



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

Appraisal Stage | Date Prepared/Updated: | Report No: PIDISDSC25492



BASIC INFORMATION

A. Basic Project Data

Country Congo, Democratic Republic of	Project ID P168756	Project Name DRC multisectoral child nutrition and health project	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 4-Apr-2019	Estimated Board Date 21-May-2019	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Democratic Republic of the Congo	Implementing Agency National Nutrition Program (PRONANUT)	

Proposed Development Objective(s):

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

Components:

- Component 1. Improving the Delivery of Community Interventions and Social and Behavioral Change**
- Component 2. Improving the Service Supply and Strategic Purchasing**
- Component 3: Convergence Demonstration Pilot**
- Component 4. Capacity Strengthening and Project Management**
- Component 5: Contingent Emergency Response Component (CERC)**

PROJECT FINANCING DATA (US\$, Millions)

Environmental Assessment Category

Moderate

Have the Safeguards oversight and clearance functions been transferred to the Practice Manager? (Will not be disclosed)

No

Decision

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Other Decision (as needed)

B. Introduction and Context

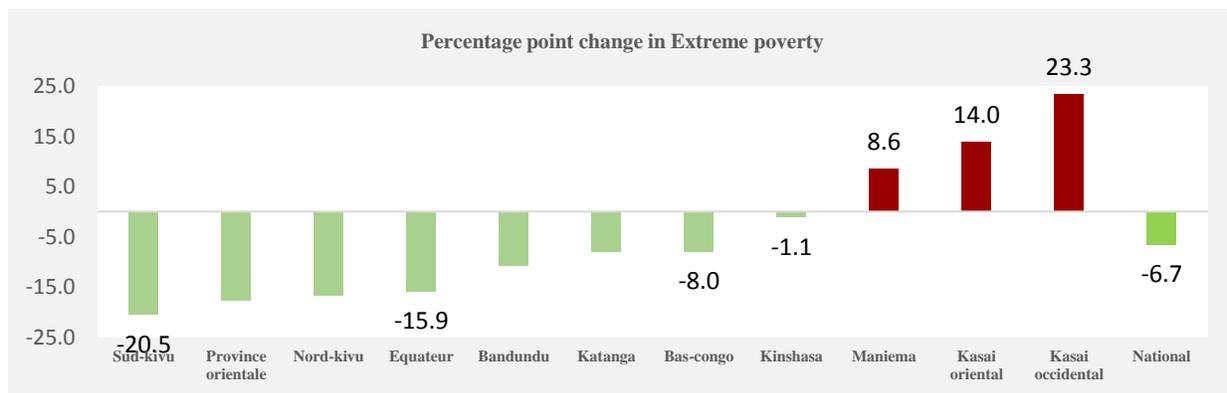
Country Context

1. Despite its tremendous wealth in natural resources and its potential for economic development, the Democratic Republic of the Congo (DRC) is one of the poorest countries in the world. The per capita gross domestic product (GDP) in 2017 was at US\$432, almost a quarter of the Sub-Saharan Africa average (US\$1,467). Between 2005 and 2012, the percentage of people living in poverty in DRC declined from 69.3 percent to 64 percent. At the same time, however, due to high population growth, the number of poor increased by 7 million (DRC Systematic Country Diagnostic, 2018). Between 2010-2015, the country has gone through a period of significant growth, with GDP increasing at the rate of 7.5 percent on average. However, the trend has recently slowed down. It is estimated that the slowdown led to a decrease in real per capita GDP, with negative consequences for poverty reduction. Growth has recently picked up again with rising commodity prices and increased activities in the extractive sector, but at a lower rate than previously anticipated.

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

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



Source: Jobs Diagnostics, 2016

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



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

4. One key factor hampering the development of high-quality formal employment and constraining the inclusiveness of economic growth more broadly is the low level of human capital (DRC Systematic Country Diagnostic, 2018). DRC ranked 176 among 188 countries on the 2016 Human Development Index and 146 among 157 countries on the 2018 Human Capital Index (HCI). DRC's HCI value of 0.37 indicates that the country's human capital achieves only 37 percent of its productive potential. Some recent progress has been noted in selected health and education indicators, but considerable challenges remain. DRC has not reached any of its Millennium Development Goals (DRC Systematic Country Diagnostic, 2018). The gross enrollment ratio for primary education improved from 93 percent in 2005 to 107 percent in 2014, but retention and achievement of learning outcomes remain challenging and there are an estimated 7 million children out of school.

5. Prospects for a demographic dividend can only be strengthened if the demographic transition is accelerated, and the investments in human capital development are put in place. On the latter, investments in health and education remain very low. For example, health expenditure in DRC is 10 percent of the Sub-Saharan Africa average (DRC Systematic Country Diagnostic, 2018). With respect to the demographic transition, life expectancy at birth was estimated at 59.6 in 2015 (6 years higher than in 2005). Moreover, the under-5 mortality rate of 104 per 1,000 live births in 2014 (from 155 in 2007) was higher than the Sub-Saharan Africa average of 78.3 per 1,000. Decline in under-5 mortality is an important precursor of fertility decline which is a necessary prerequisite for a demographic transition, after which a demographic dividend may be possible. The maternal mortality ratio increased from 543 per 100,000 live births in 2007 to 846 per 100,000 live births in 2014 and at least in part reflects the increase in total fertility rate during the same time period from 6.1 to 6.6. High fertility in DRC is driven by high adolescent childbearing as 27% of girls 15-19 years old have already either given birth or are pregnant – a figure that increases to one-third of all *rural* girls of the same age. Adolescent fertility is associated with school dropout, higher risk of death and disability as a result of pregnancy and childbirth, poor birth outcomes and ultimately, stunting. The median time between births is 30.4 months for all women, and only 25.5 months amongst adolescents (age 15-19 years). Delaying age of first birth and increasing birth spacing will have population-level temporal and quantum shifts in fertility that will serve to slow population growth, which will have downstream effects for both household and national human capital accumulation through a number of related health, nutrition, and socioeconomic pathways.



