COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED SAFEGUARDS DATA SHEET (PID/ISDS)
ADDITIONAL FINANCING

Report No.: PIDISDSA20369

Date Prepared/Updated: 06-Feb-2017

I. BASIC INFORMATION

A. Basic Project Data

Country:	Congo, Democratic Republic of	**Project ID:**	P157864
		Parent Project ID (if any):	P147555
Project Name:	DRC Health System Strengthening Additional Financing (P157864)		
Parent Project Name:	Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555)		
Region:	AFRICA		
Estimated Appraisal Date:	06-Feb-2017	**Estimated Board Date:**	31-Mar-2017
Practice Area (Lead):	Health, Nutrition & Population	**Lending Instrument:**	Investment Project Financing
Borrower(s):	Ministry of Health		
Implementing Agency:	Ministry of Health		

Financing (in USD Million)

Financing Source	Amount
IDA Grant	120.00
Global Financing Facility	40.00
Single Purpose Trust Fund	3.50
Total Project Cost	163.50

Environmental Category:	B - Partial Assessment
Appraisal Review Decision (from Decision Note):	The review did authorize the team to appraise and negotiate
Other Decision:	
Is this a Repeater project?	No

B. Introduction and Context

Country Context

DRC is experiencing significant fiscal stress due to the global economic slowdown and domestic political uncertainty with presidential elections having been postponed by a year till December 2017. The production of oil and mining products during the first half of 2016 have declined by 8.6 percent compared to 2015; the quantities of cement sold declined by 41 percent; and port activity declined by 17.6 percent. The drop in the global demand for raw materials has resulted in decreased commodity prices and lower levels of economic activities, and greater risk of increased fiscal deficits. Already, preliminary public finance figures show revenues dropping by 12.4 percent over the first seven months of 2016. The decline in 2015 revenues led the government to cut the 2016 budget by 22 percent to keep spending under control. Despite these fiscally conservative measures, the budget balance turned to a negative US$260 million as of July 2016 from a surplus of US$90 million in July 2015. The overall economy has also been impacted: GDP growth in 2015 declined to 6.9 percent from 9.5 percent in 2014, and is not expected to exceed 2.7 percent in 2016. As a result, the Government had to delay or only partially fulfill health sector expenditure commitments which jeopardize the fragile gains in health outcomes in recent years.

Public spending on health in DRC is low in absolute terms and by international standards and the recent decline in domestic revenues has further worsened the priority given to the sector. The Ministry of Health budget dropped from 6.9 percent of the overall budget in 2014 to 4 percent in 2015 and 2016. While public spending on health decreases, the share of the wage bill in total spending on health increases rapidly and reached 78 percent of total health budget in 2015, living only little resources to pay for other critical inputs. As a result, the Government had to delay or only partially fulfill health sector expenditure commitments which jeopardize the fragile gains in health outcomes in recent years. For instance, Bacillus Calmette►(GuÃ©rin (BCG) coverage declined by 9 percentage points between 2013 and 2015 (from 83 percent in 2013 to 74 percent in 2015) due to lack of Government funding for the vaccines and operational costs. Furthermore, this decline is resource led to the Government►(s inability to fulfill its co-financing commitment for the routine vaccines in 2016 where support from the World Bank on an exceptional basis was sought. Hence, the need to work with the Government to not only protect fundamental budget lines in the years to come such as vaccines, salaries, and essential drugs but also there is a major need to address key bottlenecks hampering the performance of the system such as quality of human resources and their motivation, public finance management which currently is highly inefficient, and supply chain strengthening to ensure quality/affordable drugs and improved Governance

Human development is a priority for the current government. Some recent progress has been noted in selected health and education indicators, but considerable challenges remain. DRC ranks 176 (out of 188) on the 2015 Human Development Index and it did not achieve any of its Millennium Development Goals by the end of 2015. Sixty-three percent of the population is estimated to be poor, living on less than $1.25 per day. The country poverty is more than monetary; it includes a sense of exclusion, economic instability, and the inability to cope with uncertainties and plan for the future. Poverty is also experienced as the lack of economic opportunities and physical and psychological insecurity (World Bank Country Assistance Strategy, 2012). While the primary gross enrollment ratio for education has improved considerably, reaching 101.4 percent, retention, the achievement of learning outcomes remains

challenging.

While DRC has started its demographic transition, the pace is too slow and the country is at high risk of not harvesting the demographic dividend. The demographic dividend is characterized by a period in a country demographic transition when the proportion of working age population is higher compared to the number of dependents. This period corresponds to an extra economic boost through increased savings and private investments. Triggering such a demographic dividend requires two ingredients: (i) a decreased dependency ratio which is made possible only when fertility is declining more rapidly than mortality, and (ii) adequate policies to foster human capital, employment and investments to ensure that the additional working-age population is healthy and can get good jobs. The demographic transition (the shift from high to low mortality and fertility levels) and demographic dividend are central to the discussion on both health and economic growth in DRC.

According to the 2015/2016 Global Monitoring Report classification, DRC is a pre-demographic dividend country. Two distinct phases of the demographic dividend can be defined and are described in the figure below. These demographic dividends are not automatic and to create the conditions for the dividends and be able to capitalize on them countries need to have the right policies in place.

