



Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 16-Sep-2018 | Report No: PIDISDSA23740

**BASIC INFORMATION****A. Basic Project Data**

Country Malawi	Project ID P164771	Project Name Investing in Early Years for Growth and Productivity in Malawi	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 12-Sep-2018	Estimated Board Date 19-Dec-2018	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Finance, Economic Planning and Development	Implementing Agency Ministry of Gender, Children, Disability and Social Welfare, Ministry of Health, Ministry of Local Government and Rural Development	

Proposed Development Objective(s)

The project development objective is to improve coverage and utilization of early childhood development services with focus on nutrition and early learning from conception to 59 months in selected districts of Malawi.

Components

Community-based nutrition and early stimulation interventions
Center-based early learning, nutrition and health interventions
Multisectoral coordination, capacity and system strengthening

PROJECT FINANCING DATA (US\$, Millions)**SUMMARY**

Total Project Cost	60.00
Total Financing	60.00
of which IBRD/IDA	50.00
Financing Gap	0.00

DETAILS



World Bank Group Financing

International Development Association (IDA)	50.00
IDA Grant	50.00

Non-World Bank Group Financing

Trust Funds	10.00
Global Financing Facility	10.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. Malawi is a landlocked, low-income country in south-eastern Africa neighboring Mozambique, Tanzania, and Zambia. Malawi covers approximately 118,484 square kilometers of land, 20 percent of which is Lake Malawi. In 2017, Malawi’s population was projected at 17.4 million, with a median age of 16.7 years. As one of Southern Africa’s most densely populated countries, Malawi’s land is under pressure with 200 people per square kilometer. Since its independence in 1964, Malawi has been experiencing lower than average annual GDP per capita growth and higher volatility than the rest of sub-Saharan Africa.¹ Malawi’s per capita Gross National Income was just US\$320 in 2017 and around 70 percent of the population live below the international poverty line of US\$1.90 per day.² Poverty levels are higher in rural areas where 85 percent of the population resides. The level of poverty has seen little change since 2010 with the national poverty rate increasing slightly from 50.7 percent in 2010 to 51.5 percent in 2016.³ Malawi is also ranked 170th out of 188 countries on the 2015 Human Development Index, while on the 2017 Global Hunger Index,⁴ Malawi is ranked 90th out of 119 countries.⁵ Despite decades of significant amounts of foreign aid⁶ to complement national development efforts, poverty levels have remained high.

2. Economic development in Malawi is heavily dependent on the agriculture sector, which has been adversely affected by extreme climatic events. The agriculture sector contributes 30 percent of GDP, 80 percent of total export earnings and 85 percent of employment.⁷ However, agricultural production and,

¹ World Bank (2017). Country Economic Memorandum

² World Development Indicators (WDI) 2018

³ National Statistical Office. Fourth Integrated Household Survey (HIS 4), 2017.

⁴ This is a composite indicator of undernourishment and child mortality

⁵ International Food Policy Research Institute (IFPRI), 2017

⁶ Between 2010 and 2015, Malawi received about US\$1 billion in donor aid per annum. This is equivalent to US\$60 per capita per annum, higher than the SSA average of US\$50 per capita per annum.

⁷ Malawi Economic Monitor, May 2017



consequently, household food security, have been negatively affected by frequent droughts and floods. For instance, a prolonged drought in 2015 and 2016 led to reduced agricultural production by 14.7 percent and 30.0 percent, respectively. Heavy reliance on rain-fed subsistence farming coupled with limited area of arable land makes the country susceptible to droughts and floods. These adverse weather patterns exacerbate the already volatile food security situation and consequently millions of people are pushed into poverty and hunger. For example, about 6.7 million people were food insecure in 2016, up from 2.8 million people in 2015.⁸ To address the situation, the Government of Malawi (GoM) has developed the National Resilience Strategy which seeks to break the recurrent cycle of food insecurity by putting in place resilient agricultural policies and programs with emphasis on smallholder households.

3. Despite limited progress in reducing monetary measures of poverty, Malawi has recorded some notable gains in non-monetary measures of poverty. Since the early 2000s, the rate of enrollment in primary education has been rising, and there has been a significant reduction in the under-five mortality rate. There has also been some success in reducing stunting⁹ (chronic malnutrition) among under-five children; from 47 percent in 2010 to 37 percent in 2015/16. Despite these gains, Malawi's level of human development remains low. Furthermore, most of the achievements have been skewed towards the high-income groups, with little or marginal gains for the bottom 40 percent of the population.¹⁰ Stunting of children under five years is higher in rural areas (39 percent) than in urban areas (25 percent); and among children in the lowest wealth quintile (46 percent) as compared to those in the highest wealth quintile (24 percent).¹¹ Early childbearing, early marriages, and high fertility among female adolescents¹² also contribute to poor health and nutrition outcomes, low education attainment, and a cycle of intergenerational poverty.

Sectoral and Institutional Context

4. Improving nutrition, early stimulation and early learning outcomes for infants and young children comprise critical investments in human capital that can contribute to reducing poverty and increasing economic growth and shared prosperity in Malawi. Early childhood care and experiences, especially in the first 1,000 days of life, have a profound impact on brain and cognitive development¹³, including longer term effects on learning, skills gain, and ultimately income. Global evidence shows that the first 1,000 days of a child's life is the most critical window for addressing malnutrition as it is during this period that most physical growth, brain and psychosocial development and human capital formation occurs. Irreversible damage in child development takes place if a child does not receive proper nutrition during this period. Poor childhood nutrition leads to an increase in healthcare expenses and low labor productivity, and costs Malawi US\$597 million (2012 terms) or US\$39 per capita per year.¹⁴ Globally, evidence suggests that every dollar invested in maternal and child nutrition interventions deliver a return of US\$16,¹⁵ while every dollar invested in Early Childhood Development (ECD) programs can yield US\$6-17. However, as a share of total health spending, expenditure on nutritional deficiencies was only 10

⁸ Malawi Economic Monitor, May 2017

⁹ Low height for age defined as height-for-age less than -2 standard deviation score.

¹⁰ World Bank (2017). Country Economic Memorandum for Malawi

¹¹ NSO and ICF International, 2016

¹² In 2015/16, the total fertility rate for women aged 15-49 was estimated at 4.4 children per woman, and the percentage of adolescent girls aged 15-19 who have begun childbearing at 29 percent

¹³ According to Denboba et al. (2015), ECD refers to the cognitive, linguistic, socio-emotional and physical development of the child from prenatal stage up to aged eight.

