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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 14-Mar-2024 | Report No: PIDIA00467

BASIC INFORMATION

A. Basic Project Data

Project Beneficiary(ies)	Region	Operation ID	Operation Name
Burundi, Congo, Democratic Republic of, Congo, Democratic Republic of, Congo, Democratic Republic of, Ethiopia, Kenya, Malawi, Rwanda, Sao Tome and Principe, Zambia	EASTERN AND SOUTHERN AFRICA	P504532	Democratic Republic of Congo Health Emergency Preparedness, Response, and Resilience Project
Financing Instrument	**Estimated Appraisal Date**	**Estimated Approval Date**	**Practice Area (Lead)**
Investment Project Financing (IPF)	27-Feb-2024	29-Mar-2024	Health, Nutrition & Population
Borrower(s)	**Implementing Agency**		
Democratic Republic of the Congo	Ministry of Public Health, Hygiene and Prevention		

Proposed Development Objective(s)

The Development Objective (DO) is to strengthen health system resilience and multisectoral preparedness and response to health emergencies in Eastern and Southern Africa.

Components

1.Strengthening the Preparedness and Resilience of Regional and National Health Systems to Manage HE
2. Improving the detection of and response to HEs through a multisectoral approach
3. Program Management
4. Contingent Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)? No

Is this project Private Capital Enabling (PCE)? No

SUMMARY

Total Operation Cost	**250.00**
Total Financing	**250.00**
of which IBRD/IDA	**250.00**
Financing Gap	**0.00**

DETAILS

World Bank Group Financing

International Development Association (IDA)	250.00
IDA Credit	250.00

Environmental And Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **This Project Appraisal Document (PAD) describes the scope of DRC's proposed project under Phase II of the Health Emergency Preparedness, Response, and Resilience Program (the 'HEPRR Program')** using the Multiphase Programmatic Approach with an overall financing envelope of US$ 1 billion equivalent, approved by the World Bank's Executive Directors on September 29, 2023 (P180127, Report No: PAD5376), including its first phase. Phase I provided financing for Ethiopia, Kenya, Sao Tome and Principe, the East, Central and Southern Africa Health Community, and the Intergovernmental Authority on Development.

A. Country Context

2. **DRC is the second largest country in Sub-Saharan Africa (SSA), with a territory of close to 2.3 million square kilometers (km).** It shares a 9,000 km border with nine countries and has a population of approximately 100 million people. The population is young - about 43 percent is less than 15-years of age. Armed conflict, continued insecurity, poor service delivery, weak governance, and limited access to services have led to persistently high poverty levels and

hampered socio-economic development. In 2022, DRC had a Gross Domestic Product (GDP) per capita of US$639.7, and 61.9 percent of the population—equaling 61.3 million people—lived on less than US$2.15 a day. The country has a life expectancy at birth of 62.4 years (2019), and the top causes of mortality include malaria, lower respiratory infections, neonatal disorders, and tuberculosis (2019).

3. **Maternal and child mortality remains exceedingly high in DRC.** The country is among the top 10 African countries with the highest maternal mortality ratio globally (UN estimates 2020). According to this report, maternal deaths are on the rise in the DRC, with 546 maternal deaths per 100,000 live births in 2020, and as high as 620 deaths per 100,000 live births in conflict-prone eastern DRC (most recent data).[1]While DRC has historically had, and continues to have, strong utilization of health facilities, including for childbirth at 82 percent nationally, the high level of maternal mortality points to deficits in health systems quality, as well as inequities in access to life-saving emergency obstetric and newborn care.

4. **Women in DRC, and particularly in the east, experience high levels of sexual and gender-based violence (GBV).** Malnutrition and inadequate access to water and sanitation services are primary drivers of death and disability and have remained consistent between 2007 and 2017. While the prevalence of chronic malnutrition (stunting) has declined on the African continent over the past two decades, it has been stagnant in the DRC at 46 percent in 2000, 43.7 percent in 2010, and 40.3 percent in 2022.[2]

5. **DRC ranks 164 out of 174 countries on the World Bank 2020 Human Capital Index, reflecting weak investments in areas like health and education and decades of conflict and fragility that hamper development.** DRC's Human Capital Index is 0.37, which is below the Sub-Saharan Africa (SSA) average of 0.4. This means that Congolese children born today can expect to achieve only 37 percent of their potential compared to what would have been possible if they had benefited from a full, quality schooling experience and optimal health conditions. The main contributors to the low score are low child survival under the age of five, high levels of child stunting, low life expectancy and a low quality of education.