One key trigger to opening the demographic dividend window is a rapidly declining fertility, which has yet to be achieved in DRC; total fertility and adolescent fertility remain very high. The Total Fertility Rate (TFR) is 6.6. Because of its persistently high fertility DRC has a population age structure that is heavily concentrated towards dependent children (42.9 percent of the population is less than 15 years old), which negatively affects its prospects for human development and economic growth. Annual population growth is 3 percent which means that the population is expected to double in approximately 30 years. The unmet need for contraception among married women is high (28 percent).

Sectoral and institutional Context

Progress in health outcomes remain timid in DRC. The 2013-2014 Demographic and Health Survey (DHS) reported a 30 percent reduction in under five mortality from 2007. However, chronic malnutrition rates have remained high (43 per cent of children under five yearsare stunted) and stagnant. The same survey estimated a maternal mortality ratio of 846 (per 100,000 live births), among the highest in the world. The under-5 mortality rate has decreased from 148 (per 1000) in 2010 to 104 (per 1000) in 2014 and the infant mortality rate has also decreased from 92 (per 1000) to 58 (per 1000). Despite this decline, greater progress in these rates will require improvements in both the quantity and quality of RMNCAH services. While 85 percent of pregnant women receive some professional antenatal care and two-thirds of births take place in a health facility, the high rate of maternal mortality is directly correlated with low quality of care, inadequate preparedness for obstetric emergencies and ineffective referral systems. These statistics point to an urgent need to strengthen systems that deliver good quality services with a focus on adolescent health.

The adolescent fertility rate is high with 21 per cent of adolescent females between 15 and 19 having given birth in 2014. Unmet family planning needs 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 (RH) services are stigma and cost. The regional disparities are significant: in the East and Far North, respectively, 44.2

percent and 23.4 percent of young women 15 to 19 years of age had already had a child in 2014, while in Kinshasa this rate was only 7.6 percent. Education and poverty are determining factors: 48.8 percent of adolescents aged 15 to 19 without any education were pregnant or already had a child, a rate that is three times higher than among girls with a secondary education (17.9 percent). Similarly, 31.3 percent of young women aged 15 to 19 in the poorest quintiles had begun their reproductive life, whereas only 8.6 percent of young women in the richest quintile had done so.

Modern contraceptive prevalence remains low. Most health facilities do not provide family planning services resulting in the low prevalence rate for modern contraception. According to the Service Availability and Readiness Assessment (SARA) survey (2014) on the availability of services, there is little integration of FP services in most health areas. Only 33 percent of health zones are covered by functional FP services. In 2016, as per the baseline survey conducted for the PDSS project, only 30% of health facilities surveyed offered FP services. Only 20 percent of health facilities have all six tracer drugs and the average health facility has only 4 of the 6 essential commodities for the supply of family planning services. Moreover, the quality of FP services remains worrying with low availability of a wide range of FP methods. Additionally, the laws on family planning are troubling, there is still a 1920 law in place banning the use of contraceptive methods, however a revised Reproductive Health law is currently being discussed in parliament.

The nutritional status of women and children in DRC presents an alarming situation which has severe consequences for current and future generations. DRC suffers from a high prevalence of malnutrition, despite being home to just 1 percent of the world➢(s population; it is one of the five countries which together are responsible for half of all deaths globally among children under five. (WHO 2012a). About half of these deaths are caused by malnutrition; chronic malnutrition among children under five is estimated at 43 percent (DHS 2013-2014 not changed since 2007) and almost half of the children under five are moderately or severely anemic (43.7 percent and 4.2 percent respectively). High fertility rates among adolescents is an important determinant of early life stunting. Despite efforts to improve the nutritional status of Congolese children, the prevalence of stunting among children under five has remained practically unchanged ➢(just under 45 percent of children under 5 were stunted ➢(between 2001 and 2014.

This prevalence has persisted despite reductions in the prevalence of underweight children under five (dropped from 34 to 23 percent) and wasting of children under 5 which has dropped from 21 to 8 percent. In stark contrast reduction in child stunting has seen declines of just 1 percent over the last four years (DHS 2013-14). High child stunting rates remains one of the most intransigent health issues in the DRC. Investing in nutrition can increase a country➢(s GDP by between 3 and 11 percent annually (Horton and Steckel 2013) and investments in early nutrition have the potential to boost wage rates by 5 to 50 percent, make children 33 percent more likely to escape poverty in the future, and address gender inequities. The Government of DRC and the Develop Partners (DPs) recognize the importance of investing in nutrition and are supporting nutrition interventions in PDSS and are looking to support them further through this Additional Financing.

Gender inequalities are also prevalent; DRC ranks 148 out of 157 countries on the Gender-related Development Index. However, greater women empowerment will not necessarily translate into greater reproductive choice if women do not have access to needed reproductive health services. It is therefore important to ensure that health systems provide a basic package of Reproductive Health (RH) services, including family planning (FP), which is one of the key priorities of the

Ministry of Public Health (MOPH) as reflected in the new National Health Development Plan (NHDP) for 2016-2021. Provision of these services alone isn►(t sufficient if stigma persists and financial access a barrier.

