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Report No: PAD4420

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED CREDIT

IN THE AMOUNT OF SDR 57.4 MILLION
(US$80 MILLION EQUIVALENT)

AND A
GRANT

FROM PAPUA NEW GUINEA AND PACIFIC ISLANDS UMBRELLA FACILITY
IN THE AMOUNT OF US$10 MILLION

TO THE

INDEPENDENT STATE OF PAPUA NEW GUINEA

FOR A

CHILD NUTRITION AND SOCIAL PROTECTION PROJECT

MAY 23, 2022

Social Protection & Jobs Global Practice
East Asia And Pacific Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2022)

Currency Unit =	PNG Kina (PGK)
PGK 3.52 =	US$ 1
US$ 1.3443 =	SDR 1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Manuela V. Ferro
Country Director:	Stephen N. Ndegwa
Regional Director:	Daniel Dulitzky
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Task Team Leader(s):	Changqing Sun, Aneesa Arur

ABBREVIATIONS AND ACRONYMS

AGO	Auditor General's Office
CPF	Country Partnership Framework
CMU	Component Management Unit
CSO	Civil Society Organization
DA	Designated Account
DCDC	District Community Development Center
DFAT	Australian Government Department of Foreign Affairs and Trade
DfCDR	Department for Community Development and Religion
DHS	Demographic and Health Survey
DJAG	Department of Justice and Attorney General
EAP	East Asia and Pacific
ECD	Early Childhood Development
EoI	Expression of Interest
ESF	Environmental and Social Framework
ESS	Environmental and Social Standards
FCV	Fragility, Conflict, and Violence
FMM	Financial Management Manual
FTI	Fast Track Initiative to Reduce Stunting
GBV	Gender Based Violence
GDP	Gross Domestic Product
GEMS	Geo-Enabling Initiative for Monitoring and Supervision
GM	Grievance Management
GoPNG	Government of Papua New Guinea
GRS	Grievance Redress Service
HCI	Human Capital Index
HIES	Household Income and Expenditure Survey
IA	Implementing Agency
IPF	Investment Project Financing
IPV	Intimate Partner Violence
IYCF	Infant and Young Child Feeding
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation and Learning
MIS	Management Information System
NDoH	National Department of Health
NEC	National Executive Council
NGO	Non-government Organization
NHP	National Health Plan
OPCS	Operations Policy and Country Services
P4CD	Parenting for Child Development (pasin bilong lukautim pikinini gut)
PCU	Project Coordination Unit
PFMA	Public Finances Management Act 1995
PNG	Papua New Guinea
PNG CARES	PNG Community-based Approach to Reduce and End Stunting
PHA	Provincial Health Authority

PP	Procurement Plan
PPAG	Productive Partnerships in Agriculture Project
PPG	Project Preparation Grant
PPCC	Provincial Project Coordination Committee
PPSD	Project Procurement Strategy for Development
PSC	Project Steering Committee
PSP	Payment Service Provider
SAM	Severe Acute Malnutrition
SA/MP	Social Assessment and Management Plan
SBCC	Social Behavioral Change Communication
SLOS	Social, Law and Order Sector
SSLOSWG-N	Special SLOS Working Group on Nutrition
STC	Save the Children
STEP	Systematic Tracking of Exchanges in Procurement system
SUN	Scaling Up Nutrition
VHA	Village Health Assistant
VHV	Village Health Volunteer
WASH	Water, Sanitation, and Hygiene

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Papua New Guinea	Child Nutrition and Social Protection Project	
Project ID	**Financing Instrument**	**Environmental and Social Risk Classification**
P174637	Investment Project Financing	Substantial

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
14-Jun-2022	31-Dec-2027

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The Project Development Objective is to improve utilization of priority nutrition interventions and purchasing power of first thousand-day households in selected districts.

Components

Component Name	Cost (US$, millions)

Component 1: Implementing PNG CARES (Community-based Approach to Reduce and End Stunting)	19.00
Component 2: Implementing a Nutrition-sensitive Child Grant	66.00
Component 3: National Advocacy, Coordination, and Project Management	5.00

Organizations

Borrower:	Independent State of Papua New Guinea
Implementing Agency:	National Department of Health Department of Community Development and Religion Department of Justice and Attorney General

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	90.00
Total Financing	90.00
of which IBRD/IDA	80.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	80.00
IDA Credit	80.00

Non-World Bank Group Financing

Trust Funds	10.00
Papua New Guinea and Pacific Islands Umbrella Facility MDTF	10.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Papua New Guinea	80.00	0.00	0.00	80.00
National PBA	80.00	0.00	0.00	80.00

Total	**80.00**	**0.00**	**0.00**	**80.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2022	2023	2024	2025	2026	2027	2028
Annual	0.00	6.93	9.38	13.85	19.29	20.84	9.71
Cumulative	0.00	6.93	16.30	30.16	49.45	70.29	80.00

INSTITUTIONAL DATA

Practice Area (Lead)

Social Protection & Jobs

Contributing Practice Areas

Education, Finance, Competitiveness and Innovation, Health, Nutrition & Population

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

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	Not Currently 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

Financing Agreement, Schedule 2, Section I, A, Para 1

The Recipient shall establish and maintain, throughout the Project implementation period, a Project Steering Committee, with terms of reference, composition and resources satisfactory to the Association, which shall be responsible for, inter alia, providing strategic and governance oversight of the Project, overseeing overall performance of the Project, facilitating policy discussion and coordination between agencies, and providing advice and guidance on the Annual Work Plans and Budgets. Without limitation to the generality of the foregoing, the Project Steering Committee shall be chaired by the Secretary of DJAG and be comprised of representatives from the NDOH, DFCDR, Department of National Planning and Monitoring and other representatives set forth in the Project Operations Manual.

Sections and Description
Financing Agreement, Schedule 2, Section I, A, Para 2/3

2. The Recipient shall establish and maintain, throughout the Project implementation period, a Project Coordination Unit within DJAG, with terms of reference, composition and resources satisfactory to the Association, which shall, in close coordination with the SLOS Secretariat be responsible for, inter alia: (a) implementing Part 3 of the Project; (b) coordinating between the Component Management Units on the Project; and (c) coordinating between the Recipient's relevant agencies and other stakeholders.

3. Without limitation to the generality of the foregoing, the Recipient shall by not later than six (6) months after the Effective Date (or such other date which the Association has confirmed in writing to the Recipient is reasonable and acceptable under the circumstances, as determined by the Association in its sole discretion), recruit or appoint: (a) a Project coordinator; (b) a social risk, outreach, and communications specialist; (c) procurement specialist; and (d) an accountant; each with terms of reference, qualifications and experience satisfactory to the Association.

Sections and Description
Financing Agreement, Schedule 2, Section I, A, Para 4/5

4. The Recipient shall establish and maintain, throughout the Project implementation period:

(a) for the implementation of Part 1 of the Project, a component management unit within NDOH ("NDOH CMU"); and
(b) for the implementation of Part 2 of the Project, a component management unit within DFCDR ("DFCDR CMU");

each with terms of reference, composition and resources satisfactory to the Association, which shall be responsible for carrying out day-to-day management and implementation of Parts 1 and 2 of the Project, as applicable, including, inter alia, supporting coordination, monitoring and evaluation and communication, and ensuring compliance with fiduciary and environmental and social requirements under the Project.

5. Without limitation to the generality of Section I.A.4 above, the Recipient shall:

(a) by not later than six (6) months after the Effective Date (or such other date which the Association has confirmed in writing to the Recipient is reasonable and acceptable under the circumstances, as determined by the

Association in its sole discretion), recruit or appoint the following positions within the NDOH CMU: (i) a project manager for Part 1 of the Project; (ii) a procurement specialist; and (iii) an accountant, each with terms of reference, qualifications and experience satisfactory to the Association;

(b) by not later than six (6) months after the Effective Date (or such other date which the Association has confirmed in writing to the Recipient is reasonable and acceptable under the circumstances, as determined by the Association in its sole discretion), recruit or appoint the following positions within the DFCDR CMU: (i) a project manager for Part 2 of the Project; (ii) a management information system coordinator; and (iii) a payment systems specialist, each with terms of reference, qualifications and experience satisfactory to the Association; and

(c) thereafter maintain such positions throughout the Project implementation period.

Sections and Description

Financing Agreement, Schedule 2, Section I, A, Para 6/7

6. The Recipient shall establish and maintain, throughout the Project implementation period, within each Selected Province, a Provincial Project Coordination Committee, with terms of reference, composition and resources satisfactory to the Association, which shall be responsible for, inter alia, coordinating and supervising the implementation of the Project within the respective Selected Province. Without limitation to the generality of the foregoing, each Provincial Project Coordination Committee shall be chaired by a Senior Official of the respective Selected Province, and include a representative from each of PHA and PCDO, in accordance with the Project Operations Manual.

7. By not later than six (6) months after a Province has been selected as a Selected Province, the Recipient, through NDOH, DFCDR and DJAG, shall:

(a) enter into a Memorandum of Understanding with such Selected Province's PHA and PCDO, under terms and conditions set forth in the Project Operations Manual and satisfactory to the Association to facilitate the establishment of the Provincial Project Coordination Committee and the implementation of the Project; and

(b) exercise its rights and perform its obligations under each Memorandum of Understanding in such manner as to protect the interests of the Recipient and the Association and to accomplish the purposes of the Financing. Except as the Association shall otherwise agree, the Recipient shall not assign, amend, abrogate or waive any of the Memoranda of Understanding or any of their provisions.

Sections and Description

Financing Agreement, Schedule 2, Section I, B, Para 1/2/3/4/5

1. By not later than six (6) months after the Effective Date (or such other date which the Association has confirmed in writing to the Recipient is reasonable and acceptable under the circumstances, as determined by the Association in its sole discretion), the Recipient shall:

(a) prepare and furnish to the Association, for its review and no-objection, a Project operations manual, which shall set forth, inter alia, the following detailed arrangements and procedures for the implementation of the Project: (i) institutional arrangements for the day-to-day execution of the Project; (ii) the preparation and successive updates of the Procurement Plan and its implementation arrangements; (iii) implementation arrangements for the ESS Instruments; (iv) budgeting, disbursement, auditing and financial management arrangements; (v) Project monitoring, reporting, evaluation and communication arrangements; (vi) Personal Data

collection and processing; (vii) eligibility criteria and procedures for the selection of Provinces and districts under the Project; (viii) eligibility criteria and implementation procedures to ensure inclusive and equitable service delivery, including for vulnerable groups and people of all cultural and religious beliefs; and (ix) any other administrative, financial, technical and organizational arrangements and procedures as shall be necessary for the implementation of the Project and the achievement of its development objective ("Project Operations Manual");

(b) afford the Association a reasonable opportunity to review the proposed Project Operations Manual; and

(c) adopt the Project Operations Manual as accepted by the Association, and thereafter ensure that the Project is carried out in accordance with the Project Operations Manual.

2. The Recipient, through NDOH and DFCDR, shall ensure that Parts 1.1 and 2.2(b) of the Project are carried out in accordance with the arrangements and procedures set out in the Sub-grants Manual satisfactory to the Association, that includes, inter alia: (i) the eligibility criteria, procedures and guidelines for the selection, approval, administration and supervision of an Eligible Church Health Organization and a Sub-grant Activity; criteria and implementation procedures to ensure inclusive and equitable service delivery, including for vulnerable groups and people of all cultural and religious beliefs; (ii) implementation arrangements for the ESS Instruments; and (iii) any other administrative, financial, technical and organizational arrangements and procedures as shall be necessary for the implementation of Parts 1.1 and 2.2(b) of the Project.

3. The Recipient, through DFCDR, shall ensure that Part 2.1 of the Project is carried out in accordance with the arrangements and procedures set out in the Child Grant Manual satisfactory to the Association, that sets out the detailed arrangements and procedures for the Cash Transfers, including, inter alia: (i) standards, roles and responsibilities of stakeholders involved; (ii) requirements in relation to the registration and enrolment of Beneficiaries; (iii) payment arrangements; (iv) monitoring and reporting, including on Beneficiary participation of complementary activities; (v) grievance redress with respect to the Cash Transfers; (vi) relevant financial procedures and financial systems; and (vii) any other administrative, financial, technical, environmental and social, and organizational arrangements and procedures as shall be necessary for the implementation of the Child Grant Program.

4. The Recipient shall not amend or waive, or permit to be amended or waived, any provision of the Project Operations Manual, Sub-grant Manual or the Child Grant Manual without the prior approval in writing of the Association.

5. (a) In the event of any inconsistency between the provisions of the Project Operational Manual and those of this Agreement, the provisions of this Agreement shall prevail; and (b) in the event of any inconsistency between the provisions of the Sub-grants Manual and/or the Child Grant Manual and those of this Agreement and/or the Project Operations Manual, the provisions of this Agreement and the Project Operations Manual shall prevail, in that order of priority.

Sections and Description

Financing Agreement, Schedule 2, Section I, C, Para 1/2/3

1. The Recipient shall, for the purposes of Part 1.1 and Part 2.2(b) of the Project, provide Sub-grants to Eligible Church Health Organizations for through NDOH and DFCDR, respectively, all in accordancewith eligibility criteria and procedures acceptable to the Association and set forth in the Sub-grants Manual.

2. The Recipient, through NDOH and DFCDR, as applicable, shall make each Sub-grant under a Sub-grant Agreement with the respective Eligible Church Health Organization, on terms and conditions approved by the Association, which shall include the following:

(a) each Sub-grant shall be provided to the respective Eligible Church Health Organization, as applicable, on a grant basis and be denominated in Kina.
(b) NDOH and DFCDR, as applicable, shall each obtain rights adequate to protect its interests and those of the Association, including the right to:
(i) suspend or terminate the right of the Eligible Church Health Organization to use the proceeds of the Sub-grant, and/or obtain a refund of all or any part of the amount of the Sub-grant then withdrawn, upon the Eligible Church Health Organization's failure to perform any of its obligations under the Sub-grant Agreement; and
(ii) require each Eligible Church Health Organization to:
(A) carry out its Sub-grant Activities with due diligence and efficiency and in accordance with sound technical, economic, financial, managerial, environmental and social standards and practices satisfactory to the Association, including in accordance with the provisions of the Anti-Corruption Guidelines applicable to recipients of financing proceeds other than the Recipient and the provisions of this Agreement;
(B) without limitation to the foregoing, carry out its Sub-grant Activities in accordance with criteria and implementation procedures to ensure inclusive and equitable service delivery, including for vulnerable groups and people of all cultural and religious beliefs;
(C) provide, promptly as needed, the resources required for the Sub-grant Activity;
(D) if applicable, procure the goods and services to be financed out of the Sub-grant in accordance with the provisions of the General Conditions, and utilize such goods and services exclusively in carrying out its Sub-grant Activities and for the objectives thereof;
(E) maintain policies and procedures adequate to enable it to monitor and evaluate in accordance with indicators acceptable to the Association, the progress of the Sub-grant Activities and the achievement of their objectives;
(F) (1) maintain records and accounts adequate to reflect the operations, resources and expenditures related to the Sub-grant Activities; and (2) at the Association's or the Recipient's request, have such records and accounts audited by independent auditors acceptable to the Association, in accordance with consistently applied auditing standards acceptable to the Association, and promptly furnish the records and accounts as so audited to the Recipient and the Association;
(G) enable the Recipient and the Association to inspect the Sub-grant Activities, their operation and any relevant records and documents; and
(H) prepare and furnish to the Recipient and the Association all such information as the Recipient or the Association shall reasonably request relating to the foregoing.

3. The Recipient, through NDOH and DFCDR, as applicable, shall exercise its rights and carry out its obligations under each Sub-grant Agreement in such manner as to protect the interests of the Recipient and the Association and to accomplish the purposes of the Sub-grant. Except as the Association shall otherwise agree, the Recipient shall not assign, amend, abrogate or waive any Sub-grant Agreement or any of its provisions.

Sections and Description
Financing Agreement, Schedule 2, Section I, D, Para 1/2/3/4

1. To facilitate the carrying out of Part 2.1 of the Project, the Recipient, through DFCDR, shall ensure that the

selection and enrolment of Beneficiaries and the Cash Transfers are conducted in accordance with the provisions of this Agreement and the Child Grant Manual in a manner satisfactory to the Association.

2. Without limitation to the generality of Section I.D.1 above, the Recipient, through DFCDR, shall ensure that no Beneficiary shall be eligible to receive a Cash Transfer unless the Recipient shall have documented that the following requirements, and such further requirements as may be set out in the Child Grant Manual have been satisfied:

(a) the Beneficiary constitutes a first thousand-day household; and
(b) the Beneficiary is in compliance with co-responsibilities relating to participation in complementary activities, all in accordance with the requirements of the Child Grant Manual.

3. For the purposes of carrying out Part 2.1 of the Project, and prior to the making of Cash Transfers to Beneficiaries, the Recipient, through DFCDR, shall enter into an agreement with one or more Payment Service Provider ("Payment Agreement"), under terms and conditions satisfactory to the Association and in accordance with the provisions of the Child Grant Manual and this Agreement, including the applicable provisions of the Anti-Corruption Guidelines.

4. The Recipient through DFCDR shall exercise its rights under each Payment Agreement in such a manner as to protect the interests of the Recipient and the Association and to accomplish the purposes of the Financing. Except as the Association shall otherwise agree, the Recipient shall not assign, amend, abrogate or waive any Payment Agreement or any of its provisions in such a manner so as to affect materially and adversely, in the opinion of the Association, the ability of the Recipient to comply with its Project related obligations set forth in this Agreement (including the provisions related to the Anti-Corruption Guidelines). In case of any conflict between the terms of the Payment Agreement and those of this Agreement, the terms of this Agreement shall prevail.

Sections and Description
Financing Agreement, Schedule 2, Section I, E, Para 1/2/3/4/5

1. The Recipient shall ensure that the Project is carried out in accordance with the Environmental and Social Standards, in a manner acceptable to the Association.

2. Without limitation upon paragraph 1 above, the Recipient shall ensure that the Project is implemented in accordance with the Environmental and Social Commitment Plan ("ESCP"), in a manner acceptable to the Association. To this end, the Recipient shall ensure that:

(a) the measures and actions specified in the ESCP are implemented with due diligence and efficiency, as provided in the ESCP;
(b) sufficient funds are available to cover the costs of implementing the ESCP;
(c) policies and procedures are maintained, and qualified and experienced staff in adequate numbers are retained to implement the ESCP, as provided in the ESCP; and
(d) the ESCP, or any provision thereof, is not amended, repealed, suspended or waived, except as the Association shall otherwise agree in writing, as specified in the ESCP, and ensure that the revised ESCP is disclosed promptly thereafter.

3. In case of any inconsistencies between the ESCP and the provisions of this Agreement, the provisions of this Agreement shall prevail.

4. The Recipient shall ensure that:

(a) all measures necessary are taken to collect, compile, and furnish to the Association through regular reports, with the frequency specified in the ESCP, and promptly in a separate report or reports, if so requested by the Association, information on the status of compliance with the ESCP and the environmental and social instruments referred to therein, all such reports in form and substance acceptable to the Association, setting out, inter alia: (i) the status of implementation of the ESCP; (ii) conditions, if any, which interfere or threaten to interfere with the implementation of the ESCP; and (iii) corrective and preventive measures taken or required to be taken to address such conditions; and

(b) the Association is promptly notified of any incident or accident related to or having an impact on the Project which has, or is likely to have, a significant adverse effect on the environment, the affected communities, the public or workers, in accordance with the ESCP, the environmental and social instruments referenced therein and the Environmental and Social Standards.

5. The Recipient shall 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 Association.

Sections and Description
Financing Agreement, Schedule 2, Section I, F, Para 1/2/3

1. The Recipient shall prepare and furnish to the Association, by not later than three (3) months after the Effective Date and August 31 of each subsequent year during the implementation of the Project (or such later interval or date as the Association may agree), for the Association's review and no-objection, an Annual Work Plan and Budget, which shall, inter alia: (a) list all activities (including Operating Costs and Training and Workshops) proposed to be included in the Project for the following fiscal year of the Recipient; (b) provide a budget for their financing; and (c) describe the environmental and social measures taken or planned to be taken in accordance with the provisions of Section I.E of this Schedule 2.

2. The Recipient shall ensure that the Project is implemented in accordance with the Annual Work Plans and Budgets accepted by the Association for the respective fiscal year; provided, however, that in case of any conflict between the Annual Work Plans and Budgets and the provisions of this Agreement, the provisions of this Agreement shall prevail.

3. The Recipient shall not make or allow to be made any change to the Annual Work Plans and Budgets unless the Association has provided its prior no-objection thereof in writing.

Sections and Description
Financing Agreement, Schedule 2, Section II, B, Para 1

The Recipient through NDOH, DFCDR and DJAG shall carry out, jointly with the Association, not later than thirty (30)

months after the Effective Date, or such other period as may be agreed with the Association, a mid-term review of the Project ("Mid-Term Review") to assess the status of Project implementation, as measured against the indicators acceptable to the Association, and compliance with the legal covenants included or referred to in this Agreement. Such review shall include an assessment of the following: (i) overall progress in implementation, including of activities financed under the Grant Agreement; (ii) results of monitoring and evaluation activities; (iii) progress on procurement and disbursement; (iv) progress on implementation of environmental and social measures; (v) implementation arrangements and Project staffing; and (vi) the need to make any adjustments to the Project to improve performance. To this end, the Recipient shall:

(a) prepare and furnish to the Association, at least one (1) month before the date of the Mid-Term Review, a report, in scope and detail satisfactory to the Association and integrating the results of the monitoring and evaluation activities performed pursuant to Section II.A. of this Schedule 2, on the progress achieved in the carrying out of the Project during the period preceding the date of such report and setting out the measures recommended to ensure the efficient carrying out of the Project and the achievement of the objective thereof during the period following such date; and

(b) review jointly with the Association the report referred to in the preceding paragraph, and thereafter take all measures required to ensure the efficient completion of the Project and the achievement of the objective thereof, based on the conclusions and recommendations of such report and the Association's views on the matter.

Sections and Description
Financing Agreement, Schedule 2, Section II, A, Para 1/2

1. The Recipient shall furnish to the Association each Project Report not later than one (1) month after the end of each calendar semester, covering the calendar semester.

2. Except as may otherwise be explicitly required or permitted under this Agreement or as may be explicitly requested by the Association, in sharing any information, report or document related to the activities described in Schedule 1 to this Agreement, the Recipient shall ensure that such information, report or document does not include Personal Data.

Conditions

Type	Financing source	Description
Disbursement	Trust Funds, IBRD/IDA	Financing Agreement, Schedule 2, Section III, B, Para 1 (a) Notwithstanding the provisions of Part A above, no withdrawal shall be made: (a) for payments made prior to the Signature Date;
Type	Financing source	Description
Disbursement	IBRD/IDA	Financing Agreement, Schedule 2, Section III, B, Para 1 (b) Notwithstanding the provisions of Part A above, no withdrawal shall be made:

		(b) for Sub-grants under Category (2) unless and until the Association is satisfied that the Recipient, through NDOH and DFCDR has adopted the Sub-grant Manual in form and substance satisfactory to the Association;
Type Disbursement	Financing source Trust Funds, IBRD/IDA	Description Financing Agreement, Schedule 2, Section III, B, Para 1 (c) Notwithstanding the provisions of Part A above, no withdrawal shall be made: (c) for Cash Transfers under Category (3) unless and until the Association has received evidence to its satisfaction that the following aspects of the Child Grant Program have been completed: (i) the Recipient through DFCDR has adopted the Child Grant Manual, satisfactory to the Association, for guiding the implementation of Part 2.1 of the Project; (ii) the Recipient through DFCDR has entered into a Payment Agreement with one or more Payment Service Providers for making Cash Transfers on behalf of DFCDR, under terms and conditions satisfactory to the Association; and (iii) the Recipient through DFCDR has put in place and operationalized an information management tool, satisfactory to the Association, to support implementation and monitoring of the enrolment of and payments to Beneficiaries under the Child Grant Program.

I. STRATEGIC CONTEXT

A. Country Context

1. **The Independent State of Papua New Guinea (PNG) is a lower-middle income country with remarkable diversities in culture, geography and natural resources as well as significant gaps in access to basic services between urban and rural areas.** It has 22 provinces spread across four regions – Highlands, Islands, Momase, and Southern. It is a predominantly rural country, with almost 87 percent of the population living in remote and hard-to-reach rural areas, with limited access to basic services, infrastructure, and markets. About 80 percent of rural households lack access to electricity and improved sanitation, while 60 percent have no safe drinking water.[1] Geographical dispersion and cultural diversity have induced communities to remain small in size and disconnected from each other. PNG is the most heterogeneous country in the world with more than 800 different languages spoken among a population of over 9 million people, divided into more than 1,000 ethnic clans[2]. Large distances and rugged terrain have resulted in a highly segmented society and given rise to *wantokism* – a reciprocal support relationship between kin and community members[3]. It is PNG's most important traditional social mechanism, which encourages social support obligations within a *wantok* network to look after each other, including providing funds, housing, or food in times of need. Fragmented political and social structures in PNG have created a challenging environment for efficient and effective delivery of basic services. Security is a challenge in some areas of the country and contributes to difficulties with ensuring universal access to critical services.

