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

Appraisal Stage | Date Prepared/Updated: 04-Dec-2018 | Report No: PIDISDSA25708

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Marshall Islands	P166800	RMI Multisectoral Early Childhood Development Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	26-Nov-2018	28-Feb-2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	The Republic of the Marshall Islands	Division of International Development Assistance (DIDA)	

Proposed Development Objective(s)

To improve coverage of multisectoral early childhood development services

Components

Component 1. Improve coverage of essential RMNCH-N services
Component 2. Improve coverage of stimulation and early learning activities
Component 3. Social assistance for early years families
Component 4. Strengthening the multisectoral ECD system and Project management

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	14.36
Total Financing	14.36
of which IBRD/IDA	12.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	12.00

IDA Grant	12.00
Non-World Bank Group Financing	
Counterpart Funding	2.00
Borrower	2.00
Other Sources	0.36
UN Children's Fund	0.36

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. The Republic of the Marshall Islands (RMI) is one of the world's smallest, most isolated, and vulnerable nations. The country consists of 29 atolls and 5 isolated islands (24 of which are inhabited) and has a total land mass of just 181 km² set in an area of over 1.9 million km² in the Pacific Ocean. The population of the RMI was estimated at 53,066[1] in 2016, of which the two largest urban centers, Majuro (the nation's capital) and Ebeye, have populations of 28,000 and 9,614, respectively. The RMI was consolidated into the Trust Territory of the Pacific Islands governed by the United States during the Second World War. It became self-governing in 1979 and achieved formal independence in 1986.

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

3. Economic growth accelerated in 2016 and macroeconomic forecasts predict continuous economic growth over the next five years. Growth rates are expected to revolve around 2.5 percent over the near term and remain positive (but lower) over the medium term[2]. The fishing sector remains the main source of revenue, representing 18 percent of GDP in 2017. Infrastructure development, public administration and education were the main drivers of GDP growth in 2017.

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

[1] RMI Government Statistics Office projections based on the 2011 RMI Census
[2] IMF, 2017

Sectoral and Institutional Context

5. The foundations of human capital formation are at risk in the RMI due to poor health and nutrition, lack of early stimulation and learning, and exposure to poverty and severe stress during the early years of life (Table 1). Maternal mortality rate (MMR) and infant mortality rates (IMR) are much higher than for other Pacific Island comparator countries and relative to the RMI's income level. Child stunting, or low height-for-age and an indicator of chronic malnutrition, affects over one-third (35 percent) of children under age 5. Of most recently born children age 0-59 months, 12 percent were estimated to have low birthweight (<2,500 g) at birth. Although robust measures are not available, data from the Integrated Child Health and Nutrition Survey (ICHNS) point to deficits in overall child developmental outcomes[3]. Physical health and growth, literacy and numeracy skills, socio-emotional development, and readiness to learn are vital domains of a child's overall development. According to the ICHNS, 79 percent of children are developmentally on track (see Table 2 for definition) in 3 of 4 domains, ranging from 86 percent of children age 48-59 months compared to 71 percent of children age 36-47 months. Overall, children in the wealthiest families show better health, education and nutrition outcomes compared with children in the poorest families.

Table 1: Health, nutrition, and child development outcomes

Maternal and Child Health Outcomes	
Infant mortality rate *(deaths per 1,000 live births)* [+] *(deaths per 1,000 live births)* [+]	28
Under-5 mortality rate *(deaths per 1,000 live births)* [+]	34
Maternal mortality ratio *(deaths per 100,000 live births)* [+]	92
Low birth weight (<2,500 g), *(% last born children 0-59 months*)*	11.6
Maternal and Child Nutritional Outcomes	
Underweight *(% children 0-59 months*)*	11.7
Stunting *(% children 0-59 months*)*	35.3
Wasting *(% children 0-59 months*)*	3.6
Overweight *(% children 0-59 months*)*	3.8
Underweight/Thinness (BMI<18.5 kg/m^2), % WRA*	1.8
Overweight (BMI 25.0-29.9 kg/m^2), % WRA*	72.7
Obesity (BMI >30 kg/m^2), % WRA*	45.1
Child Development Outcomes	
Percent of children age 36-59 months developmentally on track for indicated domains	
Literacy – Numeracy	55.4
Physical	92.8
Social-Emotional	72.4
Learning	87.6
ECDI Index Score*	78.9
Literacy-numeracy: Developmentally on track if at least two of the following are true: Can identify/name at least ten letters of the alphabet, Can read at least four simple, popular words, Knows the name and recognizes the symbol of all numbers from 1 to 10. *Physical*: Developmentally on track if one or both of the following is true: Can pick up a small object with two fingers, like a stick or a rock from the ground, Is not sometimes too sick to play. *Social-emotional*: Developmentally on track if at least two of the following are true: Gets along well with other children, Does not kick, bite, or hit other children, Does not get distracted easily. *Learning*: Developmentally on track if one or both of the following is true: Follows simple directions on how to do something correctly, When given something to do, is able to do it independently.	

Sources: *UNICEF Integrated Child Health and Nutrition Survey, 2017; [+]MOHHS Key Performance Indicators Report, 2017; [++]MOHHS Annual Report, 2017; Notes: WRA: Women of reproductive age (15-49). Note: Data are subject to the usual errors associated with small sample sizes, and in the case of population data such as IMR and MMR issues associated with measurement of mortality in small populations.

6. In the RMI, children experience adversities across multiple domains that undermine children's opportunities to learn, earn, innovate, and compete. Poor child development in the RMI is underpinned by a range of factors spanning across sectors. They include: (a) inadequate access to effective and quality maternal and child health (MCH) services including immunization coverage; (b) insufficient opportunities for early stimulation and early learning; (c) lack of support through formalized social protection; and (d) limited availability, affordability, and consumption of nutritious diets, especially for children from vulnerable families.[4] Cutting across all of this is a general low awareness of the importance of early child stimulation, health and nutrition.

