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Report No: PAD4498

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A
PROPOSED LOAN

IN THE AMOUNT OF US$178.1 MILLION

TO THE

REPUBLIC OF THE PHILIPPINES

FOR THE

PHILIPPINES MULTISECTORAL NUTRITION PROJECT

May 31, 2022

Health, Nutrition and Population Global Practice
East Asia And Pacific Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective December 31, 2021)

Currency Unit =	Philippine Peso (PHP)
PHP 50.5 =	US$1
US$0.02 =	PHP 1

FISCAL YEAR

January 1 - December 31

ABBREVIATIONS AND ACRONYMS

4Ps	Pantawid Pamilyang Pilipino Program
ANC	Antenatal Care
AO	Administrative Order
ARMM	Autonomous Region in Muslim Mindanao
ASEAN	Association of Southeast Asian Nations
BARMM	Bangsamoro Autonomous Region in Muslim Mindanao
BIHC	Bureau for International Health Cooperation
BLGU	Barangay Local Government Unit
BNC	Barangay Nutrition Committee
BNS	Barangay Nutrition Scholar
CBIS	Capacity Building and Implementation Support
CCT	Conditional Cash Transfer
CDD	Community-Driven Development
CHD	Center for Health and Development
CLTS	Community Led Total Sanitation
CNSPMC	Community Nutrition Sub-Project Management Committee
COA	Commission on Audit
COVID-19	Coronavirus Disease 2019
CPF	Country Partnership Framework
CPR	Certificate of Product Registration
CSO	Civil Society Organization
DA	Designated Account
DBM	Department of Budget and Management
DCS	Day Care Service
DILG	Department of the Interior and Local Government
DoA	Department of Agriculture
DOH	Department of Health
DOST	Department of Science and Technology
DSWD	Department of Social Welfare and Development
ECD	Early Childhood Development
ECCD	Early Childhood Care and Development
ENNS	Expanded National Nutrition Survey
E&S	Environmental and Social

ESCOP	Environmental and Social Code of Practice
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESFP	Environmental and Social Focal Person
ESMF	Environmental and Social Management Framework
ESMO	Environmental and Social Management Officer
ESMP	Environmental and Social Management Plan
FDS	Family Development Session
FHSIS	Field Health Services Information System
FM	Financial Management
FNRI	Food and Nutrition Research Institute
GDP	Gross Domestic Product
GPRA	Government Procurement Reform Act
GRM	Grievance Redress Mechanism
GTWA	Geotagging Web-Application
HCI	Human Capital Index
HPB	Health Promotion Bureau
HPC	Health Promotion Committee
IATF-ZH	Inter-Agency Task Force on Zero Hunger
ICT	Information and Communication Technology
IFR	Interim Financial Report
IP	Indigenous Peoples
IRA	Internal Revenue Allotment
IYCF	Infant and Young Child Feeding
Kalahi CIDSS	*Kapit-Bisig Laban sa Kahirapan*-Comprehensive and Integrated Delivery of Social Services
KC	Kalahi CIDSS
KMITS	Knowledge Management and Information Technology Service
LMP	Labor Management Procedure
LNAP	Local Health and Nutrition Action Plan
LGU	Local Government Unit
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDS	Modified Disbursement System
MHO	Municipal Health Officer
MIS	Management Information System
MLGU	Municipal Local Government Unit
MNAO	Municipal Nutrition Action Officer
MOA	Memorandum of Agreement
MSWDO	Municipal Social Welfare and Development Office
NCDDP	National Community-Driven Development Project
NCIP	National Commission on Indigenous Peoples
NDHS	National Demographic Health Survey
NNC	National Nutrition Council
NPMO	National Program Management Office
NPP	National Procurement Procedures
NNS	National Nutrition Survey

NTWG	National Technical Working Group
OCS	Office of the Cabinet Secretariat
OPT	Operation Timbang
PA	Procurement Agent
PBG	Performance-Based Grant
PCERP	Philippines COVID-19 Emergency Response Project
PCRA	Procurement Capacity and Risk Assessment
PDO	Project Development Objective
PDOHO	Provincial Department of Health Office
PDP	Philippine Development Plan
PHC	Primary Health Care
PIU	Project Implementation Unit
PMIS	Management System
PMNP	Philippines Multisectoral Nutrition Project
PMO	Project Management Office
POM	Project Operations Manual
PPAN	Philippine Plan of Action for Nutrition
PPPI	Philippines Pharmaceutical Procurement Incorporation
PPSD	Project Procurement Strategy for Development
RFB	Request for Bids
RFQ	Request for Quotations
RMNCH	Reproductive, Maternal, Newborn Child, and Adolescent Health
RPF	Resettlement Policy Framework
RPMO	Regional and Provincial Project Management Office
SBCC	Social and Behavioral Change Communication
SC	Supreme Court
SCD	Systematic Country Diagnostic
SDG	Sustainable Development Goal
SEP	Stakeholder Engagement Plan
STEP	Systematic Tracking of Exchanges in Procurement
TA	Technical Assistance
TSA	Treasury Single Account
UHC	Universal Health Care
UN	United Nations
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Philippines	The Philippines Multisectoral Nutrition Project	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P175493	Investment Project Financing	Moderate

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	[ ] Hands-on Enhanced Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
22-Jun-2022	30-Jun-2026

Bank/IFC Collaboration

No

Proposed Development Objective(s)

To increase the utilization of a package of nutrition-specific and nutrition-sensitive interventions and improve key behaviors and practices known to reduce stunting in targeted local government units.

Components

Component Name	Cost (US$, millions)

Strengthened Delivery of Nutrition and Primary Health Services	127.30
Community-Based Nutrition Service Delivery and Multisectoral Nutrition Convergence	45.60
Institutional Strengthening, Monitoring and Evaluation and Communication	5.20

Organizations

Borrower:	Department of Finance The Republic of the Philippines
Implementing Agency:	Department of Health Department of Social Welfare and Development

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	178.10
Total Financing	178.10
of which IBRD/IDA	178.10
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	178.10

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2022	2023	2024	2025	2026
Annual	0.00	50.00	50.00	45.85	32.25
Cumulative	0.00	50.00	100.00	145.85	178.10

INSTITUTIONAL DATA

Practice Area (Lead)	Contributing Practice Areas
Health, Nutrition & Population	Governance, Social Sustainability and Inclusion, Social Protection & Jobs, Water

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Substantial
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	Substantial
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [√] No

Does the project require any waivers of Bank policies?

[ ] Yes [√] No

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

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

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description
Schedule 2, Section I.A.1: The Borrower shall designate, at all times during the implementation of the Project, a Project Steering Committee led by the IATF Zero Hunger to be responsible for prompt and efficient oversight and coordination of the implementation ofactivities under the Project. To this end, the Project Steering Committee shall inter alia: (i) provide national-level strategic advice and guidance; (ii) coordinate project implementation activities with DOH and DSWD and other agencies involved in project implementation, including LGUs and the National Nutrition Council as further set out in the Project Operations Manual; and (iii) review and advise on Annual Work Plans and Budgets.

Sections and Description
Schedule 2, Section I.A.2: The Borrower shall maintain the NTWG to be co-chaired by the Department of Health (DoH) and Department of Social Welfare and Development (DSWD), to be in charge of: (i) coordinating technical support services of different agencies at the regional and LGU levels; and (ii) provision of technical inputs as well as review results of the continuing development of the project's implementation systems, processes, and Project

Operations Manual.

Sections and Description
Schedule 2, Section I.B.4: The Borrower shall, through the DoH, not later than six (6) months after the Effective Date, engage Third Party Agent(s) to conduct independent verifications of the performance indicators of the LGU Grants under Part 1.1 of the Project, as set out under the POM, and in accordance with the provisions of this Agreement.

Sections and Description
Schedule 2, Section I.A.3: The Borrower, through the DoH, shall carry out Part 1 and 3.1 (DOH Respective Part of the Project) and the DoH shall take all actions including the provision of funding, personnel and other resources necessary to enable it to perform its functions. To this end, the DoH Project Management Office “DoH PMO” shall be responsible for day-to-day coordination of their Respective Part of the Project activities, including: (i) carrying out Project financial management and procurement activities; (ii) monitoring and evaluating Project activities and preparing Project progress reports and monitoring and evaluation reports; (iii) ensuring compliance with the Environmental and Social Commitment Plan (“ESCP”), Environmental and Social Standards and other Safeguards Instruments for Project activities; and (iv) coordinating and engaging with other stakeholders on Project implementation.

Sections and Description
Schedule 2, Section I.A.4: The Borrower, through the DSWD, shall carry out Part 2 and 3.2 (DSWD Respective Part of the Project) and the DSWD shall take all actions including the provision of funding, personnel and other resources necessary to enable it to perform its functions. To this end, the DSWD Project Management Office “DSWD PMO” shall be responsible for day-to-day coordination of their Respective Part of the Project activities, including: (i) carrying out Project financial management and procurement activities; (ii) monitoring and evaluating Project activities and preparing Project progress reports and monitoring and evaluation reports; (iii) ensuring compliance with the ESCP, Environmental and Social Standards and other Safeguards Instruments for Project activities; and (iv) coordinating with other stakeholders on Project implementation.

Sections and Description
Schedule 2, Section I.B.1: The Borrower shall maintain the Project Operations Manual (“POM”) containing detailed guidelines and procedures for the implementation of the Project, including: (a) administration and coordination; (b) monitoring and evaluation; (c) financial, procurement and accounting procedures; (d) social and environmental safeguards; (e) corruption and fraud mitigation measures; and (f) roles and responsibilities of various agencies/entities in the implementation of Project, terms, conditions and eligibility criteria for the Package of Essential Health and Nutrition Services to targeted communities as well as for selection of Project Beneficiaries and Community Subprojects to be financed, and such other arrangements and procedures as shall be required for the effective implementation of the Project.

Sections and Description
Schedule 2, Section I.E.5: The Borrower shall, through DoH and DSWD, establish, publicize, maintain and operate an accessible grievance mechanism, to receive and facilitate resolution of concerns and grievances of Project-affected people, and take all measures necessary and appropriate to resolve, or facilitate the resolution of, such concerns and grievances, in a manner acceptable to the Bank.

Sections and Description

Schedule 2, Section I.C.1: 1. In order to implement Part 1.1 of the Project, the Borrower, through DoH, shall provide LGU Grants to LGUs to deliver a Package of Essential Nutrition Services: (a) in accordance with the POM and following the rules of conditionality and performance set out therein; and (b) pursuant to the provisions of an agreement (Memorandum of Agreement) to be entered into between the DOH, DSWD and each LGU containing terms and conditions satisfactory to the Bank.

Sections and Description

Schedule 2, Section I.C.2: The Borrower, through DoH, shall exercise its rights in relation to each such LGU Grant provided to a selected LGU under a Memorandum of Agreement in such manner as to:
(a) protect the interests of the Borrower and the Bank; (b) comply with its obligations under the Memorandum Agreement; and (c) achieve the purposes of the Project and the intended objective of the LGU Grant.

Sections and Description

Schedule 2, Section I.D.1: In order to effectively implement Part 2.1 (b) of the Project, the Borrower, through DSWD, shall provide Community Subgrants to Beneficiaries to carry out Community Subprojects in accordance with amounts, conditions and procedures satisfactory to the Bank and as set forth in the POM

Sections and Description

Schedule 2, Section I.E.1: The Borrower, through DoH and DSWD, shall ensure that the Project is carried out in accordance with the Environmental and Social Standards, in a manner acceptable to the Bank.

Sections and Description

Schedule 2, Section I.E.2: Without limitation upon paragraph 1 above, the Borrower shall ensure that the Project is implemented in accordance with the Environmental and Social Commitment Plan (“ESCP”), in a manner acceptable to the Bank.

Sections and Description

Schedule 2, Section I.F.1: Not later than November 1 in each Fiscal Year (or one month after the Effective Date for the first year of Project implementation), the Borrower shall, through DoH and DSWD, prepare and furnish to the Bank: (i) a draft annual work planand budget for the activities proposed for inclusion in the Project for the next Fiscal Year (including Training and Operating Costs) of Project implementation, of such scope and detail as the Bank shall have reasonably requested; and (ii) any instruments required by the Environmental and Social Commitment Plan (“ESCP”) for the implementation of the activities included in the draft annual work plan and budget.

Sections and Description

Schedule 2, Section II: The Borrower, through DoH, shall furnish to the Bank each Project Report not later than 45 days after the end of each calendar semester, covering the calendar semester.

Conditions

I. STRATEGIC CONTEXT

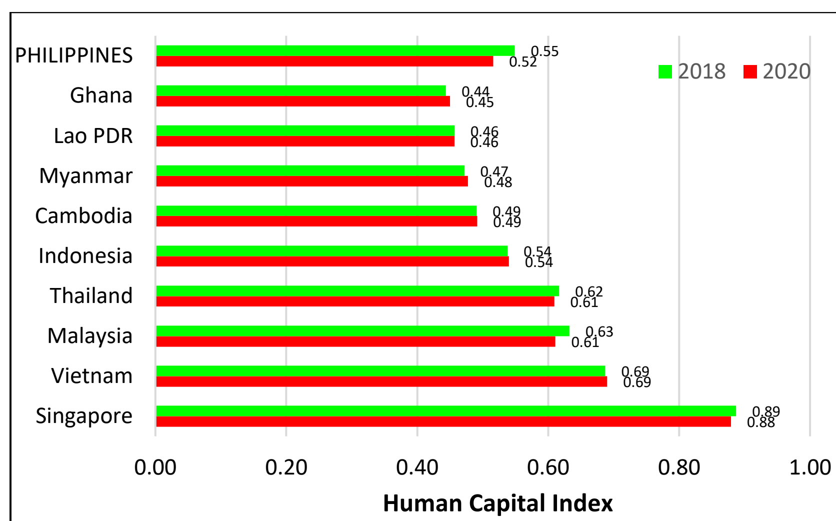
A. Country Context

1. **Before Coronavirus Disease 2019 (COVID-19), the Philippines was one of Asia's fastest growing economies.** The Philippines' unstable macroeconomic and political environment in the 1980s resulted in volatile growth rates that averaged just 2.5 percent per year over 1980–1997, far below the average of 4.6 percent of structural peers and 7.6 percent of regional peers. Structural reforms and a commitment to macroeconomic stability helped the Philippines achieve relatively high economic growth after 1998. Favorable domestic and external conditions supported growth to accelerate to an average rate of 6.4 percent between 2010 and 2017, surpassing the average of both structural and regional peers.

2. **The period of renewed growth was accompanied by an acceleration of the long-term shift of the economy and employment away from agriculture to non-agriculture, and from non-wage to wage employment.** The share of agriculture in national gross domestic product (GDP) declined from 15 percent to 9 percent between 2000 and 2019, and agricultural employment fell more dramatically (that is, from close to 40 percent in 2000 to around 25 percent in 2019). Labor productivity in the agriculture sector remains much lower than the average among regional peers. On the other hand, the services sector's share of GDP increased from 53 percent in 2000 to 61 percent in 2019, with its growth accelerating (that is, from 5.5 percent growth rate in 2000–2010 to 7.1 percent in 2010–2019). Similarly, the share of workers in wage employment increased from 51 percent to 64 percent between 2000 and 2019. Such shifts in employment were accompanied by within-sector productivity growth particularly prominent in the services sector.

3. **Prospects for sustained structural transformation and long-term economic growth will depend on the extent to which the Philippines invests in human capital, harnesses the rising tide of technological change, and expands its high-skills sectors.** The Human Capital Index (HCI)—which ranks the Philippines 84 in the world and 14 among 24 East Asia and Pacific countries (see figure 1)—captures the impact of human capital on future growth prospects and is a useful starting point for considering human capital challenges. The country's 2020 HCI of 0.52 indicates that the future productivity of a child born today could be 48 percent below what they could have achieved with a complete education and full health. In terms of the HCI's subcomponents, the Philippines ranked high in quantity (that is, expected years) of schooling but low in education quality—measured by harmonized test scores—and low in health and nutrition measures.

Figure 1. (HCI, Philippines and Select ASEAN Countries (2018–2020)



Note: ASEAN = Association of Southeast Asian Nations.

4. **The Philippines is one of the countries most affected by the COVID-19 pandemic in the East Asia and Pacific region. The country is home to the region's second highest COVID-19 burden after Indonesia, with 3.68 million cumulative cases as of April 7, 2022, and is fifth to Malaysia, Singapore, Brunei and Thailand in terms of cases per million population at 34,880[1].** The Government took an aggressive and whole-of-government approach to contain the COVID-19 pandemic. On March 24, 2020, the Congress passed the Bayanihan to Heal as One Act (Republic Act No. 11469), which declared a national emergency due to COVID-19 and granted the President expanded powers to adopt measures to prevent and suppress the spread of COVID-19. The law also authorized the executive branch to reallocate and realign savings from the national budget as well as from Government corporations. The Government has responded aggressively to waves of COVID-19 infections since the onset of the pandemic. However, with new variants emerging, and the adult population still in the process of being vaccinated, there are continued challenges. The test positivity rate has consistently been high—at over 10 percent, which is well above the World Health Organization's (WHO) recommendation of 5 percent to safely reopen the economy. The vaccination program started slowly but has accelerated considerably. As of March 2022, vaccination coverage of the overall target population is 73.47 percent, but booster coverage of high-risk populations is less than 20 percent. COVID-19 has had significant impacts on household nutrition and has affected delivery of basic health services, including maternal and child health (MCH). This has further escalated the urgency to tackle malnutrition in the country.

5. **The passage of the Mandanas ruling by the Philippine Supreme Court (SC) and the subsequent Executive Order 138 series 2021 that provides guidance on its implementation is considered as an important milestone toward full devolution, with an estimated 38 percent increase in the National Tax Allotment to local government units (LGUs) in 2022, which is expected to decline in subsequent years.[2]** While operational mechanisms to enable fund transfers to LGUs need to be worked out, the proposed

[1] *https://www.csis.org/programs/southeast-asia-program/projects/southeast-asia-covid-19-tracker*. Accessed on April 7, 2022

[2] The subnational governments filed a motion with the Philippine SC claiming that the computation basis on which the Internal Revenue Allotment (IRA) determined their share from national revenue taxes is erroneous and that this has denied the LGUs a just share from therein. The SC issued its ruling in favor of the LGUs, implementation of which will take effect in 2022. As a result of the Mandanas ruling by the SC in 2018 (and confirmed in 2019), the IRA is programmed to increase by 55 percent in the 2022 budget, reaching PHP 1.08 trillion or 4.8 percent of the country's GDP compared to 3.5 percent of GDP in 2021.

Philippines Multisectoral Nutrition Project (PMNP) will provide LGUs with a structured technical and financial path toward effective and efficient fund utilization for improving health and nutrition service delivery. The technical and financial assistance provided by the PMNP could help bridge service delivery gaps and complement the devolution transition plans currently being crafted at the national government agency and LGU levels, providing much needed support to LGUs in terms of capacity building in planning, financial management (FM), and addressing implementation bottlenecks.

B. Sectoral and Institutional Context

Sectoral Context

6. **The persistence of high levels of childhood undernutrition in the Philippines, despite the country experiencing decades of economic growth and poverty reduction, could lead to a staggering loss of the country's human and economic potential.** About 30 percent of children under five years of age are stunted,[3] 19 percent are underweight,[4] and 6 percent are wasted[5] (Expanded National Nutrition Survey [ENNS] 2019). Based on the WHO classification of public health significance of undernutrition rates, the stunting prevalence shows a 'very high' public health significance, while the wasting rates show a medium public health significance. The country's rate of stunting is high for its level of income and high compared to most of its neighbors. Other countries with similar levels of income have rates of stunting averaging around 20 percent. The Philippines' rate of 30 percent also places it fifth among countries in the East Asia and Pacific region with the highest stunting prevalence and among the 10 countries globally with the highest number of stunted children.

7. **Moreover, these national aggregates mask wide inequalities with far worse outcomes in some regions than in others.** Throughout the country, there are pockets with quite high levels of stunting—exceeding 40 percent of the cohort of children in those regions. The highest rates are found in the Bangsamoro Autonomous Region in Muslim Mindanao[6] (BARMM) (45 percent), Southwestern Tagalog Region (41 percent), Bicol Region (40 percent), Western Visayas (40 percent), Soccksargen (40 percent), Zamboanga Peninsula (38 percent), and Central Visayas (37 percent).[7] In addition, stunting rates are notably higher in rural areas (35 percent) than urban areas (26 percent). It is also noteworthy that the indigenous peoples (IP), making up between 12–17 percent of the Philippines' population, are among the most disadvantaged populations and are especially vulnerable to inequities in health and nutritional outcomes. Some of the regions with the highest levels of stunting are also regions with high IP presence. The Eighth National Nutrition Survey (NNS) (2013) estimated that 43 percent of children under five years

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[3] Stunting reflects chronic undernutrition, a consequence of a cumulative process that starts in pregnancy and continues in infancy and early childhood as repeated experiences of illness (such as diarrhea, malaria, or acute respiratory infection), combined with insufficient dietary intake, cause a child's growth to falter. It is measured by height-for-age. Children whose height-for-age is more than two standard deviations below the median of the reference population are considered short for their age and are classified as moderately or severely stunted. Those whose height-for-age is more than three standard deviations below the median are classified as severely stunted. Height growth and brain development not achieved during the first 1,000 days of life (from conception to two years of age) are largely irrecoverable and are associated with measurable negative consequences for health, cognition, productivity, and income across the life course.

[4] Low weight-for-age is the least specific and most difficult indicator to interpret. Underweight can be the result of small body size (stunting) or small body mass (wasting).

[5] Wasting, measured by weight-for-height, describes the recent or current severe process leading to significant weight loss, usually a consequence of acute starvation or severe diseases. It is a preferred indicator of use in emergency situations such as famine.

[6] The Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) was formerly known as the Autonomous Region in Muslim Mindanao (ARMM).

[7] Regional prevalence is from the 2015 NNS.

of age from IP households were stunted, compared to 31 percent from non-IP households, and 30 percent were underweight, compared with 19 percent from non-IP households. Their geographical isolation (most of them live in remote mountain areas), physical segregation, and social exclusion act as barriers to (health and nutritional) care seeking. However, the lack of more recent data makes it difficult to assess the level of health and nutrition disparity which still exists.

8. **The unprecedented global social and economic crisis triggered by the COVID-19 pandemic also poses grave risks to the nutritional status and survival of young children.** Several surveys and studies point to the significant food security and nutrition concerns aggravated due to the pandemic. The World Bank's High Frequency Monitoring Survey of a representative sample of households in the Philippines, found that 70 percent of households were worried about not having enough food during the following week. This share has declined over time, but still close to two-thirds of households reported the same concern in May 2021. The Rapid Nutrition Assessment Survey conducted from November 3 to December 3, 2020 also found that 62.1 percent of the surveyed households experienced moderate or severe food insecurity, compared with 40.2 percent before the pandemic. This indicates that unless immediate action is taken, millions of Filipino children will face the increased risk of undernutrition and likely suffer the consequences of poor school performance and low adult productivity even if they survive these deficits.

9. **With high levels of childhood undernutrition, the burden on the national economy in 2015 was estimated to be at least US$4.4 billion or 1.5 percent of the Philippines GDP.**[8] In addition, stunting has long-term adverse developmental impacts that far surpass childhood, and has been linked to slower learning outcomes, poor academic performance, and lower productivity and wages in adulthood. Stunted children are unable to develop their human capital to the full potential, with negative consequences on the aggregate level in terms of labor market productivity and economic growth. For example, a study[9] using data from the Cebu Longitudinal Health and Nutrition Survey that tracked children born in 1983 and 1984 found low height-for-age at young ages was associated with reduced likelihood of working in formal wage jobs as adults in a 2005 follow-up round to the study when participants were approximately 21 years old. This effect persisted in the follow-up survey conducted in 2009.

10. **The causes of undernutrition in the Philippines are multisectoral.** Undernutrition is an outcome of immediate, underlying, and basic causes. At the immediate level, nutritional status is determined by the availability of nutrients to the body to meet its requirements and to maintain the status of a child's health. To meet their increasing nutritional needs after six months of exclusive breastfeeding, infants should receive safe, age-appropriate, and nutritionally adequate complementary foods, combined with continuous breastfeeding, to achieve optimal growth. However, many Filipino children do not, as only 58 percent of Filipino mothers report experience of exclusive breastfeeding during the first six months, and only 10 percent of children 6 to 23 months are fed a minimum acceptable diet—a diet that meets both minimum dietary diversity and minimum meal frequency. Illnesses are both the cause and consequence of undernutrition. Poor nutrition impairs children's immune response, increasing their susceptibility to infection. Fever and other signs and symptoms of infection break down the body's reserve of nutrients more quickly and escalate the requirements. In particular, diarrhea has long been known to affect nutrition through loss of nutrients from malabsorption. The prevalence of diarrhea among children under five years of age is 6.1 percent. By age group, the prevalence of diarrhea is highest among children 6–11 months old (9.4 percent), followed by children 12–23 months old (9.0 percent) (National Demographic

[8] UNICEF (United Nations Children's Fund). 2017a. *The Economic Consequences of Undernutrition in the Philippines: A Damage Assessment Report.*
[9] Carba, D., V. Tan, and L. Adair. 2009. "Early Childhood Length-for-Age Is Associated with the Work Status of Filipino Young Adults." *Economics and Human Biology* 7: 7–17.

and Health Survey 2017). However, the Field Health Services Information System (FHSIS) 2018 reported that less than half (47 percent) of children up to 59 months of age with diarrhea received oral rehydration salts with zinc, and only 45 percent of sick children (ages 12–59 months) were given vitamin A supplements when treated in health facilities.

