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Report No: PAD3799

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON

A PROPOSED ADDITIONAL CREDIT
IN THE AMOUNT OF US$121.0 MILLION

AND

A PROPOSED ADDITIONAL GRANT
IN THE AMOUNT OF SDR 57.9 MILLION
(US$79.0 MILLION EQUIVALENT)

TO THE

DEMOCRATIC REPUBLIC OF THE CONGO

FOR A

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

May 29, 2020

Health, Nutrition and Population Global Practice
Africa Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2020)

Currency Unit =	Special Drawing Rights (SDR)
SDR 0.73 =	US$1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Hafez M. H. Ghanem
Country Director:	Jean-Christophe Carret
Regional Director:	Amit Dar
Practice Manager:	Magnus Lindelow
Task Team Leaders:	Hadia Nazem Samaha, Avril Dawn Kaplan

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
CERC	Contingent Emergency Response Component
CERIP	Contingent Emergency Response Implementation Plan
CGPMP	Cellule des Projets et Marchés Publics
COVID-19	Coronavirus Disease 2019
CRW	Crisis Response Window
DHIS	District Health Information System
DRC	Democratic Republic of the Congo
EVD	Ebola Virus Disease
GBV	Gender-based violence
GDP	Gross domestic product
GFF	Global Financing Facility
GRS	Grievance Redress Service
HNP	Health Nutrition and Population
HRITF	Health Results Innovation Trust Fund
IDA	International Development Association
IPPF	Indigenous Peoples Plan Framework
MOPH	Ministry of Public Health
NGO	Non-governmental organizations
NPF	New Procurement Framework
PBF	Performance-based financing
PDO	Project Development Objective
PDSS	*Projet du Développement du System de Santé* (Health System Strengthening for Better Maternal Child Health Results Project)
PEF	Pandemic Emergency Facility
PHEIC	Public Health Emergency of International Concern
PIU	Project Implementation Unit
PNDS	*Plan National de Développement Sanitaire* (National Health Development Plan)
REDISSE	Regional Disease Surveillance Systems Enhancement
SEA	Sexual Exploitation and Abuse
SH	Sexual harassment
SRP	Strategic Response Plan
UHC	Universal Health Coverage
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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BASIC INFORMATION – PARENT (Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) - P147555)

Country	Product Line	Team Leader(s)		
Congo, Democratic Republic of	IBRD/IDA	Hadia Nazem Samaha		
Project ID	Financing Instrument	Resp CC	Req CC	Practice Area (Lead)
P147555	Investment Project Financing	HAFH2 (9322)	AFCC2 (6546)	Health, Nutrition & Population

Implementing Agency: Ministry of Health, Ministry of Finance

Is this a regionally tagged project?
No

Bank/IFC Collaboration
No

Approval Date	Closing Date	Expected Guarantee Expiration Date	Original Environmental Assessment Category	Current EA Category
18-Dec-2014	31-Dec-2021		Partial Assessment (B)	Partial Assessment (B)

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach [MPA]	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a Non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made disaster
[ ] Alternate Procurement Arrangements (APA)	

Development Objective(s)

To improve utilization and quality of maternal and child health services in targeted areas within the Recipient's Territory and, to provide an immediate and effective response to an eligible crisis or emergency

Ratings (from Parent ISR)

	Implementation					Latest ISR
	27-Jun-2018	30-Jan-2019	29-Oct-2019	03-Jan-2020	31-Mar-2020	12-May-2020
Progress towards achievement of PDO	S	S	MS	MS	MS	MS
Overall Implementation Progress (IP)	S	MS	MS	MU	MS	MS
Overall Safeguards Rating	MS	MS	MU	MU	MS	MS
Overall Risk	S	S	S	S	S	S

BASIC INFORMATION – ADDITIONAL FINANCING (Fourth Additional Financing for Health System Strengthening for Better Maternal and Child Health Results Project - P173415)

Project ID	Project Name	Additional Financing Type	Urgent Need or Capacity Constraints
P173415	Fourth Additional Financing for Health System Strengthening for Better Maternal and Child Health Results Project	Cost Overrun	Yes
Financing instrument	Product line	Approval Date	
Investment Project Financing	IBRD/IDA	11-Jun-2020	
Projected Date of Full	Bank/IFC Collaboration		

Disbursement			
30-Jun-2022	No		

Is this a regionally tagged project?	
No	

Financing & Implementation Modalities

[ ] Series of Projects (SOP)	[✓] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a Non-fragile Country
[ ] Project-Based Guarantee	[✓] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made disaster
[ ] Alternate Procurement Arrangements (APA)	
[✓] Contingent Emergency Response Component (CERC)	

Disbursement Summary (from Parent ISR)

Source of Funds	Net Commitments	Total Disbursed	Remaining Balance	Disbursed
IBRD				%
IDA	460.00	397.54	50.03	89 %
Grants	54.50	37.71	16.79	69 %

PROJECT FINANCING DATA – ADDITIONAL FINANCING (Fourth Additional Financing for Health System Strengthening for Better Maternal and Child Health Results Project - P173415)

FINANCING DATA (US$, Millions)

SUMMARY (Total Financing)

	Current Financing	Proposed Additional Financing	Total Proposed Financing
Total Project Cost	514.53	200.00	714.53

Total Financing	514.53	200.00	714.53
of which IBRD/IDA	460.00	200.00	660.00
Financing Gap	0.00	0.00	0.00

DETAILS - Additional Financing

World Bank Group Financing

International Development Association (IDA)	200.00
IDA Credit	121.00
IDA Grant	79.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Congo, Democratic Republic of	121.00	79.00	0.00	200.00
National PBA	42.00	0.00	0.00	42.00
Crisis Response Window (CRW)	79.00	79.00	0.00	158.00
Total	**121.00**	**79.00**	**0.00**	**200.00**

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any other Policy waiver(s)?

[ ] Yes [✓] No

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Hadia Nazem Samaha	Team Leader (ADM Responsible)	Health systems	HAFH2
Avril Dawn Kaplan	Team Leader	Health Systems	HAFH2
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Lucie Lufiauluisu Bobola	Procurement Team		AFCC2

Marion Jane Cros	Team Member	Health financing	HHNGF
Michel Muvudi Lushimba	Team Member	Performance Based Financing	HAFH2
Supriya Madhavan	Team Member	Family planning	HAFH2

Extended Team

Name	Title	Organization	Location

I. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

Project Background

1. **Parent project:** The Executive Directors approved the Health System Strengthening for Better Maternal and Child Health Results Project (PDSS, P147555) on December 18, 2014 for US$226.5 million equivalent (US$130 million International Development Association (IDA) Credit 55720; US$90 million IDA Grant D0210; and US$6.5 million Health Results Innovation Trust Fund (HRITF) Grant TF018675). The project became effective on May 30, 2016. The initial project development objective (PDO) was to improve utilization and quality of maternal and child health services in targeted areas within the Recipient's Territory.

2. **First Additional Financing (AF1):** AF1 was approved on May 31, 2017 for US$163.5 million equivalent (US$120 million IDA Credit 59980; US$40 million Global Financing Facility (GFF) Grant TF0A4579; and US$3.5 million United States Agency for International Development (USAID) Grant TF0A5096). AF1 aimed to strengthen the parent project's long-term objectives of reducing maternal and child mortality and chronic undernutrition by scaling up activities. AF1 included restructuring of the parent project as follows: (i) inclusion of a Contingent Emergency Response Component (CERC), where the original Part 3(a)(iv) "preparation and implementation of the Recipient's Ebola preparedness plan" was absorbed under the new Part 4(a) "CERC"; (ii) restructuring of the Original Part 3(c) Project Management to be under Part 3(a) as Part 3(a)(iv); (iii) inclusion of a new Part 3(c) to support retirement benefits of the Ministry of Public Health (MOPH) and the organizational reform of MOHP; (iv) revision of the results framework; and (v) extension of the closing date from December 30, 2019 to December 30, 2021. The GFF grant became effective on August 18, 2017, the USAID grant became effective on November 22, 2017, and the IDA Credit became effective on February 13, 2018.

3. **Second Additional Financing (AF2):** AF2 was approved on January 24, 2018 for US$10 million from the Global Fund (Grant TF0A6945). It aimed at increasing the delivery of the existing integrated package of essential health services to the targeted population. This grant funded Performance Based Financing (PBF) under Components 1 and 2 of the parent project. The Global Fund grant became effective on August 14, 2018 and closed on August 30, 2018. By the end of the disbursement grace period, December 31, 2018, the balance of US$5.47 million was cancelled.

4. **First triggering of the CERC:** On May 8, 2018, the CERC was triggered at the request of Democratic Republic of the Congo (DRC) after the official declaration of the ninth Ebola Virus Disease (EVD9) outbreak in the province of Equateur. At this time, 30 Ebola cases were confirmed, and 27 deaths were recorded. The World Bank approved the request to activate the CERC on May 25, 2018. The Pandemic Emergency Facility (PEF) was also triggered at the request of DRC (May 25, 2018), and an additional US$11.4 million grant was mobilized under the PEF Cash Window. The PEF funding went directly to the implementing partners of the World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF) while the CERC funding was disbursed through the project and Ministry of Health.

5. **The EVD 9 outbreak was declared controlled on July 24, 2018. However, on August 1, 2018, DRC declared the 10th Ebola Virus Disease (EVD10) outbreak in the North Kivu province.** Since not all CERC financing for EVD9 had been exhausted, and due to the similar nature and urgency of the emergency activities, DRC's approved Contingent Emergency Response Implementation Plan (CERIP) was amended to include support for EVD10. The CERC reallocation was approved on November 29, 2018.

6. **Third Additional Financing (AF3):** AF3 was approved on February 27, 2019 for US$120 million. Of this amount, US$80 million was allocated from national IDA to replenish PDSS core activities that had been reprogrammed to support the EVD response under the government's Strategic Response Plan (SRP) 1 and 2 when the first CERC was triggered. The remaining US$40 million in AF3 was used to continue EVD support as part of SRP 3. To be agile, the US$40 million in AF3 was directly included in the CERC rather than being allocated to the project then reallocated to CERC. AF3 also included a restructuring to revise the PDO to reflect the activation of the CERC, update the results framework to reflect CERC results (with no changes to core project indicators) and changes in procurement arrangements to reflect the World Bank's New Procurement Framework. AF3 did not become effective until August 28, 2019. While the project was waiting to become effective, EVD10 was not contained. The virus expanded to new health zones and was identified in other countries (Uganda in June 2019) and in major cities within DRC (Goma in July 2019).

