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

Appraisal Stage | Date Prepared/Updated: 07-Feb-2023 | Report No: PIDISDSA34889

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Rwanda	P179499	Additional Financing to Rwanda Stunting Prevention and Reduction Project	P164845
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Rwanda Stunting Prevention and Reduction Project	EASTERN AND SOUTHERN AFRICA	08-Feb-2023	20-Mar-2023
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	MINISTRY OF FINANCE AND ECONOMIC PLANNING	Rwanda Biomedical Center

Proposed Development Objective(s) Parent

The proposed Project Development Objective (PDO) is to contribute to the reduction in the stunting rate among children under five years of age (with a focus on those under two) in the targeted districts.

Components

Component 1: Prevention of Stunting at Community and Household Levels
Component 2: High-impact Health and Nutrition Services
Component 3: Monitoring and Evaluation, and Program Management
CERC

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	79.00
Total Financing	79.00
of which IBRD/IDA	70.00
Financing Gap	0.00

DETAILS

World Bank Group Financing	
International Development Association (IDA)	70.00
IDA Credit	70.00
Non-World Bank Group Financing	
Trust Funds	9.00
Early Learning Partnership	4.00
Scaling up Nutrition	5.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **In recent decades, Rwanda has made impressive progress in sustaining high economic growth and improving human capital development indicators**. Rwanda's notable achievements include per capita economic growth averaging about 5 percentage points per year for more than two decades (the second-highest in Africa),[1] and major strides in non-monetary indicators of well-being, especially for maternal and child health, where Rwanda has performed on par with, or above, many lower-middle income countries. The country's poverty rate (international poverty line, US$2.15, 2017 Purchasing Power Parity) declined from 66 percent in 2005 to 48.1 percent in 2019. Of a total population of 13.7 million, more than 1.8 million people have come out of poverty or extreme poverty.[2] Rwanda is one of two countries in Sub-Saharan Africa that have achieved all the health Millennium Development Goals (MDGs). Under-five mortality declined sharply over the 2000–2020 period—from 196 to 45 deaths per 1,000 live births—and the maternal mortality ratio (MMR) dropped from 1,071 to 203 deaths per 100,000 live births (Demographic and Health Survey (DHS), 2019–2020).

2. **However, Rwanda continues to face challenges in translating strong growth into commensurate gains in poverty reduction and boosting shared prosperity.** The country has relatively high poverty rates compared to other African countries that have similar income per capita, and poverty reduction has been less responsive to growth in recent years. Poverty remains high in rural areas and among households with many children. Inequality in Rwanda, measured by the Gini coefficient, remains the highest in East Africa, at 43.7 (2016), compared to Uganda 42.8 (2016), Kenya 40.8 (2015), Tanzania 40.5 (2017) and Burundi 38.6 (2013). On the Human Capital Index (HCI), Rwanda's score of 0.38 (2020) is closer to the global low-income-country average (0.375 in 2020) but lower than the Sub-Saharan Africa average of 0.40 in 2020.

3. **After weathering the COVID-19 crisis relatively well, Rwanda now faces the fallout from the ongoing Russia-Ukraine conflict.** In 2020, domestic and global restrictions to contain the pandemic severely interrupted economic activity and depressed exports, private investment, and consumption. Travel and tourism were brought to a near halt, mining and construction value added dropped sharply. Agricultural production remained almost constant in 2020 due to poor weather (from December 2019 to February 2020), but the harvest was good in the second and third seasons. In 2021, supported by a robust fiscal stimulus, accommodative monetary policy, a solid global recovery, mass vaccination, and targeted lockdowns, the country's gross domestic product (GDP) grew by about 11 percent from the 3.4 percent contraction observed in 2020. Despite the strong recovery, Rwanda now faces the surge in global food and energy prices fueled by the war in Ukraine, which has put pressure on inflation rates, depressed consumption, and worsened the terms of trade. Weakened global economic activity is dampening Rwanda's external demand and investment. In the first half of 2022, real GDP growth slowed to 7.7 percent and the trade deficit widened by 0.4 percentage points of GDP, but the current account deficit improved slightly thanks to good performance in services and in primary and secondary balances.

