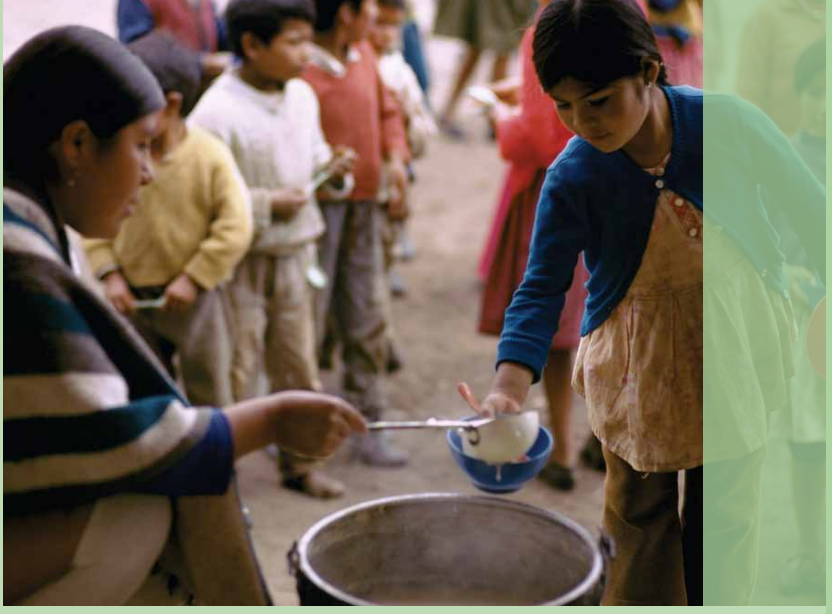

CASE STUDIES

LEVERAGING SOCIAL PROTECTION PROGRAMS FOR IMPROVED NUTRITION

Compendium of Case Studies Prepared for the Global Forum on Nutrition-Sensitive Social Protection Programs, 2015

EDITED BY ANDREA L. SPRAY

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Leveraging Social Protection Programs for Improved Nutrition

Compendium of Case Studies Prepared for the Global Forum on Nutrition-Sensitive Social Protection Programs, 2015

About the Series

This report is part of the Leveraging Social Protection Programs for Improved Nutrition series.

The series was created to capture evidence and next steps related to the Global Forum on Nutrition-Sensitive Social Protection Programs held in Moscow in September 2015. The Forum convened approximately 150 individuals from 20 countries, and the resulting technical agenda is being explored through seminars and other engagements. More information at http://www.securenutrition.org/

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Summary of Evidence Prepared for the Global Forum on Nutrition-Sensitive Social Protection Programs, 2015

Compendium of Case Studies Prepared for the Global Forum on Nutrition-Sensitive Social Protection Programs, 2015

(Fall 2016) Report on the Procedings of the Global Forum on Nutrition-Sensitive Social Protection Programs, 2015

Leveraging Social Protection Programs for Improved Nutrition:

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Edited by Andrea L. Spray

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1818 H Street NW, Washington, DC 20433
Telephone: 202-473-1000; Internet: www.worldbank.org

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This case study compendium was prepared by a team led by Andrea L. Spray. The research and writing for WBG case studies were done by Laura Figazzolo. Aaron Buchsbaum led on publishing and dissemination.

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Abbreviations

4Ps	*Pantawid Pamilyang Pilipino Program* (Bridging Program for the Filipino Family) (Philippines)
ACF	Action Contre la Faim
ADDS	*Agence Djiboutienne de Développement Social* (Djibouti Agency for Social Development) (Djibouti)
AF	Additional Financing
AM	Accompanying Measures
ANC	Antenatal Care
ASCP	Multidisciplinary Community Health Agent (Haiti)
BCC	Behavior Change Communication
BPO	Bangladesh Post Office (Bangladesh)
BWC	Beneficiary Welfare Committees (Kenya)
CAE	*Conselho de Alimentação Escolar* (School Feeding Council) (Brazil)
CECANE	*Centro Colaborador em Alimentação e Nutrição Escolar* (Collaboration Centre for School Feeding and Nutrition) (Brazil)
CC	Community Clinics (Bangladesh)
CCT	Conditional Cash Transfer
CCTMC	Community Cash Transfer Management Committee (Tanzania)
CDD	Community Driven Development
CFS	*Cellule Filets Sociaux* (Safety Net Unit) (Niger)
CHF	Community Health Fund (Tanzania)
CMC	Community Management Committee (Tanzania)
CNCD	Child Nutrition and Cognitive Development (Bangladesh)
CNCH	National Crusade Against Hunger (Mexico)
CNSA	*Coordination Nationale de Sécurité Alimentaire* (National Food Security Coordination) (Haiti)
COMSP	Community Savings Promotion
CONEVAL	*Consejo Nacional de Evaluación de la Política de Desarrollo Social* (National Council for the Evaluation of Social Development Policy) (Mexico)
CRED	*Control de Crecimiento y Desarrollo* (Growth Monitoring Checkup) (Peru)
CRM	Complaints and Response Mechanism (Nigeria)
CSO	Civil Society Organization
CT	Cash Transfer
CT-OVC	Cash Transfer for Orphans and Vulnerable Children (Kenya)
DBM	Double Burden of Malnutrition
DCS	Department of Children Services (Kenya)
DfID	Department for International Development (UK)
DG	Directorate General (Indonesia)
DGPP	*Dirección Nacional Presupuesto Público* (National Directorate for Public Budget) (Peru)
DHS	Demographic & Health Survey

DOF	Department of Finance (Philippines)
DOH	Department of Health (Philippines)
DSWD	Department of Social Welfare & Development (Philippines)
ECD	Early Child Development
ENA	Essential Nutrition Actions (Haiti)
ENCRED	*Encuesta a Establecimientos de Salud sobre Calidad Técnica del Crecimiento y Desarrollo del Niño* (Survey to Measure Health Facilities' Capabilities to Offer Nutritional Services) (Peru)
ENSANUT	*Encuesta Nacional de Salud y Nutricion* (National Health and Nutrition Survey) (Mexico)
ESIAN	*Estrategia Integral de Atención a la Nutrición* (Integrated Nutrition Strategy) (Mexico)
FAO	Food and Agriculture Organization of the United Nations
FDS	Family Development Session (Philippines)
FICASE	Cape Verdean Foundation for Social Action in Schools (Cabo Verde)
FNDE	*Fundo Nacional de Desenvolvimento da Educação* (National Fund for Education Development) (Brazil)
GDP	Gross Domestic Product
GMP	Growth Monitoring & Promotion
GOB	Government of Bangladesh (Bangladesh)
GODR	Government of the Dominican Republic (Dominican Republic)
GOE	Government of Ethiopia (Ethiopia)
GOH	Government of Haiti (Haiti)
GOI	Government of Indonesia
GOK	Government of Kenya (Kenya)
GOM	Government of Mali (Mali)
GOP	Government of Peru (Peru)
GOP	Government of the Philippines (Philippines)
HDDS	Household Dietary Diversity Score
HDI	Human Development Index
HEW	Health Extension Worker (Ethiopia)
HH	Household
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IEC	Information & Education Communication
IFAD	International Fund for Agricultural Development
IFPRI	International Food Policy Research Institute (Mali)
INPV	National Privation and Vulnerability Index (Haiti)
INSTAT	Institute of Statistics (Mali)
ISPP	Income Support Program for the Poorest (Bangladesh)
JSDF	Japan Social Development Fund
KAP	Knowledge, Attitudes & Practices
LGD	Local Government Division (Bangladesh)
LOC	Location OVC Committees (Kenya)

M&E	Monitoring & Evaluation
MAM	Moderate acute malnutrition
MAST	*Ministère des Affaires Sociales et du Travail* (Ministry of Social Affairs and Labor) (Haiti)
MCHN	Maternal Child Health and Nutrition
MCCT	Maternal and Child Cash Transfer (Myanmar)
MEF	Ministry of Economy and Finance (Peru)
MEFB	Ministry of Economy and Finance and Budget (Mali)
MIR	Matrix of Results Indicators (Mexico)
MIS	Management Information System
MIYCF	Mother, Infant and Young Child Feeding (Indonesia)
MLSSS	Ministry of Labor, Social Security and Services (Kenya)
MMSG	Mother-to-Mother Support Groups (Myanmar)
MOA	Ministry of Agriculture (Ethiopia)
MOF	Ministry of Finance (Bangladesh)
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs (Ethiopia)
MOSA	Ministry of Social Affairs (Indonesia)
MSPP	Ministry of Public Health and Population (Haiti)
NGO	Nongovernmental Organization
NHD	National Household Database (Bangladesh)
NHTS-PR	National Household Targeting System for Poverty Reduction (Philippines)
NLTA	Nonlending Technical Assistance
NNS	National Nutrition Services (Bangladesh)
NPMO	National Project Management Office (Philippines)
NSC	National Steering Committee (Mali)
NSNP	National Safety Net Program (Kenya)
NSPF	National Social Protection Framework (Tanzania)
NSPP	National Social Protection Policy (Kenya)
NSSS	National Social Security Strategy (Bangladesh)
ODHD	*Observatoire du Développement Humain Durable* (Observatory for Sustainable Human Development) (Mali)
OVC	Orphans and Vulnerable Children (Kenya)
PAA	Project Area Authority (Tanzania)
PAD	Project Appraisal Document
PAN	*Programa Articulado Nutricional* (Articulated Nutrition Program) (Peru)
PBB	Performance-Based Budgeting
PDM	Postdistribution Monitoring (Nigeria)
PIM	Project Implementation Manual
PKBM	*Program Kesehatan dan Gizi Berbasis Masyarakat* (Health and Community-based Nutrition to Reduce Stunting Program) (Indonesia)
PKH	*Program Keluarga Harapan* (Hopeful Family Program) (Indonesia)
PLHIV	Persons living with HIV
PLW	Pregnant and lactating women

PMBA	*Modul Pelatihan Pemberian Makan Bayi dan Anak* (Training Module for Feeding Infants and Children) (Indonesia)
PMS	Performance Monitoring Survey (Indonesia)
PMT	Proxy Means Testing
PMU	Project Management Unit
PNAE	*Programa Nacional de Alimentação Escolar* (National School Feeding Program) (Brazil)
PNPM	*Program Nasional Pemberdayaan Masyarakat* (Indonesian Poverty Reduction Program) (Indonesia)
PPNP	Pilot Preventive Nutrition Package (Mali)
PPP	Purchasing Power Parity
PSC	Project Steering Committee (Bangladesh)
PSNP	Productive Safety Net Program (Ethiopia)
PSSN	Productive Social Safety Net (Tanzania)
PW	Public Works
PWP	Public Works Program
RENIEC	*Régistro Naciónal de Identificación y Estado Civil* (National Registry of Identification and Civil Status) (Peru)
SAFANSI	South Asia Food and Nutrition Security Initiative
SAM	Severe Acute Malnutrition
SCCO	Sub-County Children's Officer (Kenya)
SCI	Save the Children International
SEDESOL	*Secretaría de Desarrollo Social* (Ministry of Social Development) (Mexico)
SEAS	*Secrétariat d'État chargé des Affaires Sociales* (Djibouti)
SIS	*Seguro Integral de Salud* (Integral Health Insurance Program) (Peru)
SNC	Safety Net Cells (Bangladesh)
SSN	Social Safety Net
SUN	Scaling Up Nutrition
SWAp	Sector-Wide Approach
TA	Technical Assistance
TASAF	Tanzania Social Action Fund (Tanzania)
TB	Tuberculosis
UCPS	*Unidad Ejecutora de Proyectos Sectoriales* (Sectoral Projects Coordinating Unit) (Peru)
UCT	Unconditional Cash Transfer
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URB	Unified Registry of Beneficiaries (Mali)
USAID	United States Agency for International Development
UTGFS	*Unité Technique de Gestion Filets Sociaux* (Technical Unit for Safety Nets Management) (Mali)
VA	Village Assembly (Tanzania)
VCT	Variable Conditional Transfer (Tanzania)

VDE	Village Development & Empowerment (Indonesia)
WASH	Water, Sanitation, and Hygiene
WBG	World Bank Group
WDI	World Bank World Development Indicators
WFP COE	World Food Programme Centre of Excellence Against Hunger
WHO	World Health Organization
WINNN	Working to Improve Nutrition in Northern Nigeria (Nigeria)
WV	World Vision

All dollar amounts are U.S. dollars unless otherwise indicated.

Glossary

Social Protection Instruments

Term	**Definition** (adapted from various WBG sources on social protection)
Accompanying measures (AM)	Accompanying measures (usually indicated as "soft" conditions) foster life skills and health- and nutrition-related outcomes by promoting behavioral changes among beneficiaries and, often, beyond them. They may encompass a range of activities, such as complementary workshops, family development sessions, life-skills training, community-based workshops, and home visits for the promotion of health practices that are delivered as part of the program. In unconditional programs, attendance at AM is soft—recommended but not required to receive the benefit.
Audit & control	Audit & Control mechanisms are vital to smooth program operation and contribute to improved program governance, transparency, and accountability. They can be implemented at the program level ("top-down controls"), such as audits and operational assessments; or at the beneficiary level ("bottom-up controls" or "social controls"), such as social audits or citizen committees.
Beneficiary registry	A database of actual beneficiaries of social protection interventions. The registry supports the administration and management of a social protection system. The adoption of beneficiary registries has grown steadily in the last several years. In particular, governments are widely working towards the establishment of consolidated and unified registries of beneficiaries at the national level to inform the development of their country's social protection systems. Among other things, beneficiary registries may help prevent or reduce the undesirable duplication of benefits and administrative costs across programs.
Cash transfer (CT) programs	These programs provide monetary benefits to participants for the purposes of increasing their income and stabilizing their consumption patterns. In conditional cash transfer programs (CCTs), cash is given to participants upon their fulfillment of a set of conditions or coresponsibilities; in unconditional cash transfer programs (UCT), cash is provided without particular coresponsibilities, but soft conditions encourage participants to make investments in human capital. See more on the definition and implications of conditional and unconditional transfers below.**
Community driven development (CDD)	CDD gives control over planning decisions and investment resources for local development projects to community groups and enables community-level organizations to play a lead role in designing and implementing the policies and programs that affect their livelihoods. CDD is often implemented in degrees. Decision makers at the national or regional level, responsible for planning, setting up, and delivering community services must be able to ascertain the demands of the community and be willing to provide those services. At the local level, community-based organizations must be adequately trained to contract for the services they require, and capable of autonomously planning and implementing their own microprojects with a minimum of outside support, drawing resources from their members as well as from government and private sources.[a] Microprojects typically include water supply and sanitation, school and health-post construction, nutrition programs for mothers and infants, rural access roads, and support for microenterprises.
Conditional and unconditional (**)	Programs are conditional when the provision of the cash or in-kind transfer is contingent upon participants' compliance with a set of conditions or coresponsibilities, such as ensuring a minimum level of school attendance by children, undertaking regular visits to health facilities, or attending skills training programs. Programs are unconditional when they do not require compliance with specific conditions. *In the context of nutrition-sensitive social protection, however, unconditional programs almost always involve soft conditionalities (AMs), which encourage beneficiaries to make investments in health, education, and skills development.* The intensity of the conditions varies, and, rather than being strictly conditional or unconditional, the conditions for many nutrition-sensitive social protection programs lie on a continuum.

table continues next page

Term	Definition
	Moreover, some programs have coresponsibilities at the community level or community-based conditions that generate social pressure within communities. *Conditions are particularly relevant to nutrition-sensitive social protection programs when they are linked to the use of health and nutrition services.*
Delivery or payment methods	How the transfer is delivered to participants. The type of delivery instrument depends on a variety of factors including program approach (cash or near-cash), program duration, available technology infrastructure, local capacity, and cost. Direct cash may be preferred when transfers need to be disbursed quickly, often through on-site distributions. In recent years, the number of programs introducing electronic delivery mechanisms has expanded rapidly through the adoption of smart cards, point-of-sale devices, and cell phones. Some programs rely on a combination of electronic and direct payment methods. Government agencies, post offices, NGOs or banks (using ATMs or "mobile" or branchless banks) may disburse payments or exchange vouchers and checks. Beneficiaries may also receive in-kind transfers in retail stores upon presenting vouchers, passbooks, identity cards, or electronic cards. *The nutrition-sensitivity of programs is enhanced when the time and cost to participants (particularly women due, commonly, to primary responsibility for childcare) of collecting the transfer is minimized.*
Enrollment	Once targeted beneficiaries have been identified, they must be enrolled to participate in program activities and receive benefits. Processes for enrollment vary by program and country, but generally take the form either of a survey (which identifies areas where large numbers of eligible people may live and then sends program staff or trained interviewers to interview and register all households in that area) or of an on-demand model (requiring potential beneficiaries to visit a designated site to apply for program benefits directly), or a combination of the two.
Household	Standard definitions of the household usually include some intersection of residency requirements, common food consumption, and common intermingling of income or production decisions. A widely used definition of household identifies a group of people eating from the "common pot," sharing common housekeeping and acknowledging a common household head.
In-kind transfer programs	These programs comprise the distribution of food, vouchers, or coupons (also called quasi-cash or near-cash transfers), or other in-kind transfers. Conditional in-kind transfers involve compliance with conditions such as ensuring a certain rate of monthly attendance at school or attending health checkups. School feeding programs, one of the most common conditional in-kind transfers, provide on-site meals to children in schools, and, in some cases, "take-home" food rations for children's families. Unconditional in-kind transfers do not require compliance with conditions, yet, similarly to unconditional cash transfers, often encourage participants to take part in accompanying measures. Examples of unconditional in-kind transfers include the provision of fortified food supplements for malnourished pregnant women and children. See more on the definition and implications of conditional and unconditional transfers above.**
Institutional arrangements	Roles and responsibilities of the various institutions, such as national governments, municipal governments, NGOs, and private entities, collaborating across sectors to ensure effective implementation, coordination, accountability and oversight of programs. *Effective intersectoral and multisectoral institutional coordination, most notably with the health and education ministries, is key in the context of nutrition-sensitive social protection.*
Livelihood	A means of making a living, it encompasses people's capabilities, assets, income, and the activities required to secure the necessities of life. A livelihood is sustainable when it enables people to cope with and recover from shocks and stresses, such as natural disasters and economic or social upheavals, and enhances their well-being and that of future generations without undermining the natural environment or resource base.[b]

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Term	Definition
Management information system (MIS)	An information technology platform that facilitates the collection, processing, timely management, and dissemination of high-volume data essential for program operations, accountability, and policy making across multiple sites and levels of program implementation. A well-functioning MIS is a key risk management tool to facilitate evidence-based decision making and to enable the accountability and control processes required to mitigate programs' operational risks. An effective MIS can minimize error, fraud, and corruption by warning end users when data discrepancies or violations of use occur. An effective MIS features a range of cross-cutting requirements, such as governance and institutional coordination (institutional arrangements and procedures indicating clear roles and responsibilities for program staff and institutions), infrastructure and human resources (hardware and software equipment as well as human resource requirements to develop, operate, update, and maintain the MIS), and sound application management (tools such as a user's manual, training sessions, and user-friendly interfaces that facilitate the intuitive application of the MIS). An MIS collects and defines information flows from social and beneficiary registries, cross checks the data and consolidates them in order to provide a picture of the overall system.
Microcredit	A form of microfinance, the provision of very small, microloans to poor borrowers who typically lack collateral, steady employment, verifiable credit history, or access to traditional banking services.
Monitoring & evaluation (M&E)	Strategic components of social safety net (SSN) management, M&E make available crucial data required to inform efforts to enhance program effectiveness, make projects publicly accountable, and help government better allocate budget resources. Monitoring is a continuous process of collecting and analyzing information to better understand how well a program is operating against expected outputs. Evaluation is an objective assessment of program effectiveness that uses specialized methods to determine whether a program meets its objectives, to estimate its net results or impact, and to identify whether the benefits the program generates outweigh its costs. Programs typically establish specific indicators (process, outcome, social, economic, or environmental) against which the program is measured during the M&E process. Programs designed to affect nutrition outcomes should include nutrition indicators appropriate for the specific nutrition intervention (such as anthropometric measures of nutritional status, dietary quality, participation in health and nutrition activities, micronutrient deficiencies, low birth weight, and infant and young child feeding practices).
Participant or beneficiary	The person or persons enrolled in the SSN and designated to receive the benefit and take part in its activities. Beneficiaries can be single individuals or entire households, as specified for each case study in the compendium*. From the perspective of nutrition-sensitive social protection, it is particularly important that beneficiaries belong to nutritionally vulnerable groups, usually within the 1,000-day window of opportunity between conception and the child's second birthday, that is PLW and children up to 2 years old. The benefits of nutrition-sensitive social protection are increased when payments are made directly to women, which ensures their control over the income.*
Public work programs (PWPs)	PWPs provide financial or in-kind support to participants in return for manual or labor-related activities or the provision of services to the community. When PWPs involve the distribution of cash ("wages" or similar compensation) to participants, they are also called cash-for-work programs. PWP subprojects are implemented in the framework of a PWP and typically include economic infrastructure projects (such as transport sector, gas and electricity, and large-scale irrigation systems); waste and sanitation management projects; road construction and maintenance projects; environmental infrastructure and natural resource management projects; and social projects and services. These projects can be part of a national or local development plan, but they can also be chosen by the community in response to its needs. They should be economically, technically, and socially viable and should minimize possible adverse environmental effects.

table continues next page

Term	Definition
	In particular, labor-intensive PWPs include "heavy" tasks, such as building or rehabilitating community assets and public infrastructure. Often, some groups (pregnant women, people with disabilities, and the elderly) are excluded from labor-intensive PWPs and engage in lighter, low-intensity tasks, such as providing services (cooking meals or looking after children) to PWP laborers or the community. PWPs often require participants' attendance at health, life skills, or family planning development sessions, as well as employment-related training. *A PWP proves particularly nutrition-sensitive when it is adapted to the needs of women, providing lighter tasks for PLW, allowing flexible working hours for women, providing childcare for participants' children, and offering food support to PLW.*
Social protection	The set of public interventions designed to support the poorest and most vulnerable, and to help individuals, households, and communities manage risk. Social protection interventions generally include social assistance (SSNs), contributory social insurance, and active and passive labor market programs.
Social registry	A physical or virtual database of potential beneficiaries that includes a series of individual- and household-level characteristics needed to determine eligibility for social protection programs. It can be a single database or multiple harmonized and integrated databases. Social registries can provide updated information on potential beneficiaries and contain a minimum set of information required to allow one or more program administrators to determine eligibility for their programs (such as date of birth, gender, contributory records, income, and household size and composition). In some cases, registration in the social registry is a condition of becoming a beneficiary, but it does not guarantee that the registered individual or household will participate in the program. Robust social registries can be used to link programs across sectors.
Social safety nets (SSNs)	Also referred to as social assistance or social transfers, SSNs are noncontributory transfers designed to provide regular and predictable support to targeted poor and vulnerable people. They are a component of wider social protection systems. The SSNs included in this compendium are CTs, in-kind transfers (food transfers, food vouchers, and school feeding), and PWPs.
Targeting	Targeting helps ensure that a program reaches its intended population to increase likelihood that the program will achieve its objectives, such as poverty reduction. Target groups can be defined by income, vulnerability, food gap, unemployment, or category, such as youth or war returnees. *An SSN that targets the nutritionally vulnerable population (PLW and children under 2 years old) is particularly nutrition-sensitive.* Generally, programs use a combination of targeting mechanisms to reach the intended groups: (1) administrative targeting uses a set of criteria for eligibility that can be poverty-based or categorical; (2) categorical targeting makes all individuals in a specific category (age group, gender, or demographic composition) eligible to receive benefits; (3) community-based targeting, under which a group of community members or leaders decides who in the community should benefit; (4) geographical targeting, under which the location determines eligibility for benefits; (5) means testing, in which comprehensive information on household income and wealth are collected and verified against independent sources; (6) proxy means testing, which generates a score for applicant households based on easy-to-observe household characteristics, such as the location and quality of households' dwellings, ownership of durable goods, demographic structure, and education.
Transfer, benefit, or grant	The form of the transfer depends on the program objectives and several other factors, including: • Nature—the transfer can be in cash, in-kind (food or vouchers), or a mix of both. • Size and denomination—the amount or quantity of the transfer (the amount of money transferred or the wage rate denominated in U.S. dollars or local currency, such as $10 per day), and kilograms or a commonly acknowledged measurement unit of a specific food (such as one package of maize and seeds or one kilogram of cereals), depending on the nature of the transfer.

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Term	Definition
	The nutrition-sensitivity of a program is enhanced when the size of the transfer is sufficiently large, in accordance with available research, to improve measurable nutrition outcomes without negatively affecting other important considerations for social protection systems. • Frequency—how often the transfer is distributed. *Transfers that are paid on a regular and predictable schedule foster consumption-smoothing,[c] and beneficiaries are able to plan and rely upon more certain and foreseeable food-related expenditures.* • Duration—how long a beneficiary may continue to receive the transfer (a set amount of time or until a milestone is reached, such as when the youngest child turns 5 years old), and when (year-round or seasonally, for example, during the agricultural lean season).

a. IFAD (International Fund for Agricultural Development). 2009. *Community-Driven Development Decision Tools for Rural Development Programmes*. Rome: IFAD.)

b. Adapted from Chambers, Robert, and Gordon R. Conway. 1991. "Sustainable Rural Livelihoods: Practical Concepts for the 21st Century." IDS Discussion Paper, IDS, Brighton, UK.

c. An economic concept used to express the desire or need of people to have a stable path of consumption which allows for more predictable and regular planning of expenditures on food.

