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Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 17-Sep-2018 | Report No: PIDISDSC24259

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Marshall Islands	P166800		RMI Early Childhood Development and Nutrition Project (P166800)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	Nov 05, 2018	Feb 28, 2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance	Division of International Development Assistance (DIDA)	

Proposed Development Objective(s)

The proposed project development objective is to increase coverage and utilization of essential services to improve nutrition and child development.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	12.00
Total Financing	12.00
of which IBRD/IDA	12.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	12.00
IDA Grant	12.00

Environmental Assessment Category	Concept Review Decision

	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Republic of the Marshall Islands (RMI) is one of the world's smallest, most isolated and vulnerable nations.** The country consists of 29 atolls and 5 isolated islands (24 of which are inhabited) and has a total land mass of just 181 km^2 set in an area of over 1.9 million km^2 in the Pacific Ocean. The population of RMI is estimated at 53,066[i], of which the two largest urban centers, Majuro (the nation's capital) and Ebeye, have populations of 28,000 and 9,614, respectively.

2. **RMI faces many of the development challenges common to small, remote economies with dispersed populations.** Small size and remoteness increase the costs of economic activity and make it difficult to achieve economies of scale. Remoteness also imposes transport costs that increase the costs of trade and fundamentally constrain competitiveness of exports of goods and services in world markets. These same factors also increase the cost and complexity of providing public services. Moreover, geographical characteristics, including populations centered on small, low-lying atolls, make the country extremely vulnerable to natural disasters. RMI is one of the most vulnerable countries to climate change and rising sea levels.

3. **RMI is a sovereign nation in a "Compact of Free Association" (CFA) agreement with the United States.** The first CFA was signed in 1983 and continued through 2003. An amended CFA became effective on May 1, 2004, providing approximately US$70 million in grants per year through the Compact Sector Grants (CSGs). After 2023, the CSGs will cease, although the CFA remains in force in perpetuity. While a Compact Trust Fund (CTF) was established to replace CSGs from 2024 onward, based on current projections, contributions to the CTF are inadequate to assure a smooth transition, and annual CTF income can be expected to fall short of what is needed to replace Compact grants in 2024, which presents a key challenge to the country's fiscal sustainability. With substantial constraints to export-led growth, the Marshall Islands is heavily dependent on aid and other fiscal transfers. The current account deficit is largely financed by grant inflows. Aid and fiscal transfers, primarily from the US, support reasonable though declining standards of living for most of the population.

Sectoral and Institutional Context

The status of early childhood development and nutrition in RMI

4. **There is a growing recognition that despite improvements in national and household wealth, the foundations of human capital formation in RMI are at risk.** Thousands of children in RMI are at risk of failing to reach their full potential due to poor early life health and nutrition, lack of early stimulation and learning, and exposure to

poverty and severe stress. These developmental risks are manifest in high rates of early childhood malnutrition and poor child development outcomes.

5. **The 2017 Integrated Child Health and Nutrition Survey (ICHNS) sounded the alarm on the persistent high burden of maternal and child malnutrition in RMI.**[ii] Child stunting, or low height-for-age and an indicator of chronic malnutrition[iii], affects over one-third (35%) of children under age five; further, one in ten children are severely stunted. Low maternal height is indicative of maternal malnutrition earlier in life, often signalling growth restriction and/or stunting during childhood, and over one quarter (26%) of caregivers of children under age five fall into the lowest two height categories (<149cm). Maternal malnutrition contributes to poor growth *in utero,* and the process of growth faltering begins even before birth and accumulates as Marshallese children age. Twelve percent of most recently born children age 0-59 months were estimated to be of low birth weight (<2,500 g) at birth a risk factor for neonatal mortality, stunting, and adverse long-term health and psychosocial development. Stunting prevalence rises distinctly across children's age cohorts, with 21 percent of children age 6-11 months stunted compared with 44 percent of children age 24-35 months. Maternal nutritional status is also related to children's nutritional status in RMI, with 44 percent stunting among children whose mothers are of short stature (<145 cm) compared to those whose mothers are taller (>160 cm) (15 percent).

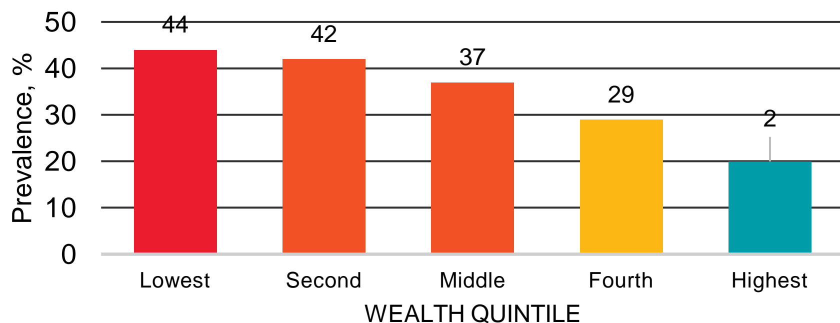
Table 1. Prevalence of undernutrition in children (<5) and their caregivers (women of reproductive age (WRA) (15-49)) in Republic of the Marshall Islands, 2017

	Status	**Level of Public Health Significance***
Underweight, % children 0-59 months	11.7	Medium
Stunting, % children 0-59 months	35.3	High
Wasting, % children 0-59 months	3.6	Low
Overweight, % children 0-59 months	3.8	--
Low birth weight (<2,500 g), % last born children 0-59 months	11.6	--
Underweight/Thinness (BMI<18.5 kg/m^2), % WRA	1.8	--
Overweight (BMI 25.0-29.9 kg/m^2), % WRA	72.7	--
Obesity (BMI >30 kg/m^2), % WRA	45.1	--

Source: ICHNS 2017 *According to World Health Organization (2010) thresholds.

