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The World Bank

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Report No: PAD977

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON

PROPOSED GRANTS TO THE

DEMOCRATIC REPUBLIC OF CONGO
IN THE AMOUNT OF SDR 47.95 MILLION
(US$73.86 MILLION EQUIVALENT)

REPUBLIC OF BURUNDI
IN THE AMOUNT OF SDR 9.84 MILLION
(US$15.15 MILLION EQUIVALENT)

INTERNATIONAL CONFERENCE ON THE GREAT LAKES REGION
IN THE AMOUNT OF SDR 1.95 MILLION
(US$3.00 MILLION EQUIVALENT)

AND A PROPOSED CREDIT TO THE

REPUBLIC OF RWANDA
IN THE AMOUNT OF SDR 9.71 MILLION
(US$14.95 MILLION EQUIVALENT)

FOR THE

GREAT LAKES EMERGENCY SEXUAL AND GENDER BASED VIOLENCE
AND WOMEN'S HEALTH PROJECT

June 12, 2014

Health, Nutrition and Population- Central and West Africa (AFTHW)
Post Conflict & Social Development Practice Group (AFTCS)
Africa Regional Integration Department (AFCRI)
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective on May 31, 2014)

Currency Unit	=	XAF, BIF, RWF
US$1	=	482 XAF, 1,550 BIF, 680 RWF
US$1	=	SDR 0.64915253

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AAP	Agence d'Achat des Performances (Performance Purchasing Agency)
AfDB	African Development Bank
APAMESK	Association Provinciale pour l'Approvisionnement en Médicaments Essentiels (Provincial Association for Provision of Essential Drugs)
ASRAMES	Association Régionale d'Approvisionnement en Médicaments Essentiels
ARV	Antiretroviral (Regional Association for Provision of Essential Drugs)
AU	African Union
AWPB	Annual Work Plans and Budget
BAT	Best Available Technique
BDOM	Bureau Diocésain des Ouvres Médicales (Diocesan Office for Medical Affairs
BMZ	German Federal Ministry of Economic Cooperation and Development
BP	Bank Policies
CAS	Country Assistance Strategy
CBO	Community Based Organization
CDR	Centrale de Distribution Régionale (Regional Drug Distribution Office)
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CENI	Independent National Electoral Commission
CEPAC	Communautés des Eglises Pentecôtistes d'Afrique Centrale (Community of Pentecostal Churches of Central Africa)
CFEF	Cellule d'Exécution des Financements en faveur des Etats Fragiles (Implementation Unit for Financing of Fragile States)
CGPMP	Cellule de Gestion des Projets et Marchés Publics (Project and Procurement Management Unit)
CNIE	Centre National d'Information sur l'Environnement (National Center for Information on Environment)
CODESA	Comité de Développement de Santé (Health Development Committee)
CoE	Centers of Excellence
CPS	Country Partnership Strategy
CPT	Cognitive Processing Therapy
CQ	Consultant Qualification
CS	Conference Secretariat
CSO	Civil Society Organization

CSO	Cellule de Suivi des Projets et Programmes (Project and Program Monitoring Unit)
DA	Designated Account
DEH	Department for Environmental Health
DfID	UK Department for International Development
DHS	Demographic and Health Survey
DL	Disbursement Letter
DRC	Democratic Republic of Congo
EA	Environmental Assessment
EC	European Community
EDPRS	Economic Development and Poverty Reduction Strategy
EMAP	Engaging Men through Accountable Practices
EMP	Environmental Management Plan
EOI	Expression of Interest
ERP	Eastern Recovery Project
ESAP	Environmental and Social Action Plan
ESIA	Environmental and Social Institutional Assessment
ESMP	Environmental and Social Management Plan
EU	European Union
FASS	Fond d'Achat des Services de Santé (Purchasing Agency for Health Services)
FBO	Faith Based Organization
FCDC	Family and Community Development Centers
FCS	Fragile and Conflict-Affected States
FEFU	Facilité en Faveur des Etats Fragiles Unit (Fragile States Unit)
FM	Financial Management
FSRDC	Social Fund of DRC
GDP	Gross Domestic Product
GEEC	Groupe d'Etudes Environnementales du Congo (Group for Environmental Studies in Congo)
GIZ	German Society for International Cooperation
GLR	Great Lakes Region
GMO	Gender Monitoring Office
GoB	Government of Burundi
GoDRC	Government of DRC
GoR	Government of Rwanda
GPN	General Procurement Notice
GRH	General Referral Hospital
HDSSP	Human Development Systems Strengthening Project
HIV/AIDS	Human Immunodeficiency Virus Infection/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
IA	Implementation Agency
IBRD	International Bank for Reconstruction and Development
ICB	International Competitive Bidding
ICGLR	International Conference on the Great Lakes Region
ICR	Implementation Completion Report
IDA	International Development Association
IDP	Internally Displaced Populations

IFC	International Finance Corporation
IPF	Investment Project Financing
IPP	Indigenous Peoples Plan
IPV	Intimate Partner Violence
IRC	International Rescue Committee
I4S	International Security and Stabilization Support Strategy
KAP	Knowledge, Attitudes and Practices Survey
LC	Letter of Credit
LCS	Least Cost Selection
LIWG	Labor Intensive Work Group
LoGICA	Learning on Gender and Conflict in Africa
MAP	Multi-Country Action HIV/AIDS Program
MAJ	Maisons d'Accès à la Justice (Justice Access Homes)
MDGs	Millennium Development Goals
MDIIT	Multidisciplinary Investigation and Intervention Team
MECNT	Ministère de l'Environnement, de la Conservation de la Nature et du Tourisme (Ministry of Environment, Conservation of Nature and Tourism)
MIDIMAR	Ministry of Disaster Management and Refugee Affairs (Rwanda)
MIGEPROF	Ministry of Gender and Family Protection (Rwanda)
MINALOC	Ministry of Local Governance (Rwanda)
MINECOFIN	Ministry of Finance and Economic Planning (Rwanda)
MINIJUST	Ministry of Justice (Rwanda)
MNSHRG	Ministry of National Solidarity, Human Rights and Gender (Burundi)
MoD	Ministry of Defense (Rwanda)
MoF	Ministry of Finance (DRC)
MoGFC	Ministry of Gender, Family and Children (DRC)
MoH	Ministry of Health and Fight Against HIV/AIDS (Burundi)
MoH	Ministry of Health (Rwanda)
MONUSCO	United Nations Organization Stabilization Mission in the Democratic Republic of the Congo
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs (DRC)
MS	Member State
MSNDPHG	Ministry of Gender
MTEF	Medium-Term Expenditure Framework
MWMP	Medical Waste Management Plan
M&E	Monitoring and Evaluation
NCB	National Competitive Bidding
NCC	National Commission for Children
NET	Narrative Exposure Therapy
NGO	Non-Governmental Organization
NMHP	National Mental Health Program
NPPA	National Public Prosecution Authority
OP	World Bank Operational Procedures
ORAF	Operational Risk Assessment Framework
OSC	One Stop Center
PBF	Performance Based Financing
PCN	Project Concept Note

PDO	Project Development Objective
PEFA	Public Expenditure and Financial Accountability
PEP	Post Exposure Prophylaxis
PFM	Public Financial Management
PFMP	Public Financial Management Program
PFS	Project Financial Statements
PHD	Provincial Health Directorate
PIM	Project Implementation Manual
PIU	Project Implementation Unit
PMR	Procurement Management Report
PNSR	National Reproductive Health Program
PPA	Performance Purchasing Agency
PRCG	Projet de Renforcement des Capacités en Gouvernance (Governance Capacity Strengthening Project)
PRCGAP	Projet de Renforcement des Capacités en Gestion des fonctions de bases de l'Administration Publique (Project for Strengthening Public Administration Management Capacity)
PREM	Poverty Reduction and Economic Management
PRSP	Poverty Reduction Strategy Paper
PSCF	Peace, Security and Cooperation Framework for the DRC and the Region
PU	Procurement Unit
QBS	Quality Based Selection
QCBS	Quality and Cost Based Selection
RBF	Results Based Financing
RECO	Relais Communautaire (Community Health Workers)
REMA	Rwanda Environment Management Authority
RH	Reproductive Health
RINR	Regional Initiative on Natural Recourses
RLDSF	Rwanda Local Development Support Fund
RNP	Rwanda National Police
RPPA	Rwanda Public Procurement Authority
RTF	Regional Training Facility
SBD	Standard Bidding Document
SDR	Standard Drawing Rights
SFP	Safeguards Focal Point
SGBV	Sexual and Gender Based Violence
SNAME	Système National d'Approvisionnement en Médicaments (National Drug Supply System)
SNIS	Système National d'Informations Sanitaires (National Health Information System)
SoE	Statements of Expenditures
SOP	Standard Operating Procedures
SPIU	Single Project Implementation Unit
SPN	Specific Procurement Notice
SSR	Security Sector Reform
SSS	Single Source Selection
STAREC	Stabilization and Reconstruction Plan for War-Affected Zones in the East
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection

TC	Tender Committee
ToR	Terms of Reference
ToT	Training of Trainers
UK	United Kingdom
UN	United Nations
UNDB	United Nations Development Business
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
US	United States
USAID	United States Agency for International Development
VSLA	Village Savings and Loans Associations
VUP	Vision Umerenge Program
WBG	World Bank Group
WGPP	Western Growth Pole Project
WHO	World Health Organization

Vice President:	Makhtar Diop
Country Director:	Colin Bruce
Sector Directors:	Tawhid Nawaz/Jamal Saghir
Sector Managers:	Trina S. Haque/Ian Bannon
Task Team Leaders:	Miriam Schneidman/Pia Peeters

AFRICA
Great Lakes Emergency Sexual and Gender Based Violence and Women's Health Project

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PAD DATA SHEET

Africa

Great Lakes Emergency Sexual and Gender Based Violence and Women's Health Project (P147489)

AFTHW/AFTCS

Report No. PAD977

Basic Information		
Project ID P147489	EA Category B - Partial Assessment	Team Leaders Miriam Schneidman/ Pia Peeters
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [X] - Fragile States - Post-Conflict	
	Financial Intermediaries [ ]	
	Series of Projects [ ]	
Project Implementation Start Date 26-June-2014	Project Implementation End Date 30-Jun-2018	
Expected Effectiveness Date 26-Sept-2014	Expected Closing Date 30-Jun -2018	
Joint IFC No		

Sector Managers	Sector Directors	Country Director	Regional Vice President
Trina S. Haque/	Tawhid Nawaz/	Colin Bruce	Makhtar Diop
Ian Bannon	Jamal Saghir		

Recipients: Democratic Republic of Congo, Republic of Burundi, Republic of Rwanda, International Conference for the Great Lakes Region

Safeguards Deferral (from Decision Review Decision Note)
Will the review of Safeguards be deferred? [X] Yes [ ] No

Project Financing Data(in USD Million)					
[ ]	Loan	[ ]	Grant	[ ]	Guarantee
[X]	Credit	[X]	IDA Grant	[ ]	Other

Total Project Cost:	106.96	Total Bank Financing:	106.96
Financing Gap:	0.00		

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	106.96
Total	106.96

Expected Disbursements (in USD Million)

Fiscal Year	2015	2016	2017	2018	2019				
Annual	27.0	29.0	28.0	22.5	0.46				
Cumulative	27.0	56.0	84.0	106.5	106.96				

Proposed Development Objective(s)

The objectives of this project are to: (i) expand the provision of services to mitigate the short and medium term impact of sexual and gender based violence; and (ii) expand utilization of a package of health interventions targeted to poor and vulnerable females.

Components

Component Name	Cost (USD Millions)
Holistic Support for Survivors of Sexual and Gender Based Violence and Violence Prevention	50.51
High Impact Basic Health Services	34.03
Regional and National Knowledge Sharing, Research, and Capacity Building	22.42
Total	106.96

Institutional Data

Sector Board

Health, Nutrition and Population

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Other social services	60		
Health and other social services	Health	40		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)		
Major theme	Theme	%
Social dev/gender/inclusion	Conflict prevention and post-conflict reconstruction	50
Social dev/gender/inclusion	Gender	40
Human development	Health system performance	10
Total		100

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ] No [X]
Does the project require any waivers of Bank policies?	Yes [ ] No [X]
Have these been approved by Bank management?	Yes [ ] No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X] No [ ]

Safeguard Policies Triggered by the Project	**Yes**	**No**
Environmental Assessment OP/BP 4.01	**X**	
Natural Habitats OP/BP 4.04		**X**
Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10	**X**	
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**

Description of Covenant

LEGAL COVENANTS

DRC

Name	**Recurrent**	**Due Date**	**Frequency**
Subsidiary Agreement		By effectiveness	

Description of the covenant: To facilitate the carrying out of Components 1(a), and selected activities under Component 3 of the Project, the Project Implementing Entity shall sign a subsidiary agreement with the Recipient under grant terms and conditions approved by the Association ("Subsidiary Agreement").

Name	Recurrent	Due Date	Frequency
PBF Agreement	Recurrent after signature		

Description of the covenant: To facilitate the carrying out of Component 2 of the Project, the Recipient shall sign PBF Agreements with the Performance Purchasing Agencies, under terms and conditions approved by the Association, as further described in the Project Implementation Manual, including the revised PBF Manuals ("PBF Agreements").

Name	Recurrent	Due Date	Frequency
Project Steering Committee	X		

Description of the covenant: The Recipient shall maintain throughout the period of Project implementation the Steering Committee to provide overall strategic direction; approve the Annual Work Program; and ensure consistency with the Recipient's policies and strategies, with terms of reference, composition and powers acceptable to the Association as further described in the Project Implementation Manual.

Name	Recurrent	Due Date	Frequency
Maintain CFEF coordination unit	X		

Description of the covenant: The Recipient shall maintain throughout the period of Project implementation the CFEF to run the day-to-day management and coordination of the Project, with staffing, terms of reference, composition and powers acceptable to the Association as further described in the Project Implementation Manual.

Name	Recurrent	Due Date	Frequency
PBF Performance Contracts	Recurrent after signature		

Description of the covenant: The Recipient shall cause the Performance Purchasing Agencies to sign PBF Performance Contracts with Health Facilities and Health Authorities in North Kivu and South Kivu in order to allow for said Health Facilities and Health Authorities to receive PBF Grants for health services delivered on a quarterly basis, including terms and conditions approved by the Association, as further described in the Project Implementation Manual including the revised PBF Manuals ("Performance Contracts").

Name	Recurrent	Due Date	Frequency
Service Contracts		No later than two months after the effective date	

Description of the covenant: To facilitate the carrying out of Component 1(c) of the Project, the Recipient shall no later than two months after the Effective Date sign and thereafter maintain service contracts with Panzi Foundation and Heal Africa under grant terms and conditions approved by the Association ("Service Contracts").

Name	Recurrent	Due Date	Frequency
Project Implementation Manual and Safeguard Documents		Within three months of effectiveness	

Description of the covenant: The Recipient shall cause the Project to be carried out in accordance with the provisions of the Project Implementation Manual and of the Safeguard Documents and shall adopt all these documents within three months of effectiveness. The Recipient shall not allow any physical or construction activity to commence before the provisions and conditions set out in the

Recipient's Environmental and Social Action Plan have been fully met to the satisfaction of the Association.

Name	Recurrent	Due Date	Frequency
Project Implementation Entity (FSRDC)	X		

Description of the covenant: The Project Implementing Entity shall maintain at all times during the implementation of the Project, the Coordination Unit to oversee the day-to-day implementation and management of Component 1(a) and selected activities of Component 3 of the Project with competent staff in adequate numbers and with terms of reference, qualification and experience satisfactory to the Association.

Name	Recurrent	Due Date	Frequency
Project Implementation Manual and Safeguards Instruments (FSRDC)	X		

Description of the covenant: The Project Implementing Entity shall carry out Component 1(a) and selected activities of Component 3 of the Project, in accordance with the provisions of the Project Implementation Manual and the Safeguard Documents.

Name	Recurrent	Due Date	Frequency
PBF Grants under PBF Performance Contracts		Prior to disbursement under category 2	

Description of Disbursement Condition: Disbursement under Category (2) (PBF Grants under PBF Performance Contracts) will commence once the Association has received the PBF Agreements, at least one PBF Performance Contract and the revised PBF Manuals, all in form and substance satisfactory to the Association.

BURUNDI

Name	Recurrent	Due Date	Frequency
Project Steering Committee		Three months after the effective date	

Description of the covenant: The Recipient shall create no later than three months after the Effective Date and thereafter shall maintain throughout the period of Project implementation the Project the Steering Committee to meet every six months and provide overall strategic direction; approve the Annual Work Programs; and ensure consistency with the Recipient's policies and strategies, with terms of reference, composition and powers acceptable to the Association as further described in the Project Implementation Manual.

Name	Recurrent	Due Date	Frequency
Project Technical Team		Three months after the effective date	

Description of the covenant: The Recipient shall create no later than three months after the Effective Date and thereafter maintain throughout the period of Project implementation the Project Technical Team within the administrative structure of MNSHRG to coordinate project activities under the mandate of the said Ministry and support capacity strengthening to coordinate activities against SGBV more broadly, with staffing, terms of reference, composition and powers acceptable to the Association as further described in the Project Implementation Manual.

Name	Recurrent	Due Date	Frequency
Project coordination Unit	X		

Description of the covenant: The Recipient shall update its mandate and thereafter maintain throughout the period of Project implementation the Project Coordination Unit within the administrative structure of MOH to run the day-to-day coordination and implementation of the Project, with staffing, terms of reference, composition and powers acceptable to the Association as further described in the Project Implementation Manual.			
Name	**Recurrent**	**Due Date**	**Frequency**
Project Implementation Manual and Safeguards Instruments		Within three months of effectiveness	
Description of the covenant: The Recipient shall cause the Project to be carried out in accordance with the provisions of the Project Implementation Manual and of the Safeguards Documents and shall adopt all these documents within three months of effectiveness. The Recipient shall not allow any physical or construction activity to commence before the provisions and conditions set out in the Recipient's Environmental and Social Action Plan have been fully met to the satisfaction of the Association.			

RWANDA

Name	**Recurrent**	**Due Date**	**Frequency**
Project Steering Committee	X		
Description of the covenant: The Recipient shall maintain throughout the period of Project implementation, the Steering Committee to meet every six months and provide overall strategic direction; approve the Annual Work Programs; and ensure consistency with the Recipient's policies and strategies, with terms of reference, composition and powers acceptable to the Association as further described in the Project Implementation Manual.			
Name	**Recurrent**	**Due Date**	**Frequency**
Technical Committee	X		
Description of the covenant: The Recipient shall maintain throughout the period of Project implementation, the Technical Committee to meet every three months, discuss and identify progress, challenges and mitigation measures for the Project and prepare Annual Work Programs, with terms of reference, composition and powers acceptable to the Association as further described in the Project Implementation Manual.			
Name	**Recurrent**	**Due Date**	**Frequency**
Single Project Implementation Unit MIGEPROF		No later than one month after the effective date	
Description of the covenant: The Recipient shall create no later than one month after the Effective Date and thereafter maintain throughout the period of Project implementation, the MIGEPROF Single Project Implementation Unit within the administrative structure of MIGEPROF to run the day-to-day implementation, fiduciary management and coordination for selected activities under Components1 and 2 of the Project, with staffing, terms of reference, composition and powers acceptable to the Association as further described in the Project Implementation Manual.			
Name	**Recurrent**	**Due Date**	**Frequency**
Single Project Implementation Unit MoH	X		
Description of the covenant: The Recipient shall maintain throughout the period of Project implementation, the MoH Single Project Implementation Unit within the administrative structure of MoH to run the day-to-day coordination and implementation for selected activities under Component 1(b) of the Project, with staffing, terms of reference, composition and powers acceptable to the			

Association as further described in the Project Implementation Manual.			
Name	**Recurrent**	**Due Date**	**Frequency**
Project Implementation Manual and Safeguard Documents		Within three months after the effective date	
Description of the covenant: The Recipient shall cause the Project to be carried out in accordance with the provisions of the Project Implementation Manual and of the Safeguard Documents and shall adopt all these documents within three months of effectiveness. The Recipient shall not allow any physical or construction activity to commence before the provisions and conditions set out in the Recipient's Environmental and Social Action Plan have been fully met to the satisfaction of the Association.			

ICGLR

Name	**Recurrent**	**Due Date**	**Frequency**
Conference Secretariat	X		
Description of the covenant: The Recipient shall maintain throughout the period of Project implementation, the Conference Secretariat to provide overall strategic direction for the Project, approve the Annual Work Programs and ensure consistency with the Recipient's policies and strategies, with terms of reference, composition and powers acceptable to the Association as further described in the Project Implementation Manual.			

Name	**Recurrent**	**Due Date**	**Frequency**
Project Implementation Unit	X		
Description of the covenant: The Recipient shall maintain throughout the period of Project implementation, the Project Implementation Unit, in charge of the day-to-day implementation, management, coordination, supervision, monitoring and evaluation of the Project, with terms of reference, staff and powers acceptable to the Association as further described in the Project Implementation Manual.			

Name	**Recurrent**	**Due Date**	**Frequency**
Project Implementation Manual		Within three months after the effective date	
Description of the covenant: The Recipient shall carry out cause the Project in accordance with the provisions of the Project Implementation Manual and shall adopt all these documents within three months of effectiveness.			

Team Composition

Bank Staff

Name	**Title**	**Specialization**	**Unit**
Miriam Schneidman	Lead Health Specialist	Task Team Leader	AFTHE
Pia Peeters	Senior Social Development Specialist	Co-Task Team Leader	AFTCS
Aissatou Chipkaou	Operations Analyst	Operations	AFTHW
Bourama Diaite	Senior Procurement	Procurement	AFTPW

	Specialist		
Daniele Jaekel	Operations Analyst	Operations	AFTHW
Alexandra C. Sperling	Legal Analyst	Legal	LEGAM
Hadia Nazem Samaha	Senior Operations Officer	Operations	AFTHW
Alain-Desire Karibwami	Health Specialist	Health	AFTHE
Antoinette Kamanzi	Procurement Assistant	Procurement	AFMRW
Antoine V. Lema	Senior Social Development Specialist	Social Development	AFTCS
Joseph-Antoine Ellong	Senior Program Assistant	Operations	AFTCS
Qinyu Cao	E T Consultant	Social Development	AFTCS
Pascal Tegwa	Senior Procurement Specialist	Procurement	AFTPE
Isabella Micali Drossos	Senior Counsel	Legal	LEGAM
Bella Lelouma Diallo	Senior Financial Management Specialist	Financial Management	AFTMW
Aissatou Diallo	Senior Finance Officer	Finance	CTRLA
Sariette Jene M. C. Jippe	Program Assistant	Team Assistance	AFTHW
Harald Hugo Hinkel	Senior Social Development Specialist	Social Development	AFTCS
Tomo Morimoto	Operations Officer	Operations	AFTHW
Jeannine Kashosi Nkakala	Team Assistant	Team Assistance	AFCC2
Rifat Hasan	Young Professional	Health	AFTHW
Wolfhart Pohl	Safeguards Adviser	Advisory	AFTSG
Gyorgy Bela Fritsche	Senior Health Specialist	Health	AFTHW
Clarette Rwagatore	Executive Assistant	Team Assistance	AFMBI
Luc Laviolette	Sector Leader	Health	AFTHD
Leanne Michelle Bayer	Senior Social Development Specialist	Social Development	SDV
Maud Juquois	E T Consultant	Health (Economics)	AFTHW
Melance Ndikumasabo	Procurement Specialist	Procurement	AFTPE
Lanssina Traore	Procurement Specialist	Procurement	AFTPW
Julia Vaillant	E T Consultant	Evaluation	AFRGI
Lisette Meno Khonde	Consultant	Social Protection	AFTSW
Faly Diallo	Financial Officer	Finance	CTRLA
Alys M. Willman	Social Development Specialist	Social Development	SDV
Diego Garrido Martin	Senior Operations Officer	Monitoring and Evaluation	AFTDE

Mulugeta Dinka	E T Consultant	Procurement	AFTPE
Eric Christian Thibaut Mallard	Senior Health Specialist	Health (Pharmaceuticals)	HDNHE
Fiona Kabura Kukunda	Temporary	Team Assistance	AFMRW
Michel Muvudi	Consultant	Health	AFTHW
Alice Museri	Team Assistant	Team Assistance	AFMBI

I. STRATEGIC CONTEXT

A. Country Context

1. **The Great Lakes Emergency Sexual and Gender Based Violence and Women's Health Project is part of the broader World Bank Group (WBG) initiative for the Great Lakes**. The regional project reflects the Bank's commitment to support governments of the Great Lakes region to reduce poverty and promote shared prosperity by targeting some of the most vulnerable groups in the Democratic Republic of Congo (DRC), Burundi and Rwanda. It also reflects the WBG's commitment to facilitate cross country learning and knowledge sharing, to promote regional cooperation on key development and public health issues, and to advance the regional policy agenda on Sexual and Gender Based Violence (SGBV) endorsed by the Great Lakes Region Heads of State (2011 *Kampala Declaration*), including support to the International Conference on the Great Lakes (ICGLR). [1]

2. **In Eastern DRC the context is characterized by continuing conflict, driven by challenges faced by the state to provide security and basic services,** long-standing ethnic tensions and land disputes exacerbated by the continued presence of armed groups and their involvement in illicit mining activities, and severe socioeconomic vulnerability of the population. While the central government has made steady progress over the past few years to sign several peace agreements, improve economic management, and attain debt relief, the situation remains precarious. In spite of the recent defeat of the Congolese Revolutionary Army (M23), a number of armed groups continue to pose a significant threat to stability in Eastern DRC. Moreover, in spite of vast mineral resources and tremendous potential DRC continues to be one of the poorest countries in the world with roughly 63 percent of the population below the poverty line. Poverty is gender biased: 28 percent of women have never gone to school, compared to 14 percent for men; women's participation in the workforce is 55 percent compared to 85 percent for men. The rapid Gross Domestic Product (GDP) growth rate over the past few years (i.e. over 7 percent) has not translated into improvements in human development. Globally, DRC is ranked last on the 2013 Human Development Index. Given that DRC is one of Africa's most rapidly growing economies and is strategically located in the Great Lakes Region, the country's development trajectory could have a positive impact on the entire sub-region.

3. **The Republic of Burundi is gradually making the transition from a post-conflict to a developing economy but progress remains fragile.** In the past decade, Burundi has made progress in consolidating peace and security, establishing a relatively stable macroeconomic environment, and rebuilding institutions. Burundi is still facing enormous challenges with over two-thirds of the population below the poverty line, continuing high dependence on agriculture, high rates of population growth, returning refugees, limited access and poor quality of basic social services, difficulties sustaining the free health care policy for women and children, and limited economic opportunities. To achieve greater stability and prosperity, Burundi aims to

[1] The ICGLR is an inter-governmental organization composed of 12 member states from the Greater Great Lakes Region, which was set up in 2006 with the assistance of the African Union (AU), United Nations (UN) and bilateral donors. The ICGLR aims to implement the *Pact on Security, Stability and Development* (Pact) which sets an ambitious agenda "to transform the region into a space of sustainable peace and security for peoples of the region". Key sectors include: (i) peace and security; (ii) democracy and good governance; (iii) economic development and regional integration; (iv) humanitarian and social issues; and (v) cross-cutting issues including gender, environment, human rights, HIV/AIDS and human settlements.

reduce the risk of renewed instability, tackle the demographic issue, and move on a path of faster and more inclusive growth, including by pursuing regional integration.

4. **The Republic of Rwanda has made dramatic progress since the genocide and war of the mid 1990s by restoring peace and stability, ensuring robust economic growth, and reducing poverty.** Prudent fiscal and monetary policies, coupled with an emphasis on building institutional capacity, promoting good governance, and creating a business-friendly environment, contributed to low inflation and average annual economic growth in excess of eight percent over the past decade *(Rwanda Country Partnership Strategy 2014-2018*). A strong focus on homegrown policies and initiatives resulted in significant improvements in access to services and human development indicators. Particularly notable have been the efforts in reducing poverty. However, while the overall poverty count has dropped from 59 percent in the early 2000s to 45 percent in 2011, extreme poverty persists with up to 73 percent of the population below the poverty line in the poorest districts (*Integrated Household Living Condition Survey*, 2012). Women are more affected by poverty than men, and inequality continues to be comparatively high. Under the flagship Vision 2020 *Umurenge* Program the government created economic opportunities and expanded access to social protection, health and nutrition services for the poorest and most vulnerable Rwandans with about 43 percent coverage nationwide. In line with Rwanda's gender policy, close to 70 percent of beneficiary households in the cash transfer program are headed by women.

5. **The ICGLR has an important and unique role in peace, stability and development in the Great Lakes region as elaborated in its constitutive Pact and Protocols[2].** Addressing Sexual and Gender Based Violence has been a key area of attention of the ICGLR since its inception. The ICGLR Pact includes a protocol focusing specifically on prevention and suppression of sexual violence against women and children. In 2011, all heads of states of the ICGLR adopted the Kampala Declaration on SGBV, or the *United to Prevent, End Impunity and Provide Support to the Victims of SGBV in the Great Lakes Region Strategy* which calls for a comprehensive approach from prevention to survivor support, involving a broad spectrum of actors and institutions (i.e. governments, civil society, parliamentarians, religious leaders and international partners)[3]. In 2014, the ICGLR opened in Kampala a Regional Training Facility (RTF) on the Fight against SGBV as agreed upon in the Kampala Declaration. The objective of the RTF is to train and sensitize relevant personnel in the medical, judicial and police sectors as well as social workers from the Great Lakes Region to provide an efficient and effective response to SGBV. The institution is also responsible for facilitating regional knowledge generation and sharing, conducting policy-oriented research, and maintaining a database of regional and international experts.

B. Situations of Urgent Need of Assistance or Capacity Constraints

6. **The main rationale for processing this operation using the flexibility provided under OP/BP 10.00 (paragraph 11) is that both DRC and Burundi are on the Harmonized List of**

[2] The ICGLR is focusing on a number of priority areas including crisis and conflict prevention in the region, tackling the challenge of illegal exploitation of natural resources in the region through the implementation of the Regional Initiative on Natural resources (RINR), efforts aimed at prevention and suppression of SGBV, protection and assistance of displaced persons, promotion of democracy and good governance, addressing human rights challenges in the region, enhancing food security, and tackling the challenges of communicable diseases in the region.

[3] The Declaration links to other anti-SGBV global initiatives and UN Security Council Resolutions (1325, 1820, 1888, 1889 and 1960).

Fragile Situations. The main geographic focus of the project, Eastern DRC, has suffered prolonged and ongoing violent conflicts, causing major adverse economic and social impacts, particularly on women. Sexual and Gender Based Violence has reached exceptionally high levels, often with high levels of cruelty, violating basic human rights. The ongoing presence of United Nations (UN) troops on the ground, currently United Nations Organization Stabilization Mission (MONUSCO), reflects the continuing fragility and severe capacity constraints.

7. **The recent defeat of the M23 has underscored new urgent needs to restore service delivery to populations living in the conflict ridden areas liberated by this rebel group in North Kivu.** The governor of North Kivu has been actively calling for the disarmament and demobilization of armed groups in the province, and has demonstrated increased interest in working with the UN to promote peacebuilding. In North Kivu authorities have prioritized several health zones previously under the control of M23 or which have been affected by other rebel groups that need urgent assistance both in terms of providing support to survivors of SGBV and delivering basic health services. In South Kivu the government is also trying to urge armed groups to lay down arms but the process is moving slowly. Humanitarian concerns persist in hot spot areas in both Kivus where armed groups continue their activities unabated and local populations have been displaced by fighting.

8. **The proposed project will contribute to the broader international effort to support stabilization and peace building in Eastern DRC**. In recognition of the limitations and challenges of past stabilization and peace-building efforts, the UN and international donors initiated a strategic review of the *International Security and Stabilization Support Strategy* (I4S), which has invested over US$340 million in security, state-building, conflict management and community level economic recovery programs. The I4S operates within the overall framework of the Government's Stabilization and Reconstruction Plan for War-Affected Zones in the East (STAREC). The revised I4S has five pillars: (i) support to democratic dialogue; (ii) security; (iii) restoration of state authority; (iv) return, reintegration, and socio-economic recovery; and (v) fight against sexual violence. The proposed project will contribute to pillar five by addressing the impact of SGBV as well as initiating efforts to prevent violence.

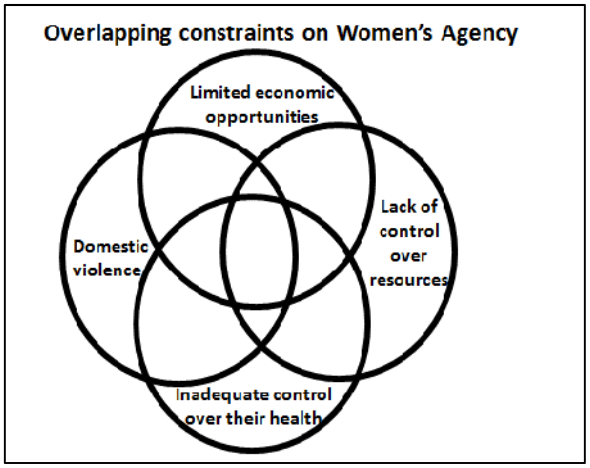
C. Sectoral and Institutional *Context*

9. W**omen are among the most vulnerable groups in the Great Lakes Region.** 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.[4]

10. The severity of the constraints varies widely across countries. For example, in DRC 97 percent of women face one or more of these constraints; 42 percent are affected by both domestic violence and inadequate control over their health and 25 percent by three key constraints (domestic violence, lack of control over their health, and inadequate control over resources). The pervasive conflict and violence in the Kivus has taken a heavy toll on Congolese women, who face continuing insecurity, lack of economic opportunities, and large gaps in access to basic services. Women in post conflict settings in Burundi face similar challenges given cultural and

[4] 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 and Rwanda, as shown in Annex 9.

economic barriers. By contrast, Rwandese women are relatively better off in terms of access to health services, economic opportunities and gender equality. Nevertheless, 64 percent of women report one or more constraints with roughly 20 percent affected by domestic violence, 16 percent by lack of control over their health, and over 5 percent by both. The three Great Lakes countries share a common post-conflict history and have much to learn from each other in terms of addressing the vulnerability of women and collectively tackling SGBV.



High Levels of Violence

11. **Violence against women and girls has become a major public health and development issue in the Great Lakes Region.** In the context of ongoing instability and numerous localized conflicts, violence against women is increasingly recognized as a threat to regional peace, security, and sustainable development. Women and children are often the first to flee across porous borders, placing undue burden on neighboring countries and placing themselves at greater risk, as refugees and displaced groups are highly vulnerable to violence.

12. **There is broad based agreement that levels of sexual violence in DRC are high in spite of challenges in producing accurate data.** The 2007 Demographic and Health Survey (DHS) found that nearly two-thirds of women in DRC report suffering from physical violence and nearly three-quarters have suffered from spousal or partner abuse at some point. A 2007 study in the *American Journal of Public Health* estimated that over 1.7 million Congolese women were raped in their lifetime. In the preceding 12 months, 400,000 women aged 15 to 29 were raped and approximately 3.0 to 3.4 million women experienced Intimate Partner Violence (IPV). Women in Nord-Kivu were significantly more likely to report all types of sexual violence in comparison to women in Kinshasa. Recent research emphasizes the fact that both men and women are affected by SGBV. For example, Johnson reports 40 percent of women and 24 percent of men experienced sexual violence in Eastern DRC.[5]

13. **Conflict in Eastern DRC contributes significantly to the high levels of SGBV.** Whereas in DRC as a whole, the majority of sexual crimes in 2012 were carried out by civilians (58 percent), in the Kivus the majority were perpetrated by armed groups (87 percent in South Kivu and 71 percent in North Kivu).[6] While high levels of SGBV in Eastern DRC are the result of continued conflict and insecurity, they also represent a more fundamental erosion and breakdown of social cohesion and norms. Although SGBV is frequently referred to as 'rape as a weapon of war', underlying causes of SGBV are much more complex: the motivation for sexual violence differs fundamentally in each context and cannot be considered in isolation of wider patterns of violence against women and men. Sexual violence is a result of ingrained negative

[5] Johnson et al. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo. Journal of American Medical Association, 2010. Territories of the Eastern Democratic Republic of Congo, Journal of American Medical Association, 2010, 304(5):553-562.

[6] Ministère de Genre, de la Famille et de L'Enfant, UNFPA, *Ampleur des Violences Sexuelles en RDC et actions de lutte contre le phénomène de 2011 à 2012,* June 2013, based upon reported cases to service providers in seven provinces in DRC.

gender norms, weaknesses in defense, security and justice institutions, widespread impunity, pervasive poverty, and the limited economic and social empowerment of women, as well as their capacities for self-protection.[7]

14. **In Burundi, gender based violence is also widespread. According to the government's** *National Strategy to Fight Gender Based Violence* (January 2009), groups most at risk of sexual violence include young women, female headed households, and marginalized populations who are easy targets. Perpetrators are increasingly targeting children and youth of both sexes. Data from a specialized facility for survivors of SGBV (Seruka Center), which has been in operation for a decade, show that those at greatest risk are girls under 18 years of age who represent nearly 70 percent of all cases. Of the total reported cases, only 22 percent were under investigation, 8 percent referred, and a small fraction were prosecuted (1.6 percent) and penalized (1.4 percent), highlighting a series of interrelated factors, including lack of access to medical and mental health services, financial barriers to accessing the judicial system, weaknesses in law enforcement, and the pervasive culture of impunity. The 2010 DHS found that 73 percent of women and 44 percent of men (15-49) reported "wife beating as justified", underscoring additional impediments, including traditional socio-cultural beliefs, and gender inequality that causes and perpetuates violence.

15. **In Rwanda, gender based violence and violence against children remain important problems in spite of the strong government commitment to promote gender equality and end SGBV.** A Gender Monitoring Office (GMO) assessment (2009) found close to 8,800 cases of SGBV and child abuse nationwide, of which economic violence was the most common (32 percent), followed by sexual (26 percent), physical (26 percent) and psychological violence (16 percent). Rwanda National Police (RNP) rape statistics for the period 2009-2010 show that 71 percent of survivors are girls under the age of 18 and 43 percent are under the age of 14, highlighting the vulnerability of young girls. Violence against children has also become a major concern with the police reporting over 3,600 cases of children raped during 2008-2009. Close to 70 percent of perpetrators (i.e. neighbours, family members, and teachers) who commit violence against children are known to the survivors. The 2010 DHS indicated that nearly half of all Rwandan women (15-49) have ever experienced physical or sexual violence with domestic violence reported as the most common form of abuse. Out of the abused women, only 42 percent sought help, and a meagre seven percent went to the police, underscoring the need to put in place medical, psychological, and legal services to support survivors to bring cases to justice.

16. **Violence against women and girls has devastating effects on physical and mental health.** These women are at greater risk of unwanted pregnancy; HIV/AIDS and other sexually transmitted infections; and genital injuries. They often lack access to basic health services that address the physical and mental consequences of violence and displacement, as emergencies cause a reduction in the number of qualified personnel, and disruption in medicines, diagnostic tests, and public services, as seen in Eastern DRC. Given the fragility of their situations, they are at greater risk of poor pregnancy outcomes, may die in childbirth, or experience high neonatal mortality. In non-emergency settings such as Burundi and Rwanda survivors also face impediments to seeking care, including long distances to facilities, inadequate quality of care, and financial barriers. These impediments can lead to delays in receiving care, greater mental and physical suffering, and poor outcomes. For children there are serious negative effects on growth, development, and social wellbeing. Moreover, the inter-generational effects of SGBV

[7] As highlighted in the recently updated International Security and Stabilization Support Strategy, I4S.

can be substantial as children who are survivors or witnesses to violence have a higher probability of engaging in violence later in their lives.

17. **Beyond the physical and psychological damage to the individuals involved, SGBV also carries important social and economic costs.** These costs are particularly high in countries in conflict or emerging out of conflict where sexual violence is rife and where it is used as a weapon of war which causes deep trauma and undermines social cohesion, such as in Eastern DRC. It is broadly recognized that the overall climate of fear impedes participation in economic, social and political life with survivors often facing stigma and rejection by spouses, families and communities. Moreover, impunity reigns as justice systems are too weak to prosecute perpetrators. These factors undermine trust at all levels of society, and adversely affect social cohesion. Empirical evidence has shown that sexual violence tends to remain high even after conflicts end, as documented in the 2011 World Development Report review of 50 countries across the globe, underscoring the importance of sustained support.

18. **Health services are an important entry point both for responding to the needs of survivors and for preventing further violence**. Given that SGBV is an important risk factor for other negative health outcomes (i.e. unwanted pregnancy, HIV/AIDS and other sexually transmitted infections) violence prevention will also contribute to preventing these outcomes. There is growing evidence that screening protocols are highly effective in increased detection and referral of survivors of SGBV, and provision of follow-up treatment with the World Health Organization (WHO) including these protocols among its ten violence prevention strategies. Routine screening for IPV can potentially improve identification, care and treatment of violence, underscoring the importance of incorporating such screening tools in a variety of public health settings. Moreover, there are important synergies from investments in SGBV and maternal, reproductive and obstetric care which require specialized expertise and health system capacity.

Inadequate control over their health

19. **In spite of progress made to date, large inequities in utilization of critical maternal and reproductive health services and in health outcomes persist across the Great Lakes states, impeding women from taking control of their health.** DRC, Burundi and Rwanda, share a common post-conflict history but a different trajectory in terms of overcoming constraints toward the attainment of the health related Millennium Development Goals (MDGs). The heterogeneity in outcomes means that country solutions need to focus on the most lagging outcomes while leveraging successes in other outcomes and learning from each other. All three countries have a common goal of reaching the poorest and most vulnerable women, including those living in geographically remote cross border areas affected by conflict, displacement, and migration. The main health inequities to be tackled include[8]:

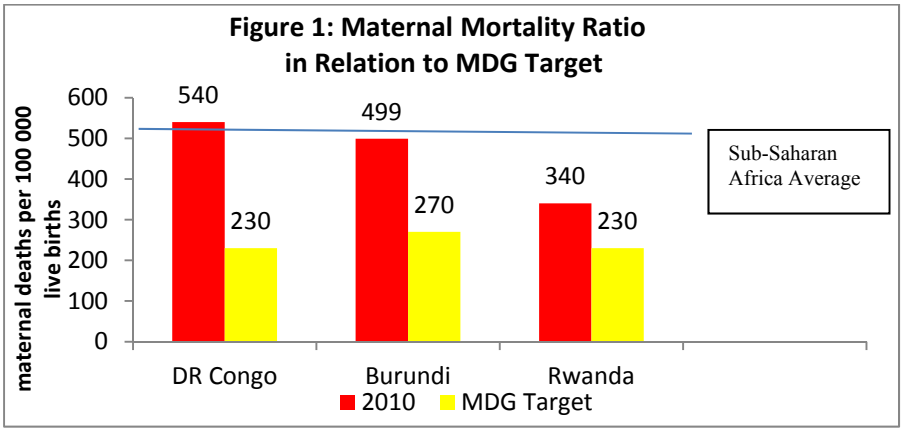
- *Large gaps in access to skilled birth attendants between the poor and non-poor***:** DRC has historically had the highest coverage levels of skilled attendants at birth, Rwanda has registered the most improvements during the past two decades, and Burundi has seen a similar but slower pattern of improvement. Based on comparable data from the last DHS in the three countries, coverage rates range from about 60 percent in Burundi, 69 percent in Rwanda, and over 80 percent in DRC. These averages mask large gaps between the

[8] To ensure comparability, the data presented below are derived from the last round of DHS surveys in the three countries.

bottom 40 percent and those who are best off with differentials ranging from up to 1.5 in Burundi and Rwanda to nearly two in the DRC. On average, less than 53 percent of the poorest women benefit from a skilled attendant at birth in DRC and Burundi and slightly more in Rwanda.

- *Low and variable use of modern contraceptives*: The contraceptive prevalence rate among the bottom two wealth quintiles of women is lowest in DRC (2.8 percent), followed by Burundi (9 percent), and highest in Rwanda (about 24 percent).

- *Low coverage and poor quality of antenatal care among the bottom wealth quintiles*: Antenatal coverage (4+ visits) among the lowest wealth quintiles is about 35 percent in Rwanda, and roughly 40 percent in DRC, the two countries which report data in a similar fashion. Inequities in skilled antenatal care between the bottom 40 percent and the better off range from 1.2 (Rwanda) to 1.5 (DRC).



20. **The countries of the Great Lakes Region also suffer from large differentials in mortality and fertility between the poor and non-poor.**

- The *maternal mortality ratio* (maternal deaths per 100,000 live births) is high in DRC (540) and Burundi (499), and relatively low in Rwanda (340) with the first two countries off track for attaining the maternal mortality MDG target (Figure 1). Persistently high levels of maternal mortality reflect systemic weaknesses in health care delivery systems and lack of high quality obstetric, reproductive and emergency care in addition to other factors (e.g. poor access to facilities, socio-cultural impediments, and financial barriers).

- The *total fertility rate* among the bottom 40 percent is highest in DRC (7.4), followed by Burundi (6.4) and Rwanda (5.3). High levels of fertility are associated with inadequate access to modern contraceptives, and socio-cultural factors (e.g. lack of control over sexual relations).

Limited Economic Opportunities

21. **Lack of adequate economic opportunities and control over resources are also critical constraints facing poor and vulnerable women in the Great Lakes Region.** While this issue affects all poor and vulnerable females it is particularly critical for survivors of SGBV because of their reduced psychological and economic functioning and potential isolation from family and community. A number of economic empowerment schemes have been successfully

piloted in the three countries with promising results. In both Burundi and DRC, Village Savings and Loans Associations (VSLA) have been successfully used to provide a system of community savings for people who cannot access banks or microfinance institutions (Annex 6). These economic empowerment schemes are based on trust and promote solidarity and social cohesion among participating beneficiaries. For survivors of SGBV these schemes are essential to support reintegration in society and to provide beneficiaries a sense of purpose and value as well as an environment for social connections. Research in Burundi showed that adding discussion groups with men and women to economic empowerment activities resulted in significant reduction in the incidence of partner violence, positive effects on attitudes towards violence again women, and positive changes in decision making between couples (Ivengar and Ferrari, 2010). A rigorous impact evaluation in DRC found that VSLA participants experienced larger declines in trauma, and larger increases in per capita food consumption, and availability of social resources among survivors in comparison to the control groups, as described in Annex 5 (Bass et al, 2014).[9]

Institutional Context

22. **All three countries, as well as the ICGLR, have demonstrated strong commitment to addressing SGBV and have put in place appropriate policy and legal frameworks and protocols**. Nevertheless, implementation and enforcement remain constrained by variable capacities and resources. Services for survivors of SGBV are provided at a limited number of facilities in Eastern DRC and Burundi with relatively stronger coverage in Rwanda. Numerous bilateral partners, UN agencies, and civil society groups are actively engaged in supporting programs for survivors in the three countries as well as the ICGLR and the proposed project has been designed to ensure complementarity with those efforts. Annex 5 provides further details on country strategies and ongoing programmatic efforts.

23. **ICGLR's operational efficiency and effectiveness needs to be strengthened**. An independent evaluation of the financial and administrative systems commissioned by the ICGLR in 2012 as well as an institutional audit financed by German Society for International Cooperation (GIZ) in 2013 outlined a number of shortcomings[10]. The technical design of the project for building ICGLR's capacity is based on the findings of this organizational audit and has been discussed with partners to include additional lessons from their experience working with ICGLR.

24. **The ICGLR grant complements efforts from other development partners to support implementation of the Kampala Declaration as well as develop the institutional capacity of the Conference Secretariat (CS)[11].** The support for SGBV will be complemented by technical assistance to the CS from the Swiss Cooperation for the implementation of proposed activities through a gender and SGBV specialist based at the CS. The International Development Association (IDA) and the United States Agency for International Development (USAID) will coordinate support to strengthen the fiduciary capacity of the CS over the period of the proposed

[9] The Johns Hopkins University and International Rescue Committee carried out the impact evaluation. The USAID Victims of Torture Program, the World Bank Learning on Gender and Conflict in Africa (LOGiCA) MDTF which is supported by the Governments of Canada, Denmark, Norway and Sweden, and the State and Peace building Fund (SPF) co-financed the evaluation.

[10] These include, among others: (i) lack of systematic planning, and long, medium and annual plans with corresponding budgets and monitoring and evaluation systems; (ii) weaknesses in quality financial reporting up to international standards; and (iii) weak coordination between National Coordinators and CS Program Officers.

[11] Annex 5 includes details of past and ongoing support from UN agencies and donors.

grant. The proposed support for a technical Partner Forum including development partners supporting the ICGLR to update partners on ICGLR progress, priorities and activities through this grant is complementary to the support provided by among others GIZ for higher level donor coordination related to the RINR in conjunction with the six-monthly Regional Inter Ministerial Committee (RIMC) meetings from the ICGLR.

D. Higher Level Objectives to which the Project Contributes

25. **The proposed project is fully in line with the World Bank Group's (WBG) twin objectives to reduce poverty and promote shared prosperity, with IDA 17 commitments for Fragile and Conflict-Affected States (FCS), and with the Africa Strategy which focuses on strengthening governance and public sector capacity.** The operation targets some of the poorest and most vulnerable groups in the Great Lakes Region. It also focuses on geographic areas with high poverty levels, continuing insecurity, high levels of violence, and lower coverage rates of high impact health interventions. It is the first IDA operation which has a major focus on SGBV in FCS and will strengthen knowledge of what works and what does not work, in line with the institutional commitment to address these issues, as outlined in the *Additions to IDA Resources: Seventeen Replenishment, IDA 17: Maximizing Development Impact (March 25, 2014)*. The project will contribute to the Africa Strategy– *Africa's Future and the World Bank's Support to it*, which emphasizes the importance of strengthening public sector capacity to the extent that it supports key public sector facilities to boost their capacity to address issues related to SGBV. The operation will also contribute to Pillar III of the *Regional Integration Assistance Strategy* (approved by the Board in April 2008) to the extent that it supports coordinated cross-country responses.

Why a regional approach?

-Addressing jointly the challenge of SGBV in the Great Lakes Region by piloting innovative approaches and sharing lessons

-Supporting the regional policy agenda, leveraging regional expertise and promoting collective national and regional action in line with the Kampala Declaration

-Supporting centers of excellence to provide specialized care and training

-Targeting support for SGBV and violence prevention in cross border areas with high levels of refugees and IDPs

Why combine SGBV and women's health work?

-Poor women face multiple sources of vulnerability

-Health sector is an important entry point for survivors of SGBV

-Key maternal health services offer an opportunity for early identification and referral of women at risk of domestic violence

-Synergies from investments in SGBV and maternal health care which both require specialized training and capacity

Why Bank support?

-Strong institutional commitment to address SGBV in FCS

-Bank's comparative advantages (knowledge sharing, intervening regionally)

-Opportunities to strengthen country systems, mainstream innovative work, support evidence based approaches, and strengthen capacity of a regional organization engaged in addressing SGBV

26. **The proposed project is also part of the WBG Regional Initiative for the Great Lakes which includes two inter-related pillars: (i) addressing vulnerable groups and improving community resilience; and (ii) promoting economic cooperation and regional**

integration. The project is consistent with the first pillar on vulnerability and resilience to the extent that the operation aims to improve access to holistic services for survivors of SGBV and to tackle broader health inequities. Expanding the provision of critical services for vulnerable groups will have benefits for countries experiencing violence and neighboring countries which need to bear the burden of periodic influxes of refugees, some of which become permanent residents. In addition, the support provided to the ICGLR will improve services for survivors of SGBV beyond the three participating countries in this project through capacity building of ICGLR's member states and sensitization and communication against SGBV in the region. The operation will contribute to the second pillar by promoting regional collaboration and knowledge sharing on SGBV and violence prevention in the Great Lakes Region. The project will support the broader Great Lakes Region agenda to tackle SGBV through bolstering the institutional capacity of the ICGLR and supporting the implementation of the Kampala Declaration by the ICGLR, complementing country specific investments.

27. **The project will be instrumental in advancing two of the main objectives of the DRC Country Assistance Strategy (CAS), FY13-16.** First, it will support the CAS goal of improving social service delivery by expanding utilization of a package of high impact health interventions and specialized services for survivors of violence. Second, it will contribute to the CAS goal of addressing fragility in Eastern DRC by piloting innovative approaches to preventing violence and expanding economic empowerment opportunities for vulnerable groups. In addition, working through community-based organizations will be instrumental in building social cohesion and reducing stigma and discrimination against women and girls.

28. **The project is also well aligned with the Burundi CAS (FY13-16)** which aims to enhance opportunities for productive employment and improve standards of living. The project will contribute to Pillar 2 related to increasing resilience by consolidating peace and social stability through improved access to quality health and social services, and complement the broader poverty reduction agenda by building trust between the state and its citizens.

29. **The operation will support the overall objectives of the Rwanda Country Partnership Strategy (FY14-18)**, with a focus on improving the productivity and incomes of the poor through rural development and social protection. Specifically, the project will assist to address unmet needs of survivors of SGBV and continue to build the capacity of the health and social welfare system to provide quality services. It will enable Rwanda to share innovative practices and successful reforms with the other countries.

II. PROPOSED PROJECT DEVELOPMENT OBJECTIVES

A. Proposed Development Objective(s)

30. The objectives of this project are to: (i) expand the provision of services to mitigate the short and medium term impact of sexual and gender based violence; and (ii) expand utilization of a package of health interventions targeted to poor and vulnerable females[12].

[12] The DRC and Burundi grants will contribute to both PDOs. The Rwanda credit and ICGLR grant will contribute only to the first PDO.

B. Project Beneficiaries

31. Project beneficiaries will include primarily vulnerable females, consisting of survivors of SGBV, and women of reproductive age, including pregnant and lactating women. Men and children will also benefit from select project activities, as survivors of SGBV, as family members of survivors, and in the case of men as agents of change. The support provided through ICGLR will reach other regional stakeholders, including policymakers, civil society, and service providers of SGBV in member states.

C. PDO Level Results Indicators

32. The following key indicators will be used to track progress towards the PDOs. The first two will be used in all three countries, while the last three will be used in DRC and Burundi.

- Direct project beneficiaries, of which females (number)
- Reported cases of SGBV who receive emergency kits within 72 hours (%)
- Reported cases of SGBV who receive at least two multi-disciplinary services-- medical, mental, legal (%)
- Prevalence of modern contraceptives, women 15-49 years old (%)
- Pregnant women who benefit from 4 antenatal care visits (%)
- Births (deliveries) attended by skilled health personnel (%)

III. PROJECT DESCRIPTION

A. Project Components

33. Given the different national contexts, the activities to be funded under the project vary across countries, and are customized to respond to the needs of each client. While all three countries aim to address SGBV, only DRC and Burundi have requested Bank support for maternal and reproductive health interventions. The project builds on successful experiences with Performance Based Financing (PBF) in Burundi and DRC to further strengthen these health systems to address both SGBV and maternal and reproductive health issues. All three Great Lakes countries are committed to piloting new models of service delivery, adopting evidence based approaches, and collaborating with the ICGLR to share knowledge and lessons learned in a systematic fashion.

34. The project aims to use a multi-sectoral approach to address both the needs of survivors of SGBV and of other vulnerable women in the targeted communities. As vulnerability is pervasive this approach will help to build solidarity and strengthen social cohesion as well as boost the capacity of health systems to deal with a full range of medical and mental health issues affecting survivors and other vulnerable women. Key maternal and reproductive health services will serve as an entry point for early identification and referral of survivors of SGBV in different health care settings, hence project supported activities are mutually reinforcing.

35. Geographic areas have been carefully selected based on the following types of criteria: (i) unmet needs for key services; (ii) violence/conflict levels; (iii) presence of refugees or internal displaced people; (iv) poverty and vulnerability levels; and/or (v) presence of other development partners, to avoid duplication or build partnerships. For *Eastern DRC*, the team has also been guided by the ongoing mapping work on the security situation to select a mixture of low and high risk security zones, and for North Kivu, priority has been given to zones, such as Rutchuro,

where security has improved following the defeat of the M23. Some health zones are in cross border areas with large populations of refugees and internal displaced persons. Given the fluidity in Eastern DRC, flexibility will be critical during the implementation phase. The prioritized zones for the Kivus will be validated prior to project implementation by the provincial *Multi-Sectoral Assistance for SGBV* working group, which includes government representatives, UN agencies and NGOs[13].

36. In *Burundi*, the government aims to expand geographic access to integrated services for survivors of SGBV and specialized maternal services at three additional hospitals, in the Western (*Cibitoke),* Eastern *(Muyinga),* and Southern *(Makamba*) parts of the country. The proposed hospitals are located in remote, cross border areas, including areas with large numbers of internally displaced persons or refugees (Cibitoke, Makamba) and those affected by difficult economic conditions (Muyinga) which can serve as a breeding ground for violence.

37. In *Rwanda,* the geographic areas as well as project activities are complementary to ongoing support from bilateral partners, especially the governments of the Netherlands and United Kingdom (UK). In December 2013, the Government, One UN Rwanda, and the Government of the Netherlands signed a three-year project to support scaling-up the *Isange* One Stop Centers (OSCs*)* which aims to strengthen six of the already existing nine centers and establishing 17 new centers. This proposed project will establish 17 new centers in the remaining districts, and upgrade five in line with the Rwanda National Scaling-up Strategy of OSCs, four of which will provide services to refugee SGBV survivors.[14] During the fourth year of the project, five additional OSCs close to refugee camps in border areas, currently supported by the Government of the Netherlands, will be supported.