Health System Context: Service Delivery and Financing

7. While health outcomes have improved slowly over time, the RMI faces significant challenges addressing the dual burden of disease. Between 1990 and 2016, IMRs declined from 45 to 30 deaths per 1000 live births and life expectancy increased from 65 to 75 years. On both outcomes, the RMI compares poorly against other Pacific Island countries (Figure 1). The incidence of communicable diseases remains high. Hepatitis B is the fourth leading cause of mortality. In 2013, the RMI had the highest mortality rate from tuberculosis in the Pacific at 40/100,000 people[5] prompting a mass screening and treatment program led by the World Health Organization in 2017. Alongside the unfinished burden of maternal, neonatal, and communicable diseases, the RMI has undergone a rapid epidemiological transition with noncommunicable diseases (NCDs) presently the leading cause of morbidity and mortality. Diabetes, cardiovascular disease and cancer were top three causes of mortality in RMI in 2017[6], and obesity is a main risk factor for premature mortality and morbidity.

8. Poor maternal health and nutrition is an underlying cause of preventable death, an impediment to improving women's endowments in health, and a threat to the human capital formation of the next generation in the RMI. The high prevalence of obesity, hypertension, and diabetes among women is not only a risk factor for chronic and non-communicable disease mortality, but also poses risks to women's health during pregnancy and requires careful management and treatment. Obese pregnant women face increased risk of obstetric complications such as recurrent miscarriage, congenital anomalies in the fetus, gestational hypertension and preeclampsia, gestational diabetes, preterm birth, cesarean delivery, and maternal mortality. Excessive weight gain during pregnancy and the inability to lose weight post-partum are linked to obesity later on in life. Moreover, maternal health and nutrition has impacts on fetal growth and development and can impact the health of the child in later life. Infants born to obese mothers are at increased risk of macrosomia (being born with birth weight >4500g) and childhood obesity. Consistent with the fetal origins of disease hypothesis, an effective response to the growing burden of NCDs involves addressing poor health and nutrition outcomes in pregnancy and early childhood.

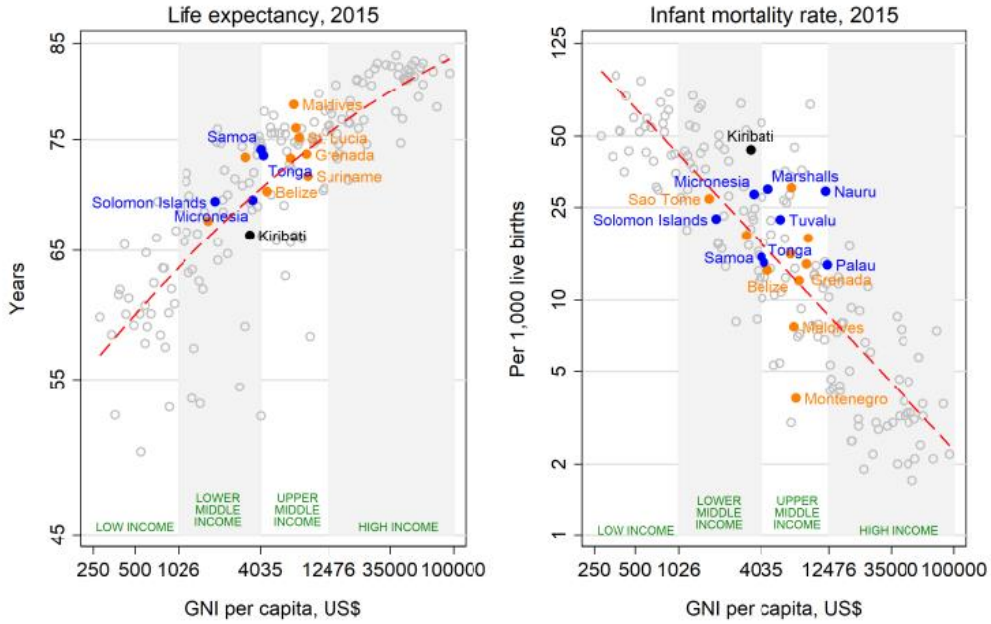
[3] The ICHNS calculates the Early Child Development Index (ECDI) based on selected milestones that children are expected to achieve by ages 3 and 4. There are notable limitations to the interpretation of the overall ECDI and the validity of the items included in the index. The literacy-numeracy items are more closely aligned with capabilities expected of children at the upper end of the age range, and physical items more closely aligned with developmental milestones for children at the lower end of the age range. Thus, it is unsurprising to see higher performance in the physical domain and lower performance in literacy-numeracy.

[4] While poor diet is a population-wide concern, there are distinct issues related to the diets and nutrient intake of women, infants, and young children that have a profound impact on nutritional status in the first 1,000 days of life. The modern Marshallese diet consists largely of starchy staples (such as rice, wheat flour products, and ramen noodles) and meat (often canned or processed). Food in the RMI is largely imported, with populations on the Outer Islands (OI) relying on traditional diets of fresh fish and fruit. Food availability is not an issue at the population level, but geographic access and affordability remain barriers to widespread improvements in consumption diversity and dietary quality. According to the 2017 ICHNS, 40 percent of households had some level of food insecurity, with 20 percent of households experiencing severe food insecurity.

[5] Witten et al. 2017.

[6] Ministry of Health and Human Services Annual Report, 2017

Figure 1: Infant mortality rate and life expectancy rate relative to income and other comparators



Note: Both X and Y axes are on log scale
Source: World Bank, 2017

9. Coverage of effective and quality health services for childhood conditions such as acute respiratory infection, fever, and diarrhea is low and variable, and an impediment to optimal health and nutrition of women and children. Care from a health provider was sought for only about half of children with diarrhea. Only about one quarter (28 percent) of diarrhea cases were treated with oral rehydration salts or recommended homemade fluids, with 8 percent of diarrhea cases receiving oral rehydration salts and zinc. Only 55 percent of children have complete immunization by the age of 5 (Table 2).