¹⁴ 2015 Cost of Hunger, United Nations and World Bank

¹⁵ Engle et al. (2011).



percent on average per annum between 2012/13 and 2014/15 which is very low given the high burden of stunting in the country. Equally important is early learning for children aged 3-5 years before they enter primary school. Therefore, for ECD to be successful, delivery of a continuum of interventions for different age groups across various sectors including health, nutrition, education, agriculture, water and sanitation, and social protection is required.

5. Over the past 25 years, Malawi has made progress in increasing coverage for key maternal, child health, nutrition, education, water and sanitation interventions, leading to improvements in some health and nutrition outcomes. Notably, Malawi has been performing above the average for low-income countries in several key human development indicators and is among the 11 countries¹⁶ in Africa that achieved the Millennium Development Goal 4 target of a two-thirds reduction in under-five mortality rate between 1990 and 2015. Despite these gains at population level, there are disparities in service coverage and outcomes by geographical location (urban-rural), income status, level of education, gender, and age. Heavy burden of disease coupled with poor quality of services and critical shortages of human resources, medicines, and other health system inputs prevent Malawi from realizing further gains in health and nutrition outcomes.

Underlying constraints to improved early childhood development

6. Despite a reduction in the prevalence of stunting, high population growth has led to an increase in the absolute number of stunted under-five children in Malawi. Between 2004 and 2015/16, the under-five population increased from 2.4 million to 3.5 million, and this contributed to an increase in the number of stunted under-five children from 1.26 million in 2004 to 1.31 million in 2015/16. With a total fertility rate of 4.4 births per woman and high adolescent fertility rate (137 births per 1,000 women aged 15-19), the country's population is projected to rise to 30.3 million by 2035,¹⁷ and this will further increase the absolute number of stunted children if high impact interventions are not implemented.

7. High levels of early marriage and adolescent childbearing in Malawi expose many newborns and infants to multiple forms of malnutrition, including stunting. Forty-six percent of the young women (18-22 years) in Malawi are married when they were younger than 18 years. Approximately 29 percent of young women in Malawi aged 15-19 years are mothers which poses a significant risk to the nutrition status of the child as adolescent pregnancy is associated with higher risk of neonatal deaths, stillbirths, preterm births, and low birth weight.¹⁸ In addition, the likelihood of infants born to teenage mothers being stunted is 6.3 percent higher than infants born to adult mothers. And, while early antenatal care (ANC) has a positive impact on stunting levels, ANC attendance within the first trimester in Malawi is very low (24 percent). Therefore, actions to improve adolescent girls' health and nutrition should focus on prevention of early marriage, adolescent pregnancy, increasing pregnancy spacing, early ANC, and ensuring that pregnant and lactating teenage mothers are adequately nourished.

8. Prevalence of stunting among children in Malawi increases with a child's age and the key underlying factors vary at each age group. Stunting levels are relatively stable in the first 6 months of life but increase steadily from 7 months through the first 23 months with the peak being 42-45 percent at 18-47 months. Using results from Malawi's Demographic and Health Surveys (MDHS) for 2010 and 2015-16,

¹⁶ The 11 countries are: Egypt, Ethiopia, Eritrea, Liberia, Madagascar, Malawi, Mozambique, Niger, Rwanda, Uganda, and Tanzania

¹⁷ Population projections - Malawi National Statistics Office

¹⁸ <https://www.bmj.com/content/bmj/351/bmj.h4173.full.pdf>



we analyzed factors associated with stunting in under-five children in Malawi by using UNICEF's hierarchical framework on manifestation of stunting.¹⁹ The results show that the immediate or proximate factors associated with stunting in under-five children in Malawi are: low weight at birth, diarrheal disease, and inadequate diet for the child. At child level, low weight at birth was the most prominent factor but the level of association by age group (0-23 and 24-59 months) was different. Each of the immediate factors associated with stunting in under-five children in Malawi can be attributed to problems at household level. The underlying factors at household level by order of significance are: mother's height (< 152cm), less than 4 ANC visits, mother's Body Mass Index (BMI)²⁰ (<18), poorest 40 percent of population, and lastly—lack of vaccination. However, the degree of association varies by child's age group. In Malawi, exclusive breastfeeding declines drastically from 81 percent at 0-1 months to 34 percent at 4-5 months while the percentage of children aged 6-23 months consuming a minimum acceptable diet is only 8 percent. Low intake of animal source foods by pregnant and lactating mothers, vital in maintaining adequate health and nutrition during pregnancy and early childhood, is the other key underlying problem. Factors associated with stunting at household level are also correlated with factors at community level. In Malawi, these are: early marriages and high levels of adolescent pregnancies, mother's level of education, and inadequate access to safe drinking water and good sanitation. Given the above, preventing malnutrition in Malawi requires interventions at both community and household levels. At household level, most of the factors that have been identified can be addressed by changing the behaviors of individuals and families. This includes choices on reproductive health, feeding and hygiene practices, health care seeking behavior, and so forth.

9. Malawian children have low access to water, good sanitation and hygiene services which are essential for optimal child growth and development. While access to any water source increased from 43 percent in 1990 to 90 percent in 2015, access to safe drinking water is questionable and progress on improved sanitation has been slower (from 29 percent in 1990 to 41 percent in 2015). Many young children in Malawi are likely to be suffering from tropical enteropathy or chronic inflammation of the small intestines, which is caused by continuous exposure to poor environmental sanitation and is one of the key causes of child undernutrition. Declining water resources, obsolete infrastructure, and aging water systems create large gaps between supply and demand for safe water. Furthermore, water resources are highly variable between wet and dry seasons and from year to year, such that the country's water storage capacity is one of the lowest in the region. Thus, low access to safe drinking water and good sanitation are binding constraints to Malawi's ECD efforts.