6. **DRC is highly vulnerable to the impacts of climate change and weather-related events, particularly flooding, which accounts for 25 percent of all hazards in the country.**[1] The country is fourth from the bottom on the Notre Dame Global Adaptation Initiative (ND-GAIN) Vulnerability Index, at 182 out of 185 countries, underlining the limited capacity in the country to adapt to climate shocks. Over the last 30 years, DRC has experienced an increased frequency of extreme weather events, particularly intense rainfall, flooding, drought, and high heat. These temperature and precipitation changes threaten food security, with implications for nutrition, livelihoods, and poverty. Climate change is anticipated to impact conflict through changes in availability of food, water, and amplified inequality, with disproportionate impacts on the most vulnerable.[2]

7. **DRC is amid an epidemiological transition.** A double burden of disease, due to an increase in the prevalence of non-communicable diseases (NCDs), poses a big risk for DRC given its weak health system and poor coordination between sectors. NCDs are currently among the main causes of morbidity and mortality in populations aged 35 and above. Per the World Health Organization (WHO), the number of deaths from NCDs in Africa is projected to exceed that from communicable diseases and perinatal deaths combined by 2030, which would prove catastrophic for DRC. The NCD burden places additional demands on health system usage which may be significantly interrupted by HEs, leading to greater morbidity and mortality both during and after HEs.

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[1] Ramazani IB, Ntela SM, Ahouah M, Ishoso DK, Monique RT. Maternal mortality study in the Eastern Democratic Republic of the Congo. BMC Pregnancy Childbirth. 2022 May 31;22(1):452. doi: 10.1186/s12884-022-04783-z. PMID: 35641954; PMCID: PMC9153209.

[2] UNICEF. (2023). *Cross-sector indicators*. UNICEF Data Warehouse. Retrieved from https://data.unicef.org/resources/data_explorer/unicef_f/?ag=UNICEF&df=GLOBAL_DATAFLOW&ver=1.0&dq=COD.NT_ANT_HAZ_NE2_MOD.&startPeriod=1970&endPeriod=2024

Sectoral and Institutional Context

8. **Recurrent disease outbreaks such as MPox, cholera, measles, and Ebola Virus Disease (EVD) have exacerbated the ongoing humanitarian crisis and weak health systems in DRC.** The health sector in DRC has faced major challenges, including recurrent and often concurrent disease outbreaks that have disrupted health service delivery. The country has faced fifteen EVD outbreaks since 1976, six of which have occurred since 2018. Recurrent outbreaks have left the health system in a constant state of emergency, with human and financial resources being allocated to outbreak control, rather than to primary care and the delivery of routine health services. The COVID-19 pandemic and other outbreaks highlighted the need for strengthening public health emergency preparedness both in-country and across neighboring countries and the region. The health of humans, animals, and ecosystems are closely interlinked. It is estimated that sixty percent of emerging infectious diseases have an animal origin (wild and domestic).

9. **Climate change debilitates the country's health system and expands the burden of climate sensitive diseases, including cholera and other diarrheal diseases, as well as vector-borne diseases such as malaria.[5]** Due to climate change, malaria, which makes up 13 percent of the country's burden of disease, is increasingly prevalent. [6,7] Further and more serious health effects are anticipated as exposure to the impacts of climate change in the health sector increases. Climate change induced shocks also negatively impact health service delivery, damaging health facilities and hindering access to health facilities. For example, severe flooding in February 2024 destroyed 267 health facilities across the country.[8] Increased flooding is expected to debilitate already weak Water and Sanitation Hygiene (WASH) facilities[9], thereby exacerbating the spread of waterborne diseases. Cholera is also fueled by flooding, as evidenced by sharp increases in the prevalence of cholera cases during floods in the first half of 2023.[10,11]

10. **Antimicrobial resistance (AMR) is a major problem for DRC's health system.** A multisectoral plan to address AMR for the period 2022-2026 has been prepared, coordinated by a multisectoral national commission which meets quarterly. Multiple factors contribute to AMR in DRC, including lack of access to clean drinking water, lack of basic WASH, and weak measures of prevention and fight against bacterial infections.[3] There is limited data on AMR in DRC, with insufficient microbial surveillance, hence the need to strengthen antimicrobial resistance surveillance sites and improve surveillance and monitoring of antimicrobial resistance.