Women are among the most vulnerable groups in DRC. They face multiple and mutually reinforcing constraints including high levels of violence, inadequate control over their health, limited economic opportunities, and lack of control over resources. The severity of the constraints varies widely across countries. For example, in DRC 97 percent of women face one or more of these constraints; 42 percent are affected by both domestic violence and inadequate control over their health and 25 percent by three key constraints (domestic violence, lack of control over their health, and inadequate control over resources).

Vulnerability is witnessed by the high prevalence of sexual and gender base violence throughout DRC and not only in the conflict areas (in eastern DRC). Sixty- four percent of women in DRC have been victims of physical violence and alarmingly 71 percent of women have suffered from spousal or partner abuse. DHS 2013-2014 found that nearly 50 percent of victims of SGBV do not seek help from any service provider. In focus groups conducted by Pathfinder International in four former provinces (including one of the PDSS provinces ►(Maniema) women stated the following reasons for not seeking help: (i) stigma associated with sex, (ii) impunity within the justice system, (iii) fear of divorce or abandonment, (iv) lack of funds, (v) preference for ►(amicable►(settlement, (vi) lack of information; (vii) lack of appropriate health care services, and (viii) fear of losing one►(s job. As a results, the AF will scale up SGBV activities building on lessons from the Great Lakes Women Empowerment and Reproductive Health Project (P147489) as to address gender violence at a larger scale beyond Eastern DRC and build on what other partners are doing in the 11 provinces targeted by this AF.

Gender norms are at the heart of maternal and child nutritional deficiencies and health outcomes. Traditional male-centered norms and values weigh heavily on women►(s access to productive resources and impede their ability to determine their well-being and that of their offspring. This starts in early adolescence and can produce harmful effects throughout different stages of the lifecycle. Therefore, the role of women as child bearers cannot be separated from that of women as providers of food security. Together they highlight a picture of conflicting demands on women►(s time and responsibilities and as a result high levels of vulnerability, which become worse during times of economic recession as witnessed in DRC.

The health system was severely weakened during the decades of conflict and continues to be both economically and politically fragile. The government recognizes the need to build strong institutions and systems for effective health, education and social protection services and has made a request to the Bank to scale-up its support in this area. The Government has launched a number of reforms focusing on decentralization and public administration reforms to strengthen the fiduciary and technical aspects of the Government. Health Financing and Public Finance Management remain very inefficient. The share of health spending remains at 4% of total Government budget, well below similar countries in Sub-Saharan Africa where spending on average is $130 per capita per year compared to $13 per capita per year for DRC.

A plethora of health workforce exists in DRC, over staffing of health facilities is common in both rural and urban areas. Adding to this problem is the fact that 70 percent of the health workforce

does not receive a salary. To cover the cost of salaries and offset the insufficient Government allocation, health facilities charge high user fees. Various partners have paid salary top-ups and financed training of health workers as a motivation bonus but this has been insufficient to improve results. Important reforms in the health workforce in DRC are required in order to improve the system➢(s efficiency. A critical aspect of this reform will be to reduce the current workforce numbers to match the needs of the system; additionally, the reform must also focus on addressing the lack of worker motivation while enhancing skills

The aging of human resources in the health sector is a real obstacle to improving the effectiveness and quality of the health system, thus jeopardizing the prospects for achieving the country's development objectives. Human resources statistics show that out of an overall workforce of 250,000 staff eligible for retirement in the DR Congo, 22,000 staff (or 8 percent) are concentrated in the health sector. It should be noted that 27 percent of human resources in the health sector are eligible for retirement. The enormous weight of these human resources negatively affects the quality of health care offered to the population. Furthermore, looking at the wage bill in the health sector, it is clear that several civil servants still active are either registered but not mechanized or new units, hence benefiting only from the bonus but not salary. While on the other hand, agents who are eligible for retirement are regularly paid in spite of their poor performance. This situation leads to the demotivation of human resources whose performance is still relatively high and which, however, must be remunerated accordingly in view of their performance. Accordingly, the AF will introduce a new sub-component 3.3 on Pension Reform to addressing the aging of human resources in health.

Strengthening key underfunded Reproductive, Maternal, Neo-natal, Child, Adolescent Health interventions continues to be the highest priority for the Government. DRC is one of the five pilot countries for the Global Financing Facility (GFF). The country launched the GFF process in a high-profile event in April 2015, demonstrating significant political commitment. A governance structure has been established to oversee the preparation of an investment case for RMNCAH as well as a health financing strategy. The GFF presents considerable opportunities for the country, on several fronts. First, the country➢(s response to RMNCAH has been fragmented, with separate analytical work and strategies for various aspects of the RMNCAH continuum. Second, some key technical elements that the GFF emphasizes ➢(such as gender, equity, and efficiency ➢(have been under-addressed in DRC. Third, progress on health financing in DRC has been limited, with no national strategy to date which is now being developed and is soon to be validated by the Government. Fourth, Civil Registration Vital Statistics almost inexistent and as part of the Human Development Technical Assistance, US$20 million has been approved to strengthen the CRVS system which will focus on the development of a strategy for programmatic CRVS reform and the instigation of school campaigns promoting delayed birth registration.