7. **Second triggering of the CERC:** The Recipient requested a second activation of the CERC in the amount of US$50 million before AF3 became effective to finance the Fourth Ebola Strategic Response Plan (SRP 4). The goal of SRP 4 was to stop the chain of EVD transmission and address the potential spread of Ebola within the country and across borders to neighboring countries. The second activation reallocated US$25 million from Category 1 of CR-55720 and US$25 million from Category 1 of Gr-D0210 under the Parent Project to the CERC.

8. **Third triggering of the CERC:** The Recipient requested the third activation of the CERC before AF3 was effective. Again, the funds were used to finance SRP-4 and to respond to the ongoing EVD10 outbreak, which was still not contained. The third triggering reallocated US$30 million from Category 1 of GFF TF0A4579 to the CERC. By 2020, the project was running out of funds for core PDSS activities. Therefore, the restructuring approved in February 2020 reallocated US$12 million from CERC-3 back to Component 1 of the project.

9. **The progression of the project, which includes three AFs and three CERC activations, is summarized in Table 1.** The total cost of the project is currently US$514.5 million. Of this total amount, US$188 million has been allocated to the EVD9 and EVD10 responses (US$80 million CERC1, US$40 million AF3, US$50 million CERC2, and US$18 million CERC3).

Table 1: PDSS AF and CERC activations

	Approval	Effective	Total (US$, million)	Cr/Gr/TF	Amount (US$, million)	Objective
Parent	Nov-14	May-16	226.5	Cr-55720	130	Improve utilization and quality of maternal and child health services in targeted health zones
				Gr-D0210	90	
				TF-18375	6.5	
AF1	Mar-17	Feb-18	163.5	Cr-59980	120	Expand geographic coverage and emphasize family planning, nutrition, health financing reforms, and
				TF-A4579	40	
				TF-A5096	3.5	

						retirement of health workers. These were key priority areas identified in the Global Financing Facility (GFF) investment case which resulted in funding from GFF and USAID
AF2	Mar-18	Aug-18	10 (5.47 cancelled)	TF-A6945	4.53	The Global Fund – a GFF partner – was included to support the core objectives of the PDSS
CERC1	Nov-18	Nov-18	80 reallocation from Categories 1-3 to CERC	Cr-59980	45 C1 → C4.2 CERC 15 C2 → C4.2 CERC 20 C3 → C4.2 CERC	Respond to EVD9, and later to EVD10
AF3	Feb-19	Aug-19	120M	Gr-D4390	80 C1-C3 40 C4.2 CERC	Reconstitute 80M allocated to CERC1 to components 1-3, add an additional 40M to CERC for EVD10 response
CERC2	May-19	Aug-19	50M	Cr-55720	25 C1 → C4.2 CERC	Respond to EVD10
				Gr-D0210	25 C1 → C4.2 CERC	
CERC3	Aug-19	Aug-19	30M	TF-A4579	30 C1 → C4.2 CERC	Respond to EVD10
L2 restructuring	Feb-20	Mar-20		TF-A4579	12 C4.2 CERC → C1	Ensure sufficient funding for C1 of the project
				Cr-59980	8.14 C4.1 → C1	

C1: Improve Utilization and Quality of Health Services at Health Facilities through PBF
C2: Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through PBF
C3: Strengthen Health Sector Performance – Financing and Health Policy
C4.1: Disease Surveillance Strengthening and Response
C4.2: CERC

10. **The project has four components:** (1) Improve Utilization and Quality of Health Services at Health Facilities through Performance Based Financing (PBF); (2) Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through PBF; (3) Strengthen Health Sector Performance – Financing and Health Policy; and (4) Disease Surveillance Strengthening and Response, which includes the CERC. The project covers 169 districts in 11 of the country's 26 provinces, which is close to a third of the population. Its intervention uses PBF, the largest of its kind globally, to strengthen service delivery and ensure quality and good governance. The contracting approach involves public and private health facilities, public health administration, central ministry of health departments and the provincial public purchasing bodies. Beyond PBF, the project is the main vehicle in DRC

to increase policy dialogue and donor engagement around human resources for health, pharmaceuticals, governance, and health financing. The project has supported capacity development and provided technical assistance for the development and implementation of key health sector policies.

11. **As of May 2020, approximately 89 percent of IDA funding has been disbursed overall and the project will close on December 31, 2021.** This includes 89 percent of the parent project, 93 percent of AF1, 100 percent of AF2 and 65 percent of AF3. Approximately US$67 million remains. Disbursement has increased in support of the results achieved to date and the project's burn rate is about US$80 million per year. Hence, the project will not have enough funds to operate through its current closing date of December 31, 2021.

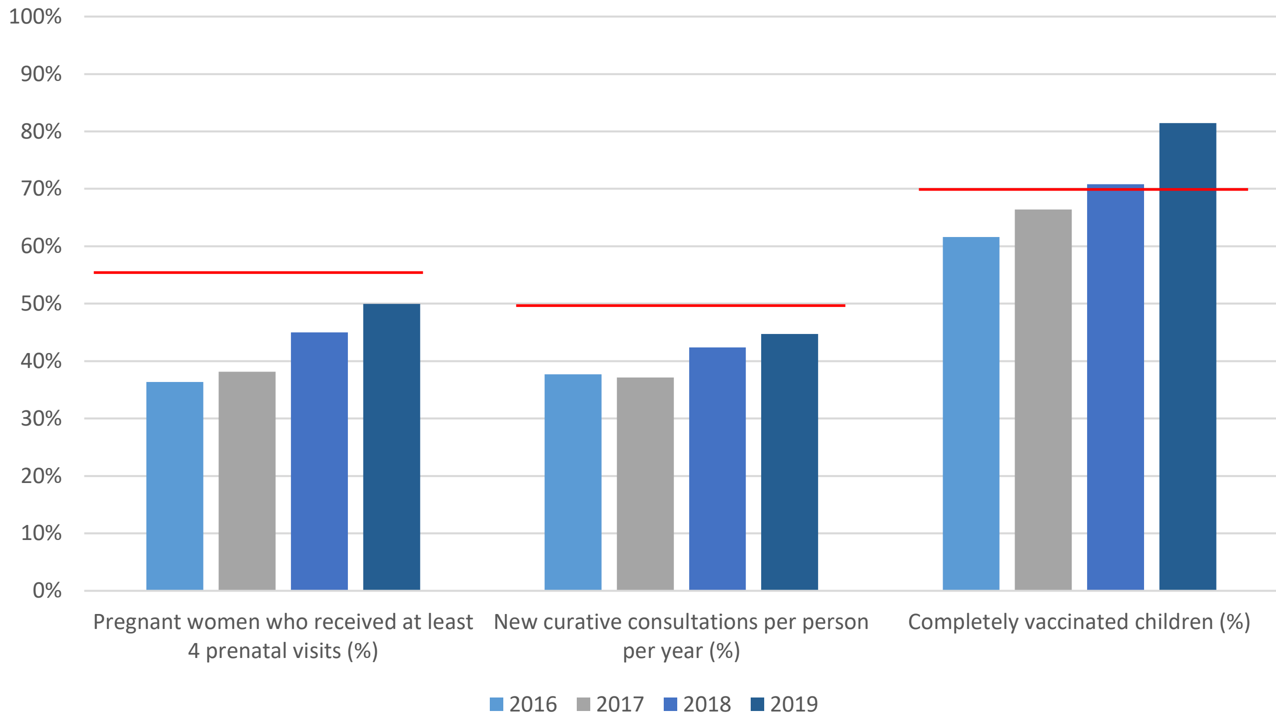
Table 2: PDSS disbursement as of May 2020

AF No.		Total (US$)	Disbursed (US$)	Undisbursed (US$)	% Disbursed
Parent	IDA-55720	130.00	113.80	8.41	88%
	IDA-D0210	90.00	82.93	1.49	92%
	TF-18375	6.50	4.43	2.07	68%
	Total	**226.50**	**201.16**	**11.97**	**89%**
AF1	IDA-59980	120.00	122.88	0.15	102%
	TF-A4579	40.00	25.28	14.72	63%
	TF-A5096	3.47	3.47	0.00	100%
	Total	**163.47**	**151.63**	**14.87**	**93%**
AF2	TF-A6945	4.53	4.53	0.00	100%
AF3	IDA-D4390	120.00	77.93	39.97	65%
Total		**514.50**	**435.25**	**66.81**	**85%**

Project Results for Core Project Activities

12. **Progress towards the PDO is currently rated Moderately Satisfactory.** At the end of 2019, three PDO indicators under the parent project have been met and the remaining three are on track to be met. In 2019 alone, 8,822,459 people received essential health, nutrition and population services (target 7,819,376 people). Figure 1 presents progress made on service delivery PDO indicators. From 2016 to 2019, the proportion of pregnant women who received at least four antenatal care visits increased from 36 to 50 percent (target 55 percent); proportion of people who had a new curative consultations increased from 38 to 45 percent (target 50 percent); and fully vaccinated children increased from 62 to 81 percent (target 70 percent).

Figure 1: Progress towards health service utilization PDO indicators, 2016-19



Source: Ministry of Public Health, District Health Information System (DHIS2)

13. **The project goes beyond increasing utilization of essential health services: it focuses on improving service quality**. The project uses a quarterly checklist to assess different aspects of health care quality.[1] The checklist aims to assess structural quality against national norms, and adherence to clinical and therapeutic protocols as defined by national policy. The quality checklist and scores differ depending on level of care and are used to adjust payment. As Figure 2a and 2b present, between 2016 and 2019, the average quality score increased from 23 to 55 percent at health centers, and from 33 to 67 percent at hospitals (target 60 percent).

[1] For health centers, the quality checklist assesses general organization of the facility, the facility's management plan, finances, committee for identifying vulnerable people, hygiene and sterilization, external consultations, family planning, laboratory, observation of services, medicine and consumables, tracer medications, maternal services, vaccinations, prenatal care and HIV/Tuberculosis. For hospitals, the checklist is the same, except vaccinations is removed and surgery is added.