Nutrition Interventions

Term	**Definition** (adapted from World Bank Group. 2013. *Improving Nutrition Through Multi-sectoral Approaches*. Washington, DC: World Bank Group.)
First 1,000 days	The period of time, or window of opportunity, from conception through a child's first 24 months, in which nutritional requirements are substantial and damage from malnutrition is largely irreversible.
Anthropometry	The study and techniques of measuring the human body. Anthropometric measurements are often used to compare or classify individuals or population groups.
Community-based management of acute malnutrition	The management of acute malnutrition through (1) inpatient care for children with severe acute malnutrition with medical complications and infants under 6 months old with visible signs of severe acute malnutrition; (2) outpatient care for children with severe acute malnutrition; and (3) community outreach.
Complementary feeding	The introduction of other foods and liquids when breast milk alone is no longer sufficient to meet the nutritional requirements of infants. The transition from exclusive breastfeeding to family foods typically covers the period from 6–24 months old, even though breastfeeding may continue beyond 2 years old. This is a critical period of growth during which nutrient deficiencies and illnesses contribute globally to higher rates of undernutrition among children under 5 years old. Complementary food is any food, whether manufactured or locally prepared, given in addition to breast milk (or a breast milk substitute) to satisfy the nutritional requirements of the child.
Deworming	Periodic drug treatment with an anthelmintic to purge the body of soil-transmitted helminths, such as roundworm, whipworm, and hookworm. Soil-transmitted helminths impair nutrition status through loss of iron and protein, and malabsorption of and competition for nutrients. WHO estimates that over 270 million preschool children and over 600 million school-age children are living in areas where these parasites are intensively transmitted and in need of treatment and preventive interventions.
Dietary diversity	The number of food groups consumed over a given period of time used as an indicator of household food security and diet quality.
Double burden of malnutrition (DBM)	The simultaneous occurrence of undernutrition and overweight or obesity in the same community, household, or individual. The DBM is linked to two simultaneous global transitions: (1) the nutrition transition, which refers to the shifting dietary consumption and energy expenditures that coincide with economic, demographic, and epidemiological changes, such as modernization, urbanization, economic development, and increased wealth; and

table continues next page

Term	Definition
	(2) the epidemiological transition that accounts for the replacement of infectious diseases by chronic diseases over time and refers to the pattern of increased population growth rates, due to improved public health, sanitation and disease therapy and treatment, followed by a releveling of population growth, due to subsequent declines in fertility rates.
Food security	When all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life.
Food system	A collaborative network that integrates sustainable food production, processing, distribution, consumption, and waste management in order to enhance the environmental, economic, and social health of a particular place.
Food fortification	The addition of one or more micronutrients (vitamins and minerals) to a food during processing. Ideally, food fortification provides a public health benefit with minimal risks to health in the population.
Growth monitoring	Growth monitoring follows the growth rate of a child in comparison to a standard by periodic, frequent, anthropometric measurements in order to assess growth adequacy and identify faltering early. Growth monitoring & promotion (GMP) consists of growth monitoring combined with counseling to increase awareness of child growth, improve caring practices, and increase demand for other nutrition-related services.
Hunger	A feeling of discomfort, illness, weakness, or pain due to a prolonged lack of food.
Infant and young child feeding	Refers to specific recommendations and guiding principles for feeding children between birth and 24 months old for optimal nutrition, health, and development. A set of eight core population-level indicators[a] have been developed to assess feeding trends over time; improve targeting of interventions; and monitor progress in achieving goals and evaluating the impact of interventions. The principles include: • Early initiation of breastfeeding—initiation of breastfeeding within one hour of birth. • Exclusive breastfeeding for infants under 6 months old—the feeding of an infant only with breastmilk from his or her mother or a wet nurse, or expressed breastmilk, and no other liquids or solids except vitamins, mineral supplements, or medicines in drop or syrup form. • Continued breastfeeding at 1 year—children 12–15 months old who received breast milk during the previous day. • Introduction of solid, semisolid or soft foods—infants 6–8 months old who receive solid, semisolid or soft foods. • Minimum acceptable diet—a composite indicator consisting of both minimum dietary diversity (children 6–23 months old receiving foods from four or more food groups) and minimum meal frequency (children 6–23 months old receiving solid, semisolid, or soft foods the minimum number of times per day or more). • Consumption of iron-rich or iron-fortified foods—children 6–23 months old who receive an iron-rich food or iron-fortified food that is specially designed for infants and young children or a food that is fortified in the home.
Intergenerational cycle of malnutrition	Also referred to as the undernutrition cycle, a concept that describes how growth failure is transmitted across generations through the mother. The theory links undernutrition in the various stages of development: Small adult women are more likely to have low-birth-weight babies; children born with a low birth weight are more likely to suffer from growth failure during childhood; girls born with a low birth weight are more likely to become small adult women; and adolescent girls who become pregnant are even more likely to have low-birth-weight babies. A child born weighing less than 2,500 grams is categorized as having a low birth weight. At the population level, the proportion of infants with a low birth weight often serves as an indicator of a multifaceted public health problem that includes long-term maternal malnutrition, ill health, hard work, and poor health care in pregnancy.
Lean or hunger season	Refers to the period between planting and harvesting, when food supplies can become scarce. Families may have to sell livestock, farming tools, and other assets to pay for food. During this period, poor farmers are at increased risk for malnutrition.

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Term	Definition
Malnutrition	Poor nutritional status caused by deficiency (undernutrition) or excess. Commonly used anthropometric measures of nutrition status include: • Stunting (chronic malnutrition)—low height for age, defined as more than 2 standard deviations below the mean of the sex-specific reference data. Stunting is the cumulative effect of long-term deficits in food intake, poor caring practices, and illness. • Wasting (acute malnutrition)—low weight for height, defined as more than 2 standard deviations below the mean of the sex-specific reference data. Wasting is usually the result of a recent shock, such as lack of calories and nutrients or illness, and is strongly linked to mortality. • Underweight—low weight for age, defined as more than 2 standard deviations below the mean of the sex-specific reference data. Other anthropometric indicators are commonly used for program purposes, including: • MAM (moderate wasting)—weight for height between 2 and 3 standard deviations below the mean of sex-specific reference data. • SAM (severe wasting)—weight for height more than 3 standard deviations below the mean of sex-specific reference data. • Global acute malnutrition (moderate and severe wasting combined)—weight for height more than 2 standard deviations below the mean of sex-specific reference data. • Moderate malnutrition (moderate underweight)—weight for age between 2 and 3 z-scores below the mean of sex-specific reference data. BMI is a measure of body fat, calculated as weight in kilograms (kg) divided by the square of height in meters (m^2). Other measures of nutrition status are calculated using BMI. Overweight is defined as a BMI between 25 and 30 kg/m^2. Obesity is defined as a BMI of 30 or more. Although BMI is a good measure for determining a range of acceptable weights, it does not take into consideration some important factors, such as body build, the relative contributions of fat, muscle, and bone to weight.
Micronutrient deficiency	Also referred to as hidden hunger, the lack of one or more micronutrients, often caused by disease or lack of access to or consumption of micronutrient-rich foods such as fruit, vegetables, animal products, and fortified foods. Micronutrients are vitamins and minerals that are needed by the body in small amounts to produce enzymes, hormones, and other substances essential for proper growth and development. Micronutrient deficiencies increase the severity and risk of dying from infectious diseases such as diarrhea, measles, malaria, and pneumonia. More than two billion people in the world are estimated to be deficient in iodine, vitamin A, iron, or zinc. Common micronutrient deficiencies include: • Anemia—the condition of having a hemoglobin concentration below a specified cut-off point, which changes according to age, gender, physiological status, smoking habits, and the altitude at which the population being assessed lives. WHO defines anemia in children under 5 years old and pregnant women as a hemoglobin concentration of less than 110g/l at sea level. It is estimated that 50 percent of anemia worldwide is due to iron deficiency. Other causes of anemia include malaria and other parasitic infections; acute and chronic infections that result in inflammation and hemorrhages; deficiencies in other vitamins and minerals, especially folate, vitamin B12, and vitamin A; and genetically inherited traits, such as thalassemia. • Iron deficiency—the most common nutritional deficiency in the world, resulting from insufficient iron in the body due to inadequate consumption of bioavailable iron, blood loss, or unmet increased iron requirements due to infection, pregnancy, rapid growth, dietary habits, or any combination of these. • Iron deficiency anemia—the condition in which a deficiency in iron causes an insufficiency of healthy red blood cells. Iron deficiency and iron deficiency anemia are associated with fetal and child-growth failure, compromised cognitive development in young children, lowered physical activity and labor productivity in adults, and increased maternal morbidity and mortality. Women and young children are the most vulnerable to iron deficiency anemia, which increases the risk of hemorrhage and sepsis during childbirth, and is implicated in 20 percent

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Term	Definition
	of maternal deaths. Furthermore, children with iron deficiency anemia suffer from infections, weakened immunity, learning disabilities, impaired physical development, and in severe cases, death. • Iodine deficiency—the condition resulting when iodine intake falls below the recommended level of 100-199 µg/l, tested through median urinary iodine concentration. • Iodine deficiency disorders—the consequences of iodine deficiency in a population that can be prevented by ensuring that the population has an adequate intake of iodine. Iodine deficiency disorders can affect children at any stage of rapid growth, with the greatest negative effect on cognitive development occurring during pregnancy. Symptoms range from mild impairment of brain development and subtle degrees of brain damage, goiter, hypothyroidism, reproductive disorders (spontaneous abortion, stillbirth, congenital abnormalities, and perinatal mortality) to its most severe form, cretinism. Iodine deficiency is the primary cause of preventable mental retardation and brain damage in the world. • Vitamin A deficiency—the condition resulting when vitamin A intake falls below recommended levels. Vitamin A deficiency may be exacerbated by high rates of infection and greatly increases the risk that a child may die from diseases such as measles, diarrhea, and acute respiratory infections. It is the leading cause of childhood blindness. Vitamin A deficiency compromises the immune systems of approximately 40 percent of the developing world's children under 5 years old and leads to the deaths of as many as one million young children each year. • Zinc deficiency—the condition resulting when zinc intake falls below recommended levels. Zinc deficiency is associated with growth retardation, malabsorption syndromes, fetal loss, neonatal death, and congenital abnormalities. Zinc supplementation reduces the duration and intensity of diarrheal illnesses and reduces clinical disease caused by acute respiratory infections and malaria.
Nutrition education	Encompasses a wide range of efforts to improve nutrition outcomes by changing nutrition practices, including one-to-one counseling and BCC, and leverages available communications channels including information and education communication, social media, and community-level education and mobilization.
Nutrition security	The ongoing access to a balanced diet, adequate care and feeding practices, a safe and clean environment, clean water, and adequate health care (both preventive and curative) for all people, and the knowledge needed to care for and ensure a healthy and active life for all household members.
Nutrition-sensitive	Interventions that address the underlying and basic determinants of maternal, fetal, and child nutrition and development, including food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment, and incorporate specific nutrition goals and actions. Nutrition-sensitive programs can serve as delivery platforms for nutrition-specific interventions, potentially increasing their scale, coverage, and effectiveness. Examples include programs for agriculture and food security; SSNs; early childhood development; maternal mental health; women's empowerment; child protection; schooling; WASH; and health and family planning services.[b]
Nutrition-specific	Interventions that have an immediate and direct impact on maternal, fetal, and child nutrition and development, including adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases. Examples include adolescent, preconception, and maternal health and nutrition; maternal dietary or micronutrient supplementation; promotion of optimum breastfeeding; complementary feeding and responsive feeding practices and stimulation; dietary supplementation; diversification and micronutrient supplementation or fortification for children; treatment of SAM; disease prevention and management; and nutrition in emergencies.[b]
Oral rehydration therapy	A type of fluid replacement used to prevent or treat dehydration, especially that due to diarrhea, which is defined as the passage of three or more loose or liquid stools per day or more frequently than is normal for the individual. Diarrhea is usually a symptom of gastrointestinal infection, which can be caused by a variety of viral and parasitic organisms. Severe diarrhea leads to fluid loss and plays a particularly

table continues next page

Term	Definition
	important role in nutrition and growth faltering, because it can lead to malabsorption of nutrients and appetite suppression. The adjusted odds of stunting at 24 months old increases by 5 percent with each episode of diarrhea in the first 24 months of life. An oral rehydration solution is a liquid electrolyte solution that is used for the management of diarrhea among children. It is typically distributed in ready-to-use sachets that are added to one liter of clean water.
Psychosocial stimulation	The maternal-infant bond formed at the beginning of life is essential for cognitive, emotional, and social development later in life. Feeding and other care practices provide opportunities for psychosocial stimulation and help to establish a positive attachment between caregiver and child.
School garden	A small plot or plots within school grounds or nearby—typically managed by the schoolchildren with the help of parents, teachers and other community stakeholders—where a variety of crops are grown for the purpose of learning, recreation, and improving diets. Crops commonly include vegetables, fruits, legumes, tubers, and nonfood plants including medicinal herbs, spices, and fuel material that are grown throughout the year. Sometimes small livestock and fish are raised.
Smallholder farmer	Marginal and submarginal farm households that own or cultivate typically less than two hectares of land. Smallholder farmer households constitute a large proportion of the population in the developing world and of households living in poverty and hunger.
Specialized nutritious foods	A wide range of foods aimed at improving nutritional intake, including: • Fortified blended foods, such as corn soya blend and wheat soya blend. • Point-of-use or ready-to-eat foods, commonly lipid-based nutrient supplements, such as ready-to-use therapeutic food, which is a high-energy and protein-rich food with added electrolytes, vitamins and minerals, specifically designed to treat SAM in the rehabilitation phase, and ready-to-use supplementary food, which is a high-energy nutrition supplement particularly suited as a nutritional support in emergency situations or in the context of nutritional programs for the prevention or treatment of moderate malnutrition and deficiency-related illnesses. Typically oil- or peanut-based, ready-to-use foods do not have to be mixed with water and are microbiologically safe to enable outpatient use. • Micronutrient powders (such as multiple micronutrient powder, multiple micronutrients, and micronutrient sprinkles) which are tasteless powders that come in individual sachets containing the recommended daily intake of 16 vitamins and minerals for one person. The powders can be sprinkled into home-prepared food after cooking or just before eating. • High-energy biscuits are wheat-based biscuits that are easy to distribute and can improve the level of nutrition in the first days of an emergency when cooking facilities are scarce.
Supplementary feeding	A direct transfer of food to target households or individuals, most commonly PLW and children. The food may be prepared and eaten onsite or given as a dry ration to take home. Supplementary feeding is often provided as an incentive for participation in public services such as primary health care and education.
Undernourishment	When a person's usual daily food consumption, expressed in terms of dietary energy (kcal), is below the energy requirement norm. An undernourished person is not able to acquire enough food to meet the daily minimum dietary energy requirements.

a. WHO (World Health Organization). 2008. *Indicators for Assessing Infant and Young Child Feeding Practices*. Conclusions of a Consensus Meeting held November 6–8, 2007. Washington, DC: WHO.

b. Ruel, Marie T., Harold Alderman, and the Maternal and Child Nutrition Study Group. 2013. "Nutrition-sensitive interventions and programmes: How can they help to accelerate progress in improving maternal and child nutrition?" *Lancet* 382: 536–51.

Executive Summary

The goal of SecureNutrition is to support the efforts of World Bank Group (WBG) staff to catalyze and foster increased nutrition-sensitive investments and activities across the key conditions that lead to poor nutrition, both within WBG and among other global stakeholders. The preponderance and scale of social protection budgets globally, and the ability of social protection programs to target the most vulnerable—the poor and infants within the 1,000-day nutrition window of opportunity[1]—increase the potential for improving nutrition outcomes.

SecureNutrition developed this compendium of nutrition-sensitive social protection program case studies with funding from the Russian Federation. The compendium is intended to augment the WBG guidance[2] on improving nutrition through multisectoral approaches and to inform ongoing and future efforts to improve nutrition outcomes through investments in the social protection sector. Since the publication of WBG's "Improving Nutrition Through Multisectoral Approaches" in 2013, numerous publications from other development partners have been launched further exploring the connections between social protection and nutrition and the components (such as conditionality, targeting, payment beneficiary and frequency) that can be adapted to increase the effect on nutrition outcomes. This compendium is an attempt to get beyond the high-level mechanics of nutrition-sensitive social protection programs and explore in more detail how these programs are being implemented. It is one of a suite of knowledge products—including an evidence review, a forum report, and a seminar series—that all result from the Global Forum on Nutrition-Sensitive Social Protection Programs in Moscow in September 2015.

The nutrition-sensitive social protection programs compendium contains 21 case studies from 6 international organizations that document a range of nutrition-sensitive social protection programs being implemented in all regions of the world. They are not offered as "gold standards" for nutrition-sensitive social protection programs but are representative examples of the type of nutrition-sensitive social protection work currently being implemented. This compendium does not provide a comprehensive list of all nutrition-sensitive social protection interventions. Case studies were selected from among those submitted to provide a wide representation of social protection instruments and mechanisms for incorporating nutrition principles. The intent is to provide WBG staff and other technical practitioners involved in the design and implementation of nutrition-sensitive social protection projects information about the types of interventions being carried out, which ones work, the achievements that can be realized, and the challenges involved.

The compendium serves as a mile marker on progress to improve nutrition outcomes through social protection investments, and a rich database of strategies and approaches in diverse contexts. Institutional arrangements, achievements, and other facets encompassed in the compendium are as varied as the programs themselves. We hope that the structured format facilitates this and other analyses as needed by program designers globally. To assist compendium users in identifying the case studies most relevant to their interests and contexts, the case studies in this compendium have been tagged according to the following 18 cross-cutting themes:

- Double burden of malnutrition (DBM)
- Multisectoral collaboration
- Integrated approach
- Rural
- Resilience
- Conflict-affected setting

- Governance
- Decentralization
- Performance-based financing
- Community participation
- Agriculture and local procurement
- Urban
- Harnessing nutrition data
- Use of mobile technology
- Behavior change communication (BCC)
- Life-cycle approach
- Gender and women's empowerment
- Early child development (ECD)

Notes

1. The 1,000-day nutrition window of opportunity begins at conception and ends at 24 months.
2. World Bank. 2013. *Improving Nutrition Through Multisectoral Approaches*. Washington, DC: World Bank.

Introduction

SecureNutrition works to bridge the operational knowledge gaps between nutrition and all of its underlying drivers. SecureNutrition offers: a curated resource library; original events, blogs, and newsletters on multisectoral nutrition; forum space on LinkedIn for community notices and discussion; social media and e-mail dissemination; and a hub for reaching potential partners and related networks.

There is a globally recognized package of cost-effective nutrition-specific interventions—those that address the immediate determinants of fetal and child nutrition and development—spanning the first 1,000 days from conception through a child's first 24 months. These interventions are delivered by and large through the health sector, but also through social protection programs, and include the promotion of an adequate and diverse diet, supplementation and fortification with essential micronutrients, and management of moderate and severe acute malnutrition. However, this core package—even if scaled up to 90 percent coverage in countries with a high burden of undernutrition—would result in a decrease of only 20 percent in global stunting, which is insufficient to achieve the global nutrition targets of the Sustainable Development Goals.[1]

More can be done to improve the coverage of nutrition-specific interventions. However, to this end, the underlying factors driving nutrition outcomes—food security, care practices, the disease environment, and access to health services—must simultaneously be addressed. Because these underlying determinants of nutrition status are multisectoral—with links to agriculture, social protection, health, water, sanitation and hygiene, and education—so too must be the interventions to address them.

Social protection is inherently nutrition-sensitive to the extent it targets families at risk of malnutrition. As of the end of 2015, 1.9 billion people were enrolled in social safety net programs in 136 countries, and the share of government expenditures devoted to social protection in low- and middle-income countries relative to other sectors is growing.[2] The preponderance and scale of social protection budgets and the potential for social protection programs to target the most vulnerable—the poor and infants within the 1,000-day nutrition window of opportunity[3]—increase the potential for improving nutrition outcomes.

The pathways by which social protection programs can address the underlying determinants of malnutrition are fairly well understood.[4] Families choose whether and how to invest in health and nutrition based on their knowledge and preferences, their income, and the price of inputs into health. Health and nutrition outcomes also depend on the available resources (such as nutritious foods and health services), the level of investment (the amounts spent to purchase nutritious foods, health services, and clean water) chosen by the household, and the skills of the household in using the chosen resources. Social protection as a platform provides the opportunity to manipulate these inputs to promote improved nutrition outcomes.

About the Compendium

SecureNutrition developed this compendium of nutrition-sensitive social protection case studies with funding from the Russian Federation. The compendium is intended to augment the WBG's guidance on improving nutrition through multisectoral approaches and inform ongoing and future efforts to improve nutrition outcomes through investments in the social protection sector. Since the publication by the WBG of "Improving Nutrition Through Multisectoral Approaches" (the Guidance Notes) in 2013,[5] other development

partners have issued numerous publications further exploring the connections between social protection and nutrition and the components (such as conditionality, targeting, payment beneficiary and frequency) that can be adapted to increase the effect on nutrition outcomes. This compendium is an attempt to get beyond the high-level mechanics of nutrition-sensitive social protection programs and explore in more detail how these programs are being implemented.

This compendium contains 21 case studies from 6 international organizations that document a range of nutrition-sensitive social protection programs being implemented in all regions of the world. They are not offered as "gold standards" for nutrition-sensitive social protection programs, but are representative examples of the nutrition-sensitive social protection work currently in use. This compendium does not provide a comprehensive list of nutrition-sensitive social protection interventions. Case studies were selected from among those submitted to provide a wide representation of social protection instruments and mechanisms for incorporating nutrition principles. The intent is to provide WBG staff and other technical practitioners involved in the design and implementation of nutrition-sensitive social protection programs information about the types of interventions being carried out, which interventions work in which contexts, the achievements that can be realized, and the challenges involved. The compendium includes case studies for the following social protection instruments: CDD, cash transfers, PWP, and in-kind transfers. It may not be representative of social protection interventions being implemented generally.

The compendium was the basis for key sessions of the Global Forum on Nutrition-Sensitive Social Protection Programs in Moscow in September 2015, a conference cosponsored by SecureNutrition and the Russian Federation and attended by approximately 150 participants from more than 20 countries. The compendium and the individual case studies will be disseminated and made available on the SecureNutrition website (www.securenutrition.org), as one of a suite of knowledge products, including an evidence review and a forum report, resulting from the event. The evidence review addresses the "why" for nutrition-sensitive social protection programs; the compendium addresses the "how." The collection will be the foundation for the SecureNutrition nutrition-sensitive social protection seminar series.

Methodology

Countries and international organizations were solicited to contribute case studies to the compendium using a standard template. The case study template was designed to highlight key aspects of selected individual social protection programs, identifying their different approaches to improving nutrition and, where possible, their effects and challenges. Although compendium case studies cannot describe in detail all aspects of each program, the intent is to present sufficient information, in an organized fashion, to describe what is possible and how to achieve it. Each case study also has a corresponding two-page brief. Case studies comprise the following sections:

- ***Program overview.*** The main characteristics of the program, including country, budget, duration, target groups, number of beneficiaries targeted and reached, funding and implementing agencies, and cross-cutting themes.
- ***Context overview.*** The specific context the program has been designed to address, both the overall country setting and the nutrition situation, including the respective country context, social protection data, and nutrition and health data.
- ***Program details.*** The program's components, including costs, transfer level, denomination, frequency, and duration; in the case of public works, the main tasks and working time;

in the case of food transfers, whether food procurement relies on local producers; institutional and implementation arrangements; issues of scalability and sustainability; and community participation.

- ***Monitoring and evaluation.*** Description of how M&E is carried out and the specific indicators used, summary of key findings from available evaluation, harmonization with other programs.
- ***Nutrition-sensitive rationale.*** Description of the pathways leveraged to make the program nutrition-sensitive (whether or not explicitly designed to improve nutrition outcomes), including: promotion of income and consumption, caring and health practices and services; targeting nutritionally vulnerable populations; accommodating women's needs; and use of nutrition indicators.
- ***Accomplishments and challenges.*** In combining social protection and nutrition objectives.
- ***Further references.*** Provides links to relevant program documents or contact staff for further information on the intervention.

Out of 79 eligible case studies reviewed (35 from WBG and 44 submitted from other international organizations and governments), 21 were selected for inclusion in this compendium. For WBG case studies, the Global Forum core team first identified pipeline, active, and recently closed social protection projects that include a nutrition component. Practice Managers then applied a regional perspective to choose which projects would be included in the compendium. For non-WBG case studies, each lead international organization or government used its own processes to decide which project to submit for consideration. These submissions were screened by the Global Forum core team for concurrence with nutrition-sensitive social protection principles as described by WBG in the Guidance Notes.

Final selections were made with the intention of providing a comprehensive representation of social protection instruments and mechanisms for incorporating nutrition principles globally. In addition, the final compendium encompasses case studies for projects that were designed from the start to be nutrition-sensitive as well as those that became nutrition-sensitive over time.

Contributing authors were asked to complete information for as many template sections as possible and invited to review and provide feedback in preparation for publication. In some instances, the interpretation of "nutrition-sensitive," such as the difference between food security and nutrition security, and the appropriate indicators to measure it, were left up to the contributing author. All case studies have been published with permission.

How to Use the Compendium

The compendium of nutrition-sensitive social protection case studies catalogues work being done in all regions of the world and provides examples for practitioners and data for researchers. It serves as a mile marker for the improvement of nutrition outcomes through social protection investments and a rich database of strategies and approaches in diverse contexts. Institutional arrangements, achievements, and other facets encompassed in the compendium are as varied as the programs themselves. We hope that the structured format facilitates this and other analyses as needed by program designers globally.

To assist compendium users in identifying the case studies most relevant to their interests and contexts, the case studies in this compendium have been tagged according to the 18 cross-cutting themes. Although this list is not exhaustive, it reflects the scope of the programs described in this compendium. The cross-cutting themes are defined below. Some of this terminology is under debate, and other definitions are in use.