Table 1: Key Health Indicators

Indicator	Value
Demographic and health indicators	
Neonatal mortality rate (deaths per 1,000 births)	28 ²
Infant mortality rate (deaths per 1,000 births)	58 ²
Child mortality rate (deaths per 1,000 births)	104 ²
Maternal mortality ratio (deaths per 100,000 live births)	846 ²
Life expectancy at birth (years)	59.6 ¹
Total fertility rate (children per woman)	6.6 ²
Adolescent fertility rate (births per 1,000 women 15-19 years of age)	138 ²
Stunting prevalence in children 0-5 years of age	42.6% ²
Health system characteristics	
Total health expenditure per capita (current US\$)	\$19.70 ¹
Domestic general government health expenditure as % of current health expenditure	16.5% ¹
Physicians per 1,000 people	0.091 ¹
Health service utilization	
Pregnant women attending 4 antenatal care visits (ANC)	48.0% ²
Deliveries assisted by qualified personnel	80.1% ²
Deliveries in a health facility	79.9% ²
Pregnant women receiving antenatal iron supplementation	58.9% ²
Children 12-23 months of age with complete vaccination	22%-45% ²
Newborns receiving postnatal care	9.7% ²

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

Sectoral and Institutional Context

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

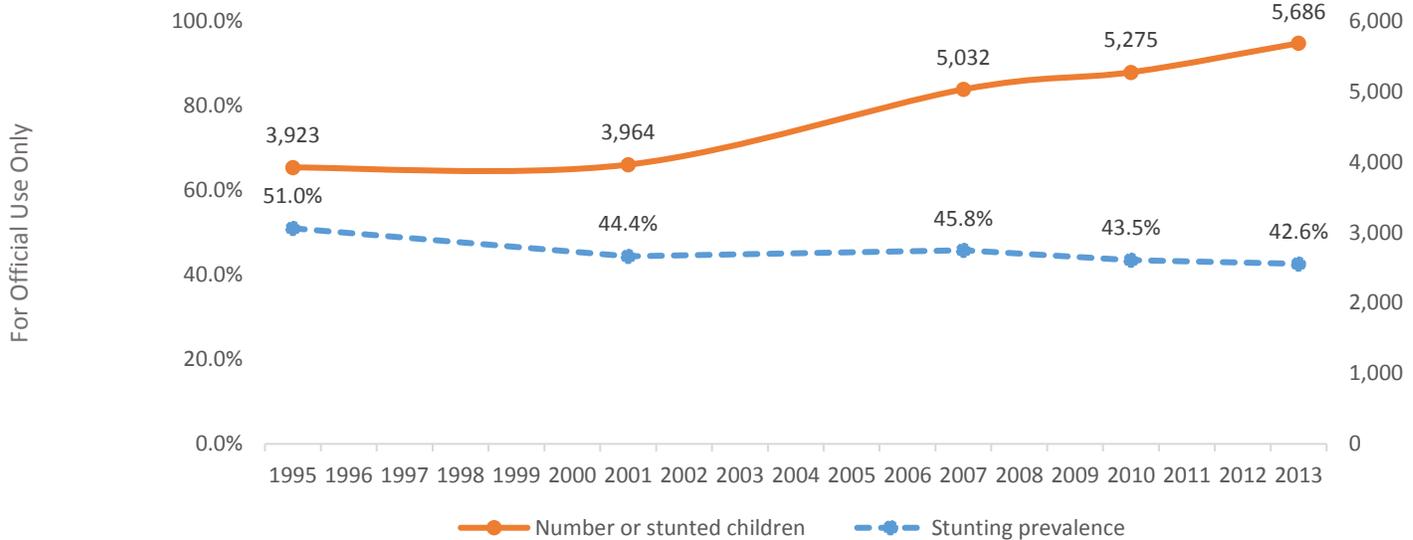
7. In DRC the negative impact of malnutrition on educational attainment seems to be particularly relevant. About 20 percent of the children entering primary school drop out before the reach second grade². While to date no systematic analysis of the factors driving this high dropout rate chronic malnutrition which hampers children’s ability to keep up with the curriculum, is hypothesized to be one of the most likely reasons behind this very high dropout rate.

² Annual School Census 2013



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

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



Source: World Development Indicators

9. Stunting presents a challenge in virtually all regions of the country. In 21 out of 26 provinces of DRC, stunting prevalence exceeds 40 percent -- the World Health Organization’s “very high public health significance” threshold. In Nord-Kivu, Sud-Kivu, Tanganyika, Lomami, Sankuru, and Kasai, more than half of all children under the age of 5 are stunted³.

10. Cross-country comparisons show that chronic malnutrition is affecting DRC more than other countries with similar income levels. Only three low-income countries have stunting prevalence higher than that in DRC --Burundi, Madagascar, and Mozambique (see Figure 3, Panel 1). In a number of countries with very similar per capita GDP stunting prevalence is substantially lower (Central African

