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Report No: PAD2782

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR 69,600,000

US$100 MILLION EQUIVALENT

TO THE

DEMOCRATIC REPUBLIC OF CONGO
FOR A

DRC – GENDER-BASED VIOLENCE PREVENTION AND RESPONSE PROJECT
June 6, 2018

Social, Urban, Rural And Resilience Global Practice
Africa Region

CURRENCY EQUIVALENTS

Exchange Rate Effective April 30 2018

Currency Unit = SDR

US$ 1 = SDR0.69538128

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Makhtar Diop
Country Director:	Jean-Christophe Carret
Senior Global Practice Director:	Ede Jorge Ijjasz-Vasquez
Practice Manager:	Robin Mearns
Task Team Leader(s):	Patricia Fernandes

ABBREVIATIONS AND ACRONYMS

AWPB	Annual Workplan and Budget
CAS	Country Assistance Strategy
CBO	Community Based Organizations
CDR	Regional Distribution Center
CoE	Center of Excellence
CPF	Country Partnership Framework
DA	Designated Account
DRC	Democratic Republic of Congo
DHS	Demographic and Health Survey
EMF/P	Environmental Management Framework/Plan
FM	Financial Management
FMA	Fiduciary Management Agency
FSDRC	Fonds Social DRC
GBV	Gender-Based Violence
GL GBV	Great Lakes Emergency Sexual and Gender-Based Violence and Women's Health Project
GoDRC	Government of the Democratic Republic of Congo
GRM	Grievance Redress Mechanism
GRS	Grievance Redress System
HCP	Health Care Providers
HMIS	Health Management Information System
HZ	Health Zone
IASC	Inter-Agency Standing Committee
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IE	Impact Evaluation
IFMS	Integrated Financial Management System
IFR	Interim Financial Report
IP	Indigenous People
IPF	Investment Project Financing
IPP/F	Indigenous People's Plan/Policy Framework
IPRs	Independent Procurement Reviews
IPV	Intimate Partner Violence
ISM	Implementation Support Mission
ISR	Implementation Status and Results Report
KPI	Key Performance Indicators
MGFC	Ministry of Gender, Family and Children
MoF	Ministry of Finance
MoPH	Ministry of Public Health
MONUSCO	United Nations Organization Stabilization Mission in the DRC
MTR	Mid-Term Review

NET	Narrative Exposure Therapy
NGO	Non-Governmental Organization
NPAGBV	National Plan of Action on GBV
NPF	New Procurement Framework
NPSV	Non-Partner Sexual Violence
NPV	Non-Partner Violence
NSCGBV	National Strategy on Combating Gender-Based Violence
OHADA	*Organisation pour l'Harmonisation en Afrique du Droit des Affaires*
PBF	Performance Based Financing
PC	Project Coordinator
PDH	Provincial Directorate of Health
PDSS	Health Systems Strengthening Project
PEP	Post-Exposure Prophylaxis
PER	Performance Expenditure Review
PFM	Public Financial Management
PIM	Project Implementation Manual
PMIS	Project Management Information System
PMU	Project Management Unit
PP	Procurement Plan
PPSD	Project Procurement Strategy for Development
PST	Project Support Team
RCT	Randomized Control Trial
SEA	Sexual Exploitation and Abuse
SGBV	Sexual and Gender-Based Violence
SOE	Statement of Expenditures
SOP	Standard Operating Procedures
SPDs	Standard Procurement Documents
STEP	Systematic Tracking of Exchanges in Procurement
STI/D	Sexually Transmitted Infection/Disease
ToRs	Terms of Reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
VAC	Violence Against Children
VSLA	Village Savings and Loans Associations
WA	Withdrawal Application
WB	World Bank
WHO	World Health Organization

BASIC INFORMATION

Country(ies)	Project Name
Congo, Democratic Republic of	DRC - Gender Based Violence Prevention and Response Project

Project ID	Financing Instrument	Environmental Assessment Category	Process
P166763	Investment Project Financing	B-Partial Assessment	Urgent Need or Capacity Constraints (FCC)

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[✓] Fragile State(s)
[ ] Disbursement-linked Indicators (DLIs)	[ ] 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)	

Expected Approval Date	Expected Closing Date
28-Jun-2018	30-Jun-2023

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The objectives of the Project are to increase in targeted Health Zones: (i) the participation in Gender-Based Violence (GBV) prevention programs; (ii) the utilization of multi-sectoral response services for survivors of GBV; and (iii) in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

Components

Component Name	Cost (US$, millions)
Gender-Based Violence prevention and integrated support for survivors at community level	54,554,792.00
Gender-Based Violence Response	27,481,300.00
Support to Policy Development, Project Management and Monitoring and Evaluation	17,963,907.00
Contingency Emergency Response Component	0.00

Organizations

Borrower: Ministry of Finance, Democratic Republic of Congo

Implementing Agency: Fonds Social Democratic Republic of Congo

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	100.00
Total Financing	100.00
of which IBRD/IDA	100.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	100.00
IDA Grant	100.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Total Amount
National PBA	0.00	100.00	100.00
Total	**0.00**	**100.00**	**100.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2018	2019	2020	2021	2022	2023	2024
Annual	0.00	7.76	15.87	22.62	23.99	24.32	5.45
Cumulative	0.00	7.76	23.63	46.25	70.23	94.55	100.00

INSTITUTIONAL DATA

Practice Area (Lead)

Social, Urban, Rural and Resilience Global Practice

Contributing Practice Areas

Gender, Health, Nutrition & Population, Social Protection & Labor

Climate Change and Disaster Screening

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

Gender Tag

Does the project plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	High
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial

6. Fiduciary	High
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

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

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09	✓	
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10	✓	
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description

The Recipient shall, by no later than six (6) months after the Effective Date, establish, and thereafter maintain,

throughout the Project Implementation period, a Project Support Team, with terms of reference satisfactory to IDA.

Conditions

Type	Description
Effectiveness	The Recipient has prepared and adopted the Project Implementation Manual, in form and content satisfactory to the Association.
Effectiveness	The Recipient has recruited an administration and finance specialist under terms and conditions and with qualifications satisfactory to the Association.
Effectiveness	The Recipient has recruited an administration and financial management oversight agent, under terms and conditions and with qualifications satisfactory to the Association.
Effectiveness	The Subsidiary Agreement between the Recipient and the Project Implementing Entity has been duly executed.
Disbursement	Under Category 2 (Performance Grants), no withdrawal shall be made until the Association has received at least one Health Service Provider Agreement in form and substance satisfactory to the Association.
Disbursement	Under category (3), no withdrawal shall be made, for Emergency Expenditures under Part 4 of the Project unless and until the Association is satisfied that all the following conditions have been met in respect of the said activities: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include said activities in the CERC Part in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has prepared and disclosed all safeguards instruments required for said activities, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section F of Schedule 2 to this Agreement; (iii) the Recipient's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section F of this Schedule 2 to this Agreement, for the purposes of said activities; and; (iv) the Recipient has adopted a CERC Operations Manual in form, substance and manner acceptable to the Association and the provisions of the CERC Operations Manual remain - or have been updated in accordance with the provisions of Section F of this Schedule 2 so as to be appropriate for the inclusion and implementation of said activities under the CERC Part.

CONGO, DEMOCRATIC REPUBLIC OF
DRC - GENDER BASED VIOLENCE PREVENTION AND RESPONSE PROJECT

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I. STRATEGIC CONTEXT

A. Country Context

Persistent Poverty

1. **Political instability, poor governance, and weak state institutions are the main factors that explain persistent poverty in the Democratic Republic of Congo (DRC)**. DRC is a post-conflict and fragile country with a rapidly growing population. Its turbulent history, along with weak governance, have limited the ability of successive governments to establish stable institutions and to improve the living standards of the population. Macroeconomic performance improved until mid-2015 and was marked by strong economic growth[1]. However, growth failed to translate into significant reduction in poverty and inequality. While the Gini coefficient improved slightly from 38 in 2005 to 35 in 2012, large portions of the population remain trapped in extreme poverty. Poverty in the DRC remains pervasive, and above the Sub-Saharan Africa (SSA) average. While the proportion of people living below the poverty line declined from 69.3 percent to 64 percent between 2005 and 2012, the absolute number of poor increased by 7 million during that same period. Almost 14 percent or one out of six people living in extreme poverty in SSA live in the DRC.[2]

2. **DRC ranked 176th out of 188 countries [3] in the 2016 Gender Inequality Index. This index benchmarks national gender gaps using economic, political, education, and health criteria.** Important gains were made in areas such as health and education, and in terms of legislation that addresses gender equality. However, persistent socio-cultural disparities restrict women's engagement in social and economic life as well as in public decision-making. Women's participation in politics is limited and they currently occupy about eight percent of parliamentary seats in both the National Assembly and in the Senate (compared with an average of 20.6 percent among low-income countries). The new Family Code (2016) removed several discriminatory provisions in terms of access to land and resources for women and increased the minimum age of marriage for girls from 15 to 18. However, much remains to be done to ensure that such legislation is enforced. Women continue to face unequal treatment with respect to labor force participation, land tenure and property ownership. The percentage of female workers was reported at 19 percent in the 2013 World Bank Enterprise Survey Results (notably lower than the average 34 percent in surveyed countries).[4] While women make up the majority of workers in the agricultural sector (53 percent)[5] their access to land and credit remains constrained limiting productivity.

[1] Ranging from 5.6 to 6.2 percent between 2002 and 2008.
[2] World Bank (2017), DRC Systematic Country Diagnosis.
[3] With a score of 0.663.
[4] World Bank website: *https://data.worldbank.org/data-catalog/enterprise-surveys*. World Bank Enterprise Survey Results collect and analyze firm level data from 139 countries.
[5] 1-2-3 Survey on Employment, the Informal Sector, and Household Living Conditions (2013-2014).

High levels of Gender-Based Violence and acceptability of such violence

3. **Gender-Based Violence (GBV) represents a significant barrier to women's full engagement in social and economic life in the DRC and remains correlated with violence and insecurity. Prevalence rates of GBV in DRC are high.** Overall, 52 percent of all women aged 15-49 reported experiencing physical violence (by any perpetrator)[6] while 27 percent have experienced sexual violence[7]**.** By comparison, the global average prevalence rates for violence against women[8] is estimated by the World Health Organization (WHO) at 35.6 percent. The regional (Africa) average is estimated at 37.7 percent.[9] Most Intimate Partner Violence (IPV) in the DRC was physical with 45.9 percent of ever married women experiencing physical violence. Emotional violence was experienced by 36.6 percent of ever married women and sexual violence by 25.5 percent. Approximately half of women who are victims of IPV (49.6 percent) suffer from bruises, injuries, sprains dislocations or burns due to their partner's actions. [10]

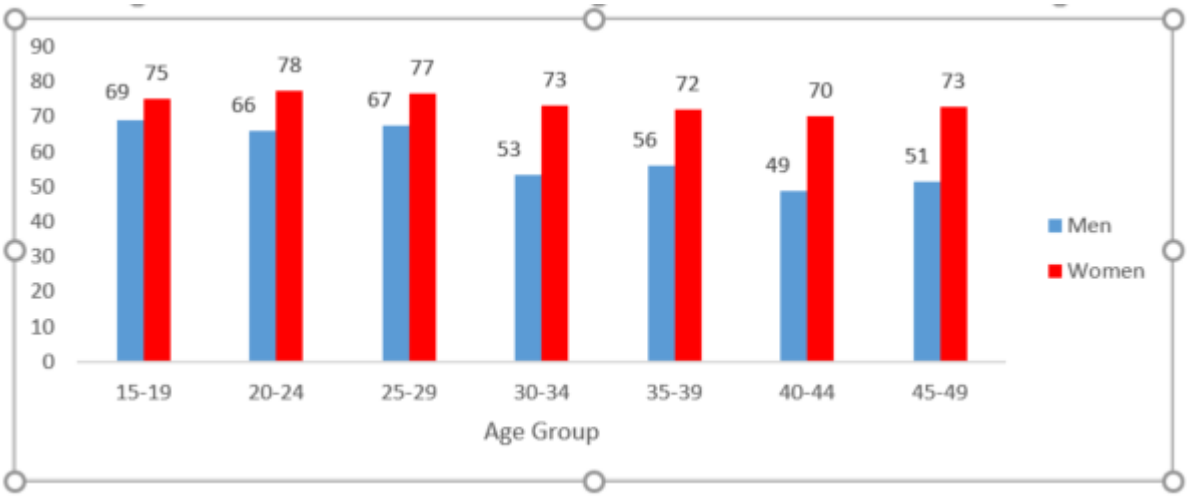
4. **For women aged 15-49 who have experienced physical violence, the perpetrator was most often a current husband or partner (56.8 percent).** Reported perpetrators also included teachers (8.6 percent) and police or soldiers (0.8 percent). Similar trends were observed for sexual violence with 60.1 percent of sexual violence against women perpetrated by a current husband or partner. [11]

5. **Levels of acceptability of IPV in the DRC are the highest in the Africa region with 74.8 percent of women and 59.5 percent of men believing that wife beating is justified for at least one specified reason[12].** Importantly, acceptability of IPV is more prevalent in younger age groups for both men and women. Intimate Partner Violence is seen as justified by over three quarters of women aged 15-29. [13]

6. **While prevalence of physical violence against women remains high it has fallen from 64 to 52 percent for women aged 15-49 between 2007 and 2014[14].** Reports of violence decreased for all age groups[15]. This downward trend was observed across all provinces with the exception of the Kasaï -Oriental, which has seen an increase in prevalence[16] during that same period of time. Prevalence of sexual violence has decreased from 33 to 27 percent between 2007 and 2014. Reports of sexual violence decreased across all age groups except for women aged 15-19[17].

[6] At least once since the age of 15 (Demographic and Health Survey, 2014).
[7] Of which 16 percent in the last 12 months (Demographic and Health Survey, 2014).
[8] Rates of physical or sexual violence for women aged 15-49.
[9] World Health Organization (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.* Geneva, World Health Organization.
[10] World Health Organization (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.* Geneva, World Health Organization.
[11] Perpetrators of Non-Partner Sexual Violence (NPSV) also included friends or acquaintances in 7 percent of cases and strangers in 4.5 percent of cases. Overall 12 percent of women experienced sexual violence before the age of 18, and 4 percent before the age of 15 (Demographic and Health Survey, 2014).
[12] Demographic and Health Survey, 2014.
[13] Around 60% of women of this age group agreeing that a husband is justified in beating his wife if she argues with him.
[14] According to the 2014 DHS data.
[15] With a slightly higher reduction in prevalence noted in urban areas.
[16] 1.6 percentage points.
[17] There was a 2-percentage point increase between 2007 and 2014 for this age group.

Figure 1: Percentage of women and men who agree that wife beating is justified for at least one specified reason (DHS, 2014)

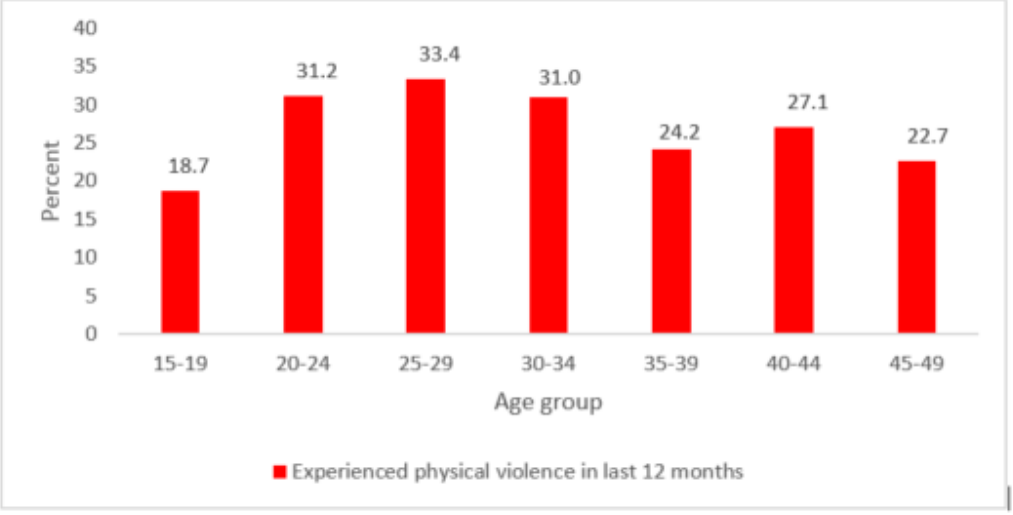


7. **Gender-Based Violence prevalence is widespread with significant regional variations.** In 2014, rates of IPV varied from 71 percent in Kasaï Occidental to 34 percent in North Kivu. Women with large families were at particular risk of violence[18]. The percentage of women having ever experienced physical violence was 60.6 for those with five to six children compared to 37.5 for women with no children. Women with no formal schooling and those who had not completed primary education were similarly at higher risk of experiencing physical violence. Overall, 38.1 percent of women with higher than secondary education reported having experienced physical violence compared to 51.5 percent of those with no formal schooling and 57.3 percent of those who had not completed primary education.[19]

8. **Younger women and adolescent girls constitute a particularly vulnerable group. Overall, younger women are more likely to experience physical violence** (See Figure 2 below) with the exception of those in the 15-19 age group. The national teenage pregnancy rate was 27 percent[2021]. Overall, 37 percent of women aged 20-24 were married before 18, compared to 6 percent of men in the same age group. Early marriage constitutes an important risk factor for violence with women married before the age of 15 being twice as likely to experience IPV than those married after the age of 25.

[18] Overall fertility rates in DRC were 6.6 children per women in 2014 (DHS). Rates vary from f 5.4 in urban areas to 7.3 in rural areas and by province (from 4.2 in Kinshasa to 8.2 in Kasaï Occidental).
[19] Demographic and Health Survey (DHS), 2014.
[20] For women aged 15 to 19.
[21] Adolescent fertility is nearly three times higher among young women living in the poorest households (42 percent) than among those living in the wealthiest households (15 percent).

Figure 2: Prevalence of physical violence by age (DHS, 2014)



Situations of Urgent Need of Assistance

9. **This operation is being processed using the flexibility provided under paragraph 12 of the Investment Project Financing Policy.** The Democratic Republic of Congo is included in the *Harmonized List of Fragile Situations* and, ss such, it is deemed by the World Bank to experience capacity constraints because of fragility. The proposed project is expected to contribute to the broader goal of reducing vulnerability of women and girls to GBV in DRC. Interventions will specifically target Provinces where high rates of GBV and high levels of acceptability of GBV have been further exacerbated by ongoing insecurity and violence.

10. **The DRC is emerging from a long period of conflict which has had a devastating impact on institutions, the economy, and the social fabric.** The Congo Wars of 1996-2002 resulted in massive displacement and loss of life[22]. The Sun City Agreement followed by the 2003 transitional government and two rounds of elections placed the country on a path to recovery. However, real GDP per capita in 2016 was only 40 percent of the 1970 level. New elections were expected to take place in 2016. When that did not occur, an agreement was reached to postpone elections with an interim government in place since December 2016. The security situation has deteriorated due to the political instability generated by non-recognition of this agreement by part of the opposition and lack of clarity about new elections. The conflict in the Eastern and in the Central Regions of the country continues to generate high levels of displacement and humanitarian needs. Provinces considered to be the most affected by the humanitarian crisis are Kasaï, South Kivu, Maniema, Tanganyika,

[22] More than 3.5 million people died during the war with nearly half being children under 5 years of age - World Bank (2017), DRC Systematic Country Diagnosis.

Haut-Katanga (Pweto Territory) and Haut-Lomami Province (Malemba-Nkulu) territory. The humanitarian situation is also considered of concern in North Kivu[23].

11. **Conflict-related Sexual and Gender-Based Violence (SGBV) is a pronounced feature of ongoing violence in DRC.** The high prevalence rates of GBV in the DRC are linked to underlying social and cultural norms and values that perpetuate power imbalances between men and women. These are often further exacerbated in the context of conflict.[24] This is especially true in the Eastern Provinces and more recently in the Kasaï and Tanganyika. Beyond cases of sexual violence linked to conflict, increased food insecurity associated with the humanitarian crisis is also likely to further exacerbate the risk of Sexual Exploitation and Abuse (SEA). [25][26]

B. Sectoral and Institutional Context

12. **The Government of the DRC recognizes the burden that gender inequality, including GBV, places on social and economic development**. Its commitment to addressing gender inequality and GBV is reflected in the recent progress made in strengthening the legal and policy framework to address GBV as follows:

    a. A Comprehensive Strategy on Combating Sexual Violence in the Democratic Republic of Congo was developed by the Government of the DRC in coordination with the United Nations Organization Stabilization Mission in the DRC (MONUSCO) in April 2009.
    b. A National Strategy on Combating Gender-Based Violence (NSCGBV) and related five-year National Action Plan were subsequently put in place in November 2009 under the leadership of the Ministry of Gender, Family and Children (MGFC). Both the National Strategy and Action Plan are currently being updated with the final version of the approved documents expected to be available before the end of 2018. The NSCGBV sets out a framework for the implementation of comprehensive GBV prevention measures and for the provision of multi-sectoral support services for survivors in the context of continued instability and conflict. It also outlines the role of various line agencies, civil society organizations and humanitarian actors at local and national levels. The NSCGBV lays out the following five areas of intervention: (i) protection from and prevention of GBV; (ii) ending impunity; (iii) security sector reform; (iv) assistance for victims of violence; and (v) data collection and mapping. The NSCGBV further highlights the challenges in implementing GBV prevention and response programs in a context of continued insecurity and lays out key gaps in terms of service provision as well as challenges in coordinating the response to GBV.

[23] UNOCHA Humanitarian Response Plan, December 2017.
[24] World Bank (2017), Gender inputs to the Country Partnership Framework
[25] In 2017, over 26 000 new cases of sexual violence were identified in areas of the country affected by the humanitarian crisis (31% of which in Nord-Kivu). UNOCHA Humanitarian Response Plan, December 2017
[26] DRC Sexual and Gender-Based Violence Sub-Cluster, August 2017

13. **The NSCGBV is complemented by a key set of legal instruments including the ratification of major international and regional agreements[27] to promote gender equality.** This includes the Constitution (2006), The Law Against Sexual Violence (2006), and the Child Protection Act (2008). The new Family Code (2016) removed a variety of discriminatory provisions and paved the way for improving gender equality. The new Code allows married women independent access to finance, property rights and expands the working age and professional options for women. It removes earlier requirements that a married woman seek the authorization of her husband to undertake certain business activities such as registering a company, opening a bank account, and seeking a loan. It further increases the minimum age of marriage for girls from 15 to 18.

Table 1 - Mandates of key Governmental institutions and other stakeholders in the implementation of the NSCGBV

Institution	Mandate
Ministry of Gender, Family and Children	Leads a coordinated prevention and response approach to GBV, establishes coordination mechanisms and is responsible for improving data collection and management.
Ministry of Health	Provides appropriate medical services (including emergency services), builds capacity of health sector staff and establishes forensic services.
Ministry of Justice	Establishes mechanisms for procuring justice for survivors of GBV with a focus on putting in place fast-track procedures. Is responsible for building capacity of judicial officers to handle GBV cases. The NSCGBV highlights the development of appropriate criminal legislation as an important area of focus.
Ministry of Interior and Ministry of Defense	Provides security, establishes mechanisms to ensure perpetrators are apprehended. Responsible for the exclusion of perpetrators from the army. Is responsible for awareness raising on GBV among security forces.
Civil Society Organizations, Development Partners (including UN Agencies)	Play a key role in multi-sectoral service delivery (including in socio-economic reintegration) and in the provision of emergency support on GBV.

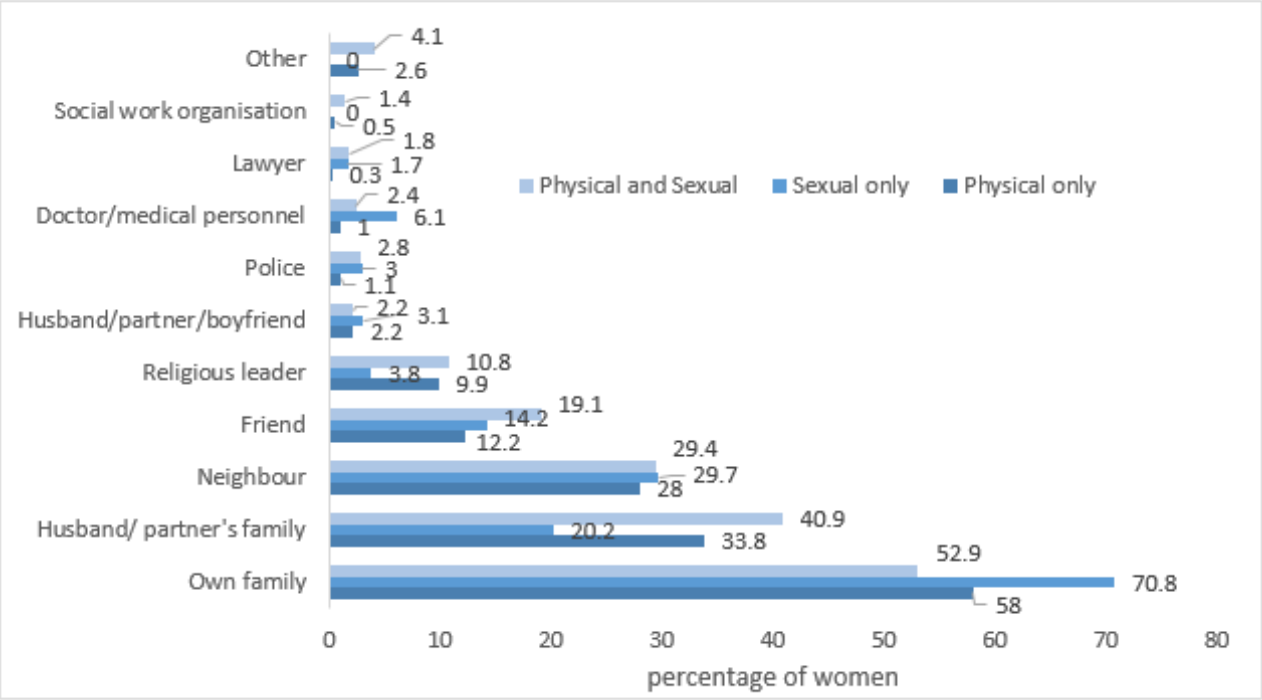
14. **National coordination mechanisms with strong participation by development partners and humanitarian actors have been in place to oversee the emergency interventions on GBV.** These are reflected in the NSCGBV, namely the Inter-Ministerial Working Group on SGBV coordinated by the MGFC. The platform receives financial and technical assistance through the UN Joint Program. Significant challenges in terms of MGFC's capacity to effectively coordinate GBV programming were identified during the preparation process. Humanitarian coordination mechanisms remain in place, with UNFPA leading the SGBV national and provincial sub-clusters.

