Project Information Document/ Identification/Concept Stage (PID)

Concept Stage | Date Prepared/Updated: 12-Feb-2020 | Report No: PIDC203639

BASIC INFORMATION

A. Basic Project Data

Project ID	Parent Project ID (if any)	Environmental and Social Risk Classification	Project Name
P172393		Low	GPSA MADAGASCAR: STRENGTHENING COMMUNITY AND MUNICIPALITY CO-ENGAGEMENT FOR BETTER BASIC HEALTH SERVICES PROJECT
Region	**Country**	**Date PID Prepared**	**Estimated Date of Approval**
AFRICA	Madagascar	12-Feb-2020	
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	SAHA	SAHA	

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	0.49
Total Financing	0.49
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Trust Funds	0.49
Global Partnership for Social Accountability	0.49

B. Introduction and Context

Country Context

Madagascar is an island nation with a population of 24 million, of which 64 percent is under 25 years of age. The country's track record suggests that Madagascar is capable of strong growth when its assets are

deployed effectively and there is political stability. Between 2003 and 2008, a period of relative political stability, large mining investments, a vibrant export processing zone, and the introduction of important reforms in a number of areas, including investment climate, led to an average growth rate of 6.3 percent. However, periods of growth have repeatedly been interrupted by political crises, the latest and longest episode of which was the 2009-2013 crisis. The Malagasy population has borne the cost of political instability and poor growth: poverty is now among the highest in the world. The average Malagasy is 42 percent poorer today than in 1960, the year of Madagascar's independence. The most recent poverty analyses[1] show that Madagascar made little progress in improving the welfare of the poor between 2001 and 2012**.** The headcount poverty rate declined slightly over this period, but it remains exceedingly high at 70.7 percent in 2012. Inequality rose between 2005 and 2012 but remains modest relative to other African countries. The Gini coefficient increased from 38.9 to 41, compared to the Sub-Saharan Africa average of 43.8. Inequality in Madagascar is not associated with much wealth at the top of the distribution but with a relatively higher inequality among the bottom 90 percent than in other poor countries – that is, different levels of deprivation. A population that is growing at 2.8 percent per year creates additional pressures on the already limited capacity to deliver basic services across the country, on natural resources, and on growth.[2]

Poverty is significantly higher in rural areas, where agriculture is the main source of income. Close to 80 percent of Madagascar's population lives in rural areas, and rural poverty rates are nearly twice as high as in urban areas. Extreme poverty is more pronounced in the southeast of the country, whereas the capital region had a notably lower incidence of extreme poverty. Agriculture is the main sector of employment of the household head for the bottom 80 percent of the country, with only the fourth and fifth consumption quintiles engaged in large numbers in services, manufacturing, and public administration. The incidence of extreme poverty is higher among female-headed households, which make up one-fifth of all households. Their households are more vulnerable as they own less productive assets: on average, they have one year less schooling, they cultivate just over half the acres of land that male heads cultivate, have three to four times fewer large livestock, and almost two times fewer small livestock.[3]

Madagascar's recurrent political crises are the result of deep-rooted governance challenges. First and foremost, the state and political system is determined by networks of a few powerful political and business leaders who form and shift alliances periodically to preserve their access to rents. Their influence is barely checked by a justice sector that is perceived as corrupted and contributes to a generalized feeling of impunity. Second, society is fragmented along ethnic, religious, wealth, and gender fault lines. The strongly centralized state system is not conducive to resolving those tensions. These social divisions are at times exploited by leaders for political purposes. Third, the abundance of natural resources, coupled with weak governance, has contributed to the rapid growth of a trafficking economy around precious woods, gold and stones, cattle, and valuable biodiversity. Finally, the system of checks and balances remains nascent because of: (i) a parliamentary system where political alliances are fragmented, unstable and not grounded in common agendas; (ii) the weakness of civil society, though a few recently formed platforms are becoming important stakeholders in the dialogue on natural resources, budget transparency, and service delivery; and