4. **Rwanda's Vision 2050[3] sets an ambitious agenda for further improvements in the standard of living.** Targets to address food insecurity and malnutrition and to further reduce poverty are evidence of the political commitment to the twin goals of poverty reduction and shared prosperity. There is broad-based recognition that stunting—and chronic childhood malnutrition generally—represents an impediment to Rwanda's aspiration to becoming a middle-income country, given its long-term negative effects on human capital development.

Sectoral and Institutional Context

5. **Although Rwanda has made progress in improving the health and nutrition status of children, the country continues to experience a high burden of all forms of malnutrition especially among children under 5**—33 percent are stunted,[4] 1 percent are wasted, 8 percent are underweight—and both pregnant and non-pregnant women, with significant disparities across income levels. Stunting is inversely related to wealth quintile, with 49 percent of children in the lowest wealth quintiles stunted. Even among children from the top wealth quintile, roughly 11 percent of them suffer from stunting, suggesting that poverty rates are not the only predictor of stunting. Stunting rates are also highest among the poorest households and those living in rural areas (36 percent versus 20 percent in urban areas), and provinces in the North and the West of the country have stunting rates above 40 percent.[5]

6. **Several supply-side barriers continue to impede the scaling up and coverage of high-impact interventions to tackle the stunting challenge created by chronic undernutrition.** The barriers include (i) the need for community health care workers – who play a key role in delivering health and nutrition services at an affordable cost and with increasing coverage – and caregivers to be better trained, motivated, and mentored; (ii) the need for the supply chain for the timely distribution of nutrition commodities to be reinforced to reduce stock-outs of critical inputs; (iii) the need for information systems to be more agile to enhance tracking and follow-up of children who are at risk to become stunted as well as tracking their overall development; and (iv) the current health communication strategy's limited focus on stunting at the community level.

7. **Demand-side barriers to addressing stunting include sociocultural factors, geographic and financial impediments to accessing health services, and widespread levels of poverty and vulnerability**. Unlike acute malnutrition, stunting tends to be a slow-developing, hard-to-recognize, and largely invisible problem that stems from inadequate knowledge and awareness at the household and community levels. Geographic and financial barriers to accessing services persist, particularly for the poor and vulnerable.

8. **WASH remains a critical issue across Rwanda and in poor and rural areas where a lack of piped water, hand washing facilities, and water filters is common**. According to the 2019–2020 DHS, 80 percent of households in Rwanda have access to an improved water source (from 72 percent in 2014/2015), urban households having much better access (96 percent) than rural households (77 percent).[6] Access to an improved water source varies widely by province, with the highest percentage

1 The World Bank Group's (WBG) FY21–26 Country Partnership Framework (CPF) for Rwanda, discussed by the Board of Executive Directors on July 9, 2020 (Report No. 148876-RW, July 9, 2022).

2 National Institute of Statistics of Rwanda, Integrated Household Living Conditions Survey 4 (EICV 4 – 2013/14) and Integrated Household Living Conditions Survey 5 (EICV 5 – 2016/16).

3 Vision 2050 is the Rwandan national development strategy. It was launched in December 2020 by President Paul Kagame and the country's Ministry of Finance and Economic Planning (MINECOFIN). The program, which follows the preceding Vision 2020 20-year development plan that rebuilt Rwanda after years of civil war and genocide, aims to transform Rwanda into an upper-middle income country by 2035, and a high-income country by 2050.

4 National Institute of Statistics of Rwanda (NISR), Ministry of Health of Rwanda (MoH) and Inner-City Fund (ICF), *Rwanda Demographic and Health Survey 2019-20 Key Indicators* (Kigali, Rwanda and Rockville, Maryland: NISR and ICF, 2020).

5 NISR, MoH, and ICF, *Rwanda Demographic and Health Survey 2019/2020*.

6 NISR, MoH, and ICF, *Rwanda Demographic and Health Survey.*

of households using an unimproved source of drinking water in the Western province (24.4 percent) and Eastern Province (27.5 percent). Nearly three quarters (73 percent) of households have access to an improved sanitation facility (only up from 69 percent in 2014/2015), although access to such facilities is higher in urban (88 percent) than in rural (69 percent) areas; 25 percent of households continue to use unimproved sanitation facilities.[7] Nearly two-thirds (64 percent) of households use a pit latrine with a slab (an improved facility); 23 percent continue use a pit latrine without a slab or an open pit.[8]