[27] DRC is party to: (i) The UN Convention on the Elimination of all Forms of Discrimination Against Women; (ii) The UN Convention of the Rights of Child and African Charter on the Rights and Welfare of the Child; (iii) The Declaration on Elimination of Violence Against Women (1993); (iv) UN Security Council Resolution 1325 on Women, Peace and Security (2000) and UN Security Council Resolution 1820 on sexual violence in situations of armed conflict (2008); (v) the African Charter on Human and Peoples' Rights and The Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol) (2003); (vi) The Protocol on the Prevention and Suppression of Sexual Violence against Women and Children of the International Conference on the Great Lakes Region (2006); (vii) the Goma Declaration on eradicating sexual violence & ending impunity in the Great Lakes Region (2008); and (viii) the Kampala Declaration on ending impunity (2003).

15. **Given the context of persistent instability, conflict and weak institutions there are significant gaps in the implementation of legal and policy instruments described above.** Access to prevention programs and basic services for survivors remains extremely limited and dependent on external funding. Available service provision is almost exclusively linked to the implementation of humanitarian programs. While additional support has recently been channeled to the Kasaï, GBV programing in Eastern DRC has been significantly reduced over the last two years with limited interventions now ongoing in both North and South Kivu as Development Partners' (DP) focus shifts to other humanitarian emergencies. (Please see Annex 6 for an overview of current GBV programs in the DRC).

16. **Limited availability and reliability of services, coupled with significant social and cultural barriers to reporting instances of GBV, is reflected in service seeking behavior by survivors.** Only approximately a third of women who experienced physical or sexual violence seek support. Women were less likely to look for help if they experienced sexual violence only, with just over a quarter of survivors of such violence seeking support. Most women who sought assistance looked to their own or their partners´ family, a neighbor or friend for help. Only a small percentage of women experiencing violence sought assistance from formal service providers such as the police or medical professionals (Figure 3).

Figure 3: Sources of support for survivors of GBV who seek services (2014, DHS)



C. Higher Level Objectives to which the Project Contributes

17. **The proposed project will directly contribute to the implementation of the DRC National Strategy on Combating Gender-Based Violence (and related five-year National Action Plan) as outlined above. In addition, the project will contribute to the two pillars of the World Bank's new global strategy, eliminating extreme poverty and promoting shared prosperity**. The project is also in line with the World Bank Group's FY13 - FY16 Country Assistance Strategy (CAS) for DRC. [28][29] The CAS for DRC recognizes profound gender inequalities reflected in DRC's ranking in terms of the Gender Inequality Index and the threat posed by GBV to sustainable development. The proposed project will directly contribute to the following strategic objectives: (i) Objective 3: improving social service delivery to raise human development indicators, and (ii) Objective 4: addressing the development deficits contributing to fragility and conflicts in DRC's Eastern provinces.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

18. Gender-Based Violence prevention programs require a sustained investment over a long period of time to achieve impacts in terms of reduction in GBV incidence. Social norms and values that may condone GBV change slowly. The project will, therefore, contribute to the longer term goal of reducing GBV prevalence by focusing on the following set of intermediate level outcomes.

19. The objectives of the Project are to increase in Targeted Health Zones: (i) the participation in GBV prevention programs; (ii) the utilization of multi-sectoral response services for survivors of GBV; and (iii) in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

B. Project Beneficiaries

20. **The project will aim to initially consolidate gains made in North and South Kivu, building on the lessons-learned under the Great Lakes Emergency Sexual and Gender-Based Violence and Women's Health Project (P147489 – GL GBV). The project will subsequently expand activities (from Year 2 of project implementation) to Tanganyika and Maniema.** These provinces were selected given the underlying high level of GBV (and acceptability of such violence) which has been aggravated by the conflict and instability.[30] By expanding operations to these Provinces, the project will be able to draw on the implementing structure already put in place in Eastern DRC. Importantly, given the rapidly changing security situation in Tanganyika, the project will further validate the selection of Health Zones during Year 1 of project implementation to confirm accessibility of the target areas (additional information on the targeting approach is provided in Annex 4).

[28] The F13-16 CAS has been extended to FY18 while the new Country Partnership Strategy is being finalized
[29] The World Bank is currently developing a new Country Partnership Framework for 2018-2021.
[30] In line with the 2018 UNOCHA Humanitarian Situation Analysis

21. **The Kasaï Famine Risk Reduction Project (P162517) currently under preparation will include targeted interventions on GBV prevention and response.** The current project will therefore not target the Kasaï Province but will, however, include the development of a targeting and roll-out strategy for GBV programming in the Kasaï as well as in Equateur Province. This will allow the project to develop: (i) tailored approaches to GBV programing in these areas, given the cultural dynamics underpinning high levels of such violence; and (ii) assess the most suited operational delivery modalities given the logistical challenges of implementation and significant additional costs of establishing programs in areas with limited presence of potential implementing partners (Additional details are provided in Annex 1).

22. **The project is expected to reach 785,000 direct beneficiaries of which approximately 400,000 women. Project beneficiaries will primarily include vulnerable women and girls at risk of GBV as well as survivors of GBV. Men and boys in targeted health zones will also benefit from project activities** as survivors of GBV, as family members of survivors and as key opinion leaders and community members promoting behavior change through GBV prevention programs.

23. **The institutional strengthening elements of the program will be national in scope and will target key line ministries and institutions:** Fonds Social DRC (FSDRC), Ministry of Health staff, Ministry of Gender, Family and Children and the Office of the Presidential Representative for Gender-Based Violence. These interventions will focus on the: (i) in service training for front line staff in the health sector, (ii) capacity building in GBV data collection, management and analysis; and (iii) the development of a basic package of community level prevention and response services for GBV.

24. **Community level GBV prevention and integrated support for survivors and the strengthening of first response services will be concentrated in the 38 Health Zones outlined in Table 2 below with an estimated population of 13.5 million people.**

Table 2: Target areas for community level prevention and response services

Targeted Health Zones			
South Kivu	**North Kivu**	**Maniema**	**Tanganyika**
1. Fizi	1. Binza	1. Kasongo	1. Kalemie
2. Kaniola	2. Kayna	2. Kibombo	2. Niemba
3. Kimbi/Lulenge	3. Mabalako	3. Kabambare	3. Nyunzu
4. Shabunda	4. Alimbongo	4. Kunda	4. Manono
5. Lulingu	5. Lubero	5. Lusangi	5. Moba
6. Minova	6. Kalunguta	6. Tunda	
7. Lemera	7. Mutwanga	7. Samba	
8. Kalonge	8. Nyirangongo	8. Saramabila	
9. Mulungu	9. Rwanguba		
10. Kitutu	10. Ruthshuru		
11. Kalole	11. Kirotshe		
12. Haut plateau	12. Masisi		
	13. Mweso		

25. **Intensive community level GBV prevention and community referral interventions will be undertaken in**

selected *Aires de Santé* [catchment area for each health center with a population of between 5,000 and 7,000 people]. This will include more intensive gender transformative training with community and opinion leaders as well as life-skills and livelihood interventions targeting women and men. Criteria for selection of benefiting Aires de Santé will be developed and included in the Project's Implementation Manual (PIM). A rapid assessment of targeted Health Zones will be undertaken and shall form the basis for selection of the *Aires de Santé*. The final proposed list of *Aires de Santé* will be shared with the World Bank for approval within three months of project effectiveness.

C. PDO-Level Results Indicators

- Numbers of direct project beneficiaries (percentage of women);
- Percentage reported decrease in accepting attitudes towards GBV in targeted Health Zones;
- Percentage increase in reported cases who receive access to multidisciplinary services, defined as at least two of the following: (medical, psychosocial, security, legal support and livelihoods support);
- Percentage of eligible reported GBV[31] cases who receive Post-Exposure Prophylaxis (PEP) Treatment within 72 hours;
- Percentage of implementing partners providing services to GBV survivors in line with defined quality standards.

III. PROJECT DESCRIPTION

A. Project Components

27. **Gender-Based Violence prevention programs require a sustained investment over a long period of time to achieve impacts in terms of reduction in GBV incidence.** Social norms and values that may condone GBV change slowly. By focusing on: (i) whole of community awareness raising approaches, gender-transformative training and livelihood interventions; and (ii) combining prevention approaches services for survivors the project aims to have an impact in terms of changes in attitudes towards GBV. Positive outcomes are also expected in terms of: (i) greater decision-making power for women at household level; (ii) a decrease in the experience of violence; and (iii) higher rates of service seeking behavior by survivors of GBV. **An overview of the proposed approach is outlined in Figure 4 below.**

28. **In line with global best practices and based on the lessons-learned during the implementation of the GL GBV, the project will focus on:**

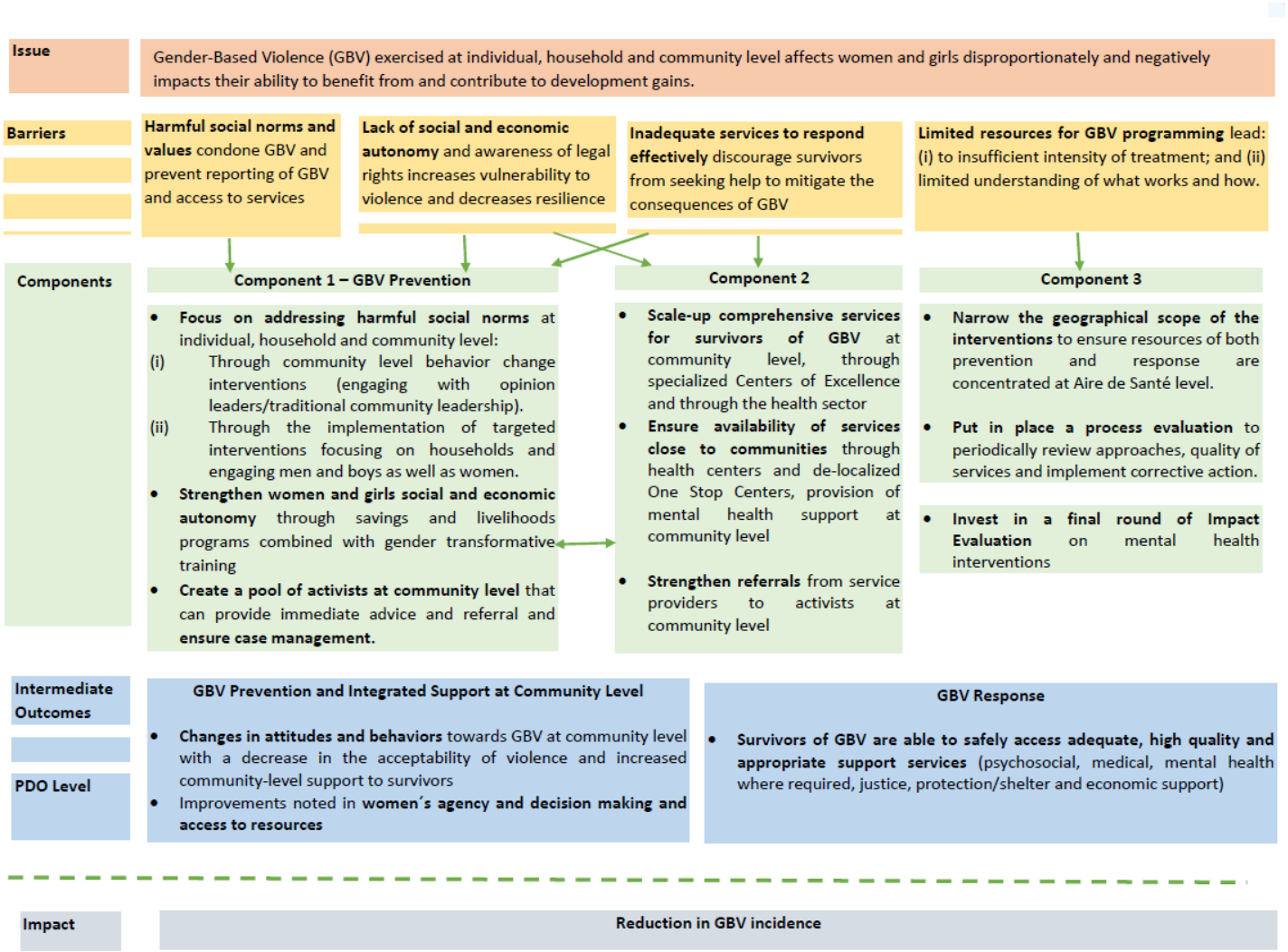
i. **Preventing GBV and improving the quality of multi-sectoral response services for survivors in targeted health zones.** Global evidence indicates that effective prevention programs encourage GBV survivors to come forward and seek services. The project will support awareness raising and gender transformative training at community level and invest in the creation of a pool of community activists that provide adequate case management and act as victims'

[31] Eligible GBV cases for PEP (provision of antiretroviral medicine following potential exposure to HIV) are usually cases of rape that are reported at a service provider within 72 hours of the incident.

advocates/ensure the referral to key services for survivors. The project will build on the experience of implementing the GL-GBV project and significantly increase the level of resources allocated to prevention activities as well as livelihood interventions;

ii. **Working primarily through partnerships with civil society organizations for service delivery while including an element of training and capacity building of the health sector for GBV response.** This approach acknowledges the challenges of providing quality services at community level given capacity constraints and growing instability in some of the areas potentially targeted. Challenges include inadequate staffing levels at the level of health facilities, increased difficulties in accessing services giving the worsening security situation, significant case backlog and "systems failures" in the criminal justice system and in terms of the services provided by security forces.

Figure 4: Overview of the proposed approach



Component 1 - Gender-Based Violence prevention and integrated support for survivors at community level (US$54.5 million equivalent to SDR 38 million

29. **The project will support the delivery of an integrated package of prevention of GBV and targeted assistance to survivors at the community level** while promoting gender equality, behavioral change and violence prevention in the targeted health zones.

30. **In order to address the underlying causes of GBV and to tackle the social norms and values that may condone GBV, the project will invest significantly in awareness raising and behavior change communication at individual, interpersonal and community level**. [32]The approach to prevention will be based on rigorously evaluated models which have shown to be effective in the context of the DRC or in comparable contexts. Particular attention will be paid to taking into account the context of insecurity and instability under which the project will operate.

31. **A detailed protocol for individual, interpersonal and community-based prevention and referral activities will be developed by the Fonds Social DRC (FSDRC) by project effectiveness.** The protocol will include the selection of *Aires de Santé* to be targeted within the selected Health Zones. The protocol will be used as the basis for selecting Non-Governmental Organizations (NGOs) who will implement prevention activities as well as community level response interventions and referral to more specialized services. In order to streamline implementation arrangements one Umbrella NGO will be selected per Province for the implementation of Component 1. The umbrella NGO will in turn establish partnerships and sub-contracting arrangements with local NGOs and Community Based Organizations (CBOs) where relevant. The structured transfer of technical expertise to CBOs is expected to contribute to the sustainability of the prevention and community referral approach put in place.

32. **The implementation of GBV prevention activities at community level will build on a critical mass of qualified and reputable community activists including para-legals and para-social workers, teachers, religious leaders, mobilizers, community health workers (*relais communautaires)* and members of women's community-based organizations.** This pool of activists will receive training on community awareness raising and behavior change interventions as well as on the referral of survivors. In addition, to ensure that activists will share a core set of knowledge, attitudes and beliefs that promote women's equality, they will undergo in-depth gender transformative training that will provide them with the tools to challenge the social norms that condone violence against women and girls. This is expected to contribute to providing, GBV survivors with a set of trusted individuals within the community to whom they can report violence and through whom they can access services. This approach will aim to broaden the current set of community mobilizers and focal points trained under the GL GBV project as first responders to the needs of survivors.

i. *Community mobilization and promotion of behavior change*: Building on the training and mentoring of the pool of community activists mentioned above, the project will implement a community mobilization intervention targeting opinion leaders, community based organizations as well as older men and women who play a key role in perpetuating accepting attitudes towards GBV. Male engagement in this process will aim to communicate that violence is an issue that needs solving at the community level rather than a private matter or a 'women's issue'.

[32] Over 50% of project resources will support the implementation of prevention activities

ii. *Livelihood interventions:* Building on the experience of the GL GBV Project, the project will support the establishment of Village Savings and Loans Associations (VSLAs). The approach will focus initially on supporting women to build savings. Dedicated technical support will be provided by the Umbrella NGO to group formation. As VSLAs are consolidated, those that have the demonstrated capacity will be further supported with business development skills. Community-based organizations will also be supported to organize small-scale income-generating activities. These activities will be selected through a market analysis of economically viable options in each Health Zone and will provide an opportunity for referral of survivors.

iii. *Gender transformative training:* Gender transformative training will be conducted to address gender inequality at the household level. This will include a focus on communication and conflict management skills. In addition, community facilitators will be selected among the pool of trained activists to implement behavior change activities with men focusing on positive masculinities.

33. **In addition, the project will support the establishment of safe spaces for women and girls at community level:** The GL GBV Project has supported a network of CBOs in North and South Kivu. These CBOs provide a key point of entry for survivors of violence in terms of access to psycho-social support and referral to additional services. The project will broaden the scope of activities by CBOs and focus on the establishment of safe spaces at community level. These spaces will be used for awareness raising and information sessions (including on the availability of services for survivors of GBV), life-skills activities but also informal gatherings and implementation of livelihood activities. Activities implemented in the safe spaces will aim to create an environment of trust around service delivery at community level and encourage service seeking. This will be done by ensuring that services for survivors take place in a space that also offers other activities targeting women and girls more broadly (so that accessing services is not stigmatizing for survivors).

34. **Community safe spaces will establish a key link between prevention activities and community referrals and access to services.** In addition to the pool of activists highlighted above, focal points selected among CBO members will receive more in-depth training on the provision of psychosocial support and referral to additional services. The basic package of services and referrals provided at community level will be as follows:

    (i) Provision of case management, psychosocial support and mental health care using the Narrative Exposure Therapy (NET) approach provided by trained Focal Points at CBO level;
    (ii) Referral to specialized health services;
    (iii) Provision of initial legal advice by paralegals trained at CBO level (with more complex cases referred to specialized staff at the level of Umbrella NGO);
    (iv) Referral to safety and security services; and
    (v) Referral to livelihood activities.

35. **This component will support the provision of mental health care to survivors of GBV through community-based organizations.** In coordination with the National Mental Health Program at Ministry of Public Health (MoPH) level, the project will invest in the implementation of a training module for the provision of mental health care at the community level based on the approaches used in the GL GBV project. Training will be provided to selected NGO / CBO staff on the use of NET piloted as part of the GL GBV project. The FSDRC will contract VIVO International for the provision of these specialized services.

36. **Finally, acknowledging the fact that project implementation will take place in a volatile security context, component 1 will include resources to support the implementation of innovative prevention programs.** This will allow the project to be flexible and respond to the potential need to target specific groups through its prevention component. This could include: (i) behavior change communication interventions with the armed forces using methodologies tested in Eastern DRC; or (ii) targeted activities focusing on highly vulnerable population groups such as internally displaced communities, or youth.

Component 2 – Response to Gender-Based Violence (US$ 27.5 million, equivalent to SDR 19.1 million)

37. **Complementing GBV prevention activities and the immediate support for groups most at risk of GBV, put in place at community level, the project will also strengthen front-line service provision for survivors** with a strong focus on improving: (i) multi-sectoral response for the most complex cases and; (ii) the quality of medical services. Building on the experience of the GL GBV project and the challenges in operationalizing activities with the health sector, the project will strengthen service provision through integrated Centers of Excellence (CoE) with a focus on outreach activities and supporting de-centralized One Stop Centers at Health Zone level. The project will also invest in targeted capacity building of the health sector to bring medical services for survivors of GBV closer to communities.

38. Sub-Component 2A – Support for existing integrated Centers of Excellence (US$20.7 million): This sub-component will support the specialized referral facilities: (i) Panzi Hospital and Foundation in South Kivu; and (ii) Heal Africa in North Kivu. Services provided by these facilities will include: (a) medical care, including for the most complex cases; (b) forensic evidence collection, analysis and training; (c) legal services; (d) facility based counseling; (e) support services for survivors and their children rejected by families; (f) mobile clinics in remote areas to reach the most vulnerable groups; (g) training and capacity building for health providers on performing complex surgeries, compiling forensic evidence, and providing high quality medical and mental health services; and (h) operational research on GBV (where relevant). Through the training provided by the CoEs the project will also aim to strengthen forensic response capacity among Health Care Providers (HCP). Forensic training will focus on HCP, police and the judiciary with a focus: (i) handling of forensic evidence, (ii) preparing for hearings and; (iii) the filling of police and medico-legal forms.

39. In addition to the activities highlighted above, the project will support the provision of specialized services in decentralized One Stop Centers currently managed by Panzi Foundation and Heal Africa as well as outreach activities in hard to reach Health Zones targeted by the project. Mobile clinics and outreach services will also be supported in Maniema (Heal Africa) and Tanganyika (Panzi Hospital and Foundation). A detailed FM assessment of both centers was carried out during preparation and the summary of key findings is included in Annex 2.

40. Sub-Component 2B – Strengthening the Health Sector Response to GBV (US$6.8 million). The main objective of this sub-Component will be to strengthen the health sector responsiveness to GBV. Key activities under this sub-component will be as follows:

41. *Training of HCPs, including community health workers in targeted Aires de Santé, in response to GBV*. Training will include: (a) GBV case screening, medical case management, including the collection of forensic evidence; (b) updating and disseminating management protocols and guidance notes for practitioners (job

aides) developed specifically for the health system; and (c) finally, this subcomponent will finance small rehabilitations of health facilities (painting, small internal repairs and provision of screens or partitions as well as secure cabinets) to create adequate conditions for consultations where they currently do not exist. In this context, the project will finance internal repairs and rehabilitation of these facilities where relevant without extending the footprint of existing hospitals or health centers.

42. *Support for service provision at hospital and health center level.* The project will build on the lessons-learned during the implementation of the GL GBV project in terms of the coordination with the Performance Based Financing (PBF) approach currently in place in North and South Kivu[33]. Considering the challenges observed in the implementation of the GL GBV project in North and South Kivu and the project will adopt the following approach:

i. Lump sum payments to Health Structures and Provincial Directorates of Health (PDH) in North Kivu, South Kivu and Tanganyika for quality services provided to survivors of violence. Such payments will be made against an assessment of the quality of the services provided. Payment will be linked to quality and not the numbers of survivors assisted to avoid creating perverse incentives that may result in an over-reporting of cases;

j. The assessments of the quality of the services provided by health centers will be carried out by the PDH and Health Zone Supervision teams using the evaluation quality grids put in place by the PBF;

k. Resources will be allocated to the PDH for the supervision and validation of the quality of the services. This quality assessment will be done with relevant experts from the National Reproductive Health and National Mental Health Programs and in coordination with the Umbrella NGO responsible for the referral of cases (in order to ensure the triangulation of the information);

l. Resources will be managed directly by the FSDRC and funding allocated will be included in the "Single Contract" currently in place in North and South Kivu to ensure that all amounts for supervision are captured at Provincial level and shared with partners providing funding to the PDH.

43. *In Maniema, the current project will align itself with the PBF approach and focus on the same eight Health Zones currently covered by the PDSS.* The quality assessment tools for the PBF will be updated to take into account the medical care of survivors. Certified evaluators among PDH Health Zone supervision teams will be trained on the use of this updated quality assessment grid. Service providers will be oriented on the type and standards of care required by survivors of GBV. An assessment of PBF readiness to include payment for services provided to survivors of GBV will be undertaken during Year 1 of project implementation. Based on the results of this assessment resources will either be programed through the PBF mechanism for service provision or will be allocated following the mechanism also used in the remaining provinces and described in paragraph 42 above.