6. **Child stunting prevalence in RMI varies by key sociodemographic indicators such as wealth, geography, child's age, and level of caregiver education.** Marshallese children are more likely to be stunted in rural areas (39 percent) compared to urban (35 percent) and when their caregiver has only primary education (41 percent) compared to higher education (21 percent). Household wealth is also a key determinant of child stunting, with prevalence twice as high among children in the poorest households (44 percent) compared with the wealthiest (20 percent) (Figure 1). Interventions are needed to both prevent the *in utero* origins of growth faltering (through improvements in maternal nutritional status), as well as address the behavioral and environmental factors which constrain growth after birth.

Figure 1. Child stunting by household wealth quintile, Republic of the Marshall Islands, 2017



Source: ICHNS 2017

7. **Although robust measures are not available, available data from the ICHNS point to deficits in overall child developmental outcomes[iv].** Physical health and growth, literacy and numeracy skills, socio-emotional development and readiness to learn are vital domains of a child's overall development. According to the ICHNS, 79 percent of children are developmentally on track in three of four domains, ranging from 86 percent of children age 48-59 months compared to 71 percent of children age 36-47 months. Overall, children in the wealthiest households (71 percent) show improved outcomes compared with children in the poorest households (48 percent).

Table 2. Percent of children age 36-59 months developmentally on track for indicated domains Republic of the Marshall Islands, 2017

Domain	Status
Literacy – Numeracy	55.4
Physical	92.8
Social-Emotional	72.4
Learning	87.6
ECDI Index Score	78.9

Children 36-59 months of age were assessed for developmentally on track in four domains:

Literacy-numeracy: Developmentally on track if at least two of the following are true: Can identify/name at least ten letters of the alphabet, Can read at least four simple, popular words, Knows the name and recognizes the symbol of all numbers from 1 to 10.
Physical: Developmentally on track if one or both of the following is true: Can pick up a small object with two fingers, like a stick or a rock from the ground, Is not sometimes too sick to play.
Social-emotional: Developmentally on track if at least two of the following are true: Gets along well with other children, Does not kick, bite, or hit other children, Does not get distracted easily.
Learning: Developmentally on track if one or both of the following is true: Follows simple directions on how to do something correctly, When given something to do, is able to do it independently.

Source: ICHNS 2017

Drivers of poor child development in Marshall Islands

8. **In RMI, children experience adversities across multiple domains that constitute barriers that undermine children's opportunities to learn, earn, innovate, and compete.** Poor child development in RMI is underpinned by a range of factors spanning across sectors. They are: (i) limited availability, affordability, and consumption of nutritious diets, especially for children from vulnerable households; (ii) inadequate access to effective and quality maternal and child health services including immunization coverage; (iii) inadequate access to clean water and sanitation; (iv) insufficient opportunities for early stimulation and early learning; and (v) lack of support through formalized social protection. Cutting across all of this is a general low awareness of the importance of early child stimulation, health and nutrition.

Limited consumption, availability, and affordability of nutritious diets

9. **There have been marked shifts in diets in RMI, with the modern Marshallese diet consisting largely of starchy staples (such as rice, wheat flour products, and ramen noodles) and meat (often canned or processed).** Food in RMI is largely imported, with populations on outer islands relying on traditional diets of fresh fish and fruit. While poor diet is a population-wide concern, there are distinct issues related to the diets and nutrient intake of women, infants, and young children that have a profound impact on nutritional status in the first 1,000 days of life.

Inadequate and inappropriate maternal nutrient Intake

10. **There is evidence of poor dietary quality among Marshallese women who are the primary caregivers of children.** Among caregivers of children under age 2 years, only 27 percent reported consuming minimum dietary diversity of at least five food groups in the previous day. Consumption of low nutrient density foods, such as sugar-sweetened beverages (41 percent) and sweet foods (47 percent) is much more common than Vitamin A-rich fruits and vegetables (36 percent) and dark green leafy vegetables (15 percent). While ability to achieve minimum dietary diversity is associated with household wealth, still less than half of caregivers in the wealthiest households consume a minimally diverse diet.

Food insecurity

11. **Household food insecurity (in terms of physical and economic access to adequate diverse food for a nutritious diet) is a concern in RMI.** Food availability is not an issue at the population level, but geographic access and affordability remain barriers to widespread improvements in consumption diversity and dietary quality. According to the ICHNS, 40 percent of households had some level of food insecurity, with 20 percent of households experiencing severe food insecurity (ICHNS 2017).[v] Almost all households (96 percent) experience worry that there is insufficient food for the household. There were no differences between food insecurity in urban and rural areas, though there were significant differences by household wealth, with households in the bottom 40 percent of the wealth distribution being most likely to experience food insecurity.

Inadequate access to effective and quality maternal and child health services

12. **Childhood illness disrupts normal linear growth, with undernutrition and illness forming a vicious cycle**. According to the ICHNS, prevalence of acute respiratory infection (ARI), fever, and diarrhea in the two weeks preceding the survey was 3 percent, 12 percent and 9 percent, respectively. There were no clear trends in cases of illness across sociodemographic characteristics. Care from a health provider was sought from about half of children with diarrhea, with care seeking much lower in rural areas (37 percent) compared to urban (53 percent). Only about one quarter (28 percent) of diarrhea cases were treated with oral rehydration salts (ORS) or recommended homemade fluids, with 8 percent of diarrhea cases receiving ORS and zinc.