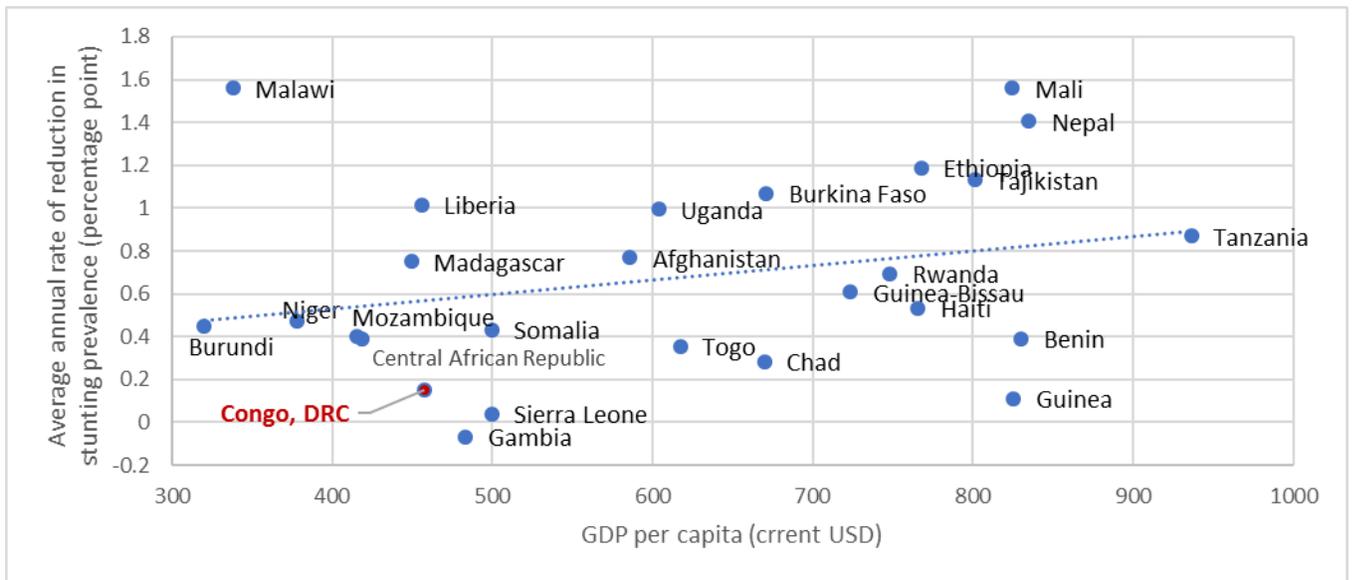
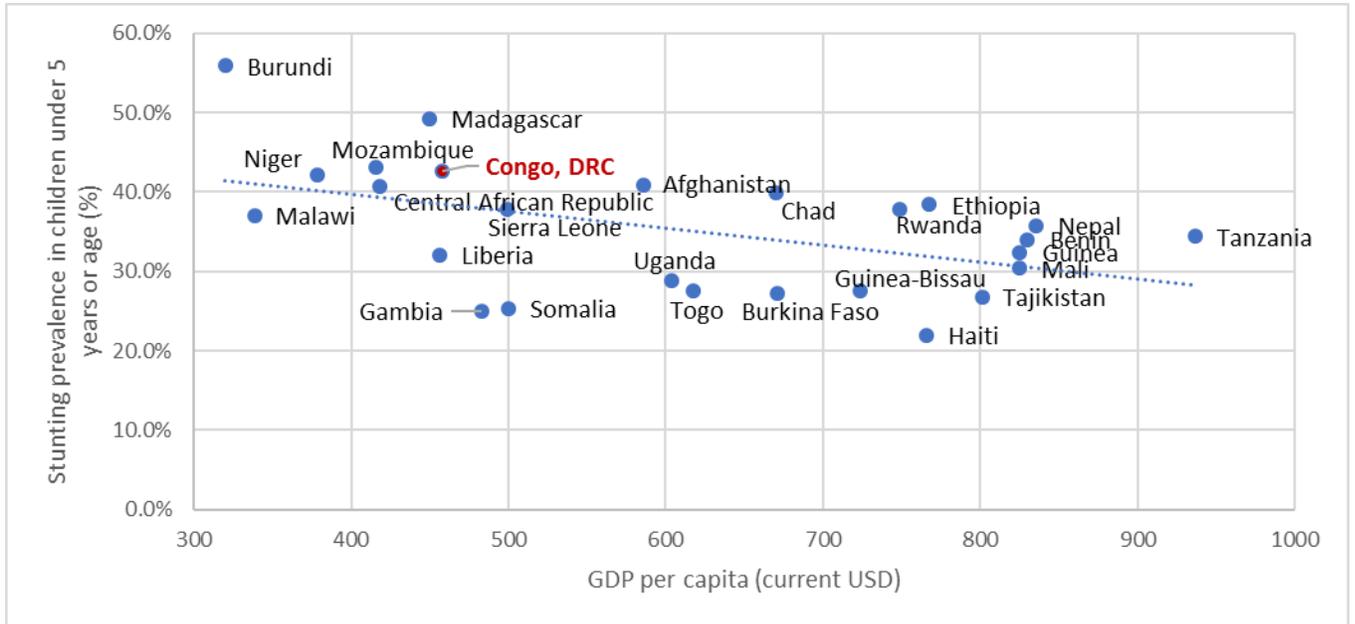
³ In addition to stunting, the prevalence of other dimensions of malnutrition remains alarmingly high. Nearly 8 percent of all children under the age of 5 suffer from acute malnutrition (DHS 2013) and 60 percent suffer from anemia. The prevalence of anemia is higher (76 percent) in younger children (6-8 months of age), which suggest inadequate accumulation of iron before birth. This is related to the high prevalence of anemia among women of reproductive age and pregnant women which reaches 38 percent and 43 percent, respectively (DHS 2013).



Republic, Malawi, Liberia, Sierra Leone, Uganda,). The pace of stunting reduction is slower in DRC than what could be expected based on its income level. In virtually all low-income countries, stunting prevalence has been declining faster than in the DRC (see Figure 3 Panel 2). This includes other fragility, conflict and violence-affected (FCV) countries such as Somalia, the Central African Republic, and Afghanistan.

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

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Source: World Development Indicators

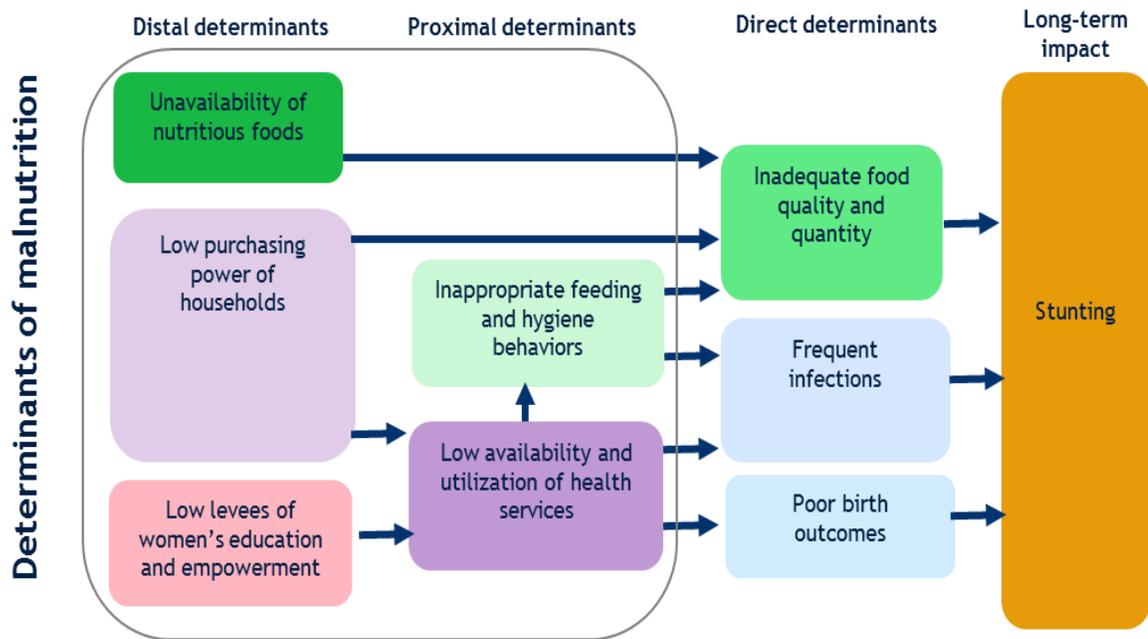


11. The comparisons with other low-income countries presented above suggests that substantial reductions in stunting prevalence in DRC can be achieved if chronic malnutrition is prioritized at the policy and programmatic level.

Determinants of Chronic Malnutrition in the DRC:

12. Child stunting is a result of inadequate food intake (both in terms of quantity and quality), repeated and untreated infections such as diarrhea, acute respiratory illness, or malaria, and poor birth outcomes, when children are born pre-term or small for gestational age. Those in turn result from inadequate access to key maternal and child health services, inappropriate feeding practices, low availability and low diversity of foods, low incomes, poor health and nutrition status of mothers and, more generally, low level of maternal education and low status of women in households and communities (see Figure 4).

