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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 16-Jun-2022 | Report No: PIDA33619

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Madagascar	P175110	Phase 2 of Improving Nutrition Outcomes Using the Multiphase Programmatic Approach	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
Eastern and Southern Africa	13-Jun-2022	30-Jun-2022	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Republic of Madagascar	Ministry of Public Health, National Nutrition Office	

Proposed Development Objective(s)

The Development Objectives are: (i) to increase utilization of a package of reproductive, maternal and child health and nutrition (RMCHN) interventions and (ii) to improve key nutrition behaviors known to reduce stunting in targeted regions

Components

1- Scale up coverage and utilization of the RMCHN minimum package
2- Strengthen capacity to manage and deliver the RMCHN minimum package
3- Support multisectoral interventions to increase impact of the integrated health and nutrition platform
4- Project Management, Capacity Building and Operations Support
5- Contingent Emergency Response

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	85.00
Total Financing	85.00
of which IBRD/IDA	85.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	85.00
IDA Credit	42.50
IDA Grant	42.50

Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Madagascar is facing multiple crises linked to the Coronavirus Disease 2019 (COVID-19) pandemic, the war in Ukraine, and climate change-induced weather changes, that compromise food security and threaten to derail the progress that has been made towards the country's goals in economic and human capital development.** The pandemic led to the deepest recession since 2002 and reversed more than a decade of progress in poverty reduction.[1] The initial impact of the COVID-19 crisis was severe. With export earnings and investment collapsing, Gross Domestic Product (GDP) contracted by 7.1 percent in 2020, the sharpest decline in two decades. The mining, tourism, textile, and transport industries were hit hardest by this crisis, while domestically oriented sectors were negatively impacted by falling household incomes and supply chain disruptions. A small rebound has been observed in 2021 with the resumption of exports in the extractive industries but restrained by the second wave of the pandemic and continued border closures, with GDP growth estimated at 4.4 percent in 2021. Overall, income per capita fell by about 10 percent between 2019 and 2021, representing the most intense economic shock since the crises of 1991 and 2002. The poverty rate is estimated to have increased from 76.5 percent in 2019 to 80.7 percent in 2020, and further to 81.1 percent in 2021. As a result, nearly two million people have fallen below the international poverty line of US$1.90 per capita per day (in 2011 purchasing power parity) in two years.

2. **Stunting (chronic malnutrition) affects four out of every ten children under five years of age in Madagascar (an estimated 1.7 million children), which is one of the highest rates in the world.[2]**

[1] 2022 Systematic Country Diagnostic (SCD) Update for Madagascar (document not yet public).
[2] UNICEF, WHO and the World Bank Group, Levels and trends in child malnutrition (2019). Madagascar was ranked 8th in the world in 2019.

However, despite the many shocks over the last few years in Madagascar, there has been slow but steady progress, as the prevalence of stunting has decreased from 47 percent in 2008-09[3] to 39.8 percent in 2021.[4] It remains a critical constraint to human capital development. In addition, 7.7 percent of children 0-5 years of age are wasted (too thin for their height), which increases the risks of morbidity and mortality.[5]

3. **The current crises are disproportionately impacting the poor and are projected to worsen as the war in Ukraine drives food prices higher and destabilizes global food supply. It is therefore critical and urgent for Madagascar to access the financing for Phase 2 of the Improving Nutrition Outcomes using Multiphase Programmatic Approach (MPA) to preserve the achieved gains and avoid disruptions in the provision of health and nutrition services to the population.** The United Nations Conference on Trade and Development estimated in April 2022 that more than 60 percent of Madagascar's wheat imports come from Russia; therefore, the ongoing war will have a crippling impact on food imports into the country. In addition, global freight costs increased by 21 percent on major grains and oil seeds routes.[6] Madagascar is facing increasing food access issues, which will worsen during the lean season, and especially for poor households, due to reductions in imports and increases in transport costs caused by increased fuel costs. In Southern Madagascar, which is suffering from its worst drought in 40 years, nearly one third of the population (1.95 million people) is experiencing high levels of acute food insecurity,[7] which is projected to expand to 2.06 million people between December 2022 and March 2023.[8]

