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Report No: PAD2136

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL CREDIT

IN THE AMOUNT OF SDR 88.4 MILLION
(USD 120 MILLION EQUIVALENT)

WITH AN ADDITIONAL GRANT
FROM THE GLOBAL FINANCING FACILITY
IN THE AMOUNT OF USD 40 MILLION

AND FROM THE UNITED STATES AGENCY
FOR INTERNATIONAL DEVELOPMENT
IN THE AMOUNT OF USD 3.5 MILLION

TO THE

DEMOCRATIC REPUBLIC OF CONGO

FOR AN

ADDITIONAL FINANCING FOR THE HEALTH SYSTEM STRENGTHENING FOR BETTER MATERNAL HEALTH AND CHILD HEALTH RESULTS PROJECT

March 10, 2017

Health, Nutrition & Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective JANUARY 31, 2017)

Currency Unit = SDR
0.73592723 SDR = USD1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AF	Additional Financing
ANJE PFE	*Alimentation du Nourrisson et du Jeune Enfant et Pratique Familiale Essentielles* (Essential Newborn and Child Feeding and Family Practices)
CAB	Cost Benefit Analysis
CAC	*Comité à Assise Communautaire (*Community Based Committee)
CAGF	*Cellule Administrative de Gestion Financière* (Administrative and Financial Unit)
CAS	Country Assistance Strategy
CBA	Cost Benefit Analysis
CERC	Contingent Emergency Response Component
CGPMP	*Cellule de Gestion des Passations de Marchés Publiques* (Procurement Unit)
CMRAP	*Cellule de Mise en Oeuvre de la Réforme de l'Administration Publique* (The Public Administration Reform Implementation Unit)
CNMN	National Multi-Sectoral Nutrition Committee
CNRD	*Commission Nationale de Résolution des Disputes* (National Dispute Resolution Commission)
COSA	Health Facility Committees
CODESA	*Comité de Développement Sanitaire* (Health Area Development Committees)
CPF	Country Program Framework
CPN	*Consultation Pré-natale* (Prenatal Consultation)
CPP	*Comité Provincial de Pilotage (*Provincial Steering Committee)
CPS	*Consultation Pré-scolaire* (School Enrollment Consultation)
CRVS	Civil Registration Vital Statistics
DAF	*Direction Administrative et Financière* (Directorate of Administration and Finance)
DALY	Disability Adjusted Life Years
DEP	*Direction de la Planification et Évaluation* (Planning and Evaluation Directorate)
DHS	Demographic Health Survey
DPS	*Direction Provinciale de la Santé* (Provincial Health Directorate)
DP	Development Partner
DRC	Democratic Republic of Congo

ECD	Early Childhood Development
ECZS	*Équipe Cadre de Zone de Santé* (Health Zone Management Team)
EUP	*Établissement d'Utilité Publique* (Public Utility Institutions)
EQUIP/PAQUE	Education Quality Improvement Project (*Projet d'Amélioration de la Qualité de l'Education)*
FM	Financial Management
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
GDP	Gross Domestic Product
GDRM	Grievance Dispute Resolution Mechanism
GFF	Global Financing Facility
GFTAM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIBS	*Groupe Inter-Bailleurs de la Santé* (Partner Group)
GRS	Grievance Redress Service
GSBV	Gender and Sexual Based Violence
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus-Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HNP	Health Nutrition and Population
HGR	*Hôpital Général de référence* (Referral Hospital)
HRH	Human Resources for Health
HRITF	Health Results Innovation Trust Fund
IBRD	International Bank for Reconstruction and Development
IC	Investment Case
IDA	International Development Agency
IMAM	Integrated Management of Acute Malnutrition
IPF	Investment Project Financing
LIC	Lower Income Countries
L-LMIC	Lower and Lower Middle Income Countries
MAM	Moderate Acute Malnutrition
MECNT	*Ministère de l'Environnement, de la Conservation de la Nature et du Tourisme* (Ministry of Environnent, Natural Conservation and Tourisme)
M&E	Monitoring & Evaluation
MDGs	Millennium Development Goals
MOPH	Ministry of Public Health
MOU	Memorandum of Understanding
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHDP	National Health Development Plan
NRH	National Reproductive Health
NU	New Units
OP/BP	Operational Policy/Bank Policy
PBF	Performance Based Financing
PCU	Project Coordination Unit

PDO	Project Development Objective
PDSS	*Projet d'Appui des Services de Santé* (Health System Strengthening for Better Maternal and Child Health Results Project)
PFM	Public Finance Management
PNDS	*Plan National de Development de la Santé* (National Health Development Plan)
PPA	Project Preparation Advance
PSRRP/PRRAP	*Projet de Réforme et Rajeunissement de l'Administration Publique* (Public Sector Reform and Rejuvenation Project)
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SARA	Service Availability and Readiness Assessment
SAM	Severe Acute Malnutrition
SBCC	Social Behavior Change Communication
SCD	Systematic Country Diagnosis
SDGs	Sustainable Development Goals
SDR	Special Drawing Rights
SGBV	Sexual and Gender Based Violence
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
SUN	Scaling Up Nutrition
TA	Technical Assistance
TB	Tuberculosis
TF	Trust Fund
TFR	Total Fertility Rate
THE	Total Health Expenditure
UHC	Universal Health Coverage (*Couverture de Santé Universelle*)
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nation Children's Fund
USAID	United States Agency for International Development
UNESCO	United Nations Educational, Scientific, and Cultural Organization
WB	World Bank
WHO	World Health Organization

Regional Vice President:	Makhtar Diop
Country Director:	Ahmadou Moustapha Ndiaye
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Trina Haque
Task Team Leader:	Hadia Nazem Samaha

DEMOCRATIC REPUBLIC OF CONGO
HEALTH SYSTEM DEVELOPMENT PROJECT

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ADDITIONAL FINANCING DATA SHEET

Democratic Republic of Congo

Additional Financing for Health System Strengthening for Better Maternal and Child Health Results Project (P157864)

AFRICA

GHN07

Basic Information – Parent			
Parent Project ID:	P147555	Original EA Category:	B - Partial Assessment
Current Closing Date:	31-Dec-2019		

Basic Information – Additional Financing (AF)			
Project ID:	P157864	Additional Financing Type (from AUS):	Restructuring, Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	B
Country Director:	Ahmadou Moustapha Ndiaye	Expected Effectiveness Date:	31-Jul-2017
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	31-Dec-2021
Practice Manager/Manager:	Trina S. Haque	Report No:	PAD2136
Team Leader(s):	Hadia Nazem Samaha		

Borrower				
Organization Name	Contact	Title	Telephone	Email
Ministry of Finances	Honoré Tshiyoyo	Cellule de Coordination des projets	243-811-696-263	tshiyoyohonore@yahoo.fr

Project Financing Data - Parent (Health System Strengthening for Better Maternal and Child Health Results Project (PDSS)-P147555) (in USD Million)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P147555	IDA-55720	Effective	18-Dec-2014	20-Jan-2015	30-May-2016	31-Dec-2019	31-Dec-2019
P147555	IDA-D0210	Effective	18-Dec-2014	20-Jan-2015	30-May-2016	31-Dec-2019	31-Dec-2019
P147555	TF-18375	Effective	20-Jan-2015	20-Jan-2015	30-May-2016	31-Dec-2019	31-Dec-2019

Disbursements

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	% Disbursed
P147555	IDA-55720	Effective	USD	130.00	130.00	0.00	17.06	102.70	13.13
P147555	IDA-D0210	Effective	USD	90.00	90.00	0.00	11.22	71.71	12.47
P147555	TF-18375	Effective	USD	6.50	6.50	0.00	0.00	6.50	

Project Financing Data - Additional Financing for Health System Strengthening for Better Maternal and Child Health Services Project (P157864)(in USD Million)

[ ] Loan [X] Grant […] IDA Grant
[X] Credit [ ] Guarantee [ ] Other

Total Project Cost: 163.50 Total Bank Financing: 120.00

Financing Gap: 0.00

Financing Source – Additional Financing (AF)	**Amount**
IDA Credit	120.00
Global Financing Facility	40.00
Single Purpose Trust Fund (USAID)	3.50
Total	163.50

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	No
Explanation	

Team Composition

Bank Staff

Name	**Role**	**Title**	**Specialization**	**Unit**
Hadia Nazem Samaha	Team Leader (ADM Responsible)	Senior Operations Officer	Project Management and Health System	GHN07
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Francis Tasha Venayen	Financial Management Specialist	Financial Management Specialist	Financial Management Specialist	GGO25

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Bella Diallo	Team Member	Senior Financial Management Specialist	Financial Management	GGO25
Boris Weber	Team Member	Senior Public Sector Specialist	Public Sector	GGO27
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Claudia M. Pardinas Ocana	Team Member	Senior Counsel	Legal	LEGAM
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Stephanie Anne Kuttner	Team Member	Consultant	Social Development	GPV01
Tazeem Mawji	Team Member	Consultant	Health Operations	GHN07

Extended Team

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
DRC	Former Bandundu	Mai-Ndombe	14	14	Health zones
	Former Bandundu	Kwilu	24	24	Health zones
	Former Bandundu	Kwango	14	14	Health zones
	Former Equateur	Sud Ubangi	16	16	Health zones
	Former Equateur	Tshuapa	12	12	Health zones
	Former Equateur	Mongala	12	12	Health zones
	Former Equateur	Equateur	18	18	Health zones
	Maniema	Maniema	8	8	Health zones
	Former Katanga	Haut Katanga	8	8	Health zones
	Former Katanga	Lomami	8	16	Health zones
	Former Katanga	Haut Lualaba	6	16	Health zones

Institutional Data

Parent (Health System Strengthening for Better Maternal and Child Health Results Project (PDSS)-P147555)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Additional Financing for Health System Strengthening for Better Maternal and Child Health Services Project (P157864)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required ?No consultants are required

I. Introduction

1. **This project paper seeks the approval of the Executive Directors to provide an International Development Agency (IDA) credit in the amount of Special Drawing Rights (SDR) 88.4 million (USD 120 million equivalent) to the Democratic Republic of Congo (DRC) for an Additional Financing to the Health System Strengthening for Better Maternal and Child Health Results Project (Crédit. 5572-zr, Grant Number D021-ZR).** The additional financing is co-financed by the Global Financing Facility (GFF) in the amount of USD 40 million and a Single Donor Trust Fund from United Stated Agency for International Development in the amount of USD 3.5 million. The proposed AF would finance the implementation of additional activities that are in line with the parent project activities. It would finance (i) the scaling up of an essential package of health, nutrition and population (HNP) services in new regions; (ii) the scaling up of interventions to further improve quality and utilization of care, thus ensuring availability of essential drugs, family planning (FP) commodities and vaccines; (iii) investing in human resources in health (HRH) through financing the retirement of those eligible, staff motivation, and in-service training; and (iv) scaling up community health workers initiatives especially in the delivery of community nutrition services. The proposed AF will also include the restructuring of the parent project in order to include a new component focused on disease surveillance strengthening and response.

2. **The Project Development Objective (PDO) of the PDSS remains unchanged. The PDO is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's territory.** The PDO level indicators will be changed to take into account the World Bank (WB) mandatory core PDO indicators not included in the parent project such as People who have received essential health, nutrition, and population services (number). In addition, eight new intermediate indicators will be added to reflect the additional AF activities. These include: (i) Average days with stock out of tracer drugs in targeted health facilities on the day of the visit (number); (ii) First time adolescent girls acceptant of modern contraceptives (number); (iii) Children under 24 months participating according to schedule in the growth monitoring and promotions activities at the community level (percentage); (iv) Health facilities receiving Client Tracer and Satisfaction Survey feedback (percentage); (v) Civil servants eligible for retirement in the Ministry of Public Health (MOPH) that have received their retirement indemnities (number); (vi) Single contract signed and implemented at province level (number); (vii) Families participating in parental education sessions at community level (percentage); and (viii) Exclusive breastfeeding for children under 6 months (percentage). The targets of the original indicators will also be revised to reflect the increase in beneficiaries and the proposed new project closing date of December 31, 2021.

3. **The proposed AF will build on the results achieved to date by the parent project as well as align to the priority areas identified by the Government through the GFF's investment case (IC).** The investment case focuses on scaling up Reproductive, Maternal, Neo-natal, Child, and Adolescent Health (RMNCAH) interventions through performance based financing and community revitalization. Prior to effectiveness, the original project benefited from two Project Preparation Advances (PPA's), as the first PPA was fully disbursed and effectiveness was still delayed when a second PPA was approved. The total amount of the PPAs was USD 10 million and both have been fully implemented and disbursed. The following results were achieved through the PPAs and cover all three components of the parent project: (i) full project team hired and

trained; (ii) validation and dissemination of administrative and technical manuals; (iii) development and validation of the performance based financing operational manual of the Ministry of Health; (iv) finalization by the Government of the safeguard documents which were disclosed in country in October 2016; (v) establishment of the four *Établissements d'utilité publique (EUP* - Public Utility Institutions) with their 10 satellite offices as purchasing agencies for Performance Based Financing (PBF) and the recruitment of their staff; (vi) training of administrative staff at all level of the health system including EUPs, verifiers, *Direction Provinciale de la Santé (DPS,* Provincial Health Directorate - PHD*)*, the *Equipe Cadre de Zone de Santé (ECZS,* Health Zone Administrative Team), and development and technical partners; (vii) signing of a memorandum of understanding with USAID and United Nations Population Fund (UNFPA), who formally joined the partnership platform set up in February 2015, and (viii) official launch of PDSS chaired by His Excellency the Minister of Health on July 29, 2016.

II. Background and Rationale for Additional Financing in the amount of USD 163.5 million

A. Background

5. **The parent PDSS (P147555) is financed by an IDA Grant of SDR 60.9 million (USD 90 million equivalent) and an IDA Credit of SDR 88.0 million (USD 130 million equivalent) and a USD 6.5 million Health Results Innovation Trust Fund (HRITF) which were approved by the Board on December 14, 2014 and became effective on May 30, 2016**. Effectiveness was delayed because the project required Parliament and Senate approvals before the President could ratify the project. The closing date is December 31, 2019. After less than a year of effectiveness, approximately 13.5 percent of the funds have been disbursed. This disbursement level is above the projections and is expected to increase over the next six months when more than 2,000 PBF contracts will be signed with the health providers to finance the RMNCAH package of services. The HRITF hasn't yet disbursed as it is linked to performance payments of health facilities that are contracted. First performance payments are due to happen in all the health zones by May 2016. Implementation of the parent project is well under way as described above and a number of results have been achieved to date, more than 1,500 health professionals have been trained, and the baseline survey for the impact evaluation has been completed providing a sound baseline to assess progress on the parent project indicators. This is the first AF of the PDSS project.

6. **The development objective of the parent project is to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's territory**. The project was designed to not only strengthen the health system at all levels but to also ensure the availability of a minimum package of RMNCAH services to the population in the context of achieving Universal Health Coverage (UHC) for every Women and Every Child in selected Provinces. The parent project put in place performance based financing strategy to support the Government's vision of improving RMNCAH outcomes and strengthening health system performance in 140 health zones covering about 25 percent of the national population through services provided in eleven provinces: Mai-Ndombe, Kwilu, Kwango (formerly Bandundu Province), Sud Ubangui, Tshuapa, Mongala, Equateur (formerly Equateur Province), Haut Katanga, Haut Lomami, Loualaba (Katanga Province), and Maniema.

7. **The PBF mechanism finances results, based on quantity and quality of services produced by health facilities and DPS at all levels of the system.** PBF is the key strategic implementation approach being used to improve the utilization and quality of health services. PBF is used by health facilities and the health administration directorates to finance a number of activities in their business plan contributing to the improvement of care as well as increasing services to be provided and to pay performance bonuses to the personal based on an indice tool. The DRC has a rich experience in PBF, with a number of pilots conducted by several development partners (DPs) including the WB. Indeed, the parent project builds on the results and lessons learned from the Health Sector Rehabilitation Support Project (2010-2013), which piloted the PBF in the health district of Haut-Katanga (2010-2014) – a catchment area composed of eight health zones and covering 160 accredited health facilities and 1.3 million people. Completed in 2014, the PBF pilot and its accompanying impact evaluation informed the design and restructuring of the scaled up PBF program currently being implemented.

8. **The parent project comprises three components**:

(a) Improve Utilization and Quality of Health Services at Health Facilities through Performance Based Financing;

(b) Improve Governance, Purchasing, Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing; and

(c) Strengthened Health System Performance Financing, Health Policy, and Surveillance Capacities.

B. Rationale for Additional Financing

9. **The proposed changes will strengthen the parent project's long term objectives of reducing maternal and child mortality and chronic undernutrition, thereby contributing to the attainment of Sustainable Development Goals (SDGs) 2, 3 and 5 and the Health, Nutrition and Population Global Practice goal of ending preventable deaths and disability through Universal Health Coverage (UHC).**[1] The relationship between nutrition, health, and wealth is well-established, with better health and nutrition resulting in enhanced cognitive development, increased human capital and a more productive labor force, better off economically and benefitting from intergenerational dividends (Mirvis and Bloom 2008; Grantham-McGregor et al 2007).

10. **The proposed AF specifically aims to scale up the package of RMNCAH interventions**. The AF proposes to: (A) scale up cost-effective essential HNP interventions in the areas of (i) family planning (FP) and more specifically the purchase of FP commodities which represent a major gap in the system as a whole and which was not funded under the parent project; (ii) introduce the delivery of community nutrition services, in addition to the health facility interventions being delivered under the parent project. A complementary essential nutrition package will be delivered through the community to mainly address chronic undernutrition

[1] SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture; SDG 3: Ensure healthy lives and promote well-being for all at all ages; SDG 5: Achieve gender equality and empower all women and girls.

(stunting) and ensure better results focusing on Early Years interventions (see Annex 4); (iii), support gender and sexual based violence (GSBV) interventions such as training and information sharing for health staff on recognition, treatment, counseling and referral for victims of gender based violence (GBV), building on the Great Lakes GSBV project in the East of DRC; (B) support adolescent sexual and reproductive health interventions to address the problems that lead to a high number of teenage pregnancies and their resulting risk for maternal death, low birth weight and chronic malnutrition, as well as transmission of Human Immunodeficiency Virus-Acquired Immunodeficiency Syndrome (HIV/AIDS) and sexual transmitted infections (STIs). Such focus on adolescent girls is needed as the reproductive health program in DRC focuses on married women (ages 15-49); an adolescent health program at MOPH was therefore established to focus on adolescent girls aged between 10-19 who are at risk of early marriage, early pregnancy, violence, and stigmatization; (C) address the inequity issue by adding to the existing 140 health zones, 16 health zones in the former Haut-Lomami and Loualaba provinces (former Katanga), thus responding to the Government's vision to ensuring universal coverage and equitable access to a similar RMNCAH package to all women and children in a given province; and (D) further strengthen the system by addressing the availability of drugs, the improvement of human resources, and a better public finance management (PFM) to achieve greater efficiencies. Activities will include procurement of the essential health drugs which are lacking in health facilities, funding the retirement of a number of eligible health workers as well as scaling up PFM activities such as the "*Contrat unique*" (Single contract). The aging workforce in the health sector is a real obstacle to improving the effectiveness and quality of the health system. The AF will partner with the Public Service Reform and Rejuvenation Project (PSRRP/*PRRAP*) to finance the payment of indemnities to about 6,000 health workers which will represent 27 percent of the total health sector workers eligible for retirement.