Table 2: Health Financing, System, and Service Delivery, the Republic of Marshall Islands, 2017

Health Financing	
Total health spending as a share of GDP (%)	23
Government (including on-budget donor) health spending as a share of GDP (%)	15
Government health spending per capita (US$)	560
Health System	
Hospital beds per capita (National)	1:357
Majuro (101 beds)	
Ebeye (54 beds)	
Human Resources for Health (total)	585
Doctors per capita	1:1,288
Nurses per capita	1:254
Primary health care facilities	58
Hospital	2
Health Center	56
Health Service Coverage	
Percent of women giving birth with a skilled provider[+]	99

Immunization rates (children 19-35 months):	
Measles Mumps and Rubella 1++	84
Immunization completeness++	55
Percent of women receiving at least one ante-natal care visit during the first trimester++	34
Percent of children with under age 5 with diarrhea in the last 2 weeks for whom advice or treatment was sought from a health facility or provider*	47.1
Percent of children under age 5 with diarrhea who received ORS and zinc*	7.5

Sources: *UNICEF Integrated Child Health and Nutrition Survey, 2017; +MOHHS Key Performance Indicators Report, 2017; ++MOHHS Annual Report, 2017; Notes; ORS: Oral rehydration solution; Complete immunization: Children age 19-35 months of age complete for 4-DTaP, 3-Polio, 3-HepB, 1-HIB, 1-MMR. Note: Data are subject to the usual errors associated with small sample sizes, and in the case of population data such as IMR and MMR issues associated with measurement of mortality in small populations.

10. Coverage of facility-based reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCH-N) services is relatively high in Ebeye and Majuro but challenges remain in ensuring sufficient supply of commodities outside Majuro. Early ante-natal care (ANC) remains an issue (34 percent of women receive their first ANC visit in the first trimester) (Table 1). Disparities in access persist for rural women and for the poorest, with only 66 percent of rural women delivering with a skilled birth attendant. Most women receive iron-folic acid supplementation (67 percent) or multiple micronutrient supplementation (49 percent) during pregnancy. However, adequate supplementation is an issue, as only 26 percent of women consume more than 90 iron/folic acid tablets, and iron/folic acid consumption is lowest among mothers less than 20 years old at time of birth (14 percent). Moreover, programs such as vitamin A supplementation (54 percent) and child deworming (32 percent) have lower coverage.

11. Teenage pregnancy and early childbearing are a growing concern in the RMI, where 15 percent of mothers of children under age 5 were under 20 years old at the time of birth (ICHNS, 2017). Access to adolescent friendly reproductive health (RH) education and services remains a gap to be filled.

12. Though health system performance has improved, considerable investment is needed to realize the healthy islands vision outlined in the Ministry of Health and Human Services (MOHHS) Strategic Plan (2017-2019) and deliver quality, effective primary health care[7] (Table 3). Health services are delivered in two hospitals (one each in Majuro and Ebeye) and fifty-six public health centers, primarily located on the OIs[8]. The MOHHS offers MCH Clinics in Majuro and Ebeye, which see infants at two weeks postpartum and according to the routine immunization schedule. A 'zone nurse' program and OIs' mobile health missions provide outreach services, though limited financing for operational cost, transport, equipment, and availability of adequately trained staff limit the frequency and quantity of outreach services provided. In both facilities and communities, little emphasis is placed on supporting caregivers to improve health and nutrition behaviors. MOHHS reports a number of human resource challenges, including: (i) suboptimal availability and distribution of human resources; (ii) limited communication across programs and providers; and (iii) insufficient staff training, supervision, and performance management. Unreliable availability essential commodities and equipment (e.g. vaccine cold chain, micronutrient supplements, communication materials) pose barriers to improving coverage of priority primary health care services, especially in the OI[9].

13. Similar to many Pacific Islands, overall spending on health is high and highly donor dependent. Government health spending (including on-budget donor assistance) in RMI is 15 percent of GDP or US$560 per capita. Government health spending accounts for 65 percent of Total Health Spending (THE), followed by off-budget development assistance (18 percent), out-of-pocket payments (13 percent) and prepaid private spending (3 percent)[10]. Hospitals are the largest cost drivers in the health sector: general hospital services and specialized hospital services represent 19 and 27 percent of government spending respectively. US Federal Grants and Programs drive spending on key preventive and public health program (e.g. immunization, maternal and child health, and family planning).

Education System Context: Service Delivery and Financing

14. The RMI is one of the only Pacific Island Countries (PICs) without a national policy on Early Childhood Care and Education or Early Learning and Development Standards[11]. The RMI school system serves kindergarten to Grade 12, has 112 schools, and is made up of public and private schools. Pre-school is provided for 3-4-year-olds by private providers only. Government funding to private pre-schools is based on enrollment, performance and accreditation. Since 2004, the national kindergarten program has been integrated into public elementary schools and provided free of charge to children who turn 5 at the start of the school year.

15. Only 5 percent of children aged 36-59 months attend an organized early childhood education program (ICHNS 2017). Enrollments in elementary school have been static for several years at around 83-86 percent, and they drop off again in secondary school to 48-58 percent[12]. Enrollment rates have increased in urban areas and decreased in the OI probably as a consequence of migration. Low school enrollments, high dropout rates, and low educational outcomes are of great concern to the Public School System (PSS), and test scores from the national RMI Standards Assessment Test series highlight poor outcomes for those in school.

Table 3: Education outcomes, system, and financing, 2017

Education Outcomes	Outcome	Education Financing and System	
Primary* enrollment rate (gross, net)	86%, 79%	Total education spending as a share of GDP (%)	-
Persistence** to Grade 8	78%	Government (including on-budget donor) education spending as a share of GDP (%)	16
Secondary enrollment rate (gross, net)	48%, 45%	Government education spending per capita (US$)	572
Persistence** to Grade 12	45%	Student:teacher ratio (elementary)	
		Majuro	17.6:1
		Ebeye	19.5:1
		OI	10:1
Students attaining proficient or above on MISAT***		Elementary schools	
		Majuro	11
Grade 3 (girls, boys)	35%, 29%	Ebeye	3
Grade 6 (girls, boys)	21%, 18%	OI	66
		Pre-schools	
		Public	0
		Private	10

*Primary/Elementary education in RMI is defined as grades K-8
** The Education Statistics Digest reporting these figures uses the term "completion"; however, based on the explanation of how these figures are calculated, it is closer to "persistence" according to the UIS definition.
*** Marshall Islands Standards Assessment Test
Source: Marshall Islands Public Schools System – Digest of Education Statistics 2016-2017