Figure 4: Simplified Conceptual Model of the Determinants of Malnutrition.



13. **Inappropriate feeding behaviors and practices:** Child feeding practices in DRC remain suboptimal and need to be substantially improved. While the overall breastfeeding rate is high - about 98 percent of children 0-23 consume some breastmilk, only 48 percent of children 0-6 months of age are exclusively breastfed and only 52 percent of newborns are fed breastmilk within the first hours after birth. Early initiation of breastfeeding is critical, because it ensures that the child consumes colostrum, which is very rich not only in nutrients, but also in antibodies and is a crucial early boost for the newborn's immune system. It also enhances uterus contraction and is fundamental in the socioemotional bonding between child and mother (newborn babies can be left on the stomach of the mother and instinctively find their way to the mother's breast and latch on for feeding). Data from DRC shows that children who were breastfed within the first hour after birth had about 20 percent lower odds of being stunted than children

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who were not (Kismul et al., 2018⁴). The most recent DHS data shows that only about 8.4 percent of children 6-23 months of age have a minimum acceptable diet based on the WHO/United Nations International Children’s Emergency Fund (UNICEF) infant and young child feeding (IYCF) standards; only 20 percent have adequate food diversity and 35 percent - adequate meal frequency. Only 11 percent of children in the poorest households consumed foods with adequate food diversity, compared to 37 percent in the richest households. However, it needs to be emphasized that the quality of diet is not simply a matter of income. Even in the richest household (top income quintile), only about 14 percent of children have the minimum acceptable diet.

14. **Low availability and utilization of maternal and child health services:** The prevalence of treatable childhood illnesses is high, and the utilization of preventive and curative services for pregnant women and for children is very low. Fewer than half (48 percent) of all women in DRC receive the required 4 antenatal care visits, only 17 percent have the first visit in the first trimester of pregnancy, and only about 59 percent of women receive any micronutrient supplementation during pregnancy. More than half (52 percent) of women do not receive any postpartum care. The level of utilization of routine health services for children is even lower: 90.3 percent of newborns do not receive any postnatal care; only 22-45 percent of children 12-23 months of age have complete vaccination (based on vaccination card and mothers’ reports, respectively); only 39 percent of children with diarrhea are treated with ORS and only 2.4 percent receive zinc. Underdeveloped health infrastructure, low quality of services offered, and financial barriers are among the key determinants of low utilization of health services (see below). Low utilization of services contributes to high prevalence and incidence of childhood illnesses, which in turn increases the risk of stunting. Analysis of the DHS data shows that children 0-23 months of age whose mothers had four or more ANC visits had 30 percent lower odds of being stunted, and children who attended the required postnatal care visits had 53 percent lower odds of being stunted than children who did not⁵.

15. **Suboptimal birth outcomes:** Poor birth outcomes put newborns at suboptimal growth trajectories at the onset of their lives and children who are born prematurely and who are born small for gestational age are likely to remain stunted throughout childhood. In DRC, 7.1 percent of children are born with low birth weight with substantially higher proportion in some geographic regions (e.g. Sud Kivu – 11 percent) and among children born to young mothers (10.6 percent). Teenage pregnancy and short intervals between births are the two key factors that increase the risk of negative birth outcomes and the likelihood of child stunting. Recent analyses show that children who were born less than 24 months after a sibling had 40 percent higher odds of being stunted than children born more than 24 months after a sibling, and children of teenage mothers had 30 percent higher odds of being stunted than children of mothers who were 20-34 years old (Kismul et al., 2018). In DRC, about 13 percent of women aged 15-19 years of age have already given birth, while 42.6% of them have a birth interval of less than 24 months. Moreover, the contraceptive prevalence rate for modern methods is only 8 percent overall, and even lower for girls age 15-19 years at 5 percent. This is further compounded by the level of unmet need for family planning which has increased from 26.2 percent to 30.8 percent between 2007 and 2014 (DHS 2013-2014) among adolescents and was 27.7% for all women in 2014.

⁴ The document focuses on early initiation because the literature shows that, in DRC, early initiation rather than exclusive breastfeeding is associated with the risk of stunting (Kismul et al., 2018). However, it needs to be noted that breastfeeding promotion interventions need to include early initiation, exclusive breastfeeding for the first 6 months, and complementary breastfeeding up to the age of 23 months.

⁵ Reanalysis of the DHS data by the project team



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

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

Interventions aimed at reducing stunting

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

19. Inappropriate feeding behaviors and practices can be improved through the **infant and young child feeding (IYCF) interventions** delivered at the community level and through health facilities (see Bhutta et al., 2013 for a review). The impact of IYCF interventions on child stunting can be increased through **social and behavior change campaigns** using multiple channels ranging from community mobilization through national media campaigns (as demonstrated by the recent experiences of the Alive and Thrive initiative in Ethiopia, Bangladesh, and Vietnam; see e.g. Kim et al, 2016; Nguyen et al. 2017; Rawat et al, 2017). A **package of interventions delivered through the health system and targeting pregnant and lactating women and children under the age of 5** is also very effective in improving health and nutrition status of children and reducing the risk of stunting. This package includes **antenatal care and micronutrient supplementation for pregnant women, post-natal care for women and children, micronutrient supplementation and deworming for children, immunization, and integrated management of childhood illnesses** (for a review see the 2013 Lancet series on maternal and child nutrition; for a summary see Shekar, Kakietek, Dayton Eberwien, Walters, 2017). The key determinants of suboptimal birth outcomes which increase the risk of stunting. can be improved by **periconceptual**



micronutrient supplementation and by **promotion and provision of family planning and modern contraceptive methods**.