13. **Coverage of essential health services[vi] being low and variable**, is **an impediment to optimal health and nutrition of women and children** (see coverage details in Annex 1 Table A2)**.** The availability, affordability, and quality of

reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N) services is necessary to reduce the burden of disease, promote family planning and optimal birth spacing, and to encourage appropriate health and nutrition behaviors. Contacts with health care providers are an opportunity to promote the nutrition, health, and wellbeing of women and their children.

14. **Despite considerable investment[vii] the Marshallese health system is lacking in many of the core building blocks needed to ensure access to effective and good quality primary health care services.[viii]** The Ministry of Health and Human Services (MOHHS) has three main bureaus providing direct health services (Primary Health Care Services, Majuro Hospital Health Care Services, and Kwajalein Atoll Health Care Services) with additional supportive planning and administrative offices at the central level. Service delivery is largely hospital-based (primarily physician-provided, curative services) in the Majuro and Ebeye hospitals. Primary health care includes a public health 'zone nurse' system aligned with each urban center hospital, 54 community health centers,[ix] and outer island mobile health missions. However, staffing, communication, transportation, management, and supervision remain challenges to the provision of comprehensive and community-based prevention, promotion, and service provision especially in the outer islands.[x] MOHHS staff report challenges in the availability and distribution of human resources and in facilitating communication across programs and providers. The national immunization program has received substantial financial support, but challenges in human resources/outreach and vaccine cold chain pose barriers to achieving universal coverage, especially in the outer islands.[xi] In addition, there are limited options to address poor health and nutrition behaviors through caregivers in the community.

15. **Coverage of facility-based RMNCAH-N services is relatively high in Ebeye and Majuro but challenges remain in ensuring sufficient supply of commodities outside Majuro.** Early antenatal care (ANC) remains an issue (44 percent of women receive their first ANC visit in the first trimester). Disparities in access persist for rural women and for the poorest, with only 66 percent of rural women delivering with a skilled birth attendant. The majority of women receive iron-folic acid (IFA) supplementation (67 percent) or multiple micronutrient supplementation (49 percent) during pregnancy. However, adequate supplementation is an issue, as only 26 percent of women consume more than 90 IFA tablets, and IFA consumption is lowest among mothers less than 20 years old at time of birth (14 percent). Moreover, programs such as vitamin A supplementation (54 percent) and child deworming (32 percent) have lower coverage. The MOHHS offers Maternal and Child Health (MCH) Clinics in Majuro and Ebeye, which see infants at two weeks postpartum and according to the routine immunization schedule. Draft standard operating procedures exist for triage (including growth monitoring), immunization sessions, breastfeeding, administration of vitamin A and deworming, and community-based immunization outreach.

16. **Teenage pregnancy and early childbearing are a growing concern in RMI,** where 15 percent of mothers of children under age five were under 20 years old at the time of birth (ICHNS, 2017). Adolescent parents and their children face increased risk for health/nutrition, psychological, developmental, and social challenges and require special support and resources in order to promote their wellbeing. A combination of biological (e.g., incomplete linear growth) and psychosocial risk factors (e.g., restricted access to health services and financial resources, low decision-making capacity, low visibility in the community, low educational attainment) contribute to the higher risk profile for teen mothers. Specifically, adolescent mothers are at high risk for inadequate pregnancy weight gain and delivery of low birth weight infants. Infants of mothers below age 18 face a 60 percent elevated risk of infant mortality relative to infants born to mothers older than age 19 (UNICEF, State of the World's Children, 2009). Many undernourished adolescent girls experience slower growth over a longer period than their well-nourished counterparts and they will not have finished growing before their first pregnancy.

17. **Access to adolescent friendly reproductive health education and services remains a gap to be filled.** Though the Public School Systems (PSS) operates a school health program (see below), this does not include advice and counseling on

reproductive health or family planning (though there is an interest in adding family life education to the health curriculum). There are no specific public services for adolescents, and NGOs play a key role in providing access to adolescent-friendly services (see below).

Inadequate access to clean water and sanitation

18. **Low access to safe drinking water, sanitation, and poor hygiene practices can increase risk of disease and impair nutrient absorption, ultimately leading to chronic and acute undernutrition.** In RMI, 100 percent of households have access to improved sources of drinking water. In both rural and urban areas, rainwater collection is the dominant source of drinking water, at 85 percent and 66 percent, respectively. Bottled water is the second most common source of drinking water in the population (18 percent), but much more common among the richest (42 percent) compared to the poorest (2 percent) households. Open defecation is practiced by 8 percent of the population, but is more common in rural (35 percent) compared to urban (4 percent) households. The vast majority (85 percent) of households have water and soap available in the household for handwashing.

Poor caring environment for women and children

19. **Low awareness and capacity of caregivers to provide optimal care to young children contributes to undernutrition in RMI.** Poor child feeding behaviors (described above) are the result of insufficient time, attention, knowledge, and support of caregivers to meet children's developmental needs. In RMI, women often lack autonomy for the care of their children, relying on extended family networks whose members (especially grandmothers) may also have insufficient knowledge on child nutrition and development. The large average household size (nine members) and high unemployment of the working age population (61 percent out of work) indicates that there may be opportunities to maximize time and social support resources by reaching adults with timely, appropriate information on parenting and child care.