38. **Component 1: Holistic Support for Survivors of Sexual and Gender Based Violence and Violence Prevention (US$50.51 Million).** This component will support delivery of an *integrated package* of short and medium term assistance to survivors of SGBV at both the community and health facility level while promoting gender equality, behavioral change, and violence prevention in the intervention zones of each participating country. The holistic or integrated response aims to support survivors' physical, mental, social and economic well-being. Guiding principles for support to survivors include: *confidentiality*, *informed consent*, and *respect*. The component aims to strengthen the capacity of existing structures and systems at the community and health facility levels with referral mechanisms strengthened in order to provide a continuum of care. The component includes three main areas of support.

39. ***Integrated Support for Survivors of SGBV and Prevention of Violence at Community Level*** includes: (i) supporting *case management,* rapid initial support, and referral (DRC,

[13] The health zones selected for North Kivu include: Birambizo, Binza, Kirotche, Nyiragongo, Rutchuru, Alimbongo, Mabalako, Kayna, Rwanguba, and Mweso, and for South Kivu: Fizi, Kimbi Lulenge, Lulingu, Minova, Shabunda, Kaniola, and Lemera. Annex 2 provides details on which zones will benefit from support under components 1 and 2.

[14] The project selected hospitals to set up and upgrade OSCs include: (i) Kigali Province: Kigali district Masaka, Muhima and Kibagabaga hospital; (ii) Western province: Karongi district Kilinda and Mugonero hospital, Nyamasheke district Kibogora hospital, Ngororero district Kabaya hospital, Rutsiro district Murunda hospital; (iii) Southern province: Ruhanga district Gitwe hospital, Gisagara district Kibilizihospital, Nyamagabe district Kaduha hospital; (iv) Northern province: Rulindo district Rutongo hospital, Gakenke district Nemba hospital and Ruli hospital; and (v) Eastern province: Bugesera district Nyamata hospital, Kayonza district Gahini hospital, and Gatsibo district Kiziguro hospital. Among these OSCs, Kilinda, Mugonero, Kiziguro, and Kibilizi hospitals are close to borders and will focus on providing services to refugees.

Burundi); (ii) providing *mental health and psycho-social support* to reduce post-traumatic stress and improve daily functionality (DRC); (iii) providing *legal aid* (DRC); (iv) providing support for *economic empowerment* (DRC, Burundi) or referrals to existing social protection programs (Rwanda); and (v) supporting *awareness building and advocacy for behavioral change* through activities that promote gender equality, behavioral change and violence prevention, including sexual violence. In addition, this sub-component will: (i) support and strengthen integrated service delivery systems in CBOs (DRC); (ii) pilot approaches to working with perpetrators (DRC); (iii) strengthen Family and Community Development Centers to provide support to survivors (Burundi); (iv) contract specialized non-governmental organizations and CBOs to support survivors of SGBV and prevent violence at community level (Burundi); (v) promote *behavioral change* through the scaling-up of effective models for working with women, men, boys and girls at the community level to change behaviors and reduce violence in cooperation with other development partners (Rwanda); and (vi) support *safe houses* to help survivors of SGBV to benefit from temporary safe housing before returning to their communities of origin (Rwanda).

40. ***Integrated Support for Survivors of SGBV at Health Facility Level***. Strengthening the health system in DRC at all levels (health center, general referral hospital, and provincial referral hospital) to boost technical capacity through specialized training and operational costs; and setting up or upgrading OSCs at existing hospitals (Burundi, Rwanda) to deliver specialized services, by: (i) supporting *clinical care,* case management, rapid initial response and referrals; (ii) providing *mental health* care; (iii) providing *medico-legal* and forensic support; and (iv) providing post exposure prophylaxis (PEP), emergency contraception kits, surgery equipment and medical consumables. In addition, this sub-component will provide support for: (i) *specialized training* in clinical care, mental health, judicial-medical support, including collection of forensic evidence, and use of screening tools (DRC, Burundi, Rwanda); (ii) contracting specialized non-governmental organizations and CBOs to support survivors of SGBV at health facility level; (iii) *legal aid* to survivors in cooperation with specialized NGOs and strengthened capacity of the police and judiciary to handle cases involving survivors, including specialized chambers and mobile courts (Burundi); and (iv) legal aid through police services, legal advice, free legal counseling and representation in court, transport and judicial follow up with social services (Rwanda).

41. ***Support for Existing Integrated Centers of Excellence in North and South Kivu***. In DRC, specialized referral facilities (*Panzi Hospital/Foundation* in South Kivu and *Health Africa* in North Kivu), will be supported to: (i) provide *medical services*, including for the most complex cases; (ii) conduct *forensic evidence collection and analysis*; (iii) provide support for legal services; (iv) provide facility based *counseling*; (v) provide support to survivors and their children rejected by families; (vi) conduct *mobile clinics* in remote areas to reach the most vulnerable groups; (vii) provide *training and capacity building* for health providers from both DRC and other countries, including serving as base for internships so that national and regional participants can take advantage of the specialized expertise in performing complex surgeries, compiling forensic evidence, and providing high quality medical and mental health services at these facilities; and (viii) conduct related *research* on SGBV.

42. **Component 2: High Impact Basic Health Services (US$34.03 Million).** The second component is being implemented in DRC and Burundi where service gaps and quality deficiencies are acute. In **DRC**, the project will improve utilization and quality of a package of health interventions targeted to underserved areas and poor and vulnerable females through *Performance Based Financing* (PBF), including: (i) provision of PBF *Grants to health facilities*,

conditional on the quantity and quality of health services delivered, as stipulated in the PBF Performance Contracts; (ii) funding of the initial replenishment of *essential drugs*; and (iii) strengthening of *regulatory capacities* at the provincial, districts and local levels through PBF Performance Contracts with Health Authorities. On the demand side, the project will support improved access to health services for the most vulnerable groups by: (i) conducting a household survey to identify constraints to accessing care; (ii) identifying the poorest households; and (iii) funding health services for identified poor in the targeted health facilities. The Performance Purchasing Agencies, responsible for the PBF scheme, will receive funding for management and operating costs and a web-based application.

43. In **Burundi**, the project will reinforce *maternal, reproductive and emergency obstetric services* at the same health facilities which participate in the national PBF program and where SGBV services are being established. The project will support: (i) *training of medical personnel* in emergency medicine and complex surgery; (ii) provision of *specialized equipment,* consumables and mobile phone applications for alerting personnel of medical emergencies and strengthening referral systems; (iii) *planning and capacity building* of the National Reproductive Health Program; and (iv) introduction of *screening tools* for SGBV. To focus on a highly vulnerable group for both sexual violence and unwanted pregnancy, the project will support expansion of *youth friendly services* in health facilities and community structures through: (i) development and introduction of educational materials to raise awareness about reproductive health and SGBV; and (ii) contracting of specialized NGOs and CBOs to expand the youth friendly community based model.

44. **Component 3: Regional and National Knowledge Sharing, Research and Capacity Building (US $22.42 Million).** This component will fund activities which will bring together stakeholders from the three participating countries as a community of practitioners who are embarking on a common agenda. Support will be provided in four main areas as described below.

45. *Regional and National Knowledge Sharing and Capacity Building* by: (i) documenting and sharing innovative activities to promote gender equality, address SGBV, and strengthen maternal health through PBF; (ii) funding study tours to neighbouring countries (including on SGBV and PBF programs); (iii) promoting knowledge sharing at the regional and national levels, including supporting or participating in annual peer learning events on SGBV and PBF organized by the ICGLR and/or by the countries; (iv) participating in high quality regional training programs; (v) carrying out institutional capacity building to assist a local institution to serve as a centre of excellence for research and training on SGBV (Burundi, Rwanda); and (vi) operationalizing ICGLR's RTF to deliver high quality regional training programs. The World Bank will contribute to the knowledge sharing agenda by bringing in experience and lessons from global knowledge on SGBV in countries such as Afghanistan, Colombia, Brazil, India, and Ivory Coast.

46. *Research and Surveys* on various thematic areas, such as: (i) understanding the underlying causes of SGBV; (ii) assessing the impact of selected service delivery models for survivors of SGBV and for women of reproductive age through quantitative and qualitative surveys; (iii) evaluating the effectiveness of screening tools for early identification and referral of women at risk; (iv) understanding the effects of interventions aimed at changing behaviours and norms to promote violence prevention and gender equality; (v) conducting research on SGBV by centers of excellence; (vi) assessing the impact of introducing community score cards (DRC); (vii) evaluating the impact of interventions aimed at perpetrators (DRC); (viii) assessing

the effectiveness of youth friendly services in responding to the special needs of youths (Burundi); (ix) producing reliable data and information on knowledge, attitudes, practices surrounding SGBV and RH (Burundi); (x) evaluating the efficiency and effectiveness of the approach chosen for the empowerment of women (Burundi); and (xi) developing a centralized GBV integrated management system (Rwanda).

47. *Communications* (DRC, Burundi), including: (i) development and implementation of a national communications strategy (i.e. including information on services offered to key groups and key laws and policies; mechanisms for facilitating intra and inter country collaboration, including use of media tools; and activities and tools for disseminating results); (ii) support to mount media campaigns during the *16 days of Activism Against Gender Based Violence*; and (iii) installation of video conferencing facilities at selected participating hospitals and ministries to facilitate communications within and across countries. In DRC, this sub-component will support the MoGFC to develop and implement a communications strategy to disseminate the forthcoming revised Family Code. For the ICGLR, this sub-component will support: (i) development and implementation of tools related to SGBV for the GLR; and (ii) capacity building on media and communications to address SGBV and facilitating networks of communication professionals.

48. *Project Management* including support to carry out efficient and effective coordination, fiduciary management, monitoring and evaluation at national and local levels through technical assistance, institutional strengthening and equipment. This component will include support for strengthening existing coordination structures and country systems to ensure mainstreaming and sustainability of project activities in each country. Support provided to the ICGLR will include: (i) supplying video conference facilities at the Conference Secretariat offices as well as the RTF; (ii) training on resource mobilization; (iii) supporting the establishment of a Partner Forum; and (iv) supporting development of a monitoring and evaluation framework for the implementation of the Kampala Declaration.

B. Project Financing

49. **Lending Instrument**: The proposed lending instrument for each country is an Investment Project Financing (IPF). Financing of country-level activities will take place through IDA grants of US$73.86 million for the Democratic Republic of Congo and US$15.15 million for the Republic of Burundi; and an IDA credit of US$14.95 million for the Republic of Rwanda, reflecting the IDA financing terms applicable to each country. The amounts allocated for each country reflect the size and scope of the problems being addressed, and the availability of alternative sources of funding.

50. In addition, ICGLR will receive a US$3.0 million grant under the regional IDA pilot to implement regional activities that are linked to the project as well as activities that support the strategic objectives of IDA on regional integration. The ICGLR grant meets the six eligibility criteria:

(i) The grant recipient will be ICGLR which has the legal status and fiduciary capacity to receive grant funding and the legal authority to carry out the activities financed;
(ii) The ICGLR does not meet eligibility requirements to take on an IDA credit because it is not generating revenue and would not be in a position to repay the credit. ICGLR's budget is contributed by its Members States;

(iii) The costs and benefits of the activity to be financed with an IDA grant are not easily allocated to national programs because of the regional nature of the activities;
(iv) The activities to be financed under the IDA grant are related to coordinated interventions to provide regional public goods because they are designed to contribute to regional knowledge and results-generating programs, principally in the area of Gender Based Violence and to strengthening ICGLR capacity to deliver its mandate on regional peace, security and development;
(v) Grant co-financing for the activity is not readily available or sufficient from other development partners whose support to ICGLR is limited to small amounts in selected areas; and
(vi) The regional entity is associated with an IDA-funded regional operation in which three out of its 12 Member States are involved. Furthermore, the project conforms to the Africa Region's selection criteria for Regional Operations in Africa, including strategic relevance, regional solution, quality, and partnership.

51. **Project Cost and Financing**: Total project costs and associated financing are presented in table 1 below. For each country IDA would fund 100 percent of the project cost.

Table 1: Total Project Costs, by Country

Project Components	Total Costs/IDA Financing (100%) US$ Million				
	DRC	**Burundi**	**Rwanda**	**ICGLR**	**Total**
1. Holistic Support for Survivors of SGBV and Violence Prevention	34.97	5.76	9.78		50.51
2. High Impact Basic Health Services	31.69	2.34			34.03
3. Regional Knowledge Sharing, Research and Capacity Building	7.20	7.05	5.17	3.00	22.42
Total Project Costs	**73.86**	**15.15**	**14.95**	**3.00**	**106.96**
Total Project Financing Required	**73.86**	**15.15**	**14.95**	**3.00**	**106.96**

C. Lessons Learned and Reflected in Project Design

52. The project design has taken into account lessons learned both from the design and implementation of programs to address Sexual and Gender Based Violence and of Performance

Based Financing funded by experienced partners as well as a number of innovative activities funded by the World Bank. [15]

53. **Sexual and Gender Based Violence**: A comprehensive literature review undertaken for this project, synthesized findings from over 40 impact evaluations, prioritizing those that applied rigorous methodologies, as presented in Annex 6. The project incorporates the following main lessons into the design:

- *Multi-sectoral interventions are critical for supporting SGBV survivors* who require multi-faceted assistance, including medical treatment, mental health counselling, and paralegal support. Multi-disciplinary services that are provided within one single facility such as OSCs, or through a referral system, have shown their effectiveness in service provision for SGBV survivors.

- *Cognitive processing therapy (CPT) and narrative exposure therapy (NET) are effective in treating post-traumatic stress disorder (PTSD) and related mental health problems.* SGBV survivors have a high tendency to suffer from PTSD, medically unexplained complaints, and suicidal ideation. CPT and NET therapy have shown their effectiveness in post-conflict setting to reduce PTSD and associated depression and anxiety symptoms.

- *VSLAs are effective in generating positive economic, social and psychosocial impact on SGBV survivors.* An impact evaluation of VSLAs and associated training in DRC demonstrated a larger decrease in trauma score, a larger increase in food consumption per capita, and a larger increase in available social resources over time among the SGBV survivors who joined VSLAs and received the training than those who did not.

- *Economic and livelihood interventions have to be gender transformative in order to empower women and prevent SGBV.* Extreme poverty and economic dependence of women on men are two of the major contributing factors of SGBV. Evidence shows that although increasing women's access to resources is crucial, economic interventions must be associated with activities that explicitly target transforming gender roles and promoting gender equality. Engaging men into women's income generating activities can be an effective approach to achieving both. Recent evidence from Rwanda and Burundi shows that engaging men contributes to: (i) more equitable household decision-making; (ii) increased couple communication and decreased couple conflict; (iii) decreased percentage of men reporting attitudes tolerant of violence; and (iv) higher income gains for families. Qualitative findings also indicated that children of these couples observed greater participation by men in household work and improved couple communication.

- *Forensic evidence is essential to addressing impunity.* The use of forensic evidence in sexual assault trials can greatly influence whether a conviction is secured, necessitating the enhancement of the capacity and technology to collect forensic evidence. Forensic evidence can consist of a medico-legal certificate issued by a doctor to confirm that an assault occurred and the accompanying collected physical evidence.

[15] In the case of SGBV, a strategic review of the Bank portfolio (*Sexual and Gender-Based Violence: What is the World Bank Doing, and What Have We Learned?*) found that historically, the majority of activities supported by the World Bank included analytical work, or small scale projects or components, often funded by trust funds (Willman and Corman, November 2013).

- *Sensitization and campaign activities to change biased gender norms that tolerate or advocate male authority and gender-based violence can make an important contribution to preventing SGBV.* Small group participatory workshops and large-scale campaign efforts are the most rigorously evaluated sensitization approaches, both demonstrating modest changes in reported attitudes and beliefs and, in some cases, reductions in reported rates of partner violence. Integrated programs with community outreach, mobilization and mass-media campaigns show more effectiveness in changing behavior than group education alone. Gender-transformative programs tend to be more effective than gender-sensitive and gender neutral approaches. Well-designed programs engaging men and boys generate evidence of changing SGBV behaviors and attitudes.

54. **Performance Based Financing**: Experience and early lessons from the implementation of PBF programs in DRC and in other countries have also been taken into account in the project design. The PBF approach has been shown to:

- *Motivate and empower providers* to focus on results and introduces a *results oriented culture* at health facilities, as it involves a participatory, bottom up process of planning activities and interventions which are spelled out in facility business plans.

- *Improve accountability* as facilities, providers and supervisors are held accountable for delivering results and are provided the required resources to carry out activities.

- *Promote quality improvements*, with systematic reviews of the quality of care using standardized checklists.

- *Contribute to enhanced supervision* and availability of data which is critical for reporting results.

- *Focus attention on underserved areas*, when used as a mechanism for redressing inequities in service delivery.

- PBF programs have also demonstrated the importance of: (i) putting in place mechanisms for *validating results* and *ascertaining client satisfaction*; (ii) introducing *penalties* for non-performance and sliding scales for remunerating results contingent on quality improvements; and (iii) conducting *rigorous impact evaluations*.

55. **Evaluations from PBF programs have found substantial improvements in utilization and quality of essential health services across a range of countries, including in fragile states.**

- A randomized trial in *Rwanda* showed a significant increase in coverage of institutional deliveries, preventive care visits for children and quality of care in the facilities with PBF as compared to the baseline and the control facilities receiving the same amount of funds but not linked to performance. It also showed that the performance-based incentives had a statistically significant effect on the weight-for-age of children aged 0-23 months and on the height-for-age of children aged 24-49 months.
- A recent impact evaluation of the *Burundi* PBF program showed that the approach increased the probability of institutional delivery (21 percentage points), antenatal care

(seven percentage points), and modern family planning services (five percentage points). The program also increased the quality of care and improved equity.

- In *Argentina*, incorporating clinics into its PBF program under *Plan Nacer* reduced the probability of low birth weight by 23 percent and reduced the probability of in-hospital neonatal death by 74 percent for beneficiaries. Better prenatal care, which prevented low birth weight and better post-natal care contributed to the reduction in neonatal mortality.
- In Adamawa state in *Nigeria* the PBF program increased coverage of institutional delivery, immunization, and family planning from 1-11 percent at baseline to 27-36 percent in less than a year, despite of the "state of emergency" security situation and sluggish health performance in the Northern states.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

56. *Regional Implementation Arrangements*. While countries will have the overriding responsibility for implementing activities at the national level, ICGLR will play a critical convening role, supporting regional knowledge sharing and advocacy efforts in SGBV. The Conference Secretariat acts as the technical arm of the ICGLR and is in charge of coordinating, facilitating, promoting, and monitoring the implementation of the Pact and other initiatives. Overall coordination of the ICGLR grant will be the responsibility of the CS. The Executive Secretary of the CS will: (i) provide overall strategic direction; (ii) approve the Annual Work Plans and Budgets (AWPBs); and (iii) ensure consistency with the policies and strategies of the ICGLR. The ICGLR will set up and maintain a Project Implementation Unit (PIU) within the CS for the overall coordination, day-to day implementation, and supervision of the project. The PIU will report to the Deputy Executive Secretary of the CS.

57. *Country-led Implementation Arrangements*. At the national level, there will be Steering Committees in each country to guide implementation and approve AWPBs. In DRC, the overall oversight for the project will be handled by the Ministry of Finance through the *Cellule d'Execution des Financements en Faveur des Etats Fragiles* (CFEF) while implementation of project activities will be the responsibility of the designated implementation agencies, which are the Ministry of Public Health (MoPH), Ministry of Gender, Family and Children (MoGFC), the Social Fund of DRC (FSRDC) and selected Centers of Excellence in the Kivus (i.e. Heal Africa and Panzi Foundation). The CFEF will be responsible for providing overall coordination, tracking and reporting results, and producing consolidated financial management reports. The unit will assume responsibility for consolidating AWPBs from key institutions at the national and provincial levels and organizing annual meetings of the Steering Committee. The CFEF will channel funds to the provincial MoPHs for health related activities while the FSRDC at the national level will channel funds for the SGBV community component as well as selected activities under component three through its well established channels to the Social Funds in the two Kivus. The bulk of the procurement will be handled at the provincial level with some goods and services procured at the national level.

58. In *Burundi,* technical coordination of the project will be handled jointly by the Ministry of National Solidarity, Human Rights and Gender (MSNDPHG) and of the Ministry of Public Health and Fight against HIV/AIDS (MoH) through the General Directorate for the Promotion of Women and Gender Equality and the General Directorate of Health Services and HIV/AIDS in each respective ministry under an *inter-ministerial framework*. Each ministry will be responsible for carrying out activities within its respective mandate. A *Steering Committee* will be

established to be co-chaired by the Permanent Secretary of MSNDPHG and the Permanent Secretary of MoH who will play the role of Vice-President to validate the annual work plan and budget. The MoH will be responsible for the overall fiduciary management with the project to be managed through a project coordination unit which oversees several other Bank-funded projects. The MSNDPHG will be supported to establish a small unit to strengthen its capacity to carry out specific activities under the project.

59. In *Rwanda*, the overall coordination of the project will be the responsibility of MIGEPROF. The Steering Committee, chaired by the Ministry of Gender and Family Protection (MIGEPROF), and comprising other key ministries (i.e. Health, Justice and Local Development) as well as the RNP and the GMO will meet every six months to assess progress and approve annual work plan and budget. A Technical Committee with similar representation will meet on a quarterly basis to discuss progress, identify challenges, and develop mitigation measures. The Single Project Implementation Unit (SPIU) of MIGEPROF will serve as the executing agency, coordinating day to day activities and implementing key activities within the mandate of the gender ministry. The SPIU within the Ministry of Health (MoH) will be responsible for activities related to integrated support for survivors at health facilities.

B. Results Monitoring and Evaluation

60. In each country, as well as at the CS of the ICGLR, a well-developed Monitoring and Evaluation (M&E) system, complemented with close World Bank supervision, will aim to ensure that the project reaches targeted beneficiaries in a timely and efficient manner. Annex 1 contains the Results Framework, including details of key indicators to be tracked during project implementation and the monitoring and evaluation mechanisms. A concerted effort has been made to standardize the PDO indicators and to the extent feasible, the intermediate outcome indicators across the three countries. This will ensure comparability of key results. During the Mid-Term Review of the project progress towards the PDOs will be evaluated and remedial action will be taken as needed.

61. **Data sources and mechanisms**: For activities under Component 1 a variety of data sources will be used, including national health management information, data collected by health facilities providing services for survivors of SGBV and case managers for survivors at the community level, as well as data from judicial aid providers and police (Rwanda). In addition, in all countries, Demographic and Health Surveys, which include specific modules on SGBV, will provide population level data on SGBV attitudes, knowledge and practices (i.e. 2014 Burundi; 2015 Rwanda; and 2014 in DRC). In Burundi the project will contribute to the funding of the 2014 DHS to generate reliable SGBV data. In DRC, the outcomes of Component 1 will be integrated into the revised M&E framework of the I4S.

62. For activities under Component 2 the national health management information systems in DRC and Burundi will be used to collect key data. Selection of indicators has been done based on the availability of information from health facilities. In addition, countries will conduct baseline and end of project surveys at participating facilities to measure the impact of project activities. In DRC, the project will fund surveys to better understand demand side impediments to accessing health services. For DRC and Burundi the project will rely on PBF community verification mechanisms to get beneficiary feedback which would be essential to improve quality of care and to address patient grievances, as discussed in Annex 2. In addition, in DRC the project will pilot use of community scorecards which aim to empower community members, as

service users, and support their constructive engagement with service providers around the delivery of health services.

63. In line with the IDA 17 *Maximizing Development Impact* agenda, the project will mainstream a wide range of evidence-based approaches and will make systematic use of impact evaluations to assess effectiveness of strategies aimed at preventing violence and promoting gender equality. As noted above, under Component 3 an operational research agenda will be developed which will contribute to documenting progress made, results attained, and lessons which will help to inform programmatic action. The grant from the regional IDA window to the ICGLR will support the development of a monitoring and evaluation framework for the implementation of the Kampala Declaration at the regional level, and strengthen the capacity of the institution to conduct knowledge sharing among the Great Lakes member states.

C. Sustainability

64. In each of the countries and at the ICGLR, the design of the project has taken into account the financial and institutional context and the need to ensure sustainability of activities initiated under the project. In all three countries specialized services for survivors of SGBV will be provided through existing hospitals and community structures to strengthen national systems and mainstream these interventions, thus improving chances of sustainability. In *Eastern DRC*, the strategy in the short term is to work through two specialized institutions which serve as Centers of Excellence in the Kivus while strengthening the capacity of the health system and the skills and competency levels of health personnel to address the full range of medical and mental health issues related to SGBV. The use of the performance based financing will build institutional capacity at the decentralized level, and foster greater autonomy at health facilities.

65. In *Burundi*, which faces severe financial constraints, holistic support for survivors of SGBV will be provided using the OSC model at three district hospitals to make optimal use of existing facilities. Providers will be trained and facilities will be equipped to deal with a full range of medical emergencies which will have multiple and mutually reinforcing benefits for both survivors of SGBV and other women suffering from obstetrical emergencies. In *Rwanda*, the OSC Isange Model is being scaled up to 17 district hospitals using the established Multidisciplinary Investigation and Intervention Team Model (MDIIT), building upon a successful pilot phase initiated with the support of the One UN. The government has prepared a national scale up plan which focuses on training existing staff, reassignment and rotation of personnel, and a careful analysis of the recurrent cost implications to ensure financial affordability. All health personnel used for the OSCs are paid by the Government of Rwanda.

66. The economic support activities under Component 1 in Burundi and DRC will promote the formation of savings groups of vulnerable women, including survivors, which have proven to be cost-effective mechanisms to improve economic empowerment of vulnerable women in a sustainable manner. While the savings groups may one day link to credit led microfinance mechanisms, their long-term survival does not depend upon access to external sources of credit. In DRC, the project will work through existing CBOs and networks, assisting their members through organization capacity building to improve income from agricultural and other activities. In addition, the project will collaborate with the Eastern Recovery Project to refer project beneficiaries to activities building agricultural value chains that have the potential to provide long-term improvements in revenues by improving the linkages between poor farmers and markets. In Rwanda, economically vulnerable survivors will be referred to existing social

protection programs promoting economic empowerment, including Vision *Umurenge* Program (VUP) and the Ministry of Local Government (MINALOC) Decentralized Funding Program.

67. Support for capacity development of the ICGLR and improving its organizational efficiency is a key element for enhancing its ability to engage with stakeholders, including civil society, member states and development partners beyond this project. It is focused specifically on institutional strengthening, to facilitate the more effective and efficient functioning of the ICGLR and allow it to better utilize the resources it receives from member states and other partners in achieving results. Support to the RTF through this project will also contribute to ensuring sustainability of regional training with the focus on developing relevant curriculum to be approved by member states. In addition, the proposed capacity building under the RTF for relevant stakeholders from all member states will have a multiplier effect through the Training of Trainers (ToT) approach and development and roll out of e-modules for offsite training. The increased focus on communication and awareness as well as sharing best practice on SGBV by ICGLR will maximize the impact of the project beyond the three participating countries, and enhance sustainability of project-supported activities.

V. KEY RISKS AND MITIGATION MEASURES

A. Risks Ratings Summary Table

Risk Category	**Rating**
Stakeholder Risk	**Substantial**
Implementing Agency Risk	
- Capacity	**Substantial**
- Governance	**High**
Project Risk	
- Design	**Substantial**
- Social and Environmental	**Moderate**
- Program and Donor	**High**
- Delivery Monitoring and Sustainability	**High**
Overall Implementation Risk	**High**

B. Overall Risk Rating Explanation

68. While the risks vary across the three countries, and for ICGLR, the overall risk is rated as *high*. The high risk rating is based on three main factors: (i) continuing volatile environment in Eastern DRC; (ii) fragile institutional capacities and persistent concerns with financial sustainability (DRC, Burundi, ICGLR); and (iii) need for multi-sector and multi-donor coordination in all countries.

69. *Volatile environment:* Eastern DRC remains a volatile area, with pockets under the control or influence of armed groups. Several districts in the project area are considered relatively insecure, and the situation is continuously evolving as armed groups move around, get

formed or disband. As a result, project implementers will have to be particularly mindful of security matters, keeping in constant touch with MONUSCO security. In such a context, flexibility and resourcefulness will be essential. To mitigate these risks, a mix of low and high risk security areas and a blend of health zones in transition and those which have urgent needs in Eastern DRC have been selected. Likewise, key implementing agencies have experience operating in Eastern DRC, and have demonstrated flexibility adapting to changing circumstances. For example, the main implementing agency for activities at the community level in DRC, the FSDRC, is used to operating in a volatile environment and has good relationships with both government and international actors.

70. *Fragile institutional capacities and concerns with financial sustainability (DRC, Burundi, ICGLR):* While there are many partners involved in SGBV activities in DRC, expertise in the public sector and at the community level to implement and manage these activities remains generally weak. In the Kivus, chronic shortages of health personnel trained in mental health and complex surgeries, and inadequate availability of emergency kits and drugs hinder the provision of quality care to survivors. A similar situation exists in Burundi which has only two centers that provide such services of which one is run by a non-governmental organization. Community structures and CBOs also have limited capacity. Moreover, both countries face serious financial constraints and are highly dependent on donor funding. In collaboration with government counterparts a number of key mitigation measures have been identified to lower these risks, as follows: (i) making provisions for the recruitment of specialized agencies with strong track records to support roll out of key activities and to provide training; (ii) placing an important emphasis on capacity building at the community, health facility, managerial and institutional levels; (iii) adopting approaches which minimize the recurrent cost implications; and (iv) relying on existing implementation structures which have experience with Bank procedures. For the ICGLR, key risks include: (i) insufficient organizational capacity to manage the implementation of the project, (ii) high staff turnover, and (iii) insufficient fiduciary management capacity in terms of procurement, finance, reporting and auditing. Key mitigation measures include: (i) strengthening the CS with a project manager and fiduciary staff, and (ii) training on World Bank fiduciary procedures and enhanced supervision.

71. *Multi-sectoral and multi-donor coordination:* The project will require effective collaboration of multiple public and private sector stakeholders at the community, district, provincial and national levels. Multi-sectoral coordination will be challenged by the number of institutions (e.g., health, gender, justice, police, and social protection) which will need to work in a seamless fashion and the variable capacity of these institutions. Multi-donor coordination will also be demanding given the number of institutions involved in supporting parallel efforts in the three countries. Finally, coordination on key activities will also be required across the three participating countries. To address these risks, multi-sectoral coordination committees will be set up in Burundi while in DRC and Rwanda existing coordination structures will be used. At the technical level, in each of the countries a strong referral system between various institutions supporting survivors of SGBV has been developed. For donor coordination, the project will build on existing coordination structures both for SGBV and health more broadly to minimize risk of duplication and maximize synergies with other donor-funded programs. At the regional level, the project will support the CS to set up a Partner Forum including development partners supporting ICGLR. The CS and the RFT of the ICGLR will play a key role in facilitating knowledge sharing across the Great Lakes countries.

72. *Additional risks relate to the PBF approach*, namely: (i) potential to game the system by inflating service delivery results; (ii) focusing only on services purchased to the detriment of

others; and (iii) favoring easier to reach regions and/or groups. In relation to PBF, risks have been mitigated by: (a) ensuring strong internal and external verification mechanisms, including community involvement; (b) purchasing a comprehensive package of critical services to maximize the impact on vulnerable and poor groups; and (c) building into the design regular monitoring of service delivery results to the most disadvantaged groups combined with demand side interventions to lower barriers to access health care services.

73. In addition to the contextual and project related risks, this is the first time that the World Bank is implementing a large-scale project designed to respond to the needs of SGBV survivors in fragile and conflict affected states. While the design has been informed by international lessons learned, including in fragile settings, as well as public and private actors who are considered global experts on the topic, this is a relatively new field for the Bank. Hence, the Bank team has planned for close implementation support and monitoring, including regular field-based supervision, and a continual learning process, as described in Annex 7.

74. Overall, the operation is characterized as *high risk-high reward* with specific mitigation measures identified for each country and for the ICGLR to reduce risk levels. The Operational Risk Assessment Framework (ORAF) provides a fuller discussion of key risks and mitigation measures (Annex 4).

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

75. **The developmental impacts of violence against women are high.** A detailed economic and financial analysis for the proposed activities related to SGBV was not carried out due to scarcity of data on the economic impact of service provision for survivors of SGBV, as well as the emergency nature of the project preparation process. It is well known that the developmental impacts of violence against women, men and children are high. A review of the literature found that the cost of intimate partner violence is significant in low and middle income countries relative to other development expenditures.[16] The same review highlighted the economic costs of inaction and emphasized the urgent need for governments to address violence against women.

76. **Violence has direct and indirect negative effects on individuals, households and communities** as reflected in additional medical expenses, decreased labor market participation, and inter-generational impacts (e.g. disruption in schooling for children in the households). Beyond the physical and psychological damage for the individuals involved, SGBV also carries important social and economic costs. Economically, survivors not only have reduced short-term income potential, they may suffer from longer term effects including injuries and trauma, reducing long-term income and productivity (Wilman, Corman 2013).[17] In addition, exposure of a child to violence against his/her mother in the home or community is one of the strongest risk factors for engaging in violence later in life (Willman, Corman, 2013). Overall, the proposed

[16] The literature review (*Intimate Partner Violence: Economic Costs and Implications for Growth and Development)* conducted for the World Bank found that in Vietnam, the total cost of intimate partner violence (IPV), including out of pocket expenditure, missed income and productivity loss, was over 3.0 percent of GDP or nearly double of what was spent on primary education. In Bangladesh the cost of IPV, with only out of pocket expenditure and reduced income for missing work, is twice what the government spent on primary education. In Uganda, the productivity loss due to IPV related absenteeism was estimated at 1.3 percent of GDP (2012).

[17] A recent study of IPV in Tanzania found that women experiencing IPV earned 29 percent less than women who did not, and this increased to 43 percent less if the violence was severe (Vyas, forthcoming)

activities to address SGBV, will contribute directly to improvements in health outcomes, poverty reduction and social inclusion.

77. **There is a strong rationale for the public provision of services for both survivors of SGBV and other poor and vulnerable women.** The project provides the Bank and the Governments of Burundi, DRC and Rwanda the opportunity to strengthen the capacity of the public sector to provide quality services for survivors of SGBV and to address information asymmetries related to the rights of survivors. The project also provides an opportunity in DRC and Burundi to strengthen the capacity of public sector facilities to address other critical women's health issues, therefore reaping synergies from investments in specialized training and specialized capacity to both SGBV and maternal health. This is particularly important as public sector facilities are often the first point of contact for poor and vulnerable groups, and many of these groups have limited or inaccurate information about the availability of medical, mental health and legal services and insufficient knowledge of how to exercise their legal rights. In all countries, although more acute in Burundi and Eastern DRC, the current capacity of the public sector is limited and financing is highly constrained and donor dependent. In addition, most programs for survivors of SGBV are of short duration, limiting opportunities for appropriate planning for service provision, as well as for developing capacity of the existing systems at the government and community levels. The proposed four year project provides the opportunity to effectively strengthen the capacity of the health system in all countries to deal more effectively with a range of issues, as well as strengthening existing mechanisms at the community level to respond effectively to the needs of survivors. The Bank's capacity to engage diverse groups, mobilize networks of experts, and bring global knowledge on SGBV and PBF to the Great Lakes Region represents value added for the countries. The proposed impact evaluations are expected to generate evidence of the economic and health benefits of the proposed interventions and identify the most cost effective strategies for responding to survivors.

78. **There is also a strong economic rationale for investing in maternal health in Burundi and DRC.** In spite of improvements in utilization of essential services and related health outcomes, regional and in country disparities persist between the poor and the non-poor. The high rates of maternal mortality in Burundi and DRC have a significant impact on economic growth through various pathways, including its effect on the size of the labor force and adverse effect on human capital formation. Moreover, the premature death of mothers tends to have negative effects on children's nutritional status, cognitive development, and survival chances, particular for very young children. There is a growing body of empirical evidence which shows that investing in high impact maternal health interventions generates not only health benefits but also improvements in lifetime earning potential and inter-generational wealth and poverty-reduction effects at the household level. Globally, research has shown that 80 percent of deaths could be averted if women had access to essential maternal and basic health care services. As part of the service continuum, reproductive health, including family planning, saves infant lives by spacing planned births and limiting unintended births. Family planning also saves maternal lives by reducing exposure to the risks of pregnancy and childbirth, including recourse to unsafe abortion, one of the main causes for deaths among young women. The proposed interventions will target resources to the most remote areas and some of most vulnerable segments of society, women and girls, contributing to improvements in health outcomes and poverty differentials. These interventions are considered cost effective and of high impact.

B. Technical

79. **The project design follows best practices for provision of quality services for survivors of SGBV as well as activities to promote gender equality and violence prevention**. The lessons from the previously mentioned review of best practices at the international level, including experiences in fragile and conflict affected states, informed the design of the project, as well as extensive discussions with Government counterparts during preparation and appraisal missions, and consultations with multi- and bi-lateral donors, INGOs, NGOs and civil society with experience implementing these type of programs.

80. **As physical violence is always accompanied with psychological trauma and violation of laws, SGBV survivors are normally in need of timely and multi-faceted assistance**, including medical treatment, mental health counselling, and paralegal support. The project design is based on multi-disciplinary services that are either provided at one single facility, OSCs, or through referrals between the health system and community based services. This reduces the need to travel long distances between services, decreasing risk of further trauma, and longer term mental health consequences. In addition, the close linkages to the community level will provide on-going longer term support for survivors. Using SGBV as an entry point to tackle other critical issues related to maternal, reproductive and obstetric care will foster service integration and strengthen the continuum of care for both survivors and other poor and vulnerable women.

81. **The proposed scale up of the VLSA model, in DRC and Burundi, which has been evaluated and proven to generate strong results, is technically sound**. Research has shown the importance of including both women and men in these schemes to promote solidarity and avoid unintentional risk of further violence. Adding discussion group activities to VSLAs and providing opportunities for dialogue about joint economic decision-making between men and women in the household will have multiple benefits in terms of challenging gender norms.

82. **The support for mental health, with a particular focus in Eastern DRC, responds to the current acute lack of capacity to provide quality mental health support**. The proposed Cognitive Processing Therapy and Narrative Exposure Therapy have proven to be effective in South Kivu treating PTSD and improving survivors' psychological, social, physical and economic functioning and related mental health problems in South Kivu. Strengthened capacity and increased resources for mental health support will not only benefit survivors, but also the broader population in the Kivus, many of whom suffer from trauma related to prolonged conflict.

83. **Facilitating access to the legal system and ensuring the provision of medical documentation are critical to bringing perpetrators to justice**. Impunity of SGBV remains a key challenge in all countries. However, addressing the responsiveness of the legal system would require separate and long term interventions and is beyond the scope of the project. On the other hand, in all countries, access to the justice system for survivors who want it, as well as medical documentation for rape and improved collection of forensic evidence will be supported. Both have proven to be effective in increasing bringing perpetrators of SGBV to justice, although at a small scale.

84. **Improved quality of high impact interventions--- prenatal care and assisted deliveries by skilled personnel-- as well as increased capacity to deal with obstetric emergencies will contribute to addressing the persistently high maternal mortality in DRC and Burundi**. Improved access to family planning, including a greater focus on adolescent

health, will contribute to reducing fertility rates. The introduction of the mobile rapid SMS system will provide the means for rapid communications in case of rapes and other medical emergencies, avoiding delays in getting medical care and saving lives. In addition, integration will support early identification and referral of SGBV survivors, preventing further violence.

85. **During project preparation the World Bank team worked with government counterpart teams to ensure the technical soundness of the activities to be supported under the health component.** For DRC, an in depth analysis was conducted with government representatives to select priority health zones, focusing on those with serious unmet health needs, high levels of violence, and relatively few partners. An assessment was done of the potential population and geographic coverage that could be attained given the financial envelope and four-year timeframe. A similar exercise was conducted in Burundi with respect to the activities to be funded, targeting three priority provinces for scale up. In Burundi, a careful analysis was conducted of complementarities between reproductive health, youth friendly services, and SGBV activities supported by the UN partners to leverage technical expertise of these partners as well as to ensure that the project contributes to the Joint UN Program on SGBV.

86. **During the design of the operation the Bank team worked closely with the ICGLR and consulted with partners on how best to strengthen the institution to fulfill its mandate.** The ICGLR recognizes the need to strengthen its institutional capacity, results monitoring and evaluation system, and program implementation to address SGBV and other priorities. In order to effectively deliver its mandate, the ICGLR engaged since 2013 in efforts at enhancing its institutional capacity working closely with Member States and development partners with a focus on strengthening human resources, fiduciary and administrative capacities and administrative systems to enhance effective delivery. The proposed grant provides the Bank and the ICGLR with the opportunity to strengthen ICGLR's institutional capacity over a four-year period, supporting longer term and sustainable institutional strengthening for the Conference Secretariat. This will maintain and build confidence with Member States and current donors, and attract potential new donors to support ICGLR as an efficient and effective regional institution playing an important role in the Great Lakes Region. The proposed activities related to SGBV will support the ICGLR to implement its commitments in line with the Kampala Declaration. The Bank's capacity to engage diverse groups, mobilize experts, and bring global knowledge of SGBV, economic empowerment and violence prevention represents value added for the ICGLR and its Member States. The proposed impact evaluations to be carried out in the three participating countries with support from the World Bank's Gender Lab are expected to generate evidence of the economic and health benefits of the proposed interventions and identify the most cost effective strategies for responding to survivors of SGBV.

C. Financial Management

87. As part of the preparation of the project, a financial management assessment of the implementing units in the three countries and the ICGLR has been carried out. The objective of the assessment was to determine whether these units have adequate financial management arrangements to ensure that: (i) project funds will be used for purposes intended in an efficient and economical fashion; (ii) project financial reports will be prepared in an accurate, reliable and timely manner; and (iii) project assets will be safeguarded. The financial management assessment was carried out in accordance with the Financial Management Practices Manual issued by the Financial Management Sector Board on November 3, 2005 as revised in March 2010. In this regard, reviews of the FM systems (budgeting, staffing, financial accounting, financial reporting, funds flow and disbursements, internal and external audit arrangements) at

the *Cellule d'Execution des Financements en Faveur des Etats Fragiles* within the Ministry of Finance and the Social Funds in DRC; Ministries of Health and Gender in Burundi; Ministries of Health and Gender in Rwanda; and the CS of the ICGLR were carried out.

88. The conclusions of the FM Assessments were that the overall residual FM risk at preparation is considered *High* for DRC, Burundi and ICGLR, and *Substantial* for Rwanda. The proposed financial management arrangements for this project for all countries are considered adequate to meet the Bank's minimum fiduciary requirements under OP/BP10.00. Detailed financial management assessment reports, including the risk assessments and mitigating measures are included in Annex 3.

D. Procurement

89. **Procurement Guidelines:** In all countries, as well as for the ICGLR, procurement will be carried out in accordance with World Bank Guidelines, including: (i) Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits and Grants (January 2011); (ii) Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers (January 2011); (iii) Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants (October 15, 2006 and revised in January 2011); and the (iv) provisions stipulated in the Financing Agreements. Following is a brief summary of procurement arrangements with details provided in Annex 3.

90. In each country as well as the ICGLR a procurement assessment was carried out. The procurement assessments found that the procurement arrangements have an overall high risk rating. In DRC, procurement activities will be carried out at three levels: (i) CFEF unit at the MoF; (ii) FSDRC; and (iii) Provincial Health Directorates (PHDs). At the CFEF unit, procurement activities will be carried out by the Procurement Management Unit (*Cellule de Gestion des Projets et Marchés Publics,* CGPMP) which reports to the General Secretary of the MoF. At the provincial level, procurement activities will be carried out by the Management Unit (*Cellule de Gestion*) within the two PHDs in North and South Kivu. The CGPMPs within the two provinces will be associated in the management of the procurement activities after their creation and full operationalization. The FSDRC will carry out procurement activities for Component 1A and selected activities of Component 3 using its existing procurement unit until the mid-term review. At that time, a decision will be taken on the most appropriate approach to be used based on progress made in establishing new institutional arrangements for procurement in accordance with the new national procurement law.

91. The assessment in DRC found that the FSDRC carried out its fiduciary responsibilities in a satisfactory manner for the previous Emergency Social Action Project (ESAP) and its two additional financings to the point that it was asked to provide fiduciary services for another IDA funded project. On the other hand, neither the CGPMP of the MoF nor the *Cellules de Gestion* within the two PHDs has the needed qualifications and experience to implement procurement activities for this project. The CGPMP of the MoF has limited experience with World Bank procurement rules and procedures. The staff of this unit has attended procurement training courses on the new Bank procurement procedures and will continue to benefit from other Bank organized training events. To further strengthen the capacity of the CGPMP, it will benefit from technical support by the procurement unit of the CFEF. The coordinating units (*Cellules de Gestion*) within the two PHDs in the Kivus do not have experience in implementing Bank-funded projects. Therefore, one procurement expert with strong experience in Bank procurement

procedures will be recruited to provide periodically technical support and training to the two units.

92. In Burundi, the procurement assessment found that procurement staff at the Project Coordination Unit of MoH which manages two Bank-funded health projects is conversant with Bank procurement procedures and has a good track record coordinating procurement activities. At MNSHRG the procurement staff is not familiar with Bank procurement procedures and the ministry does not have sufficient capacity. To expedite project implementation and ensure procurement is handled efficiently, the project will rely on the relatively experienced unit at MoH to handle procurement matters. For the procurement staff of MNSHRG, training will be provided in Bank procurement procedures.

93. In Rwanda the respective SPIU within MIGEPROF and MoH will handle procurement for the project. The SPIU unit within the MoH has experienced procurement staff and experience with among others Global Fund and World Bank procurement procedures, including through the World Bank financed MAP Project (closed) and the ongoing East Africa Public Health Laboratory Networking Project (EAPHLNP). However, the SPIU within the MoH expressed the need for additional specialized training on World Bank procurement procedures**.** Although MIGEPROF implements the Economic Empowerment of Adolescent Girls and Young Women Project (AGI) also financed by the World Bank, the newly created SPIU within the MIGEPROF that will be responsible for the overall coordination of the project does not have sufficient procurement capacity or previous experience with World Bank procurement procedures. MIGEPROF will need to recruit a well-qualified procurement specialist conversant with World Bank procurement procedures for the implementation and coordination of the project by effectiveness.

94. The PIU within the CS of the ICGLR will manage procurement for the project. The procurement staff of the CS does not have experience with World Bank financed projects and procurement procedures. A well-qualified procurement specialist conversant with World Bank procurement procedures will be recruited for the implementation and coordination of the project by the effectiveness date of the project.

E. **Environment and Social** (including Safeguards)

95. The project has an environmental category B rating. The project is not expected to have large scale, significant, or irreversible environmental or social impacts. Project activities are focused on delivery of an integrated package of short and medium term assistance to survivors of SGBV at the community and health facility level, as well as providing high impact maternal and reproductive health services for vulnerable and poor women. To ensure survivors of SGBV will be received in an appropriate environment, the project will support setting up in existing health centers special rooms and upgrade existing ones.

96. Three types of activities have a potential to cause minor adverse impacts that will need to be minimized, mitigated and managed: (i) civil works related to the small construction or rehabilitation activities may cause noise, vibrations and emissions from vehicles and machinery, generate construction waste, and involve potential risks regarding workplace and community health and safety; (ii) generation of additional quantities of medical waste during the operation of the OSCs; and (iii) in addition, in DRC small in-kind grants will be provided to CBOs in support of their ongoing activities. However, these anticipated impacts will be temporary, site specific and limited in scope. To this end, operational policy OP/BP 4.01 has been triggered.

97. Given the small scale of the activities and impacts the appropriate safeguards instruments are Environmental Management Plans (EMPs) and Medical Waste Management Plans (MWMPs). In addition, the presence of indigenous people (Batwa) in North and South Kivu was identified and confirmed during project preparation. The Batwa constitute a vulnerable and marginalized group in the project area. The risk of social exclusion of Batwa in the context of the project will be addressed during implementation. To ensure that the Batwa will benefit from the project, OP/BP 4.10 has been triggered, and an Indigenous Peoples Plan (IPP) focusing on outreach and inclusion will be prepared.

98. As the project is prepared under the special considerations clause of OP10.00, these instruments have been deferred to, and will be prepared during the project implementation period. In line with the provisions of OP10.00 for the case of deferral of safeguards instruments into the project implementation phase, the team, in consultation with Recipients prepared Environmental and Social Action Plans (ESAPs), explaining the anticipated impacts, the required safeguards approach and instruments, and the modalities and arrangements for the production of safeguards instruments during implementation.

99. The project is expected to increase social cohesion at the family and community level by specifically addressing issues of stigmatization and rejection of survivors of SGBV, as well as activities to promote gender equality and change negative attitudes and norms towards women and girls. In addition, project support will provide targeted communities with better access to basic health service. Project investments will contribute to strengthening environmental and social practices around health facilities. Annex 3 provides further details on safeguards for each country, and Annex 8 contains the comprehensive ESAPs required due to the deferral of the safeguards instruments into the project implementation phase.

Annex 1: Results Framework and Monitoring

Project Development Objectives

To expand the provision of services to mitigate the short and medium term impact of sexual and gender based violence, and expand utilization of a package of health interventions targeted to poor and vulnerable females.

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Country	Baseline	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR1	YR2	YR3	YR4	End Target			
1. Direct Project Beneficiaries, of which female	X	#	DRC	0	100,000	225,000	375,000	540,000	540,000	Annually	Sum of number of beneficiaries for all components/ Project records	CFEF
			Burundi	0	51,214	59,973	71,684	81,793	81,793	Semi-annual	Sum of number of beneficiaries for all components/Project records	PCU
			Rwanda	0	0	5,400	12,600	19,800	19,800	Semi-annual	OSC reports	MIGEPROF
2. Percentage of reported cases of SGBV who receive emergency kits (PEP) within 72 hours (broken down by , sex and		%	DRC	25	25	30	40	50	50	Quarterly	CBO, Case Managers	PHDs
			Burundi	30	30	40	50	60	60	Semi-annual	OSC reports	MoH/[18]PCU
			Rwanda	30	30	40	50	60	60	Semi-annual	OSC reports	MoH/MIGE-PROF

[18] MoH: Ministry of Health and Fight Against HIV/SIDA
PCU: Project Coordination Unit

refugee/non-refugee)												
3. Percentage of reported cases of SGBV who receive at least 2 multidisciplinary services as needed (medical, legal and psychosocial)		%	DRC	50	50	60	65	75	75	Quarterly	Case Managers CBO	FSRDC
			Burundi	0	20	30	50	75	75	Semi-annual	OSC reports	MoH/PCU
			Rwanda	20	20	40	60	80	80	Semi-annual	OSC reports	MoH/MIGE-PROF
4. Prevalence of modern contraceptive use (women between 15-49 years old)		%	DRC	9	10	12	16	18	18	Annually	HMIS/ PBF	MoF – FEF/MIPs
			Burundi	22 (HMIS 2012)	23	25	28	31	31	Semi-annual	HMIS	MoH
5. Percentage of pregnant women who benefit from 4 antenatal care visits		%	DRC	41	45	50	55	60	60	Annually	HMIS/ PBF	MoF – FEF/MIPs
			Burundi	49 (HMIS 2012)	50	55	59	64	64	Semi-annual	HMIS	MoH
6. Births (deliveries) attended by skilled health personnel		%	DRC	74	76	78	81	84	84	Annually	HMIS/ PBF	MoF – FEF/MIPs
			Burundi	72.9 (HMIS 2012)	76	80	83	85	85	Semi-annual	HMIS	MoH

Intermediate Project Indicators												
	Core	Unit of Measure	Country	Baseline	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection
Indicator Name					YR1	YR2	YR3	YR4	End Target			
1. Number of survivors who present themselves at least once to an SGBV case manager trained by the project		#	DRC	0	3,300	11,250	19,140	27,060	27,060	Quarterly	CBO, Case Managers	FSRDC
2. Number of survivors treated in a health facility		#	DRC	0	2,835	8,445	14,295	20,075	20,075	Monthly	SNIS	PHDs
3. Number of beneficiaries receiving specialized mental health care		#	DRC	0	0	1,395	4,185	6,975	6,975	Monthly	PHDs	PHDs
4. Survivors receiving psychosocial, legal services, and referral to health services at the community level(disaggregated) (#)		#	DRC	0	4,800	13,320	21,540	29,660	29,660	Quarterly	CBO, Case Managers	FSRDC
5. Survivors receiving medical treatment, psychosocial, forensic, and legal services (disaggregated) (#)		#	Burundi	0	50	120	300	550	550	Semi-annual	OSC reports	MoH, MJ, MNSHRG[19] PCU
			Rwanda	0	0	5,400	12,600	29,400	29,400	Semi-annual	OSC reports	MoH/MIGEPROF
6. SGBV cases in which referrals to community level economic support services or programs are done (#) (Rwanda) and number of poor and vulnerable women benefitting from economic empowerment activities (Burundi)		#	DRC	0	1,650	5,610	9,570	13,530	13,530	Quarterly	CBO, Case Managers	FSRDC
			Rwanda	No baseline	0	# referred first year	10% increase from Y2	20% increase from Y3	20% Increase from Y3	Semi-annual	OSC reports	MIGEPROF
			Burundi	17,000	21300	25600	29600	31600	31600	Semi-annual	NGOs reports	MNSHRG / PCU

[19] MNSHRG: Ministry of National Solidarity, Human Rights and Gender

Intermediate Project Indicators												
	Core	Unit of Measure	Country	Baseline	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection
Indicator Name					YR1	YR2	YR3	YR4	End Target			
7. Number of persons benefiting from sensitization and advocacy activities to improve awareness and knowledge of SGBV, gender equality and/or reproductive health (#), Disaggregated by gender/age group/community leader		#	DRC	0	180,000	540,000	900,000	1,260, 000	1,260, 000	Quarterly	FSDRC database	FSRDC
			Burundi	2100	3100	4875	7100	9400	9400	Semi-annual	Sensitization and advocacy reports	MNSHRG, MJ, Police, PCU
8. Sensitization and advocacy activities to promote gender equality implemented (#)		#	Rwanda	0	5	17	30	39	39	Semi-annual	PIU report	MIGEPROF
9. Reported SGBV cases taken to the prosecutor (#)		#	Burundi	240	270	600	950	1300	1300	Semi-annual	Prosecutor office report	MJ/PCU
			Rwanda	6,840	6,840	7,184	7,524	7,866	7,866	Semi-annual	RNP	RNP/MIGEPROF
10. OSCs set up and/or upgraded and staffed as per guidelines (#)		#	Burundi	0	2	3	3	3	3	Semi-annual	PBF report	MoH
			Rwanda	0	9	17	17	17	17	Semi-annual	OSC reports	MoH/MIGEPROF
11. Health facilities renovated, and/or equipped (number)	X	#	DRC	0	75	180	180	180	180	Quarterly	PHDs	PHDs
12. Staff involved in SGBV services trained in relevant areas (#)		#	Burundi	65	180	320	320	320	320	Quarterly	Training reports	MoH, MJ, Police, MNSHRG UGP
			Rwanda	0	150	230	230	230	230	Semi-annual	PIU report	MIGEPROF
13. Number of youth who benefit from reproductive health		#	Burundi	0	1350	2500	6000	10000	10000	Semi-annual	Youth repr. health	MoH PCU

Intermediate Project Indicators												
	Core	Unit of Measure	Country	Baseline	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection
Indicator Name					YR1	YR2	YR3	YR4	End Target			
services											services reports	
14. Pregnant women receiving antenatal care during a visit to a health provider (number)	X	#	DRC	0	60,000	125,000	200,000	280,000	280,000	Quarterly	Validated PBF database	Provincial Health Directions and Performance Purchasing Agencies
15. Births (deliveries) attended by skilled health personnel	X	#	DRC	59,700	122,800	189,600	261,000	337,200	337,200	Semi-annual	HMIS/ PBF	MoF – FEF/MIPs
			Burundi	24,134	25,034	26,292	27,933	29,293	29,293	Semi-annual	HMIS	MoH
16. Health personnel receiving training (number) [comp. 2]	X	#	DRC	0	250	300	350	400	400	Semi-annual	Project records PPAs/PHD	Provincial Health Directions and Perf. Purchasing Agencies
17. Average availability of essential tracers drugs at health facilities		%	DRC	63	65	70	75	80	80	Quarterly	Quality checklist	Provincial Health Directions and Perf. Purchasing Agencies
18. New curative consultations per capita per year		per capita per year ratio	DRC	54	56	58	62	65	65	Annually	Validated PBF database	Provincial Health Directions and Perf. Purchasing Agencies
19. Average quality score at health facilities (PBF check list)20		Score	DRC	NA	TBD	TBD	TBD	85	85	Quarterly	Validated PBF database	Provincial Health Directions and Perf. Purchasing Agencies
20. Percentage of identified poor people benefiting of Equity Fund		%	DRC	0	10	15	20	30	30	Quarterly	Health facilities' records,	Provincial Health Directions and Perf. Purchasing Agencies

[20] The quality check list is a comprehensive scorecard which assesses the quality of care at health facilities with all critical aspects of care (hygiene, drug availability, clinical care, equipment availability, drug management, financial management, laboratory, etc).

