Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 15-Mar-2022 | Report No: PIDA33212

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Marshall Islands	P177329	RMI Multisectoral Early Childhood Development Project - II	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	15-Mar-2022	10-May-2022	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	The Republic of the Marshall Islands	Ministry of Culture and Internal Affairs, Ministry of Education, Sports and Training, Ministry of Health and Human Services, Office of the Chief Secretary	

Proposed Development Objective(s)

To improve coverage of multisectoral early childhood development services in the Republic of the Marshall Islands and in case of an Eligible Crisis or Emergency, respond promptly and effectively to it.

Components

Improve coverage of essential RMNCH-N services
Improve coverage of stimulation and early learning activities
Social assistance for early years' families
Strengthening the multisectoral ECD system and Project management
Contingent Emergency Response

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	28.00
Total Financing	28.00
of which IBRD/IDA	28.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	28.00
IDA Grant	28.00

Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

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 five 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 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, with the remainder of the population inhabiting rural neighboring islands (NIs)[1]. The RMI was consolidated into the Trust Territory of the Pacific Islands governed by the United States (US) during the Second World War 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 make it impossible to achieve economies of scale, increasing the costs of trade and constraining competitiveness of exports of goods and services in world markets. These factors similarly raise the cost and complexity of providing public services. In addition, the RMI is extremely vulnerable to the climate change impacts of natural disasters, including rising sea levels, droughts, tropical storms and typhoons. The impacts of natural hazards in the country are exacerbated by extremely high population density, especially on the two urban islands of the archipelago (Ebeye and Majuro), high levels of poverty, low elevations (average elevation of most islands is approximately two meters above sea level, with the highest recorded point on the atoll at 10 meters above sea level), and the majority of the population living along the coastline.

3. **Average economic growth has been low by global standards and subject to high volatility and poverty remains a challenge**. Over the past 15 years, real Gross Domestic Product (GDP) has grown by a modest 1.5 percent on average. As a small, remote economy with dispersed population, RMI faces significant challenges to sustainable economic growth. The Gini index, which measures inequality, is estimated at 35.5 for RMI in 2019-

[1] The NIs are jurisdictions within the recipient's territory.

20 based on per capita consumption and is comparable to other East Asia & Pacific countries.

4. **The poverty headcount in RMI is estimated at 7.2 percent** of the total population based on the 2019-2020 Household Income and Expenditure Survey (HIES) (using a basic needs poverty definition), or 3,900 individuals living in poverty. About 70 percent of poor households live in rural areas with the remaining 30 percent spread evenly between Majuro and Ebeye. The poverty rate is consequently lowest in Majuro (2.3 percent of individuals) and highest in rural areas (21.2 percent of individuals). Poverty rates are highest for households with no labor market attachment or where the head of households runs their own business (14.5 and 22.8 percent, respectively). On the other hand, households with salaried employees are much less likely to be poor (2.8 percent poverty rate).

5. **Female-headed households and those with low levels of educational attainment are more likely to be poor**. The poverty rate for female-headed households is 8.7 percent compared to 6.6 percent for male-headed households. This gender difference is particularly pronounced in rural areas where 30 percent of female-headed households are poor. Poor Marshallese households also have lower levels of educational attainment than non-poor households, pointing to high returns to education in RMI. About 8 percent of households where the head has only completed primary education are poor compared to 1.4 percent of households headed by a person with a at least some level of post-secondary education. Moreover, most of RMI's poor are children and adolescents. However, this is driven by RMI's population being very young rather than young Marshallese suffering from higher rates of poverty. Marshallese have open access to travel, schooling, and employment the US, an important growth opportunity for RMI in terms of employment, skills acquisition, and remittance income. However, the RMI's domestic labor pool is currently unable to provide enough workers with the appropriate skills, experience, and personal traits and attitudes required by the private sector. Marshallese living in the US have lower household income relative to other migrant groups, primarily reflecting their lower skills base.

6. **The RMI is one of three sovereign Pacific Island nations in a bilateral "Compact of Free Association" (CFA) agreement with the US.** Effective in 2004, the second CFA provided approximately US$37 million per year in support to the RMI through Compact Sector Grants (CSGs). The health and education sectors receive significant shares of the US CSG support administered through the Department of Interior. Annual CSGs and access to US Federal Government grants and programs are scheduled to expire in 2023 under the current CFA agreement, with the CSGs to be replaced by annual distributions from the Compact Trust Fund. The ongoing negotiations process indicates that US support to the health and education sectors may remain broadly constant over the medium term, although the details of the scope, size and duration of any future agreement remain uncertain. However, US support is unlikely to continue indefinitely. Consequently, measures to increase economic growth and incomes, enhance fiscal sustainability and improve the efficiency and equity of public service delivery remain central to the RMI's long-term development prospects and economic stability.

7. **The Government of RMI (GRMI) took swift, bold preventive measures against COVID-19.** International borders have been closed since February 2020 and seven imported cases have been identified in quarantine. During this time, the country has prepared its quarantine, isolation and treatment wards and mobilized medical equipment, personal protective equipment, supplies, and surge health providers for the response.[2] The RMI rolled out COVID-19 vaccination efforts in December 2020 using donated vaccines through the US Operation Warp Speed. As of January 25, 2022, a total of 22,426 Marshallese adults (18+) were fully vaccinated, or over 88

[2] The consequence has been significant disruption in the international travel for both Marshallese citizens (with high dependence on open travel to/from the US) and international travelers/consultants, with many being stranded abroad. A national repatriation process, coordinated by the National Disaster Committee, was initiated in early 2021; a limited number of seats have been allocated to foreign nationals since mid-2021.

percent of the adult population. RMI has introduced vaccines for children, as well. Twenty-two percent of adolescents (12-17) and 1 percent of children (5-11) are fully vaccinated, bringing the total to 57 percent of the population 5+. Vaccination completeness ranges from 94 percent of adults on Majuro to 88 percent in Kwajalein atoll; the country has intensified its vaccine deployment in NIs, increasing full vaccination coverage from 18 percent of adults in August 2021 to 60 percent five months later. The RMI is receiving additional technical and financial assistance for COVID-19 response and vaccine rollout through several US federal agencies, while the World Bank, Asian Development Bank (ADB), United Nations Children's Fund (UNICEF), and the World Health Organization (WHO) have offered financial, technical, and/or in-kind support to overall COVID-19 prevention and response efforts. Schools in RMI have remained open throughout the pandemic.