9. **In addition to chronic food insecurity, which affects 20 percent of Rwandan families,**[9] **and low dietary diversity, there has been low progress in improving other determinants of malnutrition in children, specifically in infant and young child feeding (IYCF).** While most children are mostly breastfed during the first six months of life (99 percent)—81 percent are exclusively breastfed, and 79 percent are introduced to solid foods between ages 6 and 8 months—the timely introduction of good-quality complementary foods fares much worse.[10] In 2018, among children ages 6–23 months, only 22 percent achieved the minimum acceptable diet (MAD) in terms of food diversity and frequency (five or more food groups per day, 3–4 times a day),[11] an increase from 17 percent, as reported by the Comprehensive Food Security and Vulnerability Assessment (CFSVA).

10. **In the past few years, there has been remarkable progress in establishing more ECD facilities and increasing the number of children enrolled in ECD, but there is still insufficient progress in reaching children ages 0–3 years with ECD services.** In addition to contributing to child protection and development, the ECD services also contribute to the economic empowerment of working parents because the ECD centers provide them with safe, accessible childcare. This is particularly relevant to Rwandan women, who spend an average 25.3 hours per week doing unpaid care work, compared to 13.5 hours for men.12 Having a safe, accessible space for childcare translates into additional hours for income-earning activities and hence into economic empowerment. Currently, Rwanda has 31,967 ECD settings (up from 4,109 in 2018), benefiting 904,864 children 3–6 years old. These include 20,802 home-based ECD centers, 2,467 community-based ECD centers, 154 center-based ECD centers, and 2,809 pre-primary schools. The number of children ages 3–6 years enrolled in an ECD program rose to 61 percent by August 2021, from 24 percent in 2017. The centers provide comprehensive care for young children, parental education, and growth monitoring and promotion. Some, however, are not fulfilling all the requirements and minimum standards in the areas of Positive Parenting Education Programs, Child Protection, and Early Learning and Stimulation. Over the medium term, the

[7] NISR, MoH, and ICF, *Rwanda Demographic and Health Survey*.

[8] NISR, MoH, and ICF, *Rwanda Demographic and Health Survey*.

[9] NISR, *Comprehensive Food Security and Vulnerability Analysis (CFSVA) 2018*, https://www.statistics.gov.rw/publication/comprehensive-food-security-and-vulnerability-analysis2018.

[10] There has been a drop in the proportion of Rwandan children under 6 months who exclusively breastfeed. The percentage dropped from 87.3 (DHS 2014–2015) to 81 percent in 2019–2020. Moreover, there has been an increase in stunting among infants under 6 months.

[11] According to DHS 2020, these are the eight food groups in the minimum acceptable diet for very young children: (1) breast milk; (2) grains, roots, and tubers, including porridge and fortified baby food from grains; (3) legumes and nuts; (4) dairy products (milk, yogurt, cheese); (5) eggs; (6) meat, poultry, fish, and shellfish (and organ meats); (7) vitamin A-rich fruits and vegetables (and red palm oil); and (8) other fruits and vegetables. The minimum meal frequency recommended is solid, semisolid, or soft food at least twice a day for breastfed infants 6–8 months old, and at least three times a day for breastfed children ages 9–23 months. For non-breastfed children 6–23 months, the minimum meal frequency recommended is solid, semisolid, or soft food or milk at least four times a day, with at least one being non-milk-based.

[12] NISR, *Labour Force Survey*, annual report (Kigali, Rwanda: 2018).

government has prioritized ensuring that all ECD facilities meet the minimum standards by increasing the availability of equipment and materials in the facilities and improving the capacities and incentives of ECD volunteers, teachers, and caregivers to improve sustainable access and strengthen the standardization of good-quality services for young children.

11. **Recognizing the multifactorial causes of stunting, the parent SPRP technical design and that of the proposed AF are focused on implementing best-buy interventions that are essential to addressing the underlying determinants of stunting.** A 2019 report titled "*Barriers to accessing health and nutrition services for pregnant women, mothers, newborns and children under five years of age in Rwanda"*[13] found that the greatest barriers to accessing health and nutrition services for women and children were (i) a lack of health insurance mainly due to financial limitations; (ii) health system constraints, including staff shortages, insufficient infrastructure, and limited equipment and supplies; (iii) the limitations of the community health worker (CHW) system; stigma and discrimination stemming from either higher age during pregnancy, disability, HIV status, or poverty; and (iv) the economic dependency of women on men, in combination with the lack of partner support.