Intermediate Project Indicators												
	Core	Unit of Measure	Country	Baseline	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection
Indicator Name					YR1	YR2	YR3	YR4	End Target			
											verified PBF data	

ICGLR Intermediate Results and Indicators

Intermediate Results Indicators											
				Cumulative Target Values						Data Source/	Responsibility for
Indicator Name	Core	Unit of Measure	Baseline	YR1	YR2	YR3	YR4	End Target	Frequency	Methodology	Data Collection
1. Number of participants from ICGLR Member States benefitting from training on SGBV at the Regional Training Facility		#	0	0	100	700	1400	1400	annual	RTF report/Quarterly progress reports	RTF/CS
2. % of Trainers of Trainers (ToTs) training professionals in respective areas of training received in their respective home country		%	0	0	0	40	70	70	annual	RTF report/Quarterly progress reports	RTF/CS
3. Number of lessons learned and good practices shared among ICGLR member states		#	0	0	3	6	8	8	annual	Quarterly progress reports	CS
4. Number of member states countries using regional SGBV messages developed by the ICGLR		#	0	6	12	12	12	12	annual	Quarterly progress reports/ Kampala Declaration reports from MSs	CS
5.Number of M&E reports published of the progress of the Kampala Declaration published		#	0	1	2	3	4	4	annual	Quarterly progress reports/ Kampala Declaration reports from MSs	CS
6. Annual disclosed unqualified external financial audit with the ICGLR annual budget (planned and executed)		#	0	0	1	2	3	3	annual	Quarterly progress reports	CS

Annex 2: Detailed Project Description

1. The project will comprise the following components: (i) Holistic support for survivors of Sexual and Gender Based Violence and violence prevention, (ii) High impact basic health services, and (iii) Regional and National Knowledge Sharing, Research and Capacity Building.

Component 1: Holistic Support for Survivors of Sexual and Gender Based Violence and Violence Prevention (US$50.51 million)

DRC (US$34.97million)

2. In DRC, this component will support the delivery of an integrated package of short and medium term assistance to survivors of SGBV at both community and health facility levels. In addition, it will support activities to promote gender equality, behavioral change and violence prevention, including sexual violence. The support provided through this component will aim to strengthen existing systems at the community level as well as the health system at all levels to provide quality integrated support to survivors of SGBV. Mechanisms will be developed to ensure linkages and appropriate referrals between the support provided for survivors of SGBV at the community level and the health system. Through the envisioned support, the project will contribute to develop agreed upon norms and systems for quality services for survivors. At the community level, support for empowerment of CBOs and of vulnerable women will contribute to creating a more protective environment for women, as well as reinforce violence prevention strategies. The holistic or integrated approach aims to support survivors' physical, mental, social and economic well-being. A holistic response will contribute to preventing or decreasing different consequences related to SGBV and break the cycle of violence. Guiding principles for the support to survivors include confidentiality, informed consent, and respect and dignity.

3. The following intervention zones were tentatively selected for Component 1: Fizi, Kaniola, Kimbi Lulenge, Lulingu, Minova and Shabunda in South Kivu and Birambizo, Binza, Kayna, Kirotche, Nyiragongo, and Ruthchuru. Selection criteria used included: (i) current or in the near future unmet needs or gaps in service provision for SGBV, (ii) a mixture of low and high risk security zones to strike an appropriate balance between remote, underserved health zones and those which require moderate support, (iii) high levels of SGBV, (iv) equilibrium in geographical distribution, (v) complementarity with intervention zones for component two of the project, and (vi) potential complementarity with the Emergency Recovery Project (ERP). In South Kivu, the proposed selected zones are similar to the zones selected for Component 2, while in North Kivu two zones (Kirotche and Nyirangongo) are similar.

4. In each intervention zone, an average of 15 health facilities as well as the General Referral Hospital (GRH) will be supported. For activities at the community level, in each intervention zone, five Community Based Organizations (CBOs) will be supported, and five VSLAs. Overall, the project would support 10 intervention zones, 180 health facilities, and 60 CBOs and 60 VSLAs.

5. In each province, the Provincial Health Directorates (PHDs) and the Social Fund of DRC (FSDRC) will present the proposed zones of intervention in the sub-technical working group on

Multi-Sectoral Assistance for survivors of SGBV at the provincial level to ensure complementarity with ongoing and future planned programming.

6. Specifically, this component will support: (a) Integrated Support for Survivors of SGBV and Prevention of Violence at Community Levels, (b) Integrated Support for Survivors of SGBV at Health Facility level, and (c) Supporting Existing Integrated Centers of Excellence in the Kivus.

Sub-component 1A: Integrated Support for Survivors of SGBV and Prevention of Violence at Community Levels (US$14.55 million).

7. This sub-component will include: (i) supporting and strengthening integrated service delivery systems in CBOs; (ii) supporting case management, rapid initial support and referral; (iii) providing legal aid; (iv) providing mental health and psycho-social support; (v) providing support for economic empowerment; (vi) supporting awareness building and advocacy for behavioral change through activities that promote gender equality, behavioral change and violence prevention, including sexual violence, and (vii) piloting approaches working with perpetrators.

(a) **Strengthening integrated service delivery systems in CBOs.** The main entry point for a survivor at the community level into the integrated service system will be a CBO, potentially already engaged in supporting SGBV survivors. Each CBO selected by the project will be the hub of service delivery and the coordination system. In each CBO, two members will be selected to act as case managers for survivors of SGBV and provide either direct support or referrals. This approach will encourage survivor participation and integration into women's and girls' group social and economic activities. This approach will also address partly stigmatization and exclusion in the family and community for survivors, and increase solidarity and social cohesion. The CBOs will receive basic training including among others on SGBV, psychosocial support, HIV/AIDS and STDs, women's leadership, advocacy, and literacy and numeracy.

(b) **Case management, rapid initial support and referral.** Quality case management involves the identification of survivors' health (physical and mental), emotional and security needs and the development of an individualized service-delivery plan that addresses these needs. The case manager will provide information about available services and how to access them, and will accompany the survivors through the referral system and local support networks. The CBO case manager will also follow-up with the survivor to ensure timely and quality access to services and to help solve problems with other partners to remove any barrier to services. Specifically, the CBO case managers will:

(i) Refer the survivors to medical services in a timely manner and liaise with the focal points for survivors of SGBV in health centers for follow-up and counter referral.

(ii) Assess the mental condition of the survivors, provide basic individual counseling for the survivor and family members as needed and refer them to specialized mental health care providers as needed.

(iii) Provide information about the legal services and liaise with specialized NGOs for the provision of legal counseling and legal assistance in case the survivors decide to take judicial action. The project will also ensure survivors, their families and the witnesses benefit from psychosocial support during court cases as needed.

(iv) Develop action plans for social and economic empowerment together with the survivors. Survivors will be able to participate in social and economic activities of the CBOs and/or VSLAs, and will be linked to other existing economic programs in the area.

(c) **Legal aid.** CBO case managers will provide preliminary information about the rights of the survivors and will inform them about the possibility to receive legal counseling. Should the survivor desire further legal counseling, the CBO case manager will refer the survivors to a legal aid organization supported by the project. These will inform survivors of their rights, legal procedures available, as well as potential difficulties of pressing charges in court to allow the survivor to make an informed decision in whether to take legal action. If the survivor decides to initiate a legal process, the support provided will include free legal counseling and representation, reimbursement for transport, as well as "*accompagnement*" of the survivor and the family. The legal aid organization will work in close coordination with the CBO case manager to ensure additional support as needed including mental health support to reduce potential renewed post-traumatic stress.

(d) **Mental health and psychosocial support**. The CBO case managers will provide psychosocial support services including special therapy techniques such as psycho-education, and family mediation as needed.

(e) **Economic empowerment.** The project will provide support for economic empowerment of survivors and other vulnerable groups through VSLAs, agricultural associations/cooperatives and CBOs. For VSLAs, the project will support training in how to structure the group, developing by-laws or group rules, holding elections, managing finances for the group and each member, assessing the feasibility of business opportunities, and providing loans to members. Literacy and numeracy training will be provided based upon demand. The project will also provide support to facilitate access to existing micro-finance opportunities. Livelihood support will be supplemented by discussion groups including the partners of VSLA members. The discussion series will be tailored to build awareness around SGBV issues, to address gender inequities within the household and the community, and change behavior and attitudes that condone violence.

For agricultural associations/cooperatives, support will vary depending upon whether this project is co-located in an area where the World Bank funded ERP is operating. ERP, a project implemented by the DRC Social (FSDRC), will be working through

local farmers' cooperatives, associations and syndicates to strengthen promising value chains in South and North Kivu. Where ERP is operational, women and CBOs interested in agriculture will be encouraged to participate in ERP supported farmer groups, which will receive access to improved inputs, training and technical assistance, and support in storing, marketing, and transforming their produce. In areas where ERP is not currently operational, but is nearby, the project will advocate with ERP to expand its agricultural services into these areas.[21]

Finally, the project will provide support to the aforementioned CBOs in support of their ongoing activities. The CBOs will receive support to strengthen their organizational capacity, including on development of vision, governance, project planning, and basic financial management. The project will provide small in-kind grants in support of CBOs selected activities, as well as ongoing technical assistance and follow-up.

(f) **Awareness building and advocacy for behavioral change through activities that promote gender equality, behavioral change and violence prevention, including sexual violence.** At the community level, this sub-component will provide support for activities to promote violence prevention, social cohesion in the communities and gender equality. The project will support sensitization and advocacy activities to promote gender equality, as well as activities to promote behavioral change working with men as agents of change, including community and religious leaders. CBOs will be key partners to organize meetings with community leaders to address negative beliefs and attitudes against women and girls, including survivors of SGBV, and promote behavioral change and attitudes. In addition, the project will also work through farmer cooperatives and associations and the Labor Intensive Work Groups (LIWGs) being supported by the ERP, as target groups for sensitization and advocacy activities. The project will finance the development of educational and informative modules designed to address a range of issues directly or indirectly related to SGBV. These educational modules can include gender roles in the household, the rights of women under the newly developed family code, and SGBV and available services. These information campaigns will be accompanied by other types of media, such as radio dramas and community inter-active theater that can be used to stimulate discussion and awareness around the topic.

(g) **Piloting approaches working with perpetrators**. Experiencing violence, especially at young age may shape the human mind and create a condition that will display patterns of extreme violent behavior, in short: experiencing high levels of violence may create perpetrators. This activity will build upon a small pilot carried out in Goma to reduce violence, or "appetitive aggression" (enjoying inflicting violence), with initial promising result, using Narrative Exposure Therapy for Forensic Offender Rehabilitation (FORNET). FORNET identifies individuals who are experiencing PTSD and have difficulties managing aggression, followed by

[21] The Bank is currently preparing the Agricultural Growth Poles Project for the Bukavu-Uvira-Kalemie axis. During project preparation of this project, the Bank teams will work together to identify potential linkages or synergies between this grant for DRC.

treatment. The pilot will be scaled up, accompanied by an evaluation to measure the impact of the intervention on decreasing violence behavior among violent offenders. It is expected to result in a clinical usable treatment tool for future use in public health care.

8. To strengthen government structures at the provincial and territorial level, staff of the Technical Division of respectively gender, justice, and social affairs, as well as other government representatives will be included in the trainings as appropriate, which will also encourage more intensive interaction between civil society and the government. In order to be effective service providers, local NGOs often need help to solidify their organizational foundations. In addition to the technical capacity building, the project will invest in strengthening the management capacity of these local implementation partners particularly in areas such as governance, planning, monitoring and evaluation, financial management, fund raising and proposal writing to ensure that limited resources are used effectively. This sub-component will be implemented by the FSDRC.

Sub-component 1B: Integrated Support for Survivors of SGBV at Health Facility level (US$13.13 million).

9. The project will support strengthening the health system to provide integrated support for survivors at all levels (heath centers, General Referral Hospitals (GRHs) at the health zone level, and referral hospitals at the provincial level) to boost technical capacity through specialized training and operational cost. Support provided for survivors would involve: (i) clinical care support, case management, rapid initial support and referrals; (ii) mental health care; (iii) medico-legal and forensic support; and (iv) providing PEP emergency kits, surgery equipment and medical consumable. Following the 2006 Law on Sexual Violence, all services provided to survivors will be free of charge. In each health center, two nurses will be identified as focal points to provide support to survivors, while in each GRH, two nurses and two doctors will be identified. Specifically, this sub-component would finance the following activities:

(a) **Clinical care, case management, rapid initial support and referrals and PEP kits, surgery equipment and medical consumables**. Survivors will receive preventive and curative medical services and follow-up in a confidential manner. Prevention will include PEP kits, emergency contraceptives, and vaccinations against Hepatitis B and tetanus as needed. In addition, other basic medical care services such as pain relief and treatment of wounds will be provided as needed. All medical care, equipment and medication will be adapted to the age and sex of the patient. At the health center level, nurses will be trained to build their capacity for referral of survivors to higher level health care facilities for additional specialized medical support, including for example for fistulas, prolapsed uterus or other obstetric problems. At the GRHs, the project would support the development of capacity to carry out these types of medical procedures, including provision of surgery equipment. SGBV focal points at the health centers will refer survivors to the CBO case managers for community based support. In the third year of the project, *screening tools* to facilitate early detection of SGBV cases will be introduced in the supported health facilities, tested and adapted to the specific context of eastern DRC.

(b) **Mental health care**. To ensure an effective response, the project will support the National Mental Health Program (NMHP) in a staggered approach to integrate basic mental health services at the health center level, and strengthen the capacity in GRHs as well as in specialized mental health clinics such as SOSAME (*Soins de Santé Mentale*) in South Kivu and *Tulizo Letu* in North Kivu. The project will support the integration of evidence based advanced psychotherapies into the health system such as Group Cognitive Processing Therapy (CPT) or advanced individual psychotherapy such as Narrative Exposure Therapy (NET). Specifically, support provided will include:

(i) At the health center level, survivors will be screened for commonly found conditions of mental distress and receive from nurses specialized psychotherapeutic interventions such as CPT and NET as needed. More severe cases of mental disorders will be referred to the GRHs or to specialized mental health clinics. The health center focal points for SGBV will also liaise with the existing *Relais Communautaire* (RECO) volunteering within the health system to promote mental health and sensitize communities against stigma associated with mental conditions.

(ii) At the GRH or specialized mental health clinics, survivors with severe mental disorders will receive specialized psychotherapeutic interventions and others as needed by doctors and specialized mental health staff, including psychologist and psychiatrist where available. This would support the intention of MoPH to open a clinical psychology unit at the GRH level. The GRHs or mental health clinics will liaise with the case manager of the respective communities from the survivor once these cases are discharged.

(c) **Medico-legal support**. At the health center, a medical certificate will be prepared and shared with the survivors who desire so. The SGBV focal points nurses in health centers, as well as doctors, will be trained and supervised in best practices for forensic collection and documentation of medical certificates. Authentic copies of medical certificates and forensic evidence will be secured at the Health Zone level. At selected referral hospitals, the project will strengthen the capacity for forensic evidence collection.

10. This sub-component will be implemented by the Provincial Health Directorates (PHDs). The project will support the PHDs to develop and implement a training plan that will aim at sustainable integration of these services into the primary health care package and provincial health system as a whole. Identified focal points to treat survivors of SGBV will be trained in clinical management of survivors, including child survivors, guiding principles of working with survivors to ensure confidential, compassionate and ethical care, development of medico-legal document, and referrals to more specialized services as needed. In the third year of the project, capacity building will be provided to health providers on the use of screening tools for early detection of SGBV cases. For specialized medical needs such as fistulas, prolapsed uterus or other obstetric problems, nurses will be trained to recognize the symptoms and referral to a

higher health level as needed, while the capacity of doctors to carry out these type of interventions, will be developed as needed, building upon ongoing training. For mental health care, capacity building will be provided at all health levels to assess mental distress of survivors (and family members), as well as capacity building for psychotherapeutic interventions. Integrating a clinical psychologist and the training of medical doctors and psychiatric nurses where available will reinforce the GRH at the Health Zone level. They would also be able to provide clinical supervision to other service providers.

Subcomponent 1C: Supporting Existing Integrated Centers of Excellence in North and South Kivu. (US$7.29 million).

11. The Panzi Hospital/Foundation in South Kivu and Heal Africa in Nord Kivu have extensive experience providing high quality integrated support to survivors of SGBV. Both centers are used at the provincial level as centers of referral for survivors. In addition, both organizations are used in the Kivus as training providers to develop the capacity of health centers at all levels as well as communities to provide integrated services to survivors. The project will support both organizations to provide support to survivors including: providing medical services, conducting forensic evidence and analysis, providing support for legal services, providing facility based counseling, supporting survivors and their children rejected by their families, providing training to related medical professionals, and supporting mobile clinics. The mobile clinics who will work in close collaboration with the PHD and health centers. It is assumed that with the support to the overall health system as outlined in sub-component 1B, the need for referrals to the Panzi Foundation and Heal Africa from interventions zones of the project will decrease over the life time of the project and be more limited to the most serious cases. Specialized training to be provided will aim to strengthen the Government's capacity to provide holistic services for survivors including training and internships for surgical intervention and collection of medico-legal/forensic evidence.

Burundi (US$5.76 million)

12. This component will support the short and medium term needs of survivors of SGBV in three priority provinces: *Cibitoke, Makamba and Muyinga* with a total population of approximately 750,000 inhabitants, of which about half are females.

Subcomponent 1A: Integrated Support to SGBV Survivors and Prevention of Violence at Community Level (US$2.0 million)

13. This sub component will fund integrated support to SGBV survivors at community level through the Family and Community Development Center (FCDC) network, using community level actors. The main activities to be funded will be: (i) supporting case management, rapid initial support, and referral; (ii) addressing economic empowerment needs of survivors and other vulnerable groups through VSLAs; (iii) raising awareness of SGBV, violence prevention, and gender equality; and (iv) contracting of specialized non-governmental organizations and CBOs to support survivors of SGBV and prevent violence at community level. FCDCs are decentralized structures of MNSHRG that coordinate activities of social workers responsible for the social protection of vulnerable groups, including children, women, disabled, elderly and

those affected by conflict. FCDCs are also responsible for the implementation of sectoral policies of MNSHRG, including women's empowerment and gender equality, and prevention and protection of women against all forms of violence.

14. Given that FCDCs lack basic equipment and are poorly resourced, but have the potential to play an important entry point on SGBV, the project will strengthen select centers in the catchment areas of the three hospitals where SGBV services will be established to render them operational. Training and capacity building will be provided for social workers and health promotion technicians to supervise community level case workers to provide confidential support to survivors. Likewise, training will be provided for community health workers to disseminate messages about violence prevention. Minor rehabilitation to upgrade office space will be supported, facilities will be equipped, and personnel will receive basic transportation means (motorbikes) to conduct community outreach and accompany survivors to health facilities.

15. Training and capacity building of community case workers will be provided in the following areas: (i) rapid response approaches for survivors and basic case management development; (ii) basic initial counseling; (iii) effective referral to health facilities, including use of an SMS alert system and accompanying the survivors to health facilities; and (iv) violence awareness raising. The project will support recruitment of consultants or specialized firms to conduct training, and provision of basic materials and equipment.

16. The project will also address the economic empowerment needs of survivors and other vulnerable groups, which has been a gap in facilitating economic reintegration of SGBV survivors. The project aims to expand coverage of the Village Savings and Loan Associations scheme to other areas not yet covered in the province of Muyinga and to introduce the program in Makamba and Cibitoke. The choice of this approach was based on the fact that it promotes economic reintegration, and boosts self-esteem. At the same time it induces involvement of men and boys in the prevention of SGBV. This activity will be carried out with technical support of specialized organizations which will be recruited on a competitive basis by the project coordination unit in MoH, in close collaboration with MNSHRG.

Sub-component 1B: Integrated Support for Survivors of SGBV at Facility Level (US$3.76 million)

17. This sub-component will support the establishment of integrated services within the three selected hospitals (i.e. Cibitoke, Makamba, Muyinga) and strengthen linkages to health centers and community structures in the catchment areas of these facilities to provide a continuum of care for survivors. The proposed design is in line with the joint UN Program on SGBV which aims to expand and scale up integrated services, working in partnership with specialized NGOs and CBOs. The three hospitals will be reorganized to accommodate a space dedicated to these specialized services where a package of multidisciplinary interventions will be made available for care and protection of survivors. Services will include medical care, psychosocial support, collection of forensic evidence, provision of free medical certificates, and initiation of police investigations and legal proceedings. The overall goal is to provide survivors comprehensive support in a safe and confidential environment in an efficient manner avoiding access barriers to

services that are related to distances between services, lack of resources, and absence of qualified personnel.

18. To make optimal use of existing capacity, personnel will be dedicated to SGBV survivor care or working on a rotational basis as part of a multidisciplinary team, depending on workloads. The team will comprise a medical doctor, nurse, psychologist, with dedicated or on call policeman and legal counsel who will work together to provide comprehensive support to survivors. Medical and paramedical staff will be assigned from existing staff while the Ministry of Public Security and Ministry of Justice will assign police and legal experts. The choice of medical and paramedical staff within the hospital will be based on possible synergies with different services (e.g. reproductive health, HIV). Since SGBV does not form part of the standard medical training for doctors and nurses, they will be provided with extensive training related to clinical management of SGBV, referral of SGBV cases, and production of forensic evidence. Hospital management will ensure that minimal staff are available or on call at all times, will monitor workloads carefully, and adjust staffing patterns according to workloads.

19. The minimum package at the OSC will comprise the following services:

- ***Intake*:** At the reception there will be a trained social worker or nurse at all times. Intake will include a calm and welcoming registration process, ensuring that the survivor understands the procedures and services provided and is able to choose, with the guidance of a professional team. The person managing the reception and the intake will also play a key role in calling the multi-disciplinary team for the first briefing, where quick decisions will be made on the best way to proceed.
- ***Integrated investigative services*** include: (i) investigative interview and collection of forensic evidence; (ii) medical care; (iii) police and legal follow up; and (iv) psychological investigative services. The OSC team will jointly undertake the investigative interview as well as the medico-legal examination; collect evidence from the crime scene; and conduct the psychological, and mental status assessments. Jointly they will also make a plan to help the survivor to cope with the incident.
- ***Crisis intervention*** includes: (i) assessing danger; (ii) providing acute medical care; and (iii) offering psychological intervention services; and (iv) offering crisis counselling, as may be needed.
- ***On-going intervention services*** will include follow-up visits at the center and/or in the survivor's home or community, as follows: (i) multidisciplinary case management; (ii) psychosocial support services; (iii) medical intervention services; and (iv) legal intervention services.

20. Activities will be implemented in close partnership with specialized NGOs and CBOs to benefit from their technical expertise in the treatment of SGBV cases, especially in the initial stages of project implementation so that hospital personnel as well as other staff assigned to be part of the OSC receive adequate training and technical support. The specialized NGOs will be contracted to support capacity building for each of the three hospitals and will make available a psychologist specialized in treatment of SGBV cases who will subsequently be replaced by a psychologist assigned by the Gender Ministry to institutionalize capacity. Based on a competency transfer plan, the organization will accompany and provide comprehensive technical support to the team until they are judged to have sufficient capacity to fully manage cases.

21. For legal aspects, the project will support the functioning of the *specialized chambers* for treating SGBV cases and specialized sections responsible for examining the procedures for minors and other SGBV survivors. In addition, a computerized system for prioritizing rape cases will be put in place to accelerate their processing. To this end, the operation will support refurbishing of rooms for specialized sections as well as adequate equipment that will allow judiciary focal points to conduct a quality job with the diligence and speed required. For Cibitoke and Makamba provinces that have no detention centers, the project will support transport needs of judges and clerks to the provinces where the detainees are transferred (Bujumbura, Rumonge) to conduct *mobile courts*. Technical implementation of this activity will be the responsibility of the Ministry of Justice.

22. Capacity building of judicial and selected police structures and their human resources in the management of SBGV will be carried out by the respective ministries. Select training will be done in a multidisciplinary fashion, and will make use of existing modules and specialized materials. This will also enhance collaboration between the ministries involved in SGBV.

23. The sub-component will fund the reorganization, upgrading, and strengthening of selected district hospitals (through one-stop centers) and training of personnel to offer: (i) clinical care and referrals; (ii) mental health and psycho-social support; (iii) medico-legal support; (iv) post-exposure prophylaxis emergency kits, surgery equipment and medical consumables; (v) legal aid to survivors in cooperation with specialized non-governmental organizations, the police and the judiciary whose capacity will be strengthened to handle cases of SGBV survivors, including specialized chambers and mobile courts; and (vi) contracting of specialized non-governmental organizations and CBOs to support survivors of SGBV at health facility level. Personnel will receive specialized training in case management and referral, clinical care, mental health, judicial-medical support, including collection of forensic evidence, and use of screening tools. Other capacity building activities will be targeted to police officers, and legal experts to strengthen handling of SGBV cases, including operational support for functioning of specialized chambers and for mobile courts; upgrading of office space and provision of necessary equipment. Hospitals will receive grants to cover part of the costs related to support of SGBV cases including: transportation of survivors to hospitals or transportation for police interventions; transport of specimens for forensic evidence; support for staying in the hospital (subsistence, clothing) and costs related to legal assistance.

Rwanda (US$ 9.78 million)

Component 1: Holistic Support for Survivors of Sexual and Gender Based Violence, and Violence Prevention

24. In Rwanda, component 1 will support delivering an integrated package of short and medium term assistance to survivors of SGBV at both community and health facility levels through scaling-up the *Isange OSCs* while promoting gender equality, behavioral change and violence prevention in the intervention zones. Specifically, this component will support: (a) Integrated Support for Survivors of SGBV and Prevention of Violence at Community Levels and (b) Integrated Support for Survivors of SGBV at Health Facility level.

Sub-component 1A: Integrated Support for Survivors of SGBV and Prevention of Violence at Community Levels (US$3.28 million)

25. This sub-component will include activities to support long-term behavioral and social norm changes to promote gender equality and reduce levels of violence, including SGBV through: (i) launching sensitization and advocacy activities to promote gender equality through public awareness campaigns (including radio, theater and television shows) at the national and community level including on existing laws, policies and services as well as the development of educational/informative modules designed to examine a range of issues directly or indirectly related to SGBV; and (ii) promoting behavioral change through the scaling-up of effective models for working with women, men, boys and girls at the community level to change behaviors and reduce violence in cooperation with other development partners. In addition, this sub-component will provide support to (iii) ensuring follow-up at the community level through social services and referrals to existing social protection programs for the economically vulnerable survivors of SGBV to promote their economic empowerment; and (iv) supporting safe houses to help survivors of SGBV to benefit from temporary safe housing before returning to their communities of origin.

(a) ***Sensitization and advocacy activities to promote gender equality***. Activities will include public awareness campaigns at the national and community level related to SGBV and child abuse, including on existing laws and policies as well as available services. The project will finance the development of educational and information modules designed to examine a range of issues directly or indirectly related to SGBV. These educational modules can include gender roles in the household and the rights of survivors and available services. Information campaigns will be accompanied by other types of media, such as radio dramas, community inter-active theater**,** and TV shows that can be used to stimulate discussion and awareness around the topic. In addition, the project will support innovative activities that promote gender equality and address SGBV during the yearly 16 days of activism.

The proposed activities will build on existing mechanisms at the community level, such as the Anti-GBV Committees, community health workers and parent evening forum (*Umugoroba w'Ababyeyi*). Special attention will be given to sensitization and awareness activities in schools, including sensitizing teachers and the existing anti-GBV clubs within schools. Finally, training and sensitization on SGBV will be provided to journalists. MIGEPROF will work in close collaboration with MINALOC to ensure local government actors at district, sector, cell and village level are part of the information dissemination. The Steering Committee of the project will reward on an annual basis districts for outstanding performance in the fight against SGBV.

(b) ***Promote behavioral change.*** Rwandan policy documents acknowledge that gender violence is rooted in a patriarchal social structure, where control and power typically lie with men (MIGEPROF National Gender Policy, 2010). Activities at the community level which aim to shift norms and behavior around violence, including partner violence, have been limited. As an illustration of social norms and attitudes that condone violence: 55 percent of women believe that wife beating is justified for

one of a list of specified reasons, compared to 25 percent of men. Younger men are more than twice as likely as older men to agree that beating is justified (DHS, 2010). Activities under this sub-component will include scaling-up effective models of working with women, men, boys and girls at the community level to change behaviors to reduce violence. DFID is currently planning a project which would include scaling-up promising approaches at the community level to reduce violence against women, boys and girls by working with men and boys in collaboration with MIGEPROF, CARE International and *RWAMREC*. Activities are expected to start in 2014. Based upon the results of the DFID-funded project during its first two years, this project would scale-up through MIGEPROF the community based activities working with men and boys at the national level during the third year of the project.

(c) ***Follow-up at the community level.*** Social workers from the OSCs are responsible for follow-up with survivors at the community level. They will identify those survivors for whom follow-up visits will be beneficial. All children survivors of rape will benefit from follow-up visits. For economically vulnerable survivors, social workers will refer them to existing social protection programs promoting economic empowerment, including the Vision 2020 *Umurenge* Program (VUP) and the Ministry of Local Government (MINALOC) Decentralized Funding Program.

(d) ***Safe houses***. The project will pilot support to existing organizations supporting survivors who might benefit from staying temporarily in a safe house before returning to their communities. The pilot will build upon the experiences of the National Public Prosecution Authority (NPPA) which currently manages 12 safe houses for the Ministry of Justice (MINIJUST).

Sub-component 1B: Integrated Support for Survivors of SGBV at Health Facility Level (US$6.5 million)

26. This sub-component would support needs of survivors through scaling-up the OSCs at the district level, using the established Multidisciplinary Investigation and Intervention Team Model (MDIIT). The OSCs will be established in 17 existing hospitals which would be rehabilitated and modernized to accommodate the OCSs in line with the National Strategy to ensure multidisciplinary services and protection of survivors, 4 of which will focus on providing services to refugee SGBV survivors.[22] In addition, during the fourth year of the project, 5 additional OSCs close to refugee camps and boarder areas currently supported by the Government of the Netherlands will be supported. The services are available free of charge, 24 hours per day, 7 days a week. The support provided under this sub-component will complement

[22] The project selected hospitals to set up and upgrade OSCs include: (i) Kigali Province: Kigali district Masaka, Muhima and Kibagaba hospital; (ii) Western province: Karongi district Kilinda and Mugonero hospital, Nyamasheke district Kibogora hospital, Ngororero district Kabaya hospital, Rutsiro district Murunda hospital; (iii) Southern province: Ruhango district Gitwe hospital, Gisagara district Kibilizi hospital, Nyamagabe district Kaduha hospital; (iv) Northern province: Rulindo district Rutongo hospital, Gakenke district Nemba hospital and Ruli hospital; and (v) Eastern province: Bugesera district Nyamata hospital, Kayonza district Gahini hospital, and Gatsibo district Kiziguro hospital. Among these OSCs, Kilinda, Mugonero, Kiziguro, and Kibilizi hospitals are close to borders and will focus on providing services to refugees.

the recently signed three-year project to support the scaling-up of the *Isange* OSC model with support from the Government of the Netherlands and One-UN.

27. Specifically, this sub-component will include: (i) setting up the *Isange* OSCs in selected hospitals with the necessary facilities, equipment and medical supplies; (ii) supporting clinical care, case management, rapid initial support, and referral depending on the needs of SGBV survivors and based on an individualized and confidential service-delivery plan addressing these needs; (iii) providing PEP emergency kits, medical care services, surgery equipment and medical consumable; (iv) providing medico-legal support through the collection of forensic evidence and the completion of the standard medico-legal form from the national police with the necessary additional equipment and intervention services; (v) providing mental health and psychological support through specialized psychotherapeutic interventions, family mediation, family mental health support, and psychiatric referral, as needed in coordination with social services; and (vi) providing legal aid through police services, legal advice, free legal counselling and representation in court, transport and judicial follow-up, in coordination with social services.

(a) ***Setting-up OSCs***. To ensure survivors of SGBV will be received in an adequate environment, the project will support setting up in 17 existing hospitals special rooms, including adding safe rooms to accommodate and ensure access to medical, psychosocial, forensic and legal support, as well as separate safe rooms for male and female survivors. Ideally, an OSC should include two safe rooms, one to two consultation rooms, one private reception room, two to four adult and child therapy rooms, one judicial police officer and legal consultation room, and one investigative interview room for children and adults. In addition, the OSCs will be provided with essential medical and office equipment, as well as equipment for the child therapy rooms.

(b) ***Clinical care, case management, rapid initial support, and referral.*** Quality case management involves the identification of survivors' health (physical and mental), emotional and security needs and the development of an individualized service-delivery plan that addresses these needs. Any assistance offered is based on the wishes and needs of the client. A trained social worker or nurse at the OSC will be responsible for the initial intake of the survivor, developing an individualized service-delivery plan and calling the OSC's multi-disciplinary team for a first briefing to decide upon and initiate the individualized service-delivery plan. The survivor should understand principles of consent and confidentiality of information. For reasons of psychosocial well-being or safety, the survivor can stay at a safe room for a limited period.

(c) ***Providing PEP kits, medical care services, surgery equipment and medical consumables.*** Survivors will receive preventative and curative medical services and follow-up in a confidential manner. The medical service providers from the OSCs will use the Manual for Medical Management of SGBV survivors (MoH, 2009). The medical doctor at the OSC will be in charge of medical care, treatment and evidence protection. Prevention will include Post Exposure Prophylaxis (PEP, 72 hours), emergency contraceptives (120 hours), prevention of Sexually Transmitted Infections

(STIs), and vaccinations against Hepatitis B and tetanus, as needed. In addition, other basic medical care services will be provided. All medical care and medication will be adapted to the age of the patient. For more serious cases, additional specialized medical support, including for example for fistulas, prolapsed uterus or other obstetric problems, will be provided.

(d) ***Medico-legal support.*** The medical doctor in the OSC will be in charge of medical forensic evidence collection and responsible for completing the standard medico-legal form from the Rwanda National Police (RNP). The project will provide support for additional equipment for evidence collection, including digital cameras. The medico-legal exam will only be carried out upon consent from the survivor. The RNP is in charge of evidence protection and collection from the crime scene. Survivors, including guardians in the case of children, must give consent to release any information to individuals or agencies other than the police or prosecution. Although in Rwanda professionals working with children have a legal duty to report to the authorities any and all suspicion of child abuse or neglect, the child cannot be forced to undergo a medico-legal (forensic) exam.

(e) ***Mental health and psychosocial support.*** Survivors will be screened for commonly found conditions of mental distress and receive from nurses or social assistants specialized psychotherapeutic interventions such as Cognitive Processing Therapy (CPT). The social assistants will also provide family mediation as needed. More severe cases of mental disorders will be referred to a psychologist or psychiatrist, or to the specialized mental health clinic in Kigali. The mental health providers will liaise with the social workers of the OSC for follow-up at the community level. Mental health support will also be provided to family members as needed.

(f) ***Legal aid.*** In the OSC, a police officer will be responsible for taking statements and ensuring legal follow-up. A legal representative based in the OSC or attached to the center will provide legal advice to the survivor, including providing information about the rights of survivors of SGBV, legal procedures available, as well as potential difficulties of pressing charges in court to allow the survivor to make an informed decision. If the survivor decides to initiate a legal process, the support provided will include free legal counseling and representation, transport, as well as "*accompagnement*" of the survivor and the family. The legal support will be provided by the *Maisons d'Accès à la Justice* (MAJ) or Access to Justice Offices (AJO) at the decentralized level. The social worker or nurse from the OSC will work in close coordination with the legal aid provider to ensure additional support when needed, including mental health support to reduce potential renewed post-traumatic stress. If a survivor's point of entry for support is through the legal aid system, the legal aid provider will liaise with the OSC for further follow-up and case management.

28. To be able to provide the above services to survivors, the project will strengthen the capacity of service providers at the OSCs including medical personnel, psychologists, social workers, legal experts and police officers. Capacity building will include: case management and

referral; evidence and DNA collection, analysis and use in courts; medical support for survivors; mental health support; and legal aid support. Capacity building will also be provided for actors providing services for survivors outside of the OSCs, including prosecutors, legal aid officers and police gender desks.

29. The project will use the updated comprehensive guidelines/protocols on prevention and response to SGBV and child abuse, including the MDIIT training manual (under development), and the multi-disciplinary Standard Operating Procedures (SOP). The project will also support developing specialized manuals for support to male and child survivors, legal aid, forensic evidence collection and others as needed. Experts in their respective areas will develop methodologies and training manuals, and train trainers (ToT). The experts and ToTs will continue to provide technical advice, follow-up and supervision to the service providers inside and outside the OSCs. Finally, selected service providers will also be trained in sign language.

30. To promote peer-to-peer learning, regular learning events for service providers will be organized to provide refresher trainings, as well as exchange of experiences in providing services to survivors. Given the sensitive and potentially difficult nature of working with survivors of SGBV, measures such as self-care plans, support groups, and rotating staff between different departments of the hospital will be put in place to support OSC staff.

Component 2: High Impact Basic Health Services (US$34.03 million)

DRC (US$31.69 million)

31. **The objective of this component is to expand utilization and quality of a package of health interventions targeted to poor and vulnerable females**. The project will channel financial resources to health facilities in thirteen priority health zones covering about 2.6 million inhabitants through Performance-Based Financing (PBF), an approach in which health facilities are paid a fee for service for a defined package of basic essential health services conditional on the quality of services delivered. The thirteen health zones to be supported have been selected based on the following criteria: (i) levels of sexual and gender based violence; (ii) utilization and quality of health services; and (iii) absence of partners supporting the health zone in terms of sexual violence and primary health care.

Sub-component 2.A: Improving utilization and quality of health services (US$24.47 million)

32. The first sub-component will support interventions aimed at improving utilization and quality of health services through performance-based contracts as follows:

i. *Funding performance based quarterly subsidies* to health facilities, including upfront quality improvement funds for the targeted facilities.
ii. *Supporting essential drugs* to promote improvements in quality of basic services.
iii. *Strengthening regulatory capacities* by funding performance based contracts for regulatory entities (Health Zone teams, and Provincial Health teams).

Figure 2.1: High Impact Interventions

CONTINUUM OF CARE

	Health centers	Health zone hospitals
Preventive care	• FP: New acceptors and renewal (oral & inj) • Women covered by modern methods of family planning • Household visits for IEC on key practice (waste management, clean toilets, bed-nets, clean water access, FP utilization, immunization)	• Women covered by modern methods of family planning (oral, injection) • Women covered by modern methods of family planning • Cases of ligatures and vasectomies
Pregnancy care	• Antenatal care : new pregnant woman • VAT 2+: woman fully protected • 4th antenatal care visit – standard • High risk pregnancy referred to hospital with retro information • PMTCT- Women informed of the result of the test	• PMTCT- Women informed of the result of the test
Birth care	• Eutocic delivery with qualified health worker	• Referred pregnancy with eutocic delivery • Referred pregnancy with dystocic delivery • Referred pregnancy with C-section
Newborn/postnatal care	• Postnatal care at 6 weeks • Care of a newborn from a HIV+ woman	
Childhood care	• Growth monitoring for children between 6-59 months with deworming • Fully immunized children	
Curative care	• Curative visit (new case) • Severe case referred to the hospital (and counter referral available)	• Referred curative visit with retro-information – doctor • Counter referral with documentation • Hospitalization (intern medicine, obstetric, pediatric) • Minor surgery • Major surgery

33. **Health facilities in the two provinces will sign contracts with the two purchasing agents, stipulating the health services to be delivered**. This will include 105 facilities in North Kivu and 153 facilities in South Kivu, including referral hospitals. The contracts will be signed with the existing Performance Purchasing Agencies in each province: EUP-FASS (*Fond d'Achat des Services de Santé*) in North Kivu and AAP (*Agence d'Achat des Performances*) in South Kivu. The key interventions to be purchased consist primarily of high impact maternal and reproductive health services which are critical across the continuum of care at both the health center and hospital level, as shown in the table below.

34. **Prior to initiating the PBF approach, several priority activities will be carried out with funding from a US$6 million Project Preparation Advance (PPA).** First, a health facility survey will be conducted to assess the availability, quality, utilization and costs of health services in the targeted health zones. Second, a workshop will be organized with representatives of the provincial health teams and performance purchasing agencies from the Kivus to review and finalize the PBF manual for the project. Third, PBF training will be conducted at different levels of the health system: from training of provincial trainers, then training of health zone teams and health facility staff in all targeted health zones, and finally communication about PBF for CODESA (*Comité de Développement de Santé*- Health Committees at the health facility level) and the communities. Fourth, various clinical trainings for health staff will be conducted to strengthen capacities to ensure quality of key maternal and reproductive health services with a focus on: (i) family planning; (ii) obstetrical and neonatal emergency care; (iii) antenatal care; (iv) drug management; and (v) waste management and infection control.

35. **At the inception of the project, quality improvement funds will be provided to all participating facilities to ensure minimal capacity is in place.** To receive this one time amount, health providers will prepare "*business plans*" stipulating how funds will be used (e.g. minor rehabilitation, equipment) to achieve coverage objectives and improve quality of care.

36. **Quarterly payments to health facilities will be made after verification of results by an independent party.** Facilities will receive payments on a sliding scale depending on quantity of services provided, adjusted for quality. Subsidies will be used partly to reinvest in the facility according to the activities in the business plans and partly to improve health worker motivation, as described under the implementation arrangements section.

37. **The project will fund the initial replenishment of essential drugs to ensure quality care at participating health facilities in the targeted zones, allowing facilities to use revenues from the PBF scheme to procure drugs subsequently.** Procurement and distribution of medicines and health commodities will be done through the *Système National d'Approvisionnement en Médicament* (SNAME). Products will be purchased by health facilities from ASRAMES (*Association Régionale d'Approvisionnement en Médicaments Essentiels*), which is a private not-for-profit organization responsible for procuring drugs for the Eastern provinces of DRC. The pharmaceutical wholesaler has established a good quality assurance system and has been prequalified by USAID.

38. **The project will strengthen the Health Zone and District Health teams to perform their regulatory functions related to the performance based scheme.** These teams have a

crucial role to play in improving quality of health services: health zones teams are in charge of the quarterly quality evaluations of health centers while district health teams are responsible for the quarterly quality evaluations of hospitals.

Sub-component 2.B: Improve access to health services for the most vulnerable (US$3.92 million)

39. **This sub-component will provide support to the most vulnerable groups in the targeted health zones to overcome financial constraints to accessing health services.** To this end, three main activities will be supported:

- **Conducting a household survey** to identify constraints to accessing care, with a particular focus on impediments to accessing maternal and reproductive health services for the poorest women.
- **Identifying the poorest households in the thirteen health zones**. In both provinces, rigorous criteria for identifying the poorest groups have already been defined and used. These criteria will be updated and refined based on the findings from the household survey. The identification process will be validated by community health workers and community representatives with the list of beneficiaries provided to facilities.
- **Funding health services through the Provincial Health Equity Funds for identified poor in health centers of the thirteen targeted health zones.** Health centers will directly bill the cost of services delivered to identified poor groups to the Purchasing Agencies, and then will be reimbursed quarterly through payments, after verification that services have been delivered to identified people. It is estimated that around 10 percent of the population of the two provinces would benefit from subsidized health care.

Sub-component 2.C: Strengthening the Performance Purchasing Agencies for management of PBF (US$3.3 million)

40. **This sub-component will finance the management cost of the two Performance Purchasing Agencies to implement PBF in the additional health zones.** The PPAs have strong experience in implementing PBF in their provinces, and extending coverage for 2.6 million inhabitants will require additional staff, equipment and operating costs. The PPAs will be responsible for contracting health facilities and regulatory entities and verification of results prior to payment as discussed under the section on implementation arrangements.

41. **The project will fund the operating costs of the PPAs to perform these activities in the additional health zones.** Equipment (e.g. computers), transportation means (i.e. motorbikes) will be procured, and transportation costs will be financed for the verification and monitoring of activities. In South Kivu, an annex office rented from a local faith based organization will be reopened in Shabunda to cover health zones of Shabunda and Lulingu which are only accessible by plane from Bukavu. Finally, the project will fund the operation of a PBF web-based system to facilitate reporting and ensure transparency.

Burundi (US$ 2.34 million)

42. The project will also expand *maternal, reproductive and emergency obstetric services* at participating hospitals/health centers and strengthen *referral systems* to boost the continuum of care. These activities are complementary to interventions supported under a parallel health sector operation which provides financial incentives to health facilities through the national performance based financing scheme. The main focus of the proposed project will be on addressing unmet needs, developing specialized services, and targeting underserved groups.

43. To this end, the project will support training of medical personnel in emergency medicine and complex surgery; training and support of health facility personnel and community health workers to promote use of modern contraceptives, ensure women benefit from the 4 recommended antenatal care visits and from assisted deliveries. The interventions will strengthen capacity of the three hospitals under component 1 to provide quality and timely support for a broad range of procedures which suffer from large gaps (e.g. emergency obstetric and neonatal care; surgical contraception; fistula repairs; complicated delivery including cesareans; and reproductive cancers). Training of service providers will be provided by trainers available at health districts according to the various subject matters in the *Obstetrical and Neonatal Emergency Care*. Some theoretical and practical training will be carried out in partnership with specialized agencies for SGBV and RH activities.

44. The project will finance specialized equipment and consumables, and expansion of rapid mobile phone applications for alerting personnel of medical emergencies and strengthening referral and counter referral systems. The project will also strengthen the institutional capacity of the National Reproductive Health Program (PNSR) to better plan and program activities.

45. The participating hospitals and health centers will strengthen their capacity to identify cases of SGBV among women who visit the hospitals using key services as entry points (e.g. antenatal care, family planning, and HIV testing). To facilitate early detection of SGBV cases, *screening tools* will be introduced, tested and adapted, ensuring close coordination with the establishment of SGBV services to facilitate referral. Capacity building will be provided to health providers to ensure that screening tools are used in a confidential, appropriate and sensitive manner.

46. To complement activities under the SGBV component, the project will support expansion of *youth friendly services* at selected health centers and community structures in the catchment areas of the three hospitals. The project will provide assistance to develop educational materials, support peer educators and other youth appropriate techniques to raise awareness about reproductive health and gender based violence through health centers and community structures (FCDCs), and train health personnel on the provision of youth friendly reproductive health services. This support will build on the existing '*Centres de Santé Amis des Jeunes*" approach, in partnership with UNFPA. Specialized NGOs and CBOs will be contracted to expand the youth friendly, community based model which aims to use existing health centers at dedicated hours to provide services to youths in an acceptable manner. The model has already been established at 18 locations nationwide within proximity of primary and secondary schools.

Component 3: Regional and National Knowledge Sharing, Research and Capacity Building (US$22.42 million)

47. This component will fund activities which will bring together stakeholders from the three participating countries as well as member states from the ICGLR as a community of practitioners who are embarking on a common agenda. The component will fund: (a) Regional Learning and Capacity Building, (b) Research and Surveys, (c) Communications, and (d) Project Management. The goal is to assist countries to document good practices, and share across ICGLR member states examples of what is working and what is not working, and ensure that lessons learned are translated into policy implications and programmatic actions. The section below provides a description of activities to be supported in each country as well as the ICGLR.

DRC (US$7.2 Milion)

48. In DRC the project will support the following activities:

(a) ***Regional and National Knowledge Sharing and Capacity Building*** by: (i) documenting and sharing innovative activities to promote gender equality, SGBV, and strengthen maternal health through PBF; (ii) funding study tours to neighbouring countries (including on SGBV and PBF programs); (iii) promoting knowledge sharing at the regional and national levels, including supporting or participating in annual peer learning events on SGBV and PBF organized by the ICGLR and/or by the countries; and (iv) participating in high quality regional training programs. Each year, DRC will host a learning event for all participating countries. Congolese authorities will assist to organize site visits to innovative programs in the Kivus which address the needs of survivors of SGBV and which promote behavioral change and gender equality, and share information on programmatic developments. In alternate years, Congolese participants will participate in learning events in the other countries to learn from their experience in key thematic areas, such as mental health (Rwanda), One Stop Centers (Rwanda, Burundi), performance based financing (Burundi), and learning events organized by the ICGLR. In addition, other learning events as identified by GoDRC and IDA will be supported at the national or provincial level to facilitate peer-to-peer learning among services providers for SGBV as well as maternal and reproductive health, CBOs, NGOs and VSLAs. Finally, DRC will organize select training, capacity building activities, and study attachments for interested participants from the other countries.

(b) ***Research and Surveys.*** The project will support research on various thematic areas, such as: (i) understanding the underlying causes of SGBV; (ii) assessing the impact of selected service delivery models for survivors and women of reproductive age through quantitative and qualitative surveys; (iii) evaluating the effectiveness of screening tools for early identification and referral of women at risk of gender based violence; (iv) assessing the impact of introducing community score cards (*Tuungane*), to complement other community verification mechanisms, as a means to engage communities in the provision of health services, give them voice, and serve as a grievance mechanism, (v) conducting research on SGBV by existing centers of

excellence (Heal Africa and Panzi); and (vi) assessing the impact of introducing community score cards; and (vii) evaluating the impact of interventions aimed at perpetrators.

(c) Communications. At the national and local levels, communication aspects will include (i) development and implementation of a national communications strategy, and (ii) support to mount media campaigns during the *16 days of Activism Against Gender Based Violence*. In addition, this sub-component will support the MoGFC to develop and implement in selected areas a communication strategy for the dissemination of the to-be-adopted revised Family Code. At the provincial level, communication aspects will be implemented by the GSDRC and the PHDs.

49. In addition, this component will provide support for *project management* including support to carry out efficient and effective coordination, fiduciary management, monitoring and evaluation at national and local levels through technical assistance, institutional strengthening and equipment.

Burundi (US$7.05 million)

50. In Burundi, the project will fund:

(a) ***Regional learning and capacity building.*** This component will support the following activities: (i) documenting and sharing innovations to promote gender equality, address SGBV and violence prevention, and strengthen maternal health and youth friendly services; (ii) funding study tours to neighboring countries; (iii) promoting knowledge sharing at the regional and national level, including participation in annual peer learning events, and expanded collaboration in the East African Community joint reproductive health program; (iv) participating in high quality regional training programs, such as, *inter alia*, the fistula repair training provided at specialized facilities in Democratic Republic of Congo; and (v) carrying out institutional capacity building to support a local institution to serve as a center of excellence for research and training on SGBV. Details of specific training activities will be included in the annual work plans.

(b) **Regional and surveys.** This component will provide support to conduct research on: (i) understanding the underlying causes of SGBV and the effects of interventions aimed at changing behaviors and norms; (ii) assessing the impact and effectiveness of the one stop center model for survivors of SGBV; (iii) evaluating the effectiveness of screening tools for early identification and referral of women at risk; (iv) assessing the effectiveness of the youth friendly services model in responding to the special needs of youths; (v) understanding knowledge, attitudes and practices with respect to RH, SGBV and HIV/AIDS; and producing reliable data and information on SGBV and RH; and (vi) evaluating the efficiency and effectiveness of the approach chosen for the empowerment of women. Some of the specific activities to be funded include: (i) analysis of the situation at baseline and end of the project with respect to SGBV and youth friendly services at participating hospitals and facilities, systematically measuring changes in provider behavior and quality of care; (ii) KAP (Knowledge, Attitudes and Practices) survey among adolescents to ascertain knowledge, attitudes and practices with respect to

RH, SGBV and HIV/AIDS, and contribute to designing appropriate interventions; and (iii) support for funding the SGBV module of the 2014 DHS to get a better handle on levels and patterns of SGBV. In addition, Burundi will take advantage of the additional resources being mobilized by the World Bank team to participate in the impact evaluation on violence prevention and gender equality.

(c) ***Communications***: The project will fund the: (i) development and implementation of a national communications strategy, including support to mount campaigns during the 16 days of Activism Against Gender Based Violence; and (ii) installation of video conferencing facilities at participating hospitals and ministries to facilitate communications within and across countries. The Ministry of Gender will be responsible for developing and implementing a national communications strategy, including production of multi-media messaging, banners, and radio programs. To this end a full-time communications specialist will be recruited to work on the national SGBV communications strategy and the project specific communications activities. The communications specialist will support the production of a Bulletin Letter to be produced annually to share what the project has achieved and to disseminate information on latest developments on SGBV and reproductive health.

(d) **Project Management** to achieve efficient and effective coordination, fiduciary management, monitoring and evaluation of the project through technical assistance, capacity building, institutional strengthening and equipment for MoH and MNSHRG. It includes support for: (i) recruiting a technical focal point and an assistant M&E Officer for the existing Project Coordination Unit within MoH; and (ii) strengthening capacity of the coordination structure within MNSHRG through the recruitment of three additional technical staff (technical focal point, operations officer, and communications expert) and training of the Procurement Unit staff. In addition the project will provide office equipment and materials, and will cover some of the operational costs to ensure that coordination entities have sufficient means for supervision and monitoring of project activities.

Rwanda (US$5.17 million)

51. In Rwanda, this component will support: (i) Regional and National Learning and Capacity Building; (ii) Research and Surveys; (iii) Communication; and (iv) Project Management.

(a) ***Regional and National Learning and Capacity Building*** by: (i) carrying out institutional capacity building to support a local institution to serve as a CoE for research and training on SGBV; (ii) documenting and sharing innovative activities to promote gender equality, address SGBV, and violence prevention; (iii) funding study tours to neighboring countries; (iv) promoting knowledge sharing at the regional level, including supporting or participating annually in peer learning event; and (v) participating in high quality regional training programs.

The project will support establishing the CoE in a pre-existing, publicly used and owned building which has been identified in Kigali. The CoE's mission will be to

provide high quality research and statistics related to SGBV, child abuse and other forms of violence to the public, policy makers, law enforcement personnel and other SGBV practitioners. The Center's main activities will include: (i) research; (ii) data collection building upon ongoing data collection systems and surveys by the current *Isange* OSCs, the justice sector, and the Gender Monitoring Office; (iii) training and capacity building at the national and international level; and (iv) center of information for media and sensitization campaigns. The project will support upgrading the identified building for the CoE as well as providing equipment for the center, including for hosting international conferences and video-conference facilities. The CoE will be managed by MIGEPROF and include MoH, RNP, MINIJUST, MINALOC and MoD.

Each year, a regional learning event between the three countries of the regional project will take place for selected training, capacity building and exchanges of experiences addressing the needs of survivors of SGBV. The participating countries in the regional project will alternate hosting the learning event. In addition, other cross-regional learning as identified by GoR and IDA will be supported at the national level, including for example learning from successful OSCs, DNA testing and programs promoting behavioral and norm changes in other countries in the region.

(b) ***Research and Surveys*** on various thematic areas, such as: (i) understanding the underlying causes of SGBV; (ii) assessing the impact and effectiveness of selected service delivery models for survivors of SGBV through quantitative and qualitative surveys; (iii) evaluating the effectiveness of screening tools for early identification and referral of women at risk; (iv) research to understand the effect of interventions aiming at changing behaviors and norms and violence prevention, and (iv) SGBV in general through research and training on SGBV by centers of excellence. In addition, a centralized gender based violence integrated management system will be developed.

As part of the research, an impact evaluation will be carried out in collaboration with IDA. The impact evaluations will focus on understanding the impact of interventions aiming at changing behaviors and norms regarding gender roles and SGBV to promote violence prevention and gender equality, or service provision to survivors of SGBV. In each of the participating countries for the project, separate impact evaluations will be carried out in order to tailor the survey instruments and questions to each country context. A comparative component will be included, enabling learning between countries on what does and does not work. IDA is mobilizing resources for a Bank-executed Trust Fund to provide technical assistance to support the proposed impact evaluations in the three participating countries.

The centralized gender based violence integrated management system will be housed within MIGEPROF.[23] The system will provide a simple system to collect, store and analyze the data, and to enable the safe and ethical sharing of reported SGBV incident

[23] The GBVIMS will build upon the GBVIMS initiative which was launched in 2006 by UNOCHA, UNHCR, and the IRC. The GBVIMS Steering Committee currently includes UNFPA, UNICEF, UNHCR, IRC and WHO.

data. In each OSC, links with the centralized database for data entry will be developed.

(c) Project Management including support to carry out efficient and effective coordination, fiduciary management, monitoring and evaluation at the national and local level through technical assistance, capacity building, institutional strengthening and equipment. This will also include support for regular joint technical assistance and follow-up visits for partners involved on the OSCs to promote continuous learning and capacity building.

ICGLR (US$3.0 million)

52. For the ICGLR, this component will support: (i) Regional Learning and Capacity Building and (ii) Regional Communication to raise awareness on SGBV. It will also support Program Management and Institutional Capacity Building with a view of supporting ICGLR's capacity to deliver its mandate.

(a) ***Regional Learning and Capacity Building*** by: (i) operationalization of the RTF to deliver high quality regional training programs, and (ii) promoting knowledge sharing at the regional level.