Sectoral and Institutional Context

8. **The RMI requires continued investments in human capital to enhance the quality of the labor market, reduce poverty and improve competitiveness, adaptiveness, resilience of the population**. According to the Human Capital Index (HCI), a child born in RMI today will be 42 percent as productive when she grows up as she could be if she enjoyed complete education and full health (Figure 1). Overall HCI performance is lower than the average for East Asia and Pacific region and upper middle-income countries. RMI is in the lowest quartile of countries in terms of its HCI score, as well as all constituent measures (except for survival to age five). Increasing the efficiency and quality of education and health service delivery will be essential, as education and health services are crucial public-sector enablers to build human capital and increase the quality of the domestic labor pool.

9. **RMI faces distinct challenges in maximizing the early-life foundations of human capital.** Early childhood sets the foundation for lifelong health and wellbeing, and the cognitive and non-cognitive skills built in this period follow children for their lifetimes. Maternal mortality rate (92 deaths per 100,000 live births) and infant mortality rate (28 deaths per 1,000 live births) are high relative to the RMI's income level and other Pacific Island comparator countries. While child stunting (low height-for-age, an indicator of chronic undernutrition) affects 35 percent of children under age five, signs of early life undernutrition are evident even earlier. Of most recently born children aged 0-59 months, 12 percent were estimated to have low birthweight (<2,500 g). Data available from the 2017 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 in 3 of these 4 domains[4], ranging from 86 percent of children

[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. Another caveat is the 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 NI 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.

[4] UNICEF. 2017. Republic of the Marshall Islands Integrated Child Health and Nutrition Survey: 2017. The ICHNS defines developmentally on track for the following four domains as follows: (1) *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

aged 48-59 months compared to 71 percent of children aged 36-47 months. Overall, children in the wealthiest families show better health, education and nutrition outcomes compared with children in the poorest families.

10. **Since 2019, the GRMI has also been implementing the Multisectoral Early Childhood Development Project (ECD-I)[5], financed by the World Bank (details in section C).** ECD-I was initiated at the request from the RMI's former President to finance priority interventions of their ECD program, taking bold action in support of the country's young children and their families. The ECD-I project became effective on May 30, 2019 and the development objective is to improve coverage of multisectoral early childhood development services. The five-year, US$13 million project supports the GRMI in implementing a package of activities in health, education, and social assistance, while strengthening the governance, monitoring, and communications related to the multisectoral approach to ECD. The ECD-I project has contributed to some recent improvements in the ECD context in the health, education and social protection sectors.

Health Sector

11. **Improving early childhood outcomes requires actions along the lifespan and access to improve reproductive, maternal, newborn, child health and nutrition (RMNCH-N) outcomes and services.** The RMI has undergone a rapid epidemiological transition with noncommunicable diseases (NCDs) presently the leading cause of morbidity and mortality alongside the unfinished burden of maternal, neonatal, and communicable diseases. Diabetes, cardiovascular disease and cancer were top three causes of mortality in RMI in 20176 with obesity a main risk factor for premature mortality and morbidity. In 2017, 74 percent of deaths for adults aged 15 to 49 years were attributed to NCDs--70 percent for males and 79 percent for females. Unhealthy diet is a main contributor to obesity, which is significantly higher among women (78 percent) compared to men (66 percent).[7] Addressing these areas further demands attention to remedying gender gaps that serve to limit women's full acquisition of endowments in health.

12. **Coverage of facility-based reproductive, maternal, newborn, and child health and nutrition (RMNCH-N) services is relatively high in Ebeye and Majuro, but challenges remain in ensuring service readiness and availability, particularly outside Majuro.** Timely receipt of the first antenatal care (ANC) visit is of paramount importance as it allows for the opportunity to screen for and manage pregnancy-related NCD risks, as well as provide guidance on modifiable lifestyle factors (diet, smoking, physical activity) to improve pregnancy outcomes. However, early ANC remains an issue in RMI, with only 34 percent of women receiving their first ANC visit in the first trimester. Delivery with a skilled birth attendant can reduce the risk of maternal mortality by 20 percent, yet disparities in access persist for rural women and for the poorest, with only 66 percent of rural women delivering with a skilled provider. Moreover, there is irregular delivery of well-child clinic visits beyond the second week of life, and programs such as vitamin A supplementation (54 percent) and child deworming (32 percent) have lower coverage. Public health programs promoting healthy diet and physical activity are donor driven and

least four simple, popular words, Knows the name and recognizes the symbol of all numbers from 1 to 10. (2) *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. (3) *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. (4) *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.

[5] World Bank. 2019. Marshall Islands - Multisectoral Early Childhood Development Project. Washington, D.C. : World Bank Group. https://imagebank2.worldbank.org/search/30824838

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

[7] MOH, MIEPI, PIHOA. 2018. Marshall Islands NCD Hybrid Survey, Preliminary Results.

sporadic. Access to adolescent friendly reproductive health education and services is limited.

13. **Violence against women, girls, and children remains a threat to human capital formation.** Corporal punishment is widespread throughout RMI. According to the ICHNS, 64 percent of children in RMI aged 1-4 had experienced some form of psychological or physical punishment by household members in the past month. Entrenched gender inequality and attitudes about women in the household drive high rates of intimate partner and family violence throughout RMI, though there is limited national prevalence data on gender-based violence (GBV). The Family Health and Safety Survey (FHSS) shows: (i) that rates of intimate partner violence and non-intimate partner violence toward women are high; and (ii) attitudes held by men, and women, support and excuse GBV. Most (91 percent) female respondents never sought help after an experience of violence, and half never told anyone. Reporting is largely through informal channels and only 1 percent told police, a doctor, or a health worker. The Child Protection Baseline Study found, for example, that of the children that had been physically abused in the previous month, 46 per cent did not report the abuse.