Figure 2A: Evolution of the composite quality score Health Centers, 2016-19

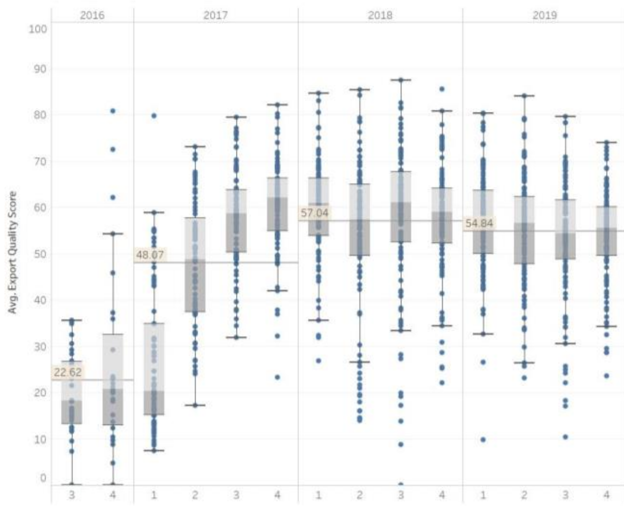
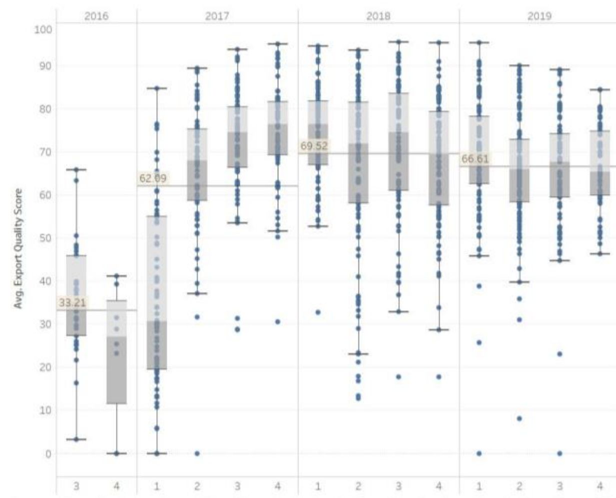


Figure 2B: Evolution of the composite quality score for Hospitals 2016-19



Source: DRC National PBF Database

14. **In addition to routine monitoring and evaluation of results using the country's National Health Management Information System and PBF database, the project includes a rigorous impact evaluation of PBF.** The midline survey of project supported PBF conducted in three out of the 11 provinces was completed in October 2018 to measure short-term impacts at the facility level and shows promising results**.** The preliminary data indicate improvements in multiple structural quality indicators in project-supported health zones. For example, the proportion of facilities that have water and soap in consultation rooms increased from 46 percent at baseline to 69 percent at midline. Furthermore, facilities are more likely to have antiseptic gel, functioning toilets, proper fencing, and basic functioning equipment for provision of maternal and child health. Facilities have also increased the number of days per week in which they provide antenatal care and the data suggest a significant increase in availability of family planning products such as birth control pills, injectables and implants. The end line survey is planned to be done by the fourth quarter of 2020, which would allow further understanding of the outcomes and impacts of the project. These results will be used to inform future investments in health systems strengthening in DRC.

15. **DRC has adopted PBF as a national policy and institutionalized the approach.** This is most evident by the government approving a National Policy on Strategic Purchasing validated by the Council of Ministers in November 2018. This policy will ensure that all parties implementing PBF will be aligned to the national policy, thereby reducing fragmentation that has hampered the health system for the past 10 years. The policy was developed after review and consultation with all the stakeholders (Government, donors, non-governmental organizations (NGOs), civil society) who have been involved in implementing PBF in DRC.

16. **PDSS plays a role in improving health system governance.** The project is well anchored in the Five-Year Health System Development Strategy (*Plan National de Développement Sanitaire 2019-2022* – PNDS) validated by the Government in November 2019 and is seen by the Government as the embryo to achieving Universal Health

Coverage (UHC) by 2030**.** The PNDS was accompanied by the development of the program-based budgeting reform in the health sector, which reflects priorities of the PNDS in the budget template. Before, priorities of the PNDS were not reflected in the budget: the budget was input-based and included mostly salary and non-salary budget lines with limited disaggregation by health priority area and province. Now, budgets of PNDS priorities are set based on the PNDS result framework, thereby allowing domestic and donor commitments and expenditures to be tracked on a yearly basis to improve governance and transparency. The PDSS is supporting the implementation of program-based budgeting at the central and provincial levels, which will permit the Ministry of Health to monitor implementation of the PNDS and institutionalize resource mapping and expenditure tracking. Additionally, the PDSS has supported several health financing analytic pieces related to public financial management and domestic resource mobilization in the health sector, leading to interventions to improve health budget execution and to better align donors.

17. **The project does not have sufficient funding to continue core activities through its closing date of December 31, 2021**. Replenishing the project's financing gap through Additional Financing 4 (AF4) will allow the project to continue making progress on its PDO indicators, and to meet its original objectives.

PDSS response to the 10th Ebola outbreak

18. **As of May 24, 2020, there have been 3,463 EVD cases, including 3,317 confirmed and 146 probable cases, of which 2,280 cases have died (overall case fatality ratio 66 percent).**[2] Of the total confirmed and probable cases, 57 percent (n=1970) were female, 29 percent (n=1002) were children aged less than 18 years, and 5 percent (n=171) were healthcare workers. As of May 24, 2020, 1,171 cases have recovered from EVD. The outbreak reached 19 health zones in North Kivu, nine health zones in Ituri and one health zone in South Kivu. EVD10 in DRC is the second largest Ebola outbreak after the 2013-16 outbreak in West Africa, and the largest in DRC history. WHO declared EVD10 a Public Health Emergency of International Concern (PHEIC) on July 17, 2019 according to International Health Regulations and plans to maintain this status through at least May 2020. The PHEIC is still effective to date as new Ebola cases were confirmed in April 2020.

19. **DRC has responded to the crisis through four SRPs.** The fourth plan was approved on July 12, 2019 to cover the period between July to December 2019. SRP 4.1, an extension of the fourth response plan, was approved on January 24, 2020 to cover response activities and preliminary transition activities at the provincial level through June 2020. It has now been extended to cover through September 2020. Between February 24 and April 10, 2020, there were no new cases of EVD. Two days before the outbreak was to be declared over, a new case was confirmed in the city of Beni on April 10, 2020. Since this date, seven new cases have been confirmed, with the last confirmed case being on April 27, 2020.[3] For the outbreak to be declared over, no new cases can emerge for 42 days – double the incubation period for infection. However, based on the West African Ebola outbreak from 2013-16, it will be critical to continue intense surveillance for 90 days once the outbreak is declared over to avoid resurgence of infection.

[2] World Health Organization. May 26, 2020. Ebola Virus Disease Democratic Republic of the Congo. External Situation Report 94. Accessed May 28, 2020 from: https://www.who.int/publications-detail/ebola-virus-disease-democratic-republic-of-congo-external-situation-report-94-2019

[3] Ministry of Health. May 26, 2020. Epidemiological Situation. Accessed May 28, 2020 from: https://www.riposte-epidemie-rdc.info/situations.php

20. **The World Bank's Health Nutrition and Population (HNP) response to the EVD10 outbreak has focused on three key pillars:** funding, technical support and pandemic preparedness. Additional World Bank support through the DRC Eastern Recovery Project (P145196 – STEP Project), has financed community-based interventions. These include high-intensive labor works that have led to improving the livelihood of about 10,000 people in Ebola affected health zones.

- **Funding**: PDSS has provided funding for the EVD9 and 10 responses through the MOPH and UN agencies. Funding has been used to deliver free health services and medicines in zones affected by the outbreak, provide hazard pay to frontline health responders, conduct surveillance activities including active cases finding, prompt case investigation and community-based surveillance, leading to earlier detection and isolation of cases. In addition, there is critical support for multi-disciplinary interventions around a confirmed case, including vaccination of primary and secondary contacts, support for prevention and control measures at health facilities and in the community, support for case management at Ebola Treatment Units and transit centers, safe and dignified burials and strengthened laboratories in areas that are vulnerable to transmission. These interventions are coupled with increased risk communication and community engagement efforts to ensure integral community appropriation of the response, improved health seeking behaviors so that new cases are immediately reported, isolated and treated.

- **Technical support:** The World Bank has been on the ground providing technical support to DRC throughout the outbreak. The World Bank has provided technical contribution to each SRP and to the development of the Center of Excellence for Ebola. The Center of Excellence for Ebola is expected to serve as the foundation for building a national public health institution for DRC, which will also play a regional role in the context of Ebola outbreaks. It has also provided technical support to establish a tool to track resource mobilization as well as expenditures per pillars and cost categories to achieve greater transparency and accountability from all implementing agencies involved in the response.

- **Pandemic preparedness:** The World Bank has been working with DRC to develop an initial one-year basic preparedness plan that targets the country's 26 provinces and has financing in place for the nine countries that border DRC. These efforts will tie into the Regional Disease Surveillance Systems Enhancement IV (REDISSE IV - P167817) project, approved in April 2019 but not yet effective. These plans are currently being used to prepare for the spread of Coronavirus Disease 2019 (COVID-19) outside of Kinshasa.

21. **The project has surpassed its PDO indicator related to the EVD response.** As of May 27, 2020, 303,905 people were vaccinated for the virus, surpassing the PDO target of 120,000.[4] Contact tracing has been a challenge throughout the response, but several initiatives have been taken to decrease loss to follow up. These include establishing a Monitoring Unit, distributing food to contacts, engaging community leaders, and conducting active case finding and door-to-door activities. This is coupled with community watch interventions to track the movement of new arrivals, deaths and illnesses within the community. During the week of May 4 to 10, 2020 there were no contacts lost to follow up.[5] To improve case management and testing, decentralized transit centers are being used to rapidly test and isolate cases in a setting close to the community. During the same week, 95 percent of suspected

[4] Ministry of Health. May 27, 2020. Situation Epi 26-05-2020. Accessed May 28, 2020 from: https://www.riposte-epidemie-rdc.info/document.php?doc=tds1590567164

[5] Ministry of Health, WHO, United Nation's Children's Fund and Partners. May 14, 2020. Dashboard on the State of the EVD Response: May 4-10, 2020. Accessed May 28, 2020 from: https://www.riposte-epidemie-rdc.info/document.php?doc=tds1589698636

EVD cases had a safe and dignified burial.[6] Community engagement has been critical throughout the response to ensure that people are vaccinated, seek care when ill, and follow procedures for safe and dignified burials. The response adopted a community-centered approach with feedback mechanisms to address rumors. At the same time, anthropologists and social scientist were engaged to provide feedback on all response pillars. Gaining trust from local religious, traditional and community leaders has been critical to mitigate community resistance and is facilitated by using community structures and community health workers who speak the local language.

22. **Halting the transmission of Ebola in Eastern Congo has been challenging due to a range of factors.** The region has experienced decades of violence and instability, which have fueled widespread poverty, gender-based violence (GBV), malnutrition and weak public sector service delivery. A key factor in the failure to stop the epidemic has been increasing mistrust from communities towards the Ebola response, including community perceptions of Ebola as business, politicization of Ebola or even a "weapon of war." The response has had the benefit of novel therapies and a new vaccine to assist in efforts to break chains of transmission. Yet, EVD10 has been challenging to control and is now in its 21st month. Lack of trust between communities and EVD response teams has been a major impediment to ending the outbreak. A combined approach of financing Ebola response in tandem with core PDSS activities in Ebola affected provinces aims to increase communities' trust in health structures and thereby their health-seeking behavior.