4. **According to 2020 Human Capital Index (HCI) estimates[9], a child born today in Madagascar will be only 39 percent as productive as they could have been as an adult had they enjoyed complete education and full health.** [10] The HCI trendline has remained unchanged over the last decade. Ninety-seven percent of 10-year-old children cannot read or understand a basic text, 40 percent of children are stunted, and social protection services cover just 3 percent of those living in extreme poverty. Although the under-5 child mortality rate and the prevalence of stunting have improved since 2010, these remain among the highest worldwide. Similarly, although the adult survival rate has improved, it is still among the lowest quarter of all countries. The picture for education is concerning, with quality decreasing (as reflected in harmonized test scores) and primary educational completion rates falling from 68 percent in 2013 to 63 percent in 2019. All key components of the HCI show strong inequalities by income; test scores

[3] National Survey on Monitoring the MDGs 2012-2013
[4] INSTAT, Demographic and Health Survey (DHS), 2021
[5] INSTAT, DHS 2021
[6] World Food Program (WFP). Implications of the Ukraine Crisis: Food, Fuel, Fertilizers and Freight Prices in the Southern Africa Region. https://reliefweb.int/report/angola/implications-ukraine-crisis-food-fuel-fertilisers-and-freight-prices-southern-africa-region [May 16, 2022]
[7] Integrated Food Security Phase Classification (IPC)] estimates of population in IPC Phase 3 or above for April and August 2022 (IPC. Madagascar (Grand South and Grand South-East: IPC Acute Food Insecurity Snapshot. https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Madagascar_AcuteFoodSecur_22Apr23Mar_Snapshot_English.pdf [May 31, 2022]). The IPC Acute Food Insecurity classification differentiates between levels of severity of acute food insecurity, classifying units of analysis in five distinct phases: (1) Minimal/None, (2) Stressed, (3) Crisis, (4) Emergency, (5) Catastrophe/Famine.
[8] The World Bank response will be supported under the new Fast Track Program for Food and Nutrition MPA https://www.worldbank.org/en/news/press-release/2022/05/18/world-bank-announces-planned-actions-for-global-food-crisis-response
[9] https://worldbankgroup.sharepoint.com/sites/wbsites/HumanCapital/Documents/HCI Index 2020 by region and country/Sub-Saharan Africa - East/HCI_2pager_MDG.pdf - *HCI 2020: Country briefs by region – Africa East - Madagascar*
[10] http://mics.unicef.org/ - Madagascar MICS 2018, except stunting rate from Demographic and Health Survey 2021.

indicate a two-tier education system, with one level of quality for the richest and another for everyone else. With children unable to reach their potential, the country will not have the labor force required to fuel a productive economy that can create jobs, boost prosperity, and reduce poverty in the long term.

5. **Climate change-induced weather changes stress the ability of the Government to react and strengthen health and nutrition services to reach the most vulnerable.** Madagascar faces a range of climate shocks, increasing in frequency and intensity due to climate change and characterized by annual cyclones and floods. Simultaneously, the southern part of Madagascar is plagued by persistent, climate change-induced drought, spurred by increasingly high temperatures and low rainfall, leading to reduced harvests and an increase in malnutrition and childhood diseases. The climate change-induced drought, amplified by outbreaks of Rift Valley Fever and migratory locusts, has spurred the ongoing food crisis in the South, driving nearly 50 percent of the population (1.3 million people) from the region's ten hardest-hit districts into acute food insecurity.

6. **Madagascar's climate shocks compromise food insecurity resulting in both acute and chronic undernutrition in the country.** The country's agricultural sector is dominated by small scale, rain fed agriculture which is highly vulnerable to climactic patterns.[11] Research in the country has shown that food insecurity increases, nutritional intake declines, and undernutrition increases during dry seasons in the country.[12,13,14] Agriculture is also negatively impacted by cyclones, which destroy crops with a substantial impact on small scale farms. A survey of small- scale farmers in three regions of the country found that cyclones destroyed about 50 percent of their rice production, a staple crop in the country.[15,16] In addition,

[11] file:///C:/Users/wb506530/OneDrive%20-%20WBG/Desktop/wb_gfdrr_climate_change_country_profile_for_MDG.pdf

[12] https://www.cambridge.org/core/journals/public-health-nutrition/article/seasonal-trends-of-nutrient-intake-in-rainforest-communities-of-northeastern-madagascar/D6C458FF4C2DA15998E08595132BE97C; Golden CD, Vaitla B, Ravaoliny L, Vonona MA, Anjaranirina EG, Randriamady HJ, Glahn RP, Guth SE, Fernald LC, Myers SS. Seasonal trends of nutrient intake in rainforest communities of north-eastern Madagascar. Public Health Nutr. 2019 Aug;22(12):2200-2209.