Health System Issues

14. **Although health system performance has improved, considerable investment and reform is needed for the RMI to realize the *Healthy Islands* vision and consistently deliver high quality, effective primary health care including RMNCAH-N services.**[8] Health services are delivered in two hospitals (one each in Majuro and Ebeye) and fifty-six public health centers (primarily health dispensaries, located on the NIs). Both hospitals provide primary and secondary care; tertiary care is provided through overseas medical referrals (primarily to Honolulu or the Philippines). The MOHHS offers MCH Clinics within Majuro and Ebeye hospitals to see infants at two weeks postpartum and according to the routine immunization schedule. In both facilities and communities, resources are limited to support caregivers to improve health, nutrition, and parenting behaviors. Human resource challenges include: (i) suboptimal availability, mix, and distribution of health providers, particularly the absence of skilled, culturally competent providers for MCH services in NIs; (ii) limited communication across public health programs and clinical service providers; and (iii) insufficient staff training, supervision, and performance management. Unreliable availability of essential commodities and equipment (e.g., vaccine cold chain, micronutrient supplements, communication materials) pose barriers to improving coverage of priority primary health care services.

15. **There are significant equity gaps in the availability and utilization of basic essential primary health care (and particularly RMNCH-N services) on the NIs.**[9] Dispensaries function as rural health posts and the site for preventive, promotive, and essential health services on the NI. They are staffed by full-time Health Assistants (high school graduates, majority male, who are trained to provide basic services). These dispensaries often have only sporadic access to running water, electricity, and/or radio communication with Majuro and inadequate equipment, supply, and pharmaceutical stocks. There are limitations in the professional competencies of Health Assistants along with cultural challenges related to the acceptability of male health assistants providing RMNCHN services. For this reason, many women on the NIs often: (a) don't seek preventive/promotive reproductive and maternal health services; (b) see traditional providers; or (c) travel to Ebeye/Majuro for only the most essential RMNCH-N services (i.e., delivery). Mobile health missions from Majuro or Ebeye to the NI provide sporadic opportunities to deliver immunization and reproductive health services. However, these are limited in frequency, quantity, and quality of services due to insufficient financing for operational cost, transport, equipment, and availability of adequately trained staff.

[8] 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

[9] US CDC, ADB Regional TA on Cold Chain, UNICEF

16. **The RMI has established foundations for GESI in the health sector.** In late 2021, MOHSS launched standard operating procedures for clinical management of rape, sexual violence and gender-based violence with support from UNFPA. Disability Policy and Action Plan 2014-2018 has the purpose of providing a "comprehensive framework for improving the quality of life of persons with disabilities and to increase their meaningful participation in society" (Republic of the Marshall Islands, 2014). Within the context of this policy, the Disability Coordination Office provides technical assistance to the Marshall Islands Disabled Persons Organization and coordinates government response. Additionally, the MOHHS supports care for children with special health care needs through collaboration with the Early Hearing Detection and Intervention Program, coordination with Shriners Hospital for overseas care, and the MOEST. Federal funds from the US support overseas specialist care for identified children. Despite these resources, not a single referral was made for delayed milestones for children 0-5 related to autism spectrum disorder, attention deficient and hyperactive disorder, or intellectual disability, highlighting weak screening and referral pathways.

17. **Similar to many Pacific Islands, overall spending on health is high and highly donor dependent, with the health system delivering outcomes and access to services are low relative to RMI's level of income and public spending on health.** 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 expenditure, 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 programs (e.g., immunization, maternal and child health, family planning, public health preparedness) and the organization of the health system. The resulting inefficiencies are quite predictable: limited coherence, alignment, and responsiveness of health spending to strategic and emerging priorities; duplication of activities and overlap across health programs; and fragmentation in planning, budgeting, and resource management.

Education Sector

18. **Early Learning and Education Enrollment.** 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.

19. **The RMI is piloting the introduction of public preschool and opened three public preschool classrooms in November 2021**. With less than 5 percent of children aged 36-59 months attending an organized early childhood education program (ICHNS 2017), there is considerable need for providing access to early childhood education (ECE). Gross enrollments in elementary school had been static for several years at around 83 percent but falling the last two years to around 78 percent, and they drop off in secondary school to 56 percent[12]. Enrollment rates have increased in urban areas and decreased in the NIs, likely the result of migration. Low school enrollments, high dropout rates, and low educational outcomes are of great concern to the Public School System (PSS) of the MOEST, and test scores from the national RMI Standards Assessment Test series highlight poor

[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 2020-2021, MOEST/PSS

outcomes for those in school. With proficiency scores on the 8th grade MISAT averaging around 44 percent through 2019, the most recent results show a significant drop to 26 percent proficiency in 2020 and 2021[13].

20. **Parenting Practices and Early Stimulation.** Parent/caregiver-child interaction and the household environment in the RMI do not compensate adequately for the lack of formal or community-based ECD services. Nationwide, 72 percent of children aged 36-59 months were engaged by adults in four or more activities in the previous three days[14]; 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). Paternal involvement in caregiving is also very low: only 2 percent of fathers engaged with their children in caregiving activities over the last three days and few men participate in existing parenting home visit services. Less than one-fifth (18 percent) of children aged 0-59 months live in families with three or more children's books, with large variations by income. The addition of Marshallese reading materials under ECD-I (500 copies of 4 board books) and with support from the Read@Home initiative (2,000 copies of seven age-appropriate titles) is catalyzing the Government's plan to make at least 25 different books available for ECE by 2025.

Education System Issues

21. **Government expenditure on education was 9.6 percent of GDP in 2019.** At around 16.7 percent of total spending, RMI's education system has ample resources relative to regional peers and global averages. Yet, increased inputs are not translating into improved learning outcomes. This indicates that more attention is needed to improve how services are being delivered. Education was the second largest expenditure item in 2019: US$24 million allocated to this sector, with salaries comprising a large share of the resources. CSGs represent the main source of financing (more than three quarters of all funds) and are expected to remain stable over the medium-term. It is estimated that roughly one tenth of the budget is allocated to pre-primary/kindergarten education, while the coverage and availability of such services is extremely limited. Primary education receives 62 percent while secondary receives 28 percent according to the most recent RMI Education Management Information System (MIEMIS) data.