Insufficient opportunities for early stimulation and learning:

20. **The early years of a child's life are critical for developing cognitive, non-cognitive, language, and socio-emotional skills, with human brain development at its peak in the first year of life.** These early skills are important for success in school and the labor market. The global evidence is clear that poverty, poor nutrition, stunting, and associated lack of early learning opportunities all contribute to slower cognitive development among children. Poor child development is further exacerbated as children progress through school and is associated with poor attendance, high drop out rates and poor test results that deteriorate as students progress through the grades.

21. **In RMI, the absence of clear ECD policies and the exclusion of early childhood education (pre-kindergarten) from the public school system are impediments to developing the ECD sector.** RMI is one of the only Pacific Island Countries (PICs) without a national policy on Early Childhood Care and Education or Early Learning and Development Standards[xii]. RMI school system serves kindergarten to Grade 12, has 112 schools, and is made up of public and private schools. Pre-school is provided for 3-4 year-olds by private providers only. Government funding to private pre-schools is based on enrolment, performance and accreditation.

22. **Since 2004, the national kindergarten program has been integrated into public elementary schools and provided free of charge to children who turn 5 at the start of the school year.** Previously, RMI had access to US Federal Funding for the Head Start Program to be delivered in communities, but this program was discontinued in 2004. Out-of-pocket costs of tuition, uniforms, meals, transportation, and contribution to teachers' salaries in the predominantly private pre-schools impose considerable barriers to pre-school enrolment. Other barriers to early learning and stimulation for children

include limited availability of pre-schools in the country, and lack of caregiver understanding of the importance of early learning and stimulation.

23. **Only 5 percent of children aged 36-59 months attend an organized early childhood education programme (ICHNS 2017).** Enrolments in elementary school have been static for several years around 83-86 percent, and they drop off again in secondary school to 48-58 percent[xiii]. Enrollment rates have increased in urban areas and decreased in the outer islands probably as a consequence of migration. Low school enrollments, high dropout rates, and low educational outcomes are of great concern to PSS, and test scores from the national RMI Standards Assessment Test (MISAT) series highlight poor outcomes for those in school.

24. **Parent/caregiver interaction and the household environment in RMI do not compensate adequately for the lack of formal or community-based ECD services**. Nationwide, 72 percent of children age 36-59 months were engaged by adults in four or more activities in the previous three days[xiv]; children were more likely to have their mothers engaged in these activities (59 percent) than their fathers (2 percent). Adult engagement with children varies most widely by the education level of the child's caregiver: it is as low as 50 percent among children whose caregivers' highest level of education is primary school compared to 85 percent among children with caregivers who attended higher education. Children are less likely to have their biological mother engaged in learning when the mother is under age 20 (42 percent) compared to age 35 and over (53 percent). Less than one-fifth (18 percent) of children age 0-59 months live in households with three or more children's books, with this being fifteen times more likely for children in the richest wealth quintile (44 percent) compared to children in the poorest wealth quintile (3 percent). Urban children are also three times more likely (21 percent) to have at least three children's books compared to children in rural areas (7 percent).

Lack of support through formalized social protection

25. **RMI has very limited coverage through formal social protection (SP) programs, even when compared to other PICs.** Over the past decades, RMI has introduced a defined benefit pension scheme for formal sector workers, as well as a school feeding program for primary school children in Majuro only. Beyond these two schemes, there are no formal SP programs to support vulnerable groups (the poor, informal sector elderly, disabled etc.). The prevalence of 'hardship' in RMI is amongst the highest for PICs.[xv] Across most PICs, 20 to 30 percent of the population lives below the nationally-defined hardship threshold. For RMI, hardship is experienced by 51.1 percent of the population.[xvi] As a result of the limited coverage of existing programs, many households that are experiencing hardship lack any type of formal social assistance from the government.

26. **The lack of formal SP programs has an impact on the uptake of ECD and nutrition services.** Liquidity and credit constraints are less of an issue for uptake in the context of RMI, given the free or low-fees charged for these services. However, as noted above, households generally underinvest in ensuring their children access these services compared to what would be considered socially optimal in RMI. There is consistent evidence from multiple countries that conditioning SP programs[xvii] can successfully bring about behavioral change in this area. This evidence extends to enrolment and attendance for ECE services, but also on the uptake of RMNCAH-N services, including antenatal visits and giving birth at health facilities. The impact of cash transfers on household expenditure has also been well documented, with food-oriented transfers, even ones that provide cash but are perceived to be linked to food security, to be able to nudge consumers to increase the share of their additional budget devoted to food, as witnessed in countries such as Columbia, Ecuador, Mexico, and Nicaragua. [xviii] Furthermore, other studies attribute changes in expenditure patterns to a combination of gender controls[xixxx] – many transfer programs earmark women as recipients, and conclude that handing transfers to women likely accounts for the observed changes in food consumption[xxi]. Lastly, a combination of cash assistance for households and specific supplements tailored to a child's needs has proven advantageous in Mexico's

transfer program as well in drought response in Africa. Numerous studies have also confirmed that school feeding programs, which can be viewed as a form of in-kind transfer, can improve micronutrient status of children.[xxii]

Government Response to Improve Child Development in the Early Years

Governance and High-Level Commitment

27. **The publication of the ICHNS solidified the commitment of the Marshallese Government—specifically the President and the Chief Secretary's Office—to invest in children's earliest years.** RMI is committed to achieving the Sustainable Development Goals (SDGs), which enshrine the vision that every woman, child, and adolescent can realize his/her full health and developmental potential and contribute to their societies. Furthermore, there is widespread agreement within the Cabinet that although progress has been made in increasing economic growth and reducing poverty, there is a clear need to invest in the foundations of human capital required to boost the productivity, competitiveness, and wellbeing of the Marshallese population.