11. **A recent Joint External Evaluation of the International Health Regulations 2005 (IHR) capacities was conducted in DRC.** This assessment highlighted the significant experience acquired by DRC in managing epidemics, thanks to strong political commitment and continued support from partners. Notable progress has been made in health security. Despite these advances, significant challenges remain, including the absence of several legislative and regulatory texts compliant with the provisions of the IHR, focusing on critical areas such as biosafety, antimicrobial resistance, emergency management, and operationalization of a Public Health Emergency Operations Center (PHEOC). Strengths were noted in surveillance, risk communication and community engagement (RCCE) and response capacities. A National Action Plan for

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3 Akilimali A, Oduoye MO, Balume A, Kachunga D, Luundo P, Sayadi R, Banga S, Aganze A, Ramandizi G, Muhoza B. Antimicrobial use and resistance in Democratic Republic of Congo: Implications and recommendations; A mini review. Ann Med Surg (Lond). 2022 Jul 22;80:104183

Health Security (NAPHS) was elaborated for the period 2019-2023 and will be updated with support from the Regional Disease Surveillance Systems Enhancement (REDISSE) Phase IV. The World Bank, through REDISSE IV, remains the largest funder for the NAPHS and has contributed significantly to its implementation. The Government of DRC has put into place a plan to improve its JEE scores, which average 1.8 across the dimensions of prevention (1.6), disease detection (2.2) and response (1.7). An action plan was put into place by the Ministry of Public Health, Hygiene and Prevention (MPHHP) in collaboration with key partners (World Health Organization, World Bank, etc.) to improve overall JEE scores for DRC, which includes targeted areas the HEPRR MPA Project can support. This includes scaling up of events-based surveillance and community-based surveillance within multiple sectors for improved detection, mobilization of resources to fully implement the current NAPHS, strengthening of laboratory quality, strengthening of a network of laboratories, scale up epidemiologic training, emergency management, biosafety, biosecurity, improving surveillance for AMR, etc.

12. **One Health Coordination.** The emergence and re-emergence of zoonotic diseases in DRC with increased interface between humans, animals and the environment require a coordinated One Health approach. The close links between human, animal and environmental health demand close collaboration, communication and coordination between the relevant sectors. This coordination should take place between key ministries including the Ministry of Health, Livestock, Agriculture, environment, etc. There is currently an existing One Health platform residing within the Ministry of Education. There have been efforts to transform this platform into a multisectoral platform through the adoption of regulatory texts, with the purpose of operationalizing a “One Health” Coordination Commission to strengthen coordination between the sectors involved in the implementation of the IHR. However, the coordination of zoonoses received a low score in the most recent 2023 JEE in DRC, thus requiring further strengthening.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The Development Objective (DO) is to strengthen health system resilience and multisectoral preparedness and response to health emergencies in Eastern and Southern Africa.

Key Results

1. DRC will have improved Joint External Evaluation scores for Prevention, Detection and Response

2. DRC will have improved detection of health emergencies, meeting 7-1-7 targets

3. Project-supported laboratories will have improved ratings)3-stars or higher) during a Stepwise Laboratory Improvement Process Towards Accreditation audit

D. Project Description

13. Following activities/investment areas, relevant to DRC are within the scope of approved menu of activities described in the Program PAD. Further details will be available in the Project Operations Manual (POM), project technical

notes, and in the project's financing agreement. The Project will implement activities in selected provinces, which build on the World Bank's earlier health sector investments.

14. **Component 1: Strengthening the Preparedness and Resilience of the Health System to manage Health Emergencies (HEs) (US$ 56.2 million).** This component will support the strengthening of essential institutions and activities that directly contribute to the resilience of the health systems to cope with HEs and complement other health systems strengthening (HSS) activities conducted by other World Bank and partner investments. The component has four sub-components and will be implemented in selected provinces.