(i) Operationalization of the RTF to deliver high quality regional training programs. The project will support the RTF to develop and implement two high quality regional training programs related to SGBV for Training of Trainers (ToTs) of member states of the ICGLR in line with the *Strategic Plan for the ICGLR Regional Training Facility on the Prevention and Suppression of SGBV, 2014 – 2017*. Initial priority areas identified for training include professionals from the judiciary and police. The RTF will: (i) develop an implementation strategy for training; (ii) develop curricula including reviewing good practices and existing training manuals regionally and internationally; (iii) identify regional experts and ToTs; (iv) develop and translate training materials; and (v) develop e-learning materials and web hosting for selected modules.

The RTF will roll out the ToTs for the selected topics including providing initial training and certification, organizing refresher training and peer to peer learning, and facilitating ongoing training by regional experts through e-learning tools for wider participation of trainees. The trainings will be implemented at the regional level, combined with national trainings as appropriate. The modules will be validated by the ICGLR member states to promote standardized curricula providing common frameworks to address and prevent SGBV in accordance with existing international and regional legislation, resolutions, standards and policies, as well as protocols, resolutions and frameworks of the ICGLR.

In addition, the project will support the RTF to develop a website to disseminate existing international, regional and national legislation protocols, and resolutions related to SGBV, knowledge and good practices on SGBV, curricula and training

materials, as well as a database of regional and international experts addressing issues on SGBV. The website will establish linkages with existing knowledge repositories covering SGBV. Finally, support for operational cost of the RTF including monitoring and evaluation will be provided.

(ii) *Promoting knowledge sharing at the regional level.* The project would support the ICGLR to organize regional workshops for all ICGLR member states to share knowledge, experience and good practices from the implementation of the regional project in Burundi, DRC and Rwanda related to SGBV. Potential areas of knowledge sharing include for example: (i) addressing mental health issues for survivors of SGBV; (ii) cost-effective interventions for survivors of SGB; and (iii) perpetrators of sexual violence. In collaboration with IDA, impact evaluations will be carried out in the three countries of this regional project. At least one regional knowledge sharing workshop will build upon the mid-term results of these impact evaluations.

In addition, the ICGLR will organize two regional symposiums bringing together policy makers, researchers, practitioners and the Regional Women's Forum on selected priority areas under the Kampala Declaration. Objectives of these regional symposiums will include to (i) take stock of current SGBV policies and programming lessons of national governments, civil society organizations and international organizations; (ii) exchange information among researchers, policy makers, and practitioners about the latest research efforts related to causes, scope and patterns of sexual violence; (iii) strengthen the community of knowledge and practice in the ICGLR, and (iv) build a network of regional technical experts addressing issues of SGBV. One symposium will focus on violence prevention, including (i) promoting behavioral changes to promote gender equality and reduce levels of violence, and (ii) reaching out effectively to the next generation for future violence prevention.

(b) *Communication* including (i) development and implementation of communication tools in the GLR related to SGBV; and (ii) capacity building on media and communications to address SGBV and facilitating networks of communication professionals. The CS validated a *'Regional Communications for Development Strategy for Addressing SGBV in the GLR'* in 2013. The strategy aims to harness the regional comparative advantage of the CS by providing direction on media and communications activities to achieve the objectives of the Kampala Declaration and present a united message on SGBV across the GLR. The project will contribute to the implementation of the strategy through supporting specific activities under the initiative's established *Intervention Strategies.*

(i) Development and implementation of communication tools in the GLR related to SGBV. The development and implementation of communication tools in the GLR will include rolling out of the following regional campaigns in selected Member States: (a) *"Zero Tolerance Now"* campaign in line with Decision 7 of the Kampala Declaration. The campaign aims to raise awareness, reduce stigma and occurrence of SGBV in communities through sensitization activities launched on the International Day for the Elimination of Violence against Women. Ministers of Gender and Justice

have committed to launching the campaign annually from 2012. (b)*"Are You Man Enough To Stop SGBV?"* campaign which aims to engage young men and boys in addressing SGBV through promoting honorable values of manhood and by exposing young men to positive community role models within the context of gender equality and SGBV prevention. The Campaign is rolled out over a 12 month period starting with community-based activities and culminating at the national level with the "Man of the Year" competition. In addition, the project will support strengthening the SGBV section of the ICGLR website with linkages to the RTF including quarterly SGBV GLR newsletter and yearly reports on progress of implementation of the Kampala Declaration.

(ii) Capacity building on media and communications to address SGBV and facilitating networks of communication professionals. The project will also support training of journalists, media professionals and ICGLR Communication Focal Points on strategic messages, appropriate SGBV reporting, communications tools and channels to address SGBV. In addition, the project will facilitate a network of the communication professionals to maintain continued dialogue on consistent SGBV messaging and media reporting in the GLR through an electronic forum (linked to website).

(c) ***Program Management and Institutional Capacity Building*** including support to carry out efficient and effective coordination, fiduciary management, monitoring and evaluation, capacity building, institutional strengthening and equipment. The project would support institutional strengthening of the ICGLR, building upon the recently carried out institutional assessment supported by GIZ. In addition, the strengthening of fiduciary capacity of the ICGLR will be complementary to ongoing support from USAID and the AfDB. Support provided will also include (i) supplying video conference facilities at the CS offices as well as the RTF to improve communications with member states, partners and community of practice and provide cost efficiencies; (ii) training on resource mobilization focusing on the private sector and philanthropic entities to generate new sources of funding and revenues for better program activities and a move toward sustainable results; (iii) supporting the establishment of a Partner Forum including development partners supporting the ICGLR to update partners on ICGLR progress, priorities and activities; and (iv) supporting development of a monitoring and evaluation framework for the implementation of the Kampala Declaration, as well as compiling national report for annual regional updates on the Kampala Declaration.

Table 1
List of Project Supported Health Facilities in DRC[24], Burundi and Rwanda

Location	Catchment Population	Potential Refugees, IDPs, and Cross Border Populations	Services to be Provided	
			Integrated Services for Survivors of SGBV	High Impact Basic Health Services
DRC	**3,448,371**			
North Kivu[25]	**2,069,130**			
Birambizo	121,080		X	
Binza	113,682		X	
Kayna	200,301		X	
Kirotche	424,453		X	X
Nyiragongo	137,381		X	X
Rutchuru	151,162	IDP camp (Kiwanja)	X	
Alimbongo	213,463			X
Mabalako	185,001			X
Kayna	200,301			X
Rwanguba	143,308			X
Mweso	178,998	IDP camps (Kivuye, Nyange, Mpati)	X	
South Kivu	**1,379,241**			
Fizi	305,806		X	X
Kimbi Lulenge	178,603	Some recent displacement	X	X
Lulingu	157,389		X	X
Minova	236,482	IDP camps	X	X
Shabunda	178,212		X	X
Kaniola	160,425		X	X
Lemera	162,324			X
BURUNDI				
Cibitoke (West)	265,019	Border with DRC	X	X
Makamba (South)	206,795	Border with DRC	X	X
Muyinga (East)	272,302	Border with	X	X

[24] The situation of IDPs differs substantially between North and South Kivu. According to the U.N., as of January 2014, North Kivu hosted 1.07 million IDPs while nearly 579,000 IDPs are known in South Kivu, with current conflict dynamics causing daily changes in numbers. A substantial influx of refugees has been seen from the CAR (over 60,000), adding to the total refugee population of 260,800 in DRC according to UNHCR (December 2013). An important difference between the two provinces is that in North Kivu the majority of IDPs are in established camps or informal sites whereas in South Kivu there are few camps with the majority of registered IDPs living in host families.

		Tanzania		
RWANDA	**5,910,614**			
Masaka (Kicukiro district)	295,455		X	
Muhima (Nyarugenga district)	284,561			
Kibagabaga (Gasabo district)	530,907		X	
Kilinda (Karongi district)	331,571	Close to Kiziba refugee camp	X	
Mugonero (Karongi district)	331,571	Close to Kiziba refugee camp	X	
Kibogora (Nyamasheke district)	383,138			
Kabaya (Ngororero district)	333,713		X	
Murunda (Rutsiro district)	323,251			
Gitwe (Ruhango district)	322,021		X	
Kaduha (Nyamagabe district)	342,112		X	
Kibilizi (Gisagara district)	322,803	Close to Gisagara refugee camp		
Rutongo (Rulindo district)	288.452		X	
Nyamata (Bugesera district)	363,339		X	
Nemba (Gakenke district)	338,486			
Ruli (Gakenke district)	338,486			
Gahini (Kayonza district)	346,751		X	
Kiziguro (Gatsibo district)	433,997	Close to Nyabiheke refugee camp		

Annex 3: Implementation Arrangements

A. Institutional and Implementation Arrangements

DRC

1 Implementation arrangements have been designed to take into account the multi-sectoral features of the project, the decentralized nature of the activities, the weak capacity and the coordination limitations within the DRC public sector which need to be addressed for the project to attain its development impact. The Project Implementation Manual (PIM) will describe the implementation arrangements in more detail and guide implementation. The arrangements include a high-level Steering Committee, the Ministry of Finance (MoF) as the coordinating ministry and three implementing agencies. This proposed implementation model aims to strike a balance between strong inter-sectoral coordination and the autonomy required for timely and effective implementation.

2 While MoF will ensure overall project oversight through its project coordination unit - *Cellule d'Exécution des Financements en faveur des Etats Fragiles* (CFEF Unit), which has coordinated the project preparation. The implementation of the project components will be the responsibility of the designated implementation agencies, which are the Ministry of Public Health (MoPH) at the provincial level, the Social Fund of the Democratic Republic of Congo (FSDRC), the Ministry of Gender, Family and Children (MoGFC), and Heal Africa and the Panzi Foundation.

3 **Steering Committee.** A high level Steering Committee will be maintained through an amendment to the existing ordinance signed by MoF. The Steering Committee will be chaired by MoF or his representative and composed of representatives from the Ministries of Public Health, Gender, Family and Children, Social Affairs, Interior, as well as the Social Fund. UNICEF, as co-lead with the MoPH for the *Multi-Sectoral Response for Survivors Pillar* of the national strategy to combat SGBV, will participate as an observer. The Steering Committee will be responsible for: (i) providing overall strategic direction; (ii) approving the work plan and the annual consolidated budget; and (iii) ensuring consistency with the policies and strategies of the Government.

4 **Coordination of the Project.** The CFEF unit under the MoF will be responsible for the overall coordination of the administrative and fiduciary aspects of the project, namely tracking and reporting of results, ensuring procurement and financial management, channeling funds to implementation agencies and consolidating Annual Work Plans and Budget (AWPB). The project components will be executed by the implementation agencies, specifically MoPH at the provincial level, FSRDC and MoGFC. Selected activities will be implemented by Heal Africa and Panzi Foundation. The procurement actions will be executed by the executing agencies, except for selected national activities (e.g. project communications) and activities for the MoGFC for which the procurement will be executed by the CFEF unit.

5 **Project Execution at the Social Fund of the Democratic Republic of Congo.** The FSDRC, a public organization created in 2002, will implement Sub-Component 1A *Integrated support for survivors of SGBV and prevention of violence at community level,* as well as selected activities under Component 3 *Regional Knowledge Sharing, Research and Capacity Building.* FSRDC has successfully managed the US$102 million IDA-financed Emergency Social Action Project (ESAP) and its two additional financings (2004-13), and is currently implementing the recently approved US$79 million IDA-financed Eastern Recovery Project (ERP).[26]

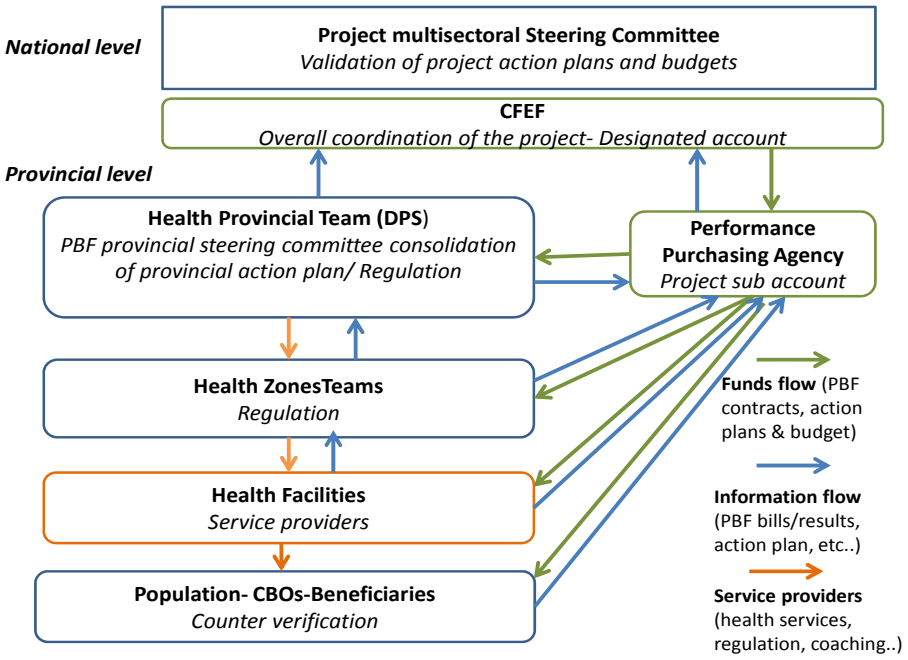
6 FSDRC will be responsible for implementation of its project activities through its headquarters in the capital and offices in both of the Kivu provinces. FSRDC responsibilities will include: (i) selecting, sub-contracting and supervising executing agencies (primarily NGOs) to work directly with communities and CBOs; (ii) selecting and contracting consultants to carry out studies and evaluations; (iii) financial management and procurement in accordance with Bank rules; and (iv) monitoring and reporting overall implementation of its activities.

7 To promote a consistent and agreed approach for service provision to survivors, the project will recruit highly experienced technical umbrella NGOs that will develop methodologies, training manuals and implement Training of Trainers (ToT) in their respective area of expertise (for example judicial, case management and economic and social support of survivors at community level, and supporting CBOs). To implement the activities, the project will recruit local implementation partners who will be trained by the technical umbrella NGOs. The technical umbrella NGOs will also provide continuous technical advice, follow-up and supervision to the local implementation partners. At least every 6 months, the technical umbrella NGOs will organize a workshop with all local implementation partners for peer to peer learning and develop a network of service providers.

8 **Project Execution in the Ministry of Public Health.** Overall coordination will be ensured by the Provincial Health Directorates (*DPS-Division Provinciale de la Santé*). The overall institutional arrangements for Component 2 (High Impact Basic Health Services) are illustrated in figure 2 below. At provincial level, the health directorates with support from the Performance Purchasing Agencies (PPAs) will be responsible for preparing *provincial annual work plans* and *budgets*. At national level the CFEF will consolidate work plans and budgets from both provinces and transfer funds from the designated account to PPA sub-accounts, following approval by the Steering Committee. Representatives of the national PBF unit will be part of the project Steering Committee and will provide strategic advice on the approach to be used in the Kivus.

[26] The Implementation Completion Report (ICR) of the project and its two additional financings confirms the impressive results achieved despite the challenging context as well as the good reputation enjoyed by the implementing agency –including a reputation for good governance and high technical quality.

Figure 3.1: Overall implementation arrangements for component 2



9 **Implementation of activities will follow best practices in terms of performance based schemes with a clear separation of functions between the different institutions.** Health facilities will be responsible for delivering services while regulatory functions will be performed by provincial health authorities at different levels. The PPAs will be responsible for contracting service providers and regulatory entities.

10 ***Service delivery*:** Health facilities (public and private not for profit) in the thirteen selected health zones will be responsible for providing quality and timely health care services. These facilities will sign contracts with their respective PPAs.

11 ***Regulatory functions*:** The provincial health directorate (*DPS- Division Provinciale de la Santé*) is in charge of regulating the health system at the provincial level. To strengthen their regulatory capacity, each directorate will sign a performance contract with the respective PPA stipulating their roles and responsibilities, how their performance will be measured on a quarterly basis, and how they will be remunerated. The main responsibilities of the DPS are to: (i) strengthen coaching of the Health Zones and District Teams; (ii) organize and participate in peer quality assessments of hospitals; (iii) improve quality control of authorized organizations distributing drugs and other health commodities; and (iv) participate regularly in the provincial PBF steering committees.

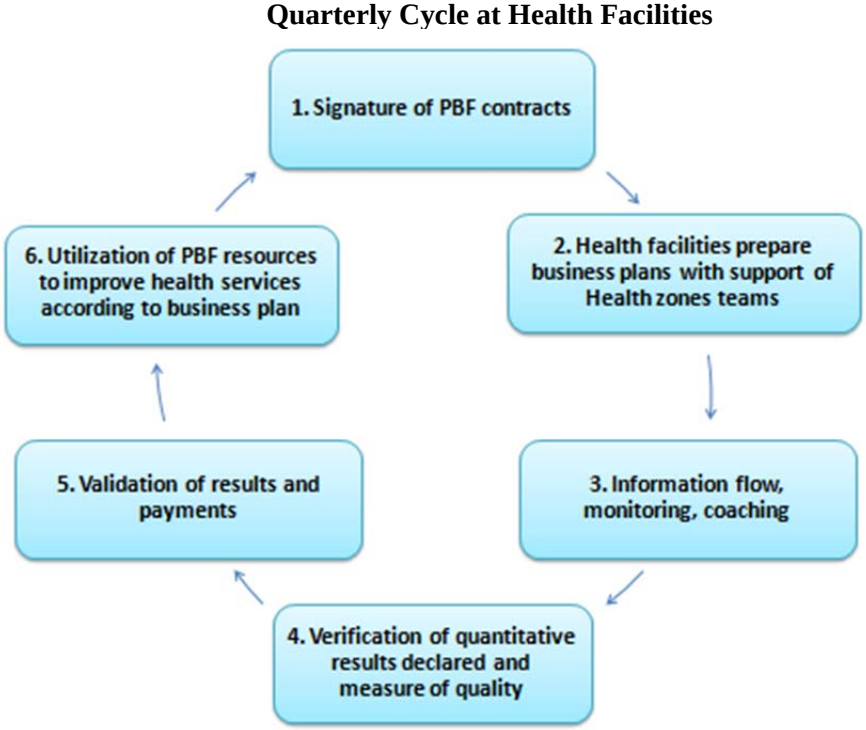
12 The *Health District Teams* are responsible for regulating the health system at the peripheral level. The Health District Teams will sign contracts with PPAs holding them accountable for: (i) conducting supervision missions of health zones teams; (ii) participating in quality assessments of hospitals; (iii) organizing the PBF district steering committees; and (iv) conducting training and capacity building for the health zone teams.

13 The *Health Zone Teams* will be responsible for ensuring regulatory functions at the health zone level**.** To this end, the health zone teams will sign contracts with PPAs to: (i) organize quarterly quality assessments at each health center; (ii) coach health facility personnel and support them in developing and implementing their business plans; and (iii) consolidate and analyze data from facilities and provide feedback so that health providers can improve their performance.

14 ***Performance Purchasing*:** The two PPAs will be in charge of purchasing services from health providers. To this end, they will sign performance contracts with health facilities, as well as with the regulatory entities (i.e. DPS, health districts and health zones teams). Contracts with health facilities will include the list of interventions to be provided; the quality check-list to be applied; and the contractual commitments of each party (e.g. preparation of business plans, coaching, quality improvements, payments, and verification mechanisms). Payments will be made quarterly following independent verification and depending on results in terms of quantity and quality of services. The PBF output budget will be on average about US$2.3 per capita annually. This amount was calculated using the ongoing experience of the two PPAs, estimated needs of the health zones and support provided by other partners, and necessary amounts to improve motivation of health workers. The estimated budget for improving access to health care for the 10 percent of the population considered to be the most vulnerable is about US$3.5 per capita annually. The system will work on a quarterly cycle, as shown in Figure 3.

15 The two purchasing agencies are autonomous, have a strong track record implementing performance based schemes, and managing other donor funded programs. The provincial health directorates and other partners are represented on the boards of each agency. In South Kivu, the agency (*Agence d'Achat des Performances*) is a not-for-profit association which has a mandate to improve the quantity and quality of health services, ensure broad based access, and promote community participation. The institution has managed performance funding since 2006, serving as the fiduciary agency for different partners (e.g. Cordaid, European Union, UNICEF, UNDP, Dutch Cooperation and GAVI). In North Kivu, the purchasing agency (*Fonds d'Achat des Services de Santé*) is also an autonomous public service institution established with the mission of "managing funds of different partners and the government for interventions to improve access to quality health services." The agency currently has a devolution convention from MoF to manage European Union funds and implement the performance based approach.

Figure 3.2: Performance Based Financing



16 ***Verification:*** An independent and transparent verification process is critical to the performance based approach, in order to ensure credibility of the process and reliability of the results. Verification will involve a three-pronged process:

a. *AAPs will verify quarterly the quantity results declared by health facilities* (i.e. checking consistency between quantity of services delivered in health facility bills and health records).
b. *Community based organizations will perform quarterly counter verifications* (AAPs will contract local organizations to verify if patients listed in health records exist and have in fact received the mentioned health service, to avoid "ghosts patients").
c. *AAPs will verify quarterly results achieved by Health Zone teams*, as stated in their performance contracts.

17 ***Data Management*:** A web-based database will ensure transparency in the performance based data reporting and invoicing. The same platform used for data management of performance based financing in other provinces funded by the PARSS and by the USAID implementing partner MSH will be expanded to the Kivus taking into account specificities of their schemes. This web-enabled solution is similar to other PBF web-enabled applications such as in Burundi, Benin, Nigeria, Chad, and Zambia. This database would include both performance measures (quantity and quality) and financial data.

18 ***Community Involvement*:** Local Health Committees will be involved in the performance based approach through their participation/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 about user fee levels; and (iv) community verification of existence of users and assessment of patient satisfaction.

19 For *Sub-Component 1B: Integrated Support for Survivors of SGBV at Health Facility Level*. The PHDs will ensure training for service providers. Also, they will be responsible to identify health facilities for the proposed support, develop annual work plans and budgets, and monitoring visits. The health facilities (health centers, referral hospitals as the health zone level, and the provincial referral hospital in each province), will provide the package of services for survivors. The health facilities, as well as specialized mental health clinics, i.e. *SOSAME* in South Kivu and *Tulizo Letu* in North Kivu will receive contracts for services to be performed. In addition, the PHDs will receive contracts for supervision as well as technical assistance to be provided to the health centers providing support for survivors of SGBV. Given the sensitive nature of service provision to survivors of SGBV, the provision of free services as per the law, as well as the first time these type of services, including mental health services, are being mainstreamed in the health system, the performance based system used for Component 2 will not be used for Component 1. At mid-term review, the Bank team will evaluate the possibility of using the PBF system for service provision to survivors of SGBV.

20 For all capacity building, trainings will be developed and delivered by highly specialized NGOs, who will also provide training for ToTs, in close collaboration with the PHDs. The Provincial Health Authorities will take part in all training, in order to be able to conduct follow-up missions after training and to ensure knowledge transfer and sustainability. Capacity building will not be limited to training, and include continuous technical assistance and follow-up from the specialized NGOs during the first years of the project. For highly specialized training such as surgeries, the project will also support internships. Finally, the PHDs will liaise with the Universities in Bukavu and Goma to include agreed norms and tools for support to survivors of SGBV into the curricula for nurses and doctors.

21 Distribution of medicines will be different between North and South Kivu. In North Kivu, the project will use the architecture of the *Système National d'Approvisionnement en Medicament* (SNAME), with the *Centrale de Distribution Régionale* (CDR) –ASRAMES– responsible for distributing pharmaceutical products to health zones and each facility responsible for picking them up at the health zone warehouse. In South Kivu, where a CDR does not exist, the project will leverage a few faith-based organizations: *Bureau Diocésain des Œuvres Médicales* (BDOM), *8ème Communautés des Eglises Pentecôtistes d'Afrique Centrale* (CEPAC) and *Association Provinciale pour l'Approvisionnement en Médicaments Essentiels au Sud-Kivu* (APAMESK) to distribute products from Bukavu to the health zones. This is a relatively informal system used by implementing organizations including MSH and PSI. The provincial pharmaceutical focal point will organize the direct contracting of the distributors. ASRAMES will be responsible for bringing products to Bukavu.

22 Health products specific for component 1 (PEP kits, neuroleptics) will be managed in a different manner. They will be purchased by ASRAMES directly from pre-identified international suppliers (most likely UNICEF or UNFPA), will be stored separately and will be

distributed ad hoc to the GRH and health areas included in the component 1 using the same partners identified above. As these products will not be subject to any cost recovery, they will be directly contracted and financed by the project for the procurement and distribution activities.

23 The project provides an opportunity to strengthen pharmaceutical management capabilities at the periphery and the two PHD will be instrumental in coordinating these activities. In that regard, the project will complement a recently-approved World Bank-financed Human Development Systems Strengthening Project which focuses on national level strengthening of the pharmaceutical systems. This will be reflected in the performance frameworks that will be established for the different stakeholders and the training sessions that will be planned. Specific attention will be paid to forecasting and information flow optimization in order to prevent stock-out at the CDR, district and facility level.

24 **Project Execution in the Ministry of Gender, Family and Children.** The activities of the Ministry will focus on the national level. Overall coordination will be ensured by the Secretary General who will coordinate the preparation and monitor the implementation of an annual work plan. The CFEF will be responsible for procurement related to these activities, as well as payments. The Ministry's CGMP will participate in the procurement process of the project.

25 **Project Execution in Heal Africa and Panzi Foundation.** *Implementation of Sub-Component 1C. Support for existing integrated centers of excellence in the Kivu* will be implemented by Heal Africa in North Kivu and Panzi Foundation in South Kivu, based on contract for consultants. Each year, activities will be discussed at the Provincial level with the PHD and the FSDRC. In addition, both institutions will carry out selected research activities under Component 3.

26 ***Coordination of SGBV Activities and Role of Partners.*** Given the multitude of stakeholders and actors in the Eastern provinces, it is crucial that project-financed activities be planned and implemented in close coordination with other initiatives. The PHDs, FSDRC and Heal Africa and Panzi Foundation for their respective provinces, will participate in the existing technical working group on SGBV as well as the sub-technical working group on *Multi-Sectoral Assistance for survivors of SGBV* at the provincial, district and territorial level. These working groups include government representatives, UN agencies and NGOs involved with SGBV and aim to ensure a coordinated support for survivors of SGBV. At the provincial level, this working group is chaired by the Provincial Minister of Health and UNICEF. In turn, the results of the sub-technical working group for multi-sectoral assistance for survivors of SGBV will be shared with the Joint Technical Committees which were created by Presidential Decree in 2009 as the provincial coordination mechanism for all matters related to STAREC/I4S and stabilization/peacebuilding. The Joint Technical Committees meet every two months, are chaired by the Governor of the province, and include all relevant ministers as well as heads of international agencies, UN sections and international and national NGOs. Detailed programs and progress of activities are discussed in technical sub-committees. At the national level, the CEFE, MoPH and FSDRC will participate in the Thematic Cluster on SGBV chaired by the Ministry of Gender and Family, as well as the Technical Working Group for *Multi-Sectoral Assistance for survivors of SGBV* chaired by the MoPH and UN-Women.

Burundi

27 Technical coordination of the project will be handled jointly by the Ministry of National Solidarity, Human Rights and Gender (MSNDPHG) and the Ministry of Public Health and Fight against HIV/AIDS (MoH) through the General Directorate for the Promotion of Women and Gender Equality and the General Directorate of Health Services and HIV/AIDS in each respective ministry. The two General Directors will oversee implementation of activities under their respective mandates while putting in place a joint collaboration framework to ensure coherence of interventions. The *inter-ministerial framework* will facilitate collaboration in: (i) producing a consolidated annual work plan and budget; (ii) conducting quarterly coordination meetings; and (iii) generating consolidated financial management reports.

28 Implementation of project activities will be the responsibility of each ministry depending on its respective mandate. MoH will be responsible for establishing health services for survivors of SGBV and for strengthening complementary maternal, reproductive, obstetrical and youth friendly services. MNSHRG will be responsible for working within its existing structures to support community level interventions, conduct advocacy, and strengthen coordination and communications. The Ministry of Public Security will lead activities related to investigation and referral while the Ministry of Justice will lead activities related to the prosecution of perpetrators.

29 A *Steering Committee* will be established and will be chaired by the Permanent Secretary of MNSHRG and the Permanent Secretary of MoH who will play the role of Vice-President. The main responsibilities of this committee will be to: (i) approve the consolidated annual work plan and budget; (ii) review the annual project implementation reports (technical and financial) from stakeholders; and (iii) provide overall direction to ensure synergies between activities carried out by stakeholders. The Steering Committee will meet twice a year and will be composed of technicians from the following sectors: gender, health, police, justice, finance, as well as other partners working in the area of SGBV and reproductive health.

30 MoH will be responsible for the overall fiduciary management of the operation and will open and manage a Designated Account for the project. The MoH already has a project implementation team with demonstrated experience working on other World Bank-financed health projects, including the ongoing Health Sector Development Support Project and the East Africa Public Health Laboratory Networking Project which is strengthening laboratory capacity at two of the three hospitals to be supported under this project. Thus, this new operation will rely on this existing structure to take advantage of its expertise with Bank financial management and procurement procedures. In order to accommodate the additional workload stemming from the new project, the current coordination unit will be strengthened by adding a technical focal point who will handle the day-to day management of the new project. The focal point will report to the General Director of Health Services of MoH.

31 Within MNSHRG a lighter structure will be put in place. The unit will be responsible for coordinating project activities under the mandate of the Gender Ministry, and will support the ministry to strengthen its ability to coordinate SGBV activities more broadly, including strengthening communications. The unit will be accountable to the General Director for the Promotion of Women and Gender Equality. The structure will include a technical focal point, an

operations officer and a communications expert, and will benefit from capacity building activities to achieve an acceptable level of technical and fiduciary knowhow capacity for managing World Bank-funded operations. This capacity building will consist of a combination of hands-on training by the MoH project coordination unit, and participation in training courses on fiduciary management provided by the Bank and other institutions. An advance account will be opened within the MNSHRG and will be replenished based on tranches for activities carried out by the Ministry.

32 For activities under the responsibility of the Ministry of Public Security and Ministry of Justice, disbursements will be made directly to service providers by the MoH project coordination unit, on the basis of requests submitted by the respective ministry. No accounts will be opened in these ministries for the purpose of this project. MoH will sign a simple Memorandum of Understanding with these ministries, stipulating activities to be carried out, personnel to be assigned to the OSCs, and clear deliverables.

33 Organizations with proven SGBV and RH-related capacity will be recruited to provide technical support in carrying out the project activities in areas where they have a strong track record and a comparative advantage. This will be the case for capacity building activities for various actors involved in the implementation of the project. The goal is to work through specialized NGOs in the first years of the project, and gradually transfer knowledge and expertise so that within a few years these structures will have the capacity to carry out activities on their own. It is expected that contracts will be signed between the respective ministries and the specialized organizations, defining clearly the activities to be carried out, specific deliverables, and the institutional and financial arrangements to be used in order to ensure close coordination.

Rwanda

34 Key Ministries involved in issues related to SGBV are: MIGEPROF, in charge of coordination, awareness raising and prevention of SGBV and child abuse and with a key role at the legal and policy level; Ministry of Health (MoH), in charge of ensuring free medical care, medical forensic investigation, and psychological care and follow-up; Ministry of Justice (MINIJUST), in charge of ensuring free legal counseling (through for instance the MAJ and legal aid forums), investigation and transmission of the cases to the court; Rwanda National Police (RNP), in charge of ensuring police and forensic investigation; and Ministry of Local Development (MINALOC), in charge of linkages with social protection programs. In addition, the Ministry of Defense (MoD) also provides support to survivors of SGBV at the Kanombe military hospital, as well as prosecution of perpetrators from the army. Project implementation arrangements will build upon the already existing strong coordination mechanisms between different line ministries as per the *National Scaling-up Strategy for OSCs*, as well as implementation arrangements put in place for the support from the Government of the Netherlands to scale up the OSCs.

35 Overall coordination of the project will be the responsibility of MIGEPROF. At the national level, the following Committees will follow overall progress of the project:

- A *Steering Committee*, chaired by MIGEPROF, and comprising of MoH, RNP, MINALOC, MINIJUST and the Gender Monitoring Office (GMO). The Steering Committee will meet on a 6-monthly basis to assess progress of the overall project. In addition, the Steering Committee will approve the annual work plan and budget (AWPB) before submitting to IDA for approval.

- A *Technical Committee*, chaired by MIGEPROF, and comprising of MoH, RNP, MINALOC and MINIJUST will coordinate and follow-up on implementation of the project. The Committee will meet on a quarterly basis to discuss progress of the project by activities, identify potential challenges and develop mitigation measures to address these constraints. Finally, the Committee will be responsible for preparing the annual work plan and budget.

36 The Single Project Implementation Unit (SPIU) within MIGEPROF will serve as the executing agency of the proposed project. MIGEPROF will coordinate day-to-day activities of the project, and implement selected activities under Components 1 and 2. The SPIU will be strengthened with a project coordinator, a financial management specialist, a procurement specialist and a monitoring and evaluation specialist, all of which will be recruited competitively, based on agreed upon Terms of Reference (ToRs) and technical skills and qualifications. The SPIU's main responsibilities will include:

- Developing and applying a Project Implementation Manual (PIM);

- Preparing in close coordination with the Technical Committee the AWPB;

- Contracting out as needed services and activities, based on transparent procedures for assessment and award;

- Reporting on a regular basis, including: (i) program implementation progress reports; (ii) financial monitoring reports; and (iii) updated procurement plans on a six month basis;

- Monitoring with support from a qualified Environmental Consultant as needed, the Environmental Management Plan, Medical Waste Management Plan and safeguard issues in the project;

- Developing and implementing a communication strategy for the project; and

- Coordinating with line ministries involved in service provision for survivors of SGBV and child abuse, as well as violence prevention and promoting gender equality, including MoH, RNP, MINIJUST, MINALOC, MoD and GMO.

37 For Sub-component 1B, *Integrated Support for Survivors of SGBV at Health Facility Level*, MoH will be the lead institution, through its SPIU. The SPIU will be strengthened with an accountant, a project officer and a Monitoring and Evaluation (M&E) officer, all of which will

be recruited competitively, based on agreed upon ToRs and technical skills and qualifications. The SPIU's main responsibilities will include:

- Identifying and assessing sites for the OSCs;
- Guaranteeing that all established OSCs adhere to the same standards and provide the same high quality services to all victims of SGBV and child abuse;
- Ensuring that in each OSC, necessary staff as per the *National Scaling-up Strategy for One Stop Centers in Rwanda* will be in place;
- Implementing of the EMP and the MWMP;
- Providing services for survivors of SGBV and referrals as needed in accordance with the PIM; and
- Coordinating closely with MIGEPROF, RNP, MINIJUST and MINALOC for activities related to their respective areas of support for survivors of SGBV.

38 MINIJUST will be in charge of ensuring free legal counseling through for instance the MAJ and legal aid forums, as well as for training of judicial staff. The RNP will be responsible for criminal investigation of SGBV and child abuse cases, including collecting evidence from the crime-scene and training for police officers and Police Gender desks.

39 To ensure complementarity of this project with ongoing support to address SGBV by the One-UN and bi-lateral donors including the Governments of the Netherlands, the UK and Switzerland, MIGEPROF will organize bi-annual meetings with stakeholders supporting programs related to SGBV and violence prevention.

ICGLR

40 While countries will have the overriding responsibility for implementing activities at the national level, ICGLR will play a critical convening role, supporting regional knowledge sharing and advocacy efforts in SGBV. The Conference Secretariat (CS), based in Bujumbura, acts as the technical arm of the ICGLR and is in charge of coordinating, facilitating, promoting, and monitoring the implementation of the Pact and other initiatives to attain sustainable peace, security, stability and development in the GLR. Overall coordination of this project will be the responsibility of the CS.

41 The Executive Secretary of the CS will (i) provide overall strategic direction; (ii) approve the Annual Work Plan and Budget (AWPB) before submitting to IDA for approval; and (iii) ensure consistency with the policies and strategies of the ICGLR.

42 The ICGLR will set up a Project Implementation Unit (PIU) within the CS. The PIU will be responsible for the overall coordination, day-to day implementation, and supervision of the project. The PIU will be strengthened with a full time project coordinator and a senior financial management specialist. In addition, a procurement consultant will be hired on a retained basis to support procurement activities and build capacity of ICGLR in World Bank procurement

processes. The RTF will be supported by an accountant. In addition, existing staff from the CS will be part of project implementation, including staff from the RTF, as well as the Gender, Women and Children Program, Administrative and Finance, Communication, and Monitoring and Evaluation units. The PIU will report to the Deputy Executive Secretary of the ES. All staff to be supported by the project will be recruited competitively, based on agreed upon Terms of Reference (ToRs), technical skills and qualifications. The PIU's main responsibilities will include:

a. Developing and applying a Project Implementation Manual (PIM);

b. Preparing the AWPB and Procurement Plans;

c. Contracting out as needed services and activities, based on transparent procedures for assessment and award;

d. Ensuring transparent and accountable administration of project resources (including procurement and financial management);

e. Reporting on a regular basis, including: (i) program implementation progress reports; (ii) financial monitoring reports; and (iii) updated procurement plans on a six month basis;

f. Coordinating with the other regional centers;

g. Organizing bi-annual meetings of the Partner Forum;

h. Monitoring and evaluation; and

i. Dissemination of internal and external audit reports and implementation of their recommendations.

B. Financial Management

Background

43 As part of the preparation of the project, Financial Management (FM) assessments of all implementing entities in DRC, Burundi and Rwanda at both the central and the decentralized levels, as well as for the ICGLR were carried out. The seven implementing entities are as follow: Ministry of Finances and PHDs in both Kivus as well as the FSDRC at the national and provincial levels, Ministry of Health and Fight Against HIV/AIDS (MoH) and the Ministry of National Solidarity, Human Right and Gender (MNSHRG) in Burundi; Ministry of Gender (MIGEPROF) and the Ministry of Health in Rwanda, and the Conference Secretariat (CS) at the ICGLR.

44 The objectives of the assessment were to determine whether these entities have adequate financial management arrangements to ensure that: (i) project funds will be used for purposes

intended in an efficient and economical way; (ii) project financial reports will be prepared in an accurate, reliable and timely manner; and (iii) the project's assets will be safeguarded. Financial management assessments were carried out in accordance with the Financial Management Practices Manual issued by the Financial Management Sector Board on November 3, 2005 as revised in March 2010.

Country issues

45 DRC and Burundi are gradually emerging from a decade of political instability, conflict, and mismanagement of public finances. Recently, structural reforms have been launched in the areas of economic governance, public expenditure management, and transparency.

46 **In DRC**, the ongoing *Projet de Renforcement des Capacités en Gouvernance* (PRCG) and the *Projet de Renforcement des Capacités en Gestion des fonctions de bases de l'Administration Publique* (PRCGAP) as well as the new Public Financial Management Program (PFMAP) will continue strengthening the DRC PFM system both at the central and provincial levels. The proposed project will be entrusted at the CFEF unit, and rely on the Western Growth Pole Project and the FSDRC's fiduciary arrangements that will be strengthened.

47 **In Burundi**, the Financial and Private Sector Development Project (P107851) has been helping the country to strengthen capacity in both public and private administration and tackle corruption and mismanagement. Although there is cause for cautious optimism and significant improvements have been made in PFM during last years, it will take some time for these reforms to yield substantial improvement in the management of public funds in the two countries.

48 **With regards to Rwanda**, the various Public Financial Management (PFM) assessments carried out for the last five years revealed that the Government of Rwanda has taken and continues to take significant steps to improve its PFM system. Most of the recommendations contained in these reviews have either been implemented or are being implemented; the comparison between 2007 and 2010 PEFA shows that PEFA scores improved in almost all categories. The timeliness of financial reporting has improved with all the Central Government ministries submitting the annual financial statements within the statutory period. For the last two years, timeliness and the quality of the audit reports prepared by the Auditor General has improved.

Risk Assessment and Mitigation Measures

The overall risk rating at preparation is *High* for DRC, Burundi and ICGLR while it is *Substantial* for Rwanda. The risk features are determined over two elements: (i) the risk associated to the project as a whole (inherent risk); and (ii) the risk linked to a weak control environment of the project implementation (control risk). Risks and mitigation measures are as follows:

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Y/N)	Residual Risk
Country level Risk arising out of CPIA ratings on question 13 (quality of budgetary and financial management) and question 16 (transparency, accountability and corruption) in the public sector. The PER, the PEFA as well as the UCS reports outlined PFM weaknesses at central and decentralized government levels as well as sector ministries level in term of governance and public funds management in DRC and Burundi?. There are still serious concerns arising from the operation of the Integrated Financial Management System (IFMIS) in Rwanda and quality of audit reports remains a challenges.	H for DRC and Burundi, S for Rwanda	The governments of all three countries are committed to a reform program that includes strengthening of the PFM, through among others ongoing IDA-financed projects PRCG and PRCGAP as well the recently approved PFMAP in DRC; the Private Sector Program in Burundi. However, it is unlikely these programs will yield results quickly enough to impact the proposed project. The assessment of IFMIS in Rwanda has been conducted and the new version has been issued which still needs some improvement. Use of project-specific procedures is required for this project.	N	H for DRC and Burundi, S for Rwanda
Entity level For DRC and Burundi, the assessment of some implementing entities, through the Public Expenditure Finance Assessment (PEFA) and the Use of Country Systems (UCS), revealed internal control weaknesses and weak fiduciary environment. In Rwanda, MIGEPROF and MoH have good	H for DRC , Burundi and ICGLR S for Rwanda	Use of project-specific fiduciary procedures will be required for this project and critical for mitigating the fiduciary risk of this project. In all countries, as well as at the ICGLR, existing FM teams will be strengthened with financial management specialist	N	H for DRC and Burundi, S for Rwanda and ICGLR

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Y/N)	Residual Risk
regulatory framework which include financial rules. For implementing the project, there could be however a delay in coordinating within the ministries and submitting relevant reports to the WB and GoR. ICGLR has financial and regulation rules revised in 2007 which governs its overall fiduciary arrangement. The assessment of ICGLR by some donors revealed internal control weaknesses and weak fiduciary environment due to non-compliance with rules and regulations.		with extensive experience with WB fiduciaries procedures.		
Project level This project will be implemented across different levels with challenges for effective coordination. Ensuring funds are used for purposes intended will be a bottleneck. In DRC and Burundi, the implementing entities at the decentralized level for the provincial directorates of health and Ministry of Gender in Burundi do not have experience implementing World Bank financed projects. The ICGLR has limited FM capacity In addition, activities will be implemented in Burundi and Uganda, with the risk of additional coordination challenges.	S for DRC, Burundi and ICGLR, M for Rwanda	Training on fiduciary procedures will be conducted for all FM staff throughout the life of the project. Clear TORs for each staff will be agreed upon and included in the manual of procedures. Ex-ante and ex-post control will be strengthened by ensuring clear separation of duties. The scope of external auditors and FM supervision will include review of expenditures incurred at all levels.	N	S for DRC, Burundi and ICGLR, M for Rwanda
Control Risk	**S**			**S**
Budgeting The budgeting process is fairly complex. Inputs are required from all implementing entities which could result in delays in the preparation of the budget; weak budgetary execution and control; risk that the institutions to which funds are sent do not spend all their funds in a timely fashion and do not report on what they have	S for DRC, Burundi and ICGLR, M for Rwanda	The project Financial Procedures Manual will define the arrangements for budget preparation and execution as well as annual detailed disbursement forecasts. Interim Financial Reports will provide information on budgetary control and analysis of variances between actual and planned budget.	N	S for DRC Burundi and ICGLR, M for Rwanda

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Y/N)	Residual Risk
spent.		The Annual Work Plans and Budgets will be prepared by the project implementing units at the decentralized levels, and consolidated at the central level by the project coordinating units.		
Accounting This project will use the accounting software as for all other World Bank financed projects in DRC and Burundi. The project coordinating unit will acquire TOM2PRO to accommodate financial information of this project. For Rwanda the IFMIS will be revised and used for this project. ICGLR uses the accounting software PASTEL which will also be used for this project. Risks include (i) Poor policies and procedures, (ii) delay in keeping reliable and auditable accounting records, and (iii) increased workload leading to delays in submitting FM reports.	S for DRC , Burundi and ICGLR, M for Rwanda	The project will adopt the OHADA accounting system. Accounting procedures will be documented in the manual of procedures; the FM functions will be carried out by qualified consultants (individuals); additional accountants to be recruited on competitive basis where need be; and the existing software will be customized to take into consideration the need for this new project. The fiduciary staff will be trained in the use of the software at all level.	N	S for DRC Burundi and ICGLR, M for Rwanda
Internal Control, Insufficient safeguards and controls may result in misuse of funds and impact the implementation of the project. The existing manual of procedures at the CFEF unit in MoF in DRC, MoH in Burundi MIGEPROF in Rwanda as well as ICGLR will be revisited and adapted to accommodate the specific need of this project. ICGLR currently does not have an internal audit unit.	S for DRC, Burundi and ICGLR, M for Rwanda	Revision and adoption of a FM Procedures Manual and training on the use of the manual by all fiduciary staff recruited for this purpose. It is expected that they will be in place before project effectiveness. Strengthen the internal audit units to ensure that the project complies with fiduciary procedures.	N	S for DRC, Burundi and ICGLR, M for Rwanda

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Y/N)	Residual Risk
Funds Flow (i) Risk of misused funds; (ii) delays in disbursements of funds to Implementing entities and beneficiaries; (iii) delay of replenishment of Designated Accounts (DAs) at the central level.	H for DRC and Burundi, S for ICGLR, M for Rwanda	Mitigation measures include: (i)bottleneck leading to slow of disbursement will be identified; (ii) payment requests will be approved by the FM Manager prior to disbursement of funds; (iii) the ToRs of the External Auditors will include physical verification of goods, services acquired; and (iv) the respective Steering Committee will approve the consolidated annual budget of the project.	N	S for DRC Burundi and ICGLR, M for Rwanda
Financial Reporting For the three countries, the risk is to have inaccurate and delayed submission of IFRs to IDA due to delays from Implementing entities. For ICGLR, given no previous experience with IDA projects, limited capacity of FM team as well as delays in financial reporting for other donors; additional risk include FM reports may not be up to standards.	S for DRC, Burundi and ICGLR, M for Rwanda	(i) A computerized accounting system will be used and IFRs format will be customized. (ii) IFR and financial statements formats and content will be discussed during project negotiations. IFRs template will be included in the FM manual of procedures. (iii) close follow-up by IDA on FM reporting including training	N	S for DRC Burundi and ICGLR, M for Rwanda
Auditing For DRC and Burundi, the nationals audit capacity is weak and not reliable. Qualified external auditor will be appointed to audit the project for DRC, Burundi as well as ICGLR. While for Rwanda, the Auditor General will conduct the audit as for all other WB's financed projects. The risks include (i) delay in submission of audit reports or qualified opinion, and (ii) delays in the implementation of audit report recommendations.	S for DRC Burundi and ICGLR, M for Rwanda	For DRC, Burundi and ICGLR, the project's institutional arrangements allow for the appointment of adequate external auditors and the ToRs will include field visit and physical verification of project assets. Annual auditing will be carried out during the project implementation period in accordance with ISA. Auditor's recommendations will be monitored during project supervision missions.	N	S for DRC , Burundi and ICGLR, M for Rwanda

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Y/N)	Residual Risk
Governance and Accountability In Burundi, DRC and ICGLR, possibility of circumventing the internal control system with colluding practices as bribes, abuse of administrative positions, misprocurement etc., will be a critical issue.	S for DRC , Burundi and ICGLR, M for Rwanda	(i) The TOR of the external auditor will comprise a specific chapter on corruption auditing. (ii) FM procedures manual approved before project effectiveness. (iii) Robust FM arrangements (qualified individual FM staff recruited under ToRs acceptable to IDA), quarterly IFRs, including budget execution and monitoring. (iv) Measures to improve transparency such as providing information on the project status to the public and encouraging participation of civil society and other stakeholders are built into the project design.	N	S for DRC, Burundi and ICGLR, M for Rwanda
OVERALL FM RISK	H for DRC, Burundi and ICGLR, S for Rwanda			H for DRC Burundi and ICGLR, S for Rwanda

Financial Management Action Plan for the Three Countries and ICGLR to Reinforce the Control System

Issue	Remedial Action Recommended	Responsible Entity	Completion Date	FM Conditions
FM staffing	For DRC, recruitment of one additional accountant at the CFEF unit (combined with HDSSP), the FSDRC at national level, and additional accountants at the PHDs. For Rwanda, recruitment of one senior financial management specialist at MIGEPROF and one accountant at the MoH For ICGLR recruitment of one senior financial management specialist at the CS and one accountant at the RTF	Respective Implementing Entities	Three months after effectiveness	N
Accounting software	For Burundi and DRC, acquire TOM2PRO train the fiduciary staff on the use of this software. For Rwanda, upgrade the Integrated Financial Management and Information System (IFMIS) For ICGLR, upgrade PASTEL system to accommodate project	Respective Implementing Entities	Three months after effectiveness	N
FM and accounting Manual of procedures	For the three countries and ICGLR, prepare a project manual of procedures which will include FM and accounting aspects.	Respective Implementing Entities	Three months after effectiveness	N
External auditing	Selection of external auditor for DRC Burundi, and ICGLR	Respective Implementing Entities	Six months after effectiveness	N
Launch workshop	Organized a launch workshop for all beneficiaries, including a discussion of the manual of procedures	Respective Implementing Entities	Three months after effectiveness	N

DRC

49 *Implementing Entity.* The existing fiduciary team within the MoF will have the overall responsibility for coordination of administrative and fiduciary aspects of the project, tracking and reporting results, financial management reporting and ensuring smooth flow of funds to different agencies and institutions. The team will be reinforced by one additional accountant who will be recruited through a competitive process. The FSDRC at the national level and PHDs will each also recruit an additional accountant. The World Bank reserves the right to review the resumes of the identified experts and provide comments before formal appointment. The overall selection should be finalized before effectiveness. The fiduciary team will be trained on the use of World Bank procedures as well as project's software.

50 *Planning and Budgeting.* The Annual Work Plan and Budget (AWPB) along with the disbursement forecasts will be prepared by the FSDRC at the national level and the PHDs at the provincial level. The documents will be submitted to the CFEF unit within the MoF for consolidation into a single project AWPB. The AWPB will be approved by the National Steering Committee and submitted to IDA no later than December 31 annually for the forthcoming year when the work plan should be implemented.

51 The implementing entities will monitor its execution with the accounting software in accordance with the budgeting procedures specified in the manual of procedures and report on variances along with the quarterly interim financial report. The budgeting system needs to forecast for each fiscal year the origin and use of funds under the project. Only budgeted expenditures would be committed and incurred so as to ensure the resources are used within the agreed upon allocations and for the intended purposes. The quarterly Interim Financial Reports (IFRs) will be used to monitor the execution of the AWPB.

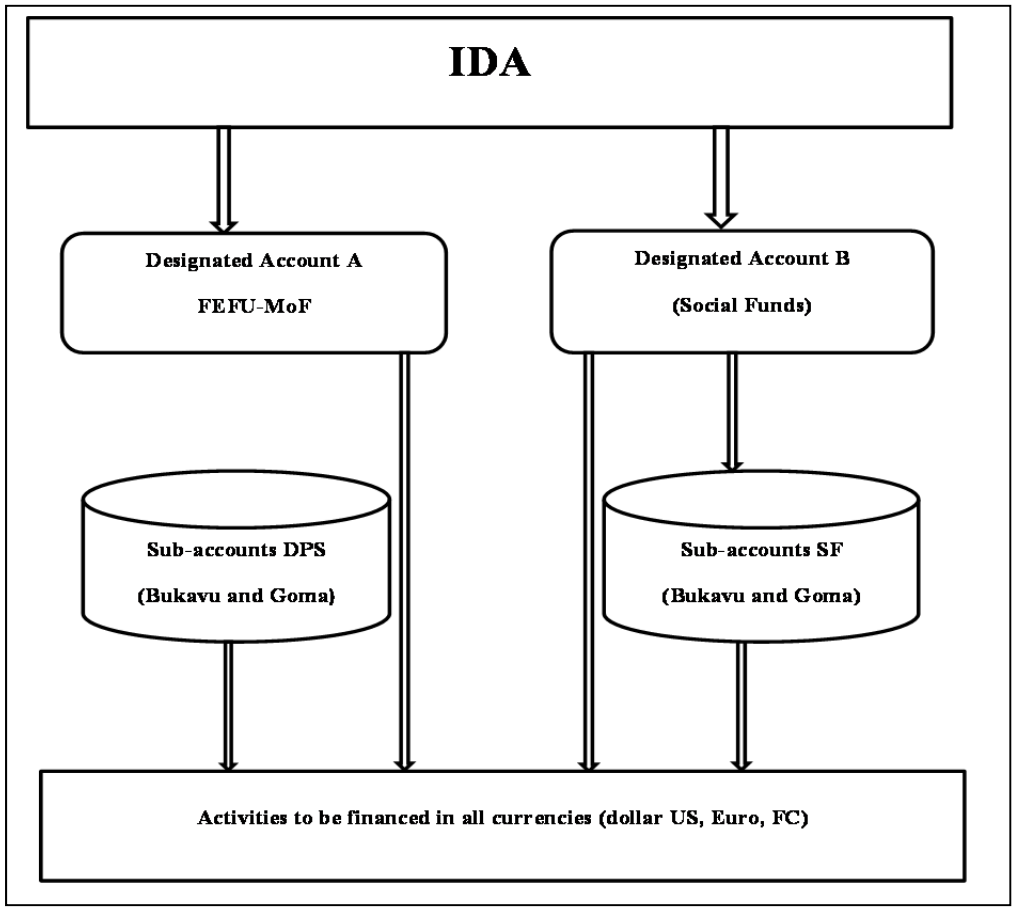
52 Information and Accounting System. The WGPP's manual of procedures currently used by the CFEF unit details the accounting policies and procedures which are in line with the Congolese accounting principles. This manual will be revised to include the new project. Integrated financial and accounting systems are already in place and being used by the fiduciary units (SUCCESS at the CFEF unit, TOMPRO at the FSDRC and the PHDs). This accounting system is multi-project, multi-site and multi-donor. The CFEF unit will acquire TOMPRO2 under this project. Newly recruited fiduciary staff will be trained in the use of the software within three months of project effectiveness.

53 Internal control and financial, administrative, and accounting manual. The existing implementing units both at the central and decentralized levels have a financial management manual which provides details on key internal control procedures from transaction initiation, review, approval recording and reporting. The manuals have to be updated within three months after project effectiveness to take into consideration any specific concerns relating to this project. There should be clear separation of duties within the financial management units. Terms of reference of the internal auditors at all levels will be revisited to take into account the specificity of this project; the internal auditors will report directly to the Steering Committee and the CFEF unit as well as the FSDRC at the national level. All control deficiencies or circumvented practices identified will be communicated in a timely manner to the overall senior management of the project for immediate corrective action as appropriate. One of each such report will also be communicated to the World Bank.

54 **Flow of Funds:** Two Designated Accounts (DAs) will be opened at a reliable commercial bank: one DA to finance activities to be managed by the CFEF unit within the MoF and a second DA to be managed by the FSDRC. The ceiling of these DAs will be set at US$2.9 million for the DA at the CFEF unit, and at US$0.8 million for the DA at the FSDRC equivalent to four months expenditures forecast and will become effective upon grant effectiveness. These DAs will be used to finance all eligible project expenditures under the different components and payments will be made in accordance with the provisions of the manual of procedures. The CFEF unit and the FSDRC will open sub-accounts at the provincial level which will be used to pay all expenditures at the decentralized level. Replenishment of these accounts will be done at least once a month by the project against submission of acceptable expenditures along with supporting

documents. Payments from the sub-accounts will be subject to acceptable arrangements for the Bank. The DAs will be replenished against withdrawal applications supported by Statements of Expenditures (SoEs) and other documents evidencing eligible expenditures as specified in the Disbursement Letter (DL). All supporting documents should be retained at the project and readily accessible for review by periodic IDA implementation support missions and external auditors.

55 *Disbursement method:* Upon Grant effectiveness, transaction-based disbursements will be used during the first year of the project implementation. Thereafter, the option to disburse against submission of quarterly unaudited IFRs (also known as the Report-based disbursements) could be considered subject to the quality and timeliness of the IFRs submitted to the Bank and the overall financial management performance as assessed in due course. In the case of the use of the report-based disbursement, the DA ceiling will be equal to the cash forecast for two quarters as provided in the quarterly unaudited IFRs. The option of disbursing the funds through direct payments to suppliers/contractors for eligible expenditures will also be available for payments equivalent to twenty percent (20 percent) or more of the DA ceiling or US$200,000. Another acceptable method of withdrawing proceeds from the IDA grant is the special commitment method whereby IDA may pay amounts to a third party for eligible expenditures to be paid by the Recipient under an irrevocable Letter of Credit (LC). The funds flows diagram for the DA are as follows:



56 *Disbursement of Funds to other Service Providers and Suppliers.* The CFEF unit and FSDRC will make disbursements to service providers and suppliers of goods and services in accordance with the payment modalities, as specified in the respective contracts/conventions as well as the procedures described in the manuals of procedures (Administrative, Accounting, and Financial Manual). In addition to these supporting documents, the CFEF unit and FSDRC will consider the findings of the internal auditor while approving the payments. In particular, the CFEF unit and FSDRC, with the support of their internal audit unit, will reserve the right to verify the expenditures ex-post, and refunds might be requested for non-respect of contractual clauses. Misappropriated activities could result in the suspension of financing for a given entity.