23. **The financing from AF4 is necessary to continue financing the EVD10 response.** It will strengthen linkages with communities and primary health care systems to rapidly detect and respond to Ebola by reinforcing critical outbreak measures such as surveillance, infection prevention and control, and existing community structures. Only through the combination of these direct response measures can this complex outbreak be effectively contained.

Relevance of PDSS to COVID-19 pandemic

24. **Continued investment in core PDSS activities is critical, particularly in light of the COVID-19 pandemic.** COVID-19 was confirmed in DRC on March 10, 2020. As of May 26, 2020, there were 2,546 cases (2,545 confirmed cases and one probable case) and 68 deaths (67 confirmed deaths and one probable death).[7] COVID-19 has now spread to seven Provinces[8], while Kinshasa remains the epicenter with 2,293 cases. If COVID-19 is not contained in DRC, it will create a surge in the demand for health services as is currently happening in countries throughout the world.

25. **The DRC COVID-19 Strategic Preparedness and Response Project (P173825, US$47.2 million, approved on April 2, 2020) and the REDISSE IV Project (P167817, US$150 million DRC allocation, approved on April 26, 2019 for US$150 million) are the main projects financing the COVID-19 response.** Neither project is effective as of May 27, 2020. The COVID-19 Strategic Preparedness and Response Project is taking the lead to contain and respond to COVID-19. It focuses on the emergency response, communication with communities and behavior change. REDISSE IV is complimentary. It will work primarily at the national level. It aims to strengthen laboratory capacity and improve community-based surveillance as well as improve human resource capacity. The two projects will exchange information to minimize the chances of duplication and maximize synergies as they respond to the pandemic. The

[6] *Ibid*

[7] Multisectoral Response Committee for the CoVID-19 Pandemic in DRC. Epidemiological situation May 26, 2020. Accessed May 28, 2020 from https://mailchi.mp/3ecf3158ce25/covid-19-bulletin-n-64-du-mardi-26-mai-3943213?e=e7794651e3

[8] Kinshasa (2,293 cases), Kongo Central (176 cases), North Kivu (35 cases), Haut-Katanga (21 cases), South Kivu (16 cases), Ituri (2 cases), Kwilu (2 cases).

geographic coverage of these projects will be the same. They will target provinces with active COVID-19 cases and adapt their geographic coverage as needed as the pandemic progresses.

26. **The Multisectoral Nutrition and Health Project (P168756, US$502 million, approved on May 28, 2019) aims to increase utilization of quality nutrition-specific and nutrition-sensitive interventions targeting children and pregnant and lactating women.** It operates in four provinces: Kwilu, Kasai Central, Kasai and South Kivu. The project overlaps with PDSS in two of the four provinces it supports. The project strengthens a vast network of community health workers to deliver basic nutrition, family planning and health services to families. It finances the expansion of the same PBF approach used under PDSS to new health zones, including those in Kasai Central, Kasai and South Kivu. Community health workers, community mobilization, and a communication strategy supported through this project will be essential to engage and educate communities about COVID-19 and to refer people for health and nutrition services. Both the community- and facility-based nutrition services strengthened through this program will be critical during COVID-19. The disruptions to food supply and livelihoods, sharp price changes, and reduced income associated with the pandemic response will restrict the availability of and people's access to sufficient, diverse and nutritious sources of food.

27. **The health system in DRC needs to be prepared to respond to the increased demand related to COVID-19.** Funding from any standalone project will not be sufficient to handle the complex nature of pandemic: PDSS plays a key role if the pandemic spreads widely outside of Kinshasa where it is currently concentrated. PDSS is the vehicle to deliver essential health services and drugs to approximately one third of the country. New mathematical models predict that service disruption associated with COVID-19 could leave 1,616,00 children without oral antibiotics for pneumonia, 3,307,900 children without the DPT vaccine, lead to 699,800 fewer deliveries in health facilities and 964,200 fewer women benefiting from family planning services. COVID-19 could increase infant mortality by 16 percent and maternal mortality by 8 percent during the next 12 months.[9] Continuing service delivery through PBF will help maintain advancements made in reproductive, maternal and child health outcomes while the pandemic is ongoing. Furthermore, the PDSS PBF quality checklist includes infection prevention control procedures that are critical to protect frontline health workers during the pandemic and reduce the spread of the new virus within a clinical setting. PBF also finances curative consultations among other primary health care services, which will be necessary to provide treatment to patients who present at health facilities with symptoms of COVID-19, as well as other conditions.[10] Households will likely have a harder time financing care due to the socioeconomic consequences of the pandemic, making PDSS subsidies for services even more critical during this time. Finally, given that testing for COVID-19 will likely be limited throughout the country, it may be difficult for providers to distinguish the new virus from other common conditions. PDSS will be essential to ensuring that COVID-19 patients are properly triaged.

PDSS Implementation Progress

28. **Project Implementation Progress is rated Moderately Satisfactory.** Implementation of most project activities, such as contracting of health facilities to support health and population services, is well underway. The contracting approach involves public and private health facilities, subnational public health administration, central ministry of

[9] Global Financing Facility. 2020. *Préserver les services de sante essentiels pendant la pandémie : République Démocratique du Congo.* (Preserve Essential Health Services during the COVID-19 Pandemic Democratic Republic of Congo).

[10] Symptoms range from mild to severe, and can include fever, cough and shortness of breath. Other symptoms, including headache, sore throat, abdominal pain, and diarrhea, have been reported, but are less common. These symptoms are similar to existing conditions, notably malaria, lower respiratory infections and other common bacterial or viral infections.

health departments and the provincial public purchasing bodies. Contracts have been put in place with 2,545 Health Centers, 166 Hospitals, 165 Health District Teams, 11 Provincial Health Teams, 11 Public Purchasing Agencies – including provincial satellites and the Central Strategic Purchasing Support Cell. Under the Ebola emergency response, the project was able to swiftly sign contract with UN agencies such as WHO, UNICEF, IOM and others to support implementation of activities outlined in multiple Ebola strategic plans developed between August 2018 and January 2020. Yet, due to the EVD9 and EVD10 outbreaks, the implementation of other activities has faced delays. For example, contracts to determine the number of civil servants eligible for retirement have been developed, and firms have been hired to calculate the pension amount and manage grievances. However, the actual launching of these activities has not started. Due to the rapid scaleup in activities due to Ebola as well as the multiple sources of funding coming through the PDSS, Implementation Progress was downgraded to Moderately Unsatisfactory for one Implementation Status Report in January 2020. Multiple actions were taken to bring the rating back to Moderately Satisfactory by March 2020. These actions included restructuring the project and scaling up the fiduciary team within PDSS – it now has three financial management specialists (up from one), two internal auditors (up from one), three procurement specialists (up from one) and six accountants (up from two).

29. **Procurement is currently rated Moderately Satisfactory.** The project previously faced difficulties with procurement, with the rating falling to Moderately Unsatisfactory between October 2019 and March 2020. However, multiple changes were made within the project to improve procurement, which led to an upgrade in rating to Moderately Satisfactory. For example, the project was restructured in February 2020 to move procurement from the Ministry's procurement unit (*Cellule des Projets et Marchés Publics* – CGPMP), to the PDSS. The World Bank has provided technical assistance to PDSS to ensure all procurements are updated and available in STEP and has conducted a rigorous examination of PDSS contracts to assess their implementation status, particularly for the Ebola contracts, which are a priority and are monitored on a daily basis.

30. **Financial Management is rated Moderately Unsatisfactory.** The project has eight Designated Accounts, which has created confusion for the project's financial management team during the EVD response when the CERC was triggered three times, and funding was shifting between categories of multiple accounts. The rating for Financial Management remains Moderately Unsatisfactory, largely due to the Project Implementation Unit's continued difficulty to adequately monitor the effects of disbursements (both planned and actual) and commitments (both current and future) on available funds (both from the loan account, and the Designated Account), both at value date and in projections. This limitation led to an excessive commitment of project funds to the CERC component of the project and created a shortfall in the funds available for other project activities scheduled for the project's remaining duration. Since the project's Mid-Term Review in July 2019, improvements have been made. For example, there was a mismatch between the Designated Account balances in the commercial banks and the balances reported in Client Connection due to errors in processing, which has now been corrected. All audit reports (latest calendar year 2018) and Interim Financial Reports (latest for the fourth quarter of 2019) were submitted on time. The calendar year 2018 audit report produced an unqualified opinion, whereas the calendar year 2017 audit report had a qualification point on Financial statements of designated account B.

31. **Environmental and Social Safeguards are rated Moderately Satisfactory.** The project is now implementing the Indigenous Peoples Plans approved under AF3. The project supports the most vulnerable groups in DRC, including indigenous people, through the equity fund that provides primary health services free of charge. On the environmental side, the project experienced challenges with operationalizing the Healthcare Waste Management Plan and improving sanitation and hygiene at health facilities. The project responded by establishing a minimal score for the Hygiene and Sterilization section of the Quality Checklists of Health Centers and Hospitals as a precondition

to receive any PDSS financing, this will begin implementation shortly. The project also recently hired a new environmental specialist to further support monitoring of safeguards compliance.

Project Risks

32. **The project's overall risk rating remains Substantial.** The rating is due to the challenging operating environment in DRC, the fiduciary risks, as well as the weak capacity of the implementing institutions. In addition, the country's political instability, frequent security crises, and the macro-economic situation has led to additional risks for project implementation. The Ebola outbreaks further add to the project's risk, as does the COVID-19 pandemic. New projections from the London School of Hygiene and Tropical Medicine form April 30, 2020 predict that after one year of an unmitigated epidemic, the total number of symptomatic cases will be between 23 and 28 million people (95 percent confidence interval 14-40 million), with an estimated 180,000 to 240,000 deaths (95 percent confidence interval 92,000-270,000 deaths).[11] If this scenario is realized, there will be major economic implications and the health system will be overwhelmed. Another project risk is related to the sustainability of the PBF model. The government has invested resources into PBF in Kinshasa, but not outside the capital. The project is working through Component 3 to expand fiscal space and increase resources for essential health services as DRC works towards UHC.