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

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

Table 2: Interventions Shown to Reduce Stunting

Determinants of stunting	Interventions	Common delivery channels
Inappropriate feeding behaviors and practices	<ul style="list-style-type: none"> • Infant and young child feeding counseling and growth monitoring • Social and behavior change communication campaigns 	Community
Low availability and utilization of maternal and child health services:	<ul style="list-style-type: none"> • Antenatal care for pregnant women • Micronutrient supplementation in pregnancy (iron/folate, multiple micronutrients) • Post-natal care for women and children • Immunization • Micronutrient supplementation for children (vitamin A, multiple micronutrients) • Deworming for children 	Health facilities

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	<ul style="list-style-type: none"> • Zinc and oral rehydration solution (zinc+ORS) for the treatment of diarrhea • Integrated management of childhood illness (IMCI) • Treatment of severe acute malnutrition 	
Suboptimal birth outcomes	<ul style="list-style-type: none"> • Promotion and provision of modern contraceptive methods • Micronutrient supplementation • Interventions aimed at delaying marriage and increasing school attainment for girls 	Community, health facilities
Low purchasing power of vulnerable households	<ul style="list-style-type: none"> • Targeted cash transfers 	Community, social safety nets programs, health facilities
Unavailability of high nutrition quality foods	<ul style="list-style-type: none"> • Promotion of biofortified crops • Support for homestead food production 	Community, agriculture extension services

National policy response:

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

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

The NAC model:

24. In 2002, the government developed a policy and a set of operational documents for the national community nutrition platform (Nutrition a Assis Communautaire; [NAC]), anchored in local governance



structures and using relais communautaires (ReCos)— a cadre of community nutrition agents, who provide a basic package of nutrition services targeting pregnant and lactating women and children under the age of 5. They also work as an interface between the community and public service providers (see Box 1 below). The NAC guidelines were updated in 2017. To date, however, the strategy has only been rolled out on a small scale (covering only 36 out of 516 [6.7 percent] health zones in DRC), largely driven by donors through short-term programs. The experience to date indicates the viability of NAC as an effective service delivery modality at the community level. At the same time, however, the multitude of actors involved, and the very limited coverage of the interventions point to an urgent need to scale the model up.

Box 1: Community Nutrition in DRC: *The Nutrition a assise communautaire (NAC) Model*

Recognizing the importance of the community in addressing the challenge of malnutrition, the government of DRC, through the National Nutrition Program (PRONANUT) adopted a model for the delivery of nutrition services and community mobilization called *Nutrition a assise communautaire* (NAC). The model consists of the following elements:

Relais Communautaires (ReCos): ReCos are community volunteers who provide a basic package of community nutrition and health services: a.) promotion of good nutrition and hygiene behaviors including infant and young child feeding and family planning through household visits and group sessions in the community; b.) provision of basic commodities (delivery kits; child health kits [zinc, ORS, paracetamol]; condoms and oral contraceptives); c.) referral to health services and other relevant services (e.g. social safety nets). The package of services provided by the ReCos is presented in detail in Annex 5.

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

Health System: ReCos are supported by the formal health sector. Their work is supervised by the chief nurse (*infermiere titulaire* [IT]) within the health zone where they work. The IT is responsible for training and supportive supervision of the ReCo and for managing and reporting to the health management information



Nutrition in key sectoral documents:

25. Nutrition is included in some of the key health sector documents and initiatives. In 2015, the Global Financing Facility in Support of Every Woman and Every Child (GFF) platform was created; it brought together the key government health stakeholders, other line ministries, civil society representatives, and development partners. The platform took the lead in developing the country's reproductive, maternal, neonatal, child and adolescent health and nutrition (RMNCAH-N) investment case which prioritizes the interventions laid out in the National Strategic Development Plan 2016-2020 (*Plan National du Développement de la Santé [PNDS]*). The investment case has identified 12 priorities with a goal of reducing maternal mortality and child mortality over a period of five years, in 14 priority provinces⁶. Improving the coverage and quality of nutrition interventions is included as Priority 3 of the investment case and stunting reduction is among its key strategic results.

26. The Ministry of Health has identified performance-based financing (PBF) as the key strategy to ensure the achievement of universal health coverage (UHC) in DRC. Both PNDS and the Investment Case emphasize its role and the Ministry is committed to ensuring that all new investments in health in DRC include PBF elements at the primary health care level.

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

28. Furthermore, the 2011 standards and guidance for integrated interventions for maternal, newborn and child health in DRC (*Normes et lignes directrices sur les interventions intégrées pour la santé maternelle, du nouveau-né et des enfants en République Démocratique du Congo*) and the integrated early childhood development policy (*Politique Nationale sur le Développement Intégré du Jeune*) adopted by nine Ministries in 2012 demonstrates that the country understands the importance of investing in support services that provide children with a good start in life involving nurturing, care and a safe environment during their early years. However, despite government efforts in promoting early childhood development (ECD), evidence gathered in the World Bank's ECD Systems Approach for Better Education Results (SABER) tool for ECD, suggests that the policy environment remains limited, with low inter institution coordination and few programs with sustained financing.

⁶ Tanganyika, Haut-Lomami, Sankuru, Maniema, Lomami, Tshuapa, Kongo Central, Sud-Kivu, Kasai, Kasai-Central, Lualaba, Mongala, Sud-Ubangi, Kwango



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

29. Despite the commitment and positive development at the policy level, three general systemic bottlenecks constrain the scale up of the evidence-based actions aimed at reducing the burden of stunting in DRC (see Table 3). These bottlenecks include: 1) absence of a coordinated response and a severely underdeveloped service delivery platform at the community level; b) low availability and quality of public services in health and other nutrition-sensitive sectors; c) weak governance and management capacity of state actors at the local, provincial, and central levels.

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

Indicator	Value
Iron supplementation in pregnancy	
<i>Any iron supplementation</i>	59.9%
<i>90 days supplementation</i>	5.0%
Intermittent Preventive Treatment of malaria in pregnancy (IPTp)	14.3%
Vitamin A supplementation for children 6-59mo	70.4%
Micronutrient supplementation for children 0-59mo	15.7%
ORS+zinc	2.4%
Deworming	60.6%
Vitamin A supplementation for pregnant women	27.0%
Intermittent iron/folic acid supplementation for women 15-49yo	0.0%
Pregnant women attending 4 antenatal care visits (ANC)	48.0% ²
Percentage of children 12-23 months of age with complete vaccination	22%-45% ²
Percentage of infants receiving post-natal care	9.7% ²
Percentage of women with met demand for modern family planning services	16.3%

