INTEGRATED SAFEGUARDS DATA SHEET
APPRAISAL STAGE

Report No.: ISDSA487

Date ISDS Prepared/Updated: 23-Jan-2012

I. BASIC INFORMATION

1. Basic Project Data

Country:	Malawi	**Project ID:**	P125237
Project Name:	Malawi Nutrition and HIV/AIDS Project (P125237)		
Task Team Leader:	John Paul Clark		
Estimated Appraisal Date:	23-Jan-2012	**Estimated Board Date:**	27-Mar-2012
Managing Unit:	AFTHE	**Lending Instrument:**	Specific Investment Loan
Sector:	Other social services (35%), Central government administration (25%), Health (20%), Sub-national government administration (20%)		
Theme:	HIV/AIDS (35%), Nutrition and food security (30%), Participation and civic engagement (15%), Population and reproductive health (10%), Child health (10%)		

Financing (In USD Million)

Financing Source	Amount
BORROWER/RECIPIENT	10.00
International Development Association (IDA)	80.00
CANADA Canadian International Development Agency (CIDA)	13.10
Total	103.10

Environmental Category:	B - Partial Assessment
Is this a Repeater project?	No

2. Project Objectives

The project development objective is to increase access to and utilization of selected services known to contribute to the reduction of child stunting, maternal and child anemia and the prevention of HIV and AIDS in children and sexually active adults.

3. Project Description

The Nutrition and HIV/AIDS Project (NHP) will be composed of two components: Component A- Support for Nutrition Improvement; and Component B- Support for the National HIV/AIDS Strategic Plan 2011-2016.

Component A - Support for Nutritional Improvement (IDA: US$30 million; CIDA TF: US$13.1 million): This component will have two sub-components: (i) enhancing and scaling-up maternal and child nutrition service delivery at community level; and (ii) strengthening sectoral policy and program development, management and coordination. CIDA will co-finance Component A of the project with CA$13.5 million (US$13.1 million). Component A will finance nongovernmental organization (NGO) sub-projects, consulting services, project management, and goods (i.e., small equipment, basic pharmaceutical products).

Sub-Component A1 - Maternal and child nutrition service delivery at community level (IDA: $23.9 million; CIDA TF: $10.5 million). This project will contribute to a strengthened nutrition service delivery platform at community level through provision of a “minimum package” of nutrition interventions offered in targeted communities. This package will be aligned with the Scaling Up Nutrition (SUN) 1,000 Special Days Initiative and the Nutrition Education and Communication Strategy (NECS, 2011-2016), including the promotion of: (i) improved infant and young child feeding practices by caregivers; (ii) improved home based care of and care seeking for common infectious diseases; (iii) improved hygiene (personal, food and environmental), utilization of safe water and sanitation; (iv) improved prevention of malaria, helminthic infections and all other parasitic infections; (v) improved iron intake through consumption of iron rich foods and iron supplementation to women and children; (vi) improved dietary intake by women before, during and after pregnancy; (vii) improved household care of pregnant women and utilization of ANC services; (viii) increased spacing of pregnancy for mothers postpartum; and (ix) adequate weight gain in children under two and pregnant women. The strategies will be implemented through Information-Education-Communication (IEC) and Behavior Change Communication (BCC) type of interventions such as group education, individual counseling and home visits as well as growth monitoring and promotion; cooking demonstrations; promotion of the production and consumption of fruits, vegetables and small livestock; community grants; mobilization for health campaigns; sanitation; and use of safe water.

The minimum package will be implemented through District-level sub-projects by NGOs, i.e., one NGO contract per District, in at least 15 Districts, where other donors in support of the SUN 1,000 Special Days Initiative are not active. The implementing NGOs will be encouraged to integrate this minimum package of interventions into their ongoing project activities in agriculture (i.e., diversification, irrigation), livelihood support (i.e., income generating activities, saving and credit schemes, social protection), or health (i.e., maternal child health, family planning). Community-based mobilization is the key mechanism for channeling nutrition interventions in this sub-component and includes: (i) setting up support groups for mothers, pregnant women, men (husbands) and grandmothers; (ii) mobilization of community volunteers as change agents; (iii) group education; (iv) regular home visits; and (v) individual situation-based counseling. NGOs will closely coordinate project development and implementation with

the District Council; and work through existing structures in the Districts such as Health Surveillance Assistants, Agriculture Extension Officers, Community Development Officers, Village Development Committees (VDC), Community-Based Organizations (CBO), Area Development Committees (ADC) and Traditional Authorities (TA).