A prioritization exercise for the GFF was led by the Government in support of improving RMNCAH results. The Investment Case (IC) which has been developed through a collaborative multi-stakeholder process anchored at the Planning and Evaluation Directorate of the Ministry of Public Health. The preparation of the Investment Case began in July 2015 and has been validated by the Government in October 2016. The value added of the GFF is that the IC takes an equity lens, prioritizing 14 underserved provinces to achieve to RMNCAH intended results. Strong accent is put on improving Public Financial Management (PMF) to improve budget planning, execution and maximize funding utilization. Efficiency is at the core of the IC which will be done through resource pooling at the provincial level via contracting in through the Contrat

Unique (single contract). In turn, PBF contributes to financial management capacity development at the health facility level (both health centers and referral hospital) though open data, autonomy, and payment made to bank accounts rather than in cash and strong verification and counter verification systems. Along with PBF, fixed fee for service schedule will be defined (including cost of drugs) will be defined and subsidized in order to make services more accessible to the population. Access to a minimum RMNACH package of services will be made available to the most vulnerable free of charge in an effort to make services accessible to the bottom 15% of the population. Along with equity and efficiency gains, both of these financing reforms improve governance and transparency.

The investment case was developed following a two-pronged approach to improving RMNCAH results. First scaling up the availability of a minimum package of maternal and child health services with a focus on family planning and nutrition; and second by strengthening three key system pill ars including human resources, supply chain, and public finance management. The Investment Case is embedded into the 5 year national health sector strategy and is seen as a prioritization of such 5 year plan. The Investment Case will only be partly financed by this additional financing, and also will help attract commitments from other financiers. Dialogue is already underway with potential financiers, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI, UNICEF, USAID, and UNFPA. The AF will finance a number of activities identified in the GFF►(s investment case as will be described below.

C. Proposed Development Objective(s)

Original Project Development Objective(s) - Parent

The proposed project development objective is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's Territory.

Key Results

At the PDO level, two PDO indicators will be changed to reflect the approved WB core indicators; namely: (i) People who have received essential HNP services (number); and (ii) Births attended by skilled professional (number). Thus the total number of PDO indicators will not be increased. The current PDO indicator ►(Percentage of children between 6-23 months receiving preventive nutritional services at least four times per year►(will becoming an intermediate indicator.

As well, six new intermediate indicators will be added to reflect the additional AF activities. These include: 1) First time adolescent girls acceptant of modern contraceptives (number); 2) Children under five participating in growth monitoring and promotion activities at community-level (number); 3) Health facilities receiving Client Tracer and Satisfaction Survey feedback (percentage); 4) Availability of Tracer Drugs (Percentage); 5) Civil servants eligible for retirement in the Ministry of Health that have received their retirement indemnities/packages and retired from active service (% of total staff eligible for retirement within the Ministry of Health); and 6) Women and children who received basic nutrition services (number).

D. Project Description

Component 1: Improve Utilization and Quality of Health Services at Health Facilities through Performance-Based Financing. Total original costs including contingencies US$120 million equivalent of which US$115 million from IDA and US$5 million from HRITF). New costs

including contingencies US$179 million equivalent of which US$154.5 million from IDA, US$5 million from HRITF, US$12 million GFF-TF, and US$2.5 million from USAID TF).

This component currently supports performance based financing (PBF) of a minimum RMNCAH package of essential health services through contracts at health facility level in order to a) increase utilization of targeted services related largely to RMNCAH; (b) improve clinical practice and health worker motivation (both intrinsic and extrinsic); and (c) structural improvements (e.g. availability of drugs and commodities, equipment, etc.). While the parent project already includes nutrition, family planning and SGBV interventions, the AF will further focus on these interventions, add early childhood stimulation and care interventions, and scale up activities as follows:

The AF will: include additional nutrition services in health facilities at various levels, these services (antenatal, maternity and infant consultations) provide gateways to the promotion of nutrition. Specifically under component 1, the project will strive to improve the quality of feeding of newborns and infants as well as improve related core family behaviors (Alimentation du Nourrisson et du Jeune Enfant et Pratiques Familiales Essentielles) and the provision of services delivered during antenatal, maternity and early childhood consultations. Staff will be trained and will receive counseling materials and appropriate management tools and will be trained in improved supervision and support to workers at the community level.

Family planning services will be substantially strengthened by ensuring a better supply of contraceptives at the health facility and community levels through the regional distribution drug centers. Activities will focus on (i) building capacity of service providers through training; (ii) extending outreach family planning services; and (iii) improving supervision. These interventions will ensure that services are available to respond to the critical issue of unmet need.

A strong focus will be placed on preventing adolescent pregnancies which lead to increased maternal, infant and child mortality rates, increased stunting rates, higher school dropout rates, decreased graduation rates, poor work force productivity and lower earning potential. As the two biggest barriers preventing adolescent girls and boys from seeking Reproductive Health (RH) services are stigma and cost. Under the FP services, the AF will fully subsidize fees and adapt facilities to provide anonymity for adolescents and youth seeking sexual and reproductive health services (for e.g. creating separate entrances, general youth spaces, etc.). Thus, the AF will primarily support one of the three broad objectives of the government's adolescent health strategic plan. Namely: ►(improving availability and access to services adapted to the needs of adolescents and youth with a view to increasing rates of utilization►(. This AF will also finance training of services providers and a package of services for adolescent reproductive health needs (as part of the broader family planning package of services currently funded under the PDSS).