22. **Challenges in the duration and quality of Marshallese education contribute to gaps in the skills and participation of the Marshallese labor force.** The female labor force participation rate (LFPR) is low at 52 percent[15] and the share of Marshallese women in paid employment (26 percent) is just over half the rate of Marshallese men (48 percent). Central to the low levels of female LFPR and women's economic activity are women's unpaid domestic work and caregiving responsibilities. For young women, the early onset of motherhood and other care responsibilities can influence their aspirations for education and employment. The

[13] The MISAT was conducted at the beginning of the academic year- with such a change likely leading to less proficiency given students have not had full year of content. There is also some concern about alignment of MISAT with curriculum.

[14] 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.

[15] Which is low compared to RMI male LFPR (66.8%), the global female LFPR average of 55%, and the female LFPR in Pacific countries including Papua New Guinea (60.5%), Solomon Islands (60.4%), Vanuatu (61.4%) and Palau (58.2%) (Pacific Community August 2017).

College of the Marshall Islands identified the lack of appropriate childcare as an obstacle to women completing their studies[16].

23. **Small schools (with fewer than eight teachers) account for just over 50 percent of all schools in RMI with the majority located in the NI**. These schools in the NIs are often under-resourced, especially around staffing. Inequities include significantly lower qualified teachers in rural schools (only 38 percent holding requisite degree/certification), limited to no access to internet, and infrastructure deficits (water/sanitation, furniture, etc.). The smaller population density and island remoteness make it difficult to allocate/attract teachers. However, in many locations there is an opportunity to expand to include pre-school on primary school premises and rely on multi-grade teachers.

Social protection sector

24. **The RMI has very limited coverage of formal social protection programs, even when compared to other Pacific countries.** Over the past decades, the RMI has introduced a defined benefit pension scheme for formal sector workers, and school feeding programs. Beyond these two schemes, there are no formal social assistance programs to support vulnerable groups (the poor, informal sector elderly, disabled etc.). The prevalence of 'hardship' in RMI is amongst the highest for PICs[17]. 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.

25. **The most significant expenditure on social protection is on the school feeding program, followed by a compact subsidy for the formal sector pension scheme.** In the 2021 budget, the budget for the school feeding program totals US$3.3 million across all islands. The second largest expenditure is a US$1.6 million subsidy for the formal sector pension scheme through the Compact. Other notable social protection expenditures are on the Four Atoll Feeding program (US$574 thousand, funded through the Compact) and on the Kwajalein scholarship program (US$0.2 million, through a US federal grant).

26. **Informally, the subsidy for the Marshallese copra industry has served as a social protection mechanism to residents on NIs.** Despite limited profitability, copra remains to be the primary source of cash income in the NIs, with a secondary objective of aiming to slow the pace of urban migration from remote areas. The copra industry is sustained by large GRMI subsidies to the state-owned Tobolar Copra Processing Authority. The atolls are widely planted with coconut trees, yet copra accounts for only about 1 percent of GDP. From FY04 to FY14, the subsidy averaged US$1.1 million (1.4 percent of recurrent expenditure). The subsidy ballooned in recent years, and nearly tripled in size between FY04 and FY19, reaching US$8.2 million (5.7 percent of recurrent expenditure)[18].

27. **There is a widespread agreement within the GRMI 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

[16] Republic of the Marshall Islands. 2018. Gender Equality: Where do we stand? Republic of the Marshall Islands. Majuro: Ministry of Culture and Internal Affairs.
[17] 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
[18] World Bank. 2021. Republic of the Marshall Islands Country Economic Memorandum and Public Expenditure Review Maximizing opportunities, enhancing sustainability. World Bank: Washington, DC.

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 GRMI has requested the World Bank's support to establish a social protection program, and the recently completed country economic memorandum/public expenditure review (CEM/PER) highlights the opportunity of copra subsidy reform as a means to efficiently finance targeted interventions, such as this program. This is all the more important as the MOCIA, with responsibility for social protection issues, 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, child protection, gender equity, historic preservation, election and voters' registration and ID cards, among others.

28. **The ECD-I has supported GRMI to lay the foundations of a social assistance delivery system.** As part of ECD-I, GRMI has developed a Cash Transfer Operational Manual (CTOM) for a conditional cash transfer (CCT) program targeting vulnerable early years families to promote investments in early life human capital. The CTOM includes program rules, processes and implementation procedures in relation to targeting, communications and beneficiary outreach, community mobilization, enrolment, payments, conditionalities, compliance verification, exit, grievances redressal mechanism, and monitoring and evaluation. The CTOM is accompanied by a functional social protection management information system (MIS) comprising a registration and enrolment module, a registry module for program beneficiary households, an eligibility verification and compliance monitoring module, a payment module – including interoperability with the project's payment service provider, the Bank of Marshall Islands (BOMI) with bank account verification, payroll authorization and push, and payment reconciliation functions – and a monitoring and evaluation module.

29. **The ECD-I has further supported the finalization of targeting of beneficiary households, the establishment of a set of ECD related conditionalities, and the identification of an adequate benefit level.** In ECD-I, eligible families have been determined to be those in Majuro and Ebeye with at least one pregnant woman and / or children between ages 0 and 59 months that are poor and vulnerable (including to climate-related disasters), as identified through a targeting exercise based on Proxy Means Testing[19] and a community verification process. The conditionalities – that have been developed jointly by MOCIA, MOHHS and PSS – comprise a combination of health and education related activities and behaviors, starting from pregnancy and continued through 60 months of age. Finally, GRMI has determined a bimonthly benefit level at US$60 per beneficiary household plus US$10 per children[20], to be provided for beneficiary households up to three children.

C. Proposed Development Objective(s) (PDO)

30. **The proposed PDO** is to improve coverage of multisectoral early childhood development services in the Republic of the Marshall Islands and in case of an Eligible Crisis or Emergency, respond promptly and effectively to it.