C. Proposed Development Objective(s)

Original PDO

The proposed Project Development Objective (PDO) is to contribute to the reduction in the stunting rate among children under five years of age (with a focus on those under two) in the targeted districts.

Current PDO

The proposed Project Development Objectives (PDO) are to contribute to the reduction in the stunting rate among children under five years of age (with a focus on those under two) in the targeted districts and provide immediate and effective response in the case of an eligible crisis or emergency.

Key Results

12. **M&E arrangements for the proposed AF will remain the same as those for the parent Project.** The overall M&E performance of the parent Project has been satisfactory. Project implementation, including oversight of M&E activities, is regularly monitored through the project steering committee, technical meetings between the NCDA and the RBC, and field supervision visits led by the two organizations. Data for most results framework intermediate indicators are readily available from routine sources and are reported in the results framework. Some M&E activities, such as monitoring the performance of the ECD centers and the DPEMs, had earlier been delayed because of the lack of

[13] Rwanda Biomedical Center (RBC), United Nations Children's Fund (UNICEF), and Swiss Tropical and Public Health Institute (TPH), *Barriers to accessing health and nutrition services for pregnant women, mothers, newborns, and children under five years of age in Rwanda* (Kigali, Rwanda: MoH, 2019).

appropriate tools. These tools have now been developed and will henceforth be used to monitor performance and progress. The results of these activities, along with data on the performance of specific indicators, inform corrective actions for the Project.

13. **Project performance indicators were selected to capture the Project's overall objectives, which are to improve nutrition, care, and hygiene practices and the utilization of good-quality, nutrition-specific interventions that are expected to contribute to a reduction in stunting**. The RBC SPIU will consolidate technical and financial reports from target districts, health centers, and other stakeholders. Project progress reports will include information on Project activities, key indicators, beneficiaries, and fiduciary and social safeguards. The PSC will review the monitoring data to assess progress and propose remedial actions for the Project-implementing entities.

14. **PDO-level indicators will be monitored through periodic population surveys (anthropometric survey, Demographic and Health Survey, Project end-line survey) in the target and comparison districts**. The target for PDO indicator "Percentage of children under 2 years with height-for-age z-score below -2 standard deviations" was revised from 27.2 percent to 25 percent. This is in light of the significant reduction in prevalence from a baseline of 37.1 percent to 28.4 percent in the 2019-2020 Demographic and Health Survey, a drop of nearly 9 percentage points. Given the additional resources, we expect to achieve at least modest rates of decline and to exceed the original target. Corporate responsibility indicators capturing beneficiary participation in the project activities, originally grouped under PDO indicators, have been shifted to intermediate indicators. Data for intermediate-level indicators are expected to be available from existing data systems, including the HMIS, the CHW monthly reports, and facility supervision reports. Indicators to assess the quality of, and satisfaction with, the home-based ECD centers will be assessed through instruments developed by the NCDA.

D. Project Description

15. **The SPRP is supporting the government to implement a bold, national strategy to reduce stunting using several existing platforms and new innovations**. It is also facilitating the strengthening of accountability by aligning incentives and actions at several critical levels, in particular these three: (i) incentivizing frontline CHWs; (ii) improving the accountability of health personnel through the national performance-based financing (PBF) schemes; and (iii) providing grant funds to district authorities to support the multisectoral nutrition convergence agenda, build capacity to mount the multisectoral response, and ensure effective implementation and monitoring of the District Plans to Eliminate Malnutrition (DPEM).

16. **The proposed AF would support the replenishment of the financing gap created by the reallocation of resources during restructuring, thereby allowing the full implementation of critical health and nutrition activities in the 13 target districts, as well as the continuation in the implementation of project activities through December 31, 2025**. A restructuring is also being processed with the AF. There are multiple and mutually substantive benefits in continuing and scaling up the activities under the SPRP. This AF is expected to improve operational efficiency and equity of access to good-quality health and nutrition services by ensuring continuity in the provision of high-impact interventions and advancing the stunting reduction agenda, especially in the post-COVID context. Additionally, the

continued knowledge creation and experience by learning will allow for a strengthened country-wide nutrition response. A US$5 million grant from SUN will finance the administering of high-impact health and nutrition services through health facilities, and a US$4 million grant from ELP-MDTF will help improve access to good-quality childcare services for children 0-6 years and enhancing the economic empowerment for working caregivers (mothers) in targeted districts. The proposed AF will therefore enable the full implementation of the effort to reach vulnerable populations with key preventive and curative nutrition activities, as well as facilitate the intensification of priority activities critical to achieving the PDO.