[13] https://pubmed.ncbi.nlm.nih.gov/31349840/; Ravaoarisoa L, Rakotonirina J, Randriamanantsaina L, de Dieu Marie Rakotomanga J, Dramaix MW, Donnen P. Food consumption and undernutrition variations among mothers during the post-harvest and lean seasons in Amoron'i Mania Region, Madagascar. BMC Public Health. 2019 Jul 26;19(1):1005.

[14] https://link.springer.com/article/10.1007/s12571-021-01153-z; Andriamparany, J.N., Hänke, H. & Schlecht, E. Food security and food quality among vanilla farmers in Madagascar: the role of contract farming and livestock keeping. Food Sec. 13, 981–1012 (2021)

[15] https://pubmed.ncbi.nlm.nih.gov/24535397/ ; Harvey CA, Rakotobe ZL, Rao NS, Dave R, Razafimahatratra H, Rabarijohn RH, Rajaofara H, Mackinnon JL. Extreme vulnerability of smallholder farmers to agricultural risks and climate change in Madagascar. Philos Trans R Soc Lond B Biol Sci. 2014 Feb 17;369(1639):20130089. doi: 10.1098/rstb.2013.0089. PMID: 24535397; PMCID: PMC3928894.

[16] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-7333-9 ; Ravaoarisoa, L., Rakotonirina, J., Randriamanantsaina, L. et al. Food consumption and undernutrition variations among mothers during the post-harvest and lean seasons in Amoron'i Mania Region, Madagascar. BMC Public Health 19, 1005 (2019).

data from Madagascar show that during periods of heavy rains, diarrheal disease increases, leading to malnutrition.[17,18,19]

Sectoral and Institutional Context

7. **Maternal mortality rates have improved, but neonatal, and infant mortality rates have not changed over the past fifteen years and remain persistently high**. Between 2008 (DHS 2008–09) and 2018 (Multiple Indicators Cluster Survey [MICS] 2018), the maternal mortality ratio fell from 498 to 426 deaths per 100,000 live births, a reduction of just over 14 percent. The neonatal mortality rate has remained at the same level at 26 per 1,000 live births between 2008 and 2021.[20] Madagascar's infant mortality rate decreased slightly, from 48 to 47 per 1,000 live births between 2008 and 2021.[21] Almost 30 percent of all deaths in Madagascar are still attributable to preventable infectious and parasitic diseases. Accessing maternal, infant, and child health services remains a serious challenge in Madagascar. Only 39 percent of deliveries occurred within a health facility in 2018[22], and this percentage remained the same in 2021.[23] Share of births attended by skilled medical professionals has declined over the last 30 years, from 57 percent in 1992 to 46 percent in 2021. Treatment for common childhood illnesses remains inadequate, with large gaps between the highest and lowest wealth groups: 51 percent, 61 percent and 72 percent of children in the highest wealth group received treatment for recent episodes of diarrhea, fever, and respiratory illness, respectively, while only 30 percent, 42 percent, and 34 percent of children in the poorest wealth group did for the same recent illnesses in 2018.[24]

8. **The main drivers of poor service delivery relate to staffing (doctors and nurses) and frontline workers, who are chronically underfinanced**. Analyses conducted during Phase 1 of the MPA underscore that the primary health care (PHC) system has neither the skilled human resources nor the financial resources to carry out basic functions. Mechanisms to protect the poorest from health financial risks and assure access to basic health services are limited and fragmented.

9. **The COVID-19 outbreak has adversely impacted the delivery and utilization of essential health services, particularly those related to Reproductive, Maternal, and Child Health and Nutrition (RMCHN).** Immediately following Madagascar's first wave of COVID-19 (March–October 2020), the World Bank conducted a follow-up analysis of essential health and nutrition services during the COVID-19 pandemic.[25] Significant and persistent disruptions were observed for outpatient consultations compared

[17] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0044533; Randremanana R, Randrianirina F, Gousseff M, Dubois N, Razafindratsimandresy R, et al. (2012) Case-Control Study of the Etiology of Infant Diarrheal Disease in 14 Districts in Madagascar.
[18] https://www.researchgate.net/publication/282190942; Randremanana, Rindra. (2012). Impact of the environment in childhood diarrhea in Madagascar: Campylobacter risk analysis.

