Public Disclosure Authorized

Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 13-Feb-2018 | Report No: PIDISDSC21881

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Cambodia	P162675		Cambodia Nutrition Project (P162675)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	Jan 25, 2019	Mar 28, 2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Kingdom of Cambodia	Ministry of Health	

Proposed Development Objective(s)

The PDO is to improve utilization and quality of priority maternal and child health and nutrition services for targeted groups in Cambodia.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	54.00
Total Financing	54.00
of which IBRD/IDA	15.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	15.00
IDA Credit	15.00

Non-World Bank Group Financing

Counterpart Funding	12.00
Borrower/Recipient	12.00
Trust Funds	27.00

Freestanding Tfs - Health, Nutrition & Population GP	2.00
Global Financing Facility	10.00
Integrating Donor-Financed Health Programs	5.00
Cambodia - Free-standing Trust Fund Program	10.00

Environmental Assessment Category

B - Partial Assessment

Concept Review Decision

Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Due to rapid and sustained growth, Cambodia has become one of the world's leaders in economic growth, poverty reduction and shared prosperity.** Cambodia has sustained an average growth rate of 7.6 percent over the period 1994-2015, ranking sixth in the world, and has now become a lower middle-income economy. Due to strong economic growth, gross national income (GNI) per capita more than tripled from USD 300 in 1994 to an estimated USD 1,070 in 2015, the year in which Cambodia became a lower middle-income economy.

2. **In addition to strong economic growth, Cambodia has achieved dramatic poverty reduction.** Poverty incidence under the national poverty line falling from 47.8 percent in 2007 to 13.5 percent in 2017. From 2004 to 2007, poverty reduction was driven by the movement of people out of agriculture and into the fast-growing garment and services sectors. Poverty reduction then became particularly dramatic during the 2007-9 period, at the peak of the agriculture commodity boom, and in a context of expansion in cultivated area, when poverty declined by 25 percentage points and 3.3 million people escaped poverty.

3. **However, Cambodian households face a high degree of economic vulnerability.** According to the 2017 Systematic Country Diagnostic (SCD), most Cambodians not in extreme poverty are either moderately poor or vulnerable according to international standards. Two thirds of the population live under US$5.50 per day PPP. There is high vulnerability to financial and weather shocks, with Cambodia ranking among the world's top ten countries in terms of out-of-pocket (OOP) health expenditure.

Sectoral and Institutional Context

4. **There have been improvements in overall health status, yet health disparities persist, as indicated by several lagging reproductive, maternal, neonatal and child health and nutrition (RMNCAH-N) indicators, including stunting.** Undernutrition has declined in Cambodia over the past 20 years but remains a significant public health

and development concern for women of reproductive age and children under five. Child stunting (low height-for-age and an indicator of chronic undernutrition) declined from 59% in 1996 to 32% in 2014 in the latest Cambodia DHS. However, prevalence remains 'high' according to WHO public health thresholds. Child wasting (9.6 percent) is also considered 'high'. Fourteen percent of women age 15-49 are underweight; the prevalence is double in Kampong Speu (21 percent) compared to Kampong Cham (10 percent), but there is relatively little variation by wealth and it affects women across all socioeconomic groups. Among women of reproductive age, close to half (44 percent) suffer from anemia. Over 1 in 10 (11 percent) children in Cambodia are born low birth weight, a contributing factor to stunting and caused in part by maternal anemia and underweight.

5. **Overall, poor households are most vulnerable to undernutrition; however, the relatively high prevalence of maternal and child undernutrition among wealthy households indicates that economic status is not the sole contributing factor.** In Cambodia, wealthier households have better child nutrition outcomes than poorer households (Figure 2). Stunting prevalence in the poorest wealth quintile (42 percent) is more than double that of the richest (18 percent). Yet, high household income alone does not necessarily lead to improved nutritional status; inappropriate health, hygiene, and nutrition-related behaviors and exposures which augment risk of disease and low nutrient intake are prevalent across socioeconomic groups.