2. **Progress in human development and poverty reduction has been hindered by a fragile social, political and environmental landscape.** PNG's Human Capital Index (HCI) score is 0.43[4], meaning that a child born today can expect to achieve only 43 percent of his or her potential productivity as a future worker, had they benefitted from full health and complete education. Thus, PNG children grow up with more than half of their potential unfulfilled. Analysis of the different indicators that make up the HCI indicates that PNG is in the bottom quartile for every component[5]. One factor contributing to PNG's low HCI score is its high child stunting rate – 48.2 percent of children under five years of age in PNG are stunted, one of the highest stunting rates in the world.[6] Poverty rates also remain high, with 38 percent of PNG's population living below the international poverty line of $1.90 per day (2011 US$ PPP). Inequality, measured using the Gini index, is also substantial and estimated at 41.9.[7]

3. **Megatrends further highlight the importance of human capital to PNG's future – high population growth, youth bulge, and high levels of informal sector employment.** According to the 2011 Census, PNG's population is young, with 53.8 percent being 25 years and under (18 percent of the population between the ages of 15-24 years old). The youth bulge, which will continue to grow with high population growth (about 1.9 percent per annum), has put pressure on related service delivery. PNG's labour force is low-skilled with most of the population not educated beyond Grade 10. An estimated 2.5 million (of a total 3 million) workers in PNG engage in activities in the informal economy, with higher rates for youth and women in informal sector jobs, the majority associated with low-productivity subsistence agriculture. Unfortunately, growth in formal sector employment has stagnated.

[1] World Bank, 2017: *Systematic Country Diagnostics.*
[2] World Bank, 2019. *FY19-23 Country Partnership Framework (CPF) for Papua New Guinea (Report No 128471-PG).*
[3] Wantok means 'same language' or 'one talk' in Tok Pisin.
[4] World Bank, 2020. *PNG Economic Update January 2020. Facing Economic Headwinds.*
[5] World Bank, October 2020, *Human Capital Project – Papua New Guinea Country Brief.*
[6] PNG Household Income and Expenditure Survey 2009-2010.
[7] Ibid.

Government estimates that just 10,000 formal sector jobs are created annually, whilst 80,000 school leavers enter the labor force. Without improving health, nutrition, early childhood development (ECD), education, and skills development outcomes, PNG cannot reap the benefits of the demographic dividend in the future. Furthermore, population growth rates have also served to erode per capita spending on health services with implications for the quality and coverage of vital services for human capital development.

4. **Gender inequality and gender-based violence (GBV) are major development challenges.** Women rank below men in almost all measures of health, education, employment, access to economic resources, political voice, and decision-making. In 2019, PNG ranked 161 out of 162 countries in UNDP's Gender Inequality Index[8], which reflects gender-based inequalities across the three dimensions of reproductive health, empowerment, and economic activity. The quality and reach of health services directed towards women is a concern, with only a third of women having access to modern contraceptive methods, only 66 percent of pregnant women attending four or more antenatal care visits, and only 37 percent of women delivering with the assistance of a skilled birth attendant. Literacy, school enrollment, and completion rates for females also remain below that of their male counterparts. For instance, for youth aged 15-24 literacy rates are 85.4 percent for males and 77.3 percent for females, lagging behind global benchmarks.[9] The HCI results indicate that while girls perform better in student assessments than boys, they have lower expected years of schooling, with 10.8 for boys compared to only 9.8 for girls.[10] At the household level, women exercise limited control over resources and household decision-making.[11] Women generally lack access to credit, banking and markets - the formal financial inclusion gender gap is estimated to be 29 percent, the highest in South Pacific.[12,13] Furthermore, GBV rates are very high, with 51 percent of women having experienced intimate partner violence (IPV) in their lifetime and 31 percent in the previous year.[14] All these factors pose additional barriers to women's equal participation in economic activity and social and political life.

5. **PNG is highly vulnerable to numerous natural hazards and climate variability.** It is ranked as the tenth most vulnerable country in the world to the risk of climate change.[15] The country's Highlands region is susceptible to extreme weather such as heavy rainfall. The coastal regions, the islands and the low-lying atoll areas are mostly vulnerable to extreme weather events, storm surge, sea-level rise, and coastal inundation. The predicted sea-level rise is estimated at 0.19-0.58 m by 2100, leading to accelerated coastal erosion and saline intrusion into freshwater sources.[16] Rising temperatures will facilitate the spread of vector-borne diseases such as malaria while climate variability is expected to increase the incidence of water-borne diseases such as cholera as access to clean water and sanitation services is limited. Increasingly intense storms as well as accompanying landslides would weaken the delivery of health services unless the disaster-resilience of service delivery is increased. Climate change will also exacerbate the occurrence of landslides, soil erosion, floods, and droughts and will have a significant impact on economic livelihoods and food security, heightening the already-high risk of malnutrition among rural population that rely on subsistence farming. In the next 50 years, PNG has a 50 percent chance of experiencing a loss exceeding US$700 million and casualties greater than 4,900 people, and a 10 percent chance of experiencing a loss exceeding

[8] UNDP, 2020. *Human Development Report*
[9] National Statistical Office, *Papua New Guinea Demographic and Health Survey 2016-2018*.
[10] World Bank, 2020. *Human Capital Index data*
[11] CARE International, 2020. *PNG Rapid Gender Analysis COVID-19: November 2020*
[12] Difference in adults with bank accounts between men and women.
[13] Pacific Financial Inclusion Programme, 2020. PoWER Women's and Girls' Access and Agency Assessment: Papua New Guinea.
[14] WHO, 2021. *Global Database on the Prevalence of Violence Against Women – National Estimates 2000-2018*.
[15] *https://climateknowledgeportal.worldbank.org/country/papua-new-guinea*.
[16] *https://climateknowledgeportal.worldbank.org/country/papua-new-guinea/climate-data-projections*.

US$1.4 billion and casualties greater than 11,500 people.[17] Without adaptation the risk of hunger and child malnutrition on a global scale could increase by 20 percent respectively by 2050, due to climate-related events.[18] There could be approximately 28.3 annual climate-related deaths per million population linked to lack of food availability in PNG by the year 2050 under the "business as usual" scenario.[19]

6. **The COVID-19 shock has had significant adverse impacts on domestic economic activity in PNG, including considerable impact on livelihoods and well-being of the poor and vulnerable, including reductions in food consumption.** It is estimated that the economy contracted by 3.8 percent in 2020 (dropping by nearly 6 percentage points from the pre-crisis estimates) and the fiscal deficit expanded to over 8 percent of Gross Domestic Product (GDP), more than doubling from the average rate of below 3 percent during 2018-19.[20] The Government of PNG (GoPNG) acted swiftly via international and domestic mobility restrictions to limit the spread of COVID-19 and introduced a support package of critical health and economic measures estimated at PGK 1,835 million (about US$525 million or 2.2 percent of GDP). A recent World Bank survey[21] reveals 35 percent of households have seen their income reduced or stopped since the start of 2020, with those from Highlands or in the bottom 40 percent most likely have been negatively affected. While there was a slight increase in the proportion of household heads working between the start of 2021 and May 2021, those living in urban area and from the middle quintile saw slight decline. Considering that the poverty rate is close to 40 percent, the middle quintile households that reported job losses are likely to fall into poverty, particularly after the last Delta variant surge which peaked in October 2021[22]. While food insecurity ranged from 63 percent in the Highlands region to 73 percent in the Islands region, only 7 percent of households reported receiving any assistance from the governments. Global estimates also show that both chronic and acute malnutrition will rise worldwide due to COVID-19 pandemic, and particularly in already vulnerable countries such as PNG.

B. Sectoral and Institutional Context

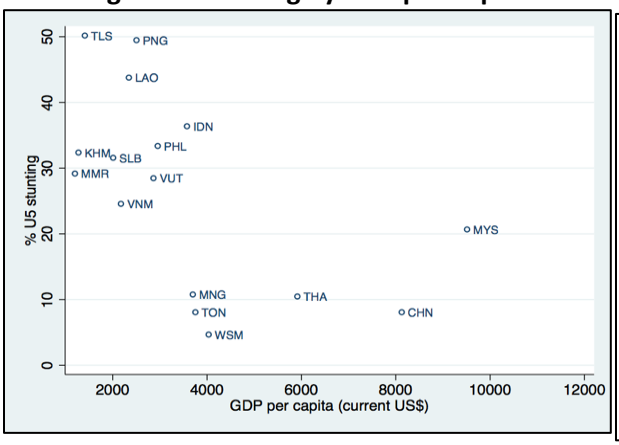
7. **PNG has the fourth highest child stunting rate in the world, which imposes heavy economic costs.** With almost every second child under five years of age being stunted (a sign of chronic malnutrition), PNG's stunting rate is double those of countries with comparable GDP per capita in the East Asia and Pacific (EAP) region (Figure 1). Further, around 28 percent of the children in the country are underweight and 5-15 percent are wasted (an indicator of acute malnutrition). Stunting is estimated to contribute to as much as 76 percent of under-five deaths in PNG. The total economic cost of child undernutrition is estimated at 2.8 percent of GDP per year, significantly exceeding PNG's budgeted expenditures for both health and education sectors in 2017.[23]

8. **While high across the board, child stunting and undernutrition[24] vary across region, wealth, gender, and parental characteristics.** PNG Household Income and Expenditure Survey (HIES) 2009-2010 showed that the Highlands region

[17] *Papua New Guinea - Country Partnership Framework for the Period FY19-FY23 (Vol. 2) (English).* Washington, D.C.: World Bank Group.
[18] World Food Program, 2015. *Two minutes on climate change and hunger: A zero hunger world needs climate resilience*.
[19] World Bank, 2021. *Climate Risk Country Profile – Papua New Guinea.*
[20] World Bank/UNICEF, High Frequency Mobile Phone Survey (Round Three), conducted in May – June 2021.
[21] World Bank, 2020. World Bank PNG High-Frequency Phone Survey on COVID-19 – Results from Round 1.
[22] The total number of confirmed cases is 36,193 and number of deaths is 590 as of January 3, 2022 (https://covid19.info.gov.pg/).
[23] Save the Children, 2017. SHORT CHANGED: The Human and Economic Cost of Child Undernutrition in Papua New Guinea.
[24] The three key indices of physical growth used as measures of child undernutrition are: stunting or low height-for-age representing chronic undernutrition; underweight or low-weight-for age representing a combination of long-term and immediate-term undernutrition; and wasting or low weight-for-height, representing acute under-nutrition. Each of these indicators is expressed in standard deviation units (Z-scores) from the median of the reference population (below two standard deviations of the mean for each respective measure).

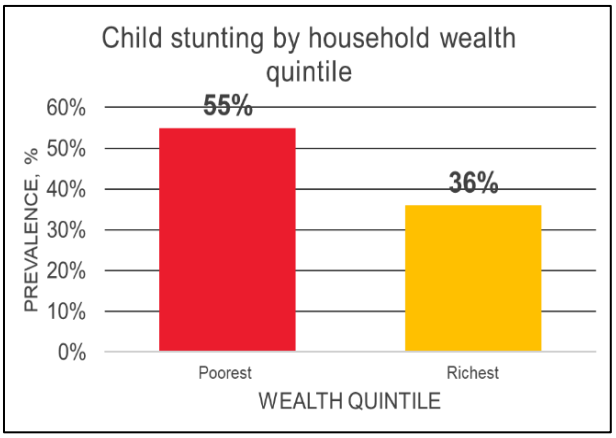
had the highest prevalence of stunting (58 percent), while the Islands Region had the lowest rate of stunting at 38.1 percent (Figure 3). Stunting was also remarkably persistent across the income distribution, though the burden of stunting was highest amongst the poorest quintile (55 percent) and lowest in the richest quintile (36 percent). The stunting rate rose quickly from 6 months onwards to 2 years and remained stable until 59 months (Figure 4). Nutrition status was worse for boys than for girls. Caloric intake, education level of household heads and incidence of diarrhea and malaria were all correlated with children under age five being stunted. Further, undernourished mothers were three times more likely to have stunted children, contributing to an intergenerational cycle of poverty and inequity.

Figure 1: Stunting by GDP per Capita



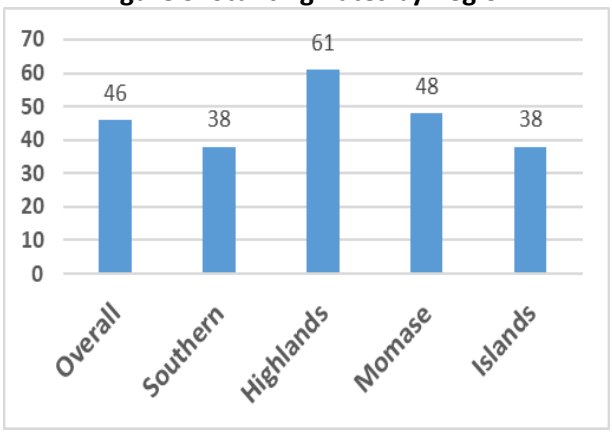
Source: World Development Indicators

Figure 2: Stunting by Wealth Quintile



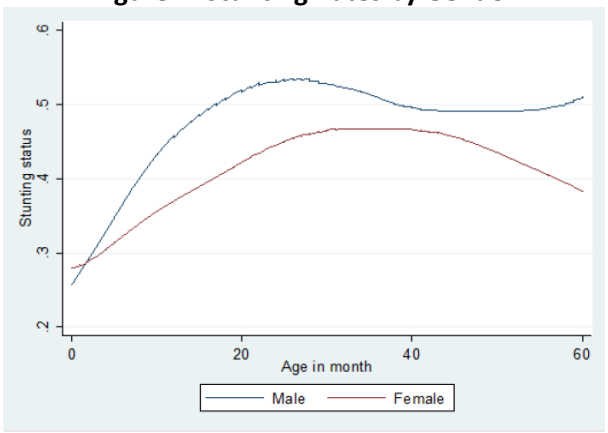
Source: HIES, 2010

Figure 3: Stunting Rates by Region



Source: HIES, 2010

Figure 4: Stunting Rates by Gender

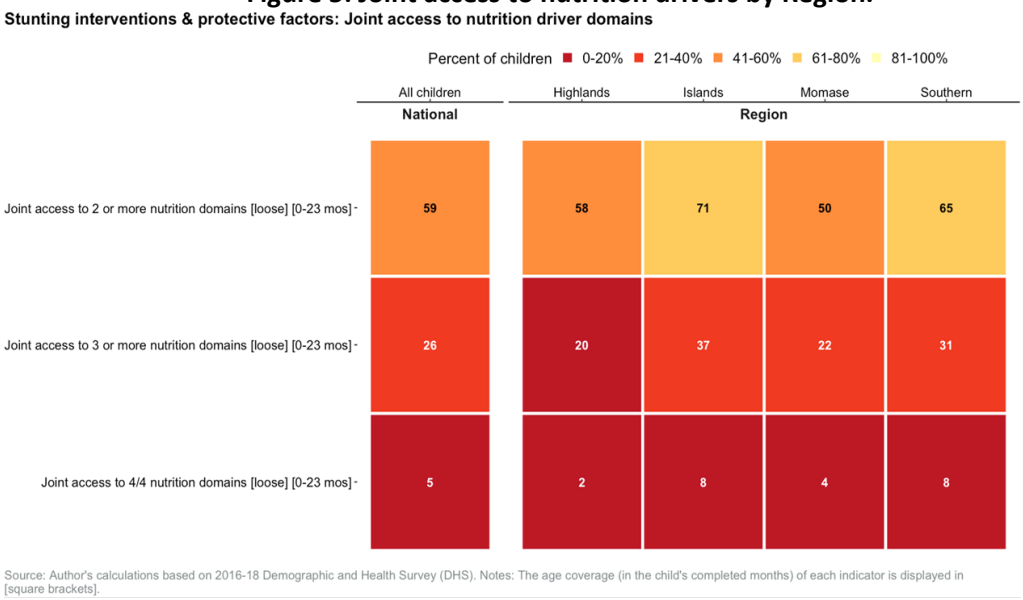


Source: HIES, 2010

9. **Little progress has been made with reducing stunting since 2010.** The Demographic and Health Survey 2016-18 data do not include reliable estimates of stunting. However, proxy analyses of access to the four major drivers of nutrition which predict stunting levels – adequate food and a diverse diet, including exclusive breastfeeding up to month 6 nurturing care; a clean environment and drinking water; and adequate access to basic health care – point to persistently high rates of stunting as only 5 percent of children have simultaneous access to all four major drivers of nutrition (figure 5). In line with previous findings, the analyses also indicate important regional differences and

suggest that stunting is likely to be the highest in the Highlands and lowest in the Islands.[25] With the exception of the National Capital District no province has good access to clean water and safe sanitation. There is some variation among provinces on access to adequate food and dietary diversity, which likely explain why some provinces fare better than others (Figure 6). And although in most provinces over 50 percent of children and mothers receive adequate prenatal care, a minority of children receives adequate postnatal care, which helps explain the accelerated increase in stunting rates after 6 months of age.

Figure 5: Joint access to nutrition drivers by Region.



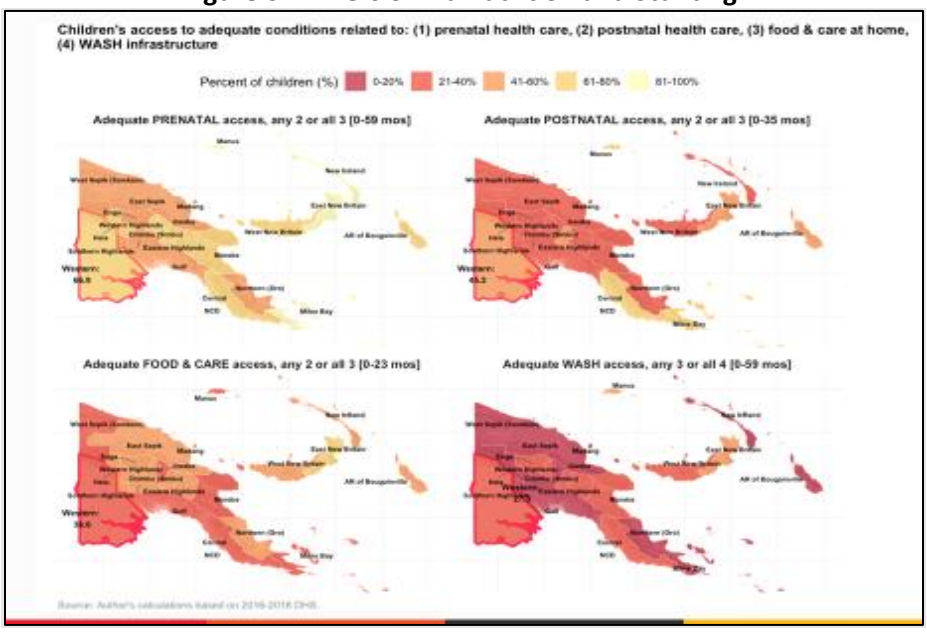
Source: Author's calculations based on 2016-18 Demographic and Health Survey (DHS). Notes: The age coverage (in the child's completed months) of each indicator is displayed in [square brackets].

10. **Food security, dietary diversity and access to a quality food basket remains a challenge**. 40 percent of the population having a caloric intake of less than 2,000 calories a day[26]. The DHS 2016-2018 shows that more than half of the population experiences moderate to severe food insecurity and about a quarter of the population experiences severe food insecurity. Region and urban/rural location are important influencers of dietary diversity. Micronutrient deficiencies also remain rampant. To illustrate, 25 percent of children aged 6 to 59 months have vitamin A deficiency, the majority does not receive the required vitamin A supplementation and 48 percent are deficient in iron.

11. **Young age at pregnancy and poor maternal nutrition contribute to low birth weight and perpetuate intergenerational inequities.** 12 percent of girls aged 15-19 years had started childbearing.[27] While overall incidence of low birth weight in PNG is 13.6 percent, the rates are particularly high in the Southern Region (16.2 percent). Only 8 percent of women age 15-49 with a child born in the past 5 years took iron tablets for at least 90 days, and 18 percent took deworming medication during the pregnancy of their last child contributing to sub-optimal maternal nutrition.

[25] DHS 2016-2018 did not report any anthropometric data. However, the drivers of nutrition are well-known and provide a scientifically valid proxy for stunting.
[26] PNG National Nutrition Policy 2016-2026.
[27] National Statistical Office, Papua New Guinea Demographic and Health Survey 2016-2018.

Figure 6: Drivers of Malnutrition and Stunting.



12. **Breastfeeding and complementary feeding practices are suboptimal**. Only 62 percent of infants under 6 months of age are breastfed exclusively for the first six months per WHO guidelines.[28] Further, infants are introduced to solid food at a much earlier stage than recommended, with 10 percent of newborns and about 27 percent of infants receiving semi-solid or solid food before 4 months of age. Factors leading to the sub-optimal feeding practices are multiple, including cultural practices, lack of understanding, and lack of the availability and accessibility of quality complementary foods.

Table 1: Access to Basic Services

Share of households or respective population	All	Residence		Region			
		Urban	Rural	Southern	Highlands	Momase	Islands
Improved sources of drinking water	45.5	83.2	41.4	55.9	39.0	43.3	63.6
Improved sanitation facility	28.9	60.0	25.7	38.5	28.1	27.1	30.4
Women age 15-49 who had a live birth in the past 5 years receiving antenatal care from a skilled provider for the most recent birth	76.1	88.6	74.5	83.3	73.3	68.2	88.7
Live births delivered in a health facility	54.7	85.4	51.1	62.6	54.5	40.1	71.7
Women aged 15-49 with a live birth in the past 2 years receiving a postnatal check in the first 2 days after giving birth	45.4	72.2	42.1	54.6	38.3	39.1	63.3
Children age 6-23 months who received a minimum of five out of eight food groups during the previous day	32.2	45.7	30.5	33.4	35.7	26.8	31.7

Source: DHS 2016-18.

[28] National Statistical Office, Papua New Guinea Demographic and Health Survey 2016-2018.

13. **Inadequate access to clean water and poor hygiene practices contribute to high burden of disease in PNG**.[29] Illness and malnutrition are synergistic as illness reduces appetite and ability to absorb and store nutrients while malnourished children are more susceptible to falling ill. The entire population is at risk of malaria, an important risk factor for stunting, and 94 percent of population live in areas with potentially high transmission (>1 case per 1000). Poor water, sanitation, and hygiene (WASH) conditions lead to increased risk of infections, including diarrhea and tropical enteropathy. About 54 percent of PNG households rely on unsafe water sources for drinking water (Table 1). However, only 10 percent of households use an appropriate method to treat their drinking water to make it safer. 28.9 percent of households use improved toilet facilities (60 percent in urban areas and 25.7 percent in rural areas). Only in the National Capital District do more than 50 percent of children have adequate access to WASH, in the majority of provinces this is less than 30 percent.

14. **There is inadequate access to and use of nutrition-relevant services.** A core set of 10 cost-effective high impact essential nutrition interventions[30] could reduce stunting by 20 percent at 90 percent coverage levels. Yet, coverage of these interventions is low, while utilization of many vital services is stagnant or declining, pointing to low and even worsening access. Only 55 percent of pregnant women received at least four antenatal care check-ups, and immunization coverage rates are extremely low and declining. In 2016, only 36.4 percent of children under age 1 were immunized against measles and less than 35 percent received the third dose of the pentavalent vaccine. Moreover, national averages hide important differences between provinces. Health systems capacity is widely considered to be a bottleneck to nutrition service delivery although systematic data are not available. The fiscal crisis precipitated by COVID-19 is likely to exacerbate problems with health and nutrition service delivery as reductions in budget allocations for essential commodities (like micronutrients) and distribution may cause further deteriorations in service availability, service outreach and quality.

15. **Limited access to nutrition-relevant services at the community level, in particular, is an important concern**. A number of factors contribute to this. A tiered network of publicly and Church-managed health facilities organized from level 1 to 4[31] seeks to deliver health and nutrition services to PNG's population at the district level and below. Most aid posts, the tier of facilities closest to communities, are understaffed, underequipped, receive limited supportive supervision and many (48 percent) are closed[32]. Service outreach from health facilities to remote rural populations has improved marginally from 28 per 1000 children under 5 in 2016 to 37 per 1000 children under 5 years,[33] although it remains considerably short of PNG's target of 60 per 1000. There are important disparities between regions as well with regions such as Momase lagging considerably behind others[34]. Small-scale community-based service delivery models to improve access to services at the village level exist and are supported by local and international non-government organizations (NGO). However, there is no functional nationwide cadre of village

[29] World Bank. *Addressing undernutrition in PNG: What can the WASH sector do to contribute?*
[30] 10 Lancet essential/high impact nutrition actions are: Maternal multiple micronutrient supplements to all; Calcium supplementation to mothers at risk of low intake; Maternal balanced energy protein supplements as needed; Universal salt iodization; Promotion of early and exclusive breastfeeding for 6 months and continued breastfeeding for up to 24 months; Appropriate complementary feeding education in food secure populations and additional complementary food supplements in food insecure populations; Vitamin A supplementation between 6 and 59 months age; Preventive zinc supplements between 12 and 59 months of age; Management of moderate acute malnutrition; and Management of severe acute malnutrition.
[31] The National Health Service Standards classifies facilities according to levels 1 to 4. These include, respectively, Aid Posts, Community Health Posts, Rural Health Centers (or Urban Clinics) and District Hospitals.
[32] The new National Health Plan 2021-2030 includes investments to build 32 additional Community Health Posts with the goal of improving access.
[33] National Department of Health, 2020 Sector Performance Annual Review.
[34] The Momase region provides less than 19 outreaches per 1000 whereas Southern, New Guinea Islands and Highlands regions provide 30, 34 and 61, respectively.

health workers in place. PNG's upcoming National Health Plan (2021-2030) focuses on addressing this concern as a priority and a national Village Health Volunteer (VHV) policy is soon to be endorsed.

16. **Partnerships with churches are especially critical for health service delivery.** Nearly half of all public health facilities[35] are run by church health providers including facilities serving remote rural and hard-to-reach populations. Church-run facilities serve many of the most under-served, remote, rural populations in PNG. Church-run health services are considered a core part of the public health system and are required to adhere to the same standards as publicly-managed health facilities. Studies in PNG also point to high quality of care and high efficiency of church health service delivery[36]. Christian Health Services and Catholic Church Health Services[37] (referred to collectively as church health providers) manage the delivery of care in church-run health facilities and receive annual grants through the public budget to pay health worker salaries and cover operational costs of delivering care.