The AF will further integrate a number of adolescent health interventions focusing largely on supporting supply-side interventions that integrate adolescent RMNCAH services (e.g. Sexual and Reproductive Health (SRH)/family planning services to young mothers, Sexually Transmitted Infections/Human Immunodeficiency Virus (STI/HIV) prevention and management including HIV testing and counseling, at the health facility level, and through community outreach services. .

Early childhood stimulation and care interventions will be included in the minimum package of

essential health care to promote a holistic approach to growth learning and development. The AF will ensure that young children and their parents/caregivers are reached with appropriate services through existing health facilities and at the community level for greater child development outcomes. Such investment would lead to strengthening the cognitive ability of the child and thus prepare him/her for primary education.

The AF will further address GBV by strengthening prevention efforts and frontline service provision. The AF will fund training and information sharing for health staff on recognition, treatment, counseling and referral for victims of GBV with a special focus on domestic violence, sexual assault, and coerced sexual relations suffered by girls and young women within the household, public spaces and state institutions (such as in schools and police stations).

Component 2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing. Total original costs including contingencies US$65.2 million equivalent of which US$63.7 million from IDA and US$1.5 million from the HRITF. Total new costs including contingencies US$90.7 million equivalent of which US$65.2 million from IDA, US$1.5 million from the HRITF, US$5 million from GFF-TF, and US$1 million from USAID-TF. The parent project finances (i) activities to support PBF implementation and supervision (capacity building, verification and counter verification through the use of Purchasing Agencies (Etablissement d►(UtilitÃ© Publique) for contract management and verification; (ii) performance frameworks at all levels of the health system to hold provincial health administrative units (DPS) accountable for services through incentive mechanisms; and (iii) internal performance framework contracts with key directorates at the Central level.

The AF will scale these interventions and more specifically will include (i) PBF contracts with communities to increase demand for and utilization of family planning and nutrition services through counseling and timely referrals for life-saving health services (e.g., hygiene, sanitation, counseling on infant and young child feeding practices and delayed first pregnancy and child spacing, referral of pregnant women and children with danger signs to health centers; (ii) complementary activities aimed at promoting behavior change and increasing demand to improve household practices related to health and nutrition through social and behavior change communication (SBCC). The proposed changes include strengthening of institutional communication with the introduction of messages around vulnerability; in addition, SBCC messages will be expanded to include adolescent health and nutrition, early childhood care and early stimulation. Furthermore, outreach programs will be adapted to appeal to adolescents; this may include peer-to-peer counselling, ►(edutainment►(and training of teachers both on the prevention of SGBV and on combatting sexual abuse of students by teachers. Finally, the National Adolescent Health Program within the MOH will be provided funding to carry out demand-side prioritized adolescent health activities in selected provinces focusing on teenage pregnancy. These include: school health programs, and community engagement with a focus on youth to increase awareness and impact of gendered decisions on adolescents►(well-being.

Component 3: Strengthen Health Sector Performance ►(Financing and Health Policy Capacities. Total original costs including contingencies US$41.3 million equivalent from IDA. Total new costs including contingencies US$110.3 million equivalent from IDA of which US $87.3 million from IDA and US$23 million from the GFF-TF.

The parent project financed a number of activities focusing on:) capacity building to improve quality of care; 2) development of health financing, human resources and supply chain strategies to improve the performance of the health sector; 3) strengthening the monitoring and evaluation and health information systems; 4) strengthening disease surveillance and response and project management.

The AF will also support ongoing capacity building for service delivery and PBF at both community and facility levels. The same activities will continue from the original project (capacity building, M&E, coordination and program management at all levels, and performance contracts). However, the scale and intensity will need to be amplified to address the geographic expansion of PBF activities, the expansion of scope to include Public Administration Reform, the intensification of quality of care, and the addition of SBCC activities, as well as the strengthened engagement at the community level. Furthermore, the AF will support efforts to strengthen the Public Finance Management (PFM) in health sector through capacity building of the newly created Directorate of Administration and Finance (DAF). These activities will be conducted in collaboration with the existing Bank➢(s PFMAP (Public Financial Management and Accountability Project) operation.

A number of bottlenecks related to quality of care have been identified since preparation of the parent project. The AF will support specific interventions to address these issues. One of the key challenges is the inadequate supply of medicines to health facilities, based on the recommendations of a procurement and supply chain assessment that has been conducted, the AF will support activities using PBF approaches to improve supply chain management and procure a short-term supply of essential medicines including FP commodities, vaccines and nutrition related commodities. Management of moderate acute malnutrition (MAM) has not received the same attention as the management of severe acute malnutrition (SAM). The AF will support the development and dissemination of guidelines for the management of MAM as part of the Integrated Management of Acute Malnutrition (IMAM) package, which includes more active and frequent monitoring and intensive management of acute malnutrition at community level. The AF will support improvements in quality of reproductive healthcare provision (e.g. quality of family planning counseling, antenatal care provision, skilled delivery), including in-service clinical training as well as continued/continuous capacity building on the delivery of obstetric care by community health centers and referral facilities. Activities will include training and re-training of midwives, nurses and community health workers in collaboration with specialized UN agencies, Non-Governmental Organizations (NGOs) and partners from bilateral cooperation agencies.