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

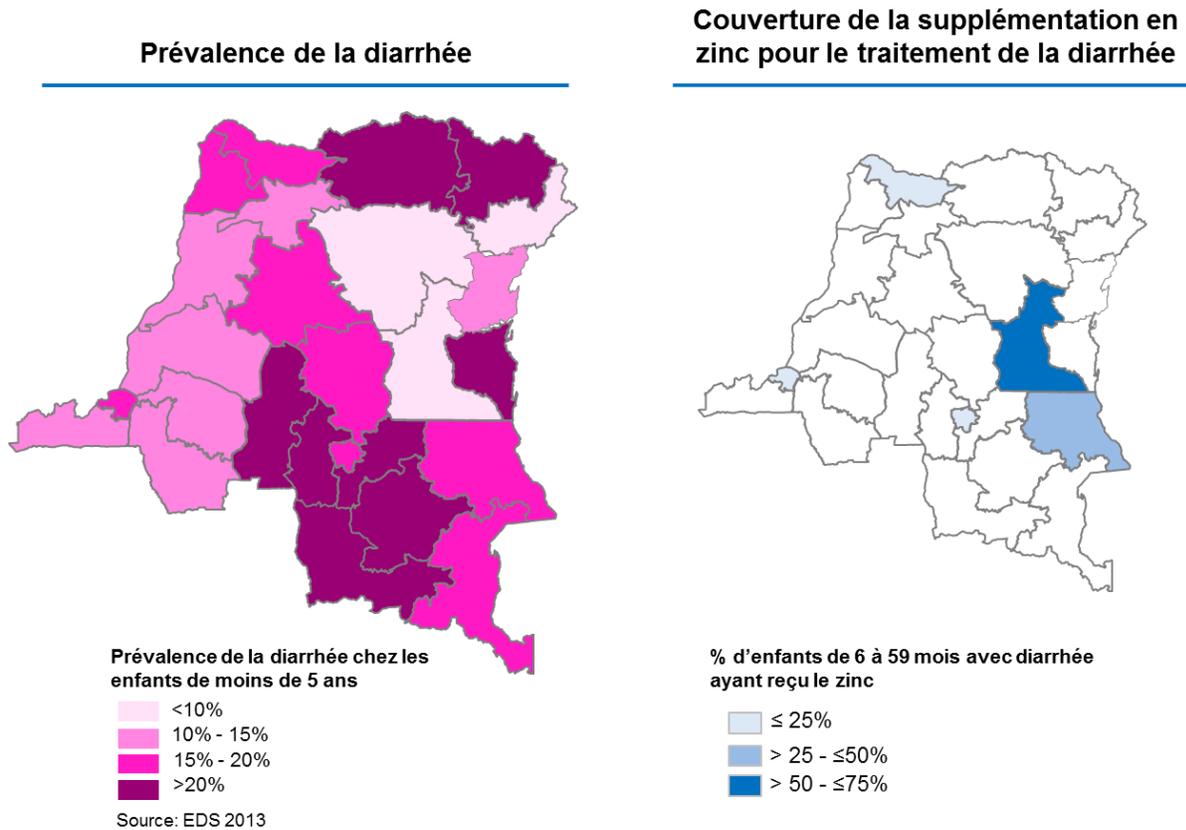
30. **(1) Absence of a coordinated response at the community level:** While key policies and guidelines regarding community-level service provision and mobilization have been developed, to date, the NAC model has only been rolled out on a small scale, largely by external donor programs, and in an uncoordinated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

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demonstrates that in addition to the absence of services at the community level, coordination across different actors remains a significant challenge.

Figure 5: Diarrhea Prevalence and the Coverage of Therapeutic Zinc.



Source: PRONANUT, 2018.

31. **(2) Low availability and quality of health, family planning, and other nutrition-sensitive services:** DRC has 0.09 physicians per 1000 inhabitants – three times fewer than the Sub-Saharan Africa average (0.3) and well below the WHO recommendation of 1 per 1000. In many regions of the country, health facilities and medical equipment have been looted and destroyed. For example, in the Kasai region, according to the emergency response plan prepared by the Ministry of Health (2017), of the 1,077 health facilities 29 percent were destroyed or looted during the recent crisis; 32 percent experienced increased requirements in demand for care due to influx of internally displaced persons; and 13 percent were abandoned by health staff, who fled fearing for their safety. In 2016, according to a survey conducted for the DRC Health System Strengthening project (P147555), only 20 percent of health facilities had all six tracer drugs, only 30 percent of health facilities surveyed offered family planning services, and the average health facility had only 4 of the 6 essential family planning commodities. Service availability and quality is low also in other key nutrition-sensitive sectors. Despite high levels of vulnerability and the existence of large groups with specific special needs, DRC has no national social protection system to provide targeted support to the poorest and

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most vulnerable (DRC Systematic Country Diagnostic, 2018). A World Bank-supported safety net assessment conducted in 2014—the first ever in the country—estimated the total funding for safety nets at about 0.7 percent of GDP, below the average of lower-income countries in Africa. Small scale, partner-financed social safety net programs have received very limited funding, lack a national social registry, and have high delivery cost. Consequently, their delivery is fragmented, and varies widely in terms of coverage, generosity and performance.

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

33. In sum, reducing the prevalence of stunting in DRC will require a focused, multisectoral effort to: a) improve infant and child feeding behaviors and practices; b) increase utilization and quality of essential maternal and child health and nutrition services; c) improve the availability and diversity of foods; d) increase the purchasing power of the most vulnerable household; and e) address the challenges of reproductive health among adolescent girls and the issues of early motherhood. This effort would need to focus on overcoming three major systemic bottlenecks including: a) absence of a coordinated response and platform at the community level; b) low availability and quality of public services in health and other key nutrition-sensitive sectors; c) weak governance and management capacity of state actors at the local, provincial, and central levels. The proposed project will address the key determinants of stunting listed above and remove the key bottlenecks by: a) strengthening and scaling up the multisectoral community-level service delivery and mobilization platform – the NAC; b) improving the supply (quality and quantity) of essential nutrition-specific interventions and selected evidence-based nutrition-sensitive actions in agriculture, social protection, and education by investing in essential infrastructure and inputs and scaling up performance-based payment schemes; and 3) building and maintaining nutrition governance capacity at the central, provincial, and local level, through innovative Technical Assistance (TA) mechanisms to incentivize performance and the use of data for program management.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)



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

Key Results

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

- Number of women and children who have received basic nutrition services (a corporate results indicator)
- Number of children who have received post-natal consultations
- Number of women who have received post-partum family planning services
- Number of pregnant women who have received iron/folic acid supplementation
- Number of beneficiaries who have received cash transfers
- Number of beneficiaries who have received household food production kits

D. Project Description

36. The proposed project will address the key determinants of child stunting in the targeted regions by focused, evidence based, nutrition-specific interventions and complementary multisectoral actions in social protection, agriculture, and education. It will support the government in establishing and scaling up the NAC - a community health and nutrition platform to deliver an essential package of services, support community mobilization, and strengthen the demand for nutrition-specific and nutrition-sensitive services. It will also strengthen the supply of evidence-based public services.

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

38. This first project in a series of projects will focus on the development and scale up of high-impact nutrition-specific interventions at the community and primary health care level and the concurrent piloting of a set of complementary nutrition-sensitive interventions with the strongest evidence of impact. During the first year, the project will focus on supporting the standardization of policy and guidelines for community-level service delivery of nutrition-specific interventions and on preparing delivery mechanism and systems (see Figure 6). It will also and launch a series of activities to strengthen the capacity of state actors. Starting in year two it will roll out the NAC approach at the community level in the targeted provinces. In year 3, the project will start implementing a convergence demonstration pilot of a set of complementary nutrition-sensitive interventions in agriculture, social protection, and education. The focus of the demonstration pilots will be to determine the value added of the multisectoral convergence and, if the pilot results are positive, to



identify the best and most efficient way of delivering multisectoral services at scale in the subsequent projects within this series of projects (SOP) or as part of WB investments in the respective sectors.