15. **Sub-Component 1.1. Multisectoral and cross-border planning, financing, and governance for improved resilience to HEs (US$ 11.73 million)** by: (a) conducting an evaluation of the 2019-2023 NAPHS with a focus on climate emergency preparedness and response and inclusive of attention to gender gaps; (b) developing a national multisectoral costed action plan for One Health with focused investments in veterinary and other animal health services, as well as on AMR, the impact of climate change on zoonotic diseases climate sensitive diseases, and responses to climate shocks; (c) developing a multimodal national operational plan for infection, prevention and control (IPC), including monitoring strategies, assessment frameworks, and health facility readiness assessments for IPC (d) support for the establishment of technical hygiene committees at health facilities to monitor IPC activities, taking into account gender and inclusion; (e) support for the integration of IPC/WASH indicators as part of a monitoring framework in support for the supervision of IPC/WASH activities by hygiene brigades, with a focus on the impacts of climate change on water and sanitation services; (f) updating of national and regional coordination and collaboration mechanisms for preparedness and response activities and protocols, public health laws or policies for coordination and collaboration, with a focus on climate shocks; (g) developing a strategy for interventions to support equitable and inclusive of non-communicable disease (NCD) prevention and treatment during a HE and; (h) providing technical assistance to strengthen the implementation of formal coordination and communication mechanisms between the human health/public health, animal health, and climate and health sectors for multisectoral response to zoonotic with a One Health focus.

16. **Sub-Component 1.2. Health workforce development (US$ 22.59 million)** by: (a) developing a multisectoral human resources for health/ health workforce plan in all relevant sectors (including animal and environmental health) to manage events according to IHR provisions and addressing gender gaps, with focus on surge workforce needs for HEs; (b) establishing a regulatory and management mechanisms to enable the swift mobilization of health workers in times of crisis by supporting the development of mapping of personnel from all sectors; c) establishing multidisciplinary surge teams at national, provincial and health zone level and cross border areas; response to climate change emergencies are a core impetus of these activities and anticipated to comprise half of the health emergencies to which the strengthened health workforce will respond. The subcomponent will also include: (d) expansion of an existing national field epidemiology training program (Field Epidemiology Training Program [FETP]) at three levels (basic, intermediate and/or advanced) with a One Health focus with selected Schools of Public Health, including strategies to incentivize female participation; (e) support for In-Service Applied Veterinary Epidemiology Training (ISAVET); (f) expansion of national training programs for all other professions, cadres, and sectors critical for delivering health security functions including the One Health approach, and specific strategies to incentivize participation of qualified female staff in trainings at all levels; (g) support for the training of representatives from hunter groups on the impact of breeding on climate change and mitigation measures; and (h) support for In-service training of staff with selected institutes and universities on health emergency management on climate change, simulations, workplace safety and IPC.

17. **Sub-component 1.3. Access to quality health commodities (US$ 16.83 million)** by: (a) strengthening laboratory capacity and laboratory quality management systems for testing of in process/finished products, including development of national reference standards with selected laboratories and institutes; (b) technical advisory services for establishing

standards for a quality health commodities package to include essential RMNCAH supplies; (c) financing a strategic stockpile of commodities and framework contracts to ensure prompt deliveries of HE commodities during emergencies; and Preparedness for climate shocks is a primary impetus and focus of pharmaceutical stockpiling.

18. **Sub-component 1.4. Information systems for HEs and the digitalization of the health sector (US$ 5.05 Million)** by (a) developing functional information systems to improve the integration of critical public health, laboratory, healthcare services disruption, environment, port health, and veterinary surveillance data developing; (b) implementing national protocols, policies, or frameworks for secure cross-border data exchange and storage, ensuring coordination and collaboration with other countries for aligning protocols and information system mechanisms in close collaboration with HEPRR regional entities (Intergovernmental Authority on Development and the East, Central and Southern Africa Health Community); (c) strengthening digital systems for relevant health security sectors in national health budget and/or relevant national strategies; and (d) developing a national legal framework for data protection and security.

19. **Component 2: Improving the detection of and response to HEs through a multisectoral approach (US$ 168.12 million).** This component will finance expenditures related to strengthening operational readiness and capacities across the critical subsystems to respond to HEs. This will have three subcomponents.