[7] WHO defines these as: (a) leadership and governance; (b) service delivery; (c) health system financing; (d) health workforce; (e) medical products, vaccines, and technologies; and (f) health information systems.
[8] Community health centers are the focus for preventive, promotive, and essential clinical health services and are staffed by full-time Health Assistants (high school graduates, majority male, who are trained to provide basic services but are reported to have insufficient professional competencies). However, there are cultural challenges related to the acceptability of male health assistants providing RMNCH-N services, and for this reason many women on OI often: (a) don't seek preventive/promotive services; (b) see traditional providers; or (c) travel to Ebeye/Majuro and for only the most essential RMNCH-N services.
[9] US CDC, ADB Regional TA on Cold Chain, UNICEF
[10] Institute for Health Metrics and Evaluation, 2018
[11] UNICEF, 2017. Status Report on Early Childhood Care and Education in Pacific Island Countries (PICs).
[12] Digest of education statistics 2016-2017, PSS

16. Parent/caregiver interaction and the household environment in the RMI do not compensate adequately for the lack of formal or community-based early childhood development (ECD) services. Nationwide, 72 percent of children age 36-59 months were engaged by adults in four or more activities in the previous three days13; children were more likely to have their mothers engaged in these activities (59 percent) than their fathers (2 percent). Adult engagement with children varies most widely by the education level of the child's caregiver: it is as low as 50 percent among children whose caregivers' highest level of education is primary school compared to 85 percent among children with caregivers who attended higher education. Children are less likely to have their biological mother engaged in learning when the mother is under age 20 (42 percent) compared to age 35 and over (53 percent). Less than one-fifth (18 percent) of children age 0-59 months live in families with 3 or more children's books, with large variations by income.

17. Government expenditures on education are 16 percent of GDP, or US$572 per capita (Table 3). Education was the second largest expenditure item in 2016 with US$24.6 million spent on this sector. Revenues from the Compact Fund represent the main source of financing (more than three quarters of all funds) and are expected to remain stable over time. It is estimated that roughly one fifth of the budget is allocated to pre-primary education, while the coverage and availability of such services is extremely limited. Primary and secondary education represent relatively small shares of the education budget (18 and 13 percent respectively) and 27 percent of the budget cannot be assigned.

Social protection system

18. The RMI has very limited coverage through formal social protection programs, even when compared to other PICs. Over the past decades, the RMI has introduced a defined benefit pension scheme for formal sector workers, as well as a school feeding program for primary school children in Majuro only. Beyond these two schemes, there are no formal SP programs to support vulnerable groups (the poor, informal sector elderly, disabled etc.). The prevalence of 'hardship' in RMI is amongst the highest for PICs[14]. Across most PICs, 20 to 30 percent of the population lives below the nationally-defined hardship threshold; for RMI, hardship is experienced by 51.1 percent of the population.

19. There is widespread agreement within the Government of RMI that although progress has been made in increasing economic growth and reducing poverty, there is a clear need to invest in the foundations of human capital required to boost the productivity, competitiveness, and wellbeing of the Marshallese population. The National Human Resource Development Plan 2014-2019 highlights the development of Marshallese talent with capacity to achieve the strategic vision for the nation as articulated in the National Strategic Plan. The Plan aims to ensure that the future of the RMI is steered toward self-sustainability and efficiency by Marshallese, and this can only be achieved by investing in their people. The President of the RMI has established a Cabinet Committee on ECD (CC) to provide high-level leadership and guidance for the RMI's flagship ECD Program.

20. The Ministry of Culture and Internal Affairs (MOCIA) has a relatively small budget (below US$2.5 million) and it is entirely funded through government general revenue. MOCIA covers a wide range of areas, such as community development, historic preservation, election and voters' registration and ID cards, among others.

C. Proposed Development Objective(s)

21. The proposed project development objective (PDO) is to improve coverage of multisectoral early childhood

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

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

development services.

Key Results

22. The achievement of the PDO will be measured through the following PDO-level results indicators:

(a) Share of women who have had at least one ANC visit by a skilled provider during the first trimester;

(b) Share of children aged 0-2 years who receive well-child visits as per established government guidelines;

(c) Number of families with children aged 0-4 years receiving home visits from parent educators;

(d) Share of children aged 3 and 4 years attending pre-school.

D. Project Description

23. This Project consists of five components, which are briefly described in the following paragraphs as follows:

- Component 1: Improve coverage of essential RMNCH-N services;
- Component 2: Improve coverage of stimulation and early learning activities;
- Component 3: Social Assistance for Early Years Families;
- Component 4: Strengthening the Multisectoral ECD System and Project management.

Component 1: Improve coverage of essential RMNCH-N services (IDA: US$3.7 million, Government: US$0.58 million)

24. **Component 1 aims to improve the availability and coverage of an evidence-based package of essential RMNCH-N and stimulation services for the first 1,000 days (pregnant and lactating women and children up to age 2).** Adolescent girls, women of reproductive age and children aged 2-5 years will be secondary target groups, with interventions for these populations incorporated in an opportunistic manner and/or in later stages of Project implementation. The component seeks to both strengthen the package of services provided and alleviate supply- and demand- side barriers to the use of this package of services. The first two years of the Project will focus on alleviating key pressure points to ensure adequate coverage of a revised and evidence-based package of RMNCH-N services in the Majuro/Ebeye Hospitals. Recognizing that greater scope and scale will be needed to re-orient services delivery towards the frontlines and accelerate RMNCH-N outcomes, the component will also support a suite of technical assistance (TA) activities to identify strategic shifts in service delivery in order to inform further scale-up beyond the initial phase focused on enhanced frontline service delivery in Majuro, Ebeye, and on the OI.

25. **The component has two sub-components, one aimed at strengthening stewardship and management of health administration and the other at directly strengthening service delivery**. Each sub-component will have four dimensions: (a) RMNCH-N service package; (b) human resources; (c) equipment and supplies; and (d) data and information. Social and behavior change communication (SBCC) activities will be financed under component 1 and other components.