11. **The underlying causes of undernutrition are related to deficits in food and inadequate care, feeding practices for mothers, and unhealthy environments.** Currently, poorer Filipinos eat a rice heavy diet with low levels of diversity and limited animal protein.[10] According to the Family Income and Expenditure Survey (2015), Filipinos consume 159 percent of the recommended consumption of starchy staples (particularly rice), but only 22 percent of the requirement for vegetables, 10 percent of the requirement for fruits, 79 percent of the requirement for meat and pulses, and 29 percent of the requirement for fats and oils. Early deficits in fetal and child growth usually stem from inadequate maternal nutrition before and during pregnancy. Prenatal care services should provide pregnant women with essential nutrition services, including iron and folic acid supplementation, energy and protein supplementation for undernourished women, and nutrition counseling to promote optimal infant and young child feeding (IYCF) practices. However, only 53 percent are reported to have made the recommended four prenatal care visits, with only 54 percent in receipt of iron with folic acid. Early deficits in fetal and child growth usually stem from inadequate maternal macro- and micronutrition before and during pregnancy. In the Philippines, 20 percent of the women who were pregnant in 2018 were found to be 'nutritionally at risk' (while it was 37 percent for pregnant women under 20 years of age). Early marriage and adolescent pregnancy can lead to higher maternal and neonatal mortality, low birth weights, and stunting of children. According to the 2017 National Demographic Health Survey (NDHS) data, while almost 95 percent of Filipino households have access to improved sources of drinking water, only about 84 percent of households in the poorest income quintile and 71 percent of BARMM households have such access. Moreover, even where water and sanitary facilities are available, the poor operation and maintenance of these assets lead to premature dysfunctionality and disruption of these services.[11]

12. **The underlying determinants are in turn heavily influenced by basic socioeconomic factors including poverty; ethnicity and social status of women; and institutional/organizational, political, ideological, economic, sociocultural, and environmental constraints.** One of the most important basic causes of undernutrition is poverty. In the Philippines, 46 percent of children from households in the poorest quintile are stunted, compared to 13 percent of children from households in the wealthiest quintile (ENNS 2018). The Philippines is also an archipelago that is known to be vulnerable to natural calamities such as typhoons, earthquakes, and volcanic eruptions—'emergences' that can lead to displacements, yield loss for major food security crops and fisheries,[12] and loss of livelihoods—thereby aggravating the underlying causes of undernutrition in those areas. While the responsibility for implementing nutrition interventions falls under the mandate of the LGUs, they often lack the budget and human resources for nutrition programs. Nutrition often competes with a long list of infrastructure priorities in the budgets of LGUs.

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[10] Social and cultural factors play a role in this consumption pattern, but economic factors are key: it is expensive for Filipinos to diversify their diets and include more nutritious foods. Most Filipino households could afford a calorically adequate diet in 2015, but one-third could not afford a nutritionally adequate diet (WFP 2015).

[11] Barnes, R., and N. Ashbolt. 2010. "Development of a Planning Framework for Sustainable Rural Water Supply and Sanitation: A Case Study of a Filipino NGO." *Int. Stud. Manag. Organ.* 40: 78–98.

[12] An estimated 63 percent of the total damages incurred by the Philippines due to extreme events and natural disasters from 2010 to 2019 came from the agriculture sector. These devastating impacts in turn contribute to food deficits, increased food insecurity, and in addition to the resulting economic costs, this is likely to cause considerable social and economic disruptions.

13. **Achieving sustainable nutrition security in the Philippines is fundamentally a challenge that requires a dual focus on direct interventions and addressing the critical determinants of nutrition that lie across multiple sectors.** To address the multisectoral determinants of undernutrition, it is essential to achieve geographic convergence of critical sectors and programs in LGUs with a heavy burden of stunting and to focus on delivering a basic package of both nutrition-specific and nutrition-sensitive interventions.[13] There is growing global and local evidence that the convergence approach is critical to accelerating improvements in health and child development outcomes and thereby reduce stunting.[14] Such an approach has been applied in Peru, Brazil, and Bangladesh.[15] In Peru, for example, child stunting rates fell by almost half in less than a decade (2008–2016), partly because of major multisectoral nutrition efforts with a focus on convergence. A recent World Bank study in Indonesia also concluded that the multisectoral convergence approach has been critical to addressing stunting and malnutrition in Indonesia.[16] The study found an upward shift in the growth faltering curve in the first 24 months of age depending on children's access to none or up to four drivers of nutrition.

14. **Significant gaps remain in the provision of nutrition-specific and nutrition-sensitive interventions that are critical to addressing the nutrition crisis that the Philippines faces.** In terms of nutrition-specific interventions, global evidence suggests that effective delivery of a set of 10[17] high-impact nutrition interventions, focused on the first 1,000 days—from conception to 24 months—can significantly reduce stunting.[18] A critical starting point is to ensure access and utilization of these interventions through coordinated community-based and primary care services as part of a strong MCH program. Strengthening this basic health and nutrition service delivery platform will also facilitate synergies with other nutrition-sensitive sectors (for example, agriculture; water, sanitation, and hygiene [WASH]; and education) for more rapid and sustained improvements in stunting levels. Table 1 summarizes key behavioral indicators and services that are known to be effective in tackling childhood undernutrition, specifically stunting. It is important to note that, like anthropometric indicators, these national averages mask significant regional, income, and likely ethnic and cultural differences.

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[13] Nutrition-specific interventions and programs address the immediate determinants of fetal and child nutrition and development—adequate food and nutrient intake and low burden of infectious diseases. Nutrition-sensitive interventions and programs address the underlying determinants of fetal and child nutrition and development—food security; adequate caregiving resources at the maternal, household, and community levels; and access to health services and a safe and hygienic environment—and incorporate specific nutrition goals and actions.

[14] Levinson, F. J., and Y. Balarajan. 2013. "Addressing Malnutrition Multisectorally: What Have We Learned from Recent International Experience?" UNICEF Nutrition Working Paper, UNICEF and MDG Achievement Fund, New York.

[15] Levinson and Balarajan 2013; Gillespie, Stuart, Judith Hodge, Sivan Yosef, and Rajul Pandya-Lorch, eds. 2016. *Nourishing Millions: Stories of Change in Nutrition*, International Food Policy Research Institute; Huicho, L., E. R. Segura, C. A. Huayanay-Espinoza, J. N. de Guzman, Y. Tam, A. J. Barros, and C. G. Victoria. 2016. "Child Health and Nutrition in Peru within an Antipoverty Political Agenda: A Countdown 2015 Country Case Study." *Lancet Global Health* 4 (6): 414–26; Huicho, L., E. R. Segura, C. A. Huayanay-Espinoza, J. N. de Guzman, Y. Tam, A. J. Barros, and C. G. Victoria. 2017. "Factors behind the Success Story of Under-Five Stunting in Peru: A District Ecological Multilevel Analysis." *BMC Pediatrics* 17: 29.

[16] World Bank, and Ministry of Health. 2017. *Operationalizing a Multisectoral Approach for the Reduction of Stunting in Indonesia*.

[17] Multi-micronutrient supplementation in pregnancy (including iron-folate), calcium supplementation in pregnancy, energy-protein supplementation in pregnancy, vitamin A supplementation in childhood, zinc supplementation in childhood, breastfeeding promotion, complementary feeding education, complementary food supplementation, and management of acute malnutrition.

[18] Reduction of global prevalence of stunting by 20 percent: Bhutta, et al. 2013. "Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done and at What Cost?" *The Lancet* 382 (9890).

Table 1. Nutrition During the Early Years: Key Service and Behavior Indicators

Priority Service Packages/Intervention Indicators	%	Data Source (most recent available)
Nutrition behaviors and practices known to improve nutrition		
Exclusive breastfeeding (0–5.9 months)	57.9	ENNS 2019
% infants ages 6–23 months who are fed a minimum acceptable diet (adequate diversity, adequate frequency, and milk)	9.9	ENNS 2019
% infants ages 6–23 months meeting minimum dietary diversity	20.1	ENNS 2019
MCH indicators		
At least 4 antenatal care (ANC) visits during last pregnancy	52.6	DHS 2017
Pregnant women given complete iron with folic acid	57.8	FHSIS 2019
Children who received vitamin A supplements in previous 6 months		
6–11 months	127.9[a]	FHSIS 2019
12–59 months	59.1	FHSIS 2019
Age-appropriate immunization		
Fully immunized	69.1	FHSIS 2019
Children 12–59 months who received deworming tablet in the last 12 months	38.1	FHSIS 2019
Adolescent 15–19 years who have begun childbearing	9%	NDHS 2017
Nutritionally-at-risk pregnant women		
< 20 years	28.5%	ENNS 2019
> 20 years	22.3%	ENNS 2019
Agriculture		
Household food security		
Proportion of food insecure households	64.1	ENNS 2019
Water and sanitation		
% of household with access to improved drinking water	72.6	FHSIS 2019
% of households with complete basic sanitation	75.1	FHSIS 2019
Early learning and development % of target households participating in family development sessions (FDSs)	TBD	TBD
Social protection		
% of households covered by Pantawid Pamilyang Pilipino Program (4Ps)	18.7	Administrative data

Note: a. This has been clarified with the Department of Health (DOH) and its explanation is that coverage during emergency situations may have been inadvertently added, as doses in those settings are based on vitamin A capsules dispensed.

15. **Supply-side barriers have potentially hindered the scale-up and coverage of high-impact health and nutrition interventions.** The capacity to plan and deliver high-quality primary health care services is highly variable between LGUs. Primary health care (PHC) workers and caregivers need to be better trained, motivated, and mentored. A recent survey of LGUs (2021)[19] found inadequate training coverage of frontline nutrition workers (Barangay Nutrition Scholars [BNSs]) for critical nutrition services (60 percent for IYCF, 31 percent for management of acute malnutrition, and 20 percent for nutrition in emergencies). The Government's capacity to manage the supply chain for timely distribution of essential nutrition commodities and supplies also needs to be reinforced to reduce stockouts of critical inputs. The various nutrition information systems need to be integrated and linked more closely to intervention delivery to enhance the identification, tracking, and follow-up of children at risk of becoming stunted. Finally, the current health communication strategy is fragmented and limited in its focus on stunting, with

[19] NNC (National Nutrition Council), and UNICEF (United Nations Children's Fund. 2021. *Nutrition Service Delivery Continuity during COVID-19*. Unpublished report.

different sets of tools and messages used by different ministries and development partners, which calls for harmonization and alignment in the design and delivery of messages around childhood stunting.

16. **Strengthening PHC services is key to achieving accessible health care that is provided for by Republic Act 11223,** the UHC[20] Act, which stipulates that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services, protection against financial risk, and a health care delivery system that will afford every Filipino a primary care provider. The DOH Administrative Order (AO) 2020-0024 on the PHC Policy Framework articulates the need "for working closely with the community and in partnership with a diversity of stakeholders within and outside of the health sector" and calls for "prioritizing the needs of the unserved, underserved and marginalized in a fair and transparent manner." The implementation of PHC strategies is expected to lead to three main outputs: integrated and comprehensive primary care services; strategic financing for primary care; and quality, safe, and affordable care. These PHC guiding principles and strategies are perfectly aligned with the proposed project's intentions.

17. **The provision of PHC is under the purview of the LGUs.** In addition to the LGU mobilization strategy of the Philippine Plan of Action for Nutrition (PPAN), the DOH AO 2020-0037 outlines the development process of PHC integration, defining preparatory, organizational, and functional capacities of LGUs in the six building blocks of the health system: (a) governance (including strategic and investment planning); (b) financing; (c) human resources for health; (d) information (covering both information management and epidemiologic surveillance); (e) medical products, vaccines, and technology (primarily procurement and supply chain management); and (f) service delivery (incorporating health promotion and disaster management).

18. **Demand-side barriers to tackling childhood undernutrition in the Philippines include socio-cultural factors, geographic and financial impediments to accessing health services, and general levels of poverty and vulnerability.** Delayed access to ANC by pregnant women has impacts on pregnancy and infant and child health outcomes. Unlike acute undernutrition, stunting tends to be an invisible problem that stems from inadequate knowledge and awareness at the household and community levels. For example, a World Bank study[21] found that caregivers of young children (and even some health workers) believe that genetics or hereditary factors are an important cause of stunting. In addition, infant and child feeding practices (IYCF) that negatively impact children's nutritional status remain prevalent. IYCF practices are crucially important especially during the pandemic. Bottled milk is consumed by half of infants 6–11 months old, while the most frequently consumed complementary foods are expensive commercial cereal preparations that do not contribute to diet diversity. Even among the rich, only 9.4 percent meet the minimum acceptable diet for the complementary feeding age group (2018 ENNS). Geographic and financial barriers to accessing services persist, particularly for the poor and vulnerable. Despite the excellent progress made to tackle poverty and vulnerability, roughly 16.8 percent of households still fall below the poverty line and are highly dependent on a precarious subsistence agricultural economy characterized by small land holdings, low productivity, and high vulnerability to climate change and rainfall patterns, factors which impede food security and nutrition outcomes.

[20] UHC = Universal Health Care.
[21] Sen, Iman, Nkosinathi Vusizihlobo Mbuya, Gabriel Demombynes, and Varun Gauri. 2020. "Mind Over Matter in the Philippines? A Study of Key Stakeholders' Perceptions of Childhood Stunting." Health, Nutrition, and Population (HNP) Discussion Paper. World Bank Group, Washington, DC.
https://hubs.worldbank.org/docs/ImageBank/Pages/DocProfile.aspx?nodeid=32329257

19. **The country's flagship conditional cash transfer (CCT) program, 4Ps, has a strong potential to contribute to reducing undernutrition among children from poor households.** Since being introduced in 2009, 4Ps has grown to be a national poverty reduction strategy, currently providing cash grants to more than 4 million low-income households (close to 20 percent of the country's population), including 8.7 million children. As part of the health conditions for receiving the cash transfers, beneficiaries are expected to use prenatal and postnatal care and skilled birth delivery services and participate in FDSs as well as children's health checkups, growth monitoring, and take-up of micronutrient supplements and immunization. The program has had a proven track record of contributing to poverty reduction and improved human capital. In particular, the FDSs have been considered as a major channel for information dissemination on good parenting and hygiene practices conducive to improved health and nutrition of children. The fact that the cash grants are provided mostly to women (about 86 percent), who are likely the main caretakers of children, also provides an important channel through which 4Ps can affect nutrition outcomes. By supporting pregnant women and young children, the program targets the critical window of opportunity of the first 1,000 days for nutrition. Despite the program design being suitable for addressing poverty and child health and nutrition, several challenges have limited 4Ps from achieving its full potential to help improve nutrition outcomes.[22] For instance, the lack of the updated social registry limited the enrollment of new beneficiaries, and only few infants and young children (under age five) are currently monitored under 4Ps.

Institutional Context

20. **Improving nutrition outcomes in the Philippines is an agenda driven by multiple agencies through a whole-of-government approach.** The Inter-Agency Task Force on Zero Hunger (IATF-ZH) provides national-level strategic direction leadership on zero hunger and multisectoral nutrition actions. Pursuant to Executive Order No. 101 Series of 2020, Section 2, paragraph B thereof, it provides that: "The IATF-ZH shall coordinate and rationalize the effects of concerned government agencies and instrumentalities to ensure a whole-of-government approach to attaining zero hunger." Moreover, paragraph C thereof provides that: "IATF-ZH shall monitor and evaluate, through the identification of key performance indicators, the government's progress in ending hunger, achieving food security, improving nutrition, and promoting sustainable agriculture." Furthermore, paragraph D states that: "The IATF-ZH shall create technical working groups from among its member-agencies to address particular concerns relative to the implementation of the said order." The Task Force is chaired by the Cabinet Secretary and has membership from the Departments of Social Welfare and Development, Agriculture, Agrarian Reform, Budget, Education, Environment, Health, Labor, Local, Government, Trade, and Science; Presidential Communications Operations Office; National Economic Development Authority; and Commission on Higher Education. The Office of the Cabinet Secretariat (OCS) provides coordination support to the activities of the IATF-ZH.

21. **A strategy of the Philippines' national nutrition program is to establish an organizational structure at all levels of the Government.** While the National Nutrition Council (NNC) is responsible for national-level planning, nutrition policy, and strategy development, the regional, provincial, municipal, and barangay[23] nutrition committees are responsible for nutrition program implementation and management at each level. These committees are headed by the highest political leaders in the respective LGUs. The barangay has been identified as the focal point of planning and implementation of the nutrition

[22] See Cho, et al. 2020. "Optimizing Pantawid for Nutrition." https://openknowledge.worldbank.org/bitstream/handle/10986/34784/Optimizing-Pantawid-for-Nutrition.pdf?sequence=1&isAllowed=y.

[23] A barangay is the smallest administrative division in the Philippines and is the native Filipino term for village, district, or ward.

program. The municipal mayors and the nutrition committees, assisted by a designated city/municipal nutrition action officer (MNAO), plan, coordinate, and manage the nutrition programs of the respective barangay. Both the municipality and the barangay have a share of IRA as a source of income and social development funds from which a certain percentage may be used for social projects, including health and nutrition projects. The municipal and barangay local chief executives and their respective legislative bodies have discretion on the budget to be allocated for such purposes in their areas. This leads to substantial variability in the capacities of LGUs to plan, budget for, and deliver quality health and nutrition services.

22. **The NNC is a semi-autonomous attached agency of the DOH, with the Secretary of Health chairing the NNC's governing board.** The NNC Secretariat is responsible for formulating national food and nutrition policies and strategies; coordinating the planning and monitoring and evaluation (M&E) of the national nutrition program; providing technical, financial, and logistics support to LGUs and agencies for the development and implementation of nutrition programs and projects; amongst other functions. The DOH works with the NNC to develop the country's nutrition policies and supports the NNC's efforts in implementing the PPAN 2017–2022. The DOH is responsible for the delivery of a considerable portion of nutrition-related services (ANC, PHC for MCH, adolescent health, and so on) through its Disease Prevention and Control Bureau and has nutrition staff at the regional level. The DOH is also the mother agency of the Food and Drug Administration, which manages and tracks the country's Food Fortification Program. Food fortification is a vital component of the national nutrition response. In addition, the DOH procures essential nutrition commodities, such as micronutrient supplements (vitamin A, iron-folic, calcium, and zinc) and ready-to-use therapeutic food, while the NNC is responsible for advocacy, multisectoral coordination, and nutrition training of frontline service providers.

23. **Reviews of nutrition service delivery at municipality and lower levels have highlighted several challenges.** The World Bank study '*Undernutrition in the Philippines: Scale, Scope and Opportunities for Nutrition Policy and Programming*' found that the major bottlenecks to improving undernutrition could be divided into three broad categories:

(a) **Insufficient funding for nutrition.** Nutrition (programs) have historically been underfunded, with financing from LGUs further complicated by competing political priorities.

(b) **Inconsistency in quality of services provided** due to the lack of adequately trained manpower at health centers and village levels and a focus on vertical/individual services/interventions, rather than an integrated package of services.

(c) **Limited capacity for strategic planning at the LGU level** because of limited (human resource) capacities; local-level plans not being evidence-based and inadequately resourced; and limited availability of timely, quality data for decision making.

24. Therefore, the proposed project will seek to address these bottlenecks by strengthening the links between the DOH and LGUs; add to the LGU and DOH financing; and build the capacity of LGUs (management, health service, and frontline staff) to address undernutrition.

25. **In addition to PHC service delivery channels in the health sector, there are strong community-based platforms developed through the Kapit-Bisig Laban sa Kahirapan-Comprehensive and Integrated Delivery of Social Services (Kalahi CIDSS) Project and service delivery modalities in other key sectors, such as water and social welfare.** However, the coverage of these platforms and coordination across them within communities varies greatly. Therefore, there is an opportunity to take a systems-thinking lens at a community level, building on existing platforms.

Climate Change

26. **The Philippines is prone to natural disasters, which are expected to increase due to climate change, highlighting the need for government systems to be more adaptive and better serve vulnerable households.** Across its 7,641 islands, the Philippines is exposed to multiple natural hazards including typhoons, earthquakes, flooding, storm surges, tsunamis, volcanic eruptions, and landslides. The Global Climate Risk Index ranked the Philippines, along with Japan and Germany, at the top of the list of the most affected countries by extreme weather events in 2018. Around 90 percent of the damage incurred in recent years was from typhoons.[24] For instance, in 2013, Typhoon Yolanda (also known as Typhoon Haiyan) alone caused 6,300 fatalities and about US$13 billion in damages, and in 2018, Typhoon Mangkhut had a devastating impact with direct damages of approximately US$623 million. These natural disasters tend to disproportionately affect poor and vulnerable households. They are more likely to depend on disaster-vulnerable livelihoods and reside in unsafe areas (that is, urban slums and coastal areas). Due to limited resources and opportunities, they invest less in reducing their risk and thus experience a significant loss when hit by a disaster. Estimates suggest that almost half a million Filipinos annually face transient consumption poverty because of natural disasters,[25] and poverty increases vulnerability to adverse natural events. A study on the Philippines estimates that the bottom quintile of households suffers 9 percent of the total asset losses from disasters but 31 percent of the total welfare losses,[26] and over one-third of the non-poor population is at risk of being pushed into poverty by typhoons in most provinces along the Eastern Seaboard.[27] [28]

27. **The Philippines also experiences strong periodic droughts that are linked to the El Niño Southern Oscillation.** According to the Philippines' Second National Communication to the United Nations Framework Convention on Climate Change,[29] key historical climate trends include (a) a rise of 0.62°C in annual average mean temperature between 1958 and 2014 and a significant increase in the number of hot days and warm nights throughout the country between 1960 and 2003; (b) an increase in the amount and intensity of rainfall because of climate change in recent years, with more rainy days observed since the 1990s; and (c) wetter conditions during the dry season, with the five-year running average showing there are more tropical cyclones of typhoon intensity happening during El Niño events. Changing climate and extreme weather events, such as droughts, flooding, and cyclones, lead to impaired food production. Increasing temperatures and CO_2 cause crop failures and reduce the protein and nutrient content of some cereal crops. Also, food supplies of subsistence-farming households are disrupted by climate-related effects such as flooding, extreme heat, or pestilence.

28. **These adverse climate events have likely exacerbated the country's food and nutrition insecurity, undermining efforts to address undernutrition and hitting the poorest hardest, especially women and children.** Climate change affects people's livelihoods and lifestyles through different pathways. Farmers and fisherfolk are already facing more challenges in producing and gathering food due to changing weather patterns, such as erratic rains and increased floods.[30] In the short term, the impacts

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[24] Philippine Statistics Authority. https://psa.gov.ph/system/files/CPES%202016%20Component%204_Extreme%20Events%20and%20Disasters.pdf.
[25] Walsh, Brian, and Stephen Hallegatte. 2019. "Measuring Natural Risks in the Philippines: Socioeconomic Resilience and Wellbeing Losses."
[26] Walsh and Hallegatte 2019.
[27] Skoufias, et al. 2019. "Identifying the Vulnerable to Poverty from Natural Disasters: The Case of Typhoons in the Philippines."
[28] Skoufias, et al. 2019. "Identifying the Vulnerable to Poverty from Natural Disasters: The Case of Typhoons in the Philippines."
[29] https://unfccc.int/sites/default/files/resource/phlnc2.pdf.
[30] FAO (Food and Agriculture Organization). 2015. "Climate Change Food Security and Nutrition." Global Forum on Food Security and Nutrition. http://www.fao.org/fsnforum/activities/discussions/climate-change-and-fsn.

can be linked to extreme weather events which contribute to casualties, household food insecurity, disease, increased population dislocation, and insecurity. In the longer term, climate change affects not only natural resources and therefore food availability and access but also environmental health and access to health care. In the most affected areas, these long-term impacts eventually can lead to transitory or permanent migration, which often leaves female-headed households behind.

29. **In this regard, climate change can be considered as a potential 'threat multiplier' for hungry and undernourished people.**[31] Increases in temperatures, heat waves, typhoons, and floods affect agriculture, with the largest effects being decreased crop yields, damaging rural infrastructure (irrigation canals, post-harvest facilities, and rural roads), and livestock productivity, as well as declines in fisheries in areas already vulnerable to food insecurity. There is also strong evidence that climate change will affect food quality (diversity, nutrient density, and safety) and food prices.[32] The effects of climate change on agriculture will, in turn, have significant implications for food security and thus human diets and nutrition. Poor health and undernutrition in turn further undermine people's resilience to climatic shocks and their ability to adapt. Moreover, increased risks of adverse weather events such as floods directly impact primary health care infrastructure, thereby disrupting access to crucial MCH services.

30. **In summary, climate change exacerbates the crisis of undernutrition through three main pathways:**[33]

(a) **Household food security.** Climate change affects what food is available and at what price, affecting overall calorie consumption and consumption of healthy foods. This in turn can have an impact on childhood stunting and micronutrient deficiencies.

(b) **Child feeding and caring practices.** Many responses to climate challenges also have implications for women's labor allocation, which in turn influences women's time available for child feeding and caring practices.

(c) **The environmental health and access to health services.** Decreased water quality and availability in some areas could result in increased sanitation problems and waterborne diseases such as diarrheal diseases, while the transmission of vector-borne diseases is projected to increase with climate change. Coupled with a potential disruption in access to health facilities and health care service delivery by climate shocks, these changes in the environment have the potential to affect nutrient need and utilization and hence lead to undernutrition.

C. Relevance to Higher Level Objectives

Relevance to the Country's National Goals

31. **The proposed project is expected to contribute to the Philippines' focus on improving human capital.** As an early adopter of the Human Capital Project,[34] the Government of the Philippines has committed to the 'whole-of-government' approach to build, protect, and use human capital. The

[31] Concern Worldwide US (2019). https://www.concernusa.org/story/climate-change-food-security/#:~:text=Alternatively%2C%20climate%20change%20can%20adversely,and%20iron%20content%20of%20crops.&text=Climate%20extremes%20also%20threaten%20fish,in%20areas%20like%20Southeast%20Asia.

[32] GLOPAN (Global Panel on Agriculture and Food Systems for Nutrition). 2015. *Help the Climate, Change Your Diet: A Cross-Sectional Study*. London: GLOPAN.

[33] Fanzo, Jessica, Claire Davis, Rabecca MaLaren, and Jowel Choufani. 2018. "The Effects of Climate Change Across Food Systems: Implication for Nutrition Outcomes." *Global Food Security* 18: 12–19. https://doi.org/10.1016/j.gfs.2018.06.001.

[34] Human Capital Project, https://www.worldbank.org/en/publication/human-capital.

proposed project will contribute to building human capital through investing in early years of life and providing better health care, ANC, and targeted childhood stimulation. It also directly contributes to the implementation of the Philippine Development Plan (PDP) (2017–2022), UHC Act, Early Years Act (Republic Act 10410, 2013), and PPAN (2017–2022). Regarding the PDP, the project will contribute to its strategy to improve nutrition and health for all. One of the indicators is to reduce the prevalence of stunting in children under five years of age to 28.2 percent by 2022. The PPAN is the Government of the Philippines' blueprint of actions for nutrition improvement and is consistent with the Duterte Administration 10-point Economic Agenda and the Health for All Agenda of the DOH. It is a results-focused plan designed to achieve outcomes in different forms of malnutrition comprising stunting, wasting, micronutrient deficiencies, and overweight and obesity. The main strategic thrusts of the plan of action comprise (a) a focus on the first 1,000 days of life; (b) convergence of nutrition-specific and nutrition-sensitive programs; (c) intensified mobilization of government units, wherein 38 areas with the highest burden of stunting will be prioritized for mobilization of LGUs; (d) reaching of geographically isolated and disadvantaged areas and communities of IP; and (e) coordination of actions of national and local governments.