[33] with IDA financing through the Health Systems Strengthening Project (PDSS)

44. *Procurement of emergency medication for survivors of GBV will be done directly through UNFPA*. This will include Post Exposure Prophylaxis (PEP), emergency contraception and treatment for Sexually Transmitted Diseases (STIs). Distribution will be carried out through the Regional Distribution Centers (CDRs) covering the targeted Provinces where these are functional: Asrames (*Association Régionale D'Approvisionnement en Médicaments Essentiels*) in North Kivu, Cedmeta (Tanganika), Cemema (Maniema), and *Dépôt Central Médico-Pharmaceutique* (South Kivu). An assessment of the functionality of the CDRs in Maniema and Tanganyika will be carried out within six month of project effectiveness and alternative approaches to distribution of these supplies developed where necessary. The FSRDC will sign contracts with these different CDRs to cover the costs of stock management and drug distribution.

Component 3 – Support to Policy Development, Project Management and Monitoring and Evaluation (US$17.9 million equivalent to SDR 12.5 million)

Sub-Component 3 A – Support to Policy Development and Capacity Building (US$1.6 million)

45. The project will aim to strengthen coordination mechanisms for GBV programming. In addition to technical coordination meetings chaired by FSRDC at National, Provincial and Health Zone level, the project will participate regularly in the GBV Inter-Ministerial Coordination group. This will aim to ensure that project activities are aligned with the efforts of other DPs and that information on project results are reflected in the GBV national monitoring system managed by the Ministry of Gender, Family and Children.

46. The project will also support the efforts by the Ministry of Gender, Family and Children and the Office of the Presidential Representative for GBV to safely and ethically map GBV programming interventions. In that regard, the project will conduct an assessment of the design and implementation of the existing national GBV database compared to global standards of good practice in GBV information management. The results of this assessment will be shared with the development partners network, and will determine the level of support that the project can provide to the national GBV database, with particular emphasis on measures that will further align it with global best practices.

47. This sub-component will fund the dissemination of the 2016 Family Code and Law on Sexual Violence at community level using the CBO and community activist platform put in place under Component 1. The project will further support the dissemination of the Victim Compensation Act (once approved by Parliament). In addition, the project will convene key actors engaged in the revision of National Medico-Legal certificate for the finalization of the certificate and guidelines on its utilization (in coordination with the Development Partners Group on GBV). The establishment of a simplified, user-friendly certificate will play a key role in easing access to forensic services by survivors of GBV.

48. Finally, this sub-component will support the development of a targeting and roll-out strategy for GBV programming for the Kasaï and Equateur Provinces. (Additional details are provided in Annex I).

Sub- Component 3 B – Project Management (US$9.9 million)

49. *This sub- component will cover overall project management costs* to ensure efficient and effective coordination, fiduciary management at national and local levels. This will be done through dedicated

support to the implementing agencies, institutional strengthening and purchase of critical equipment. This component will include support for strengthening existing coordination structures, the sustainability of project activities and the training of critical staff at national and sub-national levels.

50. Given the substantial fiduciary risk involved in project implementation, component 3 will cover the costs of a third party Financial Management Agent (FMA). The ToRs for the FMA were completed during project preparation and were considered acceptable to the WB and the bidding process was initiated. The FMA will allow the project to closely monitor transactions related to Components 1 and 2.2 where fiduciary risk is considered high.

Sub-Component 3C – Monitoring and Evaluation (US$6.4 million)

51. Given the volatile security situation and expected challenges in terms of project supervision significant resources have been allocated to this sub-component. This will allow the WB and FSDRC team to rely on a robust Management Information System (MIS) and to triangulate the information provided through the MIS with data from external quality reviews, community-based monitoring and impact evaluation data.

52. *This sub-component will ensure effective data collection on the implementation of key project activities.* The project will fund the upgrading and roll-out of the MIS currently being used by the GL GBV project[34]. In addition, the project will include a third-party process evaluation to provide feedback on the quality of services rendered. The use of this methodology is expected to allow the FSDRC to make periodic adjustments to implementation strategies and put in place corrective action as needed.

53. *In addition, this sub-component will fund an impact evaluation of mental health activities. This will be in line with NET impact assessment, initiated as part of the GL GBV project*. This impact evaluation will be conducted by researchers from the World Bank's Africa Gender Innovation Lab. The purpose of this study is to evaluate the impact of NET on the mental health, psychosocial well-being, and economic empowerment of SGBV survivors with symptoms of PTSD. (Additional details are provided in Annex I).

Component 4: Contingency Emergency Response Component (CERC) (US$0 million)

54. This component will provide immediate response in the event of an eligible crisis or emergency. This component is a "zero-dollar" Contingency and Emergency Response Component. In the case of an adverse event that causes a major disaster, the Government of DRC may request the World Bank for the rapid reallocation of grant proceeds from other components in order to provide preparedness and rapid response support to disaster, emergency and/or catastrophic events, as needed. The funds flow and disbursement arrangements will be determined at the time of activation of the contingency component and will require an amendment to the Project´s Operations Manual (PIM).

[34] Based on the GBV Information Management System.

B. Project Cost and Financing

Project Components	Project cost	IBRD or IDA Financing	Trust Funds	Counterpart Funding
Total Costs	US$100 million	US$100 million	0	0
Total Project Costs	US$100 million	US$100 million		
Front End Fees	0	0	0	0
Total Financing Required	US$100 million	US$100 million	0	0

Table 3 below presents the total summary costs and indicated International Development Association (IDA) financing for the proposed project (by Component and year).

Table 3: Summary Project Costs

Component	Amount US$	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Component 1	**54,554,792**	**17,442,215**	**10,235,205**	**13,850,215**	**7,896,201**	**5,130,958**	**54,554,793**
Component 2.A	20,714,840.91	4,531,110	3,279,794	5,041,408	4,390,724	3,471,805	20,714,841
Component 2.B	6,766,459	1,486,583	892,833	1,668,181	1,359,431	1,359,431	6,766,459
Component 2	**27,481,300**	**6,017,693**	**4,172,627**	**6,709,589**	**5,750,155**	**4,831,236**	**27,481,300**
Component 3	**17,963,907**	**4,300,000**	**3,592,781**	**3,400,000**	**3,600,000**	**3,071,126**	**17,963,907**
Component 3.A	1,634,500	326,900.00	326,900.00	326,900.00	326,900.00	326,900.00	1,634,500
Component 3.B	9,973,867	1,994,773	1,994,773	1,994,773	1,994,773	1,994,773	9,973,867
Component 3.C	6,355,540	1,978,327	1,271,108	1,078,327	1,278,327	749,453	6,355,540
TOTAL	**100,000,000**	**27,759,908**	**18,000,614**	**23,959,804**	**17,246,356**	**13,033,320**	**100,000,000**

C. Lessons Learned and Reflected in Project Design

55. A review of global evidence on effectively addressing GBV finds that a holistic approach that focuses both on prevention of GBV and on providing support services to survivors is critical. Key elements of these approaches have been included in the proposed project design[35]. In addition, project design was able to benefit from the Mid-Term Review of the DRC component of the GL GBV project in terms of: (i) reviewing and strengthening the package of interventions implemented at community level; (ii) streamlining implementation arrangements; (iii) strengthening coordination with the health sector and; (iv) simplifying analytical and knowledge exchange activities.

[35] These best practice principles have also been applied in the design of other WB supported GBV interventions (namely in Rwanda and DRC as part of the Great Lakes Emergency GBV initiative, and in Uganda).

Global Best Practice and Lessons from GBV Programming

56. **Physical and sexual violence is usually accompanied by psychological trauma and violation of laws. Survivors are therefore normally in need of multi-faceted assistance including medical treatment, health counselling, psycho-social and paralegal support.** Response programs will also need to include elements of economic empowerment for survivors. The ability to secure an independent income is often a key factor in reducing the survivor's economic dependence on the perpetrator and in improving resilience to violence. Findings across all sectors have identified the need for collaboration between law enforcement, legal aid services, health care organizations, public health programs, educational institutions, and agencies devoted to social services and economic development. For example, identifying survivors at a health clinic requires a host of follow-up responses from the judicial sector and social services. Collaboration across sectors is therefore essential.

57. **Prevention of GBV will need to focus on behavioural change, addressing social norms and involving men and boys.** Addressing the underlying causes of GBV, such as imbalanced power relations between men and women, attitudes, beliefs, and practices that exclude women and are deeply entrenched in society's beliefs and practices requires a long-term engagement and explicit focus on changing gender norms. Comparing different forms of prevention and awareness raising activities, global evidence shows that integrated approaches that include community outreach, participatory workshops and promote reflection and debate to explicitly change gender roles tend to show more promising results. It is key that programs that aim to prevent GBV recognise that violence is the outcome of the complex interaction of factors that play at individual, interpersonal (families and households), community and societal level. To be effective, prevention interventions need to promote change at all these levels.

58. **Global evidence has indicated that including men in programs is especially important for prevention.** Such programs need to acknowledge men's multiple roles as perpetrators, as witnesses, service providers, decision-makers and policymakers, as change agents as well as survivors of GBV.

59. **Lessons-learned from GBV interventions indicate that the implementation of prevention programs is most effective when accompanied by improvements in access to services by survivors.** Prevention activities encourage survivors to come forward hence demand for response services is likely to increase. Gaps in access to services in these instances can undermine the credibility of service providers and put survivors at greater risk. Providing adequate health care, addressing issues of impunity of perpetrators and ensuring security of survivors will be a key element of an integrated approach and will need to accompany prevention activities.

60. **Partnerships between government and multiple stakeholders (including civil society organizations) has a number of benefits.** Partnering with specialized agencies, NGOs and faith-based institutions can allow government institutions to draw on: (i) existing expertise for the provision of specialized services (including for the provision of psycho-social support and mental health services); and (ii) existing networks for prevention interventions at community and household level working on norms and values.

Building on the experience of the Great Lakes Emergency Sexual and Gender-Based Violence and Women's Health Project (GL GBV)

61. **The Mid-Term Review (MTR) for the GL GBV project highlighted the importance of shifting the focus towards prevention and behavior change activities at community level**. In addition, consultations with implementing partners and communities indicated that a greater weight on livelihood activities and less emphasis on legal aid/access to justice would be important. (Additional details are included in Annex I). The focus on prevention and broader dissemination of information is also considered key to create an environment of trust where survivors of violence are better able to request for services. Access to income generating opportunities was considered critical for survivors and consultations highlighted the barriers in accessing VSLA activities on the part of survivors. A staggered approach to VLSA establishment to allow referral of survivors to these groups and the support for simple subsistence level livelihood activities through CBOs were introduced as design elements in the current project to address these issues.

62. **Intensity of treatment at Health Zone level and strengthening referral mechanisms.** The MTR identified the need to further co-locate psychosocial support, case management and legal aid interventions at community level and to strengthen the current community-level referral mechanisms. The composition of field level teams under Component 1 of the current project takes this into account with paralegals to be trained at CBO level so they can act as the first "port of call" for survivors seeking legal aid. In addition, the current project will increase the number of community facilitators and activists at community level and concentrate efforts in selected *Aire de Santé* to ensure adequate intensity of prevention and response services and a closer connection with other front-line service providers.

63. **Institutional and implementation arrangements.** Building on the lessons learned from the GL GBV project, the current project will be coordinated by the FSDRC given its track record of successfully overseeing the implementation of multi-sectoral support for survivors. To address the challenges observed with GL GBV implementation, contracting under Component 1 has been streamlined with one Umbrella NGO responsible for community level activities per Province. In addition, improved mechanisms for coordination with the health sector will be put in place through a set of implementation arrangements with the PDH with terms and conditions satisfactory to the World Bank (that include clear obligations and responsibilities for providing health services). Direct payments will be made by the FSDRC to health facilities.

64. **Focus on assessing the quality of services.** The MTR also identified the importance of periodically assessing the quality of services provided. An initial quality review and social audit will be undertaken under the GL GBV. Initial results were discussed during project preparation and taken into account in terms of project design. In addition, a process evaluation has been included under Component 3 to ensure that critical aspects of service quality continue to be assessed and feedback regularly provided to the FSDRC and specialized service providers.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

65. **The project will be implemented by the Fonds Social DRC (FSDRC) and in close technical partnership with the Ministry of Publich Health (MoPH).** The FSDRC will be responsible for overall project management and consolidation of Annual Work Programs and Budgets. A single Designated Account (DA) will be established at the level of the FSDRC with Provincial Sub-Accounts in place for all targeted Provinces. The FSDRC will procure specialized service providers for the implementation of Component 1 and engage VIVO International for the provision of mental health services using the NET approach. The FSDRC will further sign contracts with the Integrated Centers of Excellence (Panzi Foundation and Hospital and Heal Africa) for the implementation of Component 2A.

66. **To streamline implementation arrangements for Component 2B and building on the lessons-learned from implementation in North and South Kivu, the FSDRC will establish a set of implementation arrangements with the PDH with terms and conditions satisfactory to the World Bank (that include clear obligations and responsibilities for providing health services).** The FSDRC will be responsible for payments made to Health Facilities (Hospitals and Health Centers), PDH and Health Zones Supervision teams in North Kivu, South Kivu and Tanganyika. In Maniema the project will aim to align with the PBF approach and target the same eight Health Zones currently being supported by the Health Systems Strengthening Project (PDSS). Funds for the provision of services and verification of quality of services may be channeled through the MoPH. The FSDRC team will conduct a review of the functionality of the PBF system in Maniema with MoPH and agree on whether to follow the approach outlined above for the remaining Provinces or to channel resources through the PBF mechanism (Figures 5 and 6).

67. **The FSDRC will be responsible for the procurement of emergency supplies through UN Agencies and for establishing contracts with Regional Medication Distribution Centers for the distribution of these supplies in targeted provinces.** The Ministry of Gender and Office of the Presidential Representative for GBV will prepare annual activity plans for the implementation of activities under Component 3A. Payments for supervision and activity costs will be made directly by the FSDRC in line with the agreed activity plans.

Figure 5: Implementation Arrangements (North and South Kivu and Tanganyika)

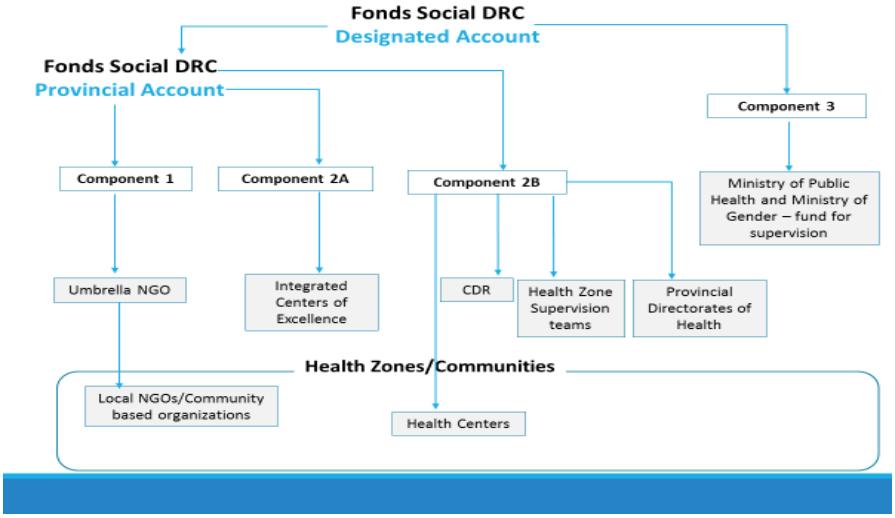
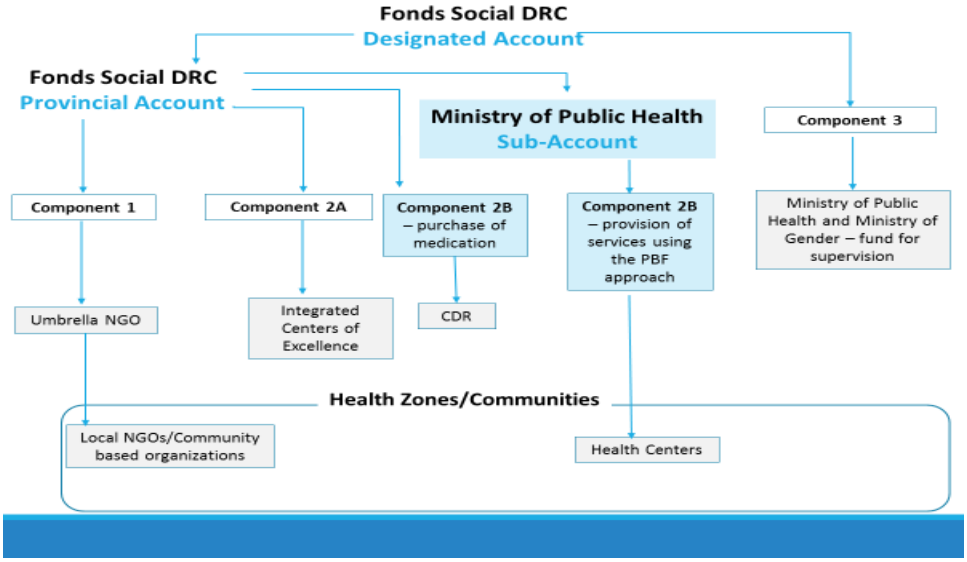


Figure 6: Implementation Arrangements (Maniema)



68. National and Provincial Coordination mechanisms: The project will ensure consistent participation in: (i) the Inter-Ministerial Working Group on GBV chaired by the Ministry of Gender, Family and Children at national level; and (ii) in the Provincial GBV Cluster Coordination meetings. In addition, monthly technical meetings will be held at national and Provincial level with FSDRC, MoPH, and specialized service providers. The technical coordination meetings will review critical issues with project implementation and identify concerns

that should be discussed and addressed through the Inter-Ministerial Working Group. The PIM will include the detailed description of the functions of participating institutions and local governments.

69. **Role of Umbrella NGOs and Integrated Centers of Excellence:** The FSDRC shall procure Umbrella NGOs contracted to provide GBV prevention interventions at household and community levels in the areas of: (i) community mobilization, (ii) livelihood support, (iii) establishment of safe spaces; (iv) community based referral and integrated service provision using evidence based GBV prevention and response approaches. VIVO International will be contracted to provide specialized mental health support using the NET approach. The Integrated Centers of Excellence Panzi Foundation and Hospital and Heal Africa will be contracted to provide: (i) medical care, (ii) forensic evidence collection, analysis and training; (iii) legal services; (iv) facility based counseling; (v) support to survivors and their children rejected by families; (vi) mobile clinics; (vii) training and capacity building for health providers; and (viii) conduct operational research on GBV where relevant. Umbrella NGOs and CoEs shall submit quarterly progress activity reports to the FSDRC Heads of Field Offices persons based on their respective work plans and budgets. Umbrella NGOs and CoEs will submit biannual project technical and financial reports to the FSDRC.

B. Results Monitoring and Evaluation

70. **Project preparation has indicated that there are significant gaps in terms of data collection on GBV through existing sources of routine data**. The project will invest in further strengthening the project specific Management Information System (MIS) using the GBV Information Management System (IMS) format and on improving the quality and reliability of project specific data. For activities under Component 1, specialized service providers will ensure the monitoring and tracking of GBV prevention activities and the provision of multi-sectoral services to GBV survivors given their critical role in ensuring effective referrals and serving as victim-advocates during the referral process. Under Component 2, data on provision of health services will be tracked using existing/routine data collection systems by MoPH. Indicators selected to track progress take into account the existing constraints in terms of data collection.

71. **The project will support efforts by the Ministry of Gender, Family and Children and the Office of the Presidential Representative for GBV to safely and ethically map GBV programming interventions**. In that regard, the project will conduct an assessment of the existing national GBV database. The results of this assessment will be shared with development partners, and will determine the level of support that the project will provide to the national database. Particular emphasis will be placed on further aligning it with global best practices.

72. **The project will include a process evaluation to closely monitor the quality of services provided as well as an impact evaluation focusing on mental health interventions.** This will include a final round of data collection to complete the evaluation process initiated under the GL GBV Project.

73. **The FSDRC will submit narrative progress reports every six months and quarterly Interim Financial Reports (IFRs) to the World Bank in accordance with the reporting requirements to be set out in the PIM.** The Mid-Term Review will provide the opportunity to assess progress for appropriate mid-course corrections as needed.

C. Sustainability

74. **Project design takes into account the context of fragility under which the intervention will be implemented**. In particular, the significant gaps in terms of public service provision mean that the implementation of GBV prevention and response services will rely heavily on civil society organizations. Community-based interventions supported by the project will aim to establish a network of trained activists and Community Based Organizations as well as Village Savings and Loans Associations to improve the sustainability of community-level interventions. Component 1 will fund systematic institutional strengthening of local organizations. In addition, building on the lessons-learned from the GL GBV project, the intervention will continue to invest significantly in the capacity of health sector service providers and ensure the provision of medical services at public hospital and health center level.

D. Role of Partners

75. **Consultations were held with bi-lateral, multi-lateral partners and civil society organizations during project preparation (please see Annex 4 for further details)**. A detailed mapping of current interventions in the area of GBV prevention and response was carried out during project preparation with the support of UNFPA. The mapping exercise was critical to identify areas where other partners are already playing a leading role and where it will be important to create synergies or to avoid duplication of efforts (primarily by informing the project health zone targeting approach).

76. **There is growing interest among partners to support evidence-based approaches to GBV programing.** A current assessment of GBV service provision in DRC (with a specific focus on the support to One Stop Centers) is currently under way under the coordination of UNFPA. The FSDRC is currently engaging with this exercise through the GL GBV project and will ensure that lessons-learned are integrated in the interventions planned under Component 2A. Project preparation indicated that there are a number of challenges with overall coordination of GBV interventions by the MGFC. The project will seek to support these efforts by ensuring systematic participation in coordination mechanisms, sharing of information with MGFC and strengthening the national database on GBV.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

77. **The risk rating for this project is high before mitigation, but could be reduced to substantial with effective implementation of the proposed mitigation measures.**

78. **Macro-economic** risk is rated substantial given high inflation and depreciation of the local currency. This risk will be partly mitigated by incurring most project expenditures in US$ including contracts with NGOs for the implementation of component 1 and with UNPFA for the purchase of essential medication.

79. **Political and Governance**. Governance and capacity challenges in the sector are high. Growing political instability and insecurity in the targeted provinces may significantly hamper project implementation. The

project will partner with integrated CoEs for essential service provision. The CoEs have extensive experience of delivering services in emergency settings, including through mobile clinics and de-localized One Stop Centers in North and South Kivu. This would allow the project to maintain life-line services should the security situation worsen considerably. In addition, the project has included a Contingency component that would allow for a reallocation of resources should priority areas of focus change for GBV programing due to an emergency situation.

80. **Technical design of project or program.** Technical design risk is substantial. The multi-sectoral nature of interventions addressing GBV and the need to focus simultaneously on prevention and response interventions based on global best practices require a relatively complex design. The proposed technical design requires strong coordination of NGO partners. In order to mitigate the risk linked to design complexity, the project has streamlined implementation arrangements by reducing the number of contracts with civil society organizations and focusing on the selection of high capacity umbrella organizations. The project has further simplified coordination arrangements with the MoPH with Service Agreements to put in place at Provincial level between the FSDRC and PDH.

81. **Institutional capacity for implementation and sustainability.** The institutional capacity risk is substantial. Administrative capacities at Provincial level are weak and service provision to survivors of violence through public structures are limited. The project will mitigate this risk by establishing partnerships with experienced civil society organizations and by reinforcing the FSDRC Provincial teams. Acknowledging capacity constraints in terms of service delivery the project will also adopt a phased approach to implementation focusing initially on a consolidation of GBV interventions in North and South Kivu (building on the lessons-learned and experience of the GL GBV project). Expansion of project activities to Maniema and Tanganyika will take place from Year 2 of project implementation.

82. **Fiduciary**. Fiduciary risk is expected to be high and may be reduced to substantial following the implementation of the proposed mitigation measures. Financial management capacities to ensure strong internal controls and adherence to proper financial procedures and procurement are limited based on the fiduciary assessments carried out during project preparation. Therefore, the project will support measures for capacity enhancement, close oversight, and periodic audits to ensure efficiency and transparency during project implementation. In particular, the project will put in place an external Fiduciary Management Agency (FMA) to provide close monitoring support and supervision by project effectiveness.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

83. **There is a strong rationale for the public provision of GBV prevention programs and response services aimed at survivors.** The impacts GBV go beyond the specific impacts on individuals and affect public health, human capital of children and the productivity of survivors' and perpetrators. The World Bank ability to mobilize global and regional expertise to support the implementation of the proposed operation constitutes added value for Government of the DRC.

84. **The economic analysis of the project, as well as the strong rationale for addressing and preventing GBV, is based on the detrimental development impacts of GBV as well as its potential economic costs.** A full-fledged financial analysis was not feasible given the absence of detailed data on service costs and monetary costs of some of the development and individual effects of GBV. Gender-Based Violence is a violation of human rights and its pervasiveness reinforces gender inequities, but the burden on economic development may be equally significant.