Cross-cutting theme	Purpose of program
DBM	Address both undernutrition and overweight and obesity
Multisectoral collaboration	Involve multiple ministries in planning and implementation
Integrated approach	Address both supply of and demand for nutrition services
Governance	Improve government ownership, engagement, and monitoring capacity
Decentralization	Address the strengths and constraints of a decentralized governance or administrative context
Performance-based financing	Tie payments to staff or beneficiaries to their achievement of agreed-upon, measurable performance targets
Community participation	Involve the community in program implementation
Agriculture and local procurement	Purchase food for the program from local farmers and retailers
Urban	Address the strengths and constraints of an urban context
Rural	Address the strengths and constraints of a rural context
Resilience	Improve the ability to resist, absorb, accommodate, and recover from the effects of economic, natural disaster, or other shocks
Conflict-affected setting	Address the strengths and constraints of conflict-affected settings
Harnessing nutrition data	Use nutrition data collected to inform the program and improve the effect on nutrition outcomes
Use of mobile technology	Leverage the use of mobile phones for data collection or BCC
BCC[6]	Improve nutrition outcomes by changing nutrition practices through, for example, education, counseling, and social media
Life-cycle approach	Address all stages of the nutrition life cycle, including adolescence and the first 1,000 days from conception to 24 months
Gender and women's empowerment	Improve women's sense of self-worth, ability to have and make choices, access to opportunities and resources, control of their own lives, and ability to influence social change
ECD	Improve young children's capacity to develop and learn, including physical, cognitive, and emotional growth

Overview of Case Studies

Social protection instruments. (See *Case Studies by Social Protection Instrument* below.) Of the 21 case studies included in the compendium, over half (13) include some form of cash transfer, either conditional (7) or unconditional (6). The Guidance Notes emphasize conditional cash transfers, but case studies indicate widespread use of UCTs. Several case studies encompass multiple social protection instruments. Four case studies are public works programs (mostly cash for work), which are often paired with a UCT component. Of the remaining case studies, four are food voucher–food transfer (in-kind transfer) programs; three are school feeding (in-kind transfer) programs; and one is a community-driven development program. In addition, six programs incorporate food or nutrition supplementation. Most of the case studies are from Africa (8) and Latin America and the Caribbean (5), although all world regions are represented.

Cross-cutting themes. (See *Case Studies by Cross-Cutting Theme* below.) Analysis of the case studies resulted in identification of 18 cross-cutting themes. The most common were BCC (18), community participation (17), gender and women's empowerment (17), and multisectoral collaboration (16). Other common themes were integrated approaches (10), lifecycle approaches (8), early child development (8), rural (8), governance (7), resilience (6), agriculture and local procurement (5), and use of mobile technology (5). Less common themes were harnessing nutrition data (4), DBM (3), decentralization (3), performance-based financing (3), urban (3), and conflict-affected settings (2).

Case study nutrition activities can be benchmarked against the programming principles and objectives outlined in the 2013 Guidance Notes, which highlight three pathways to improving nutrition through social protection investments: (1) income; (2) links with health and sanitation services (such as micronutrient supplements, nutritional counseling, health and hygiene education, and health and sanitation services); and (3) targeting of social protection intervention beneficiaries. Within these pathways, the "Guidance Notes"—referred to on page 3, bottom—"recommend" the following objectives:

- Target the most nutritionally vulnerable populations;
- Include education activities within social protection interventions to increase household awareness of care giving and health-seeking behaviors;
- Integrate nutrition services into social protection interventions; and
- Reduce the acute and long-term negative financial effects of external financial, price, and weather shocks by scaling up programs in times of crisis.

Although the common cross-cutting themes may, in part, reflect the selection criteria, they may also serve as evidence that World Bank Groups (WBG) and other international organizations and governments are absorbing guidance and putting into practice "what works." Less common themes may reflect emerging issues or areas that are more exploratory, or where more experience and research is needed. Also notable is that the majority of case studies address seven or more themes, which indicates that (1) social protection instruments are being leveraged to address many issues related to nutrition and, conversely, (2) those same issues can be addressed using different social protection instruments.

Below we summarize the Nutrition-Sensitive Rationale section across all 21 case studies to assess what can be said now about the state of nutrition-sensitive social protection programs. The Nutrition-Sensitive Rationale section contains the following components: promotes

income and/or consumption; promotes caring and health practices and/or services; targets nutritionally vulnerable populations; accommodates women's needs; has nutrition indicators; and other aspects. In addition, we summarize shared challenges across case studies and reflect on the current operational research and knowledge gaps.

Nutrition-Sensitive Rationale

Promotes income and/or consumption. The Guidance Notes indicate that focusing a program on income and/or consumption can affect nutrition through design choices on size, frequency, control, and nature (in-kind versus cash). Almost all programs in this compendium disburse transfers directly to women, and some go further to address intrahousehold dynamics—such as through postdistribution monitoring or training—acknowledging that even if the benefit is disbursed to a woman she may not retain control over it in the family context. Also included in this compendium are examples of programs that align transfers with agricultural lean seasons, provide small yet regular and predictable payments over a relatively long period of time, and determine transfer amount based on the cost of a nutritious diet. Additional examples demonstrate efforts to provide more nutrient-dense foods (such as pulses in addition to grains), earmark vouchers for fresh food purchases, and provide fortified foods to children. School feeding programs in DBM contexts focus on reducing sugar, sodium, and fat and are being used everywhere as a platform to provide more nutritious fresh foods. Several programs include a microfinance component or otherwise focus on savings and banking to increase income.

Promotes caring and health practices and/or services. The Guidance Notes indicate that linking social protection programs with health and social services can affect nutrition through the use of conditions (hard or soft) and by promoting access, thus enhancing both the demand for and the supply of services. Programs in the compendium are leveraging hard and soft conditions to promote demand for and use of health and/or nutrition services and, in some cases, enrollment and registration of newborns. Nutrition counseling is highlighted as an important component in the Guidance Notes and is a major component in most case studies. Almost across the board and for all social protection instruments there is some focus on nutrition education and behavior change, including growth monitoring and promotion, nutrition workshops, and other interventions.

Efforts around nutrition education and BCC cover many of the factors driving malnutrition beyond infant and young child feeding, including WASH, preventive care, ANC, child psychosocial stimulation, schooling, and other parenting practices. BCC is delivered not only to beneficiaries and caregivers but also in many cases to the entire community. Supply-side improvements such as training in nutrition best practices, counseling for health workers, and provision of nutrition-related equipment is also common. Public works programs provide special arrangements for PLW to ensure they have "light" labor options and child care. Programs highlight the importance of community engagement and social inclusion, especially for provision of nutrition counseling.

Although the Guidance Notes emphasize that the impact of school feeding programs on nutrition is indirect—they do not target the most vulnerable first 1,000 days—they offer strategies for making school feeding programs more nutrition-sensitive. The school feeding programs in this compendium have put into practice many of these approaches, functioning as comprehensive nutrition platforms that emphasize nutrition education and gardening. Most of the school feeding programs in this compendium also emphasize local procurement

for school feeding and other in-kind programs as a means of directly improving nutrition through provision of nutrient-dense foods while simultaneously improving nutrition indirectly through increased income to vulnerable rural farmers.

Targets nutritionally vulnerable populations. The Guidance Notes indicate that the targeting of income, nutritional status, or age group can affect nutrition. All of the case studies in this compendium focus on the first 1,000 days. Many programs use multilevel targeting and community verification, and some incorporate rates of undernutrition into geographic targeting criteria. Universal school feeding is being used as a strategy for reaching adolescent girls with nutrition services and education.

Accommodates women's needs. Programs use numerous strategies to overcome barriers to women's participation in social protection programs. Many programs employ strategies to reduce the time burden of collecting transfers, such as through the use of electronic vouchers or mobile payments and local banks, and reducing the frequency of transfers (for example, from monthly to bimonthly). Some programs account for women's special needs as primary caregivers in the timing of accompanying measures and public works activities and in allowing flexible work hours, including breaks for breastfeeding. Public works programs offer lighter tasks and provision of daycare. Many programs explicitly engage women in planning and management and provide support to community women's groups (such as MMSGs) and gender-sensitivity training to staff and beneficiaries.

Has nutrition indicators. The Guidance Notes highlight the importance of including nutrition indicators and ensuring that they are the most appropriate indicators for nutrition (for example, dietary diversity at the individual level instead of at the household level). Most of the programs in this compendium use nutrition or proxy nutrition indicators, but a few do not. Indicators used include: anthropometrics (measurements of stunting, low birth weight, acute malnutrition, underweight children under age five, women's underweight); biometrics (such as the prevalence of anemia); dietary diversity (individual dietary diversity for women, Minimal Acceptable Diet (MAD) for children); nutritional quality of school meals compared to national guidelines and recommendations; participation in program health and nutrition activities and service provision (e.g. vaccinations, ANC, assisted delivery, postnatal care, iron folate provision, growth monitoring and promotion, vitamin A supplementation (VAS), and supplementary feeding); nutrition knowledge, attitudes, and practices (measuring nutrition behaviors such as rates of exclusive breastfeeding, hand-washing, and diarrhea treated with an oral rehydration solution (ORS)); and nutrition mass media coverage. Other indicators cited that may be less relevant to nutrition outcomes include the HDDS and food consumption score and process indicators such as the proportion of beneficiaries who know their program rights and responsibilities.

The Guidance Notes also highlight the importance of M&E for continuous program improvement. Many of the programs in this compendium place strong emphasis on a learning agenda. Several are designed as randomized controlled trials, include impact evaluations, or use ongoing M&E to drive quality improvement.

Other aspects. Nearly all of the projects featured in the compendium highlight strong government leadership, and explicit efforts to facilitate multisectoral coordination, and the building of partnerships among government ministries and agencies and civil society. Other strategies employed by programs for improving nutrition outcomes include efforts to build resilience and community engagement and addressing decentralized systems through the use of localized school menus and local procurement.

Challenges. Many of the challenges cited in the case studies are common across social protection instruments and regions. Chief among them are financial sustainability, multisectoral

coordination at the federal and decentralized levels, translating high-level engagement into effective operations, maintaining the quality of services provided, effective scale up (and down), limited technical capacity, high turn-over of and reliance on volunteers for BCC, poor infrastructure (such as telecommunications networks), cost-effective delivery through government systems (especially BCC), reaching the last mile (such as indigenous populations in remote areas), and timeliness of data collection.

Operational research and knowledge gaps. The Guidance Notes highlight the following operational research and knowledge gaps: evaluating costs; results-based incentives; assessing the impact of different sizes of income transfers; improving targeting mechanisms and systems; assessing the impact of supplementation or fortification within homegrown school feeding; assessment of school feeding as a platform for obesity prevention; and assessment of microfinance for nutrition. With the compendium we see progress on some of these items while others, such as evaluating cost-effectiveness or use of results-based incentives, seem underexplored. Additionally, the Guidance Notes include the use of insurance as a potential social protection instrument that can be leveraged for improving nutrition outcomes; there are no examples of this instrument in the compendium. There is also relatively little focus on mass media for behavior change. Finally, with the exception of school feeding programs that include adolescents in nutritional supplementation and education, there are no case studies in the compendium of programs explicitly directed to adolescent girls. This stands in stark contrast to the explicit emphasis on adolescent girls in Sustainable Development Goal 2.2[7] and is a major gap warranting immediate attention.

Notes

1. Bhutta, Z. A., J. K. Das, A. Rizvi, M. F. Gaffey, N. Walker, S. Horton, P. Webb, A. Lartey, R. E. Black. 2013. "Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done and at What Cost?" *Lancet* 382 (9890): 452–77.
2. Alderman, Harold. 2016. "Leveraging Social Protection Programs for Improved Nutrition: Summary of Evidence Prepared for the Global Forum on Nutrition-Sensitive Social Protection Programs, 2015." World Bank, Washington, DC.
3. The 1,000-day window of opportunity begins at conception and ends at 24 months.
4. The UNICEF conceptual framework identifies three underlying determinants of nutrition outcomes: food security, care practices, and the disease environment and access to health services.
5. World Bank. 2013. Improving Nutrition Through Multisectoral Approaches. Washington, DC: World Bank.
6. Also referred to as social and behavior change communication
7. "By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons." (https://sustainabledevelopment.un.org)

Case Studies, by Social Protection Instrument

Country	Community driven development	Cash transfer		Public Works Program	In-kind transfer			Food or nutrition supplement
					Food voucher or transfer		School feeding	
		Cond.	Uncond.		Cond.	Uncond.		
Africa								
Cabo Verde							X	
Congo, Rep.					X			X
Ethiopia			X	X		X		
Kenya			X					X
Mali			X					
Niger			X	X				
Nigeria			X					
Tanzania		X		X				
East Asia & Pacific								
Indonesia PKH Prestasi		X						
Indonesia PNPM Generasi	X							
Myanmar			X					
Philippines		X						
Europe & Central Asia								
Kyrgyz Republic							X	
Latin America & the Caribbean								
Brazil							X	
Dominican Republic		X						X
Haiti						X		X
Mexico		X						X
Peru		X						
Middle East & North Africa								
Djibouti				X				X
Syrian Arab Republic						X		
South Asia								
Bangladesh		X						

Note: In the context of nutrition-sensitive social protection, unconditional almost always involves soft conditions (AMs) that encourage beneficiaries to make investments in health, education, and skills development. Most nutrition-sensitive social protection programs lie on a continuum between strictly conditional and unconditional.

Case Studies, by Cross-Cutting Theme

Country	DBM	Multi. Coll.	Integr. Appr.	Gov.	Decent.	PBF	Comm. Part.	Agri./ Local Proc.	Urban	Rural	Resil.	Confl. Aff. Setting	Harn. Nutr. Data	Mobile Tech.	BCC	Lifecyc. Appr.	Gen./ Wom. Emp.	ECD
Africa																		
Cabo Verde	X	X	X	X			X	X							X		X	
Congo, Rep.	X		X						X		X		X	X	X		X	
Ethiopia		X	X				X			X	X				X		X	
Kenya														X	X			
Mali		X					X		X	X	X				X			
Niger							X			X	X				X		X	X
Nigeria		X					X			X	X			X	X		X	
Tanzania			X				X								X		X	
East Asia & Pacific																		
Indonesia PKH Prestasi		X	X				X	X						X	X	X	X	X
Indonesia PNPM Generasi		X	X	X	X	X	X			X							X	
Myanmar		X					X			X	X	X			X	X	X	X
Philippines															X		X	X
Europe & Central Asia																		
Kyrgyz Republic		X		X			X								X		X	
Latin America & the Caribbean																		
Brazil	X	X	X	X	X		X	X										
Dominican Republic		X	X	X			X								X	X		X
Haiti		X		X			X	X	X	X			X	X	X	X	X	
Mexico		X	X				X								X	X	X	X
Peru		X	X	X		X	X			X			X		X	X	X	
Middle East & North Africa																		
Djibouti		X				X	X						X		X		X	X
Syrian Arab Republic		X					X	X				X			X	X	X	
South Asia																		
Bangladesh		X			X											X	X	X

Code	Cross-cutting theme	Purpose of program
DBM	Double Burden of Malnutrition	Address both undernutrition and overweight and obesity
Multi. Coll.	Multisectoral collaboration	Involve multiple ministries in planning and implementation
Integr. Appr.	Integrated approach	Address both supply of and demand for nutrition services
Gov.	Governance	Improve government ownership, engagement, and monitoring capacity
Decent.	Decentralization	Address the strengths and constraints of a decentralized governance or administrative context
PBF	Performance-based financing	Tie payments to staff or beneficiaries to their achievement of agreed-upon, measurable performance targets
Comm. Part.	Community participation	Involve the community in program implementation
Agri./Local Proc.	Agriculture and local procurement	Purchase food for the program from local farmers or retailers or otherwise linking with agriculture
Urban	Urban	Address the strengths and constraints of an urban context
Rural	Rural	Address the strengths and constraints of a rural context
Resil.	Resilience	Improve the ability to resist, absorb, accommodate, and recover from the effects of economic, natural disaster, or other shocks, including linkages with humanitarian assistance
Confl. Aff. Setting	Conflict-affected setting	Address the strengths and constraints of conflict-affected settings, including linkages with humanitarian assistance
Harn. Nutr. Data	Harnessing nutrition data	Use nutrition data collected to inform the program and improve the effect on nutrition outcomes
Mobile Tech.	Use of mobile technology	Leverage the use of mobile phones for data collection or BCC
BCC	Behavior Change Communication	Improve nutrition outcomes by changing nutrition practices through, for example, education, counseling, and social media
Lifecyc. Appr.	Life-cycle approach	Address all stages of the nutrition lifecycle, including adolescence and the first 1,000 days from conception to 24 months old
Gen./Wom.Emp.	Gender and women's empowerment	Improve women's sense of self-worth, ability to have and make choices, access to opportunities and resources, control of their own lives, and ability to influence social change
ECD	Early Child Development	Improve young children's capacity to develop and learn, including physical, cognitive, and emotional growth

Case Studies

Africa

Cabo Verde – National School Food and Nutrition Programme

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Felisberto Moreira, President of Cape Verdean Foundation for Social Action in Schools (FICASE)[a] João Semedo, Director of the National School Food and Nutrition Programme[a] Charlotte Dufour, Nutrition Policy and Programme Officer, Nutrition Division[b]
ORGANIZATION	[a]Government of Cabo Verde [b]Food and Agriculture Organization of the United Nations (FAO)
ROLE IN THE PROGRAM	[b]Technical assistance to the program design, implementation and monitoring

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	National School Food and Nutrition Programme
2. COUNTRY	Cabo Verde
3. TYPE OF PROGRAM	In-kind transfer (school feeding)
4. PROGRAM DURATION	2010 to present (Government of Cabo Verde) 1979 to 2010 World Food Programme
5. PROGRAM OBJECTIVE(S)	Encourage school attendance, improve food security, and provide a safety net to poor families. The program aims to provide every pre-primary and primary school child with "one hot meal per day". The objectives are currently being reviewed, with greater emphasis on nutrition, improving the diversity and quality of the food ration, while promoting local agriculture and enhancing nutrition education.
6. FUNDING AGENCY/IES	Government of Cabo Verde FICASE: 65 percent External donors (in-kind food donations): 20 percent Parents: 5 percent Ministry of Education and Sports (district-level staff salaries): 4 percent UN Joint Program Support to Food and Nutrition Security in Schools financed by the Luxembourg Development Cooperation: (technical assistance and piloting of diversifying school meals through local procurement)
7. IMPLEMENTING AGENCY/IES	FICASE and Ministry of Education (responsible institutions), with key partners: Ministry of Health, Ministry of Rural Development UN Joint Program Support to Food and Nutrition Security in Schools (FAO, World Food Programme, WHO, UNICEF) financed by the Luxembourg Development Cooperation Local farmers, cooperatives, and traders
8. TOTAL COST	$5,149,684 (CVEsc 489,200,000)

PROGRAM OVERVIEW		
9. TARGET GROUP(S)	All children in public preprimary and primary school, that is, nationwide blanket coverage. Approximately 80 percent are in public primary schools, and 20 percent are in public preprimary schools. Additional beneficiaries include poor women unlikely to obtain any other formal employment who will be trained and paid as cooks, local farmers from whom food will be procured, and traders.	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	90,000 children 1,078 cooks	
11. NUMBER OF REACHED BENEFICIARIES	*As of 2014–15:* 90,000 children	
12. PROGRAM CROSS-CUTTING THEMES	☒ Double burden of malnutrition (DBM) ☒ Multisectoral collaboration ☒ Integrated approach ☒ Governance ☐ Decentralization ☐ Performance-based financing ☒ Community participation ☒ Agriculture and local procurement ☐ Urban	☐ Rural ☐ Resilience ☐ Conflict-affected setting ☐ Harnessing nutrition data ☐ Use of mobile technology ☒ Behavior change communication (BCC) ☐ Life-cycle approach ☒ Gender and women's empowerment ☐ Early child development (ECD)

CONTEXT OVERVIEW	
1. CONTEXT	Cabo Verde is a state composed of 10 arid islands in the Atlantic Ocean off the coast of Senegal. When the school feeding program was initially launched in 1979 with the support of the World Food Programme, the country was facing extensive drought, malnutrition, and mass emigration. The initial objectives were to reduce food insecurity and poverty and encourage school enrollment and attendance. The program was operated with World Food Programme financial and technical assistance until 2010, when, after a transition phase, the government took over its management and funding. Since then, the government has been exploring how to expand the program, in particular for the prevention of noncommunicable disease, which has become a government priority. The government is establishing pilot programs to improve the nutritional composition of the food ration by diversifying it with fresh produce and improving the quality of health and nutrition education in schools.
2. COUNTRY INCOME LEVEL	Lower-middle-income
3. KEY CONTEXT DATA	<u>2009 data:</u> Gross domestic product (GDP) growth: –1.3 percent <u>2007 data:</u> • GDP growth: 15.2 percent • Gini index: 47.2 (World Bank Group [WBG] estimate) • Poverty rate (at national poverty lines): 26.6 percent • Poverty rate, rural (at national poverty lines): 44.3 percent • Poverty headcount ratio at $1.90 a day (2011 PPP): 17.6 percent of population • Share of population with access to improved sanitation facilities: 58 percent *World Development Indicators*

CONTEXT OVERVIEW	
4. KEY SOCIAL PROTECTION DATA	2011 data: • Public spending on social assistance programs, percent of GDP: 0.9 percent 2007 data: • Coverage of Social safety nets (SSNs) in total of population: 21.9 percent • Coverage of SSNs in extreme poor: 27.4 percent • Adequacy of benefits of SSNs in total population: 7.1 percent • Adequacy of benefits of SSNs in extreme poor: 19.1 percent • Incidence of benefits of SSNs in extreme poor: 12.7 percent • Incidence of beneficiaries of SSNs in extreme poor: 20.4 percent *ASPIRE database*
5. NUTRITION CONTEXT	The program has been reviewed to address current challenges such as the nutrition transition and the epidemiological transition. In addition to infectious diseases, the prevalence of chronic noncommunicable diseases associated with unhealthy lifestyles is increasing. In this context, promoting healthy eating habits by providing a balanced meal and through nutrition education have become priorities of the National School Nutrition Program.
6. KEY NUTRITION DATA	2009 data[a]: Children under 5 years old suffering from • Chronic undernourishment: 9.7 percent • Overweight: 5 percent • Anemia: 45 percent 2007 data[b]: • Average consumption of fruits: 3.3 days per week; • Average consumption of vegetables: 3.7 days per week • Risk of heart disease: medium for 85 percent of adults 25–64 years old 2011 data[c]: • Prevalence of undernourishment**:** 12 percent of population [a] *Inquest for the Prevalence of Anemia and Associated Factors in Children under 10 Years* [b] *Inquérito das Doenças Não Transmissíveis* [c] *WDI*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**School canteen supply.** Provision of one hot meal per day and diversification of the school menu with local products; creation of economic opportunities for producers, including design of a diversified school menu, and identification and testing of different supply models as a support for decision making. **Food and nutrition education.** Improve the knowledge of nutrition and hygiene, and skills for its use, of pupils, teachers, and school canteen managers in kindergartens and primary schools, including integration of food and nutrition education into the school curriculum, promotion of practical tools such as school gardens, and raising awareness of healthful diets. **School canteen management.** Improve the management and the quality of services provided by canteens in kindergartens and primary schools, including improvement of kitchen infrastructures and equipment, development of a set of rule and standards for hygiene and food handling in school canteens, and testing the catering model.

PROGRAM DETAILS	
	A cross-cutting component is the management of the National School Meals Program, including planning, funding, partnerships, coordination, monitoring and evaluation, and communication.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	One diversified meal is valued at CVEsc 44 ($0.44). Because space in schools is limited, primary schools run in two shifts: from 8:00 a.m.–12:30 p.m. and from 1:00 p.m.–5:30 p.m. During the first shift, meals are distributed at about 10:30 a.m., and during the second shift, meals are distributed at about 3:00 p.m. When available, through in-kind donations from a donor, a glass of milk is served at the beginning of the school day at 8:30 a.m. for breakfast and at the beginning of the afternoon shift at 1:30 p.m. Donations of powdered milk from Switzerland have for the past decade made it possible for nearly all children to regularly receive milk. The main food commodities are provided centrally by FICASE and include rice, pasta, oil (sometimes vegetable, but mainly soya) and pulses. Since the withdrawal of World Food Programme assistance, some donors have provided in-kind contributions to complement the ration such as sugar, wheat flour, and milk. With the exception of the milk from Switzerland, the scale and nature of donations have been variable, and unpredictable. Finally, schools are expected to diversify the ration with local produce, bought using a parental contribution of CVEsc 50 ($0.63) or, in some municipalities, CVEsc 75 ($0.95) per month. The menu for school meals is provided by the government and is designed to vary daily throughout the week.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The value of the transfer is determined by the nutritional content of the food ration, which is designed to cover a minimum of 20 percent of the recommended nutrient intake for children 6–12 years old. The main ration is composed of staple commodities (cereals, legumes, and oil) and efforts are being made to diversify the ration with fresh fruits, vegetables, and fish. In practice, though, insufficient funding prevents the purchase of the complementary commodities such as fruit, meat, fish, and even vegetables. This challenge has been addressed through the pilot program, which diversifies school meals with locally procured commodities. The government is now seeking ways to scale up this pilot program.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Cabo Verde is an island state with arid agro-ecological conditions that imports most of its food, including the bulk of the school meal ration. Since 2010, the government has been seeking ways to maximize investment in the local economy and to support domestic agricultural production by purchasing more food items locally, with a focus on diversifying the ration with fresh produce such as fruits, vegetables, fish, and beans. The government is investing in irrigation and focusing agricultural development on the production of high value crops, such as fruits, vegetables, and beans. During the 2012–13 and 2013–14 school years, FICASE started to examine several models of local procurement of fruits, vegetables, beans, and fish, with technical assistance by the United Nations Joint Program on Food Security and Nutrition in Schools. A total of 8,942 schoolchildren in primary schools benefitted from this initiative, and the experience proved it is possible to supply canteens with locally produced fresh foods.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Linked to enrollment and attendance.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.