(iii) the lack of independence of the media, as the major publications, radio and TV stations are affiliated with influential economic groups or owned by political leaders.[4]

Repeated crises have also shed light on the country's strengths at the local level and the astonishing resilience of its people. A vibrant informal economy has provided alternative employment (or rather under-employment) and is an important source of livelihood in urban areas. Traditional solidarity mechanisms play out within families, among neighbors, and farmers. Unfortunately, this solidarity has been put to the test in recent decades and is perceived as weakening. A long-established and respected institutional set-up of "communes" and neighborhoods (*fokontany*) provides some local services (e.g., citizen registration, trash management) and also helps to resolve local disputes (most often related to land ownership). This local structure is the foundation for a more effective decentralization.[5]

Overcoming fragility – a *sine qua non* for reducing poverty in a lasting way – requires consolidating political reconciliation and re-balancing the power between a strong central state and the decentralized structures, while addressing key constraints to pro-poor growth. These are core elements of the State Policy (*Politique Générale de l'Etat*) that has been outlined by President Rajaonarimampianina and further fleshed out by the Government in the 2015-2019 National Development Plan and the 2014 law on decentralization.[6]

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[1] World Bank (2016). "Recent Trends and Analytical Findings on the Causes of Madagascar's Persistent Poverty." It uses household

survey data from EPM 2001, 2005, 2010, and ENSOMD 2012. Also see World Bank (2014). "Face of Poverty in Madagascar:

Poverty, Gender, and Inequality Assessment."

[2] Madagascar - Country partnership framework for the period of FY17 - FY21

[3] Madagascar - Country partnership framework for the period of FY17 - FY21

[4] Madagascar - Country partnership framework for the period of FY17 - FY21

[5] Madagascar - Country partnership framework for the period of FY17 - FY21

[6] Madagascar - Country partnership framework for the period of FY17 - FY21

Sectoral and Institutional Context

The Malagasy health system is failing most of the population, especially the poor. Madagascar's epidemiological profile remains comparable to many low-income countries with a high communicable

disease burden. Almost 30 percent of all deaths in Madagascar are still attributable to preventable and infectious and parasitic diseases, with the burden of disease falling disproportionately on the poor. Over the past decade, non-communicable diseases are increasing in the population, resulting in a dual burden of disease which will tax an already fragile health system. Overall, utilization of services is unevenly distributed across locations and is marked by substantial income/wealth inequality. Coverage of essential health services is low and immunization coverage has also decreased in recent years. Immunization is a proxy indicator of the availability of primary health care in a country, and this has declined from 62 percent in 2008 to 33 percent in 2012 in some of the poorest regions. The country is also seeing a rise in non-communicable diseases (NCDs) in recent years which will put an additional strain on the health system[1]. Life expectancy has been steadily rising and stands at 65.5 years in 2015.[2]

From a financing perspective, Madagascar spends less on health than three quarters of the sub-Saharan African (SSA) countries and the system is inequitable. Since 1995, the percentage of Total Health Expenditure in GDP has been around 4-5 percent with a downward trend in recent years, compared to a SSA average of 6 percent with an upward trend. In fact, between 2009 and 2013, 80 percent of public funding to the health sector was financed through external funds. The health sector is only 20 percent financed by domestic Government resources, such a high amount of external funding poses serious challenges to the sector in terms of financing predictability, efficiency and sustainability. Recent severe cuts to the National Nutrition Office's (ONN) budget with most of the resource envelope going to central salaries is posing real challenges to realizing the multisector coordination mandate of the ONN and to the implementation of the country's National Community Nutrition Program which has been built over a 25 years period and is considered a global good practice in delivering crucial nutrition services to pregnant/lactating women and children under five across all quintiles. The cost of most medical consumables is borne by the patient through cost recovery and thus a share of the population prefers not to seek health services because of their inability to pay. Further, there are major inequities in the distribution of human resources across services and across regions, with the greatest negative impact on the poor who access first-level primary care facilities.[3]

