Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 08-Dec-2020 | Report No: PIDC30268

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Papua New Guinea	P174637		Child Nutrition and Social Protection Project (P174637)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	Oct 13, 2021	Mar 16, 2022	Social Protection & Jobs
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Independent State of Papua New Guinea	National Department of Health, Department of Community Development and Religion, Department of Justice and Attorney General	

Proposed Development Objective(s)

The Project Development Objective is to increase utilization of priority nutrition interventions and purchasing power of first thousand-day households in selected provinces and to provide immediate response in the event of an eligible crisis or emergency.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	50.00
Total Financing	50.00
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	50.00
IDA Credit	50.00

Environmental and Social Risk Classification	Concept Review Decision
Substantial	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

The Independent State of Papua New Guinea (PNG) is a lower-middle income country with significant gaps in access to basic services between urban and rural areas. PNG has remarkable diversities in culture, geography and natural resources with more than 800 different languages spoken among a population of over 9 million people[1]. It is predominantly rural country, with 86.9 percent of the population living in remote and hard-to-reach rural areas, with limited access to basic services, infrastructure, and markets. About 80 percent of rural households lack access to electricity and improved sanitation, while 60 percent have no safe drinking water.[2]

Progress in human development and poverty reduction has been hindered by a fragile social, political and environmental landscape. PNG's Human Capital Index (HCI) score is 0.43[3], meaning that a child born today can expect to achieve only 43 percent of his or her potential productivity as future workers, had they benefitted from full health and complete education. One factor contributing to PNG's low HCI score is its high child stunting rate – 48.2 percent of children under five years of age in PNG are stunted, one of the highest stunting rates in the world. Poverty rates remain high, with 38 percent of PNG's population living below the international poverty line of $1.90 per day (2011 USD PPP). Despite stagnating poverty rates, the country lacks a reliable social protection system to provide targeted social assistance to the poorest and most vulnerable, who depend entirely on informal *wantok* systems. Without improving health, nutrition, early child development (ECD), education, and skills development outcomes, PNG cannot reap the benefits of the demographic dividend.

The COVID-19 shock has had significant adverse impacts on domestic economic activity in PNG, including considerable impact on livelihoods and well-being of the poor and vulnerable. It is estimated that the economy will contract by 3.8 percent in 2020 (dropping by nearly 6 percentage points from the pre-crisis estimates) and the fiscal deficit will expand to about 8 percent of GDP (doubling from below 4 percent on average during 2018-19). The Government of PNG (GoPNG) acted swiftly via international and domestic mobility restrictions to limit the spread of COVID-19 and introduced a support package of critical health and economic support measures estimated at PGK 1,835 million (about US$525 million or 2.2 percent of GDP). The recent World Bank survey[4] reveals nearly half of the agricultural households reported expecting a decline in agricultural income for the current growing season, with female-headed households and those in the bottom 40 percent most likely to expect losses. To cope with the reduced income, more than half of households

[1] World Bank, 2019. *FY19-23 Country Partnership Framework (CPF) for Papua New Guinea.*
[2] World Bank, 2017: *Systematic Country Diagnostics.*
[3] World Bank, 2020. *PNG Economic Update January 2020. Facing Economic Headwinds.*
[4] World Bank, 2020. *World Bank PNG High-Frequency Phone Survey on COVID-19 – Results from Round 1.*

with school-aged children have reduced the number of children attending schools and nearly half of households reduce food consumption. Informal social safety nets have failed to aid all those in need during COVID-19. The same survey shows that only 41 percent of households were able to access assistance, mostly through *wantoks*, churches and community-based organizations and the bottom two quintile households were less likely to receive such assistance. In the absence of formal social protection systems and with a conservative assumption of a 5% contraction in household consumption due to COVID-19, PNG may see its poverty and vulnerability increase.