PROGRAM DETAILS	
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	*An analysis of costs by category conducted in 2013 (prior to the pilot project to diversify school meals through local procurement) showed: Food purchase: 43 percent; Management in FICASE and management at decentralized and school levels): 26 percent; Food preparation and handling (including cooks' salaries, gas, electricity, and hygiene-related costs): 23 percent; Logistics (including first-level storage, transport to decentralized storage facilities; second-level storage facilities and transport to schools): 7 percent.* *Based on the pilot project, which provided diversified school meals with locally procured food, it was estimated that food handling and management costs would increase, and that the cost of food procurement would increase by about 20 percent. But these costs vary according to islands and schools depending on proximity of supply and logistical constraints. Additional analyses are being conducted and models developed to try to obtain more precise estimates and define a scaling up strategy that would limit additional costs.*
9. INSTITUTIONAL ARRANGEMENTS	FICASE is responsible for the implementation of the program. The menu is designed by a government nutritionist in collaboration with nutritionists from local health delegations. A purchase plan is then defined and suppliers are selected by public tender or local partnerships. The nonperishable food and goods are stored in FICASE's storehouses and distributed to the regional and municipal levels before it is distributed to schools. Local supplies of fresh products are delivered directly to schools after a quality-control check. FICASE, the Ministry of Education and the Ministry of Health (MOH) cooperate with respect to nutrition education, school health, and monitoring. The School Feeding and Health law of May 2015 formalizes the institutional cooperation between these sectors in the implementation of the program. The Ministry of Rural Development, the Institute for the Development of Fisheries, and their municipal delegations provide specific support to producers and fishermen involved in local supply tests and for the quality control of the products, among others. Most municipalities provide support for logistics and transport of the goods. Other partners are involved for specific activities, such as the Food and Drugs Regulating, and the Public Purchase Regulating Agency.
10. COMMUNITY PARTICIPATION	The program was designed and is implemented through a collaborative process involving all stakeholders at national, regional (island), and council levels. The pilots for procuring local fresh produce, for example, were designed through regional consultations with government officials from the Ministries of Education, Agriculture and Rural Development, and Health, the national procurement authority, the food safety authority, producer organizations, and traders. Awareness activities and training on healthful diets and hygiene are carried out with the entire school community (students, teachers, and cooks), as well as with street vendors in front of schools. A hands-on and practical approach is encouraged (for example, learning how to cook a dish made of local vegetables using every part of the plant). Broad awareness campaigns ("Five Keys for Safer Food" and the importance of drinking water) are also being implemented, targeting the whole community.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The program has already been implemented at scale for primary schools through grade 6. There are ongoing discussions on scaling it up to grades 7 and 8.

PROGRAM DETAILS	
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	**Legal and political framework**: A School Feeding and Health Law enacted by the government in May 2015 defines the objectives and principles of school feeding and school health and establishes the responsibilities of the actors involved and the mechanisms for intersectoral coordination. **Funding**: The law stipulates that the program be financed by annual allocations from the state budget, but improving the quality of the program will require new funding sources. Program stakeholders are developing a strategy to mobilize resources from the private sector for the FICASE, and other options are being discussed, such as increasing parental contributions, which are currently mostly symbolic. **Capacity development of national institutions:** Development of the technical aspects, program management, implementation, and monitoring is being carried out with support from the UN Joint Program Support to Food and Nutrition Security in Schools.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	FICASE, Ministry of Education delegates, and school staff regularly monitor of the program, focusing on tracking goods and ensuring that menus are complied with. Parent-teacher groups and school councils are participating in the monitoring. FICASE is currently reviewing the entire monitoring system to enhance its effectiveness and comprehensiveness and to develop a mobile application.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	No formal impact evaluations have been carried out since the transition of the program to the government. An evaluation will be part of the improvement of the Monitoring & Evaluation (M&E) system, which is underway. Regular consultations with stakeholders and field visits by FICASE and the UN Joint Program team have provided insights into the program's positive effects.
3. OUTCOME/IMPACT INDICATORS	The M&E system that is under development will include a broad range of impact, outcome, and process indicators, designed to track the following effects: **Nutritional impacts—**food consumption of children; nutritional status (including micronutrient deficiencies); Household (HH) consumption of fresh produce; and dietary diversity. Nutrition-related outcomes and processes will include quality of meals and food preparation in schools (diversity and safety); improved hygiene conditions in schools; and improved nutrition knowledge among school children, their families, and the school staff. **Impact of local procurement—**contracting and employment opportunities for local producers and traders; income generated through local procurement; enhanced quality of production; and increased production of specific goods.
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	The monitoring visits and regular consultations with stakeholders regarding the pilot program for diversifying school meals with local produce reveal that children and their families are very satisfied with the improved quality of the meals. Cooks and school staff appreciate having improved knowledge about nutrition, food preparation, and hygiene. Teachers appreciate learning more about nutrition and using school gardens to support educational activities. Local producers and traders have also greatly benefitted from the program. It has provided them with incentives to increase the quality of their produce. FICASE worked with the food safety authority to define for the first time food quality standards for fresh fruits and vegetables. The standards are now used for schools and as a national reference. Producers and traders also explained that the security and visibility offered by the existence of a contract with the state empowered them to make investments they would not otherwise have made, to obtain loans from banks, and to employ more staff (Bigaud, 2014). The experience has been so positive that the government is exploring ways to scale up the initiative in the upcoming school year.
5. HARMONIZATION WITH OTHER PROGRAMS	The program is closely aligned with the National Nutrition Program, the National Food Security Plan, and National Growth and Poverty Reduction Plan.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The program promotes nutrition through the provision of diversified school meals (for current consumption and to shape future healthful eating habits) and through nutrition education in schools and the community. The school meal is an in-kind transfer that can reduce households' expenses on food; create income for farmers and traders involved in local procurement; and create income through employment of school cooks, who are primarily women.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The school nutrition program includes the integration of nutrition education into the school curriculum and the use of school gardens for educational purposes. Nutrition education is integrated into the teacher-training program. Nutrition education and courses on healthful food preparation is also provided to cooks. The schools are used as entry points for broader education on nutrition in local communities.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The program provides universal coverage of primary school children. The logic for targeting is part of a life-cycle approach: healthful eating habits in school not only enhance the learning capabilities of school-age children but also contribute to better eating habits in adolescence and later life, helping prevent the intergenerational cycle of malnutrition.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	The provision of school meals can reduce women's workload of food preparation at home. The school cooks are vulnerable women whose jobs represent an important source of income.
5. THE PROGRAM HAS NUTRITION INDICATORS	The M&E system is currently under development but should include indicators of diet for school children and their families, as well as selected nutritional outcomes, such as stunting.
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	Strong multisectoral coordination involving public and private stakeholders working in agriculture, health, and education makes the program nutrition-sensitive. The effective collaboration between these stakeholders creates incentives for the production and consumption of healthful diets.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The program represents a best practice because it encompasses all the following: provision of school meals; diversification with fresh foods; local procurement; nutrition education for students, teachers, cooks, street vendors, and communities; and improvement of school cooking and food-handling capacities and facilities. Furthermore, the genuine involvement of a broad range of government, civil society, and private stakeholders and active consultation processes are best practices of coordination.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	• Maintaining universal coverage of school meals after the cessation of financial support from World Food Programme • Developing innovative means of diversifying school meals with local fresh produce • Integrating nutrition education into the school curriculum and teacher training • Developing an integrated approach to school nutrition, embedded in law • A multisectoral approach with strong participation from all stakeholders—government, civil society, and the private sector—at all levels These achievements have been made possible through exemplary political commitment in the Ministries of Education, Rural Development, and Health, and exemplary citizen commitment among school staff and local communities. It is also notable that the program has been successful in achieving the objectives that had been set out in the 1970s, 1980s, and 1990s, of promoting school attendance and reducing poverty. School attendance in Cabo Verde is now universal, and the country achieved middle-income status in 2008. Many Cabo Verdeans attest that the National School Nutrition Program has been an important factor contributing to these positive developments—the population's high level of education has indeed had many positive spin-offs for economic development.

2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The major challenge that now faces the government of Cabo Verde, and FICASE in particular, is how to reconcile the growing demands on the program with financial imperatives and issues of economic sustainability, particularly recent economic downturns. The diversified ration will cost about 20 percent more than the current ration, and a way must be found to finance improvements in the nutritional quality of the meals. Several means can be used to keep the financial requirements of a school feeding program manageable: maximizing the managerial efficiency of the program (reducing operating costs by optimizing management and logistics and reducing staff requirements); adjusting the quality of the ration and the type of preparation (by limiting the program to staples and providing fortified biscuits rather than cooked meals); adjusting the coverage; and introducing cost-recovery mechanisms. However, these actions must be weighed against the important benefits the program has on the local economy through employment and purchasing local produce; the population's nutrition through providing healthy meals and shaping healthy eating habits; and contributing to social cohesion. The government's political commitment to the school nutrition program shows that it is determined to find solutions to these challenges.

FURTHER REFERENCES	
1. DOCUMENTS	*Bigaud, N. (2014). Approvisionnement des cantines scolaires en produits locaux: d'un projet-pilote à la préparation d'un programme national durable. Le cas du Cap-Vert. Mémoire de Mission Professionnelle auprès de la FAO Cap Vert, Supagro, Montpellier, France.* *Mirabile, M. (2012). Cape Verde: The Transition to a National School Feeding Programme. July 2012,* World Food Programme, *Praia, Cape Verde.* *PD consult, Estudo Custo-Eficacia, das cantinas escolares de Cabo Verde. Dezembre 2013, FICASE/WFP, Praia, Cape Verde.*
2. METHODS OF DOCUMENTATION	Information is compiled from the program monitoring system, consultant thematic reports, program staff discussions, and program management team experience since 2010.
3. WEB SOURCES	www.youtube.com/watch?v=RBqxBY-H6Po&index=3&list=PL8A8F9F986F79F673

Ethiopia – Productive Safety Net Program

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Laura Campbell, Social Protection Specialist
ORGANIZATION	World Bank Group (WBG)
ROLE IN THE PROGRAM	Social Protection Specialist

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Productive Safety Net Program Phase 4 (PSNP4)
2. COUNTRY	Ethiopia
3. TYPE OF PROGRAM	Public Works Program (PWP) and Unconditional Cash Transfer (UCT) or in-kind transfer (unconditional food transfer)
4. PROGRAM DURATION	2015 to 2020 (PSNP4)

PROGRAM OVERVIEW		
5. PROGRAM OBJECTIVE(S)	Increased access to safety net and disaster risk-management systems, complementary livelihood services and nutrition support for food-insecure HHs in rural Ethiopia.	
6. FUNDING AGENCY/IES	Government of Ethiopia (GOE), WBG, Department for International Development (DfID), USAID, GAC, Irish Aid, Swedish International Development Authority (SIDA), EKN, the European Union, Danish International Development Agency (DANIDA), UNICEF, World Food Programme	
7. IMPLEMENTING AGENCY/IES	Ministry of Agriculture (MOA) and Ministry of Labor and Social Affair (MOLSA) (responsible institutions) MOH USAID channels support to the PSNP4 through nongovernmental organizations (NGOs), such as Catholic Relief Services (CRS), Save the Children International (SCI), and Relief Society of Tigray (REST)	
8. TOTAL COST	$3.6 billion	
9. TARGET GROUP(S)	Chronic and transitory food-insecure HHs in rural Ethiopia.	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	10 million individuals. Starting with the existing PSNP3 caseload, PSNP4 will increase coverage to become a national program. Female beneficiaries: 50 percent	
11. NUMBER OF REACHED BENEFICIARIES	8 million beneficiaries	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM	☒ Rural
	☒ Multisectoral collaboration	☒ Resilience
	☒ Integrated approach	☐ Conflict-affected setting
	☐ Governance	☐ Harnessing nutrition data
	☐ Decentralization	☐ Use of mobile technology
	☐ Performance-based financing	☒ BCC
	☒ Community participation	☐ Life-cycle approach
	☐ Agriculture and local procurement	☒ Gender and women's empowerment
	☐ Urban	☐ ECD

CONTEXT OVERVIEW	
1. CONTEXT	Ethiopia, one of the world's poorest countries, has made substantial progress on social and human development over the past decade. Ethiopia is ranked 173 out of 187 countries in the Human Development Index (HDI) of the United Nations Development Program (UNDP). High economic growth has helped reduce poverty in both urban and rural areas. Since 2005, 2.5 million people have been lifted out of poverty, and the share of the population below the poverty line has fallen from 38.7 percent in 2004–05 to 29.6 percent in 2010–11 (using a poverty line of close to $1.25 per day). Ethiopia met its Reduce Child Mortality Millennium Development Goal several years early, slashing the number of child deaths by two-thirds from one of the highest mortality rates in Africa. The country has also made dramatic progress in its Improve Maternal Health Millennium Development Goal, reducing the maternal mortality ratio by 70 percent. Today, 49 percent of the rural population has access to safe drinking water, up from just 3 percent in 1990, and 28 percent has access to improved sanitation facilities—up from less than 1 percent in 1990. Twenty-five years ago, only 20 percent of primary school-age Ethiopian children attended school. Today, 80 percent are in school. Nearly 60 percent of Ethiopian children finish primary school, up from just 20 percent in 1999.

CONTEXT OVERVIEW	
	Ethiopia's impressive poverty reduction has been credited to three primary factors: economic growth; infrastructure investments; and the PSNP. PSNP has had substantial household and community-level effects. Through transfers alone, PSNP has reduced poverty by 7 percent. Public works (PW) have contributed significantly to the gains outlined above, transforming many rural communities. More rural communities have access to health posts, where they can obtain critical primary care and antenatal checkups. The building of roads and schoolrooms enables rural families to send their children to school. In addition, land rehabilitation, irrigation, and road construction have improved the livelihoods of small-scale farmers and entrepreneurs and have made markets more accessible. *Ministry of Finance and Economic Development. 2013. Poverty and Growth in Ethiopia (1995–96 to 2010–11).*
2. COUNTRY INCOME LEVEL	Low income
3. KEY CONTEXT DATA	2014 data: • GDP growth: 10.3 percent • Share of population with access to improved sanitation facilities: 28 percent • Life expectancy: 63 years • Infant mortality rate: 43 per 1,000 live births 2010 data: • GDP growth: 12.6% • Poverty rate (at national poverty lines): 29.6 percent • Poverty rate, rural (at national poverty lines): 51 percent • Poverty headcount ratio at $1.90 a day (2011 PPP): 33.5 percent of population • Gini index: 33.2 (WBG estimate) • Share of population with access to improved sanitation facilities: 22 percent • Life expectancy: 61 years • Infant mortality rate: 51 per 1,000 live births *WDI*
4. KEY SOCIAL PROTECTION DATA	2013 data: • Public spending on social assistance programs, percent of GDP: 1.1 percent 2010 data: • Coverage of SSNs in total of population: 13.2 percent • Coverage of SSNs in extreme poor: 15.9 percent • Incidence of beneficiaries of SSNs in extreme poor: 55.1 percent *ASPIRE database*
5. NUTRITION CONTEXT	Ethiopia saw a 39 percent reduction in the Global Hunger Index from 1990–2013. The percentage of the population that is undernourished fell from 75 percent in 1990 to 32 percent in 2015. Over the same period, rates of undernutrition among children under 5 years old decreased by 26 percent. Climate change–driven irregularities in rainfall, combined with a continued dependence on rain-fed agriculture in most of the country, has made many rural Ethiopians vulnerable to shocks such as drought. This vulnerability is demonstrated by repeated requests for humanitarian assistance, and malnutrition remains a grave concern.

CONTEXT OVERVIEW	
	Despite improvements, children's malnutrition is still high: 44 percent of children under 5 years old suffer from stunting, 10 percent suffer from wasting, and 29 percent are underweight. Micronutrient deficiencies are high due to poor dietary diversity and high rates of infection. Inadequate child feeding practices compound already high rates of child undernutrition: Only half of infants are exclusively breastfed and introduced to complementary foods at the appropriate time, and only 4 percent of young children receive a minimally acceptable diet. One quarter of women of reproductive age are thin or undernourished. A recent study showed that 28 percent of all child mortality in Ethiopia is associated with undernutrition; stunted children achieve 1.1 years less school education; child mortality associated with undernutrition has reduced Ethiopia's workforce by 8 percent; and 67 percent of the adult population in Ethiopia suffered from stunting as children. The annual costs associated with child undernutrition are estimated at Ethiopian Br55.5 billion (app. $2.5 billion), which is equivalent to 16.5 percent of GDP in Ethiopia. The quality of the typical Ethiopian diet is poor, with low consumption of nutrient-rich animal-source foods and legumes and vitamin-rich fruits and vegetables. This reflects both demand-side barriers, such as poor knowledge about nutrition and inaccessibility of diverse foods caused by limited production and market access. The persistently high burden of disease, including acute respiratory infections, diarrhea, and malaria, caused in part by insufficient access to health services and poor water and sanitation, remains a significant cause of stunting in infants and young children in Ethiopia. The high prevalence of stunting in Ethiopia is also associated with suboptimal care and feeding practices that persist in part because community-based nutrition services still have low coverage, despite great improvements over the past 7–10 years. *ORC Macro, CSA. 2012. Ethiopia DHS.* *ORC Macro, CSA. 2012. Ethiopia DHS.* *WFP. 2012. The Cost of Hunger in Ethiopia*
6. KEY NUTRITION DATA	2014 data: Children under 5 years old suffering from • Stunting: 40.4 percent • Underweight: 25.2 percent • Wasting: 8.7 percent 2013 data: • Prevalence of undernourishment: 35 percent of population 2011 data: • Children under 5 years old suffering from anemia: 50 percent *WDI*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	PSNP4 provides beneficiaries with an integrated service delivery platform including livelihood interventions, key health and nutrition services, community assets and support to graduation.[1] The design of PSNP4 is coordinated with the National Nutrition Program, capitalizing on opportunities within existing programs to improve nutritional outcomes rather than creating new programs. The PSNP represents the demand side of nutrition services, which is now strong across most PSNP woredas. Nutrition was integrated into all components of PSNP4, including • Systems development and strengthening • Transfers to chronically and transitorily food-insecure beneficiaries

PROGRAM DETAILS	
	• PW and links to social services • Livelihoods • Program management and operational processes PSNP4 aims to improve caring and health-seeking behavior through participation of male and female PW beneficiaries in monthly community nutrition BCC, early transition of pregnant and lactating women (PLW) to Direct Support[2] based on the referral of a health-service provider, and introduction of coresponsibilities and soft conditions for PLW and caretakers of malnourished children. PSNP4 includes a set of nutrition-sensitive interventions that address some of the causes of malnutrition, including promotion of maternal health, child health, vaccinations, mother, infant and young child feeding (MIYCF) practices, dietary diversity, women's empowerment, and water, sanitation, and hygiene (WASH).
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	**UCT and unconditional food transfer:** The transfer value is equivalent to 15 kg of cereals and 4 kg of pulses per person per month. Transfers are disbursed either in the form of a mixed food basket, its cash equivalent, or vouchers. PSNP4's Cash First Principle states that cash should be regarded as the primary form of transfer, unless market conditions significantly reduce the value of the cash that beneficiaries receive. PWP beneficiaries receive transfers for six months each year. Permanent Direct Support beneficiaries receive transfers for 12 months each year.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	**UCT and unconditional food transfer:** The transfer is aligned with the kilocalorie levels provided by the humanitarian food basket (2,100 kcal). **PWP:** Wage rates are also aligned with kilocalorie levels provided by the humanitarian food basket (15kg of cereals and 4kg of pulses), and are reviewed annually and adjusted if necessary to account for inflation.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not exclusively. However, it may be procured locally in some cases.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Soft conditions or coresponsibilities for women receiving direct support link vulnerable beneficiaries with existing health services (antenatal care clinics, postnatal care, growth monitoring and promotion, vaccination of children, and regular health checkups) and are designed to increase health-seeking behavior of PNSP beneficiaries. Although HHs are informed of their coresponsibilities and basic monitoring is undertaken, no penalties are enforced, and nothing is deducted from the transfer if HHs do not comply. Participation in monthly nutrition, health, and sanitation BCC sessions is mandatory and is tracked on the "client card", a record transfer receipt of a beneficiary's rights and responsibilities, and monitored.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	PW are performed five days per month for six months from January to June for a total of 30 days per year. Annual program planning and implementation must be adapted to the differences between highland agricultural and lowland pastoral and semipastoral production cycles and hungry seasons. Woredas are permitted to determine their PW projects and adjust schedules to avoid activity during peak seasons of need and peak labor periods. Women have 50 percent fewer working hours than men, as well as lighter tasks.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	PSNP4 includes a focus on the development of sustainable community assets and on improving livelihoods through watershed development planning and PW. Typical subprojects include soil and water conservation; reforestation; gully control; construction of check dams; small-scale irrigation; and social services infrastructure construction and maintenance.

PROGRAM DETAILS	
	Communities are mobilized to identify and plan nutrition-sensitive PW, such as: latrine construction; health-post construction; schoolroom construction; development of homestead or kitchen gardens on the land of female-headed HHs in areas with severe labor shortages (for example, land preparation, irrigation development, production of nursery products, vegetable and legume seeds, and fruit tree seedlings); and establishment of childcare centers at PW sites and in villages where PW are being implemented. Working in a childcare center is also eligible PW. Crop- and livestock-oriented PW projects, such as the planting of vitamin-rich fruit trees, will increase access to a more healthful diet. Male and female PW beneficiaries can participate instead in monthly nutrition, health, and sanitation BCC sessions. Three monthly sessions are equivalent to 1 day's work on a PW subproject.
8. COST BREAKDOWN BY PROGRAM COMPONENT	• **Systems development:** $161.1 million • **Productive safety nets and support for strengthening of livelihoods:** $3,031.8 million • **Institutional and management development:** $218.4 million
9. INSTITUTIONAL ARRANGEMENTS	PSNP4 is implemented through government systems, with disaster risk-management and food security line agencies at every level accountable for oversight and coordination and direct implementation undertaken by line ministries, government agencies, and other partners at all levels. At the federal level, the MOA, in close partnership with the MOLSA, is responsible for the management and coordination of the program. The Ministry of Finance and Economic Development is responsible for overall financial management and reporting, and channels resources to MOA, MOLSA, and the regions. The Food Security Coordination Directorate and MOLSA will appoint focal points for systems development, livelihoods, PW, financial management, and food management. The Early Warning and Response Directorate is responsible for the early warning system, including the triggering of a response that informs the use of the PSNP contingency budget, and the food management system for the storage handling, dispatch, delivery, and monitoring of in-kind resources. The regional cabinet approves the PSNP annual plans and budgets. The Regional Food Security Steering Committee, chaired by the Regional President or his delegate, oversees the implementation of the program, and the head of the Bureau of Agriculture is responsible for the management of PSNP and chairs the Regional Food Security Taskforce. The Regional Food Security Coordination Office is responsible for the day-to-day coordination of the program. The Bureau of Finance and Economic Development is responsible for the overall financial management at the regional level and distributes the cash transfer (CT) to woredas. At the woreda level, the woreda cabinet prepares, and the woreda council approves, the PSNP annual plans. The Woreda Office of Agriculture is responsible for the overall management of PSNP. The woreda Food Security Task Force reviews kebele (neighborhood or ward) annual PSNP plans and budgets, ensures that plans for PSNP contingency budgets are in place, participates in M&E activities, and provides assistance to kebeles. Three technical committees (transfers and resource management, PW, and livelihoods) report to the Task Force. The woreda Food Security Desk coordinates the PSNP activities. The Natural Resource Desk and the Food Security Desk cochair the woreda technical committee on PW, which manages the PSNP PW component with the support of the PW coordinator of the Food Security Desk. The kebele cabinet approves the beneficiary list for the PSNP and the plans for the program. It will also assist in establishing and ensuring the effective operation of the Kebele Appeals Committee. The kebele Food Security Task Force oversees all planning and implementation of PSNP4 activities.