Health expenditure is highly inequitable in Madagascar. Overall, health expenditures are negatively correlated to poverty rates and positively correlated with per capita consumption – even when restricting expenditures to primary health care, regional distribution is regressive. The Benefit Incidence Analysis for Ministry of Health (MOH) non-wage expenditures reveals that benefits are found to be regressive with the average benefits going to individuals in the richest quintile two to four times higher than those going to individuals in the poorest two quintiles. Distribution of benefits from all MOH expenditures directed to primary health and hospital care is pro-rich with the richest quintile benefiting from 40 percent of total expenditures. Similarly, analysis of expenditure shares by type of residence show that less than five percent goes to rural communes. Considering that approximately two-thirds of the population lives in rural areas, this represents a highly unequal distribution of expenditure shares.[4]

Madagascar has the fourth highest chronic malnutrition rate in the world with 47 percent of all children 0-5 years of age stunted. Stunting rates range from 40 to 70 percent, with the highest rates in regions with greater food production (predominantly rice). This underscores that addressing malnutrition means tackling

issues beyond just caloric intake: behavior change to promote appropriate, diverse diets, healthcare, and access to safe water and sanitation as well as improved hygiene practices. Childhood stunting elevates the risk of child morbidity and mortality, with increased potential for intergenerational impact. In addition, stunting is associated with cognitive delays and low educational attainment. For every 10 percent increase in stunting at national level, the proportion of children reaching the final grade of primary school drops by 7.9 percent thus decreasing lifelong income earning potential and labor force productivity. A recent UNICEF analysis[5] suggests that Madagascar's economy loses approximately US$740 million, or 7 percent of GDP, annually due to malnutrition.[6]

Geographic access to health service is also a challenge, as numerous communities are seasonally isolated for months at a time. Even those communities with a health center suffer during the rainy season, since referrals to hospitals are impossible, replenishment of drugs is slower, and supervisory visits are virtually non-existent. Geographic access is of particular importance to maternal mortality and morbidity outcomes, where Madagascar fares poorly. By 2013, approximately 856 primary health care facilities had closed down due to the impacts of the crisis, which has led to an increased workload in the health facilities that continue to function. The number of people served by a health facility has gone down by nearly 47 percent in rural areas. In addition, nearly 78 percent do not have the ability to transport patients to hospitals for further treatment[7].

There is no social safety net system to support basic consumption and human needs as well as productive development of the poorest of the poor. Development Partners and CSOs support a variety of programs, ranging from food assistance and training to cash-for-work programs, often responding to disasters. While these more emergency related interventions are important given the country's high level of extreme poverty, they have failed to develop a systemic approach to address the short and longer terms causes of extreme poverty. In moving toward a more development focused safety net approach, a collaborative effort by government and development partners is needed to identify the poorest according to a set of objective criteria, and combine income support with livelihood and human capital development, thus establishing a basic safety net to enable the poorest of the poor to access basic services and participate in opportunities for enhanced livelihood. Niger, Brazil and others (for the design of Human Capital Safety Nets), in establishing country wide, targeted programs for the extreme poor.[8]

Most recently, the different development partners working in Madagascar developed an intensive cooperation with the Malagasy authorities, which are encouraged to ensure sectoral coordination. With the program to combat chronic malnutrition in children in Madagascar using the new multiphase programmatic approach, the World Bank is working in association with USAID, the World Health Organization, and UNICEF, the GAVI Alliance, the Global Fund, the Power of Nutrition, GIZ, and JICA to round out the interventions designed to improve nutritional indicators. The African Development Bank and the World Bank are working together to assess and improve the Malagasy public procurement system so that it can be used in projects financed by international aid.