[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4943590/; Randremanana, R. V., Razafindratsimandresy, R., Andriatahina, T., Randriamanantena, A., Ravelomanana, L., Randrianirina, F., & Richard, V. (2016). Etiologies, Risk Factors and Impact of Severe Diarrhea in the Under-Fives in Moramanga and Antananarivo, Madagascar.
[20] DHS 2008-2009; DHS 2021
[21] DHS 2008-09, DHS 2021
[22] MICS 2018
[23] DHS 2021
[24] MICS 2018, Santé de l'enfant et soins aux enfants malades
[25] Data analysis from the national health management information system (*système d'information sanitaire*; SIS) conducted by a

with previous trends and seasonality. Outpatient consultations were substantially lower between April 2020 and February 2021 than in previous years—2.5 percent lower in April 2020, 7.3 percent in June, 18 percent in July, 24 percent in August, 15 percent in September, 11 percent in October, and 10 percent in February 2021. Compared to expected levels, disruptions were particularly intense for most indicators measuring essential health and nutrition services. There is strong evidence to suggest that women and girls in Madagascar are suffering from multifaceted negative secondary impacts as a result of the COVID-19 crisis, including increases in maternal and infant mortality, reduced access to healthcare, and an increase in unplanned pregnancies.

10. **Stunting is the cumulative result of inadequate dietary quality and intake and repeated infections that impede child growth.** Analyses undertaken in Phase 1 have helped understand the factors underlying stunting in Madagascar. The process starts before pregnancy with mothers with poor nutritional status (15 percent of women are undernourished). Poor pregnancy care and poor maternal nutrition leads to children born pre-term or small for gestational age (13 percent of children have a low birth weight). In infancy and early childhood, maternal and childcare and feeding practices are suboptimal: only 45 percent of infants are breastfed within one hour of birth and only 51 percent are breastfed exclusively until six months of age. Moreover, the Malagasy diet is largely monotonous, with only 21 percent of children consuming a diet with acceptable diversity and frequency.[26] Repeated experiences of illness such as diarrhea, malaria, or pneumonia, combined with insufficient dietary intake, cause a child's growth to falter. These factors are rooted in institutional and economic issues such as poverty and weak governance, as well as the frequent climate shocks that affect the country and are expected to increase with climate change. Close to 60 percent of the population (13 million people) are estimated to be living on resources that do not allow them to afford sufficient food intake.[27] Water and sanitation indicators are also poor, particularly in the rural areas, with 45 percent of the population practicing open defecation and 66 percent of rural households without access to clean water.[28]

11. **The Improving Nutrition Outcomes MPA supports the Government's strategic long-term vision of reducing stunting to improve human capital in Madagascar.** Through the validation of the National Nutrition Policy (NNP) and the associated Multi-Sectoral Action Plan, the Government confirmed its commitment to the strategic long-term vision that underpins the MPA. The NNP recognizes that addressing malnutrition is critical to reaching the country's development goals and that it is a complex challenge requiring a long-term investment in a multisectoral approach. The NNP outlines the priority areas under which partners and government financing will align, which are fully aligned with the MPA.

12. **Phase 1 of the MPA has shown good progress towards achievement of the project development objectives (PDO) and overall implementation progress, both of which are rated Moderately Satisfactory.** The program became effective April 13, 2018 and has disbursed US$94.19 million out of its US$111.70 million allocation (84.91 percent) as of May 31, 2022. Project implementation has enabled more than 1,875,461 women and children under five to receive health and nutrition services through 4,526 community sites and 1,081 PHC facilities strengthened with necessary nutrition and health

World Bank.
[26] MICS 2018
[27] World Bank (2014). "Madagascar: Poverty, Gender, and Inequality Assessment." World Bank Report No. 78131- MG
[28] UNICEF and WHO (2012). Progress on Drinking Water and Sanitation. 2012 Update

commodities and equipment. The Phase 1 operation is on track to achieve three of five PDO indicators by its closing date of July 31, 2023.