11. **The proposed AF would finance the implementation of the above mentioned additional activities that are in line with the parent project activities**. These additional activities would be better financed and implemented as additional financing rather than a new operation given their relevance to the parent project and the synergies expected to be produced which would positively impact the achievement of the PDO. The scope of the scale up was mainly assessed to be within the Borrower's existing implementation capacity. In areas related to additional activities that would require additional technical and fiduciary management capacity, consultants will be procured to meet the identified needs. The Borrower has committed to the scaling up of the project activities as they are aligned to their priorities in the GFF investment case and would address part of the financing gap identified.

12. ***Additional financing Scale Up and Restructuring.*** The AF will also include restructuring activities including: (i) adding a fourth component; and (ii) extending the project closing date by 24 months to December 31, 2021. Indeed, the parent project will need to be restructured to introduce a new component 4 on diseases surveillance system strengthening and response. This new component will include two sub-components: 4.1 Disease Surveillance Strengthening which was the sub-component 3.3 under the parent project named Ebola Preparedness Plan and a component 4.2 the Contingency for Emergency Response Component (CERC). The restructuring will also include the extension by 24 months of the parent project to take into account the 18 month delay in effectiveness and the alignment of the closing dates of the parent project with that of the additional funding. Such extension of the closing date will also be aligned with the Government's newly approved five-year health system development plan.

13. **The proposed AF to the PDSS is consistent with Operations Policy/Bank Policy (OP/BP) 10.00 (Investment Project Financing - IPF) under which IDA may provide AF for investment lending for scaling up the development effectiveness of a project that is performing well**. The project is consistent with the World Bank's guidelines, namely (a) the project is rated Satisfactory on the PDO and Moderately Satisfactory on implementation progress for a minimum of 12 months; (b) all legal covenants have been complied with; and (c) there are no outstanding audit reports. The project will follow the World Bank's 'Guidelines: Procurement of Goods, Works, and Non-Consulting Services under International Bank for Reconstruction and Development (IBRD) Loans and IDA Credits & Grants by World Bank Borrowers' and 'Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers' both dated January 2011 (revised July 2014), as well as the World Bank's guideline on Anti-Corruption 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants', dated October 15, 2006 and revised in January 2011. A waiver was granted to continue using the mentioned guidelines on the basis that: a) the contractual arrangements under the proposed AF are very similar in scope to the contractual arrangements of the original project thus the continuation of the original procurement guidelines would benefit the project and keep the focus on project implementation; and b) the proposed AF relies mainly on performance-based financing strategies at community level and health facility level where most contracting is being done; hence the guidelines in place are sufficient and adequate for this AF.

C. Country Context

14. **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, 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 USD 260 million as of July 2016 from a surplus of USD 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; it 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, thereby jeopardizing the fragile gains in health outcomes in recent years.[2]

15. **Public spending on health in DRC is low in absolute terms and by international standards and the recent decline in domestic revenues has further weakened the priority given to the sector.** The MOPH 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

[2] 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 decreased from 92 (per 1000) to 58 (per 1000). Despite this progress, decreasing maternal, infant, and child mortality rates further will require greater improvements in both the quantity and quality of reproductive and child health and nutrition services with significant increases in (the quantity and quality of) public expenditures.

bill in total spending on health increased rapidly and reached 78 percent of total health budget in 2015, leaving 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, thereby jeopardizing the fragile gains in health outcomes in recent years. For instance, Bacillus Calmette–Guérin (BCG) coverage declined by 9 percentage points between 2013 and 2015 (from 83 percent in 2013 to 74 percent in 2015) due to a lack of Government funding for the vaccines and operational costs. Furthermore, this decline in resources led to the Government's inability to fulfill its co-financing commitment for the routine vaccines in 2016 when 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.

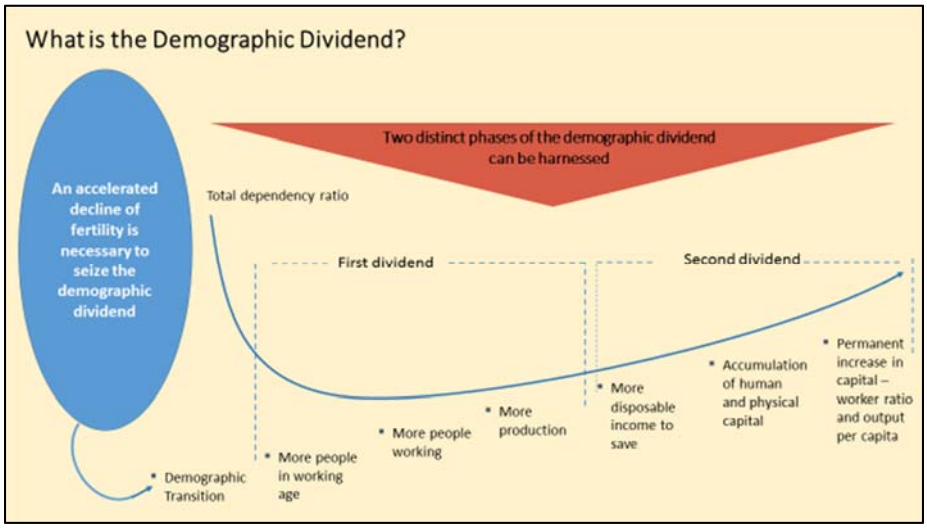
16. **Human development is a priority for the current Government**. Some recent progress has been noted in selected health and education indicators, but considerable challenges remain. The DRC ranks 176 (out of 188) on the 2015 Human Development Index (HDI) and it did not achieve any of its Millennium 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's 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 and the achievement of learning outcomes remain challenging.

17. **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's 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.

18. **According to the 2015/2016 Global Monitoring Report classification[3] 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.

[3] http://pubdocs.worldbank.org/pubdocs/publicdoc/2015/10/503001444058224597/Global-Monitoring-Report-2015.pdf

Figure 1. Demographic dividend and its two distinct phases



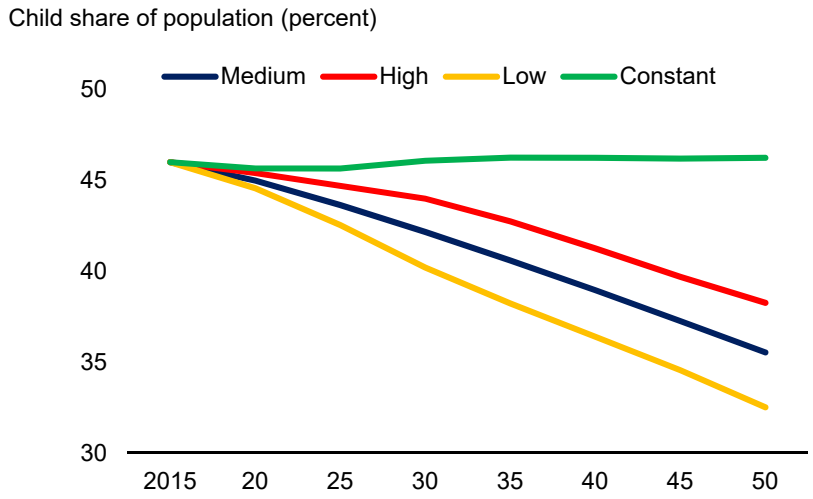
19. **To harness the demographic dividend, policies are required that first accelerate the fertility transition and in a second stage enable cohorts to be productive (education and labor policies)**.

Table 1. Potential Policies to Reap the First Demographic Dividend in DRC

Purpose	*Policies*
Accelerate the fertility decline	Reduce child mortality, morbidity, malnutrition Increase female education and gender equity Address social norms on fertility Reduce child marriage Expand comprehensive family planning programs
Reap the first economic dividend	Improve education and human capital Attract foreign direct investments Improve business environment to build demand for labor Reduce trade barriers Encourage female employment outside the home

20. **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, the 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. The 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).

Figure 2. Children could account for more than a third of the DRC's total population in 2050 even if fertility rates fall by more than half.



Source: Results from LINKAGE simulations following Ahmed et al. (2016a, 2016b). Medium, High, Low, and Constant refer to different fertility scenarios considered in the UN WPP 2015. Medium refers to the medium variant scenario, High refers to the high variant scenario, Low refers to the low variant scenario, and Constant refers to the Constant-fertility scenario. Children are defined as people under 15 years of age.

D. Sectoral Context

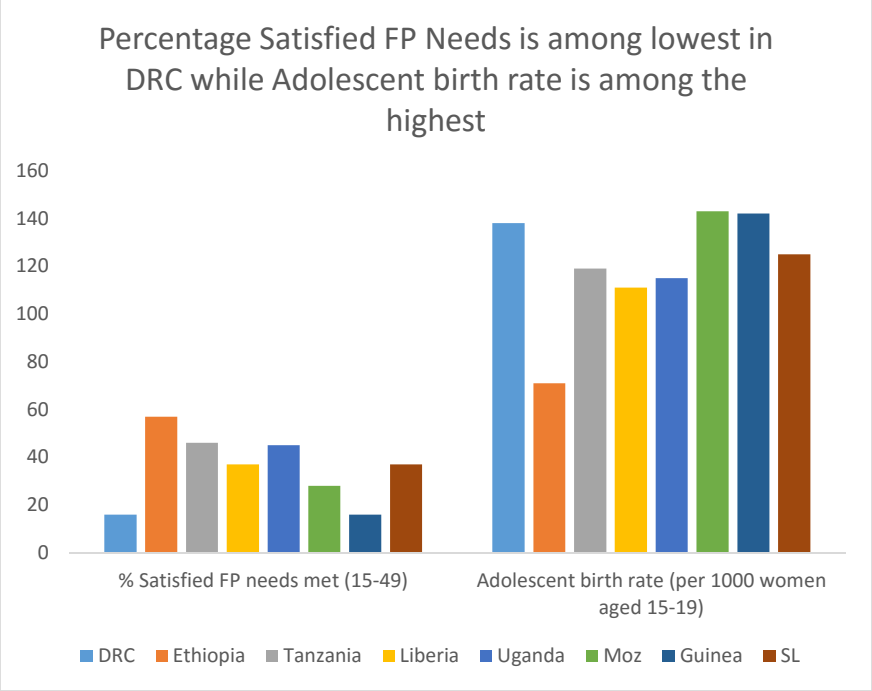
21. **Progress in health outcomes remains timid in the DRC.** The 2013-2014 Demographic and Health Survey (DHS) reported a 30 percent reduction in under-five mortality from 2007. However, chronic malnutrition rates have remained high (43 per cent of children under five years are stunted) and stagnant. The same survey estimated a maternal mortality ratio of 846[4] (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.

22. **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

[4] DHS 2013-2014

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[5].

Figure 3. SDGs Reproductive Health Indicators in DRC and other LIC countries



Source: WHO Health Statistics, 2016

23. **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 percent 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 reproductive health and family planning have yet to be updated given the last law passed dates from 1920 banning the use of contraceptive methods. However, in the past decade, the Government at the Presidential level has issued a number of decrees in support of expanding RH and FP services and committing itself to increasing budget allocation to FP to USD 3.5 million in 2017 of which USD 1 million was released in January 2017 to UNFPA towards the purchase of

[5] 2014 MICS

FP commodities. Furthermore, these decrees enabled the National Reproductive Health Services and the Adolescent Health Services Programs to be established within the MOPH with funding from the Government and donors. In the past 5 years, tremendous efforts by Government and donors were made to ensure availability of FP services (including commodities) at health facility level. The Government is also about to adopt a revised reproductive health law which has passed to the two Parliament committees and is mainly awaiting Parliament to meet again to be voted.

24. **The nutritional status of women and children in DRC presents an alarming situation which has severe consequences for current and future generations**. The 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)[6]. 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 are 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 (which dropped from 34 to 23 percent) and of the wasting of children under 5 (which dropped from 21 to 8 percent). In stark contrast, the reduction in child stunting has seen a decline of just 1 percent over the last four years (DHS 2013-14). High child stunting rates remain one of the most intransigent health issues in the DRC. Investing in nutrition can increase a country's GDP by 3 to 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 the DRC and the development 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 AF.

25. **Gender inequalities are also prevalent; the 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 RH services, including FP, which is one of the key priorities of the MOPH as reflected in the new National Health Development Plan (NHDP – *Plan National de Développement de Santé – PNDS)*) for 2016-2021. Provision of these services alone isn't sufficient if stigma persists and financial access remains a barrier**.**

26. **Women are among the most vulnerable groups in the 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.[7] The severity of the

[6] The other four countries are China, India, Nigeria and Pakistan.

[7] The World Bank Gender Group has generated estimates of different constraints on women's agency that can arise at the same time, using Venn diagrams to demonstrate these overlapping constraints. Using questions from the latest round of Demographic and Health Surveys (e.g. experience with sexual or physical violence; lack of control over household decisions; ability to refuse sex; and current employment status) composite scores have been made for each source of vulnerability for several countries, including for DRC.

constraints varies widely across countries. For example, in the 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).

27. **Vulnerability is witnessed by the high prevalence of sexual and gender based violence throughout the 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 Sexual and Gender Based Violence (SGBV) victims do not seek help from any service provider. In focus groups conducted by Pathfinder International in four former provinces[8] (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.[9] As a result, the AF will scale up SGBV activities by building on lessons from the Great Lakes Women Empowerment and Reproductive Health Project (P147489) 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. It is clear that broader policy reforms (judicial, gender, criminal, etc.) are needed to address and deter such a high level of violence against women and as such a number of initiatives led by the WB and other key partners address are engaged on these issues.

28. **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 the DRC.

29. **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 WB 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 PFM remain very inefficient. The share of health spending remains at 4 percent of the Government's total budget, well below similar countries in Sub-Saharan Africa where spending on average is USD 130 per capita per year compared to USD 13 per capita per year for the DRC.

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

[8] Kasaï /Kasaï Central, Maniema, Nord-Ubangi, Tshopo

[9] Pathfinder International. June 2016. Situation Analysis of Women and Girls in the ASSP-Supported Health Zones in DRC, Nite Tanzarn (lead author), Mbady Muanda (National Team Leader, Director of PNSA)

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 the 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.

31. **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 DRC, 22,000 staff (or 8 percent) are concentrated in the health sector. It should be noted that 27 percent of workers in the health sector are eligible for retirement. The enormous weight of these workers negatively affects the quality of the 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 (without a number) or new units (not hired through the public administration process), hence receiving only bonuses but no 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 the workforce 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 Retirement Reform Program of MOPH to address the aging of the workforce in the health sector.

32. **The high school dropout rate (22 percent in 2011) at the end of the first year of primary school represents a serious concern for equity, quality education and for the country's development**. With recent advances in science and increased knowledge about child brain development, as well as the overall importance of the early years, there is a growing consensus on the critical role of a range of physical, social, emotional and cognitive skills in order to yield highest rates of return to families, societies and countries. While acknowledging Government and DPs efforts to improve maternal and child health in the DRC, the draft national policy on Integrated Early Childhood Development (ECD) underscores the need for a comprehensive ECD package of interventions, which covers a spectrum of needs for the optimum development of young children. This project will be aligned to the Education Quality Improvement Project (EQUIP- P157922)[10] in order to pilot the implementation of a complementary package of services that include the promotion and strengthening of the attitudes of parents, families and communities towards, as well as their involvement in, children's linguistic and cognitive and socio-emotional development for a successful transition to school.

33. **Strengthening key underfunded RMNCAH interventions continues to be the highest priority for the Government.** The DRC is one of the five pilot countries for the GFF. The country launched the GFF process during a high level workshop presided by the Ministers of Plan and Public Health, 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,

[10] In DRC, it's known as PAQUE (Projet d'Amélioration de la Qualité de l'Éducation)

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 the DRC. Third, progress on health financing in the DRC has been limited, with no national strategy to date, but which is now being developed and is soon to be validated by the Government. Fourth, Civil Registration Vital Statistics (CRVS) are almost inexistent and as part of the Human Development Technical Assistance, USD 20 million have been approved to strengthen the CRVS system which will focus on the development of a strategy for programmatic CRVS reforms and the instigation of school campaigns promoting delayed birth registration.

34. **A prioritization exercise for the GFF was led by the Government**. The Investment Case (IC) was developed through a collaborative multi-stakeholder process anchored at the Planning and Evaluation Directorate of the Ministry of Public Health. The preparation of the IC began in July 2015 and was 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 the RMNCAH intended results. A strong emphasis is given to PMF to improve budget planning, execution and maximize funding utilization. Efficiency is at the core of the IC which will be achieved through resource pooling at the provincial level via contracting in through the *Contrat unique* (single contract). In turn, PBF contributes to the financial management capacity development at the health facility level (both health centers and referral hospital) through 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 the cost of drugs) 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 percent of the population. Along with equity and efficiency gains, both of these financing reforms improve governance and transparency.

35. **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 pillars including human resources, supply chain, and public finance management. The IC is embedded into the 5-year national health sector strategy and is seen as a prioritization of the said 5 year plan. The IC will only be partly financed by this additional financing, and will also help attract commitments from other financiers. Dialogue is already underway with potential financiers, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM), Global Alliance for Vaccines and Immunization (GAVI), United National Children's Fund (UNICEF), USAID, and UNFPA. The AF will finance a number of activities identified in the GFF's IC as will be described below.

36. **An innovative partnership arrangement with development partners for health was put in place**. 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 the performance-based financing program. The GFTAM, UNICEF, World Bank, GAVI, UNFPA and USAID have signed a memorandum of understanding (MOU) to join forces with the Government to better align and harmonize their interventions aiming at rapidly increasing access to essential maternal and child health services. This partnership will enable the pooling of financial and technical resources to deliver a basic

package of health services to the entire population in all the 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 of efforts and improve efficient use of resources. The original and AF projects will also rely on the large community of partners that are coordinated through the *Groupe Inter-Bailleurs de la Santé (GIBS: Inter Donor Health Group)* to ensure further alignment in key areas of the projects such as human resources, public finance management, and supply chain management.