57 *Disbursements by category.* The table below sets out the expenditure categories to be financed out of the Grant. This table takes into account the prevailing Country Financing Parameter for DRC in setting out the financing levels. In accordance with Bank standard procurement requirements, contracts will continue to be approved "all taxes included" for local expenditures. The project will, however, claim invoiced amounts excluding taxes. The Government will take appropriate steps to cover the tax portion of contracts signed by the project with contractors and suppliers of goods and services.

Category	**IDA / Amount of the Financing Allocated (expressed in US$)**	**Percentage of Expenditures to be Financed (inclusive of Taxes)**
(1) Goods, Works, Non-Consulting Services, Consultants' Services, Operating Costs, Workshops and Training for the Project	42,232,000	100%
(2) PBF Grants under PBF Performance Contracts	25,627,000	100% of amounts disbursed
(3) Refund of Preparation Advance	6, 000,000	Amount payable pursuant to Section 2.07 of the General Conditions
TOTAL AMOUNT	**73,859,000**	

58 Financial Reporting: For the proposed project, the fiduciary team in the CFEF unit will be required to prepare monitoring financial reports as defined in the Financing Agreement for the project. These reports will be submitted to IDA on a quarterly basis within the 45 days following the end of each quarter. The reports will include: (i) a table with sources and use of funds; (ii) table with use of funds per activity; (iii) table regarding use of funds according to procurement methods and thresholds; and (iv) a table with monitoring and evaluation or physical advance of activities. Financial statements will be prepared for each financial exercise covering in general activities for the past twelve months. Interim financial statements will also be prepared taking into account: (i) certified status of expenditures; and (ii) an analysis of DAs management. The format of such reports has been agreed upon during project negotiations. It is expected that one single monitoring report will be prepared which will consolidate all levels before submission to the World Bank by the CFEF unit.

59 *External Audit:* The financial statements for the proposed project should be the object of an external audit prepared by an independent firm which should be selected according to procedures acceptable to the World Bank and other donors. The CFEF unit will be responsible for the selection of the external auditor, including preparing agreed upon ToRs between IDA and the GoDRC. The project will be required to submit to IDA, no later than June 30 of each fiscal year, the annual audited financial statements of the previous year. In line with the new access to information policy, the project will comply with the disclosure policy of the Bank for audit reports and place the information on its official website within one month after acceptance of final report by IDA.

60 *Governance and Accountability***.** The risk of fraud and corruption within project activities is high given the country political environment. In the context of the project, the effective implementation of the fiduciary mitigation measures should contribute to strengthen the control environment. Also, the appropriate representation and oversight of the Steering Committee involving key involved actors, as well as the transparency in both operation implementation and dissemination to stakeholders and the public should constitute a strong starting point to tackle governance and corruption issues during project implementation.

61 *Supervision.* The project will be supervised on a risk-based approach. It will comprise inter alia, the review of audit reports and IFRs and advice to task team on all FM issues. Based on the current risk assessment which is substantial the project will be supervised at least twice a year and may be adjusted when the need arises. An implementation support mission will be carried out before effectiveness to ensure project readiness. To the extent possible, mixed on-site supervision missions will be undertaken with procurement, monitoring and evaluation and disbursement colleagues.

62 *Conclusion of the FM Assessment.* The overall residual FM risk at preparation is considered *High.* The proposed FM arrangements for this project are considered adequate to meet the World Bank's minimum fiduciary requirements under Op/BP 10.00.

Burundi

63 The **Health Ministry** has good experience in coordinating IDA financed projects and is currently the implementing agency of the ongoing Health Sector Development Support Project (P101160) as well as the East Africa Public Health Laboratory Networking Project (P111556). Unaudited Interim Financial Reports (IFRs) for the two projects are submitted on time, reviewed and found to be satisfactory. The external auditors issued a clean audit report for the year ending June 2012 and the management letter from the external auditors did not raise any major issues; there are no overdue audit reports and interim financial reports from this entity. The unit is well staffed with four experienced persons; they have been trained on the use of World Bank fiduciary procedures.

64 The projects maintains proper books of accounts which include a cash book, ledgers, journal vouchers and a contract register through the suitable Project software "TOMPRO." They prepare the necessary records and books of accounts which shall adequately identify, in accordance with accepted international accounting standards and practices. It is expected that this existing accounting system will be used for the implementation of this new project.

65 The **PARESI** also has a good financial management system in place which includes project software namely SAGE SAARI and an accounting manual of procedures. Staffing of this unit comprises one chief accountant, one accountant and one assistant accountant who has been trained on the use the financial management tools. However, the unit does not have experience in the use of World Bank fiduciary procedures (disbursement, financial management and procurement).

66 Staff will be reinforced over the project implementation with the rolling out of the training plan which includes among others, training on IDA fiduciary procedures, training on OHADA accounting principles and its implication for a donor-financed operation, and training on IDA financial reporting arrangements.

Planning and Budgeting

67 The Annual Work Plan and Budget (AWPB) along with the disbursement forecast will be consolidated into a single document by the Project Coordination Unit at the Health Ministry, and will be submitted to the Project Steering Committee for approval, and thereafter to IDA for approval no later than December 31 of the year preceding the year the work plan will be implemented. The implementing entity will monitor its execution with the accounting software in accordance with the budgeting procedures specified in the manual of procedures and report on variances along with the quarterly interim financial report. The budgeting system needs to forecast for each fiscal year the origin and use of funds under the project. Only budgeted expenditures would be committed and incurred so as to ensure the resources are used within the agreed upon allocations and for the intended purposes. The quarterly IFRs will be used to monitor the execution of the AWPB.

Internal control and financial, administrative, and accounting manual

68 Both ministries have financial management manuals which describe the key internal control procedures, from transaction initiation, review, approval recording and reporting. The manual has to be updated within three months after grant effectiveness to take into consideration any specific concern relating to this project particularly the management of advance account at the Gender Ministry. There is a clear separation of duties within the financial management units.

Disbursement arrangements

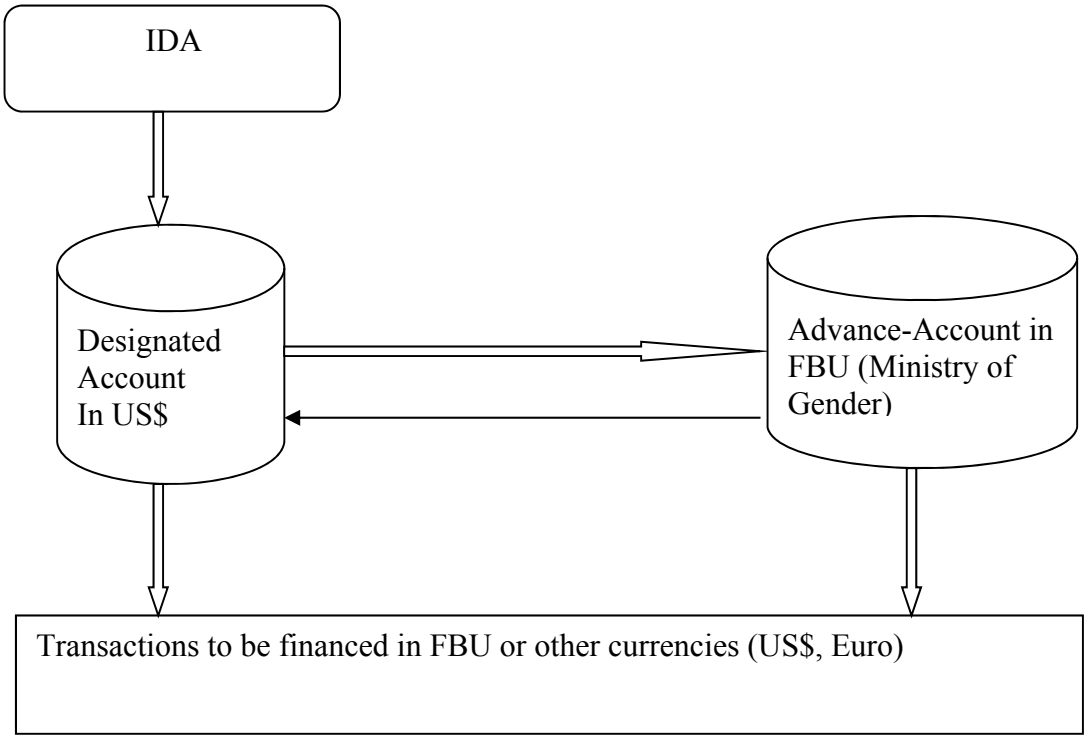
69 A Designated Account (DA) will be opened at the Bank of the Republic of Burundi (BRB) on terms and conditions acceptable to IDA under the fiduciary responsibility of MoH. The ceiling of the Designated Account will be set at US$700,000 equivalent to four months expenditures forecast and will become effective upon grant effectiveness. This Designated Account will be used to finance all eligible project expenditures under the different components.

70 The Designated Account will be replenished against withdrawal applications supported by Statements of Expenditures (SOEs) and other documents evidencing eligible expenditures as specified in the Disbursement Letter. All supporting documents should be retained at the project and readily accessible for review by periodic IDA implementation support missions and external auditors.

71 Upon grant effectiveness, transaction-based disbursements will be used during the first year of project implementation. Thereafter, the option to disburse against submission of quarterly unaudited Interim Financial Reports (also known as the Report-based disbursements) could be considered subject to the quality and timeliness of the IFRs submitted to the Bank and the overall financial management performance as assessed in due course.

72 The option of disbursing the funds through direct payments to suppliers/contractors for eligible expenditures will also be available for payments equivalent to twenty percent (20%) or more of the DA ceiling. Another acceptable method of withdrawing proceeds from the IDA grant is the special commitment method whereby IDA may pay amounts to a third party for eligible expenditures to be paid by the Recipient under an irrevocable Letter of Credit (LC).

73 One transaction account will be opened at a reliable commercial bank for activities executed by the Gender Ministry. This account will also be managed according to World Bank disbursement procedures. It will be replenished from the designated account on a tranche basis. A simplified manual of procedures will be developed for the management of this designated account. The flow of funds is pictured below:



74 *Disbursements by category.* The table below sets out the expenditure categories to be financed out of the Grant. This table takes into account the prevailing Country Financing Parameter for Burundi in setting out the financing levels. In accordance with Bank standard procurement requirements, contracts will continue to be approved "all taxes included" for local expenditures. The project will, however, claim invoiced amounts excluding taxes. The Government will take appropriate steps to cover the tax portion of contracts signed by the project with contractors and suppliers of goods and services.

Category	Amount of the Grant Allocated (expressed in US$)	Percentage of Expenditures to be Financed (inclusive of Taxes)
Goods, Works, Non-Consulting Services, Consultants' Services, Operating Costs, Workshops and Training for the Project	15,150,000	100%
TOTAL AMOUNT	**15,150,000**	

Reporting arrangements

75 *Disbursements by category.* The MoH will record and report on project transactions and submit to the World Bank Interim Financial Monitoring Reports (IFRs) no later than 45 days after the end of each calendar quarter. At a minimum, the financial reports must include the following tables with appropriate comments: (i) Sources and Uses of Funds; (ii) Uses of Funds by Project Activity/Component and comparison between actual expenditures and budget; (iii) Special account activity statement; and (iv) Note to the IFR. At the end of each fiscal year, the project will issue the Project Financial Statements (PFS) comprising: (i) a balance sheet; (ii) a statement of sources and uses of funds; (iii) accounting policies and procedures; and (iv) notes related to significant accounting policies and accounting standards adopted by management and underlying the preparation of financial statements. These PFS will be subject to annual external audits as described below.

External auditing arrangements

76 A qualified, experienced, and independent external auditor will be recruited based on approved terms of reference three months after grant effectiveness. The external audit will be carried out according to either International Standards on Auditing (ISAs) or Auditing Standards (ASs) and will cover all aspects of project activities and include verification of expenditures eligibility and physical verification of goods and services acquired. The report will also include specific controls such as compliance with procurement procedures and financial reporting requirements and consistency between financial statements and management reports and field visits (e.g. physical verification). The audit period will be on annual basis and the reports, including the project financial statements, will be submitted to IDA and to the *Cour des Comptes* six months after the end of each fiscal year.

77 The project will comply with the Bank disclosure policy of audit reports (e.g. make publicly available, promptly after receipt of all final financial audit reports (including qualified audit reports) and place the information provided on its the official website within one month of the report being accepted as final by the team.

Governance and Accountability

78 The risk of fraud and corruption within project activities is high given the country context, and inherent risks of activities. However, the proposed fiduciary arrangements will help mitigate

such risks. Nonetheless, the following measures are envisaged to further mitigate the risk of fraud and corruption, namely the MoH to implement an Anti-corruption Action Plan under the oversight of the Government Anti-corruption Watchdog – "*Observatoire Pour la Lutte Contre la Corruption.*"

79 **Conclusions of the FM Assessment**: The overall residual FM risk is considered *High*. The proposed financial management arrangements for this project are considered adequate to meet the Bank's minimum fiduciary requirements under OP/BP10.00. A detailed financial management assessment report is available upon request.

Rwanda

80 The project will be mainstreamed within the Government of Rwanda (GoR) operations managed within the existing set-up in the MIGEPROF. The Permanent Secretary of the MIGEPROF takes full fiduciary responsibility while the day-to-day financial management transactions will be processed by the Project Financial Management Specialist under the supervision of the Project coordinator.

81 MIGEPROF has experience in implementing IDA projects and is currently the implementing agency of the Adolescent Girls Initiative (TF099772) which became effective on October 28th, 2011. Unaudited Interim Financial Reports (IFRs) of this Trust Fund are submitted on time, reviewed and found to be satisfactory by the World Bank. The Auditor General (AG) issued a clean audit report for the year ended June, 2013 and the management letter did not raise any major issues; there are no overdue audit reports and interim financial reports from this entity.

82 *Budgeting Arrangements:* The project will be mainstreamed into MIGEPROF following the GoR budgeting system. An adequate and thorough consultative process is in use for the generation of budgets, using a bottom up process, starting with departmental plans, costing of activities, and consolidation before submission to the Ministry of Finance (MoF). The AWPB will be prepared by MIGEPROF and MoH, with inputs from other key counterparts, including MINIJUST and RNP and approved by the Steering Committee. The SPIU from MIGEPROF will be responsible for submitting the AWPB to IDA. The budget arrangement will be documented in the project's financial and accounting manual of procedures which will be monitored by the SPIU within MIGEPROF.

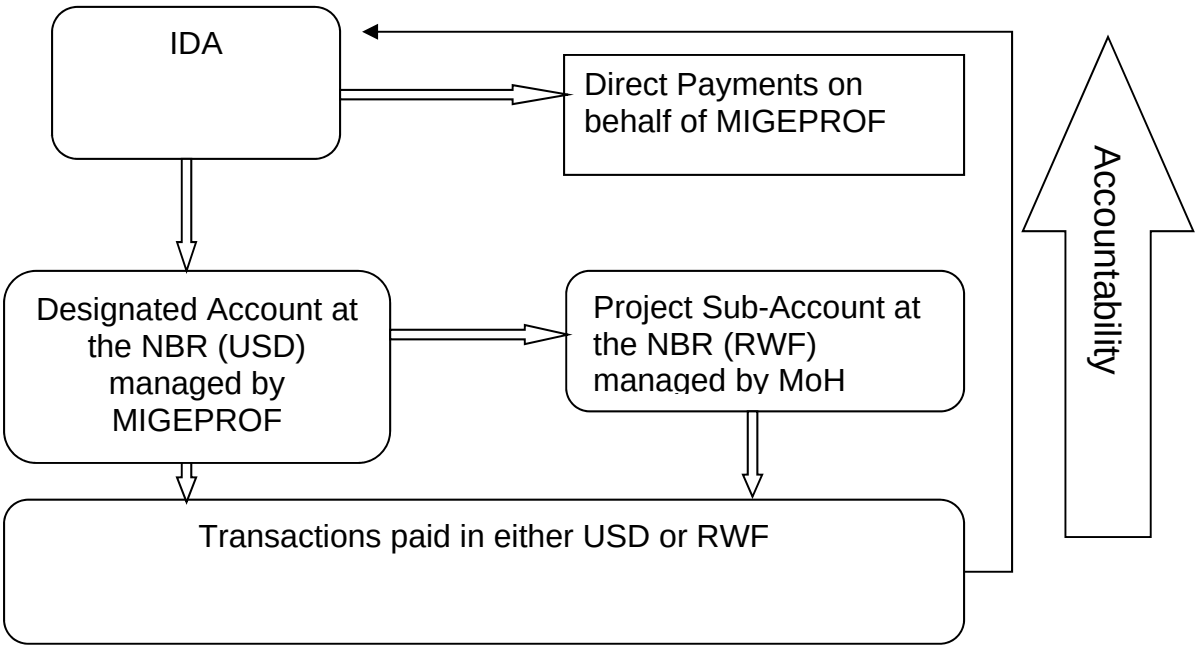
83 *Accounting System***:** Project's accounts will be prepared in accordance with article 70 of the Organic Law No 37/2006 and the Credit Agreement. The SPIU will maintain similar books of accounts to those for other IDA funded projects. The Chart of accounts should be developed in a way that allows project costs to be directly related to specific work activities and outputs of the project. Accounting policies and procedures in place follow the Government Accounting Manual developed by the Accountant General of Rwanda.

84 *Staffing:* The newly created Single Projects Implementation Unit (SPIU) unit within the MIGEPROF will be responsible for the overall coordination and consolidation of financial management and disbursement information. Staffing within that unit comprises of one project coordinator and one accountant who have experience of implementing the AGI project financed by the World Bank. A financial management specialist will be recruited to reinforce the SPIU.

85 *Internal Controls including policies and procedures:* The financial accounting policies and procedures in place are sufficient to ensure that the project complies with the relevant Bank policies (OP/BP 10.00). These include the establishment of internal controls and proper accounting procedures which are documented in the Government Accounting Manual developed by the Accountant General of Rwanda. Current internal control systems of the SPIU however indicate lack of segregation of duties, which will be solved by the recruitment of a procurement specialist and a monitoring and evaluation specialist before project effectiveness. The standard financial rules and procedure will be stated in the project's Financial Accounting Manual and will be used for this project. This includes regular post audits by the Internal Audit unit of the MIGEPROF.

86 ***Disbursement:*** MIGEPROF will open a Designated Account (DA) denominated in United States Dollars authorized by Ministry of Finance at the National Bank of Rwanda. A sub-account denominated in local currency will be used to finance all activities to be implemented by the MoH. This sub-account will be managed by the SPIU within the MoH. Funds will be periodically transferred from the DA to this sub-account to ensure sufficient funds to make payments in accordance with the project's objectives. The signatories for all project's accounts will be documented in the Project Financial Management Manual.

FUNDS FLOW CHART



87 *Disbursement Arrangements.* MIGEPROF will use the transactions based disbursement method for the management of the DA. The DA will be managed according to the disbursement procedures described in the PIM and the Disbursement Letter (DL) for the Project. The ceiling of the account will be specified in the DL, which is estimated to be the equivalent of four-month cash needs of the project and takes into account the disbursement capacity of the various project's implementing entities. The ceiling of the DA will be set at USD 700,000. Additional advances to the DA will be made on a monthly basis against withdrawal applications submitted

electronically and supported by Statements of Expenditures (SoE) or records and other documents as specified in the DL.

88 The GoR and the Bank agreed that withdrawals up to an aggregate amount not to exceed the equivalent of US$774,000 may be made for payments as of May 15, 2014 for eligible expenditures under disbursement Category 1, Goods, Works, Non-Consulting Services, Consultants' Services, Operating Costs, Workshops and Training for the project. This retro-active financing will be used among others to recruit key staff for the SPIU of MIGEPROF and the MoH, as well as consultants to develop the Project Implementation Manual, safeguards instruments and assess OSCs for rehabilitation works.

89 *Disbursements by category.* The table below sets out the expenditure categories to be financed out of the Grant. This table takes into account the prevailing Country Financing Parameter for Rwanda in setting out the financing levels. In accordance with Bank standard procurement requirements, contracts will continue to be approved "all taxes included" for local expenditures. The project will, however, claim invoiced amounts excluding taxes. The Government will take appropriate steps to cover the tax portion of contracts signed by the project with contractors and suppliers of goods and services.

Category	**Amount of the Credit Allocated (expressed in US$)**	**Percentage of Expenditures to be Financed (inclusive of Taxes)**
Goods, Works, Non-Consulting Services, Consultants' Services, Operating Costs, Workshops and Training for the Project	14,950,000	100%
TOTAL AMOUNT	**14,950,000**	

90 *Financial Reporting Arrangements.* Unaudited Interim Financial Reports (IFRs) will be produced by MIGEPROF quarterly. The IFRs will be sent to IDA within 45 days after the end of the quarter. The IFR will have the following contents:

a. A statement of sources and uses of funds for the reported quarterly period and cumulatively since project inception, reconciled with bank and cash balances with a column of cash flow projections for the next 6 months;

b. A statement of uses of funds (expenditure) by project activity/component comparing actual expenditure against the budget, with explanations for significant variances;

c. The Designated Account Activity Statement, reconciling the receipts into and payments out of the project's Designated Account;

d. Supporting bank statements and reconciliations for the bank, cash and other fund balances at the end of the quarter.

91 The format of such reports was discussed and agreed during project negotiations. For the external audit purposes, financial statements will be prepared for each financial exercise covering in general twelve (12) months.

92 *External Audit Arrangements:* In accordance with Article 183 of the Constitution of the Republic of Rwanda of 4 June 2003, as amended to date, and Law No 79/2013 of 11 September 2013, the Office of the Auditor General is the statutory auditor of all government resources including projects. However, the Auditor General can sub-contract some of his statutory responsibilities to private audit firms, while retaining overall responsibility for the final product. Audit arrangements for active Bank project in both ministries are satisfactory. It is expected that this project will be audited based on agreed Terms of Reference (ToRs). Audited financial statements for the project will be sent to the Bank within six months after the end of the financial year, accompanied by a management letter. The project will comply with the Bank disclosure policy of audit reports (e.g. make publicly available, promptly after receipt of all final financial audit reports (including qualified audit reports) and place the information provided on its the official website within one month of the report being accepted as final by the team.

93 *Conclusions of the FM Assessment:* The overall residual FM risk is considered *Substantial*. The proposed financial management arrangements for this project are considered adequate to meet the Bank's minimum fiduciary requirements under OP/BP10.00. A detailed financial management assessment report is available upon request.

ICGLR

94 **Implementing Entity.** The existing FM team at the CS of the ICGLR is composed of one program officer administration and finance, one accountant and one assistant accountant. They will be reinforced by one additional senior financial management specialist with extensive experience with World Bank project, who will be recruited through a competitive process. The World Bank will have the right to review the resume of the identified experts and meet with him before signing the contract. The selection should be finalized before effectiveness. The financial management team of the CS will be trained on the use of World Bank fiduciary procedure before project effectiveness.

95 **Planning and Budgeting.** The Annual Work Plan and Budget (AWPB) along with the disbursement forecast will be elaborated by the PIU of the project which will be submitted to Executive Secretary of the ICGLR for approval, and thereafter to IDA for approval no later than December 31 of the year proceeding the year the work plan should be implemented. The PIU will monitor its execution with the accounting software in accordance with the budgeting procedures specified in the manual of procedures as well as in the Financial Regulation and Rules. The budgeting system needs to forecast for each fiscal year the origin and use of funds under the project. Only budgeted expenditures would be committed and incurred so as to ensure that the resources are used within the agreed upon allocations and for the intended purposes. The quarterly unaudited Interim Financial Reports (IFRs) will be used to monitor the execution of the AWPB.

96 **Information and Accounting System.** ICGLR adheres to international accounting standards, IPSAS. Hence IPSAS accounting standards will apply to this project. The Project code

and chart of accounts will be developed to meet the specific needs of the project and documented in the Manual of Procedures. The accounting systems currently used by ICGLR which is supported by PASTEL software are reliable for the management of this project. They should however be revisited to accommodate this project; the system is expected to include a general diary, auxiliary diaries, general balance, cash record, fixed assets record. The charter of account should be prepared according to the wording used in tables for sources and uses of funds for the accepted eligible expenditures as agreed during negotiations of the Project.

97 **Internal control and financial, administrative, and accounting manual.** ICGLR has a draft financial management manual which details key internal control procedures from transaction initiation, review, approval recording and reporting. The manual will form the basis for the FMPM to be developed for the project and will be finalized within 3 months after the effectiveness to take into consideration any specific concern relating to this project.

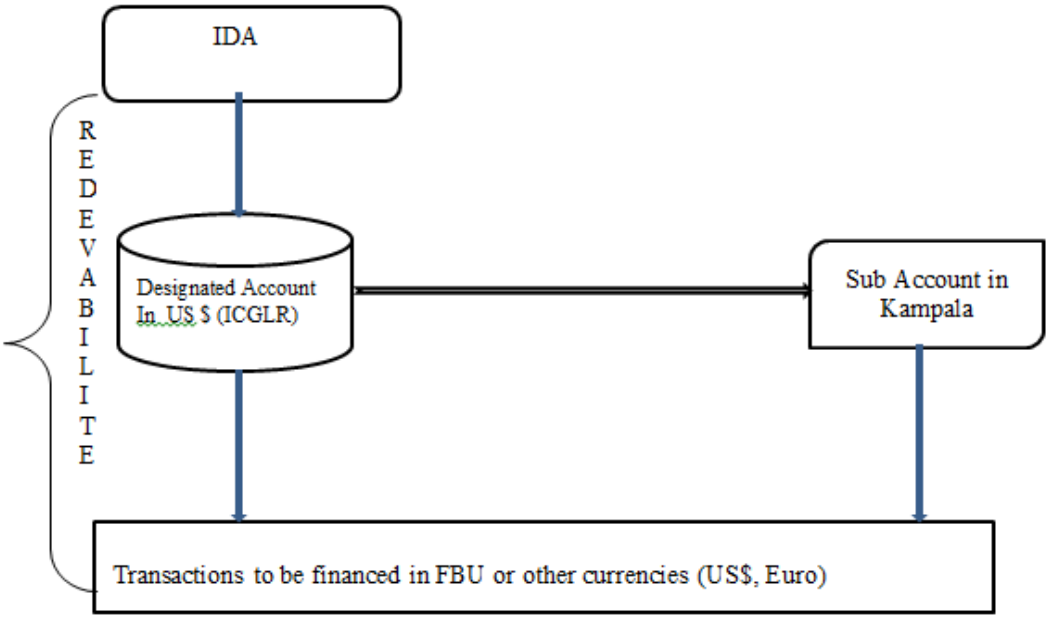
98 Recent assessment conducted by the consulting firm Moore Stephen per the request of the member states of the ICGLR as well as the 2012 external audit reports issued by GPO Partners have identified several weaknesses on the internal control system; the FMPM should address these weaknesses.

99 **Disbursement arrangement.** A Designated Account (DA) will be opened at the Bank of the Republic of Burundi (BRB) on terms and conditions acceptable to IDA under the fiduciary responsibility of the CS. The ceiling of the Designated Account will be set at US$200,000 equivalent to four (4) months expenditures forecast and will become effective upon grant effectiveness. This DA will be used to finance all eligible project expenditures under the different activities. Payments will be made in accordance with the provisions of the Project Implementation Manual (e.g., two authorized signatures will be required for any payment). A sub-account in US$ will be opened in Kampala for the RTF.

100 The DA will be replenished against monthly withdrawal applications supported by Statements of Expenditures (SoE) and other documents evidencing eligible expenditures as specified in the Disbursement Letter. All supporting documents should be retained at the project and readily accessible for review by periodic IDA implementation support missions and external auditors.

101 **Disbursement methods**: Upon Grant effectiveness, transaction-based disbursements will be used until the mid-term review of project implementation. Thereafter, the option to disburse against submission of quarterly unaudited Interim Financial Report (also known as the Report-based disbursements) could be considered subject to the quality and timeliness of the IFRs submitted to the Bank and the overall financial management performance as assessed in due course.

102 The option of disbursing the funds through direct payments to suppliers/contractors for eligible expenditures will also be available for payments equivalent to twenty percent (20%) or more of the DA ceiling. Another acceptable method of withdrawing proceeds from the IDA grant is the special commitment method whereby IDA may pay amounts to a third party for eligible expenditures to be paid by the Recipient under an irrevocable Letter of Credit (LC). The flow of funds is summarized as follows:



103 *Disbursements by category.* The table below sets out the expenditure categories to be financed out of the Grant. In accordance with Bank standard procurement requirements, contracts will continue to be approved "all taxes included" for local expenditures. The project will, however, claim invoiced amounts excluding taxes. The ICGLR will take appropriate steps to cover the tax portion of contracts signed by the project with contractors and suppliers of goods and services.

Category	**Amount of the Grant Allocated (expressed in US$)**	**Percentage of Expenditures to be Financed (inclusive of Taxes)**
Goods, Non-Consulting Services, Consultants' Services, Operating Costs, Workshops and Training for the Project	3,000,000	100%
TOTAL AMOUNT	**3,000,000**	

104 **Reporting arrangement.** The ICGLR will record and report on project transactions and submit to the World Bank Interim IFRs no later than 45 days after the end of each calendar quarter. At a minimum, the financial reports must include the following tables with appropriate comments; (i) Sources and Uses of Funds; (ii) Uses of Funds by Project Activity/Component and comparison between actual expenditures and budget; (iii) Special account activity statement; and (iv) Note to the IFR. At the end of each fiscal year, the project will issue the Project Financial Statements (PFS) comprising: (i) a balance sheet; (ii) a statement of sources and uses of funds; (iii) accounting policies and procedures; and (iv) notes related to significant accounting policies

and accounting standards adopted by management and underlying the preparation of financial statements. These PFS will be subject to annual external audits as described below.

105 **External auditing arrangement.** A qualified, experienced, and independent external auditor will be recruited on approved ToRs three months after effectiveness. The external audit will be carried out according to either International Standards on Auditing (ISAs) or Auditing Standards (ASs) and will cover all aspects of project activities implemented and include verification of expenditures eligibility and physical verification of goods and services acquired. The report will also include specific controls such as compliance with procurement procedures and financial reporting requirements and consistency between financial statements and management reports and field visits (e.g. physical verification). The audit period will be on annual basis and the reports including the project financial statements submitted to IDA six months after the end of each fiscal year.

106 The project will comply with the Bank disclosure policy of the annual audit reports (e.g. make publicly available, promptly after receipt of all final financial audit reports) and place the information provided on its official website within one month of the report being accepted as final by the team.

107 **Governance and Accountability.** The risk of fraud and corruption within project activities is high given the ICGLR context and CS current capacities. However, the proposed fiduciary arrangements will help mitigate such risks. Nonetheless, the following measures are envisaged to further mitigate the risk of fraud and corruption; mainly the ICGLR to implement an Anti-corruption Action Plan which is different from the Financial Management Action plan.

108 **Supervision Arrangements for the three countries and ICGLR:** Supervisions will be conducted over the project's lifetime. The project will be supervised on a risk-based approach. It will comprise inter alia, the review of audit reports and IFRs, and support to the World Bank task team on all FM issues. Based on the current risk assessment which is *High* for DRC, Burundi and ICGLR while Substantial for Rwanda, the project will be supervised twice a year and may be adjusted when the need arises**.** To the extent possible, mixed on-site supervision missions will be undertaken with procurement, monitoring and evaluation and disbursement colleagues.

C. Procurement

109 **Procurement Guidelines:** In all countries, as well as for the ICGLR, procurement will be carried out in accordance with World Bank Guidelines, including: (i) Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits and Grants (January 2011); (ii) Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers (January 2011); (iii) Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants (October 15, 2006 and revised in January 2011); and the (iv) provisions stipulated in the Financing Agreements and Agreement for Rwanda. The implementing entities, as well as contractors, suppliers and consultants will observe the highest standard of ethics during procurement and execution of contracts financed under this project. In each of the countries as well as for the ICGLR, a procurement assessment was carried out, each of them finding that procurement arrangements have an overall high risk rating.

DRC

110 The GoDRC and the World Bank agreed to mainstream the implementation of the project into the existing legal entities and structures and will be framed by the following principles: (i) line ministries to be made more responsible and accountable in project implementation with a focus on strengthening country systems; (ii) equity; and (iii) performance-based agreements which make providers accountable for delivering specific results. Procurement activities of the project will be carried out at three levels: (i) the CFEF unit at the MoF; (ii) the FSDRC; and (iii) the PHDs. At the CFEF unit, procurement activities will be carried out by the Procurement Management Unit (*Cellule de Gestion des Projets et Marchés Publics*, CGPMP) which reports to the General Secretary of the MoF. At the provincial level procurement activities will be carried out by the Management Unit (*Cellule de Gestion*) within the two PHDs in North and South Kivu. The CGPMPs within the two provinces will be associated in the management of the procurement activities after their creation and full operationalization. The FSDRC will carry out procurement activities for Component 1A and selected activities under Component 3 using its existing procurement unit until the mid-term review, hoping that by that time the new institutions recently set up in recommendation of the new national procurement law will have the required qualifications and experience. At that time, a decision will be taken on the most appropriate approach to be used. The existing Project Implementation Manual of the FSDRC will be updated to include the specificities of this project. The PIM for the CFEF will include procurement arrangements for the CFEF, as well as for the PHDs.

111 A procurement assessment was carried out for the CFEF unit within the MoF, the PHDs and the FSDRC. The FSDRC carried out its fiduciary responsibilities in a satisfactory manner for the previous Emergency Social Action Project (ESAP) and its two additional financings (2004-13) to the point that it was asked to provide fiduciary services for another IDA funded project. On the other hand, neither the CGPMP of the MoF nor the *Cellules de Gestion* within the two PHDs has the needed qualification and experience to implement procurement activities for this project. The CGPMP of the MoF has limited experience on World Bank procurement rules and procedures although its concerned staff has attended procurement training courses on the new procurement system and workshops on World Bank procurement procedures. To strengthen its capacity it will benefit from technical support by the Procurement unit of the CFEF. The *Cellules de Gestion* within the two PHDs in the Kivus have no experience in implementing Bank-funded projects. Therefore, one procurement expert with strong experience in Bank procurement procedures will be recruited to provide periodically technical support and training to the two units.

112 **Key risks and related mitigation measures**. The key issues and risks concerning procurement for implementation of the project in DRC include: (i) procurement staff have limited to no experience in implementing World Bank-funded projects or staff experience is limited to procurement of goods through NCB and shopping procedures, with no experience in ICB procedures of selection of large-value consultancy contracts; (ii) qualification of procurement staff is inadequate; (iii) record keeping is inadequate; (iv) working environment is inadequate in terms of space for procurement records and working space for procurement staff; (v) clear procedures and guidelines spelled out in manuals; (vi) government officials likely to be involved in project procurement through tender and evaluation committees may not be familiar with World Bank guidelines and rules; and (vii) control and regulation mechanism according to

the provisions of the country procurement law and its application procedures could delay the procurement process if mandatory reviews are required.

113 **The overall unmitigated risk for procurement is high**. Proposed corrective measures which have been agreed to mitigate the risk are summarized in table 1.

Table 1: Action Plan for Strengthening Procurement Capacity

Ref.	Tasks	Responsibility	Due date
1	Request procurement expert to be recruited to conduct on the job training for identified procurement staff on World Bank procedures.	CFEF and PHDs Units	Periodically
2	Send staff (at least two of each Management Unit and the CGPMP of Ministry of Finance) to training on World Bank procurement procedures in a specialized institution performing in DRC or abroad.	CFEF, PHDs Units and the CGPMP of MoF	Three months after effectiveness
3	Set up the project filing system in order to better keep procurement documents and reports and identify a staff responsible for this task. Train staff in data management.	CFEF, PHDs Units and the CGPMP of MoF	Three months after effectiveness
4	Establish a better working space for procurement records and procurement staff	CFEF, PHDs Units and the CGPMP of MoF	Three months after effectiveness
5	Prepare and adopt an administrative and financial manual	CFEF, FSDRC	Three months after effectiveness
6	Organize a launch workshop involving all stakeholders	CFEF and PHDs Units	Three months after effectiveness

114 **Procurement methods and review thresholds**. Procurement methods and Bank review requirements are summarized in table 2 below. All ToRs regardless of the value of the contract are subject to prior review.

Table 2: Thresholds for Procurement Methods and Prior Review

Contracts for goods and works

Procurement Method	Threshold for the method in 1000 US$	Bank review in 1000 US$
(a) International Competitive Bidding (ICB)	US$10,000 or more for works, US$1,000 or more for goods	US$ 5,000 for works and US$500 for goods
(b) National Competitive Bidding	All contracts estimated below the ICB threshold and above shopping ceiling	US$5,000 for works and US$500 for goods and the first two contracts
(c) Shopping	Below US$200 for works and US$100 for goods	Post review

(d) UN procurement agencies	No threshold	All contracts
(f) Direct contracting	No threshold	All contracts

Contracts for consultant services

Procurement Method	Threshold for the method in '000 US$	Bank review in '000 US$
(a) Quality and Cost Based Selection (QCBS)	No threshold	All contracts estimated above US$200
(b) Least Cost Selection (LCS)	No threshold	All contracts estimated above US$200
(c) Selection Based on Consultant Qualifications (CQS)	US$200	All contracts estimated above US$200
(d) Individual Consultants	No threshold	All contracts estimated above US$100
(f) Single Source Selection (SSS)	No threshold	All contracts

115 **Procurement Plan**. The borrower has prepared a Procurement Plan for the first 12 months of the project implementation which provides the basis for the procurement methods. This plan has been agreed between the borrower and the World Bank during negotiations. The Procurement Plan will be available in the project's database and on the World Bank external website. The Procurement Plan will be updated in agreement with the project team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Table 1: Goods and non-consulting services

CFEF								
Ref. No.	**Contract (Description)**	**Estimated Cost (US$)**	**Procurement Method**	**Prequalification (yes / no)**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
1	Rape Kits for collecting medico-legal evidence (North Kivu)	40,635	Shopping	No	No	Prior	Nov. 15, 2014	First two years
2	Rape Kits for collecting medico-legal evidence (South Kivu)	40,635	Shopping	No	No	Prior	Nov. 15, 2014	First two years
3	Cupboards with key (North Kivu)	96,000	Shopping	No	No	Post	Nov. 15, 2014	
4	Cupboards with key (South Kivu)	96,000	Shopping	No	No	Post	Nov. 15, 2014	
5	Tools of management (templates, medical certificate) and data collection (North Kivu)	14,460	Shopping	No	No	Post	Nov. 15, 2014	First year
6	Tools of management (template, medical certificate) and data collection (South Kivu)	14,460	Shopping	No	No	Post	Nov. 15, 2014	First year
7	PEP kit, North Kivu (Kit 3 SR UNFPA)	264,384	Direct Contracting, ASRAMES/ UNFPA	Yes	No	Prior	Oct. 15, 2014	First year
8	PEP kit, South Kivu (Kit 3 SR UNFPA)	264,384	Direct Contracting, ASRAMES/ UNFPA	Yes	No	Prior	Oct. 15, 2014	First year
9	Ambulances for HGRs (North Kivu, 12)	720,000	NCB	No	No	Prior	Dec. 15, 2014	
10	Ambulances for HGRs (South	720,000	NCB	No	No	Prior	Dec. 15, 2014	

CFEF								
Ref. No.	**Contract (Description)**	**Estimated Cost (US$)**	**Procurement Method**	**Prequalification (yes / no)**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
	Kivu, 12)							
11	Reproduction communication tools (North Kivu)	15,000	Shopping	No	No	Post	Oct. 15, 2014	
12	Reproduction communication tools (South Kivu)	15,000	Shopping	No	No	Post	Oct. 15, 2014	
13	Equipment (printer, computer, photocopier, scanner/North Kivu)	16,000	Shopping	No	No	Post	Oct. 15, 2014	
14	Equipment (printer, computer, photocopier, scanner/ South Kivu)	16,000	Shopping	No	No	Post	Oct. 15, 2014	
15	Vehicles for PNSM and PNSR (2, North Kivu)	100,000	Shopping	No	No	Prior	Oct. 15, 2014	
16	Vehicles for PNSM and PNSR (2, South Kivu)	100,000	Shopping	No	No	Prior	Oct. 15, 2014	
17	Reproduce 300 image-boxes for sensitization on prevention of sexual violence and mental health	48,000	Shopping	No	No	Post	Dec. 15, 2014	
18	ASRAMES	1,245,000	Direct Contracting	N/A	N/A	Prior	Oct, 15, 2014	Date of signature of contract
19	Hotel for Workshops (North Kivu)	40,000	Shopping	No	No	Post	Oct. 8, 2014	
20	Hotel for Workshops (South Kivu)	40,000	Shopping	No	No	Post	Oct. 8, 2014	

FSRDC								
1	Kits for Case Management	17,850	Shopping	No	N/A	Post	Nov. 30, 2014	First year
2	Kits VSLA	6,500	Shopping	No	N/A	Post	Nov. 30, 214	
3	Purchase of (2) Vehicles 4x4	100,000	Shopping	No	N/A	Post	Aug. 1, 2014	
4	Purchase of office furniture	5,000	Shopping	No	N/A	Post	Aug. 1, 2014	
5	Reproduction of training tools for psycho-education and family mediation	10,000	Shopping	No	N/A	Post	Sept. 30, 2014	
6	Office material (computers, etc.)	14,300	Shopping	No	N/A	Post	Aug. 1, 2014	
7	Produce picture boxes, comics and other IEC materials	25,000	Shopping	No	N/A	Post	March 31, 2015	

Table 2: List of Works

CFEF								
Ref. No.	**Contract (Description)**	**Estimated Cost (US$)**	**Procurement Method**	**Prequalification (yes / no)**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
1	Upgrading health centers (several small contract, North Kivu)	384,000	Shopping	No	No	Prior	Dec. 15, 2014	

CFEF								
Ref. No.	**Contract (Description)**	**Estimated Cost (US$)**	**Procurement Method**	**Prequalification (yes / no)**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
2	Upgrading health centers (several small contract, South Kivu	384,000	Shopping	No	No	Prior	Dec. 15, 2014	

Table 3: List of consulting services

CFEF						
Ref. No.	**Contract (Description)**	**Estimated Cost (US$)**	**Procurement Method**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
1	Consultant to develop Project Implementation Manual for Component 1B	10,000	IC	Prior	Aug. 15, 2014	
2	Develop communication for the project to use it in the hospitals and health centers	10,000	IC	Post	Aug. 15, 2014	
3	Recruitment of Vivo for training NET for both Kivus	195,550	Direct Contracting	Prior	Sept. 15, 2014	
4	Recruitment of JHU for training CTP for both Kivus	195,550	Direct Contracting	Prior	Sept. 15, 2014	
5	Training of trainers at the provincial level on forensic medical expertise for the two Kivus by PHR	88,225	Direct Contracting	Prior	Sept. 15, 2014	
6	Recruit consultant to review the methods of case management, psychosocial and mental health support, and develop training modules for both Kivus and workshops	30,000	IC	Prior	Nov. 30, 2014	
7	Development of materials for sensitization on mental health for both Kivus	5,000	IC	Post	Dec. 15, 2014	
8	PPA South-Kivu	800,000	Direct Contracting	Prior	Oct. 15, 2014	
9	PPA North-Kivu	800,000	Direct Contracting	Prior	Oct. 15, 2014	
10	Contract of Sosame services (including psychotropic and neuroleptic)	403,200	Direct Contracting	Prior	Jan. 30, 2015	Global cost
11	Contract of Tulizo Letu services	235,200	Direct Contracting	Prior	Jan. 30, 2015	Global cost
12	Impact Evaluation Health	500,000	CQS	Prior	Dec. 15, 2014	
13	Recruitment consultant to develop check list quality services SGBV	50,000	IC	Prior	Nov. 15, 2014	
14	Development and implementation community score cards	150,000	Direct Contracting	Prior	Jan. 15, 2015	
15	External Audit	100,000	LCS	Prior	Sep. 15, 2014	
FSRDC						
1	Identify ONG/Consortium for technical assistance support survivors (North Kivu)	475,000	QBS	Prior	Sept. 30, 2014	
2	Identify ONG/Consortium for technical assistance support survivors (South Kivu)	475,000	QBS	Prior	Sept. 30, 2014	
3	Identify judicial NGO/Consortium (North Kivu)	200,000	CQS	Prior	Sept. 30, 2014	

CFEF						
Ref. No.	**Contract (Description)**	**Estimated Cost (US$)**	**Procurement Method**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
4	Identify judicial NGO/Consortium (South Kivu)	200,000	CQS	Prior	Sept. 30, 2014	
5	Identify local NGO for support to survivors (North Kivu)	450,000	CQS	Post	Nov. 30, 2014	
6	Identify local NGO for support to survivors (South Kivu)	450,000	CQS	Post	Nov. 30, 2014	
7	Identify NGO to develop and conduct training on psychosocial support	70,000	CQS	Priori	Oct. 30, 2014	
8	Identify local NGO for legal support (North Kivu)	78,190	CQS	Post	Dec, 30, 2014	
9	Identify local NGO for legal support (South Kivu)	78,190	CQS	Post	Dec, 30, 2014	
10	Consultant to develop the Project Implementation Manual for component 1A	15,000	IC	Post	Oct. 30, 2014	
11	Consultant to develop materials for project communication at the provincial level	20,000	IC	Post	Oct. 30, 2014	
12	Identify NGO for institutional capacity building of CBOs	67,875	CQS	Post	Feb. 28, 2015	
13	Recruitment of an NGO expert on communication related to behavioral change	350,000	CBS	Post	Aug. 1, 2014	

116 The Bank standard bidding documents for goods and for works as well as the Bank standard Requests for Proposals will be used for all ICB contracts and consultant contracts advertised internationally. The same documents will be used for contracts advertised locally until the country has its own standard documents found acceptable by the Bank.

Reference to the National Procurement Regulatory Framework

117 For all contracts awarded through NCB method, the World Bank may authorize the use of the national institutions and regulations that comprise the law including its texts of application, the institutions set up for the control and regulation and the institutions responsible for procurement activities implementation. The national competitive bidding procedures currently in force in the DRC deviate slightly from the World Bank Procurement Guidelines NCB procedures for procurement of Works, Goods and services (other than consultants services); thus, they have been already reviewed and appropriate modifications have been proposed to assure economy, efficiency, transparency, and broad consistency with the provisions included in Section I and paragraphs 3.3 and 3.4 of the World Bank Procurement Guidelines (refer to the paragraph below).

Requirements for National Competitive Bidding

118 National Competitive Bidding may be used subject to using the open procedure ("appel d'offres *ouvert*") set forth in the Recipient's Public Procurement Law No 10/010 dated April 27, 2010 (the "PPL") and the Manual of Procedures of the PPL as per Recipient's Decree No 10/22 dated June 2, 2010 (the "Manual of Procedures"); provided, however, that such procedure shall be subject to the provisions of Section I and Paragraphs 3.3 and 3.4 of Section III of the Procurement Guidelines and the additional following modifications:

a. **Standard Bidding Documents**: All standard bidding documents to be used for the Project under NCB shall be found acceptable to the World Bank before their use during the implementation of Project;

b. **Eligibility**: Eligibility of bidders and acceptability of their goods and services shall not be based on their nationality and/or their origin; and association with a national firm shall not be a condition for participation in a bidding process. Therefore, except for the ineligibility situations referred to in paragraphs 1.10(a) (i) and 1.10(a) (ii) of the Procurement Guidelines, the eligibility of bidders must be based solely on their qualification, experience and capacity to carry out the contract related to the specific bidding process.

c. **Advertising and Bid Preparation Time**: Bidding opportunities shall be advertised at least in a national newspaper of wide circulation and on the website of the Recipient's Procurement Regulator (*Autorité de Régulation des Marchés Publics*) and bidders should be given at least 30 days from the date of invitation to bid or the date of availability of the bidding documents, whichever is later;

d. **Criteria for Qualification of Bidders**: Qualification criteria shall only concern the bidder's capability and resources to perform the contract taking into account objective and measurable factors. Such criteria for qualification of bidders shall be clearly specified in the bidding documents;

e. **Bid Evaluation and Contract Award**: A contract shall be awarded to the substantially responsive and lowest evaluated bidder provided that such bidder meets the qualification criteria specified in the bidding documents. No scoring system shall be allowed for the evaluation of bids, and no "blanket" limitation to the number of lots which can be awarded to a bidder shall apply. The criteria for bid evaluation and the contract award conditions shall be clearly specified in the bidding documents;

f. **Preferences**: No preference shall be given to domestic/regional bidders; to domestically/regionally manufactured goods; and to bidders forming a joint venture with a national firm or proposing national sub-contractors or carrying out economic activities in the territory of the Recipient;

g. **Publication of Contract Award**: Information on all contract awards shall be published in at least a national newspaper of wide circulation or in the Recipient's Procurement Regulator (*Autorité de Régulation des Marchés Publics*) web-site;

h. **Fraud and Corruption**: In accordance with the Procurement Guidelines, each bidding document and contract shall include provisions stating the World Bank's policy to sanction firms or individuals found to have engaged in fraud and corruption as set forth in the Procurement Guidelines;

i. **Inspection and Audit Rights**: In accordance with the Procurement Guidelines, each bidding document and contract shall include provisions stating the World

Bank's policy with respect to inspection and audit of accounts, records and other documents relating to the bid submission and contract performance;

j. **Requirement for administrative documents and/or tax clearance certificate:** The bidding documents shall not require foreign bidders to produce any administrative or tax related certificates prior to confirmation of awarding a contract;

k. **Modifications of a Signed Contract:** Any change in the contract amount which, singly or combined with all previous changes, increases the original contract amount by 15 (fifteen) percent or more must be done through an amendment to the signed contract instead of signing a new contract.

Items to be procured and the methods to be used

119 **Advertisement**: General Procurement Notice (GPN), Specific Procurement Notices (SPN), Requests for Expression of Interest, and results of the evaluation and contracts award should be published in accordance with advertising provisions in the following guidelines: "Guidelines: Procurement under IBRD Loans and IDA Credits" dated January 2011; and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated January 2011. For this purpose, the Project Coordination Unit will prepare and submit to the World Bank a General Procurement Notice (GPN). Specific Procurement Notice (SPN) for all goods, non-consulting services and works to be procured under International Competitive Bidding (ICB) and Requests for Expressions of Interests for all consulting services costing the equivalent of US$200,000.00 and above will be published in Dg Market, on the World Bank's external website, and in the national press, in addition to other media with wide circulation. All other specific procurement notices and other requests for expression of interest shall be published at a minimum in the national press with wide circulation.

120 **Procurement of goods and non-consultancy services**: Goods procured under this project will include mainly items that will contribute in bettering the works conditions of the implementing agencies and institutions to be supported by the project and to strengthen the health system to provide integrated support for survivors of SGBV at all levels; they comprise computer equipment; office furniture; data collection tools; and software. The project would also provide medicines, medical supplies, diagnostic tools, and emergency post-exposure prophylaxis kits. Non-consultancy services procured under this project will a full range of training and capacity building activities.

121 Depending on the size of the contracts, procurement will be done either under ICB using World Bank procurement rules that include the related SBD or under NCB using National Standard Bidding Documents agreed with or satisfactory to the World Bank. Small value goods may be procured under shopping procedures. Direct contracting may be used where necessary if agreed in the procurement plan in accordance with the provisions of paragraph 3.7 to 3.8 of the Procurement Guidelines. This category may cover direct contracting with ASRAMES and a few faith-based organizations to provide and distribute medicines and health commodities.

122 **Selection and employment of Consultants:** Consultancy services would include research, surveys, communication strategy, and technical studies, etc. The selection method will be Quality and Cost Based Selection (QCBS) method whenever possible. Contracts for specialized assignments estimated to cost less than US$200,000 equivalent may be contracted through Consultant Qualification (CQ). The following additional methods may be used where appropriate: Quality Based Selection (QBS); Selection Based on the Consultants' Qualifications (CQS); Selection under a Fixed Budget (FB); and Least-Cost Selection (LCS).

123 Short lists of consultants for services estimated to cost less than the equivalent of US$100,000 per contract for ordinary services and US$200,000 for design and contract supervision may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. However, if foreign firms express interest, they will not be excluded from consideration.

124 Single Source Selection (SSS) may be employed with prior approval of the World Bank and will be in accordance with paragraphs 3.8 to 3.11 of the Consultant Guidelines. This category may cover SSS of Panzi Hospital/Foundation in South Kivu and Heal Africa in North Kivu as centers of referral for survivors of SGBV to provide holistic support to survivors of SGBV and specialized trainings to strengthen the government's capacity to provide holistic services for survivors of SGBV, as well as the *Performance Purchasing Agencies* in both Kivus for the Performance Based Financing to be used under Component 2. *High impact basic health.*

125 All services of Individual Consultants (IC) will be procured under contracts in accordance with the provisions of paragraphs 5.1 to 5.6 of the Guidelines.

126 **Operating Costs:** Operating costs shall consist of operations and maintenance costs for vehicles, office supplies, communication charges, equipment, utility charges, travel expenses, per diem and travel costs, training costs, workshops and seminar and associated costs, among others. Operating costs will not include salaries of civil servants.

127 **Training and Workshops.** Training and workshops will be based on capacity needs assessment. Detailed training plans and workshops activities will be developed during project implementation, and included in the project annual plan and budget for World Bank's review and approval.

Frequency of Procurement supervision

128 In addition to the prior review supervision to be carried out by the World Bank, given limited procurement capacity of the CGPMP of the MoF and the Procurement units at the PHDs, at **least two** implementation support missions annually will be carried out, including field visits to carry out post review of procurement actions. As agreed with the government, contracts will be published on the web. Annual compliance verification monitoring will also be carried out by an independent consultant and would aim to: (i) verify that the procurement and contracting procedures and processes followed for the projects were in accordance with the Financing Agreement; (ii) verify technical compliance, physical completion and price competitiveness of each contract in the selected representative sample; (iii) review and comment on contract

administration and management issues as dealt with by the implementation entity; (iv) review capacity of the implementation entity in handling procurement efficiently; and (v) identify improvements in the procurement process in the light of any identified deficiencies.

129 **Contract Management and Expenditure Reports**. As part of the Procurement Management Reports (PMR), the CGPMP of the MoF will submit contract management and expenditure information in quarterly reports to the *Cellule de Suivi des Projects et Programmes* (CSPP) World Bank. The procurement management report will consist of information on procurement of goods, works and consultants' services and compliance with agreed procurement methods. The report will also provide information on complaints by bidders, unsatisfactory performance by contractors and any information on contractual disputes, if any. These contract management reports will also provide details on payments under each contract, and will use these to ensure no contract over-payments are made or no payments are made to sanctioned entities.

Burundi

130 **The Country Procurement Environment**. In 2008, Burundi has enacted a new public procurement law that provides asset of modern rules on standardized procurement processes, procedures and controls, and their application. However, its implementation is facing, among others, weak institutional capacity and lack of independent audit. In addition, the Government has initiated a revision of the current law. This public procurement law, as it stands now, allows external financing to take precedence over any contrary provisions in local regulations.

131 The items under different expenditure categories to be procured, identified by appraisal, are indicated in the section on the scope of procurement under the project. For each contract to be financed by IDA, the client and the Bank will agree upon, and record in the Procurement Plan, the various procurement and selection methods, the need for pre-qualification, estimated costs, prior review requirements and the time frame. The Procurement Plan will be updated annually, or as otherwise required, to reflect the actual project implementation needs and improvements in the institutional capacity. The Borrower, as well as contractors, suppliers, and consultants, will observe the highest standards of ethics during procurement and execution of contracts financed under this project.

132 **Standard Bidding Documents**. Procurement will be carried out using the Bank's Standard Bidding Documents (SBD) for goods and works for International Competitive Bidding (ICB), while selection of consultants will use the Standard Request for Proposals. For National Competitive Bidding (NCB), the Borrower will use the bidding documents already agreed and in use for the ongoing projects funded by the World Bank. In this regard and in accordance with paragraph 1.16 (e) of the Procurement Guidelines, each bidding document and contract financed out of the proceeds of the Financing shall provide that (a) the bidders, suppliers, contractors and their subcontractors, agents, personnel, consultants, service providers, or suppliers shall permit the Association, at its request, to inspect all accounts, records and other documents relating to the submission of bids and contract performance, and to have said accounts and records audited by auditors appointed by the Association; and (b) the deliberate and material violation of such provision may amount to an obstructive practice as defined in paragraph 1.16 (a)(v) of the Procurement Guidelines.

133 **Advertising:** A comprehensive General Procurement Notice will be prepared by the Borrower and published in the United Nations Development Business online (UNDB online) following Board Approval, to announce major consulting assignments and any international competitive bidding (ICB). The General Procurement Notice shall include all ICB for works, goods, and non-consulting services contracts and all large consulting contracts (i.e., those estimated to cost US$200,000 or more). In addition, a specific procurement notice is required for all works and goods to be procured under ICB in UNDB online. Requests for Expressions of Interest (EOI) for consulting services expected to cost more than US$200,000 shall be advertised in UNDB online. An EOI is required in the national gazette, a national newspaper, or an electronic portal of free access for all consulting firm services regardless of the contract amount. In the case of NCB, a specific procurement notice will be published in the national gazette, a national newspaper, or an electronic portal of free access. Contract awards will also be published in UNDB, in accordance with the Bank's Procurement Guidelines (Para. 2.60) and Consultants Guidelines (para. 2.31).