A key challenge to improving quality of care is the weakness of the Human Resources Management. The AF will include a new sub-component 3.3: supporting the retirement program within the Ministry of Health. This sub-component aims to support the retirement program within the Ministry of Health in the DRC as well as its organizational reform through the implementation of a revised organizational chart. Within the current government's public sector reform strategy, the PRRAP will focus on three specific areas of this project by: (i) supporting the retirement program for the Ministry of Health, and (ii) supporting the organizational reform of the Ministry of health by implementing a newly revised organizational chart; , and (iii) Supporting the management of the retirement program. As progress has been registered in the implementation of the current Government➢(s public administration reform, the project will adopt the ongoing operational procedures in the Public Sector Reform and Rejuvenation Project (PSRRP) for the

retirement of eligible civil servants within the Ministry of Health. Therefore, the project will capitalize on the PSRRP/PRRAP►(s pilot experiences in its targeted ministries and government agencies.

Component 4: Disease Surveillance Strengthening and Response. Total new costs including contingencies US$15 million equivalent from IDA.

The original sub-component 3.3 on Ebola preparedness which was included in the parent project as at the time Western African was witnessing the worst Ebola epidemic in modern days and an Ebola epidemic had appeared in Equateur. The Government of DRC was very effective in controlling it. As new epidemics have emerged since the preparation of the parent project such as a Yellow Fever and a Cholera epidemic it is proposed that this sub-component be renamed as ►(Sub-Component 4.1 Dis ease Surveillance Strengthening►(. This sub- component will support the enhancement of national surveillance and reporting systems and their interoperability at the different tiers of the health systems. This component will support national efforts in the surveillance of priority diseases (including emerging, re-emerging and endemic diseases) and the timely reporting of emergencies in line with the International Health Regulations (2005).

The AF will also include the sub-component 4.2: Contingent Emergency Response Component (CERC) (Total financing: US$0 million IDA): A CERC will be included under the 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.

All the new activities will be described in details in the project implementation manual to be developed by the project team at the MOH. The Ministry of Health who is the implementing agency will ensure that all key directorates are involved in the planning and implementation of the Additional Financing as per the arrangements of the parent project. The AF could support the TA support of a nutrition specialist and gender base violence specialist to reinforce the directorate in charge of these programs within the MOH. Such TA will be discussed and agreed upon once the detailed activities have been developed and a further capacity assessment has been done within three months of implementation of the AF.

Component Name

Component 1: Improve Utilization and Quality of Health Services at Health Facilities through Performance-Based Financing.

Comments (optional)

Component Name

Component 2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing.

Comments (optional)

Component Name

Component 3: Strengthen Health Sector Performance ►(Financing and Health Policy Capacities.

Comments (optional)

Component Name

Component 4: Disease Surveillance System Strengthening and Response.

Comments (optional)

E. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The original project covers 140 health zones which translates into eleven Provinces out of the newly created 26 Provinces. All of the health zones in the formerly known Provinces of Equateur and Bandundu are covered, 8 health zones out of 18 in Maniema are covered and in the former Katanga the following newly created Provinces are covered: Haut-Katanga (8HZ), Haut Lomami (8HZ), and Lualaba (6HZ). The AF will be used to increase coverage to the remainder 8 health zones in Lualaba and in Haut Lolami to achieve full coverage of these two Provincial Health Directorate (Direction Provincial de la SantÃ© ►(DPS). A total of 16 new health zones will be added. The PBF interventions in Katanga will be in full alignment with USAID and other partners. Increasing the health zones from 140-156 will increase the beneficiary population to 25 million or 30 percent of the population of DRC.

Institutional capacity building at the national and health zone level is the focus of the project. Particular attention is given to some of the most ►(foundational►(system building blocks in the health sector. No civil works will be undertaken and no adverse environmental or social impacts are expected. The project does not require any land acquisition leading to involuntary resettlement and/or restrictions of access to resources and livelihood. The project is expected to have a positive impact for all beneficiaries including vulnerable groups such as children, women and the poor who are the main target beneficiaries of the project.

This project will cover 11 provinces and hence part of the population targeted will include Indigenous Peoples (IPs). The expected impacts are positive as the IPs do not have access to quality care and hence the project will ensure that quality free care is provided to them to ensure a better health outcome. An Indigenous Peoples Plan Framework (IPPF) has been prepared and disclosed as part of the original PDSS project (P147555) in October 2016, this IPPF will be redisclosed as part of the AF.