D. Opportunities for Successful Implementation

37. **In addition to the greater focus on health systems strengthening for better quality and greater equity, the following significant changes have taken place and are essential to achieving the PDO of the parent project approved in 2014 and which justifies the AF.**

(a) The fiscal space constraints since the parent project was approved have led the Government to delay or only partially fulfill expenditure commitments such as salaries, commodities, operational costs hindering supervision and coaching of health facilities, hence jeopardizing the limited gains in health outcomes noted in recent years. 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 to help them address key bottlenecks hampering the performance of the system such as the quality of the workforce and its motivation, PFM which currently is highly inefficient, and supply chain strengthening to ensure quality/affordable drugs and improved governance. Accordingly, the AF will finance inputs such as family planning commodities, essential drugs, and vaccines necessary to make services available and contribute to improving the utilization and quality of care, mainly scaling up the content of the minimum RMNCAH package of services.

(b) Since the project was approved progress was accomplished by the Public Service Reform and Rejuvenation Project (PSRRP/*PRRAP*). A project for an amount of USD 77 million (financed by the World Bank) was developed to establish basic processes for the efficient-functioning of the public service which is important not only in fiscal terms (to lessen the wage bill) but also to ensure better delivery of basic services to citizens. The PRRAP is now being implemented by the Ministry of Public Administration. This project provides an opportunity to address human resources issues in the health sector but it does not currently cover the health sector. Accordingly, the AF will provide funding to capitalize on the PRRAP and will focus on two areas: (i) reforming the organization of the MOPH to strengthen its efficiency and its capacity to monitor and coordinate the HR reform; and; (ii) rejuvenating the health sector through management of the retirement process.

(c) In 2016, the Government of the DRC developed a new Five-Year Health Sector Strategy 2016-2021. The strategic vision is that the DRC achieves universal health coverage for mothers and children by 2030 with a strong engagement at the community level. The strategy focuses on the need to implement a universal health coverage plan for every women and every child with emphasis on offering an equitable and financially accessible package of services. It highlights two strategic ways of doing it, one through strategic

purchasing, and a second through expanding community outreach activities.[11] The strategy also highlights the need to invest more in human resources and in the supply chain while strengthening the capacity of the public institutions. Accordingly, the AF will scale up interventions related to improving access to service delivery and will strengthen the health system by focusing on supply chain and medicine, human resources, and governance. It will also support the delivery of community nutrition services to expand community outreach activities that would address mainly chronic undernutrition in addition to other services required to be delivered at the community level.

(d) **The DRC joined the Scaling up Nutrition (SUN) movement in May 2103, thus signaling its recognition of the magnitude of the problem and its commitment to addressing the high levels of malnutrition in the country.** The WB subsequently prepared a policy note to support the government in prioritizing the nutrition interventions to be scaled-up in the country. These interventions were costed and estimates of benefits in terms of lives saved, cases of stunting averted and Disability Adjusted Life Years (DALYs) saved were estimated. Scenarios for scale-up were devised. This analytical work provided a backdrop for the development of the national multi-sectoral strategic plan for nutrition, which includes an analysis of the institutional arrangements required to ensure an effective multi-sectoral coordination of the response. In December 2015, following deliberation in the Council of Ministers, the Prime Minister signed a decree creating, organizing and defining the operation of the National Multisectoral Nutrition Committee (CNMN). This body, under the Prime Minister's authority, brings together over a dozen ministers (Health; Agriculture; Planning; Gender, Family and Child; Social Affairs, Humanitarian Action and National Solidarity; Budget; Finance; Primary and Higher Education; Labor and Social Security). It is charged with consulting with those involved in nutrition and orienting them towards the Government's objectives

(e) In 2016, the Government of the DRC adopted the National Strategic Plan for the Health and Well-Being of Adolescents and Youth (2016-2020) creating a clear framework for supporting its adolescent health priorities that was not in place during the preparation of the parent project. The proposed additional financing will fully include subsidizing fees and adapting facilities to provide anonymity for adolescents and youth seeking sexual and reproductive health services (for e.g. creating separate entrances, general youth spaces, etc.). The AF support is further described below.

(f) Similarly, the Government of the DRC has recently re-affirmed its commitment to tackling gender-based violence and is therefore updating its 2009 Gender-Based Violence Strategy and developing a new 5-year plan. The new GBV activities to be financed through the AF will support the implementation of the Government's new plan as well build on early lessons learned from the implementation of the Great Lakes Emergency Sexual and Gender-Based Violence and Women's Health Project in the Eastern region of the DRC (North and South Kivu Provinces), namely, in relation to the importance of awareness raising, prevention, and establishing standard treatment and referral protocols. In particular, the Project will support community-based awareness raising on gender violence

[11] Both strategic ways are addressed through the project's Performance-Based Financing intervention

prevention, and support training of frontline service providers in the prevention, detection, treatment, counseling and referral of survivors of sexual and other GBV.

(g) Finally, when the parent project was approved, the GFF had not yet been launched and, as such, the DRC wasn't yet a pilot GFF country. The GFF presents considerable opportunities for the country, on several fronts. First, it has pushed the Government to prioritize even further its key interventions and the geographic scope as to where return on investment would lead the most in terms of curbing some of the health outcomes. It has prioritized the equitable implementation of a RMNCAH package in 14 out of the 26 provinces; it has also strengthened the 3 pillars of the system, i.e. Human Resources for Health, supply chain and PFM. As such, the AF, will respond to this by financing the RMNCAH in 9 out of the 14 Provinces (the remaining 5 are financed by other partners) and by supporting nutrition, supply chain, and family planning interventions.

38. **Link with existing strategies, policies and programs.** The proposed additional financing continues to be consistent with the Government's newly validated National Development Strategy (2016-20). The 2016 Government's Development Program defines a roadmap to improve human development focusing on systems strengthening for the social sectors. At the operational level, the fact that the activities are all implemented by the sectoral ministries ensures strong coordination with other initiatives, including World Bank-financed operations.

39. **Link to World Bank strategy.** The AF continues to support the World Bank Group's strategic Twin Goals of reducing poverty and boosting shared prosperity. The systems to be strengthened have a direct link to poverty reduction through human capital formation. Mechanisms to track and address inequity in the social sectors will also be strengthened. The AF is also aligned with the WB strategy for Africa. The project focuses on the foundation of the strategy - public sector capacity-in systems that will contribute to increased competitiveness and employment (through a well-educated and healthy workforce) as well as to reduced vulnerability and increased resilience (through improved health). The AF is an integral part of the World Bank Group's Country Assistance Strategy (CAS) for the period FY13–FY16 (Report 66158) which was extended to FY17 and a new Country Program Framework (CPF) is under development, and health is also featured into the Systematic Country Diagnosis (SCD). One of the higher-level objectives of the CAS, to which this project will contribute, is to increase access to social services and to raise human development with a focus on strengthening governance and service delivery systems. The CAS has identified the following outcomes related to that objective: (a) an increased access to clean water and sanitation; and (b) an improved access to health services in targeted areas. In particular, the CAS includes a Health System Strengthening Project which is the parent project. Furthermore, as defined in the SCD being prepared, the AF addresses two of the five emerging opportunities and priority areas where policy actions could build cumulative and virtuous cycles to sustaining growth and fostering resilience and prosperity in the DRC namely (1) building inclusive institutions and strengthening governance and (2) building human capital.

40. **Risks.** The overall risk is rated as substantial as outlined in the risk template. The unstable political environment with an interim Government in place given the fallout from not conducting elections on time and the macroeconomic risks related to the fall in commodity prices present additional risks that were not envisaged during the preparation of the parent project. The original

main risks pertained to: (i) coordinating a range of sectoral stakeholders in a multi-sectoral project; (ii) the weak fiduciary environment; (iii) uneven implementation capacity; and (iv) poor governance. To date, these risks have proven to be manageable. Close financial management (FM) supervision has been put in place with the WB team providing technical support as needed. The partnership harmonization platform has enabled the strengthening of institutional capacity at all levels of the system as defragmentation is taking place with the harmonization platform.

III. Proposed Changes

Summary of Proposed Changes

The proposed AF will expand the scope of work supported under the PDSS to support the implementation of the country's PNDS and GFF's Investment Case in the medium-long term with a clear focus on RMNCAH services. The AF will include the following elements:

- **Project Components:** Add a new sub-component 3.3 on Retirement Reform Program, and add a new Component 4 on Disease Surveillance Strengthening and Response with two sub-components, 4.1 Disease Surveillance Strengthening and, 4.2 Contingency Emergency Response Component (CERC) which replaces the disease surveillance activities as part of the Component 3 of the original project.
- **Geographical scope:** In addition to the existing 140 health zones covered by the parent project, 16 new health zones in the former Katanga Province will be added, targeting 156 health zones which represent 30 percent of the population. These 16 new health zones are added to ensure universal health coverage of the Essential Health Services package in this Province. The Indigenous Peoples Framework was updated to address the presence of indigenous people in these new health zones.
- **Additional funds:** USD 120 million equivalent IDA Credit, USD 40 million from GFF-TF, and USD 3.5 million from USAID-TF.
- **Activities:** Scale up of a package of essential HNP services both at the health facility and community level to enhance the intended results of the project as well as to address inequities, geographic disparities, and to improve health system performance. Activities will include under Component 1 a community-based contracting approach for primary health service delivery and a community health worker program as well as adolescent health and gender based violence activities. A new sub-component under Component 3 will be added to address the retirement reform program of health workers. A new Component 4 will be added to address disease surveillance strengthening and response.
- **Project end date:** Extension of the project closing date by 24 months with a new closing date of December 31, 2021.
- **Indicators:** One PDO indicator will be changed to reflect the approved WB core indicators, the new PDO indicator will be "People who have received essential health, nutrition, and population services (number)". In addition, eight new intermediate indicators are added to reflect the AF activities. The targets of the original indicators will also be revised to reflect the increase in beneficiaries and the proposed new project closing date of December 31, 2021.

Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [ ] No [X]

Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [ ] No [X]
Change of EA category	Yes [ ] No [X]
Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [ ] No [X]
Change in Loan Closing Date(s)	Yes [X] No [ ]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [ ] No [X]
Reallocation between Disbursement Categories	Yes [ ] No [X]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]
Change in Institutional Arrangements	Yes [ ] No [X]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [ ] No [X]
Change in Implementation Schedule	Yes [ ] No [X]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results

Project's Development Objectives

Original PDO

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

Change in Results Framework

Explanation:

At the PDO level, one PDO indicator will be changed to reflect the approved WB core indicators; namely: People who have received essential health, nutrition, and population services (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 become an intermediate indicator.

As well, eight new intermediate indicators will be added to reflect the additional AF activities. These include: These include: (i) Average days with stock out of tracer drugs in targeted health facilities on the day of the visit (number); (ii) First time adolescent girls acceptant of modern contraceptives (number); (iii) Children under 24 months participating according to schedule in the growth monitoring and promotion activities at the community level (percentage); (iv) Health facilities receiving Client Tracer and Satisfaction Survey feedback (percentage); (v) Civil servants eligible for retirement in the Ministry of Public Health (MOPH) that have received their retirement indemnities (number); (vi) Single contract signed and implemented at province level (number); (vii) Families participating in parental education sessions at community level (percentage); and (viii) Exclusive breastfeeding for children under 6 months (percentage).

Compliance						
Covenants - Additional Financing for the Health System Strengthening for Better Maternal and Child Health Results Project - P157864)						
Source of Funds	**Finance Agreement Reference**	**Description of Covenants**	**Date Due**	**Recurrent**	**Frequency**	**Action**
IDA	Recruitment of an independent financial institution	The Recipient shall recruit, in accordance with the provisions of Section III of Schedule 2 to the Financing Agreement, an independent financial institution ("Financial Agent"), whose terms of reference, qualifications and experience and terms and conditions of employment shall be satisfactory to the Association	31-Jul-2017	☐		New
IDA	Recruitment of the ACVE	The Recipient shall, not later than 3 months after the Effective Date, recruit and thereafter maintain, under terms of reference satisfactory to the Association, and in accordance with the PBF Manual, the ACVE to	31-Jul-2017	☐		New

		conduct independent annual verifications of: (a) the Package of Priority Health Services delivered under Part 1 of the Project; and (b) the performance of implementing agencies (including Health Administration Directorates and Services) under the Performance Frameworks of Part 2 of the Project.				
IDAT	Revise all project manuals and safeguards documents.	Schedule 2. Section I.G.1. The Recipient shall, not later than 3 months after the Effective Date, revise and update the Project Implementation Manual, PBF Manual and Safeguard Documents to take into account the requirements and specificities of this Additional Financing.	31-Jul-2017	☐		New

Conditions

Source Of Fund	Name	Type
SPTF	Execution and Delivery of Financing Agreement	Effectiveness

Description of Condition
Evidence satisfactory to Association was furnished that the execution & delivery of this Agreement on behalf of the Recipient have been duly authorized or ratified by all necessary governmental action.

Source Of Fund	Name	Type
GFF	Execution and Delivery of Financing Agreement	Effectiveness

Description of Condition
Evidence satisfactory to Association was furnished that the execution & delivery of this Agreement on behalf of the Recipient have been duly authorized or ratified by all necessary governmental action.

Source Of Fund	Name	Type
IDA	Execution and Delivery of GFF and USAID Grant Agreements	Effectiveness

Description of Condition
Evidence satisfactory to the Association has been furnished to the Association namely, that the GFF TF Additional Grant Agreement and USAID TF Additional Grant Agreement have been executed and delivered, and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals thereunder have been fulfilled.

Source Of Fund	Name	Type
IDA	Section IV. B. 1. (b) of Financing Agreement	Disbursement

Description of Condition
No withdrawal shall be made for payments under Category (2) (a) (i), unless grant proceeds made available under the GFF TF Additional Grant Agreement have been entirely disbursed.

Source Of Fund	Name	Type
IDA	Section IV. B. 1. (c) of Financing Agreement	Disbursement

Description of Condition
No withdrawal shall be made for payments of Retirement Benefits under Category (2) (b), unless the independent Financial Agent referred to in Section I.H.2 of this Schedule has been duly recruited by the Recipient

Source Of Fund	Name	Type
IDA	Section IV. B. 1. (d) of Financing Agreement	Disbursement

Description of Condition
No withdrawal shall be made for payments made under Category (4) for Emergency Expenditures under Part 4 (b) of the Project, unless and until the Association is satisfied, and notified the Recipient of its satisfaction.

Risk	
Risk Category	**Rating (H, S, M, L)**
1. Political and Governance	High
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Moderate
9. Other	
OVERALL	Substantial

Finance

Loan Closing Date - Additional Financing for Health System Strengthening for Better Maternal and Child Health Results Project - P157864)

Source of Funds	Proposed Additional Financing Loan Closing Date
Single Purpose Trust Fund (USAID)	31-Dec-2019
Global Financing Facility	31-Dec-2021
IDA Credit	31-Dec-2021

Loan Closing Date(s) - Parent (Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) - P147555)

Explanation:

To align with the new sources of funding and restructuring of project activities, the original and new loans and grants will share the same closing date, thus extending the parent project date by two years. This will be the first extension for the parent project.

Ln/Cr/TF	Status	Original Closing Date	Current Closing Date	Proposed Closing Date	Previous Closing Date(s)
IDA-55720	Effective	31-Dec-2019	31-Dec-2019	31-Dec-2021	31-Dec-2019
IDA-D0210	Effective	31-Dec-2019	31-Dec-2019	31-Dec-2021	31-Dec-2019
TF-18375	Effective	31-Dec-2019	31-Dec-2019	31-Dec-2021	31-Dec-2019

Change in Disbursement Estimates (including all sources of Financing)

Explanation:

To align with the new sources of funding and restructuring of project activities, the original and new loans and grants will share the same closing date, thus extending the parent project date by two years. Furthermore, changes in disbursement estimates are necessary to account for the delay in implementation and account for the additional USD 163.5 million.

Expected Disbursements (in USD Million) (including all Sources of Financing)						
Fiscal Year	2017	2018	2019	2020	2021	2022
Annual	0.00	29.00	39.00	38.00	42.00	15.50
Cumulative	0.00	29.00	68.00	106.00	148.00	163.50

Allocations - Additional Financing for Health System Strengthening for Better Maternal and Child Health Results Project - P157864)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement %(Type Total)
			Proposed	Proposed
IDA	SDR	(1) PBF Grants under Parts 1 and 2 of the Project	43.50	100.00
IDA	SDR	2) (a) Goods, non-consulting services, consultants' services, Operational Costs, Training and Workshops		
		(i) under Parts 1 and 2 of the Project	21.00	100.00
		(ii) under Part 3 of the Project other than under subparagraph (b) below	1.90	100.00
		(b)Retirement benefits under Part 3 (c) (i) of the Project	11.00	100.00
IDA	SDR	(3) Goods, non-consulting services, consultants' services, Operational Costs, Training and Workshops under Part 4 (a) of the Project	11.00	100.00
IDA	SDR	(4) Emergency Expenditures under Part 4 (b) of the Project	0	100.00
		Total:	88.40	

GFF	USD	Goods non-consulting services, consultants' services, Operational Costs, Training and Workshops under Parts 1, 2 and 3 (a) and (b)1-3	40.00	46.00
		Total:	40.00	
USAID	USD	(1) PBF Grants under Parts 1 and 2 of the Project	3.00	100.00
		(2) Goods non-consulting services, consultants' services, Operational Costs, Training and Workshops under Parts 1 and 2 of the Project	0.50	100.00
		Total:	3.50	

Components

Change to Components and Cost

Explanation:

Below is a brief description of the parent components and the new activities this AF will finance.

Component 1: Improve Utilization and Quality of Health Services at Health Facilities through Performance-Based Financing. Total original costs including contingencies: USD 120 million equivalent of which USD 115 million from IDA and USD 5 million from HRITF. New costs including contingencies: USD 174 million equivalent of which USD 154.5 million from IDA, USD 5 million from HRITF, USD 12 million GFF-TF, and USD 2.5 million from USAID TF.

This component currently supports PBF of a minimum RMNCAH package of essential HNP services through contracts at the 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) will provide gateways to the promotion of nutrition. Specifically, under component 1, the project will strive to improve the quality of newborn and infant feeding as well as improve related core family behaviors (*Alimentation du nourrisson et du jeune enfant et pratiques familiales essentielles – ANJE/PPE)* and the provision of services delivered during antenatal, maternity and early childhood consultations. Staff will receive counseling materials and appropriate management tools

and will be trained in improved supervision and support of workers at the community level.