10. Limited access to ECD interventions, particularly responsive parenting education, early stimulation and early learning, contribute to poor education outcomes in Malawi. Forty eight percent of children enroll in Standard 1 (first year in primary school) late, and there is high repetition at the early primary grades estimated at 25 percent and 20 percent for Standards 1 and 2, respectively.²¹ In addition, there is insufficient mastery of reading skills in the formative stages of learning and this explains why more than 80 percent of pupils in the second year in primary school were unable to read a single familiar word.²² Consequently, Malawi still records the lowest scores in the regional Southern Africa Consortium for

¹⁹ http://siteresources.worldbank.org/INTLACREGTOPNUT/Resources/UNICEF_Framework.pdf

²⁰ Body weight in kilogram divided by height in meter square

²¹ World Bank, 2015

²² World Bank. 2018. World Development Report 2018: Learning to Realize Education's Promise. Washington, DC: World Bank.



Measurement of Education Quality examinations. To improve education outcomes, Malawi must increase investments in responsive parenting, early stimulation and early learning.

11. Protecting young children from poverty, hunger, food insecurity and stress is one of the most cost-effective investments in human development.²³ In Malawi, low household income in combination with ignorance and harmful cultural practices is one of the key causes of inadequate food intake in infants, and this eventually leads to stunting. To promote steady graduation out of poverty, investments in human capital through targeted social protection interventions is extremely important. Investments in social protection can also help to scale-up ECD interventions, which can impact positively on the health, nutrition, and development of the infants.

Progress to date and opportunities for improving child development in Malawi

12. Malawi has policies and institutional frameworks in place for implementing cost-effective interventions essential for optimal growth and development of young children. Malawi joined the global Scaling Up Nutrition (SUN) movement in 2011 and developed a National Nutrition Policy 2012-2016, which has been revised and extended to cover the period 2017-21. Malawi also has one of the oldest and most extensive early learning systems in Africa that began in the 1950s.²⁴ The first ECD policy was developed in 2003 and revised in 2006, 2009, and 2017. Furthermore, ECD is high on the government agenda and is one of the key strategies in the Malawi Growth and Development Strategy (MGDS) III. Malawi also formulated the National Agriculture Policy (2016-2021) aimed at increasing agriculture productivity and farm incomes. One of the key priority areas in the agriculture policy is food and nutrition security, aimed at increasing production and consumption of nutritious foods with specific focus on smallholder households, and thereby address stunting. Through the National Social Support Policy (2012) and the second Malawi National Social Support Program (MNSSP II 2017-22), the GoM has expanded social protection programs. Emerging evidence on the performance of these programs shows positive results in reducing ultra-poverty by 14.2 percentage points; increasing consumption and investments in productive assets; and enabling resilience to seasonal shocks.²⁵ Village Savings and Loan (VSL) schemes also have a positive impact on household income and consumption.²⁶

13. Malawi is one of the 26 countries worldwide that is earmarked to receive financial and technical support from the Global Financing Facility (GFF) Trust Fund. This information was communicated in November 2017 and the project will, therefore, be co-financed by a grant from the GFF. The GFF adds value in improving the health of children, adolescent girls, and women through the following pathways: (i) employing a multisectoral approach to address reproductive, maternal, neonatal, child and adolescent health and nutrition (RMNCAH-N) challenges; (ii) strengthening prioritization and coordination of RMNCAH-N investments through implementation of Health Sector Strategic Plan II 2017-2022 (HSSP II); (iii) improving domestic resource mobilization (DRM) through efficiency gains; and (iv) placing a strong emphasis on results. The resources from the GFF Trust Fund will be pooled with IDA resources and any other funds from development partners and used to implement key activities under the project.

²³ Heckman, 2006

²⁴ UNICEF (2014). Assessment of Entry Points to Strengthen Child Protection within ECD in Malawi

²⁵ Handa et al., 2016

²⁶ Ksoll et al, 2016



14. Platforms for implementing nutrition, reproductive, maternal and adolescent health, early stimulation, and early learning interventions already exist in Malawi. Through these platforms (table 1), various interventions are being implemented by government agencies, non-governmental organizations (NGOs), development partners and communities. A community-based platform - Care Groups (CGs)²⁷ - is used to deliver a wide range of nutrition specific and sensitive interventions targeted at adolescent girls, pregnant and lactating women and under-five children; whereas the center-based platform - Community-based Childcare Centers (CBCCs) - is being used to deliver early learning interventions targeted at 36-59 months old children. Furthermore, Malawi has a well-established network of rural health centers that deliver maternal, adolescent, and child health services that complement nutrition interventions delivered through CGs and CBCCs. These service delivery platforms for nutrition, early stimulation and early learning are being supported by multiple development partners.²⁸

Table 1: Existing platforms and target groups for delivering nutrition and early learning interventions

Platform	Target Group	Intervention
Community-based CGs, coordinated by DNHA, and supported by local government structures	Pregnant & lactating women	Identification of pregnant women and promotion of ANC; maternal feeding; child spacing and contraceptive use.
	0-35 months old children	Growth monitoring & promotion; infant young child feeding (IYCF) promotion including cooking demonstration; promotion of micronutrient powders; deworming and vitamin A capsules; identification & referral of severe acute malnutrition cases; & oral rehydration solutions/zinc for diarrhea treatment.
	Household	Promotion of insecticide treated bed nets; production of nutritious food and includes backyard gardening, promotion of legumes, bio fortified crops and small livestock; promotion of WASH, fuel efficient stoves and solar drier; VSL.
Community-based CBCCs, coordinated by MoGCDSW, and supported by local government structures	36-59 months old children	Early learning, basic health and nutrition services; positive and responsive parenting education; community gardens attached to CBCC.
Health centres, coordinated by MoH and supported by local government structures	Pregnant & lactating women, 0-59 months old children, adolescent girls	Reproductive, maternal and child health services, including antenatal care, postnatal care, distribution of iron-folate tablets and contraceptives, immunization, integrated management of childhood illnesses, treatment of severe acute malnutrition; and youth friendly services.

15. The GoM with support from the World Bank and development partners has been implementing the National Nutrition Strategic Plan which has been contributing to the institutionalization and strengthening of CGs with support from local government entities. According to the national nutrition M&E system managed by the Ministry of Health’s (MoH) Department of Nutrition, HIV and AIDS (DNHA)

²⁷ Care Group – a group of 10-15 men and women volunteers in a village who are responsible for delivering nutrition specific and sensitive interventions to 10-15 households. They are supported by respective line ministry extension workers.