13. **Phase 1 supported three pillars of improvements linked to immediate improvements in nutrition: improving supply and quality of services; improving the enabling environment; and increasing utilization and demand creation.** The focus of Phase 1 was to reorient coordination and integration of two critical sectors (health and nutrition) to deliver an essential package of services. Under Phase 1, fragmentation of community-level services was reduced by integrating and strengthening health and nutrition services (previously parallel systems). The community platform is functional in nine regions, allowing beneficiaries to access an integrated health and nutrition services package at 4,526 sites and 1,081 primary health care facilities supported by the project. These are supervised by 108 local non-governmental organizations (NGOs) and health workers from PHC facilities. The project invested in ensuring the availability of essential equipment, commodities, and medication to enable the delivery of a standard package of health and nutrition services at health facility and community levels. Phase 1 focused on removing financial and geographic barriers to utilization of the minimum RMCHN package by financing community outreach for priority services and scaling up a fee exemption scheme.

14. **The importance of the MPA to improve nutrition outcomes has become increasingly evident in the context of deepening fragility and food and nutrition insecurity.** The longer-term commitment from the Bank has given some stability to this agenda to allow continued investments in health and nutrition systems and capacity throughout the unforeseen challenges related to the COVID-19 pandemic, climate-related shocks, and more recently, the food security crisis linked to the war in Ukraine. Madagascar has been able to maintain its focus on the strategic vision of stunting reduction through core activities: scaling up an essential RMCHN package, demand generation, and strengthening systems to deliver health and nutrition services more effectively. Despite the range of shocks affecting implementation, the Program has made good progress towards meeting its Program Development Objective (PrDO), with a reduction of nine percent in stunting in program areas, particularly the ones where Phase 1 implementation started in 2019 and 2020. The flexibility of the instrument has also allowed an adaptation in the timing of phases and the implementation of activities to address the changing country context and institutional readiness.

15. **Phase 2 will continue to focus on the Phase 1 core activities in the same geographical areas and will also expand to four new regions, with adaptations based on lessons learned from implementation**, including expanding the focus on district-level capacity and coordination; increased attention to supportive supervision to frontline workers to improve quality of health and nutrition services; roll-out of behavior change communication to community level; and use of digital tools to improve monitoring and supervision. Leveraging the MPA's flexibility, Phase 2 will also be adjusted to increase synergies with other sectors where there is geographical and technical convergence, including agriculture, social protection, water supply, sanitation and hygiene (WASH), education, and governance. Finally, Phase 3 is envisioned to be rolled out in FY26, for an estimated financing envelope of US$85 million (amount and delivery date indicative at this stage).

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The Development Objectives are: (i) to increase utilization of a package of reproductive, maternal and child health and nutrition (RMCHN) interventions and (ii) to improve key nutrition behaviors known to reduce stunting in targeted regions

Key Results

16. The PDO indicators from Phase 1 will be used for Phase 2, with end targets revised to account for the geographical expansion. Baseline values will also be revised accordingly to include new regions:[29] The facility-based deliveries will now be measured in percentage instead of absolute numbers to better capture the behavioral change.

- Percentage of infants 0-5 months of age exclusively breastfed (by sex) (baseline: 61.3 percent, current target: 65%, new baseline: 54.4 percent, new target: 58.4 percent)
- Percentage of women receiving any IFA tablets at last pregnancy (baseline: 0, current target: 70 percent. new baseline: 63 percent, new target: 70 percent
- Percentage of children 6-23 months of age receiving 5 of the 8 recommended food groups (baseline: 31.5 percent, current target: 36.5 percent, new baseline: 20 percent, new target: 30 percent)
- Percentage of children 6-59 months of age receiving vitamin A supplementation within the past 6 months (by sex) (baseline: 0, current target: 60 percent, new baseline: 29 percent, new target: 35 percent)
- Former indicator: Number of facility-based deliveries (baseline: 0, current target: 588,623). New indicator: Percentage of deliveries in primary healthcare facilities (baseline: 47 percent, target: 53 percent)

D. Project Description

17. **Geographical targeting:** The second phase will continue to support the nine regions under Phase 1, and the following four regions will also be added: Androy, Anosy, Atsimo Atsinanana and Atsinanana. Three of these selected regions (Androy, Anosy, and Atsimo Atsinanana) are among the four most climate vulnerable regions in Madagascar.[30] The package of interventions will be implemented in a staged approach. In Phase 1 regions, full nutrition and health package will continue to be supported and pilot multisectoral approaches will be implemented in year 1. For new Phase 2 regions: integrated health and nutrition package will be rolled-out in two additional regions in year 1 and the two remaining regions will be added in year 2, while multisectoral approaches will be progressively added in year 3 (allowing adapting and learning from pilots in Phase 1 regions). For urban areas within the project regions, specific implementation modalities would be piloted (especially in Antananarivo, linking with the social protection pilot.[31]

[29] The revised baselines are calculated based on the 2018 MICS to ensure consistency across the entire results framework. Indeed, it measures the project achievements since the start of the implementation of the MPA.