Scope of Procurement and Selection under the Project

134 **Procurement of Works.** This category will include rehabilitation of hospitals where integrated services for survivors will be provided, CDFC, and youth centers.

135 **Procurement of Goods**. This procurement will include motor vehicles, office furniture, office equipment, medical equipment.

136 **Consulting Services**. These services will include: financial audit, women's empowerment within three project implementation provinces, and various studies and research. The Bank's Standard Request for Proposal document will be used in the selection of consulting firms as well as standard Form of Evaluation. The consulting services will, as far as possible, be awarded under Quality and Cost Based Selection (QCBS) procedures. Other methods of selection will be determined for each assignment depending on the type of assignment and the provisions of the Consultant Guidelines and will be indicated in the procurement plan. Shortlists of consultants for services estimated to cost less than US$200,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

137 **Record Keeping and Filing.** To ensure transparency in the procurement process, the project staff will document all steps in the process for each contract. These procurement documents will be filed in a manner that will facilitate retrieval in the event of audits or reviews. Procurement record-keeping will be the responsibility of the procurement staff in the implementing ministries.

138 **Procurement of non-consulting services**. Non-consulting services are services that are not intellectual or advisory in nature. They will include maintenance of equipment. Procurement of non-consulting services shall follow the competitive bidding procedures acceptable to the association and as prescribed in the Project Implementation Manual (PIM) to be agreed by project effectiveness date.

139 **Community Participation in Procurement**, will be appropriate where, in the interest of project sustainability, or to achieve certain specific social objectives of the project, it is desirable in selected project components to (a) call for the participation of local communities and/or nongovernmental organizations (NGOs) in civil works and the delivery of non-consulting services, or (b) increase the utilization of local know-how, goods and materials, or (c) employ labor-intensive and other appropriate technologies, the procurement procedures, specifications and contract packaging shall be suitably adapted to reflect these considerations, provide these are acceptable to the Bank. The procedures proposed and the project activities to be carried out by community participation shall be outlined in the Financing Agreement and further elaborated in the Procurement Plan or the relevant Project Implementation Document (Manual) approved by the Bank and made publicly available by the Borrower.

140 **Procurement from United Nations Agencies**: There may be situations in which procurement directly from agencies of the United Nations (UN), following their own procurement procedures may be the most appropriate methods. In such circumstances the Recipient shall submit to the Bank for its no objection a full justification and the draft form of agreement with UN agency.

141 **Operating Costs.** Operating costs will cover, the venue and materials for workshops and training; the servicing of office machines and equipment; the operation and maintenance of vehicles and IT equipment; office supplies; communication charges; bank charges; advertising costs; per diem and travel costs for staff when travelling on duty for the purpose of project implementation, but excluding the salaries or bonuses of civil servants. Operating expenditures will be financed following procedures described in the PIM and verified by the Task Team Leader or the Financial Management Specialist (FMS). They will not be subject to the procurement guidelines or prior or post reviews.

142 **Assessment of implementation capacity for procurement.** A procurement assessment was conducted by World Bank staff in March 2014 for the two ministries which will be involved in the implementation of the project (i.e. Health Ministry and Gender Ministry). In each Ministry, the assessment analyzed the procurement organizational structure, past experience in implementing procurement procedures including those pertaining to World Bank funded projects, and ownership and interaction between the two Ministries.

143 The key procurement risks are: (i) weak capacity and experience in World Bank procurement procedures for the Ministry of Gender; (ii) limited experience of the Ministry of health in interaction with other ministries on procurement activities; (iii) increase in workload for the Ministry of Health since two other projects are being implemented by the same PIU; and (iv) record keeping and document management systems from various sources of financing.

144 The proposed mitigation measures for these risks are: (i) implementation of procurement activities to be centralized in the relatively experienced PIU of the Ministry of Health; (ii) active interaction between the two ministries (including in procurement processes for activities that directly benefit the Gender Ministry) to be highlighted in the PIM; (iii) clear assignment among the two PIU procurement specialists so that activities for the Gender Ministry are dealt with appropriately in a timely manner; and (iv) establishment of separate and strengthened procurement records and documents keeping. The implementation of these mitigation measures

by the Recipient is relatively simple and intended to be completed prior to the project effectiveness.

145 **Procurement risks**. At this stage, the overall project risk for procurement is ***Substantial***. Since no complex procurement contracts are foreseen and in case mitigation measures are implemented, procurement risk would be reassessed to Moderate on basis of procurement performance throughout project implementation.

146 **Frequency of procurement supervision.** In addition to the prior-review supervision conducted from Bank offices, the Bank will carry out annual supervision missions to conduct post review of procurement actions and contracts under prior review thresholds on basis of a sample of about 20 percent of contracts within review period.

147 **Prior review threshold.** According to the risk level and less complexity with regard to procurement processes, the prior review thresholds are as follows:

a) Procurement of Goods and Works

Expenditure category	Procurement method	Threshold (US$)	Contracts subject to prior review
1. Works	ICB	≥ US$5 million	All contracts
	NCB	< US$5 million	None
	Shopping	< US$100,000	None (*)
	Direct Contracting	All values	All contracts
2. Goods	ICB	≥ US$0.5 million	All contracts
	NCB	< US$0.5 million	None
	Shopping	< US$50,000	None (*)
	Direct Contracting	All values	All contracts
3. Non-consultancy Services	NCB	< US$5 million	None
	Shopping	< US$50,000	None (*)
	Direct Contracting	All values	All contracts

(*) Note: For shopping, when the Recipient has been unable to obtain at least three quotations, it shall provide the Bank with the reasons and justification why no other competitive method could be considered and obtain a no objection before proceeding on the basis of the only responses already received.

b) Selection of Consultants

Expenditure category	Contract value (Threshold) US$	Procurement method	Contracts subject to prior review
(a) Firms	≥ US$200,000	QCBS, QBS, FBS, LCS	All contracts
	< US$200,000	QCBS, CQS, LCS, QBS, FBS,	(Selected contracts as indicated in the procurement plan)
		SSS	
	All values		All contracts
(b) Individuals	≥ US$100,000 (*)	Three CVs	All contracts
	All values	SSS	All contracts

(*) Note: For individual consultants subject to post review, the Borrower shall obtain the Bank's no objection when it has not been able to compare at least three qualified candidates before hiring, in which case it shall provide the reasons.

148 **Procurement plan.** The Borrower, at appraisal, developed an initial procurement plan for the first 18 months of project implementation. The final procurement plan was agreed upon between the Recipient and the Bank team during project negotiations. It will be available at the MoH in the Project database and on the Bank's external website. The Procurement Plan will be updated annually, in agreement with the project management team, or as required to reflect actual project implementation needs and improvements in institutional capacity.

149 The following tables provide details of the procurement arrangements for some major contracts.

Table 1: List of contract packages of works

Ref. No.	Contract Description	Estimated Cost ('000 US$)	Procurement Method	Prequalification (yes/no)	Domestic Preference (yes/no)	Review by Bank (Prior /Post)	Expected Bid-Opening Date	Comments
1	Rehabilitation of hospitals to accommodate integrated services	150	NCB	No	No	Post	May 2015	
2	Rehabilitation of youth centers	88	NCB	No	No	Post	July 2015	
3	Rehabilitation of public offices	33	Shopping	No	No	Post	May 2015	
4	Rehabilitation of CDFC's offices	15	Shopping	No	No	Post	May 2015	

Table 2: List of contract packages of Goods and Non-Consulting Services

Ref No.	Contract (Description)	Estimated Costs ('000 US$)	Procurement Method	Prequalification (Yes/No)	Domestic Preference (Yes/No)	Prior/Post	Expected Bid Opening	Comments
1	PEP kits for rape victims	400	NCB	No	No	Post	May 2015	
2	Medical equipment for SGBV work for selected hospitals	290	NCB	No	No	Post	April 2015	
3	Motor vehicles	180	NCB	No	No	Post	December 2014	
4	Installation of video conference facilities in project	240	NCB (non-consulting services)	No	NO			Would use appropriate bidding document

	supported line ministries and/or facilities							

Table 3: List of Consulting Assignments

Ref. No.	Description of Assignment	Estimated Cost (US$'000)	Selection Method	Review by Bank (Prior / Post)	Expected Proposals Submission Date	Comments
1	Survey on Knowledge, Attitudes and Practices focused on youth	300	QCBS	Prior	September 2015	
2	Women's empowerment within three project implementation provinces	184 (per province)	QC	Prior	October 2015	
3	Reference database collection	150	QCBS	Post	July 2015	
4	Financial audit	36	LCS	Prior	November	Short-list to be agreed with the Bank

Rwanda

150 **General Procurement Environment.** Procurement in Rwanda is regulated by the Law No. 12 of 2007 which was revised in 2013, and its associated regulations, covering all aspects of public procurement at all levels of Government. The Rwanda Public Procurement Authority (RPPA) was established under the Law No. 63 of 2007 and is responsible for procurement oversight of the public procurement at both central and local government. The Procurement Law also establishes the institutional arrangement at a procuring entity level, including; (i) Procurement Unit (PU); (ii) Tender Committee (TC); and (iii) Accounting Officer or Chief Budget Manager. The SPIU is responsible for carrying out the procurement process from the planning to the completion of the contract execution. The Chief Budget Manager approves reports of the TC and signs the contract on behalf of the procuring entity.

151 **Procurement Plan.** The SPIU within MIGEPROF prepared the initial 18-months procurement plan (simplified procurement plan), which will provide the basis for the procurement methods. This plan was agreed upon by the government and the project team at negotiations. It will also be available in the project's database and in the Bank's external website. For each contract to be financed by the IDA credit, the Borrower and the World Bank will agree upon and record in the Procurement Plan, the different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements, and time frame. The Procurement Plan will be updated annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

152 **Procurement of Works and Goods.** Construction of works valued at a total of about US$0.7 million and goods valued at a total of about US$1.1 million will be procured under this

project. These will include rehabilitation of OSCs and one CoE, basic electronic equipment, medical equipment, office equipment, toys for therapeutic play, reagents for DNA testing, video conference facilities and printed communication materials.

153 **Procurement of works**. Contracts estimated to cost less than US$10 million equivalent per contract would be procured through National Competitive Bidding (NCB) procedures. Small works contracts estimated to cost less than US$200,000 equivalent per contract may be procured through Shopping procedures by comparing prices for quotations received from at least three (3) reliable contractors or suppliers. In such cases, request for quotations shall be made in writing and shall indicate the description, scope of the works, the time required for completion of the works and the payment terms. All quotations received shall be opened at the same time. If the Borrower has been unable to obtain at least three quotations, it shall provide the Bank with reasons and justification why no other competitive method could be considered and obtain a no objection before proceeding on the basis of the only responses already received. Direct Contracting (DC) for works may exceptionally be an appropriate method in emergency situation, provided the Bank is satisfied in such cases that no advantage could be obtained from competition and that prices are reasonable.

154 **Procurement of Goods.** Contract packages estimated to cost US$1 million equivalent per contract and above will be procured through International Competitive Bidding (ICB) procedures. Contracts estimated to cost less than US$1million equivalent per contract would be procured through National Competitive Bidding (NCB) procedures. Small contracts estimated to cost less than US$100,000 equivalent per contract may be procured through shopping procedures by comparing prices for quotations received from at least three (3) reliable contractors or suppliers. In such cases, request for quotations shall be made in writing and shall indicate the description and specifications, quantities, delivery period and payment terms. All quotations received shall be opened at the same time. As a general rule, a qualified supplier who offers goods or materials that meet the specifications at the lowest price shall be recommended for award of the contract. Limited International Bidding (LIB) for goods may exceptionally be used when there are only a limited number of known suppliers worldwide. Direct Contracting (DC) for goods may exceptionally be an appropriate method in emergency situation, provided the Bank is satisfied in such cases that no advantage could be obtained from competition and that prices are reasonable. Vehicles to be provided under this project could also be grouped together and delivered by UNOPS pursuant to paragraph 3.10 of the Guidelines. In this case the Borrower shall submit to the Bank for its no objection a full justification and the draft form of agreement with UNOPS.

155 **Procurement of non-consulting services.** Non-consulting services which are services that are not of intellectual or advisory in nature will include for instance maintenance of vehicles and IT equipment. The procurement of non-consulting services shall follow the existing World Bank's SBDs for ICB, or national standard bidding documents for NCB, with appropriate modifications.

156 **Use of Framework Agreements (FAs).** Common supplies, for example, stationery and consumables will be aggregated and procured through framework contracts to enable implementing agencies place orders for urgently needed supplies at short notice, at a competitive price. FAs shall not restrict foreign competition, and should be limited to a maximum duration of

3 (three) years. The Borrower shall submit to the Bank for its no objection the circumstances and justification for the use of an FA, the particular approach and model adopted, the procedures for selection and award, and the terms and conditions of the contracts. FA procedures applicable to the project are those of the Borrowers that have been deemed acceptable by the Bank, and shall be described in the Loan Agreement.

157 **Selection of Consultants**. Consultant services would include among others technical assistance and trainings for SGBV service providers, research, development of communication and sensitization materials, and development of activities for behavioral change at the community level. The consulting services would be provided by consulting firms or individual consultants. Consulting contracts will as far as possible be awarded under ***Quality and Cost Based selection (QCBS)*** procedures. Other methods of selection will be determined for each assignment depending on the type of assignment and the provisions of the Consultant Guidelines, and will be indicated in the procurement plan. ***Quality Based Selection (QBS)*** and/or ***Fixed Budget Selection (FBS)*** may be used for assignments which meet the requirements of paragraph 3.2 and 3.5 of the Consultants Guidelines respectively. However, consultants used for assignments of a standard and routine nature such as audits and other repetitive services would be selected through ***Least-Cost Selection (LCS)*** method in accordance with paragraph 3.6 of the Consultants Guidelines; and Single-Source Selection (SSS) would be followed for assignments which meet the requirements of paragraphs 3.8 - 3.11 of the Consultant Guidelines and will always require the Bank's prior review regardless of the amount. Contracts for consulting services, using firms, estimated to cost less than US$200,000 equivalent and for which the cost of a full-fledged selection process would not be justified may be selected on the basis of ***Consultant Qualifications (CQS)*** in accordance with paragraphs 3.7 of the Consultants Guidelines. ***Short List of consultants*** for services estimated to cost less than US$ 200,000 equivalent per contract may be comprised entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. For consulting assignments of engineering and contract supervision, short list of consultants for services estimated to cost less than US$300,000 equivalent per contract may be comprised entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. Individual Consultants (IC) would be selected on the basis of their qualifications in accordance with Section V of the Consultant Guidelines. Under the circumstances described in paragraph 5.6 of Section V of the Consultant Guidelines, such contracts may be awarded to individual consultants on a sole-source basis.

158 **Single-Source Selection (SSS)** of consulting firms or individuals would be applied only in exceptional cases if it presents a clear advantage over competition when selection through a competitive process is not practicable or appropriate and would be made on the basis of strong justifications and upon Bank's concurrence to the grounds supporting such justification. Paragraph 3.8-3.11 for consulting firms and paragraph 5.6 for individual consultants will be taken as a reference for use of single source.

159 **Individual Consultants (IC)** will be selected on the basis of their qualifications by comparison of CVs of at least three candidates from those expressing interest in the assignment or those approached directly by the Implementing Agency in accordance with the provision of Section V of the Consultants Guidelines.

160 **Operating Costs:** Operating costs for the implementation of this project will include rental of office space in the short term, office suppliers and consumables, communication costs, operational and maintenance of office vehicles, operation and maintenance costs for IT Equipment, per diem and travel costs when travelling on duty during implementation of this project, reasonable bank charges, vehicle maintenance costs, fuel, advertising costs, allowances and salaries of contractual staff (excluding the salaries of civil servants). These will be procured using the Borrower's administrative procedures, acceptable to the Bank. Operating expenditures are neither subject to the Procurement and Consultant Guidelines nor prior or post reviews. Operating expenditures are normally verified by TTLs and FM Specialists.

161 **Training and Workshops**: The project will also finance the cost of workshops, study tours, and various consultations with stakeholders regarding the project. The training, workshops, conference attendance and study tours will be carried out on the basis of approved annual programs that will identify the general framework of training and similar activities for the year, including the nature of training/study tours/workshops, the number of participants and estimated cost.

162 The procurement procedures and SBDs to be used for each procurement/selection method, as well as model contracts for works and goods procured & consultants, will be detailed in the project implementation manual (PIM).

163 **Procurement Staffing.** The respective SPIU within MIGEPROF and MoH will be the procurement agents for the project. Each SPIU will carry out procurement activities for their respective activities The SPIU within MIGEPROF is new and has no prior experience working with the World Bank projects on the procurement aspects. The SPIU will be reinforced with a competitively recruited experienced Procurement Specialist conversant with World Bank procurement procedures for the implementation of the project. The SPIU unit within the MoH has experienced procurement staff and experience with among others Global Fund and World Bank procurement procedures, including through the World Bank financed MAP project (closed) and East Africa Public Health Laboratory Networking Project (EAPHLN) project (ongoing). However, the SPIU within the MoH expressed the need for additional specialized training for World Bank procurement procedures**.**

164 **Internal Tender Committee.** MIGEPROF's Tender Committee is composed of five people**.** The Tender Committee members are all new, with 3 of them appointed in September 2013 and two appointed in February 2014. The newly appointed members will be soon trained by the RPPA in national procurement procedures. The Tender Committee members also need to be trained in the World Bank procurement procedures. The Tender Committee at the SPIU within the MoH is composed of 7 people with knowledge of World Bank procedures.

165 **Records Keeping.** The SPIU within the MoH has moved recently to a new office with appropriate space for records keeping. The Procurement team has a procurement assistant who helps on filing procurement documents. However, the procurement unit needs a safe to keep financial proposals, performance guarantees, original signed contracts and other confidential documents. The SPIU within MIGEPROF is new and will need appropriate space for records keeping of procurement documents as well as a safe for keeping financial proposals, performance guarantees, original signed contracts and other confidential documents.

166 **Control System.** The financial annual audit, which also covers procurement operations, is conducted by the Office of Auditor General for all government institutions. The RPPA also conducts an audit of procurement operations every two years. MIGEPROF has an Internal Auditor who also reviews procurement operations on regular basis. The Department of Internal Audit at the MoH focuses mainly on beneficiaries' activities at the decentralized level and relies on Audit General Office Reports for the Head Office.

167 **Monitoring.** Monitoring and evaluation of procurement performance will be carried out through: Bank supervision and post procurement review missions.

168 **Frequency of Procurement Supervision.** In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended semi-annual supervision missions to conduct field visits, of which at least one mission will involve post review of procurement actions.

169 **Risk Rating.** Procurement Staff at the SPIU within the MoH is conversant with national procurement procedures as well as World Bank procedures. The current procurement capacity of the newly created SPIU within MIGEPROF is limited and its staff does not have experience of working with the World Bank procurement procedures. As such, the procurement arrangements have an **overall high risk rating**. The table below describes the risk mitigations to be implemented by the project:

Procurement risks and mitigation measures

Risk	Action Required	By When	Responsible Entity
MIGEPROF - No prior experience in using World Bank procurement procedures	Recruit a well-qualified procurement specialist with experience in World Bank Procurement Procedures	Project Effectiveness Date	MIGEPROF
Newly appointed Tender Committee members at MIGEPROF lacks experience in procurement procedures	Train Committee members in procurement procedures to be organized for the tender committee members	Project Effectiveness Date	MIGEPROF/RPPA
All procurement documents including confidential documents are kept in the office of the Procurement Officer	Avail appropriate space for records keeping and procure a safe for financial proposals and other confidential documents	Project Effectiveness Date	MIGEPROF
The procurement manual used by SPIU/MoH is part of the general PIM for its whole portfolio	Prepare a specific procurement manual for the implementation of the Project	Project Effectiveness Date	MIGEPROF/MoH

170 **Prior review threshold.** The prior review thresholds are as follows:

a. **Procurement of Goods and Works**

No	Procurement Method (Goods and Works)	Thresholds (*) in US Dollars	Prior Review Threshold in US Dollars	Comments
1.1	ICB **(Goods)**	≥1,000,000 per contract	All contracts.	Contracts subject to Prior review in this category may be identified by the World Bank on a case by case basis
1.2	LIB **(Goods)**	No specific ceiling	N/A	
1.3	NCB **(Goods and Non Consultants Services)**	<1,000,000	Contract of value equal or above US$500,000	Contracts subject to Prior review in this category may be identified by the World Bank on a case by case basis
1.4	Shopping **(Goods and Non Consultants Services)**	< 100,000 per contract	None	
1.5	Direct Contracting	All values	All Contracts	
2.1	ICB (IT Systems, and Non-consulting services)	≥ 1,000,000	All Contracts	Contracts subject to Prior review in this category may be identified by the World Bank on a case by case basis
2.2	NCB (IT Systems, and Non-consulting services)	< 1,000,000	Each contract of value equal or above US$500,000	Contracts subject to Prior review in this category may be identified by the World Bank on a case by case basis
3.1	ICB **(Works**)	≥ 10,000,000 per contract	All Contracts	
3.2	NCB **(Works)**	< 10,000,000 per contract	Each contract of value equal or above US$500,000	Contracts subject to Prior review in this category may be identified by the World Bank on a case by case basis
3.3	Shopping **(Works)**	<200,000 per contract	None	
3.4	ICB**(Non-Consultant Services)**	≥ 1,000,000 per contract	≥1,000,000 per contract	
3.5	Direct Contracting	All values	All contracts	

(*) These thresholds are for the purposes of the initial procurement plan. The thresholds will be revised periodically based on re-assessment of risks

b. Procurement of Consultants

	Selection Method	Thresholds (*) in US Dollars	Prior Review Threshold	Comment
1.	QCBS	≥USD 200,000	≥USD 200,000	All TORS are subject to prior review irrespective to contract amount
2.	QBS	≥USD 200,000	≥USD 200,000	All TORS are subject to prior review irrespective to contract amount
3.	LCS	≥USD 200,000	≥USD 200,000	All TORS are subject to prior review irrespective to contract amount
4.	CQS	< USD 200,000	≥USD 200,000	All TORS are subject to prior review irrespective to contract amount
5.	SSS	All values	All Contracts	All TORS are subject to prior review irrespective to contract amount
6.	IC	No Ceiling	≥USD100,000.	All TORS are subject to prior review irrespective to contract amount

(*) These thresholds are for the purposes of the initial procurement plan. The thresholds will be revised periodically based on re-assessment of risks

171 **Procurement plan.** The Borrower, at appraisal, developed an initial procurement plan for the first 18 months of project implementation. The final version of this plan was agreed upon between the Recipient and the Bank Team during project negotiations. It will be available at the MIGEPROF website and on the Bank's external website. The Procurement Plan will be updated annually, in agreement with the Project Team, or as required to reflect actual project implementation needs and improvements in institutional capacity.

172 The following tables provide details of the procurement arrangements for some major contracts.

Table 1: List of goods, works and non-consultancy services

MIGEPROF								
Ref	**Tender (CONTRACT) Description**	**Estimated cost (budget)**	**Tendering method**	**Prequali-fication (YES/NO)**	**Domestic preference (YES/NO)**	**Review by Bank (Prior/ Post)**	**Expected Bid opening Date**	**Comments**
3	Renovation (upgrading) of center of excellence	USD 800,000	NCB	No	No	Post	March 15, 2015	To renovate center of excellence (all buildings, gardening and parking)
4	Production of sensitization materials	USD 44,066	NCB	No	No	Post	Feb 15, 2015	Includes promotional materials (banners, flyers, leaflets, brochures)
5	Printing services	US$50,000	NCB	No	No	Post	March 14, 2015	Printing booklets that will be used to train community structures
6	Hotel services for 4 stars	US$ 80,000	Framework Agreement	No	No	Post	November 20,2014	Hosting regional learning event, south-south learning event and annual regional peer assessment
1	Acquisition of a vehicle	USD 50,000	Shopping	No	No	Post	15 October, 2014	A vehicle for transporting project staff
2	Office equipment for MIGEPROF staff	USD 16,000	Shopping	No	No	Post	15 October, 2014	Office equipment (office desks,chairs,closed Office cabinet ,laptops, printers, and scanner)
7	Hotel services for 5 stars	US$50,000	Framework Agreement	No	No	Post	November 20,2014	Hosting regional learning event, south-south learning event and annual regional peer assessment
MoH								

1	Supply of Reagent for DNA detection	USD 500,000	ICB	NO	NO	PRIOR	Octobe r 30, 2015	These will be used in 2nd year, after setting up IOCs
2	Renovatio n works of 17 IOCS	USD 800,000	NCB	NO	NO	PRIOR	Novem ber 15, 2014	Setting up 17 IOCs(Murunda, Mugonero, Kilinda, Kiziguro, Kibogora, Kabaya, Gahini, Ruli, Rutongo, Kibilizi, Gitwe, Kibagabaga + 5 to be identified)
3	Office supplies	USD 32,000	Shopping	NO	NO	POST	Septem ber 30, 2014	Budget to be used in common basket to fund office supplies for SPIU(Refer to component 3 of the Project)
4	Office equipment	USD 111,238	NCB	NO	NO	POST	Septem ber 30, 2014	To equip 17 Isange one Stop Centers
5	Supplies OSCs	USD 271,813	NCB	NO	NO	PRIOR	Novem ber 15, 2014	To equip 17 Isange one Stop Centers
6	IT Equipment OSCs	USD 61,000	NCB	NO	NO	POST	Novem ber 15, 2014	To equip 17 Isange one Stop Centers
7	Commu-nication hand sets OSCs	USD 44,000	Shopping	NO	NO	POST	Novem ber 15, 2014	To equip 17 Isange one Stop Centers
8	Motorcycl es	USD 186,000	NCB	NO	NO	PRIOR	Novem ber 15, 2014	For 17 IOCs and MINIJUST
9	Medical Consumabl es	USD 105,000	NCB	NO	NO	POST	Novem ber 30, 2014	(50persons/month*$15/person* 36months*17 IOSCs)
10	92 Hospital linen	USD 14,112	Shopping	NO	NO	POST	Novem ber 15, 2014	To equip 17 Isange one Stop Centers

Table 2: List of consulting services

MIGEPROF						
Ref. No.	**Description of Assignment**	**Estimated Cost**	**Selection Method**	**Review by Bank (Prior / Post)**	**Expected Proposals Submission Date**	**Comments**
1	Project Coordinator	USD 42,000	Individual consultant	Prior	August 15, 2014	
2	Sr. Financial Management Specialist	USD 32,400	Individual consultant	Prior	August 15, 2014	
3	Procurement Specialist	USD 32, 400	Individual consultant	Prior	August 15, 2014	
4.	Monitoring and Evaluation Specialist	USD 32,400	Individual consultant	Prior	August 15, 2014	
5.	Consultancy for Safeguards Documents	USD 5,000	Individual consultant	Prior	August 15, 2014	
6.	Consultancy to develop Project Implementation Manual	USD 10,000	Individual consultant	Prior	August 15, 2014	
7.	Consultancy for developing a module	USD 5,000	Individual consultant	Prior	November 30, 2014	Hire a consultant firm to develop a training module for community structures
8.	Database design and development	USD 50,000	QBS	Prior	November 30, 2014	Consultancy to develop content of database (technical SGBV related issues) services of database design, development, system installation, train customers and among others
9.	Database development and installation	USD 500,000	ICB	Prior	March 15, 2015	Consultancy to develop technical aspects of database, system installation, train customers and among others
10.	Baseline impact evaluation	USD250,000	QBS	Prior	October 14, 2014	
11.	Consultancy for booklet development message	USD35,000	Individual consultancy	Post	February 3, 2015	
12..	Consultancy for developing a module for training of judicial staff	USD 10,000	Individual consultant	Prior	October 15, 2014	
13.	Consultancy for development live community skits	USD 25,000	Individual consultant	Post	June 15, 2015	
14.	Consultancy development message	USD 5,000	Individual consultant	Post	June 15, 2015	

	Urunana					
MoH						
1.	Basic trainings on multidisciplinary approach for 12 IOSCs service providers	USD 88440	Individual consultant	Post	November 15, 2014	10 staff per one IOSC for 10 days per session *4 sessions
2.	Advanced training on MDIIT for 12 IOSCs service providers	USD 88440	Individual consultant	Post	November 15, 2014	10 staff per one IOSC for 10 days per session *4 sessions
3.	DNA Detection	USD 265,055	Individual consultant	Prior	October 15, 2015	7 National Police Officers will be trained on DNA through training program in a specialized international institution

ICGLR

173 **General Procurement Environment.** Procurement in ICGLR is regulated by the internal procurement guidelines as revised in January 2007. These guidelines include description of procurement process for works, goods and services; contract management and asset management. Overall, provisions of these guidelines follow modern procurement principles, including transparency, fairness, competition and economy. However, terminologies as well as procurement and selection methods do not match with those of the World Bank procurement guidelines and consultants' guidelines. In addition, there is no clarity on dealing with fraud and corruption in procurement.

174 **Assessment of implementation capacity for procurement.** The Bank conducted a procurement capacity assessment of the Secretariat of the ICGLR, analyzing the internal organizational structure, actual capacity in handling procurement and past experience in implementing World Bank procurement procedures.

175 **Key risks for implementation of the projects** include: (i) discrepancies between ICGLR and World Bank procurement procedures; (ii) staff in charge of procurement has limited experience and capacity in implementing World Bank-funded projects; (iii) inadequate procurement planning; and (iv) inappropriate records keeping and documents management system.

176 **Risk rating and mitigation measures.** Based on aforementioned risks and current capacity, the procurement arrangements have an **overall high risk rating**. The table below describes the risk mitigations to be implemented by the project:

Risk	**Action**	**Completion Date**	**Responsible Entity**
Discrepancies between ICGLR and World Bank procurement procedures	Preparation of a specific procurement manual for the implementation of the Project on the basis of World Bank Procurement Procedures	Three months after effectiveness	ICGLR

Limited experience of procurement staff in using World Bank procurement procedures	Recruit a well-qualified procurement specialist with extensive experience in World Bank Procurement Procedures	Project Effectiveness Date	ICGLR
Inappropriate record keeping & documents management system	(i)Establishment of a separate and strengthened procurement records and documents keeping system following the World Bank guide on filing and archiving procurement documents. (ii) Avail appropriate space for records keeping and procure a safe for financial proposals, performance guarantees, original signed contracts and other confidential documents.	Three months after effectiveness	ICGLR

177 Prior review threshold. The prior review thresholds are as follows:

c. **Procurement of Goods and Non-consulting Services**

Expenditure category	Procurement method	Threshold (US$)	Contracts subject to prior review
1. Goods	ICB and LIB NCB Shopping Direct Contracting	≥ US$0.5 million < US$0.5 million < US$50,000 All values	All contracts None None All contracts
2.Non-consulting Services	NCB Shopping Direct Contracting	< US$0.5 million < US$50,000 All values	None None All contracts

(*) These thresholds are for the purposes of the initial procurement plan. The thresholds will be revised periodically based on re-assessment of risks

d. **Procurement of Consultants**

Expenditure category	Contract value (Threshold) US$	Procurement method	Contracts subject to prior review
(c) Firms	≥ US$200,000 < US$200,000 All values	QCBS, QBS, FBS, LCS QCBS, CQS, LCS, QBS, FBS, SSS	All contracts (Selected contracts as indicated in the procurement plan) All contracts
(d) Individuals	≥ US$100,000 All values	Three CVs SSS	All contracts All contracts

(*) These thresholds are for the purposes of the initial procurement plan. The thresholds will be revised periodically based on re-assessment of risks

178 **Procurement Plan.** The ICGLR prepared a simplified 18-months procurement plan, which will provide the basis for the procurement methods. This plan will be concluded and agreed upon before negotiations. It will also be available at the ICGLR database/website and in the Bank's external website. For each contract to be financed by the IDA Grant, the ICGLR and the World Bank will agree upon and record in the Procurement Plan, the different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements, and time frame. The Procurement Plan will be updated annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

179 The following tables provide details of the procurement arrangements.

Table 1: List of goods, works and non-consultancy services

Ref. No.	Contract (Description)	Estimated Cost (US$)	Procurement Method	Domestic Preference (yes/no)	Review by Bank (Prior / Post)	Expected Bid-Opening Date
1	ICGLR Equipment-Video Conferencing	100,000	ICB	No	Prior	Dec 15, 2014
2	Office Equipment CS	12,000	Shopping		Post	Sep 2014
3	Office Equipment RTF	6,000	Shopping		Post	Sept 2014

Table 2: List of consulting services

Ref. No.	Description of Assignment	Estimated Cost (US)	Selection Method	Review by Bank (Prior / Post)	Expected Proposals Submission Date
1	Mid-Term independent review	50,000	CQS	Prior	Dec 15, 2016
2	Consultant to development M&E database including framework Kampala Declaration	10,000	IC	Prior	Nov 15, 2014
3	Consultant-Accounting RTF	21,600	IC	Prior	Sep 2014
4	Consultancy to develop Curriculum for ToT at RTF	120,000	CQS	Prior	Feb 15, 2015
5	Project Coordinator	0 74,500	IC	Prior	August 30, 2014
6	Financial Audit- Yearly audit	40,000	LCS	Prior	Dec 15, 2014
7	Financial Management Advisor	0	IC	Prior	August 30, 2014
8	Procurement Specialist (Consultant)	7,000	IC	Prior	August 30, 2014
9	Consultancy to develop training implementation strategy for RTF	40,000	IC	Prior	October 15, 2014
10	Consultant to Develop webpage for RTF and CS	20,000	IC	Prior	Feb 15, 2015

11	Consultant to develop , e-learning training materials, web-hosting for selected modules, laws, protocols, good practices	40,000	IC	Prior	June 15, 2015
12	Implementation partner for Man-Up Campaign M1	82,500	QCBS	Prior	Sept 15, 2014
13	Implementation partner for Man-Up Campaign M2	82,500	QCBS	Prior	Sept 15, 2014
14	Consultant to develop training for journalists	10,000	IC	Prior	March 15, 2015

Note: All ToRs require prior review, regardless prior or post review contract

180 **Short List of consultants (Firms)** for services estimated to cost less than US$ 200,000 equivalent per contract may be comprised entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

181 **Bidding documents and request for proposals applicable to the project**. Procurement will be carried out using the Bank's Standard Bidding Documents (SBD) for goods for International Competitive Bidding (ICB), while selection of consultants will use the Standard Request for Proposals. For National Competitive Bidding (NCB), the ICGLR will built on the Bank's SBD and prepare, as part of annex to PIM, a type of national bidding document to be used throughout the project once agreed upon with the Bank. In this regard and in accordance with paragraph 1.16 (e) of the Procurement Guidelines, each bidding document and contract financed out of the proceeds of the Financing shall provide that (a) the bidders, suppliers, contractors and their subcontractors, agents, personnel, consultants, service providers, or suppliers shall permit the Association, at its request, to inspect all accounts, records and other documents relating to the submission of bids and contract performance, and to have said accounts and records audited by auditors appointed by the Association; and (b) the deliberate and material violation of such provision may amount to an obstructive practice as defined in paragraph 1.16 (a)(v) of the Procurement Guidelines.

182 **Advertising:** A comprehensive General Procurement Notice will be prepared by the Borrower and published in the United Nations Development Business online (UNDB online) and relief web following Board Approval, to announce major consulting assignments and any international competitive bidding (ICB). The General Procurement Notice shall include all ICB for goods and non-consulting services contracts and all large consulting contracts (i.e., those estimated to cost US$200,000 or more). In addition, a specific procurement notice is required for all goods to be procured under ICB in UNDB online. Requests for Expressions of Interest (EOI) for consulting services expected to cost more than US$200,000 shall be advertised in UNDB online and relief web. An EOI is required in the national gazette, a national newspaper, or an electronic portal of free access for all consulting firm services regardless of the contract amount. In the case of NCB, a specific procurement notice will be published in the national gazette, a national newspaper, or an electronic portal of free access. Contract awards will also be published in UNDB, in accordance with the Bank's Procurement Guidelines (Para. 2.60) and Consultants Guidelines (para. 2.31).

183 **Operating Costs:** Operating costs for the implementation of this project will include office supplies and consumables, communication costs, operation and maintenance costs for IT Equipment, per diem and travel costs when travelling on duty during implementation of this

project, reasonable bank charges, fuel, advertising costs, allowances and salaries of contractual staff (excluding the salaries of civil servants). Operating expenditures are neither subject to the Procurement and Consultant Guidelines nor prior or post reviews. Operating expenditures are normally verified by TTLs and FM Specialists.

184 **Training and Workshops**: The project will also finance the cost of workshops, study tours, and various consultations with stakeholders regarding the project. The training, workshops, conference attendance and study tours will be carried out on the basis of approved annual programs that will identify the general framework of training and similar activities for the year, including the nature of training/study tours/workshops, the number of participants and estimated cost.

185 The procurement procedures and SBDs to be used for each procurement/selection method, as well as model contracts for goods procured & consultants, will be detailed in the project implementation manual (PIM).

186 **Control System.** The financial annual audit will cover procurement operations. In addition, ICGLR is putting in place an Internal Auditor who also reviews procurement operations on regular basis.

187 **Monitoring.** Monitoring and evaluation of procurement performance will be carried out through regular Bank supervision and post procurement review missions.

188 **Frequency of Procurement Supervision.** In addition to the prior review supervision to be carried out from Bank offices, semi-annual supervision missions will conduct field visits, of which at least one mission will involve post review of procurement actions.

D. Social and Environment

189 As the project is prepared under the special considerations clause of OP10.00, the safeguards instruments have been deferred to, and will be prepared during the project implementation period. In line with the provisions of OP10.00 for the case of deferral of safeguards instruments into the project implementation phase, the team, in consultation with Recipients, prepared an environmental and social action plan (ESAP), explaining the anticipated impacts, the required safeguards approach and instruments, and the modalities and arrangements for the production of safeguards instruments during implementation.

190 The ESAPs for the three countries have been prepared in accordance with OP10.00, paragraph 11(a), with BP10.00, paragraph 47 (a) and with the Guidance Note on "Investment Project Financing Projects in Situations of Urgent Need or Capacity Constraints" (2013). The latter specifies the following structure and contents of the safeguards action plan, which was duly followed by the team during the preparation of the ESAP, which:

a. Sets out the steps for the sequential planning and coordination for project activities and the preparation of corresponding safeguard instruments (such as Resettlement Action Plans, EMPs, or Indigenous Peoples Plans);

b. Defines measures to ensure compliance with these safeguard requirements;

c. Describes the approach to be taken during implementation for screening, selecting, and designing subprojects/proposed investments and planning mitigation measures, including consultation and disclosure requirements;

d. Achieves a balance between information and conciseness that provides the required prospective detail, while allowing its preparation in a compressed timeframe of normally a few weeks; and

e. Has been annexed to the Project Appraisal Document (PAD), and referenced in the Integrated Safeguards Data Sheet (ISDS).

f. The specific structure of the ESAPs presented together with the project documentation is as follows below. The ESAP will become part of the legal agreement (by being referenced in this PAD) and its implementation and any attached conditionality (such as inception of physical activities or works) will be closely supervised by the Bank team.

a. Planned project activities, locations, and general environmental and social baseline (as far as known), and the expected environmental and social impacts.

b. For Category A and B projects, any significant, meaningful alternatives considered in project approach and/or design.

c. Sequencing and, if practical, tentative implementation schedule for safeguards processing:

- Sequencing of safeguards instruments.
- Preparation time for safeguards instruments, including Bank review, revisions, clearance, and approval steps.
- Disclosure and consultations.
- Finalization and implementation of instruments. Also, if applicable, development of secondary instruments (e.g., subproject EMPs to be developed, and specifying by whom - e.g., Contractors or other implementing entities - and by when).

d. Roles and responsibilities, including supervision arrangements for safeguards preparation, implementation, and monitoring.

e. Estimated costs for the safeguards preparation and implementation process.

f. The ESAPs are included in this PAD as Annex 8.

DRC

191 The project's environmental rating is Category B. The current project design is not expected to have large scale, significant, or irreversible environmental or social impacts. Potential adverse impacts will be temporary, site specific and limited in scope. The project activities that are

relevant in terms of a need to manage potential adverse environmental and social impacts are: Sub-component 1A (e) Integrated support for survivors of SGBV and violence prevention at the community level; and Sub-component 1B: Integrated support for survivors of SGBV at Health Facility Level, Sub-component 1C: Supporting existing integrated centers of excellence in the Kivus, and Component 2: High impact basic health services.

192 Expected impacts of upgrading the health centers are those of any small scale construction site (noise, dust, exhaust gases, waste generation, workplace and community health and safety). Depending on their location, this activity might induce potentially negative environmental impacts, but no cumulative effects are expected. Provision of medical care might cause an increase in the volume of hazardous medical waste generated, but this impact will be site specific and not large scale or irreversible. The generation of medical waste is an unavoidable feature of operating clinics. In addition, the project will provide support to CBOs, potentially in the form of small scale income generating subprojects through small in-kind grants. These will be on a very small scale and widely dispersed and so may induce only marginal adverse environmental impacts, with no significant or cumulative effects are not expected. Under OP4.01 the project was screened for its potential negative environmental and social impacts, which – due to their limited scale – resulted in a classification as category B. The appropriate safeguards instrument to address and manage the anticipated impacts is a simplified EMP.

193 The provinces of North and South Kivu are the target administrative and geographical locations of the project. At local level, established health centers, GRHs at the health zone level and referral hospitals at the tertiary level, will constitute the adjacent environments of the project. Potential sites for small scale rehabilitation of health centers will be in pre-existing medical facilities and are to be determined. Given the limited size of the proposed rehabilitation, potential localized adverse environmental and social impacts are expected to be minimal. In addition, selected villages in the two provinces will benefit from economic empowerment support. The physical environment of the target provinces is characterized by forests savanna, and highlands/mountains and hills (in North and South Kivu, landslides are frequent). Accessibility of areas off the main roads is a constant challenge. The provinces (North Kivu 59,483 km^2, South Kivu 65,070 km^2) cover an area of about 124.000 km^2; that is about the size of Belgium, Denmark and the Netherlands together.

194 The presence of indigenous people (Batwa) in North and South Kivu was identified and confirmed during project preparation. Batwa constitute a vulnerable and marginalized group in the project area. To address the risk of social exclusion of Batwa and to ensure they will benefit from the project, OP/BP 4.10 has been triggered, and an Indigenous Peoples Plan Framework (IPPF) focusing on outreach and inclusion will be prepared, building upon the recently developed IPPF for the Emergency Recovery Project (ERP) as well as the IPPF for the third Additional Financing of the PARSS project. The implementation partner for the EDRP, the FSDRC, is also the implementation partner for Sub-Component 1A of this project.

195 Future project activities are not anticipated to have long-term or indirect negative social or environmental impacts. Project activities are focused on providing services in health and community level support for survivors. The project is expected to increase social cohesion at the family and community level by specifically addressing issues of stigmatization and rejection of survivors of SGBV, as well as activities to promote gender equality and change negative

attitudes and norms towards women and girls. In addition, the project support will provide targeted communities with better access to basic health service. Project investments may strengthen sound environmental and social practices around health facilities.

196 At national level, DRC has a legislative and regulatory framework which is conducive to good environmental management. In addition, the DRC has signed a number of international treaties and conventions. However, implementation capacity is weak. Environmental policies and their compliance are governed by the Ministry of Environment, Conservation and Tourism (*Ministère de l'Environnement, de la Conservation de la Nature et du Tourisme* or MECNT). MECNT has three departments in charge of environmental monitoring and management: (i) the DRC Environmental Studies Group (*Groupe d'Etudes Environnementales du Congo* or GEEC); (ii) the National center for Environmental Information (*Centre National d'Information sur l'Environnement* or CNIE); and (iii) the Environmental Regulation and Dispute Unit (*Cellule Réglementation et Contentieux Environnementaux* or CRCE). GEEC is responsible for safeguards compliance of all projects in the country, but with emphasis on environmental category A projects. The unit is understaffed and has limited capacity. Despite several donor-funded capacity building initiatives, the unit still largely relies on donor funds to carry out its field supervision duties.

197 At the project level, FSDRC has implemented the previous Bank-funded PASU project (2004-2013) which helped this agency to lay a sound institutional foundation for preparing, managing and monitoring potential adverse environmental and social impacts of Bank-funded projects. FSRDC prepared and implemented the safeguards instruments of PASU and is currently preparing safeguards instruments for the recently approved ERP. During the implementation of PASU, environmental and social safeguards have been respected in accordance with the Environmental and Social Management Framework approved by the Bank. For health related activities, although the PHDs have no experience with World Bank projects, they will build upon the experience from the MoPH which implements the World Bank PARSS project, for which a MWMP has been prepared as well as the previously mentioned IPPF.

198 The following instruments are foreseen for the management of the anticipated environmental and social impacts:

(d) ***Upgrading health facilities: An Environmental Management Plan (EMP) using the "checklist format"*** will be developed for this activity due to the small scale, routine manner of interventions, and the expected minor, temporary and localized nature of the potential impacts. The EMP will be produced, reviewed by the Bank, disclosed, consulted on and finalized before any disbursement on physical works of this type of activity may be undertaken. The same instrument would be applied for the management of any anticipated negative impacts of the activities to create CBOs.

(e) ***Medical care***: ***A Medical Waste Management Plan*** **(MWMP)** will be produced for the generation and disposal of medical waste from the health facilities, which will cover (i) anticipated waste composition and quantity; (ii) existing medical waste management system, including free capacity, deviations from, and gaps to BAT, (iii) existing regulatory framework and supervision / monitoring arrangements; (iv) plan for using the existing medical waste management system, including any measures to

upgrade or remedy identified gaps and deviations; and (v) additional arrangements for supervision and monitoring of medical waste management.

(f) **Indigenous People: An Indigenous Peoples Planning Framework (IPPF)** will be prepared and disclosed focusing on outreach and inclusion of *Batwa* in project activities at the community level.

199 FSDRC will be responsible for the production of the IPPF. The CDEF Unit in MoF will be responsible for preparing the EMP and MWMP in close collaboration with PHDs in both Kivus. Responsibilities include (if required) the production of TORs, the management of the consultancy contracts (if required), the review and quality control of deliverables, the driving of the disclosure and consultation process, and the inclusion of the safeguards instruments into tender and contract documents, as well as operational procedures for the health centers.

200 PHDs will be responsible for the day-to-day follow up and supervision of the works implementation, including compliance with environmental and social due diligence provisions, and monitoring and supervision of the EMP implementation during construction as well as the EMP during the project implementation. FSDRC will be responsible for the day-to-day follow up and supervision of compliance with environmental and social due diligence provisions, and monitoring and supervision of the EMP and the IPP implementation for their respective activities during the project implementation.

201 As a deferral of safeguards instruments into the implementation period has been approved due to "special considerations" for the project, the EMP and MWMP will be produced during the design stage for the planned health centers and become part of the tender packages and construction contracts and operational manuals. In addition, an IPP will be prepared and disclosed before project effectiveness. An Environmental and Social Action Plan (ESAP) has been developed for the project.

202 The project is rated as an environmental category B as activities are not expected to have significant or irreversible environmental impacts, would have limited to no localized adverse impacts, and no cumulative impact. Any negative social impact of the project is expected to be very low. The project will contribute to increased social cohesion at the family and community level by specifically addressing issues of stigmatization of SGBV.

Burundi

203 The environmental baseline of the potential project locations is characterized by pre-existing use as medical facilities, usually within larger villages or cities, within urbanized areas, compounds designated as hospitals for several years already, and entirely within existing structures.

204 Regulatory oversight over waste management and general environmental impacts are shared by the National Agency for Environmental Management (NEMA) and the MoH's Department for Environmental Health (DEH) through an inter-ministerial ordinance on biomedical waste management signed by the Ministers for Health and Environment. The two ministries have been involved in drafting of the biomedical waste management plan document in health settings. Both

of them were members of a steering committee for the design of three training manuals on biomedical waste management (the first for managers, the second for nurses and the third for health workers). In total, 1500 personnel have been trained on those manuals. Overall, the ministries have exercised their responsibilities in the waste management sector in a diligent, professional and comprehensive manner.

205 It can thus be presumed that the medical facilities, within which the new services for SGBV survivors would be established, are currently reasonably well managed in terms of medical waste, and significant risks from the generation, handling, transport and treatment of medical waste are not expected.

206 The current project design will cause minimal environmental or social adverse impacts, all of which are temporary, minor, confined to locations within already existing structures, compounds and built up areas, and can be mitigated with standard, readily available measures. The project relevant activities in terms of need to manage potential adverse environmental and social impacts fall into two broad categories:

- ***Small scale construction and rehabilitation activities, including the renovation and re-configuration works within existing and operating community facilities, hospitals, and youth centers (Subcomponents 1A/1B and Component 2):*** These would entail temporary, localized and minor negative impacts, such as noise, vibrations, dust, odors by exhaust fumes, paints, fuels and lubricants, the generation of construction waste, and risks to pedestrian and traffic safety due to movements of construction machinery. Workplace health and safety would also be an important concern.

- ***Generation of additional medical waste during the operation of the planned integrated services for survivors and during provision of services for women and youth (Subcomponent 1B, and Component 2):*** The expansion and improvement of health services for SGBV survivors and other groups, as well as the increased quality of their treatment are likely to generate additional quantities of medical waste, which, classified as hazardous, would have to be diligently handled, stored and disposed of.

207 The following safeguards instruments are foreseen for the management of the anticipated environmental impacts:

- *Small scale construction and rehabilitation activities, including the renovation and re-configuration works within existing operating community facilities, hospitals and youth centers (Subcomponents 1A/1B, and Component 2):* ***An EMP using the "checklist format"*** will be developed for this activity due to the small scale, routine manner of interventions, and the expected minor, temporary and localized nature of the potential impacts. The EMP will be produced, reviewed by the Bank, disclosed, consulted on and finalized before any disbursement on physical works of this activity may be undertaken.

- *Generation of additional medical waste during the operation of the planned integrated services for SGBV survivors (Subcomponent 1B, and Component 2: **A Medical Waste Management Plan*** will be produced for the generation and disposal of additional medical waste resulting from the services for SGBV survivors and other groups, which will cover: (a) anticipated waste composition and quantity; (b) existing medical waste management system, including free capacity, deviations from, and gaps to BAT; (c) existing regulatory framework and supervision / monitoring arrangements; (c) plan for using the existing medical waste management system, including any measures to upgrade or remedy identified gaps and deviations; and (d) additional arrangements for supervision and monitoring of medical waste management.

208 As deferral of safeguards instruments into the implementation period has been approved due to "special considerations" for the project, EMP and MWMP will be produced during the design stage for the planned OSCs at existing hospitals and become part of the tender packages and construction contracts / operational manuals.

Rwanda

209 The project activities that are relevant in terms of a need to manage potential adverse environmental and social impacts are the activities (a) and (c), both planned under subcomponent 1B. *Integrated support for survivors of SGBV at health facility level*, as well as activity (b) under Component 2. *Regional and National Knowledge Sharing, Research and Capacity Building*

210 ***Setting-up One Stop Centers (OSCs) and one Center of Excellence***. To ensure survivors of SGBV will be received in an adequate environment, the project will support setting up in existing hospitals special rooms and upgrade existing ones. This will include adding safe rooms to accommodate and ensure access to medical, psychosocial, forensic and legal support, including separate safe rooms for male and female survivors of SGBV. Ideally, an OSC should include 2 safe rooms, 1-2 consultation rooms, 1 private reception room, 2-4 adults and child therapy rooms, 1 judicial police officer and legal consultation room and 1 investigative interview room for children and adults. In addition, the OSCs will be provided with essential equipment, including medical, and for the child therapy rooms. The OSCs will be established in 12 existing hospitals which would be rehabilitated and modernized to accommodate the OCSs. Under component 2, one Center of Excellence (CoE) will be established in a pre-existing, publicly used and owned building which has already been identified in Kigali, about 150 m from a major hospital facility (police hospital).

211 ***Medical care***. Survivors will receive preventative and curative medical services and follow-up in a confidential manner. The medical service providers from the OSCs will use the Manual for Medical Management of GBV survivors (MoH, 2009). The medical doctor at the OSC will be in charge of medical care, treatment and evidence protection. Prevention will include post exposure prophylaxis (72 hours), prevention of sexually transmitted infections (STI), and vaccinations against Hepatitis B and tetanus, as needed. In addition, other basic medical care services will be provided such as pain relief and treatment of wounds. All medical care, equipment and medication will be adapted to the age of the patient. In addition, for more serious

cases, additional specialized medical support, including for example for fistulas, prolapsed uterus or other obstetric problems, will be provided.

212 The environmental baseline of the project locations is characterized by a pre-existing use as medical facilities, usually within larger villages or cities, within urbanized areas, compounds designated as hospitals for several years already, and entirely within existing structures. In addition, one pre-existing, publicly used building on a government-owned plot will be upgraded. The medical facilities within which the OCSs would be established are currently well managed, especially in terms of medical waste generation, which is treated in modern incinerators, which are installed in about 90 percent of the 42 current district hospitals.

213 The current project design will cause minimal environmental or social adverse impacts, all of which are temporary, minor, confined to locations within already existing structures, compounds and built up areas, and mitigable with standard, readily available measures. In activity (i) (see section above) the expected impacts are those of any small scale construction site (noise, dust, exhaust gases, waste generation, workplace and community health and safety), in activity (iii) the main adverse potential impact could occur during the operation of the operation of OSCs, where the planned medical care services will produce medical waste, that – classifiable as hazardous – will need to be managed appropriately. The generation of medical waste is an unavoidable feature of operating clinics.

214 As the project is prepared under the special considerations clause of OP10.00, the safeguards instruments have been deferred to, and will be prepared during the project implementation period. In line with the provisions of OP10.00 for the case of deferral of safeguards instruments into the project implementation phase, the team, in consultation with Recipients, prepared an environmental and social action plan (ESAP), explaining the anticipated impacts, the required safeguards approach and instruments, and the modalities and arrangements for the production of safeguards instruments during implementation.

215 The ESAPs for the three countries have been prepared in accordance with OP10.00, paragraph 11(a), with BP10.00, paragraph 47 (a) and with the Guidance Note on "Investment Project Financing Projects in Situations of Urgent Need or Capacity Constraints" (2013). The latter specifies the following structure and contents of the safeguards action plan, which was duly followed by the team during the preparation of the ESAP, which:

a. Sets out the steps for the sequential planning and coordination for project activities and the preparation of corresponding safeguard instruments (such as Resettlement Action Plans, EMPs, or Indigenous Peoples Plans);

b. Defines measures to ensure compliance with these safeguard requirements;

c. Describes the approach to be taken during implementation for screening, selecting, and designing subprojects/proposed investments and planning mitigation measures, including consultation and disclosure requirements;

d. Achieves a balance between information and conciseness that provides the required prospective detail, while allowing its preparation in a compressed timeframe of normally a few weeks; and

e. Has been annexed to the Project Appraisal Document (PAD), and referenced in the Integrated Safeguards Data Sheet (ISDS).

216 The specific structure of the ESAPs presented together with the project documentation is as follows below. The ESAP will become part of the legal agreement (by being referenced in this PAD) and its implementation and any attached conditionality (such as inception of physical activities or works) will be closely supervised by the Bank team.

217 Planned project activities, locations, and general environmental and social baseline (as far as known), and the expected environmental and social impacts.

a. For Category A and B projects, any significant, meaningful alternatives considered in project approach and/or design.
b. Sequencing and, if practical, tentative implementation schedule for safeguards processing:
    - Sequencing of safeguards instruments.
    - Preparation time for safeguards instruments, including Bank review, revisions, clearance, and approval steps.
    - Disclosure and consultations.
    - Finalization and implementation of instruments. Also, if applicable, development of secondary instruments (e.g., subproject EMPs to be developed, and specifying by whom - e.g., Contractors or other implementing entities - and by when).
c. Roles and responsibilities, including supervision arrangements for safeguards preparation, implementation, and monitoring.
d. Estimated costs for the safeguards preparation and implementation process.

218 There are also activities under the ICGLR grant that are relevant in terms of a need to manage potential adverse environmental and social impacts.