20. **Sub-Component 2.1. Collaborative multisectoral surveillance and laboratory diagnostics with a focus on completeness, accuracy and gender disaggregation (US$ 82.49 million).** The subcomponent will expand laboratory diagnostic capacity with close attention to the expanding prevalence of climate sensitive diseases, particularly water and vector borne diseases in the context by: (a) expanding Integrated Disease Surveillance and Response (IDSR) third edition in selected provinces, including incorporation of data on gender, age, and pregnancy status; (b) expanding routine indicator and event-based surveillance (IBS and EBS) at health facilities and community health structures, with data disaggregated by gender, age, and pregnancy status; (c) expanding epidemic intelligence functions to triage, verify, investigate, and risk assess detected signals at all levels from all surveillance sources, including community-based structures, and the expansion of multi-disciplinary surge rapid response teams (RRTs) for investigation and response in selected provinces; (d) enhancing formal coordination and communication mechanisms between the human health/ public health, animal health, and environmental health sectors at national and intermediate levels, and to cross-border entities where appropriate; (e) strengthening systems for systematic specimen referral and transport for diagnostics and/or confirmation of all priority diseases at all levels with selected institutes and directorates; (g) strengthening national quality standards at national and intermediate levels, including priority licensing and accreditation of laboratories aligned with basic quality requirements or national laboratory standards, and strengthening laboratory management as well as biosafety and biosecurity. The subcomponent will also finance: (h) supporting laboratory diagnostics for national human, animal, and environmental priority diseases, emerging infectious and vector-borne diseases, AMR, epidemic-prone, and high-burden NCDs, including the detection of the Human Papillomavirus for cervical cancer; (i) strengthening the national AMR laboratory-supported surveillance system for emergence and transmission of resistant pathogens at selected laboratories and designated sentinel sites. This will also include the development and implementation of guidelines, training and operational plans to enable appropriate use of antimicrobials in health structures ensuring IPC measures are in place; (j) enhancement of disease surveillance at designated and non-designated points of entry (PoEs), including expansion of cross-border surveillance, and ensuring data on key demographics; (k) supporting the rehabilitation and/or construction of two laboratories in Boende and Mbuji-Mayi, taking into account gender-specific needs like gender-separated washrooms.

21. **Sub-component 2.2. Emergency management, coordination, and essential service continuity including for RMNCAH services (US$ 54.63 million).** The subcomponent will expand emergency management, coordination, and service continuity with close attention to the increasing pressure climate shocks (particularly floods) place on the health system,

and the increased prevalence of climate sensitive diseases, particularly water and vector borne diseases in the context by: (a) designing and implementing national and subnational multisectoral HE functional exercises to test preparedness and response capacities, attention to equity, decision-making, and protocols during a HE, including food security, education, social protection, gender, animal health, etc.; (b) supporting the implementation/ coordination of JEEs, SPARs, the Performance of Veterinary Services (PVS), environmental assessments and other IHR capacity assessments in coordination, including the gender equality core capacities; (c) developing a national patient referral and counter-referral case management system for emerging infectious diseases (EIDs), endemic diseases, and NCDs at all levels of health system; (d) developing and implementing a package of essential health services (EHS), for continuity of EHS that includes RMNCAH services and supplies, and NCDs in emergencies; (e) supporting patient-centered integrated healthcare provision, strengthening communities of practice, and use of alternative care pathways/ service delivery platforms to prevent service disruption during emergencies (e.g., task shifting and telemedicine) with attention to equitable and inclusive access to services; (f) developing and implementing a strategy for interventions to support equitable and inclusive NCD prevention and treatment during a HE; (g) updating and prioritizing multisectoral health emergency response operational plans and all-hazards risk profiles based on multi-hazard, gender-specific risk assessments through selected institutes and universities; (h) operationalizing the national public health emergency operations center (PHEOC) facility with technology infrastructure with approved standard operating procedures (SOPs), as well as expansion of Epidemiologic Intelligence Centers to additional provinces; (i) developing and implementing standardized national clinical case management guidelines and training packages for priority diseases and health hazards at national and intermediate levels, with considerations for equity and inclusion; (j) developing multisectoral all-hazards PHE contingency plans for designated PoEs, integrated into national emergency response plan; (k) implementing the minimum WASH package with the WASH Health Facility Improvement Tool (FIT) tool in healthcare establishments in selected provinces; and (l) expanding service provision and improvements to WASH infrastructure at health facilities for equitable and inclusive access