85. **Some of the developmental impacts of GBV include, lower productivity and incomes for survivors (and also perpetrators), lower rates of accumulation of human and social capital (due in part to health effects), and generation of future violence (gender-based as well as other forms)**. Direct costs, those GBV expenditures such as healthcare and judicial services, as well as indirect costs, such as the value of lost productivity, are critical components of the economic cost of GBV. In developing contexts, direct costs may not accurately reflect the magnitude of GBV, since a lack of services or underfunding of services related to GBV as well as under-reporting may result in an artificially low rate of usage.

86. **A growing body of research has focused on understanding the consequences of GBV by estimating the effects on human development outcomes for women, girls, and their children, without attaching a monetary value to these effects.** Beyond both superficial and life-threatening injuries that require immediate attention, impacts on health and education of women and girls may be significant and pose a large financial burden to the health and education sectors. In DRC, project diagnostic work based on the 2014 DHS data estimates the human development impacts of GBV. The analysis found that survivors of violence have a higher average number of children ever born (4.0 versus 3.8). Overall 21 percent of women who were survivors had terminated pregnancies at some point compared to 16 percent of women who have not experienced GBV. Survivors of GBV are also more likely to deliver at home (26 percent) when compared to women who did not experience GBV (22 percent) and more likely to suffer from Sexually-Transmitted Diseases (STD). A high proportion of women who were survivors (49.6 percent) tended to suffer from bruises, injuries, sprain dislocations or burns due to partner's actions with 6 percent reporting suffering from bigger health issues such as wounds, broken bones, broken teeth or other injuries caused by their husband or partner.

87. **Children of female survivors of IPV also suffered significant impacts in terms of human development outcomes** – Children whose mothers were survivors of violence were more likely to have had diarrhea in the last 2 weeks prior to the survey compared to children whose mothers had not experienced IPV (22.6 percent versus 16.7 percent). A similar pattern was found in terms of immunization. The immunization rate[36] among the children of survivors of IPV was 5 percentage points lower that among children whose mothers had not experienced IPV.

[36] This refers to full immunization

B. Technical

88. **Project design follows global best practices in GBV programing both in terms of community based prevention activities and in the provision of quality services for survivors of GBV**. Design was informed by a thorough analysis of international good practices, a review of evaluated programs implemented in DRC or in comparable contexts, a stock taking of lessons-learned during the implementation of the GL GBV project as well as a detailed assessment of risk factors for GBV in DRC (please refer to Annex 5 for additional details). Extensive consultations were carried out with Government counterparts during preparation at both national and provincial levels. In addition, a series of consultative workshops were held with key bi-lateral and multi-lateral partners and civil society organizations with long-standing experience in the field of GBV prevention and response in the DRC.

89. **The GBV prevention interventions included in the design are based on the adaption of interventions evaluated using a quasi-experimental design.** Specifically, the project will implement community awareness raising interventions targeting opinion leaders and key community groups to address imbalanced power and gender relations[37]. In addition, the project will target groups at risk through dedicated life-skills and economic empowerment activities[38]. Both of these approaches have demonstrated significant results in reducing GBV prevalence and reducing accepting attitudes towards GBV.

90. **GBV interventions require a certain degree of complexity, given the multi-sectoral nature of the support to survivors and the need to focus on both GBV prevention and response.** Acknowledging the risk posed by such complexity in a fragile context such as DRC, the project focuses on: (i) prevention interventions led by specialized NGOs with a proven track record of implementation of GBV programs; (ii) investing in support to survivors using a dual approach which relies on high capacity Integrated Centers of Excellence (Panzi Foundation and Heal Africa) and investing in strengthening the health sector to improve the quality of front-line medical response; and (iii) Taking a phased approach to the expansion of services to Maniema and Tanganyika from Year 2 of implementation. Drawing on lessons-learned from the GL GBV project the intervention will support strategic activities by the Ministry of Gender, Family and Children and the Office of the Presidential Representative for GBV but will not initiate new partnerships with the Ministry for Social Affairs or Education during the current phase. This is expected to allow the project to consolidate the gains made with the health sector and overcome operational challenges in the provision of medical services as a first priority.

C. Financial Management

91. **The Fonds Social RDC (FSDRC) will be responsible for overall project management and the management of fiduciary aspects.** A financial management assessment of FSDRC was carried out at the central and the Provincial levels. The objective of the assessment was to determine: (a) whether the FSDRC has adequate financial management capacity to ensure that: (a) project funds will be used for purposes intended in an

[37] Abramsky et al (2014), *Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduced HIV risk in Kampala, Uganda.*
[38] Bandiera et al (2012) *Empowering Adolescent Girls: Evidence from a Randomized Control Trial in Uganda.* ELA is operated in Uganda by the NGO Bangladesh Rural Advancement Committee (BRAC)

efficient and economical way; (b) project financial reports will be prepared in an accurate, reliable and timely manner; and (c) the project's assets will be safeguarded. **Following the assessment, the residual fiduciary risk is considered substantial.**

92. **The FSDRC fiduciary team will have the overall responsibility for coordination of: (i) administrative and fiduciary aspects of the project, (ii) financial management, reporting and ensuring the smooth flow of funds to different agencies and; (iii) implementing institutions at decentralized and central levels**. The following actions will be undertaken to strengthen financial management performance: (i) recruitment of project fiduciary staff including a Finance and Administration Specialist, an Accountant, and a Treasurer in Kinshasa and an additional accountant in each of the field offices to work exclusively on this project; (ii) updating the GL GBV financial and accounting manual to accommodate the requirements of the new project; (iii) preparing a simplified financial and accounting manual for NGOs, Integrated Centers of Excellence and health facilities for components 1 and 2 as well as for the Ministry of Health for component 3; (iv) upgrading the project software (TOM2PRO) for deployment to the provincial level; (v) hiring a third-party FMA to provide close monitoring support and conduct in depth-reviews of transactions on a quarterly basis; (vi) improve transparency and availability of information on project implementation to the public including through the establishment of a Grievance Redress Mechanism (GRM). The format for IFRs and ToRs for the third-party FMA were agreed with the counterpart during pre-appraisal.

93. **A single Designated Account (DA) will be opened in a commercial bank following terms and conditions acceptable to IDA under the fiduciary responsibility of FSRDC.** The ceiling of the DA will be set at US$5.5 million equivalent to four (4) months expenditure forecast and will become effective upon grant effectiveness. The FSRDC will open sub accounts at provincial level. These sub-accounts will be used to pay all expenditures at the decentralized level. Replenishment of these accounts will be done at least once a month upon submission of an acceptable expenditure recap along with the required supporting documents. Payments from these sub-accounts will follow arrangements acceptable to the WB. The DA will be replenished against withdrawal applications supported by Statements of Expenditures (SOE) and other documents providing evidence of eligible expenditures as specified in the Disbursement Letter.

D. Procurement

94. **Procurement for goods, works, non-consulting, and consulting services for the project will be carried out in accordance with the 'World Bank Procurement Regulations for IPF Borrowers' (Procurement Regulations) dated July 2016 and revised in November 2017** under the New Procurement Framework (NPF). Procurement will also follow 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 1, 2016), as well as the provisions stipulated in the Financing Agreement.

95. **Procurement activities for this project will be carried out by the FSRDC (procurement unit within FSRDC at central and provincial levels).** The assessment carried out by the WB procurement team in DRC in February 2018 rated the procurement risk for the project high for the following reasons: (i) the country context and associated high risk, (ii) the fact that FSRDC currently does not have procurement specialists at provincial level (where all signed contracts will be implemented); and (iii) the fact that this project will be implemented under the WB NPF with which the FSRDC has no prior experience. The prevailing risk can be reduced to substantial provided that the corrective measures outlined in Annex 2 are implemented.

96. **As per Procurement Regulation requirements, the FSDRC has prepared a Project Procurement Strategy for Development (PPSD). The Procurement Plan (PP) for the first 18 months of project implementation has been developed in line with the analysis in the PPSD**. The PPSD focuses on ensuring that procurement activities are packaged to allow expedited implementation (see Annex 2 for more details on procurement).

E. Social (including Safeguards)

97. **The Project's geographical coverage includes North and South Kivu as well as Tanganyika and Maniema Provinces with presence of the Twa Indigenous Peoples' (IP).** To ensure that this IP group is able to benefit from the proposed project interventions, safeguard policy OP/BP 4.10 has been triggered. An Indigenous People's Policy Framework (IPPF) was cleared by the Regional Safeguards Advisor on April 27, 2018 and disclosed by May 3, 2018. An Indigenous People's Plan (IPP) will subsequently be prepared once targeted *Aires de Santé* have been defined for North and South Kivu as well as Maniema Province and Health Zone coverage validated for Tanganyika Province. Free, prior and informed consultations have been carried out with Twa communities. Some of the identified potential positive effects of the project for IP communities include increased use of available health care services as well as delivery of culturally appropriate GBV prevention and response services. It is therefore essential that civil society partners selected to implement Component 1 employ staff who speak local dialects and are conversant with the socio-cultural norms and belief systems of IP groups.

98. **As part of the Indigenous Peoples Policy Framework, a Grievance Redress Mechanism (GRM) to manage possible complaints from the IP community is proposed.** The GRM includes the establishment of Grievance Redress Committees at different levels: the local level (*Aire de Santé*), intermediary (territorial level), and provincial level (governate). Sensitization and communication campaigns to disseminate information on the GRM and the various methods of filing complaints (for literate and non-literate IP communities) and their management will be conducted i throughout the project life/cycle. The project will partner with local IP associations and IP representatives to ensure the GRM is functional and accessible to IP communities. Beyond the proposed GRM, should an IP or project affected person feel their complaints are not adequately managed, recourse to provincial or national judicial courts will be available. (Please see Section H below).

99. **The project will ensure the measures to address the risk of Sexual Exploitation and Abuse (SEA) of project beneficiaries, staff and contractors are put in place.** This will include: (i) the adoption of Codes of Conduct by all staff and contractors, (ii) the development and roll-out of training modules on the prevention of SEA and Sexual Harassment by a specialized service provider; and (iii) the inclusion in the GRM of dedicated channels and approaches for the reporting and management of SEA related complaints (Please see Section H below).

F. Environment (including Safeguards)

100. **The interventions under the project involve improvement in the provision of health services, handling of medical products as well as small scale rehabilitation of health facilities (limited to small internal repairs, painting, installation of screen or partitions for further privacy).** Project activities will contribute to improved health services and a case load of two GBV survivors/month/health center are expected. Given the estimated additional case load increased generation of medical waste at health facility level is not expected. Small scale rehabilitation works may pose minor health and safety risks. In addition, Component 1 will

include support for small scale livelihood activities (potentially including agricultural and small-scale husbandry). Consequently, the Project triggered the following Environmental Safeguards Policies: Environmental Assessment OP/BP 4.01 and Pest Management OP/BP 4.09. The potential environmental impacts can be adequately managed by integrating environmental due diligence into the Project cycle. Given the limited likelihood of environmental and social impacts, the Project is rated as Environmental Assessment Category B.

101. **An environmental and Social Management Framework (ESMF) was prepared through a consultative process during project preparation.** The ESMF provides basic guidance on environmental screening and where necessary on the development of Environmental Management Plans (EMP) during implementation. The ESMF was approved on April 24, 2018 and disclosed in country on May 3, 2018.

102. **Climate change and disaster risk screening.** The Project was screened for short and long-term climate change and disaster risks as well as climate change adaptation co-benefits. The results indicate DRC may be slightly exposed to climate risks with regards to flooding, precipitation, and landslides, however, the overall risk is expected to be low with low potential impact. Similarly, no relevant adaptation co-benefits were identified. No regular assessments of potential climate change impacts (or further analysis of potential benefits) are expected to be carried out during the Project implementation period.

H. World Bank Grievance Redress

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

104. **The project will ensure that effective mechanisms for citizen´s engagement and feedback are put in place**. These will be detailed in the PIM, which is a condition of project effectiveness. Given overall design complexity and in order to streamline citizen engagement mechanisms, the project will:

    a. **Collect structured feedback on the quality of prevention interventions and responses services through qualitative analysis to be done as part of the project's process evaluation.** Anonymized information will be collected from targeted communities on access to services, responsiveness and quality of the services provided and necessary corrective action

b. **In addition, the project will make use of Health Zone monthly coordination meetings to review and address grievances that may surface during the implementation of prevention programs and the strengthening of service delivery capacity.** Community mobilizers will be the first port of call for community members to voice grievances related to project implementation. Institutions participating in project implementation will take stock of gaps in service provision and review feedback from communities on a monthly basis.

c. **Systemic issues pertaining to the performance of service providers will be reviewed on a quarterly basis at Provincial level.** Given the high level of fiduciary risk, the project grievance redress mechanism will include specific measures on the reporting and management of complaints linked to fraud and corruption. Finally, dedicated channels will be put in place to allow grievances related to SEA (both by potential beneficiaries as well as project staff and contractors) to be effectively reported and managed (in line with safety and ethical guidelines).

d. **To ensure the inclusion of IP communities in the design and implementation of project activities, a consultation framework is set forth in the IPPF**. Consultations will be conducted at different stages of project implementation and using different channels (including radio announcements, community forums, focus groups, or through sectoral meetings) in a culturally appropriate manner. As noted in paragraph 104 above, additional measures will be included in the GRM to ensure its accessibility to IP communities.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

Project Development Objective(s)

The objectives of the Project are to increase in targeted Health Zones: (i) the participation in Gender-Based Violence (GBV) prevention programs; (ii) the utilization of multi-sectoral response services for survivors of GBV; and (iii) in the event of an Eligible Crisis or Emergency, to provide immediate and effective response to said Eligible Crisis or Emergency.

PDO Indicators by Objectives / Outcomes	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets					End Target
					1	2	3	4	5	
Increase participation in Gender-Based Violence prevention programs										
Percentage reported decrease in accepting attitudes towards GBV in targeted Health Zones			Percentage	0.00					20.00	20.00
Numbers of direct project beneficiaries (percentage of women)			Number	0.00	100,000.00	250,000.00	500,000.00	600,000.00	785,000.00	785,000.00
Female beneficiaries			Percentage	0.00	50.00	50.00	50.00	50.00	50.00	50.00
Direct project beneficiaries is Twa communities			Amount(USD)	0.00	10,000.00	20,000.00	30,000.00	30,000.00	30,000.00	30,000.00
Increase utilization of multi-sectoral response services for survivors of Gender-Based Violence										
Percentage increase in reported cases who receive access to multidisciplinary services, defined as at least two of the following (medical, psychosocial, security, legal support and livelihoods suppo			Percentage	50.00	5.00	10.00	10.00	0.00	0.00	0.00

PDO Indicators by Objectives / Outcomes	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets					End Target
					1	2	3	4	5	
Percentage of eligible reported cases of eligible GBV who receive Post Exposure Prophylaxis (PEP) Treatment within 72 hours.			Percentage	13.00	20.00	30.00	40.00	60.00	80.00	80.00
Percentage of implementing partners providing services to GBV survivors in line with quality standards			Percentage	0.00	50.00	60.00	80.00	80.00	80.00	80.00

Intermediate Results Indicators by Components	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets					End Target
					1	2	3	4	5	
Gender-Based Violence prevention and integrated support for survivors at community level										
Numbers of beneficiaries participating in community level economic support services			Number	0.00	500.00	1,500.00	3,000.00	3,800.00	3,800.00	3,800.00
Number of beneficiaries receiving specialized mental health care			Number	0.00	1,500.00	2,000.00	2,500.00	3,000.00	3,200.00	3,200.00
Number of service providers trained in NET			Number	0.00	30.00	60.00	60.00	60.00	60.00	60.00
Percent reported change in women´s participation in household decision-making			Percentage	0.00	0.00				20.00	20.00
Percent change in help seeking behaviour for women and men aware of IPV cases at community level			Percentage	0.00	0.00				20.00	20.00
Response to Gender Based Violence										
Number of health personnel receiving training on GBV			Number	0.00	200.0	300.0	400.0	400.0	400.0	400.00

service provision					0	0	0	0	0	
Number of reported cases of GBV that access at least one service supported by the project (disaggregated by entry point)			Number	0.00	20,000.00	40,000.00	60,000.00	60,000.00	60,000.00	60,000.00
Percentage of rape cases that access services within 72 hours of the incident			Percentage	0.00	30.00	40.00	50.00	50.00	50.00	50.00
Percentage of beneficiaries who meet regularly with their case manager, as defined in the project manual			Percentage	0.00	30.00	60.00	80.00	80.00	80.00	80.00
Percentage of essential medication (PEP, STI Treatment and Emergency Contraception) for which there was no stock out during the implementation period			Percentage	0.00	40.00	20.00	20.00	20.00	20.00	20.00
Percentage availability of basic equipment at health facility level in line with the project´s quality check-list			Percentage	0.00	60.00	80.00	80.00	80.00	80.00	80.00
Percentage of small-scale works at health facility level complying with ESMF requirements			Percentage	0.00	100.00	100.00	100.00	100.00	100.00	100.00
Support to Policy Development, Project Management and Monitoring and Evaluation										
Percentage of grievances received by the project that are addressed in line with quality standards defined in the GRM manual			Percentage	0.00	70.00	80.00	100.00	100.00	100.00	100.00

Monitoring & Evaluation Plan: PDO Indicators	
Indicator Name	Percentage reported decrease in accepting attitudes towards GBV in targeted Health Zones
Definition/Description	This will be measured annually for the project cycle via a questionnaire on attitudes towards GBV based on DHS tools. The indicator will be disaggregated by type of respondent (general community members, prevention activity participants, community activists, and service providers). The average percentage of accepting attitudes toward GBV in the 2014 DHS for North and South Kivu, Maniema, and Tanganyika provinces was 61%.
Frequency	Baseline and Endline
Data Source	Attitude survey
Methodology for Data Collection	
Responsibility for Data Collection	Behaviour Change Communication consultant and FSDRC

Indicator Name	Numbers of direct project beneficiaries (percentage of women)
Definition/Description	This includes counts from activity monitoring of service provision for GBV cases, beneficiaries of economic support and specialized mental health care, training of service providers and community activists, specialized care for gynecological complications, children and youth spaces in centers of excellence, as well as prevention, community mobilization and advocacy activities. Community level activities are a cumulative count of the number of times prevention programs reached individuals in targeted health zones. Given that individuals will likely attend more than one prevention program session, this is counting the number of times participants were reached rather than the number of unique individuals.
Frequency	Annually
Data Source	Sum of number of beneficiaries for all components
Methodology for Data Collection	
Responsibility for Data Collection	Partners and FSDRC for compilation

Indicator Name	Female beneficiaries
Definition/Description	
Frequency	
Data Source	
Methodology for Data Collection	
Responsibility for Data Collection	

Indicator Name	Direct project beneficiaries is Twa communities
Definition/Description	
Frequency	
Data Source	
Methodology for Data Collection	
Responsibility for Data Collection	
Indicator Name	Percentage increase in reported cases who receive access to multidisciplinary services, defined as at least two of the following (medical, psychosocial, security, legal support and livelihoods suppo
Definition/Description	This indicator is calculated as the number of GBV cases that receive at least two services (including referrals) out of the total number of GBV cases that access services. This will be further disaggregated by point of entry for services. At the service provider level and as part of a process evaluation, analysis data from GBVIMS tools will also give a deeper understanding of services available, unavailable, or declined by survivors. As not all survivors need or want to access more than 1 service, we do not expect to see a percentage increase once approximately 75% of survivors are accessing at least 2 services.
Frequency	Quarterly
Data Source	Service provider partner reports
Methodology for Data Collection	
Responsibility for Data Collection	Partners and MoH, FSDRC to compile

Indicator Name	Percentage of eligible reported cases of eligible GBV who receive Post Exposure Prophylaxis (PEP) Treatment within 72 hours.
Definition/Description	Eligible GBV cases for PEP are normally cases of rape that are reported at a service provider within 72 hours after the incident. This indicator will be calculated in relation to the percentage of rape cases reported out of all GBV cases, and the percentage of rape cases that report within 72 hours of the incident out of all rape case reported.
Frequency	Quarterly
Data Source	Service provider partner reports
Methodology for Data Collection	
Responsibility for Data Collection	Partners and MoH, FSDRC to compile

Indicator Name	Percentage of implementing partners providing services to GBV survivors in line with quality standards
Definition/Description	Medical, legal and psychosocial service providers will be evaluated according to standardized quality criteria checklists relevent for each type of service. This indicator will be calculated as the number of service providers meeting the minimum quality criteria out of the number assessed.
Frequency	Annual
Data Source	Supervision reports and quality criteria checklists
Methodology for Data Collection	
Responsibility for Data Collection	Medical, legal and psychosocial supervisors

Monitoring & Evaluation Plan: Intermediate Results Indicators	
Indicator Name	Numbers of beneficiaries participating in community level economic support services
Definition/Description	This includes VSLA groups, income generating activities at CBO level, and other economic support
Frequency	Quarterly
Data Source	FSDRC
Methodology for Data Collection	
Responsibility for Data Collection	CBO, Case managers
Indicator Name	Number of beneficiaries receiving specialized mental health care
Definition/Description	Includes beneficiaries participating NET, and will be disaggregated by Health Facility or CBO service provider.
Frequency	Quarterly
Data Source	Service provider reports
Methodology for Data Collection	
Responsibility for Data Collection	Health Facilities and case managers, FSDRC to compile

Indicator Name	Number of service providers trained in NET
Definition/Description	
Frequency	Semi-Annual
Data Source	VIVO Training Records
Methodology for Data Collection	
Responsibility for Data Collection	FSDRC to compile

Indicator Name	Percent reported change in women´s participation in household decision-making
Definition/Description	This will be measured among participants in prevention activities, participants in economic support services, CBO members and where possible at the general community level. Indicator adapted from DHS standard indicators.
Frequency	Baseline and endline assessments
Data Source	Prevention activity tools
Methodology for Data Collection	
Responsibility for Data Collection	Partners and FSDRC for compilation

Indicator Name	Percent change in help seeking behaviour for women and men aware of IPV cases at community level
Definition/Description	This will be measured among participants in prevention activities, CBO members and where possible at the general community level. Denominator will be the number of men and women who report seeing/hearing IPV happening in the community in the past year. Indicator adapted from SASA GBV prevention methodology.
Frequency	Baseline and end-line assessments
Data Source	Prevention activity tools
Methodology for Data Collection	
Responsibility for Data Collection	Partners and FSDRC for compilation.