219 The ESAPs for DRC, Burundi and Rwanda are included in this PAD as Annex 8.

Annex 4: Operational Risk Assessment Framework (ORAF)

Africa: Great Lakes Emergency Sexual and Gender Based Violence and Women's Health Project (P147489)

<table>
<tr><td>Project Stakeholder Risks</td><td colspan="4">Rating: Substantial</td></tr>
<tr><td rowspan="2">Description:

Main stakeholders include line ministries, non-governmental and faith-based organizations, donors supporting parallel efforts, ICGLR women's associations/groups, men who are critical to bringing about behavioral change, and members of the UN coordinating committees working on these issues. Given the number and diversity of these stakeholders, strong coordination would be required to ensure that the project benefits from strong ownership and minimizes risk of duplication.</td><td colspan="4">Risk Management:

During project preparation in respective countries, in-depth consultations were conducted with a variety of key stakeholders including government authorities, local authorities, coordinating Commission of SGBV (DRC), UN agencies and non-governmental organizations. Modalities of coordination were discussed to ensure synergies and minimize duplication.</td></tr>
<tr><td>Resp: Bank</td><td>Stage: Preparation</td><td>Due Date: March, 2014</td><td>Status: Done</td></tr>
<tr><td colspan="5">Implementing Agency Risks (including fiduciary)</td></tr>
<tr><td>Capacity</td><td colspan="4">Rating: Substantial</td></tr>
<tr><td>Description:

Insufficient capacity of Implementation Agencies to coordinate and implement multi-sectoral activities; channel funds to other institutions; and monitor overall progress in the respective countries.</td><td colspan="4">Risk Management:

In DRC, the Ministry of Finance would chair a multi-sectoral Steering Committee and be responsible for coordination of overall project activities, handle the flow of funds to the MoPH at the provincial level and other partners as needed, and be responsible for Financial Management and M&E reporting. The FSDRC would be responsible for flow</td></tr>
</table>

	of funds for their respective activities. The PHDs, as well as the FSDRC will be responsible for procurement. For Component 2 of the project, *Performance Purchasing Agencies* will be responsible for fiduciary aspects at the provincial level. The two existing Performance Purchasing Agencies have been working with different international partners (EU, Cordaid, and GAVI)) as fiduciary agencies as well as technical managers of PBF projects. At the provincial level, the PHDs and the FSDRC will implement regular coordination and planning meetings. In Rwanda, the project will build upon the strong already existing coordination mechanism in place. The overall project coordination will be the responsibility of MIGEPROF, including chairing a multi-sectoral steering committee, handle the flow of funds, and be responsible for Financial Management and M&E reporting. The MoH will be responsible for coordinating activities related to support for survivors of SGBV in One-Stop-Centers. The financial management and procurement capacity of MIGEPROF will be strengthened. In Burundi, MoH and MNSHRG will be the two main implementing agencies, with MoH leading the technical aspects related to health services as well as fiduciary management taking advantage of the existing project implementation team that is implementing World Bank-financed projects; while MNSHRG will lead the coordination and technical supervision on SGBV. Given that MNSHRG has no experience in implementing World Bank-financed projects management at their level will be limited to activities that fall under their domain. Capacity building of their core team fiduciary management will also be ensured so that during the project implementation, competence could gradually be built. MoH project implementation team has competent staff and have sufficient experience Project) in managing WB financed operations (such as the ongoing Health Sector Development Support Project and East Africa Laboratory Networking Project). The Steering Committee, comprised of all the ministries involved, is expected to ensure strict oversight.			
Ability of sub-implementers to deliver quality services in highly volatile environments and/or remote areas will be challenging in Eastern DRC.	Resp: Bank/Client	Stage: Implementation	Due Date : December 2014	Status: Not Yet Due

<table>
<tr><td rowspan="4">Limited capacity of ICGLR in terms of procurement, finance, and reporting, auditing and effective coordination with development partners.</td><td colspan="4">Risk Management:

The Social Fund of DRC (FSRDC) will be the implementing agency for Component 1A. Integrated support for survivors of SGBV at the community level and violence prevention. This national institution (anchored in the office of the President) has successfully implemented a US$ 101.8 million IDA-funded multi-sectoral operation (the Emergency Social Action Project or PASU) from 2004-2013 and is currently implementing a new US$79.1 million IDA-funded follow-up project. It has regional offices throughout the country, including in the East where it cooperated with MONUSCO and other international partners to ensure delivery in remote areas.

Implementation mechanisms will be developed, building upon the extensive experience in Eastern DRC of non-governmental facilities, INGOs and NGOs implementing support for the health sector as well as those providing specialized support for survivors of SGBV, including in remote areas. Using umbrella implementation partners at the provincial level to ensure consistency of quality and approach of service providers will be explored. During project preparation, rapid fiduciary and operational assessments of potential implementation partners will be carried out. The health zones and corresponding communities to be targeted for support would include a combination of high and low risk settings to mitigate against the risk that implementation would come to an overall grinding halt. In addition, innovative mechanisms (e.g. transportation vouchers; mobile outreach activities) would be identified to assist women to physically access services at both the health and community levels.</td></tr>
<tr><td>Resp: Bank</td><td>Stage: Preparation/Implementation</td><td>Due Date :</td><td>Status:</td></tr>
<tr><td colspan="4">ICGLR is taking several measures under its ongoing institutional capacity building program to help mitigate the risks. By the start of the project the ICGLR will have a full project operations manual and support consultants for coordination and FM management in place. In order to manage partnership risks, the project team will continue its outreach to development partners and keep them informed</td></tr>
<tr><td></td><td colspan="4">Resp: Bank Stage: Preparation/ Implementation Due Date: Status:</td></tr>
<tr><td>Governance</td><td>Rating:</td><td colspan="3">High</td></tr>
</table>

Description: Stewardship of the proposed multi-sectoral operation may be cumbersome and complex to the extent that there are a multitude of coordination committees and multiple interest groups on SGBV.	Risk Management: In each country, the roles and responsibilities of each stakeholder, including line ministries, will be clearly explained in the project implementation manual. Provisions for regular meetings between all stakeholders will be included in the manual. In DRC, at the provincial level, Technical Divisions of Gender, Justice and Social Affairs will be included in relevant trainings to build their capacity as well as ensure their involvement in project implementation. In DRC, during project preparation, the task team consulted at the national and provincial level with the existing coordination mechanisms related to SGBV, which includes donors, UN agencies, and line Ministries. The IA at the provincial level will be included in the key coordination mechanisms related to SGBV, including the Technical Committee for multi-sectorial support for survivors of SGBV co-chaired by UNICEF and the MoH. In Burundi, preparation of this proposed operation has established a platform for collaboration, gathering all partners and all the line ministries involved to have in-depth technical discussions on the project design and mechanisms for collaboration. It is expected that this collaborative approach would continue during project implementation. Financial management and procurement aspects of the project will be closely supervised by the Bank. The Bank team will supervise closely procurement with a particular focus on larger contracts for implementation partners. Third party validation of results attained on the delivery of health interventions will be supported using similar mechanisms (e.g. community verification; and purchasing agency validation) as under IDA-supported health operations in the DRC.			
	Resp: Bank	Stage: Preparation/ Implementation	Due Date:	Status:
Project Risks				
Design	Rating:	Substantial		

<table>
<tr>
<td>Description:

The volatile and conflict prone environment in Eastern DRC may impact negatively the design and preparation of the project. At the same time, the needs for the proposed services are higher in more remote areas or those zones which are more prone to conflict.

Participating countries might move at a different pace during the design and preparation phase, which could delay processing and delivery of the project.

-Community Services: Delivering similar levels of quality services will be challenging in Eastern DRC, where a variety of implementation partners will be used.

-Health Services: Rolling out Performance Based Financing schemes in the volatile environment in Eastern DRC may be challenging in the short run; at the same time, creating parallel systems and mechanisms may distort broader reforms underway nationwide and undermine the role of the state. Risks for the PBF approach as in other countries are: (i) potential to game the system by inflating results to maximize revenues; (ii) focusing on services purchased to the detriments of others and (iii) favoring easier to reach regions and/or groups.</td>
<td>Risk Management:

Recognizing that the risks of continued violence and instability in Eastern DRC are outside of the control of the Bank, the team has selected health zones which include both high and low risk areas, thereby balancing the need to provide the proposed services to the most vulnerable populations, with the feasibility of implementing the proposed activities.
<table>
<tr><td>Resp: Bank/Client</td><td>Stage: Preparation</td><td>Due Date: March 2014</td><td>Status: Done</td></tr>
</table>
Risk Management:

The project team has monitored closely the preparation pace of each country and provided intensive support to each country to ensure that the project is delivered in a timely manner.
<table>
<tr><td>Resp: Bank</td><td>Stage: Preparation</td><td>Due Date: March, 2104</td><td>Status: Done</td></tr>
</table>
Risk Management:

-Community Level: During project preparation, clear quality standards for each service foreseen will be developed, as well as clear roles and responsibilities of quality control by the IA. In addition, using umbrella implementation partners to ensure consistency of quality and approach of service providers will be explored as this has proven effective in other Bank projects. During implementation, the client and Bank team will monitor closely quality of services provided across implementation partners. During implementation, the client and Bank team will monitor closely quality of services provided across implementation partners, including through using during the second half of the project quality assessment of mental health and legal services provided to SGBV survivors which will be piloted by a SPF project in South Kivu.

-Health Facility Level: During project preparation, the team assessed the capacity of the Provincial Health Directorates in the Kivus and their experience with PBF; it was decided that funds would be channeled through the single buyer/purchasing agencies set up in the Kivus; and lessons from the Bank-funded PBF pilot in the Haut-Katanga province and experience with PBF schemes in other countries have been incorporated into the design as follows: clear and comprehensive packages of high impact</td>
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<tr><td rowspan="2"></td><td colspan="4">interventions which can be easily measured and monitored; regular channeling of funds to facilities; relative prices which minimize risk of distortions; reliance on national health information systems to avoid creating parallel systems; a strong and independent system for data verification; and parallel reductions in user fees to enhance financial protection and overcome financial barriers to accessing health services. It was decided that the project will also fund demand side interventions (through equity funds and vouchers) to lower barriers to care for the most vulnerable people.</td></tr>
<tr><td>Resp: Bank/client</td><td>Stage: Preparation</td><td>Due Date: March 2014</td><td>Status: Done</td></tr>
<tr><td>Social & Environmental</td><td colspan="4">Rating: Moderate</td></tr>
<tr><td rowspan="2">Description:

The project is rated as an environmental category B as activities are not expected to have significant or irreversible environmental impacts, and would have limited to no localized adverse impacts, and no cumulative impact. Any negative social impact of the project is expected to be very low. Infrastructure rehabilitation foreseen in the three countries can lead to restrictions in access to areas being rehabilitated. In addition, they could cause noise, create basic safety risks, and require handling and management of waste. In each of the countries, medical waste will be created which will require proper handling. Given the nature of activities to be funded, it is likely that OP/BP 4.01 (Environmental Assessment) would be triggered for all three countries. In addition, for DRC, OP/BP 4.10 (Indigenous People) might be triggered.</td><td colspan="4">Risk Management:

For each country, an Environmental Management Plan (EMP) and Medical Waste Management Plan (MWMP) will be developed. For DRC, an IPP will be developed focusing on outreach and inclusion of Batwa will be developed. As per OP/BP10.00 for projects with special considerations, finalizing the EMPs, MWMPs and IPP will be deferred to the project implementation phase, while an action plan addressing applicable environmental and social policies will be developed during project preparation.</td></tr>
<tr><td>Resp: Bank/Client</td><td>Stage: Preparation/Implementation</td><td>Due Date :</td><td>Status:</td></tr>
<tr><td>Program & Donor</td><td colspan="4">Rating: High</td></tr>
<tr><td>Description:

Coordination and complementarity of the proposed project activities with the large number of development partners involved in both the health</td><td colspan="4">Risk Management:

During project preparation, the task team mapped out ongoing activities related to health and SGBV to identify opportunities for synergies and minimize duplication. In addition, in consultation with key stakeholders, appropriate coordination mechanisms</td></tr>
</table>

<table>
<tr><td>sector and addressing SGBV will be challenging.</td><td colspan="4">with relevant stakeholders and existing committees will be developed to ensure a good flow of information and possible joint activities.

In DRC, at the provincial level the existing coordination committee for multi-sectorial support to survivors of SGBV, including government, UN agencies and other partners, will be used to discuss the selection of intervention zones in a transparent manner.

In Rwanda, project activities have been designed to be complimentary with ongoing support from UN agencies and the Government of the Netherlands, as well as with forthcoming support from DFID for violence prevention

In Burundi, a National Strategy to tackle SGBV exists but this is not yet translated into concrete actions and coordination mechanisms to operationalize the Plan. However, a mapping exercise for all the partners involved has been conducted and the line Ministries seem to be well aware of the activities carried out by each partner. These partners have been involved in the preparatory phase of the project. The World Bank team has held close consultation with key DPs such as UNFPA to ensure close synergies with their activities and build on existing experiences.</td></tr>
<tr><td></td><td>Resp: Bank</td><td>Stage: Preparation</td><td>Due Date: March, 2014</td><td>Status: Done</td></tr>
<tr><td>Delivery, Monitoring & Sustainability</td><td colspan="4">Rating: High</td></tr>
<tr><td rowspan="2">Description:

Project delivery. In DRC, security conditions may impact the need for service delivery (i.e. temporary increase in demand for services for survivors of SGBV), accessibility of services, and capacity to deliver services (i.e. temporary delays in service delivery due to renewed conflict).</td><td colspan="4">Risk Management:
The Bank and Client will monitor closely the impact of renewed conflict on provision of services in project areas. In addition, support for mobile teams to provide emergency care will be considered. Implementation Partners will also be provided with training on how to respond in case security conditions deteriorate, including for example how to protect confidential data from survivors of SGBV.</td></tr>
<tr><td>Resp: Bank/Client</td><td>Stage: Implementation</td><td>Due Date :</td><td>Status:</td></tr>
<tr><td>Monitoring.
In DRC, security conditions may impact monitoring of activities.</td><td colspan="4">Risk Management: Additional resources will be foreseen to allow for supervision and monitoring of project implementation progress in remote areas by the IA. During project preparation, clear roles and responsibilities between the national and the provincial governments, including for monitoring will be developed. In addition, the</td></tr>
</table>

In Burundi, data related to services provided by the One Stop Centers for SGBV are not integrated in the HMIS, thus creating a somewhat parallel system.	foreseen implementation arrangements of using umbrella organizations (large NGOs already implementing activities in North and South Kivu) will facilitate monitoring in remote areas. For data availability in Burundi, the project will co-finance the forthcoming Demographic and Health Survey (DHS) which is expected to include a SGBV module; the Bank team will also explore the feasibility of incorporating SGBV data into the HMIS.			
	Resp: Bank/Client	Stage: Preparation/ Implementation	Due Date: June 2015	Status: Not yet due
Sustainability. Given the dire situation of the majority of the project beneficiaries, the difficult contexts in which the project would be implemented (e.g. DRC, Burundi), and the high cost of addressing the needs of survivors of SGBV, the chances of financial sustainability of the proposed activities may be low, particularly given the high dependence on external financing. In Rwanda, a strong policy, legal and institutional framework to promote gender equality and address and prevent violence against women and children has been developed. The high level of political commitment to end SGBV will ensure continuation of financing of SGBV services after project closing.	Risk Management: The project will include in its design lessons learn from cost-effective approaches to providing mental health and livelihood support to survivors of SGBV. In addition, a key focus of the project will be to build capacity of key institutions to provide quality services to survivors of SGBV. An important emphasis would be placed on building capacities at the community, health facility, managerial and institutional levels. In Burundi, to foster sustainability, the project design will be fully aligned with Government priorities as stipulated in the National Strategies for SGBV and Reproductive Health, as well as PRSPII. As an example, the one-stop center to provide a package of holistic services for SGBV victims will now be integrated as part of the package of services to be provided at hospital levels, allowing for sustainability and integration into the health system.			

	Resp: Bank/Client	Stage: Preparation/Implementation	Due Date:	Status: Ongoing
Other	Rating:			
Description : *Managing expectations*. The high visibility nature of the proposed operation and the complexity of	Risk Management: The Bank team is striving to ensure that it adopts an approach which minimizes the risk of overpromising and under-delivering, particularly in light of the continuing volatile			

tackling SGBV will require a concerted effort to manage expectations.	situation in Eastern DRC. To this end, the project focuses on interventions which are likely to generate medium-term benefits and does not tackle the broader drivers of conflict and instability in Eastern DRC which are well beyond the scope of this operation. While the project would make a modest contribution to prevention of SGBV (e.g. advocacy promoting gender equality and social marketing; economic empowerment; improvement in mental health; and activities to promote behavioral change and attitudes the design recognizes that this is a long-term process with numerous factors beyond the control of the Bank or an individual project.			
	Resp: Bank/Client	Stage: Preparation/ Implementation	Due Date :	Status:
The overall risk rating of the project is ***High***				

Summary: The high risk rating is based on three main factors: (i) continuing volatile environment in Eastern DRC; (ii) fragile institutional capacities and persistent concerns with financial sustainability (DRC, Burundi, Rwanda; ICGLR); and (iii) need for multi-sector and multi-donor coordination in all countries.

Annex 5: Country Strategies and Ongoing Programming

1 **Recent policies and legal frameworks in DRC specifically address gender equality and SGBV**. Articles 14 and 15 of the 2006 Constitution affirm the equal rights of men and women. A revised Family Code is pending approval in Parliament, which addresses several current constraints for gender equality, including for example removing the need for a married woman to have her husband's permission to sign a contract, take out a loan, open a bank account, register land or a business or go to court. The new Family Code also raises the minimum age of marriage for girls from 15 to 18.[27] The 2006 Law on Sexual Violence broadened the definition of sexual assault, criminalizing rape, sexual slavery, sexual harassment and forced pregnancy. The law also toughened punishments for convicted offenders. Implementation of the law however remains challenging.

2 **In 2009, the Ministry of Gender, Family and Children (MoGFC) adopted a national strategy to combat SGBV against women and girls.**[28] The strategy aims to support the efficient coordination of prevention, protection and response efforts for survivors, as well as management of information and data on SGBV related issues. The Strategy includes the following five pillars: (1) *Combating Impunity*, led by the Ministry of Justice (MoJ) and UNHCR, which focuses on judicial support and capacity building and reparations; (2) *Prevention and Protection*, led by the Ministry of Social Affairs (MoSA) and UNHCR, which focuses on empowerment, participation and psycho-social assistance; (3) *Security Sector Reform* (SSR), led by the Ministries of Defense and Interior and MONUSCO SSR, which focuses on training on SGBV, and improving discipline and oversight of the security forces; (4) *Multi-Sectoral Response for Survivors*, led by Ministry of Public Health (MoPH) and UNICEF, which focuses on socio-economic reintegration and economic empowerment; and (5) *Data Collection and Mapping*, led by the MoGFC and UNFPA.

3 **Mental health is currently included in the "*Paquet Minimum d'Activités Soins de Santé Primaire*s" in the DRC which elaborates all the services that are to be offered at primary and secondary care levels**. However, provision of mental health remains extremely challenging in DRC, both due to lack of capacity as well as resources. According to the WHO *Mental Health Gap Action Program* from 2010, DRC is cited among countries that meet the criteria for "intensified support" based on the Global Burden of Disease Project. The program aims to scale up mental health in poor resource settings or low and middle income countries. This assessment considers the burden attributable to mental, neurological, and substance use disorders vis-a-vis the available human resources in countries with low and lower middle income and as a function of the mortality, morbidity/disability, and wellbeing, high economic cost to the health system and violations of human rights they entail.

[27] The World Bank through the Investment Climate Diagnostic (P143263) Trust Fund supported the preparation of the revision of the Family Code, as well as several bi-lateral donors including the Governments of Belgium, Canada, France, Sweden, United Kingdom, USAID, and the European Union

[28] République Démocratique du Congo Ministère du genre, de la famille et de l'enfant, « Stratégie nationale de lutte contre les violence basées sur le genre (SNVBG). Draft, Kinshasa, August 2009.

4 **The international community has been supporting stabilization and peace-building in Eastern DRC through the International Security and Stabilization Support Strategy (I4S) coordinated by the UN.** The Strategy supports the Government's Stabilization and Reconstruction Plan for War-Affected Zones in the East (STAREC). The I4S was revised in 2012-13 to be more responsive to root causes of conflict and address conflict drivers.[29] Under the revised I4S the fifth pillar on the *Fight against Sexual Violence* is broadening its scope to move beyond palliative humanitarian measures and focus on addressing sexual violence as a driver of conflict. On the one hand, it aims to transform harmful gender norms and notions of masculinity and femininity, strengthen the formal system, and increase socio-political participation of women and girls, and on the other hand it aims to mitigate some of the consequences of sexual violence through reconciliation, cohesion and ending impunity, and it works across the same five pillars as the National Strategy to combat SGBV. The UN, European Community (EC) and donors including among others the Governments of Belgium, Canada, Czech Republic, Finland, France, Germany, the Netherlands, Norway, Spain, Sweden, Switzerland, United Kingdom (UK), and United States (US) have been funding various projects on prevention of SGBV and delivery of holistic services to survivors in DRC. Key partners supporting the health sector in Eastern DRC include the European Union (EU), and the Governments of the Belgium, Canada, France, Sweden, UK and the US. UNICEF and UNPFA provide support for among others purchasing and provision of pharmaceuticals. The presence of the UN, bilateral donors, donor-funded project implementation units, and international NGOs provides a viable logistical apparatus and in-depth knowledge in Eastern DRC on the ground, as well as decades-worth of cumulative experience in project implementation related to support for survivors of SGBV and the health sector. The proposed activities are in line with current government strategies, complementary to the other ongoing initiatives of donors and support the recently revised I4S.

5 **During the past decade Burundi has taken major steps to fight SGBV and vulnerability of women**. The 2005 Constitution states that ''all citizens are entitled to equal rights and to equal protection under the law. No Burundian shall be excluded from the social, economic or political life of the nation on account of her/his race, language, religion, gender, or ethnic origin". The Government's commitment is also reflected in the "*Burundi 2025 Vision*" which spells out national priorities, as well as PRSP II which calls for "strengthening of the rule of law, building good governance, and promotion of the gender equality". Under the revised penal code from 2009, rape, forced prostitution, sexual slavery, forced pregnancy, and forced sterilization, and other generalized and systematic acts of sexual violence against civilians are considered as crimes against humanity.[30] Revision of the penal procedural code in 2013 is also an important step forward as it authorizes health facilities to produce forensic evidence of SGBV for the court, free of charge to survivors. A draft *law on Prevention, Protection and Suppression of Gender-based violence* is currently pending adoption by the Parliament.

[29] The revised I4S defines stabilization as 'an integrated, holistic but targeted process of enabling state and society to build mutual accountability and capacity to address and mitigate existing or emerging drivers of violent conflict, creating the conditions for improved governance and longer term development.'

[30] République de Burundi. Loi NO 1/05 du 22 Avril 2009 Portant Révision du Code Pénal Burundais. http://www.unhcr.org/refworld/country,,NATLEGBOD,,BDI,,4c31b05d2,0.html

6 **Under the leadership of the Ministry of National Solidarity, Human rights and Gender (MNSHRG), a National Strategy to Fight Gender-Based Violence was developed in 2009 with a view to eradicating SGBV**. One of the key achievements of the strategy is the identification of major challenges to prevent and respond to SGBV in several key sectors (health, justice, education, security and social rights). Moreover, the strategy also lists key priority actions to address those challenges. The Strategy was accompanied by a 2009-2012 *National GBV Plan*, which spelled out in detail the actions to be carried out, and has served as a guiding document. Similarly, the *National Gender Policy* (2003) was updated covering the period 2011-2025, with a view to further promote gender equality and address the vulnerability of women and girls. Finally, the *National Reproductive Health Strategy 2013-2015* recognizes prevention and treatment of SGBV as an integral part of reproductive health priorities, and includes preventive interventions at community level, and health systems strengthening to improve quality of medical and psychosocial treatment.

7 **Services for survivors of SGBV are provided only at a few facilities nationwide**. The *Seruka Center*, based in Bujumbura, was the first of its kind to provide integrated medical and psychological assistance to survivors of rape. Since its opening in September 2003 until December 2010, close to 10,000 survivors have received support. The *Humura Center*, opened in August 2012 in the province of Gitega, was spearheaded by the Gender Ministry and supported by various technical and financial partners and operated by the Government. Since its opening it has provided medical, psychosocial, police and judicial support to 450 survivors. A new one-stop center (OSC) is currently planned in Rumonge which will be supported under the forthcoming United Nations Joint Program.

8 **Various bilateral partners, UN agencies and civil society organizations (CSOs) are active in support to SGBV and this project aims to ensure complementarity with these efforts**. GIZ has been supporting the national police's gender analysis, psychosocial support to SGBV survivors and other aspects of SGBV as a cross-cutting issue in its 2013-2016 Reproductive Health Program. The Netherlands also supports sexual and reproductive health as one of its cross-cutting areas, and focuses on security and judicial issues which are often neglected but crucial. The USAID-funded RESPOND Project has been supporting SGBV prevention efforts in the provinces of Kayanza and Muyinga. The Swiss Cooperation supports a regional program of psychosocial care for women from Burundi, Rwanda and the DRC. As part of the UN Joint Program, agencies such as UNFPA and UNDP are actively supporting the Seruka and Humura centers, as well as efforts to establish a database for SGBV, conduct advocacy, and strengthen institutional capacity. The second UN Joint Program will support prevention and behavior change; integrated support to survivors; and support to judicial response.

9 **Supported by political will at the highest level, Rwanda has established a strong policy, legal and institutional framework to promote gender equality and address and prevent violence against women and children.** Gender equality is highlighted as a crosscutting issue in Vision 2020 as well as the Second Economic Development and Poverty Reduction Strategy (EDRSP2), thus offering vehicles for addressing gender-based related issues. This is materialized

through the National Gender Policy, which provides guidance for equality of opportunities between men and women in every sector. The Government's *National Policy against Gender-Based Violence* (2011) and the *National Strategic Plan against Gender Based Violence for 2011-2016* lay out policies and actions to address gender violence.

10 **In 2009, the Government of Rwanda (GoR) with support from the One UN piloted the *Isange* OSC to provide holistic services to survivors of SGBV and contribute to preventing SGBV and child abuse.**[31] Following the successful pilot of OSCs, Rwanda is now embarking on a full-fledged national scale-up of the model in health facilities across the country. In 2013 the GoR developed the *National Scaling-up Strategy for One Stop Centers in Rwanda* which is the basis for support of the proposed project. It strives to ensure the best possible prevention and response for survivors of gender based violence and child abuse, including refugees. In addition, it is recognized that quality services, conviction of perpetrators and sustained community awareness-raising help build the resilience of survivors and their families as well as prevent violence and abuse.

11 **The proposed project is complementary to ongoing support from bi-lateral partners, especially the Governments of the Netherlands and United Kingdom (UK)**. In December 2013, the GoR, One UN Rwanda, and the Government of the Netherlands signed a three-year project to support scaling-up the *Isange* OSC model. This proposed project will support establishing new centers in the remaining districts of the country as per the National Scaling-up Strategy. The UK Department for International Development (DFID) is in the process of developing a project to strengthen capacity at community level to prevent violence against women and children through scaling up promising community-level SGBV prevention mechanisms in 7 districts. Based upon the results of the DfID-funded project during its first two years, this proposed project would scale-up through the Ministry of Gender and Family Protection (MIGEPROF) successful community based activities working with men and boys at the national level during the third year of the project. In addition, the Swiss Cooperation provides support to address SGBV by engaging NGOs as part of a regional program in Burundi, Rwanda and DRC with a focus on psychosocial support.

12 **Addressing SGBV has been a key area of attention of the ICGLR since its inception.** The ICGLR Pact includes a protocol focusing specifically on the prevention and suppression of sexual violence against women and children. In 2011, all heads of state of the ICGLR adopted the Kampala Declaration on SGBV, or the *United to Prevent, End Impunity and Provide Support to the Victims of SGBV in the Great Lakes Region Strategy,* which calls for a comprehensive approach from prevention to survivor support, involving a broad spectrum of stakeholders and institutions (i.e. governments, civil society, parliamentarians, religious leaders, and international partners). The Declaration links to other anti-SGBV global initiatives and UN Security Council Resolutions (1325, 1820, 1888, 1889 and 1960).

[31] *Isange* means "feel welcome" in Kinyarwanda.

13 **In 2014, the ICGLR opened in Kampala a Regional Training Facility (RTF) on the Fight against SGBV as agreed upon in the Kampala Declaration[32].** The objective of the RTF is to train and sensitize relevant personnel in the medical, judicial and police sectors as well as social workers from the Great Lakes Region to provide efficient and effective response to SGBV. It also includes among others facilitating regional knowledge generation and sharing, conducting policy-oriented research, and maintaining a database of regional and international experts. Furthermore, the RTF will also build capacities of the proposed Special Courts as envisaged under the Kampala Declaration.

14 **Operational efficiency and effectiveness of all corporate and administrative functional areas including human resources, planning, finance, procurement, information technology, and conference management are a key concern around the ICGLR**. An independent evaluation of the financial and administrative systems commissioned by the ICGLR in 2012 as well as an institutional audit financed by GIZ in 2013 outlined a number of shortcomings that require immediate attention. These include, among others: (i) lack of systematic planning, and long, medium and annual plans with corresponding budgets and monitoring and evaluation systems; (ii) weaknesses in quality financial reporting up to international standards; and (iii) weak coordination between National Coordinators and CS Program Officers.

15 **In performing its functions the ICGLR engages with multiple development partners and actors.** It works closely with the UN Special Envoy to the Great Lakes Region, the UN Special Envoy on Sexual Violence in Conflict as well as bilateral and multilateral development institutions to promote and support peace building and other ICGLR sector programs, including implementation of the *Peace, Security and Cooperation Framework* from February 2013.

16 **Various donors have provided supports to the ICGLR.** The donor community, including among others African Development Bank (AfDB), European Union (EU) in collaboration with the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and the German Federal Ministry for Economic Cooperation and Development (BMZ), and the governments of China, Norway, Sweden, Switzerland, and United States have provided assistance to the ICGLR. In addition, UN Women, UNFPA and UNHCR also provided support since ICGLR's inception. Support provided focuses on the areas of conflict prevention, gender and sexual violence prevention, natural resource management, SGBV, and capacity building and. Table 1 provides an overview of past and ongoing support to ICGLR.

[32] As per Decision 14 from the Kampala Declaration. The RTF was validated by the Regional Inter-Ministerial Committee (RIMC) in 2013.

Table 1. Summary of Donor Contribution to the ICGLR			
Donor	Amount (USD million)	Time Frame	Areas of Support
SGBV Related Contribution			
ACCORD	0.03	Nov 2011	Arusha Expert Meeting in preparation of the Special Summit on SGBV in Kampala of 2011 (Kampala Declaration)
Norway	0.08	Oct -Dec 2011	Arusha Expert Meeting in preparation of the Special Summit on SGBV in Kampala of 2011 (Kampala Declaration)
	0.22	Dec 2011 - June 2012	Special Summit on SGBV in Kampala of 2011 (Kampala Declaration)
SDC	0.19	2012 - mid 2014	1. TA, workshop, training related to gender including among others support to the Kampala Summit, the Regional Women Forum, special court sessions in Burundi and Zero Tolerance Campaign 2. Capacity building member states gender focal point including Burundi, Rwanda and civil society
	0.02	Jun 2014	Second General Assembly of the Regional Women Forum
SIDA	0.12	Dec 2011	Special Summit on SGBV in Kampala of 2011 (Kampala Declaration)
UNFPA	0.02	Oct -Dec 2011	Arusha Expert Meeting in preparation of the Special Summit on SGBV in Kampala of 2011 (Kampala Declaration)
UNIFEM	0.48	Dec 2008 -Dec 2009	1. Women network; 2. Regional gender desk/observatory; 3. Domestication and implementation of SGBV Protocol; 4. Women CSO, formal and informal justice 5. Capacity building on gender mainstreaming
	0.98	Jul-Dec 2010	1. Work plan for the Regional Women's Forum; 2. Share experience and good practices; 3. Operational plan for the Gender Observatory; 4. Domesticate SGBV Protocol into national laws and policies; 5. Advisory services
	0.20	Oct 2010 - Sep 2011	Strengthen the Regional Women Forum
UN Women	0.11	Oct 2012 - Apr 2013	1. Special courts; 2. Gender desk and recovery center; 3. Advocacy for gender equality in support of Kampala Declaration
	0.05	Dec 2013	1. Coordination and office set-up of RTF; 2. Consultative meetings.
US Embassy	0.05	Nov 2011	Arusha Expert Meeting in preparation of the Special Summit on SGBV in Kampala of 2011 (Kampala Declaration)
UNICEF	0.03	July - Aug 2010	1.Auditing legal instruments and legislations against SGBV and translation of legal instruments on SGBV

			2. High level consultation of Ministers for Gender and Justice
Non-SGBV Related Contribution			
AfDB	2.25	Jul 2013- Jul 2015	Regional Initiative against the Illegal Exploitation of Natural Resources RINR: Capacity building to operationalize the Regional Certification Mechanism
BGR	9.60	Jul 2012- Dec 2016	RINR: Implementation of the Regional Mechanism & formalization of ASM
China	0.10 per year	2011-2013	Budgetary support
EU	4.10	Jul 2012- Dec 2016	RINR: Capacity building to operationalize the Regional Certification Mechanism
	1.33	Jul - Dec 2013	Establishment of EJVM
GIZ	11.70	Jul 2012- Dec 2016	RINR: Capacity building to operationalize the Regional Certification Mechanism
	0.13	2010	1. Technical meeting of RINR and special summit of Heads of States; 2. Capacity Building of personnel and National Coordination Mechanism for RINR.
	0.84	Apr 2011 - Feb 2012; May 2013 – March 2014	Capacity building of personnel and National Coordination Mechanism for RINR
SDC	0.11	May 2008 - May 2009	Capacity building of personnel for the establishment of the CS.
UN-OHCHR	0.06	Jun-Dec 2009	Regional Observatory on Good Governance, Human Rights, and Civic Education
	0.06	Oct 2009 - Dec 2010	Regional Observatory on Human Rights
USAID	0.50	Sep 2012- Sep 2014	Institutional support and capacity building, including establishing RINR Unit

Annex 6: Review of Literature on Lessons Learned from Sexual and Gender Based Violence Programs

1. This annex presents key findings of a review of evidence based lessons learnt for provision of holistic services to survivors of SGBV and prevention of SGBV. This review examined over 40 impact evaluations and prioritized those that applied rigorous assessment methodologies such as randomized control trial and quasi-experimental methods, as well as overviews of good practices.

1. Provision of holistic services for survivors of SGBV

A. Multi-Sectoral Intervention

2. As physical violence and SGBV is usually accompanied with psychological trauma and violation of laws, SGBV survivors are normally in need of multi-faceted assistance at the same time, including medical treatment, mental health counselling, and paralegal support. Multi-sectoral interventions apply a series of approaches to prevent SGBV and provide services to SGBV survivors. Although systematic impact evaluations measuring multi-sectoral intervention is still at its preliminary stage, there has been results drawn from qualitative interviews and observations from the field. Services for SGBV survivors frequently provided in multi-sectoral initiatives include health services, counseling services and psychological care, income-generating services, legal aid, police intervention, telephone hotlines, emergency shelters, and child welfare services. Community-based networks for coordinating services to survivors help to improve access to justice and promoting violence prevention.

3. Among all multi-sectoral approaches, OSCs (OSCs) are a typical model that holistically and systematically provides SGBV survivors with integrated and multi-disciplinary services, including medical treatment, psychological care, and access to justice and legal services, within a hospital or a stand-alone center or through a referral system that links services. Some OSCs also provide access to microcredit, vocational training, community education and ongoing social support. The model can be embedded in a network of government and nongovernmental services.

4. Despite of lack of tests across different regions, OSCs have shown its effectiveness in SGBV response in certain countries. The evaluations of the Zambia OSC model (Morel-Seytoux et al 2010; CARE Gender and Empowerment, 2013) showed that the OSC can "provide the survivors with a more comprehensive and survivor-centered service experience than if the services were provided piece meal from each service provider individually." Specifically, the evaluation found that the OSCs have the following advantages: 1) high level of client satisfaction with the quality and manner of services provided; 2) engaging and consultative service processes, contributing to clients' feeling of empowerment; and 3) strong institutional linkage with government in providing services, which also strengthened linkages to other key services providers.

5. The evaluations also suggested that OSC service provision should go hand in hand with public outreach and sensitization activities that help to transform attitudes and norms and break the silence regarding SGBV. In the case of Zamia, the evaluation found that the dual-pronged approach of providing direct services at the same time as conducting public outreach and sensitization campaigns/activities at all levels – from the community to the national level – was the most effective approach to comprehensively address SGBV in Zambia.

6. The client satisfaction survey (CARE Gender and Empowerment, 2013) revealed that SGBV survivors attach great importance to several specific aspects of service provision at the centers. These aspects include friendly and welcoming environment, cases treated with privacy and without bias, positive and respectful interactions with staff, consistent follow-ups on cases, handling cases without corruption or bribery, free services that anyone could access and linkage to safe houses for certain cases.

7. Good practices for OSC models include:
    a. Broad-based awareness-raising on SGBV is likely to result in an increasing number of survivors seeking for help from the OSCs. Commensurate broad-based capacity building of local service providers must be associated in order to ensure that SGBV survivors can receive quality services within their locality.
    b. Specialized training and mentoring should be offered to counselors on specific topics such as child counseling, couples counseling and paralegal support. Specialized support tailored to the needs of child survivors is especially important.
    c. Clearly marked stand-alone OSCs that offer services exclusively for survivors are likely to increase stigmatization. It is recommended that OSCs be located within existing facilities which provide other services. In addition, this also tends to be more cost-effective and sustainable.
    d. Given the challenges of retaining volunteer staff and keeping them motivated in the face of high time demand, heavy case loads and potential secondary traumatization, programs should be careful not to rely too heavily on or overburden volunteers.
    e. Absence of 24-hour service can have negative implication for SGBV survivors, particularly with regard to accessing timely medical services. At a minimum, any stand-alone centers without 24-hour services should aim to have a counselor on-call during off hours and offer a safe place for survivors to stay overnight until services are available.
    f. OSCs should lobby for permanently assigned police support officers.
    g. Integration with national strategies, government ministries, and NGOs is critical to ensure the sustainability of future SGBV programming.

B. Mental Health Interventions

8. SGBV are known factors threatening survivors' mental health and psychological wellbeing. SGBV survivors have a high tendency to suffer from post-traumatic stress disorder (PTSD), medically unexplained complaints, and suicidal ideation. Mental health interventions apply a variety of approaches, including cognitive processing therapy, individual counselling, support

groups, etc. However, few rigorous impact evaluations exist to examine the effectiveness of these approaches addressing SGBV, especially in low-income and conflict-affected countries. Nevertheless, preliminary research shows that psychosocial interventions in general have positive effects on SGBV survivors (Tol, 2013).

9. A recently conducted rigorous impact evaluation co-financed by the World Bank in Eastern DRC (Bass, 2013) proves the comparative effectiveness of cognitive processing therapy (CPT). This randomized control trial shows that in comparison to individual psycho-social support, group cognitive processing therapy can more efficiently and effectively reduce PTSD and combined depression and anxiety symptoms and improve functioning for sexual-violence survivors, although both individual and group therapies showed positive impact on SGBV survivors.

10. Although its impact has not been specifically measured on SGBV survivors, narrative exposure therapy (NET), a short-term intervention for PTSD, has shown its positive impact on refugees and survivors of mass violence, many of which are SGBV survivors or share similar experience of SGBV survivors. A recent review (McPherson, 2011) examining randomized control trials and assessing the effectiveness of NET for survivors of mass violence and torture proves that NET significantly decreases PTSD as compared to other treatments.

C. Economic Empowerment and Livelihood Interventions

11. Economic vulnerability, such as extreme poverty and economic dependence of women on men, is one of the major contributing factors of SGBV, especially for Intimate Partner Violence (IPVs). Economic empowerment interventions are designed to increase the economic resources available to women in order to empower them by strengthening their agency. Common forms of such interventions include microfinance, village saving and loan associations (VSLAs), conditional and unconditional cash transfers, and entrepreneurship and skills training.

12. Studies show that women's economic empowerment programs do not necessarily reduce women's risk of violence, at least in the short term. Some evaluations suggest that violence tends to be higher among women who newly participate in the program but will progressively decrease as they stay longer in the programs, as husbands gradually become more accustomed to seeing women in new economic roles and initial resentment gives way to acceptance, even appreciation. This is especially the case in relatively more conservative cultures and when a man is unable to fulfill his gender-ascribed role as bread-winner whereas a woman begins to contribute relatively more to family maintenance. These observations suggest that, with time, the risk of violence may decrease as collective empowerment and women's autonomy become more accepted. (Ahmed, 2005)

13. In addition, programs that increase women's access to resources do not necessarily bring empowerment, unless biased gender norms are shifted. Even in the situation where women have successfully achieved significant income increases, women's independence and status in the community or freedom from IPV do not necessarily improve. (Battleman, 2013)

14. The level of education may also impact the effectiveness of women's empowerment interventions. In Brazil, the expansion of the *Bolsa Familia* conditional cash transfer program resulted in a decrease in domestic violence. However, the observed decrease was concentrated among women with higher education levels and no reduction in homicide was found among women with primary education or less Holmes and Jones, 2010).

15. Engaging men into women's income generating activities not only helps to increase profits, but also decreases couple conflict. Barker and Peacock (2012) cited the result of one recent controlled trial conducted in Rwanda with CARE-Rwanda and Promundo. The evaluation found that engaging men contributed to: (1) more equitable household decision making, (2) increased couple communication and decreased couple conflict, and (3) higher income gains for families. Qualitative findings also indicated that greater participation by men in household work and improved couple communication was witnessed by children.

16. An impact evaluation of VSLAs in southern Burundi (Iyengar and Ferrari, 2010) compared the experiences of women participating in VSLAs combined with trainings for women and men, with a group that only received the VSLA intervention. The training provided in this program addressed household decision-making and power dynamics to increase women's authority in the household. The evaluation found a decreased percentage of men reporting attitudes tolerant of violence in the treatment group. A significant reduction in physical harm was also found with women who were in the high or moderate risk category at baseline.

17. A rigorous impact evaluation co-financed by the World Bank was conducted in the DRC province of South Kivu to measure the economic, social and psychosocial impact of VSLA and its associate training on survivors of SGBV (Bass et al, 2014). The study showed that VSLA participants experienced a statistically significant decrease in trauma than the control group. In addition, VSLA participants also experienced a decrease in functional impairment between the immediate post intervention assessment and the final assessment six months later. On the economic side, the study found that the VSLA participants experienced a statistically significant increase in food consumption per capita over time. Furthermore, VSLA participants also reported higher increases in levels of available social resources in comparison with the control group.

D. Justice Sector Interventions

18. Interventions in this area are based on the argument that discriminatory legal frameworks and lack of access to justice institutions pose obstacles that hinder women from leaving abusive relationships, or from holding perpetrators accountable. Strengthening access to justice include civil law remedies, specialized courts, legal aid support for survivors, use of forensic evidence in sexual assault trials, legal reforms, and strengthening justice institutions.

19. Approaches of civil law remedies include arrest and incarceration, restraining orders, training police, and women's police stations. Women's police stations are the only interventions that have been evaluated in developing country settings. Women's police stations were originally

designed to facilitate women's access to justice, where they can visit to seek emergency shelter, guidance, support and legal advice. A recent World Bank study suggests that in Brazil women's police stations are effective in reducing violence against women in urban areas (Perova et al., 2013), as establishment of such facilities is likely to trigger a 15 percent reduction in domestic violence. However, the study did not find any effect on domestic violence in rural areas.

20. The evidence on the effectiveness of specialized courts is overwhelmingly from high- and middle-income countries[33] and creates some concerns for application in lower income countries. These courts require high levels of training for judges and courts, and high levels of resources to maintain. They have also raised concerns that diverting domestic and sexual violence cases to a separate court trivializes the issue of SGBV.

21. A report by Human Rights Watch suggests that the use of forensic evidence in sexual assault trials plays an important role in influencing the beliefs of both the police and doctors about whether a woman was raped, and can greatly influence whether a conviction is secured. In India, this evidence consists of a medico-legal certificate, issued by a doctor to 'confirm' that an assault occurred, together with the collection of physical evidence. (Human Rights Watch, 2010) A study in Kenya (Ajema et al, 2012) developed and tested a locally assembled rape kit as a strategy to improve the collection of forensic evidence in health facilities and to develop mechanisms to promote the recording of this evidence in police medical examinations and its inclusion as legal evidence in trials. These kits improved collection of evidence, as the intervention site was more than three times as likely as the control site to have the proper documentation completed and filed.

22. Legal reforms that promote stronger legislation on domestic and sexual abuse are intended to prevent recidivism and deter further abuse. Although integrating gender equality into policies and legal framework has its theoretical rationale to prevent SGBV since it redefines the boundaries of acceptable behavior, the evidence for this is weak, partly due to the fact that few studies have explored this relationship empirically. (Heise, 2011)

23. In a review that examines good practices to prevent SGBV and offer services to its survivors or perpetrators in Latin America, Morrison et al (2004) underscore that legislative reforms to include SGBV aspect is only the first step in a long process, whereas enforcement of legislation is equally, if not more, important. Such promising initiatives include training and sensitizing police, judges and other law enforcement personnel; improving services to SGBV survivors in justice sector reform projects; creating women's police stations; improving medico-legal response to SGBV; and improving knowledge of women's right to live free of violence.

24. Some interventions to build on existing informal justice institutions show positive impact. An increasing number of communities are exploring non-formal ways to sanction perpetrators and to increase rights awareness. Some communities in India, for example, use public shaming in front of the homes of abusive men. Though these approaches are certainly promising, others have

[33] For example, for the UK see http://wlv.openrepository.com/wlv/handle/2436/22612.

warned against assuming the informal institutions are necessarily better suited to dealing with SGBV or to issues that concern primarily women; these structures are heterogeneous, and in some cases can be exclusionary or even repressive to women. (Pouligny, 2011). Some that are often cited as promising rely primarily on anecdotal evidence and do not include key groups such as perpetrators in the evaluations.

2. Prevention of SGBV

A. Triggers of SGBV

25. In order to better understand what works to prevent SGBV and provide services to SGBV survivors, it is important to explore triggers that lead to SGBV. Heise (2011) adopted the ecological model to explain the causes of intimate partner violence (IPV), one of the most common forms of SGBV, positing that IPV is a product of the interaction of many factors at different levels of the "social ecology", which includes life histories, traumatic scars and personalities, contextual factors, social norms and ideology. Specifically, triggers for men using violence can include biased gender norms and misconception that tolerate or advocate SGBV, women's economic vulnerability and dependency, malfunction of legal and justice system, inadequate capacity to enact laws and provide services, abuse of drugs and alcohol, human trafficking, and early exposure to violence in childhood. (Morel-Seytoux et al, 2010; Barker and Peacock 2012). In extreme cases, SGBV is used as a weapon of war, which not only detriments physical and mental health of individuals at a large scale, but also harms social structure and intergenerational development.

B. Sensitization and Changing Social Norms

26. Sensitization and campaign activities to change biased gender norms that tolerate or advocate male authority and gender-based violence are essential in preventing SGBV. Among various approaches, the most rigorously evaluated are small group participatory workshops and large-scale "edutainment" or campaign efforts. (Heise, 2011) The former is designed to challenge existing beliefs, build pro-social skills, promote reflection and debate, and encourage collective action. The latter is normally accompanied with efforts to reinforce media messages through street theatre, discussion groups, cultivation of "change agents", and print materials. Both strategies have demonstrated modest changes in reported attitudes and beliefs and, in some cases, reductions in reported rates of partner violence.

27. Comparing different forms of sensitization activities, it is evidenced that integrated programs with community outreach, mobilization and mass-media campaigns show more effectiveness in changing behavior than group education alone, although both types of programs can lead to positives changes in attitudes. In addition, sensitization activities can be categorized into gender neutral, gender sensitive, and gender transformative. Gender neutral refers to programs that distinguish little between the needs of men and women, neither reinforcing nor questioning gender roles. Gender-sensitive program are those that recognize the need to treat

men and women differently, but do not actively seek changes to change overall gender relations. It is evidenced that gender-transformative programs tend to have a higher rate of effectiveness than gender-sensitive and gender neutral approaches. This indicates that programs with an explicit objective to change biased social norms have a higher likelihood to succeed in doing so than those without such explicit objectives.

28. Engaging male counterparts is significant in achieving equitable gender norms. Existing research (Barker, 2007) shows that well-designed programs engaging men and boys generate compelling evidence of changing SGBV behaviors and attitudes. Promising results from such programs include decreased self-reported use of physical, sexual and psychological violence in intimate relationship, increased contraceptive use, increased communication with spouse or partner about child health, contraception and reproductive decision-making, more equitable treatment of children, increased use of sexual and reproductive health services by men, decreased rates of sexually transmitted infections, and increased social support of spouse.

Annex 7: Implementation Support Plans

Strategy and Approach for Implementation Support

1 The implementation support plan for the project has been developed based on the specific nature of the technical assistance activities, the existing capacity of the government counterparts, the fragile environment in some countries involved, the complex and multi-sectoral nature of the project, and sector and project's risk profile in accordance with the Operational Risk Assessment Framework (ORAF). The implementation support (IS) plan aims to enhance the client's quality delivery of the proposed project interventions and address critical issues that may affect project implementation. The IS will specifically focus on: (i) strengthening technical and fiduciary capacity of the respective government counterparts at the beginning of the project; and (ii) regular provision of implementation support through three times a year Bank Implementation Support Missions (ISM), including technical, institutional, safeguards, monitoring and evaluation, and fiduciary aspects.

2 An adequate skill mix of qualified staff and consultants. Some skills will be needed on a regular basis, while others will be required on a need basis. It is therefore proposed to establish a core implementation support team that will include expertise on public health, social development, financial, procurement, complemented by specialists in key areas (e.g. SGBV, health systems and financing, and M&E). The core implementation support team will include the following: Task Team Leaders (TTLs), Senior Health Specialist, Senior Social Development Specialist, FM Specialist, Procurement Specialist, Safeguards (both environmental and social) Specialists, M&E Specialist and Operation Officer. Other staff will be brought in periodically, as necessary.

3 Formal ISMs and field visits will be carried out three times a year during the first year, and every six months in subsequent years. In addition, the country-based Bank staff would conduct more frequent meetings with staff from various ministries involved in the project, as well as carry out field visits to provide ongoing assistance to clients, help identify implementation bottlenecks early, and propose remedial actions. The country based staff would also maintain close working relationships with the other main development partners engaged in SGBV and reproductive health.

4 The Bank ISMs , including field visits would concentrate in the following areas:

a. **Technical**: Implementation support missions will concentrate on the overall implementation of the project activities at all levels. Randomized field visits will serve to verify compliance with the Project Implementation Manual. Additional technical assistance will be provided for Performance Based Financing, maternal and reproductive health services, SGBV services, mental health support, specialized services for male and child survivors of SGBV, innovative activities at the community level to promote gender equality and behavioral change towards women and girls, and DNA testing (Rwanda).

The project will require intensive technical support, given the complex nature of the activities to be financed and relatively limited in country experience with some of the main approaches. Support will be provided by the World Bank, in collaboration with other experts, to ensure that activities are implemented in a cost-effective fashion and in accordance with the project development objectives, and that they are fully aligned with government strategies. The Bank team will also facilitate exchange of knowledge with other countries involved in this regional project as well as mobilize appropriate global expertise.

b. **Monitoring & Evaluation**: A M&E specialist will (i) provide regular technical assistance and oversight of data collection; (ii) ensure effective flow of data between the multiple government counterparts involved in service delivery, as well as between the provincial and national level; and (iii) ensure effective use of data by the counterpart to inform ongoing progress of activities and take appropriate action as needed. Additional support will be provided for the development of studies and evaluations to improve the understanding of underlying causes of SGBV, effective delivery of service delivery for survivors of SGBV and challenges related to access maternal and reproductive health services.

c. **Client Relations**: The Task Team Leaders (TTLs) will: (i) coordinate Bank implementation support to ensure consistent project implementation, as specified in the legal documents (i.e., Financing Agreement, Project Implementation Manual); and (ii) meet regularly with the client's senior representatives at central and decentralized levels (where appropriate) to gauge project progress in achieving the PDO and address implementation bottlenecks, as they arise. In addition, the TTLs will ensure regular exchanges of information with other key donors supporting activities related to primary health care and SGBV, as well as bilateral donors and UN agencies.

d. **Financial Management:** FM implementation support will take place twice a year to: (i) ensure the capacity of staff to manage flow of funds and accounting procedures; (ii) review of audit reports and IFRs; (iii) ensure effective FM support functions of the Performance Purchasing Agencies; and (iv) in Rwanda, ensure effective reporting on FM matters using the Integrated Financing Management System (IFMS) of the Ministry of Finance. Based on Substantial current risk assessments for each of the countries as well as ICGLR, the project will be supervised at least twice a year and may be adjusted when the need arises. An ISM will be carried out before effectiveness to ensure the project readiness.

e. **Procurement:** The Bank will support procurement staff involved in the project to effectively carry out the procurement activities, in accordance with World Bank guidelines and procedures as well as with the Project Implementation Manual. In

this regard, the in-country procurement specialists will provide training and mentoring in areas such as roles and responsibilities of key actors in the procurement chain, internal governance processes, and monitoring of contract compliance. The country based procurement specialists will undertake onsite visits and desk reviews of procurement documents. Intensive Bank support will be provided during the first year to ensure timely delivery and distribution of goods and services. In terms of procurement supervision, in addition to the prior-review supervision conducted from country offices, the Bank will carry out annual supervision missions to conduct post review of procurement actions and contracts under prior review thresholds on basis of a sample of about 20 percent of contracts within review period. To the extent possible, mixed on-site supervision missions will be undertaken with procurement and financial management staff.

f. **Safeguards**: The Bank team's social and environment safeguard specialists will assume responsibility for initiating the timely commencement of the preparation of Environmental Management Plan (EMP), the Medical Waste Management Plan (MWMP) by Governments, and the Indigenous Peoples Plan (IPP) for DRC, and will further ensure that no contract for works that have any physical impact are signed, or construction, or operation of health facilities and One Stop Centers start without the required safeguards instruments in place. The Bank task team will assist the Government teams in reviewing the ToRs for EMP, MWMP, and IPP (DRC), as well as the finalized products, and ensure their scope and quality is satisfactory to the Bank. The task team will also follow up on the EMP, MWMP and IPP implementation and application through regular ISMs (which will include an environmental specialist, as well as a social development specialist for DRC) during which document reviews, site visits and spot-checks will be conducted. The team will use the concrete tasks and challenges in the project as platforms for capacity building, which –depending on demand– will be expanded by targeted training and hands on exercises.

Implementation Support Plan

5. The implementation support will be provided by direct support from the World Bank team and additional consultants to provide technical assistance as needed. During the first year of the project, it is foreseen regular technical assistance missions will take place to essential areas to support the client in initiating activities given the complexity and multi-sectoral nature of the project. Several of the World Bank team members are based in in the field and will be able to provide on-going implementation support, with additional inputs from team members based in Washington, Nairobi, Kigali and elsewhere. The World Bank team will not only carry out ISMs in distant areas as well as in the capital cities but would also provide additional support in between these missions. The volume of support is expected to be particularly high in the first two years of the project implementation. An IS plan for the first year of the project, as well as following years is provided below, including required skills mix.

