

**PROJECT INFORMATION DOCUMENT (PID)
IDENTIFICATION/CONCEPT STAGE**

Report No.: PIDC62019

Project Name	
Region	AFRICA
Country	Ghana
Lending Instrument	IPF
Project ID	P159735
Borrower Name	Ministry of Finance
Implementing Agency	World Vision Ghana
Environmental Category	B - Partial Assessment
Date PID Prepared	30-Jan-2017
Estimated Date of Approval	13-Feb-2017
Initiation Note Review Decision	The review did authorize the preparation to continue

I. Introduction and Context

Country Context

Recent macroeconomic instability in Ghana is putting at risk the gains in poverty reduction experienced prior to 2011. Ghana experienced rapid economic growth followed by an economic downturn - gross domestic product (GDP) growth rose from 8% in 2010 to close to 14.5% in 2011, and then dropped to 4% in 2015 (World Bank, 2014). The fiscal deficit reached 12% of GDP in 2012 and dropped to 10.2% in 2014 (IMF Review Mission, 2015), and the current account deficit reached 11.9% of GDP in 2013. The depreciation of the Ghana Cedi (GHc) has resulted in a lower income in real terms, which in turn results in pushing many near-poor families into poverty. In fact, macroeconomic challenges disproportionately affect the poor members of the society. By 2014, gross national income (GNI) per capita reached US\$1,590, reflecting Ghana's lower middle income status (World Bank, 2014).

Ghana made a significant progress in poverty reduction, and met the Millennium Development Goal (MDG) of halving poverty rates by 2015 to 24% in 2013 from 52% in 1991. However, inequalities remain widespread and are reflected in significant disparities in access to economic, social, and political opportunities. The Northern Savannah regions (with 25% of the country's population) recorded an average poverty rate of 58%, compared to 19% in the rest of the country. In effect, the number of people living in poverty fell by 2.5 million in the South while increasing by 0.9 million in the North. The Gini coefficient for consumption per adult increased from 0.394 in 2005 to 0.428 in 2013 (UNDP, 2013).

Sectoral and Institutional Context

According to the Ghana Demographic and Health Survey of 2014, the estimated infant mortality rate is 41 deaths per 1,000 live births and under-5 mortality is slightly higher at 60 deaths per 1,000 live

births. At these levels, one in every 24 Ghanaian children dies before reaching age 1, and one in every 17 does not survive to his or her fifth birthday. Infant mortality has declined by 28% since 1998, while under-5 mortality has declined by 44% over the same period. Under-5 mortality is highest in the Northern, Upper West, and Ashanti regions of Ghana (DHS, 2014).

Undernutrition (fetal growth restriction, suboptimum breastfeeding, stunting, wasting, and micronutrient deficiencies of vitamin A, iron, and zinc) slows economic growth and perpetuates poverty through direct losses in productivity from poor physical status; indirect losses from poor cognitive function and deficits in schooling; and losses owing to increased health care costs. Productivity losses are estimated at more than 10% of lifetime earnings, and up to 2-3% of GDP (World Bank, 2013). Worldwide, undernutrition causes 45% of all deaths of children younger than 5 years, representing more than 3 million deaths each year (3.1 million of the 6.9 million child deaths in 2011) (Lancet, 2013).

In Ghana, statistics continue to show high instances of undernutrition which hinders human development and economic growth. Every year in Ghana, 12,000 children die because their weight is too low for their age (underweight) (PROFILES, 2011). In 2014, 19% of Ghanaian children under age 5 were stunted (short for their age). This is a big improvement from 10 years ago (2003) when stunting rates hovered around 35%. Bringing the stunting rates further down will require new strategies. Moreover, stunting varies by region; the highest being the Northern (33%), Upper West (22%), and Central (22%) (DHS, 2014). It is estimated that, for the period 2011 to 2020, there will be 97,000 deaths of children under 5 years will be related to stunting alone (PROFILES, 2011). Wasting (thin for their height) also continues to be a pervasive issue with 5% of children under 5 considered wasted and 11% were underweight (thin for their age). Wasting is more prominent in the Upper East (9.4%), Central (7.7%), and Brong Ahafo (4.5%) regions. In addition, micronutrient malnutrition is highly prevalent and persistent; 66% of children ages 6 to 59 months are anemic (DHS, 2014).