[19] A Proxy Means Test (PMT) is a method to identify poor households for the targeting of social protection programs. A PMT is based on an econometric model that identifies observable household-level variables (e.g. household size, asset ownership) that are strong predictors of household consumption using a representative household survey. This statistical relationship is then extrapolated ot the population at large to predict a household's level of consumption and, consequently, their eligibility for social protection programs aimed at the poor. A potential PMT formula aiming to identify the 1000 poorest household in RMI was developed using data from the 2019-2020 HIES survey. It evaluates a household's social protection eligibility based on 22 observable household characteristics.

[20] Simulations conducted using the 2019-2020 HIES indicate that this benefit amount would yield an adequacy of about 9 percent of post-transfer consumption for the bottom 1000 households identified using the PMT.

Key Results

31. **The achievement of the PDO will be measured through the following PDO-level results indicators.** Where appropriate, sub-indicators will be generated by gender:

(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[21];
(c) Number of families with children aged 0-5 years receiving home visits from parent educators;
(d) Share of children aged 3 and 4 years old enrolled in public pre-school;
(e) Number of vulnerable early years families receiving social assistance benefits.

D. Project Description

32. **The RMI ECD-II project will maintain the original four components from ECD-I with the addition of the component for a Contingent Emergency Response (CERC).**

Component 1: Improve coverage of essential RMNCH-N services (*US$6.62 million equivalent*)

33. **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. The component will deploy a progressive and stepwise approach to increasing the availability, quality, and utilization of essential RMNCH-N services. The activities will both build on and anchor the primary health care strategic plan (under development in ECD-I). The component will support systems strengthening and integration of Nurturing Care through the health system across four main building blocks: (a) RMNCH-N service package and delivery (including services for GBV treatment and for developmental/disability screening, referral, intervention, as appropriate); (b) human resources; (c) infrastructure, equipment and supplies; and (d) data and information. The component seeks to improve the supply-side governance, facility readiness, delivery model, and quality of the package of services provided, while and alleviating demand- side knowledge and access barriers to the receipt of the package of services and uptake of prioritized health behaviors.

34. **Subcomponent 1.1: Strengthening MOHHS management and stewardship capacity to deliver essential RMNCH-N services *(US$1.52 million)*.** 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 as the foundation of strong primary health care. In addition to standard SRH, ANC, delivery, PNC, immunization, and well-child services, the essential package will include activities to integrate nurturing care, early stimulation, developmental monitoring and disability screening (and referral and treatment, as contextually appropriate), and support for the prevention, identification, treatment, and referral for victims of violence against women and children into health service provision. This subcomponent will finance: (a) the project implementation unit (PIU) consultants in the MOHHS; (b) technical assistance and assessments; (b) development and printing of materials and operational guidance; (c) deployment of training and capacity building to strengthen MOHHS governance, institutional capacity, and public health program management; and (d) small office renovation, office equipment, and supplies. A specific TA may be deployed to identify to possibility of pilot grants to NIs to strengthen the availability, continuity, and quality of health and ECD services provided through dispensaries. The MOHHS will enlist the support of a regional partner, such as the Pacific Island Health Officer's Association or a regional

[21] The guidelines are under development under ECD-I.

academic agency, to provide a comprehensive package of technical assistance under Component 1.1, aiming to increase relevance for Pacific context, minimize fragmentation, and expedite procurement and delivery.

35. **Subcomponent 1.2: Enhancing delivery of essential RMNCH-N services *(US$5.1 million)*.** The objective of this sub-component is to ensure all Marshallese women and children have access to and utilize a package of essential RMNCH-N services. Under this sub-component the Project will finance: (a) incremental operating cost for service delivery; (b) individual contracted service providers to achieve a more optimal number, distribution, skills/skills mix in health facilities; (c) upskilling existing health care professionals and NI health assistants (including through the support for certification programs) and performance management of health care professionals to effectively deliver the RMNCH-N service package; (d) facility and service quality monitoring, including through routine patient feedback; (e) procurement of small equipment (including anthropometric measurement equipment), materials, pharmaceuticals/commodities needed to meet standards of readiness to deliver the basic essential RMNCH-N package[22]; (f) minor works to rehabilitate existing facilities to accommodate the essential service package with the involvement of members of early years families in the local communities (to the extent possible)[23]; (g) digital health system improvement for RMNCH-N, including consultant services improve patient and service utilization records across health facilities, supply chain and stock management, quality monitoring and improvement, and provide remote consultations and provider supervision in NI contexts, and procurement of associated equipment (hardware, software) to implement new systems; and (h) incremental operating cost.

Component 2. Improve coverage of stimulation and early learning activities (*US$6.0 million equivalent*)

36. **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 three ongoing interventions focused on improving the school readiness of children: (a) the delivery of caregiver education home visits to the most vulnerable families with children aged 0 to 5 years; (b) the continued expansion of public pre-school classrooms for 3- and 4-year-old children; and (c) provision of more and better Marshallese language children's books and associated activities for caregiver engagement in early stimulation/literacy.[24]

37. **Sub-component 2.1: Strengthening MOEST management and stewardship of ECD services (*US$1.3 million*)**. The objective of this sub-component is to strengthen the capacity of the MOEST to manage early childhood development programs, including: (a) strengthening the regulatory framework for early childhood development; (b) financing the PIU consultants in MOEST (international advisor and local coordinator); (c)

[22] Vehicles may be included as justified by the assessment of service delivery costs

[23] As part of this intervention, interested work-able members of local early years families would have access to relevant work opportunities that fit their skills profile (likely low to medium skilled jobs at minimum wage). The involvement of workers would not be a requirement; however, it would be supported through communications and outreach activities in project locations, as well as through standardized instruments (operational manual, standard job descriptions, information system support – to be developed as part of Subcomponent 3.1) to be provided for local governments where the projects are being implemented.