PROGRAM DETAILS	
	The Health Extension Worker (HEW) is a member of the kebele and Community Food Security Task Forces who supports the targeting and graduation processes and provides needed input, such as ensuring referral for timely transition of vulnerable PSNP beneficiaries from PW to temporary direct support; identifying non-PSNP HHs with malnourished children who should be referred to PSNP for transitory direct support; educating PW beneficiaries on the improved gender and social development provisions; planning and implementing monthly BCC sessions for PW beneficiaries; and promoting compliance with coresponsibilities. At community level, the Community Food Security Task Force is responsible for identifying beneficiaries for the program. It also mobilizes the communities participate in planning PW and livelihood activities. The Development Agents facilitate the implementation of PSNP4 and are members of the Community Food Security Task Force and kebele Food Security Task Force.
10. COMMUNITY PARTICIPATION	The selection of HHs into PSNP is carried out through a community-targeting process. Task forces consisting of community members and local officials use PSNP targeting criteria to identify eligible HHs. This selection is then ratified at broader community meetings, where both beneficiaries and nonbeneficiaries debate and agree on which HHs to include in the PSNP under PW or direct support. Each year, the PSNP creates thousands of PW subprojects in PSNP areas. These are identified through a community-based participatory watershed management planning process. These arrangements are designed to ensure that PW are valuable to the community in general and to balance the competing interests of various interest groups, including men and women. "Client cards" track transfers and enable beneficiaries to know their rights and responsibilities as PSNP beneficiaries. The government has committed to publicly disclosing key program information, including budgetary information and beneficiary lists. Grievance redress mechanisms are available to HHs who have a complaint, including the kebele Appeals Committees at community level. Through linkages with the Ethiopia Social Accountability Program, a civil society organization (CSO)-facilitated Social Accountability process, beneficiaries and communities regularly evaluate and provide feedback on the quality of PSNP services they receive.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	Previous phases of the PSNP included contingencies to absorb price hikes and other natural shocks or to scale up the program accordingly. Localized shocks continue to be covered by woreda contingency budgets in PSNP4. For larger-scale emergencies, the PSNP4 federal contingency budget will be coordinated with broader humanitarian response systems. Both the contingency budget and the humanitarian response system will be triggered by the same early warning information and coordinated through a joint response plan. This will improve the efficiency of risk-management responses.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	Despite the significant mitigating influence of the PSNP, rural households in Ethiopia continue to experience shocks and transitory food insecurity. Under PSNP4, the first step toward reducing the effect shocks is the inclusion of HHs who have received emergency assistance year after year into the PSNP as full beneficiaries. PSNP will provide with six months of predictable transfers, reducing the need for emergency assistance. PSNP transfers are critical to preventing families from going hungry and sliding further into poverty, but transfers on their own do not enable HHs to pull themselves out of poverty. PW are the first step toward strengthening livelihoods and making HHs and communities more resilient to shocks. PW projects have rehabilitated soils, increased the availability of water for agricultural production, and built roads to enable farmers to access towns where they can buy inputs and sell their products. PSNP4 will build on this foundation to further enhance agricultural productivity and access to services, with new explicit links to livelihood, nutrition, and other social services, climate resilience, and disaster risk management. PW contribute to climate resilience and disaster risk management through land rehabilitation and other activities that sequester carbon, an increased focus on water-harvesting structures, and improved siting, design, and construction of culverts and bridges to ensure they can withstand extreme weather events. Environmental

PROGRAM DETAILS	
	sustainability is built into the PW subprojects through measures to avoid negative impacts and the need for site-specific mitigating measures. During the PW reviews, spot checks are done to monitor how successfully this process has been implemented. PSNP4 will improve financial sustainability by reducing fragmentation and improving cost effectiveness through harmonization of targeting and approaches across key programs and reduce overlap and inefficiencies. Sustainability will require, over time, the GOE to increase its financing of the safety net and a gradual move toward a program within the national budget. The GOE has committed to contribute approximately $500 million to the program, and the existence of a fiscal space to do this was confirmed during project design. The GOE contribution should reach 1 percent of total annual national expenditures by the end of PSNP4.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	The GOE has established an M&E system for the PSNP4, which is designed to assess progress toward higher-level objectives while responding to the realities of collecting regular monitoring data through government systems. Ethiopia needs to move to a more integrated system for M&E and to better use information for management decision making. Therefore, PSNP4 will include investment in an Management Information System (MIS) to create a unified registry, delivery systems, and monitoring to strengthen the existing M&E of results. The MIS will improve the collection and analysis of M&E indicators to enable evidence-based decision making. The M&E system is guided by an integrated logical framework to ensure progress toward the overall objective of reducing food insecurity in rural Ethiopia. The revised targeting and the development of a unified registry database will form the basis for monitoring and evaluating the entry and exit of PSNP beneficiary households. It will also enable coordinated monitoring across various social-protection interventions over time. Information at the output and activity levels will be collected regularly through government systems, including information on beneficiaries, transfers, PW, and referring PSNP beneficiaries to livelihood support and nutrition services. Regular monitoring data are augmented with real-time data from a range of sources. PSNP implementers and beneficiaries will learn how to use social accountability tools, such as citizen report cards, community score cards, and social audits, to provide feedback and form the basis for interface meetings, and develop joint action plans with implementers. PSNP will commission independent studies and reviews to assess progress toward outputs and identify any adjustments needed.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	A baseline for PSNP4 was conducted in 2015. A regionally representative household survey will be independently carried out every two years to assess the impact on direct and indirect beneficiaries as a result of activities initiated by PSNP. This survey also provides valuable information on implementation progress. Quantitative HH-level information is augmented by qualitative assessments, addressing beneficiary perceptions and related social issues. A second independent evaluation assesses the impact of PSNP PW at the watershed and community levels using a sample of watersheds from across program woredas. This evaluation examines the impact of PW to determine whether they have met their objectives—conserving soil or moisture, growing crops through irrigation, or providing market access through road networks.
3. OUTCOME/IMPACT INDICATORS	Project development objective indicators: • Percent of PSNP beneficiaries who receive community-based nutrition counseling services

MONITORING AND EVALUATION	
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	Not yet available for PSNP4. However, PSNP3 and its counterpart livelihood programs resulted in increased food security for rural families. In the highlands, PSNP HHs have seen their food gap (the number of months during which the family does not have enough to eat) reduced by nearly half. Food security continues to improve as program capacity increases and transfers become even more timely and efficient. PSNP transfers contributed substantially to the 45 percent reduction in Ethiopia's poverty rate from 2000–11. Yet the total impact of the PSNP is estimated to be far greater, because PW have directly contributed to improvements in rural infrastructure and watershed development: **Road construction and rehabilitation** have had a particularly important impact on poor and remote rural communities, linking them to small towns where they can access agricultural inputs and markets, and other services. Over the past 8 years, PSNP PW participants have constructed over 40,000 km of roads and maintained an additional 85,000 km. PW have also **improved access to education and health services** through the construction of over 600 health posts and the construction or rehabilitation of 4,600 schoolrooms. The availability of new social infrastructure—plus the roads to access them—has had a profound effect on communities' access to health services and schooling for children. PW have **rehabilitated the environment**, increasing soil fertility and enabling the growth of forages that make livestock fattening and beekeeping viable. PSNP participants have constructed 676,000 km of soil and stone bunds, which enhance water retention and reduce soil and water run-off, and protected 974,000 *ha* of land in area enclosures, which increases soil fertility and carbon sequestration. Finally, PW have improved **access to water** for household and agricultural use through the construction or rehabilitation of 209,000 ponds, 8,600 springs, 35,000 wells, and 28,000 km of canals. Livelihood interventions through the Household Asset Building Program have played an important role in increasing **rural households' access to finance** through the creation of strong rural savings and credit cooperatives.
5. HARMONIZATION WITH OTHER PROGRAMS	PSNP4 aims to support the transition from a series of time-bound programs to an efficient and effective system for delivering elements of social protection and disaster risk management. It also aims to contribute to the GOE's Growth and Transformation Plan and to the achievement of four key government policies, strategies, and programs: • The Social Protection Policy • The National Policy and Strategy on Disaster Risk Management • The National Nutrition Program • The Climate Resilient Green Economy

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	PSNP transfers are designed to reinforce HH income during the agricultural slack season to help HHs smooth their consumption and avoid asset depletion. A recent impact evaluation concluded that the program is smoothing household consumption and protecting assets even during times of crisis. Evidence from 2012 shows that HHs tend to spend 75 percent of CTs on consumption and 25 percent on investments. PSNP previously provided 15 kg of cereals per person per month (or its cash equivalent). PSNP4 provides 15 kg of cereals plus 4 kg of pulses per person per month (or its cash equivalent), which supplies the recommended caloric requirement of 2,100 kcal per day. For food beneficiaries, this means a direct nutritional benefit from the consumption of pulses. For cash beneficiaries, it means an increased CT to purchase pulses or other nutritious foods.

NUTRITION-SENSITIVE RATIONALE	
	Actions to enhance women's control over the use of cash or food transfers include the development of community conversation manuals and guidelines to promote awareness of the use of transfers for improved HH food and nutrition security; education of communities and kebele Appeals Committees (PSNP's grievance redress mechanism) on the issue of inappropriate use of transfers; piloting of approaches to ensure that women benefit equally from transfers; and training on intrahousehold dynamics regarding transfers and PW. PSNP4 will facilitate the formation of development groups comprising 20–30 village members to participate in livelihood interventions. These groups can promote nutrition-sensitive income-generation activities. For example, in areas where critical nutrition-related services (such as milk marketing or the processing of complementary foods for young children) are identified as a potential income-generation activity, PSNP4 may support their inclusion as off-farm enterprises eligible for program support. These groups will also provide an entry point for supporting active link to the health and nutrition education and training provided by HEWs and for nutrition and health related BCC. Increased focus on livelihoods might increase HH income, which can lead to improved caring practices if combined with nutrition and health care BCC.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	Nutrition community BCC will be organized as part of the PW requirements. PSNP4 beneficiaries will participate in community health days, BCC sessions at PW sites, and community conversations conducted as part of community-based nutrition education. These activities promote health-seeking behavior and good caring practices for children and are expected to increase the nutritional impact of participation in the PSNP. PW are designed to enable women to participate, and priority is given to works that reduce women's regular work burden. PSNP4 established a 50 percent reduction in the work load for women compared to that of men to enable them to arrive late at and leave early from PW sites. Women are exempt from PW and receive temporary direct support during pregnancy and after the birth of their child. The length of time a woman is exempt from PW projects has been increased from 12 months to a minimum of 17 months, from the first ANC visit (at the fourth month of pregnancy at the latest) until the child is 1 year old. During this period, women are referred to health and nutrition-related services provided through the health extension program, including attendance at ANC or counseling sessions, participation in nutrition BCC, growth monitoring, and child vaccination. The primary caregiver of a malnourished child under 5 years old is exempt from PW and receives temporary direct support during the period of treatment. This provides time for caregivers to adequately care for malnourished children and oversee their treatment.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	Although the criteria for targeting focus on food insecurity and poverty, communities are encouraged to target poor HHs with vulnerable PLW or malnourished children. In addition, attention is given to ensuring that vulnerable HHs affected by nutrition emergencies are targeted. Non-PSNP HH that seek health services for the treatment of moderately malnourished children can be referred for transitory inclusion in PSNP.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	PSNP4 aims to sustain and strengthen the program's efforts to address the needs of women as beneficiaries, caregivers, and decision makers. PSNP encourages women's active participation in PW planning and decision making, and requires women's participation on food security task forces and appeals committees. Women have 50 percent fewer working hours than men, as well as lighter tasks. Light work must be identified in advance for each type of subproject and be included in the PW guidelines. Light work must also be defined contextually—watering seedlings in a nursery may be considered light work in some areas, but not in other areas where one must walk several miles in order to reach a water source. Female beneficiaries have reported that their participation in PW and on committees has strengthened their standing in the community and contributed to their empowerment.

NUTRITION-SENSITIVE RATIONALE	
	PSNP4 requires the development of standards for day care center construction at PW sites and in villages, and the education of communities as to the value of such centers and that these are the types of community assets that PW are designed to deliver. Livelihood transfers target poor women and female-headed HHs. Recognizing that women often have less access to extension services and credit than men, PSNP has committed to ensuring that women account for as many as half of livelihood beneficiaries. This will require engaging with women's groups, providing training and demonstrations at the village level whenever possible, and ensuring that project activities take place at times that are convenient to women.
5. THE PROGRAM HAS NUTRITION INDICATORS	• Percent of stunting in children under 5 years old in operational areas (PSNP's contribution to National Nutrition Program indicator "percent height for age") • Percent of children 6–23 months old who receive a minimum acceptable diet • HH dietary diversity • Percent of HHs with adequate knowledge, attitude, and practices of nutrition-related behaviors • Percent of female beneficiaries who report that PW are implemented following gender and social development considerations • Percent of women pregnant or with children under 2 years old in safety net HHs participating in community-based nutrition activities • Percent of beneficiaries who receive community-based nutrition counseling services • Percent of HHs whose adult members attend at least three BCC sessions annually • Percent pregnant women transitioning to temporary direct support before the fourth month of pregnancy on the basis of a health facility referral
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	PSNP4 was designed to support the transition toward a social protection system by ensuring that poor and vulnerable HHs benefit from an essential suite of services including safety net transfers, livelihood interventions, key health and nutrition services, community assets constructed through PW, and support to HHs up to, during, and beyond exit from the safety net program. As part of the system-building approach, PSNP4 includes a set of nutrition-sensitive interventions that address some of the causes of malnutrition, including maternal and child health, vaccinations, MYICF practices, dietary diversity, women's empowerment, and WASH. Besides encouraging its PW beneficiaries to attend BCC sessions on health, nutrition, and sanitation, PSNP now implements a "link to social services" component, which promotes health-seeking behavior for PLW and their young children through soft conditions and coresponsibilities.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	PW contributed to the increasing availability of health services at the kebele level through the construction or improvement of health posts, houses built for HEWs, and through the construction of feeder roads, which improved people's access to health facilities located in woreda centers. Previous phases of PSNP improved household food security and household dietary diversity.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Challenges include coordination of activities with the MOH at the federal and decentralized levels; assessing availability of related health and nutrition services and workload of HEWs; developing guidelines for HEWs and Development Agents; availability of BCC tools; educating program implementers and the community about the new provisions; and navigating tensions between the labor requirement and the organization of six BCC sessions during PW planning. In addition, increasing the capacity of the MOA and MOH to engage with each other is a challenge because there is little incentive provided to the staff of either sector to collaborate. Translating high-level engagement into effective operations in the field. Program-specific tools and capacity for improved nutrition still need to be strengthened. Multisectoral collaboration and coordination mechanisms at the district and community levels require further guidance. Region specificity is essential but challenging. Children in PSNP HHs are more likely to be stunted (47 percent) than children in non-PSNP rural HHs (42 percent). However, PSNP4 faces numerous competing priorities, and its nutrition-sensitive interventions cannot address all the causes of nutrition deprivation. Moving from nutrition-sensitive design to nutrition-sensitive implementation. The early months of implementation will be crucial for establishing links and preparing implementation tools.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects/P146883?lang=en
2. METHODS OF DOCUMENTATION	Desk-based research: WBG resources: *World Bank. 2014. Productive Safety Nets Project Phase 4. Project Appraisal Document. September 4. Washington, DC: World Bank.* External resources: *Federal Democratic Republic of Ethiopia. 2014. Productive Safety Net Program 4. Program Design Document. Addis Ababa, Ethiopia: Ministry of Agriculture.* *Federal Democratic Republic of Ethiopia. 2014. Productive Safety Net Program 4. Program Implementation Manual. Addis Ababa, Ethiopia: Ministry of Agriculture.* *Federal Democratic Republic of Ethiopia. 2013. National Nutrition Program. June 2012–June 2015.* *Bossuyt, A. 2014. Increasing Nutrition Outcomes in PSNP and HABP: Part I Main Report. January 28.* *Bossuyt, A. 2014. Increasing Nutrition Outcomes in PSNP and HABP: Part II Annexes. January 28.*
3. WEB SOURCES	No information available.

Kenya – Cash Transfers for Orphans and Vulnerable Children

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Emma Mistiaen, Social Protection Specialist[a] Michael Mutemi Munavu, Social Protection Specialist Cornelia Tesliuc, Senior Social Protection Specialist

INFORMATION ON THE RESPONDENT	
ORGANIZATION	World Bank Group (WBG)
ROLE IN THE PROGRAM	[a]Task Team Leader

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Cash Transfers for Orphans and Vulnerable Children (CT-OVC) (AF)
2. COUNTRY	Kenya
3. TYPE OF PROGRAM	UCT with Food/Nutrition Supplement
4. PROGRAM DURATION	October 2013 to December 2016 (AF) 2009 to December 2015 (parent project)
5. PROGRAM OBJECTIVE(S)	To increase access to the social safety net for extremely poor orphans and vulnerable children (OVC) HHs and to build the capacity of the government to more effectively deliver the National Safety Net Program (NSNP) OVC are (a) single or double orphans; (b) children who are, or whose caregivers are, chronically ill; and (c) child-headed HHs
6. FUNDING AGENCY/IES	WBG International Development Association (IDA) $10 million WBG (IDA) $50 million (parent project) DfID $56.4 million
7. IMPLEMENTING AGENCY/IES	Government of Kenya (GOK): Ministry of Labor, Social Security and Services (MLSSS) (Department of Children's Services) (responsible institution)—as of 2016, the Ministry of East African Community Affairs, Labour and Social Protection
8. TOTAL COST	$66.4 million (additional financing [AF]) $126 million (parent project)
9. TARGET GROUP(S)	HHs that (a) include as permanent members OVC from birth to 17 years; (b) are extremely poor; and (c) are not the beneficiary of other cash transfer programs that directly support OVC beneficiaries
10. NUMBER OF TOTAL TARGETED BENEFICIARIES SHARE OF FEMALE BENEFICIARIES	500,000 HHs having approximately five members per HH on average, for a total of 2,500,000 individual beneficiaries Female beneficiaries: 50 percent
11. NUMBER OF REACHED BENEFICIARIES	*As of October 2013:* 253,318 HHs/500,000 HHs (50.7 percent)
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM ☐ Multisectoral collaboration ☐ Integrated approach ☐ Governance ☐ Decentralization ☐ Performance-based financing ☐ Community participation ☐ Agriculture and local procurement ☐ Urban ☐ Rural ☐ Resilience ☐ Conflict-affected setting ☐ Harnessing nutrition data ☒ Use of mobile technology ☒ BCC ☐ Life-cycle approach ☐ Gender and women's empowerment ☐ ECD

CONTEXT OVERVIEW	
1. CONTEXT	In spite of a decade of relatively strong economic growth, high rates of poverty persist in Kenya. Latest available data show that poverty rates tend to be higher among vulnerable groups such as children (53.5 percent), including OVC (54.1 percent), older people (53.2 percent), and people with disabilities (57.4 percent). *WBG Project Appraisal Documents PAD44040-KE February 2009 and PAD731 October 2013. WBG Project Information Document Additional Financing PIDA1318 September 2013.*
2. COUNTRY INCOME LEVEL	Lower-middle-income

3. KEY CONTEXT DATA	2006 data:
	
	• GDP growth: 6.3 percent
	• Gini index: 48.5 (WBG estimate, 2005)
	• Poverty rate: 46.6 percent
	• Poverty rate, by location: rural, 49.7 percent
	• Poverty rate, by population group:
	  • Children, 53.5 percent,
	  • Older people, 53.2 percent,
	  • People with disabilities, 57.4 percent
	• Share of population with access to improved sanitation facilities: 28 percent
	• Number of OVC: 2.4 million
	• Extremely poor OVC: 25 percent
	
	WDI and WBG project appraisal document (PAD)

4. KEY SOCIAL PROTECTION DATA	2014 data: • Public spending on social assistance programs, percent of GDP: 2.7 percent 2005 data: • Coverage of SSNs in total of population: 20.0 percent • Coverage of SSNs in extreme poor: 28.0 percent • Adequacy of benefits of SSNs in total population: 8.0 percent • Adequacy of benefits of SSNs in extreme poor: 5.3 percent • Incidence of benefits of SSNs in extreme poor: 20.8 percent • Incidence of beneficiaries of SSNs in extreme poor: 59.0 percent *ASPIRE database*
5. NUTRITION CONTEXT	The National Social Protection Policy (NSPP), approved by the Cabinet in May 2012, aims to strengthen the delivery of social assistance to poor and vulnerable populations. As a first step in this reform agenda, the government has established an NSNP to strengthen operational systems while expanding the coverage of cash transfer programs. Within this framework, a CT-OVC was launched by the GOK in the Department of Children Services (DCS) in 2004. The broad objective of the program is to strengthen the capacity of HHs to foster and retain OVC within their families and communities, and to promote their human capital development, by providing a social protection system that uses regular cash transfers to families with OVC. *WBG Project Appraisal Documents PAD44040-KE February 2009 and PAD731 October 2013.* *WBG Project Information Document Additional Financing PIDA1318 September 2013*

CONTEXT OVERVIEW	
6. KEY NUTRITION DATA	2009 data: Children under 5 years old suffering from • Stunting: 35.2 percent • Underweight: 16.4 percent • Wasting: 7.0 percent *WDI and WBG PAD.*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**Policy Development and Institutional Strengthening.** This component contributes to the ability of the GOK to deliver the NSNP by (a) strengthening program systems to ensure good governance; (b) harmonizing cash transfer programs to improve sector coherence; and (c) building capacity for expanding cash transfer programs to promote more comprehensive and equitable coverage. **Program Implementation in Selected Subcounties.** This component supports the implementation of the CT-OVC program in selected subcounties by using cash transfers to strengthen the ability of vulnerable HHs to protect and care for OVC, ensuring that OVC stay within their communities and are cared for effectively. It also promotes the investment in human capital of the extreme poor in the medium term, while reducing the poverty gap in the short term. The AF component, funded with cofinancing from DfID, is consistent with the objectives and activities of the original project with the exception of the number of HHs to be supported. The original project supported the expansion of the CT-OVC program to an estimated 60,000 HHs in 25 subcounties. The AF supports an estimated 40,000 HHs.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	K Sh2,000 ($20) monthly per HH Payments are disbursed every two months through a payment service provider Although the value of the transfer has been increased once since the project's inception, discussions are under way on the need (based on evidence) to adjust the transfer value to reflect inflation and consider scaling it to the number of children in the HH, rather than offering a standard HH transfer value
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The transfer was intended to cover approximately 20 percent of poor HH expenditures
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	To encourage increased human capital development of OVC living in beneficiary HHs, caregivers are informed at enrollment in the program about the importance of sending their children to school and taking them for regular health check-ups. The caregivers are also encouraged to obtain birth certificates for their children. The program tests the extent to which cash transfers can promote the use of education and health services. To evaluate the impact of incentives, CT-OVC is conducting a pilot program that conditions the transfer payments on compliance with coresponsibilities for approximately 2,000 beneficiary HHs in 10 counties. For example: • Children from birth to 1 year must attend health facilities for immunization, growth monitoring, and vitamin A supplements six times per year • Children 1–3 years old must attend health facilities for immunization, growth monitoring, and vitamin A supplements twice a year • Children 6–17 years old must enroll in school and attend basic school institutions for at least 80 percent of the effective school days • One adult parent or caregiver per HH must attend health information sessions once per year Subcounties with penalties are compared with subcounties without penalties to assess the efficiency of the penalties in promoting compliance with coresponsibilities.

PROGRAM DETAILS	
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	• **Policy Development and Institutional Strengthening:** $10 million (WBG IDA) and $5.2 million (DfID cofinancing) • **Program Implementation in Selected Subcounties:** $51.2 million (DfID cofinancing) *Costs by category can be estimated as follows: direct cash transfers 85 percent; operation and administration 15 percent.*
9. INSTITUTIONAL ARRANGEMENTS	CT-OVC is implemented by the DCS within the MLSSS. GOK is in the process of establishing the National Social Protection Council, which will provide overall policy direction and oversight for social protection in Kenya. The council is supported by a Social Protection Secretariat, which is already established and is currently located within the MLSSS. The Social Protection Secretariat will oversee the implementation of the NSNP, including assessing program implementation according to the M&E framework, producing management reports, maintaining the single registry, and updating the Medium Term Expenditure and Financing Framework and expansion plan. The NSNP Steering Committee has been established to provide oversight of the program and to address key policy and operational issues as they arise. The Steering Committee will be supported by a technical working group, which will regularly monitor implementation progress. Currently, payments are made through Equity Bank and Kenya Commercial Bank. Both are private sector banks that offer electronic payments and reconciliations and the use of beneficiary biometric details to issue payments. The payments are sometimes made using banking agents in remote parts of the country, enhancing beneficiaries' access to pay points. To ensure delivery of the coresponsibilities, DCS works closely with education and health providers at the local level.
10. COMMUNITY PARTICIPATION	At the community level, CT-OVC has established Location OVC Committees (LOCs) and Beneficiary Welfare Committees (BWCs). The main roles of the LOC are to identify OVC within their location, assist in identifying enumerators for HH surveys, validate selection of beneficiaries from within the community, and assist with enrollment. The BWCs, which are composed of and elected by beneficiaries, are responsible for representing and empowering beneficiaries. For example, the BWCs inform beneficiaries of payment dates, compile lists of beneficiaries who did not receive a payment during a payment cycle for follow-up by the Sub County Children's Officer (SCCO), collect and forward information to SCCOs concerning any changes in beneficiary status, and forward any complaints submitted by beneficiaries to SCCOs. The program also has appropriate mechanisms to ensure adequate community participation in monitoring. These include means of identifying OVC and an M&E process that creates structures for public information, reporting, and the handling of complaints. This ensures that program financial management information is promptly disseminated to the community and that the community members are able to give feedback on various aspects of the program.