6. **Reducing the burden of child malnutrition in Cambodia will require progress on the immediate drivers of malnutrition:** nutrient intake and disease. Maternal nutrient intake during pregnancy and the adequacy of complementary feeding are main barriers to proper nutrient intake in the first 1,000 days. Furthermore, progress has been uneven in addressing the underlying drivers of undernutrition (food insecurity, inadequate care for women and children, and poor access to health services and health environment). Large increases in food availability (e.g. national rice self-sufficiency) have been accompanied by only small improvements in food access (namely geographic and economic access to a diverse, nutrient rich diet). Moreover, in the absence of strong family, community, and social support, high levels of women's labor force participation places increasing constraints on the time and quality of care for young children; there is concern over the availability and quality of secondary caregivers (e.g. grandmothers, neighbors) in providing for optimal care and child development. The consumption of antenatal care and institutional delivery services has rapidly increased; however, geographic and economic barriers limit the consumption of many preventive and promotive services, including post-natal care and well-child visits. Moreover, there are continued concerns with the quality of public health and nutrition services, in addition to demand side constraints for immunization and other well-child services.

7. **Addressing undernutrition can help lock in human capital, accelerating growth Cambodia's growth and productivity.** Undernutrition has economic and social development consequences that reverberate across generations. Undernutrition slows growth and perpetuates poverty through direct losses in productivity due to poor health status; indirect economic losses from impaired cognition and schooling deficits, and economic losses due to increased health care costs. Recent estimates indicate that Cambodia foregoes US$240-420 million annually due to malnutrition. Ensuring that children begin life well-nourished will give them the greatest opportunities to learn, earn, innovate, and compete, boosting the country's economic prospects in the medium and long term.

8. **Ending extreme poverty and achieving shared prosperity cannot be realized without early life investments**. Globally, undernutrition is an underlying cause of almost half of child deaths (Black et al. 2013). In Cambodia, maternal and child undernutrition remained among the top five risk factors for premature death and disability in 2015. During the first 1,000 days between conception and two years of age conception, early life nutrition sets the trajectory for an individual's growth, cognition, and long-term health. Though the first 1,000 day window is important, women's pre-pregnancy nutritional status is also priority concern. Because malnutrition can be passed

from mother to child, investments in nutrition are necessary to ensure the health and wellbeing of the next generation. Reducing the intergenerational consequences of undernutrition will be central to poverty reduction and sustainable development in Cambodia.

Relationship to CPF

9. **The new CPF for Cambodia is currently under preparation, but addressing malnutrition is a key development challenge highlighted in the Cambodia Systematic Country Diagnostic (SCD) published in 2017.** Social inequity and malnutrition contribute to a cycle of poverty for those at the margins. When properly targeted, addressing the multisectoral determinants of chronic malnutrition can improve the health and well-being of the bottom 40 percent, one of the WBG twin goals. Three development pathways are necessary for the country to overcome these challenges, sustain growth, reduce poverty, and boost shared prosperity: (i) Increasing economic competitiveness and diversification to sustain strong growth and create jobs, (ii) Building human assets to facilitate economic mobility and shared prosperity, and (iii) Ensuring a sustainable growth pattern by investing in natural capital, climate resilience and urban. Investing in the Early Years through nutrition and pre-primary education is a critical focus area of Pathway 2. Thus, the proposed project directly supports the pathway of investing in early life nutrition and child development.

C. Proposed Development Objective(s)

To improve utilization and quality of basic maternal and child health and nutrition services in targeted areas of Cambodia.

Key Results (From PCN)

10. **The higher-level objective to which the project contributes is to improve maternal, infant, and young child nutritional status, and particularly child stunting.** The project seeks to address key immediate drivers of child stunting (namely maternal nutrition, nutrient intake, and disease), underlying drivers of child stunting (focused primarily on health services), and creating an enabling environment for convergence of multi-sectoral actions at the community level.

Given project scope and timeframe, the PDO indicators will focus on a sub-set of factors which can capture improvements in nutrition and immunization service utilization and coverage of the facility- and community-based interventions. At the concept stage, an illustrative set of PDO indicators includes the following, which will be further developed and finalized during project preparation:

- Number/percent of children age 6-59 months receiving vitamin A supplementation in the previous 6 months (from Admin data) OR Number/percent of children age 6-23 months receiving a minimum dietary diversity[1] (from CDHS)
- Number/percent of children age 12-23 months fully immunized (from CDHS) OR Number/percent of children immunized for identified tracer vaccines such as Penta-3 or MR1 (from Admin data)
- Number/ percent of health facilities scoring over 60 percent on their Nutrition and Immunization Scorecards
- Number/percent of communes receiving performance based grants for nutrition

D. Concept Description

11. **The project will build upon global evidence and national policies and strategies to operationalize the scale-up of**