²⁸ Partners include European Union (EU), Department for International Development, UK (UKAID), United States Agency for International Development (USAID), Norwegian Agency for Development Cooperation (NORAD), Irish AID, Japan International Cooperation Agency (JICA), United Nations Children’s Fund (UNICEF), World Food Program (WFP) and the World Bank



and adopted by all districts, to date, the country has established 8,662 CGs through which 681,686 under-five children and 266,274 pregnant and lactating women throughout the country have been reached with a standard package of community-based nutrition interventions.

16. CBCCs have been established with active community participation and contribution, following support and guidelines provided by the Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW). Children aged 36-59 months are expected to attend pre-school before joining the formal primary education. However, the quality of services provided through the CBCCs is generally poor. Most of the CBCCs suffer from lack of trained caregivers, poor housing conditions, and lack of basic supplies of learning materials. Further, most of the communities in rural areas do not have access to CBCCs given that they are mainly concentrated in urban and peri-urban areas.

17. A cluster randomized control study in Zomba District in Malawi suggests that CBCCs can be an effective platform to deliver nutrition and early learning interventions to 36-59 months old children.²⁹ The study revealed that CBCCs can provide a platform for positive change on behaviors related to food production and consumption at household level. Moreover, evidence from the study indicates that community contributions through the CBCCs had a protective effect during periods of high food insecurity and can be a sustainable option for improving early child development outcomes. In summary, the study concludes that CBCC-based activities including demonstration and social behavioral change communication can help to achieve improvements in household food production and diversity, maternal knowledge of child nutrition, and preschool children's diets.

Implementation gaps for child development in Malawi

18. Current coverage of quality ECD interventions at community level is low and does not include early stimulation interventions. Access to home-based early stimulation and learning opportunities for children aged 0-35 months, estimated at 5 percent in 2017 is critically low.³⁰ The community-based nutrition package does not include early stimulation interventions. Only 32 percent of children aged 36-59 months receive early childhood education provided through CBCCs³¹ partially due to limited availability of CBCCs. Most of the CBCCs are overcrowded, the quality of services provided is poor, and only 49 percent of the caregivers are adequately trained.³² Other challenges include poor infrastructure and inadequate learning materials, unhygienic sanitary facilities, and lack of gardens.³³ Expansion of ECD services should include early stimulation interventions at CGs and focus on improving CBCC quality.

Existing World Bank support in nutrition and ECD-related sectors

19. From 2012-2018, the World Bank through the Nutrition and HIV/AIDS Project (P125237) supported DNHA to deliver community-based nutrition intervention through CGs in 14 out of the 28 districts in

²⁹ Gelli et al. (2017). Improving child nutrition and development through community-based childcare centres in Malawi

³⁰ MoGCDSW, 2017

³¹ MoGCDSW, 2017

³² UNICEF (2014). Assessment of Entry Points to Strengthen Child Protection within ECD in Malawi

³³ UNICEF (2014). Assessment of Entry Points to Strengthen Child Protection within ECD in Malawi



Malawi. The 14 districts were selected because they had the highest burden of malnutrition and stunting in the country. NGOs were contracted to oversee and coordinate implementation of a minimum package of nutrition-specific interventions targeting adolescent girls, pregnant and lactating women and children aged 0-35 months in the 14 districts. While the on-going or pipeline Bank-supported education sector projects do not address pre-school or primary school going children as primary beneficiaries, there are other complimentary on-going World Bank-supported operations in the agriculture, social protection and WASH sectors.

20. Given the above context, the proposed project will support the government’s commitment to improving ECD outcomes through the implementation of the National Nutrition Policy 2017-21 and the National ECD Policy 2017-21. Specifically, the project will finance nutrition specific and sensitive interventions and introduce early stimulation activities delivered through the CG and CBCC platforms. To enhance the quality of service delivery, in each district the project will upgrade 25 CBCCs, expand CGs to ensure full coverage, train all frontline and extension workers on an integrated package of multisectoral nutrition, early stimulation and early learning interventions, and equip the upgraded CBCCs and all CGs with basic resources and materials. The project will promote multisectoral collaboration at national and district levels from the oversight function down to community level implementation. Health system strengthening (e.g. M&E) and capacity building at district level (e.g. planning, budgeting) will be critical, particularly given the recent decentralization of the sector.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The project development objective is to improve coverage and utilization of early childhood development services with focus on nutrition and early learning from conception to 59 months in selected districts of Malawi.

Key Results

21. Progress towards achieving the PDO will be monitored routinely through intermediate results indicators focusing on the project inputs and outputs that are expected to have an impact on nutrition and learning outcomes of children 0-59 months. Achievement of the PDO will be measured through the following IEY core indicators and key GFF indicators:

- (a) Percentage of children aged 0-6 months exclusively breastfed.
- (b) Percentage of children aged 6-36 months who receive a minimum acceptable diet.
- (c) Percentage of children aged 36-59 months who completed at least one year of early learning at CBCCs.
- (d) Number of children under 5, adolescent girls, and pregnant women who are beneficiaries of the project.

D. Project Description

22. Components and activities under the project are built on the national nutrition and ECD policies and designed to implement the National Nutrition Strategic Plan 2018-21, National ECD Implementation Plan 2018-21, National Strategic Plan for Adolescent Nutrition 2018-22 (draft), and Health Sector Strategic Plan II (HSSP II) 2017-21. Delivered through existing community-owned service delivery platforms, the project will support GoM to implement high impact and cost-effective nutrition, early



stimulation and learning interventions through a multisectoral approach as well as strong leadership from the local government institutions. Over the last decade, the GoM has been implementing a similar set of interventions with support from a number of development partners. However, the implementation has been primarily through NGOs with minimum engagement from local government entities particularly District Executive Committees. This project is transformational in that it aims to improve ownership, sustainability and accountability by placing existing local government structures including District Executive Committees and Area Executive Committees at the forefront of the project implementation. As such, project financed activities are structured under three components as follows:

- Community-based nutrition and early stimulation interventions
- Center-based early learning, nutrition and health interventions
- Multi-sectoral coordination, capacity and systems strengthening

23. An estimated 21 percent of projected disbursements will be linked to the verified achievement of Disbursement Linked Results (DLRs), each of which is directly linked to the achievement of the PDO. The project includes 4 DLIs with annual results from year 1 to year 5, with a total of US\$12.5 million. The DLI approach for financing is used under all project components as follows: DLI 1 under Component 1; DLI 2 under Component 2; DLIs 3-4 under component 3. Each DLR target is priced at a value that reflects its significance in the results chain and that incentivizes the achievement of the respective result. The World Bank Group Financial Management guidelines will apply to the selected Eligible Expenditures Program (EEP) underlying DLI financing. Disbursements against DLRs will be (a) contingent on the satisfactory achievement of a set of targets, as verified by an Independent Verification Agent (IVA); and (b) against selected project budget line items, referred to as EEP. The EEP includes sizeable recurrent expenditures of mainly salaries and wages; but also including other recurrent expenses of the budget allocated to MoGCDSW, MoH, MoLGRD and their affiliated entities. Capital cost that can be incurred at District level will also be included as part of the EEP.