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

39. The long-term programmatic objective of this component will be to support the government in implementing the NAC approach - a standardized community-level delivery platform and package of services whose scale up could be financed by the government and development partners (including the future phases of this SOP) either individually or through pooled financing mechanisms (e.g. a multi-donor community health and nutrition trust fund).

Component 2. Improving the Service Supply and Strategic Purchasing

40. This component will focus on improving the supply (quantity and quality) of key nutrition-specific and nutrition-sensitive interventions delivered through primary health care facilities. It will finance the expansion of the existing performance-based financing scheme implemented under the Health System Strengthening Project (P147555) to the proposed project regions. The scheme will provide health facilities with financial incentives in the form of discretionary spending based on the quantity and quality of their service output. The project will expand the current PBF program in terms of scale and scope. First PBF will be implemented in the regions that are not currently covered by the PDSS program, in parallel and in coordination with activities under Component 1. Second, the PBF incentive scheme will emphasize key nutrition-specific and nutrition sensitive services. PBF incentives will target the following services for pregnant and lactating women, children 0-5 years, and adolescent girls: ante-natal care (including iron/folic acid supplementation and intermittent preventive treatment for malaria during pregnancy [IPTp]), routine child health visits for children 0-59 months of age (consultations *prescolaire*), family planning, assisted deliveries, immunization, management of acute malnutrition, and integrated management of child illnesses. In cholera-endemic areas, cholera-related indicators will be included. In addition to providing financial incentives, the project will also finance key inputs and equipment. The project will finance the procurement of family planning commodities for PDSS facilities in the target provinces to reduce the incidence of stockouts. Family planning services will also be strengthened by putting special emphasis on improving the quality of postpartum services for all women, and especially amongst adolescent girls, through the use of clinical vignettes and by the measurement of patient-reported quality of counseling through interviews of family planning clients ⁷.

41. Given that only 34 percent of women using contraception receive services from public providers (DHS 2013-2014), this project will consider responding to the needs of women and couples who may not want or be able to go to a public facility by providing other options closer to the household. Moreover, for adolescent girls who may perceive greater stigma around using contraception, a non-public provider may feel more confidential and safer. Countries that have successfully increased modern contraceptive use at scale have done so by increasing access to a range of methods and providers. In an effort to expand choice of FP providers, the project will facilitate access to FP counseling and methods through non-state actors (NSAs) who will provide a

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



full range of sexual and reproductive health services and will ensure a confidential, quality service offered through a fixed or mobile site. The NSAs will be subjected to the same quality standards and measurement tools that the facility-based FP service would use. Moreover, the NSAs may also provide PAC services if the Ministry of health is keen to include it in their Terms of Reference. These NSAs will be different from those overseeing the ReCos and will, in fact, be precluded from applying for both contracts (ReCo support and FP service delivery).

Component 3: Convergence Demonstration Pilot

42. This component is intended to demonstrate the added value of the multisectoral convergence to improve nutrition outcomes. To do this, in a sub-set of the health zones targeted by Components 1 and 2, the project will finance complementary activities in social protection (targeted cash transfers), agriculture (biofortification, targeted distribution of household food production kits), and education (parental education in support of early childhood development and stimulation; micronutrient supplementation in schools). The actions selected for the pilot have shown effectiveness in improving nutrition outcomes and there exists experience of successful, albeit small-scale, implementation in DRC. Once the added value of the convergence approach is demonstrated, specific interventions (e.g. cash transfers, biofortification, and so forth), could be expanded in a coordinated fashion through sector-specific World Bank investments and broader initiatives and programs. For example, nutrition-sensitive cash transfers could be scaled up through future social safety net programs, biofortification could be expanded through future agriculture investments, and so forth.

43. The demonstration project will provide **unconditional cash transfers to pregnant women and mothers of children 0-23 months of age to improve access to adequate quantity and quality of foods**. Targeted cash transfers are a strategy recommended in the most recent DRC Systematic Country Diagnostic (2018) to improve social safety nets. Malnourished pregnant women and mothers of children suffering from severe acute malnutrition will receive a basic transfer of USD 15 per child per month. Because more than one child per household may suffer from severe acute malnutrition, the cash transfer will target up to two children per households. Thus, households with two or more children suffering from severe acute malnutrition may receive USD 30 per month. Cash will be distributed at regular intervals at health facilities to create incentives and an opportunity for the women and children who receive cash to use health services at the same time. Transfers will be unconditional. The appropriate targeting mechanisms (e.g. based on poverty, based on acute malnutrition status), and frequency of transfers (e.g. bi-weekly, monthly) will be during the first year of project implementation based on the experience from DRC and other countries, putting emphasis on coordination and consistency with other World Bank SP operations in DRC, most notably the Productive Inclusion Project (PIP). The project will finance the transfers, cover the cost of identifying and hiring the national and local implementation agencies, cover the cost of the supervision of the transfers by the Ministry of Social Affairs, and the development of the beneficiary registry. If this nutrition-sensitive cash transfer pilot proves to be effective and scalable, it is envisioned that it could then be taken over and scaled up by an existing (e.g. through additional financing) or a new World Bank social protection project.

44. To restore the productive capacity of the households of vulnerable women and children and prevent their relapse into food insecurity and malnutrition, **the demonstration project will**



complement the cash transfers with food production kits (agriculture inputs kits and small animals/protein kits) for households with food production capacity. The PIU will sign a technical assistance agreement with the Food and Agriculture Organization (FAO) of the United Nations (UN), which has a track record of delivering agricultural inputs and support in project areas. The partner will initially lead this activity. At the same time, however, through the joint design of a pilot intervention, and on-the-job training, it will gradually build the capacity of the government (Ministry of Agriculture, Ministry of Fisheries and Livestock) to eventually take over the implementation of this activity. The project will first finance the production of the key inputs that will constitute the kits. Through beneficiaries targeting conducted jointly with the cash transfer activity, vulnerable women will be identified. They will receive training to set up food production units in their homes. At the end of the training, women beneficiaries will receive a food production kit that will include items such as: small animals (protein kits), nutrient-rich seeds and cuttings (including biofortified varieties), and farming tools to replicate activities at home. In order to ensure availability of seeds and small animals, the project will train and work through women's associations and other existing community structures within the communities hosting the production units to multiply the seeds, cuttings, and small animals, as well as build the capacity of the National Vulgarisation Service (Service National de Vulgarisation [SNV]) to support this production. An assessment study will be conducted to determine actual composition of kits, including whether fisheries can be part of them.