Adequate provision of nutrients, beginning in early stages of life, is crucial to ensure good physical and mental development and long-term health. The importance of improving the nutritional status of children especially during their first 1,000 days or the first three years from conception to their second birthday in order to reduce stunting and wasting has been widely recognized. This period is often marked by poor infant and young child feeding practices that result in poor nutrition, including micronutrient deficiencies and repeated episodes of infection that interfere with optimal growth. Fetal growth restriction and suboptimal breastfeeding together cause more than 1.3 million deaths, or 19.4% of all deaths of children younger than 5 years, representing 43.5% of all nutrition-related deaths (Lancet, 2013).

Malnutrition in women perpetuates the intergenerational cycle of malnutrition since the 1,000 days starts from conception, therefore enabling women (from the age of 15) to have a nutritious diet is crucial not only for themselves but also for the lifelong health of children. Malnutrition in women also leads to reduced productivity, increased susceptibility to infections, and slowed recovery from illness. Low body mass index and short stature, anemia, and other micronutrient deficiencies results in increased risk of complications in pregnancy including poor fetal development, a heightened risk of adverse pregnancy outcomes, and death from postpartum hemorrhage. In Ghana, anemia levels in reproductive age women (15 to 49 years) stands at 42%. Anemia levels vary by region; the highest being Volta (49%), Northern (48%), and Central (47%) (DHS, 2014).

Efforts to reduce the prevalence of stunted, wasted and underweight children depend largely on an adequate supply of food with good nutritional content. Considerable global and national efforts and attention have been devoted to breastfeeding promotion, however less attention has been paid to

complementary feeding practices (Gosh, et al., 2014). This is confirmed by the outcome indicators on Infant and Young Child Feeding in Ghana. While early initiation of breastfeeding is practiced in 56% of newborn babies and exclusive breastfeeding during the first six months is practiced by 52 percent of mothers, only 13% of children in the age range of 6-23 months receive a minimum acceptable diet. In Ghana, complementary foods (CFs) tend to be introduced too early and are often of poor quality and quantity in terms of nutrient diversity, density and feeding frequency. Traditional complementary foods (CFs) are mostly plant-based, low in fatty acids, low in energy and micronutrients with poor protein quality because of limited presence of the essential amino acids, lysine and tryptophan. Koko is a typical Ghanaian CF made of fermented corn consumed by Ghanaian infants and young children. It does not meet the WHO recommended nutritional requirements because it does not provide a sufficient amount of essential amino acids, and micronutrients.

In Ghana, the primary strategies for decreasing micronutrient deficiency are supplementation and fortification. Vitamin A is distributed through high-dose supplements to children aged 6-59 months twice a year. Twice yearly campaigns of vitamin A supplementation have been a mainstay for the last 10 years, but they are costly to run and coverage varies enormously between each round (with the second round sometimes being abandoned entirely) (UNICEF, 2007). Therefore, Ghana is trying to strengthen routine supplementation, but coverage remains low after children stop coming for consultation once the vaccination schedule is completed by the age of 24 months. High-dose supplements are also provided to mothers within the first eight weeks of delivery but coverage among women remains low as well. Prophylactic iron supplements are provided only to pregnant women during antenatal care. However, because women often came for first consultation late into pregnancy, the benefits of iron supplementation are compromised, with negative consequences to iron storage in mothers and newborns. No prophylactic iron supplements are provided to children, unless diagnosed as clinically anemic. In Ghana, fortification is also used. Cooking oil is fortified with vitamin A and wheat flour is fortified with iron. Unfortunately, these commodities only reach a small portion of children aged 6-59 months. Another complementary approach to reduce micronutrient deficiency is biofortification. Biofortification is the process of adding micronutrients to staple crops using conventional breeding techniques to decrease vitamin A, iron, and zinc deficiencies. Considering biofortification uses staple crops households are already consuming, it is a cost-effective approach to decreasing micronutrient deficiencies. In fact, the 2008 Copenhagen Consensus Centre ranked biofortification as fifth on their 15 items list of cost-effective beneficial solutions to 10 of the world's foremost problems (Copenhagen Consensus, 2008).