32. **On November 29, 2018, in declaring the country's determination to eliminate hunger and reduce all forms of malnutrition, the President of the Philippines signed the Republic Act 11148 titled 'Kalusugan at Nutrisyon ng Mag-Nanay Act',** which focuses on multisectoral programs and interventions focused on targeting the first 1,000 days of life as the golden window of opportunity. One of the main aims of this act is "to provide comprehensive, sustainable, multisectoral strategies and approaches to address health and nutrition problems of newborns, infants and young children, pregnant and lactating women and adolescent females, as well as multi-factorial issues that negatively affect the development of newborns, infants and young children, integrating the medium and long-term plans of the government to end hunger. And improve health and nutrition and reduce malnutrition." In this regard, the act mandates LGUs to integrate maternal, neonatal, child health, and nutrition programs in the Local Health and Nutrition Action Plans (LNAPs) and investment plans for health and instructs the NNC and other concerned national government agencies to provide appropriate technical assistance (TA) to LGUs in the implementation of the act.

Relationship to the CPF

33. **The World Bank Country Partnership Framework (CPF) for the Republic of the Philippines FY2019–FY2023 (Report No. 143605-PH) sets the stage for supporting the Government in addressing malnutrition.** The CPF recognizes childhood stunting as a key development challenge that undercuts the country's demographic advantage by eroding the long-term capacity of individuals. Hence, the proposed project will contribute to CPF Objective 2 (of Focus Area 1 - Investing in Filipinos), which is to increase access to affordable health services. The 2019 Philippines Systematic Country Diagnostic (SCD) (Report No. 143419-PH) also identified seven priorities to achieve Ambisyon Natin 2040,[35] eliminate extreme poverty, and boost shared prosperity. Reducing child malnutrition is one of these priorities, and the SCD identifies key action points for reducing malnutrition, which include improving MCH, increasing consumption of healthy foods by young children and mothers, expanding access to sanitation facilities, leveraging the 4Ps Program to promote the demand for health services, making food more affordable, and possibly providing a targeted funding mechanism that could drive action to reduce malnutrition by local governments.

[35] The Philippines 2040 Vision Plan, https://2040.neda.gov.ph/about-ambisyon-natin-2040/.

34. **At the global level, the project relates to the World Bank Group's initiative on Investing in the Early Years, which aims to reduce childhood undernutrition, ensure that children receive early stimulation and learning, and protect vulnerable children.** It also relates to the Human Capital Project, which aims to enhance investment in people through nutrition, health care, quality education, jobs, and skills to help build human capital, a key to ending extreme poverty and creating more inclusive societies. Finally, the proposed project remains highly relevant to the World Bank Group's twin goals to reduce poverty and promote shared prosperity as it continues to focus on service delivery at frontline levels and incentivize integrated outreach services in reproductive, MCH, and nutrition services.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

35. The project development objective (PDO) is to *increase the utilization of a package of nutrition-specific and nutrition-sensitive interventions and improve key behaviors and practices known to reduce stunting in targeted local government units*.

36. **The primary target group for this project will be 1,000 day households, that is, those households with pregnant women and children under two years old (see Section C) in the 235 targeted municipalities.** The package of interventions could include the following, depending on local contexts: high-impact nutrition interventions and essential MCH services;[36] WASH-Social and Behavioral Change Communication (SBCC) for handwashing with soap at critical times; demand creation activities to stop open defecation, and activities that will contribute to increased access to improved sanitation; and small-scale activities that could contribute to increased household (and/or community) access to safely managed drinking water supply; early childhood care and development (ECCD)—implementation of nutrition-focused child development activities such as early learning and stimulation and parenting/childcare education; and social protection—promoting and supporting household's access to the 4Ps Program.

PDO Level Indicators

37. **The proposed project's contribution to the country's overall stunting reduction goal** will be monitored primarily through indicators that focus on utilization of key services and practices and behaviors that are known to have an impact on the nutritional status of infants and children and pregnant and lactating women. The proposed key PDO (outcome) indicators for this project are included in table 2.

Table 2. PDO-Level Indicators

PDO Elements	PDO Indicators
Increase utilization of nutrition-specific and nutrition-sensitive interventions	• Percentage of pregnant women in project areas who have received complete iron-folic acid supplements • Percentage of pregnant women in project areas receiving prescribed ANC services from the first trimester of pregnancy • Percentage of households in project areas with access to improved toilets

[36] Support for optimal infant and young feeding practices, regular growth monitoring and promotion, multiple micronutrient supplements for children 6–23 months, iron-folic acid supplementation for pregnant women, vitamin A supplementation for children, dietary supplementation for nutritionally-at-risk pregnant women and during management and treatment of moderate and severe acute malnutrition, ANC, assisted institutional deliveries, immunization, integrated+- management of childhood illnesses, and activities aimed at improving adolescent girls' health and development.

PDO Elements	PDO Indicators
	• Percentage of households in participating barangays with convergence of priority nutrition-specific and nutrition-sensitive interventions
Improve key nutrition behaviors known to reduce stunting in targeted regions	• Percentage of 6–23 months-old children in project areas who meet the minimum age-appropriate diet

B. Project Components

38. **This Multisectoral Nutrition Project will adopt a bold, multisectoral nutrition approach to deliver a coordinated package of nutrition-specific and nutrition-sensitive interventions across the various LGU platforms together with a harmonized social behavior change and communications strategy.** The project design is guided by these overarching principles:

- **Design and roll out an evidence-based multisectoral approach** that will draw upon the science base and global recommendations and best practices for improving nutrition.
- **Establish geographic convergence** of key sectors—down to the household level—to address the multidimensional causes of undernutrition.
- **Invest in both supply-side interventions** (Component 1), which will be complemented by demand-side interventions (Component 2), to remove financial, geographic, and behavioral barriers to using essential nutrition and health services by project beneficiaries.
- **Incentivize achievement of nutrition results** at the LGU level.
- **Emphasize equity** to ensure that lagging LGUs catch up with their well-performing peers and improve the country's overall achievement on the HCI.
- **Leverage ongoing Government of Philippines-World Bank investments** in social protection, and WASH sectors to deliver on nutrition results.

39. **Central to the design of the proposed project is the delivery of essential adolescent, MCH, and nutrition services and the convergence of nutrition-specific and nutrition-sensitive interventions at the village and household levels.** The project will support LGUs by financing inputs that would enable the delivery of quality adolescent and MCH services through the PHC system, and by incentivizing multisectoral nutrition convergence across the key sectors that are responsible for delivering the PPAN's priority nutrition interventions.

40. **In light of the Mandanas ruling shifting a greater share of public sector resources to the LGUs, the project will support the preparation and implementation of costed multisector LNAPs to improve the level and quality of budgetary allocations for nutrition.** It will help strengthen evidence- and results-focused local multisector nutrition action plans and provide incentives to LGUs to spend more and better on nutrition and nutrition-related interventions and monitoring systems. At the village level, the project will support, build on, and/or leverage the delivery of nutrition-sensitive interventions by non-health sectors and actors and facilitate the convergence of these multisector activities on targeted households and villages. The proposed project enables a major paradigm shift in the Philippines as the proposed project enables the Government to implement at scale a coordinated package of high-impact interventions.

41. **By extending performance-based grants (PBGs) to LGUs, tied to the improvement of local-level planning and budgeting and achievement of critical nutrition-related results, the project will increase the availability of nutrition funds at the local level for capacity building and activity implementation.** Through also ensuring that the nutrition challenges are addressed across sectors, it will increase the efficiency of resource use by creating incentives for better aligning local-level nutrition interventions with nutrition needs. The project will encourage a focus on results through the provision of financial incentives at the local level for the attainment of nutrition results. Interventions to be funded under each component are described in the following paragraphs.

42. **Project Components 1 and 2 shall also be informed by three cross-cutting areas:**

(a) **IP:** The project will include some indicators with ethnicity disaggregation to monitor service delivery to IP and develop culturally sensitive activities to better target the communities in the project area. This will include concerted efforts to systematically collect relevant health and nutrition data on IP and ethnicity in the project's management information systems (MISs) at the central and local levels

(b) **Climate change:** The project intends to reduce climate change vulnerabilities arising from extreme weather conditions, including flooding, more frequent heavy precipitation, droughts, and so on, by, for example, integrating climate change and health/nutrition education into relevant project activities.

(c) **Gender:** Given the underlying role of gender inequalities in the targeted nutrition and health behaviors and practices, community-based activities will be designed to narrow gaps in rural women and children's access to services in selected project areas.

Component 1: Strengthened Delivery of Nutrition and Primary Health Services (IBRD: US$127.3 million)

43. **Global evidence has shown that efforts to deliver on nutrition results require an integrated nutrition service delivery system and a robust Primary Health Care system that complements community-based nutrition initiatives.** Therefore, this component finances the delivery of selected nutrition and health care services at the primary care level. Within this context, the component will support the DOH in addressing key gaps in the delivery of essential MCH and nutrition services by: (a) financing health and nutrition inputs, capacity-building initiatives, and TA to LGUs to enable them to deliver the defined packages of health and nutrition services in PHC facilities; (b) entering into performance-based agreements with LGUs to roll out a defined package of high-impact health and nutrition-specific interventions (table 3), and; (c) supervising such health and nutrition services delivered by LGUs through the engagement of health supervision providers (DOH regional offices) under results-based service delivery contracts.

Table 3. Package of Nutrition-Specific and Essential MCH Interventions/Services

High-Impact Nutrition Interventions	Essential MCH Services
• Promotion and support of optimal IYCF practices, especially for children 0–23 months old • Regular growth monitoring and promotion for children under five years of age • Micronutrient powder supplementation for children 6–23 months old • Iron-folic supplementation for pregnant women and women of reproductive age	• ANC • Assisted institutional deliveries • Postnatal care • Immunization • Integrated management of childhood illness • Adolescent girls' health and development

High-Impact Nutrition Interventions	Essential MCH Services
• Vitamin A supplementation for children 6–59 months • Zinc supplementation during management of diarrhea • Dietary supplementation for nutritionally-at-risk pregnant women and children 6–23 months old • Nutrition in emergencies and management of moderate and severe acute malnutrition	

44. **Following the first year of preparatory activities to collect baseline information and strengthen the capacity of Local Government Units to deliver health and nutrition services, the project will finance Performance Based Grants to LGUs to catalyze their implementation of the package of high-impact nutrition interventions and essential Maternal and Child Health services (table 3).** By extending grants to LGUs, the project will serve as a platform to prepare their readiness for local investments to design and roll out high-impact nutrition interventions and incentivize health sector planning and service delivery. This will be achieved by tying the project PBGs to the achievement of critical health and nutrition-related results, thus presenting a sustainable multisector model for utilizing increased IRA for health, nutrition, food security, and social protection. LGUs will develop LNAPs in the first year of the project as a step to enroll into the PBG scheme. The DOH will review these plans to ensure that they prioritize high-impact interventions consistent with the PPAN and project objectives. The DOH and NNC will provide technical support to LGUs to strengthen the quality of the LNAPs. The PBGs will serve to incentivize and create ownership in the municipalities to focus on achieving priority results at the LGU and community levels. They are intended to motivate the LGUs to invest in their capacities (including human resources and systems strengthening) to deliver quality health and nutrition services. These nutrition-related PBGs will build on similar principles such as the already-in-use LGU Health Scorecard, but with a bonus payment attached to the achievement of results. The formulation of LGU performance measures (PBG indicators) is based on a subset of interventions that have been found to be essential for the improvement of nutrition-related actions and outcomes.

45. **Component 1 will comprise the following subcomponents:**

Subcomponent 1.1. Primary Health Care Support (US$106.6 million)

46. **This subcomponent finances performance-based grants to selected LGUs to deliver a defined package of high-impact essential health and nutrition services delivered at the primary level of care through a Performance Based Grant mechanism.** Six LGU performance measures have been carefully selected to: (a) improve nutrition and health outcomes and (b) strengthen institutional capacity and accountability between LGUs and national-level agencies for nutrition outcomes (table 4). These indicators will reflect not only the key results of the project's results framework but also the areas where it is important to have transformational change focusing on the most challenging areas that have the potential to influence the success of the PPAN. The indicators will support the strengthening of the LGUs' (multisectoral nutrition) planning, budgeting, and implementation of nutrition-specific and nutrition-sensitive actions by the health sector. The indicators will be reviewed based on implementation experiences and evidence during the project. The project's information system will be used for reporting and needs-based planning and the quality of the RMNCH, and nutrition services provided by PHC facilities measured through an enhanced LGU Health Scorecard. A baseline assessment of indicators prioritized under the PBGs will be undertaken by the DOH within the first six months of project effectiveness. Findings

of the baseline survey will inform LGU-specific baseline, annual, and end line values for prioritized indicators.

Table 4. Summary of PBG Indicators (Performance Measure)

Improved Service Delivery of Essential Health and Nutrition Interventions	
PBG Indicator 1	Number of children 0–2 years old in program areas receiving age-appropriate feeding
PBG Indicator 2	Number of pregnant women receiving prescribed ANC services within the first trimester of pregnancy [37]
PBG Indicator 3	Number of households in participating Barangays receiving convergence priority nutrition - specific and nutrition-sensitive interventions[38]
Improved Multisectoral Nutrition Planning and Management at LGU Levels	
PBG Indicator 4	LGUs has approved LNAPs and budgets and expenditures in accordance to plans
PBG Indicator 5	LGU reports regularly and adequately in the PMNP information system
PBG Indicator 6	Average quality score for RMNCH and nutrition services provided by primary health care facilities in PMNP areas

Note: RMNCH = Reproductive, Maternal, Newborn Child, and Adolescent Health.

47. **In addition, and to ensure the delivery of quality primary health care and nutrition services, incremental human resources directly linked to the achievement of the PDO, where needed, will be recruited to coordinate the development and implementation of local-level health and nutrition action plans.** Facilitative supervision through the DOH, Department of Social Welfare and Development (DSWD), and NNC regional and provincial offices will be enhanced. The financing of LGU grants, along with the requisite TA and the LGUs' own resources, will enable the delivery of the package of essential MCH and high-impact nutrition services.

48. **A Tripartite Memorandum of Agreement (MOA) between the DOH, DSWD, and each of the participating LGUs for all project components** will provide the basis for a performance mechanism which commits LGUs to achieve the performance measures and for the government to reward such achievement. The MOA will provide a framework for the DOH and DSWD to engage LGUs to implement the PMNP. A supplementary MOA will be signed to include: (a) the roles and responsibilities of all parties; (b) principles of these LGU grants; (c) list of performance measures (PBG indicators) to be achieved, including the total value available to each LGU; and (d) a description of the annual internal and external assessment and verification process.

49. **Performance Based Grants definition, targets, and verification procedures** will be detailed in the Project Operations Manual (POM) and included in the MOA. Targets will be set to balance between "stretch" and "realism." A ceiling for the total PBG to be provided to the individual LGU will be based on

[37] The DOH AO 2016-0035. Guidelines on the Provision of Quality Antenatal Care (ANC) in All Birthing Centers and Health Facilities Providing Maternity Care Services. Focused ANC is an individualized goal-oriented care that provides specific evidence-based interventions to women, carried out at certain critical times in the pregnancy. This comprises the following essential elements: pregnancy tracking or the identification and surveillance of the pregnant woman and her expected child; screening for conditions and diseases such as anemia, sexually transmitted infections particularly syphilis, HIV infection, Hepatitis B infection, mental health problems, and/or signs of stress or domestic violence; recognition and management of pregnancy-related complications, particularly hypertensive disorders of pregnancy; recognition and treatment of underlying and concurrent illness; preventive measures, including tetanus toxoid immunization, deworming, iron and folic acid supplementation, calcium carbonate supplementation, and iodine oil capsule supplementation in areas with low urinary iodine excretion levels; and in malaria endemic areas, intermittent preventive treatment of malaria in pregnancy and insecticide-treated bed nets.

[38] See box 1.

the population, with a qualifier derived from remoteness as well as the share of indigenous population in the LGU. The PBGs will reward improvements in coverage and quality of priority MCH and nutrition services known to improve outcomes during the first 1,000 days of life. However, the targets will be on a sliding scale and not an all or nothing reward system.

50. **Internal and external verification:** Internal verification will be carried out by national and regional DOH teams based on data reported routinely through the LGU information system with sample comparison of reported data with primary data from facility records. For external verification, the DOH will contract a third-party independent agency—possibly an academic institution and/or international consulting firm—which will develop the procedures to verify the internal achievement through selection of random and risk-based samples of LGUs, health centers, and villages. In addition to data verification from local records, telephone interviews will be conducted with randomly selected patients and home visits to a sample of patients. During the project such capacity may be developed, and an autonomous government institution may be set up for the purpose of independent verification. Based on reports of internal and external verification and documentation of the eligible expenditures, the World Bank will transfer funds to a special account in the DOH. DOH in turn will transfer the grants earned to a special account in each LGU. Disbursements will be done on an annual basis to minimize transaction costs on the DOH and LGUs

51. **The use of the grants will be guided by a "menu approach,"** that is, a list of defined expenditures that LGUs would be able to choose from and which do not contradict agreed restrictions on financing. The LGUs will enjoy autonomy to prioritize activities to finance to improve MCH and nutrition outcomes, subject to the activities being within the purview of the approved LNAP.

52. **The PBGs have been designed to reflect lessons from past DOH grants to LGUs and the World Bank's global experiences from performance-based incentives in the health sector including in India, Argentina, and Brazil, among other middle-income counties.** Such lessons will inform the structuring of incentives, frequency of data verification, disbursement, and reporting by LGUs.

Subcomponent 1.2. Health and Nutrition Service Systems Strengthening (US$19.5 million)

53. This subcomponent will comprise four broad activities:

- **Local Government Unit mobilization.** Project funds will be used to support (i) the formulation of the LNAPs[39] at the provincial, municipal, and barangay levels, which will integrate both nutrition-specific and nutrition-sensitive interventions as stipulated in the Memorandum Circulars issued by both the Department of the Interior and Local Government (DILG) and the Department of Budget and Management (DBM) (MC 2018-42, JMC 2019-001, and the successive Local Budget Memorandum from the DBM); (ii) integration of nutrition in the Annual Investment Programming of LGUs, which will ensure increased investments for health, nutrition, and other community services in support of the delivery of nutrition outcome; (iii) provision of TA to LGUs in local development planning and mobilization of community support for nutrition programs; and (iv) advocacy with local chief executives to secure support for nutrition programs and elicit community participation in

[39] Provincial committees, municipal committees, and barangay nutrition committees (BNCs) will formulate the LNAPs, under the guidance of the provincial, municipal, and barangay development committees and any additional TA if required. Such plans will be finalized within the first year of the proposed project. The LNAPs are incorporated into the LGU Comprehensive Development Plans and the Annual Investment Programming to ensure increased investments in both nutrition-specific and nutrition-sensitive interventions and enabling programs. The plan will include all activities to be financed under Component 1 and Component 2 of the project.

accessing basic health, nutrition, and other community services.

- **Capacity building.** The first year of the project will focus on building the capacity of the LGUs to plan, deliver, and monitor primary health and nutrition services. This will entail two sets of investments: (i) procurement of essential equipment and supplies to improve LGUs' PHC facilities to deliver a minimum package of services mostly during the first year of the project and (ii) training and mentorship to strengthen health care workers' skills to deliver high-quality MCH and nutrition services. In line with this, this subcomponent will provide financial support for the procurement of equipment and supplies and include the financing of LGU grants. Procured items will include growth measuring equipment and training on the use of various tools, for example, electronic Operation Timbang (OPT)[40] Plus tool, ECCD checklist, mid upper arm circumference tapes, and growth monitoring charts, to enable the LGUs to deliver the package of MCH and nutrition services in line with national standards. Health worker capacity building will include provision of project funds to produce job aids and competency-based training and coaching for LGU staff, PHC staff, and community health and nutrition volunteers. Capacity building will be streamlined, with all trainings driven by assessment of LGU skills gap and needs and through provision of cadre- or audience-specific training, thus consolidating all needed competencies of each health care professional into a single training curriculum (for example, one training for planners, one for physicians, one for midwives, one for BNSs, and so on). In addition, training and capacity building will be based on coaching and practical application in the workplace rather than traditional classroom training. Online training courses and job aids, including job aid apps, will also be considered.
- **Information systems.** The proposed project will directly contribute toward strengthening existing information systems and development of a benchmark assessment of IP and ethnicity data, and information systems across participating institutions aimed at improving tracking performance of indigenous people in the following areas: (i) anchoring monitoring of the nutrition-specific and nutrition-sensitive information to the existing Kalahi-CIDDS database, the Project Information Management System (PIMS), and Geotagging Web-Application (GTWA); it will be harmonized to the system which will be developed under this component; (ii) particularly for the supply-side systems, the project will support capacity building initiatives and strengthen information and communication technology (ICT) standards and procedures; and (iii) timely utilization of data will be strengthened by building in local data processing and use of LNAP time charts and annual outputs. Through the PBGs, the project will support activities that will allow the local system to collect and analyze service coverage and nutrition outcome data and support local planning and budgeting and transmit this to the regional and national levels in an effortless manner. The project provides incentives for LGUs to use integrated information systems for data entry, analysis, and timely reporting to Municipal Councils and to national agencies.
- **Social Behavior Change Communication.** The project will support two sets of SBCC interventions: (i) the development and rollout of multimedia, cross-cutting communications on nutrition and nutrition-related behaviors and (ii) health facility- and community-based

[40] OPT Plus is the annual weighing and height measurement of all preschoolers under five years old in communities to identify and locate malnourished children. Data generated through OPT Plus are used for local nutrition action planning, particularly in quantifying the number of malnourished and identifying who will be given priority interventions in the community. Moreover, results of OPT Plus provide information on the nutritional status of the preschoolers and the community in general, thus, providing information on the effectiveness of the local nutrition programs.

social behavior change and communication interventions to enable targeted households and communities to adopt behaviors crucial to improving nutrition outcomes for women and children. The first set of SBCCs will create the environment for giving priority to nutrition and position it as part of an integrated approach to PHC strengthening. The second set of SBCCs will be the development and rollout of context-specific communication and use of local languages and facilitation packages that will increase awareness of community stakeholders on health and nutrition issues and concerns, enable them to participate in taking action, and contribute to efforts to sustain the adoption of behaviors crucial to improving nutrition outcomes among women and children including household-level and community-level efforts on improving access to food and food diversification. Development of the second set of SBCCs will be done based on a social ethnographic assessment about perception of nutrition services among different target communities, particularly indigenous communities.

Subcomponent 1.3. Technical Assistance to BARMM (US$1.2 million)

54. **To support the BARMM in developing and implementing child-focused programs, including health and nutrition interventions, the DOH, in collaboration with NNC and DSWD, will provide TA and capacity-building support to the region.** The DOH will provide TA to the BARMM Ministries of Health and of Social Services, as well as the BARMM regional nutrition coordinator, to develop context-appropriate health and nutrition action plans and strengthen management of nutrition interventions. The project will provide the needed assistance in program development and planning and training of ministry personnel to equip them with the necessary competencies to implement and manage primary health care and community-based nutrition interventions. In addition, the TA will provide cadre-specific training like that provided for non-BARMM LGUs. The TA will be informed by a needs assessment to be completed in 2022. In consultation with relevant BARMM authorities, the project will develop detailed capacity-building plans for the BARMM before project effectiveness. The DSWD's programs on basic services and social protection are being transitioned over to the BARMM's Ministry of Social Services and Development since beginning of 2022.

55. **This subcomponent will also seek to adapt and tailor culturally sensitive health and nutrition interventions for IP across all supply-side interventions.** One of the key gaps to address will be barriers to accessing health and nutrition services among IPs. The project will provide training on culturally sensitive techniques and practices to relevant staff, to support implementation of the package of nutrition and essential MCH interventions and services at national and local levels in participating LGUs. Where feasible, the project will encourage the recruitment and training of IP to become community health workers in their own communities, effectively reducing social, cultural, and language constraints and enhancing access and acceptability.

Component 2: Community-Based Nutrition Service Delivery and Multisectoral Nutrition Convergence (IBRD: US$45.6 million)

56. This component will focus on multisectoral interventions that aim to prevent childhood undernutrition, and especially stunting, at the community and household levels. The component will facilitate the convergence of priority nutrition-specific and nutrition-sensitive interventions for targeted communities and households in the project LGUs (see box 1) as aligned with the Municipal Local Government Unit (MLGU) LNAPs also known as the MLGU nutrition action plan and in accordance with the service standards set under Component 1. The community and household convergence plan will also feed into the MLGU nutrition plan to ensure inclusive, responsive, and targeted interventions. Building on

the Kalahi CIDSS-National Community-Driven Development Project (KC-NCDDP), several of the poorest and most vulnerable LGUs will be selected for intervention, and within those LGUs, vulnerable populations such as 4Ps beneficiaries, nutritionally-at-risk women and young children, and IP will be identified as target households. The KC-NCDDP has strong engagement with the MLGU to ensure its counterpart support (technical and financial). These households and communities will receive multisectoral interventions with a convergence approach central to the PPAN 2017–2022. In this regard, specifically the following activities will be supported: (a) increasing access to and use of clean water, appropriate sanitation, and improved hygiene practices; (b) access to ECCD services; (c) increased access for 4Ps beneficiaries to nutrition programs and services; and (d) community capacity building and implementation support (CBIS). The BNC will ensure convergence of services and will link with the Municipal Nutrition Committee primarily to ensure TA from concerned agencies/MLGU technical offices, particularly from the Municipal Health Office/DOH Municipal Representative; the Municipal Nutrition Officer; Municipal Agricultural Office; Rural Sanitary Inspector; and Municipal Social Welfare and Development Office (MSWDO).

Box 1. Household Convergence Scorecard

The nutrition convergence of nutrition-specific and nutrition-sensitive intervention will be assessed at the household level using a convergence scorecard that will focus on key interventions in the health and nutrition, WASH, social protection, and ECCD sectors. The 15 indicators are listed in table 5.

Table 5. Convergence Scorecard

Sector	Indicator
Nutrition	1. Child has up-to-date growth monitoring chart as per national guidelines 2. Caregiver has participated in at least 4 village health and nutrition SBCC sessions in the last year 3. Pregnant woman has received iron-folic acid supplements as per national guidelines 4. Child 0–5 years received two vitamin A supplements during the past year 5. Nutritionally-at-risk pregnant woman received dietary supplements 6. Infant/child with severe acute malnutrition received treatment at the facility
Health	7. Pregnant woman attended at least one ANC session in each of the first two trimesters and two in the third trimester 8. Mother gave birth to their child in a health facility 9. Mother of a child 0–2 years attended at least three postnatal sessions 10. Child has completed all age-appropriate immunization 11. Adolescent girl has participated in health-worker-facilitated adolescent activities
ECCD	12. Caregivers of children 0–5 years have participated in at least 4 parenting/childcare sessions in the past year
Social Protection	13. Eligible households are registered for/receiving CCTs from the 4Ps program
WASH	14. Household has access to functional safely managed drinking water supply[a] 15. Household has access to improved sanitation[b]

Note: a. According to Sustainable Development Goal (SDG) 6 definition, safely managed drinking water supply is an improved source located on premises, available when needed, and free from microbiological and priority chemical contamination.

b. According to the SDG 6 definition, improved sanitation are facilities that hygienically separate human excreta from human contact. Examples are connection to a public sewer, connection to a septic system, pour-flush latrine, pit latrine, and ventilated improved pit latrine.