Table 5: Activities supported in component 1

Dimension	Sub-component 1.1	Sub-component 1.2
RMNCH-N Service Package	• TA to define essential service package and delivery options • Supply-side readiness assessment • Health Financing Systems Assessment	• Incremental operating costs of revised RMNCH-N package

Human Resources	• Human Resource Needs Assessment • Development of capacity building and training packages	• Contract staff to optimize number and skill mix • Delivery of comprehensive training and capacity building
Equipment and Supplies	• TA on forecasting, purchasing, procurement, and commodity management	• Small equipment and supplies to ensure readiness to deliver RMNCH-N package
Data and Information	• Development/revision of databases to meet monitoring and evaluation (M&E) needs associated with revised RMNCH-N package	• Minor upgrading of information technology hardware and software to improve record keeping and decision making

26. ***Sub-component 1.1: Strengthening MOHHS management and stewardship capacity to deliver essential RMNCH-N services.*** The objective of this sub-component is to strengthen the management and stewardship capacity of the MOHHS to scale up access to the package of essential RMNCH-N services. Under this sub-component the Project will finance: (a) a suite of TA activities to define an essential RMNCH-N package, assess supply-side readiness to deliver the package and recommend strategic shifts in service delivery needed to improve coverage and utilization; (b) a human resources mapping and needs assessment to develop a human resource strategic plan focusing on the delivery of the essential RMNCH-N package, TA to develop a performance management system and the development of training and coaching packages as identified in the needs assessment; (c) TA on forecasting, purchasing, procurement, and commodity management, as needed; and (d) gaps in the support from Taiwan, China, for the health management information system (HMIS) and a rapid assessment of the data needs of the MCH and RH programs to monitor RMNCH-N service utilization and outcomes.

27. ***Sub-component 1.2: Enhancing delivery of essential RMNCH-N services.*** The objective of this sub-component is to scale up access to and coverage of a package of essential RMNCH-N services as well as simulation and early learning services for young children and their caregivers. Under this sub-component the Project will finance: (a) the incremental operating costs of delivering a revised (under component 1.1) package of essential package of RMNCH-N services; (b) support to MOHHS to achieve a more optimal number, distribution, skills/skills mix, and performance of health care professionals to effectively deliver the RMNCH-N service package; (c) procurement of small equipment (including anthropometric measurement equipment), materials, pharmaceuticals/commodities, in order to meet standards of readiness to deliver the basic essential RMNCH-N package; and (d) filling in gaps in the information technology system infrastructure (hardware, software, and training) to monitor RMNCH-N patient records and service utilization, manage stock, and assess performance.

Component 2: Improve coverage of stimulation and early learning activities (IDA:US$3.8 million, Government: US$0.6 million)

28. **Component 2 aims to improve children's cognitive and socio-emotional development and facilitate children's readiness for on-time transition to primary school through expanding access to stimulation and early learning services.** In the absence of a national program for children under five years old, component 2 will work with the PSS to strengthen their mandate and capacity to implement and scale up two interventions focused on improving the school readiness of children. This component will strengthen existing service platforms through the delivery of home visits to the most vulnerable families[15] with children aged 0 to 4 years, and the provision of public pre-schools for 3- and 4-year-old children. Component 2 has two sub-components, one aimed at strengthening stewardship and management capacity of Government for this sub-sector and the other aimed at directly improving delivery of stimulation and early learning services.

[15] See component 3 for more details.

29. ***Sub-component 2.1: Strengthening PSS management and stewardship of ECD services.*** The objective of this sub-component is to strengthen the management and stewardship capacity of Ministry of Education (MOE)/PSS. This will involve strengthening the institutional capacity and regulatory framework of ECD programs in the RMI, including budgeting and allocation of resources across concerned agencies, and enhancing the availability and capacity of skilled cadres to support delivery of ECD services. The Project will finance: (a) international and local TA to assess existing capacities and recommend strategies for strengthening capacity; (b) assisting MOE/PSS in developing the regulatory framework for inclusion of pre-school in the formal school system; (c) capacity assessment (infrastructure and equipment available, staffing) and actionable plan for setting up and operationalizing public pre-schools; and (c) a training plan for staff and materials beyond those produced under sub-component 2.2.

30. ***Sub-component 2.2: Enhancing delivery of stimulation and early learning activities.*** Activities under this sub-component will focus on strengthening existing platforms of ECD services for caregivers and children under five years old. Two interventions with supporting global evidence of positive impacts on outcomes for children will be implemented and scaled up: a home visit program targeted at the most vulnerable families, and public pre-schools to cater to children ages three and four years old. For each intervention, the Project will finance: (a) TA to develop curricula, training programs and other materials to strengthen quality of service delivery and ensure context appropriateness following a review of existing materials; (b) the recruitment where needed and training of dedicated personnel providing the services; (c) procurement and printing of necessary resources; and (d) procurement of additional facilities and equipment as required.

31. **Home visits.** Under the Project, an existing PSS-financed home visiting program, *Ajri In Ibwinini* (AII), implemented by Women United Together Marshall Islands (WUTMI)[16] will be expanded to increase dosage, coverage and quality. Due to limited financial capacity, AII currently provides support through home visits to only a limited number of vulnerable families with children under 5 in Majuro for one hour each month. The AII program would be strengthened and scaled up through resourcing, training, increasing the number of monthly visits to families, and expanding the number of target families to ensure the most vulnerable families across Majuro and Ebeye have access to the program.

32. **Public Pre-schools.** The Project will support setting up pre-schools in public elementary schools in RMI to cater for children ages 3-4 years old. Teaching aides will be hired and trained to deliver an age-appropriate, play-based learning curriculum, with sufficient numbers of teaching aides in each classroom to ensure the child to educator ratio is appropriate for the target age-group. Due to space and capacity challenges in the urban centers, a gradual roll-out of public pre-schools will take place, with expansion based on a capacity assessment and roadmap for expansion developed during the first year of the Project, which will also identify ways to maximize the space to cater for a larger number of children. The ultimate goal is to support the government in institutionalizing pre-school for 3-4-year-old children in the public system.

Component 3: Social assistance for early years' families (IDA: US$2.4 million, Government: US$0.6 million)

33. **Component 3 aims to introduce a conditional cash transfer (CCT) pilot to modify care practices and behaviors and promote uptake of ECD services.** Cash transfers would not only directly address financial barriers to accessing key ECD services (e.g., transport and opportunity costs)[17], but also be instrumental in addressing cultural behaviors and motivational barriers to accessing health and education services in the longer term. This component would also begin the process of building up a social assistance system in the RMI to drive the ECD agenda. Component 3 has two sub-components, one aimed at providing TA to establish the social assistance system, and the other aimed at the provision of cash transfers to beneficiary families. There are a number of climate-related advantages to the

[16] WUTMI is an independent, registered non-governmental organization (NGO)

[17] ANC visits, vaccinations and growth monitoring visits are free of charge.

interventions being financed through the project. Under this component for Social Assistance, the social registry of vulnerable households being developed can be used to help target resources to poor and vulnerable families with young children and pregnant women who are most prone and disadvantaged to natural disasters. This will ensure that limited resources are well targeted and disbursed in a timely manner in the wake of disasters.