22. **Sub-Component 2.3. Risk Communication and Community Engagement (RCCE), empowerment, and social protection during HEs (US$ 11.0 million**). The subcomponent will expand RCCE, empowerment, and social protection during HEs with close attention to the increasing pressure climate shocks (particularly floods) place on the health system, and the increased prevalence of climate sensitive diseases, particularly water and vector borne diseases in the context by: (a) developing multisectoral RCCE plans, SOPs, guidelines, policies, and procedures for routine and emergency contexts at national and subnational level, to inform decision-making, as well as appropriate safety nets for the most vulnerable; (b) completing stakeholders mapping and support to engagement at national, intermediate, and community levels including female and male religious leaders, civil society, and community-based organizations; (c) establishing two-way community feedback mechanism and communication channels that ensure gender-equitable inclusion to inform multisectoral emergency response strategy; (d) training of RCCE personnel at all levels on transparent, systematic, contextually appropriate, gender-specific and timely communication strategies and methods both across sectors; (e) developing infodemic management plans at all levels including systems for information-gathering on gender-specific perceptions; (f) ensuring gender-equitable engagement of community members and community structures in defining, developing, evaluating, and reviewing health service delivery (including IPC, WASH, etc.).

23. **Sub-Component 2.4: Climate change adaptive emergency preparedness and response ($US 20 million). Climate change is mainstreamed throughout the operation** and this subcomponent will focus on investments specifically targeted to addressing the impacts of climate change through proven interventions and investments, especially for climate-adaptive resilient health systems and health care facilities. Given the increased risk of flooding in DRC the subcomponent will finance: (a) the development of facility-level climate emergency preparedness and management plans, including for climate adaptive infrastructure; (b) trainings and simulations for health workers and administrators on climate and HE preparedness and response at national, decentralized, and community levels; (c) develop an observatory for climate events thought the development of a surveillance system by integrating meteorological data, as well as the development

and monitoring of climate and health early warning system, for climate shocks (such as flooding), and climate-sensitive diseases (such as malaria and cholera). It will also focus on (d) developing a national response plan for flooding focused on the prevention of climate-sensitive diseases; (e) conducting risk assessments for climate shocks and climate sensitive diseases (e) developing and implementing WASH climate risk management plan for HEs; and (f) ensuring appropriate climate-resilient WASH improvements to health facilities for the purpose of reducing the transmission of climate sensitive diseases and flooding.

24. **Component 3: Project Management (US$ 25.68 million).**

25. **Subcomponent 3.1: Project M&E.** This subcomponent will provide financing for data collection, analysis and use in decision making. TA for developing impact evaluations to assess the impact of selected interventions, and third-party monitoring, where appropriate, will be financed to ensure the validity of data and impacts. National and regional cross-border learning platforms will be established, and learning agenda studies, assessments and evaluations will be financed.

26. **Subcomponent 3.2: Learning agenda.** This will finance national and regional cross-border learning platforms to exchange knowledge and experience, facilitate peer coaching, provide technical support, and share lessons. The focus is on making health systems better able to prevent, detect, and respond to emergencies and more resilient, equitable, and inclusive. Given the lack of attention to identifying and addressing gender gaps in health outbreaks, the learning agenda will also contribute to building a body of evidence on gender in PPR, including in human resources for HEPPR.

27. **Subcomponent 3.3: Project coordination and management.** This would finance gaps, including equipment and materials, to comply with Financial Management (FM), procurement, and environmental and social risk management requirements. At the national level, these activities will be undertaken by the Project Implementation Units (PCTs).

28. **Component 4: Contingent Emergency Response Component (CERC).** This component will facilitate access to rapid financing by allowing for the reallocation of uncommitted project funds in the event of a natural disaster in a country, either by a formal declaration of a national emergency or upon a formal request from the government. Following an eligible crisis or emergency, the government may request that the World Bank reallocate project funds to support emergency response and reconstruction. This component would draw upon uncommitted resources from other project components to cover emergency response. A CERC Manual and an Emergency Action Plan, acceptable to the World Bank, will be prepared and constitute a disbursement condition for this component.