57. **The component will 'dovetail' on the success and structures of the KC-NCDDP.** In particular, the component will build on the KC-NCDDP's participatory approach and provide financial and technical support to communities to better understand their health- and nutrition-related issues and engage them in developing and/or supporting solutions to these issues. Such an approach will ensure that, among other benefits, the proposed nutrition-specific and nutrition-sensitive interventions receive full support and ownership by the concerned households, communities, and respective LGUs and improve engagement with marginalized groups and vulnerable communities (for example, IP). The project activities will build on two ongoing programs implemented by the DSWD and supported by World Bank operations: the community-driven development (CDD) program and the Philippines Beneficiary First Social Protection Project[41].

58. **Kapitbisig Laban Sa Kahirapan-Comprehensive and Integrated Delivery of Social Services (Kalahi-CIDSS) will mobilize the Area Coordinating Team (ACT) and Community Nutrition Sub-project Management Committee (CNSPMC) in conducting the participation situational analysis.** The results of participation situational analysis will be used by the BDC and BNC to develop the barangay nutrition action plan (BNAP) led by NNC focal. The BNAP will be budgeted through allocated funds for health and nutrition and Barangay Annual Investment Plan as necessary. For Component 2, it will fund activities that were approved for the proposed sub-projects for ECCD and WASH.

59. **Component 2 will provide block grants to communities in project areas which shall be used for eligible nutrition-related activities that are in the barangay health and nutrition action plans.** The DSWD, will disburse project funds to communities by tranches and as advances for implementation of the subprojects that respond to community-identified priorities as contained in the approved sub-project proposal. Community block grants will be administered through the CNSPMC, which will report to the BNC and BDC. By involving the BNC, Component 2 will contribute to its organizational development. The detailed process and implementation arrangements for the community-based nutrition intervention will be contained in a field guide that will be prepared as an accompanying document to the POM.

60. **A menu approach will be used for sub-project investments[42], meaning that the community grants will be eligible for funding if it does not contradict agreed restrictions on financing, as will be outlined in the project operations manual.** Eligible nutrition-related activities in the barangay action plan that communities will be able to choose from will include the following:

(a) **Increased availability and access to and use of clean water, appropriate sanitation, and improved hygiene practices.** Safe and sufficient drinking water, sanitation, and hygiene (WASH) are essential to health and well-being and are particularly crucial for child growth. In addition to the more readily recognized consequences of diarrhea, inadequate WASH conditions put a growing child at risk for Environmental Enteric Dysfunction (EED). EED is a subclinical condition that causes inflammation of the gastrointestinal lining, preventing the effective absorption of nutrients that is now known to contribute to child stunting and may impair the immune response to orally administered vaccines, such as those for polio and

[41] World Bank. 2020. Philippines - Beneficiary FIRST Social Protection Project. Washington, D.C. : World Bank Group. https://imagebank2.worldbank.org/search/32417210

[42] Eligible sub-project investments under community subgrants could include, depending on community priorities: digging small community wells, maintenance and management of community water systems, construction of basic HH and/or community toilets; providing more or updated learning materials/sessions on nutrition as well as technical support from concerned MLGUs to integrate nutrition-focused child development activities such as early learning and stimulation, parenting/childcare education, hygiene and sanitation education, complementary feeding and cooking demonstrations into existing day care center activities and minor civil works for upgrading day care centers; etc.

rotavirus. In this context, the project support could include the following activities, as needed: demand creation activities to stop open defecation and activities that will contribute to increased access to improved sanitation; and small-scale activities that could contribute to increased household (and/or community) access to safely managed drinking water supply and promote the establishment of local operation and maintenance arrangements.[43]

(b) **Access to Early Childhood Care and Development services.** There is a growing body of evidence from the disciplines of both nutrition and Early Childhood Development (ECD) that suggests that there are common skills for effective caregiving and by enhancing these common skills, it is possible to benefit both nutrition and child development. Hence given that poor nutrition and inadequate opportunities for early learning are both risks for poor children's development, nutritional and ECCD inputs should be optimized—and possibly integrated—for best developmental outcome. In this regard, the PMNP support could include activities such as: providing more or updated learning materials/sessions on nutrition as well as technical support from concerned MLGUs to integrate nutrition-focused child development activities such as early learning and stimulation, parenting/childcare education, hygiene and sanitation education, and complementary feeding and cooking demonstrations into existing day care center activities.

(c) **Increasing access of 4Ps beneficiaries to nutrition programs and services.** The 4Ps program provides an important demand side (household) incentive and promotes behavioral changes through cash transfers and conditionalities (which include take up of maternal child health care services, immunization, nutrition, early childhood education, and family development session participation). This will greatly complement supply side interventions pursued by PMNP and create synergies through a holistic approach. In order to maximize the synergies between PMNP and 4Ps, the project will pursue the following activities: i) for existing 4Ps women, identify and update information of new pregnancy/newborn children so that they can also be monitored under 4Ps (leveraging Philippine Identification System (PhilSys) adoption, unified beneficiary database through Beneficiary First Social Protection Project; ii) support 4Ps beneficiaries to benefit from the PMNP activities (esp. WASH and ECCD Support interventions); iii) include in the PMNP the monitoring of 4Ps recipients of the program; and iv) potentially use FDS modules/platforms for beneficiaries beyond 4Ps through SBCC.

(d) **Community Capacity Building and Implementation Support.** The project will provide community mobilization and capacity-building support to barangay LGU officials, parent leaders, and core community volunteer groups to enhance their competencies in implementing and managing nutrition-sensitive community projects complementing the nutrition-specific interventions in Component 1. The activities to be identified and implemented under CBIS will also prepare them to sustain the results of the interventions and continuously contribute to the achievement of desired nutrition outcomes. Capacity building will focus on increasing awareness and knowledge on the importance of the communities in achieving the desired health and nutrition outcomes; key nutrition-sensitive interventions, community-based project design, implementation, and management; procurement following required government policies; and Financial Management (FM). CBIS

[43] The operation and maintenance arrangements for water supply and sanitation services aim at ensuring that related infrastructure and services are maintained over time. The arrangements could be, among others, establishment of a Rural Water and Sanitation Association, a Barangay Water and Sanitation Association, a cooperative, or a community-based association.

will also support the hiring of implementation team members to be deployed as front liners in the implementation of the project. These teams shall provide the necessary TA to the communities to ensure that the interventions and targets are delivered and that necessary coordination and technical support to LGUs and communities is provided.

61. The access and utilization of these multisectoral opportunities for eligible households will be captured through a household convergence scorecard that will be administered to all the participating project areas annually. Component 2, therefore, is more than just demand generation; it will support the delivery of essential nutrition-sensitive interventions with comprehensive community mobilization and participation; as well as support multisector community-based promotion of essential health and nutrition practices and health care-seeking behaviors for improved MCH and nutrition outcomes. This could be achieved through: (a) technical assistance support to eligible communities to better understand their health and nutrition related issues; (b) the provision of subgrants to beneficiaries to carry out subproject investments in the areas of nutrition, health, and access to clear water services; and (c) the provision of requisite training to beneficiaries for the purpose.

Component 3: Institutional Strengthening, Monitoring and Evaluation and Communication (IBRD US$5.2 million)

62. This component will include two subcomponents, one under DOH, and the other under DSWD, financing the following activities:

(a) **Institutional strengthening.** An institutional assessment of the lead implementing agencies (DOH and DSWD) was completed during preparation of the project. Based on findings from the institutional assessment, the proposed project, through the provision of TA, training, operational costs and goods required for the purpose, will strengthen each PMO's (DSWD and DOH) capacity to plan, implement, and evaluate high impact essential health and nutrition interventions and institutional coordination at various levels from the national to the LGU levels.

(b) **Project management.** Through the provision of TA, training, operational costs and goods required for the purpose, the project will support both PMOs under DOH and DSWD with the day-to-day implementation, coordination, communication, procurement, FM, environmental and social (E&S) management, and M&E of the project.[44] The human resources in both the DOH and DSWD PMOs will be complemented, as needed, by additional contracted staff. The project will finance technical, fiduciary, and E&S specialists to strengthen the implementation capacity of the implementing agencies.

(c) **Monitoring and Evaluation.** The component will finance M&E of the project components. Through the provision of TA, training, operational costs and goods required for the purpose, the support both PMOs under DOH and DSWD in the development of planning guidelines to be used at different levels; training and operational costs for the execution of the coordination, development, and implementation of M&E functions (that is, additional

[44] Two Project Management Offices (PMOs), one located in the DOH (primarily responsible for overseeing the implementation of Component 1 activities) and another in the DSWD (primarily responsible for overseeing the implementation of Component 1 activities), will have overall responsibility for the day-to-day management of the project. Two program managers will lead the respective PMOs, with the DSWD program manager assuming a lead role in reporting to the IATF-ZH and the World Bank on project-related issues. The PMO located in the DOH, as the lead PMO in project monitoring and reporting, will track the overall progress of the project and consolidate project reports (progress and/or updates, financial and safeguards monitoring, and so on) for reporting to the IATF-ZH and the World Bank.

staffing, facilitation of and/or support for organizing regular multisectoral nutrition coordination meetings at the LGU levels, and regular supervision); development of information systems to facilitate M&E activities and ensure links to 4Ps and other program activities; and studies and/or surveys and citizen engagement activities to assess operational effectiveness of the convergence approach. A comprehensive M&E framework will be established to (i) track the convergence of the nutrition-specific and nutrition-sensitive interventions at the barangay level and (ii) report on nutrition outputs and outcomes indicators. This component will also support capacity-building activities to systematically include and collect data into different health and nutrition surveys at the national and local levels. General information on indigenous populations will be collected and integrated into the overall system. This will also include administrative data as well as the third-party and independent monitoring of PBG indicators. The component could also finance operations research on behavior change, nutrition interventions, and PHC.

(d) **Independent institution for verification of PBG indicators.** The project, through DOH, will contract an independent verification team to conduct the annual review of achievements of PBG indicators, to be funded by the project. The task of the independent verification agent will be to externally verify data on PBG targets achieved by the LGU implementing agencies, using sample and/or risk-based survey methodology agreed in advance with the project implementing entity.

C. Project Beneficiaries

63. **Targeted beneficiaries.** Primary project beneficiaries will comprise children under five years (with attention to children under two years who will be reached by project activities before stunting becomes largely irreversible) as well as pregnant and lactating women in LGUs prioritized for PMNP support. Other beneficiaries will include adolescent girls, to reach women early and improve their health and nutrition status before their most critical reproductive health years. The poorest households will benefit from improved nutrition-sensitive interventions (delivered by the health, social protection, WASH, and education sectors), and the public at large will benefit from national media campaigns as well as health and nutrition-related SBCC.

64. Project beneficiaries who are part of the identified population groups will benefit from culturally acceptable and appropriate health and nutrition services provided by the PMNP. The project will target LGUs based on the following criteria: i) municipalities with stunting rates higher than or equal to 17.5 percent, ii) the incidence of poverty, iii) LGUs with experience in Kalahi-CIDSS implementation, and iv) those covered by the HDPRC/PPAN priority areas. In this regard, the project will cover 235 municipalities and 5,936 barangays in the 12 regions and 26 provinces as well as 3 provinces in the BARRM region as shown in table 6.

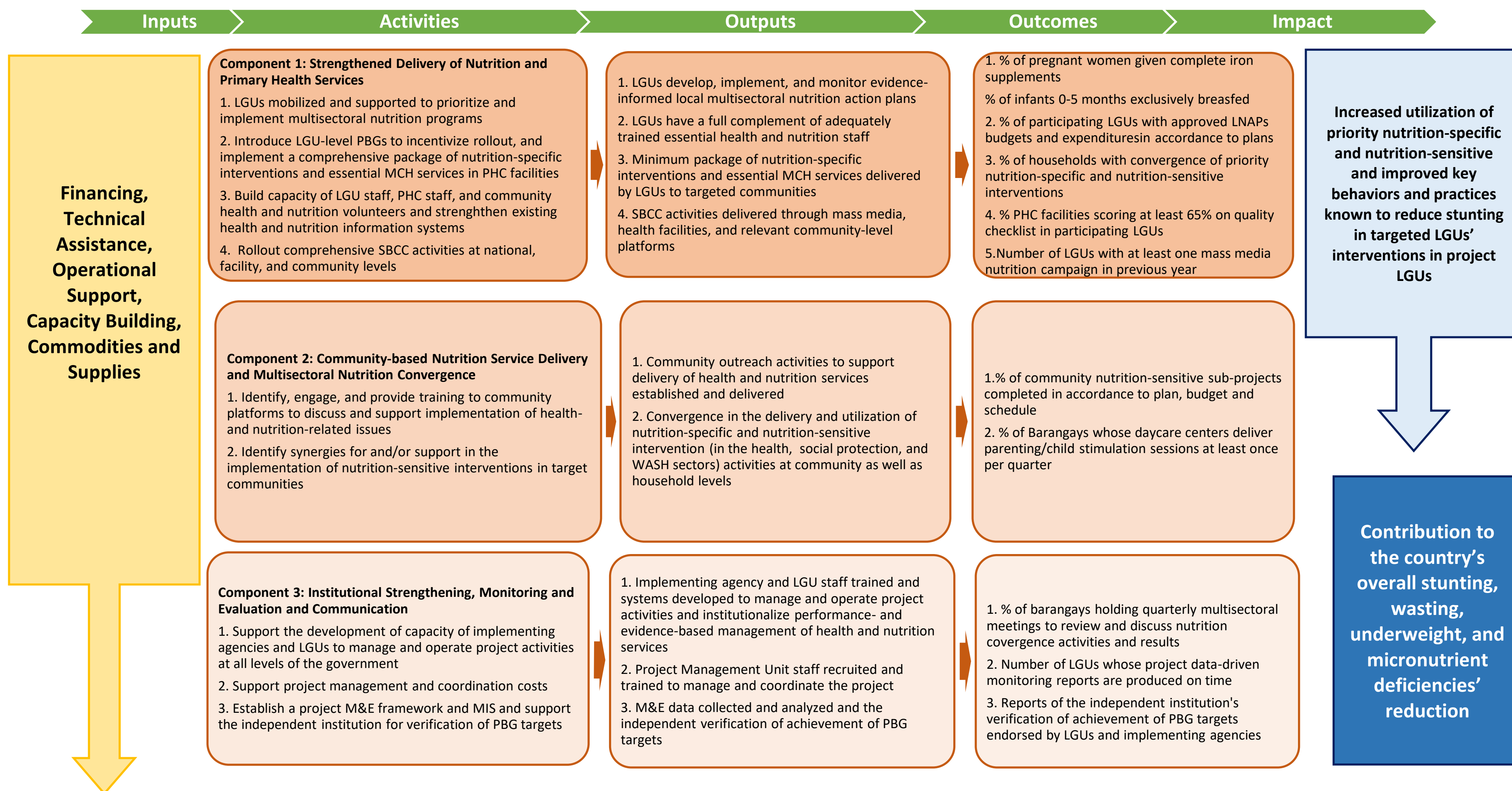
Table 6. Regions and Provinces Covered by the Project

Region	Provinces
Region III (Central Luzon)	Nueva Ecija
Region IV-A (Calabarzon)	Quezon
Region IV-B (Mimaropa)	Occidental Mindoro, Romblon
Region V (Bicol)	Camarines Sur, Catanduanes, Masbate, Sorsogon
Region VI (Western Visayas	Iloolo, Negros Occidental
Region II (Central Visayas)	Cebu, Negros Oriental
Region VIII (Eastern Visayas)	Eastern Samar, Leyte, Northern Samar, Western Samar

Region	Provinces
Region IX (Zamboanga Peninsula)	Zamboanga Del Norte, Zamboanga Del Sur
Region X (Northern Mindanao)	Bukidnon, Lanao Del Norte
Region XI (Davao)	Davao Del Sur, Davao Occidental
Region XII (SOCCKSARGEN)	North Cotabato, Sarangani, Sultan Kudarat
Region CARAGA	Surigao Del Sur
BARRM	Sulu, Maguindanao, Lanao Del Sur

65. **The Municipal Local Government Units in the BARMM region were selected based on the following**: (a) municipalities selected in Sulu are ECCD areas; (b) municipalities selected in Maguindanao have active MNAOs and NDDPs; (c) MLGUs in Lanao del Sur, selected based on their expression of interest, endorsed by the NNC Regional Office in the BARMM. The project will support the MLGUs in developing local health and nutrition plans.

D. Results Chain



Note: HH = household; MIS = Management information system; PBGs = performance-based grants to LGUs.

E. Rationale for Bank Involvement and Role of Partners

66. **The project addresses key gaps and bottlenecks that have hindered nutrition performance through the following:** (a) financial and capacity strengthening of underperforming LGUs; (b) addressing both supply and demand sides through a convergence approach including WASH, and social protection; and (c) community engagement and mobilization together with the use of behavioral interventions**.**

67. **Historically, the Government has invested in largely vertical nutrition programs.** The key bottleneck has been that such programs were not comprehensive, and covered pockets of the country's LGUs. This limited geographic coverage was partly driven by limited budgetary resources and technical capacity of government agencies. The proposed project brings a major paradigm shift through investments that combine demand- and supply-side interventions at scale in LGUs with lagging MCH and nutrition outcomes.

68. **Beyond financing, the World Bank brings a comparative advantage in sourcing global knowledge and TA to inform project design and implementation.** The Government of the Philippines will benefit from targeted knowledge products that focus on implementation of results-based approaches and TA to build the client's capacity to effectively implement the project. The World Bank Group is unique in its ability to mobilize investment financing, TA, and advisory services and galvanize relevant stakeholders, including development partners, in support of a multisectoral approach toward improving nutrition outcomes. The project design will build on local and international best practices and lessons from current and past interventions to strengthen nutrition. The World Bank will finance and facilitate knowledge exchange between the Philippines and regional and global peers with successful track records in tackling malnutrition. It will also provide TA and implementation support to central agencies and LGUs to enable successful rollout and execution of high-impact interventions.

69. **Various development partners provide support for nutrition in the Philippines, including the United Nations Children's Fund (UNICEF), the World Food Program, Nutrition International, the European Union, and Food and Agriculture Organization of the United Nations, among others.** These development partners work through a wide range of nongovernmental organizations and community-based organizations. The large number of partners supporting the Government's program underscores the importance of enhanced coordination, particularly at the municipal level. To this end, during project preparation, efforts were made to consult and seek collaboration with other development partners to ensure synergies across interventions in support of the Government of Philippines' efforts. The proposed project will be closely coordinated with UNICEF, the World Food Program and Nutrition International. These agencies will support select technical areas and provide technical support to the DSWD, DOH, and LGUs in close coordination with the World Bank.

F. Lessons Learned and Reflected in the Project Design

70. **The proposed approach for multisectoral nutrition convergence and a special focus on the first 1,000 days build on a wealth of evidence and experience from across the world.** The early years, or first 1,000 days, of life—from conception, through pregnancy and birth, the newborn period, infancy, and transition to primary school—is a critical period of development. Exposure to risks and adversities during these years can disrupt cognitive, emotional, and physical development and hold children back from reaching their full potential. Such adversities and risks include poverty; malnutrition; lack of access to clean water and sanitation facilities; lack of nurturing care and stimulation; high levels of family stress; exposure to conflict, violence, child abuse, or neglect; and lack of access to quality health care and education services.

71. **Since almost a decade ago, two research initiatives, the Stories of Change and the Exemplars in Global Health, have conducted rigorous studies of 11 countries[45] and four Indian states[46] where childhood stunting has declined significantly (and for exemplar countries, relative to economic growth).**[47] The purpose was to understand which factors contributed to stunting declines and which policy levers and programs across sectors were important for improving the nutrition situation in those countries (or states). Consistent with previous analyses, the case studies revealed that health care, household wealth, and parental education were important predictors of stunting declines in most studies. The roles of other drivers of stunting varied across countries, emphasizing the importance of context. For example, reductions in open defecation were particularly important in South Asian countries, whereas in Ethiopia, improved household food security was key to stunting reduction. In some countries, including Peru, stunting reduction was driven by strategies explicitly focused on improving childhood growth and, in others, pursuing sector-specific targets (for example, WASH interventions and education) indirectly led to improvements in stunting rates. Pivotal enabling factors in almost all countries included high-level political and donor commitment, strong country leadership advocating for mainstreaming nutrition across multiple sectors, attention to cross-sectoral and vertical (national to community) coherence in planning and action, and investments in granular data for monitoring and decision making.

72. **There is also growing evidence that a multisectoral 'convergence approach'—in which coordinated interventions across several sectors are jointly targeted at selected geographical areas down to the household level—can accelerate improvements in child nutritional outcomes.**[48] Such an approach has been successfully applied in Peru, Brazil, and Bangladesh.[49] For example, child stunting rates in Peru fell by almost half in less than a decade (2008–2016),[50] partly because of major multisectoral nutrition.

73. **Modern mass media campaigns and behavior change communications with appropriate cultural messages can potentially play an important role in making stunting visible.** Global evidence on SBCC shows that different types of communication and social mobilization can be used to promote and influence healthy behaviors and sustain behavior change. At its core is change in normative behavior which is expected to lead to new or changed habits. SBCC can directly achieve many positive health and nutrition behavior and social changes, but it may not achieve all without complementary interventions. For example, well-designed SBCC campaigns promoting iron folate acid or vitamin A can successfully increase demand for these supplements; however, without functioning supply chains and sufficient stocks in place in the facilities or communities, the desired levels of use of iron folate acid or vitamin A cannot be attained no matter how high the demand. Likewise, complementary feeding and family planning commodities and staff to administer them must be available to cater to any increase in demand for these. Similarly, for sanitation, SBCC can help influence social norms around open defecation and create demand for toilets usage. However, if affordable and suitable products are not easily accessible in the local market,

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[45] Senegal, Burkina Faso, Ethiopia, Zambia, Tanzania, Rwanda, Nepal, Bangladesh, Vietnam, Kyrgyzstan, and Peru.
[46] Odisha, Chhattisgarh, Gujarat, and Tamil Nadu.
[47] Heidkamp, Rebecca A., Ellen Piwoz, Stuart Gillespie, Emily C. Keats, Mary R. D'Alimonte, Purnima Menon, Jai K. Das, Augustin Flory, Jack W. Clift, Marie T. Ruel, Stephen Vosti, Jonathan Kweku Akuoku, and Zulfiqar A. Bhutta. 2021. "Maternal and Child Undernutrition Progress 2: Mobilizing Evidence, Data, and Resources to Achieve Global Maternal and Child Undernutrition Targets and the Sustainable Development Goals: An Agenda for Action." www.the lancet.com. https://doi.org/10.1016/S0140-6736(21)00568-7.
[48] Levinson and Balarajan 2013; Gillespie et al. 2016.
[49] Huicho et al. 2016; Huicho et al. 2017; Levinson and Balarajan 2013.
[50] Huicho et al. 2016.

and if financing options are not available, actual behaviors may prove difficult to change and sustain, especially for cash-constrained households.

74. **Globally, the World Bank has supported performance-based incentives for health and nutrition.** The proposed project will build on lessons from these programs, including on: (a) structuring the incentives appropriately to avoid disadvantaging poorer LGUs, (b) timely flow of incentives to LGUs, and (c) period review of indicators to align with implementation experiences of LGUs.

75. **The DOH will also draw lessons from its extensive experience in project leadership and management, particularly with those involving LGU implementation.** LGU accountability for performance and fiduciary and procurement management is crucial not just for accounting or auditing purposes but also as they move toward maturity in health systems operations and management. Projects with multi-stakeholder and multisectoral governance are considered good practices, as they encourage greater transparency and accountability. Moreover, strong engagement with civil society organizations (CSOs) improve responsiveness, especially for vulnerable and key affected populations. CSO engagement facilitates agility in the execution, as issues and concerns are quickly raised by the project end users.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

76. **The project's implementation arrangements are based on the respective institutional and jurisdictional mandates and technical competencies of each agency.** The project implementation arrangements are embedded in the overall national coordination mechanism for the multisector nutrition response under the auspices of the IATF-ZH (table 7).

Table 7. Summary of Project Implementation Arrangements

Component	Responsible/Lead Agency	Support Agency/Collaboration
Governance and Interagency coordination	**IATF-ZH (Governance) Office of Cabinet Secretariat**	
Component 1: Strengthened Delivery of Nutrition and Primary Health Services	DOH	NNC, DILG, DoA
Component 2: Community-Based Nutrition Service Delivery and Multisectoral Nutrition Convergence	DSWD	DILG, M/BLGU
Component 3: Institutional Strengthening, Monitoring and Evaluation and Communication	DSWD and DOH	DOH, DILG

77. **The IATF-ZH will provide national-level strategic leadership of the project and, as the steering committee for the project, will also convene the various departments and agencies participating in the project.** Given its powers and functions pursuant to Executive Order No. 101 Series of 2020, the Task Force shall review project progress and performance and resolve specific issues, as required, and will also advise on the project's annual reports. The DOH will formally share updates on the IATF-ZH's resolutions and decisions on the proposed project with the NNC for information purposes only. The OCS will provide coordination support to the activities of the IATF-ZH and will monitor the roles of the Technical Working Group members to ensure delivery of their commitments to the project.

78. **The IATF-ZH was also tasked to "monitor and evaluate, through the identification of key performance indicators, the government's progress in ending hunger, achieving food security,**

improving nutrition, and promoting sustainable agriculture.” In this regard, the National Food Policy’s six key result areas include reviewing and rationalizing existing policies, ensuring available and affordable food, securing nutrition adequacy, securing food accessibility, ensuring resilience in case of emergency, and ensuring awareness and people participation. As a result, the PMNP M&E system will be aligned with the NFP’s goals and will contribute to data collection and reporting on specific key result areas targetsand indicators.

79. **The NTWG, comprising technical departments from the IATF-ZH will enhance inter-agency coordination to plan, implement, and report on interventions.** Comprising technical departments from the membership of the IATF-ZH, the NTWG will be responsible for coordinating technical support services of different agencies at the regional and LGU levels. The NTWG will also provide technical inputs as well as review results of the continuing development of the project’s implementation systems, processes, and technical manuals. The NTWG will be co-chaired by the DSWD and DOH.