Component 1: Community-based nutrition and early stimulation interventions (US\$26.0 million)

24. The primary objective of Component 1 is to consolidate and scale up delivery of a comprehensive set of high impact and cost-effective nutrition and early stimulation interventions through CGs. The CGs are aligned to decentralized structure at local government level. In the project districts, capacity of 3,000 CGs (300 per district) will be enhanced to deliver the interventions with support from a multisectoral team of community-based volunteers and extension workers.³⁴ While Malawi has a track record of implementing a comprehensive set of nutrition interventions to young children, adolescent girls and pregnant women, activities to promote early stimulation and responsive parenting have not been incorporated into the volunteer and extension worker training as well as service delivery package. Therefore, one of the key priorities of the project will be to ensure that interventions on early stimulation and responsive parenting are adequately incorporated into capacity building, service provision and routine supervision and monitoring activities for CGs and extension workers. This component will be financed through: (i) a DLI which will finance CG capacity building activities and funds will be released after verified achievement of agreed targets; (ii) district grants which will finance operating costs to cover

³⁴ Volunteers refer to Care Group Promoters and Cluster Leaders. Extension workers refer to Health Surveillance Assistant (HSA), Child Protection Worker (CPW), Agriculture Extension Development Officer (AEDO) and Water Monitoring Assistant (WMA)



district-level activities and local procurement of minor goods and services; and (iii) input financing at the national level which will finance operating costs, procurement of goods and services and other activities, including technical support from relevant national ministries.

25. This component aims to build the capacity of CGs, including training and equipping of CG Promoters, Cluster Leaders and extension workers from line ministries, notably HSAs, CPWs, AEDOs and WMAs, to deliver community-based nutrition and early stimulation interventions. While inputs for nutrition specific interventions will be procured directly by the project and will be provided to each primary target beneficiary, inputs for nutrition sensitive interventions will be used only for demonstration purposes so that beneficiary households can adopt best practices. This component will support following activities which will be delivered by CGs:

(a) **nutrition specific activities:** carry out monthly growth monitoring and promotion (GMP) of 0-35 months old children with specific focus on weight for age to promote child growth; impart social and behavioral change communication (SBCC) campaign to improve maternal, infant and young child feeding (MIYCF) practices, including promotion of exclusive breastfeeding and demonstration of complementary feeding best practices through cooking demonstrations; distribute micronutrient powder (MNP) to 6-35 months old children to enhance micronutrient contents of complementary food; promotion of deworming and vitamin A supplementation; screen, refer and follow-up of 0-35 months old sick children including those who suffer from severe and moderate acute malnutrition; and distribute once a week iron folate supplements and deworming tablets for 11-19 years old adolescent girls.

(b) **early stimulation activities:** responsive parenting education for caregivers of 0-35 months old children complemented by the promotion of toys made with locally available materials for 0-35 months old children. Skills to manufacture toys with locally available materials will be included in the CG training package, and the trained CG promoters and Cluster Leaders will transfer the skills to caregivers of 0-35 months old children along with education on good parenting skills.

(c) **nutrition sensitive activities:** early identification and mobilization of pregnant women and their male partners to promote ANC delivered through a nearby health facility; promotion of the utilization of insecticide treated bed nets; mobilization of adolescent boys and girls aged 11-19 years to receive education on a package of sexual and reproductive health module; promotion of household and personal hygiene including hand wash and the use of safe latrine; promotion of safe drinking water protocols, including the use of waterguard³⁵; and promotion of production and utilization of nutritious foods, including biofortified crops, and small livestock. In addition, VSL scheme will be integrated in each CG as one of the approaches to sustain the activities of its Promoters and Cluster Leaders. The Unified Beneficiary Registry or social registry that has been put in place by GoM will be used to prioritize social protection beneficiaries for inclusion in the project.

26. Improving capacity of CGs to promote community mobilization to deliver nutrition and early stimulation interventions. This includes: (i) strengthening and/or setting up CGs in every group village in all project districts (each CG Cluster Leader covers a cluster comprised of 10-12 households); (ii) mobilizing target beneficiaries, including 11-19 years old adolescent boys and girls, pregnant and lactating mothers

³⁵ Waterguard is a locally available low-cost chlorine containing liquid which is used to purify drinking water.



and children aged 0-35 months including their parents; (iii) conducting monthly home visits; and (iv) organizing monthly village nutrition forums and group education sessions. To promote MIYCF good practices, the Cluster Leader will conduct cooking demonstrations using local ingredients and provide counselling on appropriate nutrition and dietary practices during adolescence, pregnancy, lactation, infancy and childhood. The Cluster Leader will also conduct door to door visits to reinforce uptake of nutrition specific and nutrition sensitive interventions; and to identify sick children, and those with moderate and severe acute malnutrition for referral to a nearby health facility for treatment. Further, Cluster Leaders will follow up acutely malnourished children who have already been referred or discharged from health facilities after treatment to monitor progress.

27. DLI 1: CG CLs and Promoters delivering an integrated nutrition and early stimulation package (US\$7.0 million). This component will utilize a DLI to finance capacity building activities to enhance skills of community-based volunteers and extension workers, and to ensure quality and effectiveness of such activities, and rationale is to: (i) build on existing capacity of DNHA that has been acquired through the implementation of World Bank financed Nutrition and HIV/AIDS Project since 2012; (ii) ensure adequate ownership of the local government entities including District Executive Committees, Area Executive Committees and Village Development Committees; and (iii) leverage resources and promote greater partnership with development partners and NGOs. The project funds will be disbursed to DNHA based on the verified achievement of agreed in 6 DLR areas. Final achievement of this DLI will be defined as percentage of CG CLs and Promoters delivering IYCF package.