28. **The National Human Resource Development Plan 2014-2019 highlights the development of Marshallese talent with capacity to achieve the strategic vision for the nation as articulated in the National Strategic Plan (NSP).** The NSP aims to ensure that the future of RMI is steered toward self-sustainability and efficiency by Marshallese, and this can only be achieved by investing in their people.

29. **A Cabinet-level Steering Committee on Early Years issues has been established and is chaired by the President.** The committee has mandated that the Chief Secretary's office be the location to facilitate the ECD agenda. Within the Ministry of Culture and Internal Affairs (MoCIA) the Human Rights Committee has the responsibility for operationalizing the Marshallese commitments under the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW).

30. **Furthermore, the Government is keen on developing its social protection system and employing it to address and contribute towards the Early Years agenda.** The Government has expressed interest in conducting a capacity assessment at the organizational and individual levels to identify the appropriate institutional home for the social protection initiative and provide recommendations on the human resources required to deliver on a multi-sectoral approach. The MoCIA has been proposed as a potential institutional home, though there are other options which will be explored during project preparation.

31. **Developing cost-effective interventions with sustainable financing will be critical for sustaining the high level policy focus on the early years**. Compact grants have been important sources of financing for social sectors, but have also skewed the development of systems and programs to align with those of the US, with mixed results.[xxiii] The Compacts and federal grants account for a large proportion of health and education expenditures (>80 percent) in RMI, and thus the transition from the current financing arrangement post 2023 is critical. The Government of the Marshall Islands is keen to increase the allocative and technical efficiency of expenditures in these sectors, and identify cost savings.

Development Partner Support

32. **The Marshallese Government is currently leveraging NGOs and CSOs in the health and education sectors to close gaps in implementation capacity for essential early years services.** Government financing supports local CSOs in the provision of community-based services and those targeting high risk populations, largely focusing on various dimensions of public health education, community mobilization, and service provision. The NGO Youth-to-Youth in Health

(Y2YIH) received funding from the US Centers for Disease Control and Prevention to operate a Teen Pregnancy Prevention program, which included a school-based intervention in Majuro and Ebeye targeting seven middle and high schools. Y2YIH also supports a Safer Sex intervention through a private clinic and Majuro/Ebeye hospitals to provide reproductive health services to youth in collaboration with MOHHS. PSS finances the NGO Women's United Together Marshall Islands (WUTMI) to deliver "*Ajri In Ibwinini*" (formerly Parents as Teachers), the main ECD program in RMI. This program has been in operation since 2002 and has 85 families enrolled across Majuro at present. Women are enrolled into the program as early as possible in their pregnancy but no later than the third trimester, and continue in the program through to the age of five of the child. Priority is given to single women, and/or vulnerable households. The program employs a total of nine community workers who deliver the ECD support such as promotion of antenatal and post-natal care, child health and nutrition services, and early stimulation and learning activities at home. The total annual cost of this program is US$ 65,000. Other NGOs, such as the Canvassback Mission, play an important role in community-based promotion of nutrition and physical activity.

Relationship to CPF

33. **The proposed project is in line with the four Focus Areas of the Regional Partnership Framework, with three areas directly supported through the project.** The Regional Partnership Framework (RPF) FY17-21 for nine Pacific Island Countries, including RMI identified the World Bank's support in the following Focus Areas: (i) Fully exploiting the available economic opportunities; (ii) Enhancing access to employment opportunities, with key interventions on improving education outcomes; (iii) Protecting incomes and livelihoods, with interventions to help countries strengthen health systems and address NCDs; and (iv) Strengthening the enablers of growth and opportunities (macro-economic management, infrastructure and addressing knowledge gaps), with interventions improving access to basic services and addressing the prevailing knowledge gaps. Global evidence shows education outcomes, as referenced in Focus Areas 1 and 2, are strongly predicted by the time a child enters the first year of primary school, and are strengthened through interventions focused on health, nutrition and early stimulation. Addressing focus Area 4, the project aims to address needed improvements in the availability and quality of essential health and nutrition services for girls and women of reproductive age, pregnant and lactating women, and children aged 0-3, and establish community-based platforms to promote growth promotion, early childhood stimulation and play-based learning for children aged 0-5.

34. **Further, the project has strong support from the government throughout the highest levels, with the request for the project coming from the President, and Cabinet members showing interest and commitment to the project.** It is also aligned with all ten themes highlighted in RMI National Strategic Plan 2015-2017 through multiple development objectives, including strengthening health systems, improving education outcomes, and enhancing the capacity of youth and vulnerable peoples to meet their full potential.

C. Proposed Development Objective(s)

The proposed project development objective is to increase coverage and utilization of essential services to improve nutrition and child development.