80. **The DSWD and DOH, as co-lead implementing agencies:** the DSWD, through the Kalahi-CIDSS National Program Management Office (KC-NPMO), and the DOH PMO shall be responsible for preparation of the project’s plans; project implementation, management, and monitoring; and facilitation and management of fiduciary process and other fund management concerns of the budget allocation per component. The two PMOs shall also prepare the progress reports and other required reports to be submitted to the NTWG, IATF-ZH, and the World Bank. They will also provide technical assistance to their regional/provincial/municipal implementation teams and coordinate with the other participating agencies in ensuring the project work plan is implemented. DSWD and DOH shall work closely with the IATF on Zero Hunger and the members of the National Technical Working Group (NTWG) in the development of program policies and guidelines to be used by the DSWD’s and DOH’s local teams during implementation. Convergence points of implementation and sustainability strategies shall be at the implementation levels**:**

- Regional level wherein DOH and DSWD Regional Program Management Offices meet and consolidate technical inputs and feedback to the RSDCs;
- Health Promotion Committees (HPCs) with representatives from different sectors including Health and Social Welfare officers, guide the Province/City Health Board (P/CHB) in the development of local policies, programs and activities for health promotion emphasizing the social determinants of health and health risk factors;
- DSWD Social Welfare and Development Offices (Provincial Offices) Provincial DOH Offices (PDOHO), and Provincial Nutrition Councils to consolidate provincial-level implementation and technical assistance. DSWD Municipal Area Coordinating Teams and Municipal Nutrition Committees to address implementation concerns at the municipal level;
- Community Nutrition Sub-Project Management Committees and Barangay Nutrition Committees to facilitate and monitor delivery of activities at the community level.

81. **The DSWD will lead the planning, implementation, and reporting on demand-side/community-based multisectoral nutrition interventions, building on the community structures and platforms established under the Kalahi CIDSS Project.** These include WASH, ECD, and increasing access of 4Ps beneficiaries to nutrition programs and services. The DSWD Kalahi CIDSS PMO will be expanded to support the proposed project and will be staffed with technical, fiduciary, and ESF specialists. Internally, the DSWD PMO will build synergies with other ongoing DSWD programs, such as the 4Ps and the Kalahi CIDSS Project. The Office of the Assistant Secretary for Special Programs will have oversight of the PMNP. A Director will

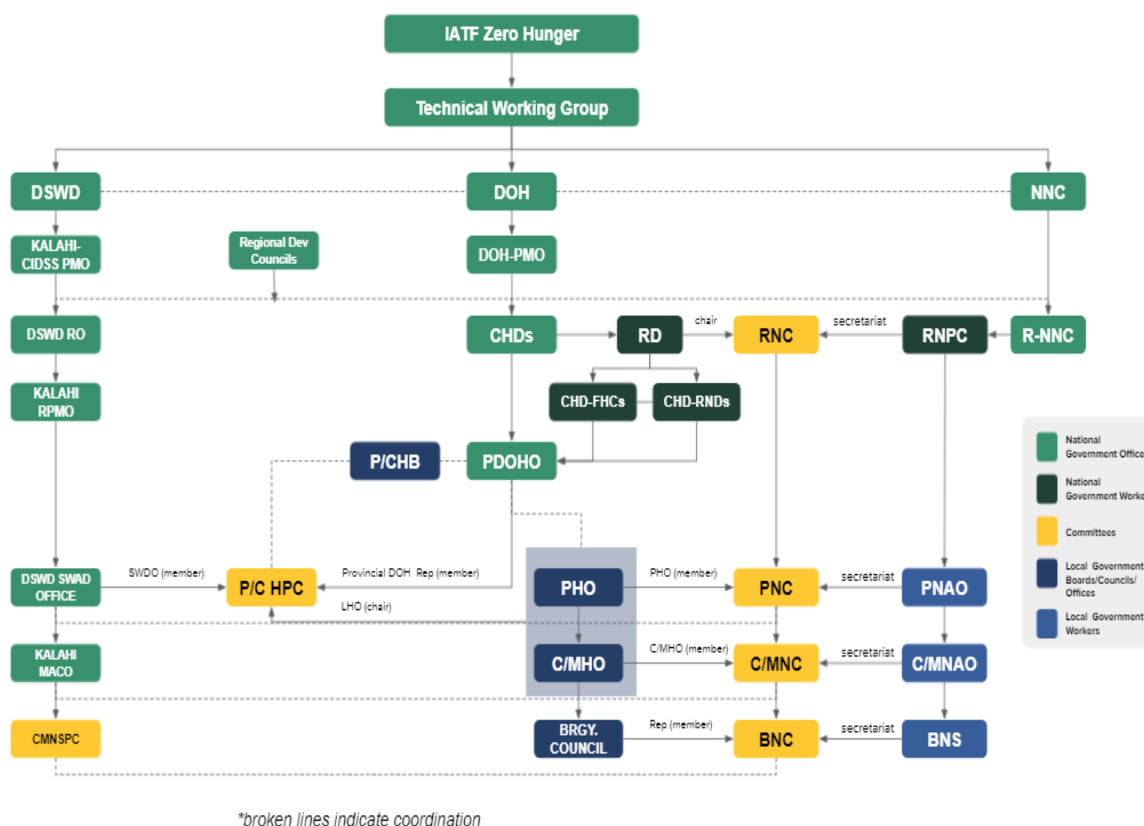
oversee the day-to-day management of the project, and an Under Secretary will be overall responsible for activities under the DSWD.

82. **The DOH will lead the planning, implementation, and reporting on supply-side health and nutrition interventions and SBCC interventions.** The DOH and NNC will provide regulatory guidance on the design and implementation of health and nutrition interventions. These interventions include those executed at the national and LGU levels. At the national level, an NPMO will be established to reinforce technical, project management, and ESF compliance capacity. The DOH PMO will be co-led by Directors of the Bureau for International Health Cooperation (BIHC) and Disease Prevention and Control Bureau (DPCB). The DOH Health Promotion Bureau (HPB) and Knowledge Management and Information Technology Service (KMITS) will also provide national-level support for SBCC activities. The DOH Centers for Health and Development (CHDs) will directly support project implementation at the regional and LGU levels with the help of the Provincial Department of Health Office (PDOHO). The Under Secretary of Health Policy and Systems Development and the Under Secretary of Public Services Health will be overall responsible for the project in the DOH. The DOH shall have the technical oversight of project implementation and shall closely work with the implementation teams of the DSWD KC-NPMO and KC-Regional and Provincial Project Management Offices (RPMOs) in project monitoring and management, especially on the monitoring of target outcomes related to improvement of the nutritional status of children targeted by the project. Appropriate strategies on how to deliver services shall be developed in consultation with the tribal leaders.

83. **The DoA will have technical oversight for the inclusion of food diversification and production as part of messages in the SBCC activities of the PMNP.** With food diversification and production included as components of SBCC, the DoA shall help provide technical assistance and training to local government units aiming to influence behaviors that improve food diversification and help ensure that these communities will be able to develop viable and sustainable alternative sources of food to support the nutrition targets of their families.

84. **To strengthen integrated implementation and reporting of PMNP activities, the DOH will be the lead agency to consolidate reports on the project's technical and fiduciary progress and on E&S safeguards compliance to the IATF-ZH, as the project steering committee, and to the World Bank. .** However, both DOH and DSWD will fulfill E&S and fiduciary responsibilities for their respective activities. In line with this, both the DOH and DSWD will be responsible for preparing their annual work plans for their respective parts of the project.

Figure 2. Implementation Arrangements



Note: C/MHO = City/Municipal Health Officer; P/C/MNAO = Provincial/City/Municipal Nutrition Action Officer; CHD = Center for Health & Development (DOH Regional Office); CHD-FHC = CHD Family Health Cluster; CHD-RND = CHD Regional Nutrition-Dietitian; CNSPMC = Community Nutrition Sub-Project Management Committee; LHO = Local Health Office; P/CHB = Provincial/City Health Board; P/C HPC = Provincial/City Health Promotion Committee; PDOHO = Provincial DOH Office; R/P/C/MNC = Regional/Provincial/City/Municipal Nutrition Committee; RD = Regional Director; RNPC = Regional Nutrition Program Coordinator; SWDO = Social Welfare and Development Office.

85. **The MLGUs will have the primary responsibility for developing their LNAPs, costing them out, and defining targets.** MLGUs will utilize PBGs to plan and implement interventions to expand the coverage and quality of MCH and nutrition services based on the approved LNAPs. The MLGUs will also set up and manage special funds where the money earmarked for the project's multisectoral nutrition plans would be kept. The MLGUs will apply the same methodology and protocol to the development of the LNAPs as they use for their standard planning processes. The MLGUs will be supported and guided by the expanded Municipal Nutrition Council. The signing of Tripartite MOA will be completed within ninety days following project effectiveness. The LGUs will self-report their progress on the PMNP semi-annually based on a format outlined in the POM.

86. **The BLGUs shall be the operational platforms for the delivery and management of institutional nutrition-specific and nutrition-sensitive interventions.** They will serve as focal points for planning, coordinating, and implementing project activities across concerned sectors. They will also provide oversight to the BNCs and the CNSPMCs. Comprising BNSs, Barangay Health Workers, ECCD Workers, and other designated Barangay health staff, BNCs' key roles in the implementation of project activities shall include the following: facilitating the profiling of households with pregnant women and children under

five years old; assisting Barangay Health Centers in the delivery of essential nutrition and MCH services in primary health facilities; and delivering health and nutrition-related SBCC to communities and direct project beneficiaries.

B. Results Monitoring and Evaluation Arrangements

87. **The results framework indicators for the project shall be monitored using a combination of administrative and survey data.** The project's MIS will serve as the primary source of administrative data for tracking process- and output-level indicators. The project's MIS will be harmonized with other data information systems, including the Kalahi-CIDSS Project Information Management, NNC's ECCD First 1,000 Days Reporting System, Pantawid Pamilyang Information System, and the DOH FHSIS. In addition to the project's MIS, the project will strengthen existing reporting systems at the LGU levels to improve timeliness and accuracy of data on nutrition outputs and outcomes. Progress reports will include key information on project activities, beneficiaries, fiduciary, and E&S management. The PMOs, in close coordination with the NTWG, will review monitoring data to access implementation progress and, where necessary, propose remedial actions. Outcome- and impact-level indicators are expected to be monitored through existing periodic household surveys, such as the Department of Science and Technology (DOST) NNSs and the PSA Agriculture and Food Consumption Surveys, in the target provinces and the rest of the country. More crucially, routine information systems, such as the DOH FHSIS and the NNC's OPT (for growth monitoring), will be strengthened and harmonized for LGU use in their LNAP. The project results framework is provided in section VII.

88. **Due to the paucity of data on some of indicators in the results framework, and especially for those provinces targeted by the Project, as well as among IP communities, the baseline values for those indicators have been assigned as "to be determined (TBD)". Consequently,** a comprehensive baseline survey will be conducted by the third quarter of calendar year 2022 to establish actual performance status of the selected LGUs, as well as baseline values for project indicators. In addition to the nutrition-specific indicators, the baseline will provide information on systems capacities that will be the basis for the PBGs that the project will use to incentivize LGUs. Following completion of the baseline survey, the results framework will be updated accordingly, including review and confirmation of indicator target.

89. **The progress and achievement of the PDO will be monitored and evaluated through the following activities:** (a) semiannual implementation support missions, (b) annual project status and progress reports, (c) midterm project review, and (d) a final review of the project outcomes upon closing of the project.

C. Sustainability

90. **The project is fully aligned with the PDP and PPAN 2017–2022.** The project supports the Government's efforts to reduce childhood malnutrition, thereby contributing to human capital development in the long term. The prospects for sustainability of activities supported under the project are considered reasonably good from an institutional perspective. Several sustainability enhancing measures augur well for the institutional sustainability of the proposed interventions. First, the project focuses on training and capacity building at all levels, from parents, caregivers, and BHWs/BNSs at the community level to health staff, LGU personnel, and national stakeholders. Strengthened decentralized capacity to oversee, monitor, and coordinate multisectoral activities will bolster LGU institutional capacity. Enhanced knowledge and awareness of childhood stunting among mothers, caregivers, health personnel, and the public at large are expected to lead to behavior changes that will go beyond the life of the project. Second, the design leverages and builds on the existing institutional structures that have been in effect for several decades such as the decentralized structures and an experienced implementation

unit. The DOH seeks to use the PMNP to functionally integrate nutrition, as provided for in RA 11148, as part of PHC services, as the country's health system transitions toward UHC. Strengthening PHC services is key to achieving accessible health care that is provided for by Republic Act 11223, the UHC Act, which stipulates that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services, protection against financial risk, and a health care delivery system that will afford every Filipino a primary care provider.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

Development Impact in Terms of Expected Benefits and Costs

91. **Improving child nutrition, especially during the first 1,000 days, is critical for building human capital.** The cognitive skills acquired during the early years form the basis of future learning and economic productivity. Human capital matters for the economy since, according to some literature, between 10 percent and 30 percent per capita income difference can be attributed to cross-country differences in human capital. Globally, productivity losses due to childhood undernutrition represent more than 10 percent of an individual's lifetime earnings, and the GDP lost to undernutrition could be as high as 2–10 percent.

92. **Two studies have sought to assess the total cost of undernutrition for the Philippines.** The first, by Save the Children (2016),[51] estimated the loss due to lives lost because of stunting in terms of income forgone and the cost in terms of lost productivity for the stunted who survive. Approximately 838,000 lives were estimated to have been lost due to stunting before the age of five among children who would have reached working age in 2013. Excluding this group from the workforce implies a loss in income to the country estimated at PHP 160 billion (US$8.9 billion). For those under five years of age who were stunted but survived, the cost of lost productivity resulting in lower earnings was estimated to be 2.83 percent of GDP. The study also estimated that school grade repetitions equated to 0.01 percent of GDP. Morbidity attributed to undernutrition (stunting and low birth weight due to intrauterine growth retardation, diarrhea, acute respiratory infection, and anemia) was estimated at 3.7 million episodes, resulting in private and social health costs equivalent to 0.05 percent of GDP.

93. **A second study by UNICEF (2017b) estimated the cumulative economic loss from undernutrition due to various nutritional indicators.** The study considered the following consequences of malnutrition: (a) earnings losses due to child mortality attributed to undernutrition marked by poor maternal nutrition, low weight-for-age, suboptimal breastfeeding, and zinc and vitamin A deficiencies; (b) losses in productivity due to poor cognition as a consequence of undernutrition; (c) current losses in productivity due to anemia among the working adult population; and (d) losses expressed as spending on health care to address zinc deficiencies, suboptimal breastfeeding, and low birth weight. The total cost to the economy through all these channels amounted to US$4.4 billion or 1.5 percent of the Philippines GDP in 2015. Earnings forgone due to productivity losses associated with undernutrition constituted two-thirds (71 percent) of this burden, while stunting alone contributed to half of the burden.

94. **Investments in nutrition are highly cost-effective.** Unlike investments in physical infrastructure, investments intended to reduce malnutrition generate benefits that are durable, inalienable, and portable. These investments also fuel progress on all 17 development goals enshrined in the SDGs,

[51] Save the Children. 2016. *Cost of Hunger: Philippines. The Economic Impact of Child Undernutrition on Education and Productivity in the Philippines.* Makati City, Philippines: Save the Children Philippines.

including improving education and alleviating poverty. Hoddinott et al. (2013)[52] estimated the benefit-cost ratio for nutrition investments in the Philippines at 43. In other words, every dollar invested in nutrition has the potential of yielding a US$43 return. A UNICEF (2017b)[53] study obtained a lower estimate, projecting the benefits accruing from a nutrition intervention scenario at the national level through key nutrition-specific interventions rolled out over 10 years at full coverage. The cumulative benefits estimated are US$12.8 billion over a 10-year period with a corresponding cost of US$1,062 million, yielding a benefit-cost ratio of 12:1.

95. **The results of the economic analysis conducted for this project show that the project is economically viable with an economic internal rate of return of 33.6 percent and a net present value (at 10 percent) of PHP 25.3 billion.** The benefits quantified include benefits of averted mortality, benefits from averted morbidity, and lifetime productivity benefits. The benefits were estimated using the package of nutrition interventions targeting pregnant women and children to reduce child stunting by Bhutta et al. (2013) and the analysis by Wong and Radin (2019)[54] for Haiti and converted to Philippine currency. While three percent is traditionally used as the discount rate in health economics papers, here the estimated values use a 12 percent discount rate and take the value at the 25th percentile for conservative estimates that may be applied to the Philippines context. Thus, the economic benefits presented are on the lower end of estimates. Morbidity-averted benefits are valued using the willingness to pay to avoid a case of diarrhea and applying this value to all other cases of averted illnesses (acute lower respiratory infections and other infections), which is estimated at US$10 per child reached. Finally, since averting stunting in childhood has significant impacts on future productivity as an adult, lifetime productivity benefits are estimated and monetized following the typical age-earnings profile approach used in education literature. The benefit is estimated at US$109 per child. The estimated benefits of averted mortality, benefits from averted morbidity, and lifetime productivity are multiplied by the number of children beneficiaries estimated each year of the project beginning in 2026 and calculated as net present value of PHP 25.3 trillion, with an economic rate of return of 33.6 percent. Finally, the project costs are compared to project benefits to compute the benefit-cost ratio. The investment in 2022 will generate a 3:2 benefit-cost ratio.

Technical

96. **The design of this project was guided by global evidence that a package of high-impact interventions, delivered at scale and focused on the critical 'first 1,000 days', can significantly reduce stunting.[55]** In 2013, and again in 2021, the Lancet Series on Nutrition identified effective interventions that would reduce the burden of stunting by at least one-fifth if all delivered at 90 percent coverage. Implementing multisectoral nutrition-sensitive interventions that address the multidimensional causes of malnutrition simultaneously with nutrition-specific interventions is expected to reduce the remaining 80 percent. Reversal of stunting requires nutrition-specific interventions that focus on improving both child

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[52] Hoddinott, J., A. Alderman, J. Behrman, L. Haddad, and S. Horton. 2013. "The Economic Rationale for Investing in Stunting Reduction." *Maternal and Child Nutrition* 9 (Suppl. 2): 69–82.
[53] UNICEF (United Nations Children's Fund). 2017b. *Business Case for Nutrition Investment in the Philippines.*
[54] Wong, B., and M. Radin. 2019. "Benefit-Cost Analysis of a Package of Early Childhood Interventions to Improve Nutrition in Haiti." *Journal of Benefit-Cost Analysis* 10 (Suppl 1): 154–184. https://doi.org/10.1017/bca.2019.1.
[55]Bhutta, et al. 2013. "Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done and at What Cost?" *The Lancet* 382 (9890).

and maternal health.[56] To this end, the project aims to scale up best-buy nutrition-specific interventions in high stunting municipalities, targeting children under five (with a focus on those under two) and pregnant and lactating mothers.

97. **The design also draws on global experience, including data gathered by Alive and Thrive in Bangladesh, Vietnam, and Ethiopia, that showed that contextualized communication and mass media messages can rapidly improve knowledge about nutrition and child feeding practices at scale** (a priority area of behavior change for stunting reduction). These experiences are also reflected in the central role of the community-based health and nutrition services in the project, as a key platform to facilitate regular education, counseling, and mobilization of families and caregivers to improve nutrition behaviors and practices. The project also strengthens links between the community-based nutrition and health services and primary care facilities to improve uptake of facility-based interventions in the minimum MCH package and can support the synergistic relationship between nutrition and health outcomes. It will further support the strategy through efforts to increase coordination and convergence of this project with nutrition-sensitive actions in other sectors focusing on agriculture, WASH, and social protection and leveraging existing community-based nutrition and health platforms.

Rationale for Public Sector Provisioning/Financing

98. **Public investment in nutrition in the Philippines is justifiable due to equity considerations and widely recognized market failures resulting from limited competition, imperfect information, and externalities.** The burden of stunting in the Philippines falls disproportionately on poor households, with 42 percent of children from households in the poorest quintile being stunted compared to 11 percent of children from households in the wealthiest quintile. Therefore, targeted public financing and provision of nutrition and nutrition-related services are necessary to improve the benefits to the most vulnerable individuals and society, more so given the invisible nature of childhood stunting. Investments in behavior change communications and awareness raising have a large public good element with benefits accruing to society at large as improved nutrition reduces the impact of disease and improves national productivity.

B. Fiduciary

(i) Financial Management

99. **Based on the FM assessment of the project carried out in accordance with the 'Financial Management Practices in World Bank-financed Investment Operations'**, the FM systems at the DSWD and the DOH meet the World Bank's requirements, provided the recommended mitigating measures described below and in Annex 1 are incorporated in the design and implementation of the project. There is sufficient basis to rely on the country systems for all FM aspects of this project.

100. **The project will be implemented by both the DSWD and DOH, which will have overall responsibility for its coordination and management.** The project will involve implementation of various components in partnership with other agencies such as the NNC, DoA, and DILG as well as with the LGUs. The DSWD has been implementing World Bank-assisted projects and is familiar with World Bank requirements on the maintenance of acceptable FM arrangements. Likewise, the DOH has an extensive history of managing internationally financed projects, including from the World Bank, the most recent being the COVID-19 vaccine projects. Adding in the multisectoral and highly decentralized nature of the

[56] Maternal stature and nutrition are important predictors of intrauterine growth retardation and size at birth (Ozaltin et al. 2010). Maternal birth weight not only affects the birth weight of the offspring (Ramakrishnan et al. 1999) but also extends to health later in life. For example, birth weight is inversely related with the risk of coronary heart disease and stroke (Barker and Clark 1997; Huxley et al. 2007).

project involving multiple implementing and partner agencies including the LGUs and the complexity of administering PBGs pose significant FM risks. Thus, the residual FM risk of the project is assessed to be Substantial after the proposed mitigating measures, described in the following paragraph, are implemented and have shown effective impact.

101. **The mitigating measures to reduce risks associated with the current FM systems are to** (a) maintain separate books of accounts for the project; (b) finalize and adopt a POM that includes an FM section to formalize control processes specific to the project; (c) strengthen regional/sub-national PMOs and hire adequate FM staff complement in DOH and DSWD at the national, regional, LGU, and community levels to ensure adequate oversight over project funds; (d) approved Work and Financial Plan to be agreed between the DSWD and DOH Central and Regional offices as a requirement for fund transfers for better funds monitoring; (e) formalize agreed implementation arrangements through an MOA for components that will be implemented through partner agencies and LGUs, enumerating the roles and responsibilities and accountability over funds downloaded; (f) use of Treasury Single Account (TSA) and Modified Disbursement System (MDS) subaccounts for project disbursements; (g) address findings of the Commission on Audit (COA) on the annual audited project financial statements within six months from the issuance of the audit report for the project; and (h) provide relevant fiduciary training/capacity building for the project staff.

(ii) Procurement

102. **Applicable Procurement Framework.** Procurement under the project will be carried out in accordance with the World Bank's Procurement Regulations for IPF Borrowers - Fourth Edition, dated November 2020 (hereinafter referred to as "Procurement Regulations"), the relevant provisions of the Loan Agreement, and the Procurement Plan agreed with the Bank. All contracts for goods, works, and non-consultancy and consultancy services to be procured in line with the national market approach shall follow the Philippines' national procurement procedures (NPP) set out in the Philippines' Government Procurement Reform Act (GPRA) (Republic Act 9184), which were assessed and found to be broadly consistent with the requirement of the World Bank Procurement Regulations, section V - paragraph 5.4, National Procurement Procedures. The project will be subject to the Bank's Anticorruption Guidelines, dated October 15, 2006, revised in January 2011 and as of July 1, 2016. The project will use the Systematic Tracking of Exchanges in Procurement (STEP) to plan, record, and track procurement transactions.

103. **Procurement capacity and risk assessment (PCRA).** The two agencies which will be responsible for conducting the major procurement under the project are the DOH and DSWD. The DOH will be responsible for procurement under Component 1 and the DSWD will be responsible for all procurement under Component 2 while the procurement for Component 3 will be carried out by both agencies. PBGs of Component 1 cover in-kind and in-cash assistance. For in-kind support, the procurement of primary health care equipment will be implemented by the DOH through its Regional Offices (Centers for Health Development). The procurement activities using cash grants[57] will have small values and simple scope and will be conducted by the concerned LGUs with support of the Regional Offices. Component 2 will be implemented by the DSWD and will follow the structures of the Kalahi-CIDSS Project. In particular, the component will build on the Kalahi-CIDSS Project's community-driven approach.

104. A menu approach will be used for implementation including procurements, meaning that the community grants will be eligible for funding as outlined in the POM. An assessment of the procurement capacity and risks of the implementing agencies conducted during project preparation revealed the

[57] Total cash grant is PHP 3,584 million, equivalent to around US$71 million, approximately US$100,000 per LGU per year.

following findings: the DSWD has relevant experience in procurement under the World Bank-financed KC-NCDDP (using the Bank's Procurement and Consultant Guidelines), KC-NCDDP Additional Financing, and Beneficiary First Social Protection Project, applying the Bank's Procurement Regulations, but implementation commenced only recently. The DOH has some experience in implementing externally financed projects including the ongoing Philippines COVID-19 Emergency Response Project (PCERP) [58] funded by the World Bank. The DOH's Regional Offices and the LGUs PBG recipients have had experience in doing similar procurements in the other projects/programs. The procurement scope and scale of the proposed project require multisectoral and multi-stakeholder collaboration with huge demand for supplies and equipment, as well as products/services delivery to the LGUs and communities. The community recipients are expected to be able to handle the required procurement activities based on the experiences and institutional arrangements that have been generated under the KC-NCDDP. With the specific risk mitigation measures to be implemented, the DOH, DSWD (including their regional offices), and LGUs are considered having adequate capacity for executing procurement activities of the proposed project. The procurement residual risk was assessed as Substantial. The following key procurement risks and mitigation measures were identified and agreed with the Implementing Agencies:

S. no.	Risk Descriptions	Mitigation Measures
1	The start of project implementation depends on the approval of the Work and Financial Plan (WFP), which follows government procedures and often delays. The approval of the Procurement Plan can only come after the approval of the WFP.	• The WFP and Procurement Plan shall be prepared and submitted on time • Concerned units of the DOH and DSWD assigned to the PMNP, such as the Finance and Procurement Units, to work closely with the relevant Offices/Bureaus/Services/Units of the Departments to facilitate the timely approval of the WFP
2	Delays in procurement process due to capacity constraints (weak procurement capacity, lack of experience in Bank's Procurement Regulations, constraints of staffing resources, face-to-face capability building activities may be affected by health protocols for COVID prevention)	• Recruitment of a Procurement Agent (PA), or consultancy firms/individuals to support procurement implementation • The initial start-up procurement activities are going to focus on introduction and capacity strengthening of LGUs to implement the PBGs. The Terms of References (TORs)s of the PA will include tasks for an on-the-job training of selected number of designated members of the DOH regional procurement units during procurement management process by the PA. • Separate and exclusive BAC for the Bank project, accelerate the Government's internal approval of procurement documents • Bank will provide training on Procurement Regulations and the use of STEP • Bank's prior and post review, regular implementation support missions, hands-on fiduciary advice and guidance • To arrange facilities for online trainings
3	Low procurement readiness in the first year of the project	• Enhancement of procurement readiness by mobilizing resources to prepare TORs of critical consultancy services, specifications/draft bidding documents of key goods/works packages, training on procurement procedures and STEP before project effectiveness

[58] World Bank. 2020. *Philippines - COVID-19 Emergency Response Project*. Washington, DC: World Bank Group. https://imagebank2.worldbank.org/search/32002941

S. no.	Risk Descriptions	Mitigation Measures
4	Improper packaging plan, inappropriate technical requirements/design, and low levels of interest/participation from market, which may result in bidding failure or low value for money of concerned procurement activities	• Appropriate procurement packaging arrangements, detailed and realistic procurement schedules, contract management plan are defined in the PPSD • Preparing technical specifications/TORs based on market surveys • All factors, such as delivery and hauling of materials, among others, shall be considered in the preparation of technical documents
5	Procurement failure due to lack of adequate supply of essential goods and services, especially during pandemic time: disruption of supply chains, supply shortage, higher price and longer delivery periods, disruption in transport and logistics	• Implementing Agencies will explore opportunities to use relevant selection arrangements approved in Procurement Regulations which enable capitalizing competitive advantages of existing entities and promote value for money of concerned investments • Proactive planning, taking into consideration the anticipated challenges and identifying mitigating activities • Realistic cost estimation, considering the risk of higher price due to the pandemic
6	Integrity risks	• Ensure transparency and fairness as per requirements in the Bank's Procurement Regulations • Training COA auditors involved in the review of community sub-project expenditures and procurement • Engaging CSOs to support procurement transparency and monitoring

Note: Some other risks and mitigation measures are detailed in the PPSD.