Component 2: Center-based early learning, nutrition and health interventions (US\$19 million)

28. The primary objective of this component is to improve the coverage and quality of preschool education and reproductive, maternal and adolescent health services. This component will support preschool or early learning interventions for 36-59 months old children through “model” CBCCs in the project districts. In addition, support will be provided to promote health and nutrition for pregnant and lactating women as well as adolescent girls aged 11-19 years through enhancing the quality of services that are routinely delivered through health facilities in the project districts. This component will be financed through: (i) a DLI which will support capacity building of CBCC caregivers, supervisors and management committee members, and will be based on the verified achievement of agreed targets; (ii) a district grant which will finance district-level activities and procurement of small commodities; and (iii) input financing at the national level which will finance procurement of commodities and activities.

29. MoGCDSW has developed criteria for the selection of 25 model CBCCs in each district which will be supported by the project. The criteria include: (i) uniform geographic distribution covering the entire district; (ii) existence of a functional CBCC with at least 0.5 acres of conflict free agricultural land in order to establish nutrition sensitive agriculture demonstration garden; (iii) no previous record of conflict amongst the CBCC management committee members to avoid any potential fiduciary risk; and (iv) written commitment of community contribution from Group Village Chief and the Chair of the existing CBCC management committee.

30. Sub-component 2.1: CBCC interventions. This sub-component will primarily aim to enhance the coverage and quality of early learning delivered by CBCCs for children aged 36-59 months. Specific activities that will be financed under sub-component 2.1 include: (i) capacity building of caregivers, mentors and CBCCs management committee members in 25 model CBCCs and 25 percent of the



remaining CBCCs that are present in each selected district, and this activity will be financed through DLI 2; (ii) upgrading and equipping the 25 model CBCCs in each district; (iii) delivery of the package of interventions³⁶ implemented at each model CBCC; (iv) establishment of communal garden and integration of VSL in each model CBCC.

31. DLI 2: Children aged 36-59 months enrolled at least one year of early learning in CBCCs (US\$3.0 million). This sub-component will utilize a DLI to build capacity of caregivers, mentors and management committee members of 25 model CBCCs and 25 percent of the remaining CBCCs that are present in each selected district, and the rationales are to: (i) build on existing capacity of MoGCDSW that has been acquired over years in supporting communities to manage over 11,000 CBCCs nationally; (ii) ensure adequate ownership of the local government entities including District Executive Committees, Area Executive Committees and Village Development Committees; and (iii) leverage resources and promote greater partnership with development partners and NGOs. Project funds will be disbursed to MoGCDSW based on the achievement of agreed targets (indicators) in 6 DLRs areas. Final achievement of this DLI will be defined as children aged 36-59 months enrolled at least one year of early learning in CBCCs.

32. Sub-component 2.2: Health facility interventions. This sub-component will support activities aimed at improving the quality of selected reproductive, maternal, and adolescent health and nutrition interventions, which are routinely delivered through existing health facilities in the project districts with support from Health Surveillance Assistants (HSAs). While the procurement is carried out by GoM and its health partners, this sub-component will support the delivery of iron-folate and deworming tablets for pregnant and lactating women. Also, this sub-component will finance improved health record keeping at health facilities as well as promotion of good hygiene, health and nutrition aimed at improving the quality.

Component 3: Multisectoral coordination, capacity and system strengthening (US\$15.0 million)

33. The primary objective of this component is to support capacity building activities from national to district levels in order to strengthen management, coordination and implementation of nutrition, early stimulation and early learning interventions; enhance systems and service delivery at all levels; and improve citizen engagement.

34. Sub-component 3.1: Multisectoral coordination and capacity development. This sub-component will support capacity building and multisectoral coordination across relevant sectors in nutrition, early stimulation and early learning from national to district levels. Activities to be financed through sub-component 3.1 include: (i) training of national and district level officials as well as community facilitators to plan, coordinate and implement nutrition, early learning and early stimulation activities; (ii) annual joint planning and review of nutrition, early learning and early stimulation activities at district and national levels; (iii) strengthening the ECD and nutrition management information system; and (iv) provision of certificate, diploma and degree courses for national and district level officials on ECD and/or nutrition.

35. DLI 3: Number of DIPs implemented that incorporated ECD and nutrition (US\$1.5 million). Project funds will be disbursed to the Ministry of Local Government and Rural Development based on the verified

³⁶ Package of interventions delivered at each model CBCC: (i) early learning, development and stimulation materials complemented by an interactive radio instruction (IRI) program; (ii) nutrition services including deworming, Vitamin A supplementation and establishment of CBCC gardens; (iii) health services (routine health check-ups and referral of sick children) for 36-59 months old children; (iv) responsive parenting education for caregivers; (v) promotion of handwashing and personal hygiene; and (vi) integration of VSL.



achievement of agreed targets (indicators) in the 6 DLRs areas. The final achievement of the DLI will be defined as number of districts implementing DIPs that incorporate ECD and nutrition. DLRs 3.1-3 will be defined as a district's capacity is enhanced planning budgeting; financial management using IFMIS as well as in incorporating of nutrition and ECD activities in its District Implementation Plan (DIP); whilst DLR 3.4-5 will be defined as a district has incorporated nutrition and ECD activities in its DIP with appropriate budget allocation and a district is able to monitor and report implementation in a timely manner through the established local government structure.

36. DLI 4: Number of officers completing nutrition and ECD short and long-term courses (US\$1 million).

Project funds will be disbursed to the MoLGRD based on the verified achievement of agreed targets (indicators) in the DLR areas. The achievement will be defined as government officers of who have completed Diploma and Masters in Nutrition and ECD.

37. Sub-component 3.2: Project management, learning, monitoring and evaluation and citizen engagement.

This sub-component will support: (i) day-to-day management of project activities at national and district levels, which includes monitoring the implementation of project activities, procurement, financial management, and reporting; (ii) learning and knowledge sharing, including process documentation and operational research; (iii) Independent Verification Agent to verify claimed results pertaining to DLIs; and (iv) project management, monitoring and evaluation and citizen engagement. To support multisectoral coordination and district level implementation, this sub-component will finance one full time District Financial Management Officer (DFMO) per district and one Community Facilitator per Traditional Authority (TA).³⁷

38. Citizen engagement will be supported to ensure that the project implementation activities are transparent, accountable, effective, and efficient.