Rationale for AF4

33. **Financing gap for core activities:** The reallocation of funds to the CERC created a financing gap for core PDSS activities (Components 1, 2 and 3). Core project activities covered by the financing gap include: the provision of a package of priority health services targeting children, adolescents, pregnant women and mothers through PBF; strengthening capacity of health administration directorates within the Ministry of Public Health, health verification teams and civil society organizations to administer PBF; and providing support to the health reform process, particularly as it relates to health financing and UHC. Without AF4, the project will not be able to run through its closing date and will likely not achieve its intended objectives. AF4 is particularly important to ensure that gains made in reproductive, maternal, neonatal and child health are maintained during COVID-19. As of April 2020, a total of US$188 million has been allocated to the EVD9 and 10 responses through the CERC component of PDSS, as shown below:

CERC 1 - US$80M
+ CERC 2 - US$50M
+ CERC 3 - US$18M
<u>+ CERC funding as part of AF3 - $40M</u>
Total of US$188M financing gap
<u>- US$80M replenished in AF3</u>
Total of US$108M financing gap

AF3 initially replenished US$80 million to the project. However, AF3 only replenished funds that reallocated to the Ebola response when the first CERC was triggered. It did not account for the remaining funds that were put into the CERC during AF3, nor the reallocated funds when the second and third CERC were triggered. The PDSS therefore has a financing gap of US$108 million (US$188 million allocated to the CERC, of which US$80 million was replenished during AF3).

[11] LSHTM CMMID COVID19 Working Group. April 30, 2020. Modelling projections for COVID19 epidemic in Dem. Republic of the Congo. Accessed May 28, 2020 from https://cmmid.github.io/topics/covid19/LMIC-projection-reports.html

34. **Cost-overrun for core activities:** AF4 will add US$42 million to support core activities in Components 1-3 of the project. This funding will cover a cost-overrun resulting from the socio-economic impact of COVID-19 on households. As a result of the pandemic, households will have greater difficulty accessing and financing primary health care. Health facilities will have greater difficulties procuring drugs and vaccines. The US$42 million will be allocated to i) increase subsidies to the 2,800 health centers contracted by the PDSS in the Provinces already covered by the project so that financial access does not deter care seeking; ii) purchase essential drug and vaccines to ensure that facilities do not encounter massive stock outs; iii) improve the infection prevention control and water and sanitation aspects of the health facilities to reinforce quality of care; and iv) finance GBV interventions as per the GBV action plan developed under the safeguard documents, which to had not been fully costed to take into account the greater risk of GBV due to the COVID-19 response.

35. **Cost-overrun for EVD10 response:** AF4 will add US$50 million to support the ongoing EVD10 response. While PDSS was deeply involved in the costing of the EVD10 response, it was not foreseen that the outbreak would last for more than 21 months and have a geographic spread across three provinces in a fragile and conflict-affected settings. As part of the international scale-up strategy, efforts to expand coverage of treatment centers, reinforce point of entry controls and strengthen community surveillance led to a cost overrun for the Ebola response as compared to the estimations completed in early 2019 to inform AF3. Without AF4, PDSS will not have sufficient resources to support SRP4.1, which covers through September 2020.

36. **Overall project amount:** AF4 is for US$200 million. This includes US$108 million to cover the financing gap after triggering the CERC a second and third time, and US$50 million to cover the EVD10 response cost overrun, both of which will be financed with Crisis Response Window funds. It also includes US$42 million to cover a cost overrun resulting from lower socioeconomic status of households due to COVID-19, which will be financed through IDA resources.

37. **Relationship to Crisis Response Window (CRW) eligibility note:** The CRW eligibility note requested a financing amount of US$280 million, with US$180 million being allocated to PDSS through AF4. Out of the US$180 million, US$50 million would go directly to continue Ebola response activities, whereas US$130 million would go to replenish the funds that were taken from core PDSS activities to finance the emergency response to Ebola. However, in the meantime AF3 had already reallocated US$80 million to replenish some funding from national IDA and was then subsequently not re-directed to Ebola emergency response as foreseen at the time of finalization of the CRW eligibility note. This discrepancy between the CRW eligibility note (requesting US$180 million replenishment) and the PDSS AF4 Project Paper (requesting US$158 million replenishment with CRW funds) is due to responding to a fast-moving landscape of Ebola Crisis funding while in parallel trying to safeguard funding to keep essential PDSS project activities running. The need to continue ensuring funding for core PDSS activities is especially important given that the Project is aiming to address the underlying health system weaknesses that make it so difficult to effectively respond to outbreaks when they occur.

II. DESCRIPTION OF ADDITIONAL FINANCING

38. **This AF will cover the PDSS financing gap and cost overrun related to the COVID-19 pandemic and ongoing EVD support.** It will allocate US$150 million to core project activities (US$108 million financing gap and US$42 million cost overrun) and US$50 million to the CERC for the EVD10 response (cost overrun). The proposed changes in project allocation by components are summarized in Table 3. As the table illustrates, AF4 will add US$80 million to component 1, US$40 million to Component 2, US$30 million to Component 3; and US$50 million to the CERC (Component 4.2). This funding will fill the financing gap after using PDSS as the main vehicle to finance the Ebola response and will finance core activities through the project's closing date. It will also cover the cost overrun resulting from COVID-19 and that is required to end the EVD10 outbreak and provide ongoing surveillance in the Ebola-affected provinces as recommended by WHO.

Table 3: Project Allocation by Component (US$ million)

Components	Parent	AF1	AF2	CERC1	AF3	CERC2/3	L2 Rest.	Proposed AF4
1. Improve Utilization and Quality of Health Services at Health Facilities through PBF	120	174 (+54)	176.5 (+2.5)	131.5 (-45)	176.5 (+45)	126.5 (-50)	146.6 (+20.1)	226.6 (+80)
2. Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through PBF	65.2	90.7 (+25.5)	92.7 (2)	77.7 (-15)	92.7 (+15)	62.7 (-30)	62.7	102.7 (+40)
3. Strengthen Health System Performance – Financing/Health Policy	41.3	110.3 (+69)	110.3	90.3 (-20)	110.3 (+20)	110.3	110.3	140.3 (+30)
4.1 Disease Surveillance Strengthening and Response	0	15 (+15)	15	15	15	15	6.9 (-8.1)	6.9
4.2 CERC	0	0	0	80 (+80)	120 (+40)	200 (+80)	188 (-12)	238 (+50)
TOTAL	**226.5**	**390**	**394.5**	**394.5**	**514.5**	**514.5**	**514.5**	**714.5**

39. **The project's results framework is being updated to add the methodology for data collection for each indicator.** The results framework was revised during the last project restructuring approved in February 2020. The indicator baselines, targets, definitions and data sources remain the same.

Climate Change Co-Benefits

40. **The project has been screened for climate and disaster risks and the risk is Moderate to Low.** Changes in the epidemiology of infectious diseases associated with climate variability in Africa over the last 40 years have been reviewed and documented, and there is growing evidence of the impact of climate change on infectious disease transmission patterns, nutritional status, reproduction and geographic range. Ebola outbreaks are projected to become more frequent with global warming due to its intermittent connection to wildlife and climate. Some researchers are connecting deforestation to the disease, noting that the change in landscape is bringing wildlife in

closer contact with humans. As the virus is typically found in wildlife, and transmission from animals to humans occurs through contact with infected bodily fluids, causing a spillover in species. In addition, the impact of climate change on nutrition outcomes is expected to increase with rising temperatures, which can reduce protein and certain micronutrients in crops. Also, climate change undermines efforts to address undernutrition, hitting women and children the hardest. Poor health and undernutrition in turn further undermine people's resilience to climatic shocks and their ability to adapt.

41. **The project intends to address the above vulnerabilities by strengthening community engagement and outreach, thereby improving community knowledge and thus empowering households.** AF4 will continue to ensure access to safe water sources and essential WASH services to reduce the potential for illness and spread of infection.

III. KEY RISKS

42. **The Overall risk for the proposed AF is rated Substantial.** The Political and Governance risk is rated High mainly due to the continued unstable political environment, while recent elections resulted in the election of a new President, volatile security situation in North Kivu and other Provinces where recurrent attacks have taken place throughout the EVD10 response. These attacks have been against health workers and have resulted in the destruction of health facilities treating Ebola patients. The project has supported community engagement throughout the EVD10 response to try to gain trust of communities and mitigate violence targeted at health workers and facilities. The Macroeconomic risk is rated Substantial due to the fall of commodity prices and the global COVID-19 pandemic, which present additional risks that were not envisaged during the preparation of the parent project. DRC has extensive exposure to heavily affected COVID-19 economies (specifically China, Europe and the United States). A slowdown in global growth and reduced demand for mining product (which account for more than 90 percent of total exports), with adverse consequences on commodity prices, will weigh on the DRC's economic prospects through reduced net exports and foreign direct investment. The project aims to increase subsidies for households who will be hard hit by the economic slowdown to mitigate households from incurring out of pocket expenditures, which could push them further into poverty, when seeking essential health services. Technical Design risks remain Substantial due to the challenges of implementing PBF in remote regions of the country that are difficult to access. This risk is mitigated through the provision of technical assistance to review and revise the PBF approach as needed and to build capacity in country to analyze data and trends in service delivery to track achievements and inform changes to the project design. Institutional capacity risks are High given the complexity of addressing the Ebola response. The Project Implementation Unit has been scaled up to expand capacity to implement project activities. Fiduciary risk is High. Fiduciary mitigating measures include the hiring of additional technical assistance (account and financial management specialists) as well as continuing to use the manual the project developed for Hazard Pay procedures. Furthermore, looking at the geographical scope, the associated issues of access, and the complexities of working closely with development partners to achieve results continues to present a risk for which mitigating measures have been put in place. These measures include joint operational plans with development partners to capitalize on the value added of each to achieve greater efficiency.

43. **Social risk rating remains Moderate**. The project's risk for sexual exploitation and abuse (SEA) and sexual harassment (SH) was rated Moderate during the recently completed DRC portfolio review assessing risk for GBV, including SEA/H. The project developed a risk mitigation plan outlining associated mitigation measures that the project intends to implement, including an accountability and response framework, which would incorporate codes of conduct for health care personnel, a grievance redress mechanism set up to handle SEA/H-related complaints ethically and confidentially, as well as a response protocol for ensuring access to integrated services for survivors.

Planned mitigation measures also include awareness-raising around SEA/H and community consultations with women in addition to training activities related to SEA/H prevention and response for project and health care personnel as well as clinical care for sexual assault survivors for health care providers. To support implementation of all these measures, the project is in the process of hiring two safeguards specialists and will hire a GBV specialist to oversee all related SEA/H mitigation and response activities. Furthermore, the existing SEA/H risk mitigation plan will be updated within 60 days of effectiveness.