105. **PPSD Summary and Procurement Plan**: The DOH and DSWD have prepared a PPSD to inform fit-for-purpose procurement arrangements that will support the PDO achievement. Based on the PPSD findings, the two agencies recommended a Procurement Plan that was agreed by the World Bank. Both the PPSD and Procurement Plan will be regularly updated during project implementation as needed. The major procurement categories to be financed by the Bank and their implementation arrangements are described below:

(a) **Goods and Non-consulting Services.**

i. *Component* 1: The large procurements envisaged are Primary Health Care Services Support, Health and Nutrition Service Systems Strengthening, nutrition commodities, and seed packages of health care equipment as a part of PBGs for LGUs, accounting for around 40 percent of the total procurement value of the component. In general, these commodities are available in the Philippines market. In case of shortage of any specific items in the national market, international bidding will be considered. The PPSD recommended the DOH's NPMO to hire a United Nations (UN) Agency such as the United Nations Office for Project Services (UNOPS) or UNICEF as a third-party PA to help carry out bidding for the nutrition products and the other critical goods and services to be procured centrally by the DOH.[59]

[59] Justifications for the PA arrangement are provided in Annex 1.

ii. *Component 2*: Goods, equipment, and non-consulting services to implement community sub-projects to increase access to appropriate sanitation and hygiene practices (Community Led Total Sanitation [CLTS]), and access to ECCD will be procured through the CDD arrangement as per guidance in the Procurement Regulations and the POM.

iii. *Component 3*: Goods, equipment, and non-consulting services required for institutional strengthening and project management support: There is a competitive market in the country for such types of goods and services. Request for Bids (RFB) or Request for Quotations (RFQ) procedures as per the Procurement Regulations will be followed.

(b) **Works.** Some small value construction works at the LGU level would be funded by the community (block) grants under Component 2 through the CDD arrangement as per guidance in the Procurement Regulations and POM.

(c) **Consulting services.** Consulting firms/individuals will be required for various capacity building, TA activities, advisory services, and project management support under the three components. The commonly used methods in this project should be Quality Cost Based Selection (QCBS), Consultant’s Qualifications Based Selection (CQS), and International Competitive Bidding (ICB).

106. More details on the PCRA, the procurement approaches, and implementation support arrangements are presented in Annex 1.

C. Legal Operational Policies

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

D. Environmental and Social

107. **The proposed project interventions are expected to have positive long-term health benefits to communities in targeted areas.** The project will be co-led by both the DOH and DSWD and envisages delivering nutrition-specific and nutrition-sensitive interventions across participating LGUs primarily by enhancing nutrition service delivery, introducing LGU PBGs, and community-based nutrition services. The project will also support minor civil works for interventions at the community or household level.

108. **An E&S due diligence has been conducted for the project.** Based on project characteristics and the key findings of the E&S diligence, ESS1 (Assessment and Management of Environmental and Social Risks and Impacts), ESS2 (Labor and Working Conditions), ESS3 (Resource Efficiency and Pollution Prevention and Management), ESS4 (Community Health and Safety), ESS5 (Land Acquisition, Restrictions on Land Use and Involuntary Resettlement), ESS7 Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities), and ESS10 (Stakeholder Engagement and Information Disclosure) are deemed relevant to the project.

109. **E&S risks and impacts associated with these interventions are considered Moderate.** Potential E&S impacts are expected to be generated mainly from health care and nutrition services at the local level, and small value construction works at the LGU level funded by the community (block) grants, for example: (a) generation of health care wastes (for e.g. syringes, personal protective equipment, spent vaccine vials, etc.) from the immunization, deworming, and other health care and nutrition services; (b) nuisance and pollution from minor construction activities as part of small value works such as digging small community/household wells, maintenance and management of community water sources, construction of basic HH and/or community toilets; (c) noise, water and air (dust) odor pollution; and (d) community and workers occupational health and safety under the COVID-19 pandemic mainly from minor construction works. The E&S risks associated with health care waste will be localized and mitigated effectively by implementing the Philippines Health Care Waste Management Manual and through the Environmental and Social Management Framework (ESMF), which includes the Environmental and Social Management Plan (ESMP), Environmental and Social Codes of Practice (ESCOPs), and Labor Management Procedures (LMPs).

110. **Although the project will have long-term positive social impacts on the nutrition status of beneficiary populations, a significant risk associated with the project's design is ensuring equitable access to project benefits, particularly for indigenous communities.** Likewise, health and nutrition interventions should be designed and implemented in a manner that is culturally appropriate and adapted to the social and cultural characteristics and norms of indigenous populations. To mitigate these risks, an indigenous people's approach has been integrated as core design and as a cross-cutting theme across different components and subcomponents. Additional E&S institutional arrangements and requirements will be reflected in the Environmental and Social Commitment Plan (ESCP).

111. **The project and E&S instruments were prepared and informed by a consultation process implemented in May and September 2021. For this purpose, the project developed a Stakeholder**

Engagement Plan (SEP) and a Resettlement Policy Framework (RPF). Although the project will rely primarily on land donations and use of public land for small civil works activities, the project has prepared an RPF as a precautionary measure in case right of way access and land acquisition is needed during implementation. The SEP was developed to ensure participation from different government agencies, LGUs, Barangays, communities, and other key stakeholders from civil society and indigenous communities. The SEP also includes a grievance redress mechanism (GRM) by which people can raise concerns, provide feedback, or make complaints about the project during implementation.

112. **An ESMF has been prepared to assess and manage the E&S risks and impacts of the PMNP.** The framework has been prepared since the project involves a series of sub-projects, whose specific locations, detailed design, and other relevant information are not known until implementation. The ESMF serves as a tool for the E&S assessment process to be undertaken once the respective technical details of the sub-projects are available and includes criteria and procedures to screen, identify, and mitigate potential E&S risks of the proposed activities and interventions. During implementation, the sub-projects or activities will be screened, and the associated E&S instruments will be prepared and implemented in accordance with the guidelines and requirements set forth in the ESMF.

113. **An LMP has been prepared in accordance with national law and the requirements of ESS2 on Labor and Working Conditions as part of the ESMF.** These procedures are designed to protect the workers employed under the project and include requirements to implement adequate occupational health and safety measures for them. The LMP identifies the main labor requirements and risks associated with the project and is designed to help the implementing agency in determining the resources necessary to address project labor issues.

114. **Arrangements for E&S implementation, monitoring, and supervision.** To ensure coordination and collaboration among the two co-leading departments, DOH and DSWD, the institutional arrangement includes two PMOs and internal agreements to formalize coordination for E&S compliance purposes. One environmental and one social qualified staff/resources will be engaged at each of the DOH and DSWD NPMOs to support management of E&S risks and the implementation of the E&S instruments. Formal implementation arrangements in the form of an MOA between the DOH, DSWD, and LGUs will be established and maintained to support the implementation of the project at national, regional, and provincial levels and enable smooth reporting to the Bank on implementation progress, monitoring, and supervision.

115. **Public consultation and disclosure of information.** Stakeholder consultations on the ESMF, LMP, RPF, SEP, and ESCP were conducted in March and July 2021 with various stakeholder representatives from (a) institutional/government that include the National Commission on Indigenous Peoples (NCIP), National Anti-Poverty Commission (NAPC), and the Presidential Commission for the Urban Poor (PCUP); (b) local government chief executives/representatives; (c) IP communities and mandatory representatives along with the NCIP; and (d) nutrition experts and partners from various groups, including international organizations, civil society groups, and academic institutions. The feedback from the consultations has been reflected in the revised E&S documents. To comply with disclosure and access to information requirements, the DOH disclosed the ESCP (February 2022), ESMF and SEP (March 2022) on their official websites[60]. The ESCP, SEP, and appraisal Environmental and Social Review Summary were

[60] https://doh.gov.ph/project/philippines-multisectoral-nutrition-project; https://kalahi.dswd.gov.ph/press/downloads/category/52-environmental-and- social-management- frameworks.

disclosed by the World Bank on May 29, 2022, with the appraisal Project Information Document being disclosed on November 4, 2021. The ESMF was disclosed by the World Bank on March 23, 2022.

Gender

116. **Gender differences in nutritional status and diet are common in the Philippines.** For instance, the prevalence of child stunting is consistently higher for boys than for girls, though with little significant difference. In 2008, 33.6 percent of boys and 31.1 percent of girls under five years of age were stunted, improving only slightly more than a decade later at 29.5 and 28.1 percent, respectively. In the first six months of life, stunting prevalence is 14.3 percent, increasing with age up to 40.7 percent for boys 12–23 months old before falling to 35.4 percent at 48–59 months old. On the other hand, stunting prevalence in the first six months for girls is 11 percent and rapidly rises to 31.7 percent at 12–23 months old, until the prevalence is higher than that of boys in the following age ranges: 40.3 percent and 38.3 percent at 36–47 months and 48–59 months old, respectively (NNS 2015). For women, a measure of maternal nutrition used by the DOST-Food and Nutrition Research Institute (FNRI) in its last three NNS reports—the percentage of pregnant women who are 'nutritionally at risk'—has not improved. In 2011, 2013, and 2015, about one in four pregnant women was estimated to be nutritionally at risk. Furthermore, in 2015, pregnant women under the age of 20 were twice as likely to be nutritionally-at-risk than women above the age of 20 (39.6 versus 21.9 percent).[61] Iron deficiency is also more common among women of childbearing age (8.2 percent) than among men (3.4 percent) because of iron loss during menstruation (ENNS 2019).

117. **Limited access to health and nutrition services and economic opportunities are significant determinants of childhood undernutrition and they have notable gender gaps.** Literature on the drivers of stunting in the Philippines points to resources for food security; home care; and health care drivers such as the mother's marriage status, employment status, and education level. Nationally, women and adolescent girls face limited access to quality and essential family planning, maternal health, and nutrition services.

118. **The government sector is the most popular source for modern contraception in the Philippines, serving 56 percent of users through barangay health stations, government hospitals, and urban or rural health centers.** However, over 48.7 percent of unmarried women and 27.9 percent of married adolescents still have an unmet need for family planning (NDHS 2017). Challenges and gaps in access to family planning services persist despite the enactment of the Responsible Parenthood and Reproductive Health Act of 2012 (RH Law[62]), which asserted universal access to family planning and contraceptive use and sexuality education while reiterating the Catholic country's total ban on abortion. Particularly, women and adolescents in the Philippines still face many legal, social, and political barriers to access sexual and reproductive health services.[63] Provisions in the RH Law required parental consent for minors, unless the adolescent had been pregnant before, and spousal consent before undergoing permanent surgical

[61] Capanzana, Mario V., Gabriel Demombynes, and Paul Michael Gubbins. 2020. "Why Are So Many Children Stunted in the Philippines? (English)." Policy Research Working Paper No. WPS 9294, World Bank Group, Washington, DC. http://documents.worldbank.org/curated/en/195651592920718373/Why-Are-So-Many-Children-Stunted-in-the-Philippines.
[62] Republic Act No. 10354: An Act Providing for a National Policy on Responsible Parenthood and Reproductive Health 2012. http://www.officialgazette.gov.ph/2012/12/21/republic-act-no-10354/.
[63] Melgar, J., A. R. Melgar, M. Festin, A. J. Hoopes, and V. Chandra-Mouli. 2018. "Assessment of Country Policies Affecting Reproductive Health for Adolescents in the Philippines." *Reproductive Health* 15 (1): 205. https://doi.org/10.1186/s12978-018-0638-9; Cuaton, G. P. 2019. "Challenges and Issues on Reproductive Health and Family Planning Products and Services: Evidence in the Philippines." *International Journal of Caring Sciences* 12 (3): 1340–1345.

contraceptive methods. Moreover, bans on modern contraceptives still exist in part because the Government of the Philippines has not formally declared previous executive orders banning contraception unlawful, leading to confusion among local health care providers and denial of reproductive health services for women and adolescent girls.

119. **Although the utilization of antenatal and delivery care is common, with over 80 percent of pregnant women attending at least four antenatal visits and 85 percent receiving assistance during delivery by a skilled practitioner (NDHS 2017), disparities in maternal prenatal care associated with income and education are high.** According to the NDHS in 2017, 86 percent of pregnant women from the poorest income quintile households received ANC from a skilled provider, compared to 98 percent in the richest income quintile households and 94 percent in the country. The same trend is observed for other ANC services such as urinalysis (58 percent from the poorest income quintile households versus 78 percent nationally), blood tests (51 percent versus 72 percent), and weight (97 percent versus 99 percent) and height monitoring (84 percent versus 87 percent). There were also gaps in place of deliveries: nationally, 78 percent of pregnant women give birth in health facilities and 20 percent at home, while only 58 percent of women from the poorest income quintile households give birth in health facilities, and 39 percent deliver at home. More recent data from the FHSIS 2019 show that nationally, 58 percent of pregnant women were going to health facilities for ANC, whereas in the selected project provinces, only 49 percent of pregnant women completed at least four antenatal checkups. Similarly, 51 percent of pregnant women in the project provinces completed iron with folic acid supplementation, compared to the national rate of 58 percent. During the post-partum period, only 53 percent of women together with their newborns in the project provinces completed at least two checkups, while the national rate was 62 percent.

120. **While 95 percent of mothers with college education had skilled assistance during delivery, only 62 percent of mothers with elementary education or less had skilled assistance.** Children whose mothers have college education are 1.6 times more likely to have adequate prenatal conditions than children whose mothers had at most an elementary education. In the first two months of life, children of women with elementary educational attainment or less are 16 percent are more likely to be breastfed compared to children of college-educated women. At just over a year old, children of elementary-educated women are 66 percent more likely to be breastfed compared to children of college-educated women (Capanzana, Demombynes, and Gubbins 2020).

121. **Cross-cutting gender dimensions and social and cultural norms also contribute to the Philippines' high stunting prevalence.** The World Bank's Philippines Nutrition Study, when describing the causes of stunting in the Philippines, points to elements such as women's and mothers' level of education and age of pregnancy, among others, as determinants of stunting. Up to one-quarter of cases of stunting among children under two years of age and one-fifth of cases of stunting of children ages two to five years can be attributed to exposure to a suboptimal prenatal environment—measured by having a normal birth weight and a mother with normal body mass index and stature, as well as access to appropriate ANC and support during labor. That maternal short stature is associated with child nutrition outcomes and stresses the importance of adolescent and reproductive health for girls, not just nutrition during pregnancy (Capanzana, Demombynes, and Gubbins 2020). Moreover, another factor that is significantly correlated with stunting is the mothers' level of education, and about 54 percent of children 19–60 months old had mothers who received elementary or no education.

122. **Children born to mothers ages 18 years and below are also more likely to be stunted.** The Philippines adolescent birth rate has been the highest in the region—about 55 out of 1,000 births are by girls ages 15 to 19 years, compared to East Asia's regional average of 47 out of 1,000 births. Beyond

teenage pregnancy, cultural beliefs that are potentially detrimental to pregnant women and children also affect behaviors at the household level and are often promoted, and at times enforced, by influential family members such as grandmothers and husbands. Moreover, social and cultural stigma may constrain their access to services and other support mechanisms. Adolescent reproductive health services, while mandated, are limited in number and are, for the most part, untracked through information systems.

123. **The project will seek to address some of those gender gaps that should contribute toward improvements in nutrition-related behaviors.** As described earlier, there are notable gender gaps, including limited access to quality MCH care, as evidenced by the low percentage of women delivering with the help of a skilled birth attendant, particularly in rural areas. To address these challenges, the project will promote the delivery of quality MCH and nutrition services including adolescent reproductive health, deliveries assisted by skilled birth attendants, and antenatal as well postnatal services (indicator 4 under Component 1 in the results framework) in project areas with lower levels of access to these services. As increases in the ANC are often associated with reduced maternal mortality, such increased attendance will improve maternal health and nutrition behaviors for pregnant women and infants in these areas and will be monitored through the second PDO indicator.

124. **The project will also address other gender-specific determinants of undernutrition and decision making within households.** For example, by incentivizing women, as well as men and community leaders, to gain knowledge about nutrition and adolescent reproductive health, these behaviors are likely to improve over time. The project will also ensure that SBCC addresses issues related to age of pregnancy and includes male heads of household to ensure greater buy-in of messages beyond pregnant women and mothers who are often beholden to other influences. Intermediate results indicator 9 under Component 1 in the results framework will track progress on attendance to SBCC sessions.

Citizen Engagement

125. **The project will conduct periodic public consultations according to the stakeholder engagement plan (SEP) in order to increase awareness of all stakeholders and collect their feedback throughout the project cycle.** The project conducted multiple virtual consultations with representatives of LGUs and civil society. No in-person community consultations were organized for the project yet due to COVID-19. The project will build on the KC-NCDDP's participatory approach in engaging the communities to better understand their health- and nutrition-related issues and engage them in developing and/or supporting solutions to these issues. Such an approach will ensure that, among other benefits, the proposed nutrition-specific and nutrition-sensitive interventions receive full support and ownership by the concerned households, communities, and respective LGUs and improve engagement with marginalized groups and vulnerable communities (for example, IP). Key stakeholders include households with pregnant women or children 2 years old and below. Particular attention will be paid to indigenous people and households residing in geographically isolated and disadvantaged areas. The project will monitor the progress and report the results every year throughout the implementation. The feedback received from the beneficiary surveys and stakeholder engagements will inform the operation to strengthen the service delivery, while the project GRM will ensure that beneficiaries have a safe and secure way of communicating any complaint with the IAs. Semi-annual missions among IAs and the WB will provide a regular forum where the results and feedback from various citizen engagement activities can be shared and discussed. Through the results framework, the project will track the percentage of registered grievances satisfactorily resolved in line with the Grievance Redress Mechanism.

Climate Change

126. **The proposed project is expected to address some of the vulnerabilities, caused by climate change, and will support several adaptation measures**. Several aspects of the project design are expected to promote climate change awareness and improve resilience to climate change, as follows (also see Annex 2 for more details):

(a) **Under Component 1,** the project will support, through provision of the PBGs, an enhancement of LGUs capacities under Sub-component 1.1 to deliver a package of quality health and nutrition services, which will ensure early identification of undernourished pregnant and lactating women and infants and young children (who are the most vulnerable in society) and will also enable timely provision of essential MCH and nutrition services. Through PBG indicators 1, 2 and 3, the project will provide food security and nutrition support to improve overall adaptive capacity of vulnerable populations. In this aspect, since the project is focused on supporting LGUs with highest levels of stunting and extreme poverty, the project will reduce climate risks of malnutrition at the community level by including the population most vulnerable to the impacts of climate change and affected groups of climate hazards and increasing capacity to deliver nutrition services to prevent malnutrition and stunting. PBG indicator 4 will enhance climate resilience by considering the impacts of climate change on food security, as well as encouraging better nutrition practices for climate change adaptation in the Local Nutrition Plans. Through PBG indicator 5 the project will include climate-related indicators in the PMNP information system to monitor nutrition at the on-set of climate-induced disasters. Furthermore, through PBG Indicator 6 the project will consider climate risks in health care facilities and provide training to anticipate and activate prevention measures to minimize increases in diarrheal diseases following weather events.

(b) **In addition, Subcomponent 1.2** will support, through LGU mobilization, nutrition-specific and nutrition-sensitive interventions considering the impacts of climate change in food security and as a measure to enhance climate resilience. By providing capacity building, the project will support health care workers to provide health and nutrition support to improve the adaptive capacity of populations. Provision of these services will also contribute to better treatment of diarrhea and other climate-sensitive vector-borne diseases among 1,000-day households, as well as to more resilience to adverse health and nutritional consequences of these diseases. In addition, there will be a specific focus on enhancing LGUs' capabilities to tackling undernutrition in emergencies, and especially after climate-related catastrophes (floods, droughts, and so on).[64] Through the improvement of information systems, the project will enhance preparedness and response capacity to respond to climate-related extreme events by better monitoring the impact of weather events on nutrition. SBCC activities under Subcomponent 1.2 will include climate change awareness raising and behavior-change initiatives to improve nutrition practices to enhance the communities' knowledge and behavior for optimal IYCF and caring practices.

(c) **Under Component 2, project areas which shall be used for eligible nutrition-related activities that are in the barangay action plan.** The grants will support community activities

[64] Project support to communities for activities described in (c), (d), and (e) will be provided as block grants based on communities' assessment of their needs. In this regard, it is not possible to determine, a priori, how much of the balance of Component 2 (US$62.14 million) will be allocated to each of the activities. But it is estimated that 80 percent of this balance (approximately US$49.71 million) will be allocated equally for activities (e) and (e) and the rest for other Component 2 activities.

aimed at addressing community-level drivers of childhood undernutrition, and that respond to community-identified priorities. A menu approach will be used for sub-project investments, meaning that the community grants will be used for subject investments, meaning that any type of sub-project will be eligible for funding if it does not contradict agreed restrictions on financing, as outlined in the POM. Eligible nutrition-related activities in the barangay action plan that communities will be able to choose from will include the following:

i. Activities that will also support eligible households with pregnant women and children under five years of age to enroll and participate in 4Ps-related project activities, including access to cash benefits and participation in FDS. These cash benefits will directly help them cope with the impact of climate change by providing additional resources to buy nutritious food and manage health-related climate impacts.

ii. Activities will finance improvements in WASH services, specifically supporting small-scale water and sanitation activities, which will enhance climate resilience by reducing the potential for vector-borne and waterborne diseases and associated malnutrition risks.

V. GRIEVANCE REDRESS SYSTEM

127. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, because of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service.For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VI. KEY RISKS

128. **The overall risk for the project is assessed to be Substantial,** in part given the 'other risks' presented by a high degree of uncertainty on the duration and depth of the COVID-19 pandemic. The risk rating is also driven by Substantial risks related to macroeconomic, sector strategies and policies, institutional capacity, technical design, and fiduciary issues, which are all described in the following paragraphs, along with proposed mitigation measures.

129. **The macroeconomic risk is Substantia**l. While the economy is expected to recover in the medium term, there are significant threats that can slow the recovery momentum and further narrow the policy space. These threats are the decelerating global growth, the Russia-Ukraine war, and the tightening of global financing conditions. An economic downturn, coupled with weaker market confidence and heightened uncertainty, may lead to weaker public revenue generation and wider budget deficit. The narrower fiscal space, along with tighter financing conditions, may compel the authorities to reprioritize public spending away from health and nutrition-related projects, or spread the limited budget among competing priorities. While the Philippines has limited direct exposure from the Russia-Ukraine war

through trade or financial flows, the conflict and sanctions are affecting it in terms of higher energy and food prices. Rising domestic inflation risks impairing food security especially among poor households, jeopardizing their family's health and nutrition. There are mitigating factors including the government's actions to address rising food prices such as freer importation and lower tariff to increase domestic supplies as needed. The government has signaled intent to prioritize health and nutrition expenditures given the sizable share of the social service sector (about 38 percent, which includes health programs for universal health care, COVID-19 vaccines procurement, etc.) in the budget.

130. **Sector strategies and policies risk is Substantial.** The project rightly aims to address undernutrition multisectorally, which is a challenge and is highly dependent on political commitment, strong multisectoral collaboration, and community engagement. Though nutrition has been adopted as a key government priority with the PPAN as its guiding framework, public sector ownership of this issue is still low as evidenced by limited government and LGU investment and substantial financing gaps. Multiple measures will help mitigate this risk. The project's alignment with the priorities of the PDP and PPAN and the country's commitment to international initiatives, including the SDGs and the Scaling Up Nutrition movement, mitigate the risk that a new government will deprioritize undernutrition. In addition, the project and other parallel TA will continue to support the development and implementation of nutrition and related strategies and policies and high-level policy dialogue.

131. **Technical design risk is Substantial.** The technical design promotes use of 'best buy' interventions that are essential to dealing with the underlying determinants of stunting, including adoption of a multisectoral approach; a mix of supply- and demand-side interventions; and broad-based involvement of communities and national stakeholders. Nonetheless, the technical design risk is rated substantial because of the complexity of the multisectoral convergence approach and the inability to support activities to improve household food production and diversification, as well as minor civil works in primary health facilities to improve quality of health and nutrition service delivery. Hence for this approach to succeed, project activities would need to be implemented in a coordinated manner across several departments and agencies (DSWD, DOH, DILG, DoA, and NNC) at the national level and with decentralized LGUs. In addition, the implementing agencies have limited experience in using an output-based approach, that is, a PBGs approach. However, based on experiences of the agencies working with LGUs through traditional input financing, an output-based approach was found to be more appropriate. To partly mitigate these risks, the project will leverage existing institutional structures and largely rely on well-established country systems and platforms. The project design builds in a large-scale capacity building component, which will strengthen the technical and implementation capacity of the DSWD, NNC, and DOH. The World Bank will provide targeted training and TA to the implementing agencies, which will be scaled up progressively during preparation of the operation. The TA from the World Bank will be aimed at ensuring a rapid implementation start-up phase. The project will strengthen the functions of multisectoral committees at all levels to facilitate effective collaboration and coordination among the enabling and implementing agencies.