[24] This activity augments those as originally envisaged under the ECD – I project. Activities will focus on further strengthening the development and distribution of age-appropriate, Marshallese reading books. The team has leveraged Global Partnership for Education financing to pilot the Read@Home program. With these Bank-executed resources, more books have been printed and delivered. A book supply chain analysis has been completed; printing and distribution (in Majuro, Ebeye, and Enewatak) of seven new book titles is completed. Additional project-financed support would ensure broader reach for literacy and literacy support among caregivers in RMI.

planning for preschool expansion by assessing human resource capacity, venue requirements and options for pre-school programs in some NIs; (d) developing the strategy for gender equality and social inclusion including data collection, development of inclusive education modules for teacher training, and male caregiver modules for the home visits; (e) conducting assessments of existing capacity and developing training plans and strategies for strengthening this capacity; (f) deepening a culture of literacy in RMI through the development of a national literacy strategy that includes Marshallese book development; and (g) plan for introducing continuity of learning approaches as well as options for coaching for teachers.

38. **Sub-component 2.2: Enhancing delivery of stimulation and early learning activities (*US$4.7 million*)**. Activities under this sub-component will focus on carrying out a program of activities designed to strengthen the MOEST's delivery of early childhood development stimulation and learning activities, including:

a. **Preschool expansion**: (a) rehabilitation/renovation and equipping venues for additional public pre-school classrooms and NI pre-school venues, with the involvement of work-able members of early years families in the local communities (to the extent possible)[25]; (b) recruiting, maintaining, and training service delivery providers (e.g. teachers[26], teacher assistants) to deliver preschool including coaching and summer professional development programs; and (c) exploring continuity of learning approaches such as digital materials, edutainment, alternative venues and community playgroups, especially for NI programs[27]. The opening of classrooms and enrollment will be informed by the NI expansion and CCT rollout criteria, as outlined in the project operations manual.
b. **Improving and expanding the number and quality of home visits by parent educators** conducted through the existing caregiver education home visit program and adding male caregiver engagement activities (such as "Daddy and me" classes) from 85 to 700 families[28];
c. **Improving availability and quality of learning materials for early stimulation and learning activities**: more and better local language books, toys, ECE kits, Marshallese stories development, training, NI programs, accessible teaching and learning materials (large print, audiobooks, Braille, multimedia, etc.); and
d. **Extending interventions to children with disabilities:** including training preschool teachers on inclusive practices combined with adaptations for more accessible materials.

Component 3: Social assistance for early years' families (*US$9.6 million equivalent*)

39. **The project will continue its support to the GRMI to introduce a CCT pilot to provide economic support to vulnerable households and improve care practice and utilization of ECD services**. The component is expected to build MOCIA's capacity for delivering core social protection services, with a view to enable the government to design and implement additional social protection interventions. The project will finance two sub-components: (3.1) the development of a social assistance delivery system in MOCIA; and (3.2) the provision of cash transfers

[25] Similar to the intervention supported in Subcomponent 2.1, work-able members of local early years families would have access to relevant work opportunities under projects financed through investments that fit their skills profile (likely low to medium skilled jobs at minimum wage). The involvement of workers would not be a requirement; however, it would be supported through communications and outreach activities in project locations, as well as through standardized instruments – operational manual, standard job descriptions – to be provided for local governments where the projects are being implemented.
[26] Certified teachers are reallocated by GRMI to the public preschools and their salaries are not covered by the project funds. However, they do receive training under the project.
[27] Digital materials will help ensure students can continue accessing information when disasters strike.
[28] While the parenting home visit financed under Component 2 is not a formal CCT conditionality, WUTMI have agreed to target the same households to maximize program benefit.

to early years households. To this end, the component will finance consultancy activities to develop social assistance systems, the delivery of cash transfers to reduce vulnerability and improve the uptake of key nutrition and early childhood development services.

40. **Sub-component 3.1: Strengthening Government of RMI's capacity to establish and deliver social assistance program (*US$2.6 million*).** Continuing on the activities developed under ECD-I, this sub-component will finance technical assistance and preparatory activities to set the building blocks for a social assistance delivery system in RMI, including: (a) the PIU consultants for MOCIA; (b) individual consultants to support CCT implementation (MIS officer, compliance officer, payments officer) and fiduciary oversight; (c) designing beneficiary outreach[29], intake and registration of CCT beneficiaries – both in Majuro and Ebeye (as included in the scope of ECD-I) as well as those residing in neighboring islands (following the project's expansion); (d) adjustment of eligibility criteria and verification processes to align to the specific context of neighboring islands; (e) compliance verification, payment management, graduation / exit, and grievance redress mechanism phases. Activities will include the adaptation of the cash transfer operational manual (developed under ECD-I) to incorporate ECD-II areas of expansion, an implementation plan[30], and the full rollout of the management information system (MIS) developed under ECD-I, with modules covering each phase of the delivery process and interoperability features for effective payment management vis-à-vis the project payment service provider (Bank of Marshall Islands) and compliance verification vis-à-vis implementing partners (MOHHS and PSS). The MIS beneficiary registry will further include the functionality to be used as the backbone of a full-fledged social registry[31] to ensure the enrollment of near-poor households in social assistance programs in case of covariate shocks affecting their livelihoods. To expand to the NIs, activities may further include the establishment of digital[32] and other appropriate payment solutions (mobile wallets, prepaid cards and EFTPOS terminals) given the lack of adequate financial infrastructure outside of Majuro and Ebeye.

