PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: AB2895

Project Name	Scaling Up Nutrition
Region	AFRICA
Sector	Health (100%)
Project ID	P105092
Borrower(s)	GOVERNMENT OF GHANA
Implementing Agency	
	The Government of Ghana Ghana
	Ministry of Health; Ghana Health Services Ghana
Environment Category	[ ] A [ ] B [X] C [ ] FI [ ] TBD (to be determined)
Date PID Prepared	February 19, 2007
Estimated Date of Appraisal Authorization	April 6, 2007
Estimated Date of Board Approval	June 21, 2007

1. Key development issues and rationale for Bank involvement

Country and sector issues. Ghana has been enjoying a sustained economic growth in recent years. However, this favorable situation has not been equally translated into every aspect of the human development, leaving the health and nutrition status of children lagging behind. Improvement in macroeconomic management and strong export growth has sustained the annual real GDP growth rate at almost 6% in 2004 and 2005 and the fiscal deficit has continued falling. Poverty and food insecurity have also fallen. The poverty headcount has declined by 7 percentage points since 1997, reaching 35% in 2003. At the same time, the proportion of people with insufficient food has declined from 37% in 1991 to 18% in 1996 and further down to 11% in 2003. Health outcomes such as infant and under five mortality rates, on the other hand, have not improved as much or stagnated since the late 1990s, even though health service delivery has continuously expanded.

A recent study suggested that high prevalence of undernutrition coupled with inadequate maternal and child care behaviors might be reasons for the stagnated child mortality levels. Undernutrition has enormous consequence for morbidity, mortality, and development of children. It retards their physical growth and increases their susceptibility to disease. In Ghana, it is estimated that 40% of all deaths occur before age five. While there was a steady improvement of the nutritional situation until 1998, the most recent national survey in 2003 showed mixed results. The prevalence of stunting among children under the age of five declined from 30% to 26%, while that of underweight declined from 30% to 25% between 1988 and 1998. The prevalence of underweight declined further to 22% between 1998 and 2003, yet that of stunting increased back to 29% during the same period. While protein and energy undernutrition is the major problem in Ghana, high prevalence of micronutrient deficiencies also poses the significant loss of productivity: a recent national survey shows that 77% of children age 6-59 months and 47% of women aged 15-49 are anemic. One third of districts are reported to have severe iodine deficiency disorder

problems. At these rates, Ghana could lose up to $359 million as a consequence of productivity loss caused by stunting and anemia as well as mental impairment caused by iodine deficiency over five years.

Policy/Program Environment and Challenges. Recognizing the significance of high prevalence of undernutrition and its effects on other human development outcomes including MDGs and economic growth, the government, in close partnership with development partners, has implemented a number of priority interventions. Similarly, the government, especially MoH and GHS spearheaded the launch of *'Imagine Ghana Free of Malnutrition'*, a multi-sectoral strategy for addressing malnutrition as a development problem in the context of Ghana Poverty Reduction Strategy and the Second Five Year Programme of Work of the MoH. The government adopted a new National Health Policy in 2006, which emphasizes child as well as adult nutrition. These will serve as an excellent platform to prioritize, strengthen and coordinate nutrition programming at all levels.

However, there remain several challenges for the country to bring down high prevalence of undernutrition. These include;

- *Inadequate cross-sector coordination and collaboration:* nutrition is the outcome of many factors and is affected by policies/strategies and activities of numerous sectors including health, water and sanitation, education, agriculture, and finance. However, the coordination and collaboration of these actors have been sub-optimal as there is no formal institutional arrangement to discuss and commit to achieve good nutrition.
- *Low coverage of comprehensive health and nutrition services*: the MoH and GHS, with the support of partners, have expanded over the last several years the core health and nutrition services (i.e., immunization, vitamin A supplementation, ITN, de-worming) that affect nutritional status of children. However, delivery of other essential health services including intensive health and nutrition education have not been at a scale large enough to bring desirable outcomes at the regional or national level.
- *Mismatch between causes of undernutrition and nutrition actions*: food insecurity is certainly a factor that contributes to a high prevalence of undernutrition. Many researches including those in Ghana, have shown that inappropriate feeding and caring practices of children and mothers, poor environment (e.g., poor sanitation and hygiene), and limited utilization of basic health care services are the key factors. Many nutrition actions in the country however have not addressed the major causes of undernutrition in a comprehensive manner at the household level. Instead, single component interventions (e.g., Supplementary feeding, vitamin A supplementation) were more common due to limited understanding, capacity and/or resources.
- *Weak targeting*: while it is well known that undernutrition occurs mostly during pregnancy and the first two years of life, many programs in the country have targeted much wider groups (e.g., school age children).
- *Inadequate capacity to implement nutrition and other preventive care programs:* the focus of the health sector has been curative care, rather than preventive care until recently. Thus, while the new Health Policy states the importance of healthy lifestyles and environment, and places its emphasis on health promotion and good nutrition, health professionals have not been properly trained to provide such services. Also, the health budgets on *nutrition and other preventive care programs have been insufficient and irregular.*

RATIONALE FOR BANK INVOLVEMENT

The proposed project has strong links to the CAS in two ways: first, reducing high prevalence of undernutrition among children under the age of five is the core of the human development and service delivery pillar of the CAS. Second, assisting the government to integrate and rationalize activities across ministries and other levels of government will contribute to the main issues of governance by clarifying functions for each level of government. Also strong involvement of civil society (e.g., communities and NGOs) in service delivery and M&E will improve efficiency of pubic services.