132. **Institutional capacity risk is Substantial.** The DSWD and DOH are the lead implementing agencies. They have substantial experience and expertise planning and delivering related interventions, albeit at a much lower scale than what is anticipated under the proposed project. Both agencies have strong track records of implementing large-scale national (World Bank-financed) programs such as the PCERP, the Kalahi-CIDSS, and the 4Ps Projects. Moreover, the implementation arrangements for this proposed project will leverage the existing functioning systems in other implementing/partnering agencies including the DOH, DILG, and NNC. However, while institutional capacity at the national level is relatively strong, capacity at the LGU level varies, and the low-resource LGUs with low nutrition outcomes will require

technical and hands-on implementation support. In addition, the capacity for managing effective multisectoral programs at the different levels of government is also generally constrained. Risk mitigation measures will include extensive capacity building during the first year of the project. Throughout the preparation stage, the World Bank will work with the Government to identify needed TA and help coordinate with other development partners to mobilize support. Component 3 will address capacity constraints at two levels: building management capacity of the participating agencies, that is, the DSWD, NNC, DOH, and DILG at the central level, and strengthening the DOH's supportive supervision of lower-level structures and training of LGUs on institutionalization of performance-based management and quality supervision.

133. **The overall fiduciary risk is Substantial** based on the fiduciary assessment of the implementation arrangements and the agencies that will be carrying out the procurement and FM responsibilities. The DSWD has been implementing World Bank-assisted projects and as such, is familiar with World Bank requirements on the maintenance of acceptable FM arrangements. Likewise, the DOH has an extensive history of managing foreign-assisted projects, including from the World Bank, the most recent being the COVID-19 vaccine project. Adding in the multisectoral and highly decentralized nature of the project involving multiple implementing and partner agencies including the LGUs, and the complexity of administering PBGs, poses substantial FM risks. The PCRA carried out by the World Bank and the PPSD prepared by the Borrower during project preparation identified the key procurement risks such as capacity constraints, inappropriate procurement arrangements, procurement failure due to lack of supply of essential goods and services, weak inventory management of supplies and equipment, Government's lengthy internal procedures for procurement-related decision making, and integrity risks. Suitable risk mitigation measures have been developed and agreed with the DOH and DSWD, for example, hiring consultants and technical experts to support procurement and contract management, preparing a PPSD to work out appropriate procurement arrangements, enhancement of procurement readiness in the first year of the project, expediting the DOH's and DSWD's decision making process, capacity building for LGUs to do procurement, training COA auditors involved in the review of community sub-project expenditures and procurement, engaging CSOs to support procurement transparency and monitoring, applying the templates of bidding documents acceptable to the Bank with provisions on Frauds and Corruption, and so on. Further details are discussed in Annex 1.

134. **Environment and Social.** The project will operate within a well-established legal and institutional framework that provides the policies and regulatory instruments for effective E&S management, as it pertains to the nutrition sector. E&S risks will be moderate and are related to the inappropriate and unsafe handling, transportation, treatment, and disposal of hazardous medical waste, including infectious waste. The E&S risks associated with these activities are localized and are expected to be mitigated effectively under the latest amendments to the Philippines Health Care Waste Management rules. The project under Component 2 will include minor civil works for infrastructure interventions at community or household level and the expected impacts are minor and temporary in nature with low E&S risks. The overall expected E&S risks will have limited area of influence restricted to the community level and mitigable with necessary measures integrated as part of the implementation of activities. Considering that the project coverage spreads over 235 LGUs and 5,936 barangays with varied E&S settings, there is a need for a systematic management practice and framework to manage these. Social risks are assessed as moderate and related to ensuring equitable access to project benefits, labor, and working conditions at the local level; proper coordination among different public institutions and clear roles and responsibilities for delivering nutrition activities across a large geographical area; and design and implementation in a manner that is culturally appropriate or adapted to the social and cultural characteristics and norms of vulnerable

people, including IP. Social risk associated with small civil works activities are predictable, site specific, and likely to have minimal adverse social impacts which are mitigable with the capacity strengthened to address the issues within the implementing agencies. These risks will be mitigated by including experience and lessons learned from the implementation of the CDD KC-NCDDP Project that over several years has been improving the CDD approach and integrating key elements of community mobilization and investment in communities. The DOH and DSWD are both experienced in implementing World Bank-financed projects and the proposed implementation arrangements will enable effective management of E&S risks and impacts.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Philippines
The Philippines Multisectoral Nutrition Project

Project Development Objectives(s)

To increase the utilization of a package of nutrition-specific and nutrition-sensitive interventions and improve key behaviors and practices known to reduce stunting in targeted local government units.

Project Development Objective Indicators

Indicator Name	PBC	Baseline	End Target
Increase utilization of nutrition-specific and nutrition-sensitive interventions			
Percentage of pregnant women in project areas who have received complete iron-folic supplements (Percentage)		50.00	75.00
Percentage of pregnant women in project areas receiving prescribed antenatal care services from the first trimester of pregnancy (Percentage)		51.00	75.00
Percentage of households in participating barangays with convergence of priority nutrition-specific and nutrition sensitive interventions (Percentage)		0.00	50.00
Improve key nutrition behaviors known to reduce stunting in targeted regions			
Percentage of children 6-23 months of age in project areas who meet age-appropriate minimum acceptable diet (Percentage)		9.00	20.00
Percentage of households in project areas with access to improved toilets (Text)		TBD	60%

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	End Target
Component 1: Strengthened Delivery of Nutrition and Primary Health Services			
Percentage of primary health care facility staff trained on Growth monitoring, Infant and Young Child Feeding (IYCF) & Nutrition in Emergencies in each barangay (Text)		IYCF: 60%; NiE: 30%	IYCF + CGM: 80% NiE: 80%
Percentage of primary health facilities with an agreed package of equipment and supplies for providing care to maternal and child health care services according to DOH standards (Text)		TBD	20% increase from baseline
Percentage of Municipal Local Government Units (MLGUs) with a full complement of health care workers at the primary health care level in line with DOH staffing norms (Text)		TBD	20% increase from baseline
Percentage of primary healthcare facilities scoring at least 65% on the Quality Checklist in participating local government units (LGUs) (Text)		TBD	20% increase from baseline
Percentage of infants 0–5.9 months of age in project areas who are exclusively breastfed, as an age-appropriate diet (Percentage)		57.00	75.00
Percentage who are indigenous people (IPs) who are exclusively breastfed, as an age-appropriate diet (Text)		TBD	60%
Percentage of 6-59 month-old children who received Vitamin A within the past six months (Percentage)		59.00	75.00
Percentage of 6-59 month-old children who are IPs who received Vitamin A within the past six months (Text)		TBD	60%
Number of participating LGUs (municipal and barangay) with approved Local Nutrition Action Plan (LNAP) budgets and expenditures in accordance to plans (Text)		119/235	219/235
Number of municipal local government units (LGUs) with at least one mass media nutrition campaign (Text)		0/235	188/235

Indicator Name	PBC	Baseline	End Target
Number of parents and/or caregivers of children under 5 years who participated in at least 4 barangay level health and nutrition social behavior change communications (SBCC)/Family Development Session (Number)		202,840.00	223,124.00
Number of parents and/or caregivers who are IPs (Number)		6,553.00	7,208.00
Component 2: Community-Based Nutrition Service Delivery and Multisectoral Nutrition Convergence			
Percentage of community nutrition-sensitive sub-projects completed in accordance to plan, budget and schedule (Percentage)		0.00	85.00
Percentage of target households with access to a functional Level II Water Supply System (Percentage)		0.00	60.00
Percentage of target households with access to ECCD facility (Percentage)		0.00	60.00
Number of beneficiaries of project interventions (Number)		48,866.00	3,720,000.00
Number of women of reproductive age (including pregnant and lactating women) who were beneficiaries of project interventions (Number)		0.00	2,328,853.00
Number of children under 5 years old who were beneficiaries of the project interventions (Number)		0.00	1,063,991.00
Number of women and children who are Pantawid Pamilyang Pilipino Program (4Ps) beneficiaries accessing the project interventions (Text)		28,475 of 4Ps children under 5 yo; 20,391 of 4Ps female grantee with children under 5 yo.	31,323 of 4Ps children under 5 yo 22,430 of 4Ps female grantees with children under 5 yo
Number of IPs households benefiting from the project interventions (Number)		0.00	273,403.00
Component 3: Institutional Strengthening, Monitoring and Evaluation and Communication			
Percentage of registered grievances satisfactorily resolved in line with the Grievance Redress System (Percentage)		0.00	80.00
Number of barangays with updated nutrition information on the status of HHs with pregnant and lactating women and children under 5 years old (Text)		0/5936	3382/5936

Indicator Name	PBC	Baseline	End Target
Percentage of project areas with functional nutrition committee (NC) at the LGU (municipal and barangay) level (Text)		PMNP Sites: 119/235	PMNP Sites: 219/235

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Percentage of pregnant women in project areas who have received complete iron-folic supplements	The percentage of eligible pregnant women who have received at least 180 daily doses of iron-folic acid supplements during their most recent (or current) pregnancy Refers to the number of pregnant women who have taken a complete iron tablet with folic acid supplementation among the total estimated number of pregnant women in the population. Refers to the number of pregnant women who have taken a complete iron tablet	Annual	● Baseline Survey ● End Line Survey ● Annual PMNP Evaluation Report	FHSIS	DOH, NNC

	with folic acid supplementation among the total estimated number of pregnant women in the population. Complete iron tablet with folic acid supplementation refers to 60mg of elemental iron with 400 mcg Folic Acid, once a day for 6 months or 180 tablets for the entire period of pregnancy. ● Regardless of where the supplement was sourced from. ● Iron tablet should be taken as soon as pregnancy is confirmed ● If the pregnant woman did not take full course of 180 tablets, she is not counted ● Include in the report pregnant women who bought their own iron with folic acid supplements but need to validate and dosage should meet DOH's standard.				

Percentage of pregnant women in project areas receiving prescribed antenatal care services from the first trimester of pregnancy	Refers to the number of pregnant women with at least 4 prenatal check-ups (availed as follows among the total estimated number of pregnant women in the population): ● 1st tri = up to 12 weeks and 6 days AOG (at least 1 check-up) ● 2nd tri = 13-27 weeks and 6 days AOG (at least 1 check-up) ● 3rd tri = 28 weeks AOG and more (at least 2 check-ups) - Numerator - The number of eligible pregnant women from project areas who have had at least 4 ANC visits to the health facilities as per DOH recommendations (that is, at least one during the first trimester, one during the second trimester and two during the third trimester) for ANC services. - Denominator - total number of eligible pregnant women in project areas	Annual	Annual PMNP Progress Report	Reports data	Local/Regional/ National, DOH, NNC, LGU staff

Percentage of households in participating barangays with convergence of priority nutrition-specific and nutrition sensitive interventions	Convergence will be measured using a household-level convergence scorecard administered to eligible households with a pregnant woman or child under 2 years old, the results of which will be aggregated	Annual	Baseline and End line Survey, Annu al PMNP, Evalu ation Report	Specialized Study	DSWD, DOH, NNC, DA
Percentage of children 6-23 months of age in project areas who meet age-appropriate minimum acceptable diet	Numerator: Children, 6-23 months old from project barangays who are reported to have consumed at least four out of the seven recommended food groups (using a classification of food groups based on international recommendations) during the 24 hours preceding the time of interview. Denominator: Total number of children 6-23 months in the project interventions areas.	Annual	Baseline and End line Survey, Annual PMNP, Evaluation Report	Impact: specialized study Surveillance: FHSIS	DOH
Percentage of households in project areas with access to improved toilets	Percentage of target households in project areas with access to improved toilets. Improved toilet facilities include flush/pour-flush toilets or latrines connected	Annual	Baseline Survey ● End Line Survey ● Annual PMNP Evaluation Report	Impact: Specialized study Surveillance: FHSIS	DSWD, DOH

	to a sewer, septic tank or pit; ventilated improved pit latrines; pit latrines with a slab or platform of any material which covers the pit entirely, except for the drop hole; and composting toilets/latrines. Unimproved facilities include public or shared facilities of an otherwise improved type; flush/pour-flush toilets that discharge directly into an open sewer or ditch or elsewhere; pit latrines without a slab; bucket latrines; hanging toilets or latrines; and the practice of open defecation in the bush, field or bodies of water. - Numerator - Total number of targeted HHs benefitting to completed improved toilets - Denominator - Total number of targeted HHs on the funded improved toilets.				

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Percentage of primary health care facility staff trained on Growth monitoring, Infant and Young Child Feeding (IYCF) & Nutrition in Emergencies in each barangay	This indicator refers to the proportion of BNSs who have received pre- and/or in-service training on IYCF, PIMAM, NiE as prescribed by NNC regulations	Annual	Annual PMNP Progress Report	IYCF and NiEm: MELLPI-Pro CGM: Reports Data	Local/Regional/ National, DOH, NNC, LGU staff
Percentage of primary health facilities with an agreed package of equipment and supplies for providing care to maternal and child health care services according to DOH standards	Percentage of primary health facilities with an agreed package of equipment and supplies for providing care to maternal and child health care services according to DOH standards	Annual	Annual PMNP Progress Report	Reports data	Local/Regional/ National, DOH, NNC, LGU staff
Percentage of Municipal Local Government Units (MLGUs) with a full complement of health care workers at the primary health care level in line with DOH staffing norms	Percentage of Municipal Local Government Units (MLGUs) with a full complement of health care workers at the primary health care level in line with DOH staffing norms	Annual	Annual PMNP Progress Report	Reports data	Local/Regional/ National, DOH, NNC, LGU staff
Percentage of primary healthcare facilities scoring at least 65% on the Quality Checklist in participating local government units (LGUs)	Service quality will be measured using a quality checklist developed by the DOH and administered to primary health facilities in project areas	Annual	Annual PMNP Progress Report	Reports data	Local/Regional/ National, DOH, NNC, LGU staff

Percentage of infants 0–5.9 months of age in project areas who are exclusively breastfed, as an age-appropriate diet	Exclusive breastfeeding: breastfeeding with no other food or drink, not even water. Breastfeeding by a wet nurse, feeding of expressed breastmilk, and feeding of donor human milk all count as being fed breastmilk. Prescribed medicines, oral rehydration solutions, vitamins and minerals are not counted as fluids or foods. However, herbal fluids and similar traditional medicines are counted as fluids, and infants who consume these are not exclusively breastfed. - Numerator - number of children 0.59 months old fed exclusively with breastmilk during the previous day preceding the assessment/survey. - Denominator - total children 0-5.9 months old in project areas as estimated by population projections.	Annual	Baseline Survey ● End Line Survey ● Annual PMNP Evaluation Report	Impact: Specialized study Surveillance: FHSIS	DOH
Percentage who are indigenous people (IPs) who are exclusively breastfed, as an age-appropriate diet	Number of indigenous children 0-59 months in target areas who are	Annual	● Baseline Survey ● End Line Survey ●	Reports Data ● FHSIS	DOH

	exclusively breastfed. - Numerator - number of indigenous children 0-59 months old fed exclusively with breastmilk during the previous day preceding the assessment/survey. - Denominator - total indigenous children 0-5.9 months old in project areas as estimated by population projections.		Annual PMNP Evaluation Report		
Percentage of 6-59 month-old children who received Vitamin A within the past six months	Refers to the number of infants/ children who completed Vitamin A supplementation among the total estimated number of infants/ children in the population. Recommended dosage: 6-11 months old - 1 dose of 100,000 IU. One capsule is given at 6 months or any time before reaching 12 months Children between 12-59 months old - given two doses of 1 capsule of Vitamin A 200,000 IU with 6 months interval in a given year - Numerator - number of	Annual	Annual PMNP Progress Report	FHSIS	Local/Regional/ National, DOH, NNC, LGU staff

	children 6-59 months old who received Vitamin A supplements from health facilities or during vitamin A supplementation campaigns within the past six months preceding the assessment/survey. - Denominator - total children 6-59 months old in project areas as estimated by population projections.				
Percentage of 6-59 month-old children who are IPs who received Vitamin A within the past six months	Number of indigenous children 6-59 months old in target areas who received Vitamin A supplements from health facilities or during vitamin A supplementation campaigns within the past six months. - Numerator - number of indigenous children 6-59 months old who received Vitamin A supplements from health facilities or during vitamin A supplementation campaigns within the past six months preceding the assessment/survey. - Denominator - total indigenous children 6-59 months old in project areas	Annual	Annual PMNP Progress Report	Reports Data	Local/Regional/ National, DOH, NNC, LGU staff

	as estimated by population projections.				
Number of participating LGUs (municipal and barangay) with approved Local Nutrition Action Plan (LNAP) budgets and expenditures in accordance to plans	Refers to the budgeted programs, projects and activities in the Local Nutrition Action Plan that are integrated in the LGU Annual Investment Program and implemented.	Annual	Annual PMNP Progress Report	Field reports from Regional Nutrition Councils (RNCs)	DOH, NNC
Number of municipal local government units (LGUs) with at least one mass media nutrition campaign	Number of municipal local government units (LGUs) with at least one mass media nutrition campaign	Annual	Annual PMNP Progress Report	Field reports	DOH
Number of parents and/or caregivers of children under 5 years who participated in at least 4 barangay level health and nutrition social behavior change communications (SBCC)/Family Development Session	Number of parents and/or caregivers of children under 5 years who attended at least 4 barangay level health and nutrition social behavior change communications (SBCC) and/or Family Development Session (FDS)	Annual	Annual PMNP Progress Report	Field reports from Parent Education Sessions in Day Care Centers and FDS Pantawid records	DOH
Number of parents and/or caregivers who are IPs	Number of indigenous parents and/or caregivers that attended the social behavior change communications (SBCC) and/or Family Development Session (FDS)	Annual	Annual PMNP Progress Report	Reports data	Local/Regional/ National, DOH, NNC, LGU staff
Percentage of community nutrition-sensitive sub-projects completed in accordance to plan, budget and schedule	Percentage of community nutrition-sensitive sub-projects completed in	Annual	Annual PMNP Evaluation Report	Data capture from DSWD Sub-Projects Completion Report	Local/Regional/National, DSWD, DA and LGU staff

	accordance to plan, budget and schedule - Numerator - Total number of community nutrition-sensitive sub-projects with Sub-Project Completion Report (SPCR) - Denominator - Total number of funded community nutrition-sensitive sub-projects			(SPCR) with Final Inspection Report and Certificate of Completion and Acceptance	
Percentage of target households with access to a functional Level II Water Supply System	Refers to access to water supply systems at Level II (or higher) in which there is: (i) a minimum continuity of 8 hours/day and e-coli free; (ii) there is a O&M arrangement which includes a designated operator and a revenue arrangement to cover O&M at community level. - Numerator - Total number of targeted HHs benefitting to completed functional Level II Water Supply System - Denominator - Total number of targeted HHs in the funded Level II Water Supply System	Annual		SPCR and Sub-project Household Beneficiary Form	

Percentage of target households with access to ECCD facility	Percentage of target households whose eligible children are enrolled in ECCD facilities - Numerator - Total number of targeted HHs whose eligible children are enrolled in completed ECCD facilities - Denominator - Total targeted number of HHs whose eligible children are enrolled in funded ECCD facilities			SPCR and Sub-project Household Beneficiary Form	
Number of beneficiaries of project interventions	Number of beneficiaries of project interventions	Annual	Annual PMNP Progress Report	Data capture from: DOH Component 1 Interventions, 4Ps record, Sub-project Household Beneficiary Form, SPCR	DSWD, DA
Number of women of reproductive age (including pregnant and lactating women) who were beneficiaries of project interventions	Number of women of reproductive age (including pregnant and lactating women) who were beneficiaries of project interventions			DOH Data, Sub-project Household Beneficiary Form, SPCR	
Number of children under 5 years old who were beneficiaries of the project interventions	Number of stunted children under 5 years old who were beneficiaries of the project interventions			DOH Data, Sub-project Household Beneficiary Form, SPCR	
Number of women and children who are Pantawid Pamilyang Pilipino	Number of Female 4Ps Grantees with Children			4Ps record, Sub-project Household Beneficiary	

Program (4Ps) beneficiaries accessing the project interventions	Under 5 years old and number of 4Ps Children Under 5 years old accessing the project interventions			Form, SPCR	
Number of IPs households benefiting from the project interventions	Number of IPs household benefitting from the project interventions			4Ps record, Sub-project Household Beneficiary Form, SPCR	
Percentage of registered grievances satisfactorily resolved in line with the Grievance Redress System	Percentage of registered grievances satisfactorily resolved in line with the Grievance Redress System	Annual	Quarterly PMNP Progre ss Report	Monthly recording of grievances and resolutions at the barangay, municipal and PMO levels	DSWD, DOH
Number of barangays with updated nutrition information on the status of HHs with pregnant and lactating women and children under 5 years old	Number of barangays utilizing PMNP information system, including nutrition surveillance on the status of HHs with pregnant and lactating women and children under five years old	Annual	Annual PMNP Evaluation Report	Management information system	DSWD, DOH
Percentage of project areas with functional nutrition committee (NC) at the LGU (municipal and barangay) level	Percentage of project areas with functional nutrition committee at the barangay and municipal level	Annual	Annual PMNP Evaluation Reports	Specialized Study	DOH, NNC

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Philippines
The Philippines Multisectoral Nutrition Project

FIDUCIARY

Procurement

1. **PCRA.** The Bank team conducted the PCRA of the implementing agencies (DOH and DSWD) during the project preparation and rated the residual procurement risk as Substantial. The assessment identified the following findings.

2. **Capacity Assessment of DOH**: The DOH has had experience in implementing some World Bank-funded projects which completed nearly 10 years ago, and since April 2020 has been managing the PCERP applying the World Bank Procurement Regulations and using STEP. The department also has some experience in procuring through UN Agencies (UNOPS, UNICEF) under the ADB-financed projects (for example, the HEAL Project). It was noted that some of the DOH staff have the required expertise in procurement and contract management following the Bank's policies and procedures. Procurement implementation at the central level is usually handled by the DOH through its Procurement Service which has two divisions: (i) Procurement Planning Management Division and (ii) Contract Management Division, in cooperation with the NPMO and the technical and beneficiary units of the ministry. The DOH's Regional Offices and LGUs also accumulated experience of doing similar procurements in the past. A key procurement risk is the inadequate manpower to address additional work demand as currently the DOH is overloaded with the COVID-19 pandemic response activities including the PCERP. To mitigate this risk, the DOH needs to hire additional consultants/personnel to help facilitate the procurement implementation.

3. **Capacity assessment of DSWD.** The procurement that will be carried out by the DSWD will be done through its procurement service. The DSWD has experience in implementing World Bank-funded projects (Social Welfare Development and Reform Project II [SWDRP II] and NCDDP). The DSWD has been implementing the NCDDP Additional Financing and the Philippines Beneficiary First Social Protection Project using the World Bank Procurement Regulations and STEP. The procurements for implementing project activities under the CDD approach will be carried out by BLGUs using CDD procedures and will adopt a procurement manual and institutional arrangements like the one prepared under the NCDDP AF, with necessary updates and customization. The DSWD staff is noted to have the required expertise in procurement and contract management in accordance with the Bank policies and procedures with a track record of procurement success.

4. **Justifications for hiring an UN Agency as a PA for some procurement activities of Component 1:**

The large procurements envisaged are Primary Health Care Services Support, Health and Nutrition Service Systems Strengthening, nutrition commodities, and seed packages of health care equipment as a part of PBGs for LGUs, accounting for more than 40 percent of the total procurement value of the component. These commodities are available in the Philippines market with certificate of product registration (CPR) approval by the Philippines Food and Drug Administration. If being imported from abroad, nutrition commodities will be subject to CPR procedures. The DOH Nutrition Program had good experience with procuring all the local nutrition commodities through the Philippines Pharmaceutical Procurement Incorporation (PPPI) as a PA. But procurements of this project involve interaction with international suppliers/manufacturers, therefore engaging the PPPI as a PA seems not to be justified. The PPSD revealed

a finding that the UN Agencies have strong capacity and advantages in procurement of nutrition products and health care facilities. The recommended procurement approach is for the DOH's NPMO to hire a UN Agency such as the UNOPS or UNICEF as a third-party PA to help carry out competitive bidding for the nutrition products (international or national competitive RFB) and the other critical goods and services to be procured centrally by the DOH. The justifications for this approach are: (a) the DOH's constrained capacity and manpower shortage because of the pandemic response programs including World Bank-financed PCERP, a UN Agency's support will be supplementation and complementation for the DOH Procurement Service work, which at this time is stretched in its capacity due to the pandemic; (b) the DOH has accumulated procurement experience with UN Agencies in the COVID-19 response programs; and (c) the UN Agency has good understanding of and experience with the market (national and international), they have strong capacity to access the market which would provide more leverage for the DOH. In particular, UNICEF is a specialized agency for children's education and health including nutrition. They have been supporting many departments across the government in procuring and supplying such nutrients as required under the project. Similarly, UNOPS is a specialized agency and has acted as PA for many projects including the COVID response for the Government of the Philippines. Hence both the agencies have the requisite experience and capacity to carry out such procurements and help in smooth implementation of the project for the first year. Given the subsequent procurement to be done by LGUs with support of the DOH regional offices, it will be helpful to include in the TORs of the UN PA the obligation to allow for an on-the-job training of selected number of designated members of the DOH regional procurement units during the process of management of the procurement by the PA.

5. **Proposed procurement arrangements for key scopes:**

Contract Title, Description and Category	Estimated Cost; Risk Rating	Bank Oversight	Procurement Approach/ Competition	Selection Methods	Evaluation Method
Community Sub-projects (Goods and Works);	PHP 2,213,013,500 (equivalent to US$43.8 million) Moderate	Post	CDD	Detailed guidance in the POM	Most Advantageous Quotation (Qualified, substantially responsive, and lowest evaluated)
Community Planning (see the below note on Training events which are non-procurement)	PHP 89,055,000 (equivalent to US$1.76 million) Moderate	Prior/Post	Open National	For Goods, Non-CS: RFQ or RFB For Consulting services: QCBS, CQS, or IC	Most Advantageous Quotation/Bid /Proposal
Performance Evaluation	PHP 100,000,000 (equivalent to US$1.98 million), Moderate	Prior/Post	Open National	QCBS, CQS, or IC	Most Advantageous Proposal
Project Evaluation	PHP 77,000,000 (equivalent to US$1.52 million) Substantial	Post	Open National	QCBS, CQS, or IC	Most Advantageous Proposal
Information System (DOH)	PHP 90,160,000 (equivalent to US$1.78 million) Substantial	Prior/Post	Open National	RFQ or RFB	Most Advantageous Proposal
PBGs	PHP 3,584,400,452 (equivalent to US$70.98 million) Substantial	Post	Open National	In accordance with the Philippines' NPP set out in RA 9184, subject to conditions in Procurement Plan agreed with World Bank	in accordance with the Philippines' NPP set out in RA 9184, subject to conditions in Procurement Plan agreed with World Bank

Capacity Building (see the below note on training events which are non-procurement)	PHP 755,873,012 (equivalent to US$14.97 million) Substantial	Prior/Post	Open, National, or International	For Goods, Non-CS: RFQ or RFB For Consulting Services: QCBS, CQS, or IC	Most Advantageous Proposal
Seed equipment for input support (financed by seed fund of PBGs)	PHP 1,058,961,225 (equivalent to US$20.97 million) Moderate	Prior/Post	Open, National, or International	RFB or RFQ	Most Advantageous Quotation/Bid
Nutrition supplies	PHP 131,000,000 (equivalent to US$2.59 million) Substantial	Prior/Post	Open, National, or International	RFB	Most Advantageous Bid

6. **Project implementation support staff.** Individuals to be contracted for positions to support agencies in carrying out its project management functions (as assessed in the PPSD), as distinct from individual consulting positions identified in the Procurement Plan, may be selected according to Agency/Government's personnel hiring procedures, as reviewed, and found acceptable by the Bank. This means that such project implementation support staff are not deemed Consultants as defined in the Bank's Procurement Regulations and their selection and contracts are not governed by the consultant selection procedures under the Bank's Procurement Regulations, but by the Agency/Government's own rules. Such personnel should not be included in the Procurement Plan in STEP but identified in the project implementation/staffing plan. They are eligible expenses under the project under the IOC category. Similarly, the recurrent services and supplies to maintain project office operations (office rental, internet, stationery, and so on) should be financed by the IOC of the Loan or the Government's budget, thus not included in the Procurement Plan or STEP.