17. **The proposed AF and restructuring shall be guided by the following principles**: (i) maintaining the integrity of the original design that was based on best-buy interventions; (ii) protecting critical areas of the project such as the CHW program, behavioral change communications strategy, and district-level convergence agenda, and (iii) introducing new innovations for improved multisectoral coordination at the local level and peer-to-peer learning that would accelerate progress toward the achievement of the PDO as well as scaling up what works well.

18. **With the decision to retain the current institutional arrangements, the project components will also remain unchanged.** However, the AF shall incorporate new innovations that could accelerate the achievement of Project objectives, activities such as the Nutrition Command Posts at the sector level to improve multisectoral coordination, peer-to-peer learning, and so on.

19. **Below is a component-level summary of the activities that would be supported by the proposed AF**.

20. ***Component 1. Prevention of Stunting at Community and Household Levels (US$56.8 million IDA, 500,000 SUN, 3.7 million ELP-MDTF):*** This component is aligned with Pillar 1 of the GCRF, "*Responding to Food Insecurity*," in that it will protect the most vulnerable from the impoverishing effects of high food prices. By supporting investments in early childhood development to help build human capital, Component 1 is also aligned with Pillar 4 of the Framework, "*Strengthening Policies, Institutions and Investments for Rebuilding Better*." The component will continue to support high-impact health and nutrition interventions in the 13 priority districts but with a sharpened focus on community- and district-level approaches. Specifically, the AF will support the government's reform of the CHW model aimed at improving the training, certification, and accreditation of CHWs and incentive payment systems for them. CHWs will benefit from receiving enhanced training on a revised curriculum, improved supportive supervision and mentoring, and innovative technologies to enhance their effectiveness and strengthen their links to the health system. In addition, progress on the community PBF scheme remains strong, but the Project has now overspent on this activity. Hence, the AF will also be used to continue to support community PBF for CHWs.

21. **Although the parent Project scaled-down its support for WASH-related interventions following its restructuring in 2019, project beneficiaries and district leaders have keenly stressed the importance of reintroducing Project support for these interventions to improve the WASH conditions of the beneficiaries**. As such, the proposed AF shall reintroduce, intensify, and scale up the implementation of essential WASH activities in Project districts by providing targeted support to vulnerable households with pregnant women and young children to improve their WASH conditions. Relevant activities that could be financed by Project proceeds include the provision of essential inputs for the construction of sanitary latrines and handwashing stations, supplies for household-level water

treatment, and safe water storage. The Project will also provide similar WASH support to home-based ECD centers.

22. **Chronic food insecurity is an enormous challenge in Rwanda, especially among the SPRP target beneficiaries.** The AF will therefore be used to continue to support the FBF program while also pursuing additional multisectoral solutions in the form of more sustainable collaborative efforts to address chronic food insecurity.

23. **In the context of a strengthened multisectoral response to improve maternal and child nutrition, the SPRP has contributed significantly to the upgrading of ECD services in Rwanda.** The SPRP is already supporting the procurement of materials for the ECD centers in the 13 SPRP districts, but the AF will ensure that the above challenges can continue to be addressed in a sustainable manner, and that effective strategies are implemented to close the current gap between the quality of care provided in home-based ECD settings and the care provided in center-based settings.

24. **Multisectoral planning and coordination form the backbone of the SPRP's implementation success, and concerted efforts have been made at the district level to prioritize and plan activities targeting vulnerable households.** The proposed AF will support the district-level response to enhance the districts' oversight, coordination, supervision, and implementation of the multisectoral nutrition activities outlined in their expanded plans, including coordination for climate aspects of food insecurity and undernutrition. Based on feedback from participating districts regarding inadequate resources, the Project support for DPEM will be doubled from the current US$100,000 per district per year to US$200,000 per district per year with the AF.