Indicator Name	Number of health personnel receiving training on GBV service provision
Definition/Description	
Frequency	Semi-Annual
Data Source	Project records
Methodology for Data Collection	
Responsibility for Data Collection	MoH

Indicator Name	Number of reported cases of GBV that access at least one service supported by the project (disaggregated by entry point)
Definition/Description	This indicator is an estimate of services needed rather than a target, given that the ultimate goal of GBV programs is to see a decrease in the incidence of violence. This will be disaggregated by GBV cases presenting at medical facilities, CBO and NGO service providers and Integrated Centers of Excellence. Referral mechanisms at each type of service facility will also be tracked and accounted for in calculating this indicator.
Frequency	Quarterly
Data Source	Service provider partner reports
Methodology for Data Collection	
Responsibility for Data Collection	Partners and MoH, FSDRC to compile

Indicator Name	Percentage of rape cases that access services within 72 hours of the incident
Definition/Description	Calculated as number of rape cases accessing services within 72 hours after the incident out of the total number of rape cases accessing services. In areas where GBV services are newly accessible, this indicator may be very low as survivors access services for incidents of violence that happened to them months or even years previously. As services become more accessible and community knowledge of services improves, the number of cases accessing services within 72 hours should increase as well.
Frequency	Quarterly
Data Source	Service provider partner reports
Methodology for Data Collection	
Responsibility for Data Collection	Partners and MoPH, FSDRC to compile

Indicator Name	Percentage of beneficiaries who meet regularly with their case manager, as defined in the project manual
Definition/Description	This indicator is relevant for survivors accessing case management services at the community level, and is an indication of good practices in follow up care.
Frequency	Quarterly
Data Source	CBO, Case managers
Methodology for Data Collection	
Responsibility for Data Collection	FSDRC

Indicator Name	Percentage of essential medication (PEP, STI Treatment and Emergency Contraception) for which there was no stock out during the implementation period
Definition/Description	
Frequency	Annual
Data Source	Quality check-list
Methodology for Data Collection	
Responsibility for Data Collection	FSDRC/MoH

Indicator Name	Percentage availability of basic equipment at health facility level in line with the project´s quality check-list
Definition/Description	
Frequency	Annual
Data Source	Quality check-list
Methodology for Data Collection	
Responsibility for Data Collection	MoH/FSDRC

Indicator Name	Percentage of small-scale works at health facility level complying with ESMF requirements
Definition/Description	This indicator will monitor the percentage of small works sub-projects at health facility level that prepare and implement ESMPs in line with the requirements of the ESMF
Frequency	Quarterly
Data Source	Progress reports
Methodology for Data Collection	
Responsibility for Data Collection	MoH and FSDRC to compile

Indicator Name	Percentage of grievances received by the project that are addressed in line with quality standards defined in the GRM manual
Definition/Description	This indicator will track how grievances received through the project´s GRM are managed and whether the guidelines/standards set in the GRM manual are effectively applied
Frequency	Quarterly reports
Data Source	Progress reports
Methodology for Data Collection	
Responsibility for Data Collection	FSDRC

ANNEX 1: DETAILED PROJECT DESCRIPTION

COUNTRY : Congo, Democratic Republic of
DRC - Gender Based Violence Prevention and Response Project

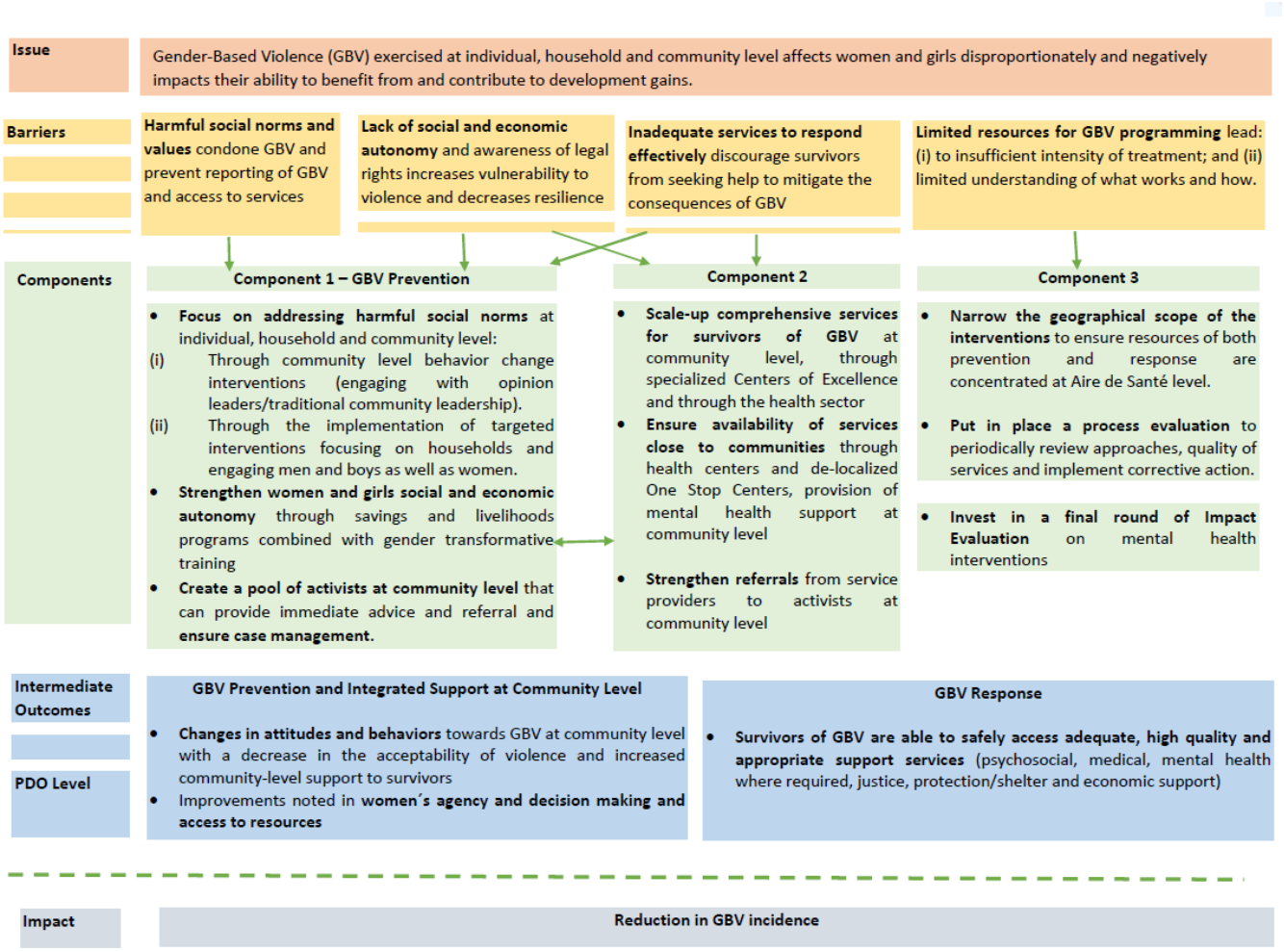
105. **Gender-Based Violence prevention programs require a sustained investment over a long period of time to achieve impacts in terms of reduction in the incidence of GBV.** Social norms and values that may condone GBV change slowly. By focusing on: (i) whole of community awareness raising approaches, gender-transformative training and livelihood interventions; and (ii) combining prevention approaches services for survivors the project aims to have an impact in terms of changes in attitudes towards GBV. Positive outcomes are also expected in terms of: (i) greater decision-making power for women at household level; (ii) a decrease in the experience of violence; and (iii) higher rates of service seeking behavior by survivors of GBV. An overview of the proposed approach is outlined in Figure 7 below.

106. **In line with global best practices and based on the lessons-learned during the implementation of the GL GBV, the project will focus on:**

iii. **Preventing GBV and improving the quality of multi-sectoral response services for survivors in targeted health zones.** Global evidence indicates that effective prevention programs encourage GBV survivors to come forward and seek services. The project will support awareness raising and gender transformative training at community level and invest in the creation of a pool of community activists that provide adequate case management and act as victims' advocates/ensure the referral to key services for survivors. The project will build on the experience of implementing the GL GBV and significantly increase the level of resources allocated to prevention activities as well as livelihood interventions;

iv. **Working primarily through partnerships with civil society organizations for service delivery while including an element of training and capacity building of the health sector for GBV response.** This approach acknowledges the challenges of providing quality services at community level given capacity constraints and growing instability in some of the areas potentially targeted. Challenges include inadequate staffing levels at the level of health facilities, increased difficulties in accessing services giving the worsening security situation, significant case backlog and "systems failures" in the criminal justice system and in terms of the services provided by security forces.

Figure 7: Overview of the proposed approach



Component 1 - Gender-Based Violence prevention and integrated support for survivors at community level (US$54.5 million equivalent to SDR 38 million)

107. In order to address the underlying causes of GBV and to tackle the social norms and values that may condone GBV, the project will invest significantly in awareness raising and behavior change communication at individual, interpersonal and community level.[39] The approach to prevention will be based on rigorously evaluated models which have shown to be effective in the context of the DRC or in comparable contexts. Particular attention will be paid to taking into account the context of insecurity and instability under which the project will operate.

[39] Over 50% of project resources will support the implementation of prevention activities

108. A detailed protocol for individual, interpersonal and community-based prevention and referral activities will be developed by the FSDRC by project effectiveness. The protocol will include the selection of *Aires de Santé* to be targeted within the targeted Health Zones. The protocol will be used as the basis for selecting NGOs who will implement prevention activities as well as community level response interventions and referral to more specialized services. In order to streamline implementation arrangements one Umbrella NGO will be selected per Province for the implementation of Component 1. The umbrella NGO will in turn establish partnerships and sub-contracting arrangements with local NGOs and CBOs where relevant. The structured transfer of technical expertise to CBOs is expected to contribute to the sustainability of the prevention and community referral approach put in place.

109. The implementation of GBV prevention activities at community level will build on a critical mass of qualified and reputable community activists including para-legals and para-social workers, teachers, religious leaders, mobilizers, community health workers (*relais communautaires)* and members of women's community-based organizations. This pool of activists will receive training on community awareness raising and behavior change interventions as well as on the referral of survivors. Additionally, to ensure that activists will share a core set of knowledge, attitudes and beliefs that promote women's equality, they will undergo in-depth gender transformative training that will provide them with the tools to challenge the social norms that condone violence against women and girls. This is expected to contribute to providing, GBV survivors with a set of trusted individuals within the community to whom they can report violence and through whom they can access services. This approach will aim to broaden the current set of community mobilizers and focal points trained under the GL GBV project as first responders to the needs of survivors.

iv. *Community mobilization and promotion of behavior change*: Building on the training and mentoring of the pool of community activists mentioned above, the project will implement a community mobilization intervention targeting opinion leaders, community based organizations as well as older men and women who play a key role in perpetuating accepting attitudes towards GBV. Male engagement in this process will aim to communicate that violence is an issue that needs solving at the community level rather than a private matter or a 'women's issue'.

v. *Livelihood interventions:* Building on the experience of the GL GBV project, the project will support the establishment of Village Savings and Loans Associations (VSLAs). The approach will focus initially on supporting women to build savings. Dedicated technical support will be provided by the Umbrella NGO to group formation. As VSLAs are consolidated, those that have the demonstrated capacity will be further supported with business development skills. Community-based organizations will also be supported to organize small-scale income-generating activities. These activities will be selected through a market analysis of economically viable options in each Health Zone and will provide an opportunity for referral of survivors.

vi. *Gender transformative training:* Gender transformative training will be conducted to address gender inequality at the household level. This will include a focus on communication and conflict management skills. In addition, community facilitators will be selected among the pool of trained activists to implement behavior change activities with men focusing on positive masculinities.

110. In addition, the project will support the establishment of safe spaces for women and girls at community level: The GL GBV project has supported a network of CBOs in North and South Kivu. These CBOs provide a

key point of entry for survivors of violence in terms access to psycho-social support and referral to additional services. The current project will aim to broaden the scope of activities by CBOs and focus on the establishment of safe spaces at community level. These spaces housed with the CBOs will be used for awareness raising and information sessions (including on the dissemination of services available to survivors), life-skills activities but also informal gatherings and implementation of simple livelihood activities. Activities implemented in the safe spaces will aim to create an environment of trust around service delivery at community level and encourage service seeking. This will be done by ensuring that services for survivors take place in a space that also offers other activities targeting women and girls more broadly so that service seeking is not stigmatizing.

111. **Community safe spaces will establish a key link between prevention activities and community referrals and access to services.** In addition to the pool of activists highlighted above, focal points selected among CBO members will receive more in-depth training on the provision of psychosocial support and referral to additional services. The basic package of services and referrals provided at community level will be as follows:

(i) Referral to specialized health services;
(ii) Provision of case management, psychosocial support and mental health care using the Narrative Exposure Therapy (NET) approach provided by trained Focal Points at CBO level;
(iii) Provision of legal aid. Initial advice will be provided by Paralegals trained at CBO level with more complex cases referred to specialized staff at the level of Umbrella NGO;
(iv) Referral to safety and security services; and
(v) Referral to livelihood activities. Building on the lessons-learned from the GL GBV project, simple livelihood activities will be implemented at CBO level[40]. These can be used as the mechanism for immediate/short term referral of survivors to livelihood support. While referral of survivors to more structured activities implemented by VSLAs will be feasible this will entail a waiting period. New VSLAs will be established at community level in a phased manner to allow for the enrollment of additional participants. Livelihood assistance will be offered in a manner that protects the survivor's identity and prevents further stigmatization. It will be key to closely monitor the referral of survivors to livelihood activities implemented at CBO level and in VSLAs to ensure they are not subjected to further exploitation and risk as a result of their selection for a livelihood program.

112. **Umbrella NGOs and trained activists will be responsible for ensuring access by survivors to a minimum package of response services as follows**:

Health care

113. While standards for medical care will be set under Component 2 of the proposed action, component 1 will focus on effective referral and counter-referral procedures, to ensure survivors have access, if they choose to do so, to timely medical care in line with quality standards outlined by component 2. Under this component, Umbrella NGOs will be responsible for monitoring and reporting on the effectiveness of access to care. This will include reporting on the availability of complete post-rape kits, and the respect of a survivor-centered approach by HCP.

[40] Drawing on small scale livestock interventions such as Pigs for Peace and Rabbits for Resilience, tested in the DRC for example.

Case management, psychosocial support and mental health

114. In line with global practices, mental health and psychosocial support aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders.[41] Case management services will be offered to all women and girls disclosing a GBV incident, in line with the newly released Inter Agency Guidelines[42], to ensure survivors regain their psychosocial well-being and protect their mental health. Case management will make sure: (i) that survivors are informed of all the options available to them; (ii) that issues and problems facing survivors are identified and followed up in a coordinated way; (iii) that the survivor is provided with emotional support throughout the process. In addition, a case manager will support individual positive coping mechanisms on the part of survivors and build on their strengths and networks (family, friends and community member). Case management will respect the following guiding principles: (i) right to safety; (ii) right to confidentiality; (iii) right to dignity and self-determination; and (iv) right to non-discrimination.

115. To foster an environment of trust between service providers and community members (including potential survivors of GBV), and avoid further stigmatization of clients, it is important that case management is provided in safe spaces (as described above). Creating accessible safe spaces where survivors of GBV can go to receive services, support or seek immediate safety if they are at risk is an effective psychosocial intervention that promotes safety, healing and recovery.[43]

116. Case management will also be the primary entry point for survivors to receive psychosocial and emotional support and basic mental health care. Community-based service providers will be trained on NET. The individual therapy will focus on the reprocessing and integration of life experiences, allowing the survivor to establish a chronological narrative of her/his life, concentrating on traumatic experiences, but also incorporating some key positive events. This aims to foster a sense of personal identity. The therapy will only be delivered to a minority of survivors who show with Post-Traumatic Stress Disorder (PTSD) symptoms and who are unlikely to recover without therapeutic support. During the implementation of the GL GBV project the therapy was adapted to be implemented by non-specialized staff. Building on this experience, the provision of NET will be expanded through the proposed project to the community level, strengthening the referral pathway and accessibility for survivors. The FSDRC will contract VIVO International for the provision of these specialized services. While this intervention will be implemented by CBOs, the project will ensure technical oversight by the National Mental Health Program.

Legal aid

117. In spite of ongoing efforts, significant barriers remain in terms of access to justice by survivors of GBV. They include: (i) a lack of trust in the system; (ii) impunity for perpetrators; (iii) a lack of awareness of laws and knowledge of rights; (iv) the inability to *de facto* access remedies and reparation for crimes of sexual violence; (v) and possible re-victimization, leading survivors to feel further disempowered. In some instances, justice systems do not serve the needs of survivors and may cause further harm, especially in the absence or inefficiency of protection measures.[44] Survivors may also encounter significant social pressure that prevents

[41] IASC, Mental Health and Psychosocial Support (MHPSS) in Humanitarian Emergencies - What Should Protection Programme Managers Know?
[42] *http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf*
[43] UNFPA, Minimum Standards for Prevention and Response to GBV in Emergency, *https://www.unfpa.org/sites/default/files/pub-pdf/GBVIE.Minimum.Standards.Publication.FINAL_.ENG_.pdf*
[44] Centre International pour la Justice Transitionnelle, S. Parmar et G. Mushiata, Déni de justice. Les victimes de crimes graves ne reçoivent pas

them from reporting incidents and accessing legal services. The issue is systemic and while *audiences foraines* [45]had some success in ensuring survivors have access to justice, their impact is limited, especially in virtue of the number and vast geographical distribution of incidents. Their sustainability is intrinsically dependent on international funding, with limited engagement of national authorities.

118. Legal services remain, however, an essential part of the survivor-centered approach**.** Information dissemination sessions and other community-based activities will be conducted by paralegal officers at the community level. This will contribute sharing accurate information on laws that protect the population from GBV, remedies and types of support available. Paralegal community activists will work in close collaboration with psychosocial activists providing case management and mental health services. This is expected to improve the effectiveness of the referral pathways and of the coordination of multi-sectoral response. It is important that survivors be provided with transparent information (including on the challenges likely to be faced) to be able to make an informed decision regarding the pursuit of a legal case. Legal aid services staffed by appropriately trained personnel will be made accessible at no cost to the survivor [46] and integrated into the general GBV referral system.

119. Recognizing the impact that *audiences foraines* had in ensuring access to justice to survivors of GBV the project will support the organization of mobile courts. These will be particularly important for populations in rural areas otherwise not covered by judicial infrastructure. The project will put in place much needed measures to ensure the protection of victims and witnesses (including children when they are part of such proceedings).

Safety and security services

120. GBV case management providers will consider and regularly assess potential dangers and risks to the safety and wellbeing of survivors to prevent additional harm**.** This will include offering physical protection when necessary (with the informed consent of the survivor), and pre-emptively addressing potential retaliation against complainants. Referral to security actors can play an important role in maintaining or re-establishing safety and security for survivors. [47]

121. A referral pathway will be established to include safety and security services delivered by personnel who have received training on prevention and response to incidents of sexual violence and on how to treat survivors of GBV. In parallel, the project will contribute to strengthening existing safe houses and other safety measures being implemented by specialized actors such as the Integrated Centers of Excellence (see component 2.1). The project will regularly monitor potential GBV-related risks and vulnerabilities of affected populations, particularly women and girls, through a variety of approaches that may include safety audits and other community-based monitoring strategies.

les réparations ordonnées par la Cour de justice en République démocratique du Congo, février 2013 and OHCHR, Avancée et obstacles dans la lutte contre l'impunité des violences sexuelles en RDC, avril 2014, para 152-153.

[45] Fast-track mobile courts.

[46] Support will include legal costs, and costs related to transportation and accommodation.

[47] In some cases, however, security sector actors have been implicated as perpetrators of GBV or aren't seen as a safe option by survivors.

Component 2 – Response to Gender-Based Violence (US$ 27.5 million equivalent to SDR 19.1 million)

122. Complementing GBV prevention activities and the immediate support for groups most at risk of GBV, put in place at community level, the project will also strengthen front-line service provision for survivors with a strong focus on improving: (i) multi-sectoral response for the most complex cases and; (ii) the quality of medical services. Building on the experience of the GL GBV project and the challenges in operationalizing activities with the health sector, the project will strengthen service provision through integrated Centers of Excellence (CoE) with a focus on outreach activities and supporting de-centralized One Stop Centers at health zone level. The project will also invest in targeted capacity building of the health sector to bring medical services for survivors of GBV closer to communities.

123. Sub-Component 2A – Support for existing integrated Centers of Excellence (US$20.7 million): This sub-component will support the specialized referral facilities: (i) Panzi Hospital and Foundation in South Kivu; and (ii) Heal Africa in North Kivu. Services provided by these facilities will include: (a) medical care, including for the most complex cases; (b) forensic evidence collection, analysis and training; (c) legal services; (d) facility based counseling; (e) support services for survivors and their children rejected by families; (f) mobile clinics in remote areas to reach the most vulnerable groups; (g) training and capacity building for health providers on performing complex surgeries, compiling forensic evidence, and providing high quality medical and mental health services; and (h) operational research on GBV where relevant. Through the training provided by the CoEs the project will also aim to strengthen forensic response capacity among HCP. Forensic training will focus on HCP, police and the judiciary with a focus: (i) handling of forensic evidence, (ii) preparing for hearings and; (iii) the filling of police and medico-legal forms.

124. In addition to the activities highlighted above, the project will support the provision of specialized services in decentralized One Stop Centers currently managed by Panzi Foundation and Heal Africa as well as outreach activities in hard to reach Health Zones targeted by the project. Mobile clinics and outreach services will also be supported in Maniema (Heal Africa) and Tanganyika (Panzi Hospital and Foundation). A detailed FM assessment of both centers was carried out during preparation and the summary of key findings is included in Annex 2.

125. Sub-Component 2B – Strengthening the Health Sector Response to GBV (US$6.8 million). The main objective of this sub-Component will be to strengthen the health sector responsiveness to GBV. Key activities under this sub-component will be as follows:

126. *Training of HCPs, including community health workers in targeted health areas, in response to GBV*. Training will include: (a) GBV case screening, medical case management, including the correct collection of forensic evidence; (b) updating and disseminating management protocols and guidance notes for practitioners (job aides) developed specifically for the health system; and (c) finally, this subcomponent will finance small rehabilitations of health facilities (painting, small internal repairs and provision of screens or partitions as well as secure cabinets) to create adequate conditions of consultation where they currently do not exist. In this context, the project will finance internal repairs and rehabilitation of these facilities where relevant without extending the footprint of existing hospitals or health centers.

127. *Support for service provision at hospital and health center level.* The project will build on the lessons-learned during the implementation of the GL GBV project in terms of the coordination with the Performance Based Financing (PBF) approach currently in place in North and South Kivu[48].

128. The PBF approach consists overall of subsidizing service delivery at health facility level through quarterly payments made after the verification of a set of service delivery results (in terms of quantity and quality of services) following verification by an independent party. Under the GL GBV and PDSS projects, facilities payments on a sliding scale depending on quantity of services provided, adjusted for quality. Subsidies are used to invest in the facility and to improve health worker motivation.

129. Considering the challenges observed in the implementation of the GL GBV project in North and South Kivu and the fact that the Health Systems Strengthening Project (PDSS) is not present in Tanganyika the project will follow the following approach:

m. Lump sum payments to Health Structures and Provincial Directorates of Health (PDH) in North Kivu, South Kivu and Tanganyika for quality services provided to survivors of violence. Such payments will be made against an assessment of the quality of the services provided. Payment will be linked to quality and not the numbers of survivors assisted to avoid creating perverse incentives that may result in an over-reporting of cases;

n. The assessments of the quality of the services provided by health centers will be carried out by the PDH and Health Zone Supervision teams using the evaluation quality grids put in place by the PBF;

o. Resources will be allocated to the PDH for the supervision and validation of the quality of services. This quality assessment will be done with relevant experts from the National Reproductive Health and National Mental Health Programs and in coordination with the Umbrella NGO responsible for the referral of cases (in order to ensure the triangulation of the information).

p. Resources will be managed directly by the FSDRC and funding allocated will be included in the "Single Contract" currently in place in North and South Kivu to ensure that all amounts for supervision are captured at Provincial level and shared with partners providing funding to the PDH.

130. *In Maniema, the current project will align itself with the PBF approach and focus on the same eight HZ currently covered by the PDSS.* The quality assessment tools for the PBF will be updated to take into account the medical care of survivors. Certified evaluators at level of PDH and Health Zones will be trained on the use of this updated quality assessment grid. Service providers will be oriented on the type and standards of care required by survivors of GBV. An assessment of PBF readiness to include payments for services provided to survivors of GBV will be undertaken during Year 1 of project implementation. Based on the results of this assessment resources will either be programed through the PBF mechanism for service

[48] with IDA financing through the Health Systems Strengthening Project (PDSS)

provision or will be allocated following the mechanism also used in the remaining provinces and described in paragraph 128 above.

131. *Procurement of emergency medication for survivors of GBV will be done directly through UNFPA*. This will include Post Exposure Prophylaxis (PEP), emergency contraception and treatment for Sexually Transmitted Diseases (STIs). Distribution will be carried out through the Regional Distribution Centers (CDRs) covering the targeted Provinces where these are functional: Asrames (North Kivu), Cedmeta (Tanganika), Cemema (Maniema), and DCMP / 8th CEPAC (South Kivu). An assessment of the functionality of the CDRs in Maniema and Tanganyika will be carried out within six month of project effectiveness and alternative approaches to distribution of these supplies developed where necessary. The FSRDC will sign contracts with these different CDRs to cover the costs of stock management and drug distribution.

Component 3 – Support to Policy Development, Project Management and Monitoring and Evaluation (US$17.9 million equivalent to SDR 12.5 million)

Sub-Component 3 A – Support to Policy Development and Capacity Building (US$1.6 million)

132. The project will aim to strengthen coordination mechanisms for GBV programming. In addition to technical coordination meetings chaired by FSRDC at National, Provincial and Health Zone level, the project will ensure regular participation in the GBV Inter-Ministerial Coordination group. This will aim to ensure that project activities are aligned with the efforts of other Development Partners and that information on project results are reflected in the GBV national monitoring system managed by the Ministry of Gender, Family and Children.

133. The project will support the efforts by the Ministry of Gender, Family and Children and the Office of the Presidential Representative for GBV to safely and ethically map GBV programming interventions. In that regard, the project will conduct an assessment of the design and implementation of the existing national database of GBV incidents. The approach currently used in DRC will be compared to global standards of good practice in GBV information management. The results of this assessment will be shared at national level and will determine the type and level of support the project would be able provide to the national GBV database. Particular emphasis will be placed on measures that will further align it with global best practices.

134. This sub-component will fund the dissemination of the 2016 Family Code and Law on Sexual Violence at community level using the CBO and community activist platform put in place under Component 1. The project will further support the dissemination of the Victim Compensation Act (once approved by Parliament). In addition, the project will convene key actors engaged in the revision of National Medico-Legal certificate for the finalization of the certificate and guidelines on its utilization in coordination with the Development Partners Group on GBV. The establishment of a simplified, user-friendly certificate will play a key role in easing access to forensic services by survivors of GBV.

135. Finally, this sub-component will support the development of a targeting and roll-out strategy for GBV programming for the Kasaï and Equateur Provinces. This analysis will take into account the programming challenges given the extremely high levels of acceptability of IPV particularly (acceptability of

IPV by women in the Kasaï s varies between 92 and 82 percent and with a rate of 80 percent in Equateur). In addition, the strategy will assess operational options and costs for the roll-out of services given the current lack of service providers and challenges in access.

Sub- Component 3 B – Project Management (US$9.9 million)

136. *This sub- component will cover overall project management costs* to ensure efficient and effective coordination, fiduciary management at national and local levels. This will be done through dedicated support to the implementing agencies, institutional strengthening and purchase of critical equipment. This component will include support for strengthening existing coordination structures, the sustainability of project activities and the training of critical staff at national and sub-national levels.

Sub-Component 3C – Monitoring and Evaluation (US$6.4 million)

137. Given the volatile security situation and expected challenges in terms of project supervision significant resources have been allocated to this sub-component. This will allow the WB and FSDRC team to rely on a robust Management Information System (MIS) and to triangulate the information provided through the MIS with data from external quality reviews, community-based monitoring and impact evaluation data.