The rationale for the Bank's involvement is threefold: first, the multisectoral collaboration and coordination required for effective implementation of large scale actions proposed is much more possible within the context of a Bank operation than it is in most bilateral projects; second, emphasis on nutrition is consistent with the Africa Action Plan, which calls for scaling up nutrition actions in at least 8 countries with worse indicators as well as the new Health Policy of the GOG; third, a recently closed pilot project supported by the Bank produced impressive outcomes with an integrated community based approach for basic health and nutrition service delivery, which deserves to be scaled up and institutionalized to better benefit from consolidated forms of financing (e.g., SWAp, PRSC, etc).

2. Proposed objective(s)

The Project Development Objective (PDO) is to contribute to the improvement of the nutritional status of *children under the age of two, and pregnant and lactating mothers* in selected regions. The PDO will be achieved by (i) strengthening institutional capacity to bring cross-sectoral coordination and collaboration for effective and efficient management for results; and (ii) expanding outreach and delivery of basic health and nutrition services directly related to health and nutrition outcomes (e.g., promoting child growth through behavior change communication (BCC) at community and household level).

Considering the short life of the project (3 years), the progress toward PDO ***will not be measured by*** nutrition status of children (e.g., prevalence of underweight), while it will be closely monitored through periodic growth monitoring as well as independent evaluation of selected samples. Instead, the project achievement will be measured by availability of outputs from functional working committees (e.g., policy), coverage of growth monitoring and promotion (GMP) and behavior changes that are linked nutrition outcomes such as prevalence of exclusive breastfeeding and appropriate complementary feeding.

3. Preliminary description

The project will have two components; (1) institutional strengthening for coordination, implementation, and outcomes; and (2) basic health and nutrition service delivery. The project will also promote and enhance a decentralized management system.

Component 1. Institutional strengthening for coordination, implementation, and outcome

Sub-component 1.1. Institutional strengthening at the community/district level will support two main activities: (i) activities that improve health sector ownership, stewardship and accountability of basic health and nutrition service delivery (e.g., building capacity of DHMT, convergence between the community-based and facility-based service delivery); and (ii) activities that mainstream the nutrition issues into cross-sectoral operations (e.g., building capacity of the District Assemblies (DAs)) and strengthen its linkages at the community and district level.

Sub-component 1.2. Institutional strengthening at the regional/national level will support the development of effective inter-sectoral coordination, ownership, accountability, and leadership for nutrition towards the establishment of a coherent national program (e.g., by establishing an inter-ministerial committee or ministerial committee under the MoH with the membership of relevant ministries). This sub-component will support reforms towards reliable financing of child survival interventions and development/ revision of national policies and strategies, notably community based service delivery. This sub-component will also support the activities that will enhance incorporation of health and nutrition into other sector programs such as development of curriculum for school health and nutrition education as well as M&E system (e.g. surveillance) as part of overall HMIS in the country.

Component 2. Basic Health and Nutrition Service Delivery

Sub-component 2.1. Outreach and community based delivery of basic health and nutrition services will support the scaling up of community-based basic health and nutrition service delivery including

health and nutrition promotion through BCC and demand generation for essential health services such as immunization. The services will be delivered by community health promoters who will be supported by community committees under the overall management oversight of the District Health Management Teams(DHMTs)/DAs. Formative supervision will be ensured by a potential range of human resources at district level, namely the sub-district community nurses for health aspects. While capacity building for all functionaries will be one of the key activities, NGOs will be called upon in areas where capacity is low. Performance based incentive system will be also tested.

Sub-component 2.2. National/regional support system for community based delivery of basic health and nutrition services will support regional and national level activities that (i) enhance effectiveness and efficiency of sub-component 2.1 (community based service delivery) such as development and implementation of IEC/BCC strategies; and (ii) strengthen management for results at the district level such as addressing the bottleneck of micronutrient deficiency control (e.g., enforcement of salt iodization).

4. Safeguard policies that might apply

No safeguard policies are triggered.

5. Tentative financing

Source:	($m.)
BORROWER/RECIPIENT	.5
International Development Association (IDA)	15
Total	15.5

6. Contact point

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