7. **Training events** (including logistic arrangements for training) will be categorized as non-procurement activities and will be implemented in accordance with the Statement of Expenditures (SOE) procedures of the World Bank. As such training events will not be included in the Procurement Plan in STEP.

8. **Bank's STEP.** The project will use the STEP system to plan, record, and track procurement transactions. The applicable method of procurement for each specific contract and the Bank's review requirements (prior or post review) will depend on the nature, value, and risk of each contract and are specified in the Procurement Plan approved by the Bank. STEP will help the World Bank to monitor the procurement progress and take appropriate supportive actions in due course. All relevant procurement and contract documents will be recorded in STEP.

9. **Disclosure of procurement information.** The following documents shall be disclosed on the websites of procuring entities/implementing agencies and PhilGEPS, the Government's e-procurement system (https://www.philgeps.gov.ph): (a) a Procurement Plan and updates, (b) an invitation for bids for

goods and works for all contracts, (c) request for expression of interest for selection/hiring of consulting services, (d) contract awards of goods and works procured following international and national procedures, (e) a list of contracts/ purchase orders placed following shopping procedures on a quarterly basis, and (f) a list of contracts following direct selection on a quarterly basis. For international competitive bidding, in addition to PhilGEPS, international publication will be done in accordance with the requirements in the World Bank's Procurement Regulations.

10. **Frequency of procurement supervision.** The World Bank's oversight of procurement will be done through increased implementation support and increased procurement post review based on a 10-percent sample. All contracts not covered under prior review by the Bank will be subject to post review during implementation support missions and/or special post review missions, including missions by consultants hired by the Bank. To avoid doubts, the Bank may conduct, at any time, Independent Procurement Reviews (IPRs) of all the contracts financed under the loan.

Financial Management

11. **The FM assessment for the project was carried out in accordance with the "Financial Management Practices in World Bank-Financed Investment Operations" issued by the Financial Management Sector Board on November 3, 2005**, and as further rationalized in the "Principles Based Financial Management Practice Manual" issued by the Board on March 1, 2010. Under the Bank's OP/BP 10.0 with respect to projects financed by the Bank, the borrower and the project implementing agency are required to maintain FM systems—including budgeting, internal control, accounting, financial reporting, and auditing systems—adequate to provide the Bank with assurance that funds will be used in an efficient and economical way to enable the PDOs to be met. The conclusion of the assessment is that the FM systems at the DSWD and DOH meet the Bank's requirements, provided the recommended mitigating measures described below are incorporated in the design and implementation of the project. There is sufficient basis to rely on the country systems for all FM aspects of this project.

12. **The project will be implemented by both the DSWD and DOH which will have the overall responsibility for its coordination and management.** The project will involve implementation of various components in partnership with other agencies such as the DOH, DoA, and DILG as well as with the LGUs. The DSWD has been implementing World Bank-assisted projects and as such is familiar with Bank requirements on the maintenance of acceptable FM arrangements. Likewise, the DOH has an extensive history of managing foreign-assisted projects, including from the World Bank, the most recent being the COVID vaccine project. Adding in the multisectoral and highly decentralized nature of the project involving multiple implementing and partner agencies including the LGUs and the complexity of administering PBGs pose significant risks on FM. The FM risk of the project before mitigating measures is assessed as high but is being reduced to substantial after the following proposed mitigating measures described below are implemented and have shown effective impact.

13. **The mitigating measures to reduce risks associated with the current FM systems** are to: (a) maintain separate books of accounts for the project; (b) finalize and adopt a POM that includes an FM section to formalize control processes specific to the project; (c) strengthen regional/sub-national PMOs and hire adequate FM staff complement in the DOH and DSWD at the national, regional, LGU, and community levels to ensure adequate oversight over project funds; (d) maximize the use of direct payments for large contracts; (e) approved Work and Financial Plan to be agreed between the DSWD and DOH Central and Regional Offices as a requirement for fund transfers for better funds monitoring; (f) formalize agreed implementation arrangements through an MOA for components that will be implemented through LGUs and other partner agencies, enumerating the roles and responsibilities as well

as accountability over funds downloaded; (g) use of TSA and MDS sub-accounts for project disbursements; (h) address findings of the COA on the annual audited project financial statements within six months from the issuance of the audit report for the project; and (i) provide relevant fiduciary training/capacity building for the project staff.

14. **FM implementation arrangements.** The existing FM systems of the DSWD and DOH will be used for the implementation of the project. It includes acceptable budgeting, accounting, reporting, and internal controls including internal audit and staffing. The FM functions of the project will be mainstreamed, with the Finance Service of both the DSWD and DOH providing oversight. Two PMOs, one housed at the DSWD and another at the DOH will have the overall responsibility for the day-to-day management of the project. The PMO located in the DOH, as the lead PMO in Project Monitoring and Reporting, will track the overall progress of the project and consolidate project reports including financial reports for reporting to the IATF-ZH and the World Bank. To ensure that FM arrangements for the project are adequately maintained, both the DSWD and DOH will hire FM staff complement at the central, regional, and local levels who will facilitate implementation and monitoring of FM requirements as well as ensure oversight over project funds.

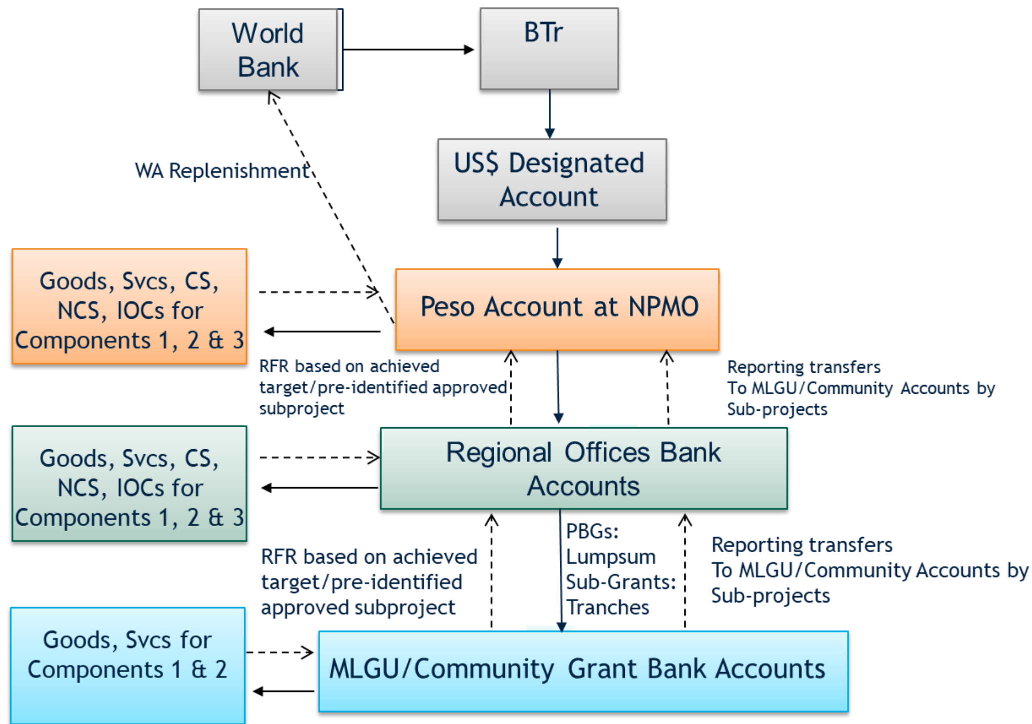
15. **Budgeting arrangements.** Budget proposals are prepared annually by the DSWD and DOH and submitted to the DBM, which after review are incorporated into the General Appropriations Act each year. The project shall prepare an Annual Work and Financial Plan together with disbursement projection to be submitted to the Bank before the start of each fiscal year.

16. **Accounting arrangements.** The accounting records of the project shall be maintained by the DSWD and DOH using the government-prescribed FM system. The chart of accounts complies with the eNGAS chart of accounts prescribed by the COA. The Accounting Division under the Finance Service for both the DSWD and DOH shall maintain the accounting records in accordance with the country accounting procedures and policies. Processing and accounting of project transactions shall be mainstreamed. Hence, adequate staff resources at the PIU and the Accounting Division shall be made available to ensure timely completion of the financial reports, monitoring of the Designated Accounts (DAs), and preparation of withdrawal applications. Separate books of account will be maintained for the project. There shall also be separate bank accounts (DA) for the project. FM staff complement shall be hired for the PIU at central to regional and local levels to support day-to-day operations.

17. **Internal control and internal auditing.** The project shall follow the internal controls and policies found in eNGAS, Government Audit and Accounting Manual, COA and DBM memoranda and circulars, and other laws and regulations. These include basic internal controls such as separation of conflicting functions, segregation of bookkeeping functions from custodianship of assets, reconciliation of subsidiary records with the corresponding general ledger control account, and a multilevel system of review and approval of transactions before their execution. Both the DSWD and DOH have Internal Audit Service (IAS) which maintains a robust program that can provide additional oversight over the project. The POM that includes a separate section on FM arrangements will be prepared to ensure adequate controls are in place for project implementation.

18. **Fund flow arrangements.** The funds from the loan proceeds will flow from the World Bank to the TSA of the Bureau of Treasury (BTr) at the Bangko Sentral ng Pilipinas (Central Bank of the Philippines or BSP). The DBM shall issue the Notice of Cash Allocation (NCA) which shall be the peso equivalent of the U.S. dollar amount received using the BSP reference exchange rate at the date of receipt of funds as certified by the BTr. The DSWD and DOH will open and maintain a separate MDS peso project account at the Land Bank of the Philippines.

Funds Flow Diagram for PMNP



19. The NPMO at the Central DOH and DSWD office will manage the DA and will ensure that adequate funds are transferred to the regional offices and ultimately to the beneficiaries. The regional offices will be responsible for reviewing and approving the Request for Fund Release (RFR) of grants to the beneficiaries based on the process to be outlined in the POM. The regional offices will be responsible for providing quarterly financial reports to the NPMO for consolidation and the NPMO will submit the consolidated report to the World Bank.

20. Funds will be transferred to the regional offices from the NPMO based on quarterly forecasts and will be treated as an advance. The regional offices will report back monthly to the NPMO on the use of funds.

21. The financing for PBGs/subgrants will be disbursed by the regional offices on a lump-sum/per tranche basis and will be categorized as PBGs/subgrants. The World Bank will account for the eligible expenditures (that is, record that the eligible expenditures are documented) when the amounts are paid to the beneficiaries, as there are mechanisms and procedures are in place, overseen by the DOH and DSWD (together with the World Bank oversight), to ensure that grants are being implemented as planned and are being used for the purposes intended.

22. Disbursements to the MLGUs/communities will be made on a lump-sum/per tranche basis. For PBGs, disbursements will be made based on the verification protocols on the achievement of targets. For subgrants to communities, disbursements will be made in tranches, based on among other things, an approved sub-project proposal for the first tranche, and documentation of physical and financial progress

for succeeding tranches. The MLGUs/communities will open a bank account specifically to receive and manage the grant funding.

23. **Financial reporting arrangements.** The DSWD and DOH will prepare and submit unaudited interim financial reports (IFRs) within 60 days after the end of each calendar quarter consisting of the financial reports on the project's: (a) statement of financial position; (b) statement of sources and uses of funds, which should include the current and cumulative data compared with plan and by fund source; and (c) bank reconciliation statements, both U.S. dollar and all peso project bank accounts. The IFR should also be accompanied by a narrative explanation of the progress of the project and the significant variances between actual against planned and financial against physical accomplishments. The format of the IFR will be agreed before negotiation and shall be included in the POM.

24. **External audit arrangements.** The audit of the Project Financial Statements (consisting of the statement of financial position, statement of financial performance, a statement of changes in net assets/equity, and a cash flow statement) will be conducted by the COA (the auditor for all government agencies in the Philippines). The COA has extensive experience in auditing government agencies and World Bank-funded projects and is an auditor acceptable to the Bank. The audit will be conducted in accordance with International Standards on Auditing and the report will be submitted to the Bank within six months after the end of the financial year. Based on experience there is a substantial risk that the audit may not be received within the period prescribed in the Loan Agreement. Finance staff will be advised to work closely with the COA to minimize the risk of late receipt of the audit report.

Disbursements

25. The proceeds of the loan will be disbursed against eligible expenditures in accordance with the financial plan of the project. The disbursement methods allowed under the project are: (a) advance, (b) direct payments, (c) reimbursements, and (d) special commitment. The project will maximize the use of direct payments for large contracts. The proposed minimum value of application for direct payments and reimbursements and special commitment is US$50,000.

26. The project will use a report-based documentation method for disbursements. Under the advance method, Bank funds will flow to the DSWD and DOH upon submission of a withdrawal application at least on a quarterly basis based on the six-month cash flow needs of the project. The DA ceiling is variable and flexible based on the project's needs and acceptable to the Bank (approved by the Task Team Leader). The DSWD and DOH will forecast the cash needs of the project for a six-month period and submit a Withdrawal Application to the Bank. In succeeding withdrawal applications, the cash forecast requirements and Statement of Uses of Funds (SSUF) for previous receipt of funds will be submitted as supporting documents. Submission of IFRs and copies of records will be required for the reporting of fund usage at least on a quarterly basis.

27. Disbursements under the project shall comply with the Bank policies and procedures on disbursements and FM as reflected in the Bank's Disbursements Handbook and Financial Monitoring Report Guidelines. All replenishments to the DA shall only be for eligible expenditures based on the agreed eligibility/financing percentage in the Loan Agreement and shall have adequate supporting documents. The frequency for reporting eligible expenditures paid from the DA will be quarterly or as need arises.

28. To allow the submission of Withdrawal Applications and supporting documentation, for expenditures incurred on or before the Closing Date, the project will be granted a four-month grace period to report these eligible expenditures.

29. FM implementation support missions will be conducted twice a year focusing on the adequacy of the FM system to ensure that funds are used for the intended purposes with due regard to economy and efficiency. Based on the level of FM risks at time of FM supervision, the reviews may include any or all the following: (a) review and verification of specific transactions, (b) review of bank reconciliations, (c) analysis of the financial statements in relation to the funds disbursed by the Bank, and (d) physical verification of structures as to existence. Desk reviews will also be conducted on a regular basis and upon submission of the annual external audit of the project and the IFR. Issues arising from these reports will be used to review and adjust the scope of the planned FM implementation support.

30. The loan shall be disbursed over a period of four years based on the following categories of expenditures. Disbursements for the first two years is expected not to exceed 60 percent of the loan.

Strategy and Approach for Implementation Support

31. The innovative approach of the operation and the engagement with multiple sectors and actors will require intensive implementation support, particularly for the lead implementing agencies (DSWD, NNC, and DOH) in the initial stages of the project. The team composition and the expected time allocation required for project supervision are described in table 1.1. The implementation support proposed focuses on implementing the risk mitigation measures, more specifically as follows:

- **Implementation capacity.** The World Bank task team will work in close collaboration with the IATF-ZH Technical Working Group and implementing agencies to ensure effective design and setup of the project.
- **Coordination.** The World Bank core team will closely monitor project implementation to promote more effective multisector coordination and detect possible lack of communication, duplication of efforts, and delays in implementation.
- **M&E.** The function of M&E will be significant for the project and for the overall multisectoral as well as nutrition convergence approach and therefore requires specialized support. Dedicated support from the core as well as extended members of the World Bank task team and working closely with the Technical Working Group to monitor the project performance across the project components.
- **FM.** During implementation support, the World Bank's FM specialist will support the implementing agency (including with ad hoc training) and routinely review the project's FM capacity, including, but not limited to, accounting, reporting, and internal controls to ensure that they are satisfactory to the World Bank.
- **Procurement.** The World Bank's procurement specialist will work closely with the implementing agencies to build capacity and support them in the periodic procurement activities.
- **E&S Management.** During project preparation an environmental management framework was developed, consulted, and disclosed. Measures to enhance inclusion of ethnic groups, infection control, and Health Care Waste Management (HCWM) were also integrated in the QPSs of the health centers. An E&S management committee with representatives from the DOH technical departments has been established for the project. A safeguard consultant will be recruited to provided capacity building to the committee and ensure ESF compliance during the project implementation.

Implementation Support Plan

32. Key World Bank task team members involved in implementation support will be based in the Philippines, Thailand, and Washington, DC to ensure timely, efficient, and effective implementation support. The core team is expected to conduct four formal implementation support missions—subject to lifting of COVID-19 related restrictions—during the first year of implementation, including field visits. After the first year, the periodicity of the implementation support missions is expected to be reduced to two missions a year and maintained throughout the project. Detailed inputs from the World Bank team are outlined as follows:

(a) **Technical inputs.** (i) technical experts and professionals to support the elaboration of TOR (consultant and non-consultant services), (ii) field visits to follow implementation of the planned operational enhancements, (iii) TA to the systems' components, and (iv) the organization of technical workshops to share best practices and support the evaluation agenda.

(b) **Fiduciary requirements.** During preparation, the World Bank team identified capacity-building needs to strengthen the FM capacity and improve procurement management capacity in the context of World Bank operations. Support will be provided from the World Bank office in the Philippines. Formal implementation support of FM reports and procurement will be carried out semiannually, while prior review will be carried out for contracts specified in the Procurement Plan as required.

(c) **Social aspects.** During implementation the social specialist will closely monitor the implementation of the project to ensure full inclusiveness of IP.

(d) **Environmental Risk Management.** The environmental specialist will focus on the nature and type of project activities and monitor the effectiveness of the application of the ESMF and integration of necessary ESMPs as part of implementation. The specialist will review quarterly progress reports and provide overall supervision in close coordination with the Environmental and Social Management Officers (ESMOs) at the NNC and DSWD NPMOs. The specialist from time-to-time will also determine the effectiveness and adequacy of implementation capacity and suggest necessary measures to enhance the prior planned capacity building plans.

33. The project will require the following implementation support in the first year. The Implementation Support Plan will be revised after the first year of implementation.

Table 1.1. Required Project Supervision

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Senior Nutrition Specialist/Program Leader (Task Team Leaders)	16	8	Senior Nutrition Specialist and Program Leader will oversee the entire operation, ensure the project performance toward the PDO, and manage partner relationships.
Operations Analyst	4	2	Operations analyst will provide operation support to the task team and ensure the performance of the project indicators is on track, as well as monitor the compliance based on the Financing Agreement.
Senior Economist	2	0	Senior Economist will provide implementation guidance for coordination with the 4Ps Project.

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Senior Water Supply and Sanitation Specialist	2	2	Senior Water Supply and Sanitation Specialist will provide overall implementation support to the activities.
Nutrition Specialist (Consultant)	16	0	Specialist will be responsible for the TA to the design and implementation of project activities.
Senior Procurement Specialist	5	2	Senior Procurement Specialist will support the implementing agencies on related issues.
Senior FM Specialist	5	0	Senior FM Specialist will support the implementing agencies on related issues.
Senior Social Development Specialist (Social Safeguards)	4	0	Senior Social Development Specialist will support the implementing agencies on related issues and ensure effective inclusion of IP into project design and implementation.
Senior Environment Specialist	5	2	Senior Environmental Specialist will provide implementation support in close coordination with the ESMOs and the Environmental and Social Focal Persons (ESFPs) at regional level. The specialist during the first year of implementation will closely guide the implementation of monitoring mechanisms and provide necessary inputs for capacity building

ANNEX 2: Summary of Climate Change Adaptation Efforts

Component 1: Enhancing Nutrition Service Delivery Through Primary Health Care Integration (IBRD: US$127.3 million)		
Subcomponents/Activity	**Financing Allocation (US$, millions)**	**Adaptation Measures**
Subcomponent 1.1	**US$67.8 million**	PBGs will support an enhancement of LGUs' capacities to deliver a package of quality health and nutrition services, which will ensure early identification of undernourished pregnant and lactating women and infants and young children (who are the most vulnerable to climate hazards in society) and will also enable timely provision of essential MCH and nutrition services. Through PBG indicators 1, 2, and 3 the project will provide food security and nutrition support to improve overall adaptive capacity of vulnerable populations. In this aspect, since the project is focused on supporting the LGUs with the highest levels of stunting and extreme poverty, the project will reduce climate risks of malnutrition at the community level by including the population most vulnerable to the impacts of climate change and affected groups of climate hazards and increasing capacity to deliver nutrition services to prevent malnutrition and stunting. PBG indicator 4 will enhance climate resilience by considering the impacts of climate change in food security, as well as encouraging better nutrition practices for climate change adaptation in the Local Nutrition Plans. Through PBG indicator 5 the project will include climate-related indicators in the PMNP information system to monitor nutrition at the onset of climate-induced disasters. Furthermore, through PBG indicator 6 the project will consider climate risks in health care facilities and provide training to anticipate and activate prevention measures to minimize increases in diarrheal diseases following weather events.
Subcomponent 1.2	**US$12.9 million**	1. Subcomponent 1.2 will support through LGU mobilization nutrition-specific and nutrition-sensitive interventions, considering the impacts of climate change in food security and as a measure to enhance climate resilience. The subcomponent will support training of the health care workers to provide food security and nutrition support to improve the adaptive capacity of populations. Provision of these services will also contribute to better treatment of diarrhea and other climate-sensitive vector-borne diseases among 1,000-day households, as well as to more resilience to adverse health and nutritional consequences of these diseases. In addition, there will be a specific focus on enhancing LGUs' capabilities to tackling undernutrition in emergencies, and especially after climate-related catastrophes (floods, droughts, and so on). 2. Subcomponent 1.2 will finance SBCC activities that will include climate change awareness raising and behavior-change initiatives to improve nutrition practices to enhance the communities' knowledge and behavior for optimal IYCF and caring practices. The subcomponent will finance the improvement of information systems which will enhance preparedness and response capacity to respond to climate-related extreme events by better monitoring the impact of weather events on nutrition.

Component 2: Community-Based Nutrition Service Delivery and Multisectoral Nutrition Convergence (IBRD: US$45.6 million)		
Subcomponents/Activity	**Financing Allocation (US$, millions)**	**Adaptation Measures**
Community block grants	**US$43.8 million**	The grants will support community activities aimed at addressing community-level drivers of childhood undernutrition, and those that respond to community-identified priorities. A menu approach will be used for sub-project investments, meaning that the community grants will be used for subject investments.
(a) Increased Access to CCTs		This activity will target nutritionally vulnerable populations such as at-risk women and children living in poverty. These populations are the most affected by climate hazards and the project, through the Kalahi-CIDSS NPMO and RPMOs, shall coordinate with the Pantawid Pamilyang Pilipino Program Management Office for the participation of Pantawid beneficiaries in the PMNP activities and other project initiatives which will allow them to address health risks from weather shocks.
(b) Increased access to and use of safely managed drinking water supply, improved sanitation, and improved hygiene practices		The project will support small-scale WASH interventions that will improve good hygiene and sanitation practices to prevent the spread of diseases exacerbated by climate change.

ANNEX 3: Map of the Philippines

IBRD 33466R5

PHILIPPINES

- SELECTED CITIES
- PROVINCE CAPITALS
- REGION CAPITALS
- NATIONAL CAPITAL
- RIVERS
- MAIN ROADS
- RAILROADS
- PROVINCE BOUNDARIES
- REGION BOUNDARIES
- INTERNATIONAL BOUNDARIES

I Ilocos Region
1 Ilocos Norte
2 Ilocos Sur
3 La Union
4 Pangasinan

CAR Cordillera Admin. Reg.
5 Abra
6 Apayao
7 Benguet
8 Ifugao
9 Kalinga
10 Mountain Province

II Cagayan Valley
11 Batanes
12 Cagayan
13 Isabela
14 Nueva Vizcaya
15 Quirino

III Central Luzon
16 Aurora
17 Bataan
18 Bulacan
19 Nueva Ecija
20 Pampanga
21 Tarlac
22 Zambales

NCR National Capital Reg.

IV-A CALABARZON
23 Batangas
24 Cavite
25 Laguna
26 Quezon
27 Rizal

MIMAROPA
28 Marinduque
29 Mindoro Occidental
30 Mindoro Oriental
31 Palawan
32 Romblon

V Bicol
33 Albay
34 Camarines Norte
35 Camarines Sur
36 Catanduanes
37 Masbate
38 Sorsogon

VI Western Visayas
39 Aklan
40 Antique
41 Capiz
42 Guimaras
43 Iloilo

VII Central Visayas
44 Bohol
45 Cebu
46 Siquijor

VIII Eastern Visayas
47 Biliran
48 Eastern Samar
49 Leyte
50 Northern Samar
51 Samar
52 Southern Leyte

IX Zamboanga Peninsula
53 Zamboanga del Norte
54 Zamboanga del Sur
55 Zamboanga Sibugay
--- City of Isabela

X Northern Mindanao
56 Bukidnon
57 Camiguin
58 Lanao del Norte
59 Misamis Occidental
60 Misamis Oriental

XI Davao Region
61 Compostela Valley
62 Davao del Norte
63 Davao del Sur
64 Davao Oriental
65 Davao Occidental

XII SOCCSKSARGEN
66 Cotabato
67 Sarangani
68 South Cotabato
69 Sultan Kudarat
--- Cotabato City

XIII Caraga
70 Agusan del Norte
71 Agusan del Sur
72 Dinagat Islands
73 Surigao del Norte
74 Surigao del Sur

NIR Negros Island Region
75 Negros Occidental
76 Negros Oriental

ARMM Autonomous Reg. in Muslim Mindanao
77 Basilan
78 Lanao del Sur
79 Maguindanao**
80 Sulu
81 Tawi-Tawi

** Shariff Aguak (Maganoy) and Sultan Kudarat serve as co-capitals of the province.

Luzon Strait · Babuyan Channel · Luzon · Philippine Sea · Sulu Sea · Celebes Sea · Mindoro · Samar · Palawan · Mindanao · MALAYSIA · MANILA

0 50 100 150 Kilometers
0 50 100 Miles

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