F. Environmental and Social Safeguards Specialists

Claude Lina Lobo (GENDR)

Lucienne M. M'Baipor (GSU01)

II. Implementation

Institutional and Implementation Arrangements

The implementation arrangements for the Additional Financing will remain largely the same as for

the original project. The high level Steering Committee will continue to provide oversight and strategic guidance to the project: The Ministry of Public Health (MOPH) will implement the project through the Planning and Evaluation Directorate (Direction de la Plannification et Evaluation - DEP) The DEP was reinforced as part of the original project by a mix of Government staff and external technical assistance recruited through a merit-based process. Given the focus of this AF on nutrition, the DEP will need to hire a nutrition specialist to support the Nutrition program within the MOH so as to ensure the proper design and implementation of activities related to nutrition and ensure coordination among other sectors. The DEP also strengthened its fiduciary capacity by hiring a financial manager, a procurement specialist, an internal auditor and two accountants. The strategic purchasing is being conducted by the Etablissement d►(UtilitÃ© Publique to ensure proper contracting with health facilities and verification of results prior to payments; this arrangement will continue under the AF.

Local Committees will be involved in the performance based approach through their participation and oversight in: (i) health facility committees (COSA) and health area development committees (CODESA); (ii) fund utilization at the health facility to achieve business plan targets; (iii) discussions and negotiations with the heads of health centers regarding user fee levels; and (iv) community verification of existence/confirmation of users and assessment of patient satisfaction. Finally, to ensure greater community engagement to achieve behavior change in the target population and improve the levels of citizen participation in the management of the health system, the AF will: i) develop and implement an information, education and communication strategy; ii) strengthen the household visit intervention to take into account the new interventions being covered by this AF to increase demand of health services and improve healthy behaviors at the household level; and iii) engage the community in the planning and management of health activities including those aimed at enhancing transparency and accountability in the delivery of services.

Partnership arrangements: As part of the original project, a unique and innovative partnership has been put in place which will finance and support the scale up of performance-based financing (PBF) program. The Global Fund, UNICEF, World Bank, GAVI, UNFPA and USAID have signed a memorandum of understanding (MOU) to partner r with the government to better align and harmonize their interventions to increase access to essential maternal and child health services. This collaboration will enable the pooling of financial and technical resources to deliver a basic package of health services to the entire population in all eleven provinces in which the PDSS is being implemented. The six agencies will work synergistically to complement each other and utilize their comparative advantage to maximize effectiveness, avoid duplication and improve efficient use of resources. The original and the AF projects will also rely on the large community of partners that are coordinated through the Groupe Inter-bailleurs de la santÃ© (GIBS) to ensure further alignment in key areas such as human resources, public finance management, and supply chain management.

III. Safeguard Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The environmental assessment as well as the Health Care Waste Management Plan (HCWMP) were prepared for the Parent project, consulted upon and disclosed in country and at the Infoshop in October 2016. These documents will be re-disclosed before the project appraisal for the purpose of this AF.

Natural Habitats OP/ BP 4.04	No	The project will not affect natural habitats.
Forests OP/BP 4.36	No	The project does not involve forests or forestry.
Pest Management OP 4.09	No	The project does not involve pest management.
Physical Cultural Resources OP/BP 4.11	No	The project does not involve physical cultural resources.
Indigenous Peoples OP/BP 4.10	Yes	An Indigenous Peoples Plan was prepared for the Parent project, consulted upon and disclosed in country and at the Infoshop in October 2016. It aims to ensure that Indigenous Peoples will benefit from social outputs of the project as it will cover indigenous areas. The IPP of the Parent Project will be re-disclosed before the project appraisal.
Involuntary Resettlement OP/BP 4.12	No	The project does not involve land acquisition leading to involuntary resettlement and/or restrictions of access to resources and livelihoods.
Safety of Dams OP/ BP 4.37	No	The project does not involve dams.
Projects on International Waterways OP/BP 7.50	No	N/A
Projects in Disputed Areas OP/BP 7.60	No	N/A

IV. 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 is not expected to have large scale, significant, or irreversible environmental or social impacts. Project activities are focused on delivery of an integrated package of health services both at the community and health facility level, as well as providing high impact maternal and reproductive health services.

Project activities that could potentially cause an adverse impact that will need to be minimized, mitigated and managed include: (i) During the operation of the health facilities the generation of additional quantities of medical waste will increase slightly over the current baseline. (ii) In addition, the health facilities will receive an investment bonus at the beginning of each year, which they can use to do some minor rehabilitation such as painting, opening a window, fixing the roof etc. These activities may cause noise, vibrations and emissions from vehicles and machinery, generate construction waste and involve potential risks regarding workplace and community health and safety. However, these activities anticipated impacts will be temporary, site specific and localized, and limited in scope.

The presence of indigenous people (IP) in the targeted Provinces was identified and confirmed during project preparation. IPs constitute a vulnerable and marginalized group in the project area. The risk of social exclusion of IPs in the context of the project cannot be ignored, to ensure that IPs will benefit from the project, OP/BP 4.10 has been triggered, and an Indigenous Peoples Plan (IPP) focusing on outreach and inclusion has been prepared for the parent project.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

The planned project activities are not anticipated to have long-term or indirect negative social or environmental impacts. The project is expected to increase social cohesion at the family and community level as well as activities to promote gender equality and change negative attitudes and norms towards women and girls. In addition, the project support will provide targeted communities with better access to basic health service. Project investments may strengthen sound environmental and social practices in the construction sector and around health facilities. In addition, the expected impacts on the indigenous people are positive as the IPs do not have access to quality care and hence the project will ensure that free quality care is provided to them to ensure better health outcomes.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

Not applicable.