Addressing the health and nutrition challenges from the youngest age will require focusing on strengthening the ability of the system to deliver an essential package of quality services, combined with removing demand-side barriers to utilization of services. The essential health package, which will must be delivered through basic health centers and community services, focuses on interventions that have a high impact on maternal and child health and nutrition. Financial barriers to access will have to be addressed by removing out-of-pocket costs for essential medicines and services at facility level, strengthening risk-pooling and safety-net mechanisms.[9]

The project is well-aligned with recent Government efforts to address the consequences and the causes of the above-mentioned challenges. In its 2015-2019 National Development Plan, specifically in its strategic area 4 it reads: *Adequate human capital for the development process* it is stated that a strong nation requires better management and equitable and sustainable development of human capital through access to health and education services, access to potable water, strong social protection mechanisms for vulnerable groups and promotion of cultural values and sports. The National Strategy on the Universal Health Coverage (December 2015) defines the universal health coverage as a situation in which all the population may have high quality health services without financial difficulties for the users due to the cost of these services. This strategy underlines the mutual dependence and complementarity between all the stakeholders for health promotion. The National Policy of Community Health (July 2017) provides guidance of the community approach to health. This policy states the political will of the government to decentralize the basic health management, underlining the importance of the Municipality's accountability. Its main strategic approach is focused on the Community's accountability in every social and health actions of development (inter-ministerial order No.8014/2009 of September 02, 2009).

Budget processes (sharing information, consultation and monitoring efforts) as a potential channel to engage local communities in supporting community health. The government has started some years ago to adopt the "budget citoyen" (Citizen budget) as a transparency tool. This has certainly improved the country's image in terms of budget openness, but the initiative remains centralized at the national level. In addition, the involvement of CSOs in the national budget process exists but remains ineffective in influencing a structural change of the budget, as consultations always come after sectoral budget conferences.

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[1] Madagascar – Systematic country diagnostic FY16

[2] Madagascar - Country partnership framework for the period of FY17 - FY21

[3] Madagascar - Country partnership framework for the period of FY17 - FY21 and Madagascar – Systematic country diagnostic FY16

[4] Madagascar – Systematic country diagnostic FY16

[5] UNICEF (2016), Nutrition Investment Case

[6] Madagascar - Country partnership framework for the period of FY17 - FY21

[7] Madagascar – Systematic country diagnostic FY16

[8] Madagascar – Systematic country diagnostic FY16

[9] Madagascar - Country partnership framework for the period of FY17 - FY21

Relationship to CPF

The project is well-aligned with the FY 2017-2021 Country Partnership Strategy's (CPS) for Madagascar, and specifically to the *Focus Area I: Increase resilience and reduce fragility, objective (4) Enhanced Transparency and accountability*. This area includes mechanisms that are being tested to ensure greater accountability at the local level and could be scaled up. Under a closed IDA-funded project, an innovative approach for districts was developed that integrated revenue mobilization, decentralized land management (as one source of increasing local financing), participatory budgeting, and social accountability tools. This approach, which is known as the Communal Operation of Integrated Support, has been largely adopted by other projects supporting local governments, covering now 30 percent of the 1,695 existing communes.

The project will also seek to coordinate and complement interventions with other projects supported by the World Bank or other Donors. Such coordination will enable the project to use its limited resources efficiently, while increasing the potential to achieve the desired results. Relevant World Bank projects include the *Nutritional Results Improvement Project* (PARN) and the *Performance Based Financing Project* in support of the administration reform led by the Reform Program for Effective Administration (PREA) partly funded by the World Bank.

C. Project Development Objective(s)

Proposed Development Objective(s)

The Project Development Objective (PDO) is to improve the quality and utilization of health care services through collaborative social accountability mechanisms in target basic health centers and across the health delivery chain in Madagascar.