Chronic malnutrition is far more concentrated in the north of Ghana than it is in the south. Most development partners have therefore concentrated their efforts to the northern five Regions, and they have done so for many years. The Bank-supported Nutrition and Malaria Control for Child Survival Project (P105092; \$25 million; closed in March 2013) focused on the northern 5 Regions. UNICEF invested predominantly in these northern Regions as well. While many indicators have improved as a result of the system strengthening efforts (vaccination coverage, antenatal care), nutrition outcomes are making very little progress. There is a tremendous challenge around infant and young child feeding practices. Most of the past efforts have been in the promotion of breastfeeding practices. More recently, the focus is shifting to complementary feeding practices. However, the challenges are different as availability of quality foods need to be part of the behavior change communication (as opposed to the promotion of breastfeeding practices which has the benefit of always available breast milk). Current service delivery models have been inadequate to address the problems in complementary feeding and innovative new thinking is needed to complement efforts by Government and development partners to generate better results. It is this thinking that has led to the current proposal. World Food Programme is also exploring new ways of improving complementary feeding practices, mostly through the introduction of new products and have shown great interest to learn from

the proposed experience.

In addition to the nutritional and economic benefits, biofortification is advantageous for agricultural reasons. Low productivity in the agriculture sector has major implications for food and nutrition security in the country. Natural phenomena, especially floods, regularly result in disasters that cause severe food insecurity and disruption of livelihoods. Such adverse weather conditions often exacerbate drought-related crop failures, especially through bush fires that have a disproportionately severe impact on smallholder farm enterprise. If there is good access to planting material or seeds, biofortified crops can be grown and consumed for multiple years by smallholder farmers and does not have adverse effects on productivity, and may actually increase yields and thereby food security.

Relationship to CAS/CPS/CPF

The contribution of poverty in the complex relationship between food security and malnutrition cannot be overemphasized. The proposed project will contribute to achieving two of the newly adopted United Nations Sustainable Development Goals (SDGs) namely: "Goal 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture; and Goal 3: Ensure healthy lives and promote well-being for all at all ages". More specifically, this project seeks to address two SDG targets namely: 1) Goal 2.2: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons; and 2) Goal 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

Ghana's National Medium Term Development Policy Framework and Health Sector Medium Term Development Plan (2014-2017) identify accelerating agricultural modernization and human development as key priority areas. The health situation in Ghana has been characterized by significant inequalities over the years. Although the health status of the general population may be improving, the health of the less endowed is improving more slowly than the rest of the country.

The proposed grant activity directly responds to two focus areas of the CPS, namely (1) Improving Competitiveness and Job Creation, and (2) Protecting the Poor and Vulnerable. The mobilization and use of Village-Based Entrepreneurs (VBE) will promote jobs and generate income for women in remote areas of the countries. VBEs are members from within the target population and selected by their Village Savings and Loan Associations (VSLAs), trained, provided products, and then empowered to sell door-to-door in their local communities. Furthermore, by strengthening local supply chain networks and using VBEs to distribute innovative nutritional supplements in their communities, this project will also result in improved access to nutritional supplements for poor women of reproductive age and children under 2 years old in hard to reach communities. The proposed grant will also support the local food economy through the development of local vegetable gardens using biofortified seeds, fruit trees production and small animal rearing, thereby increasing the availability of diversified food throughout the year in remote areas with limited access to the main markets.

The proposed grant activity will complement the Maternal, Child Health and Nutrition Project (P145792; \$73 million) especially on improving the utilization of community-based health and nutrition services by women of reproductive age, pregnant women, and children under the age of 2 years. The activities proposed under this project cannot be funded through the Maternal and Child Health Improvement Project as the current design does not have space to include a social business model as part of the implementation arrangements. Moreover, the current project aims to scale up

service delivery of essential interventions, but does not cater for the piloting of new approaches, such as the development of a social business model for the promotion of complementary feeding, and testing a new delivery approach to get essential commodities to the hard to reach areas at affordable rates. If successful, these new approaches will represent important complements to the existing service delivery model particularly for services where the public sector supply-driven model appears to be inadequate to achieve results. Beyond the Ghana experience, there is growing interest to work with social entrepreneurs to improve public sector program efficacy and various countries have shown interest in learning from the Ghana pilot. Similarly, beyond complementary feeding, there are other services which could benefit from similar service delivery models to hard to reach areas including oral rehydration salts, family planning commodities and bed nets for as far as the health sector is concerned as well as seeds, fertilizer and other commodities and technologies to enhance local food security, and even commodities under humanitarian assistance. This pilot thus feeds into the global interest in social enterprise innovations, including through the Bank's Leadership, Learning and Innovation (LLI).