Sectoral and Institutional Context

PNG has the fourth highest child stunting rate in the world and there is considerable variation across region, wealth, gender, and parent characteristics. With almost every second child under five years of age being stunted in 2010, PNG's child stunting rate is double those of countries with comparable GDP in the East Asia Pacific region. Stunting is estimated to contribute as much as 76 percent of under-five deaths in PNG. The total cost of stunting is estimated to be about 2.8 percent of GDP annually, significantly exceeding PNG's budgeted expenditures for both health and education sectors in 2017. The Highlands region has the highest prevalence of stunting (58 percent), while the Islands Region has the lowest rate of stunting at 38.1 percent. The burden of stunting is highest amongst the poorest quintile (55 percent) and lowest in the richest quintile (36 percent). Caloric intake, education level of household heads and incidence of diarrhea and malaria all correlated to children under age five being stunted. Stunting rate rises quickly from 6 month onwards to 2 years and remains stable till 59 months. The nutrition status is worse for boys than for girls. Further, undernourished mothers are three times more likely to have stunted children, contributing to an intergenerational cycle of poverty and inequity. There is a considerable body of global scientific evidence that stunting in early years can prevent children from achieving their full development potential through its impacts on cognition and educational performance, as well as through the implications of poor health and mortality.

Figure 1: **Stunting Rates by Region**

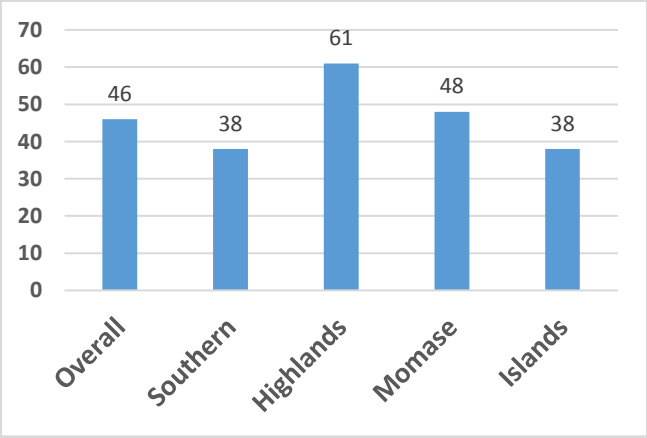
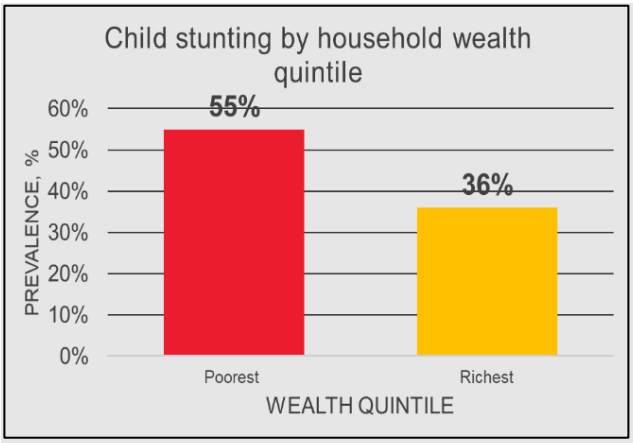