Sub-Component A2 - Strengthening policy and program development, management and coordination (IDA: $6.1 million; CIDA TF: $2.6 million). This project will support: (i) joint planning with and financial support to the sectors for nutrition-relevant activities at central and district levels; (ii) orientation and training workshops with stakeholders; (iii) monitoring, reporting, surveillance and operational research (e.g. one particular issue of concern is gender equality and the role of women in the project); (iv) advocacy and strategic communication; (v) technical assistance for key responsibilities to fill gaps relevant to the stewardship, oversight and coordination function at central and district level, including a project specific gender analysis, particularly with gender-related perceptions of nutrition and care-giving roles and responsibilities at the household level; and (vi) improved office space for DNHA through lease and/or supply of office equipment. The essence of this sub-component is that effective community-based development is dependent on an enabling institutional environment, both at central and district level, for support, supervision, monitoring and coordination. Hence, the need to strengthen the coordinating and supervisory role of the DNHA and line ministries, as well as the district-based capacity for nutrition program planning, management, monitoring and coordination of NGOs and DCs.

Component B - Support for the National HIV/AIDS Strategic Plan (2011-2016) (US $50 million). Under the previous IDA funded Multi-sector AIDS Project (MAP), the majority of funds ($65 million) were made available to support the national HIV/AIDS response through a pooled funding mechanism (the HIV Pool) administered by the National AIDS Commission (NAC). Financial contributions to the HIV Pool are also made by the Global Fund for AIDS, TB and Malaria (GFATM), which historically has provided 70% of pool funds, as well as the U.K. Department for International Development (DFID). Similar to the current MAP, this project will contribute to the HIV Pool and the implementation of the new National Strategic Plan 2011-2016 (NSP). In addition, approximately half of the IDA funds for this component have been earmarked for specific interventions to prevent new HIV infections. This component therefore has three sub-components: (i) Support for the implementation of the NSP 2011-2016; (ii) Voluntary medical male circumcision (VMMC); and (iii) Prevention of mother to child transmission (PMTCT)..

Sub-component B1- Support to the National Strategic Plan for HIV and AIDS (2011-2016) - $24.4 million: This sub-component will contribute to the overall implementation of prioritized activities in the new NSP, which is consistent with prior and ongoing financing of the HIV Pool under the MAP. The IDA contribution to the HIV Pool will not be used for the procurement of anti-retroviral drugs, which are provided outside the HIV Pool by the GFATM. Specific activities and expenditures required to implement the NSP will be detailed in annual work plans, which will be prepared by NAC and will be subject to IDA no objection on behalf of HIV Pool partners.

Priorities in the NSP include effective prevention, care and support activities as well as systems strengthening. The HIV Pool will be used to fund identified priority activities planned under each of the national responses' nine strategic themes (see Annex 2). Resources under this sub-component will be used to fund interventions which improve: (i) the implementation efficiency and governance of the national response; (ii) the functional capacity of local government plans, implementation and monitoring of activities at local level; (iii) M&E systems; and (iv) the supply chain management system.

34. Sub-component B2 – Voluntary Male Medical Circumcision - $15.6 million: There is ample evidence that male circumcision is an effective tool to prevent new HIV infections in countries with high incidence of HIV infection and low rates of male circumcision. Benefits from the VMMC intervention will accrue primarily to men in the short term and as circumcision prevalence increases to the whole of the adult at risk population. VMMC is flagged as being a prioritized intervention in the prevention thematic area of the NSP and the NSP strategy is to scale up VMMC and neo-natal circumcisions country-wide, initially targeting districts with the highest levels of prevalence (e.g. Southern Region) and incidence.