138. *This sub-component will cover the costs of a set of measures to ensure effective data collection on the implementation of key project activities.* The project will fund the upgrading and roll-out of the Management Information System used by the GL GBV project. The project will also support the implementation of tools for the systematic assessment of service quality, including client satisfaction, and tools for measuring knowledge and change in attitudes at a community level. In addition, to ensure close monitoring and evaluation, the project will include a process/ third party evaluation to accompany the implementation process and provide feedback to stakeholders. This process evaluation may cover: (i) an analysis of service data, including types of service accessed, entry points, and multi-sectoral services desired by survivors by type of violence; (ii) quality and accessibility of services, including detailed analysis of quality criteria checklists for each type of service, activities that target risk groups, and prevention activities; (iii) beneficiary satisfaction, including a sense of security by accessing medical and legal services, and an analysis of complaints submitted through the feedback mechanism; iv) a detailed analysis of GBV acceptance attitudes among service providers (medical, legal, psychosocial) and prevention actors (victim advocates, community protection groups, change promoters, community facilitators, v) capacity building and mentoring of CBOs as service providers, including of economic empowerment activities.

139. The process evaluation will include a specific focus on documenting and collecting evidence on the partnerships with CBOs as GBV service providers and agents of change within the community. It is expected to focus on their overall sustainability, quality of service provision, organizational capacity, external capacity building and support models (such as providing financial incentives to focal points), profitability of income-generating activities and business plans, interactions with the community and empowerment of CBO members as leaders and role models.

140. *In addition, this sub-component will fund an impact evaluation of mental health activities. This will be in line with NET impact assessment, initiated as part of the GL GBV project*. This impact evaluation will be conducted by researchers from the World Bank's Africa Gender Innovation Lab. The purpose of this study is to evaluate the impact of NET on the mental health, psychosocial well-being, and economic empowerment of SGBV survivors with symptoms of PTSD. Particular emphasis will be placed on the evaluation of the 'train the trainers' approach which aims to ensure the sustainability of the intervention through the appropriation of the approach by local service providers. Due to difficulties in implementing the NET, independent of the impact assessment, the sample size initially planned for the first round of the impact evaluation has not yet been reached. The approach to NET was modified during the Mid-Term Review of the GL GBV project, to include the training of psycho-social assistants within CBOs among the NET providers. An additional year of data collection will therefore be required to reach the necessary sample size to be able to draw reliable conclusions about the effectiveness of the NET and the training of trainers' approach adopted.

Component 4: Contingency Emergency Response Component (CERC) (US$ 0 million)

141. This component will provide immediate response in the event of an eligible crisis or emergency. This component is a "zero-dollar" Contingency and Emergency Response Component. In the case of an adverse event that causes a major disaster, the Government of DRC may request the World Bank for the rapid reallocation of grant proceeds from other components in order to provide preparedness and rapid response support to disaster, emergency and/or catastrophic events, as needed. The funds flow and disbursement arrangements will be determined at the time should the contingency response be activated and requires an amendment to the Project´s Operations Manual (PIM).

ANNEX 2: IMPLEMENTATION ARRANGEMENTS

COUNTRY : Congo, Democratic Republic of
DRC - Gender Based Violence Prevention and Response Project

Project Institutional and Implementation Arrangements

142. The project will be implemented by the Fonds Social DRC (FSDRC) and in close technical partnership with the Ministry of Public Health (MoPH). The FSDRC will be responsible for overall project management and consolidation of Annual Work Programs and Budgets. A single DA will be established at the level of the FSDRC with Provincial Sub-Accounts in place for all targeted Provinces. The FSDRC will procure specialized service providers for the implementation of Component 1 and engage VIVO International for the provision of mental health services using the NET approach. The FSDRC will further sign contracts with the Integrated Centers of Excellence (Panzi Foundation and Hospital and Heal Africa) for the implementation of Component 2A.

143. To streamline implementation arrangements for Component 2B and building on the lessons-learned from implementation in North and South Kivu, the FSDRC will establish Memoranda of Understanding with Provincial Directorates (PDH) of Health. The FSDRC will be responsible for payments made to Health Facilities (Hospitals and Health Centers), PDH and Health Zones Supervision teams in North Kivu, South Kivu and Tanganyika. In Maniema the project will aim to align with the PBF approach and target the same eight HZ currently being supported by the Health Systems Strengthening Project (PDSS). Funds for the provision of services and verification of quality of services may be channeled through the MoPH. The FSDRC team will conduct a review of the functionality of the PBF system in Maniema with MoPH and agree on whether to follow the approach outlined above for the remaining Provinces or to channel resources through the PBF mechanism (Figures 8 and 9).

144. The FSDRC will be responsible for the procurement of emergency supplies through UN Agencies and for establishing contracts with Regional Medication Distribution Centers for the distribution of these supplies in targeted provinces. The Ministry of Gender and Office of the Presidential Representative for GBV will prepare annual activity plans for the implementation of activities under Component 3A. Payments for supervision and activity costs will be made directly by the FSDRC in line with the agreed activity plans.

Figure 8: Implementation Arrangements (North and South Kivu and Tanganyika)

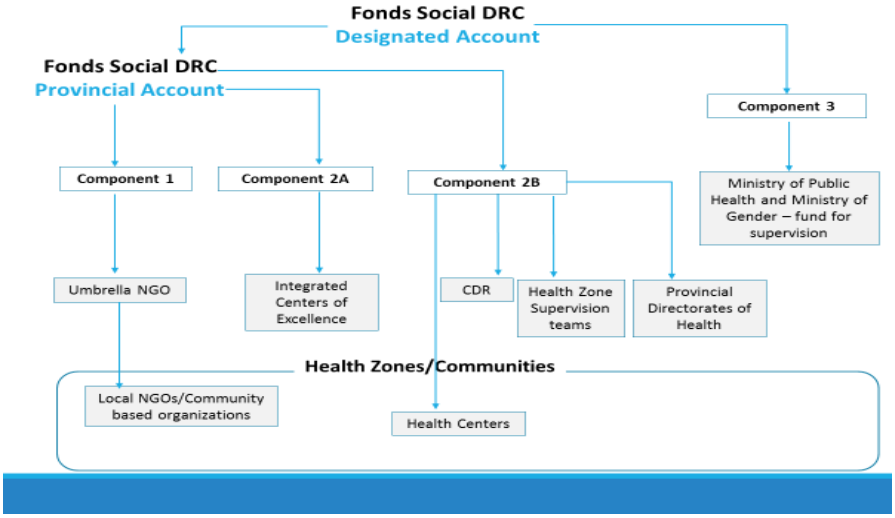
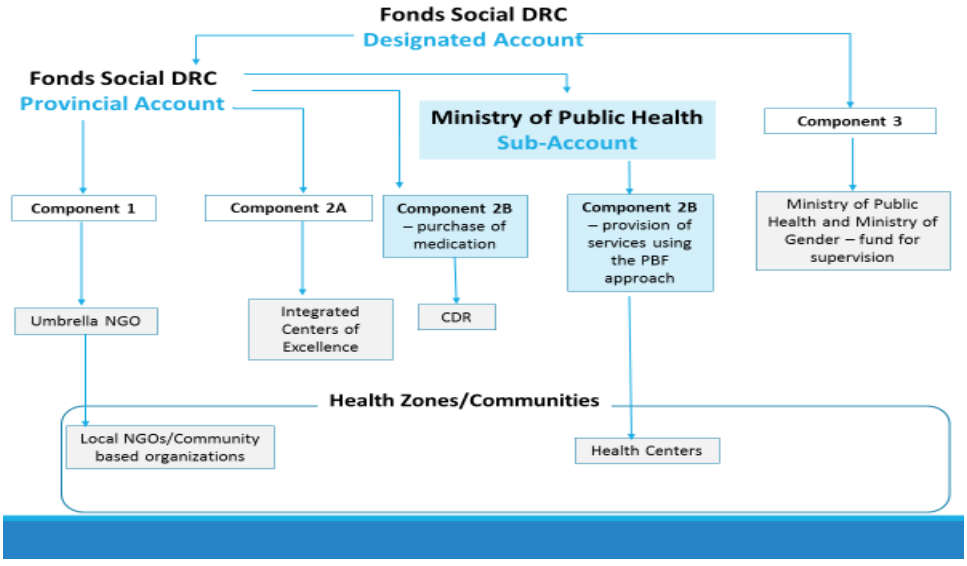


Figure 9: Implementation Arrangements (Maniema)



145. National and Provincial Coordination mechanisms: The project will ensure consistent participation in: (i) the Inter-Ministerial Working Group on GBV chaired by the Ministry of Gender, Family and Children at national level; and (ii) in the Provincial GBV Cluster Coordination meetings. In addition, monthly technical meetings will be held at national and Provincial level with FSDRC, MoPH, and specialized service providers. The technical coordination meeting will review critical issues with project implementation and identify concerns/issues that should be discussed and addressed through the Inter-Ministerial Working Group. The PIM will include the detailed description of the functions of participating institutions and local governments.

146. Role of Umbrella NGOs and Integrated Centers of Excellence: The FSDRC shall procure Umbrella NGOs contracted to provide GBV prevention interventions at household and community levels in the areas of: (i) community mobilization, (ii) livelihood support, (iii) establishment of safe spaces; (iv) community based referral and integrated service provision using evidence based GBV prevention and response approaches. VIVO International will be contracted to provide specialized mental health support using the NET approach. The Integrated Centers of Excellence Panzi Foundation and Hospital and Heal Africa will be contracted to provide: (i) medical care, (ii) forensic evidence collection, analysis and training; (iii) legal services; (iv) facility based counseling; (v) support to survivors and their children rejected by families; (vi) mobile clinics; (vii) training and capacity building for health providers; and (viii) conduct operational research on GBV where relevant. Umbrella NGOs and Integrated Centers of Excellence shall submit quarterly progress activity reports to the FSDRC Heads of Field Offices persons based on their respective work plans and budgets. Umbrella NGOs and Integrated Centers of Excellence shall submit biannual project technical and financial reports to the FSDRC.

Project Management Unit

147. As the implementing agency, the FSDRC will recruit and put in place a Project Management Unit (PMU) responsible for the day to day management of project activities under the overall oversight of the FSDRC General Coordinator. This will include: (i) a dedicated Finance and Administration Specialist; (ii) Project Coordinator; (iii) a Community Mobilization and Behavior Change Specialist; (iv) Health Specialist; (v) Livelihoods Specialist; (vi) Monitoring and Evaluation Specialist; (vii) a M&E assistant focusing on GRM; (viii) a Chief Accountant; (ix) a Procurement Specialist; and (x) a Social and Environmental Safeguards Expert.

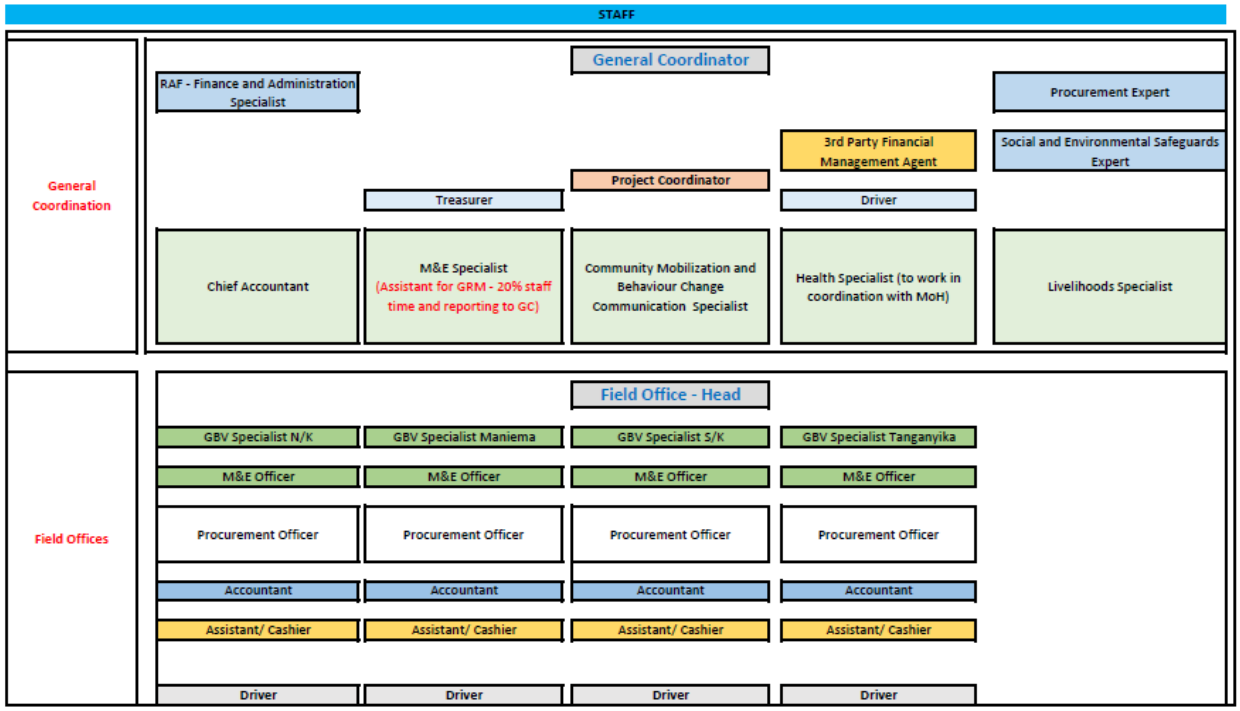
148. The main responsibilities of the FSDRC will be as follows: (i) developing the PIM; (ii) preparing Annual Work Programs and Budgets (AWPB); (iii) contracting goods; (iv) preparing regular reports including quarterly reports on program implementation progress and financial monitoring reports; (v) updating procurement plans (every six months); and (vi) coordinating project activities with key line agencies. Dedicated GBV Specialists, M&E and Procurement Officers and Accountants will be put in place at field office level to ensure effective oversight of project activities.

149. The MoPH Reproductive Health Department will oversee the technical aspects of Component 2B implementation. The current composition of the MoPH team is considered adequate to perform this function. The MoPH team will be supported through the additional Health Specialist position at FSDRC level.

150. All new positions will be competitively recruited, based on agreed upon Terms of Reference (ToRs) and technical skills and qualifications. A number of positions: (i) Project Coordinator; (ii) Procurement Specialist; (iii) Chief Accountant; (iv) Monitoring and Evaluation Specialist are already in place at FSDRC level and will

require an adjustment in Terms of Reference to reflect the increased level of responsibility and seniority. In order to maintain the continuity at the level of the FSDRC technical staff it is expected that staff currently holding these posts will continue performing these duties under the new ToRs following a performance review.

Figure 10: Project Support Team



Financial Management

151. **As part of project preparation, a financial management assessment of the FSRDC was carried out (at the central and Provincial levels)**. The objective of the assessment was to determine whether the FSDRC has adequate financial management capacity to ensure that: (a) project funds will be used for purposes intended in an efficient and economical way; (b) project financial reports will be prepared in an accurate, reliable and timely manner; and (c) the project's assets will be safeguarded. The financial management assessment was carried out in accordance with the Financial Management Practices Manual issued by the Financial Management Sector Board on November 3, 2005 as revised in March 2010. In this regard, a review of the existing FM system (budgeting, staffing, financial accounting, financial reporting, funds flow and disbursements, internal and external audit arrangements) of the FSRDC in Kinshasa and at the Provincial level was conducted.

Implementation arrangements

152. The FSDRC will be responsible for overall project management including the fiduciary aspects. The FSRDC has good experience in implementing WB financed projects, and is currently managing the ongoing Eastern Recovery project (P145196) as well as the GL GBV project (P147489). Currently, the FSDRC is staffed, in Kinshasa, on the FM side, with: (i) an experienced FM Manager in charge of the coordination of all FM activities of the two ongoing projects mentioned above, (ii) an experienced Accountant, and (iii) a Treasurer. Fiduciary staff at provincial level is comprised of one accountant and a cashier for each province.

153. In order to mitigate fiduciary risks to the extent possible, the following actions will be undertaken: (i) recruitment of project fiduciary staff including a Finance and Administration Specialist, an Accountant, and a Treasurer in Kinshasa and an additional accountant in each of the field offices to work exclusively on this project; (ii) updating the GL GBV financial and accounting manual to accommodate the requirements of the new project; (iii) preparing a simplified financial and accounting manual for NGOs, Integrated Centers of Excellence and health facilities for components 1 and 2 as well as for the Ministry of Health for component 3; (iv) upgrading the project software (TOM2PRO) for deployment to the provincial level; (v) hiring a third-party FMA to provide close monitoring support and conduct in depth-reviews of transactions on a quarterly basis; (vi) improve transparency and availability of information on project implementation to the public including through the establishment of a Grievance Redress Mechanism (GRM). The format for IFRs and ToRs for the third-party FMA were agreed with the counterpart during pre-appraisal.

Country issues

154. DRC is gradually emerging from a decade of political instability, conflict, and mismanagement of public finances. Recently, structural reforms have been launched in the areas of economic governance, public expenditure management, and transparency. The ongoing Strengthening PFM and Accountability project (PRCGAP P145747) as well as the DRC Establishing Capacity for Core Public Management (PFMAP P117382) are helping the country to strengthen capacity in both public and private administration and tackle corruption and mismanagement. Although there is cause for cautious optimism, it will take time for these reforms to yield substantial improvement in the management of public funds. Given the fragility of the fiduciary environment, the Government has requested that a ring-fenced approach to implement the project be used (in line with the approach followed for other WB financed projects in the country).

Risk Assessment and Mitigation

155. The following risk identification worksheet summarizes the significant risks with the corresponding mitigating measures. **The overall residual FM risk rating is deemed Substantial**

Table 4: FM Risks

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Y/N)	Residual Risk
Inherent risk	**MI**			**MI**
Country level DRC is a high-risk country from the fiduciary perspective. The PER, the PEMFAR reports outlined PFM weaknesses at central and decentralized government levels and sectoral ministries level in term of governance and of management of public funds.	H	The government is committed to a reform program that includes strengthening PFM systems. Ongoing IDA-financed projects PRCGAP (P117382), and PFMAP (P145747) will strengthen the PFM system at central level and in selected provinces. However, it is unlikely to yield results quickly enough to impact the proposed project. Use of IDA FM procedures is required for this project.	N	H
Entity level The assessment of some ministries during the PEFA revealed internal control weaknesses and weak fiduciary environment.	S	Dedicated FM team to be recruited. Use of WB's fiduciary procedures will be critical to mitigate fiduciary risk in the project. Hiring a third-party fiduciary monitoring agent to provide close monitoring support and conduct transaction reviews on a quarterly basis.	N	S
Project level The project will be implemented at National and Provincial level and may face coordination challenges. Ensuring funds are used for purposes intended may constitute a challenge.	S	Training on fiduciary procedures will be conducted for all FM staff throughout the life of the project. Clear TORs for each staff will be agreed and included in the PIM. Ex-ante and ex-post controls will be strengthened by ensuring clear separation of duties. The scope of external auditors' and FM supervision will include review of expenditures incurred at all levels.	N	S
Control Risk	**S**			S
Budgeting The budgeting process is fairly complex. Inputs are required from all implementing entities which could result in delays in the preparation of the budget; weak budgetary execution and control; risk that the institutions to which funds are sent do not spend allocated funds in a timely fashion and do not accurately report on expenditures.	S	The project´s financial and accounting manual will define budget preparation and execution arrangements as well as the procedures to develop annual detailed disbursement forecasts. IFRs will provide information on budgetary control and analysis of variances between actuals and budget. The Annual Work Plans and Budgets (AWPB) will be prepared by the FSDRC with inputs from MoPH at the Provincial level and will consolidated at National level by FSRDC before submission to the WB.	N	M

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Y/N)	Residual Risk
Accounting This project will use the accounting software as for all other World Bank financed projects in DRC. The existing software (TOM2PRO) might be adapted and used to accommodate financial information for this project. The risks will be the following: Poor policies and procedures, delay in keeping reliable and auditable accounting records. Risk of increasing the workload leading to some delays in submitting the reports.	S	The project will adopt the OHADA accounting system. Accounting procedures will be documented in the manual of procedures; the FM functions will be carried out by qualified staff to be recruited on a competitive basis; and the existing software will be customized to take into consideration the project needs. Fiduciary staff will be trained on the use of the software at all levels.	N	S
Internal Control Insufficient safeguards and controls may result in misuse of funds and impact project implementation	S	Revision and adoption of a FM manual of procedures (which will be distinct from the PIM). Training on the use of the manual by all fiduciary staff recruited. It is expected that FM staff will be in place before project effectiveness.	N	M
Funds Flow: (i) delays in disbursements of funds to Implementing entities and beneficiaries, (ii) delays in DA replenishment at central level, (iii) potential misuse of funds/ use of funds for non-intended purposes.	S	The following are the mitigating measures: (i) close monitoring by the fiduciary oversight agency, (ii) frequent WB supervision missions, (iii) the ToRs of the External Auditors will include physical verification of goods and services acquired.	N	S
Financial Reporting Inaccurate and delayed submission of IFRs to the WB due to delays on the part of implementing entities.	S	(i) A computerized accounting system will be used and the IFR format will be customized, (ii) IFR and financial statements formats were agreed upon. The format used for the GL GBV project will be maintained. The IFR template will be included in the FM manual of procedures.	N	M
Auditing The national audit capacity is weak and not reliable. A qualified external auditor will be appointed to audit all projects.	S	(i) The project's institutional arrangements allow for the appointment of adequate external auditors and the ToRs will include field visits and physical verification of project assets.	N	S

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Y/N)	Residual Risk
The risk would be the delay in submission of audit reports or qualified opinion and delays in the implementation of audit report recommendations. Lack of coordination for the selection of external auditor and acceptability of audit reports.		(ii) Annual auditing will be carried at FSDRC (central and Provincial levels) at the level other implementing entities. This will be done in accordance with International Standards on Audit. (iii) Auditor's recommendations will be monitored during project supervision missions.		
Governance and Accountability Possibility of circumventing the internal control system with colluding practices such as bribes, abuse of administrative position, mis-procurement, is a critical issue.	S	(i) The TOR of the external auditor will comprise a specific chapter on corruption auditing. (iii) Robust FM arrangements (qualified individual FM staff recruited with ToRs acceptable to IDA, quarterly IFRs, including budget execution and monitoring). (iii) Measures to improve transparency such as providing information on the project status to the public. (iv) A GRM for the project put in place at all levels.	N	M
OVERALL FM RISK	**H**			**S**

Capacity assessment of Integrated Centers of Excellence (CoEs)

156. A detailed assessment of the FM capacity of the Integrated CoEs Panzi Foundation and Heal Africa was carried during project preparation. The assessment report findings are available in the project records. Overall, both CoEs were found to have appropriate fiduciary platforms, operating manuals that comply with international standards, accounts maintained in accordance with OHADA accounting standards. Importantly, the financial and accounting systems reviewed were found to allow for the adequate management of funds from several donors and funding sources. Based on the detailed assessment carried out FM risk at level of the Integrated Centers of Excellence was rated Moderate.

Implementing Entity

157. The FSRDC fiduciary team will have overall responsibility for the coordination of administrative and fiduciary aspects of project implementation, financial management reporting and for ensuring the smooth flow of funds to different agencies and institutions at the central and Provincial levels. The World Bank will have the right to review the CV of identified experts and provide comments before their formal appointment. The overall selection should be finalized before effectiveness. The hiring of the Finance and Administration Specialist is a condition of effectiveness. The fiduciary team and other implementing entities will be trained on the use of the FM manual as well as the project's software.

Planning and Budgeting

158. The Annual Work Plan and Budget (AWPB) and the disbursement forecasts will be consolidated at provincial level by the FSRDC. This document will then be submitted to the FSDRC at central level for further review and consolidation. The final consolidated AWPB will be submitted to the WB no later than December 15 of the year preceding planned implementation.

159. Implementing entities will monitor AWBP execution using the accounting software and in accordance with the budgeting procedures specified in the PIM. Variances will be reported in the quarterly IFR. The budgeting system will forecast for each fiscal year the origin and use of funds under the project. Only budgeted expenditures will be committed and incurred to ensure that resources are used within the agreed upon allocations and for the intended purposes. The quarterly IFRs will be used to monitor the execution of the AWPB.

Information and Accounting Systems

160. DRC is a member of the "*Organisation pour l'Harmonisation en Afrique du Droit des Affaires"* (OHADA). It adheres to its accounting standards, (Syscohada), in line with the international standards. Syscohada standards will therefore apply to this project. Integrated financial and accounting systems are already in place and being used by the FSDRC (SUCCESS at the central level, TOMPRO at the decentralized level). The project code and chart of accounts will be developed to meet the specific needs of the project and documented in the PIM. The software programs will be upgraded for the project. The upgraded system is expected to include a general diary, auxiliary diaries, general balance, cash and fixed assets records. The chart of accounts should be prepared according to the wording used in tables for sources and uses of funds for the accepted eligible expenditures as agreed during project negotiations. These diaries and records will be maintained with the support of financial management software that should be operational no later than three (3) months after project effectiveness. Newly recruited fiduciary staff will be trained in the use of the software.

Internal control and financial, administrative, and accounting manual

161. The existing implementing units at central and decentralized levels have a financial management manual which details key internal control procedures covering transaction initiation, review, approval recording and reporting. The manual will be updated within 3 months of effectiveness to take into consideration any specific concerns relating to this project. There will be a clear separation of duties within the financial management units.