[30] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6313613/; Rakotoarison, N., Raholijao, N., Razafindramavo, L. M., Rakotomavo, Z., Rakotoarisoa, A., Guillemot, J. S., Randriamialisoa, Z. J., Mafilaza, V., Ramiandrisoa, V., Rajaonarivony, R., Andrianjafinirina, S., Tata, V., Vololoniaina, M. C., Rakotomanana, F., & Raminosoa, V. M. (2018). Assessment of Risk, Vulnerability and Adaptation to Climate Change by the Health Sector in Madagascar. International journal of environmental research and public health, 15(12), 2643.

[31] Additional Financing for COVID-19 response under the Madagascar Social Safety Net Project (AF3) (P174886); Subcomponent 1.4 “Urban Safety Net Pilot”

Component 1: Scale up Coverage and Utilization of the RMCHN Minimum Package *(US$41.8 million equivalent)*

18. **Similar to Phase 1, this component facilitates beneficiary access to the minimum RMCHN package and utilization of high impact nutrition interventions at critical times during pregnancy and a child's first years of life.** To achieve this, the following activities will be supported: (i) establish and scale up and integrated primary health and nutrition community service delivery platform; and (ii) reducing barriers to the utilization of nutrition and health services at community and primary levels by comprehensive Behavior Change Communication and demand creation, including social mobilization and use of mass media and by free provision of the minimum RMCHN package and removal of other financial and geographic barriers to utilization.

Component 2: Strengthen Capacity to Manage and Deliver the RMCHN Minimum Package *(US$27.7 million equivalent)*

19. This component will continue to support and scale-up interventions to remove the key bottlenecks that can impede the scale up of the RMCHN minimum package by the following: (i) increase capacity of frontline workers ; (ii) Strengthening availability and utilization of health/nutrition data; (iii) strengthening supervision and management capacities at district, regional and central levels; (iv) improving quality of service delivery through the scale up of a RBF model which has demonstrated promising results; and (v) continuing to support evidence-based program with analytical work and technical assistance to inform decision-making.

Component 3: Support Multisectoral Interventions to Increase Impact of the Integrated Health and Nutrition Platform *(US$7.0 million equivalent)*

20. **Phase 2 will increase synergies with other sectoral investments, particularly in the areas of Agriculture and Social Protection, to support improved nutrition outcomes**. **These complementary and convergent multisectoral interventions will be coordinated with the different sectoral projects underway**. Phase 2 will focus on establishing these multisectoral linkages in the Phase 1 regions where the integration of health and nutrition services are well established and will be intensified in subsequent years to be expanded in other regions.

Component 4: Project Management, Capacity Building and Operations Support *(US$8.5 million equivalent)*

21. This component will continue to finance operational costs and capacity building to ensure effective coordination, management, and implementation of the first three components of the project. The project will also finance the costs related to implementation entities within the Ministry of Public Health (MoPH) and the National Nutrition Office (ONN), namely the MoPH's Project Coordination Union (*Unité de Coordination des Projets* - PCU), which is responsible for managing all donor funds within the MoPH, and the ONN's National Community Nutrition Program Unit (UPNNC), which is responsible for implementation of the National Community Nutrition Program. Both entities will share responsibility for

the fiduciary and monitoring and evaluation (M&E) aspects of this operation. Specifically, the component will support the costs of coordination, contracting, and management of project implementation consultants, M&E, independent verification, quality surveys, external audit, and project management. Workshops and seminars to advance the work under the project will be eligible for financing. In addition, there will be capacity building of managerial and technical teams from the health and nutrition sectors, at all levels of the system, on effective management and implementation of programs as well as relevant technical skills. There will be comprehensive training and coaching for all implementing agencies. It will also finance environmental and social activities, including waste management. Monitoring the project's climate-related activities will also be included in this subcomponent.