35. Malawi is currently scaling up VMMC interventions with assistance from the US President's Emergency Plan for AIDS Relief (PEPFAR) and its development partners and the country has identified strategic locations for initial investments. Lack of funds, technical capacity, and other resources preclude a nationwide roll-out at this time. PEPFAR's partners also have additional constraints, which include lack of a mechanism to pool funds to procure VMMC kits and other commodity inputs.

The project will support the national VMMC program in four areas: (i) support for NGO/PEPFAR partners who will operate mobile clinics in a number of high prevalence districts (target 420,000 clients in the five year project); (ii) support for 28 district hospitals throughout the country which will offer the VMMC services (target 80,000 clients in the five year project); (iii) neo-natal male circumcision in 40 birthing centers country-wide (target 140,000 circumcisions over five years); and (iv) program monitoring and evaluation. Apart from circumcising about 640,000 males and reducing their risk of acquiring HIV infection additional benefits will accrue because all (or most) adult males undertaking VMMC will also be: (i) screened and counseled for HIV and referred to ART where needed; (ii) screened, counseled and treated for sexually transmitted infections (STIs); and (iii) provided with condoms and IEC/BCC literature. The project will support the procurement of disposable MC kits, rapid test kits for HIV screening, STI drugs, condoms, and IEC/BCC materials. Mobile clinical services and training and supervision for service providers at both mobile and fixed sites will be provided by PEPFAR. Other inputs will be provided by NGO partners for mobile clinics and by the Ministry of Health (MoH) for permanent sites and neonatal circumcisions.

Sub-component B3 –Prevention of Mother to Child Transmission - $10.0 million. Malawi has made considerable progress in delivering PMTCT services nation-wide but there are still considerable gaps. In particular: (i) the maternal, neonatal and child health delivery system is weak; (ii) many women start ANC late; (iii) there is limited access to CD4 tests for HIV positive women; (iv) nutritional support services for pregnant women and infants are poor; (v) follow-up of mothers and children is inadequate; (vi) there is inadequate capacity to identify HIV exposed children and provide early infant diagnosis, and (vii) lack of a family centered approach in the currently existing ANC and PMTCT program.

There are approximately 17,000 new pediatric infections annually and this comprises about 25 percent of the country's new annual infections. The GoM is currently developing a strategy for the Elimination of Mother to Child Transmission (E-MTCT) in line with international goals and targets. The Nutrition and HIV/AIDS Project will assist the GoM to reduce the high rate of vertical transmission and to achieve its goal of less than 0.5 percent vertical transmissions by 2xxx (source: E-MTCT draft strategy). To support the government's PMTCT program, the project will provide assistance to PMTCT sites in four service areas: (i) pregnancy confirmation; (ii) HIV counseling and testing; (iii) early infant diagnosis; and (iv) family planning for HIV positive women participating in PMTCT programs. Support and technical assistance will be provided in (i) training (including PMTCT mentoring); (ii) procurement of commodities (HIV test kits, STI treatment, family planning products); (iii) the equipment and refurbishment of PMTCT centers; (iv) monitoring and evaluation, and (v) operations research to increase demand among men for HIV testing and couples counseling. Antiretroviral drugs for HIV positive pregnant women and very young children are not part of the program as these are

provided by GFATM.

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

The project will support services throughout Malawi with HIV and AIDS interventions (including clinical activities) taking place in district hospitals in all Districts, and in a limited number of health centers and mobile clinics in some Districts. Nutrition interventions will target at least 15 Districts (i.e. roughly half of all Districts nationally).