PROGRAM DETAILS	
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The project has scaled up coverage of beneficiaries over the past few years, based on both government and partner financing, from 150,000 HHs in 2012 to 253,318 HHs in 2015. As part of the broader NSNP, the project is putting in place infrastructure that can flexibly adapt to a rapidly increasing or decreasing beneficiary caseload, such as in the case of an emergency. The use of a single registry and robust MIS, as well as private sector banks, represent the building blocks to support rapid scaling up or down of the project.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	Government and partners have developed and agreed on a financial plan for scaling up the project, in which GOK will progressively increase the level of domestic financing. At the same time, partners will progressively reduce direct financing of cash transfers and devote more resources to building effective and sustainable delivery systems.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	A comprehensive M&E system is already in place for the program through the use of an MIS. The project supports the strengthening of M&E capacity (system development, technology investments, and training) to monitor and evaluate both the program's outcomes and processes. The strengthened M&E system includes internal and external systems to enable and ensure regular monitoring of program inputs, outputs, and outcomes and to inform management decisions during implementation. The purpose of these instruments is to (a) verify that the program is being carried out in accordance with the operational manual; (b) provide external monitoring of key risks, including fiduciary risks, to ensure they are being mitigated in accordance with specified mitigation measures; and (c) assess beneficiary and public satisfaction and perception of the program. The implementation of the external monitoring is done through a spot check verification system; a citizen report card survey; and an independent grievance mechanism.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	Evaluation has been designed around the program's targeting and beneficiary selection system, and is based on purposively sampled household survey data collected three times—a baseline and follow-up surveys in years 2 and 4. The survey covers both targeted and nontargeted locations within the districts supported by the program. Nonexperimental impact-evaluation methodologies, including propensity-score matching techniques and pipeline comparisons using double-difference estimators, are used to determine whether changes in outcome indicators are attributable to the project.
3. OUTCOME/IMPACT INDICATORS	Project Development Objective indicators: • Additional number of beneficiary households receiving timely and predictable cash transfers • Proportion of beneficiary households that meet the targeting criteria • Proportion of OVC 6–17 years old in beneficiary households who have completed or are enrolled in basic education
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	A four-year randomized experimental design evaluation analyzing the impact of the CT-OVC on individual and household decision making shows that the program has had a positive and significant impact on the accumulation of productive assets, especially on the ownership of small livestock such as sheep and goats. Findings show robust indirect evidence of a positive impact on the share of food consumption coming from home production. In particular, impact evaluations and follow-up studies show a significant increase in household spending on meat, fish, and dairy products. There is a 20 percent increase in poultry ownership. There is also a reduction in diarrhea among children 3–5 years old of 9.5 percentage points, and a 12 percent increase in vaccinations. The program has had a variety of generally positive effects on the adult labor supply, varying by gender and by type of wage and own-farm labor, and has led to a large reduction in child labor on family farms. *Handa, S. et al. 2012. Impact of the Kenya CT-OVC on the Transition to Adulthood Carolina Population Center, University of North Carolina at Chapel Hill. August 2012.*

MONITORING AND EVALUATION	
5. HARMONIZATION WITH OTHER PROGRAMS	CT-OVC is coordinated with the four other interventions—the Older Persons Cash Transfer, the Hunger Safety Net Program, and the Persons With Severe Disabilities Cash Transfer—that constitute the NSPP, which was approved by the Cabinet in May 2012.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The size of the cash transfer is set to have an impact on consumption and represents approximately 20 percent of estimated average monthly HH expenditures.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The transfer payment is linked to attendance at growth-monitoring appointments and to the use of vitamin A supplements, as well as attendance at awareness-raising health information activities at the community level. Health education covers the importance of good diet, locally available resources, the need for well-child visits, and broader health issues such as HIV/AIDS.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The program targets at-risk groups. Eligibility is determined in each area using the characteristics of extreme poverty, for example, actual availability or lack of resources, and number of meals per day. In particular, extreme poverty is defined by the following characteristics: • Caregiver is unemployed or has no regular income • Adult members of the HH currently have difficulty finding a daily paid job • No ownership of house or land • No cattle, pigs, chicken or goats • No access to safe drinking water • Floor, roof, and walls of dwelling made of mud or cow dung, grass, sticks, or "makuti" (thatched roofing) • No HH assets besides a place to sleep • Children of the household do not attend school because of a lack of materials or uniforms or the need to help parents or caregivers meet daily food needs • Family members wear very deteriorated clothing • HH members are evidently in very weak health • Very poor sanitary conditions • Number of meals per day (1 or less = poor) • Other reasons identified The CT-OVC pilot conditions the transfer payments on compliance with coresponsibilities to test the extent to which penalties improve the behavior of beneficiaries with respect to the health and education outcomes of the children under their care.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	Use of biometric smart cards and local "agency banks" in communities has the potential to reduce the time beneficiaries spend collecting transfer payments.
5. THE PROGRAM HAS NUTRITION INDICATORS	No information available.
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	No information available.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY NUTRITION-RELATED ACCOMPLISHMENTS OF THE PROGRAM	In Kenya, CT-OVC is the first UCT program to pilot and test, through randomized controlled trials, the effect of applying penalties for lack of compliance with attendance at health and education facilities CT-OVC has expanded the use of technology in Kenya, and is one of the first CT programs to use biometric smart cards and local "agency banks" in communities to ensure wide reach and secure payments for project beneficiaries
2. INDICATE KEY NUTRITION-RELATED CHALLENGES FOR THE FUTURE OF THE PROGRAM	The program's financial sustainability is at issue. The institutional capacity for delivery must be more sophisticated, and the capacity of the system must be increased to deliver a larger number of transfer payments in the long run. The need for data on HH inequality is increasing. Robust impact evaluation is necessary to shed light on both achievements and shortfalls. Finally, the project's governance needs to be strengthened both in terms of institutional capacity. Public awareness on the relevance of the project needs to be strengthened, too.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects/P146161?lang=en and http://www.worldbank.org/projects/P111545/kenya-cash-transfer-orphans-vulnerable-children?lang=en
2. METHODS OF DOCUMENTATION	**Desk-based research** WBG resources: *Project Appraisal Document PAD44040-KE February 2009* *Project Appraisal Document PAD731 October 2013* *Project Information Document Additional Financing PIDA1318 September 2013* External resources: *Handa, S, et al. 2012. Impact of the Kenya CT-OVC on the Transition to Adulthood Carolina Population Center, University of North Carolina at Chapel Hill, August 2012.* *Taylor, J. Edward, Justin Kagin, and Mateusz Filipski. 2013. "Evaluating General Equilibrium Impacts of Kenya's Cash Transfer Program for Orphans and Vulnerable Children (CT-OVC)." University of California, Davis. FAO: Rome* *Hurrell, Alex, Patrick Ward, and Fred Merttens. 2008. Kenya OVC-CT Programme Operational and Impact Evaluation, Baseline Survey Report. Oxford Policy Management, Oxford, UK* *Ward, Patrick, Alex Hurrell, Aly Visram, Nils Riemenschneider, Luca Pellerano, Clare O'Brien, Ian MacAuslan, and Jack Willis. 2010 Cash Transfer Programme for Orphans and Vulnerable Children (CT-OVC), Kenya Operational and Impact Evaluation, 2007-2009. Final Report. Oxford Policy Management, Oxford, UK* **Interview with Task Team Leader**
3. WEB SOURCES	http://www.worldbank.org/projects/P146161?lang=en http://www.worldbank.org/projects/P111545/kenya-cash-transfer-orphans-vulnerable-children?lang=en http://web.worldbank.org/archive/website01259/WEB/0__C-145.HTM

Mali – Emergency Safety Nets Project (Jigisèmèjiri)

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Philippe George Leite, Senior Social Protection Economist

INFORMATION ON THE RESPONDENT	
ORGANIZATION	World Bank Group (WBG)
ROLE WITHIN THE PROGRAM	Task Team Leader

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Emergency Safety Nets Project (Jigisèmèjiri)
2. COUNTRY	Mali
3. TYPE OF PROGRAM	UCT
4. PROGRAM DURATION	April 2013 to June 2018
5. PROGRAM OBJECTIVE(S)	To provide targeted cash transfers to poor and food-insecure HHs and to establish building blocks for a national safety net system in Mali
6. FUNDING AGENCY/IES	WBG (IDA)
7. IMPLEMENTING AGENCY/IES	Government of Mali (GOM): Unité Technique de Gestion Filets Sociaux (UTGFS) attached to the Ministry of Economy and Finance and Budget (MEFB) (responsible institution)
8. TOTAL COST	$70 million
9. TARGET GROUP(S)	Chronically food-poor HHs in rural areas of the five regions in the south of the country and in the urban areas of the Bamako district. The UCT targets HHs according to their poverty levels, needs, characteristics and capabilities, such as HHs having fewer than two meals a day, with children or elderly, or no source of income.
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	**UCT:** 62,000 HHs Female beneficiaries: 40 percent **Social Registry:** 122,000 HHs at the end of the fifth year (62,000 HHs in the first three years plus 30,000 additional HHs in each of the fourth and fifth years) With an average of six individuals per HH, the program targets approximately 372,000 UCT individual beneficiaries overall
11. NUMBER OF REACHED BENEFICIARIES	*As of September 2015:* **UCT:** 43,613 HHs (70 percent of 62,000 HHs targeted); 349,031 individuals, of whom 15 percent are children from birth to 5 years old, 19 percent are school-age children (6–14 years old) and 5 percent are people age 60 and over. Female beneficiaries: 46 percent **Social Registry:** 57,001 HHs identified and enrolled
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM ☒ Multisectoral collaboration ☐ Integrated approach ☐ Governance ☐ Decentralization ☐ Performance-based financing ☒ Community participation ☐ Agriculture and local procurement ☒ Urban ☒ Rural ☒ Resilience ☐ Conflict-affected setting ☐ Harnessing nutrition data ☐ Use of mobile technology ☒ BCC ☐ Life-cycle approach ☐ Gender and women's empowerment ☐ ECD

CONTEXT OVERVIEW	
1. CONTEXT	Mali is a landlocked country in the Sahel with a narrow natural-resource base, rapid population growth, and high poverty levels (43.6 percent in 2010). Recent political events, combined with Mali's vulnerability to environmental, social, political and economic shocks (including from both international prices and climate) have aggravated the living conditions of a large majority of the country's population *WBG Emergency Project Paper 74954-ML March 2013. Project Information Document Concept Stage AB7178 November 2012*
2. COUNTRY INCOME LEVEL	Low income
3. KEY CONTEXT DATA	2012 data: • GDP growth: –1.5 percent • Chronically food-insecure population: more than 25 percent 2010 data: • Gini index: 33.0 (as of 2009) • Poverty rate: 43.6 percent • Poverty rate, by location: rural, 51 percent • Share of population with access to improved sanitation facilities: 22 percent *WDI and WBG PAD*
4. KEY SOCIAL PROTECTION DATA	2009 data: • Public spending on social assistance programs, percent of GDP: 0.5 percent *ASPIRE database*
5. NUTRITION CONTEXT	Latest available data in 2013 estimated that more than 25 percent of the population (more than 3 million people) was chronically food-insecure and approximately 1.7 million people were permanently at risk of hunger. For the period 2015–16, in the regions of Gao, Timbuktu, and Kidal, as well as in some areas of Mopti, food security is being seriously affected by a combination of low food reserves and a volatile security situation. Stocks in cereal banks are at levels much lower than those in 2014. Small, adverse climate changes could have important effects on food security in 2016, potentially increasing the number of food-insecure HHs and malnourished children. *WBG Emergency Project Paper 74954-ML March 2013. Project Information Document Concept Stage AB7178 November 2012* *Système d'Alerte Précoce du Mali*
6. KEY NUTRITION DATA	2006 data: Children under 5 years old suffering from • Stunting: 38.5 percent • Underweight: 27.9 percent • Wasting: 15.3 percent *WDI and WBG PAD*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**CT program and accompanying measures (AM).** The combined interventions offer support to chronically food-poor HHs to cope with current low consumption and seasonal shocks, as well as opportunities for a sustained improvement of living conditions. The planned interventions also offer complementary benefits for the chronically food-poor, implemented in the same villages and targeting the same population. Selected villages receive a preventive nutrition package through the Pilot Preventive Nutrition Package (PPNP), an intervention that is designed to reach pregnant women and all children under the age of five. The PPNP is designed to address the complexity of service delivery and of tracking the beneficiaries of the program.

PROGRAM DETAILS	
	Establishment of a basic safety net system. This component covers the set up of basic elements of the safety net system. GOM is developing a system to support a long-term safety net interventions in the country. To this end, activities financed by this component support (a) the development of an MIS, including modules to track payments and compliance of AM and nutritional packages delivery, prepare reporting information, and set up a grievance reporting system; (b) the set up of a Unified Registry of Beneficiaries (URB) of potential beneficiaries of safety net programs; (c) the set up of an Information and Education Communication (IEC); (d) the set up of M&E procedures; (e) training programs at the central and regional levels; (f) TA in the design of a cash-for-work program as part of the safety net programs; and (g) additional studies on targeting mechanisms, payment mechanisms, and AM. **Project management**. This component supports project management by ensuring that the UTGFS is operational and that it successfully and efficiently implements the project in conformity with the financing agreement, project documents, and the PIM.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	CFAF 10,000 ($20) monthly per HH for 36 months. Payments are disbursed quarterly to the head of the HH or to the person designated by the head of the HH.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The transfer represents 10 percent of the 2011 food-poverty line in the country and more than 20 percent of the average HH consumption of food for poor HHs in the country.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	AM related to health and education have been introduced to generate incentives for households to invest in human capital accumulation that can reduce the intergenerational transmission of poverty. AM at the commune or village level provide information to beneficiaries to promote investment in the human capital of their children. Beneficiaries of the UCT are expected to attend accompanying activities, but their absence does not result in a penalty or suspension. The AM include a package of various interventions, such as: • Information sessions on the program's objective and a moral contract to participate in registration • Community- and village-level information campaigns to promote good practices in health, education, nutrition, family planning, and savings and investments planning.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORK TAKES PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	• **CT program and AM:** $56.5 million • **Establishment of a basic safety net system:** $6.8 million • **Project management:** $6.7 million *Costs by category can be estimated as follows: direct cost of transfer 72 percent; targeting, implementation, management, monitoring 13 percent; payment and distribution 3 percent; management 12 percent.*

PROGRAM DETAILS	
9. INSTITUTIONAL ARRANGEMENTS	The project is managed by the UTGFS, which has been established under the MEFB. The NSC has been established pursuant to the Prime Minister's decree, which will provide policy orientation and supervise the implementation of the project. The UTGFS is responsible for (a) the day-to-day management of the proposed project, including setting up and implementing the CTs and AM; and (b) the production of financial reports, and implementation progress reports and assessments every quarter, semester, and year. The UTGFS becomes, under the NSPF established by GOM, the lead agency for implementing the social safety net in the country.
10. COMMUNITY PARTICIPATION	The geographical targeting process that accounts for social indicators at the community level has identified 106 communities for participation. At the community and village level, information is provided to community leaders, and the program relies on community committees that help to identify beneficiaries and with campaigns to promote good practices in health, education, nutrition, family planning, and savings and investments planning.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The program has expanded in three phases. A pilot in three regions served 5,000 HHs. Approximately 30,000 HHs were added through 2014 and by the end of 2015, another 22,000 HHs were added for a total of about 57,000 HHs from six regions (almost 100 communes).
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	GOM will consider the option of establishing credible and sustainable institutional arrangements, including a specific line in the national budget through the budget law for safety net interventions, as soon as the political environment allows. In addition, since a peace agreement was signed in June 2015, GOM intends to use the set up of the CT programs in the south, in particular the building block of the safety net system, as a basis for expanding the project into the northern region. The program aims to produce outputs that extend beyond the life of the project, including MIS, URB, M&E mechanisms, feasibility assessments for introducing a national cash-for-work program as part of the safety net programs, strengthened institutional capacities both at the central and local levels, and the PIM. In addition, an expansion of the social registry to improve coordination with multiple programs will be considered.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	The program establishes the basics for developing a national monitoring system. The primary data (registration forms) for the development of the URB are collected by the UTGFS at the village level. During the project, only the HHs listed and identified by the commune committees are interviewed by the interviewers. Data are consolidated at either the commune or, more likely, the district level for analysis and sharing at the regional and national level for further aggregation and dissemination. The data analysis is done at two levels, first at the district level and at the national level. At the district level all data are captured into a simple computerized MIS. At the village level, a paper-based system is used.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	M&E is a key subcomponent that enables the project to be analyzed regularly to inform GOM, the WBG and other development partners about its results and effects. The MIS combines data collection, processing, and information management to facilitate the operation of project components through the five-year implementation period, and across all levels (UTGFS and regional), to follow the program's progress and measure its results. Data capture remains paper based, but a system connected to the central office will be installed at district level. The M&E specialists of UTGFS will then create plans for running regular process evaluations, spots checks, and standard impact evaluation. More specifically, the M&E subcomponent of the project finances the following: • Annual process evaluations between 2014 and 2017 • Annual spot checks (including beneficiaries' surveys and qualitative evaluations) at the village level • One full impact evaluation with two rounds of data collection • Annual independent audits of the system

MONITORING AND EVALUATION	
3. OUTCOME/IMPACT INDICATORS	Project Development Objective indicators: • Number of HHs with access to CT disaggregated by gender of the head and geographical location • Number of children benefiting from CT disaggregated by gender and geographical location • Number of direct beneficiaries from CT disaggregated by gender and geographical location • Share of beneficiary HHs of CT who are poor (with incomes below the national poverty line) • Development of a registry for potential beneficiaries of safety net programs (database with information on potential beneficiaries)
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	After the second transfer, a post-transfer survey was conducted in August and September of 2014 of about 5,000 HHs, indicating that about 70 percent of the transfer payment was used for food. The remaining 30 percent was spent on medicine and rent in urban settings, while rural beneficiaries were more likely to invest in education and hygiene. Also, 94 percent of beneficiaries were very satisfied with the amount of the transfer, and 90 percent were satisfied with the time spent waiting to receive the transfer (three hours on average). Finally, 97 percent of beneficiary HHs proved very satisfied with the quarterly distribution of transfers. In addition, the baseline survey of 3,000 HHs selected by the International Food Policy Research Institute (IFPRI) for the overall impact evaluation of the program was completed under the project's independent impact evaluation. The baseline report analysis has highlighted that the project displays good targeting for identifying food-insecure households, and that more than 80% of selected beneficiaries are below the international poverty line of $1.25 PPP per day. Given the high prevalence of chronic undernutrition and anemia, however, IFPRI suggested that interventions, such as the provision of vitamins, be added to the program, in addition to the current package of CTs, AM, and nutritional packages, to boost the program's expected impact on nutrition.
5. HARMONIZATION WITH OTHER PROGRAMS	The program is linked with the provision of health insurance for the poor that is managed by the MOH. As of June 2015, 51,314 beneficiary HHs were referred to the health insurance agency, Agence National d'Assurance Maladie, which started enrolling and providing insurance cards to beneficiaries. The agency's target is to provide health insurance cards to all current program beneficiaries.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The size of the CT is set to have an impact on nutrition. The level of transfer is calculated to be: (a) commensurate with available international evidence on CT (below 15 percent of a national poverty line and below 20 percent of beneficiary HHs' expenditure levels); (b) likely to have a significant impact on the level and quality of HH food consumption; and (c) likely to reduce the food-poverty headcount by 4.6 percent and the food-poverty gap by 5.8 percent. The PPNP provides flour, soy, peanuts, sugar, iodized salt, minerals, and vitamins. The PPNP also provides fortified nutritional supplements (farine enrichie) that are approved by the Comité Technique National, which includes members of the MEFB, the MOH, the Ministry of Education, the Ministry of Rural Development, the Ministry of Women, Family and Children, and the Ministry of Social Affairs and Solidarity. This fortified supplement is designed for preventive care, and other partners may consider complementary interventions to address the acute malnutrition in the selected areas. All children under 5 years old in the selected areas are eligible for this component.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The program has an explicit nutrition component, AM linked to health and nutrition through soft conditions. That is, it aims to promote behavioral changes through AM sessions focused on health and nutrition delivered by NGOs. AM sessions are open to all adults who would like to learn good human development practices. Program implementers are monitoring actual attendance of beneficiaries to determine whether to make attendance a firm condition.

NUTRITION-SENSITIVE RATIONALE	
	The program also has a PPNP as a complementary intervention to AM sessions focusing on preventive care for children and pregnant women that will be tested in a few villages. About 20 villages out of the 106 selected for the CT have been identified for this pilot according to the AM agencies' capacity to deliver in-kind nutrition packages. In selected villages, an information campaign has been carried out to inform the communities that the nutrition packages would be provided to all children from birth to 59 months old and pregnant women during the AM sessions. The AM agencies that are providing the education sessions distribute the nutrition packages and inform attendees during the sessions how to use the products. The nutrition packages are tailored to each zone of intervention according to the population's needs.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The program has been implemented in all five regions in the south (Sikasso, Segou, Mopti, Koulikoro, and Kayes) and in the district of Bamako, but these regions can be ranked (if necessary) according to an index that combines poverty levels from the Institute of Statistics (INSTAT) poverty map and the Severe Acute Malnutrition (SAM) index from UNICEF. Within each region, districts are ranked based on a weighted index that combines poverty and infrastructure indicators from INSTAT. Within each district, communes are ranked based on a poverty index that combines poverty and infrastructure indicators from INSTAT and a community level infrastructure index from the Observatoire du Développement Humain Durable (ODHD). UTGFS started implementation in a few of the poorest communes of the country, selected from up to three of the poorest districts in each of five regions (plus Bamako) in the southern part of the country. The selection of areas of intervention (regions, districts, and communes) was done on the basis of a geographic-targeting process that combined socioeconomic indicators. As communes were selected, quotas for the number of expected beneficiary HHs in each village were determined, but all villages in the commune are deemed eligible. The final list of HHs is approved by the villagers, and the community committee is responsible for informing the selected HHs. Once a commune has been selected, the community committee, district regional staff, regional staff and UTGFS sign an agreement endorsing the program and defining the specific institutional responsibilities for the operation. Once potential beneficiaries have been identified, key data are collected by a third party (most likely staff from National Statistics Office) for each of these HHs and entered in the URB at the district level.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	No information available.
5. THE PROGRAM HAS NUTRITION INDICATORS	• Beneficiaries complying with the requirement of participating in the AM • Children benefiting from the PPNP in HHs receiving the CT • Proportion of targeted HHs with increased consumption • Proportion of targeted HHs with a food consumption score over 35
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The project is nutrition-sensitive in its careful selection of HHs. In all targeted communes, a sensitization campaign is carried out to ensure that program officials (including education and health staff), district, community committee, and village authorities, and villagers are aware of the program objectives, basic rules and benefits, and the overall program processes. The community committee discusses the program objectives with village councils and identifies potential beneficiary households using predetermined criteria established by the UTGFS and presented in the PIM. They identify HHs based on the quota previously set by the program.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Increased food diversity of targeted HHs Increased food security levels of targeted HHs
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	No information available.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found here at http://www.worldbank.org/projects/P127328/mali-social-protection-employment-project-spep?lang=en
2. METHODS OF DOCUMENTATION	**Desk-based research:** WBG resources: *Emergency Project Paper 74954-ML March 2013* *Project Information Document Concept Stage AB7178 November 2012* **Interview with Task Team Leader**
3. WEB SOURCES	http://www.worldbank.org/projects/P127328/mali-social-protection-employment-project-spep?lang=en http://www.jigisemejiri.org/

Niger – Niger Safety Net Project

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Ali Mory Maidoka, Coordinateur National, Cellule Filets Sociaux[a] Patrick Premand, Senior Economist[b] Carlo del Ninno, Senior Economist[c]
ORGANIZATION	[a]Government of Niger [b]World Bank Group (WBG) [c]WBG
ROLE WITHIN THE PROGRAM	[a]National Coordinator, Safety Nets Unit [b]Impact Evaluation Task Team Leader [c]Project Task Team Leader

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Niger Safety Net Project
2. COUNTRY	Niger

PROGRAM OVERVIEW		
3. TYPE OF PROGRAM	UCT and PWP	
4. PROGRAM DURATION	September 2011 to June 2017 AF to further expand the project is under preparation.	
5. PROGRAM OBJECTIVE(S)	Establish and support an effective safety net system that will increase access of poor and food-insecure people to CT and cash-for-work programs	
6. FUNDING AGENCY/IES	WBG (IDA)	
7. IMPLEMENTING AGENCY/IES	CFS (responsible institution) of the Office of the Prime Minister, in collaboration with many local NGOs	
8. TOTAL COST	$70 million	
9. TARGET GROUP(S)	**UCT:** Chronic poor HHs **PWP:** HHs in communities affected by temporary food insecurity caused by unpredictable events The project is implemented in the regions of Dosso, Maradi, Tahoua, Tillabery, and Zinder, which have the highest incidence of poverty and where 95 percent of the poor of Niger live.	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	**UCT:** 80,000 HHs (targeted to the first wife in polygamous HHs) **PWP:** 60,000 individuals (at most one individual per HH) Total: 140,000 poor and food-insecure HHs With an average of seven members per HH, approximately 1,000,000 people will directly benefit from the project. Female beneficiaries: 50 percent	
11. NUMBER OF REACHED BENEFICIARIES	*As of August 2014:* **UCT:** 45,469 of 80,000 target HHs **PWP:** 26,177 of 60,000 target individuals Female beneficiaries reached: 50.60 percent	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM	☒ Rural
	☐ Multisectoral collaboration	☒ Resilience
	☐ Integrated approach	☐ Conflict-affected setting
	☐ Governance	☐ Harnessing nutrition data
	☐ Decentralization	☐ Use of mobile technology
	☐ Performance-based financing	☒ BCC
	☒ Community participation	☐ Life-cycle approach
	☐ Agriculture and local procurement	☒ Gender and women's empowerment
	☐ Urban	☒ ECD

CONTEXT OVERVIEW	
1. CONTEXT	Niger is one of the poorest countries in the world and faces severe challenges in early childhood nutrition and development. In 2011, when the project was designed, it was estimated that 48.9 percent of the population in Niger lived on less than $1.25 per day, and 75.23 percent on less than $2 per day. More than 50 percent of Niger's population was food insecure, with 22 percent of the population suffering from chronic food insecurity (per capita consumption of less than 1,800 kcal/person/day) in any given year. Human development indicators are particularly alarming for children. The infant mortality rate was 66.4 per 1,000 live births in 2010. Seasonal and

CONTEXT OVERVIEW	
	acute malnutrition are also very high. Recent food crises (for example in 2001, 2005, 2008, and 2010) brought on by local droughts and international high prices, have exacerbated the vulnerability of the poor to food insecurity. Historically, most of the safety net programs operated in Niger provided ad hoc emergency assistance. The effectiveness of these programs in reducing chronic food insecurity is limited. *WBG Project Appraisal Document 59609-NE April 2011.* *WDI 2011.* *Demographic and Health Survey (DHS) 2013.*
2. COUNTRY INCOME LEVEL	Low income
3. KEY CONTEXT DATA	2011 data: • GDP growth: 2.3 percent • Gini index: 31.5 • Poverty rate: 75.2 percent • Extreme poverty rate: 48.9 percent • Infant mortality rate: 66.4 per 1,000 live births • Life expectancy: 58.4 years • Share of population with access to improved sanitation facilities: 10 percent • Food insecure population: more than 50 percent • Chronically food-insecure population: 22 percent *WDI and WBG PAD*
4. KEY SOCIAL PROTECTION DATA	2011 data: • Coverage of SSNs in total of population: 2.7 percent • Coverage of SSNs in extreme poor: 3.2 percent • Incidence of beneficiaries of SSNs in extreme poor: 47.9 percent • Public spending on social assistance programs, percent of GDP: 0.9 percent *ASPIRE database*
5. NUTRITION CONTEXT	Nutrition-based indicators confirm the high level of chronic and seasonal food insecurity and malnutrition. According to the 2012 DHS, the prevalence of chronic malnutrition as measured by stunting (low height for age) was estimated at 43 percent, which makes Niger one of the worst affected countries in Sub-Saharan Africa. Seasonal and acute malnutrition is also very high. Recurrent countrywide droughts have made midyear famines a regular occurrence. *WBG Project Appraisal Document 59609-NE April 2011.* *DHS 2012*
6. KEY NUTRITION DATA	2012 data: Children under 5 years old suffering from • Stunting: 43 percent • Underweight: 37.9 percent • Wasting: 18.7 percent *WDI and WBG PAD*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**Safety Net System.** This component supports the establishment of a well-performing safety net system by investing in an MIS, targeting and payment systems, monitoring and evaluation, and capacity building. **CTs for Food Security.** The cash transfers and accompanying measures support targeted poor and food-insecure households by increasing their income and investing in their human capital. The component provides regular cash transfers of CFAF10,000 (approximately $20) for 24 months to 80,000 HHs. The CT program is accompanied by parenting training on nutrition, psychosocial stimulation, health, and sanitation. **Cash-for-work.** This component provides short-term income support to individuals through cash-for-work programs in areas affected by temporary, acute food insecurity and will produce and maintain public goods. The program provides 60 days of temporary working opportunities to approximately 15,000 people annually. **Project Management.** This component finances all costs related to the management of the project.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	**UCT:** CFAF10,000 ($20) monthly per HH for 24 months **PWP:** CFAF 1300 ($2.20) daily for 60 days. Payments are disbursed to workers bimonthly.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	**UCT:** The transfer is equal to approximately 15 percent of the poverty line for a rural HH, in line with international best practices. **PWP:** The wage per day is set just below the market wage at CFAF 1,300, which is equal to the minimum wage set by law in Niger for unskilled labor in rural areas. This low level of wage is meant to facilitate self-targeting and discourage the displacement of people from other productive activities.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	The CT program is accompanied by parenting training on nutrition, psychosocial stimulation, health, and sanitation. Participation in parenting training is a soft condition for receipt of the CT. Participants make a formal oral commitment to participate as a coresponsibility of receiving the CT. However, the condition is soft, not enforced; even if a beneficiary does not participate she will still receive the cash. Participation in community assemblies, small-group meetings, and HH visits is monitored and captured monthly in the project MIS for each beneficiary. Even if participation in the accompanying measures is not a formal condition, participation in the AMs is close to 95 percent over the life of the project. Strong participation of nonbeneficiaries in beneficiary villages is also observed.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	The sequencing of cash-for-work activities follows to a large extent the agricultural cycle. Most cash-for-work activities take place during the lean agricultural season between January and April, although some activities, such as planting trees may occur in July and August and others, such as maintaining pastoral areas (firebreaks), may take place in October and November. Each year, the cash-for-work program targets 2,500 people between October and December, 10,000 between January and March, and 2,500 between July and August. Individuals participate in the cash-for-work program for 60 days during these periods.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Activities eligible for the cash-for-work component include soil conservation to slow desertification, protection of the environment, rehabilitation of small infrastructures, sanitation projects, and other activities that respond to local needs as expressed by communities. Activities are also selected to meet the following basic criteria: (a) providing a public good or service; (b) benefiting the broader community; and (c) not adversely affecting the environment or having negative social consequences.