17. **The Provincial Health Authority (PHA) reform seeks to improve oversight of service delivery at the province level in PNG**. Public health service delivery is financed through a number of national and sub-national sources as well as development partner contributions. While the National Department of Health (NDoH) holds overall responsibility for health policy and oversight of the health sector, PHAs were introduced as a pilot starting in 2007[38] and rolled out progressively across the country to counteract fragmentation in the health sector and create a single point of responsibility for health service delivery at the provincial level. PHAs are responsible for planning and overall delivery of health services in their province as well as for coordinating among the multiple national and sub-national state and non-state players involved in financing and delivering health and nutrition services. Memoranda of Understanding governing health service delivery partnerships with churches are signed with the NDoH. Nevertheless, in line with their mandate to ensure planning and implementation of health services, PHAs are responsible for oversight of service delivery by church health providers.

18. **While ECD opportunities are very limited in PNG, a firm commitment to ECD[39] is being made.** Quality and holistic support for children in their early years and their parents is a critical part in the multisectoral approach to stunting reduction with a focus on early stimulation to build healthy brains and establish the foundation for all future learning as well as positive parenting and involving the family in the upbringing of the child. Recently there has been a significant upsurge in activity and support, including (a) National Executive Council (NEC) approval of PNG's Early Childhood Education Policy 2020; (b) a revision of the ECD Policy; (c) inclusion of ECD in the 2020-2029 National Education Plan; and (d) establishment of the ECD Alliance in 2019[40]. The GoPNG, with the support of UNICEF, is developing concrete ECD interventions focusing on positive parenting and early stimulation in the first 1,000 days of life at the community level as part of the new ECD policy.

[35] This statistic includes district hospitals and health centers but not aid posts.
[36] A 2017 World Bank study found church-run facilities to outperform state-run facilities on both quality and availability of health services (Khan et al. 2017)
[37] Recognized by parliament under the Christian Health Services Act 2007 and Associations Incorporation Act in 1976
[38] Provincial Health Authorities Act 2007
[39] ECD is a comprehensive approach to child protection, education, health as well as nutrition policies and programs for children from pre-conception and aims to fully develop children's cognitive, emotional, social and physical potential.
[40] The ECD Alliance consists of GoPNG Departments and Offices (Office of the Prime Minister and National Executive Council, Department of National Planning and Monitoring, National Office of Child Family Services, and National Department of Education) and Development Partners (Australian Government, Child Fund, Churches, Digicel, Oil Search Foundation, Save the Children in PNG, PNG Disability Council and UNICEF).

19. **Despite stubbornly high poverty and vulnerability rates, PNG has no formal social safety net system to protect its vulnerable populations and promote their human development.** PNG is one of a small and shrinking number of countries globally which has no national social assistance program in place. The only safety net program currently operational is a social pension program targeting elderly and disabled people in New Ireland Province funded from provincial resources.[41] While the Department for Community Development and Religion (DfCDR) has a general mandate for protection of poor and vulnerable groups in PNG, it has very limited resource, capacity, and experience required to manage a national social safety net program. As a result, PNG's social assistance spending is less than 0.01 percent of GDP, compared to the EAP regional average of around 1 percent of GDP. While the State is mandated to assist families and communities whose own resource capacities have been exhausted or depleted, almost 83 percent of the national budget allocated for social protection is spent on pensions primarily for ex-military and civil service personnel, who are not vulnerable or disadvantaged. Inclusive and robust social protection systems to address poverty and promote investments in children (such as the ones found in Indonesia, The Philippines, Myanmar, and Lao PDR) do not yet exist in PNG.

20. **Informal *wantok* systems do not adequately protect the poor and vulnerable**. Existing evidence suggests that many households experiencing the most severe hardship are not receiving the necessary level of assistance from traditional networks. In PNG, households in the bottom quintile of the income distribution give more than they receive, whilst many wealthier households receive more than they give.[42] Moreover, wantok systems are unlikely to be effective in insuring against aggregate or repeated shocks. During COVID-19 only 41 percent of households were able to access assistance, mostly through wantoks, churches and community-based organizations and the bottom two quintile households were less likely to receive such assistance. Whilst informal systems may quickly react to emergency situations, covariate, large and sustained crises like COVID-19 are likely to challenge the effectiveness and sustainability of informal arrangements. In the absence of formal social protection systems and with a conservative assumption of a 5 percent contraction in household consumption due to COVID-19, PNG may see its poverty and vulnerability increase.

21. **Social protection and nutrition are intrinsically linked by the fact that poverty is the most important root cause of malnutrition**. Social protection interventions can directly contribute to improving diets, for example, by providing food through food transfers and supplementary feeding programs, can facilitate access to health care through cash transfers that encourage the use of health services and/or enable households to access items for personal and household hygiene and clean water. Dietary intake of households can improve with the availability of cash, as the quantity and the quality of foods consumed increase. In addition to cash or in-kind food benefits, social protection programs often incorporate knowledge and education related to good practices such as dietary choices. When stunting is not recognized as a child development problem or some behavior changes are necessary, social protection interventions can help raise the awareness by integrating nutrition promotion activities, such as growth monitoring of children[43] as part of the program design. Following the decision of the NEC in 2009 to develop a formal policy on social protection in PNG, some progress has been made related to child protection (under the Lukautim Pikinini Act) and disaster assistance (under the Disaster Relief and Emergency Office).

22. **High-level commitment to nutrition in PNG has increased considerably in recent years.** In April 2016, PNG joined the global Scaling Up Nutrition (SUN) movement and the country is demonstrating a commitment to prioritizing

[41] The Provincial Program was initiated in 2009 and had over 11,000 beneficiaries as of June 2021. It has transitioned from cash payment to electronic payment using a commercial bank since 2020.
[42] World Bank, forthcoming. *Asia and Pacific Social Protection Report – Pacific Background Paper*
[43] FAO, 2015. Nutrition and Social Protection.

nutrition in its social and economic development agenda. A multi-sectoral National Nutrition Policy[44] for 2016-2026 was adopted. In addition, PNG is a Human Capital Project Early Adopter. The Medium-Term Development Plan III (2018-2022) includes an ambitious target to reduce stunting among children under 5 years old to less than 30 percent by 2022. The Plan also highlights a number of nutrition-sensitive priorities, including increasing production of fresh fruit and vegetables, fortification for domestic rice production, increasing the contribution of livestock to domestic food production, encouraging smallholder farming for household consumption and improving the affordability of fisheries for the local population, as well as ambitious targets to improve access to safe drinking water and sanitation.

23. **In July 2020, the NEC endorsed the Fast Track Initiative (FTI) to Reduce Stunting.** The FTI is a unified, whole-of-government approach, to address stunting in PNG by investing in children to build PNG's human capital and drive economic growth. It seeks to catalyze district-led, multi-sectoral action to tackle stunting and undernutrition, improve policy coherence and localize the implementation of multi-sectoral evidence-based nutrition interventions to accelerate reductions in undernutrition and stunting. The Social Law and Order Sector (SLOS) has been assigned institutional responsibility to lead FTI implementation through the Special SLOS Special Working Group on Nutrition (SSLOSWG-N), which was established in October 2020. The Justice sector is responsible for chairing SLOS and the Minister of Justice is the current champion of the FTI.

24. **NDoH is in the final stages of endorsing a VHV Policy and the recently launched the National Health Plan (2021-2030) clearly highlights the pivotal role of VHVs in achieving health and nutrition goals in PNG.** VHVs or Village Health Assistants (VHA) as they will become under the draft VHV Policy, are the linchpin of the nutrition activities at the community level in nearly every country. While PNG lacks a national VHV program, currently a number of different VHV models have been implemented at small scale in a number of different sites across the country. The new National Health Plan (NHP) views empowering people to seek and plan for their individual and families' health as a key goal for PNG's health system. Under the new NHP, the role of VHVs, envisioned as local community recruits, is critical to improve connections with the community and deliver primary health care services, improve access and reduce inequities.

25. **NDoH is in the final stages of endorsing the Child and Adolescent Health Policy and Plan 2021-2030.** This policy clearly outlines malnutrition as a major contributing factor to child morbidity and mortality and highlights nutrition as a priority program area in which all forms of malnutrition should be addressed. Further, the policy calls for measures such as promoting and supporting appropriate infant and young child feeding (IYCF) practices, improving vitamin A coverage and improving health facility and community services for essential nutrition services delivery and treatment of severe acute malnutrition (SAM).

26. **The DfCDR is also developing a new medium-term national social protection policy, which aims to establish an integrated social protection system to support the poor and vulnerable and contribute to the broader human development outcomes.** The COVID-19 pandemic has highlighted the need for an enhanced social protection system in the country. In part motivated by that, DfCDR is finalizing the first National Policy on Social Protection

[44] The National Nutrition Policy identifies a comprehensive set of priorities to develop and implement an effective multi-sectoral response: (i) establishing national and provincial multi-sectoral coordination mechanisms to lead, support advocacy for financing and support, oversee and monitor effective implementation; (ii) building nutrition capacity of the workforce across sectors and institutions; (iii) developing and implementing comprehensive strategies to prevent and manage under-nutrition in the Health, Education, Agriculture and Livestock and Community Development sectors; and (iv) developing and implementing comprehensive strategies to identify and treat micronutrient deficiencies. Institutional responsibility for implementing the Policy has been shifted to the Department for National Planning and Monitoring whereas it previously rested with the NDoH.

(2022-2030) with technical support from the World Bank and Asian Development Bank. The draft Policy includes an implementation roadmap of priority social protection interventions, including phased roll-out of a child nutrition grant, expansion of the national network of District Community Development Centers (DCDC), and building social assistance delivery systems to support program implementation and respond to future shocks, including climate related disasters. It is expected to be submitted for NEC endorsement in early 2022. DfCDR is also housing the National GBV Secretariat and has recently launched the first national GBV website as part of implementing the National GBV Strategy (2016-2025).

C. Relevance to Higher Level Objectives

27. **The operation is in line with the PNG Country Partnership Framework (CPF) for FY19-23 (Report No 128471-PG)**. The operation contributes to CPF focus area 2 "Ensuring more effective and inclusive service delivery, particularly in underserved areas." The operation is consistent with the proposed engagement principles of the CPF, including: (a) World Bank Group corporate commitments on gender and citizen engagement; (b) portfolio-wide focus on human capital development; and (c) responding to governance and institutional challenges across the portfolio. The operation aims to address the very high stunting levels with a multi-sectoral approach, start building a social protection system to help address high poverty rates, and strengthen the delivery of frontline health and nutrition outreach services. In doing so, the operation will directly contribute to improvements in future human capital and the quality of life for women and girls as well as men and boys. The proposed project will complement the ongoing operations including Water Supply and Sanitation Development Project (P155087), Improving Access to and Value from Health Services in PNG: Financing the Frontlines (P167184), and PNG Agriculture Commercialization and Diversification Project (P166222). The operation is also aligned with the Country Gender Action Plan for PNG FY19-23 and World Bank Group COVID-19 Crisis Response Approach Paper.

28. **The project is also aligned with GoPNG development plans and strategy to address child stunting and undernutrition and to establish a national social protection system.** GoPNG's commitment to addressing nutrition issues is highlighted in the National Nutrition Policy (2016-2026), Medium-Term Development Plan III (2018-2022), National Strategic Vision (2010-2050), and PNG Development Strategic Plan (2010-2030). The new National Health Plan (2021-2030) focuses on nutrition as a central priority. The NDoH is at the final stages of approving a national VHV policy as a key pillar to improving community health and nutrition. Similarly, the draft National Policy on Social Protection (2022-2030), which is expected to be endorsed in early 2022, has identified nutrition as one priority policy area and proposed a nutrition sensitive child grant as the first national social assistance program.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

The Project Development Objective (PDO) is to improve utilization of priority nutrition interventions and purchasing power of first thousand-day households in selected districts.

PDO Level Indicators

The PDO will be measured by the following indicators:

(a) Percentage point increase in the proportion of children at 6-23 months of age who have received at least two doses of Vitamin A supplement;
(b) Proportion of first 1,000-day households receiving child nutrition grant;
(c) Proportion of female child nutrition grant beneficiaries who are first-time owners of an account (bank account or mobile wallet); and
(d) Percentage point increase in proportion of mothers/caregivers who demonstrate adequate infant and young child feeding practices.

29. All four PDO indicators will be measured and reported for the project-supported districts and measured for "first 1000-day households", which include all households with pregnant women and/or children under age two. The focus of the project on children's first 1,000 days of life is because stunting prevention has the highest impact during the window of opportunity: the first 1,000 days of life when infant and child growth, physical and brain development, are at their peak. The four PDO level indicators reflect the three channels that the project interventions are expected to contribute to reducing child stunting (Figure 7) – improving systems and services for health, enhancing household food security and diversity with cash transfer through digital payment modalities, and promoting good behavior of nurturing and parenting.

B. Project Components

30. **The project consists of three components: (a) Component 1: Implementing PNG CARES (Community-based Approach to Reduce and End Stunting); (b) Component 2: Implementing a Nutrition-sensitive Child Grant; and (c) Component 3: National Advocacy, Coordination, and Project Management.** The design of project components 1 and 2 interventions incorporates climate change adaptation and gender equity promotion as two cross-cutting themes. The project will also learn from a grant-funded pilot which would help test out delivery modalities for the nutrition grant to inform and fine tune implementation arrangements under the project proper. The project design recognizes the importance of converging services to reduce stunting, and targets convergence at the village-level.

31. **The key principles in which the design of the project is anchored include**: (a) addressing the gaps in both supply and demand sides to improve child nutrition by facilitating a multi-sectoral convergence of nutrition-related services and actions at the community level; (b) tailoring the project design to the diverse realities of PNG and recognizing the particular risk of GBV and existing community norms; (c) leveraging the existing structures and mechanisms, particularly at the sub-national level, to maximize the replicability of the project design beyond the operational areas; and (d) strengthening government capacity and partnerships with NGOs, such as the church based organizations that have considerable experience working at the community level. Considering implementation capacity constraints, the project will focus on a subset of provinces and districts that have strong commitment and reasonable local capacity for implementation and take a phased approach to gradually expand the operation.

32. **In terms of geographic coverage, the project would be gradually rolled out in 19 districts in a phased approach.** In Phase One (calendar year 2022-2023), four provinces have been already selected by GoPNG to implement the project – Chimbu, Western, East New Britain, and Madang – one from each region. In addition to regional representation, the criteria used to select the four provinces included: (a) high stunting levels; (b) strong political commitment at province and district levels; and (c) supply side capacity to implement nutrition-specific health systems interventions and community-level nutrition interventions and favorable preconditions to implement the child grant. The selection of districts within the four provinces will follow the same principles. For Phase Two of project implementation (calendar year 2024-2027), an Expression of Interest (EoI) process would be adopted to

select four additional provinces to ensure that participation in the project is based on demand from district and province stakeholders. The Project Steering Committee (PSC) will invite candidate provinces to submit an EoI for participation in the project and make the selection of provinces (and districts within selected provinces) based on agreed evaluation criteria. The EoI process and evaluation criteria will be established by PSC and communicated to sub-national governments during Phase One.

Component 1: Implementing PNG CARES (US$19 Million)

33. **This component seeks to promote critical nutrition behaviors including use of health services, early stimulation and positive parenting behaviors among first 1,000-day households as well as to support the convergence of multi-sectoral nutrition-relevant services.** Since health systems capacity to deliver nutrition-specific health services at health facilities and through outreach is a critical bottleneck to the use of these services, this component also seeks to strengthen capacity to deliver these services and integrate them into routine health service delivery and outreach. Convergence of other nutrition-sensitive interventions such as WASH and local food production would be embedded in the social behavior change communication (SBCC) messages and strategy under this component.

Sub-component 1.1. Community-level Multi-sectoral Actions for Nutrition and Early Childhood Development (US$7.5 Million)

34. **This sub-component will finance subgrants from NDoH to church health organizations to support the implementation of community-level activities that will address the multisectoral drivers of stunting and promote ECD.** The community-level activities will be focused on: (a) raising awareness and promoting critical nutrition behaviors as well as early childhood stimulation and positive parenting behaviors among first 1,000-day households and their communities, and (b) advocacy and other support targeted at local authorities and decision makers to ensure convergence of nutrition-relevant services across sectors. Subgrant disbursement will cover the incremental implementation costs of community-level activities focused on the drivers of stunting and on ECD. Disbursements will be linked to simple outputs.

35. **Church health organizations, which are a core part of the public health system, will be responsible for mobilizing community actors to carry out these activities**. VHV/VHAs or other community actors to be identified in areas where VHVs are not active will be provided on-the-job training and support by the selected church health organizations to: (a) promote appropriate IYCF practices, good hygiene practices, better cooking methods, early stimulation and positive parenting through organized group sessions and individualized counselling sessions on child growth during the group sessions and home-visits; (b) promote appropriate care seeking at health facilities for children with diarrhea, acute respiratory infections, SAM, ante-natal and post-natal care visits, and growth monitoring, as well as use of nutrition-specific services delivered via service outreach to communities (childhood immunization[45], deworming, Vitamin A supplementation, Iron Folic Acid or IFA);[46] (c) promote dietary diversity, kitchen gardens, and small animal husbandry to increase access to nutritious foods, particularly animal protein; (d) support communities to make simple village action plans and monitor progress using village scorecards; and (e) advocate with local decision makers for convergence of pro-nutrition health and WASH investments. The SBCC messages and strategy encompassing all these themes are being developed specifically for the project and tailored to PNG's diversity at the community level. In addition, in targeted SBCC sessions, risks posed by climate change as

[45] This will not include COVID-19 immunizations.
[46] This sub-component will not finance the delivery of these services. Sub-component 1.2 includes financing to build capacity to deliver nutrition services through the health system.

well as adaptation and mitigation measures will be included to address the heightened risk of climate disasters on nutrition, especially for the target group of this project. It should be noted that while church health organizations will provide on-the-job training and mentoring to VHV/ VHAs or other community actors with an emphasis on mentoring and supervision support, sub-component 1.2 will include comprehensive pre-service and on-going training and other support for these actors.

36. **Positive parenting and early stimulation sessions will be part of the SBCC program**. Positive parenting will involve community-based activities and hands-on parent coaching to improve parents' knowledge of child development and communication and problem-solving skills for family wellbeing. The positive parenting activities will follow Pasin bilong lukautim pikinini gut (Parenting for Child Development or P4CD), a proven PNG model of the GoPNG and UNICEF funded by the Australian Department of Foreign Affairs and Trade (DFAT). Early stimulation activities will consist of doing simple, everyday activities with a child, such as talking, singing, reading, and playing with ongoing, attentive, and responsive interaction between the caregiver and the child. There will be a particular focus on how fathers can interact with their children that involves saying no to violence, being proud to be a dad, playing and turning the focus to learning. The sessions will be facilitated by VHVs and be supported by volunteers and Family Life Educators in Churches, government and com munities. Child Protection Officers will also be trained on the program and will participate in some sessions.

37. **A phased approach is proposed for implementation of sub-component 1.1 under subgrants.** In Phase One of project implementation, the focus will be on implementation of direct nutrition activities as well as on-the-job training and other support to VHVs or other volunteers. The implementation focus will extend in Phase Two to convergence, including early childhood stimulation and positive parenting, advocating with local decision makers for pro-nutrition health and WASH investments, and promoting kitchen gardens and small livestock rearing to promote diet diversification, especially in areas with limited market access. This phased approach, using a building blocks strategy, is deemed more effective as this full set of interventions have never been implemented simultaneously at the community level in the targeted provinces.

Sub-component 1.2. Strengthening Health Systems (US$11.5 Million)

38. **Community activities focused on promoting utilization of nutrition-specific services and critical nutrition behaviors cannot succeed without adequate service delivery support and oversight from the health system**. This sub-component therefore focuses on building capacity in the health system to perform these functions. Some activities under sub-component 1.2 will be national in scope (e.g., systems strengthening for nutrition at the national level), and others focused on nutrition service delivery will be implemented in Project-supported provinces/districts. Recognizing the high rates of GBV in PNG, and recent evidence on the links between high maternal stress and stunting, sub-component 1.2 will also seek to better link GBV services into the health system.

39. Health systems strengthening activities under this sub-component will finance goods, equipment, training, technical assistance and operations costs. Health systems strengthening activity will include activities to:

    (a) strengthen capacity to deliver nutrition-specific services, including through comprehensive training and supervision of the frontline community workers (VHV/VHAs) or other community volunteers. The training would be delivered with technical support financed through this sub-component and organized under the leadership of the PHA in each participating province;

(b) capacity building support to church health organizations and PHAs to support the delivery of community multisectoral services for nutrition. This would also include support for 1-3 nutrition coordinators in each participating province PHA to provide on-going support and mentoring as well as operating costs to support supervision by PHAs of community-level nutrition activities. This will also include Financial Management capacity building;

(c) integrate nutrition-specific services into service delivery at the facility level and in service delivery outreach clinics through training for health facility staff. Basic equipment (e.g., weighing scales, height boards or length mats, etc.) and supplies (micronutrients, supplements for treatment of SAM) may also be procured to support nutrition service delivery;

(d) improve linkages between facility and community-based activities focused on nutrition, including developing and supporting the implementation of referral pathways through technical assistance and training, mainstreaming training on nutrition SBCC and quality of community-based nutrition interventions into health worker curricula;

(e) strengthen coordination at the community level with regards ongoing school-nutrition activities (deworming and micronutrients supplementation) as well as provide recommendations to strengthening the school nutrition education curricula;

(f) strengthen the collection and use of data and technologies for nutrition service delivery through technical assistance, training and purchase of IT equipment including basic smartphones and tablets and operations cost for use of IT equipment. These digital tools will facilitate collection of data and progress monitoring using village scorecard data;

(g) train health facility staff and VHVs to identify, counsel and promote support services for women experiencing any forms of violence and refer them appropriately;

(h) strengthen national-level capacity to develop and support the implementation of nutrition-relevant policy and monitor and evaluate progress;

(i) finance a Component Management Unit (CMU) to support the NDoH as Implementing Agency (IA) to manage component 1 activities and support oversight and monitoring of nutrition activities more broadly. A Component Manager, Nutrition Specialist, Project Accountant, and Procurement Specialist (expected to be national consultants) will be recruited for the CMU. The CMU consultants would collaborate closely with the Nutrition Unit within the NDoH and NDoH staff will be nominated to 'pair' with CMU consultants to ensure sustainable capacity building beyond the lifetime of the project.

40. **In addition, this sub-component will finance a mass media-based advocacy campaign on investing in child nutrition and ECD**. In PNG, as in many other countries, stunting is a poorly understood condition and most people do not realize its negative consequences last a lifetime. Global experience suggests that national level advocacy campaigns with high level support and engagement early in the preparation stage of a new program have proven successful in raising awareness and building commitment to the interventions across multiple sectors and at all levels of society. The stunting focused advocacy and awareness campaign activities will include: (a) development and rollout of a nation-wide mass media-based campaign targeted at the general public and focusing on the range of issues relevant to stunting in PNG, such as awareness of stunting, dietary diversity, cooking skills, etc.; (b) sub-national advocacy events to garner support from local decision makers to support and resource the multisectoral nutrition agenda especially implementation of PNG CARES approach and the child nutrition grant at the communities; and (c) nationwide advocacy and awareness activities focused on early stimulation and positive parenting. Finally, awareness around the impacts of climate change on nutrition and health as well as appropriate adaptation and mitigation measures will be included in the relevant sessions.

Component 2. Implementing a Nutrition-sensitive Child Grant (US$66 Million)

41. **Component 2 would support introduction of a child nutrition grant will be introduced to address food insecurity among the first 1,000-day households and incentivize the adoption of nutrition enhancing behavior changes.** In addition to financing child nutrition grant benefits, the project will support DfCDR to develop the rules, operational procedures, and institutional arrangements, to acquire ICT tools and systems, and to build capacity at both national and subnational level to implement the grant program. For a small number of project districts with DCDCs already built, the project would also support the existing DCDCs to serve as venues for project communication, coordination, and training by providing necessary communication equipment and internet connection.

42. The delivery of the grant also will synchronize with some activities of Component 1 to maximize impacts on the nutritional status of the pregnant or lactating women and children under 2 years of age. For example, the community outreach effort to register the targeted beneficiaries for the grant can be bundled with the SBCC activities of promoting adequate feeding practices, early stimulation and positive parenting, and timely utilization of key health services under Component 1. As the supply side of complementary interventions is assured, the households receiving child grant will be expected to utilize essential health and nutrition services as well as participate in complementary SBCC sessions and parenting classes. Initially the beneficiaries will be encouraged through "nudging" or "soft" conditioning and subsequently their compliance will be more closely monitored and enforced as the required services are fully operational and monitoring systems are robust. The delivery systems for the grant will therefore take into account the need of such a linkage explicitly, including establishing clear roles for provincial, district, and church health organizations involved, and mechanisms to monitor and report on beneficiary participation in SBCC and parenting interventions.