Figure 2: Stunting by Wealth Quintile

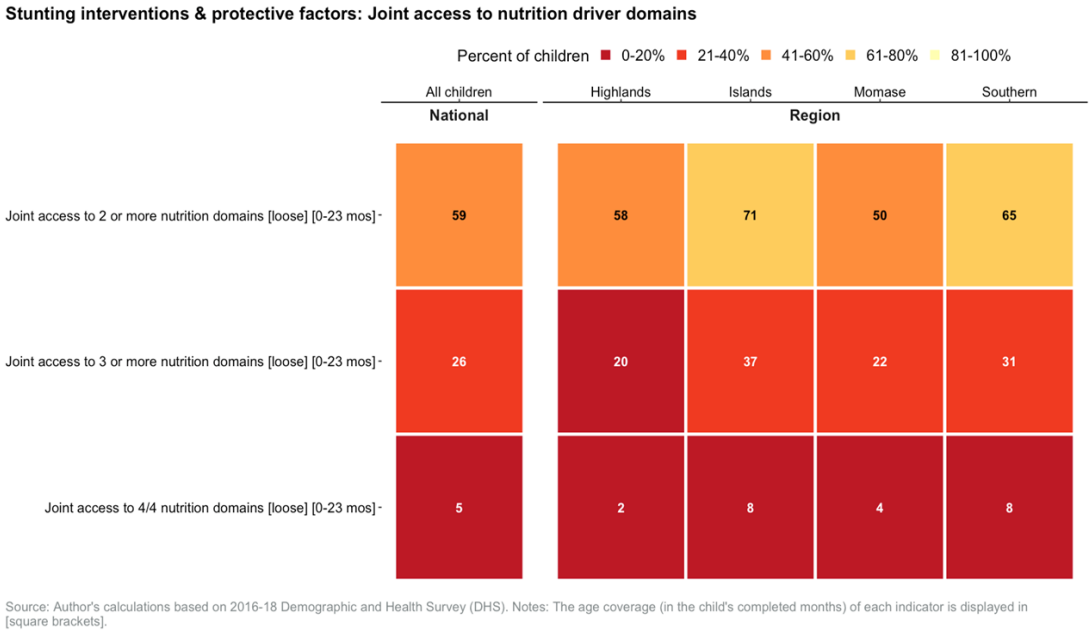


Source: HIES, 2010

While there are no more recent reliable stunting estimates, the DHS 2016-18 data suggests that little progress has been made since 2010. There are two immediate or direct causes of child undernutrition: (i) nutrient intake: not having enough, or the right kinds of, food intake; and (ii) burden of infectious disease, which influences the body's energy needs and ability to absorb and store nutrients. These in turn are influenced by four grouped domains or so-called drivers of malnutrition. Nutrient intake is influenced by several factors including (i) child care and feeding practices; (ii) food availability, dietary diversity and security; while the burden of infectious disease is affected by (iii) environmental factors, particularly water, hygiene and sanitation (WASH) practices and (iv) the availability and utilization of health and nutrition

services (pre- and post-natal). International research has shown that children who have access to two or more drivers of nutrition, adequate access to basic health care, nurturing care, food and a diverse diet as well as a clean environment and drinking water have lower rates of stunting. Hence simultaneous access to the drivers of nutrition can be used as a proxy for stunting levels. Figure 3 shows very few children in PNG have simultaneous access to two or more drivers of nutrition. Also, the DHS data suggests that stunting is likely the highest in the Highlands and the lowest in the Islands. Access to two or more drivers simultaneously is less than 50% in all but 4 provinces in PNG.

Figure 3: Stunting Interventions by Region



Source: Author's calculations based on 2016-18 Demographic and Health Survey (DHS). Notes: The age coverage (in the child's completed months) of each indicator is displayed in [square brackets].

Sub-optimal childcare and feeding practices is one contribution factor to PNG's high stunting rates. While a majority of children enjoys early initiation breastfeeding, only 56 percent of infants under 6 months of age are breastfed exclusively for the first six months as per WHO guidelines (DHS, 2006). Further, infants are introduced to solid food at a much earlier stage with 10 percent of newborns and about 27 percent of infants receiving semi-solid or solid food before 4 months of age. Factors leading to the sub-optimal feeding practices are multiple, including cultural, lack of understanding and lack of the availability of quality complementary foods. Poor nutrition during pregnancy impacts the development of the baby in utero and can lead to delivering a low birthweight baby, which is at greater risk of being stunted. While overall incidence of low birth weight in PNG is 7.9 percent, the rates are very high in the Southern Region (22.8 percent). Young age pregnancy also increases the risk of low birth weight and 12.9 percent of girls aged 15-19 years had started childbearing in PNG (DHS, 2006). Parents and caregivers often lack awareness and knowledge of appropriate childcare and feeding practices.

Food security, dietary diversity and access to a quality food basket remains a challenge. A large share of the population remains at risk of food insecurity as a recent study[5] finds that the bottom 40 percent rural households surveyed in four provinces consume less than the recommended 2,250 calories per day per person. Dietary diversity is poor with a majority of provinces having less than 50% adequate access to a diverse diet for children in their early years. 25 percent of children aged 6 to 59 months have vitamin A deficiency and 48 percent are deficient in iron (National Nutrition Survey, 2005). Region and urban/rural location are important influencer of dietary diversity. In rural areas, where 80 percent of the

[5] IFPRI 2019. *Papua New Guinea survey report: Rural household survey on food systems*.

population lives, diets tend to be low in either animal or vegetable source protein. Typical rural diets mainly include root crops, which contain less zinc than animal protein. Diets in the Highlands are particularly low in protein, a crucial growth building block for young children. In coastal, riverine and swamp areas, the typical diet includes fish and sago but inadequate consumption of vegetables. There is also anecdotal evidence that women in some locations adhere to the erroneous belief that reducing protein intake during pregnancy can reduce the risk of having large baby and reduce complications during childbirth.