PROGRAM DETAILS	
8. COST BREAKDOWN BY PROGRAM COMPONENT	• **Safety Net System:** $3.1 million • **CTs:** $47.9 million (AM $9.6 million) • **Cash-for-work:** $10.2 million • **Project Management:** $7.1 million • **Contingencies:** $1.7 million
9. INSTITUTIONAL ARRANGEMENTS	The project is managed by the CFS under the Office of the Prime Minister. The accompanying measures are based on a structured delivery—procedures are standardized using a technical guide that establishes technical content and means of implementation, and the implementation strategy is systematized and linked to the MIS. AMs are delivered through local NGOs, with strong oversight and quality control ensured by having one community educator for every 25 HHs; one NGO field worker for every 300–400 beneficiary HHs; and one quality controller for every eight NGO field workers. Each project office has a specialized staff overseeing implementation.
10. COMMUNITY PARTICIPATION	As part of the coresponsibilities for the CTs, each beneficiary HH participates in three activities per month: a village assembly led by an NGO operator, a small-group meeting led by a community educator, and a home visit from the community educator. The village assembly is open to nonbeneficiary HHs in those villages as well. In practice, many nonbeneficiaries participate to these activities, creating strong social dynamics around the program.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	Additional financing for the project is under preparation as part of the Adaptive Social Protection Program in the Sahel. In addition to capitalizing on lessons learned from the project and consolidating its gains, the additional financing will integrate adaptive elements in the social protection system to make poor and vulnerable people more resilient to shocks.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	In the medium to long term, the project aims to establish a social protection system that can help support poor and food-insecure HHs improve their living conditions by allowing small accumulation of resources, by investing in food and in productive assets, and by improving their human capital.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	The MIS includes a database of relevant information on potential and participant beneficiaries, which is used to assess the efficiency and progress of the project. Regular project M&E includes process evaluations to assess the procedures of project implementation from identification, targeting, registration, and payment, and targeting evaluation to assess percentage of poor participants and the extent of exclusion and inclusion errors.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	A rigorous prospective impact evaluation of the UCT is planned. The objective will be to (1) rigorously evaluate the effectiveness of the UCT in improving nutrition and development of children under 5 years old, and (2) assess additional effects of complementing UCTs with the soft condition of a parenting-training intervention. The impact evaluation relies on a multiarm randomized design. The study will provide evidence to improve project design and scale up in its second phase of implementation, including an impact evaluation report documenting the added value of integrating into the social protection system parenting interventions that encourage behavioral changes. Results are expected in 2016. More details on the impact evaluation can be found at http://www.worldbank.org/en/programs/sief-trust-fund/brief/niger-safety-nets-project-impact-evaluation.

3. OUTCOME/IMPACT INDICATORS	Project Development Objective Indicators: • Number of HHs with access to the CT system established by the project • Number of individuals with access to the cash-for-work program • Number of direct beneficiaries and Percent of direct project beneficiaries who are female • Percent of beneficiaries who receive their payments according to the frequency highlighted in the project implementation manual • Percent of targeted HHs who are poor
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	Results are expected in 2016.
5. HARMONIZATION WITH OTHER PROGRAMS	Synergies are being established between the Niger Safety Nets Project and the Niger Population and Health Support Project. In particular, the implementation of the demand-side CT and coresponsibilities will build on the Safety Nets Project. The Niger Population and Health Support Project also includes a complementary supply-side component for increasing the quality of nutrition for reproductive, maternal, newborn and child, and adolescent health.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	UCT payments are designed to address food insecurity by providing small, yet regular and predictable transfers over a relatively long period of time (24 months). This contrasts with the approach of many humanitarian interventions that provide larger amounts but for a shorter period of time, usually after a crisis or temporary shock. The UCT is given to women representing the HH, typically the first wife of the head of HH. The UCT program includes the soft conditions of parenting training and activities for beneficiaries.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The UCT is accompanied by soft conditions of parenting training and activities for beneficiaries. The parenting training is a BCC component (volet comportemental). The training curriculum builds on the “essential family practices” package developed by UNICEF and adopted by the government of Niger, but goes beyond the package to provide a holistic approach to children’s development by promoting improvements in parenting practice on nutrition, psychosocial stimulation, health and sanitation. As part of the coresponsibilities of the UCT, each beneficiary HH participates in three activities per month: a village assembly led by an NGO operator, a small-group meeting led by a community educator, and a home visit by the community educator. One village assembly is organized for every 50 beneficiary HHs on average. The village assembly is open to nonbeneficiary households in those villages as well. The community educator leads one small-group meeting (causerie) for a group of 25 beneficiaries each month. The community educator also visits each HH in the group each month. The household visit lasts two hours and includes educational content. The curriculum covers child nutrition (such as exclusive breastfeeding for the first 6 months, complementary feeding after 6 months, recognizing signs of malnutrition and referring malnourished children to health services, vitamin A supplementation, deworming, and iron absorption); health (the use of preventive health services to protect children against disease, health visits for children at the onset of illness, hygiene and hand washing, and family planning); psychosocial stimulation (language stimulation, stimulation through play, school readiness, brain development, and sleep management); and child protection (birth registration, discipline, punishment and conflict management, attachment, and psychosocial development).
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The program targets chronically food-insecure HHs, in areas where chronic poverty and food insecurity are prevalent. Geographical targeting is used to select the poorest regions and communes to participate in the CT program. Within the five regions, departments and communes eligible for the CT program are selected based on information available as to poverty, vulnerability, and food insecurity, and validated through stakeholder assemblies.

NUTRITION-SENSITIVE RATIONALE	
	In the selected communes, many more villages are eligible than the project could serve. To ensure full transparency and equal chances of participation for all villages, public lotteries are used to select beneficiary villages from among all equally eligible villages. In each commune, the public lotteries were carried out in the presence of village chiefs, commune authorities, and program staff. Within selected villages, PMT is used to identify the most chronically poor HHs. The community validates the final list of beneficiaries.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	The schedule of the AM is determined after consultation with beneficiaries to ensure that their timing does not conflict with other activities.
5. THE PROGRAM HAS NUTRITION INDICATORS	The program does not include nutrition indicators in its results framework, but the impact evaluation will measure effects on nutrition indicators.
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	As part of the proposed AF, the project is being restructured to be more adaptive, efficient, and responsive, to strengthen the ability of poor and vulnerable HHs to respond to shocks and build their resilience. Adaptive social protection programs can protect poor HHs from climate and other shocks before they occur (through predictable transfers, building community assets, and other programs that help them cope), scale up to respond to extreme events when they hit.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The coresponsibilities focus on training parents on a range of practices that are conducive to holistic early childhood development, including nutrition, psychosocial stimulation, health and sanitation. Messages are reinforced by a combination of repetition and activities. Beneficiaries participate in three activities per month for 18 months: monthly community assemblies led by NGO workers; monthly meetings led by community educators; and monthly HH visits by community educators. These practices rely on animation techniques adapted to the local context and conducive to community dynamics (a "positive deviance" approach). The activities primarily target beneficiary women, but are open to nonbeneficiaries in the target villages.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	AM are tailored for relevance to the local context. To this end, development of content for the AM is essential but not sufficient, and structured delivery is critical for both scalability and oversight. The participation and interest from the population is very high even when the transfer is not dependent on formal conditions. Community-level activities engender strong social dynamics, which help produce positive behavioral changes. A strong focus on quality is essential for effective delivery of AM. Quality requires continuous training of providers (such as NGOs and educators), oversight of NGOs and community educators in the field, and enforcement of performance-based contracts for service providers.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The program is scaling up rapidly, and one of the core objectives is to ensure the efficiency of the safety net system in timely targeting, enrollment, and regular payment of beneficiaries. The process of enrollment, for instance, is very time consuming and should be sped up. For the coresponsibilities, the core challenge is to sustain the quality of implementation during rapid scale up, particularly with regard to NGOs managing coresponsibilities around behavior change activities. Cross-sectoral coordination remains a challenge. Although a cross-sectoral social protection platform exists, coordination remains challenging at the operational level.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects/P123399/niger-safety-net-project?lang=en

FURTHER REFERENCES	
2. METHODS OF DOCUMENTATION	**Desk-based research:** WBG resources: *Project Appraisal Document 59609-NE April 2011* *World Development Indicators (WDI) 2011* External resources: *Demographic and Health Survey (DHS) 2013* *Demographic and Health Survey (DHS) 2012* **Interview with Task Team Leader**
3. WEB SOURCES	http://www.worldbank.org/projects/P123399/niger-safety-net-project?lang=en http://www.worldbank.org/en/news/feature/2013/11/05/niger-invests-in-early-childhood-through-social-safety-nets https://www.youtube.com/watch?v=QR5009bqjHU http://www.worldbank.org/en/programs/sief-trust-fund/brief/niger-safety-nets-project-impact-evaluation

Nigeria – Child Development Grant Program

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Kerina Zvogbo, Social Protection Advisor[a] Mercy Jibrin, Nutrition/BCC Advisor[b] Solomon Bahiru, Deputy Program Manager[c]
ORGANIZATION	Save the Children International (SCI)
ROLE IN THE PROGRAM	[a]Technical Lead [b]Nutrition Lead [c]Operations and Team Leader

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Child Development Grant Program (CDGP)
2. COUNTRY	Nigeria
3. TYPE OF PROGRAM	UCT
4. PROGRAM DURATION	April 2013 to March 2018
5. PROGRAM OBJECTIVE(S)	Goal/Impact • Improved nutritional status of children under 5 in Jigawa and Zamfara States Purpose/Outcome • A scalable program showing how cash transfers can bring cost-effective immediate and long-term food security and nutrition benefits to poor HHs with young children in northern Nigeria
6. FUNDING AGENCY/IES	UK AID

7. IMPLEMENTING AGENCY/IES	Save the Children Action Against Hunger (AAH) GON: Ministry of Local Government and Economic Planning (responsible institution) Stanbic IBTC (service provider for the delivery of CTs)	
8. TOTAL COST	$78 million	
9. TARGET GROUP(S)	Pregnant women in randomly selected villages in five local government areas in Zamfara and Jigawa States	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	90,000 pregnant women	
11. NUMBER OF REACHED BENEFICIARIES	*As of October 2015:* 30,000 pregnant women	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM	☒ Rural
	☒ Multisectoral collaboration	☒ Resilience
	☐ Integrated approach	☐ Conflict-affected setting
	☐ Governance	☐ Harnessing nutrition data
	☐ Decentralization	☒ Use of mobile technology
	☐ Performance-based financing	☒ BCC
	☒ Community participation	☒ Life-cycle approach
	☐ Agriculture and local procurement	☒ Gender and women's empowerment
	☐ Urban	☐ ECD

CONTEXT OVERVIEW	
1. CONTEXT	Poverty, hunger, and malnutrition are widespread in northern Nigeria and affect the potential for children to survive and thrive. Sixty-four percent of Nigeria's 158 million people live on less than $1.25 per day (calculated using the 2004 Nigerian Living Standards Survey and the 2010 UN Population Division population projections). Approximately 77 percent of the population is poor. Nationally, nearly one in five children under the age of 5 dies each year. In the north the rate is 40 percent higher, and about one-third of the deaths are caused by malnutrition. Maternal mortality rates are three times the national rate. More than two-thirds of girls 15–19 years old cannot read, and only 3 percent finish secondary school. Development efforts will have limited impact until the root causes of food insecurity and malnutrition are addressed. Poverty, social exclusion, a growing sense of injustice, and frustration with corrupt and chronically weak governments have been exploited by radical religious ideologues. This has led to instability and conflict that are growing worse and spreading elsewhere in the country. If it continues, progress in reducing poverty will remain beyond reach. Inclusive broad-based and poverty-focused development in the north is an essential part of the solution to this problem. Compared to other African countries, Nigeria's social-sector spending as a percentage of GDP is relatively low, and the allocation to social protection is even lower. *Child Development Grant Programme, Business Case, DFID Nigeria, August 2012.* *CDGP Baseline Household Survey. 2014.* *DFID Nigeria Bilateral Aid Review Offer*

CONTEXT OVERVIEW	
	Holmes, R., M. Samson, W. Magoronga, and B. Akinrimisi, with J. Morgan. 2011. "The Potential for Cash Transfers in Nigeria." London: Overseas Development Institute *National Population Commission (Nigeria) and ICF Macro. 2009: Nigeria Demographic and Health Survey 2008. Abuja: NPC and ICF Macro*
2. COUNTRY INCOME LEVEL	Lower-middle-income
3. KEY CONTEXT DATA	2013 data: • GDP growth: 5.4 percent • Share of population with access to improved sanitation facilities: 30 percent • Life expectancy: 52 years • Infant mortality rate: 74 per 1,000 live births 2009 data: • GDP growth: 6.9 percent • Poverty rate (at national poverty lines): 46 percent • Poverty rate, by location (at national poverty lines): rural, 52.8 percent • Poverty headcount ratio at $1.90 a day (2011 PPP): 53.5 percent of population • Gini index: 43 (WBG estimate) • Share of population with access to improved sanitation facilities: 31 percent • Life expectancy: 51 years • Infant mortality rate: 84 per 1,000 live births *WDI*
4. KEY SOCIAL PROTECTION DATA	2014 data: • Public spending on social assistance programs, percent of GDP: 0.3 percent 2012 data: • Coverage of SSNs in total of population: 3.5 percent • Coverage of SSNs in extreme poor: 4.5 percent • Adequacy of benefits of SSNs in total population: 0.8 percent • Adequacy of benefits of SSNs in extreme poor: 1.0 percent • Incidence of benefits of SSNs in extreme poor: 19.9 percent • Incidence of beneficiaries of SSNs in extreme poor: 63.1 percent *ASPIRE database*
5. NUTRITION CONTEXT	The rural poor are particularly vulnerable to increases in food prices. Most HHs do not produce enough food for consumption and have to purchase the majority of it with cash. Producing enough to eat through farming and herding alone is becoming harder because of desertification and climate change: most HHs produce only 25 percent of their own food. HHs typically spend three-quarters of their income on food, and since 2003, food prices in Nigeria have risen steadily. Hunger and malnutrition are common: 20 percent of women are undernourished and half of the children under five are stunted. Children who are stunted are immediately disadvantaged, with effects lasting throughout their lifetimes. Stunting affects health and education prospects and is likely to be passed on to the next generation. In CDGP communities, fewer than 1 percent of children from birth to 6 months old are breastfed exclusively and 16 percent of children 6–23 months old receive foods from four or more food groups.

CONTEXT OVERVIEW	
	Recent research in Katsina State shows that very poor HHs (47 percent of all HHs) don't have enough money for a nutritious diet even in the post harvest period when prices are at their lowest. To fill the gap between what they eat and what they should be eating would cost approximately $14–19 a month. (These findings are comparable to those in parts of southern Niger.) *Child Development Grant Programme Logframe* *Household Economy Analyses and Cost of Diet Assessments (2008 and 2011).* *ODI (Overseas Development Institute): Food, Finance and Fuel: The Impacts of the Triple F Crisis in Nigeria—Kano State Focus Report. 2011. London: Overseas Development Institute* *Save the Children Niger (2008, 2009, 2010, 2011)* *Save the Children Nigeria November 2010: Cost of Diet Assessment, Daura LGA, Katsina State)* *Save the Children Nigeria 2010: Household Economy Analysis, Millet and Sesame Livelihood Zone, Daura LGA, Katsina State*
6. KEY NUTRITION DATA	Data from ePact situational analysis: Children under 5 years old suffering from • Stunting: 66 percent • Underweight: 35 percent • Wasting: 7 percent 2013 data[a]: Children under 5 years old suffering from • Stunting: 36.4 percent • Underweight: 31 percent • Wasting: 18.1 percent [a] *WDI*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	CDGP is a five-year pilot program designed to address poverty and hunger and reduce malnutrition in children in northern Nigeria (Zamfara and Jigawa states). SCI is leading the INGO consortium delivering the program, in partnership with AAH. A key component of the CDGP is an increase in the political and institutional commitment to implementing effective statewide social protection programs that ensure improved nutrition, food security, and poverty reduction for women and children. For this reason, advocacy and community engagement are important functions of the program. **Monthly UCTs.** A grant of ₦3,500 (approximately $18) a month each to pregnant women and women with children under two in Jigawa and Zamfara states accompanied by nutritional education and advice. **MIYCF trainings for community volunteers and health extension workers** **BCC.** Mass media, IEC materials, voice messaging, support groups, one-on-one counseling, food demonstrations, drama groups, health education sessions, and community sensitization. **Complaints and Response Mechanism (CRM).** A mechanism to capture and respond to community concerns, including complaints, requests for information, and guidance from beneficiaries and community members.

PROGRAM DETAILS	
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	₦3,500 ($18) monthly for approximately 30 months. The program targets, as much as possible, the 1,000-day nutrition window of opportunity starting with the confirmation of pregnancy and ending at the age of 2.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The transfer value was calculated by subtracting HH expenditure on food from the cost of a healthy diet. The cost of a healthy diet analysis was conducted in 2010 and the cash transfer amount was determined in 2012 using an inflation-adjusted figure.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	CDGP is an unconditional cash transfer that is strongly linked to nutrition BCC. Beneficiaries are encouraged to attend support group sessions, one-on-one counseling, drama groups and food demonstrations. They also receive voice messaging and radio communication.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	No information available.
9. INSTITUTIONAL ARRANGEMENTS	The program is multisectoral but is monitored by the National Planning Commission at the federal level. Local Government and Economic Planning are the lead ministries at the state level. Staff from the Ministry of Local Government who are involved in program implementation are seconded to the program. The Ministry of Economic Planning leads in providing strategic oversight to the program with inputs from the MOH and the Ministry of Women's Affairs. Oversight is conducted through quarterly State Steering Committee meetings and participation in planning and learning events for the program.
10. COMMUNITY PARTICIPATION	Community participation takes place throughout program, at initial sensitization, targeting and enrollment, nutrition BCC activities, and the CRM. Traditional leaders identify women who belong to the community prior to pregnancy testing, enrollment, and registration. Community volunteers ensure that beneficiaries are guided through community verification, pregnancy testing, enrollment, and registration. Community volunteers also support the MIYCF support groups and provide one-on-one counseling. The community-based Traditional Ward Committees, consisting of community leaders and members, help identify community volunteers and form the Beneficiary Reference Groups to register and respond to complaints and questions. Community volunteers and traditional leaders provide feedback to the program during monthly meetings.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	This is a pilot program that does not have the financial capacity to operate beyond its lifetime without government counterpart funding. CDGP is currently engaging state governments to advocate for this and build capacity for government scale up of the program.

PROGRAM DETAILS	
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	The State Steering Committee, consisting of key state ministries such as Budget and Economic Planning, the MOH, and the Ministry of Women's Affairs, provides oversight to the program and supports planning and monitoring. Staff from the Ministry of Local Government are seconded to the program and provide support in targeting and enrollment, implementation, and M&E. A State Engagement–Advocacy Strategy will be developed that will include a Transition Plan for transferring control of the program to government. The Transition Plan will also include the costs of different options for rolling out the program to assist the government's analysis.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	A logical framework is being used in this program and provides the basis for the M&E. An MIS is being developed to capture all program activities across all program sites. CDGP staff use field-monitoring checklists for all program components. The CRM is monitored, documenting the number and type of complaints received and responses. Postdistribution monitoring (PDM) is conducted quarterly to measure the key program indicators.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	A process evaluation will be conducted in 2016, and an impact evaluation is currently planned for 2017. Both will be conducted by ePact from Oxford Policy Management, an external evaluation team contracted by DfID.
3. OUTCOME/IMPACT INDICATORS	The program has outcome and impact indicators that are part of the logical framework: **Impact:** Improved nutritional status of children under five in Jigawa and Zamfara states. **Impact Indicator:** Prevalence of stunting among children under five in CDGP communities will be reduced by 10 percent. **Outcome:** A scalable program showing that CTs can bring cost-effective immediate and long-term food security and nutrition benefits to eligible households with young children in poor communities in northern Nigeria. **Outcome Indicator 1:** Status of state policy, legislative support, and approval of plan for noncontributory social protection. **Outcome Indicator 2:** Percent of HHs that borrowed money in the previous year to cope with insufficient food availability in CDGP communities. **Outcome Indicator 3:** Proportion of children 6–23 months old who receive foods from four or more food groups in CDGP communities. **Outcome Indicator 4:** Percent of children from birth to 6 months old who are exclusively breastfed in CDGP communities.
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	PDM in June 2015 shows that 89 percent of beneficiaries are food secure, reporting to never worry about their access to or availability of food. Ninety-five percent of beneficiaries (92 percent and 98 percent for Jigawa and Zamfara states, respectively) say they have never had to purchase food on credit, failed to pay someone's health bill to pay for food, or sold items in the household to pay for food. Ninety-four percent of beneficiaries in Zamfara and 86 percent of beneficiaries in Jigawa reported having heard messages on the importance of always purchasing nourishing food.
5. HARMONIZATION WITH OTHER PROGRAMS	During inception, the donor requested that the CDGP be implemented at sites without other programs so that any impact can be directly attributed to the CDGP. However, CDGP collaborates closely with another large SCI program, Working to Improve Nutrition in Northern Nigeria (WINNN), in the design of nutrition BCC tools and activities promoted by the national MIYCF guidelines. To facilitate this collaboration, CDGP and WINNN attend each other's planning meetings. CDGP will also collaborate with WINNN on a joint study of community volunteer man-hours and incentive packages across DfID programs.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The size of the CT was determined by the cost of an easily accessible nutritious diet. Payments are reliable and delivered monthly. The CT is delivered to women; the PDM and impact evaluation will determine whether women maintained control over the income or whether they had input into the use of the cash.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	Although CDGP is primarily a CT program, it has the potential to improve the food and nutrition security of the beneficiary HHs. The program is strongly linked to BCC activities (soft conditions) and promotes behavioral changes through exposure to MIYCF trainings, support groups, one-on-one counseling, food demonstrations, drama groups, and mass media focused on BCC. CDGP food demonstration sessions provide guidance on how to prepare nutritious meals for beneficiaries and their children 6–23 months old. They also receive educational information to promote handwashing, personal hygiene, and health-seeking behavior. The program promotes capacity building through MIYCF trainings at the community level.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The program universally targets an at-risk age group, children in the first 1,000 days and pregnant women. Support starts when pregnancy is confirmed and continues until the child reaches the age of 2. The program is implemented in northern Nigeria, which has high numbers of malnourished children. The states and local government areas that are participating in the program were selected in part based on high malnutrition indicators.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	Payment agents deliver the cash to the communities in which the women live, which minimizes the participants' travel time and costs of transport. As mobile payments develop within northern Nigeria, the program will transition to a community-agent-based model, which will enable women to access their payments at a convenient time during the month.
5. THE PROGRAM HAS NUTRITION INDICATORS	The nutrition indicators for the program are built into the program's logical framework and carry the same weight as the CT component. At outcome levels, the program indicators measure dietary diversity and the rate of exclusive breastfeeding. The output indicators measure the reach of the BCC activities. The program also measures involvement of beneficiaries in support groups and support group activities, the coverage of mass media, and improvement in knowledge and practice on health and nutrition.
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	The program is research-oriented. An impact evaluation will be conducted by an external evaluation team under contract with DfID that will assess the impact of high intensity and low intensity nutrition BCC in two different treatment groups and a control. CDGP improves resilience by providing support throughout the year, especially during the hunger season, which typically runs from March until September.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The program has the potential to be a best practice once key components have been reviewed and strengthened. Improvements should include a payment system and a CRM for remote, illiterate communities.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Training of community health extension workers and community volunteers in MIYCF builds community capacity in implementing this and other similar programs. Conducting a second cost-of-diet analysis to ensure that the current transfer level meets HH needs. Establishment of support groups in the communities. The federal and state governments are strongly engaged, participating in the program, and supporting the approach and focus on nutrition. The program has been able to provide regular monthly CTs.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Inability to leave nutrition documents for community to use because of high illiteracy. Poor telecommunication network limiting the impact of nutrition voice messages. Reliance of program on community volunteers for BCC support. Challenges on payment mechanisms have limited the ability to introduce a community-agent based model, which would enable flexibility for beneficiaries in accessing payments.

FURTHER REFERENCES	
1. DOCUMENTS	Documents available at http://sc-cdgp.org/: • CDGP Programme Brief • CDGP Factsheet (June 2015 ed.) • Technical Brief: Achieving Accountability and Learning in CDGP using Post Distribution Monitoring *CaLP (Cash Learning Partnership). 2014. "Planning for Government Adoption of a Social Protection Programme in an Insecure Environment: The Child Grant Development Programme in Northern Nigeria."* http://www.cashlearning.org/news-and-events/news-and-events/post/105-new-case-study-planning-for-government-adoption-of-a-social-protection-programme-in-an-insecure-environment-the-child-grant-development-programme-in-northern-nigeriaMonitoring Strategy
2. METHODS OF DOCUMENTATION	The information was collected through fieldwork and participatory methodology.
3. WEB SOURCES	No information available.