25. **The AF will also incorporate new innovations that could accelerate the achievement of Project objectives.** Notably, the AF will support the creation and operationalization of Command Posts at the sector level, whose goal would be to coordinate and improve the implementation of all interventions aimed at combating malnutrition, especially stunting among young children, and to increase campaigns on all pillars aimed at promoting children's growth. The AF will also support a new peer-to-peer model that already has been successfully pretested in Rwanda. The model will be used to disseminate best practices in IYCF and care for improved child outcomes through a positive deviance approach using model mothers to teach others. These new innovations will complement current activities that have proven to be successful, including supporting the delivery of national and local-level SBCC activities using innovative communications approaches customized to the Rwandan context in order to provide targeted support to the most vulnerable households (and/or ECD centers) with young children, with inputs to establish backyard fruit and vegetable gardens and/or rear domestic animals.

26. **The ELP-MDTF grant will provide additional and complementary support to improve access, quality, and equity in childcare services in targeted districts.** Specifically, the grant will finance (i) the establishment of additional childcare settings, including model center-based and community-based ECD settings; (ii) the training of caregivers and other stakeholders involved in ECD/childcare service provision at all levels (from village to central levels); (iii) the provision of tools and materials to the newly established childcare/ECD settings in the Project districts; and (iv) support for peer-to-peer learning among home-based childcare/ECD centers to promote innovative practices. To use ECD settings to support women's economic participation and boost productivity, newly established ECD

services will be designed to fulfill a childcare role, possibly including through locating the services near parents' workplaces, increasing hours of operation to better align with working parents' needs, and ensuring that measurement and monitoring mechanisms assess the impact of services on child, family, and women's economic empowerment outcomes. This approach is already being taken in some districts. In Rubavu District, for example, a childcare/ECD setting has been established at the border with the DRC for the benefit of mothers who engage in cross-border trade' and in Rusizi District, a childcare/ECD setting has been established in the vicinity of a market where mothers sell products.[14]

27. ***Component 2. High-Impact Health and Nutrition Services (US$10.8 million IDA, 4.3 million SUN):*** By offering support to help accelerate progress toward universal health coverage and to strengthen health security, this component is aligned with Pillar 4 of GCRF. The proposed AF shall continue to support the implementation of the facility PBF initiative, for which early indications are showing improved delivery and utilization of essential MCH and nutrition services. Competency-based training of health staff, and procurement of essential health and nutrition equipment, commodities, and supplies for health facilities will continue under the proposed AF. In addition, with the maintenance of incinerators and other medical waste management equipment still a challenge, the AF resources will support a wide range of activities to address this, including the disposal and management of construction waste and the management of biomedical waste, occupational health and safety, community health and safety, biosafety risks, and labor and working conditions. In response to the GoR's request January 4, 2023, the restructuring will also facilitate the reallocation of US$1,769,565 from the ANIS Grant (MTDTF A6567) Category 2 (Goods, Non-Consulting Services and Training under part 2(ii) of the Project) to ANIS Grant Category 3 (Performance-Based Payments under part 2(i) of the Project). This will enable the settling of the overspend in Category 3.

28. ***Component 3. Monitoring & Evaluation and Project Management (total US$2.4 million IDA, 200,000 SUN, 300,000 ELP-MDTF):*** The AF resources allocated to this component will support project coordination and M&E. The proposed AF will also support the digitization of the Child Scorecard to increase efficiency, reduce recording errors, and improve data visualization and analytics to enhance data use at the district, sector, cell, and village levels. The AF will also finance the upgrade of the Integrated ECD Monitoring Dashboard to enhance its interoperability with other data-source systems and improve data utilization to inform the planning and budgeting process at the national and subnational levels. The ELP-MDTF grant will also contribute to the M&E activities of the proposed AF, which will include costs related to project management, stakeholder coordination, routine monitoring, and production and dissemination of best practices in the provision of good-quality childcare. It will also be used to finance M&E, including some impact evaluation to explore how access to ECD services/childcare facilities has increased women's economic engagement, family welfare, and child outcomes. The overall strengthened monitoring system will thus enhance the government's oversight of multisectoral nutrition programs and its accountability for results.