Implementation Support Plan-DRC

Time	*Focus*	*Skills Needed*	*Partner Role*
First twelve months	Project start-up, preparing safeguards instruments, conducting training for fiduciary staff, setting-up support for survivors at health facility level and community level, initiating support for the PBF scheme for reproductive and maternal health services, supporting CoEs	As per skills mix required table below	UN, MONUSCO, multi- and bi-laterals
12-48 months	Supporting (i) implementation of project activities for survivors of SGBV and PBF scheme for high impact health services, (ii) innovative activities to promote gender equality and promote behavioral change, and (iii) research and knowledge sharing	As per skills mix required table below	UN, MONUSCO, multi- and bi-laterals

Skills Mix – DRC

Skills Needed	*Number of Staff Weeks per FY*	*Number of Trips per FY*	*Comments*
Health Specialist /TTL	16	3	HQ - based
Social Development Specialist/co-TTL	16	3	Regional - based
Health Specialist	6	1 (local)	Kinshasa - based
Operations Officer	12	3	HQ-based
PBF Specialist	12	2	Kinshasa-based
Health Economist	8	2	HQ based
Social Protection Specialist	20	4 (local)	Kinshasa -based
Pharmaceutical Chain Specialist	4	2	HQ - based
Financial Management Specialist	6	2 (local)	Kinshasa - based
Procurement Specialist	6	2 (local)	Kinshasa - based
Gender Based Violence Specialist	10	2	tbi
Safeguards Specialist	2	1	Regional - based

Monitoring and Evaluation Specialist	4	2	Regional - based
Legal Counsel	1	-	Europe - based
Team Assistant	8	-	Country - based

Partners

Name	***Institution/Country***	***Role***
UN	UN Kinshasa/Kivus	Coordination complementary activities
MONUSCO	UN Kivus	Coordination complementary activities/security assessments
Multi-lateral and bi-lateral partners	Kinshasa/Kivus	Coordination complementary activities

Implementation Support Plan - BURUNDI

Time	**Focus**	**Skills Needed**	**Partners and Partner Roles**
• First 12 months	• Project start-up, procurement to acquire key project inputs, contracting of NGOs and other actors to be involved	• Team leadership, Public Health Specialist, Social Development Specialist, safeguards specialist, M&E specialist, finance management and procurement specialists. Other specialists and consultants will be brought in as and when necessary	• a) Partners: UNFPA, UNICEF, UN Women, USAID, GIZ, Dutch) • b) Role: Technical knowledge sharing and training, resource contributions, scaling up of approaches, implementation knowledge
• 12- 36 months	• Same as above for ongoing supervision and mid-term review		
• 36-48 months	• Same as above for ongoing supervision and implementation completion report preparations		

Skill Mix Required - BURUNDI

Skills Needed	**Number of Staff Weeks**	**Number of Trips**	**Comments**
• Team Leader	• 6 wks	• 4 trips the first year; 2 trips or more (based on need) thereafter	• Washington based
• Public Health Specialist and Co-TTL	• 6 wks	• At least 2 field trips or more as needed; but day to day support in-country	• Based in country
• Social Development Specialist	• 4 wks	• 4 trips the first year; 2 trips thereafter	• Washington based
• Safeguards Specialist	• 4 wks	• 4 trips the first year; 2 trips or more (based on need) thereafter	• Regional - based

		(for both environmental and social)	
• Financial Specialist	• 4 wks	• 3 field trips, multiple MoH and MCDMCH onsite visits, with more as needed	• Based in country
• Procurement Specialist	• 4 wks	• 2 field trips, multiple MoH and MCDMCH onsite visits, with more as needed	• Based in country
• M&E Specialist	• 2 wks	• As needed, especially in MTRs and other ad hoc reviews	• Washington or region based

Implementation Support Plan – RWANDA:

The main focus in terms of support to implementation

Time	***Focus***	***Skills Needed***	***Partner Role***
First twelve months	Project start-up; preparing safeguards instruments; developing training, training for fiduciary staff; setting-up of OSCs	As per skills mix required table below	One-UN Government of the Netherlands, DFID
12-48 months	Supporting (i) implementation of project activities for survivors of SGBV; (ii) development of Center of Excellence; (iii) innovative activities to promote gender equality and promote behavioral change; and (iv)research	As per skills mix required table below	One-UN Government of the Netherlands, DFID

Skills Mix Required – RWANDA

Skills Needed	***Number of Staff Weeks per FY***	***Number of Trips per FY***	***Comments***
Social Development Specialist/Task Team Leader	10	3	Regional - based
Health Specialist	6	3	HQ - based
Operations Officer	16	3	Country-based/HQ-based
Financial Management Specialist	6	3	Regional – based
Procurement Specialist	6	-	Country - based
Gender Based Violence Specialist			TBI
Safeguards Specialist	2	1	Regional - based
Monitoring and Evaluation Specialist	4	2	Regional - based
Legal Counsel	1	-	Europe - based
Team assistant	6	-	Country - based

Partners

Name	***Institution/Country***	***Role***
One-UN	UN Rwanda	Coordination complementary activities
DFID	DFID Rwanda	Coordination complementary activities
GoNetherlands	Embassy of the Netherlands, Rwanda	Coordination complementary activities

Implementation Support Plan – ICGLR:

The main focus in terms of support to implementation

Time	***Focus***	***Skills Needed***	***Partner Role***
First twelve months	Project start-up; development of Project Implementation Manual, training for fiduciary staff; initiating first training of RTF; communication activities to be launched in November	As per skills mix required table below	AfDB, USAID, Swiss Cooperation, GTZ, UN
12-48 months	Supporting (i) implementation of project activities for RTF, communication; (ii) continuous institutional strengthening CS including fiduciary; (iii) implementation of Symposiums and learning events related to SGBV; and (iv) partner/donor coordination	As per skills mix required table below	AfDB, USAID, Swiss Cooperation, GTZ, UN

Skills Mix Required – ICGLR

Skills Needed	***Number of Staff Weeks per FY***	***Number of Trips per FY***	***Comments***
Social Development Specialist/Task Team Leader	8	3	Regional - based
Health Specialist/co-TTL	10	3	Country-based
Lead Operations Officer (Regional Programming)	2	2	HQ-based
Operations Analyst	10	3	HQ-based
Financial Management Specialist	6	3	Regional – based/Country-based
Procurement Specialist	6	-	Country - based
Gender Based Violence and Training Specialist	6	3	TBI
Monitoring and Evaluation Specialist	4	2	Regional - based
Legal Counsel	1	-	Europe - based
Team assistant	6	-	Country - based

Partners

Name	***Institution/Country***	***Role***
AfDB	AfDB Nairobi	Coordination complementary activities
USAID	USAID Regional (Nairobi), USAID Burundi	Coordination complementary activities
Swiss Cooperation	Swiss Cooperation Burundi/Regional office Rwanda	Coordination complementary activities; technical assistance for ICGLR through Swiss Cooperation support
GTZ	GTZ Burundi	Coordination complementary activities

Annex 8: Environmental and Social Action Plan

1. Objectives

1 The Environmental and Social Action Plan (ESAP) provides general policies, guidelines, codes of practice and procedures to be integrated into the implementation of World Bank supported Great Lakes Emergency Sexual and Gender Based Violence and Women's Health Project.

2 The objective of the abbreviated ESAP is to help ensure that activities will be in compliance with the national legislations of Burundi, DRC and Rwanda and the World Bank's operational safeguards policies.

2. General Principles

3 Due to the emergency nature of the proposed operation and the related need for providing immediate assistance while at the same time ensuring due diligence in managing potential environmental and social risks, the ESAP is based on the following principles:

a. To ensure effective application of the World Bank's safeguard policies, the ESAP provides guidance on the approach to be taken during multi-sector emergency project implementation for the selection and design of subprojects and the planning of mitigation measures.

b. No physical resettlement issues are expected in any of the proposed subprojects under the emergency Project as they are primarily concerned with rehabilitation and reconstruction.
The proposed emergency operation will finance feasibility and detailed design studies for subsequent investments to include environmental and social assessments as required by the World Bank safeguards policies.

c. Employment/income generating opportunities within the subproject areas will be targeted and expanded as much as possible to the affected communities and households that lost their livelihoods due to the political crisis and/or to natural disasters. Special attention will be given to women, youth and other most vulnerable groups, including host-communities for displaced and/or disaster-affected populations.

d. Participatory Public Consultation and Disclosure requirements, as specified by World Bank Safeguards policies, will be simplified and adopted to meet the special needs of these operations. All subprojects which require public consultations with local communities or beneficiaries will be conducted to help elicit the views and comprehension of the male and female populations.

4 The ESAP prepared by the Task Team complies with World Bank safeguards policies and is subject to public consultation and disclosure by the Borrower during project implementation. As such, it will be disclosed both in-country (in the appropriate communication channels, concerned sector ministries, and other public places of project intervention areas) as well as at the World Bank InfoShop during project implementation.

3. Project Scope

5 The Great Lakes Emergency Sexual and Gender Based Violence and Women's Health Project is part of the broader World Bank Group (WBG) initiative for the Great Lakes launched following the May 2013 visit to the region of the President of the World Bank and the Secretary General of the United Nations. The regional project reflects the Bank's commitment to support governments of the Great Lakes Region to reduce poverty and promote shared prosperity by targeting some of the most vulnerable groups, including survivors of Sexual and Gender Based Violence (SGBV). To maximize the impact of the proposed operation, support is provided to DRC, Burundi and Rwanda, as well as the ICGLR in this regional operation, as this would facilitate cross country learning and knowledge sharing, and contribute to the broader goal of strengthening regional cooperation.

6 Due to the urgent need of assistance the team requested, and was granted, the deferral of the safeguards instruments until the project implementation phase as provisioned by OP10.00, paragraph 11, on projects under special considerations. This plan covers the entire portfolio of the regional activities, describing country specific arrangements for DRC, Burundi and Rwanda in Attachment 1.

7 The project activities that are relevant in terms of a need to manage potential adverse environmental and social impacts are:

8 **In DRC**:

a. Sub-component 1A (e) Integrated support for survivors of SGBV at the community level and violence prevention, Economic empowerment of women. The project will provide support to Community Based Organizations (CBOs) in support of their ongoing activities. The CBOs will receive support to strengthen their organizational capacity, including on development of vision, governance, project planning and basic financial management. The project would provide small in-kind grants in support of the CBOs selected activities, as well as ongoing technical assistance and follow-up.

b. Sub-component 1B. Strengthening the health system to provide integrated services for survivors of SGBV, Sub-component 1C. Supporting existing integrated centers of excellence in the Kivus, and Component 2. High impact basic health services. Activities under these Components will include medical care for survivors of SGBV as well as support for reproductive and maternal health services. In addition, the project would support under Component 1B small scale upgrading of health centers at the community level to receive survivors in an appropriate and confidential manner.

c. The provinces of North and South Kivu are the target administrative and geographical locations of the project. At local level, established health centers, General Referral Hospitals (GRHs) at the health zone level and referral hospitals at the tertiary level, will constitute the adjacent environments of the project. Potential sites for small scale rehabilitation of health centers will be in pre-existing medical facilities and are to be determined. Given the limited size of the proposed rehabilitation, potential localized adverse environmental and social impacts are expected to be minimal. In addition, selected villages in the two provinces will benefit from economic empowerment support. The physical environment of the target provinces is characterized by forests savanna, and highlands/mountains and hills (in North and South Kivu, landslides are frequent). Accessibility of areas off the main roads is a constant challenge. The provinces (North Kivu 59,483 km^2, South Kivu 65,070 km^2) cover an area of about 124.000 km^2; that is about the size of Belgium, Denmark and the Netherlands together.

9 **In Burundi**, the project activities that are relevant in terms of the need to manage potential adverse environmental and social impacts are activities planned under subcomponent 1B Integrated Support for Survivors of SGBV at Facility Level and Component 2 High Impact Basic Health Services:

a. Small scale construction and rehabilitation activities, including the renovation and re-configuration works within existing and operating community structures, hospitals and youth centers (Subcomponents 1A/1B and Component 2): These would entail temporary, localized and minor negative impacts, such as noise, vibrations, dust, odors by exhaust fumes, paints, fuels and lubricants, the generation of construction waste, and risks to pedestrian and traffic safety due to movements of construction machinery. Workplace health and safety would also be an important concern.

b. Generation of additional medical waste during the operation of the planned integrated services for SGBV survivors and other groups (Subcomponent 1B and Component 2): The expansion and improvement of health services for SGBV survivors and other groups, as well as the increased quality of their treatment are likely to generate additional quantities of medical waste, which, classified as hazardous, would have to be diligently handled, stored and disposed of.

10 For the grant with the **ICGLR,** there are no activities that are relevant in terms of a need to manage potential adverse environmental and social impacts.

11 The environmental baseline of the project locations is characterized by a pre-existing use as medical facilities, usually within larger villages or cities, within urbanized areas, compounds designated as hospitals for several years already, and entirely within existing structures. The current project design will cause minimal environmental or social adverse impacts, all of which are temporary, minor, confined to locations within already existing structures, compounds and built up areas, and can be mitigated with standard, readily available measures. The expected impacts are those of any small scale construction site (noise, dust, exhaust gases, waste

generation, workplace and community health and safety). The main adverse potential impact could occur during the operation of the operation of OSCs, where the planned medical care services will produce medical waste, that – classifiable as hazardous – will need to be managed appropriately. The generation of medical waste is an unavoidable feature of operating health facilities.

12 No alternatives were developed to the locations, the rehabilitation activities for the regional project and the operation of the targeted health facilities. The project is focused on providing health services in a limited number of health facilities in three provinces to be supported under the project. The projected small scale civil works and subsequent activities at health facilities are expected to induce minor, adverse environmental and social impacts. The anticipated adverse impacts are not expected to go beyond the scope, intensity, and duration that would be generated by similar projects using Best Available Techniques (BAT). The impacts are expected be site specific, limited in scope, and duration.

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13 **In Rwanda**, the project activities that are relevant in terms of a need to manage potential adverse environmental and social impacts are the activities (a) and (c), both planned under subcomponent 1B. Integrated support for survivors of SGBV at the Health Facility Level, as well as activity under component 2. Regional and National knowledge Sharing, Research and Capacity Building:

a. Setting-up One Stop Centers (OSCs) and one Center of Excellence. To ensure survivors of SGBV will be received in an adequate environment, the project will support setting up in existing hospitals special rooms and upgrade existing ones. This will include adding safe rooms to accommodate and ensure access to medical, psychosocial, forensic and legal support, including separate safe rooms for male and female survivors of SGBV. Ideally, an OSC should include 2 safe rooms, 1-2 consultation rooms, 1 private reception room, 2-4 adults and child therapy rooms, 1 judicial police officer and legal consultation room and 1 investigative interview room for children and adults. In addition, the OSCs will be provided with essential equipment, including medical, and for the child therapy rooms. The OSCs will be established in 12 existing hospitals which would be rehabilitated and modernized to accommodate the OCSs. Under component 2, one Center of Excellence (CoE) will be established in a pre-existing, publicly used and owned building which has already been identified in Kigali, about 150 m from a major hospital facility (police hospital).

b. Clinical care. Survivors will receive preventative and curative medical services and follow-up in a confidential manner. The medical service providers from the OSCs will use the Manual for Medical Management of GBV survivors (MoH, 2009). The medical doctor at the OSC will be in charge of medical care, treatment and evidence protection. Prevention will include post exposure prophylaxis (72 hours), emergency contraceptives (120 hours), prevention of sexually transmitted infections (STI), and vaccinations against

Hepatitis B and tetanus, as needed. In addition, other basic medical care services will be provided such as pain relief and treatment of wounds. All medical care, equipment and medication will be adapted to the age of the patient. In addition, for more serious cases, additional specialized medical support, including for example for fistulas, prolapsed uterus or other obstetric problems, will be provided.

14 The medical facilities within which the One Stop Centers (OSCs) that would be established are currently well managed, especially in terms of medical waste generation, which is treated in modern incinerators, which are installed in about 90 percent of the 42 current district hospitals.
15

4. Compliance with World Bank safeguards policies

16 Activities supported by the proposed operation are expected to have certain site-specific adverse environmental and social impacts; therefore, the following Safeguards policies are triggered: **OP 4.01 (Environmental Assessment)** and in DRC **OP 4.10 (Indigenous People)**.

17 Overall, the current project design will cause minimal environmental or social adverse impacts, all of which are temporary, minor, confined to locations within already existing structures, compounds and built up areas, and mitigable with standard, readily available measures. In activity 1B (see section 3 above), the expected impacts are those of any small scale construction site (noise, dust, exhaust gases, waste generation, workplace and community health and safety). The main anticipated adverse potential impact could occur during the operation of the health facilities, where the planned medical care services will produce medical waste, that – classifiable as hazardous – will need to be managed appropriately. The generation of medical waste is an unavoidable feature of operating clinics. In activity 1A, the expected impacts will be on a very small scale and widely dispersed and so may induce marginal adverse environmental impacts, significant or cumulative effects are not expected.

18 The presence of indigenous people (Batwa) in North and South Kivu was identified and confirmed during project preparation. Batwa constitute a vulnerable and marginalized group in the project area. The risk of social exclusion of Batwa in the context of the project cannot be ignored.

5. Sequencing and, if practical, tentative implementation schedule for safeguards processing

19 Prior to subproject appraisal, the implementing agencies will agree to apply the following minimum standards during implementation: (1) inclusion of standard Environmental Codes of Practice (ECOP) (Attachment 4) in the rehabilitation, improvement and reconstruction bid documents of all subprojects; review and oversight of any major reconstruction works by specialists; (2) implementation of environmentally and socially sound options for disposal of medical waste, debris or drain spoils; and provisions for adequate and satisfactory budget and

institutional arrangements for monitoring effective implementation; and (3) in case of DRC, organizing free, prior and informed consultations, ensuring broad community support to the project by the affected Indigenous Peoples.

20 *Sequencing of safeguards instruments during project implementation.* The following three safeguards instruments are anticipated to fully manage and mitigate the potential adverse impacts of activities 1A (e), 1B, 1C and 2.

a. ***Upgrading health facilities: EMP using the "checklist format"*** will be developed for this activity due to the small scale, routine manner of interventions, and the expected minor, temporary and localized nature of the potential impacts. The EMP will be produced, reviewed by the Bank, disclosed, consulted on and finalized before any disbursement on physical works of this type of activity may be undertaken. The same instrument would be applied for the management of any anticipated negative impacts of the activities to support CBOs.
b. ***Medical care***: ***Medical Waste Management Plan*** will be produced for the generation and disposal of medical waste from the health facilities, which will cover (a) anticipated waste composition and quantity; (b) existing medical waste management system, including free capacity, deviations from, and gaps to BAT, (c) existing regulatory framework and supervision / monitoring arrangements; (c) plan for using the existing medical waste management system, including any measures to upgrade or remedy identified gaps and deviations; and (d) additional arrangements for supervision and monitoring of medical waste management.
c. ***Indigenous People: an Indigenous Peoples Plan (IPP)*** **for DRC** will be prepared and disclosed focusing on outreach and inclusion of *Batwa* people in project activities at the community level.

21 *Preparation time for safeguards instruments, including Bank review, revisions, clearance, and approval steps.* The preparation of the EMP is estimated to require a maximum time period of about 3 months, including Bank review and approval, disclosure, consultations and finalization. The preparation of the MWMP is estimated to require a maximum time period of 6 months including Bank review and approval, disclosure, consultations and finalization. The preparation of the IPP is estimated to require a maximum time period of 6 months, including Bank review and approval, disclosure, consultations and finalization.

22 *Consultations and Disclosure.* The EMP, MWMP and the IPP will be disclosed after Bank review as final draft versions, for a period no less than 30 days, during which the Recipient will organize consultations for the affected stakeholders. The provisions of the three safeguards instruments, including the feedback received from consultations will be considered for the finalization of the project's technical design.

23 *Implementation of safeguards instruments. If applicable, development of secondary instruments (e.g., subproject EMPs to be developed, and specifying by whom—e.g., contractors or other implementing entities—and by when).* After finalization of the EMP, MWMP and DRC

IPP no further safeguards instruments will be required. The checklist-format EMP will be customized to specific construction projects and become part of the tender and contract documents. No tender package will be issued without an attached EMP and no contract signed without respective clauses obliging the Contractor to the EMPs use and implementation. The MWMP will become part of the health facilities operational procedures, in line with existing national regulations, and the DRC IPP will be the guideline for outreach to ensure services to indigenous people.

24 The selection, design, contracting, monitoring, evaluation and implementation of subprojects will be consistent with the following guidelines, codes of practice and requirements:

a) **Attachment 1**: Roles and responsibilities, including supervision arrangements for safeguards preparation, implementation, and monitoring for Burundi, DRC and Rwanda.
b) **Attachment 2**: A list of negative characteristics rendering a proposed subproject ineligible for financing;
c) **Attachment 3**: Guidelines for preparation of the Environmental and Social Management Plan (ESMP);
d) **Attachment 4:** Relevant elements of the codes of practice for the prevention and mitigation of potential environmental impacts;
e) **Attachment 5:** A sample Environmental Safeguards procedures for Inclusion in the Technical Specifications of Contracts.
f) **Attachment 6**: Guidelines for Incorporating Indigenous Peoples in the Project for activities in DRC.

Attachment 1: Country specific roles and responsibilities, including supervision arrangements for safeguards preparation, implementation, and monitoring for DRC, Burundi and Rwanda

1.1 Democratic Republic of Congo

1. At the national level, overall safeguards compliance will be ensured by the Ministry of Environment, Conservation and Tourism (*Ministère de l'Environnement, de la Conservation de la Nature et du Tourisme* or MECNT). The MECNT has three departments in charge of environmental monitoring and management: (i) the DRC Environmental Studies Group (*Groupe d'Etudes Environnementales du Congo* or GEEC); (ii) the National center for Environmental Information (*Centre National d'Information sur l'Environnement* or CNIE); and (iii) the Environmental Regulation and Dispute Unit (*Cellule Réglementation et Contentieux Environnementaux* or CRCE). The GEEC is responsible for safeguards compliance of all projects in the country, but with emphasis on environmental category A projects. The unit is understaffed and has limited capacity. Despite several donor-funded capacity building initiatives, the unit still largely relies on donor funds to carry out its field supervision duties; the MECNT also has representations at provincial level. The project will seek the proximity services of the MECNT as need be.

2. At the project level, the FSDRC will be responsible for the production of the IPP in close collaboration with the PHDs. The CEFE Unit in the MoF will be responsible for preparing the EMP and MWMP in close collaboration with the PHDs in both Kivus. Responsibilities include (if required) the production of ToRs, the management of the consultancy contracts (if required), the review and quality control of deliverables, the driving of the disclosure and consultation process, and the inclusion of the safeguards instruments into tender and contract documents, as well as operational procedures for the health centers.

3. The FSDRC has implemented the previous Bank-funded PASU project (2004-2013), helped to lay a sound institutional foundation for preparing, managing and monitoring potential adverse environmental and social impacts of Bank-funded projects. The FSRDC prepared and implemented the safeguards instruments of PASU and is currently preparing safeguards instruments for the recently approved ERP. During the implementation of PASU, environmental and social safeguards have been respected in accordance with the Environmental and Social Management Framework approved by the Bank. The FSDRC will be responsible for the day-to-day follow up and supervision of compliance with environmental and social due diligence provisions, and monitoring and supervision of the EMP and the IPP implementation for their respective activities during the project implementation.

4. For health related activities, although the Provincial Health Directorates (PHDs) have no experience with World Bank projects, they will build upon the experience from the MoPH which implements the World Bank PARSS project, for which a MWMP as well as an IPPF The PHDs will be responsible for the day-to-day follow up and supervision of the works implementation, including compliance with environmental and social due diligence provisions, and monitoring

and supervision of the EMP implementation during construction as well as the EMP and IPP for their respective activities during the project implementation.

5. The World Bank Task Team will be responsible for ensuring the timely commencement of the preparation of EMP, MWMP and the IPP, will ensure that no contracts for works that have a physical impact are signed, or construction, or operation of OSCs starts without the required safeguards instruments in place. The Task Team will review ToRs (if required) as well as EMP, MWMP and IPP, to ensure that their scope and quality are satisfactory to the Bank, will review tender documents and construction contracts regarding due consideration of the safeguards instruments, and the inclusion of effective and enforceable contractual clauses.

6. The task team will also monitor the implementation of the EMP, MWMP the IPP through regular supervision missions (which will include an environmental and/or social specialist) during which document reviews, site visits and spot-checks will be conducted.

Estimated costs for the safeguards preparation and implementation process

7. The cost of EMP preparation, disclosure and consultation is estimated to about US$ 20,000. The cost of EMP implementation on specific construction sites will be covered by the Contractor's remuneration, as EMP implementation will be part of the contract and the underlying financial offer. Preparation of the MWMP, disclosure and consultation are estimated to cost about US$25,000. The cost of management and disposal of the medical waste will be covered by the health facilities operational budgets. As it will rely on a small incremental use of the existing system, effective costs are expected to be very low.

8. The IPP preparation, disclosure and consultation are estimated at US$60,000. The cost for implementing the IPP will be covered by the project.

1.2 Burundi

9. The environmental baseline of the potential project locations is characterized by pre-existing use as medical facilities, usually within larger villages or cities, within urbanized areas, compounds designated as hospitals for several years already, and entirely within existing structures.

10. Regulatory oversight over waste management and general environmental impacts are shared by the National Agency for Environmental Management (NEMA) and the MoH's Department for Environmental Health (DEH) through an inter-ministerial ordinance on biomedical waste management signed by the Ministers for Health and Environment. The two ministries have been involved in drafting of the biomedical waste management plan document in health settings. Both of them were members of a steering committee for the design of three training manuals on biomedical waste management (the first for managers, the second for nurses and the third for health workers). In total, 1500 personnel have been trained on those manuals. Overall the

Ministries have exercised their responsibilities in the waste management sector in a diligent, professional and comprehensive manner.

11. It can thus be presumed that the medical facilities, within which the new services for SGBV survivors will be established, are currently reasonably well managed in terms of medical waste, and significant risks from the generation, handling, transport and treatment of medical waste are not expected.

1.3 Rwanda

12. The project will be coordinated by Technical Committee chaired by MIGEPROF. The Technical Committee will be responsible to supervise and monitor the progress of the project by activities, identify potential challenges and develop mitigation measures to address these constraints as needed.

13. The SPIU in MIGEPROF will be responsible for the production of the EMP and MWMP during the project's initial preparation period, including (if required) the production of TOR, the management of the consultancy contracts (if required), the review and quality control of deliverables, the driving of the disclosure and consultation process, and the inclusion of the safeguards instruments into tender and contract documents, as well as operational procedures for OSCs. The Technical Committee of the project, chaired by MIGEPROF, and comprising of MoH, RNP, MINALOC and MINIJUST (others to be confirmed) will review and approve the EMP and MWMP. It is very likely that the Technical Committee MIGEPROF will draw on additional resources and expertise from REMA and MoH-EHD, since these agencies are currently jointly mandated with the regulatory supervision of the health sector.

14. The SPIU will be responsible for the day-to-day follow up and supervision of the works implementation, including compliance with environmental and social due diligence provisions, and monitoring and supervision of EMP and MWMP implementation during construction and operation.

15. The World Bank Task Team will be responsible for ensuring the timely commencement of the preparation of EMP and MWMP, will ensure that no contracts for works that have a physical impact are signed, or construction, or operation of OSCs starts without the required safeguards instruments in place. The Task Team will review ToRs (if required) as well as EMP and MWMP and ensure their scope and quality is satisfactory to the Bank, will review tender documents and construction contracts regarding due consideration of the safeguards instruments, and the inclusion of effective and enforceable contractual clauses. The task team will also follow up on the EMP and MWMP implementation through regular supervision missions (which will include an environmental specialist) during which document reviews, site visits and spot-checks will be conducted.

Estimated costs for the safeguards preparation and implementation process.

16. The cost of EMP preparation, disclosure and consultation is estimated to be about US$20,000. The cost of EMP implementation on specific construction sites will be covered by the Contractor's remuneration, as EMP implementation will be part of the contract and the underlying financial offer.

17. The cost of MWMP preparation, disclosure and consultation is estimated to about US$25,000. The cost of management and disposal of the medical waste will be covered by the OSCs operational budgets. As it will rely on a small incremental use of the existing system, effective costs are expected to be very low.

Attachment 2: List of Negative Project Attributes

Subprojects with any of the attributes listed below will be ineligible for support under the proposed Great Lakes Emergency Women's Health and Empowerment Project.

Attributes of Ineligible Subprojects	Explanation
Natural Habitats Concerning Activities that involve significant conversion or degradation of critical natural habitats, regardless of their formal legal protection status. Such habitats may e.g. include: • Wildlife Reserves • Ecologically-sensitive marine and terrestrial ecosystems • Parks or Sanctuaries • Protected areas, natural habitat areas • Forests and forest reserves • Wetlands • National parks or game reserves • Any other environmentally sensitive areas	The management of natural resources, including sensitive and critical habitats, has not yet progressed to a point in RSS where institutional stewardship and capacities exists sufficiently to effectively manage and mitigate potential impacts on habitats.
Physical Cultural Resources Damage physical cultural resources, notwithstanding the type of PCR and the scale of the damage. Such PCR may e.g. include, but would not be limited to: • Archaeological sites, structures or objects • Religious monuments or structures • Works of art, artifacts • Natural sites or objects, e.g. trees, rocks, rock formations, hills, forests, rivers (or their sources) or lakes with cultural or religious values • Cemeteries, graveyards, and graves • Sites of any other cultural or religious significance	PCR play an extremely important and sensitive role in the country's cultural identity. The management of physical cultural resources, including the definition and implementation of chance find procedures, salvage digs and the safe storage of salvaged PCR, has not yet progressed to a point in RSS where institutional stewardship and capacities exists sufficiently to effectively manage and mitigate potential impacts on PCR. The well justified relocation of cemeteries, graveyards and graves may be undertaken on a case by case basis in full coordination with religious authorities and local communities.
Irrigation New large scale irrigation and drainage schemes, as well as the significant expansion of irrigated agricultural areas.	
Income Generating Activities Activities involving the use of fuel wood, except	For these activities the capacities and experience in RSS are perceived

	when harvested from sustainably managed existing plantations. Activities involving the use of hazardous substances. Activities involving the collection of natural products (e.g. non timber forest products) on a commercial scale.	currently too low to allow to effectively manage and enforce environmental due diligence during implementation.

Attachment 3: Guidelines for the preparation of the Environmental and Social Management Plan (ESMP)

Under the ESIA process, once the potential impacts of the relevant activities have been identified, the next step of the ESIA process involves the identification and development of measures aimed at eliminating, offsetting, and/or reducing impacts to levels that are environmentally acceptable during implementation and operation of the Project. The ESMP should describe the identified negative environmental and social impacts, proposed mitigation measures, responsibilities for implementation of these measures, timeline for implementation and indicative budget for each item. A sample EMP Checklist for Low-Risk Topologies will be provided to the project implementing agencies as a stand-alone attachment.

Description of mitigation measures

Feasible and cost effective measures to minimize adverse impacts to acceptable levels should be specified with reference to each identified impact. The plan includes compensatory measures if mitigation measures are not feasible, cost-effective, or sufficient. Specifically, the ESIA/ESMP should:

- Identify and summarize all anticipated significant adverse environmental impacts, including those involving involuntary resettlement;
- Describe each mitigation measure, including the type of impact to which it relates and the conditions under which it is required;
- Estimate any potential environmental impacts of these measures; and
- Provide linkage with any other mitigation plan (e.g. for involuntary resettlement) required for the Project.

Monitoring program

In order to ensure that the proposed mitigation measures have the intended results and comply with national standards and donor requirements, an environmental performance monitoring section should be included in the ESMP. The ESMP identifies monitoring objectives and specifies the type of monitoring, with linkages to the impacts assessed and the mitigation measures described in the ESMP**.** The monitoring program should give details of the following:

- Monitoring indicators to be measured for evaluating the performance of each mitigation measure (for example national standards, engineering structures, extent of area replanted, etc.);
- Monitoring mechanisms and methodologies;
- Monitoring frequency;
- Monitoring locations; and
- Monitoring budget.

Capacity development and training

The ESMP will draw on the existence, role and capability of environmental units on site or at the

implementing agency and ministry levels. If necessary the ESMP will include actions to strengthen environmental and social capability in the agencies responsible for its implementation.

Institutional arrangements

Institutions/entities responsible for implementing mitigation measures and for monitoring their performance should be clearly identified. Where necessary, mechanisms for institutional coordination should be identified, as monitoring often involves more than one institution.

Implementing schedules and cost estimates

The ESMP provides timing, frequency, and duration of mitigation, monitoring and capacity development measures with links to overall implementation schedule of the Project, as well as related capital and recurrent cost and sources of funding. The plan for the ESMP should be specific in its description of the individual mitigation and monitoring measures and its assignment of institutional responsibilities.

Attachment 4: Codes of Practice for Prevention and Mitigation of Environmental Impacts

Potential Impacts	Prevention and Mitigation Measures
Impacts during construction: • Fuelwood collection • Excessive water harvesting • Poor sanitation • Generation of solid (including hazardous) wastes • Groundwater contamination (oil, grease) • Accidents during construction • Impacts to physical cultural resources • Influx of migrant workers	• Provision of fuel and water sources at the work camps to prevent stress to local communities due to cutting of firewood and collection of water. • Provision of proper, gender separated sanitation facilities at the work camps. • Removal of work camp wastes, proper disposal of oil, bitumen and other hazardous wastes. • Management of worker health and safety during construction period (refer to WBG Environmental Health and Safety Guidelines). • Use of chance-find procedures (refer to Attachment 4). • Provide comprehensive community participation in the planning, migration issue to be resolved through local redress mechanism. • Preference to employment of local workers.
Medical waste	• Wastes should be segregated at the point of generation according to their type: (a) Infectious, bio-contaminated wastes (including sharp materials); (b) chemical wastes (drugs, chemical solutions, etc.); (c) non infectious, common wastes (paper, cardboard, glass, or the like; empty chemical product containers should be treated as chemical wastes). • Only puncture proof, hermetic plastic containers of 2–5 litre capacity or opaque glass bottles should be used to store sharp objects • For each hospital room, washable and easily disinfected PVC containers with a capacity of 40–50 liters should be used. Waste should be disposed of in coloured bags according to national codification. Usually they are: red bags for bio-contaminated wastes; yellow bags for chemical wastes; black bags for common wastes. • These wastes should then be collected separately at latest 12–24 hours. The personnel assigned to handle medical waste should be properly trained and should wear protective gear such as with aprons, masks, boots and gloves. • Treatment should be done according to the type of waste. Sharp materials disposed in puncture proof containers should then buried in a protected sharp pit. Existing functioning nearby waste treatment facilities should be used but only if safe means of transport can be ensured.

	• Burial area should be isolated and protected to avoid illegal recycling. However, this may not be possible in permanent health facilities, due to lack of space. In such cases, protected areas should be used at landfill sites to receive treated wastes. Common wastes may be managed by the municipal waste-collection service, as long as they are not mixed and do not contain hazardous materials.
Borrow sites Erosion of land	• Design to prevent soil erosion and maintain slope stability • Avoid to have a borrow area close of the settlements
Access Roads	
Disruption of drainage: • Design to provide adequate drainage and to minimize changes in flows, not limited to the road reserve. • Hampers free drainage, causes stagnant pools of water. • Increased sediments into ponds, streams, rivers due to erosion from road tops and sides. Increased runoff and flooding	• Design to provide adequate drainage and to minimize changes in flows, not limited to the road reserve. • Provision of energy dissipaters, cascades, steps and check dams. • Provision of sufficient number of cross drains. • Balancing of cut and fill. • Revegetation to protect susceptible soil surfaces. Rehabilitation of borrow areas.
Erosion: • Erosion of land downhill from the road bed or in borrow areas; • Landslides, slips or slumps; Bank failure of the borrow pit.	• Design to prevent soil erosion and maintain slope stability. • Construction in the dry season. • Protection of soil surfaces during construction. • Physical stabilization of erodible surfaces through turfing, planting native vegetation for slope maintenance and creating slope breaks. • Rehabilitation and re-grading of borrow pits and material collection sites prior to finalization of the project.
Loss of vegetation:	• Balancing of cut and fill. • Revegetation with native species to protect susceptible soil surfaces. • Minimize loss of natural vegetation during construction. • Revegetation and replanting to compensate any loss of plant cover and tree felling.

Attachment 5: Sample Environmental Safeguards Procedures for Inclusion in the Technical Specifications of Contracts.

I. General

1. The Contractor and his employees shall adhere to the mitigation measures set down and take all other measures required by the Engineer to prevent harm, and to minimize the impact of his operations on the environment.

2. The Contractor shall not be permitted to unnecessarily strip clear the right of way. The Contractor shall only clear the minimum width for construction and diversion roads should not be constructed alongside the existing road.

3. Remedial actions which cannot be effectively carried out during construction should be carried out on completion of each Section of the road (earthworks, pavement and drainage) and before issuance of the Taking Over Certificate:

- these sections should be landscaped and any necessary remedial works should be undertaken without delay, including grassing and reforestation;
- water courses should be cleared of debris and drains and culverts checked for clear flow paths; and
- borrow pits should be dressed as fish ponds, or drained and made safe, as agreed with the land owner.

4. The Contractor shall limit construction works to between 6 am and 7 pm if it is to be carried out in or near residential areas.

5. The Contractor shall avoid the use of heavy or noisy equipment in specified areas at night, or in sensitive areas such as near a hospital.

6. To prevent dust pollution during dry periods, the Contractor shall carry out regular watering of earth and gravel haul roads and shall cover material haulage trucks with tarpaulins to prevent spillage.

II. Transport

7. The Contractor shall use selected routes to the project site, as agreed with the Engineer, and appropriately sized vehicles suitable to the class of road, and shall restrict loads to prevent damage to roads and bridges used for transportation purposes. The Contractor shall be held responsible for any damage caused to the roads and bridges due to the transportation of excessive loads, and shall be required to repair such damage to the approval of the Engineer.

8. The Contractor shall not use any vehicles, either on or off road with grossly excessive, exhaust or noise emissions. In any built up areas, noise mufflers shall be installed and maintained in good

condition on all motorized equipment under the control of the Contractor.

9. Adequate traffic control measures shall be maintained by the Contractor throughout the duration of the Contract and such measures shall be subject to prior approval of the Engineer.

III. Workforce

10. The Contractor should whenever possible locally recruit the majority of the workforce and shall provide appropriate training as necessary.
11. The Contractor shall install and maintain a temporary septic tank system for any residential labor camp and without causing pollution of nearby watercourses.

12. The Contractor shall establish a method and system for storing and disposing of all solid wastes generated by the labor camp and/or base camp.

13. The Contractor shall not allow the use of fuel wood for cooking or heating in any labor camp or base camp and provide alternate facilities using other fuels.

14. The Contractor shall ensure that site offices, depots, asphalt plants and workshops are located in appropriate areas as approved by the Engineer and not within 500 meters of existing residential settlements and not within 1,000 meters for asphalt plants.

15. The Contractor shall ensure that site offices, depots and particularly storage areas for diesel fuel and bitumen and asphalt plants are not located within 500 meters of watercourses, and are operated so that no pollutants enter watercourses, either overland or through groundwater seepage, especially during periods of rain. This will require lubricants to be recycled and a ditch to be constructed around the area with an approved settling pond/oil trap at the outlet.

16. The contractor shall not use fuel wood as a means of heating during the processing or preparation of any materials forming part of the Works.

IV. Quarries and Borrow Pits

17. Operation of a new borrow area, on land, in a river, or in an existing area, shall be subject to prior approval of the Engineer, and the operation shall cease if so instructed by the Engineer. Borrow pits shall be prohibited where they might interfere with the natural or designed drainage patterns. River locations shall be prohibited if they might undermine or damage the river banks, or carry too much fine material downstream.

18. The Contractor shall ensure that all borrow pits used are left in a trim and tidy condition with stable side slopes, and are drained ensuring that no stagnant water bodies are created which could breed mosquitoes.

19. Rock or gravel taken from a river shall be far enough removed to limit the depth of material

removed to one-tenth of the width of the river at any one location, and not to disrupt the river flow, or damage or undermine the river banks.

20. The location of crushing plants shall be subject to the approval of the Engineer, and not be close to environmentally sensitive areas or to existing residential settlements, and shall be operated with approved fitted dust control devices.

V. Earthworks

21. Earthworks shall be properly controlled, especially during the rainy season.

22. The Contractor shall maintain stable cut and fill slopes at all times and cause the least possible disturbance to areas outside the prescribed limits of the work.

23. The Contractor shall complete cut and fill operations to final cross-sections at any one location as soon as possible and preferably in one continuous operation to avoid partially completed earthworks, especially during the rainy season.

24. In order to protect any cut or fill slopes from erosion, in accordance with the drawings, cut off drains and toe-drains shall be provided at the top and bottom of slopes and be planted with grass or other plant cover. Cut off drains should be provided above high cuts to minimize water runoff and slope erosion.

25. Any excavated cut or unsuitable material shall be disposed of in designated tipping areas as agreed to by the Engineer.

26. Tips should not be located where they can cause future slides, interfere with agricultural land or any other properties, or cause soil from the dump to be washed into any watercourse. Drains may need to be dug within and around the tips, as directed by the Engineer.

VI. Historical and Archaeological Sites

27. If the Contractor discovers archaeological sites, historical sites, remains and objects, including graveyards and/or individual graves during excavation or construction, the Contractor shall:

(a) Stop the construction activities in the area of the chance find.
(b) Delineate the discovered site or area.
(c) Secure the site to prevent any damage or loss of removable objects. In cases of removable antiquities or sensitive remains, a night guard shall be present until the responsible local authorities and the Ministry in charge of management of cultural heritage take over.
(d) Notify the supervisory Engineer who in turn will notify the responsible local authorities and the Ministry in charge of management of cultural heritage immediately (less than 24 hours).

(e) Contact the responsible local authorities and the Ministry in charge of management of cultural heritage who would be in charge of protecting and preserving the site before deciding on the proper procedures to be carried out.

(f) This would require a preliminary evaluation of the findings to be performed by the archaeologists of the Ministry in charge of management of cultural heritage (within 72 hours). The significance and importance of the findings should be assessed according to the various criteria relevant to cultural heritage, including the aesthetic, historic, scientific or research, social and economic values.

(g) Ensure that decisions on how to handle the finding be taken by the responsible authorities and the Ministry in charge of management of cultural heritage. This could include changes in the layout (such as when the finding is an irremovable remain of cultural or archaeological importance) conservation, preservation, restoration and salvage.

(h) Implementation for the authority decision concerning the management of the finding shall be communicated in writing by the Ministry in charge of management of cultural heritage; and

(i) Construction work will resume only after authorization is given by the responsible local authorities and the Ministry in charge of management of cultural heritage concerning the safeguard of the heritage.

VII. Disposal of Construction and Vehicle Waste

28. Debris generated due to the dismantling of the existing structures shall be suitably reused, to the extent feasible, in the proposed construction (e.g. as fill materials for embankments). The disposal of remaining debris shall be carried out only at sites identified and approved by the project engineer. The contractor should ensure that these sites (a) are not located within designated forest areas; (b) do not impact natural drainage courses; and (c) do not impact endangered/rare flora. Under no circumstances shall the contractor dispose of any material in environmentally sensitive areas.

29. In the event any debris or silt from the sites is deposited on adjacent land, the Contractor shall immediately remove such, debris or silt and restore the affected area to its original state to the satisfaction of the Supervisor/Engineer.

30. Bentonite slurry or similar debris generated from pile driving or other construction activities shall be disposed of to avoid overflow into the surface water bodies or form mud puddles in the area.

31. All arrangements for transportation during construction including provision, maintenance, dismantling and clearing debris, where necessary, will be considered incidental to the work and should be planned and implemented by the contractor as approved and directed by the Engineer.

32. Vehicle/machinery and equipment operations, maintenance and refuelling shall be carried out to avoid spillage of fuels and lubricants and ground contamination. An oil interceptor will be provided for wash down and refuelling areas. Fuel storage shall be located in proper bounded areas.

33. All spills and collected petroleum products shall be disposed of in accordance with standard environmental procedures/guidelines. Fuel storage and refilling areas shall be located at least 300m from all cross drainage structures and important water bodies or as directed by the Engineer.

Attachment 6: Guidelines for Incorporating Indigenous Peoples in the Project for Activities in DRC

Based on initial technical work related to the Bank portfolio, there are several groups that have been identified as "indigenous peoples" in DRC. This term is used in a generic sense to refer to a distinct, vulnerable, social and cultural group possessing the following characteristics in varying degrees:

a) self-identification as members of a distinct indigenous cultural group and recognition of this identity by others;
b) collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories;
c) customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and
d) an indigenous language, often different from the official language of the country or region.

In those cases where Indigenous Peoples are ***not*** the overwhelming majority of direct project beneficiaries, then a social assessment should be prepared by the Borrower; there should a process of free, prior, and informed consultation with the affected Indigenous Peoples' communities at each stage of the project, and particularly during project preparation, to fully identify their broad community support for the project; and, an IPP should be prepared and disclosed.

The IPP should include baseline information on the demographic, social, cultural, and political characteristics of the project-affected indigenous communities, the land and territories that they have traditionally owned or customarily used or occupied, and the natural resources on which they depend. It should also elaborate, where necessary, a culturally appropriate process for consulting with the communities at each stage of project preparation and implementation.

The IPP, based on free, prior, and informed consultation with the affected communities, should describe potential adverse and positive effects of the project. Critical to the determination of potential adverse impacts is an analysis of the relative vulnerability of, and risks to, the affected communities. The EA should include identification and evaluation, based on free, prior, and informed consultation with the affected communities, of measures necessary to avoid adverse effects, or if such measures are not feasible, the identification of measures to minimize, mitigate, or compensate for such effects, and to ensure that the affected communities receive culturally appropriate benefits under the project.

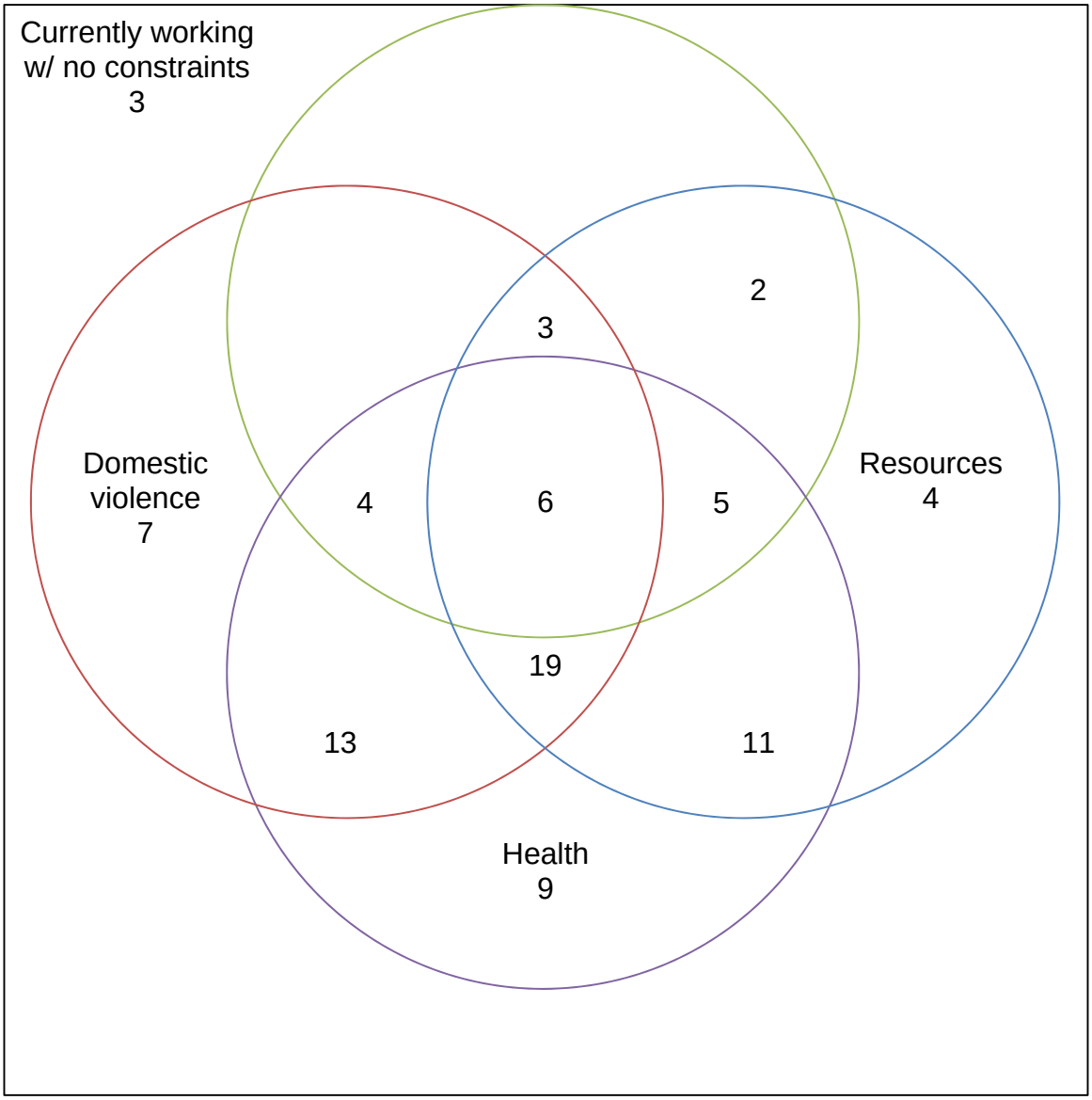
Following the IPP process, the project should, as required:

a) Ensure that free, prior, and informed consultation with the affected communities was carried out during project preparation and that there is broad community support for the project;

b) Include a framework for ensuring free, prior, and informed consultation with the affected communities throughout the project's life-cycle;
c) Include an action plan of measures to ensure that the affected communities receive social and economic benefits that are culturally appropriate, including, if necessary, measures to enhance the capacity of the project implementing agencies;
d) When potential adverse effects on the communities are identified, an appropriate action plan of measures to avoid, minimize, mitigate, or compensate for these adverse effects;
e) Accessible procedures appropriate to the project to address grievances by the affected communities arising from project implementation. When designing the grievance procedures, the borrower takes into account the availability of judicial recourse and customary dispute settlement mechanisms among the communities; and
f) Mechanisms and benchmarks appropriate to the project for monitoring, evaluating, and reporting on the implementation of these issues. The monitoring and evaluation mechanisms should include arrangements for the free, prior, and informed consultation with the affected communities.

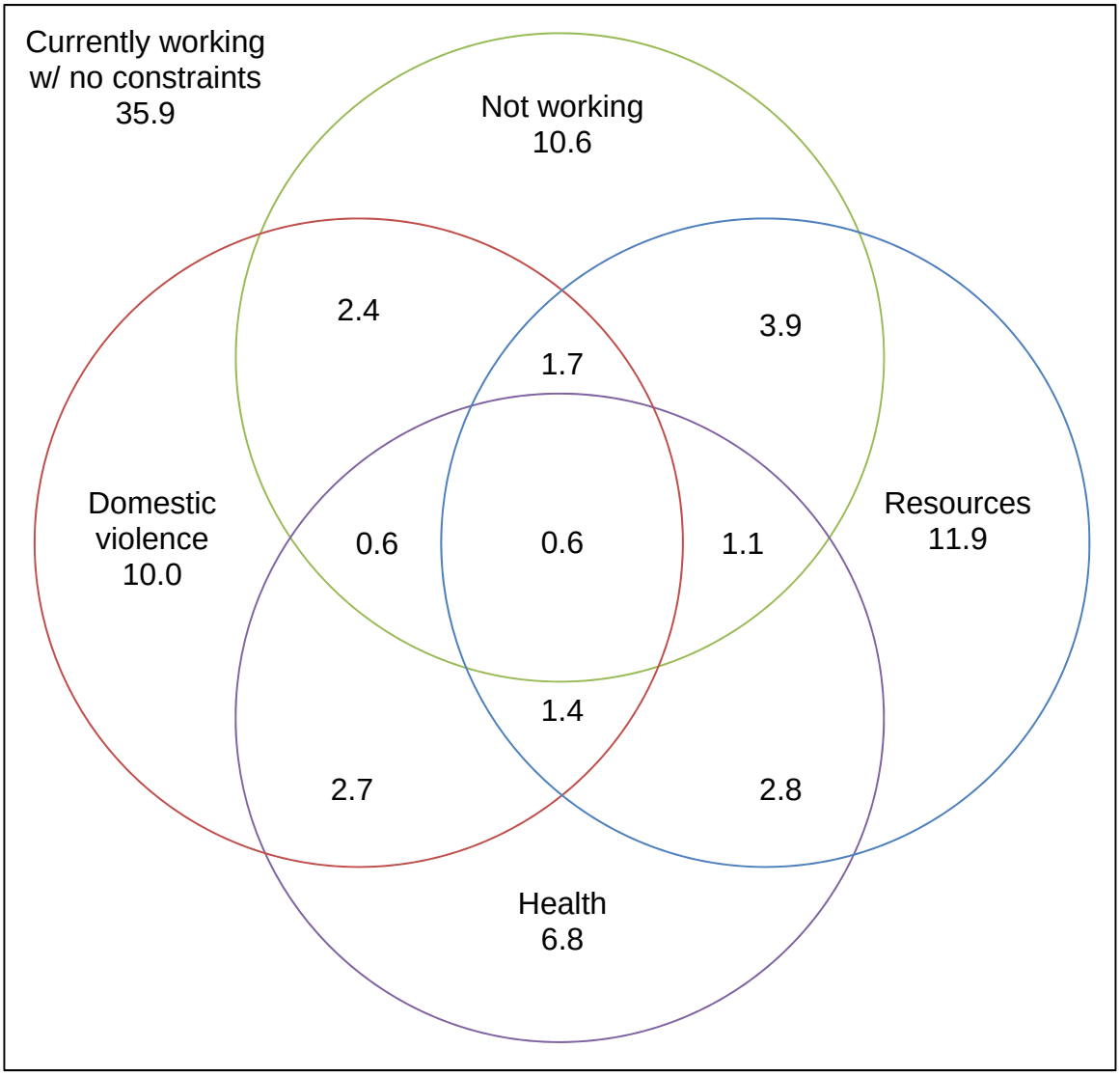
Annex 9: Overlapping Constraints

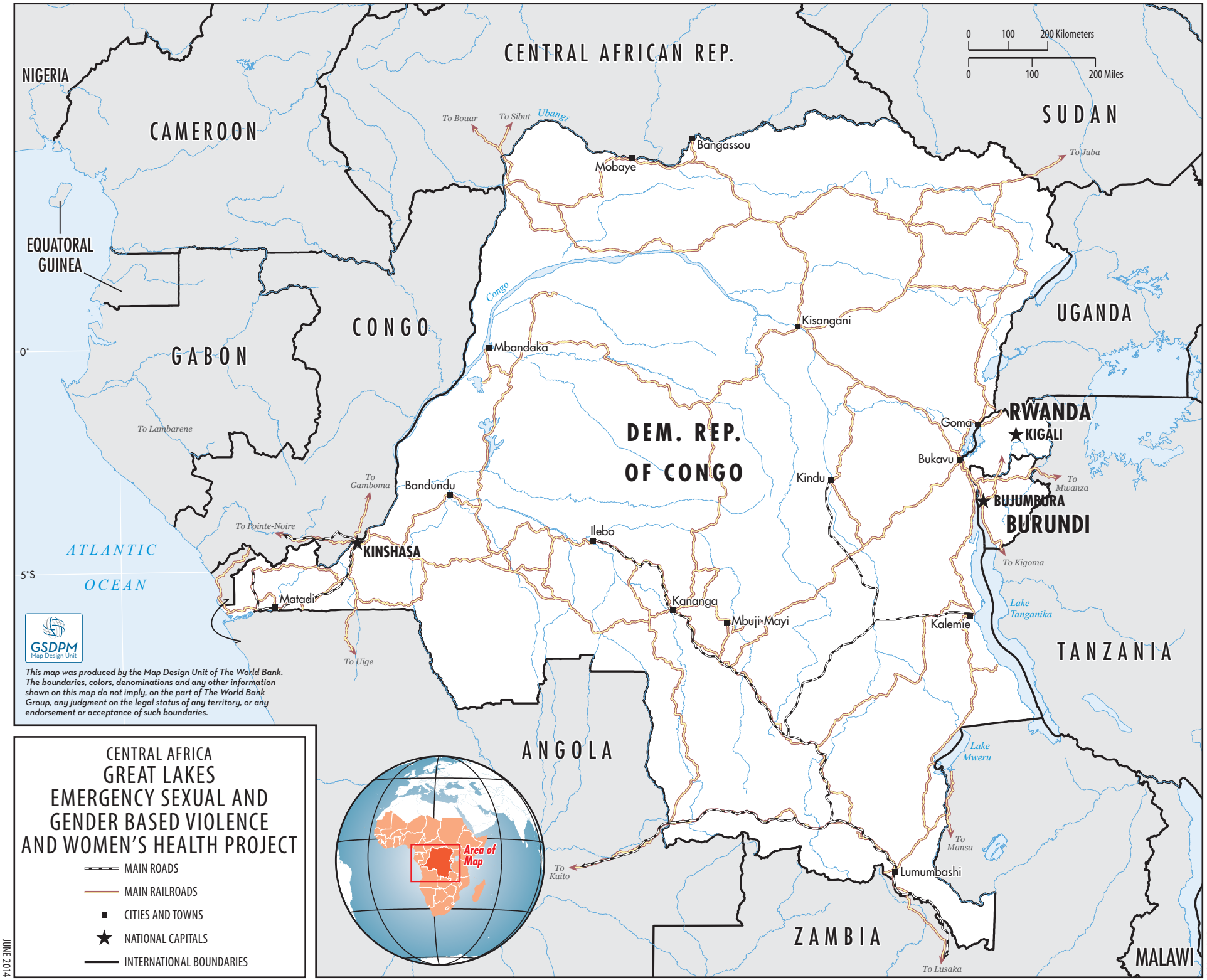
A. Democratic Republic of Congo: health, resources, domestic violence (percentages)



Source: Calculations made by PRMGE using last DHS survey for Democratic Republic of Congo

B. Republic of Rwanda: Overlapping constraints: health, resources, domestic violence, and not working (percentages)




CENTRAL AFRICAN REP.
NIGERIA
CAMEROON
SUDAN
EQUATORIAL GUINEA
CONGO
GABON
UGANDA
DEM. REP. OF CONGO
RWANDA
BURUNDI
ANGOLA
TANZANIA
ZAMBIA
MALAWI
ATLANTIC OCEAN
0°
5°S
0 100 200 Kilometers
0 100 200 Miles
To Bouar
To Sibut
Ubangi
Bangassou
Mobaye
To Juba
Congo
Kisangani
Mbandaka
Goma
KIGALI
Bukavu
Kindu
To Mwanza
BUJUMBURA
To Lambarene
To Gamboma
Bandundu
To Pointe-Noire
KINSHASA
Ilebo
To Kigoma
Lake Tanganika
Matadi
Kananga
Mbuji-Mayi
Kalemie
To Uige
Lake Mweru
To Mansa
To Kuito
Lumumbashi
To Lusaka
Area of Map
GSDPM
Map Design Unit
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CENTRAL AFRICA
GREAT LAKES EMERGENCY SEXUAL AND GENDER BASED VIOLENCE AND WOMEN'S HEALTH PROJECT
MAIN ROADS
MAIN RAILROADS
CITIES AND TOWNS
NATIONAL CAPITALS
INTERNATIONAL BOUNDARIES
JUNE 2014
IBRD 41036