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.

At national level, the DRC has a legislative and regulatory framework which is conducive to good environmental management. In addition, the DRC has signed a number of international treaties and conventions. However, implementation capacity is weak. Environmental policies and their compliance are governed by the MinistÃ¨re de l►(Environnement, de la Conservation de la Nature et du DÃ©veloppement Durable (MECNDD) ►((Ministry of Environment, Conservation and Sustainable Development). The MECNDD has three departments in charge of environmental monitoring and management: i) the national agency ACE (Agence Congolaise de l►(Environnement), the former GEEC (Groupe d►(Ã©tudes environnementales du Congo); ii) le Centre National d►(Information sur l►(Environnement (CNIE); and iii) La Cellule RÃ©glementation et Contentieux Environnementaux (CRCE). The ACE is responsible for safeguards compliance of all projects in the country, but with emphasis on environmental category A project. This agency is also familiar with the safeguard instruments such as the Environmental and Social Management Framework (ESMF) and the Resettlement Policy Framework (RPF). The unit (ACE) is understaffed and has limited capacity. Despite several donor-funded capacity building initiatives, the unit still largely relies on donor funds to carry out its field supervision duties.

Under the original project two safeguard policies were triggered: 1) OP/BP 4.01 Environmental Assessment because of the potential negative environmental and social impacts related to the handling and the disposal of medical and health waste (such as placentas, syringes, and material used for delivery of pregnant women) in health facilities covered by the project area. However, Health Care Waste to be generated by the project is expected to be site specific, small scale and easily manageable; and 2) OP/PB 4.10 on Indigenous People. As such the original project developed and disclosed the IPPF as well as the Social and Environment Framework in October 2016. As the exact project sites are not yet determined by the project, an Indigenous People Plan is developed. Once the project site is clearly identified, the project will prepare an Indigenous

Peoples Plan (IPP). For the AF will re disclose the document of the parent project as the AF covers the same activities and health zones. To manage properly health care waste in accordance with OP/PB 4.01, the existing Health Care Waste Management Plan (HCWMP) disclosed by the PDSS in October 2016 will be used for the AF. The project team will recruit respectively environmental and social specialists as needed to ensure implementation of the instruments. The project will put in place a budget for the implementation of the agreed safeguards measures, which will include the cost for the recruitment of specialists (social and environment) to supervise the project, for monitoring as well as capacity building of the various stakeholders. This costing/ budget will be provided to the Bank prior to negotiations.
5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
The preparation of the project has relied on consultations with government officials at relevant levels, provincial officials, donors➢(community, implementation partners, community and civil society groups, and direct beneficiaries of the project. The implementation of the project will likewise rest on various consultations. The preparation of safeguards instruments (MWMPs, and IPP), once the project site is clearly identified, will include additional consultations, at local, provincial and national level. Upon review and approval by the government, the MWMPs and IPP will be disclosed by governments in local languages to project-affected groups and NGOs in publicly accessible places for consultations in country, and by the World Bank, in the Infoshop.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	01-Feb-2017
Date of submission to InfoShop	06-Feb-2017
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
"In country" Disclosure	
Congo, Democratic Republic of	06-Feb-2017
Comments:	
Indigenous Peoples Development Plan/Framework	
Date of receipt by the Bank	01-Feb-2017
Date of submission to InfoShop	06-Feb-2017
"In country" Disclosure	
Congo, Democratic Republic of	06-Feb-2017
Comments:	
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

OP/BP/GP 4.01 - Environment Assessment	
Does the project require a stand-alone EA (including EMP) report?	Yes [×] No [ ] NA [ ]
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?	Yes [×] No [ ] NA [ ]
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?	Yes [×] No [ ] NA [ ]
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 [×] No [ ] NA [ ]
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?	Yes [×] No [ ] NA [ ]
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?	Yes [×] No [ ] NA [ ]
The World Bank Policy on Disclosure of Information	
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [×] No [ ] NA [ ]
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 [×] No [ ] NA [ ]
All Safeguard Policies	
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have costs related to safeguard policy measures been included in the project cost?	Yes [×] No [ ] NA [ ]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [×] No [ ] NA [ ]

V. Contact point

World Bank

Contact: Hadia Nazem Samaha
Title: Senior Operations Officer

Borrower/Client/Recipient

Name: Ministry of Health
Contact: Honore Tshiyoyo
Title: Coordonnateur
Email: tshiyoyohonore@yahoo.fr

Implementing Agencies
Name: Ministry of Health
Contact: Alain Iyeti
Title: Director
Email: alainiyeti@yahoo.fre

VI. For more information contact:

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

VII. Approval

Task Team Leader(s):	Name: Hadia Nazem Samaha	
Approved By		
Safeguards Advisor:	Name: Maman-Sani Issa (SA)	Date: 08-Feb-2017
Practice Manager/ Manager:	Name: Trina S. Haque (PMGR)	Date: 08-Feb-2017
Country Director:	Name: Yisgedullish Amde (CD)	Date: 09-Feb-2017