Family planning services will be 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. The two biggest barriers preventing adolescent girls and boys from seeking 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 utilization rates". This AF will also finance the training of service 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 HNP services 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: USD 65.2 million equivalent of which USD 63.7 million from IDA and USD 1.5 million from the HRITF. Total new costs including contingencies: USD 90.7 million equivalent of which USD 83.2 million from IDA, USD 1.5 million from the HRITF, USD 5 million from GFF-TF, and USD 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 EUPs for contract management and verification; (ii) performance frameworks at all levels of the health system to hold the 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 counseling, 'edutainment' and training of teachers both on the prevention of SGBV and on combating sexual abuse of students by teachers. Finally, the National Adolescent Health Program within the MOPH 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, Health Policy. Total original costs including contingencies: USD 41.3 million equivalent from IDA. Total new costs including contingencies: USD 110.3 million equivalent from IDA of which USD 87.3 million from IDA and USD 23 million from the GFF-TF.

The parent project financed a number of activities focusing on: 1) 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; and 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, monitoring and evaluation (M&E), coordination and program management at all levels, and performance contracts). However, the scale and intensity will be amplified to address the geographic expansion of PBF activities, the expansion of the scope to include Public Administration Reform, the intensification of the 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 PFM in the health sector through capacity building of the newly created *Direction Administrative et Financière* (*DAF* - Directorate of Administration and Finance). These activities will be conducted in collaboration with the existing WB's Public Financial Management and Accountability Project operation.

A number of bottlenecks related to the quality of care have been identified since the 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 the 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 United Nations (UN) agencies, Non-Governmental Organizations (NGOs) and partners from bilateral cooperation agencies.

A key challenge to improving the 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 Public Health. This sub-component aims to support the retirement program within the MOPH 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 MOPH, and (ii) supporting the organizational reform of the MOPH 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 PSRRP for the retirement of eligible civil servants within the MOPH. 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: USD 15 million equivalent from IDA.

The original sub-component 3.3 on Ebola preparedness 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 DRC Government was very effective in controlling it. As new epidemics have emerged since the preparation of the parent project such as Yellow Fever and a Cholera epidemic, it is proposed that this sub-component be renamed as "Sub-Component 4.1 Disease 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 also includes the sub-component 4.2: Contingent Emergency Response Component (CERC) (Total financing: USD 0 million IDA): A CERC will be included under the project in accordance with OP 10.00 paragraphs 12 and 13, for projects in situations of urgent need of assistance or capacity constraints. This will allow for the 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 detail in the project implementation manual to be developed by the project team at the MOPH. 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 parent project. The AF could support additional TA support of a nutrition specialist and gender based violence specialist to reinforce the directorate in charge of these programs within the MOPH. 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. Similarly, the implementation unit (the DEP) will hire a social and environment specialist to oversee, as needed, the safeguards activities.

Current Component Name	Proposed Component Name	Current Cost (USDM)	Proposed Cost (USDM)	Action
Component 1: Improve Utilization and Quality of Health Services at Health	Additional FP, nutrition, adolescent health, and SGBV activities included	120.00	174.00	Revised

Facilities through Performance Based Financing.	in the RMNCAH PBF package of services			
Component 2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance Based Financing.	Community based interventions added focusing on demand side of the RMNCAH package of services.	65.20	90.70	Revised
Component 3: Strengthen Health System Performance Financing, Health Policy, and Surveillance Capacities.	A new sub-component on retirement reform program will be added to this component and additional activities will be financed to support supply chain and availability of drugs & vaccines, and capacity building.	41.30	110.30	Revised
	Component 4: Disease Surveillance Strengthening and Response	0.00	15.00	New
	Total:	226.50	390.00	

Other Change(s)

Implementation Arrangements:

The implementation arrangements for the Additional Financing will remain largely the same as for the parent project in the 156 health zones that are targeted.

The high level Steering Committee will continue to provide oversight and strategic guidance to the project. The MOPH will implement the project through the Planning and Evaluation Directorate (*Direction de la Planification et de l'Évaluation - 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 MOPH 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 four EUPs to ensure proper contracting with health facilities and the verification of results prior to payment; this arrangement will continue under the AF.

The DPS is the main lever of the health pyramid for technical support areas in the provision and regulation of health services. Starting June 2017, as part of the PBF implementation, the DPS will sign a single integrated performance contract ("*contrat unique*") with the provincial Ministry of Health or the

Secretary General MOPH (to be determined) that will be evaluated quarterly by the monitoring and evaluation cell of the MOPH in collaboration with an external verification agency. The DPS will have among other functions: (i) the regular supervisory visits to their health zones, (ii) to organize and participate --in collaboration with clinicians specialized in quality of care-- in quarterly quality assessments in the first level referral hospitals (*Hopital Général de Référence, HGR*); and (iii) to provide the secretariat of the provincial PBF steering committee.

The ECZS will have an important role in the regulation of the quality of health facilities. As part of the implementation of the PBF, the health zone team signs a performance contract with the EUP. The health zone health team will be responsible for: (i) conducting, each quarter, a quality of care assessment in each contracted health center using a quantified quality checklist; (ii) providing technical support (supervision, coaching, compliance etc.) to health facilities; (iii) strengthening the analysis and consolidation of the health management information system (HMIS) data and providing feedback on the quantity and quality of services of health facilities as well as supporting providers in the organization of services and the implementation of their management plans; and (iv) organizing monthly review meetings to discuss the quantity and quality indicator trends.

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.

Diagram 1: Parent Project Institutional Arrangements

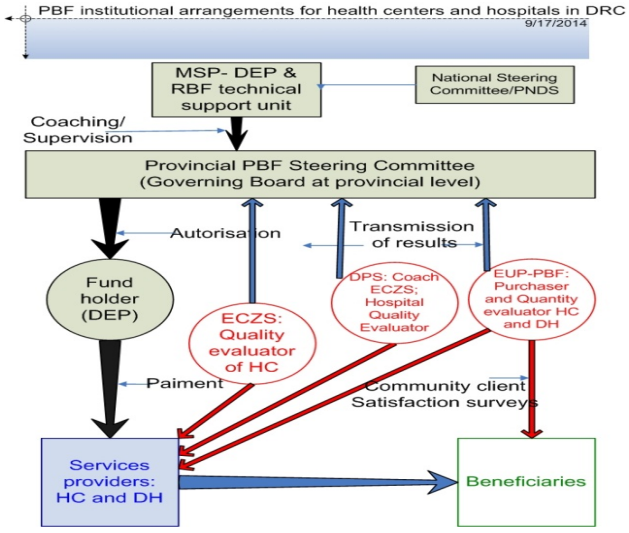
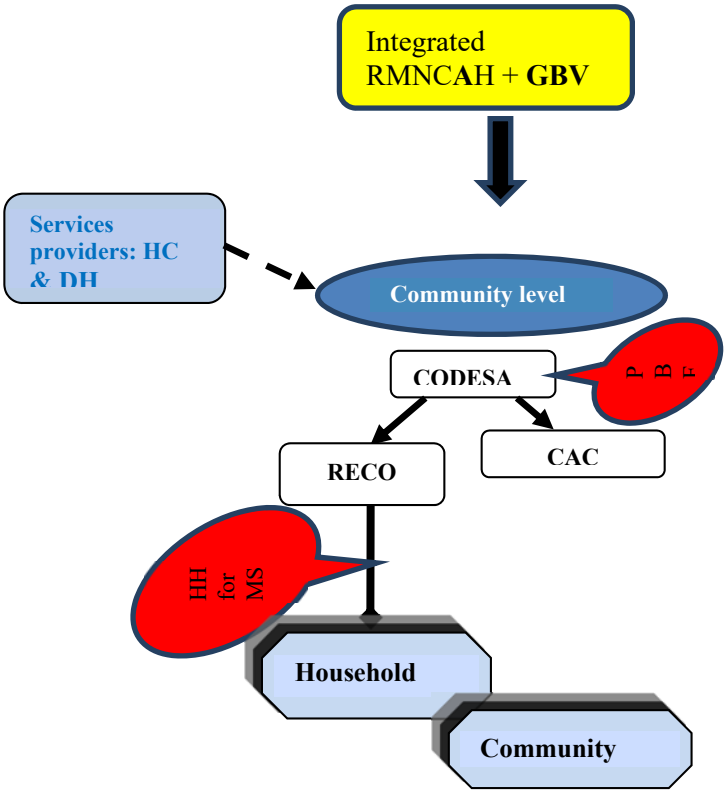


Diagram 2: Community level PBF



The AF will be implemented in coordination and alignment with the development partners that are part of the PDSS Partnership Platform. The agencies will work synergistically to complement each other and utilize their comparative advantage to maximize effectiveness, avoid duplication of efforts and improve efficient use of resources. UNICEF will not only contribute to the purchase of quality health outputs, but will also introduce Family Kits (both at the household and health facility level) as well as introduce and strengthen their community based interventions in the project targeted areas. Collaboration with UNICEF will benefit from their large contingent of project staff (UNICEF has 510 staff in the DRC – the largest UNICEF office in the world) to strengthen coaching at health facility levels. GAVI, GFTAM, UNFPA and USAID will continue to finance the purchase of commodities and complement the technical assistance and implementation arrangements of the AF with their own.

IV. Appraisal Summary

Economic and Financial Analysis

Project development impact

The project will contribute to improving mother, child and adolescent girl survival and reducing mortality related to communicable diseases by promoting interventions that address malnutrition; by increasing the coverage of effective mother and child health interventions such as family planning, assisted deliveries, pre- and post-natal care and integrated management of childhood illnesses; by promoting preventive care and vaccination; and by improving the management and treatment of communicable diseases, in particular HIV/AIDS, tuberculosis (TB), and malaria.

The project will contribute to reducing the health care costs related to disease treatment by focusing on cost-effective preventive and curative measures, and to reducing the social economic burden that is

related to the extra care needed for children who are stunted and who suffer from preventable diseases; it will also reduce cost related to unsafe delivery that can have lifelong consequences. Family planning can also save infant lives by spacing planned births and limiting unintended births; it also saves maternal lives by reducing exposure to the risks of pregnancy and childbirth, including recourse to unsafe abortion.

This project will generate long-term economic benefit by increasing an active and productive labor force who can potentially contribute to economic growth and poverty elimination. A recent study on the impact of maternal and child health on economic growth found a bi-directional relationship in the DRC between mortality and changes in Gross Domestic Product (GDP) meaning that changes in GDP have an impact on children under five and maternal mortality and vice versa. The study further demonstrates that the effect of marginal health investments on health outcomes is higher at low levels of GDP, i.e. in countries where the level of health investments is generally lower, such as DRC[12].

This AF will also generate economic benefit through its greater emphasis on addressing the key determinants of chronic malnutrition in DRC. A WB study estimated that vitamin and mineral deficiencies in the DRC collectively added up to an estimated loss of over USD 100 million in GDP every year[13]. By contrast, investments in early nutrition have the potential to boost wage rates by 5 to 50 percent and make children 33 percent more likely to escape poverty in the future, as well as to address gender inequities[14]. As there is strong evidence that improving nutrition during the critical 1,000-day window spanning from a woman's pregnancy to her child's second birthday can save lives, help millions of children develop fully and thrive, and deliver greater economic prosperity[15], this AF will support the streamlining of cost-effective nutrition interventions in the DRC. For instance, poor new-born and infant feeding practices will be addressed by strengthening the prenatal consultations and growth monitoring consultations for children under five years of age at the facility level at the same time as the counseling and behavior change communication for these target groups at the community level.

This project will promote equity and shared prosperity by targeting the most vulnerable populations, that is to say mother, adolescent girls and children under five. The results-based financing arrangement coupled with the *tarification forfaitaire* will help ensure that health care services are provided at a reasonable cost to prevent households and individuals from catastrophic or impoverishing expenditures when seeking care.

The project will contribute to improved technical efficiency in the health service delivery system. Thanks to PBF which contributes to strengthening institutional capacity and improving the availability and quality of key inputs, more facilities will be pushed to the production function frontier, and therefore, deliver better services to the extent possible at a given cost. The *Contrat unique*, which will be implemented at the provincial level for administrative activities, will also contribute to efficiency gains by cutting administrative and transaction costs as well as avoiding duplication of efforts.

[12] Amiri, A. and Gerdtham, U.G., 2013. *Impact of maternal and child health on economic growth: New evidence based granger causality and DEA analysis.* Newborn and Child Health, Study Commissioned by the Partnership for Maternal, Lund University, Sweden.

[13] World Bank. 2011. *Nutrition at a Glance: The Democratic Republic of Congo*. Washington, DC. World Bank Group.

[14] Shekar, Meera; Mattern, Max; Laviolette, Luc; Eberwein, Julia Dayton; Karamba, Wendy; Akuoku, Jonathan Kweku. 2015. *Scaling up nutrition in the Democratic Republic of Congo: what will it cost?*. A policy brief. Washington, DC; World Bank Group.

[15] World Bank. 2016. *Investing in nutrition: the foundation for development – an investment framework to reach the global nutrition targets*. Washington, D.C.: World Bank Group.

T**he project will also contribute to improved allocative efficiency at health facility and community levels.** By its focus on primary health care and community-based activities, which are the most cost-effective modalities to provide a defined package of high impact services, the project will support DRC's health system to be more results-focused. It will also facilitate efficiency improvements by allocating resources to where marginal benefits and utility are highest and by focusing on areas that are lagging behind.

This additional financing also addresses the issue of the aging workforce in the health sector that hampers the effectiveness of health spending in DRC and jeopardizes the achievement of the country's development objectives. Human resources statistics show that out of an overall workforce of 250,000 staff and civil servants eligible for retirement in the DRC, 22,000 workers (8 percent) are concentrated in the health sector. In the health sector itself, 27 percent of the workforce are eligible for retirement. By supporting the implementation of the retirement program within the health sector, this project will contribute to the success of reforms aimed at improving the efficiency of the health system. Given the envelope available, more than 4,000 health officials who are over the age of retirement, will be targeted by the project. An estimated budget saving of about USD 5 million (on the basis of the salary and bonus envelope) will be achieved on an annual basis and may be used to support other inputs of the health sector and notably the pay of regular but non-mechanized agents and the possibility of conditional regularization of the situation of certain agents still having the status of the new units.

Rationale for working with the public sector. Public sector engagement is justified by the critical role of the government in regulating the health sector, and by the Project's economic and social goals. Investments funded through the Project will strengthen health service delivery and improve institutional capacity. Public sector intervention is critical to promote good health in the general population, making sure that no one is left behind. Public sector investments are key to provide and promote preventive health services and support equity improvements to access good quality RMNCAH services. These interventions also have positive externalities and important spillovers (societal returns of investing in women's and children's health for economic growth) which advocate the intervention of the public sector.

The project will support public facilities as well as selected faith-based and private for profit facilities. Nevertheless, and although it is estimated that about 40 percent of health facilities are faith-based non-for-profit organizations, the MOPH has limited information about such facilities. It is therefore recommended that further information be collected on the private sector in the DRC as it stands for a major provider of health care. Such data could be used to inform a study on how to better engage the private sector in health financing and service delivery in DRC.

Value added of the World Bank support to DRC is: (i) its technical input based on international experience on health systems strengthening and specifically on results-based financing and capacity to mobilize a wide-range of technical expertise to support key strategies and reforms but also (ii) its convening role in DRC to support the mobilization of additional resources for innovative health interventions in the country. Furthermore, the ongoing PDSS is successful in supporting the Government to implement key reforms such as Performance-Based Financing, *Contrat unique*, and *tarification forfaitaire*.

The Cost-Benefit analysis (CBA) analysis performed for the parent project[16] showed a rate of return of approximately 16 percent. This demonstrates the positive economic performance of the PBF approach proposed in the project and its capacity to generate large returns for the country's economy and society. As

[16] The analysis performed in 2015 focused on the PBF output-related component. The method consisted of: (i) identifying the PBF project's inputs and outputs, (ii) monetizing benefits of project, (iii) discounting benefits and costs and (iv) computing the net returns. Costs and benefits were discounted with a real social discount rate over 5 years estimated at 5 percent in real terms.

interventions provided through the AF under the PBF component are comparable to those in the parent project, the same rate of return is expected for the AF.

Financial Analysis

Macroeconomic situation

DRC has shown considerable economic growth over the last decade after two decades of civil war. Between 2010 and 2014, the GDP increased by 7.8 percent per year on average. In 2014, the DRC real GDP growth rose to 9.5 percent, well above the average for sub-Saharan Africa (5.2 percent).

The global economic slowdown and domestic political uncertainty have taken their toll on the economy in the last quarter of 2015 and the first half of 2016. GDP growth in 2015 decelerated to 6.9 percent from 9.5 percent in 2014, and may not exceed 2.7 percent in 2016. Demand for commodities is falling, public investment declining, and activity slowing down. Revenues from extractives also declined, and the government reduced the 2016 budget by 22 percent. It is expected that protracted political tensions and uncertainty may keep growth in 2017-2018 lower than in 2012-2015. In the long term, infrastructure and human capital are expected to remain key to diversify and improve resilience[17].

The Total Health Expenditure (THE) in the DRC is low in absolute term and by international standards. THE per capita in real terms amounted to USD 15.5 in 2015 for DRC, far below the average for Low- and Lower-Middle Income Countries (L-LMIC) of USD 76.9. Besides, the composition of THE reveals that households, through out of pocket expenditures, are the main spenders on health in the DRC, followed by donors. Public spending represents a very limited share of THE (14 percent). The structure of THE in DRC suggests major issues in terms of financial protection as households have to pay out-of-pocket to receive health care services, thus incurring the risk of catastrophic expenditure and forgone care. Health financing is also highly dependent on external assistance which raises issues as to the sustainability of funding as well as of the alignment with the needs and priorities of the country.

Health is given low priority in the Government's budget in the DRC. In 2014, the Ministry of Health budget accounted for 6.9 percent of the overall budget. This share dropped to 4 percent in 2015. Over the last decade, health represented about 4 to 5 percent of the total budget, way below the 15 percent Abuja target stated in the health financing policy under development. Despite the chronic issue of the underfunding of health by the Government, public spending is also characterized by a poor execution rate. In years when public allocation to health increased, the MOPH was indeed not able to execute the additional resources available. A study commissioned by the WB has further looked into public finance management issues related to health in the DRC. This AF as well as the GFF funded activities laid out in the investment case will aim to support the country in implementing some of the proposed recommendations.

Public spending on health is distorted towards spending on wages, leaving little flexibility and room to the Ministry of Health to finance other critical inputs. Real spending on wages doubled between 2007 and 2012. The share of the wage bill in total spending in health increased overtime and reached 78 percent of total budget in 2015.

Health financing in DRC is highly reliant on external sources. External aid accounted for an average of 40 percent of total health sector funding in 2008-2014. Despite this, external health aid remains low at USD 5.7 per capita in 2013 according to the national health accounts (NHA), which is half the average for sub-Saharan Africa. External assistance is mainly focused on funding for communicable diseases. It also

[17] World Bank. *DRC Macro Poverty Outlook.* Issue number 215. October 2016. World Bank Group.

finances investments in health care (nearly 90 percent of total capital expenditure are covered by external assistance).