29. ***Component 4. Contingency Emergency Response Component (CERC) (US$0 million):*** This component

[14] Several formal sector employers and development partners, including the Office of the President of Rwanda, the City of Kigali, the National Agricultural Export Development Board (NAEB), farmers' cooperatives, tea factories, UN Women, and UNICEF have shown a model to follow by establishing childcare/ECD settings at their workplaces. Additionally, home- and community-based ECD centers that were established under the expanded Public Works scheme aimed, in addition to child development outcomes, to address the challenge faced by working parents whose lack of access to childcare facilities constrained their ability to engage in additional income-earning activities.

will remain, but no AF will be allocated to it at this time.

30. **Closing Date Extension**: The Project closing date (and that of the ANIS TF, Grant Number A6567) will be extended by 32 months from April 30, 2023, to December 31, 2025. This is necessary to mitigate the impact of the implementation delays linked to COVID-19 and to provide enough time for the implementation and completion of nutrition, health, and WASH activities that are essential to the attainment of the government's nutrition goals. This will bring the cumulative Project implementation period to 7 years and 10 months.

31. **Results Framework Revision**: The Project results framework will be revised to: (i) enable greater clarity of current indicator formulation and definition; (ii) revise the baseline and end line values of reformulated indicators; (iii) include indicators for new activities as well as for activities not previously reflected in the results framework of the parent Project; and (iv) ensure that intermediate indicators comprise those that can be easily reported through existing routine channels such as HMIS. In addition, all indicator targets are being revised to reflect the new Project closing date.

E. Implementation

Institutional and Implementation Arrangements

32. **The implementation arrangements for the AF will remain the same as those of the parent Project.** The Project is anchored in the MoH which ensures oversight and coordination among health actors and development partners, including by being part of the Project Steering Committee (PSC), along with senior officials from the RBC and the NCDA. The RBC, through the SPIU is managing the Project with a full complement of dedicated specialists overseeing implementation and coordination. This team includes an FBS/SPIU Coordinator, Program Manager, School Readiness Specialist, Environmental Specialist, Social Specialist, an M&E and Planning Specialist, a Financial Management (FM) and SBCC Specialist, all based in Kigali. To support the proposed AF, these positions will be continued during the AF and the Project will support the recruitment of new staff at the NCDA, including fiduciary, project management, and technical staff to support the agency's oversight of Project activities under their purview. The existing Project Implementation Manual (PIM) would continue to be used and updated, which incorporates all operational details at the national and districts levels, including technical guidelines, M&E, E&S, and administrative and fiduciary functions. The PIM would be updated as required to include specific processes arising from the new activities/ innovations under the proposed AF.

33. **At the district level, district authorities are responsible for providing oversight, ensuring effective coordination, and promoting multisectoral collaboration.** In accordance with the financing agreement between districts, the NCDA and RBC, funds to support district activities under the SPRP are transferred to the districts' designated bank accounts opened in the National Bank of Rwanda specifically for the SPRP operations. Funds disbursed are then used to support all relevant activities. This will continue to be the case, but improved support/oversight on the use of the grants for district multisectoral activities will further develop district capacities and strengthen the implementation of the DPEM.

34. **The PSC was constituted in December 2018 to provide strategic guidance and oversight to the Project and advice on corrective measures regarding outstanding technical and administrative**

issues, review progress on PDOs, and review achievements and success. Chaired by the MoH and co-chaired by the NCDA, the Steering Committee is made up of the Social Cluster Ministries[15] and their affiliated implementing agencies, including the Ministry of Gender and Family Promotion, Ministry of Agriculture, Ministry of Local Government, Ministry of Infrastructure, Ministry of Education, Ministry of Finance and Economic Planning, the RBC, the NCDA, Rwanda Agriculture Board, Local Administrative Entities Development Agency, and the districts of Gakenke, Nyabihu, Ngororero, Rubavu, Rutsiro, Karongi, Rusizi, Nyaruguru, Nyamagabe, Huye, Ruhango, Bugesera and Kayonza.