The project's interventions will focus on a twofold objective:

(a) Testing, iterating, adjusting and institutionalizing a joint citizen-health management monitoring mechanism to assess health services performance aimed at increasing service utilization and quality. The mechanism's design will build on lessons learned and on problem-driven applied political economy analysis. Health committees (COSAN) and health users will be mobilized to assess service performance, jointly with key stakeholders, including Municipal Health

Development Committees (CCSDs and Management Committees (COGE) of health centers (CSB), and

(b) Strengthening of the linkage between municipal and health sector planning through the adoption of concerted action plans and a participatory budgeting process at the municipal level, based on universal health coverage policy standards (quality, spatial coverage, increased access to care, diseases prevention). The project will help local actors to identify and target specific issues by municipality through collaborative social accountability mechanisms , with an emphasis on inclusive participation the local population and vulnerable groups, and on reinforcing the link between municipal consultation organs such as SLC (Local Consultation Structures) and CCDS.

Building on identified gaps, revisions to the proposed mechanism will zero in on critical gaps, including (i) the ability of community agents (CAs) to comply with their mandate, (ii) community agents' interface with health centers and relevant municipal decision-making instances, and (iii) links between municipal decision-making and district/regional health sector plans and resource allocation. This would enable municipal decision-makers to better understand health resource allocation and to advocate for more transparency and efficiency from regional and central levels.

Key Results

Key performance results indicators for this project include:

- Service delivery issues and problems identified and followed-up through the project's social accountability mechanisms in target municipalities and at the central government level
- Project-generated recommendations on improvements to public spending in health and at the municipal level taken up by target municipalities and other decision-making instances across the service delivery chain (e.g. Devolved Health Technical Services, central government)

D. Preliminary Description

Activities/Components

The project's "collaborative social accountability" approach combines two dimensions:

- The first one is the *horizontal accountability approach*, implementing both social (informal) and institutional (formal) accountability at the municipality level. This dimension consists in reinforcing the interactions between, on the one hand, the authorities in charge of coordination of basic and community health care services (COGE, CCDS, COSAN), and on the other hand the municipal structures such as the Local Structure for Consultation (SLC) and their colleges constituted by different types of actors, including colleges of citizens and chiefs of fokontany.

- The second one is the *vertical accountability approach* between the Municipalities and the Devolved Technical Services of the health sector, such as the Health District, the Regional Directorate of Health and the Department of Basic Health Care (DSSB) at the Public Health Ministry level.

The initial project design draws from the proposal submitted by SAHA NGO to the GPSA fourth global call for proposals, which was evaluated by an independent roster of experts and selected by the GPSA Steering Committee in July 2019. The GPSA promotes Adaptive development approach across its project portfolio as it seeks to operationalize adaptive principles, with the measure of success often being the extent to which projects have helped implementers solve problems that they have discerned themselves, using collaborative social accountability mechanisms. By carrying out interventions through a collective identification of clear locally relevant problems, collaborative social accountability mechanisms developed under GPSA grants seek relevance, legitimacy and practicality. Adaptive development emphasizes the importance of clearly identifying and understanding the nature of the problem being addressed as well as its political economy factors, and taking small, incremental steps and adjustments towards a long-term goal. The project's design makes the presumption that not every facet of the project can be planned, and no implementing partners can accurately forecast at the beginning what will happen. The Adaptive development approach is reflected in the SAHA project as follows.

The SAHA project's design has been enhanced by taking into consideration the GPSA's theory of change, tailored in this case to the Malagasy health sector context. By engaging multiple stakeholders-under the coordination of SAHA NGO and its partner CSOs - to cooperate in order to better leverage the existing health system (programs, policies, chains and decision-making arenas), the project attempts to contribute to addressing problems of lack of collaborative governance and the capacities needed for this. The project combines (i) flexible funding for civil society-led coalitions to work with government to solve problems that local actors have prioritized with (ii) sustained non-financial support to meaningful engagements, including implementation support, capacity building, facilitation, and brokering. The aim is to contribute to improved health' using collaborative social accountability mechanisms that also tackle obstacles to improving relevant service delivery.