The burden of disease is high, but access to and use of health and essential nutrition services is inadequate. Illness can reduce appetite and ability to absorb and store nutrients and diarrhea and malaria are in particular associated with higher risks of stunting. The entire PNG population is at risk of malaria and 94 percent of population live in areas with potentially high transmission (>1 case per 1000, WHO, World Malaria Report, 2015). A core set of 10 cost-effective high impact essential nutrition interventions[6] could reduce stunting by 20 percent at 90 percent coverage levels. Yet, coverage of these interventions is low, while utilization of many vital services is stagnant or declining pointing to low and even worsening access. Only 55 percent of pregnant women received at least four antenatal care check-ups, and more than half of children across all provinces have no access to adequate post-natal care, which explains why many children start faltering growth around 6 months of age. Immunization coverage rates are extremely low and declining. In 2016, only 36.4 percent of children under age 1 were immunized against measles and less than 35 percent received the third dose of the pentavalent vaccine. Declining service coverage reflects a weak health system which is unable to deliver quality services to a predominantly rural population. The number of outreach services of which essential nutrition services are part, has declined from 42 outreach clinics per 1,000 children under-five in 2010 to 29 in 2016, mainly due to lack of funding. While non-state organizations support small-scale community-based models, these programs rely on Village Health Volunteers (VHV) and Village Birth Attendants as there is no functional nationwide cadre of Village Health Workers in place. The fiscal crisis precipitated by COVID-19 is likely to exacerbate problems with health and nutrition service delivery as reductions in budget allocations for essential commodities (like micronutrients) may cause further deteriorations in service availability and quality.

Poor WASH conditions in PNG contribute to high stunting levels. Access to clean water and safe sanitation is very low. About 41 percent of the population rely on a river, stream, lake or pond for their water (48.5% in rural areas), with a further 11.8 percent relying on rainwater. Only 12.1% of the population have tap water piped into their homes and 13.7% have water piped into their village or community. 19 percent of the population have access to improved sanitation facilities and 12 percent practice open defecation. While 56 percent of urban households had improved sanitation facilities, only 13 percent of the rural population had these (UNICEF, 2016). Inadequate access to clean water, safe sanitation and poor hygiene practices leads to increased risk of infections, especially diarrhea. Moreover, it also increases the risk of suffering a chronic condition, tropical enteropathy, in children which reduces the absorption of nutrients in the small gut, causes blood loss and chronic inflammation.

High-level commitment to nutrition in PNG has increased considerably in recent years. In April 2016 PNG joined the global Scaling Up Nutrition (SUN) movement and the country is demonstrating a commitment to prioritizing nutrition in its social and economic development agenda. A multi-sectoral National Nutrition Policy (NNP)[7] for 2016-2026 has been

[6] 10 Lancet essential nutrition / high impact actions: Maternal multiple micronutrient supplements to all; Calcium supplementation to mothers at risk of low intake; Maternal balanced energy protein supplements as needed; Universal salt iodisation; Promotion of early and exclusive breastfeeding for 6 months and continued breastfeeding for up to 24 months; Appropriate complementary feeding education in food secure populations and additional complementary food supplements in food insecure populations; Vitamin A supplementation between 6 and 59 months age; Preventive zinc supplements between 12 and 59 months of age; Management of moderate acute malnutrition; and Management of severe acute malnutrition.

[7] NNP identifies a comprehensive set of priorities to develop and implement an effective multi-sectoral response: (i) Establishing national and provincial multi-sectoral coordination mechanisms to lead, support advocacy for financing and support, oversee and

adopted. The Medium-Term Development Plan III (MTDP III: 2018-2022) includes an ambitious target to reduce stunting among children under 5 years old to less than 30 percent by 2022. In July 2020, the National Executive Council (NEC) endorsed the Fast Track Initiative (FTI) to Reduce Stunting. The FTI is a unified, whole-of-government approach, to address stunting in PNG by investing in children to build PNG's human capital and drive economic growth. It seeks to catalyze district-led, multi-sectoral action to tackle stunting and undernutrition, improve policy coherence and localize the implementation of multi-sectoral evidence-based nutrition interventions.