Funds Flow Mechanism

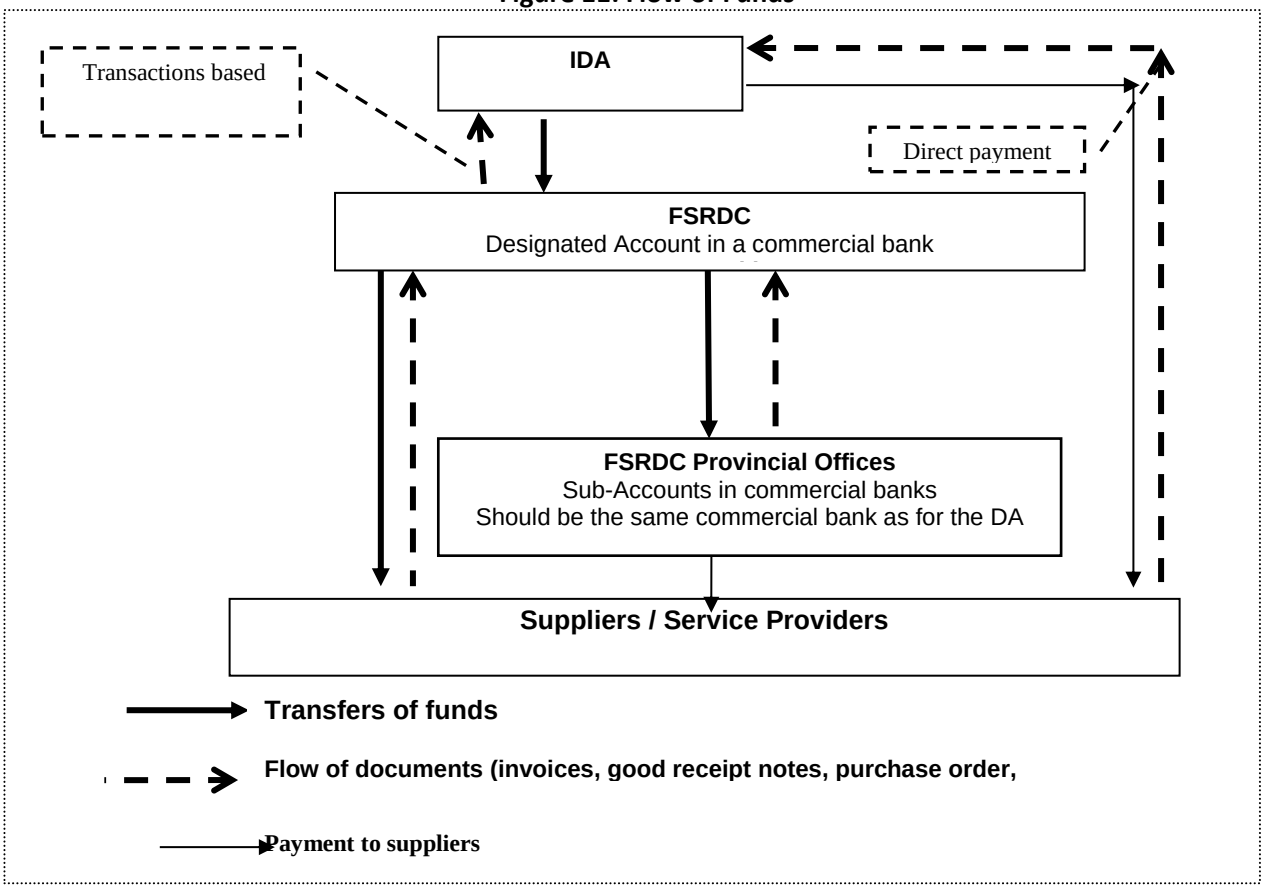
162. **Funds Flow and Disbursement Arrangements**: A DA will be opened, under the fiduciary responsibility of FSRDC, in a commercial bank on terms and conditions acceptable to IDA. The ceiling of the DA is set at US$ 5.5 million equivalent to four (4) months expenditures forecast and will become effective upon grant effectiveness. This DA will be used to finance all eligible project expenditures under the different components. Payments will be made in accordance with the provisions of the PIM (e.g., two authorized signatures will be required for any payment). FSRDC will open sub accounts at provincial level. These sub-accounts will be used to pay all expenditures at the decentralized level. Replenishment of these accounts

will be done at least once a month upon submission of acceptable expenditures recap along with supporting documents. Payments from the sub-accounts will be subject to arrangements acceptable to the WB. The DA will be replenished against Withdrawal Applications (WA) supported by Statements of Expenditures (SOE) and other documents providing evidence of eligible expenditures as specified in the Disbursement Letter (DL). All supporting documents will be retained by the project and will be readily accessible for review by periodic IDA Implementation Support Missions (ISM) and external auditors.

Disbursements

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

Figure 11: Flow of Funds



164. Disbursement of funds to other service providers and suppliers*:* The FSRDC will make disbursements to service providers and suppliers of goods and services in accordance with the payment modalities, as specified in the respective contracts/conventions and the procedures described in the PIM. In addition to these supporting documents, the FSRDC will consider the findings of the FMA while approving payments. The FSRDC, with the support of the FMA, will reserve the right to verify the expenditures ex-post, and refunds might be requested for non-respect of contractual clauses. Misappropriated activities could result in the suspension of financing for a given entity or service provider.

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

Table 5: Disbursement categories

Category	IDA / Amount of the Financing Allocated (expressed in US$)	Percentage of Expenditures to be Financed [(inclusive of Taxes])
(1) Goods, works, non-consulting services, consulting services, Training and Operating Costs	96,829,310	100%
(2) Performances Grants	1,239,840.00	Amount payable pursuant to Section 2.07 of the General Conditions
(3) Emergency Expenditures	0	
(4) Refund of preparation advance	1,930,850	
TOTAL AMOUNT	100,000,000	100%

Financial Reporting

166. For the proposed Project, the FSRDC will be required to prepare monitoring financial reports as defined in the Project's Financing Agreement (FA). These reports will be submitted to IDA on a quarterly basis within the 45 days following the end of each quarter. This report will include: (i) a table with sources and use of funds; (ii) table with use of funds per activity; (iii) table regarding use of funds according to procurement methods and thresholds; and (iv) table with monitoring and evaluation or physical advance of activities. Financial statements will be prepared for each financial exercise covering in general twelve (12) months. Interim financial statements will also be prepared considering: (i) certified status of expenditures; and (ii) an analysis of DA management. The format of such reports was agreed during Project preparation. It is expected that a single monitoring report will be prepared consolidating information provided by all

implementing agencies before submission to the World Bank.

External Audit

167. The financial statements for the proposed project will be the object of an external audit prepared by an independent firm selected according to procedures acceptable to the WB. Audit reports produced by this auditor will be submitted to IDA six (6) months after the end of each fiscal year (before June 30). These reports will include: (i) report on the financial statements; (ii) report on special accounts and certified statements of expenditure; and (iii) a report on internal control procedures or letter of recommendation. The terms of reference for the selection of the external auditor will be prepared by the FSRDC and submitted to IDA for comments.

168. **Governance and Accountability:** the risk of fraud and corruption is high. The effective implementation of fiduciary mitigation measures is expected to contribute to strengthening the control environment. Oversight by the FMA and the establishment of the project's GRM will further contribute to tackling governance and corruption risks during implementation

Financial Management Action Plan

169. The Financial Management Action Plan described below has been developed to mitigate the overall financial management risks.

Table 6: Financial Management Action Plan

Issue	Remedial action recommended	Responsible entity	Completion date	FM Conditions
FM staffing	Recruit project fiduciary staff both at the central and the provincial levels.	FSDRC	By effectiveness	Y (only for the Finance and Administration Specialist at central level)
Accounting software	Upgrade the existing software and train the fiduciary staff on the use of that software.	Implementing Entities	Three months after effectiveness	N
FM and accounting Manual of procedures	Update the FM manual and prepare a simplified manual of procedures for implementing entities	FSDRC	Within 3 months of project effectiveness	N
FM and accounting Manual of procedures	Staff training on the use of these manuals	FSDRC	Within 3 months of project effectiveness	N
Fiduciary agency	Recruitment of a fiduciary monitoring agency	FSDRC	By effectiveness	Y
Complaint handling mechanism	Develop a complaint handling mechanism	FSDRC	Three months after effectiveness	N
Reporting (IFRs)	Agree on the format and content of Unaudited Interim Financial Reporting's (IFRs)	FSDRC/BM	Agreed during negotiations	N
External auditing	Selection of external auditor	FSRDC	Six months after effectiveness	N

Implementation Support Plan

170. Supervision missions will be conducted over the project's lifetime. The project will be supervised following a risk-based approach. Supervision will include the review of audit reports and IFRs and advice to the WB task team on all FM issues. Based on the current risk assessment, the project will be supervised at least twice a year. The frequency of supervision may be adjusted when the need arises. The ISR will include the FM rating for the project. An implementation support mission will be carried out before effectiveness to ensure project readiness. To the extent possible, mixed on-site supervision missions will be undertaken with procurement, monitoring and evaluation and disbursement colleagues. Based on the outcome of the FM risk assessment, the following implementation support plan is proposed:

Table 7: Implementation Support Plan

FM Activity	Frequency
Desk reviews	
Interim financial reports review	Quarterly
Audit report review of the program	Annually
Review of other relevant information such as interim internal control systems reports.	Continuous as they become available
On site visits	
Review of overall operation of the FM system	Annually (Implementation Support Mission)
Monitoring of actions taken on issues highlighted in audit reports, auditors' management letters, and other reports	As needed
Transaction reviews (if needed)	As needed
Capacity building support	**As needed**

Procurement

171. **Applicable Procurement regulations:** The procurement of goods, works, non-consulting, and consulting services for the project will be carried out in accordance with the procedures specified in the 'World Bank Procurement Regulations for IPF Borrowers' dated July 2016 (Procurement Regulations) and revised in November 2017 under the New Procurement Framework (NPF). Procurement will also take place under the World Bank's 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants' (revised as of July 1, 2016), as well as the provisions stipulated in the Financing Agreement.

172. **A PPSD was prepared with WB support to ensure the procurement activities are packaged to expedite implementation considering**: (i) the market analysis and the related procurement trends; and (ii) the procurement risk analysis. The PPSD includes the recommended procurement approaches for the project that have been reflected in the Procurement Plan covering the first 18 months of project implementation.

Box 1: Summary of PPDS

The FSDRC will procure and implement activities envisaged for the project. The FSDRC will competitively select Umbrella NGOs for the implementation of Component 1. The provision of mental health support under Component 1 will be undertaken by the NGO VIVO international through a Single Sourcing Selection (SSS) process. Similarly, the FSDRC will enter into SSS contracts with Integrated Centers of Excellence following Single Sourcing Selection for the implementation of Component 2A. In addition, the FSDRC will procure emergency medication through existing agreements with UN Agencies for the implementation of Component 2B. The Ministry of Public Health will be a sub-recipient under the FSDRC.

The procurement profile of the project is comprised of various consultancies, procurement of goods such as motor vehicles, ICT and office equipment, emergency medication, and alterations and refurbishment works of low value, and non-consulting services for printing of various materials required under the project. Critical consultancy contracts are also envisaged under the project. After careful evaluation of various options for contracting strategy, hybrid contracting methods (lump sum and time based) would be used for optimum benefit and as fit for purpose for the project. This approach will ensure the optimum utilization of resources and value for money.

In consideration of the geographical disparities of the project districts and the scattered nature of minor works envisaged under the project, such as alterations and refurbishment of health centers contracts will be packed on a Provincial basis.

To monitor the implementation progress of the various initiatives at Provincial level a multi-tiered institutional monitoring mechanism has been created and a Project Management Information System MIS will be rolled out to targeted Health Zones. To mitigate procurement capacity risks, there will be need for staff capacity building and training, continuous oversight, reviews and audits and use of real-time monitoring and tracking tools. An international procurement expert will be recruited to provide training to the FSDRC during the project´s start-up and a FMA will be recruited to provide additional support and oversight on financial management.

173. Procurement Plan. The Procurement Plan, includes the following information for each contract (a) a brief description of the activities/contracts; (b) the selection methods to be applied; (c) the cost estimates; (d) time schedule; (e) the World Bank's review requirements; and (f) any other relevant procurement information. The final Procurement Plan covering the first 18 months of the project implementation was approved during project negotiations. Any updates of the Procurement Plan shall be submitted for World Bank approval. The recipient shall use the World Bank's online Systematic Tracking of Exchanges in Procurement tool (STEP) to prepare, clear, and update the Procurement Plans and manage all procurement transactions and related documentation.

174. Institutional arrangements for procurement. The FSRDC will be responsible for ensuring that the fiduciary aspects of the project are managed appropriately. The procurement unit will be trained and strengthened to carry out procurement activities under the project. An international qualified and experienced procurement expert will be recruited temporally to train and assist the procurement unit. Procurement staff will be trained on procurement regulations.

175. Procurement risk assessment. Given the (i) country context and associated risk; (ii) the fact that FSRDC does not yet have specialists at provincial level (where all signed contracts will be implemented), and (iii) the fact that this project will be implemented under the World Bank New Procurement Framework for which FSRDC has no experience, **the procurement risk is rated High**. **The prevailing risk can be reduced to substantial provided that the corrective measures in the table below are implemented**.

Table 8: Procurement Action Plan

Ref	Tasks	Responsibility	Due Date
1	Recruit a qualified procurement specialist for each FSRDC provincial field office responsible to carry out procurement activities	FSDRC RDC	Within three months of effectiveness
2	Train the procurement staff on the World Bank's New Procurement Framework (online courses and face-to-face courses).	FSDRC	Within six months of effectiveness
3	Strengthen capacity on the use of Systematic Tracking of Exchanges in Procurement (STEP) tools, to manage all procurement transactions and related documentation.	FSDRC	Within six months of effectiveness
5	Update the PIM to include procurement procedures and arrangements for the project along with the standard and sample documents to be used.	FSDRC	Condition of effectiveness
6	Develop a contract management system to ensure that all contracts under the project are effectively and efficiently managed.	FSDRC	Continuously
7	Recruit an international qualified and experienced procurement expert who will provide support for specific training sessions for the procurement unit at central and provincial level.	FSDRC	Within three months of effectiveness

176. Frequency of procurement supervision. In addition to the prior reviews to be carried out by the WB, at least two Implementation Support Missions will be carried out annually (including field visits) for a post review of procurement actions. As agreed with the Borrower, contracts will be published online. Annual compliance verification monitoring will also be carried out by the FMA and will aim to (a) verify that the procurement and contracting procedures and processes followed for the projects were in accordance with the Financing Agreement; (b) verify technical compliance, physical completion, and price competitiveness of each contract in the selected representative sample; (c) review and comment on contract administration and

management issues as dealt with by the Procurement unit; (d) review capacity of the FSRDC in handling procurement efficiently; and (e) identify improvements in the procurement process in light of any identified deficiencies.

Environmental and Social (including safeguards)

177. **The Project's geographical coverage includes North and South Kivu as well as Tanganyika and Maniema Provinces with presence of the Twa Indigenous Peoples' (IP).** To ensure that this IP group is able to benefit from the proposed project interventions, safeguard policy OP/BP 4.10 has been triggered. The Indigenous People's Policy Framework (IPPF) was approved by the Regional Safeguards Advisor on April 27, 2018 and disclosed on May 3, 2018. An Indigenous People's Plan (IPP) will subsequently be prepared once targeted *Aires de Santé* have been defined for North and South Kivu as well as Maniema Province and Health Zone coverage validated for Tanganyika Province. Free, prior and informed consultations have been carried out with Twa communities. Some of the identified potential positive effects of the project for IP communities include increased use of available health care services as well as delivery of culturally appropriate GBV prevention and response services. The project will promote socio-cultural interaction, coordination and consultation with traditional leaders prior and during implementation. It is therefore essential that civil society partners selected to implement Component 1 employ staff who speak local dialects and are conversant with the socio-cultural norms and belief systems of IP groups.

178. **The project will ensure the measures to address the risk of Sexual Exploitation and Abuse (SEA) of project beneficiaries, staff and contractors are put in pla**ce. This will include: (i) the adoption of Codes of Conduct by all staff and contractors, (ii) the development and roll-out of training modules on the prevention of SEA and Sexual Harassment by a specialized service provider; and (iii) the inclusion in the GRM of dedicated channels and approaches for the reporting and management of SEA related complaints.

179. **The interventions under the project involve improvement in the provision of health services, handling of medical products as well as small scale rehabilitation of health facilities (limited to small internal repairs, painting, installation of screen or partitions for further privacy).** Project activities will contribute to improved health services and a case load of two GBV survivors/month/health center are expected. Given the estimated additional case load, increased generation of medical waste at health facility level is not expected. Small scale rehabilitation works may pose minor health and safety risks. In addition, Component 1 will include support for small scale livelihood activities (potentially including agricultural and small-scale husbandry). Consequently, the Project triggered the following Environmental Safeguards Policies: Environmental Assessment OP/BP 4.01 and Pest Management OP/BP 4.09. The potential environmental impacts can be adequately managed by integrating environmental due diligence into the Project cycle. Given limited likelihood of environmental and social impacts, the Project is rated as Environmental Assessment Category B.

180. **An environmental and Social Management Framework (ESMF) was prepared through a consultative process during project preparation.** The ESMF provides basic guidance on environmental screening and where necessary on the development of Environmental Management Plans (EMP) during implementation. The ESMF was shared with the Regional Safeguards Advisor on April 20, 2018 and approved on April 24, 2018.

Disclosure took place on May 3, 2018.

181. Climate change and disaster risk screening. The Project was screened for short and long-term climate change and disaster risks as well as climate change adaptation co-benefits. The results indicate DRC may be slightly exposed to climate risks with regards to flooding, precipitation, and landslides, however, the overall risk is expected to be low with low potential impact. Similarly, no relevant adaptation co-benefits were identified. No regular assessments of potential climate change impacts (or further analysis of potential benefits) are expected to be carried out during the Project implementation period.

Monitoring and Evaluation

182. Project preparation has indicated that there are no significant gaps in terms of data collection on GBV through existing sources of routine data currently used by the GL GBV project. The project will invest in further strengthening the project specific Management Information System (MIS) using the GBV Information Management System (IMS) format and on improving the quality and reliability of project specific data. For activities under Component 1, specialized service providers will ensure the monitoring and tracking of GBV prevention activities and the provision of multi-sectoral services to GBV survivors given their critical role in ensuring effective referrals and serving as victim-advocated during the referral process. Under Component 2, data on provision of health services will be tracked using existing/routine data collection systems by MoPH. Indicators selected to track progress take into account the existing constraints in terms of data collection.

183. The project will include a process evaluation to closely monitor the quality of services provided as well as an impact evaluation focusing on mental health interventions. This will include a final round of data collection to complete the evaluation process initiated under the GL GBV Project.

184. The FSDRC will submit narrative progress reports (every six months) and IFRs (quarterly) to the World Bank in accordance with the reporting requirements to be set out in the PIM. The mid-term review will provide the opportunity to assess progress for appropriate mid-course corrections as needed.

ANNEX 3: IMPLEMENTATION SUPPORT PLAN

COUNTRY : Congo, Democratic Republic of
DRC - Gender Based Violence Prevention and Response Project

Strategy and Approach for Implementation Support

185. **All costs related to implementation support are covered directly by the World Bank. The implementation support arrangements and team composition reflect the multi-sectoral nature of the project (with social development, health and social protection expertise).** The strategy for supporting project implementation will focus on successfully putting in place measures to address the risks identified during project preparation and consists of: (i) implementation support missions and (ii) technical assistance in areas of greater technical complexity.

186. **In addition, the approach to supervision takes into account the volatile security situation in targeted Provinces and the fact that the World Bank team may face difficulties in temporarily accessing targeted Health Zones**. Given the accelerated project preparation time-frame and the complexity of the multi-sectoral intervention required to address GBV in line with international best practice, significant implementation support is expected to be required during the initial implementation stages.

187. **Key preparatory activities to kick-start implementation proper will take place during Year 1 of project implementation including**

- **Component 1:** (i) development of the detailed protocol of community based prevention and integrated support activities; and (ii) validation of selected *Aires de Santé* in North and Kivu as well as Tanganyika and Maniema.
- **Component 2:** (i) detailed costed assessment of the rehabilitation and equipment needs of health centers; (ii) and assessment of the current PBF mechanism in Maniema.
- **Component 3:** (i) detailed design of the Project process evaluation; and (ii) development of the community-based M&E system.

Implementation Support Plan and Resource Requirements ~

188. **The Implementation Support plan will include**: (i) implementation support missions conducted every three months; and (ii) Mid-Term Review (MTR) to carry out a comprehensive assessment of the progress achieved at the mid-point in implementation and identify project design and/or implementation issues that would require substantial adjustments to the proposed approach. In addition, the project will put in place a comprehensive monitoring system to ensure the robustness of the MIS data collected and to triangulate information received from the field building based on the lessons-learned by the WB in terms of implementation in fragile contexts. The key building blocks of the approach to monitoring and implementation support are as follows**.**

189. **Support to strengthen the project´s MIS.** The preparation process included a rapid review of the MIS currently used by the GL GBV project. The system is based on the GBV Information Management System and was found to provide reliable information on project activities and outcomes. The current project will therefore support the roll-out of this system and ensure adequate training of new partners on its use as well as the establishment and

signature of clear data sharing protocols with all new partners. The FSDRC team will include a dedicated Monitoring and Evaluation Officer in each of the Provincial field offices. This will strengthen their ability to review the quality of the data received in a timely manner and to conduct field level checks. The on-line database will allow the coordination team in Kinshasa to have an overview of trends in project implementation and to identify areas where additional implementation support and corrective action may be required.

190. External Process Evaluation focusing on the quality of services delivered and conducting spot checks of MIS data. Building on the lessons-learned from the GL GBV implementation, the project will include a stronger focus on periodically assessing the quality of services provided. A dedicated firm or NGO will be brought on board by the FSDRC to oversee the implementation of an annual process evaluation using qualitative research methods. The scope of this external assessment will be adjusted annually based on project needs and can be scaled up and modified to review challenging areas in terms of project implementation and to provide detailed information on more remote areas. The process evaluation will include an element of spot checks based on the available MIS data. This will allow the FSDRC to verify the quality of MIS data and to triangulate the information received.

191. Spot checks of the quality of medical services delivered by the Umbrella NGOs providing support to survivors. The NGOs to be contracted for the implementation of GBV prevention and integrated community support activities will play a key role as victims´ advocates. Through their case management interventions, the NGOs will generate and share information on the quality of the medical services received. A check-list will be developed for this purpose by the project. This approach will similarly allow FSDRC and MoPH to triangulate the information on the quality of services, availability of essential medication and equipment at health center level.

192. A community-based monitoring approach will be put in place by the FSDRC. This will include a set of periodic consultations to be undertaken semi-annually. These will be managed by the FSDRC M&E unit and will seek primarily to elicit feedback on the overall quality and inclusiveness of the GBV prevention and response programs implemented. The FSDRC will rely on the trained pool of community activists to lead these sessions and will apply participatory social audit and/or community score cards methodologies to ensure a degree of standardization of the information collected.

193. Robust Grievance Redress Mechanism (including periodic community consultations). The information collected through the project's GRM will be analyzed by the FSDRC's monitoring unit and help identify areas where implementation will require further strengthening and/or corrective action. Given the expected barriers to reporting at community level the GRM will include multiple entry channels for complaints as well as the community feedback sessions highlighted above. This will create a dedicated space for communities to voice their grievances and provide feedback on the general quality of services available to them.

194. Finally, as highlighted in the Fiduciary Management section, the project will include dedicated support to monitor financial transactions through an external FMA. The firm to be selected will support the FSDRC in building the capacity of partners on FM and will complement the FSDRC's own supervision.

195. In addition, Implementation Support Missions will specifically focus on: (i) reviewing the quality of implementation, (ii) finding solutions to issues identified with FSDRC and MoPH, (iii) assessing the likelihood of achieving the PDO in line with the results achieved against the indicators in the project's results framework; (iv) reviewing progress with the implementation AWPBs; (v) reviewing compliance with legal covenants; (vi) taking stock of project's fiduciary aspects, including disbursement and procurement; (vii) verifying compliance of project activities with Word Bank environmental and social safeguard policies.

196. At the technical level, the World Bank team will ensure that the appropriate mix of technical skills and experience is mobilized for implementation support missions and to provide just-in-time technical advice as needed.

- **Financial management**. The World Bank will require that quarterly interim financial reports and an annual external audit report be submitted for review. The World Bank will also review project-related information such as the internal control systems' report. Bi-annual onsite visits will also be carried out to review the financial management system including internal controls. Monitoring of actions taken on issues highlighted in audit reports, auditors' management letters, reports by the FMA and other reports will be reviewed (including transaction reviews). Financial management training of relevant staff is expected to be carried out within three months of project effectiveness. Additional financial management training will be conducted during project implementation as needed.

- **Procurement**. The World Bank will undertake implementation support missions every six months. These will include a thorough review of contracts in place and an assessment of performance in following procurement procedures. Similarly, training in procurement of the PIU staff will be carried out within six months of project effectiveness and additional training conducted throughout implementation as needed.