Key Results (From PCN)

i. Increased number/percent of children 0-2 years old receiving regular growth monitoring and promotion;

ii. Increased number/percent of children age 6-23 months receiving minimum dietary diversity

iii. Increased number/percent of children aged 0-5 years attending ECD services in the target communities

iv. Increased number of caregivers routinely engaging in stimulation activities with their children

v. Number of households with pregnant women/children under age five receiving regular cash transfers

D. Concept Description

35. ***Nurturing Care* consists of a set of conditions that provide for children's health, nutrition, security and safety, responsive caregiving, and opportunities for early learning that can help Marshallese children realize their full developmental potential** (WHO, UNICEF, World Bank 2018). Nurturing Care is dependent not only on the relationship between child and caregiver, but also the overall enabling environment related to policies and programs that support parents and caregivers with knowledge, resources, and services needed to deliver this care. Children need healthcare and nutrition to survive, but to thrive they also need early stimulation. Early stimulation lays the foundations for future learning and life success and this can be provided by parents and caregivers through daily activities. Children are born ready to learn, and much can be provided by parents and caregivers to maximize their potential in the early years when their brains develop faster than at any other time in life.

Geographic Scope

36. **It is envisaged that most project activities will be rolled out nationally; specific targeting mechanisms—particularly regarding the cash transfer—will be further elaborated during preparation, as necessary.** The design of the program recognizes that service delivery solutions need to be adapted to the geographic and fiscal realities of RMI. Thus, the program will support service delivery models that are flexible and adaptable to the major population centers such as Ebeye and Majuro versus outer islands settings, as well as the operational learning required to discern what works in each context. Further, the uncertainty around continued US federal funding for key services makes it imperative to introduce more cost-effective and efficient service delivery mechanisms across human development sectors.

Intervention Scope

37. **Aligned with the World Bank's approach to Investing in the Early Years, the program will focus on expanding access to services that can enhance children's physical, cognitive, and socio-emotional development by improving health and nutrition of young women, mothers and children, promoting early learning and stimulation, and protecting young children and supporting their families.** Complementary activities will also strengthen the systems needed to deliver and coordinate these interventions and stimulate demand through social and behavior change.

Component 1. Increasing access to health and nutrition services

38. **The health system currently serves as the primary platform to reach adolescents, women, infants and children with early years services in RMI.** Most essential RMNCAH-N services exist in health sector strategies and guidelines[xxiv]; however, the challenge is in ensuring that these services are available and delivered with sufficient quality and are accessible such that they can improve outcomes. Therefore, the project will build upon existing health sector services and contact points to improve access to quality RMNCAH-N services. In the first phase of the program, the project will focus on enhancing the availability of essential services and removing geographic access barriers to utilization. The project will leverage existing entry points in hospital and facility-based service delivery and focus on ensuring that a comprehensive package of RMNCAH-N services is made available. Simultaneously, longer term strategic reforms will be initiated to re-orient health financing and service delivery towards a strengthened frontline primary care and community outreach system. Early in Phase 1, the project will support the design, testing, and adaptation to find an appropriate outreach model, building on assets such as the zone nurses to identify a contextually relevant model that can be rolled out in the later years of phase 1 and further institutionalized, with a focus on quality, in Phase 2, including strengthening human

resources, infrastructure, information, management and governance in the health system. Project interventions will pay specific attention to increase access to vulnerable populations and increasing quality of service provision.

39. **There will be two sub-components:** (i) the development, testing and roll-out of effective delivery models for RMNCAH-H services at the frontline adapted to different geographic contexts; and (ii) strengthening of MOHHS management and stewardship of RMNCAH-H services.

Component 2. Increasing access to stimulation and early learning activities.

40. **In the absence of a national program to promote early stimulation and learning for children under five years old, component 2 will take an adaptive learning approach to developing suitable models that lead to better child development outcomes.** This component will build on or improve existing formal and non-formal services where appropriate, or support creation of community-based services and activities to engage children and parents outside of formal settings, such as through Community Child Development Groups (CCDGs), mother support groups, and/or home visits. The pilots will be evaluated during the first phase and adapted during the course of the program taking into account feasibility and cost-effectiveness of the different models piloted.

41. **There will be two subcomponents.** Subcomponent 2.1 will (i) pilot a community-based approach to delivering parental awareness and stimulation for children through play-based activities, and (ii) strengthen existing platforms of ECD services for parents/caregivers and children aged 0-5. The play-based activities will be delivered through CCDGs, which provide interactive, play-based sessions with activities arranged by age groups to engage in early stimulation and early learning with peers in a safe environment, organized and facilitated by trained facilitators selected by the community. Caregivers will be required to participate and receive education to promote child development through better parenting practices. In addition to CCDGs, this subcomponent would also build on existing platforms of ECD services in RMI such as WUTMI providing support to parent through home visits, and providing additional resources and training to teachers of the existing kindergartens who have been trained solely to teach 5 year olds. The project would support training to equip teachers to master skills on multi-age teaching and play-based learning, which could be opened up to include three and four-year old children. Subcomponent 2.2 will strengthen the capacity of relevant government agencies to manage and steward the implementation of ECD interventions. This includes enhancing the availability and capacity of skilled cadres to support delivery of ECD services at the community level as well as strengthening the capacity of the concerned government agencies (MOE/PSS, MoCIA/local government) in providing support, quality assurance and monitoring implementation.

Component 3: Social assistance for Early Years Households

42. **With social protection being a relatively new concept in RMI, the project will focus on developing the basic foundation of a social assistance delivery system and implementing an effective national program for Early Years.** This component will serve to operationalize this interest through finance for the development of systems and the delivery of cash to reduce vulnerability and improve the uptake of key nutrition and early childhood development services. It is envisaged that this component will help build the government's capacity to deliver core social protection services and encourage the government to consider moving towards more advanced and sophisticated SP systems and policy frameworks in subsequent project phases.