5. Environmental and Social Safeguards Specialists

Stephen Ling (AFTEN)

6. Safeguard Policies Triggered	Yes	No	Explanation
Environmental Assessment OP/BP 4.01	✗		Potentially negative environmental and related social impacts are associated with: a) Clinical activities under the project which will generate modest amounts of both general and health care waste; and b) Minor interior office refurbishment activities, and minor upgrades to existing, on-site health care waste disposal facilities at district hospitals and health centers.
Natural Habitats OP/BP 4.04		✗	
Forests OP/BP 4.36		✗	
Pest Management OP 4.09		✗	
Physical Cultural Resources OP/BP 4.11		✗	
Indigenous Peoples OP/BP 4.10		✗	
Involuntary Resettlement OP/BP 4.12		✗	There are no activities under the project that would involve land-taking or disruption of livelihoods.
Safety of Dams OP/BP 4.37		✗	
Projects on International Waterways OP/BP 7.50		✗	
Projects in Disputed Areas OP/BP 7.60		✗	

II. 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:

Negative environmental and social impacts of the project activities are expected to be modest and easily manageable. The activities that are financed by or will directly contribute to the PDO of the Nutrition and HIV / AIDS project are well-defined and budgeted. Potentially negative environmental and related social impacts are associated with:

a) Clinical activities under the project which will generate modest amounts of both general and health care waste; and

b) Minor interior office refurbishment activities, and minor upgrades to existing, on-site health care waste disposal facilities at district hospitals and health centers.

The project will generate health care waste through a number of clinical activities, namely male circumcisions, HIV testing, STI screening & treatment, ART drugs to prevent mother-to-child transmission of HIV, and through some blood testing under nutrition surveys. In most cases the incremental hazardous health care waste (e.g. sharps, infectious & anatomical waste) will be small, in the order of a few kg per month. The district hospitals to which mobile circumcision clinics will be attached stand to generate the highest incremental amount of hazardous health care waste, perhaps in the order of 100kg per month on average. Health care waste management is essentially a workplace and public health and safety issue. A small fraction of medical waste may contain toxic heavy metals and radio-isotopes that can have a broader impact on the natural environment, but these forms of waste will not be generated by project activities.

Health care waste management is best addressed through appropriate standards and procedures to be implemented as part of routine work practices in all health care facilities in which the project will work rather than via separate treatment of the materials and waste associated only with project activities. A Health Care Waste Management Plan (HCWMP) has been prepared to review and strengthen existing health care waste management systems in health care facilities within which the project will operate. The overall objective of the HCWMP is to ensure appropriate and safe management of HCW generated by the project in a way that leaves a lasting improvement in the health care waste management systems of Malawi. Specifically, the HCWMP:

a) Estimates the types, volumes and locations of HCW expected to be generated by the project;

b) Reviews existing national regulations, systems and practices;

c) Identifies both national and site-level activities needed to strengthen HCWM practices to adequately deal with the HCW generated by the project – including finalization of the National Health Care Waste Management Policy, development of National Guidelines, development of training materials, provision of training, development of plans for each project health care facility, provision of additional equipment, and upgrading on-site waste disposal facilities;

d) Identifies a minimum set of standards, consistent with WHO and World Bank guidelines, to be followed in all project-supported health care facilities, until such time as these are superseded by finalization of more detailed national guidelines;

e) Identifies roles and responsibilities, including reporting and M&E procedures; and

f) Identifies resource and funding requirements and to ensure effective implementation of the HCWMP, which have subsequently been incorporated into project budgets and documents.

Addressing systematic strengthening of health care waste management from the national to site-level, the primary audience for the HCWMP is the project implementation team, but it also details specific minimum health care waste management standards to be followed by front-line health care workers at all project-supported sites, until these are furtherer elaborated in the form of National Guideline and site-specific plans. The minimum standards are based on the existing guidelines in the Ministry of Health HCWM training manual as appropriate to the categories of waste which will be involved in the project, but have been supplemented in places to ensure consistency with WHO and World Bank guidance.

Minor refurbishment of existing office and health care facilities housing may also be financed under the project. This will involve interior refurbishment / re-equipping of existing offices, and upgrades or installment of small, low temperature incinerators and disposal pits on the grounds of existing health care facilities, with no new breaking of ground, and is therefore expected to have insignificant impacts. Applicable national standards and regulations will be followed for all such activities, including (where necessary) building codes of practice from the Ministry of Transport & Public Infrastructure, and any appropriate city council development planning permits.