II. Project Development Objective(s)

Proposed Development Objective(s)

The Project Development Objective (PDO) is to improve the feeding practices among targeted women of reproductive age (including pregnant and lactating women) and children under two (the so-called "first 1,000 days of life").

The PDO will be achieved through a comprehensive and multisectoral approach of evidence-based and cost effective interventions at the household level and by working in partnership with communities, public service providers, and non-governmental organizations (NGOs) to build local capacity and ensure the long-term sustainability of the approach to:

- Create an innovative, social, and sustainable business model for deployment of nutritional supplements, reaching targeted beneficiaries who are typically underserved in hard to reach areas;
- Improve dietary diversity through promotion of fruits, vegetables, biofortified foods (Orange-Flesh Sweet Potato), and animal source foods; and
- Provide nutrition education and messaging.

While all targeted women of reproductive age, i.e., 14-49 years, are part of the project, special attention will go out to adolescent, pregnant and lactating women because of their higher needs and vulnerabilities.

The proposed approach for this project, and the specific activities, have been designed and informed by the ongoing field work of World Vision Ghana over the past several years. World Vision Ghana has been working in these vulnerable communities for over 10 years, and is applying lessons learned from its nutrition-sensitive agriculture activities in Ghana.

Key Results

The proposed project will leverage a comprehensive approach to provide cost-effective solutions to achieving health impacts at the village level. Through the proposed activities, this project will promote behavior change and build local capacity to ensure ongoing nutrition best practices. This project aims to (i) increase access to effective complementary feeding practices, (ii) increase knowledge of good nutrition practices, (iii) increase income of VBEs, and (iv) improve dietary diversity at the household level.

Preliminary key performance indicators with tentative estimates for baseline and target data are proposed as follows:

- Percentage of children 6-23 months who have consumed a nutritional supplement (with both micronutrients and amino acids) at least 3 times in the last 7 days (baseline 0%; target 40%)
- Percentage of children 6-23 months with minimum dietary diversity (4 or more food groups) (baseline 13%; target 40%)
- Percentage of women of reproductive age and children 6-23 months consuming eggs, orange-flesh-sweet potatoes, and Moringa among beneficiary households in the last 7 days (baseline 0%; target 50%)

Minimum dietary diversity is defined as the proportion of children 6–23 months of age who receive foods from 4 or more food groups (total being 7) as per the WHO report (2008) on "Indicators for assessing infant and young child feeding practices", and commonly included in the Demographic Health Surveys (DHS).

The estimated number of direct beneficiaries of this proposed project include:

- 4,900 children 6-23 months of age whose quality of diet/nutrition is improved through the distribution of nutritional supplements with both micronutrients and amino acids
- 140 VBEs, selected from 70 villages, receive financial services and business training
- 1,050 farmer group members with household-level agriculture receive agriculture inputs and training to increase dietary diversity for household consumption
- 200 mother facilitators and 60 male champions trained on nutrition, health, sanitation, and hygiene best practices, who in-turn communicate these messages in their villages reaching an estimated 3,300 lactating and pregnant women

III. Preliminary Description

Concept Description

IV. Safeguard Policies that Might Apply

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

V. Financing (in USD Million)

Total Project Cost:	2.797052	Total Bank Financing:	0
---------------------	----------	-----------------------	---

Financing Gap:	0	
Financing Source		Amount
Japan Social Development Fund		2.797052

VI. Contact point

World Bank

Contact: Menno Mulder-Sibanda
 Title: Sr Nutrition Spec.
 Tel: 458-7724
 Email: mmuldersibanda@worldbank.org

Borrower/Client/Recipient

Name: Ministry of Finance
 Contact: Emmanuel Adjetey
 Title: Head, World Bank Unit, Ministry of Finance
 Tel: 233-244973278
 Email: EAdjetey@mofep.gov.gh

Implementing Agencies

Name: World Vision Ghana
 Contact: Raymond Kofi Owusu
 Title: Grants Manager
 Tel: 233302227216
 Email: raymond_owusu@wvi.org

VII. For more information contact:

The World Bank
 1818 H Street, NW
 Washington, D.C. 20433
 Telephone: (202) 473-1000
 Web: <http://www.worldbank.org/projects>