Table 2: Summary of Component Financing

	DRC
Component 1: Strengthening the preparedness and resilience of regional and national health systems to manage HEs	56.20
Component 2: Improving early detection of and response to HEs through a multisectoral approach	168.12
Component 3: Program Management	25.68
Component 4: Contingent Emergency Response Component	0
Total	250

C. Project Beneficiaries

Direct beneficiaries will include the general population, particularly considering the vulnerability of as women in prenatal and postnatal stages, the elderly, people with disabilities, children, adolescent girls, refugees, internally displaced

populations and marginalized communities, who will benefit from a strengthened and more resilient health system. Beneficiaries also include staff of public health, veterinary services and laboratories involved in health emergencies preparedness and response. In addition, due to the One Health focus of the Program, the beneficiaries also include livestock farmers and the general population, who benefit from less exposure to zoonoses. The project is expected to benefit a total population of 43.8 million (36 percent of the total population of DRC), based on the total population coverage in targeted provinces this project will cover.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Area OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

Project activities could entail environmental and social risks and impact that include waste management and disposal, pollution of soil and water resources, the workforce and working conditions, the possible exclusion of members of vulnerable groups, security, gender-based violence, occupational and community health and safety risks.

E. Implementation

Institutional and Implementation Arrangements

29. **The proposed project will build on the WBG's Health Nutrition and Population portfolio in DRC. The overall responsibility for the project implementation will be with the Ministry of Public Health, Hygiene and Prevention (MPHHP) and conducted through existing PCT that are embedded within the MPHHP (i.e., not to be stand-alone entities).** A National Technical Steering Committee will be responsible for defining project implementation strategies, will provide overall operational guidance, general oversight of Project implementation, performance monitoring, cross-sectoral coordination and validating the Annual Work Plan and Budget (AWPB) of the project. The NSC will be chaired by the Minister of Health and made up of representatives from all project beneficiary ministries, including Ministries of Fishery and Livestock, Environment and Sustainable Development and Agriculture and the Ministry of Higher Education. The project will be managed by the PCT which is in charge of coordination of all Bank-financed health projects in DRC such as the REDISSE IV (P167817), DRC COVID-19 Strategic Preparedness and Response Project (SPRP) (P173825), Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) (P147555) and the Multi-sectoral Nutrition and Health Project (PMNS) (P168756), under the auspices of the Secretary General for Health.

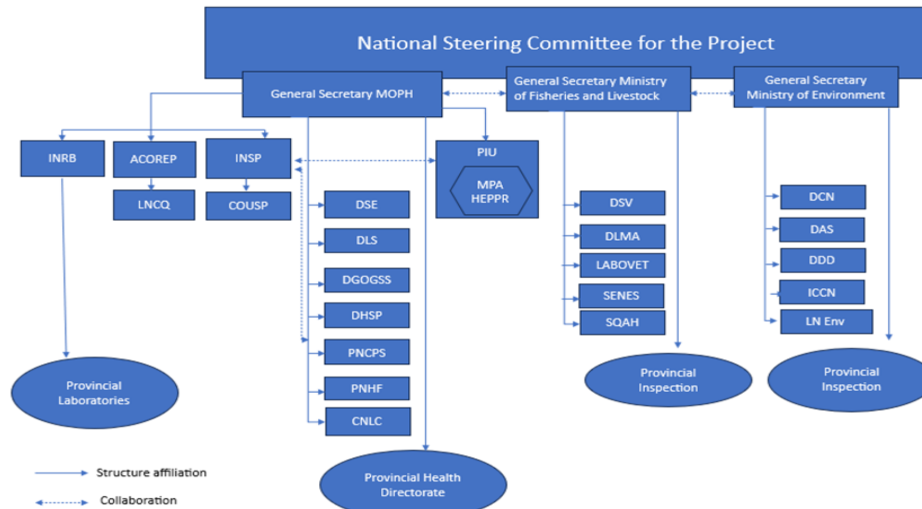
30. The project will strengthen existing structures withing the MPHHP and build their capacity to manage health emergencies. The PCT will use the existing institutional arrangements and processes in place to support project implementation. The staff will include: i) a Project focal point, who will ensure efficient implementation of the various project components carried out in collaboration with other relevant ministries; ii) a Financial Management (FM) specialist; iii) an accountant; iv) a procurement specialist; v) three technical assistants (epidemiologist, animal health, laboratory expert), v) a communication specialist, vi) a M&E specialist; viii) a project administrative assistant; vii) a social safeguards specialist; and (viii) an environmental safeguards specialist. The project will finance the PCT staff mentioned, their training, as well as basic equipment and other necessary inputs. The PCT will work in close collaboration with the Secretary General and relevant Directorates and Programs (see Figure 2).