IV. APPRAISAL SUMMARY

A. Economic and Financial Analysis

Parent Project Activities

44. The economic and financial analysis of the parent project activities remains valid. AF4 will continue to generate economic benefits through a greater emphasis on addressing Reproductive, Maternal, Neonatal, Child and Adolescent Health. Investment in essential health services is even more relevant in the context of COVIVD-19, as demand for services at health facilities will likely increase rapidly and substantially, while households have less ability to pay for services. A Cost-Benefit Analysis of PDSS was conducted in 2015 to measure the project's economic performance and assess its returns against alternatives. The cost benefit analysis showed a rate of return of 16 percent. The project is expected to continue with the same or higher rate of return given that AF4 replenishes funding for core activities.

45. Disease outbreaks affect economic activity by decreasing demand (in response to reduced consumer and business confidence, which can substantially and abruptly reduce spending; exports may fall due to disruptions in logistics) and reducing supply (labor absenteeism and disruptions of supply chains will reduce production in agriculture and other sectors; some businesses will close altogether). The impacts of EVD10 and COVID-19 will be to reduce productivity of both labor and capital, which are the major components of growth. PDSS has directly supported the EVD9 and 10 responses, which have reduced the number of cases, deaths and duration of the illness, all of which have implications on the economic toll of the outbreak. While PDSS is not financing the COVID-19 response directly, the services delivered through the project will also be a critical to reduce deaths associated with the virus.

46. The 2014-16 Ebola outbreak in West Africa demonstrates the potential loss associated with a major Ebola outbreak. The outbreak resulted in an estimated 28,616 cases and 11,310 deaths in Guinea, Liberia and Sierra Leone.[12] Ebola in West Africa quickly reversed much of the recent economic growth in the region due to a sharp decrease in private sector investment and cross border trade. For example, a recent study of economic activity in Liberia before and after the Ebola outbreak, 12 percent of firms had closed, more than double the annual firm closure rate of 5 percent per year in Africa.[13] Multiple studies have estimated the economic loss associated with the crisis, as summarized by Huber, Finelli and Stevens and presented in Table 4.[14] In a 2018 analysis of the

[12] Centers for Disease Control, 2016. Available at: https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/index.html
[13] Bowles, J., Hjort, J., Melvin, T., Werker, E. Ebola, jobs and economic activity in Liberia. *J Epidemiol Community Health.* 2016;70:271–277.
[14] Huber, C., Finelli, L., Stevens, W. The Economic and Social Burden of the Ebola Outbreak in West Africa. The Journal of Infectious Diseases. 2018; Suppl 5.

economic and social burden of the Ebola outbreak in West Africa, the authors argue that most of these estimates do not consider the broader social costs of the outbreak. They estimated that the combined economic and social burden of the outbreak was much higher, at US$53.19 billion. As compared to the macroeconomic and social approach used in other estimates, Bartsch, Gorham and Lee examined the cost of a case of Ebola from a different perspective.[15] They considered the costs of supportive care, personal protective equipment, personnel wages and productivity losses for mortality and absenteeism, and estimated that the cost per case of Ebola ranged from US$480 to US$912 when a patient fully recovered, and from US$5,929 to US$18,929 when a patient died, varying by age and country. Their estimate of the total cost in West Africa ranged from US$82 to US$356 million.

Table 4: Summary of estimates of economic cost of 2014-15 Ebola outbreak

Estimate	Direct cost of controlling outbreak	Impact on economic output	Impact on economic growth
World Bank 2014	US$18 million preparation costs in Senegal and Nigeria	0.1%-3.3% reduction in investment (2015) 2%-3.4% reduction in exports (2014)	US$3.8-US$32.6 billion lost GDP (affected countries, 2014-15)
World Bank 2015			US$6.8 billion lost GDP (affected countries, 2014-15) US$550 million lost GDP (non-affected sub-Saharan African countries 2015)
World Bank 2016		40% decrease in working Liberians (2014-16)	US$2.8 billion lost GDP (2014-16) for Guinea, Liberia and Sierra Leone
UN Economic Commission on Africa 2015	US$290.6 million for Sierra Leone, Guinea, Liberia (2014-15) US$5.4 million preparation costs in Central African Republic, DRC, Sao Tome and Principe (2014)	US$335.3 million reduction in Sierra Leone exports (2014)	US$716 million lost PPP (2014) for Guinea, Liberia and Sierra Leone
UN Food and Agriculture Organization (2015)		12% reduction in crop volume (2014)	
UN Development Programme (2014)		Loss of exports (2014): 30% in Guinea 14% in Liberia 10% in Sierra Leone	
UN Development Programme (2015)			US$4.7 billion lost GDP (2017) for Guinea, Liberia and Sierra Leone
Office of the UN Special	US$5.9-US$8.9 billion global		

[15] Bartsch, S.M., Gorham, K., Lee, B.Y. The cost of an Ebola case. Pathogens and Global Health. 2015; 109(1).

Envoy for Ebola (2015)	support (2015)		
African Development Bank (2015)			US$1.4 billion lost PPP (2014) for Guinea, Liberia and Sierra Leone

Source: Huber, Finelli and Stevens, 2018

47. **In September 2019, the World Bank produced initial estimates of the economic impact of EVD10.**[16] The report models four scenarios, the least severe assumes that EVD-10 does not spread to additional provinces or outside of the country and is contained by February 2020, whereas the most severe assumes that EVD10 spreads to three additional provinces and regionally to Burundi, Rwanda and Uganda resulting in border closures. In the best-case scenario, the short-term economic impact is mild: Gross Domestic Product (GDP) would be 0.2 percent lower than baseline without the outbreak resulting in foregone nominal GDP of US$230 million in 2020. However, in the worst-case scenario, the short-term economic impact is more severe: GDP would be 1.4 percent lower than baseline, resulting in US$1.7 billion in foregone nominal GDP in 2020. The long-term estimates through 2025 are more pronounced, with GDP losses of 0.4 and 1.8 percent for the best- and worst-case scenarios respectively.

48. **The true economic impacts of EVD10 are difficult to assess given the uncertainty of the disease's epidemiological path, the complex environment where the outbreak is playing out, and the emergence of the COVID-19 pandemic.** Continued investment in health system strengthening and in the EVD10 response with strong community involvement will support a secure environment for trade, travel, and commerce links as the region emerges from both EVD10 and COVID-19. Based on expected social and economic benefits, the implementation of the continued health system strengthening and EVD10 activities is fully justified. Substantial resources have been invested into the response since August 2018, and now that the disease is close to being contained, it is critical to continue investing in the response and surveillance until the outbreak is declared over.

B. Technical

49. **The technical justification for the parent project activities and for emergency Ebola activities funded under the CERC remains valid.** PDSS core activities are now even more critical during the COVID-19 pandemic to be able to provide optimal medical care, maintain essential health services close to the community and minimize risks for patients and health personnel. The World Bank is one of the largest funders of the EVD10 response. The approach employed through SRP 4.1 uses proven public health measures (surveillance, contact tracing, laboratory confirmation/testing, infection prevention and control, engaging communities) as well as new tools at hand (vaccine and therapeutics), to contain the outbreak and to bring it to an end.

C. Institutional Arrangements

50. **The project's institutional arrangements remain the same**. The institutional arrangements were revised after the parent project's Mid Term Review in July 2019 and restructuring that was approved in February 2020. The restructuring aimed to improve the fiduciary oversight of the project. The Project Implementation Unit is at the Secretary General level, which is placed under the MOPH. The Secretary General ensures that health policy documents, national directives and health standards are applied in the sector according to the country's policies. The Secretary General monitors all projects anchored in the General Secretariat and ensures the smooth running

[16] World Bank Group. September 2019. The Economic Impact of the 2018 Ebola Epidemic in the Democratic Republic of Congo: Estimates for DRC and Neighboring Countries: preliminary draft.

of all the reforms affecting health system administration on behalf of the Minister of Health. The Secretary General chairs the Technical Coordination Committee of the National Steering Committee, which is responsible for validating sectoral documents that are submitted by commissions, departments or specialized programs. Fiduciary responsibilities for project implementation are integrated into the Project Implementation Unit's mandate. The Project Implementation Manual will be updated within 60 days of project effectiveness.

51. **The PDSS Project Implementation Unit is now managing four HNP projects.** Beyond PDSS, this includes the COVID-19 Strategic Preparedness and Response Project, the REDISSE IV Project and the Multisectoral Health and Nutrition Project. The rationale for using the same Project Implementation Unit for these projects is to increase efficiency and coordination among health sector activities supported with World Bank finances. Currently, efforts are being made to ensure that fiduciary, safeguards and GBV retrofitting are addressed in a complementary manner and across the portfolio rather than project by project.

D. Financial Management

52. **All financial arrangements remain the same, which were confirmed at the time of the CERC triggering.** The Financial Management rating to the parent project from latest archived PRIMA Assessment, filed in January 8, 2020 was Moderately Unsatisfactory. The Financial Management performance rating has been Moderately Unsatisfactory since July 2017 and there are substantial and long outstanding performance issues under this operation that need to be addressed. An action plan has been put in place to address financial management shortcomings, including improved budget and funds flow management, reinforcement of the internal control environment and addressing the inherent shortcomings of the current institutional arrangements of the project that have been made evident during implementation. These actions are aimed at improving overall financial management.

53. **For disbursement purposes, a Designated Account will be opened in a financial institution acceptable to IDA and managed by the Project Implementation Unit**. This account will be held in US dollars. The Designated Account will receive cash advances to pay for project expenses eligible for IDA financing. Any interest earned on funds deposited in the Designated Account shall be deposited into the project account. Payments will be made in accordance with the provisions of the manual of procedures (i.e., joint signatures by the Project Implementation Unit Coordinator and Chief Financial Officer).

54. **Disbursement Arrangements.** The transaction-based disbursement method will be applied for the Designated Account, which will receive an initial advance of equivalent to six months expenditure forecast. Replenishments will be based on six months forecast. Other disbursement methods - reimbursements, special commitments and direct payments will apply as well and the minimum value of applications for these methods is established at 20 percent of the Designated Account ceiling. Documentation of the Designated Account will be carried out on a monthly basis. As the country is currently under remedies due to lapsed loans, the Designated Account will open once the lapsed loans issue is resolved. Until then, the advance disbursement method is not permitted for this project except for Emergency Expenditures for the CERC.

55. **Mandatory Direct Payment pilot**. Since this project is prepared under Situations of Urgent Need of Assistance or Capacity Constraints, PDSS will be required to use the Direct Payment disbursement method for disbursement under contracts for goods, works, non-consulting services and consulting services procured/selected through international open or limited competition or Direct Selection, unless the Special Commitment disbursement

method is used.