Following the GPSA's adaptive management approach, some activities and their sequencing may be adjusted during the project's inception phase to better respond to beneficiaries' needs and other contextual factors.

Project Components:

***Component 1*: Capacity-building for collaborative social accountability :** this component aims at enhancing horizontal accountability and to generate systematic citizens' feedback on services' quality and to ensure that COSAN, COGE, CCDS and the SLCs become effective interfaces in the coordination and harmonization of health actions in the municipality, and enable them to collaborate and create synergies to achieve the objectives of universal health coverage at the local level.

The main component activities will consist of, inter alia:

1. Carrying out a rapid capacity assessment to map capacity gaps, incentives, interests, opportunities and constraints for effective collective action: as part of the project's inception phase activities -and with support from the independent evaluator that will design the project's monitoring, evaluation

and learning methodology (including the baseline)-, the team will conduct a rapid assessment aimed at understanding stakeholders' capacities and, in turn, preparing a capacity-building plan.

2. Strengthening citizens' and health users' active participation for improving health services at the municipal level. Specifically, activities will include: (i) mobilizing citizens, health users and providers (CSB, CSB drugstores, AC) to evaluate service performance and formulate concerted improvement plans, (ii) strengthening SLCs' (colleges of citizens) as institutionalized and inclusive participation spaces for following-up on concerted improvement plans; and (iii) target activities aimed at including vulnerable groups in SLCs' colleges.
3. Strengthening the linkage between the consultation spaces / consultation bodies at the level of municipalities, i. e. updating, strengthening and formalizing the roles of the different actors and existing structures in their interface role between the population and the health facilities to improve the services and their use by the users. Specifically, activities will include: (ii) strengthening the CCDS (Municipal Committee for Health Development) as a multi-stakeholder body for steering, monitoring and coordinating local community health; and (iii) strengthening the linkage between the CCSD and the SLC for a concerted planning and budgeting at municipal level.
4. Supporting the institutionalization of the COSAN at the municipal level. Specifically, activities will include: (i) providing technical assistance to CA to develop services that meet primary needs in terms of care; and (ii) strengthening the COSAN Fokontany and municipal COSAN in their functions of supporting the care services provided by the Community Agents.

***Component 2*: Implementing collaborative social accountability mechanisms for linking health and territorial planning and service delivery at the municipal level:** This component aims at enhancing vertical accountability mechanisms, i. e. strengthening information exchange mechanisms between local and District levels, so that local governments are better informed about district and regional health sector plans and resource allocation. Furthermore, improved coordination mechanisms at district level through existing monthly regular gathering of all the technical decentralized services representatives and municipalities representatives (mayors) will allow municipalities to pool resources and provides them with a strong mandate to advocate for more transparency on resource allocation from regional, even central level, and for more influence on the use of these funds[1]. Community assessment actions and public debates on a regular basis will involve the representatives of vulnerable groups so that their specific needs are considered in the proposed improvement plans for municipalities or health centers. One way that the project plans to adopt is the integration of the vulnerable in the Colleges of the SLCs.

The project can share and advocate issues at national level by combining efforts with COMARES (our project implementing partner ASOS is a key member of COMARES) and ROHY, a CSO platform which is involved in CSO advocacy in key areas such as the health sector at national level

The main component activities will consist of, inter alia:

1. Strengthening the mechanisms of dialogue between the District and the Municipality (municipal Health facilities through COSAN, COGE, CCDS and the SLCs) so that the Regional Direction and District

Public health sector can better align their respective sector implementation strategies to municipal development plans as well as address issues raised by SLC and CCDs at the level of the municipalities (with ASOS support)
2. Advocacy for greater transparency and increase of the resources allocated to the health sector at the district, regional and national levels (with CCOC support).
3. Supporting at the district level CSBs to prepare their annual plan by considering the SLC proposals and municipality plan/ budget. The CSB annual plan will be shared with the health district to feed into the district annual health plan.

