic of

20-Apr-2018

Comments

The cleared version of the document was disclosed on May 3, 2018. This included feedback sessions with IP communities at Provincial level (North and South Kivu, Maniema and Tanganyika) held between May 1 and 3, 2018.

Pest Management Plan

Was the document disclosed prior to appraisal?

Yes

Date of receipt by the Bank

03-May-2018

Date of submission for disclosure

04-May-2018

"In country" Disclosure

Congo, Democratic Republic of

20-Apr-2018

Comments

The cleared version of the document was disclosed on May 3, 2018 by the counterpart.

If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.

If in-country disclosure of any of the above documents is not expected, please explain why:

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

OP/BP/GP 4.01 - Environment Assessment

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

No



OP 4.09 - Pest Management

Does the EA adequately address the pest management issues?

Yes

Is a separate PMP required?

No

If yes, has the PMP been reviewed and approved by a safeguards specialist or PM? Are PMP requirements included in project design? If yes, does the project team include a Pest Management Specialist?

Yes

OP/BP 4.10 - Indigenous Peoples

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

Yes

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

Yes

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

NA

The World Bank Policy on Disclosure of Information

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

Yes

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

Yes



All Safeguard Policies

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

Yes

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

Yes

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

Yes

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

Yes

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APPROVAL

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