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

The project will contribute to the reduction in stunting rate among children under five years of age (with a focus on those under two) in targeted districts of Rwanda. The proposed districts are as follows: Nyabihu, Ngororero, Karongi, Rubavu, Rutsiro, Rusizi, Nyamagabe, Huye, Nyaruguru, Ruhango, Gakenke, Kayonza and Bugesera. While the project would promote a national approach, targeted districts would benefit from more intensive support to make optimal use of limited resources. District plans to combat malnutrition would serve as the basis for financing a package of interventions. Health facilities in the targeted districts will be supported to improve access to an enhanced package of high-impact nutrition and health interventions by addressing supply side bottlenecks and strengthening key delivery platforms. No civil works are planned. The support to improve service delivery is anticipated to increase the utilization of health services and facilities, which is likely to generate incremental health care waste, such as sharps or infectious waste. But improvements in access and utilization of health care services, could increase the generation of medical waste in participating health facilities which may adversely affect the environment and local populations if not managed appropriately. To this end, a Medical Waste Management Plan (MWMP) has been prepared and cleared by the Bank and publicly disclosed in-country as well as through the InfoShop on December 1, 2017. The EA category for this project is Category B, owing to the location specific and manageable nature of the potential environmental impacts. The project is not expected to have long term significant negative social impacts.

G. Environmental and Social Safeguards Specialists on the Team

George Bob Nkulanga, Social Specialist
Yacob Wondimkun Endaylalu, Environmental Specialist

[15] Rwanda's Social Cluster ministries include the Ministry of Health, Ministry of Gender and Family Promotion, Ministry of Local Government, Ministry of Agriculture and Animal Resources, and Ministry of Education.

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	
Involuntary Resettlement OP/BP 4.12	No	
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/BP 7.60	No	

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
The project is expected to increase utilization of health services which is likely to generate incremental health care waste. No large scale, significant and/or irreversible impacts are anticipated.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
No potential indirect and/or long term impacts due to anticipated future activities are expected.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
Not relevant

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 implementation and coordination arrangements for the project will be largely anchored on existing platforms and seek to strengthen relevant capacities and systems for project implementation. The Rwanda Biomedical Center (RBC), an executive agency under the MoH will be responsible for overall project management. RBC/SPIU has experience in implementation of World Bank funded projects. The SPIU under RBC will handle among other functions providing oversight of safeguard implementation. At district-level Implementation/ local government level, district authorities

will be responsible for providing oversight, ensuring effective coordination, and promoting collaboration among key stakeholders. The different administrative levels of the district namely, sectors, cells and villages, will play their respective roles to ensure coordination and fulfill their basic service delivery mandates for prevention and reduction of stunting.

The borrower has prepared a Medical Waste Management Plan (MWMP) that provides guidance on how the project will handle medical waste. The MWMP overall objective is to prevent and/or mitigate the negative effects of increased generation of medical waste on human health and the environment. The plan proposes measures to prevent the spread of infection and reduce the exposure of health workers, patients and the public to the risks from medical waste. The MWMP is intended to be adopted by all project implementation entities to manage medical waste associated with project activities. These entities will have appropriate procedures and capacities in place to manage the medical waste.

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

The consultation with all stakeholders begun during the scoping phase, and continued throughout the entire project preparation cycles. RBC team organized public and stakeholder consultations in September/October 2017 to collect views and concerns with respect to the project design and discuss proposals to remedy potential adverse impacts. Participants were briefed on the scope and content of the project, and local authorities, CHWs, and opinion leaders in the targeted districts were given the opportunity to share their insights. The project offers numerous opportunities for citizen engagement, such as: (i) community sensitization/mobilization and awareness campaigns; (ii) community outreach activities; (iii) community dialogues; (iv) district study tours; (v) radio programs; and (vi) ECD centers. To further enhance citizen participation, the RBC/MoH team proposes to use platforms available at decentralized level to enable effective citizen participation. These include community meetings during umuganda, and other open days organized at district level to facilitate access to information. Beneficiary feedback on services and activities will be annually collected through an independent survey of beneficiaries using score cards. The Results Framework includes specific citizen engagement indicators to be monitored and tracked during implementation.

Other relevant stakeholders at the national level (MINECOFIN, NECDP, MIGEPROF and WASAC, MINAGRI) were also consulted. Thus, a Project Steering Committee (PSC) will be established to provide strategic guidance on technical and operational issues. The PSC will review progress and take stock of lessons learned. With the chairpersonship of the Permanent Secretary of the MoH, the PSC will be comprised of permanent secretaries or other senior level officials from the Social Cluster Ministries, MINECOFIN, NECDP, MIGEPROF and WASAC, MINAGRI, and representatives of the target districts.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

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

"In country" Disclosure

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

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