Sub-component 2.1 Provision of Child Nutrition Grant (US$58 Million)

43. **This sub-component will finance the child grant benefit paid to eligible first 1,000-day households and the operating expense to deliver these benefits at the community level**. Building on global experiences and evidence of nutrition-sensitive cash transfers, the child nutrition grant will target the households with pregnant or lactating women and young children under age 2. This child grant is designed deliberately to be as simple as possible to take account of limited implementation capacity and the novelty of the intervention in the PNG context. The benefit level would be a flat and modest amount of Kina 30 (approximately USD 8.5) per month per household.[47] All first 1,000-day households are eligible as high stunting rates are observed across the board and systems for household level targeting do not exist. The expectant mothers or mothers of young children (or caregivers when mothers are not present) will be the recipient, based on global experience suggesting that mothers make better spending decisions, especially on health and education. As services and monitoring systems are operating reliably and consistently, the beneficiary households will be expected to utilize essential health and nutrition interventions and participate in family oriented SBCC sessions as a co-responsibility under the program. In addition to enhancing the purchasing power of the beneficiary households, this child grant can serve the goals of mitigating the negative welfare impacts of COVID-19, empowering women through financial inclusion, and building the foundations of social protection delivery systems for future emergency responses.

[47] Kina 30 per month is close to half of the estimated average household consumption of the bottom quintile (Kina 2.11 per day). The only existing cash transfer program in PNG, New Ireland Province's social pension for elderly and disabled, had the same benefit level until 2020.

44. **As the child nutrition grant is GoPNG's first social assistance program, its purpose needs to be carefully communicated to potential beneficiaries and their communities.** The project frames this child grant as a shared responsibility between GoPNG and first 1,000-day households toward the healthy growth of their young children. The GoPNG provides the child grant to help beneficiaries improve affordability of a nutritious diet and finance transport to regularly use health and nutrition services. To receive the benefit, the enrolled beneficiaries are required to take responsibility for nurturing their young children appropriately. The program design aims to provide a "cash + SBCC" package to the beneficiary households because evidence has shown that a cash + SBCC approach tends to be more effective in addressing child stunting than only cash or only SBCC[48]. The grant implementation will follow a phased approach: during the initial phase of the project, the expectation of participation in SBCC sessions will be communicated to beneficiaries while the monitoring system of SBCC participation is yet to be established and operational reliably. The beneficiary households will be provided with a grant amount of Kina 30 per month. If any beneficiary fails consecutively to participate in the SBCC sessions, a follow-up household visit by VHV/VHA will be triggered to provide the necessary support and encourage participation in future sessions. Once the SBCC sessions are being delivered consistently and the monitoring system is fully functioning, consistent SBCC participation by beneficiary households will be required. Beneficiary households who are not complying would be given warnings and continued non-compliance could result in reduction and even cessation of benefits. In a further phase, once the access to selected maternal and child health services (to be determined) is available reliably and the monitoring system can also record beneficiaries' utilization of these services, a requirement for take-up of these specific health services is anticipated. In the final years of project life, the project would consider introducing an additional amount of Kina 15 on top of the base benefit if beneficiary households participate in the SBCC sessions consistently. The decision whether to add the top-up benefit would be taken by the PSC after reviewing the project evidence on utilization of essential health and nutrition interventions and participation in SBCC sessions by beneficiary households, as well as the capacity of the delivery systems to monitor and verify beneficiary participation.

45. **The sub-component would also finance the operating costs related to outreach, communication and stakeholder consultation for implementing the grant**. As this child grant is the first social assistance program of its scale in PNG, DfCDR will work with subnational governments and communities to ensure the purpose, process, and requirements are clearly communicated and implementation actions properly coordinated. To this end a Provincial Social Protection Coordinator (PSPC) will be hired in each of the project provinces and housed at the relevant Provincial Community Development Office (PCDO).[49] The PSPC will provide the necessary project coordination and technical support at the subnational level and also play an important role in monitoring the activities at the community level by the Church based organizations, payment service providers (PSP), and other local actors. In addition to hiring and operational costs associated with PSPCs, this sub-component will finance all capacity building and trainings associated with the child grant for subnational government, church based organizations, VHVs/As, and other local actors.

Sub-component 2.2. Building Delivery Systems and Capacity Building for Child Grant (US$8 Million)

[48] Save the Children, 2018. *Legacy Maternal and Child Cash Transfer MCCT Program Learning Brief*.

[49] The Provincial Administrations across PNG have Community Development branches/divisions/offices, which employ a small number of Welfare Officers and Child Protection Officers to provide services on behalf of the DfCDR.

46. **Since PNG has no formal social safety net program[50], its delivery systems and DfCDR's management capacity to deliver the child grant will need to be built from scratch**. To that end, the key activities to be financed under this sub-component include: (a) developing an end-to-end operations manual for implementing child grant to stipulate procedures, standards, and roles and responsibilities of involved stakeholders related to beneficiary registration and enrolment, payment, grievance redress, and monitoring and reporting; (b) procuring consulting services to design business process and management information system (MIS) and develop a full modular MIS; (c) providing subgrants to church health organizations to support beneficiary enrollment and facilitation; (d) establishing payment service arrangements by engaging with financial service institutions as payment agents to deliver child grant benefits; (e) strengthening institutional capacity of DfCDR and its subnational counterparts; and (f) procurement of office equipment and supplies including tablets, hardware, and software required for project implementation. The delivery systems and institutional capacity of the child grant program can be adapted to enable GoPNG to provide rapid assistances to households and communities negatively affected by future emergencies, including climate change induced disasters.

47. **The sub-component will finance subgrants for church health organizations involved in implementation of the child grant**. DfCDR will engage with church health organizations through subgrants, to carry out the following activities: (a) informing communities about the new child grant program; (b) registering and enrolling eligible beneficiary families into the program on behalf of DfCDR and providing beneficiary information to DfCDR; (c) facilitating beneficiary participation in complementary "cash plus" activities such as SBCC sessions provided under the Component 1 as well as other nutrition relevant programs, including connecting project beneficiaries to agriculture and agribusiness programs operating in their localities and sharing lessons from nutrition initiatives (e.g., Morobe School Gardens Project); and (d) assisting DfCDR in monitoring and reporting on participation in complementary activities by the beneficiary families. The church health organizations will mobilize VHV/VHAs and other local actors to be identified depending on the local situation (e.g., women's groups or youth groups). The same church health organizations would undertake both component 1 and 2 in the same location to promote synergies. They would also work closely with Province and District Community Development Officers at the sub-national level.

48. **The sub-component will also support DfCDR to engage with financial service institutions to provide payment services to the intended recipients**. Benefit payments would be made through electronic means wherever possible, and may be done through multiple PSPs such as commercial banks, micro-banks, savings and loan societies, and mobile operators with financial service licenses (such as Digicel's CellMoni). Some key principles related to payment arrangements will be applied in the selection of PSPs: (a) beneficiaries can choose which selected PSPs to open their accounts and receive their child nutrition grant benefits, considering the best combination of cost, convenience, user interfaces, and privacy; (b) apply common payment service standards when forging payment service agreements with multiple PSPs; (c) follow existing know your customer requirements for account opening; and (d) DfCDR needs to assess the business models, service fees, agent network and liquidity requirements, and payment management capacity of interested PSPs and identify prescreening criteria for selecting PSPs in project districts. To ensure that benefit payments would be made in a timely, secure, accessible, and cost-effective manner, a mix of payment options will be considered due to the diverse nature of access to digital platforms in PNG and the remoteness of many locations. In addition to facilitating linkages with financial institutions (by helping open accounts), the sub-component will also promote account utilization through sensitizing beneficiaries, the majority of which having never had an account or undertaken financial transactions, on basic financial literacy and money

[50] The only formal safety net program in PNG is the social pension program funded and implemented by the Provincial government of New Ireland.

management, and financial products, especially training on the use of basic electronic payment services (using ATM, EFTPOS).

49. **Further, the sub-component will support the design, development, and operationalization of a new MIS to support end-to-end implementation of the child grant as well as the upgrading of DfCDR's IT infrastructure and data management practices**. The program MIS will have a centralized database to support integrated planning and supervision of the program implementation. In addition, the design of the MIS will be module-based and in compliance with the GoPNG's IT policies and technical standards as well as international best practices on data privacy and security. The initial priority of the information management solution is to collect the data of potential beneficiaries to determine their eligibility status and to make payments through the selected PSPs. In addition to beneficiary household profile and payment, other MIS modules may include payment reconciliation, grievance management (GM), monitoring of beneficiary families' participation in complementary activities, and reporting in accordance with the Child Grant Operations Manual. The monitoring function would be an important priority in development of the MIS modules. Tablets and other digital technologies will also be employed to improve monitoring and reporting at the community level. The MIS will be able to share information efficiently and securely with other external programs and databases such as the country's disaster management system. DfCDR's existing capacity in terms of both ICT infrastructure and information management capacity will be strengthened under the project. The proposed child grant program MIS will be designed and developed using open-source technologies, wherever possible, to ensure DfCDR can operate, manage and extend the solution as required.

50. **Lastly, the sub-component will strengthen the institutional capacity of DfCDR through training and support the partnerships between DfCDR and subnational governments in the project areas**. A CMU will be set up under DfCDR for Component 2 and acquire relevant technical expertise that is not available within DfCDR. The operating costs of the CMU will also be financed. During the project implementation, the sub-component will support to DfCDR to build its internal staff capacity under the project to manage the project implementation with less need of external consultants over time. In addition, to strengthen the partnerships in delivering the child grant in the project districts, the sub-component will equip a small number of DCDCs that have been built or are going to be built by DfCDR and sub-national governments to support project implementation by serving as venues for communication, coordination, and training.

Component 3: Advocacy, Coordination, and Project Management (US$5 Million)

51. **The objective of this component is to support advocacy of the FTI agenda, oversight and coordination of nutrition relevant interventions, and overall project management**. This component will finance the operational costs needed to advocate and coordinate nutrition policies and programs, the consultancy support to carry out a series of project monitoring surveys and thematic studies, and the personnel costs for managing project related financial management (FM), procurement, monitoring and evaluation (M&E) and learning, and safeguards to facilitate project implementation. The support will include: (a) strengthening the Department of Justice and Attorney General (DJAG), SSLOSWG-N, and the SLOS Secretariat housed in DJAG to enhance coordination among FTI stakeholders related to the project implementation and to build institutional capacity for the oversight, coordination and monitoring of the FTI; (b) organizing National Nutrition Summits to highlight the importance of child stunting reduction, its determinants, and review the progress; (c) facilitating the planning and implementation of FTI activities at the province and district level; (d) developing and coordinating the implementation of a unified M&E and learning strategy; and (e) managing the project M&E, reporting, and planning. The proposed M&E and learning strategy will capitalize on existing systems, particularly the electronic National Health Information System (e-NHIS),

and project financed evidence generation activities to improve the tracking of progress made on stunting using common indicators across implementing levels – provinces, district, local level government, and wards, down to villages. More importantly, it will also seek to document and capture lessons learned on the effectiveness of both Government-financed and Project-supported actions to reduce stunting and promote ECD, and to guide adaptation of design and implementation arrangements of those activities based on the evidence and lessons generated in earlier implementation.

Citizen Engagement

52. **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.** No direct community consultations were organized for the project yet due to COVID-19. However, the project design incorporates feedback from non-government stakeholders such as church health organizations and a few NGOs working in the nutrition space in PNG. The World Bank's accompanying program of Advisory Services and Analytics (P177234) also includes two analytical studies that will organize community consultations in the first four provinces to be included in the project as a part of an assessment of supply-side health service delivery innovations and to inform the design of SBCC approaches tailored to local realities. Community consultations are also planned as a part of the Project Preparation Grant (PPG). 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 survey results every year throughout the implementation. The feedback received from the beneficiary surveys, spot checks, and stakeholder engagements will inform the operation to strengthen the service delivery, while the project GM will ensure that beneficiaries have a safe and secure way of communicating any complaint with the IAs. Moreover, the project will support the IAs to link the project GM with existing relevant GMs to engage a broader population beyond the target beneficiaries. Semi-annual missions among IAs, World Bank, and DFAT 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 beneficiary satisfaction with health and nutrition services received using the planned iterative beneficiary surveys as well as monitor child grant related grievance redress performance.

Climate Co-Benefits

53. **The negative impacts of climate change are expected to increase for the population already at risk of malnutrition in a variety of ways, particularly for pregnant women, mothers, and children.** Climate change is expected to increase the frequency of extreme weather events, affecting livelihood shocks for households dependent on agriculture and directly affecting food availability and affordability. Households facing climate-induced livelihood shocks will have less reliable access to a sufficient, safe, and adequately diverse diet due to increased risks of crop failure. Infants in particular are at higher risk due to their specific needs in the early years, including premature weaning and maternal undernutrition. Increased flooding and rainfall due to climate change will contaminate water sources more often and unsanitary environments increase the incidence of vector- and water-borne diseases, particularly among the elderly, women, and children who are especially vulnerable to cholera outbreaks. Floods and landslides can destroy infrastructure, thus preventing delivery of health services to vulnerable populations. Both human safety and access to health centers are directly affected by climate related disasters. Poor health and undernutrition in turn further undermines people's adaptation and resilience to climatic shocks, compounding the impacts of these shocks. Lack of a national social safety net program and delivery systems has prevented the Government from providing rapid assistance to those negatively affected by various natural disasters in the past.

54. **The project aims to reduce the risks posed to nutrition outcomes due to climate change and to increase the beneficiary population's resilience to changes in the frequency of flooding, precipitation and other climate related events through several interventions.** These include: (a) national level campaigns to raise awareness about chronic malnutrition and build commitment to both nutrition and climate actions; (b) community engagement activities to promote behavior change on nurturing care and IYCF practices and environmental issues related to water and food safety and to promote kitchen gardens to grow locally viable nutritious foods for consumption; (c) deployment of a MIS to register/identify beneficiaries which would also be used for early warning and immediate response in the event of disasters; (d) capacity building activities to enhance nutrition-sensitive and climate-resilient service delivery; and (e) child nutrition grants which directly reduce the risks of food insecurity during the climate disasters and builds resilience to climate induced shocks. Project implementation will increase the beneficiaries' awareness of nutrition-specific and climate-sensitive programs, improve their access to food, social benefits, and access to services such as water and sanitation that will contribute to sustained improvement of nutrition outcomes. The first four provinces selected to roll out project interventions (Madang, East New Britain, Chimbu, and Western) are prone to various disasters, especially with high risks to flood and precipitation-triggered landslides.[51] As all PNG provinces are vulnerable to one or more climate disasters such as flood, landslide, and wildfire, the project interventions will help reduce the negative impacts of those climate disasters and build resilience. The detailed activities and measures are presented in the table below:

Table 2: Climate Change Risks and Mitigation/adaptation measures

Project Component	Mitigation/Adaptation Measures/activities	Relevant Indicators
Component 1: Implementing PNG CARES (US$19 million)	**Sub-component 1.1, Community-based multi-sectoral actions for nutrition and ECD (US$7.5 million)** • The community engagement activities will include a comprehensive SBCC program, tailored to PNG diversity, to raise awareness on climate change impacts on nutrition and help vulnerable communities improve the drivers of chronic malnutrition and cope with the additional risks posed by climate change and its impacts. Specifically, the program will integrate climate-related knowledge in the good hygiene practice to prevent the spread of diseases exacerbated by climatic changes (e.g. diarrhea) and dietary diversity sessions to raise awareness on food security risks to climate disasters. In addition, by promoting dietary diversity and kitchen gardens under this sub-component, project beneficiaries will be less reliant on longer food supply chains which are vulnerable to disruptions due to weather events. • Early Stimulation and Positive Parenting. The hands-on parent coaching and the positive parenting session will increase the parent knowledge on climate change and promote preparedness for the climate-related emergencies in line with the heightened awareness about the additional risks posed by climate change on nutrition and health.	Proportion of mothers/caregivers attending monthly SBCC activities Percentage point increase in the proportion of mothers/caregivers who demonstrate knowledge of WASH Proportion of children aged 6-23 months who received an adequate diverse diet

[51] *https://thinkhazard.org/en/report/192-papua-new-guinea/FL*

	Sub-component 1.2, Strengthening health systems (US$11.5 million): • The capacity building activities will enhance the primary health care system's capacity to deliver nutrition-specific services both at the facility and community-level and include specific training modules on climate-sensitive diseases and impact on nutrition and immune system. • Support to procure medical supply including micronutrients and supplements for treatment of SAM will help ensure medical supply is available during extreme weather events and help reduce food security risks due to climate change / extreme weather events. • The mass-media advocacy campaign will improve nutrition and hygiene practices that reduce the impact of climate change impacts on nutrition and build climate resilience. This includes messages related to consumption of locally grown nutritious foods, cultivation of kitchen gardens, promoting good handwashing, safe drinking water and hygiene practices that reduce vulnerability to diarrheal disease • The use of digital tools where possible will facilitate the effective and timely delivery of communication messages on climate-related diseases and efficient skills building to promote behavioral change and build resilience. • The digital tools will meet the energy efficiency standards including energy star certification in IT equipment.	Percentage increase in the number of Health Workers and Village Health Volunteers/Village Health Assistants trained on nutrition
Component 2: Implementing Nutrition Sensitive Child Grant (US$66 million)	**Sub-component 2.1, Child nutrition grant (US$58 million):** • The child nutrition grant will target pregnant women and children under age two. It will incentivize the beneficiary households to participate in the complementary SBCC sessions on climate change and climate induced disaster preparedness, and basic financial literacy and management to help them secure food and better cope financially to climate events. • The cash grant will increase the capacity of households to manage climate change impacts better through increased savings and build resilience, which can address challenges such as crop failures, food insecurity, food price fluctuation, water contamination from climate disasters, and livelihood shocks, thus helping reduce health and malnutrition risks due to climate change, negative copping strategies and contributing to a more climate resilient community.	Proportion of first 1,000-day households receiving child nutrition grant Beneficiaries of social safety net programs (CRI, Number)

	Sub-component 2.2, Building delivery systems (US$8 million): • The MIS will build a geo-coded beneficiary database that will help identify communities vulnerable to climate change / areas prone to climate risks with possible links to the country's disaster management system and National Health Information System to support more timely emergency response to climate disasters and climate-related disease incidence • The business process design should be adaptable and consider the continuity of service delivery during the climate-related disasters. The grant delivery systems would be climate resilient as they will help ensure beneficiaries can access financial resources even when physical locations are disrupted due to weather events. • The training of DfCDR and subnational government staff involved in the delivery of child grants will increase awareness of climate change and preparedness for climate change-induced emergencies such as cyclones. • The financial inclusion (i.e., open and manage bank account, financial literacy) will promote saving to cope with future shocks and invest ex ante in disaster preparedness.	Modular Management Information System (MIS) developed and operationalized Number of DfCDR staff, Province and District Community Development Officers trained per their roles and responsibilities in managing child nutrition grant

Gender

55. **Gender inequality remains a significant barrier to human capital development, and PNG has the second-highest level of the Gender Inequality Index globally**.[52] PNG is ranked 161 out of 162 countries globally with the highest level of gender inequalities in reproductive health, empowerment and labor market participation. Furthermore, the high prevalence of GBV and persistent traditional gender roles within the household significantly limit women's opportunities to engage in income-generating activities. A 2018 time-use study of the agricultural sector in the country revealed that rural women dedicate nearly four times more of their day than men doing household work (e.g., cooking, elder and childcare, fuel/water provisioning, household building/maintenance work).[53] ILO estimates that, in 2019, female labor force participation rate was 48.0 percent compared to 48.9 for men.[54] These statistics, however, do not demonstrate that female labor is mainly concentrated in rural work (informal and subsistence work) in agriculture and that women have limited access to wage employment. In 2018, only 14 percent of women were waged or salaried workers, as opposed to 33 percent of men.[55] Such wage employment gaps have led to women in PNG having limited control over household spending, lower access to financial services, and being excluded from the formal financial sector.

[52] UNDP, 2020. *Human Development Report*.
[53] World Bank, 2018. *Household Allocation and Efficiency of Time in Papua New Guinea*.
[54] ILOSTAT Database.
[55] Pacific Financial Inclusion Programme, 2020. *PoWER Women's and Girls' Access and Agency Assessment: Papua New Guinea*.

56. **Through Component 2 activities, the project will close the gender gap in financial inclusion and account utilization.** It is estimated that the formal financial inclusion gender gap in PNG is 29 percent, the highest in the South Pacific. In addition to supply side constraints, such as higher concentration of access points in urban areas, multiple barriers are responsible for the financial inclusion gender gap in PNG. These include higher levels of poverty among women, sociocultural norms that limit women's control over their time and money, disparities in education and literacy levels and employment, resulting in limited knowledge of or exposure to financial services. Of the 1.2 million new bank accounts opened as part of National Financial Inclusion Strategy (2014-2015), only 30 percent were by women, and men owned up to two times more financial products than women.[56] However, data from the 2018 DHS reveals that ownership of an account is not indicative of use: only 18.4 percent of the women and 27 percent of men surveyed reported having and using a bank account or mobile-money service provider.[57] Research from PNG shows that women often do not understand and trust formal financial products and feel put off by their perceived image of financial services as intimidating, risky, and by and for men.[58] Component 2 of the project will aim to reduce the gender gap in financial inclusion in PNG, as well as promote account utilization by: (a) offering a mix of payment options for the child nutrition grant through a variety of financial service providers, EFTPOS and cash-out points, especially considering remoteness of many locations; (b) promoting the use of digital payment via bank account or mobile wallet, where feasible; (c) targeting pregnant women or mothers of young children as grant recipients and supporting them to open bank or mobile wallet accounts, particularly those who have never owned an account; and (d) training grant recipients on the use of basic electronic payments services (using ATM, EFTPOS, mobile wallet), money management, and basic financial services. The financial inclusion training will be developed building on the Gender and Women's Financial Inclusion Initiative spearheaded by the Center for Excellence in Financial Inclusion (CEFI), the organization responsible for coordinating, advocating, and monitoring all financial inclusion activities in PNG. The trainings and outreach activities undertaken by the project will help increase women's awareness and trust in financial products and services.

57. **Component 1 activities will seek to reduce gender inequality at home and communities through the promotion of health seeking behaviors and nutrition-oriented SBCC, with a focus on closing the gender gaps related to care**. Results from the PNG DHS 2016-18 shows that gender inequality at home (decision making and control over resources) is associated with lower women's health seeking behavior. Empowered women are more likely to seek and use health services. Women who do not participate in any household decisions were much less likely to receive antenatal care from a skilled provider (61%), delivery care from a skilled provider (42%), and a postnatal checkup (34%) than women participating in all three decisions (78%, 60%, and 51%, respectively).[59] The sociocultural norms in PNG put an unequal burden of domestic duties on women, particularly childcare. However, evidence suggests that fathers can and do distinctly contribute to foundational components for children's growth and development including nutrition and safety, early learning and responsive care.[60] Overviews of interventions by WHO (2007)[61] and Promundo (2013)[62] provide useful insights into what works and how best to engage fathers in nutrition and care interventions, e.g., MenCare which promotes men's involvement as equitable, responsive and non-violent fathers and caregivers in order to promote children's, women's and men's well-being and gender equality. Activities under

[56] Ibid.
[57] National Statistical Office, 2018. *Papua New Guinea Demographic and Health Survey 2016-2018*.
[58] Pacific Financial Inclusion Programme, 2020. *PoWER Women's and Girls' Access and Agency Assessment: Papua New Guinea*.
[59] National Statistical Office, 2018. *Papua New Guinea Demographic and Health Survey 2016-2018*.
[60] Promundo-US. 2020. The role of fathers in Parenting for gender equality.
[61] World Health Organization and Promundo. 2007. *Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions.*
[62] Promundo, CulturaSalud, and REDMAS.2013. *Program P – A Manual for Engaging Men in Father- hood, Caregiving, Maternal and Child Health*. Promundo: Rio de Janeiro, Brazil and Washington, D.C. USA.

Component 1 seek to raise awareness and promote critical nutrition behaviors among first 1,000-day households and their communities including use of health services, early stimulation and positive parenting behaviors through behavior change communication in organized group sessions, individualized counselling sessions and home visits. In PNG, the *P4CD* pilot engaged parents in 12 group parenting sessions over six weeks. The sessions aimed to improve parents' knowledge of child development, understanding of children's behavior, knowledge and use of positive parenting strategies, develop awareness of emotions and strategies for emotional self-control, and help parents to apply the knowledge and skills to problem-solving and communication in the family. The pilot demonstrated that in the four provinces where the program was implemented, there were significant improvements in family wellbeing and an increased understanding of the father's significant influence on children's development.

58. Activities under Component 1 seek to raise awareness and promote critical nutrition behaviors among first 1,000-day households and their communities including use of health services, early stimulation and positive parenting behaviors through behavior change communication in organized group sessions, individualized counselling sessions and home visits. The project will include hands-on parent coaching for men, women and couples based on P4CD with a focus on how fathers can interact with their children, and community-based activities implemented by church groups as part of the integrated PNG CARES program.