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

The project will not result in any long-term environmental impacts. Prevention programs will reduce the overall burden of sub-nutrition and HIV / AIDS infection, and therefore the amount of treatments and health care waste generation in the future. The measures implemented under the HCWMP will significantly contribute to long-term improvements in health care waste management systems in Malawi, and the appropriate handling and disposal of a much larger volume of waste than that generated by the project itself.

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

The volume of health care waste to be generated by the project could be reduced by the purchase of re-usable needles, syringes and scalpel blades as opposed to disposal kits for activities such as male circumcision. However, the safety risks involved with re-usable sharps (additional handling and risk of incomplete sterilization) outweigh the modest waste generation involved given the high rates of serious transmissible blood infections and varying levels of professional training amongst front-line health care staff in Malawi. Disposable kits are therefore generally preferred.

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.

A national Health Care Waste Management Plan was prepared in 2002 under previous Bank support to the health sector SWAp in Malawi. Activities consistent with that plan have since been carried out through a variety of projects, including drafting of a national policy and training materials, and training and provision of equipment and waste disposal facilities at the site-level. This has resulted in significant improvement of health care waste management in Malawi. Most health care facilities have at least basic waste management systems in place, and in some they are largely effective. Implementation has not been consistent, or effectively coordinated and monitored, however, producing gaps in implementation and a lack of standardization. Staff have high mobility between districts and health care facilities, and therefore frequently have to learn new systems at new locations.

The Ministry of Health has developed the HCWMP for the Nutrition and HIV/AIDS Project to be consistent with and build on the approach of the previous national plan, including actions to complete development of national regulations. The current project differs previous support to the SWAp, however, in that it will fund a limited set of identified activities, the health care waste implications of which have been identified and roughly quantified. The current HCWMP will therefore ensure that project impacts are suitably mitigated through a standardized approach to be applied at all project health care facilities. Whilst it will strengthen national systems in parallel, it is not intended to provide a comprehensive plan to address all health care waste management issues in Malawi.

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

Main beneficiaries of the HCWMP are the front-line health care staff and patients who will benefit from a cleaner and safer environment in the health care facilities they frequent, and therefore a reduced risk of infection. Health risks to local populations, and to waste handlers and scavengers at public dumps, will also be reduced by the safe disposal on-site of hazardous waste generated by project health care facilities. Other key stakeholders include the various government agencies, NGOs, private organizations and donors involved in providing health services in Malawi.
During the development of the HCWMP, discussions were held with front-line health care staff at a number of district health care facilities. A consultation meeting was held in Lilongwe on 16th December 2011 with key health sector stakeholders to present and discuss the proposed activities, and comments were incorporated into the draft document. As soon as the draft HCWMP is cleared, it will be disclosed publically in Malawi and via the World Bank Infoshop, and feedback invited, up until completion and disclosure of the final document at Appraisal.

B. Disclosure Requirements Date

Environmental Assessment/Audit/Management Plan/Other	
Was the document disclosed prior to appraisal?	Yes
Date of receipt by the Bank	19-Jan-2012
Date of "in-country" disclosure	20-Jan-2012
Date of submission to InfoShop	19-Jan-2012
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why:	

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			
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?	Yes [ ]	No [ ]	NA [ ]
The World Bank Policy on Disclosure of Information			
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [X]	No [ ]	NA [ ]
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 [X]	No [ ]	NA [ ]
All Safeguard Policies			
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [X]	No [ ]	NA [ ]
Have costs related to safeguard policy measures been included in the project cost?	Yes [X]	No [ ]	NA [ ]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [X]	No [ ]	NA [ ]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [X]	No [ ]	NA [ ]

III. APPROVALS

Signed and submitted by:	***Name***	***Date***
Task Team Leader:	Stephen Ling	23-Jan-2012
Approved By:		
Regional Safeguards Coordinator:	Cary Anne Cadman (RSA)	23-Jan-2012
Comments:		
Sector Manager:	Patricio V. Marquez (SM)	23-Jan-2012
Comments:		

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