- **Safeguards.** The World Bank's safeguard team will consist of social and environmental specialists who will: (i) guide the project team in implementing the project's safeguard instruments; and (ii) review compliance with safeguard policies during implementation support missions.

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	• Project implementation start up • Establishment of the PMU and coordination mechanisms at national and Provincial level • Orientation and strengthening of implementation capacity, including monitoring and evaluation (M&E) • Capacity building and mentoring of staff at all levels on procurement, financial management, M&E, and safeguards • Development of monitoring and evaluation strategy • Establishment of the project's GRM • Engineering assessments to inform rehabilitation of facilities • Development of Protocol for Community-Based GBV intervention and procurement of specialized service providers	• Project Management • Health • Gender-Based Violence • Livelihoods • Environment • Social Development • Financial management • Procurement • M&E	US$250,000	
12-48 months	• Implementation Support missions with Government counterparts to monitor implementation performance including progress against targets of the Results Framework • Review of annual work plans and disbursement schedule • Review quality of quarterly/annual reports • Review of audit reports and	• Project Management • Health • Gender-Based Violence • Livelihoods • Access to Justice • Environment • Social Development • Financial management	US$180,000/annually	

	interim financial report • Review adequacy of the financial management system and compliance • MTR undertaken (during year 3)	• Procurement • M&E		
Other	Same as above and in addition • Project Evaluation • Project completion and Implementation Completion Report preparation	• Same as above	Same as above	

ANNEX 4: TARGETING APPROACH

188. The proposed project will focus its interventions on Provinces where underlying high level of GBV and acceptability of GBV have been exacerbated by growing insecurity. The project will therefore focus initially on consolidating the gains made in North and South Kivu, building on the lessons-learned under the Great Lakes Emergency Sexual and Gender-Based Violence and Women's Health Project (P147489 – GL GBV). The project will subsequently expand activities (from Year 2 of project implementation) to Tanganyika (part of Katanga Province under the 2014 administrative boundaries) and Maniema.

189. Project resources funding: (i) community level GBV prevention and integrated support for survivors as well as; (ii) the strengthening of first response services will be concentrated in the 38 Health Zones outlined in Table 9 below with an estimated average population of 13.5 million people.

Table 9: Target areas for community level prevention and response services

Targeted Health Zones			
South Kivu	**North Kivu**	**Maniema**	**Tanganyika**
1. Fizi	1. Binza	1. Kasongo	1. Kalemie
2. Kaniola	2. Kayna	2. Kibombo	2. Niemba
3. Kimbi/Lulenge	3. Mabalako	3. Kabambare	3. Nyunzu
4. Shabunda	4. Alimbongo	4. Kunda	4. Manono
5. Lulingu	5. Lubero	5. Lusangi	5. Moba
6. Minova	6. Kalunguta	6. Tunda	
7. Lemera	7. Mutwanga	7. Samba	
8. Kalonge	8. Nyirangongo	8. Saramabila	
9. Mulungu	9. Rwanguba		
10. Kitutu	10. Ruthshuru		
11. Kalole	11. Kirotshe		
12. Haut plateau	12. Masisi		
	13. Mweso		

190. The Kasaï Famine Risk Reduction Project (P162517) currently under preparation will include targeted interventions on GBV prevention and response. The current project will therefore not target the Kasaï Province but will include the development of a targeting and roll-strategy for GBV programming in the Kasaï and in Equateur Provinces (Additional details were provided in Annex I).

191. The process for the selection of Health Zones in North and South Kivu followed a detailed consultative process led by the FSDRC with: (i) DHP, (ii) the GBV Coordination Cluster including UN Agencies and Humanitarian Actors; (iii) Integrated Centers of Excellence and civil society organizations. Activities will continue in the areas currently covered by the GL GBV. In addition, further health zones were identified based on estimated incidence of GBV and absence of other partners and service providers as well as

accessibility and security considerations. In Maniema, the project will align itself with the ongoing health interventions funded by PDSS to create synergies with broader capacity building efforts with the health sector. Finally, a field assessment and consultations were conducted with partners in Tanganyika during project preparation to ensure that a similar consultative process and review of available data. This included a preliminary review of exiting service providers by Health Zone and of their current capacity and expertise. Given the rapidly changing security situation in Tanganyika, the project will further validate the selection of Health Zones during Year 1 of project implementation to confirm accessibility of the target areas.

192. **Intensive community level GBV prevention and community referral interventions will be undertaken in selected Aires de Santé in each of the selected Health Zones.** This will include more intensive gender transformative training with community and opinions leaders as well as life-skills and livelihood interventions targeting women and men. Criteria for selection of *Aires de Santé* will be developed and included in the PIM. A rapid assessment of targeted Health Zones will be undertaken and shall form the basis for selection of the *Aires de Santé*. The final proposed list of *Aires de Santé* will be shared with the World Bank for approval within three months of project effectiveness.

ANNEX 5: ANALYSIS OF RISK FACTORS FOR GBV IN DRC

Objectives and approach

193. The main objectives of this analysis were to assess the prevalence and risk factors for GBV and the impact of GBV on women and their children in DRC. It was compiled using the 2014 DHS which is a nationally representative household survey. It includes descriptive statistics of: (i) GBV prevalence disaggregated by relevant socio-economic and demographic indicators; (ii) changes in physical violence prevalence between two rounds of surveys in 2007 and 2013-2014. (iii) Intimate partner violence (IPV) prevalence; (iv) health outcomes for survivors of IPV compared to women who did not experience IPV; (v) a logit regression to estimate the probability of ever-married women ever experiencing IPV based on their characteristics; and (vi) a summary of service seeking behavior for survivors.

Prevalence of GBV in the DRC

194. Available data shows that rates of GBV, particularly Intimate Partner Violence (IPV)[49], are high in the Democratic Republic of Congo. According to the 2014 DHS:

- 56.7 percent of all women aged 15-49 reported experiencing physical or sexual violence (by any perpetrator) at least once since the age of 15, a higher percentage than the global average of 35.6 percent and the regional (Africa) average of 37.7 percent[50].
- In the last 12 months pre-survey, 27.2 percent of women reported experiencing physical violence.
- The main perpetrators of physical and sexual violence were a current or former husband/partner, indicating high levels of IPV in DRC. Overall 57.4 percent of ever-married women aged 15-49 report experiencing emotional, physical, or sexual violence committed by their current partner.
- The prevalence of GBV varies geographically. The share of women who have ever experienced physical violence is highest for women in Sankuru, Equateur and Kasaï provinces (above 67 percent). Women aged 15-49 in rural areas have a similar likelihood of having ever experienced physical violence as women living in rural areas but experienced a higher prevalence of physical violence in the last 12 months.
- In terms of age, the prevalence of GBV is lower for younger cohorts. 38.2 percent of young women aged 15-19 reported experience of physical violence compared with 60.4 percent of women age 30-34.
- Prevalence rates vary by religious and ethnic group with some groups experiencing higher rates of physical or sexual violence.
- In terms of wealth, poorer women are more likely to experience physical GBV (all women). IPV is less variable by wealth for ever-married women. Across employment categories, physical violence prevalence is highest for women who are employed for cash at 55.4 percent compared with 49.0 percent for those employed not for cash, or 44.9 percent for those not employed.
- Regarding education the highest prevalence of women reporting physical violence in their lifetimes are those with no schooling (51.5 percent) and those not having completed primary level education (57.3 percent).
- Women who are no longer together with a partner or separated reported experiencing GBV at a higher rate.

[49] IPV is defined as any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.
[50] World Health Organization (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.* Geneva, World Health Organization.

Risk Factors and Drivers of GBV

195. In DRC, a logit analysis undertaken by the World Bank team of the 2014 DRC DHS data on ever married women shows that:

- **Empowerment characteristics** such as education and employment are **not the primary determinants** of lifetime physical IPV in DRC.
- **Women's participation in decision making** is associated with lower likelihood of experiencing physical IPV.
- **Age has a positive relationship with the probability of experiencing physical IPV,** but the association does not appear to be linear. Age at marriage is not associated with the probability of experiencing IPV, except for women who are above 25 when they marry, who are half as likely to experience IPV as those who are marry before they are 15.
- **Women with more than one union are twice as likely to experience lifetime IPV** as those with only one.
- **Women whose partners are often drunk are 3.8 times more likely** to experience lifetime physical IPV than those whose partner does not drink.
- **Household wealth appears not to be a protective factor** with women from the richest quintile not significantly less likely to experience violence.

196. The DRC DHS highlights high levels of acceptance of violence. Acceptability of domestic violence in the DRC is the highest in the Africa region with 74.8 percent of women and 59.5 percent of men believing that wife beating is justified for at least one specified reason. Importantly, acceptability of spousal violence is more prevalent in younger age groups for both men and women. Domestic violence is seen as justified by over three quarters of women aged 15-29.

Changes in violence prevalence

197. Violence prevalence has decreased since the previous survey round in 2007. Prevalence of physical violence against women has fallen from 64 percent of women aged 15-49 in 2007 to 52 percent in 2013-2014. Reports of violence decreased across all age groups and across all categories of women's employment, wealth and education characteristics. The reduction was slightly larger for women residing in urban areas and for those employed not for cash. Among ethnicities, all groups have seen a decrease in lifetime physical violence prevalence, however there is large variation in terms of the magnitude of the decrease.

Impacts of GBV

198. In DRC, available data highlights the costs of IPV in terms of health outcomes. (i) Half of women survivors (49.6 percent) suffer from injuries due to their husband's actions (vs. 13 percent of women who had not experienced violence); (ii) 5.8 percent of GBV survivors suffer from major injuries such as wounds, broken teeth or other serious injuries (vs 2.0 percent for women who had not experienced violence). (iii) 22.8 percent of survivors suffered eye injuries, sprains, dislocations or burns (vs 0.8 percent of women who had not experienced violence).

199. Children whose mothers have experienced IPV also suffer. The prevalence of diarrhea in the last 2 weeks

among children whose mothers had experienced IPV was 22.6 percent, compared to 16.7 percent for children whose mother had not experienced such violence. Children whose mothers experienced IPV were more likely to have had at least one vaccination, but less likely to have received all vaccinations compared to children whose mothers had not experienced violence (at a 5 percent significance level). 20.9 percent of women survivors had terminated pregnancies at some point (vs. 15.8 percent of women that had not experienced violence).

200. **Table 9 below compares health and demographic statistics for a sample of GBV survivors with women who did not experience IPV.** Survivors had a higher average number of children ever born. Whether a last child was wanted or not was not significantly different for survivors. Survivors of GBV are more likely to suffer from Sexually-Transmitted Diseases (STD). Overall, 10.2 percent of survivors had a STD in 12 months prior to the survey versus 6.5 percent of women who had not experienced violence.

Table 10. Health and demographic characteristics of survivors of IPV and women who did not experience IPV

Characteristics	Non-survivors of physical violence	Survivors of physical violence	Significance. of difference	N
Women's demographics and health characteristics				
Average number of children ever born	3.83	4.03	***	5,691
Average number of living children	3.35	3.46	*	5,691
Ever had a terminated pregnancy (%)	15.8	20.9	***	5,691
Last child wanted (%)			not sig.	
wanted them	74.5	73.2		3,201
wanted but later	21.3	22		938
wanted no more children	4.2	4.8		196
Place of delivery of last child (%)			***	
respondent's / other home	21.5	26.1		1,030
public hospital / health center / post / other	67.0	58.9		2,731
private hospital / clinic / other private	10.4	13.8		523
other	1.1	1.2		49
Last child's birth weight	3.41	3.43	not sig.	2,999
Visit health facility in last 12 months (%)	42.7	45.1	*	5,690
Had any STD in last 12 months (%)	6.5	10.2	***	5,665
Injuries due to husband's actions (any kind) (%)	13.1	49.6	***	2,868
Bruises (%)	11.9	45.3	***	2,868
Eye injuries, sprains, dislocations or burns (%)	0.8	22.8	***	2,865
Wounds, broken bones, broken teeth or other serious injury (%)	2.0	5.8	**	2,865
Children's health				
Diarrhea (in last 2 weeks) (%)	16.7	22.6	***	803
Immunization of children 12-24 months (%)			**	
no immunization	13.0	13.0		537
at least one vaccine	68.6	71.5		2,885
all vaccines	18.4	15.5		698
Children under 5 slept under mosquito bed net			not sig.	
none	10.5	9.7		449
all children	53.3	50.9		2,320
some children	9.4	11.1		456
no net in household	26.8	28.3		1,225
Children's education			not sig.	
Average years of education (age 6-9)	0.82	0.80		3,798
Average years of education (age 10-15)	3.69	3.60		3,274

Note: Summary measures disaggregated by whether women have ever been exposed to physical violence by their current, or any previous husband/partner. Statistics are unweighted to estimate the significance of the difference between groups.
*** p<0.01, ** p<0.05, * p<0.1. Estimates based on DRC DHS 2014.

Help seeking behavior

201. Over a third of women who experienced physical or sexual violence (by anyone) sought help to stop such violence. For sexual violence this figure was just over a quarter. Most women who sought help looked to their own or their partner's family, to their neighbors or friends for assistance. Only a small percentage of women experiencing violence sought help from institutions such as the police or from medical professionals.

ANNEX 6: CONSULTATIONS HELD DURING PREPARATION

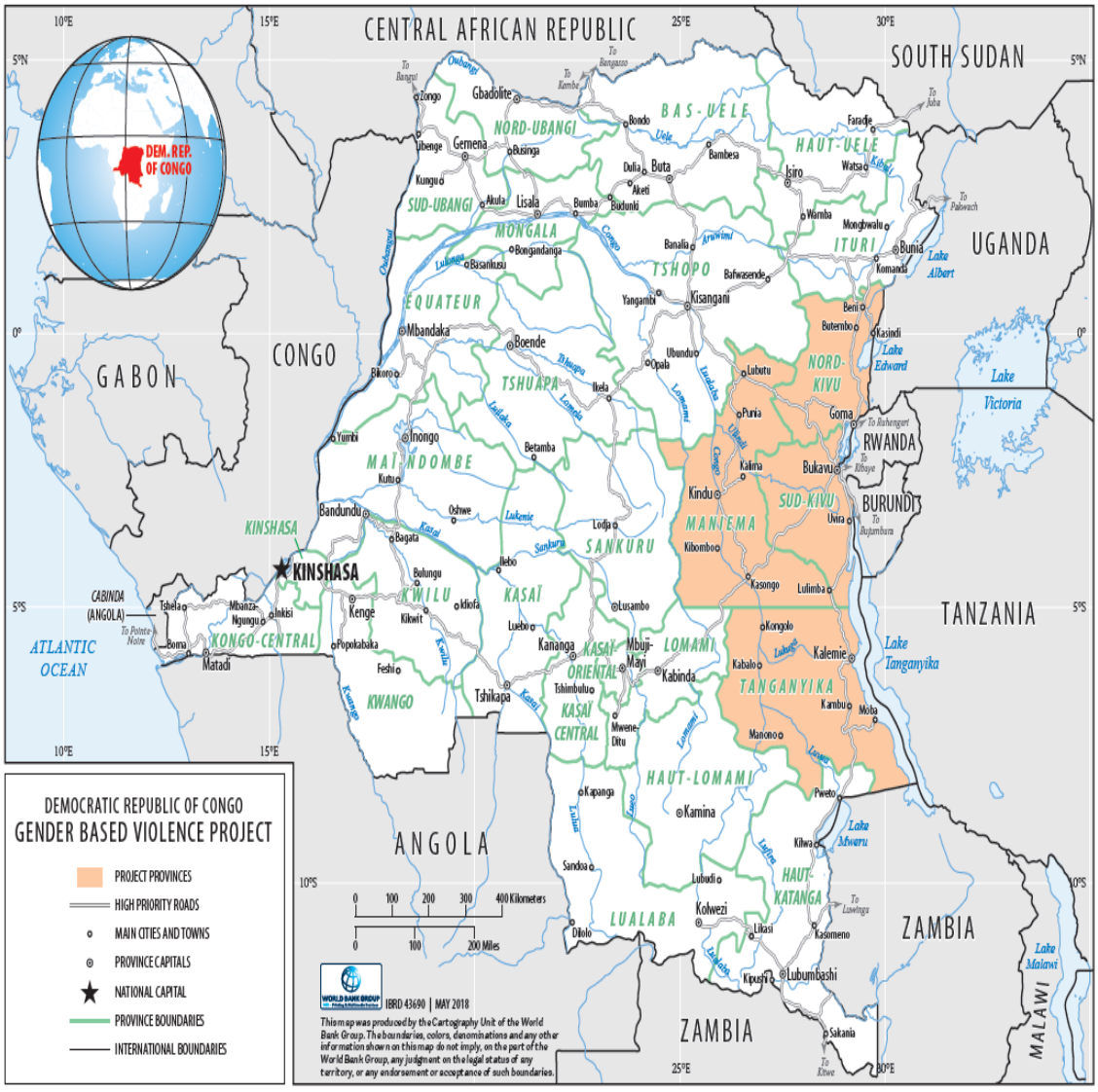
A series of consultations were held during project preparation between February and April with: (i) key Government agencies; (ii) Development Partners active in the field of GBV; and (iii) civil society organizations with expertise in the implementation of GBV prevention and response programs. An overview of key interventions by key partners was developed based on these consultations as outlined in Table 11 below.

Table 11: Overview of ongoing and recently closed (2018) GBV intervention in DRC

#	Development Partner	Health Zone or Provincial Coverage	Type of interventions (prevention/response/ both)	Implementing Partners	Funding Amount	Implementation period (expected start and end date)
1	Belgian Government	Tshopo (1,005,900 euros) a Makiso-Kisangani Kwilu (477,200 euros) in Monsango Sud-Ubangi (477.200 euro) in Gemena et Budjala	Support for survivors of sexual violence through health sector, by providing improved and better accessibility and quality of care through a multi-sectoral approach.	**Ministry of Health**	3,000,000 Euros	From 2015-2018 **CLOSED**
2	DFID	Maniema: Kailo, Kalima, Kampene, Pangi, Punia, Alunguli, Kindu, Lubutu, Obokote, Ferekeni. Tshiopo: Banalia, Ubundu, Bengamisa; Kasaï Centrale, Kasaï and Nord Ubangi	Support to Primary Health Care (Appui aux Soins de Sante Primaires - ASSP). Objectives: Training of health structures in the medical response to sexual violence, inputs (PEP kit), in some cases, activities in the community to ensure a better referencing of cases to health structures. The program also includes Fistula repair interventions.	IMA, with Caritas, Sanru, and World Vision	Not available	2013-2018
3	Ministry of Global Affairs, Canada	Eastern DRC	Joint Project on Fighting Impunity, Supporting Victims of Gender-Based Violence, and Women's Empowerment in Eastern DR Congo "TUPINGE UBAKAJI". Objectives: 15 000 GBV survivors received medical and psychosocial care GBV database set up and operational online; 4 One Stop Centers offering a holistic care to SGBV survivors in the targeted provinces (North-Kivu, South - Kivu and Ituri)	UNDP With UN agencies: UNFPA, OHCHR, UNESCO and as IP of the UN: Government Entity (National and Provincial Ministries of Gender), Women's rights CSO, National NGOs	15 224 554 (18 000 000 Can$	March 2013 - March 2018 **(CLOSED)**
	Ministry of Global Affairs, Canada	Ituri, North and South Kivu, Kasaï Central and Kinshasa	Fight against GBV: justice, empowerment and dignity for women and girls in the DRC (JAD project).	UNDP, UNFPA and UN Joint Office on Human Rights (BCNUDH/MONUSCO)	US$14 million	2018-2022

4	Netherlands	**North Kivu** Lubero, Masisi, Rutshuru **South Kivu** Uvira, Ijdwi	The program aims to contribute to equal rights and opportunities for women and men, enabling women to fully participate in peacebuilding and reconstruction efforts in North and South.	Stichting CMC Mensen met een Missie (leading) with consortium partners CARE Nederland and Tosangana	Not available	Nov 2016 – Dec 2019
		North Kivu South Kivu	The goal of the JeuneS3 alliance is to ensure that young people (especially girls) are able to make informed choices about their sexual and reproductive health and that their sexual and reproductive rights are respected.	SRHR Cordaid Jeune S3	Not available	Jan 2016 – dec 2020
		North Kivu Mweso, Kashuga. Kitchanga. Lushebere, Masisi Centre, Sake, Ndosho, Katindo-military camp, National Police academy, **South Kivu** Rusisi, Bukavu	Achieving sustainable, gender-equitable peace by **I:** providing psychosocial support to families affected by violence and **II:** preventing sexual and Gender-Based violence by working with men and boys to transform norms related to masculinities	Living Peace institute	Not available	Jun 2016 - 2019
		North Kivu Rutshuru, Goma, Nyiragongo **South Kivu** Bukavu, Walungu	Three major approaches: **I:** CARE's Village Savings and Loan Association (VSLA) model as a platform for women's economic, social, personal and coalition-building gains; (ii) engagement of men; (iii) Comprehensive Sexuality Education (CSE) for youth.	CARE Netherlands	Not available	Dec 2015 – May 2019
		North Kivu Beni, Oicha, Masisi and Goma **South Kivu** Miti-Murhesa, Walungu, Lemera, Katana	**I:** Continuous availability of RH / FP commodities at all service delivery points; **II:** Strengthening community resilience to prevent and respond effectively to SGBV; **III:** Enhancing the quality of care provided by Health Facilities so that they respond in a holistic way to the needs of SGBV survivors (Women, Girls, Youth, Men, and Boys).	UNFPA	Not available	Oct 2016- Sept 2019
5	Stabilization Coherence Fund (SCF)	Eastern DRC	Land Governance, Social Cohesion, Socioeconomic Reintegration, and Gender-Based Violence Prevention in the priority Stabilization Zone around Kitshanga, North Kivu, DR Congo Expected results related to GB : 1) The level of GBV cases is reduced in the priority zone of Kitshanga thanks to changes in harmful practices and social norms that contribute to GBV; 2) Community leaders and youth are effectively involved in Gender promotion and peacebuilding culture	UN Habitat With UN agencies: UNFPA, UNHABITAT, UNESCO and as IP of the UN: INGOs and Local NGOs, CSOs	US$3 million	July 2017 - June 2019
6	Sweden	Kinshasa	Project to improve the sexual and reproductive health of adolescents and young people in the city of Kinshasa.	UNFPA/Médecins du Monde/Pathfinder	Not available	2016-2019

7	UK Foreign and Commonwealth Office	Eastern DRC	Combating Stigma against Rape Survivors and Children Born of Rape in Armed Conflict.	World Vision	£153,871	1 April 2017-31 March 2018 **CLOSED**
8	United Nations Central Emergency Funds (CERF)	Single country program	Prevention and response of GBV in 11 health zones affected by the Kasaï crisis. Objectives: 1) GBV survivors in conflict affected communities in 11 health zones in Kasaï, Kasaï-Central, Kasaï-Oriental and Lomami are identified and referred to services by communities; 2) 15 840 persons, including 2,640 GBV survivors, access reproductive health services for case management (medical, psychosocial and legal counselling) according to needs; 3) 115,846 beneficiaries are informed of the risks and consequences of GBV.	UNFPA Implementing with through other CSOs (I-NGOs) : Alima, MAGNA, CARE International and CISP	US$ 1.4 million	from 06/10/2017 to 05/04/2018 **(CLOSED)**
9	UNFPA, UN Women	Single country program	"Break the silence" Campaign. Objectives: The level of SGBV cases is reduced due to coordinated GBV prevention and response related actions	Special Representative to the President on sexual violence and child solders	Not available	2016 - ongoing
10	UNICEF	Kasaï; Kinshasa; North Kivu, Ituri	Psychosocial support to victims of sexual violence in emergency affected areas. Objectives: Provision of essential multi-sectoral services for survivors of SGBV, including referrals; application of the national Family Code; dissemination of multi-sectoral assistance protocols; provision of PEP.	UNICEF, IPs of UN (NGOs such as Heal Africa, Lizadeel, SOFEPADI, Hope in Action, Rejeer, Ministry for Women, Family and children, Ministry of Health, Ministry of Social Affairs)	US$ 500,000	2017-18
11	USAID	North and South Kivu (Walikale, Karisimbi, Katana, Walungu and Mubumbano)	Gender-Based Violence Program focusing on: (i) evidence based approaches to GBV drawing on the earlier USAID Ushindi program; (ii) focusing on prevention; (iii) target youth and; (iv) focus on implementation at scale. The PEPFAR (U.S. President's Emergency Plan for AIDS Relief) HIV prevention program also integrates GBV response with a focus on Kinshasa, Haut-Katanga and Lualaba.	IMA World Health; in partnership with the Panzi Foundation, Heal Africa, American Bar Association-Rule of Law Initiative (ABA-ROLI) and Search for Common Ground.	US$ 15 Million	2018-2023


CENTRAL AFRICAN REPUBLIC
SOUTH SUDAN
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LUALABA
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Lake Victoria
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Lake Mweru
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DEMOCRATIC REPUBLIC OF CONGO
GENDER BASED VIOLENCE PROJECT
PROJECT PROVINCES
HIGH PRIORITY ROADS
MAIN CITIES AND TOWNS
PROVINCE CAPITALS
NATIONAL CAPITAL
PROVINCE BOUNDARIES
INTERNATIONAL BOUNDARIES
0 100 200 300 400 Kilometers
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