59. In addition, considering the high rates of GBV, this component will also train health workers and VHVs to refer GBV survivors to GBV services per the national protocols.[63] Furthermore, recent evidence from Bangladesh suggests that combining cash transfers with nutrition-oriented SBCC by engaging peer groups (women or men) and community leaders could reduce IPV that last beyond project time frames.[64] One of the mechanisms outlined in Roy et al. (2019) is that participating in peer group SBCC activities could increase women's visibility in communities, thus raising women's social capital, which then increases social costs of men's violent behavior. This is of particular relevance in the PNG context, where community life plays a key role with relatives, family elders, chiefs, and church pastors often seen as the first point of contact for both children and families requiring support and dispute resolution. [65]

60. **In sum, this project will specially address and close the following gender gap:**

Gender gap	How the project addresses the gap	Indicator to be measured
Closing the gender gap in financial inclusion and account utilization: of the 1.2 million new bank accounts opened as part of the National Financial Inclusion Strategy (2014 – 2015), only 30 percent were by women, and men owned up to two times more financial products.	• For female child grant beneficiaries with no accounts with financial service institutions, open accounts on their behalf • Provide information on using bank account or mobile wallet, including ATM and	• Percentage of female child nutrition grant beneficiaries who are first-time owners of an account (bank account or mobile wallet) Baseline: 0% Target: 60%

[63] Based on the DHS 2016-2018, 63% of ever-married women in PNG have experienced spousal physical, sexual, or emotional violence. Intimate-partner violence against women is widely accepted, with 72 percent of men and 70 percent of women stating that wife beating is justified under certain circumstances.
[64] Roy, Hidrobo, Hoddinott and Ahmed. 2019. *Transfers, Behavior Change Communication, and Intimate Partner Violence: Posprogram Evidence from Rural Bangladesh*. Review of Economics and Statistics. Volume 101. Issue 5.
[65] Save the Children. 2019. *Unseen and Unsafe: The Underinvestment in Ending Violence against Children in the Pacific and Timor-Leste.*

	EFTPOS, and provide training on basic financial literacy • Female child nutrition grant beneficiaries using the accounts to receive child grants	

C. Project Beneficiaries

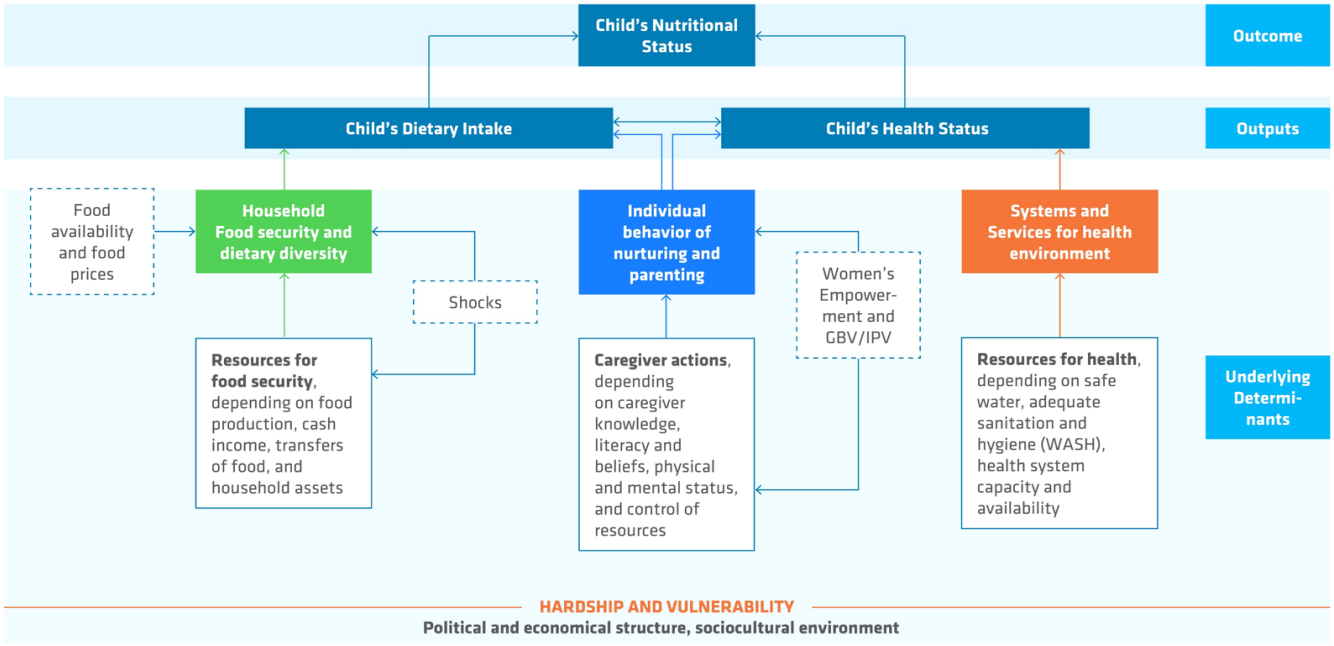
61. **The direct beneficiaries are the first 1,000 days households covered by the project.** While the pregnant women or the mothers of infants under 2 would be the direct recipients of the child nutrition grant, their family members would also benefit from the project in terms of more and better-quality food and exposure to SBCC to improve nutrition as well as nutrition enhancing activities like kitchen gardens and livestock rearing. Activities such as community-level hygiene promotion would benefit the wider community in Project-supported areas. The secondary beneficiaries are health workers in the public and non-governmental sectors who will receive training for delivering the essential health and nutrition services. The national and sub-national government officials that are involved in the FTI planning and implementation will also benefit from capacity building activities and coordination mechanism established by the project.

D. Results Chain

62. **Multi-sectoral convergence approaches are a critical element of successful country responses to stunting.** The policy framework in PNG clearly recognizes this, and the FTI's multi-sectoral approach includes actions for advocacy, commitment building, knowledge sharing, and coordination mechanism to create an enabling environment for convergence of both direct nutrition-specific and nutrition-sensitive interventions at community level. All nutrition relevant interventions addressing drivers of undernutrition such as burden of illness and infections, inadequate care, nutrient intake and feeding practices, inadequate food security, poor quality diet and inadequate diet diversification, and inadequate WASH need to be synchronized in timing and sequence for the same set of households to maximize their impact on the ground. In addition to the needs of co-locating of key programs and services, the importance of synchronization of multiple actions also calls for strong systems requirements and adequate use of monitoring information to facilitate coordination and sustained progress.

63. **Figure 7 outlines the conceptual framework for the project design.** Three channels have been identified for the project interventions: (a) food security and dietary diversity at the household level (demand-side); (b) behavior and practices of nurturing and parenting at the individual level; and (c) systems and services for health environment at the community level (supply-side). Component 1 will address the drivers of children stunting and undernutrition associated with the second and third channels while component 2 will address the drivers of child stunting associated with the first channel and support to address those associated with the second channel. Component 3 will support the overall enabling environment and coordination across sectors and layers of governments.

Figure 7: Conceptual Framework: Approach to Reducing Stunting

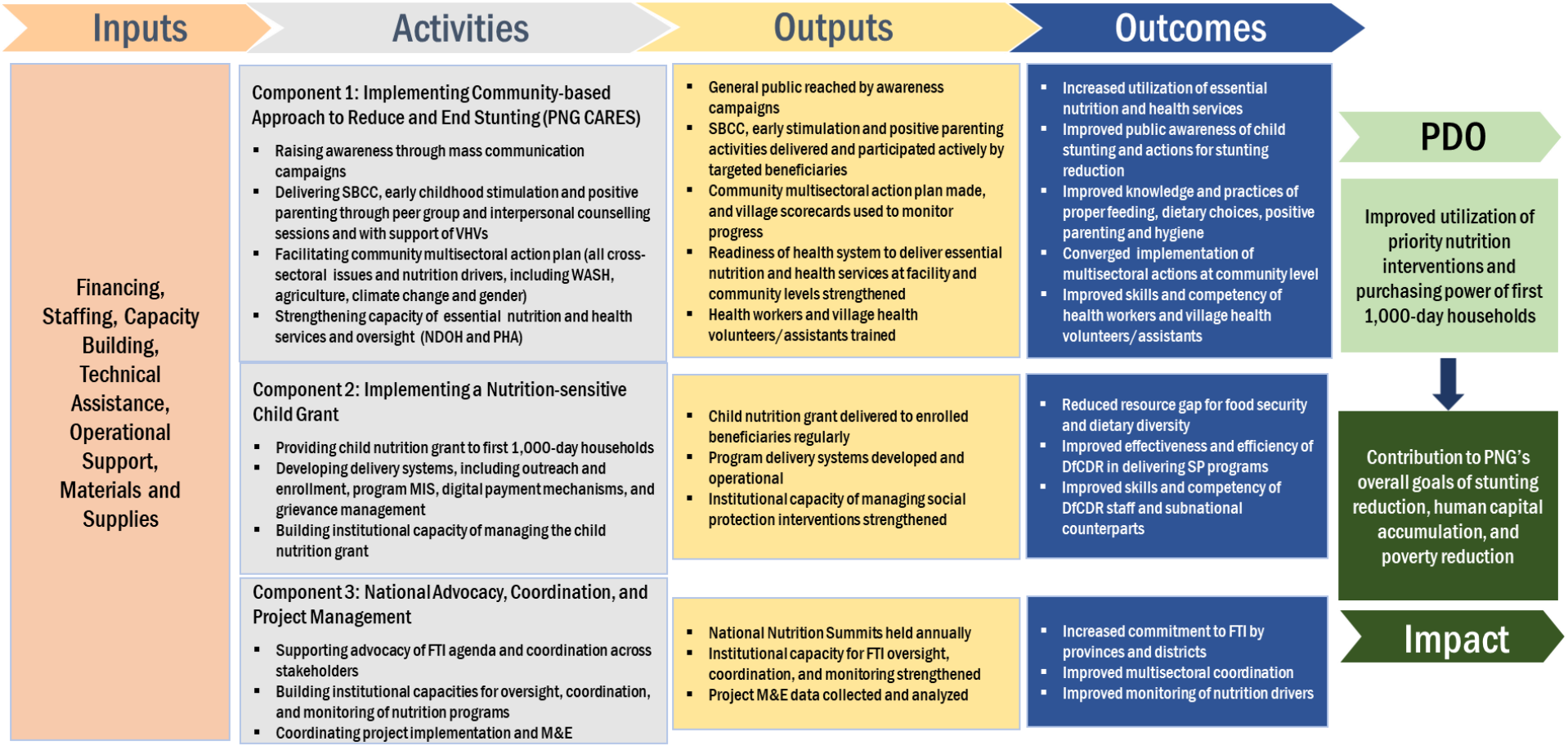


Source: World Bank staff adaptation of De Groot *et al.* (2017).[66]

64. **The proposed results chain for the project is presented in Figure 8**. Through the project financed interventions, the project intends to increase utilization of priority nutrition interventions and purchasing power of first 1,000-day households, which will contribute to PNG's overall goals of child stunting reduction, human capital accumulation, and poverty reduction.

[66] de Groot, R., Palermo, T., Handa, S., Ragno, L. P., Peterman, A. (2017). *Cash Transfers and Child Nutrition: Pathways and Impacts*. Dev Policy Rev, 35:621– 643.

Figure 8: Results Chain



E. Rationale for Bank Involvement and Role of Partners

65. **The Bank's support adds value in four ways.** First, the World Bank has extensive experience in both EAP region and globally in supporting stunting reduction programs through a multi-sectoral approach, including both supply and demand side interventions (e.g., cash transfer for nutrition purpose). Second, the Project can build on existing Bank operations and other development partner programs in PNG that are addressing the underlining factors of stunting, including health, agriculture, rural service delivery, water and sanitation, and several infrastructure operations. In particular, the NDoH is implementing a Bank financed project Improving Access to and Value from Health Services in PNG (IMPACT Health), which supports the strengthening of rural health care services to ensure service delivery readiness – funding is being channeled to support rehabilitation of health facilities, performance monitoring tools development to support oversight as well as capacity building. Third, the World Bank has extensive experience in the Pacific, EAP and beyond in supporting countries to establish basic social assistance delivery systems (including registration, payment, MIS, GM, etc.), in a number of cases from scratch as in PNG (e.g., in Tonga, RMI, Lao PDR and Myanmar). The lack of such social assistance delivery platforms has clearly weakened the GoPNG's capacity to protect vulnerable populations, both in normal times and in crisis periods such as the COVID-19 pandemic. Fourth, the IDA financing will play a catalyst role to leverage additional financing from the governments and development partners. While this operation will not be able to cover the whole of PNG, by focusing on strengthening institutions and systems and generating evidence and learning, it will strengthen the alliance among government stakeholders and development partners to ensure greater programmatic and financial sustainability of the FTI agenda and scale up the project interventions.

66. **Various development partners including UN agencies and civil society organizations (CSO) have been supporting the nutrition agenda in PNG and formed a strong alliance for FTI.** DFAT has joined hands with the World Bank in supporting the FTI agenda and committed AUD 21 million funding to the program, out of which US$10 million is to co-finance the project and the remainder to support the analytical work which has informed project design, to support GoPNG to carry out a pilot in advance of full project implementation, and to provide technical assistance to GoPNG during the project implementation. The pilot will be financed via a Project Preparation Grant and is expected to test out the key project design features and implementation arrangements in four districts, one from each region, and to inform the detailed design and implementation arrangements. UNICEF's longstanding program on nutrition and care practices in PNG aims to promote and increase availability of therapeutic foods and micronutrients, treatment of SAM, promote IYCF practices through mother groups in selected provinces, and provide ongoing technical assistance. UNICEF, NDoH and Catholic Church Health Services are also jointly implementing a pilot project that is very similar to sub-component 1.1 activities in a few districts. WHO is also providing technical assistance to the NDoH on nutrition programming. The SUN CSO network jointly led by Save the Children (STC) and Susu Mama are working on various interventions and activities to mobilize joint action and resources to improve nutrition in PNG. These partners are all members of the SSLOSWG-N. The STC also had carried out a cash and voucher assistance assessment in PNG and one of the main findings is that nearly two thirds of respondents prefer cash over in-kind assistance.

F. Lessons Learned and Reflected in the Project Design

67. The project design draws on best practices and innovative approaches from both PNG and lessons from countries that have mounted successful national stunting reduction programs, which have demonstrated how a combination of factors can achieve significant changes in child nutrition outcomes. For example, lessons are drawn from small scale community nutrition and health projects and pilots implemented with support from STC, World Vision and

UNICEF in PNG, with a particular focus on behavior change, working with VHVs and at the community level. Also, important lessons with regards to sanitation and hygiene and dietary diversity are taken from the water and agriculture sector[67] programs that are and have been implemented in PNG in remote areas. International experience, especially related to cash transfers and governance of community nutrition programs is drawn from a variety of countries ranging from the Pacific Islands to Cambodia, Indonesia, Bangladesh, Malawi, Rwanda and Peru.

68. Global studies indicate that the first 1,000 days of life is a pivotal period of development. Exposure to risks and adversities during these early years starting in pregnancy, 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 stimulation and nurturing care, lack of access to clean water and sanitation, high levels of family stress, exposure to conflict, violence and child abuse, negative impacts of climate change and lack of access to adequate health and education services. The 1,000 days offers a window of opportunity in which reversing such adversities and mitigating the risks will preventing lasting damage so that children can reach their potential.

69. International research on successful approaches demonstrates that holistic ECD programs that enhance not only nutrition, but also health and early stimulation are more likely to support children reaching their full developmental potential. Integrating nutrition and ECD programs in the first two years of life has many advantages, including using the same personnel, the same platforms, and the same points of contact, thereby offering opportunities to engage in multiple complementary interventions with the same group. The project seeks to integrate early stimulation, positive parenting as well as cross-sectoral issues as the effects of climate change and gender related issues in a gradual manner in the SBCC strategy and program implementation.

70. Modern mass media campaigns with appropriate cultural messages play an important role in raising awareness about stunting. Stunting is a condition which is not easily recognized as it is a gradual process, occurring in a majority of a population (children under age five) in the same community. In order to prevent stunting, parents need to be made aware it is a problem. As was done for other public health problems (e.g., HIV/AIDS) worldwide in the previous decade, a state-of-the-art mass media campaign about the causes and implications of stunting is included as priority in the government led FTI and will be part of the project. The media campaign will use multiple channels that are appropriate to the local context (e.g., rural radio).

71. Building on the awareness raised, high quality interpersonal counseling that draws on locally appropriate behavior change strategies and global lessons, will bring about the behavior change needed to prevent stunting. A comprehensive SBCC strategy focused on both mass-media and interpersonal counselling on child growth, drawing on both international and local experiences is being developed and will be implemented under the project. For example, two interventions that demonstrate positive results include providing key messages to mothers, fathers, grandmothers and other household members through peer support groups, and the positive deviance approach to behavior change.

72. Lessons from community-based programs such as Healthy Islands have shown the essence of community participation and pivotal role of community health workers and community volunteers play in increasing awareness of linkages between individual behavior, their living environment, and poor health/nutrition outcomes and in integrating SBCC activities to promote use of clean water, improved sanitation, and personal hygiene practices at the community level. Other key emerging lessons point to the importance of community leadership engagement in the support to community volunteers and the use of innovative tools such as community scorecard. These tools

[67] World Bank. *What can the Agriculture sector do to reduce undernutrition in PNG?*

help communities, households, and caregivers visualize children's growth progress are key to behavior change. The use of scorecards is showing promising results for example in Indonesia. As part of the analytical program supporting the project preparation and the implementation of the pilot, technical assistance is ongoing to gather information and lessons learned from nutrition specific and sensitive activities, including the Healthy Islands program. This TA will feed into the innovation lab which is being established as a multi-partner platform to share experiences and lessons learned.

73. The Bank-financed Productive Partnerships in Agriculture Project (PPAP) in PNG also provides rich lessons. Closed recently, PPAG implemented a number of activities that are similar to those being planned in this project: SBCC for behavior change in IYCF practices, promoting dietary diversity, working directly at the community level with farmers, community leaders, community volunteers and women's groups. PPAP's experience suggests the importance of engaging early on with community leaders and of rewarding volunteers either financially or through recognition. Both these elements are built into project design and will be reflected in implementation. PPAP's experience also suggests the relevance and effectiveness of the convergence approach in project: convergence is driven through bottom-up implementation strategies and bolstered through provincial and national coordination. Finally, PPAP's experience highlights the importance of intensive supervision and implementation support to community volunteers as well as other implementation partners. The project design applies this insight and extensive technical assistance will be provide to PHAs, Church health providers as well as to VHVs/ VHAs.

74. The inclusion of a nutrition-sensitive cash grant program as part of a multi-sectoral package reflects several lessons from regional and global experience:

    (a) First, global reviews of cash transfers overall have found unambiguous improvements in dietary diversity and use of health and nutrition services, both crucial elements of better nutritional outcomes. In Asia and Pacific, they have also improved parental care practices and health behaviors. Largely in line with earlier reviews of global experience,[68] a recent comprehensive global review specifically on nutrition-sensitive cash transfers finds significant positive impacts on height-for-age and stunting among child beneficiaries.[69] This is consistent with results from the Asia-Pacific region, including in Indonesia, Philippines, Cambodia and Sri Lanka. These impacts have been most pronounced in children under three years of age, consistent with the first 1,000 days focus of this project.

    (b) Second, global and regional evaluations have found that the positive impacts on child nutrition are more pronounced when cash transfers are combined with SBCC on nutritional and parenting practices and other behaviors,[70] the so-called "cash plus" approach being used in this project. This approach is being followed in other parts of EAP region with support from World Bank projects, including in Indonesia, Philippines, Lao PDR and Myanmar. In Indonesia for example stunting among children 0-5 fell by 9-10 percentage points using such a combined approach[71], and a pilot program in Cambodia saw it reduced by an impressive 24 percentage points for children under 1 year of age.[72]

    (c) Third, while novel in the context of GoPNG, use of cash as the benefit modality is aligned with available information on the expressed preferences of households. A recent survey by STC in PNG found that 93 percent of respondents felt that cash and vouchers were appropriate forms of transfers, and that 62 percent had a

[68] Bastagli et al, 2016
[69] Manley et al, BMJ 2020
[70] World Bank, forthcoming
[71] Chayadi et al, 2018
[72] World Bank, 2014

preference for cash-only, while only 7 percent of households preferred in-kind transfers. The experience of New Ireland in implementing its provincial social pension program over the past decade also reveals that the cash transfers made a positive contribution to the well-being of beneficiary households.[73] Further, the program's experience of transitioning the initial cash-based payment method to bank account-based electronic payment method and of developing a cloud and mobile-based program MIS[74] to replace the initial manual paper-based system provides very relevant lessons for the child nutrition grant. Some innovative approaches by PNG's micro-banks such as Mama Bank in serving rural communities are also illustrative.[75]

(d) Fourth, global reviews of cash transfer programs suggest that although cash transfers were not designed to address IPV, they can reduce IPV. A mixed-method review of 21 studies in low- and middle-income countries in Latin America and the Caribbean, Africa and Asia identified that most studies have evidence that cash transfers decreased IPV and limited evidence to support that cash transfers increase IPV.[76] Although the authors do not formally compute average effect sizes, 13 coefficients show a decrease on IPV outcomes from the baseline from 11 percent to 66 percent reduction; nine of these impacts have a reduction higher than 30 percent. Evidence from Bangladesh indicates that when cash is combined with SBCC ('cash plus'), like the proposed operation, the reduction of IPV continues even after project closure.[77] Women receiving transfers with SBCC experience 26 percent less physical violence six to ten months after project closes. The project will also use the World Bank Operational Guidance Note, *Safety First: How to leverage social safety nets to prevent Gender Based Violence*, with practical considerations for cash transfer operations aimed to optimize cash transfers design and implementation to prevent GBV and empower women.[78]

(e) Lastly, this project is built on the Bank's extensive experience of working with capacity constrained clients on building and strengthening social protection programs in highly fluid and dynamic fragile settings around the world. These global lessons learned stress the importance of flexibility, simplicity and adaptability when designing a cash transfer program. The pilot planned before introduction of nutrition-sensitive cash transfers at scale allows for adjustments in both program messaging and complementary informational services to better align with cultural norms, and for testing of delivery modalities to assess feasibility.

75. Digital tools can be utilized effectively to counter fragility and remoteness risks. For example, Geo-Enabling Initiative for Monitoring and Supervision (GEMS) is a digital tool for effective project monitoring and greater transparency and accountability. Given PNG's fragmented geography, capacity constraints, and logistical challenges of travelling, the project implementation will consider an open-source IT tool for timely access to field information. The success of GEMS approach in several Asian countries in the last two years has demonstrated the value of such tools for real-time M&E, remote supervision, and risk and safeguards monitoring in fragility, conflict, and violence (FCV) contexts compounded by remoteness and inaccessibility.

[73] World Bank, 2014. The New Ireland Social Pension – A review of the New Ireland Social Pension and implications for the Papua New Guinea National Social Pension.
[74] https://systemate.tech/case-studies-testimonials/oldage-disability-pension.
[75] GPFI, 2020. *Advancing Women's Digital Financial Inclusion.*
[76] Ana Maria Buller, Amber Peterman, Meghna Ranganathan, Alexandra Bleile, Melissa Hidrobo, Lori Heise, A Mixed-Method Review of Cash Transfers and Intimate Partner Violence in Low- and Middle-Income Countries, The World Bank Research Observer, Volume 33, Issue 2, August 2018, Pages 218–258, *https://doi.org/10.1093/wbro/lky002*
[77] Roy, Shalini; Hidrobo, Melissa; Hoddinott, John F.; and Ahmed, Akhter. 2017. Transfers, behavior change communication, and intimate partner violence: Postprogram evidence from rural Bangladesh. IFPRI Discussion Paper 1676. Washington, D.C.: International Food Policy Research Institute (IFPRI). http://ebrary.ifpri.org/cdm/ref/collection/p15738coll2/id/131411.
[78] Botea, Ioana; Coudouel, Aline; Heinemann, Alessandra; Kuttner, Stephanie. 2021. Safety First : How to Leverage Social Safety Nets to Prevent Gender Based Violence. Washington, DC: World Bank.

76. The design and implementation strategies proposed also incorporate broader lessons gleaned from Implementation Completion Reports for nutrition projects in Zimbabwe and the Gambia[79]. These include: the value of engaging with non-state providers (in this case, Churches) who may have good service delivery reach at the community level; the importance of community-engagement; the pivotal role that strategies to improve accountability to communities plays in improving nutrition; and the importance of taking lessons from early implementation to adapt project implementation arrangements for subsequent project implementation.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

77. **NDoH, DfCDR, and DJAG will be the lead government agencies for the implementation of project components 1, 2 and 3, respectively.** As IAs, they will serve as the main planning and implementing bodies of this project and will also have overall responsibility for managing and accounting for project disbursements. NDoH will implement Component 1 activities which are within the purview of the health sector. DfCDR will implement Component 2 given the Department's mandate to oversee the development of the social protection system. Both NDoH and DfCDR would establish their respective CMUs to administer the related component activities. For Component 3, the DJAG will establish a Project Coordination Unit (PCU), to coordinate between the two CMUs on project matters (e.g., reporting) as well as with concerned government agencies and other stakeholders. The PCU and two CMUs will establish a clear coordination mechanism to ensure synchronized planning, implementation, supervision, and reporting of various project activities, including having at least monthly meetings between the three project units and providing quarterly briefings to the PSC and SSLOSWG-N regarding the implementation progress.

78. **The two CMUs and PCU will be staffed by both designated officials and project-financed consultants**. The NDoH and DfCDR CMUs will each include a Component Manager who reports to the relevant Department Secretary and leads the management of activities of respective project components. The PCU of DJAG will include a Project Coordinator who reports to the Secretary and leads the implementation of Component 3. The NDoH CMU will include the following additional full-time project-financed positions: (a) Nutrition Specialist; and (b) Project Accountant. The DfCDR CMU will consist of contract or assigned staff including (a) Payments Specialist; (b) MIS Systems Coordinator; (c) Systems Developer; (d) Operations Specialist; and (e) Compliance Monitoring Specialist. In addition, the CMUs/ PCU will share project-financed consultants with the following expertise: Monitoring, Evaluation and Learning (MEL), Financial Management, Procurement, and a Social Risk, Outreach, and Communication. Technical staff from the three IAs will be paired with and assigned to work closely with their counterparts in the CMUs/PCU to build the former's capacity so that project management and technical functions can be progressively transferred into the IAs. Project activities will be implemented in accordance with the Project Operations Manual.