31. To get timely, systematic, and independent status of the project implementation progress, a TPM will be financed by the project for the entire project duration. The main objective of the TPM will be to ensure that all activities (technical, fiduciary and safeguards) are being implemented as defined in the project legal agreements and results framework. The TPM will ensure follow-up and oversight of a representative sample of project sites across the country. The TPM will report directly to the PCT and will develop quarterly reports.

32. **At the regional level, IGAD and ECSA-HC, both of whom meet the eligibility criteria under the IDA regional window, were selected to implement regional activities**, based on their working relationship with countries and technical institutions in the region, and their track record of implementing World Bank financed projects. IGAD will be responsible for the multisectoral, regional aspects of the MPA and will convene political stakeholders beyond the health sector, while ECSA-HC will be responsible for the health aspects and convening of relevant health sector stakeholders. To influence national and regional policies and processes, the HEPRR Program will leverage the convening power of IGAD and ECSA-HC. Directly partnering with these two regional entities, the HEPRR Program will liaise with the RECs, such as the EAC and SADC, and technical agencies such as the New Partnership for Africa's Development (NEPAD), Africa CDC, and WHO Regional Office for Africa (AFRO). For ECSA-HC and IGAD, PTUs will be financed to coordinate work on the HEPRR Program.

33. **The Regional Advisory Committee (RAC) will serve as the bridge between the HEPRR Program and the overall regional agenda and priorities.** The RAC will consist of representatives of all participating countries and regional bodies that support project implementation, as well as global experts, representatives of the Association, and other entities, as described in the Program Operations Manual. The RAC will provide a forum for broader technical and regional engagement beyond the specific focus of the MPA, with an emphasis on ensuring program alignment with the broader regional agenda and strategic direction.

Figure 2 Institutional arrangement of the project



CNLC: Centre National de Lutte contre le Cancer (National Cancer Center), **COUSP:** Public Health EOC Emergency Operations, **DAS :** Direction d'Assainissement (Sanitation departement), **DCN** Direction de Conservation de la Nature (Directorate for Nature conservation), **DDD :** Direction de Développement Durable (Directorate for Sustainable development), **DES :** Direction de la surveillance épidémiologique (Epidemiological Surveillance Department), **DGOGSS :** Direction Générale de l'Organisation Gestion de Service de Santé (General Directorate for Health Service Organization and Management), **DHSP:** Hygiene and Public Health Department, **DLCQ/ACOREP :** Quality Control Laboratory Division, **DLE :** Division Laboratoire de l'Environnement (Division of Environmental Laboratory), **DLMAL :** Direction de Lutte contre les Maladies Animales (Animal Disease Control Department), **DLS :** Direction des laboratoires de la Santé (Health Laboratories Division), **DSV :** Veterinary Services Department, **ECOM-ALGER :** Ecologie des Maladies Infectieuses (ECOM-ALGER) University of Kinshasa, **ERSP/UCB:** Bukavu Regional School of Public Health, **ESP:** Lubumbashi School of Public Health, **ESPK :** Kinshasa School of Public Health, **ICCN :** Congolese Institute for Nature Conservation, **INRB :** National Institute for Biomedical Research, **INSP :** Institut National de Santé Publique (NPHI), **LaboVet:** Laboratoire Vétérinaire Central (Central Veterinary Laboratory), **PNHF** National Border Hygiene Program, **PNPCS:** National Program for Health Promotion and Communication, **SENES:** Service National d'Epidémiologie et Surveillance (National Epidemiology and Surveillance Service), **SG :** Secrétariat General, **SQAH :** Service de Quarantaine Animale et Halieutique (Animal and Fish Quarantine Service)

34. To get timely, systematic, and independent status of the project implementation progress, a TPM will be financed by the project for the entire project duration. The main objective of the TPM will be to ensure that all activities (technical, fiduciary and safeguards) are being implemented as defined in the project legal agreements and results framework. The TPM will ensure follow-up and oversight of a representative sample of project sites across the country. The TPM will report directly to the PCT and will develop quarterly reports.

35. **The Regional Advisory Committee (RAC) will serve as the bridge between the HEPRR Program and the overall regional agenda and priorities.** The RAC will consist of representatives of all participating countries and regional bodies that support project implementation, as well as global experts, representatives of the Association, and other entities, as described in the Program Operations Manual. The RAC will provide a forum for broader technical and regional engagement beyond the specific focus of the MPA, with an emphasis on ensuring program alignment with the broader regional agenda and strategic direction.

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