Component 3: **Improving knowledge and learning on collaborative social accountability in the Malagasy health sector and project management:** The objective of this component is to establish an internal adaptive knowledge and learning process to regularly adjust project implementation based on experience and contextual circumstances, and to generate knowledge and learning for targeted external dissemination amongst key stakeholders that may take up lessons from the project to apply, sustain or scale collaborative social accountability and/or inform substantive decisions.

The main component activities will consist of, inter alia:

1. Setting up the project's monitoring, evaluation and learning (MEL) system, including, but not limited to, contracting an independent evaluator (individual or firm) at the onset of the project. The independent evaluator will conduct the project's evaluation (including baseline, midterm and final evaluation), inform quality bi-annual technical reports as well as provide support to the project team to develop capacities to adaptively manage the project.
2. Conducting regular internal project MEL sessions focused on adjusting the project's social accountability strategy and operations, including, but not limited to, the civil society partnership, and "reality check" discussions
3. Developing and implementing a plan for disseminating the project's Knowledge and Learning products to key target audiences, with a focus on the uptake of relevant aspects and elements of the collaborative social accountability process and mechanism (implemented by the project) that may be sustained or scaled up and/or inform substantive decisions.
4. Contributing to the GPSA's mandate to broker and promote knowledge and learning about collaborative social accountability, the local adaptation of the GPSA's theory of change and feeding back lessons that may inform practitioners and the GPSA Global Partnership.
5. Organizing several National-level workshops on social accountability in health care with the public sector to harmonize participatory planning and budgeting tools as well as producing lessons learned to be contributing to the GPSA Knowledge Management virtual platform.
6. Organizing a media and communications plan for target audiences, including policy dialogues and other events aimed at disseminating and building support for the project. The project plans to strengthen the communication and sharing of experiences and lessons learned (documentation of success stories, sharing workshop, distribution of small brochures, etc).

7. Project Management: support to carry out day to day Project implementation and monitoring, all through the provision of consultant services (including audit), Operating Costs, and Training.

[1] as foreseen in the National Decentralization and Deconcentration Policy Paper (2005).

Environmental and Social Standards Relevance

E. Relevant Standards

ESS Standards		Relevance
ESS 1	Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10	Stakeholder Engagement and Information Disclosure	Relevant
ESS 2	Labor and Working Conditions	Relevant
ESS 3	Resource Efficiency and Pollution Prevention and Management	Not Currently Relevant
ESS 4	Community Health and Safety	Not Currently Relevant
ESS 5	Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
ESS 6	Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7	Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
ESS 8	Cultural Heritage	Not Currently Relevant
ESS 9	Financial Intermediaries	Not Currently Relevant

Legal Operational Policies

Safeguard Policies	Triggered	Explanation (Optional)
Projects on International Waterways OP 7.50	No	
Projects in Disputed Areas OP 7.60	No	

Summary of Screening of Environmental and Social Risks and Impacts

From the preliminary assessment of the project, three ESS are considered to be relevant such as ESS1 Assessment and Management f Environmental and Social risk and impact, ESS 2. Labor and working conditions, and ESS10 Stakeholder engagement and Information disclosure. However in line with the World Bank ESF guidelines the environmental and social risk rating for this project has been classified as low. It is

expected that the project activities will have strong positive social impacts both by reinforcing social dynamics and also by contributing to the reinforcement of public participation to a better public services quality. The potential environmental and social impacts and risks on human populations and on environment are likely to be minimal or negligible. Because of the objectives of the project to reinforce community participation, the project need to ensure inclusivity, gender equality. Even though the risk is low, the PMU will ensure to have in place an operational Grievance Mechanism (GM) and will also ensure that the PMU appoints one staff responsbile for broader social development and risk management issues. Prior to final validation of the grant, the Recipient need to prepare and disclose a (i)Draft Environmental and Social Commitment Plan (ESCP), (I) Draft Labor Management Procedures (LMP), (iii) a Draft Stakeholder Engagement Plan (SEP).

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