[1] Minimum dietary diversity (MDD) among children 6-23 months is a measure of dietary quality (reflecting nutrient adequacy, dietary diversity, and feeding practices). It captures whether children in this age group consumed 4 or more (out of 7) food groups in the previous 24 hours.

nutrition-specific and immunization services targeting the first 1,000 days of life. The project seeks to contribute to acceleration of stunting reduction by rapidly increasing the scale, scope, and coverage of nutrition-specific interventions while stimulating demand and convergence of nutrition-sensitive elements (water, sanitation and hygiene and agricultural diversification) at the commune level. Cambodia's rapid economic development is expected to yield a progressive decline in donor financing, which has already accelerated in the nutrition sector. Therefore, the project will focus on four complementary approaches to institutionalize a national program to promote good nutrition:

1. ***Build*** upon existing government health sector platforms, such as HEFs and SDGs, to enhance supply-side delivery and maximize the contributions of these instruments to the nutrition and immunization agendas.
2. ***Extend*** service provision beyond health facilities through a streamlined, comprehensive approach to outreach and community mobilization.
3. ***Stimulate*** demand, convergence, accountability and resource availability for good nutrition at the commune level.
4. ***Adapt*** to implementation realities through robust process and impact monitoring.

Component 1. Strengthening delivery of basic nutrition and immunization services through the health system

12. The objective of this component is to enhance supply-side service delivery for key interventions through the health sector. This component will build upon institutionalized, results-based mechanisms in the Ministry of Health to improve supply-side delivery of nutrition interventions outlined in the Fast Track Road Map for Improving Nutrition and in the National Immunization Programme Strategic Plan. These interventions are among the high impact nutrition interventions which, when implemented with quality and at high coverage, can have a measurable impact on stunting reduction. This component will finance (a) activities to build upon Cambodia's performance-based Service Delivery Grants system to channel operational funds to the frontline based on the achievement of maternal and child nutrition and immunization results; and (b) expanding health equity funds to increase nutrition and immunization service utilization. The component will support the development and implementation of nutrition and immunization quality scorecards; enhanced supervision and coaching of nutrition and immunization activities; incentives to increase the provision of nutrition and immunization services in facilities and through outreach; and efforts to minimize economic barriers to service utilization.

Component 2. Stimulating demand and accountability for nutrition at the community level

13. **The objective of this component is to complement supply-side interventions by stimulating demand for good nutrition and child health focusing on the community level.** Activities under Component 2 are aimed at: demand creation through awareness raising; performance-based incentives at community levels to build awareness, increase community mobilization, and enhance utilization of health and nutrition services; and stimulating social change by leveraging the leadership of local authorities in the communities they serve. This component will finance: (a) institutionalization of community mobilization and the community-based provision of nutrition and child health behavior change communication and services; and (b) incentives to communities for achieving nutrition and child health results.

Component 3. Monitoring, evaluation, adaptive learning, and project management

14. **The objective of this component is to strengthen technical and management capacities and systems to enhance the effectiveness and sustainability of project investments.** Activities financed under this component will be related

to human resource capacity development across administrative levels and relevant line ministries; enhanced coordination for the multisectoral nutrition agenda; strengthened monitoring, evaluation and learning, including through improvements in data and information systems; and the use of evidence base for policy, programming, and planning and central and decentralized levels.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

Project activities may be financed throughout the Kingdom of Cambodia. It is anticipated that most of the project support activities will be delivered at the community and health facility levels to improve nutritional status of women and children under the age of two years. However, location and type of investments, specifically for subprojects and project investments financed under Component 1 and Component 2, will not be known before appraisal.

The support under the component 1 and component 2 is expected to increase utilization of immunization services and will generate incremental health care wastes, such as sharps or contaminated wastes, which needs to be handled properly. The MoH has prepared the National Guidelines for Health Care Waste Management, which will guide any support related to this aspect provided by the Project.

The Project will align to existing Performance-based Service Delivery Grant (SDG) system to finance activities in component 1, whereby eligible expenditures of the SDG allow for (i) purchasing drugs; (ii) financing activities related to pesticides for vector-borne disease control such as malaria and dengue; and (iii) minor works such as construction of toilets, installing hand washing facilities or repair of health center buildings in existing health facilities. Misuse of antibiotics has the potential to accelerate antibiotic resistance. The government has developed a national policy and strategic plan to combat antimicrobial resistance. In addition, the World Bank's on-going Health Equity and Quality Improvement Project (H-EQIP) is supporting improvements in quality of service delivery, including rational drug use and infection prevention and control. A pesticide review has been
conducted for the HSSP2 and found that all larvicide products used in Cambodia passed WHO Pesticide Evaluation Scheme (WHOEP). The generic construction impact from small scale works are expected to be minor, for a short time and site specific within the health facilities, if any, and can be mitigated by preparation and implementation of a good environmental management plan.