Carefully designed social protection interventions hold immense potential in strengthening household food security and promoting utilization of essential health and nutrition services by the poor and vulnerable. Social protection interventions can directly contribute to improved diets by increasing purchasing power of beneficiary families for more and better food. Further, the social protection interventions often can facilitate access to health and nutrition services and build in knowledge and education to promote behavior changes related to good feeding practices and dietary choices. However, PNG has no national social protection program to address poverty and promote investment in children like the ones found in Indonesia, Peru and Rwanda, which have played a important role in these countries' success in reducing stunting. The COVID crisis highlights the fact that the lack of national program and platform for social protection severely limits the Government's capacity to provide timely responses to protect families that have been negatively affected by the shock and have fallen into poverty. The Department for Community Development and Religion is developing a National Social Protection Policy 2020-30, which has the potential to contribute to the broader human development outcomes in health and nutrition.

PNG has also made a firm commitment to ECD and developing a comprehensive support package for children in their early years and their parents. Positive parenting and early stimulation are key ECD interventions in the first 1,000 days of life and a critical part in the multisectoral approach to stunting reduction. While ECD opportunities are very limited, the government is developing the related policy frameworks, including (i) Early Childhood Education Policy 2020 approved by NEC, (ii) a revision of the ECD Policy, (iii) inclusion of ECD in the 2020-2029 National Education Plan (NEP), and establishment of ECD Alliance in 2019, as well as concrete actions at the community level as part of the implementation of the approved ECD policy.

Various development partners including UN agencies and civil society groups (CSO) have been supporting the nutrition agenda in PNG and formed a strong alliance for FTI. UNICEF's longstanding program on nutrition and care practices in PNG aims to promote and increase availability of therapeutic foods and micronutrients, treatment of severe acute malnutrition, promote infant young child feeding including mother to mother groups in select provinces, and provides ongoing technical assistance. WHO is also providing technical assistance to the National Department of Health (NDoH) on nutrition programming. The SUN CSO network jointly led by Save the Children and Susu Mama are working on various interventions and activities to mobilize joint action and resources to improve nutrition in PNG.

Relationship to CPF

The operation is in line with the PNG Country Partnership Framework (CPF). The operation contributes to CPF focus area 2 "Ensuring more effective and inclusive service delivery, particularly in underserved areas." The operation is consistent with the proposed engagement principles of the CPF: (i) World Bank Group corporate commitments on gender

monitor effective implementation; (ii) Building nutrition capacity of the workforce across sectors and institutions; (iii) Developing and implementing comprehensive strategies to prevent and manage under-nutrition in the Health, Education, Agriculture and Livestock and Community Development sectors; and (iv) Developing and implementing comprehensive strategies to identify and treat micronutrient deficiencies. Institutional responsibility for implementing the NNP has been shifted to the Department for National Planning and Monitoring (DNPM) whereas it previously rested with the NDOH. This has considerable significance given DNPM's role in directing investments and leverage with coordinating across multiple sectors.

and citizen engagement; (ii) portfolio-wide focus on human capital development; and (iii) responding to governance and institutional challenges across the portfolio. The operation aims to address the very high stunting levels with a multi-sectoral approach, start building a social protection safety net system to address high poverty rates, and strengthen the delivery of frontline health and nutrition outreach services. In doing so, the operation will directly contribute to improvements in future human capital and the quality of life for women and girls as well as men and boys.

C. Proposed Development Objective(s)

The Project Development Objective is to increase utilization of priority nutrition interventions and purchasing power of first thousand-day households in selected provinces and to provide immediate response in the event of an eligible crisis or emergency.