E. Procurement

56. **Procurement under AF4 will be carried out in accordance with the following:** World Bank Procurement Regulations for Investment Project Financing for Borrowers (dated July 2016, revised November 2017 and August 2018) under the New Procurement Framework (NPF) and the World Bank's Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by International Bank for Reconstruction and Development (IBRD) Loans and IDA Credits and Grants (dated July 2016) as well as the provisions stipulated in the Financing Agreement. All contracts envisaged under this AF will require the project team to further develop the simplified Project Procurement Strategy for Development (PPSD), prepared for negotiations, and a procurement plan to be validated by the World Bank. Taking into account that (i) this AF4 will also finance activities under CERC relevant for the emergency response; and (ii) it has not been possible for the Borrower to complete a PPSD and procurement plan for the entire project during project preparation, referring to documents covered under the World Bank Policies, particularly World Bank Guidance, Procurement in Situations of Urgent need of Assistance or Capacity Constraints that includes inter alia a Guidance on the use of streamlined Procurement Arrangements for Projects prepared in accordance with IPF Policy, Paragraph 12 of Section III: Projects in Situations of Urgent Need of Assistance or Capacity Constraints under Section "III," part "A" point 3 and Part F of the same Section III, it is acceptable that the Borrower has prepared a short and simplified PPSD and an initial Procurement Plan supported for this PPSD for the negotiations of this AF. The AF4 will provide the required resources to continue with signing of contracts and initiation of activities. The performance rating from the latest archived P-RAMS Assessment, filed March 7, 2020, was Moderately Satisfactory. Given (i) the country context and associated risk, (ii) the authority's interference in procurement activities; and (iii) that this project will be implemented in DRC under the World Bank's NPF, the procurement risk is rated High.

F. Safeguards

57. **Since the proposed AF4 is only addressing the financing gap and cost overrun due to COVID-19 and the ongoing Ebola response, the scope and nature of the parent project activities remain the same and thus there is no change in the Safeguard Policies triggered**. The parent project has been assigned Environmental Category B. While the safeguard policies have not changed, the project paper notes that the Safeguard Policies Triggered have changed (Table VI: Summary of Table Changes) to reflect that the relevant safeguard documents, as described below, were updated and res-disclosed due to AF4.

58. **The originally approved Indigenous People's Plan Framework (IPPF) remains valid, as no changes in the location of the current project activities are envisioned**. This was also confirmed when the CERCs were triggered. In particular, OP 4.10 (Indigenous Peoples) was triggered under the parent project and will remain triggered under the proposed operation. The IPPF was prepared and disclosed under the parent project. Nine Indigenous Peoples Plans were updated and disclosed in February 2019 as part of AF3. They are being implemented as per World Bank guidelines. The IPPF was updated and have been publicly disclosed in-country and on the World Bank's external website on May 22, 2020 for AF4. Overall, the project social safeguards performance is Moderately Satisfactory.

59. **The parent project triggered the OP 4.01 (Environmental Assessment), which will remain triggered under the proposed operation.** The Environmental and Social Management Framework and Health Care Waste Management Plan were disclosed in country in October 2016 and updated and disclosed as per World Bank guidelines in

December 2017 and subsequently re-disclosed in February 2019. These documents were updated and have been publicly disclosed in-country and on the World Bank's external website on May 22, 2020 for AF4. Overall, the project environment safeguards performance is Moderately Satisfactory.

V. WORLD BANK GRIEVANCE REDRESS

60. Communities and individuals who believe that they are adversely affected by a World Bank-supported project may submit complaints to existing project-level grievance redress mechanisms or the World Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit *http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit *www.inspectionpanel.org*

VI SUMMARY TABLE OF CHANGES

	Changed	Not Changed
Results Framework	✓	
Components and Cost	✓	
Safeguard Policies Triggered	✓	
Implementing Agency		✓
Project's Development Objectives		✓
Loan Closing Date(s)		✓
Cancellations Proposed		✓
Reallocation between Disbursement Categories		✓
Disbursements Arrangements		✓
EA category		✓
Legal Covenants		✓
Institutional Arrangements		✓
Financial Management		✓
Procurement		✓
Implementation Schedule		✓
Other Change(s)		✓

VII DETAILED CHANGE(S)

COMPONENTS

Current Component Name	Current Cost (US$, millions)	Action	Proposed Component Name	Proposed Cost (US$, millions)
Improve Utilization and Quality of Health Services at Health Facilities through PBF	146.70	Revised	Improve Utilization and Quality of Health Services at Health Facilities through	226.67

			Performance-Based Financing	
Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through PBF	62.70	Revised	Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through Performance-Based Financing	102.70
Strengthen Health Sector Performance – Financing and Health Policy Capacities	110.30	Revised	Strengthen Health System Performance - Financing, and Health Policy	140.30
Disease Surveillance System Strengthening and Response	194.90	Revised	Disease Surveillance Strengthening and Response	244.86
TOTAL	**514.60**			**714.53**

Expected Disbursements (in US$)

Fiscal Year	Annual	Cumulative
2015	0.00	0.00
2016	10,075,930.03	10,075,930.03
2017	47,858,471.77	57,934,401.80
2018	62,263,533.15	120,197,934.95
2019	110,000,000.00	230,197,934.95
2020	80,000,000.00	310,197,934.95
2021	90,000,000.00	400,197,934.95
2022	119,802,065.20	520,000,000.15
2023	0.00	520,000,000.15
2024	0.00	520,000,000.15
2025	0.00	520,000,000.15
2026	0.00	520,000,000.15

2027	0.00	520,000,000.15

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Latest ISR Rating	Current Rating
Political and Governance	High	High
Macroeconomic	Substantial	Substantial
Sector Strategies and Policies	Moderate	Moderate
Technical Design of Project or Program	Substantial	Substantial
Institutional Capacity for Implementation and Sustainability	High	High
Fiduciary	High	High
Environment and Social	Moderate	Moderate
Stakeholders	Moderate	Moderate
Other		
Overall	Substantial	Substantial

COMPLIANCE

Change in Safeguard Policies Triggered

Yes

Safeguard Policies Triggered	Current	Proposed
Environmental Assessment OP/BP 4.01	Yes	Yes
Performance Standards for Private Sector Activities OP/BP 4.03	No	No
Natural Habitats OP/BP 4.04	No	No
Forests OP/BP 4.36	No	No
Pest Management OP 4.09	No	No
Physical Cultural Resources OP/BP 4.11	No	No

Indigenous Peoples OP/BP 4.10	Yes	Yes
Involuntary Resettlement OP/BP 4.12	No	No
Safety of Dams OP/BP 4.37	No	No
Projects on International Waterways OP/BP 7.50	No	No
Projects in Disputed Areas OP/BP 7.60	No	No

LEGAL COVENANTS – Fourth Additional Financing for Health System Strengthening for Better Maternal and Child Health Results Project (P173415)

Sections and Description
SCHEDULE 2. Section I.E. (i) No later than sixty (60) days after the Effective Date, or such later date as agreed by the Association, update the Project Implementation Manual; and (ii) immediately thereafter, shall carried out the Project in accordance with the provisions of the Project Implementation Manual;
SCHEDULE 2. Section I.E. (i) No later than sixty (60) days after the Effective Date, or such later date as agreed by the Association, update and publish a SEA/H Plan; and (ii) immediately thereafter, shall carried out the Project in accordance with the SEA/H Plan;

Conditions

Type	Description
Disbursement	SCHEDULE 2. Section III. B. 1. b. (CERC Disbursement Conditions)

VIII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Congo, Democratic Republic of
Fourth Additional Financing for Health System Strengthening for Better Maternal and Child Health Results Project

Project Development Objective(s)

To improve utilization and quality of maternal and child health services in targeted areas within the Recipient's Territory and, to provide an immediate and effective response to an eligible crisis or emergency

Project Development Objective Indicators by Objectives/ Outcomes

Indicator Name	PBC	Baseline	End Target
Improve the utilization and quality of maternal and child health services in targeted areas.			
Women having at least 4 antenatal care visits before delivery (%) (Percentage)		36.00	55.00
Action: This indicator has been Revised			
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		5,208,170.00	7,819,376.00
Action: This indicator has been Revised			
Number of children immunized (CRI, Number)		434,750.00	1,063,706.00
Number of women and children who have received basic nutrition services (CRI, Number)		4,352,206.00	5,505,670.00

Indicator Name	PBC	Baseline	End Target
Action: This indicator has been Revised			
Number of deliveries attended by skilled health personnel (CRI, Number)		421,214.00	1,250,000.00
Average score of the quality checklist at the health centers (%) (Percentage)		21.00	60.00
Action: This indicator has been Revised			
Children Fully Immunized (%) (Percentage)		62.00	70.00
Action: This indicator has been Revised			
New curative consultations per capita per year (Text)		0.38	0.50
Action: This indicator has been Revised			
Provide an immediate and effective response to an eligible crisis or emergency			
Eligible individuals vaccinated during EVD (# - cumulative) (Number)		0.00	120,000.00
Action: This indicator has been Revised			

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	End Target
Improve Utilization and Quality of Health Services at Health Facilities through PBF			
New acceptors of modern contraceptives (%) (Percentage)		5.00	15.00
Action: This indicator has been Revised			
First time adolescent girls acceptant of modern contraceptives (%) (Percentage)		0.00	3.00
Action: This indicator has been Revised			
Pregnant women counseled and tested for HIV (%) (Percentage)		15.00	25.00
Action: This indicator has been Revised			
Existing users of modern contraceptives (%) (Percentage)		2.00	15.00
Action: This indicator has been Revised			
Contraceptive prevalence (new and existing female users %) (Percentage)		6.00	15.00
Action: This indicator has been Revised			
Births attended by skilled professional (%) (Percentage)		52.00	85.00
Action: This indicator has been Revised			
Health service delivered to target population through PDSS support (# – annual) (Number)		0.00	20,000,000.00

Indicator Name	PBC	Baseline	End Target
Action: This indicator has been Revised			
Improve Governance, Purchasing and Coaching and Strengthen Health Administration Directorates and Services through PBF			
Health personnel receiving training (# - cumulative) (Number)		0.00	10,000.00
Action: This indicator has been Revised			
Average availability of tracer medicines at hospitals/health centers (%) (Percentage)		69.00	70.00
Action: This indicator has been Revised			
Single contract signed at province level (# – annual) (Number)		2.00	11.00
Action: This indicator has been Revised			
Average performance score of Provincial Health Directorates under Single Contract (%) (Percentage)		72.00	77.00
Action: This indicator has been Revised			
Strengthen Health Sector Performance – Financing and Health Policy Capacities			
Civil servants eligible for retirement in the Ministry of Health that have received their retirement indemnities/packages (# - cumulative) (Number)		0.00	4,000.00
Action: This indicator has been Revised			
Poor people benefiting from fee exemption mechanisms (%) (Percentage)		0.00	20.00