Through an active engagement of the Early Childhood Development Coalition and Malawi Nutrition Alliance, citizen engagement will be mainstreamed in the project to enhance transparency and accountability inclusiveness and effectiveness for service delivery, finances and results. The measures under citizen engagement includes, making information available to project beneficiaries, public consultations and dialogues as well as creating stakeholders' feedback loop system. As part of the feedback loop system, a comprehensive community score card will be used for assessment, planning, monitoring, and evaluation of service delivery. The score card will be applied every six months and findings will be disseminated to relevant government ministries, policy makers, legislators, media, and development partners. In addition, the government is also expected to conduct third party monitoring, particularly for tracking progress on the renovation of CBCCs and service delivery.

³⁷ Each district is sub-divided into TAs. The number of TAs per district ranges from 2-8 depending on the size of the district.

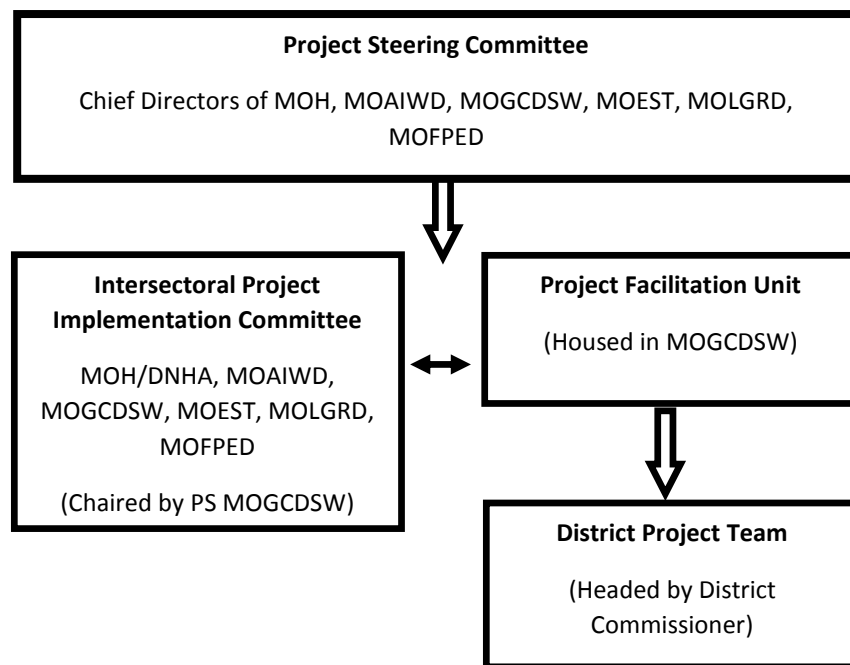


E. Implementation

Institutional and Implementation Arrangements

39. Overall project management: The project will take place at national, area and community levels. The project’s Project Facilitation Team (PFT) will be anchored within the MoGCDSW and will responsible for overall coordination and implementation. At service delivery level, CGs and CBCCs will implement nutrition, early stimulation and early learning interventions in selected districts. The Project Implementation Manual (PIM) will describe institutional and implementation arrangements at all levels and their roles and responsibilities. Formal adoption of the PIM will be an effectiveness condition for the project. Figure 1 provides a simplified framework for the project implementation arrangement.

Figure 1: Simplified implementation arrangements



National level

40. Project Steering Committee: This committee will provide strategic guidance and implementation oversight, review policy recommendations and facilitate inter-ministerial coordination for nutrition, early stimulation and early learning. This committee will be chaired by the Principal Secretary, MoGCDSW and co-chaired by the Secretary, MoH and comprised of the Permanent Secretaries or designees of MoH, MoFEPD, MoGCDSW, Ministry of Agriculture, Irrigation and Water Development (MoAIWD), Ministry of Education, and Science and Technology (MoEST), MoLGRD.

41. Intersectoral Project Implementation Committee (ISPIC): This committee will review project progress, facilitate joint monitoring, identify challenges and agree on actions to address implementation bottlenecks. This committee will be chaired by the Director of the Child Affairs Directorate, MoGCDSW and co-chaired by the Director DNHA and comprise of Director Reproductive Health Services, MoH;



Director Child Affairs, MoGCDSW; Director Planning and Policy, MoLGRD; Director Agriculture Extension Services, MoAIWD; and Director Basic Education, MoEST.

42. Project Facilitation Team (PFT): The PFT will be established prior to effectiveness, housed in MoGCDSW and responsible for overseeing the overall implementation of the project. Specifically, the unit will implement the day-to-day operations of the project which include procurement; financial management - including timely disbursement of funds to implementing entities based on approved annual work plans and budget (AWP/B); monitoring, evaluation and reporting. The PFM will also consolidate the AWP/B from DNHA, DCA and districts. The PFT will be responsible for preparing technical and unaudited interim financial reports (IFRs) for the designated account (DA) and related project account. The technical report and IFR are to be produced on a quarterly basis and submitted to the Bank within 45 days after the quarter end. The unit will also ensure that covenants are complied with and that the project is implemented according to the PIM. The unit will be comprised of the following project-financed positions: Project Coordinator, Accountant, Assistant Accountant, Procurement Specialist, Assistant Procurement Specialist, M&E Specialist and Assistant M&E Specialist.

District Level

43. District Council: At the district level, the project will be implemented through the existing local government structures. All project activities will be coordinated through the District Council with support from a District Project Unit (DPT). The District Council is chaired by the District Commissioner and represented by district level officials from line ministries, including MoH, MoAIWD, MoGCDSW, and MoEST. The primary responsibility of the District Council will be to approve the district AWPB. The District Council will also ensure integration of project activities into the annual DIP.