Key Results (From PCN)

Progress towards achieving the PDO will be measured through three (3) key results indicators provided below:

a) Increased utilization of priority interventions (tracer): Proportion (%) of children at one year of age who are immunized with 3 doses TA / Pentavalent vaccine (first three months)

b) Child nutrition grant delivered: Proportion (%) or number of first 1,000 days households (those with pregnant or nursing mother and/or child under age 2) receiving child nutrition grant

c) Improved awareness of stunting, positive parenting and behavior changes needed: Proportion (%) of first 1,000 days households reached with SBCC activities

D. Concept Description

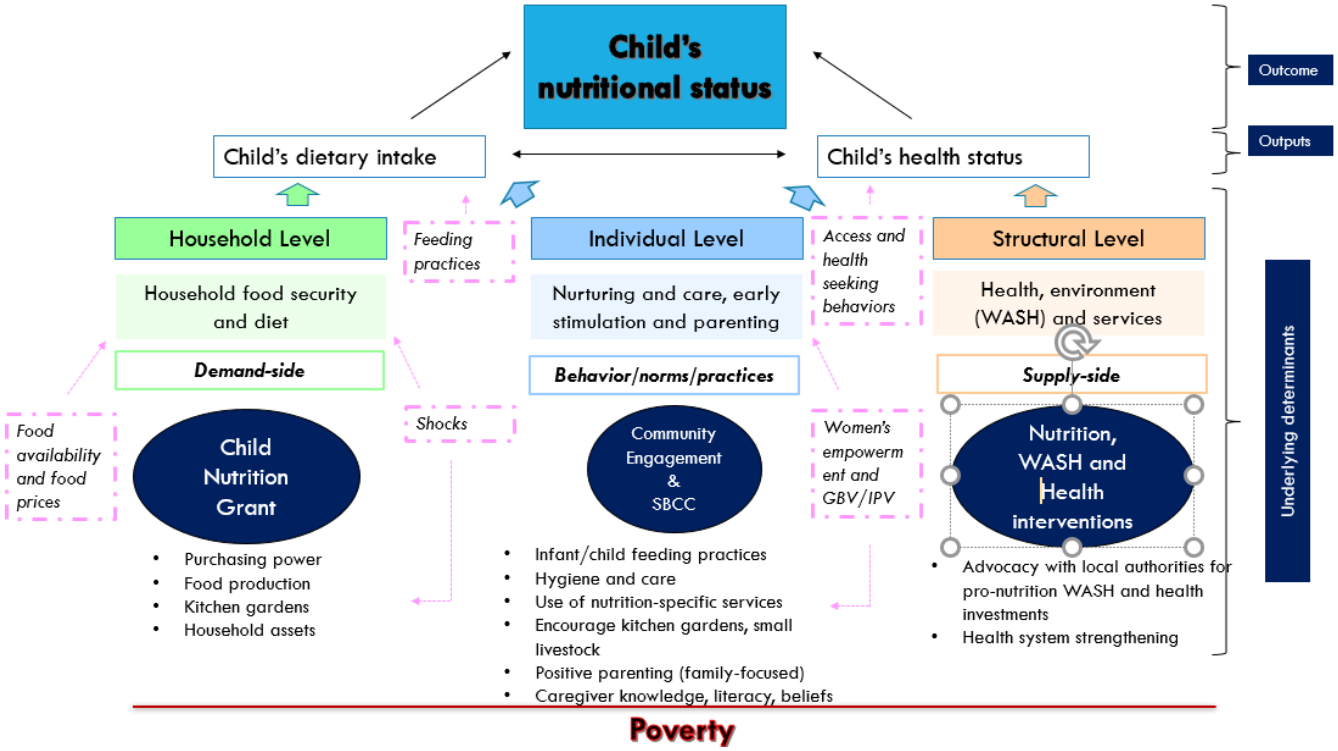
Multi-sectoral approaches are a critical element of successful country responses to stunting. The policy framework in PNG clearly recognizes this, and actions for advocacy, commitment building, knowledge sharing, and policy engagement can support the operationalization of a multi-sectoral approach in GoPNG actions. Multi-sectoral initiatives can address poor nutrition through three main pathways: (i) direct nutrition (or nutrition specific) interventions and programs which target the direct drivers of undernutrition, burden of illness and infections, inadequate care, nutrient intake and feeding practices, poor quality diet and inadequate diet diversification, inadequate WASH; (ii) nutrition sensitive programs and approaches, which target the underlying determinants of undernutrition and call for applying a nutrition lens to existing sector interventions; and (iii) coherent policy to create an enabling environment.