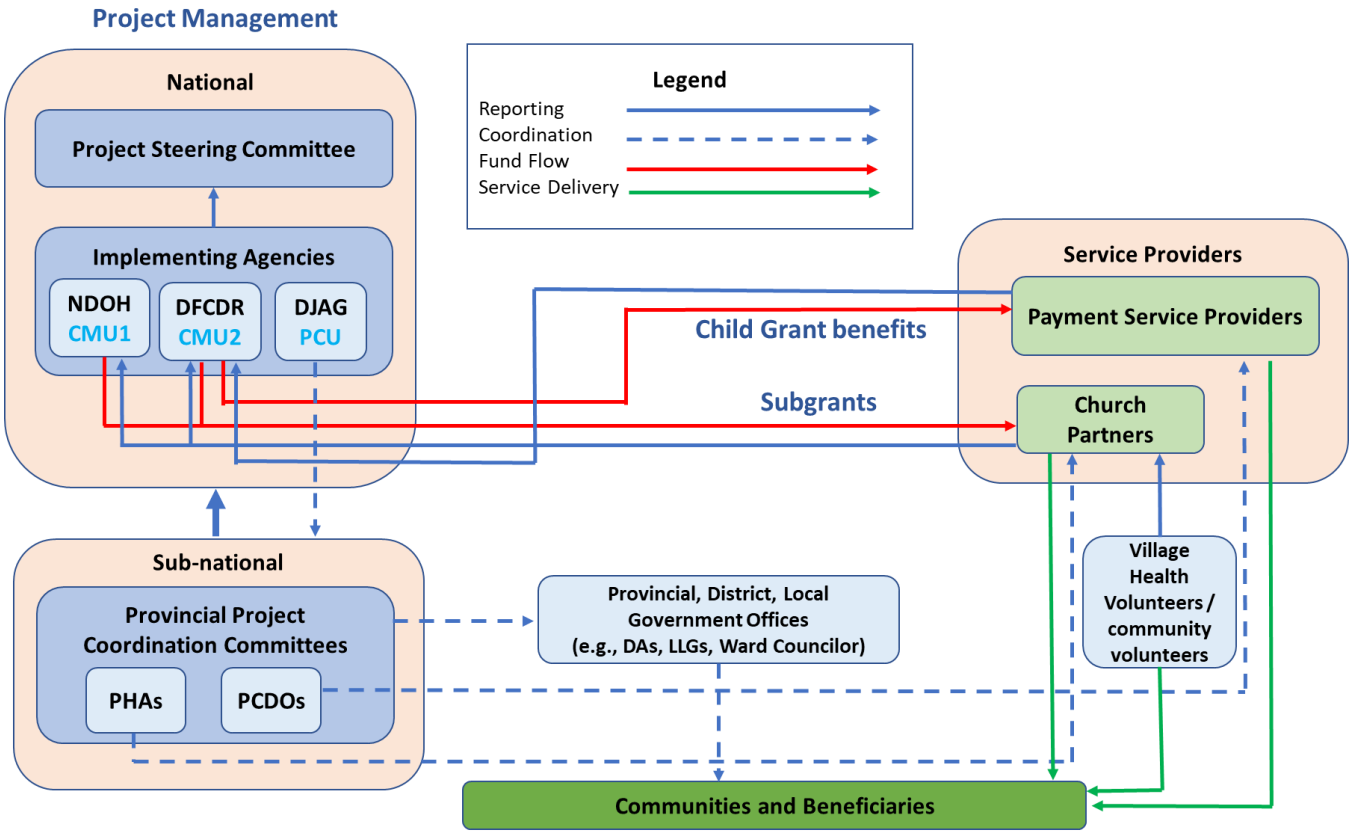
79. **A PSC will be established to ensure soundness of policy decisions and guide project implementation.** Given the multisectoral nature of the project, it is important to maintain appropriate levels of vertical and horizontal coordination and promote inter-agency convergence. As IAs, the NDoH and DfCDR are primarily responsible for respective policy development while DJAG will undertake the coordination function. Because the SLOS currently has the mandate to lead, coordinate, and oversee the FTI and has the convening power for cross-sectoral and sub-

[79] Gambia Maternal and Child Nutrition and Health Results Project (P143650); and Zimbabwe Health Sector Development Support Project (P125229).

national level coordination, the PSC will leverage the SLOS mechanism and will be chaired by the Secretary of DJAG, with the Secretaries of NDoH, DfCDR, and Department of National Planning and Monitoring as members. Other agencies may be invited into the PSC as deemed necessary by the Committee. The PSC will review the project progress and provide advice and guidance on the project's annual work plans and budgets.

80. At the sub-national level, a Provincial Project Coordination Committee (PPCC) will be established and include PHA, PCDO, and other key sub-national stakeholders to coordinate and supervise the project implementation within each project province. The PPCC will be chaired by the Governor or a senior official designated by the Governor. The project will finance the recruitment of one Provincial Nutrition Coordinator (PNC) and one PSPC, whose roles will include supporting the PPCC by closely coordinating with concerned subnational government offices, selected Church organizations and PSPs, and other community actors involved for the outreach and communication of the project interventions. PHAs will, in keeping with their institutional mandate for coordination with subnational stakeholders in health sector, be responsible for coordination with all subnational stakeholders for Component 1. PCDOs will mobilize the District Community Development Officers and be responsible for coordination with district, local level government, and ward councilors to support the Component 2 implementation. Figure 9 illustrates the project's institutional and implementation arrangements.

Figure 9. Project Implementation Arrangements.



81. **The project technical design targets convergence for nutrition services at the village level for nutrition impact**. The project-financed subgrants arrangements between NDoH and DfCDR with church agencies across the

components would ensure convergence at the community level through a common implementation partner for community-level service delivery. In addition, the proposed village scorecard (which is a new tool to be introduced through the project) is intended to act as an accountability mechanism to track convergence across services and enable stakeholders to monitor any gaps starting from community level.

B. Results Monitoring and Evaluation Arrangements

82. **The Results Framework indicators shall be monitored using a combination of administrative data and survey data.** There will be two primary sources of administrative data for tracking output-level indicators: NHIS managed by NDoH and a new Program MIS to be developed for the child nutrition grant. In addition, the project will introduce two new data collection instruments to be implemented as part of project interventions – a village scorecard and a beneficiary feedback survey – and both will leverage digital tools for timely and accurate data collection, transmission, and reporting. Financing and technical support to implement the village scorecard is included in component 1 while the beneficiary survey will be financed through component 3. Progress reports will include key information on project activities, beneficiaries, fiduciary, and environmental and social management. The progress monitoring of outputs and evaluation of outcomes are primarily the responsibility of IAs. This exercise is not only important in measuring the project's end results but also to inform and adjust the implementation of the project, as needed. Data, which include beneficiary updates and grievances, will be regularly collected, recorded and monitored through the MIS. It will also be complemented by data from spot checks and impact evaluations. In addition, data collected by the DHS are also valuable in monitoring the effectiveness of the project.

83. **The progress and achievement of the PDO will be monitored and evaluated through the following activities:** (a) at least semi-annual implementation support missions; (b) annual project status and progress reports; (c) a mid-term review; and (d) a final review of the project outcomes upon project closing. Findings from these activities will provide the basis for concrete policy actions and course corrections in the operations of the project.

C. Sustainability

84. The investments in Component 1 are well aligned with key program areas and priorities in the National Nutrition Policy (2016-2026) and the draft Child and Adolescent Health Policy and Plan (2021-2030). There is strong political commitment, especially with NDoH and the SLOS Committee, to ensure that investments are integrated into their relevant implementation plans for nutrition-specific activities. Component 1 implementation builds on existing implementation structures with the church organizations and is expected to strengthen the health system's capacity and community-based support to address the multisectoral drivers of stunting. In particular, investments in the community-engaged activities such as promoting critical nutrition behaviors among first 1,000-day households and their communities – including appropriate care seeking at health facilities for children with diarrhea, acute respiratory infections, well-child visits and growth monitoring, adopting appropriate IYCF, and early stimulation and positive parenting – are expected to go a long way in building sustainable community systems and healthy behaviors that will be continued and have impact beyond the project period.

85. The project focuses on training and capacity building at all levels, from parents, caregivers and community health workers and volunteers, as well as the management levels of the church organizations and government officials, to national stakeholders. Strengthened decentralized capacity to oversee, monitor and coordinate multi-sectoral activities will bolster local level institutional capacity and accountability. Enhanced knowledge and awareness of childhood stunting among mothers, caregivers, and community leaders and volunteers is expected to lead to

behavioral change that will go well beyond the life of the project. Under the draft VHV Policy each VHV is expected to be responsible for about 50 children, so the average village may need 2 VHVs. The Project proposes to integrate the community-based nutrition services into the VHV program. This is in line with the proposed focus on nutrition in the draft National Health Policy and the draft Health Volunteer Policy.

86. The sustainability of nutrition grants under the project is a natural question given that eventual mainstreaming of the cash transfer program would require incremental funding. Sustainability can be approached from a few angles:

(a) First, spending on nutrition grants is a high-return economic investment in human capital. The substantial positive economic impacts of improved early years nutrition have been demonstrated in multiple countries.[80] The impact channels include improved cognitive performance and educational attainment, higher employment rates and labor incomes across the life course, and lower incidence of non-communicable diseases in both childhood and adult life. Investments in maternal nutrition, including through cash transfers, also have positive inter-generational impacts on these elements. As core elements of human capital accumulation and deployment, nutritional investments thus contribute to higher economic growth over time and higher revenues to fund future public expenditure.

(b) Second, while PNG spends almost nothing on cash transfers currently, the experience of the overwhelming majority of developing countries globally, and more recently in the Pacific, suggests that increased social assistance spending could be expected in future, with or without the project. Such an expectation is supported by the draft National Social Protection Strategy for 2022-30 to be submitted to NEC in the near future which identifies nutrition grants as a priority safety net intervention. In EAP, safety net spending averages around 1 percent of GDP, including in neighbors such as Samoa, Fiji, and Kiribati. While the future level of budgetary spending on safety nets in PNG cannot be predicted with confidence, it seems likely to be more than the current minimal level. Taking 2019 GDP and approximately 260,000 new births nationally each year (based on UN estimated birth rates in recent years) as a base, implementing the cash grant program for all children under 2 and pregnant women would cost around Kina 235 million annually, or around 0.28 percent of GDP.

(c) Third, assuming that the nutrition grant intervention proves effective, it is likely to attract sustained support from donors beyond the life of the project, as improved nutrition is a high donor priority in PNG, as is sustained support to safety nets in the Pacific and beyond.

(d) Fourth, continued improvements in penetration of financial services in PNG, in particular digital and mobile payments, are likely to contribute to lowering the costs of administration of the nutrition grant over time and thus total program costs per beneficiary. The cost-effectiveness of digital payments has been demonstrated repeatedly in developing countries, and there is likely to be continued improvement in expanding the financial service provider and agent network in PNG over project life.

(e) Finally, the project investments in the social protection delivery platforms under DfCDR (for enrollment, payments, management information system and M&E, grievance redress mechanism, and DCDCs) will have benefits beyond the child grant program itself, facilitating outreach of other social programs such as child protection services. This will be the first time that PNG has the foundations for a social protection delivery system that can be leveraged more broadly across government programs. The positive externality of investment in social protection delivery systems will thus make the wider social service delivery systems more efficient and more inclusive.

[80] Von Salmuth et al., 2021; Shekhar et al, 2017.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

Technical

87. The project design is in line with global evidence that a package of high-impact interventions focusing on the critical first 1,000 days window of opportunity and delivered at scale simultaneously can significantly reduce stunting. Further, the project will contextualize mass media communication and SBCC messages to reflect the specificities of the PNG context. Through implementing a nutrition-sensitive child grant program, the project draws on lessons of similar "cash-plus" transfer programs in the region (e.g., in Myanmar and Lao PDR) and beyond (e.g., in Peru and Rwanda) that show the combination of cash transfers with SBCC and nutrition services has notably higher impacts on child and maternal nutrition than cash or SBCC and services alone.[81] The project will also contribute significantly to the development of PNG's social protection delivery platforms such as enrollment, payments, information system, grievance redress, and the DCDC network. Lastly, the project's implementation arrangements leverage existing service providers to carry out community level activities, including the enrollment of eligible first 1,000-day households for child grant. The engagement of church health providers and PSPs is beneficial to the project because these organizations have good capacity and reasonable reach at the community level.

88. Church health services are long-standing health service delivery partners financed through public funds. These organizations are well placed to deliver community level activities as they are already providing 47 percent of the health services in PNG. In a 2017 assessment on health facilities capacity to delivery health services, the results indicate that church run facilities were performing better than other public facilities.[82] The survey findings indicate that churches are not necessarily better resourced in terms of staff or medical supplies, but the governance and administrative structure allows for more autonomy resulting in greater efficiencies and effectiveness to respond to needs. Churches also received more favorable feedback from beneficiaries than public facilities and are noted to be more active in providing services in remote areas. As some subgrant activities (e.g., registration of first 1,000-day households and village scorecard) are new to church health providers, the quality of initial and refresher training is critical. Like in many FCV contexts, this public private partnership with churches ensures that publicly financed services are available in areas where services are not otherwise available, and which do not exclude religious or cultural groups. Three channels will be used to track and ensure that different groups are not excluded: (a) Village scorecards which can track availability of services to local communities; (b) The Project grievance redress mechanisms; and (c) The Subgrant Manual would also include a requirement around non-discrimination. The desire to focus on a single delivery channel that has comparative advantage, demonstrated track record and scale with service delivery is intended to reduce complexity and one that is endorsed by the NDoH and DfCDR.

89. To ensure that child grant benefit payments would be made in a timely, secure, accessible, and cost-effective manner, the project will leverage PNG's existing National Payment System (NPS) and digital payment options offered by financial service institutions. The steady progress made by the Bank of PNG (BPNG) toward modernizing the NPS during the last decade has led to substantial expansion of digital payment systems in the country, particularly in terms of mobile and online banking (most noticeably by BPS, MiBank's MiCash and Digicel's CellMoni). These financial service institutions have also been steadily expanding their agent networks (e.g., with retail stores) in order

[81] Manley et al, 2020.
[82] World Bank, 2017. *Service Delivery by Health Facilities in PNG*

to facilitate cash in and cash-out by their clients. In 2019, the BPNG launched the Retail Electronic Payments System (REPS) which is a new payment systems infrastructure that comprises all elements required to further support retail payments at the national level. In addition to processing local debit card transactions undertaken at EFTPOS terminals and ATMs across different financial institutions, the REPS capacity allows to support additional payment instruments (for example, retail transfers, credit cards, etc.) and acceptance media (e.g. mobile phones), which in turn will support a number of different payment channels and expanding financial services. On the other hand, operational challenges such as geographical isolation of many rural communities, dominance of cash economy and limited digital payment ecosystem in the rural areas, and low levels of financial literacy need to be taken into consideration when engaging with selected financial service institutions as PSPs. Further, the project will allow beneficiaries to choose their preferred PSPs and encourage the adoption of digital payment modalities where feasible. This could substantially reduce the cost of "last mile" payment delivery, while also providing an important opportunity for the government to improve financial inclusion, particularly among women. The DfCDR should review the costs associated with the delivery of the payments through different channels, reducing and possibly absorbing any fee to be charged to beneficiaries when utilizing basic payment services such as cash-out. Lastly, the DfCDR should screen interested financial service institutions as PSPs to ensure that they can effectively manage and report on benefit payments, including presence of branches, ATMs, agents, and EFTPOS points. The project GM and annual beneficiary surveys will be used to independently verify the receipts of benefit payments by beneficiaries.

Economic

90. **There is increasing recognition of the crucial role nutrition plays in fueling human capital and its potential to address intergenerational poverty.** Investment in nutrition is key to improving the stock of human capital of a country which would reap returns in the future. PNG's HCI score is 0.43, indicating that a child born in PNG today can expect to achieve less than half of his or her productivity potential, given current inputs towards the accumulation of their human capital. One essential factor contributing to PNG's low HCI score is its high child stunting rate – 48.2 percent of children under five years of age in PNG are stunted, one of the highest stunting rates in the world.

91. **Early childhood interventions are widely recognized to be among the most cost-effective investments that a country can make in building human capital, reducing inequality, and promoting future growth and prosperity.**[83] Early childhood health interventions, with a focus on stunting, aim to use the window of opportunity to halt or even reverse stunting in the first 1000 days of life. Globally, every dollar invested in high-quality early childhood education programs can yield between US$6-17 in return,[84] while every dollar invested in proven maternal and child nutrition interventions can deliver returns of US$16.[85] The costs of inaction, on the other hand, are enormous. Without intervention, children who are at risk of poor development in low- and middle-income countries, due to extreme poverty and stunting (low height-for-age), are expected to earn 26 percent less as adults than if they had reached their full developmental potential.[86] The costs of inaction as a percentage of GDP can be double what some countries currently spend on health as a proportion of GDP. For PNG the economic cost of stunting has been estimated by STC to be 2.81 percent of GDP per year.

[83] Black et al. (2016), Heckman (2008), Campbell et al. (2014), Walker et al. (2011).
[84] Engle et al. (2011).
[85] IFPRI (2016).
[86] Richter et al. (2016).

92. **A number of studies have investigated the benefits and costs of such interventions.** Alderman and Behrman (2006) demonstrate for example the economic benefits of reducing Low Birth Weight (a determinant of stunting later in life) for one infant in a developing country. They detail the various long-term and short-term benefits as: a rise in productivity due to reduced stunting and increased ability; reducing the costs of chronic diseases; intergenerational benefits; and averting the costs resulting from infant deaths, neonatal care as well as from infant or child illness.

93. **Multi-sectoral initiatives, as proposed in the project can address poor nutrition through three main pathways: (a) direct nutrition interventions and programs; (b) nutrition-sensitive programs and approaches; and (c) policy coherence that creates an enabling environment.** Nutrition-sensitive interventions target the underlying determinants of undernutrition such as poverty, food insecurity, access to health care, water and sanitation services. Nutrition-sensitive programs in agriculture, social protection, WASH and education have tremendous potential to accelerate the rate of reduction in undernutrition given the clear causal pathway to impact. This potential is underscored by the experiences of countries that have achieved dramatic reductions in stunting. The existing literature documents the impact of agriculture programs on intermediate outcomes such as diet that can lead to impact on nutritional status. The evidence base on the impact of conditional cash transfer programs, which form a large part of the project, has evolved over the years and the most recent global meta-reviews find positive impacts on height-for-age and stunting among child beneficiaries in a number of country studies.[87] In addition, improvements in intermediate outcomes have been seen and do provide a good basis for nutrition-sensitive actions across sectors.

94. **The project to be initiated in 2022, aims to increase the utilization of priority nutrition interventions and purchasing power of the first thousand-day households in selected provinces**. Initially, four provinces will be targeted: Madang, East New Britain, Chimbu, and Western and four additional provinces will be included over a six-year period of implementation. The number of beneficiaries for the following groups – pregnant mothers, 0–1 year old, and 1–2 year old – amounts to about 505,500 direct beneficiaries by the end of the project. Benefits that indirect beneficiaries enjoy, are not taken into this benefit analysis. The methodology of the economic analysis for this project in PNG is described in a technical note prepared separately.

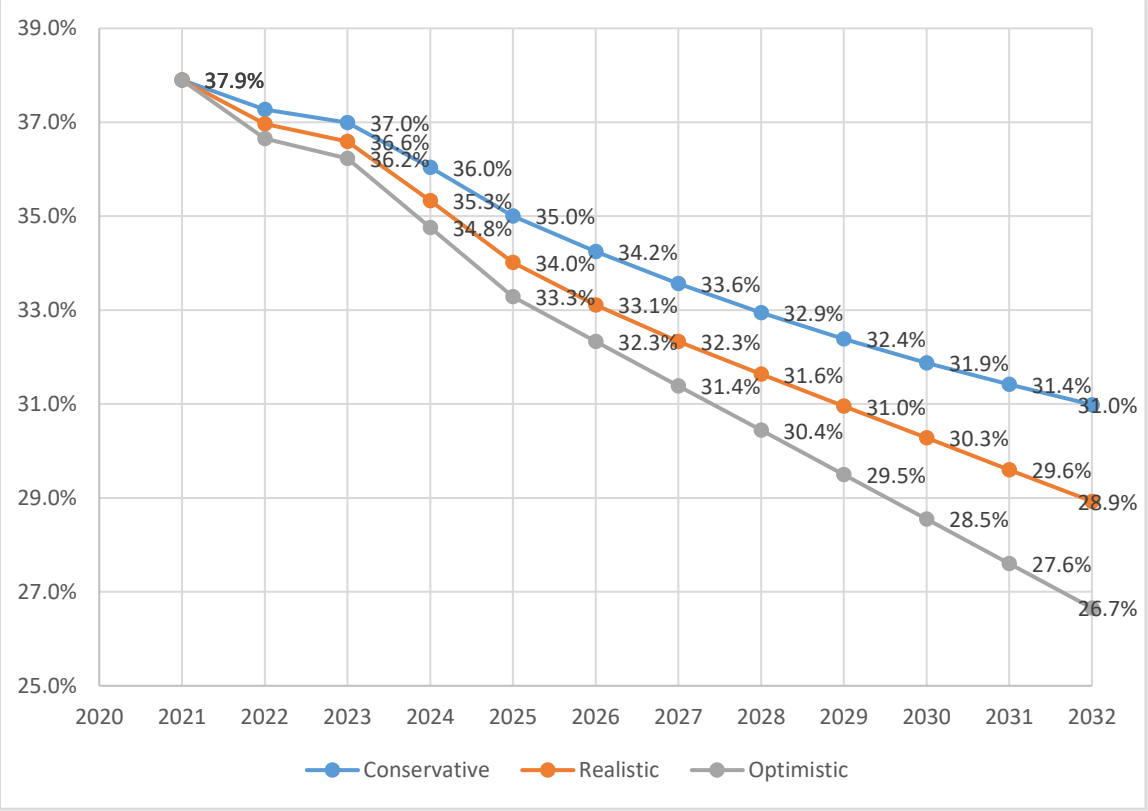
95. **In valuation of benefits from PNG's investment program, a conservative approach of valuing benefits for those who survive stunting but do not include the benefits for lives saved, is used**. However, since the proposed program focuses on health system strengthening, we measure additional benefits from maternal lives and neonatal lives saved from improvements in healthcare due to these interventions as well as the lives saved from timely immunizations as a result of the enhancement in the provision of health care services, leading to an increase in service utilization and a realization of the benefits.

96. **The benefits have been calculated for the 6 years of program intervention and five additional years**. This is based on the assumption that the health system strengthening interventions will have a lasting effect for at least five more years, even though the benefits are expected to last for a longer period than five years. For the additional five years, no further increases in utilization are assumed and utilization will remain at the level of the last year of intervention. All benefits are valued in terms of the present value of current (for maternal lives saved where the gains accrue immediately) or future income gains (for children's lives saved where earnings trickle in when the child enters the labor force). Taking the national stunting rate of children under 2, the following trends can be predicted for three different scenarios, conservative, realistic and optimistic estimates of stunting reduction in the projects target areas.

[87] Manley et al, BMJ 2020.

97. **With a total cost of US$90 million, the benefit/cost ratio is 1.8 under a conservative scenario.** The benefit/cost ratio for a realistic, but less conservative, scenario is 2.16, and that for an optimistic scenario is 2.46. The three scenarios are based on the assumption that PNG starts from a low base, and with a slow start-up, a conservative 10 percent increase is expected. The realistic scenario assumes 15 percent increase and the optimistic scenario assumes a 20 percent increase. Using the baseline conservative scenario where we assume that the coverage of services increases by at most 10 percent each year, we get a present value of the total benefits of the program of US$160,455,191, using a discount rate of 3 percent. Three-fifths of the benefits are contributed by gains from stunting reduction and a third of the benefits come from lives saved from immunizations by the age of two years. The realistic scenario considers a smooth start up and an increase of 15 percent in coverage of interventions and the optimistic scenario assumes an acceleration and increase of 20 percent. The stunting rate, as mentioned above, declines from 38 percent to 31 percent under a conservative scenario in a 12-year period. Under the less conservative scenario, the decline achieved by 2032 is 29 percent and reaches a rate of 26.7 percent assuming an optimistic scenario (Figure 10).

Figure 10. Simulated Stunting Rates under Three Scenarios of the Project Intervention Coverage



98. **The project's overall budgetary implication is relatively modest**. The community-based nutrition services and SBCC activities under Component 1 are relatively low cost. The annual funding under the project would amount to only around 0.6 percent of the 2021 budgetary spending on the health sector, and just over 0.4 percent of the 2022 budgetary allocation. The estimated annual costs of scaling up the child grant to the whole country would only be around 0.28 percent of GDP which represents around 1.5 percent of total government spending in recent years. In

comparison, the combined education and health spending was 15 percent of government spending in 2020 and accounts for 18 percent of the government budget in 2022. Further, the cost of the proposed project interventions is just a fraction of the extremely high economic cost of child stunting and undernutrition for PNG – 2.8 percent of GDP per year in lost output.

B. Fiduciary

Financial Management

99. **A FM assessment was carried out in accordance with the World Bank Directive "*Financial Management Manual for World Bank Investment Project Financing Operations*" issued by the Vice President, Operations Policy and Country Services (OPCS) on February 10, 2017 and as further elaborated on in the Bank Guidance "*Financial Management in World Bank Investment Project Financing Operations*" issued by the Director, Operations Risk Management, OPCS on February 28, 2017.** Under Bank Policy Investment Project Financing with respect to projects financed by the Bank, the borrower and the project IAs are required to maintain FM arrangements—including planning and budgeting, accounting, internal controls, funds flow, financial reporting, and auditing arrangements—acceptable to the Bank to provide reasonable assurance that the proceeds are used for the purposes for which they were granted. These arrangements are deemed acceptable if they are capable of correctly and completely recording all transactions and balances relating to the project. In addition, such arrangements are acceptable if they can facilitate the preparation of regular, timely and reliable information regarding project resources and expenditures and safeguard the projects assets; and are subject to auditing arrangements acceptable to the World Bank. There are three IAs for the project, NDoH, DfCDR, and DJAG. **The project's overall FM risk is rated as "High."**

100. **The existing FM systems for NDoH are assessed as adequate to the meet the FM requirements as stipulated in Bank Policy Investment Project Financing.** The project's FM risk for NDoH is rated as **"High"**.