Financial sustainability

It is expected that this project will be financially sustainable but close monitoring of the macroeconomic and budget situation will be needed. The proposed project investment, USD 50 million per year over a four-year period, is equivalent to 26 percent of the MOPH budget (when considering the executed MOPH budget in 2015). The "*rajeunissement*" (rejuvenation) component of the project is expected to have a positive effect on the project sustainability as it will create some fiscal space for the Ministry of Health. By freeing up resources that used to be spent on the salaries of people eligible for retirement, the project will contribute to reduce the share of the wage bill in total MOPH spending and allow the Ministry to allocate resources to other purposes, thus relying less on external assistance or households' contributions.

Technical Analysis

The Appraisal Summary developed for the parent project remains largely relevant, with the exception of the nutrition interventions. The Project would support a package of cost-effective interventions that are focused on the first 1,000 days of life, the critical period when timely interventions have the most impact.

The health sector is primarily responsible for delivering most direct nutrition-specific interventions for children and women, largely through outreach activities. In 2013, a major analysis by The Lancet identified 10 feasible and effective interventions that would reduce the burden of stunting by one-fifth if they were all delivered at 90 percent coverage. Stunting, a result of chronic malnutrition, is practically irreversible after age two. Its prevention requires interventions from conception to age two by focusing on improving both maternal and child nutrition through improved dietary intake. To ensure effectiveness of nutritional interventions, these need to be accompanied with growth monitoring and promotion, which reinforce the importance of good nutrition. In a study covering 36 countries, stunting prevention interventions resulted in as much as a 33 percent reduction in stunting and a 25 percent reduction in mortality between zero and 36 months.[18]

The AF activities focus on gaps in the delivery and quality of high-impact RMNCAH interventions. The gaps as identified by the Government include support to family planning, nutrition, adolescent health and SGBV interventions through performance based financing at both community and health facility levels. These interventions will be complemented by support from other partners such as UNFPA, USAID, the GFTAM, UNICEF, and GAVI.

The AF activities are consistent, complimentary and sequential with other projects and activities in the WB's broad portfolio in the DRC. The AF will further support complementary interventions to the parent project to strengthen the health system by focusing on three pillars identified by the Government as bottlenecks to achieving better health results: supply chain management, human resources for health (HRH), and public finance management (PFM). PFM interventions will be closely linked to the broader Public Finance Management project (PROFITS) where the establishment of a fiduciary directorate at the central and province level will be supported to improve efficiency and transparency in PFM. In terms of HRH, close alignment is being made to the PRRAP project whose objective is pension reform. The AF will also strengthen the linkages with the EQUIP funded by the Global Partnership for Education with the World Bank as the supervising entity in order to ensure a successful transition to primary school and provide teachers with training on SGBV prevention. Finally the project will build on alignments with the Human Development Systems Strengthening Project focusing on strengthening the supply chain and HMIS and on

[18] Bhutta et al. 2008.

the Emergency Sexual and Gender-Based Violence and Women's Health Project (P147489) to capitalize on lessons learned in the Eastern region of the DRC and replicate them in some provinces of the PDSS project.

Enhancing the quality of public sector governance and strengthening state effectiveness is an essential condition for the DRC's exceptional resource endowment to be translated into long term sustainable growth and poverty reduction. Today in the DRC, the public service continues to suffer from the progressive depletion of skilled manpower and a constantly aging workforce. It is estimated that 50-55 percent of all Congolese civil servants have passed the mandatory retirement age, which is 65 years old or 35 years of service, with many officials continuing to work until 75 years of age and upward. The lack of resources to pay end of career benefits together with the low credibility of the State in terms of meeting its obligations to pay pensions, constitute the main reason for this issue. As a result, this situation creates incentives for officials to remain in their positions well beyond the legally established retirement age, but also effectively hinders young professionals from pursuing a public administration career. Managing the retirement process is therefore a key precondition for effective public service reform. Furthermore, in the context of the preparation and the implementation of the public service reform, the DRC Government has carried out several technical analyses, particularly on the wage reform, the assessment of the payroll system (Bankarization), the study on the establishment of the Pension Funds as well as the review of the organizational charts for the targeted Ministries supported by the WB Project/PRRAP.

The project implementation arrangements are cognizant of capacity constraints. The AF will build on the capacity that has been built at the central and province level by supporting additional TA and to help implement the new activities. The proposed AF will finance experienced firms and NGOs, where necessary, to assist the MOPH, and build their implementation capacity.

Financial Management

Implementation arrangements of the ongoing PDSS project will be maintained under the AF. The existing arrangements provide for the Administrative and Financial Directorate *(Cellule Administrative et de Gestion Fiduciaire – CAGF)* to be the main implementing unit, with an ongoing FM technical assistance provided by the fiduciary team hired under the parent project. This team comprises two accountants, an internal auditor, and a financial management specialist who provide the support to the CAGF to properly manage these funds. Quarterly supervision mission will be conducted by the WB to build the capacity of the CAGF and ensure that project funds are being managed properly. To this end, the financial management aspects of the parent project have been reviewed to which the proposed AF will be entrusted.

The proposed project will use the existing financial management arrangements currently in place at PDSS that will be strengthened by the additional mitigation measures described below. The overall FM risk at preparation is considered substantial. The proposed financial management arrangements including the mitigation measures for this project are considered adequate to comply with the provisions of the WB Directive: Financial Management Manual For World Bank Investment Project Financing Operations (Catalogue Number OPCS5.05-DIR.01), Issued (Retrofitted): February 4, 2015 and Effective from March 1, 2010, and World Bank Guidance: Reference material - Financial Management in World Bank Investment Project Financing Operations (Catalogue Number OPCS5.05-GUID.02). Issued and Effective February 24, 2015.

The project team will need to be strengthened. Indeed, staffing of the project implementation team will be strengthened due to an increase in the scope and amount of the financing to be managed by the project, and the resultant increase in the scale of activities performed. The current project team was established with a lower scope and scale of activities, as well as a lower amount of financing, but following the increase in all these dimensions, three additional staff at least will need to be recruited: an additional Financial Management specialist that will double as a financial controller, an internal auditor and an accountant at the central level. Additional controls including internal audit processes will be executed at both the central and

provincial levels. The Project Manual of Financial and Administrative procedures will need to be updated to take into account the expanded activities.

Procurement

There will be no major changes in procurement arrangements. The procurement specialist hired by the parent project will provide the needed TA to the Procurement Unit *(Cellule de Gestion de la Passation des Marchés Publiques –CGPMP)*, and WB supervision will be enhanced in the first year of the AF implementation to ensure the volume of procurement is well managed by the current team.

Social Analysis

Institutional capacity building at the national, provincial and sub-provincial levels continues to be the focus of the project. The environmental and social safeguards frameworks developed for the parent project were disclosed in country in October 2016 and this AF will not trigger any additional environment or social safeguards that are not already taken into account in the recently disclosed documents. The AF will rely on the original project's safeguard documents, which were re-disclosed in country in February 2017. There will be no civil works, nor investments that would lead to social exclusion.

Environmental Analysis

Under the proposed AF, the environmental category of the project will remain B. Institutional capacity building at the national, provincial and sub-provincial levels continues to be the focus of the project. The environmental and social safeguards frameworks developed for the parent project were disclosed in country in October 2016 and this AF will not trigger any additional environment or social safeguards that are not already taken into account in the recently disclosed documents. The AF will rely on the original project's safeguard documents, which were re-disclosed in country in February 2017, including the Health Waste Management Plan. There will be no civil works, nor investments that would lead to social exclusion.

Risk

The overall risk is rated as Substantial. The unstable political environment with an interim Government in place given the fallout from not conducting elections on time and the macroeconomic risks related to the fall of commodity prices present additional risks that were not envisaged during the preparation of the parent project. The original main risks pertained to: (i) scaling up to 156 health zones and the resulting challenges posed by the geographical complexity and the associated issues of access; (ii) the complexities of working closely with development partners to achieve results; (iii) tackling key health system reforms such as user fee policies, pharmaceutical drug costs and drug management and quality. To date, these risks have proven to be manageable. Close financial management supervision has been put in place with the WB team providing technical support as needed. The partnership harmonization platform has enabled the strengthening of institutional capacity at all levels of the system. The anchoring of the project within the MOPH will be complemented by additional technical assistance for project coordination, management, as well as PBF expertise. Additionally, the web-application for results monitoring that is put in place by the project will allow a transparent and open way to follow the project achievements; it is expected that with these measures in place, implementation risks in the project would continue to be mitigated.

V. World Bank Grievance Redress

41. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which

determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate GRS, please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex1: Revised Results Framework and Monitoring Indicators

Project Development Objective Indicators							
Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Revised	Percentage of pregnant women having at least 3 antenatal care visits before delivery	☐	**PERCENTAGE**	Value	57.00	59.00	65.00
				Date	31-Jul-2014	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas
Marked for Deletion	Percentage of children aged between 6-23 months receiving preventive nutritional services at least four times per year	☐	Percentage	Value	26.90		35.00
				Date	31-Jul-2014		31-Dec-2019
				Comment			The results are monitored at the level of the project target areas
New	People who have received essential Health, Nutrition, Population services	☐	Number	Value	0.00	0.00	14,350,000.00
				Date	31-Dec-2016	31-Dec-2016	31-Dec-2021
				Comment	No data is available for the baseline as this is a new indicator.		The results are monitored at the level of the project target areas
Revised	New curative consultations per capita per year	☐	Text	Value	.25	.25	.50
				Date	31-Jul-2014	31-Dec-2016	31-Dec-2021
				Comment	Number is calculated by dividing nc/hab/an		

Revised	Percentage of Children Fully Immunized	☐	Percentage	Value	54.00	56.00	65.00
				Date	31-Jul-2014	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas
Revised	Average score of the quality checklist at the health centers	☐	Percentage	Value		20.00	55.00
				Date	31-Jul-2014	31-Dec-2016	31-Dec-2021
				Comment	N/A		The results are monitored at the level of the project target areas

Intermediate Results Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Revised	Number of new and existing acceptors of modern contraceptive use	☐	Number	Value	194,480.00	233,376.00	500,000.00
				Date	31-Jul-2014	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas
New	Average number of days with stock out of tracer drugs in targeted health facilities on the day of the visit	☐	Text	Value	>30 days	>30 days	>15 days
				Date	31-Dec-2016	31-Dec-2016	31-Dec-2021
				Comment	Baseline Data will be available at negotiations		The results are monitored at the level of the project target areas
New		☐	Number	Value	0.00	0.00	50,000.00
				Date	31-Dec-2016	31-Dec-2016	31-Dec-2021

	First time adolescent girls acceptant of modern contraceptives			Comment			The results are monitored at the level of the project target areas
New	Percentage of children under 24 months participating in the Growth Monitoring and Promotion activities at community level	☐	Percentage	Value	26.90	28.00	45.00
				Date	31-Dec-2015	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas
New	Health facilities receiving Client Tracer and Satisfaction Survey feedback	☐	Percentage	Value	0.00	0.00	80.00
				Date	31-Dec-2016	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas
New	Civil servants eligible for retirement in the Ministry of Health that have received their retirement indemnities/packages and retired from active service	☐	Number	Value	0.00	0.00	5,000.00
				Date	31-Dec-2016	31-Dec-2016	31-Dec-2021
				Comment			
New	Single contract signed and implemented at province level	☐	Number	Value	2.00	2.00	11.00
				Date	31-Dec-2016	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas
New	Percentage of families participating in parental	☐	Percentage	Value	0.00	0.00	50.00
				Date	31-Dec-2016	31-Dec-2016	31-Dec-2021

	education sessions at community level			Comment			The results are monitored at the level of the project target areas
New	Exclusive breastfeeding for children under 6 months	☐	Percentage	Value	N/A	54	66
				Date	31-Dec-2015	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas
Revised	Percentage of pregnant women counseled and tested for HIV	☐	Percentage	Value	17.50	23.00	38.00
				Date	31-Jul-2014	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas
Revised	Average quality of nutritional services	☐	Percentage	Value	0.00	20.00	55.00
				Date	31-Dec-2015	31-Dec-2016	31-Dec-2021
				Comment			
Revised	Number of poor people benefiting from fee exemption mechanisms	☐	Number	Value	5,248.00	5,300.00	6,500.00
				Date	31-Jul-2014	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas
Revised	Health personnel receiving training (number)	☒	Number	Value	0.00	4,000.00	10,000.00
				Date	31-Jul-2014	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the

							level of the project target areas
Revised	Number of Direct Beneficiaries, of which female	☐	Number	Value	0.00	5,351,089	20,090,000
				Date	31-Jul-2014	31-Dec-2016	31-Dec-2021
				Comment			The results are monitored at the level of the project target areas

Annex 2: Economic Analysis

The Health System Strengthening Project for better maternal and child health results (PDSS) Additional Financing (AF) aims to improve utilization and quality of maternal and child health services in the targeted areas of DRC. The PDSS AF project will build on project activities and achievements of the ongoing project (PDSS), which constitute a solid foundation, while trying to increase the impact on the performance of the health system. It will not only maintain the good results already achieved (maternal and child health services), but also (i) improve other strategic programs such as family planning and immunization; (ii) foster efforts against malnutrition; and (iii) boost the efficiency of public spending supporting the retirement process of health care professionals and managers.

1. Project development impact

The proposed project will contribute to DRC's development through the following pathways: improving mother, child and adolescent girls' survival and reducing mortality related to communicable diseases; saving unnecessary health care costs and social care costs; increasing productive labor force; promoting equity and shared prosperity; and improving health system efficiency.

The project will contribute to improving mother, child and adolescent girls survival and reducing mortality related to communicable diseases by promoting interventions that address malnutrition; by increasing the coverage of effective mother and child health interventions such as family planning, assisted deliveries, pre- and post-natal care and integrated management of childhood illnesses; by promoting preventive care and vaccination; and by improving the management and treatment of communicable diseases, in particular HIV/AIDS, TB and malaria. According to the World Health Organization (WHO), more than half of under-5 child deaths are due to diseases that are preventable and treatable through simple, affordable interventions. Strengthening health systems to provide such interventions to all children will save many young lives. Further, malnourished children, particularly those with severe acute malnutrition (SAM), have a higher risk of death from common childhood illness such as diarrhea, pneumonia, and malaria. Nutrition-related factors contribute to about 45 percent of deaths in children under 5 years of age. Similarly, most complications during and following pregnancy and childbirth are preventable or treatable. The major complications that account for nearly 75 percent of all maternal deaths are severe bleeding (mostly bleeding after childbirth); infections (usually after childbirth); high blood pressure during pregnancy (pre-eclampsia and eclampsia); complications from delivery and unsafe abortion. The project will contribute to maternal mortality reduction by addressing barriers that limit access to quality maternal health services, in particular through addressing inequalities in access to quality reproductive, maternal and newborn health care services; ensuring universal health coverage for comprehensive reproductive, maternal, and newborn health care; strengthening the health system to respond to the needs and priorities of women and girls; and ensuring accountability in order to improve quality of care and equity.

The project will contribute to reducing the health care costs related to disease treatment by focusing on cost-effective preventive and curative measures, and to reducing the social economic burden that is related to the extra care needed for children who are stunted and suffer from preventable diseases; it will also reduce cost related to unsafe delivery that can have lifelong

consequences. Family planning can also save infant lives by spacing planned births and limiting unintended births; it also saves maternal lives by reducing exposure to the risks of pregnancy and childbirth, including recourse to unsafe abortion. The table below provides an overview of the cost-effective interventions included in the PBF package supported by the PDSS AF, their cost per DALY and DALYs averted.

Table 2. Cost-effective interventions for mothers, adolescent girls and children included in PDSS AF

Intervention	Intervention setting	Objective	Target population	Cost-effectiveness (USD/DALY)	Cost-effectiveness range (USD/DALY)	Number of DALYs averted (hundreds)
Case management at community or facility level	Clinic, community	Cure	Children under 5	129	50–208	5.15
Case management package at community, facility, and hospital levels	Clinic or district hospital	Cure	Children under 5	398	—	11.26
Increased primary care coverage	Clinic or district hospital	Primary prevention	Pregnant women	88 (Sub-Saharan Africa)	—	27.88 (Sub-Saharan Africa)
Improved quality of comprehensive emergency obstetric care	Clinic or district hospital	Acute management	Pregnant women	87 (Sub-Saharan Africa)	—	28.28 (Sub-Saharan Africa)
Improved quality of care and coverage	Clinic	Primary prevention, acute management	Pregnant women	86 (Sub-Saharan Africa)	85–86 (Sub-Saharan Africa)	56.93 (Sub-Saharan Africa)
Family, community, or clinical neonatal package	Clinic, community or household	Primary prevention	Mothers and infants	345 (Sub-Saharan Africa)	338–351(Sub-Saharan Africa)	—
Family-planning programs	Clinic	Primary prevention	Women of childbearing age	117	—	—
Supplements with oral rehydration salts	Clinic or district hospital	Primary prevention	Children under 5	73	—	—

Source: Adapted from Laxminarayan R, Chow J, Shahid-Salles SA. Intervention Cost-Effectiveness: Overview of Main Messages. In: Jamison DT, Breman JG, Measham AR, et al., editors. Disease Control Priorities in Developing Countries. 2nd edition. Washington (DC): The World Bank; 2006. Chapter 2.

This project will generate long-term economic benefit by increasing active and productive labor force who can potentially contribute to economic growth and poverty elimination. With improved health and nutrition status, more children will survive into adulthood and work more productively as a result of a better cognitive development. Women who are saved from maternal

deaths will contribute directly to productive activities or relieve household members who would have had to provide child care without their presence. A recent study on the impact of maternal and child health on economic growth found a bi-directional relationship in the DRC between mortality and changes in GDP meaning that changes in GDP have an impact on under-five and maternal mortality and vice versa. The study further demonstrated that the effect of marginal health investments on health outcomes is higher at low levels of GDP, i.e. in countries where the level of health investments is generally lower, such as in the DRC[19]. A study on the World Health Organization Africa Region (WHO AFRO) countries also found that maternal mortality of a single person reduces per capita GDP by USD 0.36 per year[20].

This AF will also generate economic benefit through its greater emphasis on addressing the key determinants of chronic malnutrition in DRC. Malnutrition, particularly in very young children, leads to increased mortality rates, increased illness, and longer-term effects on cognitive abilities. These result in irreversible losses to human capital that contribute to later losses in economic productivity. A World Bank study estimated that vitamin and mineral deficiencies in the DRC collectively added up to an estimated loss of over USD 100 million in gross domestic product (GDP) every year[21]. By contrast, investments in early nutrition have the potential to boost wage rates by 5 to 50 percent and make children 33 percent more likely to escape poverty in the future, as well as to address gender inequities[22]. As there is strong evidence that improving nutrition during the critical 1,000-day window from a woman's pregnancy to her child's second birthday can save lives, help millions of children develop fully and thrive, and deliver greater economic prosperity[23], this AF will support the streamlining of cost-effective nutrition interventions in the DRC. For instance, poor newborn and infant feeding practices will be addressed by strengthening the prenatal care *(Consultation Pré-natal –CPN)* and school enrollment consultation *(consultation pré-scolaire – CPS)* at the facility level at the same time as the counseling and behavior change communication at the community level.