Direct nutrition interventions, essential or high impact nutrition actions, are critical but will not suffice to achieve sustained and large reductions in child undernutrition. Direct nutrition interventions address the immediate causes of undernutrition, i.e., by improving nutrient intake and reducing burden of illness, and are typically delivered through health and nutrition programs, implemented by the health sector. The first 1,000 days from conception to age 2 years are the most critical to reduce stunting. Global evidence suggests that scaling up coverage of a package with ten proven cost-effective nutrition-specific interventions to 90 percent could achieve a mean 20.3 percent reduction in stunting and a 61.4 percent reduction in severe wasting. This could make a substantial dent in undernutrition, particularly in the many countries that are far from the 90 percent coverage rate for this proven and cost-effective package of interventions.

Both direct nutrition specific and nutrition-sensitive actions must come together for improved impact. To maximize the impact on the ground these actions need to be synchronized in timing and sequence for the same set of households and the relevant policies and programs are coordinated to support such synchronization. The importance of synchronization of

multiple actions that are critical to improving nutrition across various sectors highlights the needs of co-locating of key programs and services, strong systems requirements, and adequate use of monitoring information to make the necessary changes for greater impact. Figure 4 below outlines the importance of a multi-sectoral interventions that are targeted at the household, individual and structural level to address the main drivers of child stunting: access to food security and diversity at the *household level* (*demand-side*); access to health, nutrition and WASH interventions at the *structural level* (*supply-side*); and change in behavior, norms and practices that will help to break the cycle of undernutrition-poverty at the *individual side*. The global and regional evidence is clear that appropriately designed and well implemented social protection, ECD and community-based nutrition programs are an investment in a country's future, with significant economic as well as social returns. The converged approach also is in line with the principles laid out in the PNG's FTI.

Figure 4: Conceptual Framework: Approach to Reducing Stunting



Source: World Bank staff adaptation De Groot *et al.* (2017)[8]

The key principles in which the design of the project is anchored include: (i) addressing the gaps in both supply and demand sides to improve child nutrition by facilitating a multi-sectoral convergence of nutrition-related services and actions at the community level; (ii) tailoring the project design to the diverse realities of PNG and recognizing the particular risk of violence against women (VAW) and existing community norms; (iii) leveraging the existing structures and mechanisms, particularly at the sub-national level, to maximize the replicability of the project design beyond the operational areas; and (iv) strengthening local government capacity and partnerships with NGOs, such as the churches who have considerable experience working at the community level. Considering implementation capacity constraints, the project will focus on a subset of provinces and districts that have strong commitment and reasonable local capacity for implementation and take a phased approach to gradually expand the operation.

[8] de Groot, R., Palermo, T., Handa, S., Ragno, L. P., Peterman, A. (2017). Cash Transfers and Child Nutrition: Pathways and Impacts. Dev Policy Rev, 35:621– 643. https://doi.org/10.1111/dpr.12255

The direct beneficiaries are the first 1,000 days households covered by the Project. While the pregnant women or the mothers of infants under 2 would be the recipients of the child nutrition grant, their family members would also benefit from the Project in terms of more and better-quality food and exposure to SBCC. The secondary beneficiaries are health workers that would receive training for delivering the essential health and nutrition services. The national and sub-national government officials that are involved in the FTI planning and implementation would also benefit from capacity building activities and coordination mechanism established by the Project.

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

Summary of Screening of Environmental and Social Risks and Impacts

While environmental risks are considered low (the generation of small volumes of waste only), social risks have been assessed as substantial and include i) inequitable access to project supported services particularly for vulnerable social groups (women, poor, disabled, elderly, isolated groups); ii) elite capture, power and corruption iii) social tensions, conflict and civil unrest within or between diverse cultural groups/communities resulting from real or perceived inequities; iv) unintended gender impacts including changes to family dynamics which may lead to family conflict and increases in intimate partner violence; v) poor labor and working conditions for health workers and community/village health volunteers; vi) misuse of personal data; vii) unintended community health impacts including transmission of COVID-19 and sexual exploitation and abuse and sexual harassments (SEA/SH).

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APPROVAL

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