101. **The existing FM systems for DfCDR for the components excluding sub-component 2.1 Child Nutrition Grant, are assessed as adequate to the meet the FM requirements as stipulated in Bank Policy Investment Project Financing.** The project's FM risk for DCDR is rated as **"High"**. Note, as started earlier, GoPNG currently has no policy, legislation, procedures, systems for safety net cash transfers, which the child nutrition grants will be; therefore no assessment can be performed for the sub-component 2.1 at present. However, the project will support the GoPNG to develop the related policy, procedures, systems, institutional arrangements and capacity to implement the child nutrition grants. Once these are established and approved by GoPNG, they can be assessed. Therefore, developing an Operations Manual stipulating the rules, procedures, standards, and roles and responsibilities of parties involved in implementation of the child grant will be a disbursement condition for the category covering child grant benefits (cash transfers). The financial procedures and financial systems stipulated by the Operations Manual shall be in full compliance with GoPNG's FM regulations. In addition, DfCDR reaching formal payment service agreements with selected financial service institutions for child grant benefit payment services and having put in place and operationalized a MIS that contains the required information of the enrolled beneficiaries and their child grant benefit payments per the Operations Manual can serve as disbursement conditions.

102. **The existing FM systems for the DJAG are assessed as adequate to the meet the FM requirements as stipulated in Bank Policy Investment Project Financing.** The project's FM risk for DJAG is rated as **"Substantial"**.

Procurement

103. Procurement for the Project will be carried out in accordance with the World Bank Procurement Regulations for Investment Project Financing (IPF) Borrowers (Procurement Regulations), November 2020, as well as the provisions stipulated in the Financing Agreement. The project will finance goods, services and consultant assignments (firms and individuals) for the three IAs. Procurement support to DJAG and DfCDR will be provided by a full time Procurement Specialist to be hired to the DJAG PCU as well as a part time procurement officer for NDoH. The procurement process to hire this specialist will be supported by the Procurement Specialist previously competitively selected and contracted by the NDoH under other World Bank health sector financed projects in PNG. This support will include facilitating the procurement process, and may also include some training on the use of procurement systems and capacity building. Where a procurement activity is being supported for DJAG, they will lead the procurement activity.

104. **Procurement Risk Assessment.** A procurement assessment of each of the IAs' existing capacity and experience for managing procurement has been completed and was used to determine the Project Procurement Risk rating "Substantial". The completed risk assessment questionnaires will also be used to inform a combined procurement and FM risk rating (SORT) for the project. NDoH, has more than four years of experience implementing Bank financed projects and the procurement performance rating for the three existing NDoH World Bank financed projects in PNG is currently Moderately Satisfactory. NDoH will establish its own CMU for the implementation of the project and will utilize the services of the Procurement Specialist currently engaged under the other World Bank financed projects. DfCDR, having no experience implementing World Bank financed projects, will also establish its own dedicated CMU, whereas the DJAG will establish a PCU to fulfil its broader coordination role. The DJAG PCU will include another Procurement Specialist to help support the implementation of planned and approved procurement activities for DJAG and DfCDR (the procurement process for this specialist will be supported by NDoH and their existing resources). The DJAG PCU and DfCDR CMU will each have a dedicated Procurement Officer to support the implementation of planned and approved procurement activities. However, until a Procurement Specialist is hired to the DJAG PCU, some support and coaching will be provided by the NDoH Procurement Specialist to harmonize systems and approaches across the project.

105. The NDoH and DfCDR will use subgrant arrangements to support the delivery of a set of defined services at a district level (not payment of cash transfers). It is important to note that experienced and qualified church health organizations will be required to apply for subgrants and these applications will be subject to rigorous assessment by the two IAs per the Subgrant Manual, to be prepared in compliance with the legal agreement covenants. The Bank assessment of the IAs includes their ability to assess subgrant proposals and then monitor and oversee the grant recipients against the requirements of both Government and World Bank, including compliance with World Bank procurement. Further, this arrangement will be progressively rolled out to 19 districts in 8 provinces by the 4th year of implementation. The phased approach will enable the NDoH and DfCDR to progressively assess the capacity of the grant recipients to undertake procurement financed by subgrants and for the Bank to be assured of the IAs ability to oversee this.

106. A preliminary review of the Catholic Church Health Services (CCHS), one of potential recipients of the subgrants under the project, was carried out during project preparation. CCHS is the largest of the church health organizations that are already being engaged by the Government to support the delivery of frontline health services through budget appropriation of grants to the churches to fund their operations. The preliminary review was to understand how these types of organizations ordinarily undertake procurement of the type envisaged, to ensure that procedural gaps are understood, and risks mitigated to the extent possible. This enables the Subgrant Manual and oversight

arrangements by the IAs to be tailored as needed to mitigate the identified risks. While the full scope of services for the subgrants have not yet been determined, it is expected the majority of this will be for incremental operating costs, training and workshops, possibly 1-2 consultants, and some small value goods. These individual consultants will only be required if there are not existing resources that can be strengthened.

107. **Procurement Plan (PP) and Project Procurement Strategy for Development (PPSD)**. A detailed PP for the first 18 months of the project will be prepared based on the information, including procurement arrangements detailed in the PPSD. A PPSD for the Project is currently being prepared and will be completed and approved prior to the conclusion of the negotiations.

108. **Project Preparation Grant (PPG).** The GoPNG has requested for a Project Preparation Grant to support the project preparation and to progress agreed preparatory procurement activities ahead of the project effectiveness. A simplified PPSD and PP for the PPG is currently being prepared as a priority.

109. **Systematic Tracking of Exchanges in Procurement (STEP) system**. The use of the World Bank's STEP system will be mandatory for use under the project.

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

110. **The environmental risks associated with the project have been assessed as Low**, given the Project will have minimal impacts on the environment. Environmental risks relate to Component 1 activities including the potential to finance the purchase of equipment such as hardware (smart phones and tablets), vehicles to assist with community outreach activities, medical equipment and small-scale immunization activities which could result in the generation of small volumes of waste (including e-waste). The risks associated with these small volumes of waste are expected to be easily managed through compliance with PNG legislation and the development and implementation of a waste management plan (WMP). Under Component 2, the project will fund fit out activities for DCDCs including purchase of furniture, installation of internet and audio systems. These centers will provide a base from which social protection and community development programs can operate. Key environmental risks for these works include noise impacts, waste management, hazardous materials management (including potentially asbestos and lead), sourcing of materials from unsustainable sources, and occupational health and safety (OHS) risk during fit out. The operation of the centers will also carry the risk of inadequate waste management processes to deal with wastes including e-waste. Social risks include community health and safety risks due to interactions with construction workers and construction equipment, and the risk of COVID-19 transmission to workers and the community.

111. **The social risks associated with the project have been assessed as Substantial.** These risks and how they will be managed are outlined below:

(a) Equitable access to Project services. There is a risk that marginalized and vulnerable social groups are unable to access services designed to improve nutrition and address child stunting, in a way that undermines the central objectives of the project. This includes the risk that Church Service Providers favor their own congregation at the expense of others within the community. Project design elements that seek to address this risk include: community participation in the design of PNG CARES and Child Nutrition Grant, strengthened health system support and outreach activities; the Child Nutrition Grant's focus on vulnerable and disadvantaged groups, pregnant women and children under two years of age (including broad coverage among this target group); and requirements for implementing partners to ensure equitable delivery of services. The project design also includes detailed mapping of stakeholders, services, entry points and the development of community engagement strategies to support inform the design of key project activities and the implementation of the FTI roadmap. Measures for ensuring equitable delivery of services to vulnerable and disadvantaged groups are outlined in the SA/MP. A strategy for engaging vulnerable and disadvantaged groups is included in the SEP.

(b) Elite capture, power and corruption – Project activities, and particularly the Child Nutrition Grant, present the risk of elite capture of project benefits, power and corruption. The Project design seeks to address these risks through clear and transparent provincial and district selection criteria and Child Nutrition Grant scheme eligibility criteria; social accountability mechanisms (i.e. score cards); effective stakeholder engagement and information dissemination planning and implementation; and robust monitoring and reporting framework – including management information system.

(c) Social tensions, conflict and civil unrest within or between diverse cultural groups. Real or perceived inequities regarding access to project services, and particularly the Child Nutrition Grant scheme have the potential to lead to social tensions, conflict and civil unrest within and between diverse cultural groups/communities. This risk may be exacerbated by existing tribal tensions and conflict. The SA/SMP assesses this risk and provides a Rapid Social Conflict Analysis tool to be conducted in each province to inform and strengthen measures to manage this risk during implementation.

(d) Gender and Gender-based Violence. PNG has high rates of gender inequity and gender-based violence. Violence against women based on accusations of sorcery also exists. While Project activities seek to benefit women and promote women empowerment, there is potential for unintended negative consequences including the risk that changes in family dynamics lead to domestic conflicts and increases in intimate partner violence. The Project seeks to mitigate these issues by ensuring the design and implementation of the project considers diverse local culture and norms that exist across PNG. Project activities will also include mapping violence against women (VAW) services through PNG CARES and leveraging the health platform to promote health services for women experiencing any form of violence. The Borrower has developed a GBV action plan including measures to prevent, manage and respond to the risk of negative impacts associated with behavior change interventions as well as SEA/SH associated with the project workforce.

(e) Labor and working conditions. Project activities will be implemented by government, church health workers and community/village health volunteers working across several provinces and districts. Key risks for the project workforce include working conditions, particularly for community health workers and occupational health and safety issues associated with working in remote areas and in communities with the potential for civil unrest and conflict to occur. These risks have been assessed in the SA/MP. Labor Management Procedures have been developed in accordance with GoPNG Law and ESS2 to manage these risks.

(f) Personal data. Potentially large volumes of personal data, personally identifiable information and sensitive data are likely to be collected and used in connection with the nutritional grants program. Potential risks

related to protecting this data and ensuring the legitimate, appropriate and proportionate use and processing of that data. These risks have been assessed in the SA/MP and measures including the development and implementation of a data privacy and protection policy for the project which complies with international best practice have been outlined.

(g) Community Health (COVID-19) - Project activities may increase the risk of COVID-19 transmission. A COVID-19 Safety Protocol has been developed in accordance with WHO guidelines and GOPNG requirements which outlines principles and approaches to manage this risk.

112. SEA/SH risks associated with the Project have been assessed as Moderate. The key risks relate to the opportunities that may arise for the workforce - consultants, contracted workers through agreements with church/faith-based organizations, other implementing partners and works contractors – to perpetrate SEA during the delivery of project services, most notably, the potential risk of male workers sexually exploiting female beneficiaries during the provision of the child nutrition grant program.

113. The project's Social Assessment and Management Plan (SA/MP) examines the key social and environmental risks and potential impacts associated with the project and presents a plan with measures for managing and monitoring these risks during detailed design, piloting and broader project implementation. The SA/MP outlines the main instruments/tools that will be used to manage and monitor risk during implementation including a Social and Conflict Analysis tool, GBV Action Plan, Code of Environmental and Social Practice, Stakeholder Engagement Plan (SEP) (including a Grievance Redress Mechanism - GRM and COVID-19 Safety Protocol) and Labor Management Procedures (LMP) which have been developed line with the applicable Environmental and Social Standards (ESS) of the World Bank's Environmental and Social Framework (ESF).

V. GRIEVANCE REDRESS SERVICES

Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level grievance redress mechanisms or the World Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of World Bank 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 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

114. **The overall risk rating for the project is High**. The key risks are: (a) limited fiscal space due to elevated deficit; (b) limited technical capacity and experience in implementing World Bank-financed projects, including the areas of procurement and FM; (c) no existing policy, procedures, and systems for several new interventions introduced, particularly child nutrition grant; and (d) the challenge of multisectoral coordination among a number of stakeholders across national and sub-national levels to converge essential health, nutrition, and social protection

service delivery at the frontlines. Security and conflict risks will likely add a compounding factor to the implementation risk.

115. **Macroeconomic risks are High**. PNG's macroeconomic vulnerability has been worsened by the COVID-19 shock. While reducing undernutrition and stunting to unlock the potential of PNG remains is a high priority, the fiscal space to increase spending on essential nutrition specific and sensitive interventions is expected to be limited. This risk is being mitigated by continued advocacy on the importance of addressing stunting for the long-term inclusive growth.

116. **Political and governance risks are Substantial**. While the current national political situation is expected to remain stable up to the June 2022 elections, significant changes in government priorities and key ministerial positions post-election could take place. There is uncertainty about who would be the champion of the FTI agenda in the new government and if the SLOS mechanism to coordinate the multi-sectoral approach to nutrition would remain in its current shape and form. However, as the FTI has been adopted by the NEC and reducing stunting has been a policy priority in the NHP (2021-2030) awaiting adoption, in the National Nutrition Policy, Medium Term Development Plan III as well as in the National Policy on Social Protection under the preparation by DfCDR, a high level of political interest and support for the project can be expected. Furthermore, potential political champions for implementation at the subnational levels (such as Governors and Members of Parliament) may also change. The risk to a large extent is being mitigated by selecting only those provinces and districts that have committed to the priority of stunting reduction for Phase two during the phased expansion. In addition, the project will support a national awareness campaign to mobilize support from diverse stakeholders and support the DJAG to organize National Nutrition Summits annually to keep the momentum of the FTI agenda with both national and subnational leadership.

117. **Environmental and Social risks are Substantial.** While Environmental risks for the Project have been assessed as low, Social risks have been assessed as Substantial. Some social risks are significant due to their potential magnitude and spatial extent, and potential to give rise to limited degree of social conflict. The project's SA/MP examines the key social and environmental risks and potential impacts associated with the project and presents a plan with measures for managing and monitoring these risks during detailed design, piloting and broader project implementation. The SA/MP outlines the main instruments/tools that will be used to manage and monitor risk during implementation. The risk related to potential increases in GBV/IPV due to women receiving child grant and potential control of the child grant benefit by men is mitigated by incorporating global best practices on how cash transfers can reduce IPV and operational design features, such as prior agreement on the use of resources ('moral contract'), outreach strategies to 'label' transfers as intended to improve child nutrition and others outlined in the SA/MP. To ensure adequate E&S capacity, the IAs have committed to retaining a full-time Social, Environmental and Communication Specialist and part-time GBV Specialist within the PCU; and two part-time Social, Environmental and Communication Specialists within the CMUs.

118. **Risks associated with the technical design of the project are assessed as Substantial.** The Project's multi-sectoral community-based approach is complex and must take into account diverse local contexts, including capacity constraints and gaps in access to services. To mitigate the risk, the Project design builds on the good practices of related operations implemented by NGOs and Development Partners and carry out consultations with local stakeholders. Because the proposed child nutrition grant is new and the first formal social safety net program implemented by the GoPNG, its design will be carefully tailored to fit the diverse geographic and socio-cultural contexts through broad consultation with stakeholders during project preparation and pilot implementation. In particular, as the desired recipients of the child grants will be pregnant women or mothers of children 0-2 years of age, the design of the outreach and related SBCC activities will build on several existing family-centered practices in

PNG as well as global best practices in social protection, specifically on addressing GBV risks in cash transfer operations. Analysis of political economy, government systems and governance, FM, and implementation capacity has been carried out to assess risks associated with the introduction of the child grant. To mitigate the risks, a pilot will be conducted to test the preliminary design, bring in learning and generate evidence to fine tune the final design of the Project. All component 1 interventions have been implemented in PNG. The community-level component 1 nutrition interventions are currently being implemented by NDoH in collaboration with UNICEF. The ECD elements included in the project are relatively simple interventions delivered individual and group communications sessions. The positive parenting interventions in particular draw on successful implementation experience in PNG mitigating implementation risk. Use of existing multi-sectoral structures and integration of ECD elements into the other project components will be undertaken to mitigate the complexity.

119. **Institutional capacity for implementation and sustainability risks are High.** The systems for the delivery of direct nutrition interventions are weak and coverage and utilization of these interventions is limited. All direct nutrition interventions (except food fortification) fall within the domain of the public health system and currently nutrition is managed and coordinated under NDoH. WASH, Agriculture and Education sectors also contribute to stunting reduction and similar weaknesses with coverage and quality of WASH and Education services exist. DfCDR has no experience of implementing a social safety net program and needs to establish delivery systems and build capacity to implement the child nutrition grant. The SLOS mechanism to coordinate across sectors is a relatively young institutional arrangement and the mandate for DJAG to lead coordination among SLOS member departments and hence house the SLOS Secretariat could be changed by GoPNG during the project life. Finally, given PNG's decentralized operating environment, sub-national level engagement and support is critical to successful implementation.

120. Project design takes into account and seeks to mitigate these risks. All component 1 nutrition interventions to be managed by the NDoH are relatively simple and are within the responsibility of the NDoH. Convergence with WASH and Agriculture is sought at the community level through actions that are within the span of control of local communities (e.g., kitchen gardens, behavior change on WASH, community advocacy to local Members of Parliament to use discretionary constituency development funds to invest in WASH etc.). Furthermore, NDoH has prior experience with implementing all proposed component 1 nutrition interventions albeit, in some cases, at a small scale and in collaboration with other development partners (such as UNICEF) and ECD interventions are relatively simple and to be delivered through the same platforms as nutrition interventions (i.e., individual and group counseling sessions). To address concerns with systems capacity to deliver direct nutrition services the Project includes financing for goods, training and technical assistance, including financing for nutrition commodities that are expected to be affected by the impact of COVID-19 on broader health financing. The project will support DfCDR in developing the systems and building capacity at both national and sub-national level. A pilot, to be implemented as part of a PPG to test detailed implementation arrangements, will tailor implementation arrangements for the nutrition grant, test appropriate communication messages and inform the detailed project design and implementation arrangements. In addition, the body of analytics though the Bank's executed Program of Advisory and Analytics Services will support the capacity strengthening of the general health and social protection systems. Finally, given the importance of the sub-national level to successful implementation, a demand-driven approach has been taken to the identification of districts to be included in the Project. Future provinces and districts to be included in the Project will be selected by the PSC using a transparent and objective EoI process wherein Province and District authorities would jointly submit a proposal indicating interest in participating in the Project. Finally, Project design includes support for communications targeted at decision makers at national and sub-national levels raising

awareness about the importance of action focused on stunting. This type of internal advocacy has been found to be critical to the success of stunting reduction globally and helps to sustain a focus on stunting.

121. **Fiduciary risks are High**. The primary FM risk is due to the fact that the proposed child grant as a cash transfer program is new to the GoPNG and no procedures, delivery systems, or experience for cash transfer exist yet within GoPNG. This risk will be mitigated by several measures: (a) the development of a child grant Operations Manual, with relevant financial procedures and financial systems in compliance with the GoPNG's FM regulations, will be set as disbursement conditions for the Cash Transfers Category; (b) the child grant benefit payment function will be carried out by selected financial service institutions as payment agents and entering a formal payment service agreement will be the second disbursement condition for the Cash Transfers Category; (c) the child grant program MIS being able to perform essential functions (i.e., containing the required information of the enrolled beneficiaries and their child grant benefit payments) per the Operations Manual will serve as the third disbursement condition; and (d) the lessons from the pilot to be supported under the PPG will help refine the procedures and implementation arrangements.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Papua New Guinea

Child Nutrition and Social Protection Project

Project Development Objectives(s)

The Project Development Objective is to improve utilization of priority nutrition interventions and purchasing power of first thousand-day households in selected districts.

Project Development Objective Indicators

Indicator Name	PBC	Baseline	Intermediate Targets	End Target
			1	
Increased utilization of priority interventions				
Percentage point increase in the proportion of children at 6-23 months of age who have received at least two doses of Vitamin A supplement (Number)		0.00	15.00	30.00
Child nutrition grant delivered				
Proportion (%) of first 1,000-day households receiving child nutrition grant (Percentage)		0.00	40.00	80.00
Proportion (%) of female child nutrition grant beneficiaries who are first-time owners of an account (bank account or mobile wallet) (Percentage)		0.00	40.00	60.00
Improved awareness of stunting, positive parenting and behavior changes needed				

Indicator Name	PBC	Baseline	Intermediate Targets	End Target
			1	
Percentage point increase in proportion of mothers/caregivers who demonstrate adequate infant and young child feeding practices (Number)		0.00	20.00	40.00

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	Intermediate Targets	End Target
			1	
Component 1: Implementing PNG CARES (Community-based Approach to Reduce and End Stunting)				
Proportion of mothers/caregivers attending monthly SBCC activities (Percentage)		0.00	30.00	60.00
Percentage point increase in the proportion of mothers/caregivers who demonstrate knowledge of WASH (Number)		0.00	20.00	40.00
Percentage increase in the number of Health Workers and Village Health Volunteers/Village Health Assistants trained on nutrition (Percentage)		0.00	30.00	60.00
Percentage increase in the number of Health Facilities that are providing treatment of severe acute malnutrition (SAM) (Percentage)		0.00	25.00	50.00
Proportion (%) of communities with village scorecard data updated and published every six months (Percentage)		0.00	30.00	60.00
Proportion (%) of fathers/husbands from first thousand-day households participating in positive parenting sessions (Percentage)		0.00	25.00	50.00
Proportion (%) of children (6-23 months) who		32.00	40.00	50.00

Indicator Name	PBC	Baseline	Intermediate Targets	End Target
			1	
received an adeqaute diverse diet (Percentage)				
Increase in proportion (%) of children under 1 year of age who are immunized with 3 doses TA/Pentavalent (Percentage)		0.00	30.00	60.00
Proportion of mothers/caregivers from first 1,000-day households reporting satisfaction with health and nutrition services received (Percentage)		0.00	35.00	70.00
Component 2: Implementing a Nutrition-sensitive Child Grant				
Beneficiaries of social safety net programs (CRI, Number)		0.00	90,000.00	180,000.00
Beneficiaries of social safety net programs - Female (CRI, Number)		0.00	87,500.00	175,000.00
Proportion (%) of child nutrition grant beneficiaries receiving benefit payment via an account (bank account or mobile wallet) (Percentage)		0.00	40.00	60.00
Proportion (%) of child nutrition grant beneficiaries receiving timely payment (Percentage)		0.00	35.00	75.00
Modular Management Information System (MIS) developed and operationalized (Yes/No)		No	Yes	Yes
Proportion (%) of registered grievances resolved in accordance with the program's grievance redress policy/procedures (Percentage)		0.00	60.00	75.00
Number of DfCDR staff, Province and District Community Development Officers trained per their roles and responsibilities in managing child nutrition grant (Number)		0.00	55.00	110.00
Component 3: National Advocacy, Coordination, and Project Management				
Number of provinces and districts having made public commitments to accelerating stunting		0.00	20.00	40.00

Indicator Name	PBC	Baseline	Intermediate Targets	End Target
			1	
reduction (Number)				
Number of National Nutrition Summits held (Number)		0.00	3.00	6.00

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Percentage point increase in the proportion of children at 6-23 months of age who have received at least two doses of Vitamin A supplement	Percentage point increase in the proportion of children at 6-23 months of age who have received at least two doses of Vitamin A supplement is 100 * the difference between the proportion of children at 6-23 months of age who received at least two doses of Vitamin A supplement at t1 and that proportion at t0. Proportion of children at 6-23 months of age who received at least two doses of Vitamin A supplements at any time is defined by: Numerator is the number of	Annually	NHIS/eNHIS	Routine National Health Information Sytem (NHIS) reporting	NDoH

	children at 6-23 months of age receiving recommended Vitamin A supplementation according to the national guideline (i.e., at least two doses), and Denominator: total number of children at 6-23 months of age from first 1,000 households in project supported districts.				
Proportion (%) of first 1,000-day households receiving child nutrition grant	Numerator is the number of first 1,000-day households, which have enrolled into the Child Nutrition Grant Program and are receiving the benefit, and Denominator: total number of estimated first 1,000-day households, which are households with pregnant or lactating women and/or child under age 2 in project supported districts.	Annual	Child Nutrition Grant Program MIS and Payment Service Providers' payment records	The denominator is from the most recent population estimates for the project area. The numerator is from the Child Nutrition Grant Program MIS.	DfCDR
Proportion (%) of female child nutrition grant beneficiaries who are first-time owners of an account (bank account or mobile wallet)	Numerator is the number of child nutrition grant beneficiaries receiving benefit payment via an account (bank account or mobile wallet0, i.e., through digital payment methods	Annual	Child Nutrition Grant Program MIS	Administrative data	DfCDR

	Denominator is total number of child nutrition grant beneficiaries from first 1,000-day households in project supported districts.				
Percentage point increase in proportion of mothers/caregivers who demonstrate adequate infant and young child feeding practices	Percentage point increase in the proportion of mothers/caregivers who demonstrate adequate infant and young child feeding practices is 100 * the difference between the proportion of mothers/caregivers who demonstrate adequate infant and young child feeding practices at t1 and that proportion at t0. Proportion of mothers/caregivers who demonstrate adequate infant and young child feeding practices is defined by: Numerator is the number of mothers/caregivers who participate IYCF sessions and demonstrate adequate complementary feeding practices, and Denominator is total	Annual	Project Iterative Beneficiary S urvey	Project Progress Report	DJAG

	number of mothers/caregivers from first 1000 day households in project supported districts, who participate IYCF sessions and are surveyed.				