34. ***Sub-component 3.1: Strengthening Government of RMI's capacity to establish and deliver social assistance program for ECD.*** This sub-component will finance a suite of TA activities to support the development of (a) a registry of program beneficiaries; (b) a sound management information system (MIS) for enrollment, compliance verification of conditionalities, payments of the CCT pilot, and case management; (c) a grievance redress mechanism (GRM); (d) setting out the guidelines for an M&E framework; (e) a communications strategy for the social assistance program including SBCC and the implementation of it; and (f) support to administrating the program in Majuro and Ebeye including a training strategy and plan for MOCIA staff and field officers.

35. ***Sub-component 3.2: Provision of cash transfers to early years' families in selected areas.*** **Families in selected areas of Majuro and Ebeye with pregnant women and children aged between 0-59 months who are facing hardship would be eligible to enroll and benefit from the program.** During the Project life, the CCT pilot will aim to target the most vulnerable families living in Majuro and Ebeye, approximately ten percent (10%) or other proportion agreed on between the Government of RMI and the Bank. The program will develop a localized vulnerability and hardship criteria, to reach at least 1000 families out of the total number of poorest total families living in the target areas, by developing a localized vulnerability and hardship criteria. To determine the most relevant hardship and vulnerability indicators for targeting purposes, the Project will explore developing a simplified Family Assessment form using key welfare indicators taken from the Household Income and Expenditure Survey (HIES), appropriate to the Marshallese context, during the first year of the Project preparation. The payments will be channeled to the mother or caregiver of the children. The payment amount will be set at a level that accounts for the travel and opportunity costs faced by families, while also providing an incentive to use services for the benefit of children. Cash transfers will be paid every two months to provide regular and predictable transfers to families and thus smooth consumption. A base level of US$30 will be provided to the families plus a bonus amounts of US$3 up to a minimum of 3 children, 'conditional' on families being enrolled in the program and attending the predetermined schedule of health facility visits on a regular basis and attendance of ECD education sessions. The program will start with soft conditionalities, for the first year of program implementation until capacity is strengthened and tested, including the development of the management information systems (MIS) and Memoranda of Understanding (MOUs) with clear roles for MOCIA, MOE, MOHSS, Majuro Atoll Local Government (MALGOV) and Marshall Islands Social Security Administration (MISSA). Given that banking and financial services are limited in RMI, the program will use the banking services being offered by the Bank of Marshall Islands (BOMI), and all beneficiaries will be made electronic payments into their bank accounts. In its initial phase, the program will pilot the cash transfer model in Majuro and Ebeye, followed by close third-party program monitoring through process evaluations, spot checks and an impact evaluation after the first complete year of program implementation. The program will be managed by the MOCIA's Community Development Division.

Component 4: Strengthening the multisectoral ECD system and Project management (IDA: US$2.10 million; Government: US$0.22 million; Development Partners: US$0.36 million)

36. **Component 4 will finance the systems functions and activities necessary to sustain an effective multisectoral ECD program and project management.** The system functions include: (a) development of a multisectoral national ECD strategy and approach to program implementation; (b) development of a national monitoring, evaluation, and learning framework and implementation of the system; and (c) the preparation of a national communication strategy for ECD and the delivery of public awareness and social and behavior change (SBCC) campaigns. The component will support the OCS in leading and coordinating an ECD program based on evidence-

based best practice through TA activities and support for operational costs. It will aim to increase program effectiveness by: ensuring line ministry activities are underpinned by a strategic approach to program implementation; creating and using data for decision-making; and harmonizing communication activities and messages across various channels.

37. ***Sub-component 4.1: National Multisectoral ECD Strategy and Governance.*** Sub-component 4.1 will finance TA to develop RMI's National Strategy for ECD. The strategy will define clear objectives for the national ECD program, describe key activities and interventions, and clearly delineate the roles and responsibilities of the main actors and governance mechanisms. It will further support OCS and the CC in leading ECD program governance and coordinating implementation across key line ministries, such as Ministry of Finance (MOF), MOE/PSS, MOCIA and MOHHS. This sub-component will finance the TA and operational costs needed to develop the strategy and conduct periodic implementation reviews, as per agreed governance arrangements.

38. **Monitoring, Evaluation and Learning (MEAL):** Sub-component 4.1 will also finance the development and operationalization of a comprehensive ECD monitoring, evaluation, and learning (MEAL) framework. MEAL activities will assess the performance of the ECD program using adequacy and/or plausibility evaluation and promote adaptive learning throughout program implementation over time. The MEAL platform will consolidate indicators of service provision, quality, utilization rates, drawing from the three implementing line ministries' (MOHHS, MOE, MOCIA) routine data collection systems to the extent possible. Sub-component 4.1 will finance activities and inputs above and beyond investments in line ministry data and information systems under components 1-3, including activities to enable Economic Policy Planning and Statistics Office (EPPSO) to support ECD program monitoring and evaluation. The sub-component will finance a MEAL Coordinator to support the Project Implementation Unit (PIU) and: (i) develop the MEAL framework; (ii) convene regular MEAL reviews; and (iii) build line ministry capacity to produce quality ECD program data. Further, it will finance monitoring of child development outcomes in cohorts over time, either through surveillance methods or appending appropriate child health, nutrition, and development modules to population-based surveys, as feasible[18]. The sub-component will finance technical assistance to each line ministry to conduct rapid/process/qualitative assessments during implementation, including beneficiary assessments of knowledge and practice. These assessments will aim to document program challenges and successes and incorporate feedback loops that can contribute to continuous improvement of intervention design and implementation.