43. **There will be two sub-components:** (i) the provision of cash transfers to early years households and (ii) the development of key social assistance delivery systems. Given low levels of service utilization at present, all households in Majuro and Ebeye with pregnant women and children aged 0-5 years in the pilot areas would be eligible to benefit and

there will be no household-level poverty targeting. Agreement on the specific co-responsibilities will be reached as part of preparation; initial 'soft' co-responsibilities could include participation in the CCDGs or other caregiver education sessions, and subsequent 'hard' co-responsibilities related to age-stratified and minimum attendance requirements could be considered at a later stage. The second subcomponent will look at developing and strengthening the key building blocks for an effective social assistance delivery system in RMI, which will include: (a) setting up beneficiary outreach and enrolment systems, (b) developing a management information system (MIS) for effective program implementation and monitoring, (c) establishing payment systems for efficient and transparent beneficiary cash transfers, (d) compliance verification mechanisms, and (e) grievance redress mechanisms.

Component 4: Project Management and Institutional Strengthening

44. **There will be two sub-components:** (i) project management, monitoring, evaluation and adaptive learning and (ii) institutional strengthening for a multi-sectoral response to ECD and nutrition. The latter will help establish and strengthen institutional arrangements and processes for multi-sectoral coordination, implementation, coordination and accountability for ECD at the central, and atoll levels.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The project will include activities in the two main population centres, Majuro and Ebeye, as well as the outer islands. The country is comprised of 29 atolls and 5 isolated islands, 24 of which are inhabitated. The islands of Majuro, located on the Majuro Atoll, and Ebeye, located on the Kwajalein Atoll, are both virtually completely urbanised, with natural environment confined to sections of coastal boundaries, on the lagoon and ocean sides. Nearly all islands share the geology of coral atolls, with the exception of Mejit and Jabat Islands. The location of activities is not known at concept stage, beyond that investments will focus on Majuro and Ebeye, and potentially also involve all inhabited islands.

B. Borrower's Institutional Capacity for Safeguard Policies

The implementing agency's capacity to manage environmental and social risks is limited. If the project involves repair or construction of health and ECD facilities, or significant waste management, the implementing agency will engage consultants to prepare environmental assessments, health care waste management plans, or similar assessments.

C. Environmental and Social Safeguards Specialists on the Team

Penelope Ruth Ferguson, Environmental Safeguards Specialist
Ross James Butler, Social Safeguards Specialist

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Repair, refurbishment or construction of facilities for early childhood development and health services is not planned to be financed by the project. However,

		the project will involve use of public buildings in Ebeye, Majuro and other islands, some of which may require refurbishment or reconstruction. Audit of each building's adequacy for use in the project, including available space, other safety considerations, and sanitation, will be carried out during implementation. The audit may identify the requirement for refurbishment or minor construction activities at specific facilities. The range of activities planned for Component 1 will increase the number of healthcare beneficiaries, and thus may lead to an increase in medical waste production by health facilities. Geographic constraints in RMI, primarily related to limited land availability and sensitivity of groundwater systems to pollution, mean that any improper disposal of waste has potential environmental or social impacts. The current waste management practices in RMI will be assessed during project preparation. The assessment will also determine whether project-related increases in medical waste can be mitigated through existing practices, or if a project-specific waste management plan is required. An Environmental and Social Management Framework (ESMF) will be prepared as part of project preparation. The ESMF will include an initial assessment of the likely environmental and social risks. It will set out the necessary screening, assessment and planning to be followed in the event that the project involves physical investments (directly or indirectly). It will also describe arrangements for stakeholder engagement and grievance redress. A central part of the ESMF will be the preparation of a social assessment which can, among other things, identify vulnerable groups, document social risks and challenges as well as opportunities. Citizen engagement will be important during this process to ensure that beneficiaries are aware of the project and how they can be involved in the decision making process. The citizen engagement will also assist in relating this project with other Bank supported projects, particularly in the outer islands.
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	The project is not likely to involve physical investments or other activities that may impact on natural habitats.
Forests OP/BP 4.36	No	

Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	The project is not likely to involve physical investments or other activities that may impact on physical cultural resources.
Indigenous Peoples OP/BP 4.10	No	RMI's population is relatively homogenous. The policy is not triggered because there are no social groups that meet the characteristics of the policy.
Involuntary Resettlement OP/BP 4.12	No	The project will not involve physical investments or other activities that may involve land acquisition. It is not anticipated that any additional land would be required for the project however this will be confirmed during preparation.
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/BP 7.60	No	

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Nov 01, 2018

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

ESMF including social assessment to be carried out July-September 2018.

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APPROVAL

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Approved By

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Country Director:	Mona Sur	20-Sep-2018

[i] 2011 RMI Census
[ii] The ICHNS was conducted from April to June 2017 by the Ministry of Health and Human Services and the Economic, Policy Planning and Statistics Office (EPPSO). Technical and financial support for the survey was mainly provided by UNICEF Pacific Country Office in Fiji. The ICHNS 2017 is based on a sample of 581 households with children under 5 that were interviewed and provides a comprehensive picture of children and their caregivers at the national level and urban and rural strata in RMI.
[iii] Childhood undernutrition is responsible for nearly half of childhood deaths (Black et al. 2013). For children who survive, chronic malnutrition in the first years of life is associated with significant impairments in cognitive development in childhood. Children evidencing chronic malnutrition by age two are more likely to enter school later, perform worse in school, and complete fewer years of schooling (Hoddinott et al. 2011; Adair et al. 2013; Martorell et al. 2010). Further, one study has found that they are 33% less likely than other children to escape poverty (Hoddinott et al. 2011).
[iv] The ICHNS calculates the Early Child Development Index (ECDI) based on selected milestones that children are expected to achieve by ages 3 and 4. There are notable limitations to the interpretation of the overall ECDI and the validity of the items included in the index. The literacy-numeracy items are more closely aligned with capabilities expected of children at the upper end of the age range, and physical items more closely aligned with developmental milestones for children at the lower end of the age range. Thus, it is unsurprising to see higher performance in the physical domain and lower performance in literacy-numeracy.
[v] The ICHNS uses Household Food Insecurity Access Scale (HFIAS) to measure household food insecurity, a subjective measure of the access domain of food insecurity. The HFIAS captures the extent to which the household experiences anxiety/worry about