45. To improve micronutrient status for women and young children, **the demonstration pilot will also finance the scale up of the locally-developed biofortified varieties of key crops**, including vitamin-A enriched maize and cassava, iron-rich beans and/ or orange flesh sweet potatoes. The National Seed Service (SENASEM), and the National Institute for Agricultural Studies and Research (INERA), with the help of HarvestPlus, the International Institute of Tropical Agriculture (IITA), and the International Center for Tropical Agriculture (CIAT), have been adaptively breeding and testing biofortified varieties of vitamin-A cassava and maize and high iron beans, which also have higher levels of zinc since 2011 (see Annex 6 for a summary of the recent biofortification experiences in DRC). To expand biofortification, the project will finance a TA contract between the PIU and HarvestPlus to support INERA and SENASEM. HarvestPlus will work with Ministry of Agriculture and the National Vulgarization Service (Service National de Vulgarisation) to identify and contract local partners, including NGOs, farmer associations and cooperatives working in the target areas to grow the biofortified crops. Once sufficient quality seeds and vines are available, HarvestPlus will train the Ministry, SNV and partners to manage the dissemination of biofortified crops to farmers. HarvestPlus will also provide targeted technical assistance to SENASEM, INERA, SNV, and the Centers for Adaptation and Improved Seed Multiplication Centres d'Appui et de Production de Semences Amélio that fall under the Ministry of Agriculture. The project will support study tours and training (examples of how other countries are building biofortified seed systems), as well as lessons from the private sector. The TA will also focus on best practices for aflatoxin control for maize, including engagement with Partnership for Aflatoxin Control in Africa (PACA) at the African Union (AU).

46. In addition to targeting adolescent girls through community-based services, the education system can be used as a platform to reach them. The demonstration project will, therefore, finance **deworming for school-aged children, intermittent micronutrient supplementation for adolescent girls**, and capacity strengthening for teachers to deliver these interventions with the support of the ReCos. The intermittent micronutrient supplementation for adolescent girls will serve as a platform for health and nutrition education sessions. The activity will be supported by performance-based



contracts with NGOs (see Component 1). In the areas where the pilot will be implemented, the NGOs contracted to identify and monitor the ReCos and support their supervision will also provide the training for the teaches, procure and deliver commodities, and monitor the distribution.

Component 4. Capacity Strengthening and Project Management

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

Component 5: Contingent Emergency Response Component (CERC)

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

E. Implementation

Institutional and Implementation Arrangements

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

50. **Sectoral anchoring:** The Ministry of Health has been identified by the government as the ministry within which the project will be anchored. Ministries of Education, Social Affairs, Agriculture, and Fisheries and Livestock will provide support to the Ministry of Health in overseeing specific activities and interventions implemented as part of the project that fall within their sectoral purview.

51. **Project Technical Committee:** Project implementation and oversight will be incorporated into the existing nutrition governance structures, more specifically, the national Scaling up Nutrition (SUN) platform. PRONANUT serves as the SUN platform's executive secretariat and is responsible for the coordination and monitoring of the implementation of the National Multisectoral Nutrition Strategy. In this function, PRONANUT is mandated to hold regular meetings with sectoral ministries, development partners, and NGOs. Within this framework, PRONANUT will lead a small multi-sectoral technical committee that will provide technical guidance to the PIU, review annual work plans and semi-annual and annual monitoring reports, and facilitate dialogue with the participating sectors in order to deal with bottlenecks as they arise. In addition to PRONANUT, the committee will include



representative from four additional key directorates within the MoH (Community Health, Family and Reproductive Health, Studies and Planning, and Hygiene), as well as representatives from the Ministry of Social Affairs, Ministry of Education, Ministry of Agriculture (DEP, SNV, SENASEM), and Ministry of Fisheries and Livestock, Ministry of Research (INERA).

52. **Project Implementation Unit:** To capitalize on the existing expertise and enable quick and efficient implementation, the proposed project will use the existing Health System Strengthening Project PIU. This PIU is already implementing a PBF program, and the proposed project will use the existing institutional arrangements and processes (e.g. PBF manual, purchasing agencies, verification processes and agencies) to implement the PBF subcomponent (Subcomponent 2.1).

53. The PIU team will be expanded to allow for efficient and effective implementation. A separate team will be created within the PIU that will focus on the management of the proposed project. At minimum, the additional PIU staff hired will include: a.) a project manager, b.) a FM specialist, c.) an accountant, d.) a procurement specialist, e.) a nutrition specialist, f.) a social protection specialist; g.) an agriculture specialist h.) a monitoring and evaluation specialist and i.) a project administrative assistant. In addition, a social safeguards specialist and an environmental safeguards specialist will be recruited by the PIU. Those two staff members will work on the proposed project and on other projects managed by the PIU. The project will finance additional PIU staff, their training, as well as basic equipment and other necessary inputs.

54. **NGOs – Roles and Responsibilities:** Because of the public sector’s severe capacity constraints, non-governmental organizations (NGOs) will support the implementation of the NAC. NGOs will support the identification, training, supervision, and monitoring of the ReCos. Several large NGOs are present in the provinces supported by the project (e.g. CRS, IMA, ADRA, others). Some of them have worked with PRONANUT and UNICEF on the implementation of NAC in other provinces (e.g. ADRA). Others have experience with programs targeting acute malnutrition (e.g. IMA). NGOs will be contracted directly by the PIU using performance-based contracts. It is envisioned that one or two NGOs will be contracted in each province (a total of 4-8 NGOs). Additional NGOs will be contracted to provide family planning services.

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

56. **Verification and Counter-Verification Agencies – Roles and Responsibilities:** Following the PDSS model, PIU will contract with the Public Utility Entities (*Entités d’Utilité Publique [EUP]*) to provide payments for PBF facilities and NGOs and verify their performance. A counter verification agency – CREDES, will be contracted to carry out counter-verification.



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

55. The project will be implemented in the following priority provinces: Kasai, Kasai Central, Kwilu and Sud Kivu. At this stage, the exact areas of implementation have yet to be identified, this will be determined during the first pre-appraisal mission, as well as after effectiveness. In regard to Indigenous Peoples, they are found in at least three of the four targeted Provinces, including Kasai, Kasai Central and South Kivu.

G. Environmental and Social Safeguards Specialists on the Team

- Richard Everett, Sr. Social Specialist
- Jean-Pierre Lungenyi Ntombolo, Social Specialist
- Joelle Nkombela Mukungu, Sr. Environmental Specialist
- Christophe Ngongo Muzyumba, Environmental Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
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KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

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

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

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

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

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

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B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

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APPROVAL

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Approved By

Safeguards Advisor:		
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Country Director:		

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