39. ***Sub-component 4.2: ECD Awareness and SBCC Campaign.*** Sub-component 4.2 will finance communications, advocacy, and awareness- raising activities for the ECD program. A centralized approach to the development of communications and advocacy materials is intended to promote linkages across the components and ensure consistency of messages. The sub-component will finance: (i) a SBCC and Advocacy Coordinator to provide centralized strategic and technical leadership to the development, implementation, coordination, and monitoring of ECD advocacy, awareness raising, and SBCC activities; and (ii) development of a SBCC strategy and associated campaign content intended to increase the intensity of intervention and exposure to campaign messages. The SBCC and Advocacy coordinator will work with the relevant line ministries to ensure buy-in and consistency of messages and activities across channels.

40. Achieving optimal child health, growth, and development in RMI is dependent on changing behaviors. Evidence indicates that a multichannel approach, including mass media, interpersonal communication and counselling, community-based interventions, and community and social mobilization can be effective in changing behaviors related to infant and child care and nutrition. To support this, a robust, contextually/culturally/linguistically relevant SBCC strategy and associated campaign content developed to increase the intensity of intervention and

[18] Including ongoing discussions to assess anthropometric status and child development in a subset of the 2019 Household Income and Expenditure Survey (HIES) sample to use as a project baseline.

exposure to campaign messages. It is anticipated the SBCC will be comprehensive, with content including elements such as maternal, infant, and young child nutrition; water, sanitation and hygiene; health care seeking; parenting; early stimulation; and early learning, with messages defined based upon delivery channel. The development and coordination of SBCC activities for ECD will be the responsibility of the OCS with support from the ECD PIU and SBCC and Advocacy Coordinator. Sub-component 4.2 will support the development of the SBCC strategy and campaign content; delivery of SBCC through mass media channels; and cross-sectoral coordination and monitoring. Sub-component can also finance additional formative research required to improve the relevance of messages and implementation approaches. Each implementing line ministry will be responsible for implementing SBCC activities through their respective channels (see Table 6). Attention will be paid to ensure that there are links and reinforcement of nutrition and stimulation messages across components 1 and 2.

Table 6: SBCC Activities and Channels Across Project Components

Component	Activities and Channels
Component 1	• Production of materials for the health sector; training of health personnel in delivery of the component 1 SBCC package • One-to-one interpersonal communication during ANC, deliver, postnatal care, and well/sick child visits • Group interpersonal communication at health facilities and in communities
Component 2	• Production of materials for the education sector; training of education personnel in delivery of the component 2 SBCC package • One-to-one interpersonal communication during home visits • Community-based activities for home visit beneficiaries • Group interpersonal communication at kindergartens
Component 3	• Production of materials for MOCIA; training of cash transfer personnel in delivery of the component 2 SBCC package • Community gatherings linked to cash transfer payouts
Component 4	• Development of SBCC Strategy • Development of SBCC content for all channels • Development of SBCC monitoring, supervision, and coaching guides • Development of social and community mobilization approaches • Mass and social media campaigns • Social mobilization activities • Multisectoral ECD Community gatherings • Targeted ECD advocacy to improve the enabling environment

41. **Food systems assessment and other TA as needed.** The sub-component 4.2 will also finance a food systems assessment that will support the Government in developing policies and interventions to improve the availability, accessibility, affordability, and desirability of a nutritious diet in the RMI. Other TA needs that arise during implementation may also be considered under this component.

42. **Sub-component 4.3 will support project management activities.** A PIU will be established with specific responsibilities to support and coordinate implementation of Project activities. The PIU will work in coordination with the Central Implementing Unit (CIU) of Division of International Development Assistance (DIDA) within the MOF for FM, procurement, safeguards, communications, and monitoring. The sub-component will finance (a) external consultancies required for ongoing Project staffing; (b) technical consultancies required for adherence to program operations and procedures; (c) office and other equipment; (d) training for PIU and CIU staff, as needed; and (e) travel and operational costs.

E. Implementation

Institutional and Implementation Arrangements

43. **The MOF, MOHHS, MOE and MOCIA and their relevant divisions will be the implementing agencies** for the core Project activities as follows: (a) MOHHS for component 1; (b) MOE/PSS for component 2; (c) MOCIA for Component 3; and (d) MOF/DIDA for component 4 in collaboration with PIU under the OCS, as well as the disbursement and replenishment of the program's Designated Account (DA). A PIU will be established within OCS responsible for overall coordination, results monitoring, and communicating with the World Bank on Project implementation. As with other World Bank projects, the CIU-DIDA will support implementing agencies, as required, in safeguards and fiduciary functions associated with the Project implementation.

44. **The highest level of the program's governance is the High Level ECD Cabinet Committee (CC), established by the Cabinet on June 21, 2018 via Cabinet Minute 130 (2018) to provide high-level strategic leadership and guidance for the RMI's flagship ECD Program and broader efforts in this area.** The CC is chaired by the President and comprises the following ministers: 1) Minister of Health and Human Services, 2) Minister of Education, 3) Minister of Culture and Internal Affairs, 4) Minister of Finance. The CC will be supported by an ECD Program Steering Committee (PSC), comprised of heads of the relevant line ministries (see Annex 1) and chaired by the Chief Secretary; the PSC will provide oversight, coordination, and implementation support for the RMI's flagship ECD Program and other efforts in this area. An ECD Working Group will be formed, chaired by the ECD Program Officer, that will include relevant technical focal points from the implementing line ministries and other relevant agencies (e.g. Economic Policy Planning and Statistics Office, national training institute), staff from the World Bank-financed PIU, and other stakeholders. The WG will facilitate coordination across the RMI's ECD program and will provide technical inputs to the PSC.

45. **The PSC will provide Project oversight, coordination and implementation support with the ECD Program Officer, as the Secretariat reporting to the Chief Secretary.** The PSC will meet quarterly and work closely with all development partners supporting ECD related efforts in the RMI and provide regular reports and updates to the CC on ECD. As this is a nascent program, the PIU with technical assistance from international experts to establish the program, with the understanding that many of these functions will be transferred to line ministry staff in years three to five of the Project. The PIU will include (a) an ECD Program Officer, internationally recruited; (b) an M&E expert, internationally recruited; (c) an SBCC and Advocacy coordinator, international recruited; and (d) locally hired support staff. The PIU's functions will be directed by the OCS. The PIU will be responsible for all core functions of the Project's implementation, management and the coordination of activities of the implementing agencies. Additionally, each line ministry will have one internationally recruited ECD Coordinator plus one locally recruited ECD Coordinator hired as PIU staff to sit within the respective line ministries of MOHHS, MOE, and MOCIA. The International ECD Coordinator will work closely with the line ministry's local ECD Coordinator(s) to provide TA to the implementation of the Project's activities and build capacity of the sectoral ministries. Ensuring that local staff take over ECD program coordination responsibilities within the line ministries at a later stage of the Project is a key goal of the Project and will be an explicit objective in the Terms of Reference (TORs) of the international advisors. ECD Coordinators, both international and local, will jointly report to the relevant line ministry Secretary and the ECD Program Officer/Chief Secretary.