Component 5: Contingent Emergency Response (US$0)

22. This component will facilitate access to rapid financing through reallocation of uncommitted project funds in the event of an eligible crisis or emergency, either by a formal declaration of a national emergency or upon a formal request from the government. Following a natural or man-made disaster or crisis that has caused—or is likely to cause—an imminent major adverse economic or social impact, the government may request that the World Bank reallocate project funds to support emergency response. A Contingent Emergency Response Manual, which details the simplified financial management, procurement, guarantees, and other implementation arrangements, and an Emergency Action Plan acceptable to the World Bank will be prepared and constitute a disbursement condition for this component.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

E. Implementation

Institutional and Implementation Arrangements

23. **Institutional and implementation arrangements in place for Phase 1 of the MPA will be maintained and strengthened during Phase 2. The ONN and MoPH will continue to have joint responsibility for overseeing the implementation of the second phase of the Program.** The technical coordination and fiduciary aspects of the project will be co-managed by the existing fiduciary units within these institutions, namely the UPNNC of the ONN and the PCU of the MoPH. The UPNNC and PCU have jointly agreed to divide fiduciary responsibilities across the four components. Overall, the fiduciary responsibility of community-based services will rest with the UPNNC, while that of primary care services as well as regional and district level activities will continue to largely rest with the PCU. Even though the fiduciary responsibility of activities is divided between both implementing agencies, from a technical

perspective, all the activities are undertaken in an integrated, highly coordinated manner between both institutions from central level down to community level.

24. **Multisectoral Steering Committee (SC)**: The MOF will continue to chair the SC established under Phase 1 to monitor implementation. The SC composition will be amended to add stakeholders from other sectors such as agriculture and social protection within one month after effectiveness. Under Phase 1, the SC meets twice a year to (i) validate the annual budgeted work plan of the project last quarter of the calendar year and mid-year; and (ii) review progress in implementation of activities, make recommendations for achieving objectives and amend the annual budgeted work plan accordingly.

25. As in Phase 1, **the MoF's Directorate of Public Debt/Projects Monitoring Services (DDP/SSP)**, in charge of monitoring all external financing to the Government, will oversee coordination of the two Project Implementation Units (PIUs), monitor technical and financial progress of UPNNC and PCU, analyze bottlenecks, formulate proposals for remedial measures, and facilitate joint multisector supervision. The DDP/SSP will continue to also serve as the secretariat of the SC.

26. **To guide the technical implementation of Component 3, a small multisectoral technical committee will be established not later than one month after effectiveness,** to provide technical inputs for the activities that fall within their sectoral mandate with representatives from ONN, MoPH, the Ministry of Agriculture and Livestock, the Ministry of Population, Social Protection and Women's Promotion, and the Funds for Development.

27. **Multisectoral coordination at regional and district levels.** To ensure coordinated implementation and integrated supervision and monitoring of the operation, similar arrangements as those outlined for SC at central level will continue to be established at lower levels. Specifically, multisectoral technical committees consisting of regional/district health teams and regional nutrition teams are in place. In regions where the agriculture and social protection activities under Component 3 will be implemented, these technical committees will be expanded to include the regional and district levels sectoral specialists.

28. **Technical assistance.** To support project implementation, partnerships with UN agencies and other organizations will continue. Technical assistance is envisaged in the following areas: (i) the testing and scale-up of strategies to improve the competencies of health workers and community health and nutrition workers; (ii) the roll-out of demand-side strategies for behavioral change (for example, exclusive breastfeeding); and (iii) multisectoral linkages with social protection, agriculture, and WASH to take advantage of the spatial approach. Contracts for technical assistance are expected with some UN agencies.

29. **Project Implementation Manual (PIM).** The project will be implemented in accordance with the PIM that will be updated before the implementation of new activities (no later than two months after effectiveness). The revised PIM will more specifically detail coordination and implementation mechanisms for multisectoral approaches. The PIM will include a detailed description of (i) institutional coordination and day-to-day execution of the project, including key milestones in project implementation; (ii) monitoring, evaluation, reporting, and communication; (iii) administration, financial management, procurement and accounting, including the Anti-Corruption Guidelines; (iv) eligibility

criteria, modalities, terms and conditions, and procedures for preparation, targeting, approval, payment, verification, monitoring, evaluation, reporting, and auditing of subgrants; (v) modalities, procedures, amounts, and verification mechanisms for RBF payment; (vi) environmental and social aspects; (vii) personal data collection, in accordance with applicable national law and best international practices; and (viii) other administrative, technical, and organizational arrangements.

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