44. District Project Team: The DPT will be headed by the district Director of Planning and Development (DPD), and comprised of District Health Officer (DHO), District Social Welfare Officer (DSWO), District Agriculture Development Officer (DADO), as well as a full-time project-financed District Financial Management Officer (DFMO). The DPT will develop and oversee implementation of the dAWP/B. The DPT will meet regularly with the District Council and provide activity and fiduciary reports. The DPT will be responsible for providing quarterly technical and financial reports to the PFT not later than 15 days following quarter end. These reports will include all project activities to be undertaken by the district, CBCCs and CGs. To assure timely availability of funds, approximately six months estimated funding will be available in the district account for access by relevant entities in the district as needed and justified.

Area and Group Village Levels

45. At the area level, an Area Project Team (APT) will be formed headed by the Chair of the Area Executive Committee and comprised of a Health Surveillance Assistant (HSA), Agriculture Extension and Development Officer (AEDO), Child Protection Worker (CPW), Water Monitoring Assistant (WMA), and a full-time project financed CF. The APT will assist in the development of a Community Annual Workplan and Budget (cAWP/B) and provide coordination and technical support in the implementation of the project financed activities by CBCCs and CGs.

46. At the Group Village level, a cAWP/B will be developed collectively by the model CBCC and its CGs with support from APT, and will submit for District Council's approval to the DPT. The cAWP/B will be implemented at the Group Village level by the CBCC and its CGs.



F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The project will be implemented nationwide. Component 1 (Community-based nutrition and early stimulation interventions) will support food production, however, the project will not support supply of inputs such as in-organic fertilizers and pesticides. No new agricultural fields will be opened but the project will support seed for nutritious crops and extension support to households. Under sub-component 2.1 (CBCC-based interventions to promote early learning) the project will support rehabilitation of existing ECD centres in school premises. The project locations were identified, hence the preparation of ESMPs was decided based on the screening and environment and social assessment reports. The ESMP has been consulted on and disclosed. The consolidated ESMP will be incorporated in bidding documents and contractors contracts for implementation. Knowing that rehabilitation activities will take place in school premises, in some cases, contractors code of conduct will be annexed in the ESMP and included in bidding documents. The code of conduct will include limitations on interactions with children in the community. Sub-component 2.2 (Health facility interventions) will support provision of health care and family planning services to adolescent girls and pregnant women. Antenatal care includes a package of standard services including provision of iron tablets, measurement of blood pressure and diabetes, etc. Health centers and CBCCs will not generate any significant additional health care waste as a result of project implementation. However, a simple medical waste management plan was included in the ESMP to guide medical waste disposal, if any.

G. Environmental and Social Safeguards Specialists on the Team

Fisseha Tessema Abissa, Environmental Safeguards Specialist
Violette Mwikali Wambua, Social Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Due to rehabilitation related works on the ECD centres, there is a possible risk on the environment because of construction materials that will be used. Workers, school children and surrounding communities will need to be safeguarded from noise and dust pollution that may result from works. Social impacts that may arise from the proximity of contractor workers to school children as well as labour influx related risks will be taken into



		consideration in ESMPs for the project sites. It is not anticipated that significant additional waste will be generated as a result of this project, however, a simple health care waste management plan has been developed. The ESMP includes workers code of conduct to ensure safety of children on worksites. The ESMP has been consulted on and disclosed.
Performance Standards for Private Sector Activities OP/BP 4.03	No	Not applicable
Natural Habitats OP/BP 4.04	No	The sub projects involve rehabilitation of already existing structures hence OP4.04 is not triggered.
Forests OP/BP 4.36	No	Since the activities are confined in existing institutions and structures, OP4.36 is not triggered.
Pest Management OP 4.09	No	The project will not use inorganic fertilizers but will encourage use of organic fertilizers.
Physical Cultural Resources OP/BP 4.11	No	The policy is not triggered because the sub projects are all rehabilitations of known and existing ECD centers within existing school premises and there will not be excavation of new areas.
Indigenous Peoples OP/BP 4.10	No	This is not applicable in Malawi.
Involuntary Resettlement OP/BP 4.12	No	The policy is not triggered as all rehabilitation works are confined to known and existing ECD centres within existing institution premises and there will be no opening up of new areas.
Safety of Dams OP/BP 4.37	No	No opening of dams hence OP 4.37 is not triggered.
Projects on International Waterways OP/BP 7.50	No	The sub projects will be implemented within ECD/school premises hence OP7.50 is not triggered.
Projects in Disputed Areas OP/BP 7.60	No	The sub projects will be implemented within ECD/school premises hence OP7.60 is not triggered.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The project supports the delivery of health and nutrition interventions that may generate incremental health care waste. The project will also finance the rehabilitation of existing CBCCs to promote early learning. However, the project is expected to attract no land acquisition as all civil works will be within the confines of existing schools and there is no other major construction or other civil works envisaged under the project. The environmental impacts of the project are location specific and manageable. The project is thus not expected to have long term significant negative environmental impacts.



2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

N/A

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

N/A

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

It is anticipated that the incremental waste (i.e. medical and general) attributed to the project activities will be adequately managed within the existing waste management mechanisms of the project-supported health centers. Appropriate management of other environmental and social risks in the rehabilitation of CBCCs and other activities of the project are incorporated into Environmental and Social Management Plan. The two required safeguards instruments, an environmental and social management plan (ESMP) and a health care waste management plan (HCWMP) were prepared by the MoH (for HCWMP) and the MoGCDSW (for ESMP). Both instruments were reviewed by the World Bank and have been publicly disclosed through the MoH and MoGCDSW websites respectively and through the WB website. To enhance environmental and social sustainability of the project, and make a significant contribution to effective project implementation, a citizen engagement plan has been prepared.

The Ministry of Environmental Affairs and Climate Change which will oversee the implementation of the safeguards instruments has been enhancing its capacity at the district level through the hiring of a significant number of Environmental Inspectors who act as district focal persons.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The key stakeholders include communities in the 10 project districts, ECD centers, civil society organizations such as Global Scaling-Up Nutrition (SUN) Movement, Faith Based Organizations, Community Based Organizations, development agencies etc. The mechanisms for consultation and disclosure include focus group discussions, interface meetings , conducting biannual tracking of resource use in the project, publications of safeguards instruments on local news papers and government websites, media engagement etc.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
23-Mar-2018	18-Apr-2018	

"In country" Disclosure

Malawi
11-Apr-2018
Comments



Disclosed on the Ministry of Gender, Children, Disability and Social Welfare website.

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

No

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

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APPROVAL

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Country Director:	Preeti Arora	17-Sep-2018