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

The project will include activities in the two main population centers, Majuro and Ebeye, as well as the outer islands. The country is comprised of 29 atolls and 5 isolated islands, 24 of which are inhabited. The islands of Majuro, located on the Majuro Atoll, and Ebeye, located on the Kwajalein Atoll, are both virtually completely urbanized, with natural environment confined to sections of coastal boundaries, on the lagoon and ocean sides. Nearly all islands share the geology of coral atolls, with the exception of Mejit and Jabat Islands. The location of activities will focus on Majuro and Ebeye, and potentially also involve all inhabited islands. Physical investments will be limited to renovations / reconstruction of existing government buildings (health and education sector) on Government leased land in urban areas and villages. The project will benefit families with children under 5, pregnant women and women of reproductive age.

G. Environmental and Social Safeguards Specialists on the Team

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

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project will involve use of public buildings in Ebeye, Majuro and other islands, some of which may require refurbishment or reconstruction or the addition of play equipment. Audit of each building's adequacy for use in the project, including available space, asbestos, other safety considerations, and sanitation, will be carried out during implementation, and management plans for safety, waste and other risks included in the works contract and implemented by the contractor. The range of activities planned for component 1 will increase the number of healthcare beneficiaries, and thus may lead to an increase in medical waste production by health facilities. Geographic constraints in the RMI, primarily related to limited land availability and sensitivity of coastal areas to pollution, mean that any improper disposal of waste has potential environmental or social impacts. The Environmental and Social Management Framework

		(ESMF) notes that the WBG EHS Guidelines and Ministry of Health protocols will be followed to ensure compliance with the RMI waste regulations and good environmental practice. The social benefits will be overwhelmingly positive, however there are residual risks relating to 1) the fairness / equity of access to services, which the project design has addressed through targeting the most vulnerable, 2) increases in domestic disputes related to cash payments, and 3) discord between those that receive benefits and those that do not. The ESMF has been prepared as part of project preparation. It sets out the necessary screening, assessment and planning to be followed for physical investments and technical assistance. It also describes arrangements for stakeholder engagement, feedback and grievance redress in the context of the 'adaptive management' approach for this project. Citizen engagement will be important during this process to ensure that beneficiaries are aware of the project and how they can be involved in the decision making process and provide feedback to evaluate and improve on services through the 'adaptive management' approach. The citizen engagement will also assist in relating this project with other Bank supported projects, particularly in the Outer Islands.
Performance Standards for Private Sector Activities OP/BP 4.03	No	There are no Private Sector Activities under this project.
Natural Habitats OP/BP 4.04	No	The project will not involve physical investments or other activities that may impact natural habitats. Physical works will be within existing Government land / compounds.
Forests OP/BP 4.36	No	There are no forests in the project area of influence.
Pest Management OP 4.09	No	There will be no requirement to manage pests under this project.
Physical Cultural Resources OP/BP 4.11	No	The project will not have any physical investments or other activities that may impact physical cultural resources.
Indigenous Peoples OP/BP 4.10	No	RMI's population is relatively homogenous. The policy is not triggered because there are no social groups that meet the characteristics of the policy.
Involuntary Resettlement OP/BP 4.12	No	The project will not involve physical investments or other activities that may involve land acquisition.

		Physical works will be within existing Government land / compounds.
Safety of Dams OP/BP 4.37	No	This project does not involve the construction of dams or rely on an existing dam.
Projects on International Waterways OP/BP 7.50	No	There are no international waterways in the project area of influence.
Projects in Disputed Areas OP/BP 7.60	No	This project is not located in a disputed area.

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 impacts are overwhelmingly beneficial for some of the most vulnerable people in the RMI (babies and young children, pregnant women and families with low income or hardship). There are no potential large scale, significant or irreversible impacts. Unintended social consequences have been identified in the ESMF as potential increase in domestic violence from cash payments, lack of ability to access services by the most vulnerable, overworked health and education staff from increased workload, and discord between those that get extra assistance (such as cash payments) and those that do not. The residual impacts requiring management are minor and able to be managed through management plans (waste, construction impacts) or through sustained and effective social and behavior change communications (SBCC) such as media outreach, awareness raising, one-on-one and group mentoring, and effective feedback mechanisms and grievance redress mechanism.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
The long-term impacts are overwhelmingly beneficial and relate to the improved health and educational capabilities of the RMI's youth.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
No project alternatives were considered relevant. Avoidance and minimization of impacts has been incorporated into project design.

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.
The borrower has carried out stakeholder and community consultations during preparation and has prepared an Environmental and Social Management Framework to manage the residual social and environmental impacts from the Early Childhood Development project. The Ministries involved do not have safeguard policy experience, however a Project Implementation Unit (PIU) will be established to deliver the project which will include international and local staff dedicated to social and behavior change and advocacy who will have the capacity and capability to implement the consultations and social mitigation measures from the ESMF. The PIU will draw on the support of the national safeguards advisor in the Central Implementation Unit of the Division of International Development Assistance (DIDA). This person will provide training to the PMU and relevant Ministry staff on how to implement the ESMF and will provide ad hoc specialist support for screening and developing instruments for construction activities, medical waste management etc. during project implementation.

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 are the health providers, education providers, NGOs in the health, social welfare and education sectors, local government, and the beneficiary families and women. Institutional consultations were carried out during meetings and site visits during project preparation. The stakeholder engagement plan in the ESMF highlights that there are numerous ways that beneficiaries and potentially affected people will be engaged, such as the integrated social behavior change and advocacy role, outreach activities, one-on-one mentoring, and feedback mechanisms to improve the project activities.

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
29-Nov-2018	30-Nov-2018	

"In country" Disclosure

Marshall Islands
29-Nov-2018

Comments

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?
Yes
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?
Yes
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?
Yes

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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