sufficiency of food, as well as perceptions of insufficiency of the quality and quantity of food accessible to the household. Severe food insecurity is defined as the household answering affirmatively to any of the following items: the household did not have any food at home; a family member went to bed hungry at night; or a family member went a whole day and night without eating due to low availability of food. For more information see: Coates J, Swindale A, Bilinsky P. 2007. Household Food Insecurity Access Scale (HFIAS) for Measurement of Household Food Access: Indicator Guide (v. 3). Washington, D.C.: FHI 360/FANTA.

[vi] Key services to promote nurturing care include: family planning, preconception care, antenatal care, early and essential newborn care, postnatal care, immunization, growth monitoring and promotion, management of childhood illness, nutrition counselling and supplementation, nutrition rehabilitation, and services for children with developmental difficulties or disabilities (WHO UNICEF World Bank 2018).

[vii] Most notably through the US Compact Funds (in 2017 this amounted to approximately $1.8m to RMI Health Sector along with $0.5m for Ebeye Special Needs Health) and support from the US Department of Health and Human Services, Center for Disease Control (CDC) and Prevention, the United States Department of Energy, Taiwan, China, United Nations Population Fund, and the Canvassback Mission, including the Wellness Center.

[viii] WHO defines these as: i) leadership and governance; ii) service delivery; iii) health system financing; iv) health workforce; v) medical products, vaccines, and technologies; and vi) health information systems.

[ix] Community health centers are the focus for preventive, promotive, and essential clinical health services and are staffed by full-time Health Assistants (high school graduates, majority male, who are trained to provide basic services but are reported to have insufficient professional competencies). However, there are cultural challenges related to the acceptability of male health assistants providing RMNCAH-N services, and for this reason many women on outer islands often: i) don't seek preventive/promotive services; ii) see traditional providers; or iii) travel to Ebeye/Majuro and for only the most essential RMNCAH-N services.

[x] The 'zone nurse' system is highly functional on Ebeye; the reported 99% vaccination rate on Ebeye is attributed to the strong public health nursing support; however, the approach has had relatively less success in Majuro and on the outer islands, largely due to insufficient nurse:patient ratios.

[xi] US CDC, ADB Regional TA on Cold Chain, UNICEF

[xii] UNICEF, 2017. Status Report on Early Childhood Care and Education in Pacific Island Countries (PICs).

[xiii] Digest of education statistics 2016-2017, PSS

[xiv] The maximum number of activities is six, including: (A) Reading books to or looking at picture books with the child, (B) Telling stories to the child, (C) Singing songs to or with the child, including lullabies, (D) Taking the child outside the home, compound, yard, or enclosure, (E) Playing with the child, and (F) Naming, counting, or drawing things to or with the child.

[xv] The term 'hardship' relates specifically to national poverty measures. Incidence of 'hardship' is defined as the proportion of the population whose expenditure is below a threshold that includes an allowance for minimum food and non-food needs.

[xvi] It should be noted that this measure has been calculated from the 2002 HIES data. However, in the absence of economic or job growth over this period, these figures are unlikely to have improved significantly.

[xvii] Conditioning SP refers to making cash transfers conditional on certain behaviors or actions which are required to be met by eligible families in order to receive the cash payment

[xviii] Attanasio, Battistin, and Mesnard 2012. "Food and Cash Transfers: Evidence from Columbia". Economic Journal 122 (559): 92-124.

[xix] Haddad, Hoddinott, and Alderman 1997. "Intrahousehold Resource Allocation in Developing Countries: Methods, Models and Policy". Baltimore: Johns Hopkins University Press.

[xx] Duflo 2003. "Grandmothers and Granddaughters: Old-Age Pensions and Intra-household Allocation in South Africa". World Bank Economic Review 17 (1): 1-25.

[xxi] Angelucci and Attanasio 2013. "The Demand for Food of Poor Urban Mexican Households: Understanding Policy Impacts Using Structural Models". American Economics Journal: Economic Policy 5 (1): 146-205.

[xxii] Best et. Al. 2011. "Can Multi-Micronutrient Fod Fortification Improve the Micronutrient Status, Growth, Health, and Cognition of School children? A Systematic Review". Nutrition Reviews 69 (4): 186-204.

[xxiii] A report from the US General Accounting Office found that "local conditions have limited the effectiveness" of most reviewed programs because the design—intended for the United States—was not appropriate for the differing geographic, economic, and social conditions of a developing island nation. Critical early years services, such as Head Start for preschoolers and Maternal and Child health were among the ineffective services, in part due to the lack of complementary public and private health care services (GAO 2002).

[xxiv] Child development is noticeably absent from health sector services and this component will also explore opportunities (such as interpersonal contacts with health providers in facilities or in outreach) to integrate early stimulation into the services provided by healthcare workers.