An Environmental Management Framework (EMF) including specific environmental safeguard mitigation measures and a Pest Management Plan, and an Indigenous Peoples Planning Framework (IPPF) will be prepared to address potential impacts.

B. Borrower's Institutional Capacity for Safeguard Policies

The institutional arrangements are based on the implementation experience of the on-going H-EQIP, as well as the PFM reforms envisaged in the country. The main implementing agency for the project will be the MOH, acting through its

technical departments, national programs as well as the Provincial Health Departments , Operational Districts, referral hospitals and health centers. The Ministry of Health (MOH) has significant work experience in implementing safeguards requirement of the Bank projects.

The task team will further verify the borrower's institutional responsibilities and capacity-building needs during the preparation stage. Based upon capacity and needs, the team will provide safeguard training to staff of the implementing agencies to further familiarize them with the Bank's safeguard policies and requirements during the project preparation and implementation stage.

C. Environmental and Social Safeguards Specialists on the Team

Erik Caldwell Johnson, Social Specialist
Wasittee Udchachone, Environmental Specialist

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	his policy is triggered due to potential impacts from the footprint on the ground of health facilities they are associated with (such as installation of hand washing facilities, construction of toilets or repairs of health center buildings) and incremental health care waste. These impacts are expected to be site-specific and can be mitigated. The Project is therefore assigned as category "B". An EMF that includes construction waste management and health care waste management plan will be prepared to address OP/BP 4.01 requirements during project implementation. Stakeholder engagement through public consultations will be done as required.
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	The project interventions will be in existing health facilities and communities, so this policy is not triggered.
Forests OP/BP 4.36	No	The project interventions will be in existing health facilities and communities so this policy is not triggered.
Pest Management OP 4.09	Yes	The project will support Service Delivery Grant for improving quality nutrition service delivery. Therefore, parts of the grants may be used for activities related to pesticides for vector-borne diseases control such as malaria and dengue. A pesticide review has been

		conducted for the HSSP2 and a Pest Management Plan will be prepared accordingly, as part of the EMF, before project appraisal.
Physical Cultural Resources OP/BP 4.11	No	The project interventions will be in existing facilities and communities which are not recognized as heritage structures, so this policy is not triggered.
Indigenous Peoples OP/BP 4.10	Yes	As this project will be national in coverage, indigenous communities will likely be affected as direct beneficiaries of project activities. To this end an indigenous people planning framework (IPPF) will be developed to guide the design and implementation of project activities. The preparation of this instrument will be informed by a social assessment focusing on the unique barriers of indigenous people communities, in particular, women and children, to benefit from nutrition and immunization services.
Involuntary Resettlement OP/BP 4.12	No	he project will not involve the expansion of facilities outside of its current sites, no land acquisition is foreseen, and there will be no displacement of persons/families. Therefore, this policy is not triggered.
Safety of Dams OP/BP 4.37	No	The project will not finance any activities related to the construction of dams nor affect operations of existing dams or affiliated reservoirs.
Projects on International Waterways OP/BP 7.50	No	The project will not affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	No activities are planned in disputed areas.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Aug 01, 2018

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

During the project preparation, the task team will work with MOH to prepare safeguards instruments including: (a) an EMF that includes Environmental Code of Practice (ECOPs) to address generic construction impacts, a simple health care waste management plan, and a pest management plan; and (b) a social assessment to inform the preparation of an IPPF.

CONTACT POINT

World Bank

Somil Nagpal
Senior Health Specialist

Borrower/Client/Recipient

Kingdom of Cambodia
Vissoth Vongsey
Secretary of State
vongsey_vissoth@mef.gov.kh

Implementing Agencies

Ministry of Health
H.E Prof.Tan Vuoch Chheng
Secretary of State
vuochchhengtan@gmail.com

FOR MORE INFORMATION CONTACT

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

APPROVAL

Task Team Leader(s):	Somil Nagpal

Approved By

Practice Manager/Manager:	Enis Baris	25-Jan-2019
Country Director:	Inguna Dobraja	27-Jan-2019