41. **Sub-component 3.2: Provision of cash transfers to early years' families in selected areas (*US$7.0 million*).** The second sub-component will provide enhanced cash transfers for up to 3,500 vulnerable families in Majuro, Ebeye and NIs. This component will expand the breadth, depth, and geographical reach of the CCT beyond that envisaged in ECD-I. As established during ECD-I, beneficiaries will include families with pregnant women and / or children aged 0-5 years[33] who have been found eligible based on a needs-based targeting process, and the program may include other families, as well. Co-responsibilities will include an adjusted set of

[29] The design of the beneficiary outreach will include climate change considerations such as registration of vulnerable communities and climate risks of the location.
[30] The implementation plan will include guidance of adjustments to the delivery process during weather events.
[31] Social registries are information systems that support outreach, application, registration, and determination of potential eligibility for one or more social protection programs. In addition to supporting core operational procedures in the social protection delivery system, social registries also have a key social policy role as inclusion systems, by providing a gateway for potential inclusion of intended populations into social programs – including when a rapid scale-up is needed, such as in case of economic shocks or natural disasters.
[32] [32] By establishing digital payment solutions, RMI will strengthen its resilience by ensuring communities can cope with weather disasters as digital payment services will avoid service disruptions during weather events which can affect cash delivery.
[33] Women and children are particularly vulnerable to weather events and climate change. In particular, women in the Marshall Islands (similar to other Pacific countries) generally bear the burden of productive and reproductive activities, all of which are significantly impacted by climate change. As droughts and storms intensify, resources become scarcer, and women often have to travel further in order to collect enough food, water and other resources for their families. In fulfilling these duties, women may not have enough time to engage in income-generating activities or to take on extra roles in their communities. (UNDP, 2019)

conditionalities, including participation in scheduled maternal and child health appointments, regular growth monitoring and awareness sessions, enrolment in preschool, and attendance compliance.

Component 4. Strengthening the multisectoral ECD system and Project management (*US$5.78 million equivalent*)

42. **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, implementation of the system, and conducting routine monitoring, process, and impact evaluations; (c) the preparation of a national social and behavior change communication strategy for ECD and the delivery of public awareness and SBCC campaigns; and (d) project management.

43. **Sub-component 4.1: National Multisectoral ECD Strategy and Governance (*US$1.25 million*).** 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 Office of the Chief Secretary (OCS) and the CC in leading ECD program governance and coordinating implementation across key line ministries, such as Ministry of Finance (MOF), MOEST, MOCIA and MOHHS. The subcomponent will finance TA and operational costs needed to develop the strategy, convene annual ECD summit/implementation reviews, and conduct regular coordination within government and across agencies/partners. It will also finance background assessments (e.g., food fortification, nutrition-sensitive food systems, etc.) and/or TA on specialized topics (such as ECD resource mapping, budget tagging, and expenditure tracking; strengthening civil registration for early childhood through enhanced data systems and processes), as outlined in the project operations manual.

44. **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. Sub-component 4.1 will finance a local MEAL Coordinator in the PIU and international advisors, as requested. The component will support GRMI in the development of an MIS system and data dashboard which can support the cross-sectoral monitoring of ECD financing, service utilization, quality, and coverage, and child development outcomes over time (either through surveillance methods or appending appropriate child health, nutrition, and development modules to population-based surveys, as feasible)[34].

45. **Sub-component 4.2: ECD Awareness and SBCC Campaign *(US$1.25 million).*** This sub-component 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. It is anticipated the SBCC will be comprehensive and multi-sectoral and include elements such as antenatal and early childhood health and nutrition, positive parenting and nurturing care, and others. The sub-component will finance a SBCC and Advocacy Coordinator; the recruitment of a UN agency/international firm to contextually/culturally/linguistically relevant SBCC strategy and associated campaign content intended; the deployment of SBCC content through mass and social media channels; cross-sectoral coordination and advocacy; and monitoring 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. The development and coordination of SBCC

[34] Including ongoing discussions to assess anthropometric status and child development in a subset of the 2019 HIES sample to use as a project baseline.

activities for ECD will be the responsibility of the OCS with support from the ECD PIU and SBCC and Advocacy Coordinator.

46. **Component 5: Contingent Emergency Response Component (CERC)** ***(IDA: US$0)***. Following an eligible crisis or emergency, the Government may request the Bank to re-allocate project funds to support emergency response and reconstruction, following the procedures governed by OP/BP 8.00 (rapid response to crisis and emergencies).

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

47. The project is classified as having moderate environmental and social risks and impacts; similar to ECD-I. Key environmental risks relate to the renovation of existing education and health buildings. Waste management and disposal and pollution impacts, procurement of imported materials for construction (to avoid unsustainable sources of local aggregates), risks to the community and workers during renovations including health and safety from construction related activities and disruptions to building use. All other technical advisory services and the implementation of health services, education services and outreach to communities are unlikely to have any environmental impacts, except for the management of small volumes of medical waste.

48. Key social risks relate to social exclusion of eligible beneficiaries and/or vulnerable or marginalized persons without typical means to access project benefits, increased demand on project workers (health, education or CCT workers) leading to fatigue and reduced care, and increased gender-based violence/SEA/SH risks to project workers, beneficiaries as a result of workplace SEA/SH incidents or intimate partner violence.

49. The purchase and deployment of vessels for outer island service delivery have health and safety risks for operators and passengers. Boat operators and medical personnel will undergo training of Standard Operating Procedures for vessels. Suitable safety equipment, such as life jackets and communications equipment, will be procured under the project.

50. Activities funded by the CERC may have environmental and social impacts; typically these relate to social inclusion, stakeholder engagement, resource use and waste management but will be specific to the emergency event and the response that will be funded under the component.