This project will promote equity and shared prosperity by targeting the most vulnerable populations, that is to say mothers, adolescent girls and children under five. The results based financing arrangement coupled with the *tarification forfaitaire* will help ensure health care services are provided at a reasonable cost to prevent households and individuals from catastrophic or impoverishing expenditures when seeking care.

The project will contribute to improved technical efficiency in the health service delivery system. Due to PBF which contributes to strengthening institutional capacity and improving the

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[19] Amiri, A. and Gerdtham, U.G., 2013. *Impact of maternal and child health on economic growth: New evidence based granger causality and DEA analysis.* Newborn and Child Health, Study Commissioned by the Partnership for Maternal, Lund University, Sweden.

[20] Kirigia, J.M., Oluwole, D., Mwabu, G.M., Gatwiri, D. and Kainyu, L.H., 2006. *Effects of maternal mortality on gross domestic product (GDP) in the WHO African region.* African journal of health sciences, *12*(3), pp.55-64.

[21] World Bank. 2011. *Nutrition at a Glance: The Democratic Republic of Congo*. Washington, DC. World Bank Group.

[22] Shekar, Meera; Mattern, Max; Laviolette, Luc; Eberwein, Julia Dayton; Karamba, Wendy; Akuoku, Jonathan Kweku. 2015. *Scaling up nutrition in the Democratic Republic of Congo: what will it cost?*. A policy brief. Washington, DC; World Bank Group.

[23] World Bank. 2016. *Investing in nutrition: the foundation for development – an investment framework to reach the global nutrition targets*. Washington, D.C.: World Bank Group.

availability and quality of key inputs, more facilities will be pushed to the production function frontier, and therefore, deliver better services to the extent possible at a given cost. The *Contrat unique*, which will be implemented at the provincial level for administrative activities, will also contribute to efficiency gains by cutting administrative and transaction costs as well as avoiding duplication of efforts.

The project will also contribute to improved allocative efficiency at health facility and community levels. By its focus on primary health care and community-based activities, which are the most cost-effective modalities to provide a defined package of high impact services, the project will support the DRC's health system to be more results-focused. It will also facilitate efficiency improvements by allocating resources to where marginal benefits and utility are highest and by focusing on areas that are lagging behind.

This additional financing also addresses the issue of the aging workforce in the health sector that hampers the effectiveness of health spending in the DRC and jeopardizes the achievement of the country's development objectives. Human resources statistics show that out of an overall workforce of 250,000 staff and civil servants eligible for retirement in the DRC, 22,000 workers (8 percent) are concentrated in the health sector. In the health sector itself, 31 percent of the workforce are eligible for retirement. By supporting the implementation of the retirement program within the health sector, this project will contribute to the success of reforms aimed at improving the efficiency of the health system. Given the envelope available, more than 4,000 health officials who are over the age of retirement, will be targeted by the project. An estimated budget saving of about USD 5 million (on the basis of the salary and bonus envelope) will be achieved on an annual basis and may be used to support other inputs of the health sector and notably the pay of regular but non-mechanized agents and the possibility of conditional regularization of the situation of certain agents still having the status of the new units.

2. Rationale for working with the public sector

The public sector involvement is justified by the critical role of the government in regulating the health sector, and by the Project's economic and social goals. Investments funded through the Project will strengthen health service delivery and improve institutional capacity. Public sector intervention is critical to promote good health in the general population, making sure that no one is left behind. Public sector investments are key to provide and promote preventive health services and support equity improvements to access good quality RMNCAH services. These interventions also have positive externalities and important spillovers (societal returns of investing in women's and children's health for economic growth) which advocate the intervention of the public sector.

The project will support public facilities as well as selected faith-based and private for profit facilities. Nevertheless, and although it is estimated that about 40 percent of health facilities are faith-based non-for-profit organizations, the MOPH has limited information about such facilities. It is therefore recommended that further information be collected on the private sector in the DRC as it stands for a major provider of health care. Such data could be used to inform a study on how to better engage the private sector in health financing and service delivery in DRC.

3. Value added of the World Bank support

The value added of the World Bank support to the DRC is: (i) its technical input based on international experience on health systems strengthening and specifically on results-based financing and capacity to mobilize a wide-range of technical expertise to support key strategies and reforms, but also (ii) its convening role in the DRC to support the mobilization of additional resources for innovative health interventions in the country. Furthermore, the ongoing PDSS is successful in supporting the Government to implement key reforms such as Performance-Based Financing, *Contrat unique*, and *tarification forfaitaire*.

4. Cost-Benefit analysis

Justification

Economic analysis aims to assess whether the dollar benefits of a program outweigh its dollar costs. Cost benefit-analysis allows comparing the pros and cons of policies and programs to help policymakers identify the most valuable options to pursue. The CBA monetizes all major benefits and all costs associated with a project so that they can be directly compared with each other.

A CBA of PDSS was conducted in 2015 to measure the project's economic performance and to assess its returns against alternatives. As the PDSS AF aims to pursue the same interventions under the PBF component of the project, a distinct cost-benefit analysis was not performed for the purpose of this AF.

Methodology

The analysis performed in 2015 focused on the PBF output-related component. The method consisted of: (i) identifying the PBF project's inputs and outputs, (ii) monetizing benefits of the project, (iii) discounting benefits and costs and (iv) computing the net returns. Costs and benefits were discounted with a real social discount rate over 5 years estimated at 5 percent in real terms[24].

Results

The CBA analysis showed a rate of return of approximately 16.09 percent. This demonstrates the positive economic performance of the PBF approach proposed in the project and its capacity to generate large returns for the country's economy and society. As interventions provided through the AF under the PBF component are comparable to those in the parent project, the same rate of return is expected for the AF.

5. Financial Analysis

Macroeconomic situation

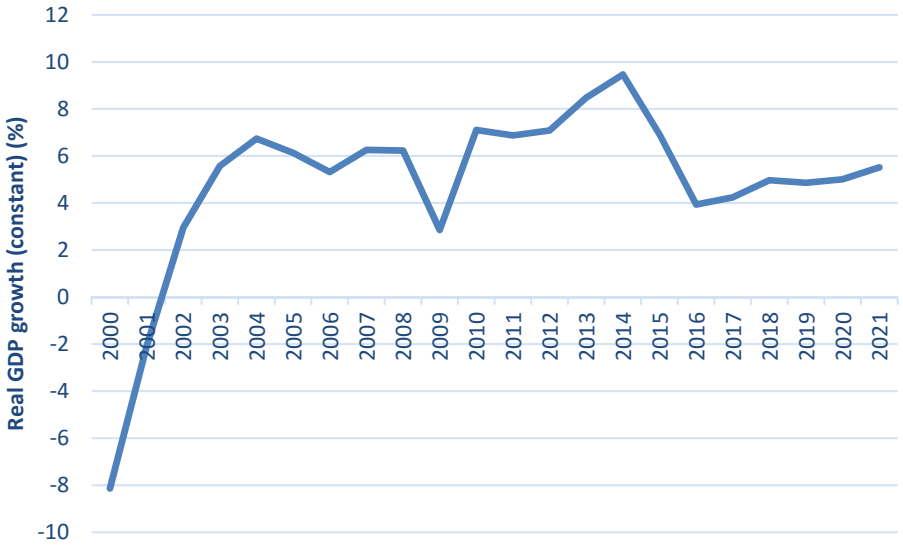
The DRC has shown considerable economic growth over the last decade after two decades of civil war. Between 2010 and 2014, the GDP increased by 7.8 percent per year on average. In

[24] For further details about the full Cost-Benefit Analysis, see the Project Appraisal Document (PAD) of PDSS (P147555).

2014, the DRC's real GDP growth rose to 9.5 percent, well above the average for sub-Saharan Africa (5.2 percent).

The global economic slowdown and domestic political uncertainty have taken their toll on the economy in the last quarter of 2015 and the first half of 2016. GDP growth in 2015 decelerated to 6.9 percent from 9.5 percent in 2014, and may not exceed 2.7 percent in 2016 (Figure 4). Demand for commodities is falling, public investment declining, and activity slowing down. Revenues from extractives also declined, and the government reduced the 2016 budget by 22 percent. It is expected that protracted political tensions and uncertainty may keep growth in 2017-2018 lower than in 2012-2015. In the long term, infrastructure and human capital are expected to remain key to diversify and improve resilience[25].

Figure 4. Real GDP growth: past trends and projections

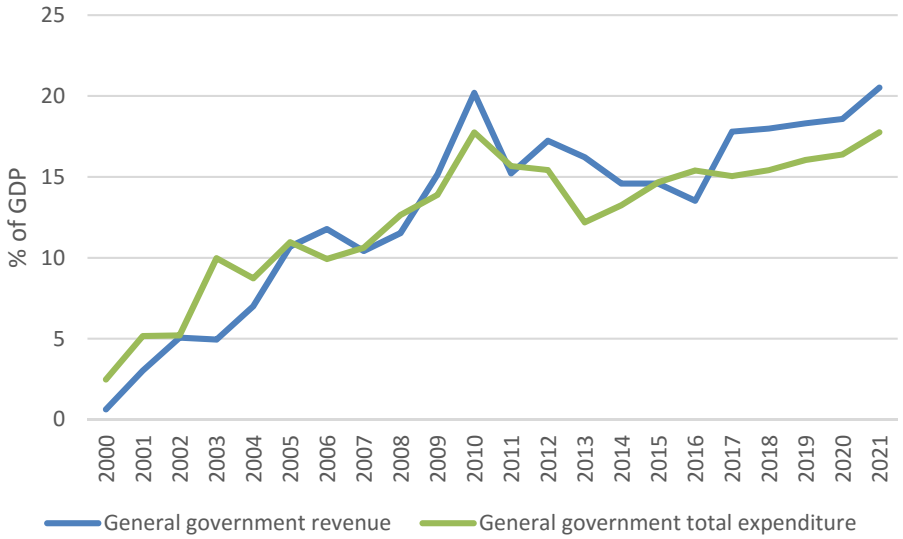


Source: IMF World Economic Outlook

With the last decade encouraging performance, domestic Government revenue as a share of GDP grew faster than the economy as a whole. Domestic revenue doubled between 2005 and 2010. In 2013 and 2014, however, Government revenues stagnated; they started to decline in 2015. In order to maintain fiscal balance, Government spending has also been eroded in recent years. Preliminary public finance figures show a drop by 12.4 percent in revenues over the first seven months of 2016. This decline motivated the government to cut the 2016 budget by 22 percent and to keep spending under control. It is however expected that both revenues and expenditures will increase in the next few years. Growth in 2017-18 would benefit from a gradual recovery in extractives responding to a slow recovery in commodities' global demand, and from the expansion in agriculture and services. The slow recovery in domestic revenue mobilization would restore some fiscal space, hence allowing for additional government spending[26] (Figure 5).

[25] World Bank. *DRC Macro Poverty Outlook.* Issue number 215. October 2016. World Bank Group.
[26] ibid.

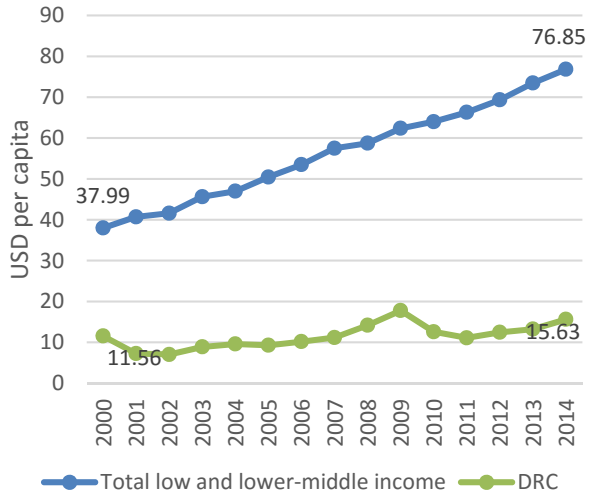
Figure 5. General Government Revenues and Expenditures (2000-2021)



Health sector expenditure

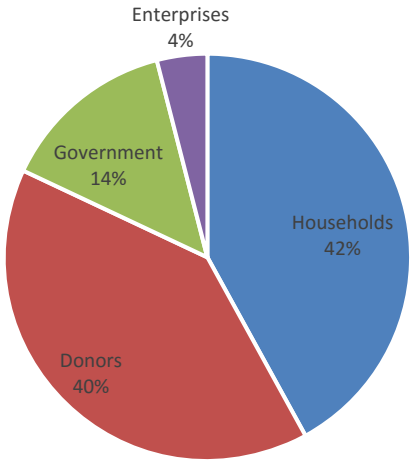
Total Health Expenditure in the DRC is low in absolute terms and by international standards. THE per capita in real terms amounted to USD 15.5 in 2015 for the DRC, far below the average for Low- and lower-middle income countries (L-LMIC) of USD 76.9 (**Error! Reference source not found.**). Besides, the composition of THE reveals that households, through out of pocket expenditures, are the main spenders on health in the DRC, followed by donors. Public spending represents a very limited share of THE (14 percent) (Figure 7). The structure of THE in DRC suggests major issues in terms of financial protection as households have to pay out-of-pocket to receive health care services, thus incurring the risk of catastrophic expenditure and forgone care. Health financing is also highly dependent on external assistance which raises issues of sustainability of funding as well as of alignment with the needs and priorities of the country.

Figure 6. Real THE per capita (2000-2014)



Source: WHO GHED

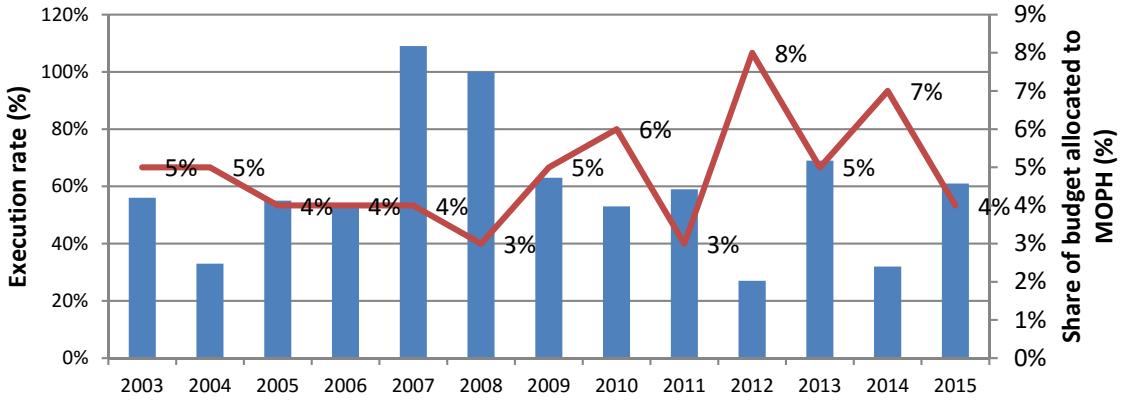
Figure 7. Health financing sources



Source: MOPH, NHA 2014 (2016)

Health is given low priority in DRC's Government budget in the DRC. In 2014, the Ministry of Public Health budget accounted for 6.9 percent of the overall budget. This share dropped to 4 percent in 2015. Over the last decade, health represented about 4 to 5 percent of the total budget, way below the 15 percent Abuja target stated in the health financing policy under development. Despite the chronic issue of the underfunding of health by the Government, public spending is also characterized by a poor execution rate. In years when public allocation to health increased, the MOPH was indeed not able to execute the additional resources available (**Figure 8**). A study commissioned by the World Bank has further looked into public finance management issues related to health in the DRC. This additional financing, as well as the GFF funded activities laid out in the IC, will aim to support the country in implementing some of the proposed recommendations**.**

Figure 8. Budget allocation to health and execution rate (2003-2015)



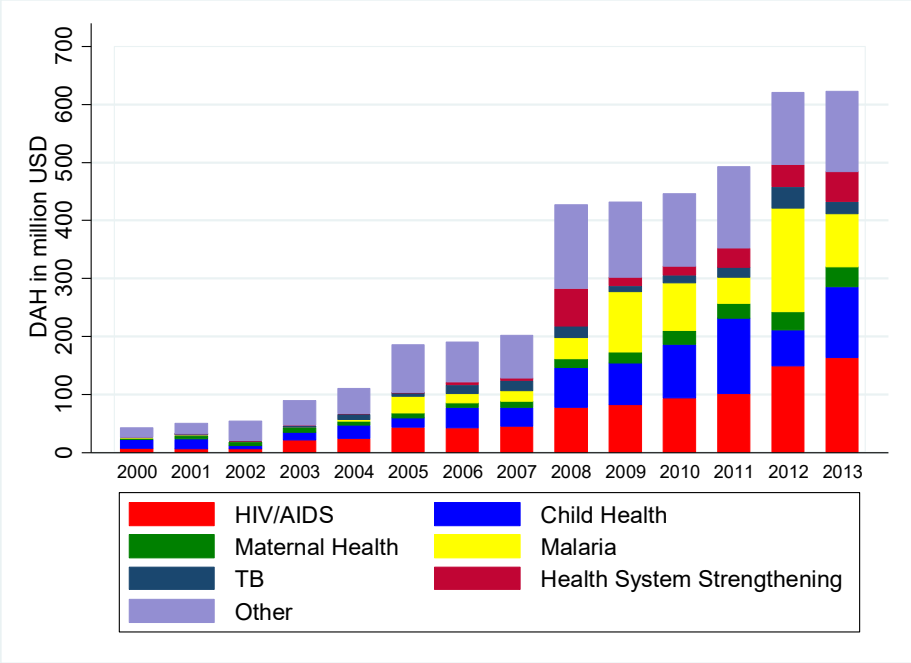
Source: NHA 2014 and MOPH (2016).

Public spending on health is distorted towards spending on wages, leaving little flexibility and room to the MOPH to finance other critical inputs. Real spending on wages doubled between 2007 and 2012. The share of the wage bill in total spending in health increased overtime and reached 78 percent of total budget in 2015.

Health financing in DRC is highly reliant on external sources. External aid accounted for an average of 40 percent of total health sector funding in 2008-2014. Despite this, external health aid remains low at USD 5.7 per capita in 2013 according to the NHA, which is half the average for sub-Saharan Africa. External assistance is mainly focused on funding for communicable diseases. It also finances investments in health care (nearly 90 percent of total capital expenditure are covered by external assistance).