Indicator Name	PBC	Baseline	End Target
Action: This indicator has been Revised			
Disease Surveillance Strengthening and Response ***(Action: This Component has been Revised)***			
Contacts of suspected or confirmed EVD cases lost to follow up (%) (Percentage)		0.00	0.00
Action: This indicator has been Revised			
Suspected EVD samples received that have been tested (%) (Percentage)		0.00	100.00
Action: This indicator has been Revised			
Suspected and confirmed EVD cases for whom safe and dignified burials have been carried out (%) (Percentage)		0.00	100.00
Action: This indicator has been Revised			

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Women having at least 4 antenatal care visits before delivery (%)	Numerator: Pregnant woman who received 4th antenatal care visit or more during the quarter Denominator: Number of pregnant women in the population (4%).	Quarterly	Health Management Information System (HMIS) (*Système National d'Information*	All monthly data reported by health facilities into the HMIS at completion of each quarter. Data entry is due one month after the quarter is complete.	Ministry of Health (MoH)/Project Implementation Unit (PIU)

	Data for Kinshasa added in Q4 2018. Baseline set by taking average between Q1 and Q2 2016.		*Sanitaire - DHIS-2*)	However, due to internet connectivity issues, data entry often takes longer than one month. Hence, the Project team download data for each targeted province (or health zone in provinces that are not completely covered) 3-6 months after the end of each quarter to ensure data is complete. The team will track trends in each indicator on a quarterly and annual basis. Major fluctuations in the indicator will be examined in greater detail.	
People who have received essential health, nutrition, and population (HNP) services		Quarterly. Note: targets are for annual sum. Reporting is cumulative over the year.	HMIS	Sum of first growth monitoring visits for children aged 6m-23m, children fully immunized and women who had skilled delivery.	MoH/PIU

Number of children immunized		Annual sum of fully vaccinated children. Baseline takes sum of Q1 2016 and Q2 2016 and multiples by 2.	HMIS		
Number of women and children who have received basic nutrition services		Annual sum of first growth monitoring visits for children aged 6m-23m. Nutrition advice and feeding supplements are part of the package delivered.	HMIS database		Purchasing agencies (public utilities; EUPs)
Number of deliveries attended by skilled health personnel		Annual sum of women who had delivery	HMIS		

		attended by skilled professional . Baseline calculated by taking sum of Q1 and Q2 2016 and multiplying by two.			
Average score of the quality checklist at the health centers (%)	Numerator: Sum of the quarterly quality score (%) of all PBF health centers. Denominator: Number of health centers contracted through PBF. Criterion-based clinical measures and vignettes will also be included in the quality checklist. The quality check list will be applied at two levels: at the health center and at the first level referral hospital level.	Quarterly	PBF Database	Take average of verified quality scores for all health facilities covered by project financed PBF.	MOHP/HMIS
Children Fully Immunized (%)	Numerator: Number of fully immunized children under one year of age. Denominator: Number of	Quarterly	HMIS Database	Download data 3-6 months after the end of quarter for targeted provinces or targeted	MoH/PIU

	children less than one year old (3.49%). A child is considered fully immunized when she/he has received immunization for BCG, polio, DTC3, and measles. In the last few years the DTP vaccine has been replaced by Penta, which includes apart from DTP, Hemophilus Influenza and Hepatitis The project will also measure fully immunized children under 1 which is a more sensitive and complete measure of correct and timely application of all obligatory immunizations done prior to 11 months of age. This measure is also a proxy of the quality of the EPI program (follow-up on defaulters; quality and effectiveness of outreach and community based programs).			health zones (when entire province not covered). Track trends for quarterly and annual estimates, explore major fluctuations as needed.	

New curative consultations per capita per year	Numerator: Number of new curative consultations in target health zones during year Denominator: Total population in target health zones during year	Quarterly	HMIS Database	Download data 3-6 months after the end of quarter for targeted provinces or targeted health zones (when entire province not covered). Track trends for quarterly and annual estimates, explore major fluctuations as needed.	MOH/PIU
Eligible individuals vaccinated during EVD (# - cumulative)	Sum of eligible individuals who were vaccinated during the past month. Eligible individuals are those defined by national protocol.	Monthly	Periodic vaccination reports	Extract data from monthly reports.	Ebola Implementing Agencies/MoH/PIU

Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
New acceptors of modern contraceptives (%)	Numerator: Number of new acceptors of modern contraceptive methods. Modern methods such as injections, pills, implants and IUDs, excluding condoms. These methods are purchased in health centers / communities and	Quarterly	HMIS database	Download data 3-6 months after the end of quarter for targeted provinces or targeted health zones (when entire province not covered). Track trends for quarterly and annual estimates, explore major	MOH/PIU

	first level referral hospitals. Denominator: Women of reproductive age (estimated at 21% of the total population)			fluctuations as needed.	
First time adolescent girls acceptant of modern contraceptives (%)	Numerator: Number of new adolescent acceptors of modern contraceptive methods. Modern methods such as injections, pills, implants and IUDs, excluding condoms. Denominator: Number of adolescent girls (estimated at 32 percent of the population)	Quarterly	HMIS database	Download data 3-6 months after the end of quarter for targeted provinces or targeted health zones (when entire province not covered). Track trends for quarterly and annual estimates, explore major fluctuations as needed.	MOH/PIU
Pregnant women counseled and tested for HIV (%)	Numerator: percentage of pregnant women who were counseled and tested for in target health zones during the quarter Denominator: number of pregnant women in target health zones during the quarter (estimated at 4% of the population)	Quarterly	HMIS database	Download data 3-6 months after the end of quarter for targeted provinces or targeted health zones (when entire province not covered). Track trends for quarterly and annual estimates, explore major fluctuations as needed.	MOH/PIU
Existing users of modern contraceptives (%)	Numerator: Number of existing users of modern contraceptive methods. Modern methods such as injections, pills, implants	Quarterly	HMIS database	Download data 3-6 months after the end of quarter for targeted provinces or targeted health zones (when	MOH/PIU

	and IUDs, excluding condoms. These methods are purchased in health centers / communities and first level referral hospitals. Denominator: Number of women of reproductive age (estimated at 21% of total population)			entire province not covered). Track trends for quarterly and annual estimates, explore major fluctuations as needed.	
Contraceptive prevalence (new and existing female users %)	Numerator: sum of new and existing users of modern contraceptives Denominator: number of women of reproductive age (estimated at 21% of the total population)	Quarterly	HMIS database	Download data 3-6 months after the end of quarter for targeted provinces or targeted health zones (when entire province not covered). Track trends for quarterly and annual estimates, explore major fluctuations as needed.	MOPH
Births attended by skilled professional (%)	Numerator: number of births attended by a skilled professional Denominator: number of births (estimated at 4 percent of the population)	Quarterly	HMIS database	Download data 3-6 months after the end of quarter for targeted provinces or targeted health zones (when entire province not covered). Track trends for quarterly and annual estimates, explore major fluctuations as needed.	MOPH

Health service delivered to target population through PDSS support (# – annual)	Annual sum of verified services of the PMA package and the PCA package	Quarterly	PBF database	Download data 3-6 months after the end of quarter for targeted provinces or targeted health zones (when entire province not covered). Track trends for quarterly and annual estimates, explore major fluctuations as needed.	MOPH
Health personnel receiving training (# - cumulative)	Number of health personnel who received training through project support This indicator measures the cumulative number of health personnel receiving training through a Bank-financed project.	Quarterly	Project records	Extract from project records the number of individuals trained each quarter. Training can be technical (related to service quality or clinical protocols), managerial, or related to PBF implementation.	MOH/PIU
Average availability of tracer medicines at hospitals/health centers (%)	Numerator: sum of the quality score on the availability of Essential Medicines (%) of all health centers contracted via PBF Denominator: Number of health centers contracted through PBF. Hospitals not included Note: data was available as of Q4 2017.	Quarterly	PBF database	Extract verified data from PBF database three months after quarter ends to ensure data completeness.	MOH/PIU

Single contract signed at province level (# – annual)	Annual number of Single Contracts signed at the provincial level. The single contract sets up a performance framework for all donors. It is a budgeted business plan in the provincial health administration, funded with available national and external funds. Note: this is the signed contracts. After it is signed, it remains active for the whole year.	Quarterly	Project records	Document province name when contract is formally signed in project results tracking sheet.	MOH/PIU
Average performance score of Provincial Health Directorates under Single Contract (%)	Numerator: sum of DPS performance score under single contract (%) Denominator: Number of DPS who signed the single contract Baseline available as of Q3 2017	Quarterly	Project Records	Document performance score for each province when it is finalized. Maintain records in centralized location.	MOH/PIU
Civil servants eligible for retirement in the Ministry of Health that have received their retirement indemnities/packages (# - cumulative)	Cumulative sum of civil servants eligible for retirement in the Ministry of Health that have received their retirement indemnities/packages	Quarterly	Project Records	Extract from project records the number of civil servants who received retirement indemnities/packages.	MOH/PIU
Poor people benefiting from fee exemption mechanisms (%)	Numerator: Number of poor people benefiting from fee exemption	Quarterly	PBF database	Extract verified data from PBF database three months after quarter	MOH/PIU

	mechanisms. Denominator: Number of people eligible for fee exemption mechanisms (estimated at 5% of the total population) The project would support mechanisms to exempt poorer people of fee payments, or to lower their level of fee payment at the health facility. These data are directly accessible through the PBF system. At the health center level up to 5% of all consultations can be exempted, and at the hospital level, up to 10% of referred patients can be exempted, and up to 10% of admissions can be exempted. The exemptions are reimbursed through the PBF mechanism.			ends to ensure data completeness.	
Contacts of suspected or confirmed EVD cases lost to follow up (%)	Numerator: Number of people who encountered suspected/confirmed Ebola case that could not be contacted during the past month Denominator: Number of	Monthly	Reports from implementing agencies	Extract data from reports of implementing agencies.	Ebola Implementing Agencies/MoH/PIU

	people who encountered suspected/confirmed Ebola case during the past month The end target is to have no contacts lost to follow up (0%).				
Suspected EVD samples received that have been tested (%)	Numerator: number of EVD samples tested during the past month Denominator: number of EVD samples received during the past month	Monthly	Implementing agency reports	Extract data from implementing agency reports	Ebola Implementing Agencies/MoH/PIU
Suspected and confirmed EVD cases for whom safe and dignified burials have been carried out (%)	Numerator: Number of safe and dignified burials conducted for suspected/confirmed Ebola deaths during the past month Denominator: Number of deceased who were suspected or confirmed Ebola cases during the past month Safe and dignified burial is defined as per national protocol.	Monthly	Implementing agency reports	Extract data from implementing agency reports.	Ebola Implementing Agencies/MoH/PIU