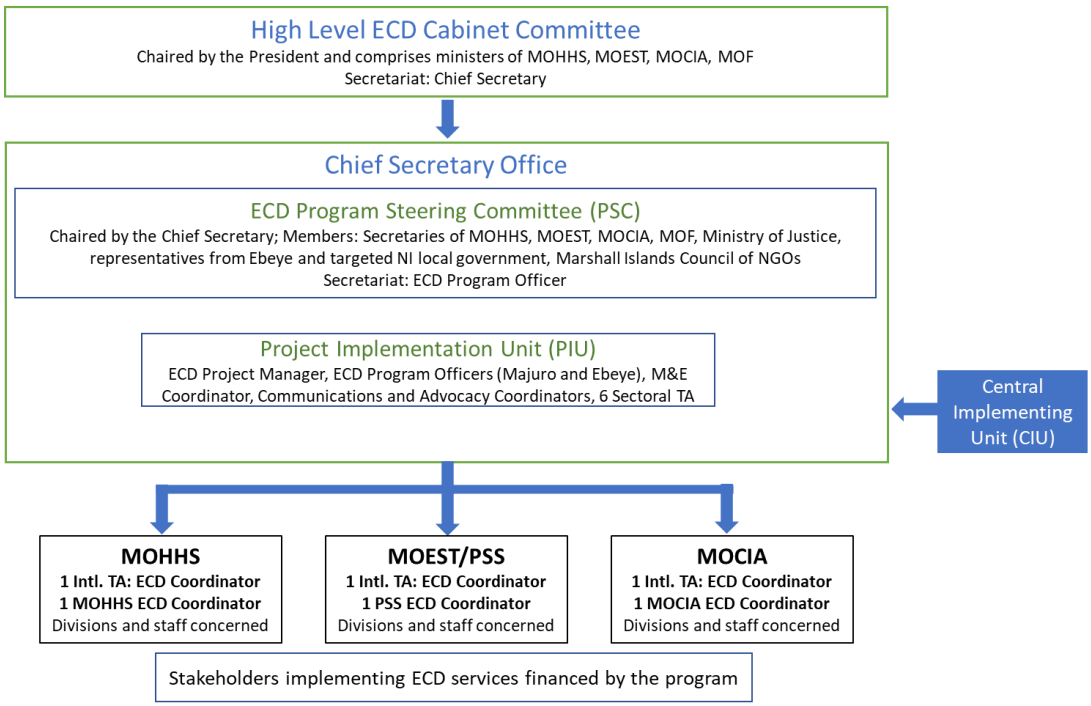
51. Social risks will be primarily avoided or mitigated through project design. For all residual environmental and social risks, an Environmental and Social Management Framework has been prepared (updated from the ECD-I Project and now covers both projects) which includes risk screening processes, ESMP templates and other tools to manage risks and impacts from all Components, including eligible activities under the CERC and technical advisory services. A Labor Management Procedure, draft Stakeholder Engagement Plan and Environmental and Social Commitment Plan have been prepared and disclosed prior to project appraisal.

E. Implementation

Institutional and Implementation Arrangements

52. **The proposed ECD – II will adopt the implementation arrangements already established for the ECD-I project (Figure 1)**. MOF, MOHHS, MOEST and MOCIA and their relevant divisions will be the implementing agencies for the core Project activities as follows: (a) MOHHS for Component 1; (b) the PSS of the MOEST for Component 2; (c) MOCIA for Component 3; and (d) MOF and OCS for components 4 and 5, as well as the disbursement and replenishment of the program's Designated Account (DA). The National Disaster Management Office of the OCS will support implementation of the CERC (Component 5). MOCIA would further support the implementation of minor works activities under Subcomponents 1.2. and 2.2. to facilitate the involvement of local early years community members in the projects, in close collaboration with local government counterparts.

Figure 1. Project Implementation and Governance Arrangements



53. **The PIU established for ECD-I, under the oversight of OCS, will be maintained with responsibility for all core functions of the Project's implementation, management, and the coordination of activities of the implementing agencies, results monitoring, and communicating with the WB on Project implementation.** The PIU includes: (a) an ECD Project Manager, internationally recruited; (b) ECD Program Officers for each Majuro and Ebeye (locally recruited); (c) international advisors for each of MOHHS, PSS, and MOCIA; (d) locally hired ECD coordinators for each of MOHHS, PSS, and MOCIA; (e) a locally hired MEAL coordinator; and (f) a locally hired communications officer. The PIU work in close coordination with a National ECD Advisor recruited by UNICEF. The PIU's functions are directed by the OCS. For each line ministry, the International ECD Advisor will work closely with the respective local ECD Coordinator(s) facilitate engagement of and TA to the line ministry on implementation of the Project's activities capacity building. 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 is an explicit objective in the terms of reference (TORs) of the international advisors. ECD Advisors and Coordinators will jointly report to the relevant line ministry Secretary and the ECD Project Manager/Chief

Secretary.

54. **The CIU, which is housed within the Division of International Development Assistance (DIDA) in MOF will provide support for procurement, financial management (FM), and environmental and social management needs.** The CIU is a centralized fiduciary model, which will provide periodic training, guidance, and support to the PIU project team. The World Bank will monitor and supervise this through implementation support mission which will include reviewing the: (a) effectiveness of internal controls; (b) interim unaudited financial reports; and (c) following up on the status of issues raised in audit reports and supervision mission.

55. **The expansion to NIs will be sequenced and phased, with a subset of NIs targeted for early intervention with batches added as feasible and aligned to local government demand.** Selection of the priority NIs for expansion will be based on a mapping of selection criteria endorsed by the government, including: (a) population density; (b) implementation feasibility and logistics (especially with respect to banking access); and (c) needs of the education and health sectors (as evidenced by at-risk school status and immunization service delivery gaps). The prioritization will be confirmed through endorsement of local government and also consider vulnerability and climate risk, as feasible.

56. **Governance arrangements for the ECD-II project will follow those for ECD-I:** (a) a High Level ECD CC to provide overall strategic leadership and guidance for the RMI's flagship ECD Program and to take high-level policy decision related to ECD; (b) an ECD PSC, comprising of heads of the relevant line ministries and chaired by the Chief Secretary to provide oversight, coordination, and implementation support for the IDA-financed project and other ECD efforts. The ECD Working Group will facilitate coordination across the RMI's ECD program partners and actors.

CONTACT POINT

World Bank

Anne Marie Provo
Nutrition Specialist

Deborah Newitter Mikesell
Senior Education Specialist

Sandor I. Karacsony
Senior Economist

Borrower/Client/Recipient

The Republic of the Marshall Islands

Implementing Agencies

Ministry of Culture and Internal Affairs
Amenta Matthew
Minister
na@gmail.com

Ministry of Education, Sports and Training
Wilbur Heine
Minister
na@gmail.com

Ministry of Health and Human Services
Kalani Kaneko
Minister
na@gmail.com

Office of the Chief Secretary
Antonio Eliu
Secretary General
antonio_eliu@hotmail.com

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Anne Marie Provo Deborah Newitter Mikesell Sandor I. Karacsony

Approved By

Practice Manager/Manager:		
Country Director:	Kara Mouyis	17-Mar-2022