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Proportion of mothers/caregivers attending monthly SBCC activities	Numerator is number of mothers/caregivers attending in 9 out of 12 monthly SBCC activities in the past year Denominator is total number of mothers/caregivers from first 1,000 days households in project supported districts.	Annual	Attendance list/Project data	Project Progress Report	NDoH
Percentage point increase in the proportion of mothers/caregivers who demonstrate knowledge of WASH	Percentage point increase in the proportion of mothers/caregivers who demonstrate knowledge of WASH is 100 * the difference between the proportion of mothers/caregivers who	Annually	Project Iterative Beneficiary Survey	Project Progress Report	DJAG

	demonstrate knowledge of WASH at t1 and that proportion at t0. Proportion of mothers/caregivers who demonstrate knowledge of WASH at any time is defined by: Numerator is the number of mothers/caregivers who participate IYCF sessions and demonstrate knowledge of WASH, and Denominator is total number of mothers/caregivers from first 1,000-day households in project supported districts, who participate IYCF sessions and are surveyed. This indicator reflects the effort to reduce water-borne diseases (i.e. diarrhea), which is expected to increase due to climate change and hence can become the project's climate indicator.				
Percentage increase in the number of Health Workers and Village Health Volunteers/Village Health Assistants	Percentage increase in the number of Health Workers and Village Health	Annual	Training List/Project Data	Project Progress Report	NDoH

trained on nutrition	Volunteers/Village Health Assistants trained on nutrition in project supported districts is the ratio of the number of Health Workers and Village Health Volunteers/Village Health Assistants trained on nutrition at t1 and that number at t0 - 100%.				
Percentage increase in the number of Health Facilities that are providing treatment of severe acute malnutrition (SAM)	Percentage increase in the number of Health Facilities that are providing treatment of severe acute malnutrition (SAM) is the ratio of the number of Health Facilities providing treatment of SAM in project supported districts at t1 and that at t0 - 100%	Annual	Project Data	Project Progress Report	NDoH
Proportion (%) of communities with village scorecard data updated and published every six months	Numerator is the number of communities with village scorecard data updated and published every six months Denominator is total number of communities in project supported districts	Annual	Project Data	Project Progress Report	DJAG
Proportion (%) of fathers/husbands from first thousand-day households participating in positive parenting sessions	Proportion (%) of fathers/husbands from first thousand-day households participating in positive parenting sessions	Annually	Project Data	PMU Report	PMU

Proportion (%) of children (6-23 months) who received an adeqaute diverse diet	Numerator is the number of children aged 6-23 months who received a minimum of five out of eight food groups during the previous day Denominator is total number of children aged 6-23 months from first 1,000-day households in the project supported districts	Annual	Project Iterative Beneficiary Survey	Survey	DJAG
Increase in proportion (%) of children under 1 year of age who are immunized with 3 doses TA/Pentavalent	Proportion (%) of children under 1 year of age who are immunized with 3 doses TA/Pentavalent	Semi-annually	NHIS/eNHIS	Routine National Health Information System (NHIS) reporting	NDOH
Proportion of mothers/caregivers from first 1,000-day households reporting satisfaction with health and nutrition services received	Numerator is number of mothers/caregivers who report being satisfied with health and nutrition services received in the past 12 months Denominator is total number of mothers/caregivers from first 1,000-day households who provide feedback	Annual	Project Iterative Beneficiary Survey	Project Progress Report	DJAG
Beneficiaries of social safety net programs		Annual	The Child Nutrition Grant Program MIS	Administrative data	DfCDR
Beneficiaries of social safety net programs - Female		Annual	Child Nutrition	Administrative data	DfCDR

			Grant Program MIS		
Proportion (%) of child nutrition grant beneficiaries receiving benefit payment via an account (bank account or mobile wallet)	Numerator is the number of child nutrition grant beneficiaries receiving benefit payment via an account (bank account or mobile wallet0, i.e., through digital payment methods Denominator is total number of child nutrition grant beneficiaries from first 1,000-day households in project supported districts.	Annual	Child Nutrition Grant Program MIS	Administrative Data	DfCDR
Proportion (%) of child nutrition grant beneficiaries receiving timely payment	Numerator is the number of child nutrition grant beneficiaries who receive benefit payments within a period as defined by the Child Nutrition Grant Program's payment service requirements. Denominator is total number of child nutrition grant beneficiaries in the project supported districts.	Annual	Child Nutrition Grant Program MIS	Administrative Data	DfCDR
Modular Management Information System (MIS) developed and operationalized	MIS modules are developed and deployed as per the business operation requirements, with intermediate modules	Annual	Project Progress Report	Progress Report	DfCDR

	developed over the years.				
Proportion (%) of registered grievances resolved in accordance with the program's grievance redress policy/procedures	This indicator is meant to capture the efficacy of project delivery systems, specifically the grievance redress mechanism which will capture grievances or perceived irregularities. Stipulated service standards for response times will be outlined in the Child Nutrition Grant Operations Manual. Numerator: Total number of grievance cases from the Child Nutrition Grant Program addressed in accordance to established protocol. Denominator: Total number of grievance cases received from the Child Nutrition Grant Program.	Annual	Project Progress Report	Administrative Data	DfCDR
Number of DfCDR staff, Province and District Community Development Officers trained per their roles and responsibilities in managing child nutrition grant	The project will provide training designed to build capacity of the government officials involved in the implementation of child nutrition grant program.	Annual	Administrative data	Project Progress Report	DfCDR
Number of provinces and districts having made public commitments to accelerating	Number of Province and District Government	Annual	Project Progress	Project Progress Report	DJAG

stunting reduction	Representatives have signed a formal pledge in public (e.g., at the National Nutrition Summit) to indicate their governments' commitment to FTI and determination to take actions within their jurisdictions to address child undernutrition.		Report		
Number of National Nutrition Summits held	National Nutrition Summit is a high-level event with participants from national and subnational government leaders as well as other key stakeholders to commit or recommit their determination of ending child stunting in PNG, review progress and evidence, and find solutions for accelerating the progress	Annual	Project Progress Report	Project Progress Report	DJAG

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Papua New Guinea
Child Nutrition and Social Protection Project

A. Project Institutional and Implementation Arrangements

1. **Project Steering Committee (PSC).** A PSC will be established to provide project implementation oversight and coordinate project policy concerns with the World Bank. Because the Social, Law and Order Sector (SLOS) currently has the mandate to lead, coordinate, and oversee the Fast Track Initiative to Reduce Stunting (FTI) and has the convening power to both coordinate across sectors, as well as at the subnational level, the PSC will leverage the existing SLOS mechanism to the extent possible. Therefore, the PSC will be chaired by the Secretary of Department of Justice and Attorney General (DJAG), in his/her capacity as the chair of the SLOS Department Heads. Other key members include the Secretaries of National Department of Health (NDoH), Department of Community Development and Religion (DfCDR), and Department of National Planning and Monitoring. Other agencies may be invited into the PSC as deemed necessary by the Committee. The PSC will review the project progress and provide advice and guidance on the project's annual work plans and budgets.

2. **Project Implementing Agency (IA)**. The NDoH, DfCDR, and DJAG will be the IAs of project components 1,2, and 3 respectively. All three IAs are also key members of the Special SLOS Working Group on Nutrition (SSLOSWG-N) and will implement their respective project activities in collaboration with each other and other SSLOSWG-N members such as UNICEF. NDoH and DfCDR will each establish a Component Management Unit (CMU) to manage daily implementation of components 1 and 2 respectively. A Project Coordination Unit (PCU) will be established under DJAG to manage project component 3, including ensuring coordination between the two CMUs on project implementation management matters (e.g., procurement, safeguards, learning, and reporting) as well as with other key government stakeholders. The two CMUs and PCU will collaborate closely in planning and supervising several project activities to optimize the use of project resources and ensure implementation performance. For example, it is envisaged in any project district the same church health organization should be engaged for the delivery of community level activities under subcomponent 1.1 and for outreach and enrollment of eligible first 1,000-day households under subcomponent 2.1. Therefore, the two CMUs will jointly develop the Subgrant Agreement and Manual, manage the process of selecting qualified organizations, and monitor the delivery of outputs specified in the Subgrant Agreement. Similarly, the NDoH's CMU and DJAG's PCU should coordinate between the proposed general awareness raising on nutrition and stunting at the local and community level under component 1 and the national level advocacy on nutrition and stunting through dedicated events such as the National Nutrition Summits under component 3.

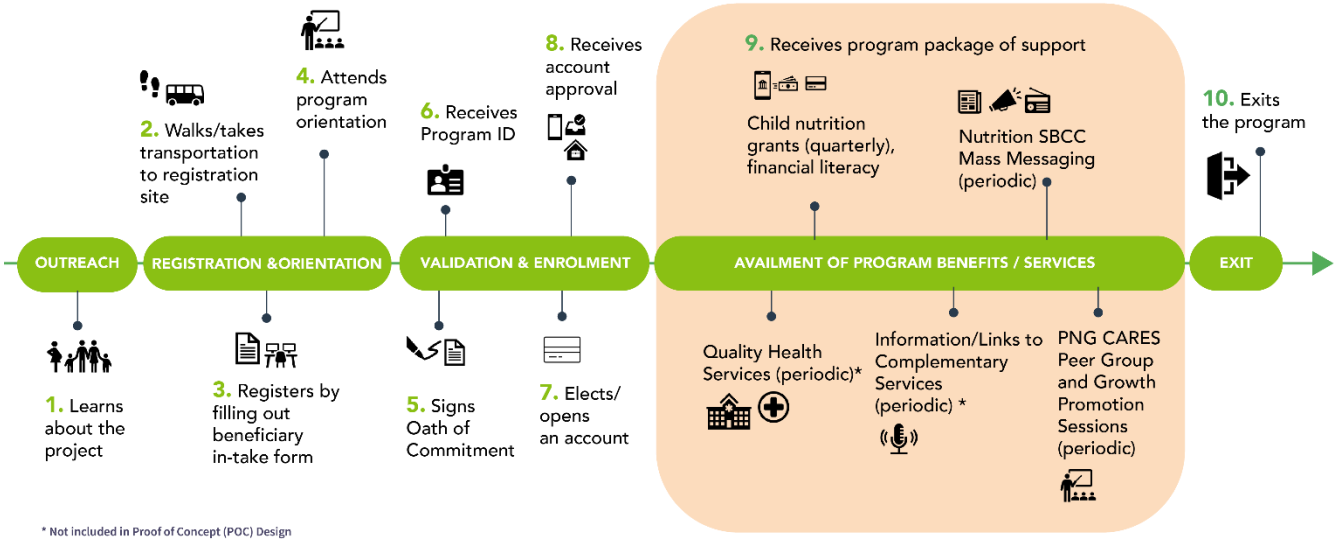
3. **Subnational Governments**. A Provincial Project Coordination Committee (PPCC) will be established and include Provincial Health Authority (PHA), Provincial Community Development Office (PCDO), and other key sub-national stakeholders to coordinate and supervise the project implementation within each project province. The PPCC will be chaired by the Governor or a senior official designated by the Governor (e.g., CEO of PHA or Provincial Administrator). A Memorandum of Understanding between the Provincial authorities and three IAs for each selected Province will be signed to facilitate the establishment of the PPCC. The project will finance the recruitment

of one Provincial Nutrition Coordinator (PNC) and one Provincial Social Protection Coordinator (PSPC) to support the PPCC by closely coordinating with concerned subnational government offices, selected Church organization and payment service providers, and other community groups involved for the outreach and communication of the project interventions. PHAs will, in keeping with their institutional mandate for coordination with subnational stakeholders in health sector, be responsible for oversight, coordination and technical support to project activities under component 1 on behalf of the NDoH. PCDOs will coordinate with subnational stakeholders on behalf of DfCDR and mobilize the District Community Development Officers to support the Component 2 implementation.

4. **Service Providers**. Church health organizations (or other qualified Non-Government Organizations when needed) will be selected by NDoH and DfCDR as grant recipients through a subgrant arrangement to undertake community-based activities for components 1 and 2. The selected grant recipient will engage with village health volunteers or assistants (VHV/VHAs) and other community actors to deliver social behavior change communication (SBCC) and other community level activities under component 1, and to support outreach, registration and grievance monitoring of eligible cash grant beneficiaries in the community under component 2. The project will provide relevant training and capacity building in this area. The DfCDR will select and contract out relevant payment service providers for the disbursement of the child grant benefits. The PSPs will facilitate the account opening of beneficiaries, credit benefit payments to beneficiary accounts, support cash-out needs via their service networks, address payment related grievances, and submit payment reconciliation reports through the DfCDR CMU.

5. **Project Operations Manual.** All project activities will be implemented in accordance with the Project Operations Manual, which includes the Operations Manual for child grant and Subgrant Manual as annexes and will provide the details on the overall project design, implementation phases and operation guidelines, and coordination mechanism between CMUs and PCU.

Figure 1: Beneficiary Journey Map



6. **Child Grant Program MIS**. A new program MIS will be developed to support all key operational processes of child grant, including registration and enrolment of beneficiaries, beneficiary registry management (updates and exits), payments and reconciliation, grievances redressal, and monitoring and reporting of participation of complementary activities. The MIS solution will have the following information management capabilities and standards: (a) the MIS

will be accessible online (web-based) on a 24/7 basis through secure login id protocols; (b) the MIS will be able to interact and exchange data with other systems and devices; (c) data may be captured on paper forms at community level or on mobile tablets with offline-online synchronization capabilities; (d) DfCDR's system administrator and sub-national users will have data access and decision authority per their responsibilities and beneficiary records will have a complete audit history; (e) verification and validation rules on duplicate records and data anomalies will be built in across the program dataset; and (f) the MIS will be compatible with and optimized for operating systems, web browsers and settings, relevant to users and DFCDR administrators of the program. The enrollment and payment modules will be developed first and followed by the monitoring module to collect information for validating beneficiaries' compliance of the required actions.

7. **Enrollment of and benefit payment to child grant beneficiaries**. The enrollment process is expected to collect basic information about beneficiaries such as pregnancy status or birth date of child from relevant documents (prenatal care visit or birth records). The information captured initially may not be fully digitized and DfCDR with support of subnational authorities will carry out periodic spot checks to validate the eligibility requirements. As the MIS is further developed, the data capturing and data flow are expected to be gradually automated to enable DfCDR to validate the eligibility requirements more efficiently. Whether beneficiaries have received their benefit payments in a timely manner will be included in the planned Beneficiary Feedback Survey. In addition, under the Component 3, a series of thematic studies will be carried out to assess the project implementation performance and will focus initially on the fundamental processes such as enrollment and payment.

B. Financial Management and Disbursements

8. **Budgeting**. All donor funded projects will be included in the Government of Papua New Guinea's Public Investment Program (PIP) and National Budget to have aid on plan and aid on budget. Currently project is in both the PIP 2022-2026 and the 2022 National Budget. However, not all three IAs had included their respective components in their 2022 budget requests. Annual budget submissions will be required to be submitted by NDoH, DCDR and DJAG to the Department of Treasury from 2022 onwards. A budget for the whole project is required, as well as one for each IA. Each budget will need to be broken down by year, and appropriate levels of detail (e.g. component or category, activities, etc. whichever is deemed most relevant and useful).

9. **Counterpart Funding.** No counterpart funding is envisaged.

10. **Flow of Funds.** Funds will flow from the World Bank to Government of Papua New Guinea via: (a) advances; (b) direct payments; (c) reimbursement of GoPNG expenditures; and (d) special commitments, if required (refer to the Disbursements section below for more details on disbursement arrangements).

11. **Accounting and Maintenance of Accounting Records.** All government funds are bound by the Public Finances Management Act (PFMA) 1995 and the PNG Financial Management Manual (FMM). GoPNG is currently implementing a new IFMIS (Finance One) and transitioning departments over from the old PGAS system. The NDoH, DCDR and DJAG transitioned to IFMIS and will use the new IFMIS to record accounting information. NDoH, DCDR and DJAG and GoPNG operates on a cash basis of accounting. Accounting records are to be maintained by NDoH, DCDR and DJAG and are to be made available to both auditors and the World Bank, as required.

12. **Internal Controls.** NDoH, DCDR and DJAG are bound by the PFMA and PNG FMM for its policies and procedures manual. Financing Instructions (FI) require all departments to have an internal audit division and an audit

committee. NDoH, DCDR and DJAG each have an internal audit division an audit committee. The Project should be included in the annual internal audit plan for the NDoH, DCDR and DJAG and included in relevant reports to the Audit Committee.

13. **Financial Reporting.** Interim unaudited financial reports (IFRs) of the consolidated Project, and the Project activities of each IA, will be prepared on a quarterly basis. The financial reports will include an analysis of actual expenditure for the current period, year-to-date and for the cumulative to date, plus outstanding commitments, compared against total project budget. The format will be developed and agreed by the IAs and the World Bank prior to due date for the submission of the first IFRs. The IFRs will be forwarded to the World Bank within 45 days of the end of each calendar quarter.

14. **External Audit.** An annual audit of the consolidated Project financial statements, and the project activities of each IA, will be required. The Auditor General's Office (AGO) of PNG is mandated to audit all Government funds. The AGO can choose to sub-contract out the audit of Bank funded projects to private auditor firms, overseen by the AGO. The cost of this sub-contract is eligible for financing under the Project. The Auditor General requires annual financial statements to be prepared in accordance with IPSAS accounting standards. The audited financial statements, audit report and management letter must be received by the World Bank within six months of the end of the fiscal year and shall be made publicly available by the Recipient in a manner acceptable to the Bank as per the General Conditions for IDA Financing, Investment Project Financing.

15. **Disbursement Methods and Supporting Documentation Arrangements**. The project could use four disbursement methods: (a) advances; (b) direct payment; (c) reimbursement; and (d) special commitments. Direct payments would be used for most of payments due to the risks and issues identified by audit reports on incorrect use of project and donor funds. Reimbursement would only be used if the Government of Papua New Guinea funds were used for project expenses. Special commitments may be needed if goods are purchased from overseas. Disbursements will be against Statements of Expenditure. Required supporting documentation for disbursements will be outlined in the Disbursement and Financial Information Letter.

16. **Designated Account (DA).** The PFMA and FMM allow for donor sourced funds for projects to be held in separate trust accounts. Three segregated DAs will be required, one for each IA in NDoH, DCDR and DJAG. The currency of the DAs would be PNG Kina. At present, a single central treasury account is not being used for donor projects. Should donor projects also be moved to single central treasury account then, while there may be one physical bank account, there will need to be general ledger sub-codes for each IA and project to ensure the segregation of funds. The ceiling for each of the DAs will be specified in the Disbursement and Financial Information Letter and be set to enable enough cash flow to cover 3–4 months of project operations. Sub-component 2.1 of the project, i.e. Provision of Child Nutrition Grant, will be jointly financed by IDA credit and PPIUF grant; as such, to the extent practical, funds from PPIUF grant will be exhausted before IDA credit proceeds are accessed.

17. **Eligible Expenditures**

Category	IDA Credit Amount of Credit Allocated (expressed in SDRs)	IDA Credit Amount of Credit Allocated (expressed in Dollars equivalent)	PPIUF Grant Amount of Grant Allocated (expressed in Dollars)	Percentage of Expenditures to be Financed (inclusive of Taxes)

(1) Goods, non-consulting services, consulting services, Operating Costs, Training and Workshops for the Project	16,930,000	23,600,000		100%
(2) Sub Grants under sub-components 1.1 & 2.2(c)	7,760,000	10,800,000		100%
(3) Cash Transfers under sub-component 2.1	32,710,000	45,600,000	10,000,000	100%
TOTAL AMOUNT	**57,400,000**	**80,000,000**	**10,000,000**	

18. **Funding Sources**

Source	**Amount** ($ million)	**Share of Total** (%)
World Bank – IDA Credit	80.0	89%
PPIUF – TF Grant	10.0	11%
Total	**90.0**	**100%**

19. **Disbursement Conditions.** The following disbursement conditions will be considered:
    (a) For Category 2 - Sub Grants, until the Subgrant Manual is developed by NDoH and DfCDR and approved by the Bank.
    (b) For Category 3 - Cash Transfers, until (i) the Operations Manual for child grant is developed by DfCDR and approved by the Bank, with financial procedures and financial systems involved in compliance with GoPNG's PFMA and FMM; (ii) DfCDR enters a payment service agreement with selected financial service institutions for child grant benefit payment services; and (iii) DfCDR has put in place and operationalized an information management tool that supports the enrollment of and payments to beneficiaries.

Should there be any lapsed loans, advance disbursement method and use of DA will not be available until the issue of any lapsed loans is fully resolved.

C. Procurement

20. **Institutional Arrangement for Procurement.** The IAs will be responsible for ensuring the procurement requirements of all the components and sub-components are met.

21. **Applicable Procurement Regulations.** Procurement for the project will be carried out in accordance with the World Bank Procurement Regulations for IPF Borrowers (Procurement Regulations), November 2020, and the provisions stipulated in the Financing Agreement. For international competitive procurement activities based on method thresholds, the Bank's Standard Procurement Documents shall be used.

22. **Procurement Risk Assessment.** A procurement risk assessment of each IA responsible for implementing the procurement activities under the Project was carried out and the overall Project Procurement Risk rating is "substantial".

23. **Procurement Types.** The various types of procurements to be financed and indicative cost estimates are noted in the following table and described below.

24.

Type of Procurement (approximately)

1.	Non-Consulting Services (US$1.8 million equivalent)
2.	Goods (US$0.5 million equivalent)
3.	Consulting Services (US$12.9 million equivalent)

25. **Non Consulting Services.** Engagement of a service provider to support enrollment and onboarding of grant recipients. It will also include the engagement of a firm to undertake the project assessment survey (baseline, annual, mid and end).

26. **Procurement of Goods**. The procurement of goods will include a vehicle, office equipment and digital tools for data collection and monitoring.

27. **Procurement of Consulting Services (firms and individuals)**. Details of all the proposed positions will be detailed in the PPSD and related Procurement Plan. They will include the engagement of a UN Agency to support government nutrition as well as various individual consultants to support project implementation or other technical areas such as a payment specialist, project component managers, project coordinator, nutrition specialist, FM specialist, project accountant, M&E, social risk and outreach, social protection coordinators, procurement specialist etc.

28. **Advance Contracting**. Provision for Advance Contracting will be included for the project and detailed in the PPSD.

29. **Frequency of Procurement Supervision**. In addition to the prior review to be carried out by the World Bank, implementation support missions will be undertaken at least once per year. One in five procurement packages not subject to World Bank prior review will be examined ex-post on an annual basis.

30. **Procurement Plan.** A Project Procurement Plan has been prepared covering the planned procurement activities for the first 18 months of project implementation. The procurement arrangements for the key procurement activities under the Project are detailed in the PPSD.

31. **Systematic Tracking of Exchanges in Procurement**. Use of the World Bank's Systematic Tracking of Exchanges in Procurement (STEP) system will be mandatory under project. This system is currently being used on other Projects in Papua New Guinea. Regular virtual STEP training is being conducted given COVID 19 restrictions on travel. Face-to-face training will resume when it is safe to do so.

D. Strategy and Approach for Implementation Support

32. As the project takes a multi-sectoral approach and will engage with multiple actors at the subnational government and community levels, it will require intensive implementation support, particularly for the three IAs (NDoH, DfCDR, and DJAG) in the initial stages of the project. The team composition and the expected time allocation required for project supervision are described in Table x. The implementation support proposed focuses on implementing the risk mitigation measures, more specifically as follows:

    (a) Implementation capacity. The World Bank task team will work in close collaboration with the PSC, SSLOSWG-N and three IAs to ensure effective design and setup of the project.
    (b) Coordination. The Bank core team will closely monitor project implementation to promote more effective multi-sector coordination and detect possible lack of communication, duplication of efforts, and delays in implementation.

(c) 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 Bank task team and work closely with the SSLOSWG-N to monitor the project performance across the project components.
(d) FM. During implementation support, the World Bank's FM specialist will support the IAs (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.
(e) Procurement. The Bank's Procurement Specialist will work closely with the IAs to build capacity; to ensure that the IAs are trained and able to use the World Bank STEP system; and to ensure procedural compliance. They will also work with the NDoH/DJAG Procurement Specialists and the DJAG/DfCDR Procurement Officers to ensure that the planned and approved procurement activities in each IA are programmed and carried out in a compliant and timely manner.
(f) E&S Management. During the project preparation, several ESF instruments were developed, consulted, and disclosed. A social risk, outreach, and communication consultant will be recruited to provide capacity building to the committee and ensure the ESF compliance during the project implementation.

E. Implementation Support Plan

33. Key Bank task team members involved in implementation support will be based in Port Moresby, Sydney, 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 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) technical assistance to the systems' components, and (iv) the organization of technical workshops to share best practices and support the evaluation agenda.
(b) Fiduciary requirements.
(c) Social and environmental risk management.

34. 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 x. Required Project Supervision

Profile/Skills Needed	Number of Staff Weeks	Comments
Senior Economist /Task Team Leader(s)	12	Oversees the entire operation, ensure the project performance toward the PDO, and manage partner relationships
Nutrition Specialist	6	Provides technical advice and implementation guidance to the CMU (Component 1) and PCU focusing on the nutrition specific interventions and policies
SP Specialist	8	Provides technical advice and implementation guidance to the CMU (Component 2) focusing on the child nutrition grant

Procurement Specialist	1	Provides technical advice and implementation guidance focusing on procurement implementation
FM Specialist	1	Provides technical advice and implementation guidance focusing on FM implementation
Social Development Specialist	1	Provides technical advice and implementation guidance focusing on ESF implementation
IT/MIS Expert (Consultant)	8	Provides technical advice and implementation guidance to the design, development/adaptation, and operation of the child nutrition grant program MIS, including data process, standards, and database administration
Payment Expert	4	Provides technical advice and implementation guidance to the payment service arrangements to deliver child nutrition grant

MAP OF PAPUA NEW GUINEA