Between 2000 and 2013, external assistance increased more than 10-fold in constant 2015 USD. External assistance on health is primarily disease oriented. It finances mainly maternal and child health programs as well as HIV/AIDS and malaria programs. The share of external resources going to health systems strengthening, although limited, has been growing in recent years (Figure 9). Fiscal space for health in the DRC critically depends on the sustainability of external funding, the extent to which additional Government and other domestic resources can be used to finance health services, and efficient use of the money available.

Figure 9. External assistance on health by program (2000-2013) in constant 2015 US dollars



Source: IHME
Note: "Other" includes other infectious diseases, NCDs, and other.

Financial sustainability

It is expected that this project will be financially sustainable but close monitoring of the macroeconomic and budget situation will be needed. The proposed project investment, USD 50 million per year over a four-year period, is equivalent to 26 percent of the MOPH budget (when considering the executed MOPH budget in 2015). The "*rajeunissement*" component of the project is expected to have a positive effect on project sustainability as it will create some fiscal space for the Ministry of Health. By freeing up resources that used to be spent on the salaries of people eligible for retirement, the project will contribute to reduce the share of the wage bill in total MOPH spending and allow the Ministry to allocate resources to other purposes, thus relying less on external assistance or households' contributions.

Annex 3: Supporting the Retirement Reform Program for the Ministry of Public Health

Context of the Country's Public Administration Reform

1. The Government of DRC has set objectives of making the DRC an emerging country by 2030. Accelerating the achievement of these objectives will require implementing reforms in the public sector to support better service delivery and long term development. However, several constraints still limit the effectiveness of the DRC public service, in particular: (i) a dysfunctional public administration, (ii) uncontrolled recruitment leading to a large number of new public servants (*Nouvelles Unités - NU*) and a plethora of staff, (iii) low human resource capacity and performance, (iv) low wages, and (v) an aging civil servant population.

2. Cognizant of the ills plaguing the public administration, the Government of the DRC has committed to reforming its administration to improve its efficiency. Over the last decade, public sector reforms continue to be one of the DRC Government's priority actions, as it constitutes a foundational axis to help consolidate peace and move the country towards a sustained economic and social recovery.

3. Significant progress has been made to date in the implementation of the public administration reform in the DRC:

(i) First, the country has adopted a new legal framework that takes into account the decentralization process: (a) the organic law that establishes the organization and functioning of the national, provincial and local public service and, (b) the new law on the Revised Statute for Civil Servants Career of the State's Public Services;

(ii) Secondly, ministries have begun to rationalize their missions and organizational structures, and as a result to set up standard structures with need based competencies;

(iii) Thirdly, a new pilot, the "Young Professional Program", is being executed to rejuvenate the human resources of the public service; and

(iv) Fourth, the process of reforming the social security system for civil servants in the DRC has been launched, through the setting up of the National Social Security Fund for Public Agents.

4. Despite these very promising advances, the aging of civil servants remains a major challenge that undermines public administration reform efforts as well as public service delivery in the DRC. In order to address this challenge, the Government has launched the pilot retirement program supported by World Bank's PSSRP project.

Pilot Retirement and Rejuvenation Program for Civil servants

5. Retirement and rejuvenation of national civil servants is one of the cores of the public administration reform, as over 800,000 civil servants (excluding the Army and the Police) of the DRC have exceeded the mandatory retirement age. The Ministry of Public Service estimates that

nearly 250,000 civil servants, or nearly 30 percent, would be eligible for retirement. This situation partly explains the inefficiency of the public administration in the DRC. Therefore, the weight of passive agents has become unsustainable.

6. The WB is providing a support grant of USD 77 million to the DRC's Government, through the PSRRP to: (i) to ensure organizational rationalization and improvement of human resources performance for 5 pilot ministries in charge of essential and cross-cutting functions of the State (Public Service, Finance, Budget, Planning and Portfolio), (ii) to rejuvenate their staff, and (iii) to strengthen their human resources management. More than 4,000 civil servants of the abovementioned ministries will be retired as part of this project, which creates a space for competitive recruitment for 1,000 young professionals. Recruiting and training high performing young professionals into the administration is aimed to modernize the public administration, rejuvenate it and add more efficiency in the public sector.

Institutional context of the Ministry of Health

7. The creation of a functioning and effective health system is one of the key development challenges in the DRC. The WB is providing support to the Health Sector, through the PDSS. As part of the AF for this project, it is planned to support the institutional reform of the MOPH. This support will focus on financing a retirement program, with an allocation of USD 15 million.

8. The aging of the workforce in the Healthcare sector is a real obstacle to improving the effectiveness of the health system in the DRC, 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 DRC, 22,000 staff (or 8 percent) are concentrated in the health sector. It should be noted that 31percent of the workforce in the health sector are eligible for retirement. The heavy weight of these human resources negatively affects the quality of health care services offered to the population of the country by a staff with low yield.

9. In addition, a closer look at the wage situation in the Health sector reveals that several civil servants still active are either registered but not mechanized or new units, which receive only bonuses while 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.

10. Under these conditions, the implementation of a retirement program within the health sector is not only a necessity but a requirement, as it determines the success of all reforms aimed at improving the efficiency of the health system, upon which the development of the country largely depends on.

B. **Project Beneficiaries**

11. Direct beneficiaries of this operation are retired civil servants and youth wishing to pursue a public service career and current civil servants who will have access to improved retirement benefits and better career prospects in the health sector. Given the amount available, more than

4,000 civil servants, who are over the age of retirement, will be the first to be targeted by this important operation.

12. Budgetary saving of approximately USD 3 million (based on the salary and bonuses) will also be achieved on an annual basis and can be used to support other objectives of the reform within the health sector, mostly the pay of regular but non-mechanized agents and the possibility of conditional regularization of the situation of certain civil servants that still have the status of the new units.

13. The impacts will also be positive for the population, as they will be able to benefit from the provision of health services of good quality, provided by more efficient agents. The effectiveness of the health system could be improved if the process of retirement is accompanied by organizational rationalization, including the optimal use of high-yield resources, which could have a positive effect on the quality of health care services and possibly on human development indicators such as the rate of mortality and the prevalence of certain diseases suffered by the population in the DRC.

Sub-Component Activities Description

15. This sub-component aims to support the retirement program within the MOPH 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 MOPH, and (ii) supporting the organizational reform of the MOPH by implementing a newly revised organizational chart; and (iii) supporting the management of the retirement reform program.

16. 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 PSRRP for the retirement of eligible civil servants within the MOPH. Therefore, the project will capitalize on the PSRRP/PRRAP's pilot experiences in its targeted ministries and government agencies in supporting the following nine set of activities for the health sector:

i. Production of a comprehensive declarative lists of civil servants eligible for retirement;
ii. A comprehensive review of the declarative lists by a multi-stakeholder "Change team" that will be created within the health sector;
iii. Publishing the list of retirement eligible civil servants;
iv. Biometric identification of staff eligible for retirement;
v. Grievances and Redress mechanisms established;
vi. Certification of lists;
vii. Calculation of retirement indemnities (compensation packages);
viii. Notification; and
ix. Payment of retirement indemnities by an independent agency.

17. Specifically, the project component will cover the following activities

Activity 1: Supporting the payment of retirement indemnities for the Ministry of Public Health (USD 15 million).

18. This activity will support the retirement of civil servants who have reached the retirement age. Currently, the applicable retirement law states 65 years of age or 35 years of service. The payment of retirement indemnities for about 4,000 civil servants will be paid on the basis of (a) the applicable legal new framework (the Organic Law on Public Service, 2016, Law n0 16/ 013 promulgated on July 15, 2016) as well as the Inter-ministerial decree on the repatriation fee set at USD 2,000 in May 2010 through the " (CAB.MIN/FP/BUDGET/FIN/004/2010 of 12 May 2010) and the "Decree of Repeal of Orders 93" (Decree N° 10/20 of 21 May 2010). These legal acts had the following elements:

(a) Defining the indemnity rate (repatriation fee): as shown in the analytical note, according to the statute of public servants, 1982, indemnities are composed of the retirement allowance and repatriation fee. However, given that this law has never been reviewed since then and that the repatriation fee is identified with the *Zaire* currency, an inter-ministerial decree has set the repatriation fee to take current financial and social conditions into account.

(b) Retirement indemnities have been calculated on the following formula:
    (i) Retirement allowance: Article 117, 119, 122 and 126 of the new law on the status of the staff (personnel) of public services of the State stipulates: "The amount of retirement allowance is equal to 2/4, 3/4 or 4/4 of the last annual salary according to the number years of services less than 25 years, 25 to 30 years and more than 35 years". Since the project targets only staff having reached 65 years of age and who have served for 35 years or more, indemnities are calculated at **100 percent of the last annual salary.**
    (ii) Repatriation fee: **USD 2,000** will be accounted as a repatriation fee package for the appointed officer and his/her dependents.

19. In terms of the eligibility criteria, it has been agreed with the Government that the retirement age will be applied. This means that the current retirement age of 65 or 35 years of service will be applied. In addition, the retirement indemnities will be paid in priority to the health civil servants within the provinces already supported by the PDSS. The proposed operation will cover the civil servants of the following targeted provinces:

a) eligible staff of the Ministry of Public Health in the province of Haut Katanga; Tanganyika and Lomami
b) eligible staff of the Ministry of Public Health in the province of Kwango, Kwilu and Maindombe
c) provinces of Mongala,
d) eligible staff of the Ministry of Public Health in the provinces of Twapa, Equateur, Ubangi

19. Building on the experience of the current Governance project that is supporting 5 targeted Ministries, the retirement program for the MOPH will cover the following aspects:

i. finalization of the formula to be used to calculate indemnities;
ii. preparation and launch of the biometric identification;
iii. technical assistance to finalize a methodology to manage the HR data collected with the biometric identification; and
iv. payment of indemnities to eligible staff.

20. ***Need to capitalize the progress made by the WB project and the strategic approach for the implementation of the retirement program for the MOPH***. The Government has recruited 3 firms with the support of the PSRRP project. These firms are in charge of the following activities:

(a) ***Financing payment agency:*** Drawing lessons from the successful experience of payment for 2,700 agents in the *Ministère de l'Environnement, de la Conservation de la Nature et du Tourisme* (*MECNT* - Ministry of Environment, Natural Conservation and Tourism) by an independent and external payment agency, all identified eligible staff through the biometric identification process will be paid retirement allowance by an externally recruited payment agency. This is expected to reduce the fiduciary risks.
(b) ***Grievance and dispute resolution mechanism*** It has been agreed to set up a firm responsible for the establishment of a grievance and dispute resolution mechanism (GDRM), which will be handled by a legitimate, trusted, and predictable structure called "National Dispute Resolution Commission (CNRD)". The proposed GDRM will play a pivotal role by providing help in the prevention, management, resolution and monitoring of potential conflicts related to the retirement programs implementation. In particular, it will help secure persons or groups of persons affected by retirement programs and ensure that due process will be followed when processing such programs. Learning from past experiences, providing such independent mechanism is essential to ensure the transparent retirement process and protect the rights of retiring staff.
(c) *Firm in charge of the biometric identification*: With the many risks associated with managing a retirement process, including governance and fiduciary risks, it was critical to set up an independent body to ensure that eligible civil servants are correctly identified and accounted for in order to avoid double payments or payments to ghost civil servants.

Establishment of the Pension Fund

21. Another critical aspect of the retirement process refers to the criteria and methods to be used for calculating benefits and pension benefits. Staff regulations for career civil servants stipulate that pension benefits consist of: (i) severance payment; (ii) repatriation allowance; and (iii) a pension. The first two are known as retirement benefits and are normally one-off payments. Over the past few years, the criteria for calculating retirement benefits have changed, generating different practices that need to be reconciled into a coherent and unique formula.

22. Moreover, the credibility of any retirement scheme rests on the reliability of pension payments. Currently, pension payments are paid out of the national budget in the DRC and they are calculated using the base salary. While pensions are being paid, the budget for retirement benefits, which constitute the bulk of the payment, has not been made available. As a result, many civil servants have lost faith in the system, and tend to reject retirement plans. To restore

confidence in the system, the present government has decided to establish a pension fund with contribution defined benefits.

Activity 2: Supporting the implementation of the revised organizational chart (USD 1 million)

23. This activity will support the Health Sector through financial assistance to elaborate the action plan for the implementation of the revised organizational charts. This activity will be based on a governance-auditing approach, which will aim at reviewing organizational structures, institutional arrangements, and processes and capacity against the institutional mandates. The findings of the audits should be used to re-organize the health sector, help to elaborate an action plan to improve senior management leadership as well as assessment of staff competences (skills) for a better delivery of their mission.

24. This activity will finance the following aspects: (i) technical assistance to implement the revised organizational/functional for the Ministry of Health; and (ii) technical assistance to elaborate and implement an action plan based on the recommendations of the organizational audits, including assessment of staff competencies and re-assignment according to newly identified needs and functions.

Activity 3: Supporting the management of retirement program (USD 2 million)

25. This component is intended to cover technical assistance work, goods and services associated to the above two activities as well as some of the operational and logistic costs.

Institutional Arrangements for the implementation of the institutional project component

26. The existing institutional arrangements for the PSRRP will be used for the management of the subcomponent related to the retirement program for the health sector. The institutional framework is articulated around five main structures:

(i) ***The Public Administration Reform Steering Committee (Comité de Pilotage pour la Modernisation de l'Administration Publique (CPMAP***)) was established in 2012 by decree of the Prime Minister, who chairs it. This Committee includes the Ministries of Finance, Budget, Public Service and Planning. The Ministry of Health will systematically participate in all Invitational Steering Committee meetings to ensure sector involvement;

(ii) ***The Public Administration Reform Implementation Unit (Cellule de Mise en Œuvre de la Réforme de l'Administration Publique (CMRAP)*** was established by decree of the Minister of Public Service. It provides the secretariat of the CPMAP;

(iii) ***Units of change*** or **Change Team** are operational steering units for sectoral reform; these units or teams are embedded in each ministry to ensure an organic reform and a better flow of information to and from the targeted ministries;

(iv) ***The Health System Development Project*** (PDSS): This project will be responsible for the fiduciary management of retirement operations for the health sector;

(v) ***Public Service Reform and Rejuvenation Project*** (PSRRP): This project will be responsible for managing retirement operations on the basis of the agreement to be signed between PDSS and PRRAP.

Annex 4: Investing in Early Years

1. The Project would support a package of cost-effective interventions that are focused on the first 1,000 days of life, the critical period when timely interventions have the most impact. Evidence from neuroscience on early brain and child development shows that survival, growth and development are not sequential but simultaneous processes with progress in one domain acting as catalyst in other domains. Early interventions fostering good health, nutrition and early stimulation yield the greatest benefits in terms of children's health, their overall development as well as many far-reaching positive impacts on human development. The benefits of investing in early years include improved physical and cognitive development, greater educational success and increased productivity in life, and prevent draining societies' resources.

Health, nutrition and early stimulation interventions package

2. The health sector is primarily responsible for delivering most direct nutrition-specific interventions for children and women, largely through outreach activities. In 2013, a major analysis by The Lancet identified 10 feasible and effective interventions that would reduce the burden of stunting by one-fifth if they were all delivered at 90 percent coverage. Stunting, a result of chronic malnutrition, is practically irreversible after age two. Its prevention requires interventions from conception to age two by focusing on improving both maternal and child nutrition through improved dietary intake. To ensure effectiveness of nutritional interventions, these need to be accompanied with growth monitoring and promotion, which reinforce the importance of good nutrition. In a study covering 36 countries, stunting prevention interventions resulted in as much as a 33 percent reduction in stunting and a 25 percent reduction in mortality between the ages of zero and 36 months.[27]

3. Maternal stature and nutrition are important predictors of intrauterine growth retardation and size at birth.[28] Effects of small birth size are not confined to one generation, but extend to the next generation, with maternal birthweight affecting the birthweight of the offspring (Ramakrishnan et al. 1999). The adverse effects of size at birth also extend to health later in life. For example, birthweight is inversely related with the risk of coronary heart disease and stroke.[29] Prenatal care, with a focus on maternal nutritional counseling alongside fetal growth monitoring, immunization, and advice on micronutrient supplements, is a prerequisite for any stunting intervention. Even if a child is born with a low birthweight or height, there is a compensatory period of up to two years of age when growth can catch up.[30] During the first six months following birth, exclusive breastfeeding is emphasized as one of the most effective ways of reducing infant morbidity (which negatively affects growth) and mortality.[31] Therefore the Project's main interventions include breastfeeding promotion, regular growth monitoring (which would also identify any need for vitamin supplements), and immunizations to reduce morbidity and mortality. In addition, the project's focus on tackling teenage/adolescent pregnancies and family planning

[27] Bhutta et al. 2008.
[28] Ozaltin et al. 2010.
[29] Barker and Clark 1997; Huxley et al. 2007.
[30] Victoria et al. 2008.
[31] Jones et al. 2003; WHO 2000.

for all women in order to reduce the risk of low birth weight among adolescent pregnancies, short-interval pregnancies and high risk pregnancies.

4. Focusing on the age group of seven to 24 months, complementary feeding is emphasized along with growth monitoring, immunization, and micronutrient interventions (including iron, vitamin A, iodine, and zinc supplementation). Complementary feeding education strategies can increase height by one centimeter up to the age of three years.[32] Zinc supplementation can reduce diarrhea, and iron is known to reduce anemia and improve cognitive ability, whereas vitamin A results in reduced mortality and morbidity due to fewer episodes of diarrhea (Caulfield et al. 2006).[33]

5. Other interventions include deworming and administering anthelminths to reduce the incidence of parasite and bacterial infections among pregnant women, infants, and children (Horton el al. 2008a, also see Horton et al.2008b). Sanitation and hygiene play an even greater role in the prevention of diarrheal morbidity and mortality. Esrey (1996) found that improvements in sanitation are associated with a 0.8 centimeter to a 1.9 centimeter increase in height. Similarly, ensuring access to clean water is also critical as a means to reduce infection from water-borne illnesses. Studies in Bangladesh, Guinea-Bissau, Ghana, and Peru demonstrate that the odds of stunting at the age of two rose by a factor of 1.05 with each diarrheal episode (Black et al. 2008). An intervention as simple as hand washing with soap can reduce diarrhea for children under five by 42 to 46 percent (Fewtrell 2005; Waddington et al. 2009) and can increase newborn survival rates by up to 44 percent when used by birth attendants and mothers (Rhee et al. 2008).

6. The project would also promote ECD interventions through the provision of care and services required to support young child's cognitive, social and emotional development. School readiness depends not only on students' cognitive skills, but also on their physical, mental and emotional health. Experience and interactions with parents, caregivers and other family members in the first years of life, influence the way the child's brain develops and sets the stage for later success in school as well as on the nature and extend of adult capacities. A broad range of evidence has demonstrated that there are prime times to acquire different knowledge and skills and the brain is particularly open to new experiences during the first 1,000 days. If this sensitive period elapses without the brain receiving an appropriate stimulation, opportunities for various kinds of learning may be substantially reduced. All the key factors that determine how a child learns and relates in school and in life in general are determined by the kind of early care and nurturing experiences received from parents and caregivers in the natural environment of their home. Practically this means that when young children are cared for, held, touched, talked to in soothing ways, they tend to thrive and this prepares them for school participation, completion and achievement.

7. However, worldwide evidence highlights that most early dropouts and repeaters at school are students disadvantaged by gender, poverty, geographical location, ethnicity, health status, conflict or natural disasters. While efforts are being made to equip and prepare schools to provide optimal learning environments for all children, there is need to raise families and communities' awareness on the importance of the early years as they care for young children and equip them with the knowledge and skills needed to ensuring that surviving children are healthy and possess

[32] Bhutta et al. 2008.
[33] Caulfield et al. 2006

the skills to thrive and to live full and productive lives. In the DRC, as more children enter school, many are enrolling too late or too early, repeating grades, dropping out, or failing to learn. Of the gross enrollment rate of a 136 percent in the first grade of primary school in 2011, it was estimated that only 70 per cent would still be in school at the end of the cycle. The biggest decline --20 percentage points-- occurs between the first and the second years of the cycle, mainly because of the economic circumstances or priorities of their families and/or students are ill-equipped to start their first year of schooling. Acknowledging the adverse impact of dropout in the education system internal efficiency, the equity perspective and for the overall country's development, the DRC's 2016-2026 Education sector strategy has identified a number of strategies to address the multiples barriers and bottlenecks that prevent children from staying in school and for those that remain, what prevents them from learning? At preprimary school level, these strategies include the reduction of school fees, increased access to quality community based child care.

8. Seizing the opportunity of the implementation of the AF and the PAQUE (Quality of Education Enhancement Project) in 4 provinces, an integrated ECD (health, nutrition and early stimulation) operating model that is grounded on equity-based approach will be designed and tested in the project area for fostering successful ECD program in the DRC.

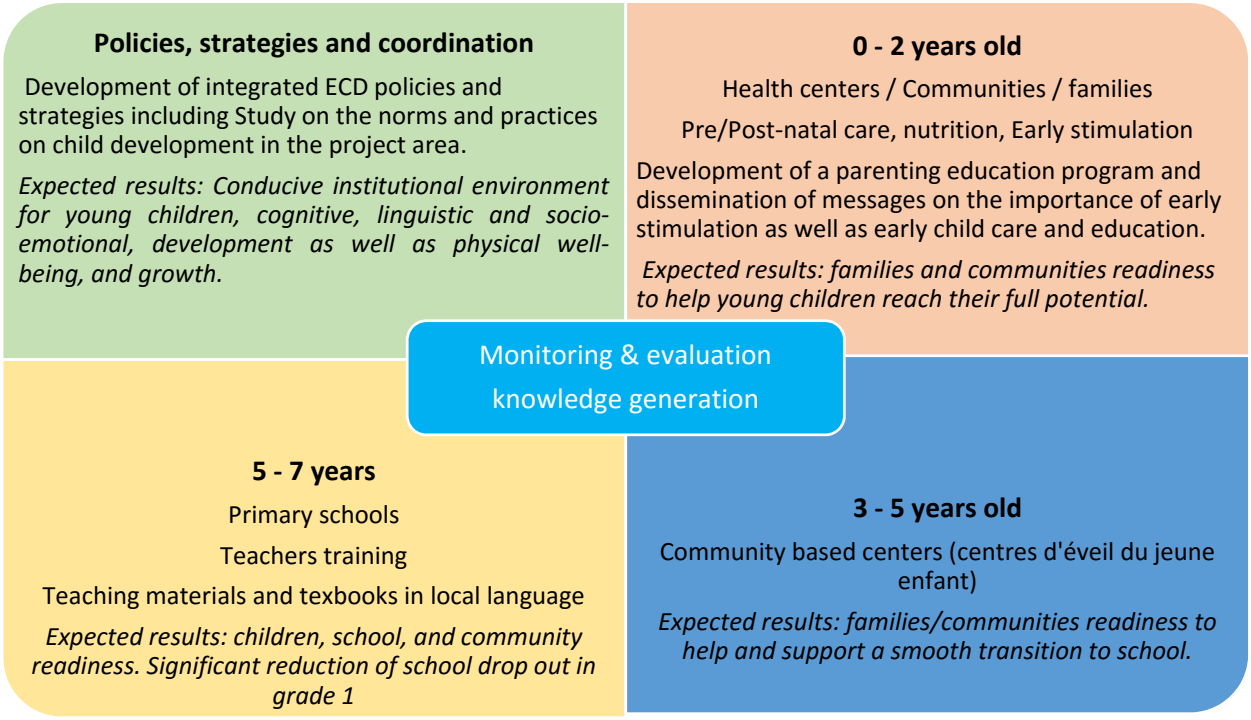
Geographical targeting and mainstreaming of services to support young child development

9. The project will adopt a geographical convergence approach to foster cross-sectoral collaboration by leveraging the comparative advantage of each sector (health, nutrition and education) while delivering an integrated package of high impact interventions that incorporates a holistic consideration of the need of young children. By doing so, the project will achieve better synergy between the project and the Education Quality Improvement Project[34] in the following 4 selected provinces: Equateur, Sud-Ubangi, Tshuapa, and Mongala. In addition, although the majority of the interventions will be supply-side interventions, the AF would support other important complementary interventions to increase demand and promote adoption of healthy behaviors. Communities will be engaged in the design and implementation of an integrated ECD parenting training program derived from local cultures and/or adapted to fit local culture and tailored to the varying needs of children and their caregivers.

10. This will be in addition to national level interventions --i.e. evidence generation, policy and strategy formulation, standard setting-- aiming at supporting government efforts to promote an enabling environment that provide an integrated response to the physical, socio-emotional, cognitive, economic and cultural needs of young children's development.

[34] PAQUE is a new Global Partnership for Education funded project.

Figure 10: ECD multi-dimensional and sequential process



Beneficiaries

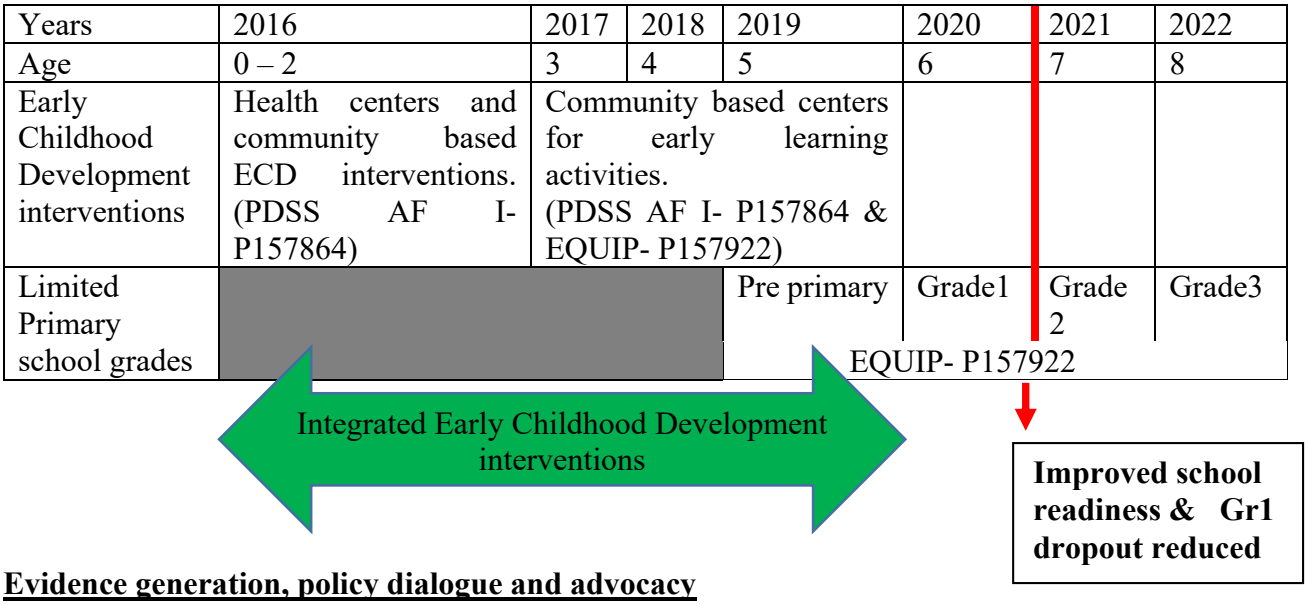
11. The geographical targeting and the limited number of beneficiaries are intended to support the achievements of tangible results, and lessons learnt through the implementation of the project will serve as the basis for the scaling up of initiatives aiming at investing in young children for high returns in similar context. Communities will be identified in the following 4 provinces covered by the two projects (PDSS AF I- P157864 & EQUIP- P157922) to effectively monitor the impact of an integrated ECD package on child development as well as on school readiness.

Province	Chef-lieu	Population	Effectif scolaire[35]
Equateur	Mbandaka	2 281 398	320 628
Sud-Ubangi	Gemena	2 788 694	448 312
Tshuapa	Boende	1 950 466	189 517
Mongala	Lisala	2 395 807	299 855
Total		**9 416 365**	**1 258 312**

12. Finally, in order to effectively monitor young students' progression till at least the end of grade 2, the sample will include a significant number of families with children aged 3 to 5 years old in 2017.

[35] Source: Statistics Directory 2013-2014

Figure 11. Health, nutrition, early stimulation and school readiness tracking sheet



Evidence generation, policy dialogue and advocacy

13. The above interventions will be supported by an overarching component on strengthening national and subnational capacities, including continued support in building systems that enhance effectiveness and sustainability, as well as cross-sectoral collaboration within sectors and between partners for an effective ECD program in the DRC. Sectoral ministries at central and decentralized level and community based structures will be assisted to develop integrated, costed action plans and use resources to reach all parents and their young children in the project areas.

14. A robust and tight monitoring system will be developed to inform which strategies are likely to have the most important impact on young child survival and development and how to best implement them. Baselines will be collected to effectively monitor the implementation and impact of the selected interventions. Where there is an information gap, a key priority will be to invest in bridging the information gap. A final evaluation to assess the impact of the ECD services and the differential effects of ECD packages services and delivery systems on early childhood development outcomes will be undertaken.

Implementation arrangement

15. The implementing arrangement has been designed to take into consideration the multi-sectoral nature of the ECD and Care in order to address and support children's multi-dimensional and age-specific needs. The health sector will be used as a strategic entry point to improve parental education as well as the early stimulation of young children in the DRC. Close coordination, collaboration between the MOPH and MOE will be required at national and decentralized levels in order to ensure better integration of early stimulation interventions into the PDSS and, more generally, to the child health and development agenda in DRC.

16. **At the national level**: The health service delivery system will serve as a vehicle to increase awareness of the importance of early stimulation as well as early child care and education from

parents and caregivers. This approach will, to the extent possible, build on existing cadre of health workers who can reach many parents of children aged 0-3. A parental support program that includes early stimulation and age-appropriate parental ECD education will be designed into the planned information, education, and counseling activities that are part of the PDSS to build on the AF efforts to improve access to maternal and child health services and scale up interventions.

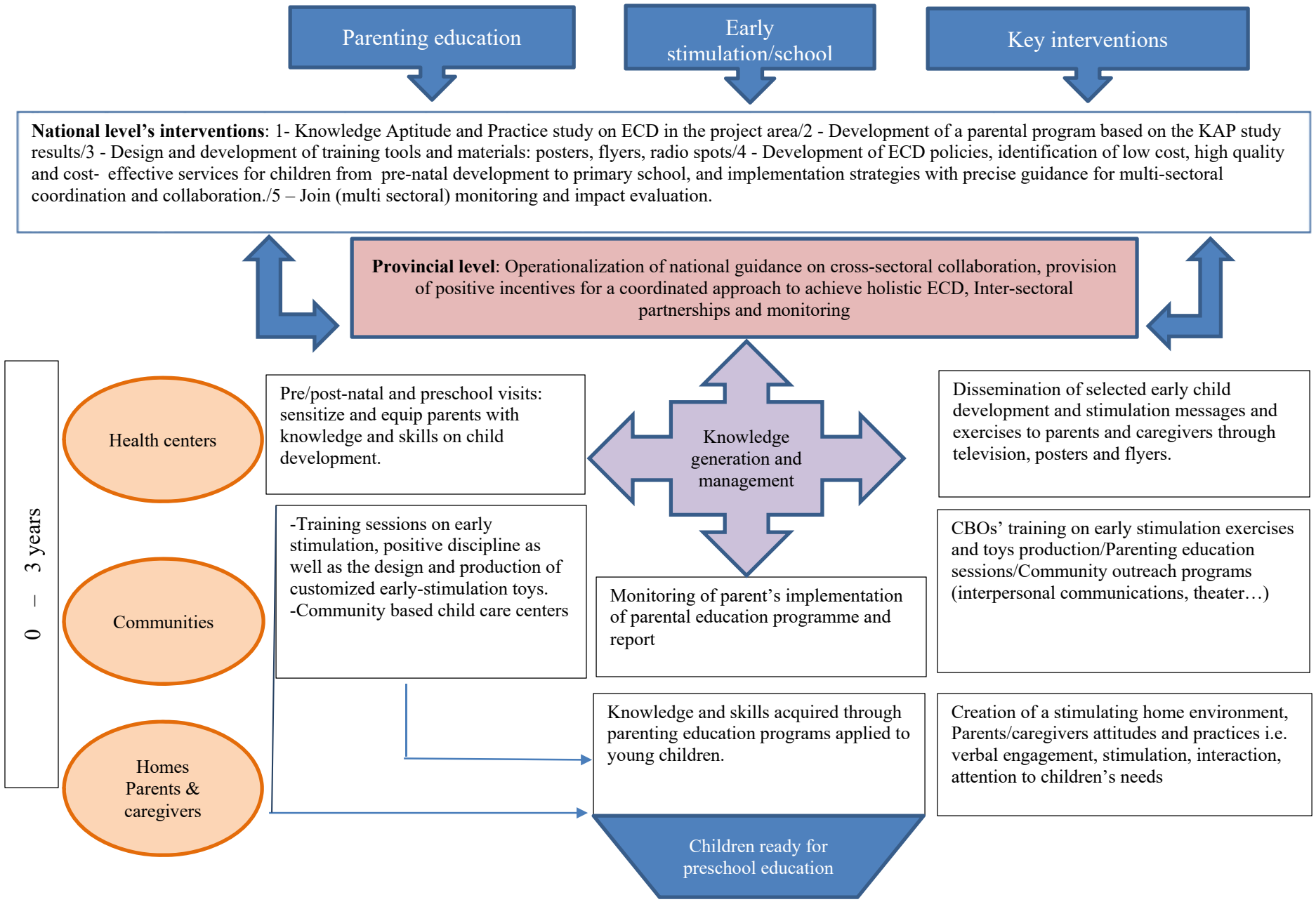
17. **At the provincial level:** Specific interventions will target the PDSS and PAQUE beneficiaries as a pilot to the development of a national ECD program and assess both the feasibility and the impact of early stimulation and parental involvement on school readiness. The parental education program will accompany the interventions implemented by UNICEF through local NGOs and associations and the AF will join these efforts through 1) the finalization and/or reproduction of the parental education modules; 2) the training of service workers on these modules; and 3) the scale-up of the delivery of the modules through organized sessions in facilities and/or by disseminating information (flyers, posters, etc.) on early education benefits through parental support. To the extent possible, health centers will be used as the primary delivery mechanism for the program. Given the focus on adolescent health of the AF, this will be even more relevant as 30 percent of pregnancies and parents are adolescent girls who need information to better raise and provide for their newborns and children.

18. The Provincial level steering committee *(Comité Provincial de Pilotage- CPP)* will be strengthened and extended to the provincial education offices (PROVED) to facilitate coordination, foster collaboration and synergy in the implementation of integrated services in the project area. The CPP will validate the management plan which identifies relevant structures that meet local needs and use local resources to integrate early stimulation messages in child health messaging for behavior change. The DPS will be responsible to establish and maintain a database to facilitate planning, development and monitoring of the quality of ECD services.

19. **At the community level:** The project will be grounded in the participation of families and communities combining existing knowledge about the best environment for optimal development and traditional child rearing practices in order to appropriately reinforce or change practices and behaviors around ECD. Building on existing formal and informal networks of cooperation, partnerships will be established with community/faith-based organizations to provide parents and caregivers with thematic parenting child development information in order to impart or reinforce positive parenting skills.

20. Early Child Stimulation program materials will be designed, and service providers trained to provide services while adhering to minimum-standards and procedural guidelines established at provincial and central levels. Early stimulation messages and materials will be disseminated in communities through radio during parental education sessions, home visits, child care, immunization events and nutrition campaigns.

21. **At the family level:** In bearing the primary responsibility of the care and development of their children, families and caregivers shall –among other responsibilities– create a home environment that encourages free expression, and stimulates exploration and creativity. Positive early stimulation and parental responsiveness behaviors will be promoted in order to provide children with a variety of early stimulation and learning opportunities.


Parenting education
Early stimulation/school
Key interventions
National level's interventions: 1- Knowledge Aptitude and Practice study on ECD in the project area/2 - Development of a parental program based on the KAP study results/3 - Design and development of training tools and materials: posters, flyers, radio spots/4 - Development of ECD policies, identification of low cost, high quality and cost- effective services for children from pre-natal development to primary school, and implementation strategies with precise guidance for multi-sectoral coordination and collaboration./5 – Join (multi sectoral) monitoring and impact evaluation.
Provincial level: Operationalization of national guidance on cross-sectoral collaboration, provision of positive incentives for a coordinated approach to achieve holistic ECD, Inter-sectoral partnerships and monitoring
0 – 3 years
Health centers
Communities
Homes Parents & caregivers
Pre/post-natal and preschool visits: sensitize and equip parents with knowledge and skills on child development.
-Training sessions on early stimulation, positive discipline as well as the design and production of customized early-stimulation toys.
-Community based child care centers
Knowledge generation and management
Monitoring of parent's implementation of parental education programme and report
Knowledge and skills acquired through parenting education programs applied to young children.
Children ready for preschool education
Dissemination of selected early child development and stimulation messages and exercises to parents and caregivers through television, posters and flyers.
CBOs' training on early stimulation exercises and toys production/Parenting education sessions/Community outreach programs (interpersonal communications, theater…)
Creation of a stimulating home environment, Parents/caregivers attitudes and practices i.e. verbal engagement, stimulation, interaction, attention to children's needs

Annexe 5: Map of the Democratic Republic of Congo