Republic of Congo – Nutrition-Sensitive Urban Safety Net Program

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Gautier Massamouna, Assistant Vulnerability Analysis and Mapping Officer[a] David Bulman, Country Director Koffi Akakpo, Deputy Country Director Angele Ayenoue, Program Officer and HIV/Nutrition, Focal Point Thibaut Ackondjo, Senior Program Assistant, Safety Net
ORGANIZATION	World Food Programme
ROLE IN THE PROGRAM	[a]Vulnerability Analysis and Mapping; monitoring and evaluation of nutrition and safety net activities

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Nutrition-Sensitive Urban Safety Net Program
2. COUNTRY	Republic of Congo
3. TYPE OF PROGRAM	In-kind transfer (conditional food voucher) with Food/Nutrition Supplement
4. PROGRAM DURATION	January 2015 to December 2018 April 2012 to December 2014 (pilot)

PROGRAM OVERVIEW		
5. PROGRAM OBJECTIVE(S)	Strengthen the capacity of the government to implement a safety net program to reduce hunger and improve access to basic and social services for the most vulnerable populations by • Improving food consumption of vulnerable populations • Ensuring access to care for PLW and children under 2 years old • Improving the living conditions of HHs affected by HIV and TB • Supporting treatment adherence with antiretroviral therapy or directly observed treatment, short course, by Persons living with HIV (PLHIV) and people with TB, respectively.	
6. FUNDING AGENCY/IES	Government of the Republic of Congo (60 percent) World Food Programme (40 percent)	
7. IMPLEMENTING AGENCY/IES	World Food Programme Ministry of Social Affairs, Humanitarian Action and Solidarity (responsible institution)	
8. TOTAL COST	$24,223,139	
9. TARGET GROUP(S)	HHs with less than $60 income per month and with one of: (a) a PLW; (b) a PLHIV or person with TB under treatment and malnourished; or (c) at least two school-age children not attending school.	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	117,600 individuals (19,600 HHs) 81,600 PLW (69.39 percent of targeted individuals)	
11. NUMBER OF REACHED BENEFICIARIES	36,828 beneficiaries (6,138 HHs)	
12. PROGRAM CROSS-CUTTING THEMES	☒ DBM	☐ Rural
	☐ Multisectoral collaboration	☒ Resilience
	☒ Integrated approach	☐ Conflict-affected setting
	☐ Governance	☒ Harnessing nutrition data
	☐ Decentralization	☒ Use of mobile technology
	☐ Performance-based financing	☒ BCC
	☐ Community participation	☐ Life-cycle approach
	☐ Agriculture and local procurement	☒ Gender and women's empowerment
	☒ Urban	☐ ECD

CONTEXT OVERVIEW	
1. CONTEXT	Although the Republic of Congo is an oil-rich, middle-income country, more than half of the population live below the poverty line. Food insecurity affects 5 percent of the population (approximately 216,000 people), while high undernutrition has produced a stunting prevalence of 30 percent among children below the age of 5. The mortality rate of children is 128 per 1,000 live births, one of the highest rates in the world. The UNDP Human Development Index of 2013 ranked the Republic of Congo at 140 out of 187 countries, placing it in the "low" category for human development. Poverty affects 46.5 percent of the population. The Gini coefficient is 0.43, indicating significant inequalities. Of the estimated 4.2 million inhabitants, 64 percent live in urban areas, mainly in Brazzaville and Pointe-Noire. According to the index of world hunger, the score of the Republic of Congo, rose from 18.4 in 2005 to 20.5 in 2013. The Republic of Congo imports 75 percent of its food. In 2011, food imports exceeded $400 million.

CONTEXT OVERVIEW	
2. COUNTRY INCOME LEVEL	Lower- middle-income
3. KEY CONTEXT DATA	2011 data: • Access to health services: 66 percent 2010 data: • Rate of incidence of TB: 256 per 100,000 population 2009 data: • HIV prevalence: 3.2 percent 2012 data[a]: • GDP growth: 7.2 percent • Gini index: 42.1 (WBG estimate) • Poverty rate (at national poverty lines): 63.6 percent • Poverty rate, by location (at national poverty lines): urban, 61.6 percent • Poverty headcount ratio at $1.90 a day (2011 PPP): 77.2 percent of population • Share of population with access to improved sanitation facilities: 28 percent • Life expectancy: 58 years • Infant mortality rate: 81 per 1,000 live births *United Nations Development Programme. Human Development Report. 2013. New York: United Nations.* *Measuring undernourishment, child malnutrition and infant mortality* *World Food Programme. 2013. Depth Analysis of Comprehensive Food Security and Vulnerability Assessment.* *African Development Bank. 2011. Study of the Agricultural Sector* *Congolese Household Survey, 2012.* *Seroprevalence Survey and AIDS Indicator Congo. 2009.* *[a]WDI*
4. KEY SOCIAL PROTECTION DATA	2005 data: • Coverage of SSNs in total of population: 0.9 percent • Coverage of SSNs in extreme poor: 0.9 percent • Adequacy of benefits of SSNs in total population: 39.8 percent • Adequacy of benefits of SSNs in extreme poor: 102.2 percent • Incidence of benefits of SSNs in extreme poor: 48.5 percent • Incidence of beneficiaries of SSNs in extreme poor: 53.8 percent *ASPIRE database*
5. NUTRITION CONTEXT	In addition to impeding human development and opportunities for economic advancement, food insecurity and undernutrition are major factors in the transmission of HIV, which affects 2.8 percent of the population 15–49 years old. In urban areas 3.3 percent of the population is affected. Poverty and food insecurity limit access to basic social services, including education. Chronic malnutrition affects 24.4 percent of children in the Republic of Congo, and the department of Lekoumou has the highest level at 38.6 percent. Micronutrient deficiencies are widespread. Moderate acute malnutrition affects about 65 percent of PLHIV and people with TB.

CONTEXT OVERVIEW	
6. KEY NUTRITION DATA	2009–12 data: Children under 5 years old suffering from • Wasting: 6 percent • Underweight: 12 percent • Anemia: 67 percent • Iron deficiency: 67 percent • Vitamin A deficiency: 52 percent Women of childbearing age with acute malnutrition: 14 percent Pregnant women are deficient in iron and folic acid: 70 percent Low birth weight: 13 percent 2013 data[a]: Children under 5 years old suffering from • Stunting: 42.6 percent • Wasting: 8.1 percent 2011 data[a]: • Children under 5 years old suffering from anemia: 67 percent *Congolese Household Survey, 2012.* *Seroprevalence survey and AIDS Indicator Congo. 2009* *National Report of support centers for PLHIV and TB, 2011* [a]*WDI*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	World Food Programme Urban Safety Net program addresses the immediate food and nutritional needs of those most vulnerable to food insecurity, poor nutrition, and poverty in the main suburban areas of Brazzaville and Pointe Noire, and in four new rural areas (Owando, Sibiti, Kinkala and Djambala) starting in 2014. Implemented by the Ministry of Social Affairs, Humanitarian Action, and Solidarity, with technical and capacity building support from World Food Programme, the Urban Safety Net provided electronic vouchers redeemable for food to some 6,138 HHs in 2015, and nutritional supplementation for the treatment of acute malnutrition among PLHIV and people with TB. **Allocation of electronic vouchers for CFAF 30,000 ($60).** HHs exchange their vouchers for particular commodities in the shops according to the nutritional needs of each category (PLW, PLHIV, and people with TB). **Nutrition supplement.** Moderately malnourished beneficiaries with TB or HIV are fortified with CSB+ and oil fortified with vitamins A and D, for the treatment of moderate malnutrition. Micronutrient powders are provided to PLW and children between 6 and 23 months.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	The food voucher is valued at US$60 monthly per HH for 18 months.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The transfer amount was determined based on average HH food expenditure, as determined by the 2011 feasibility study, and cost of diet and market data analyses.

PROGRAM DETAILS	
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Food is procured locally by shopkeepers from any supplier. Beneficiaries can exchange their electronic vouchers to purchase food at certain shops. The shops are selected according to their supply capacity and their commodity prices to avoid inflation.
5. IS THE TRANSFER LINKED TO CONDITIONS?	HHs must: • Adhere to antiretroviral therapy or directly observed treatment, short course, for HIV and TB patients, respectively • Attend prenatal and postnatal monitoring for PLW and vaccinate children • Reintegrate children in school and ensure their attendance
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	No information available.
9. INSTITUTIONAL ARRANGEMENTS	The Ministry of Social Affairs, Humanitarian Action and Solidarity (MASAHS) coordinates the implementation of project activities at the national level. In the field, activities are coordinated at the level of the circumscriptions of social action and the health centers for PLHIV and people with TB, which carry out the coordination. The project has a steering committee composed of representatives of various ministries, headed by a president appointed by the Ministry. This committee provides strategic direction, control, and evaluation of the level of implementation of project activities.
10. COMMUNITY PARTICIPATION	The project is supported by a strategy for BCC and project-output mechanisms that involve community participation in the disclosure of the strategy.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The project should be extended to semiurban and rural areas but a lack of resources has prevented it.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	By 2018, the project may become part of the national strategy for social protection, which would be entirely funded by the Republic of Congo.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	The project uses a logical framework with monthly monitoring of HHs through home visits, care centers, and integrated health centers using a World Food Programme beneficiary identification and management tool referred to as "SCOPE".
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	Midterm and annual evaluations (monitoring and PDM) are provided according to the logical framework for M&E.

MONITORING AND EVALUATION	
3. OUTCOME/IMPACT INDICATORS	• Nutritional status • Socioeconomic status • Access to basic social services • Food Consumption Score • Coping Strategies Index • Food expenditure share • Household Dietary Diversity Score (HDDS) • Adherence to the treatment for PLHIV • Success rate for treatment of TB • Number of pre- and postnatal exams for PLW • Number of children vaccinated • Adherence rate for out-of-school children • Coverage rate of nutritional supplementation for PLHIV and people with TB
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	The last annual evaluation of the project showed improved food security, nutritional status, and socioeconomic status, as well as access to basic social services for vulnerable HHs. The project demonstrated the effectiveness of food transfers through mobile money against food insecurity and in stimulating economic activity. The evaluation also shows that the project can help fight poverty sustainably through exit strategies in partnership with other actors The program has had a positive impact among beneficiaries as some are engaged in income generating activities. There has also been a strengthening of knowledge among health workers through BCC implemented in health centers and circumscriptions of social action.
5. HARMONIZATION WITH OTHER PROGRAMS	The government plans to link the project with the national school program.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The electronic voucher is sent to beneficiary HHs using mobile money, providing access to a selected range of food commodities with a ceiling on cereals to ensure a nutritious balanced diet. The voucher can be used to purchase of fresh products, including fruits, vegetables, and meat.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The program addresses the immediate determinants of undernutrition (such as inadequate dietary intake and disease) and targets the complex and interrelated underlying determinants (such as poor practices for food use, insufficient health services, and inadequate care for children and women). World Food Programme food and nutrition assistance to vulnerable HHs provides incentives for the use of and access to basic social services provided by the government. The use of conditional voucher transfers not only reduces hunger and immediate poverty, but also promotes positive behaviors that increase resilience to food insecurity and undernutrition in the long term. A program for BCC supports the project through campaigns to promote better feeding and hygiene practices for infants, children, PLW, PLHIV and persons with TB. Training for health workers and awareness workshops and are conducted on the benefits of a balanced and diversified diet and the importance of health monitoring and vaccinations. Brochures and publications are provided on these topics.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The program targets PLHIV and TB malnourished-vulnerable individuals. They are assisted in a supplementary feeding program for the treatment of moderate acute malnutrition (MAM). Along with PLW, these groups are followed through awareness programs for balanced diets, to fight against all forms of malnutrition during pregnancy, and to ensure the nutritional status of children in the first 1,000 days.

NUTRITION-SENSITIVE RATIONALE	
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	PLW are trained in food practices through BCCs and nutrition education sessions. Food vouchers are delivered electronically through mobile money.
5. THE PROGRAM HAS NUTRITION INDICATORS	• Nutritional recovery rate • HDDS • Number who attend the sessions of nutrition education • Number of nutrition education sessions conducted • Percentage of children born with low birth weight • Number of antenatal and postnatal visits • Number of childhood vaccines administered
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	The project contributes to the Republic of Congo's capacity to address hunger reduction, which will lead to the development of a national social protection policy. The program has created strategic partnerships (including for the nutritional health training of FEFA and health workers) with UNICEF and the MOH's National Nutrition Service. FAO and IFAD expertise assist the program in rural areas and support a multisectoral approach to the implementation of exit strategies for HHs in the project. The project includes exit mechanisms that can increase HH resilience. Beneficiary HHs are assessed for participation in livelihood-related projects such as income-generating activities, training for trades and cooperatives, and other group activities. Contracts have been signed between the Ministry of Social Affairs, World Food Programme, and partners with expertise in microbusiness training and support for income-generating activities.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The program encourages the use of and access to basic social services provided by the government. The use of conditional transfers not only reduces immediate hunger and poverty, but also promotes positive behaviors that increase resilience to food insecurity and undernutrition in the long term.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	• With the help of World Food Programme nutritional assistance, the recovery rate from malnutrition was 91 percent among PLHIV and 97 percent among people with TB. • Ninety-nine percent of PLW received postnatal check-ups, compared to a national rate of 64 percent in urban areas. • 100 percent of children 9–15 months old were vaccinated on schedule.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	• Introduction of a nutritional supplement for children under 2 years old and PLW. • Extension of the project to four rural departments most affected by malnutrition and food insecurity. • Establishment of a joint strategy between the MOH and the Ministry of Social Affairs, aimed at integrating nutrition and social protection. Because of the lack of a common strategy, nutritional support is not taken into account in social protection programs.

FURTHER REFERENCES	
1. DOCUMENTS	Midyear evaluation, public reports, technical fact sheets, posters, pictures, video and audio, and two annual reports are available upon request.
2. METHODS OF DOCUMENTATION	*2011 feasibility study* *CFSVA Rep. of Congo 2013* *Cost of Diet Rep. of Congo* *Market Analyses* *Monthly report on food market price*
3. WEB SOURCES	www.wfp.org/countries/congo

Tanzania – Tanzania Productive Social Safety Net

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Muderis Abdulahi Mohammed, Senior Social Protection Specialist
ORGANIZATION	World Bank Group (WBG)
ROLE WITHIN THE PROGRAM	Task Team Leader

PROGRAM OVERVIEW		
1. NAME OF PROGRAM	Tanzania Productive Social Safety Net (PSSN)	
2. COUNTRY	Tanzania	
3. TYPE OF PROGRAM	Conditional Cash Transfer (CCT) and PWP	
4. PROGRAM DURATION	August 2012 to December 2017 (extended to December 2019)	
5. PROGRAM OBJECTIVE(S)	To create a comprehensive, efficient, well-targeted productive social safety net for vulnerable sections of the Tanzanian population.	
6. FUNDING AGENCY/IES	WBG (IDA) $220 million (expanded to $420 million in 2016) Government of Tanzania $4 million DfID $16 million (expanded to $186 million in 2016) Government of Spain $0.9 million (expanded to $75.90 million in 2016)	
7. IMPLEMENTING AGENCY/IES	Tanzania Social Action Fund (TASAF) (responsible institution) under the President's Office	
8. TOTAL COST	$240.90 million (expanded to $685.90 million in 2016)	
9. TARGET GROUP(S)	Poor and vulnerable HHs living in PAAs and villages identified as being worst affected by poverty. In addition to the direct beneficiaries, HHs living in selected villages benefit from the creation of community assets under the labor-intensive public works component of the program.	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	1,100,000 extremely poor HHs (comprising 6 million people) living in selected villages. The program is implemented in all districts (expanded to 1,700,000 HHs). Female beneficiaries: 50 percent	
11. NUMBER OF REACHED BENEFICIARIES	*As of August 2015:* 1,100,000 HHs (Female: 55 percent)	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM	☐ Rural
	☐ Multisectoral collaboration	☐ Resilience
	☒ Integrated approach	☐ Conflict-affected setting
	☐ Governance	☐ Harnessing nutrition data
	☐ Decentralization	☐ Use of mobile technology
	☐ Performance-based financing	☒ BCC
	☒ Community participation	☐ Life-cycle approach
	☐ Agriculture and local procurement	☒ Gender and women's empowerment
	☐ Urban	☐ ECD

CONTEXT OVERVIEW	
1. CONTEXT	The latest available data in 2007 showed that income poverty in Tanzania was very high, with 33.6 percent of the population living below the basic needs poverty line and 16.6 percent, or 6.4 million people, living below the food-poverty line. The poor in Tanzania remain overwhelmingly rural. Eighty-four percent of the vulnerable poor are in rural HHs, highly dependent on agriculture (74 percent) both for income and food consumption. The average rural HH is larger than its urban counterpart (6.7 members compared to 5.7 members), has a higher proportion of dependents (children under 15 years old and elderly over 61 years old) than its urban counterpart, and has less adult labor force capacity, further limiting income earning opportunities and exacerbating poverty. *WBG Project Appraisal Document (PAD) 67116-TZ March 2012*
2. COUNTRY INCOME LEVEL	Low income
3. KEY CONTEXT DATA	2007 data: • GDP growth: 8.5 percent • Gini index: 40.3 (WBG estimate) • Population living below basic-needs line: 33.6 percent • Population living below food-poverty line: 16.6 percent • Share of population with access to improved sanitation facilities: 12 percent • Vulnerable poor in rural areas: 84 percent • Average number of members per HH, rural: 6.7 • Average number of members per HH, urban: 5.7 *WDI and WBG PAD*
4. KEY SOCIAL PROTECTION DATA	2010 data: • Coverage of SSNs in total of population: 14.7 percent • Coverage of SSNs in extreme poor: 13.7 percent • Adequacy of benefits of SSNs in total population: 1.9 percent • Adequacy of benefits of SSNs in extreme poor: 1.3 percent • Incidence of benefits of SSNs in extreme poor: 14.3 percent • Incidence of beneficiaries of SSNs in extreme poor: 35.6 percent 2009 data: • Public spending on social assistance programs, percent of GDP: 0.3 percent *ASPIRE database*
5. NUTRITION CONTEXT	2007 data showed a significantly high level of food insecurity, particularly for rural Tanzanian HHs. Because rural households are highly dependent on agriculture for both income and food consumption, variations in rainfall and vulnerability to climatic shock mean that income and food availability can vary significantly. In addition to limited and variable rainfall, rural Tanzanians suffer from the lack of proper markets, which would allow them to sell surplus or buy more to offset deficits in production, poor access to services, and variations in soil quality. Seasonal variance in the supply and demand for food, coupled with weak markets, leads to significant swings in prices and a drastic reduction in poor HH consumption. Seasonality also affects the demand for labor. During the lean seasons, off-farm employment does not compensate for the drop in demand for agricultural work, resulting in a gap of demand and supply for jobs in the short term. Malnutrition remains stubbornly high, with long-term consequences for educational attainment and adult productivity. Poor nutrition in Tanzania, as elsewhere, is a consequence of a combination of inadequate and poor diet, poor caring practices,

CONTEXT OVERVIEW	
	heavy disease burdens, and poor hygiene and sanitation. According to the data available at time of project design, approximately 42 percent of children under 5 years old were stunted, and 13 percent were severely stunted. *WBG Project Appraisal Document (PAD) 67116-TZ March 2012*
6. KEY NUTRITION DATA	2007 data: Children under 5 years old suffering from • Stunting: 42 percent • Severe stunting: 13 percent Prevalence of undernourishment: 34 percent *WDI and WBG PAD*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**Consolidation of integrated social safety net interventions for extremely poor and food insecure HHs through:** • CCT comprising two benefits: (a) A basic transfer to all eligible registered HHs; and (b) a VCT for HHs with children younger than 18 or pregnant women, or both, subject to compliance with coresponsibilities by each of the eligible members of the HH • PWP that offers a guaranteed 15 days of paid work per month for four months (totaling 60 days per year) for one member of each eligible HH. HHs can continue to access the program as long as they remain eligible under the common targeting mechanism, enabling them to plan, save, and invest with the assurance that this income is available. HHs are eligible for the PWP if they have been listed by the common targeting system and have at least one able-bodied adult member 18–65 years old who is not more than four months pregnant or disabled. • Community Savings Promotion (COMSP) that complements the PWP by mobilizing beneficiaries to save through a group savings methodology. Activities to be financed include community mobilization for savings, community-group institutional building, record keeping, and technology-based innovations, such as using information and communication technology whenever possible and providing well-designed savings messages to communities on a regular basis using mobile technology. As groups progress, they may be linked to legally constituted financial institutions to ensure that the poor operate in a viable and sustainable savings framework. A rigorous impact evaluation is part of the implementation subcomponent used to assess the evidence of impact. **Institutional Strengthening.** The program (a) supports the government of Tanzania in incorporating the PSSN into a national social protection framework; (b) supports TASAF in implementing the PSSN under the current structure and gradually moving toward permanent institutional arrangements; and (c) supports program management and M&E of the PSSN. The component finances activities at the national, PAA, and community levels to improve accountability and transparency in the use of project resources.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	CCT: Basic transfer of $5 monthly per HH; VCT of up to $14 monthly. Payments are disbursed bimonthly. PWP: $1.35 daily for 60 days. PSSN is expected to cover about 1.1 million HHs across the country, with varying degrees of benefits. Within this framework, and subject to HH composition, the eligible HHs may receive a benefit of between $60 per year (the basic transfer) and up to a maximum of $200 per year (for HHs with labor capacity and children or pregnant women benefiting from all three transfers).

PROGRAM DETAILS	
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	With a benefit equivalent to up to 30 percent of targeted HH consumption (when combined with the CT resulting from the participation in the PWP), the program is expected to significantly increase HH consumption while making a considerable contribution to poverty reduction. The PWP daily wage rate, which is lower than the average market rate for unskilled labor, provides a certain degree of self-targeting. Preliminary estimates indicate that a combined intervention of CTs and PWP benefits under the above-mentioned general framework and the programs' generosity would reduce the poverty headcount by around 8 percent and the poverty gap by about 15 to 20 percent at an annual cost equivalent to 0.25 percent of GDP per year (accounting for targeting errors).
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Beneficiary HHs register all eligible members in the program and all must comply with their respective coresponsibilities. Management of benefits is designed to assist HHs in complying with their coresponsibilities to maximize the number of HHs that receive full payment. The first failure to comply does not result in a penalty, but instead the HH receives a warning and counseling from the CMC. No penalty is applied for the first two rounds after initial enrollment. The following conditions apply: • Education: Annual enrollment of children 5–18 years old in preprimary, primary, and secondary schools (where available) and regular attendance for at least 80 percent of the school days per month • Maternal and infant health: All pregnant women in beneficiary HHs must attend a minimum of four prenatal medical examinations; deliver at a health facility or be assisted by skilled personnel; and attend a postnatal checkup according to the government's health protocol. Children under 2 years old must receive regular checkups at health services at least once per month, including regular growth monitoring and counseling and distribution of micronutrients. All children in the HH 24–60 months old must attend routine health services at least once every six months • Workshops to reinforce nutrition practices and investment in human capital: At least one parent or guardian must attend monthly workshops organized by the program in coordination with the education, health, and social welfare sectors to promote, for example, good nutritional practices, childcare, home hygiene, water usage, and the importance of starting education at the right age
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	The PWP operates only during those times of the year when labor demand for agricultural activities is at its lowest—just before or when additional income is most needed. The exact period of implementation of PWP in each PAA is determined at the PAA level, depending on the specific conditions of the PAA.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Labor-intensive PWP activities contribute to the overall objective of food security and help build resilience to climate-related shocks (such as drought and floods). Most are in the areas of agriculture, soil and water conservation and management, and rehabilitation of degraded areas, with the longer-term objective of enhancing livelihoods.
8. COST BREAKDOWN BY PROGRAM COMPONENT	• **Consolidation of integrated social safety net interventions for extremely poor and food insecure households:** $140 million • **Institutional strengthening:** $93.90 million • **Unallocated contingencies:** $7 million *Costs by category can be estimated as follows: direct cost of transfer 80 percent, administration and operational costs 20 percent.*

PROGRAM DETAILS	
9. INSTITUTIONAL ARRANGEMENTS	The institutional arrangements under which the PSSN will be consolidated fall under the NSPF, whose goal is to provide guidance to all government and nongovernmental actors involved in the funding, planning, and provision of social protection programs in Tanzania. For the success of NSPF and the achievement of its objectives, it is crucial that the purposes and intervention strategies of the implementing agencies be clearly articulated. To carry out this integrated approach, capacity building is necessary for all institutions that provide assistance to vulnerable groups in the country, including TASAF. As a first stage, the NSPF promotes an integrated approach—an internal coordination of institutions and an alignment of their interventions—so that in subsequent stages, each agency is able to coordinate with other agencies in the NSPF to ensure coherent interventions in beneficiary communities. At the regional and local levels, a sustained strategy needs to be determined and implemented to train key members of the PAAs and keep them informed and engaged in the program. TASAF works with PAAs on an ongoing basis to ensure adequate support and ownership at the PAA level. In addition, the CMCs, which are at the core of the implementation of the PSSN, require significant support to enhance their capacity to implement both PWP and CCT.
10. COMMUNITY PARTICIPATION	The community is involved in the project at different stages, from targeting, to selection of activities to be undertaken in PWP, to community awareness activities, and COMSP. Overall, a key responsibility for project implementation is rooted within the CMCs.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The project has greatly scaled up in response to the government's decision to reach all people below the food poverty line. The project started with Wave 1 in 14 PAAs, Wave 2 in 19 PAAs, and has now completed the rollout of Wave 5 in 47 PAAs. The project massively increased its coverage from the original plan of 275,000 HHs to 1.1 million HHs.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	• **Financial Sustainability.** The Government has provided substantial amounts to demonstrate political will and commitment, with the understanding that its contribution will grow to compensate for reductions in development partner support. The challenge will be for all the donors and the government to honor their pledges in a timely manner. • **Sustainability of Systems and Institutions.** TASAF will be strengthened through an administrative restructuring to ensure adequate management and operation of the PSSN in the mid- and long term. Adequate institutional arrangements will be also enforced by government regulation and norms. Day-to-day program implementation will continue to be the responsibility of the PAA administration, or its equivalent in Zanzibar, in accordance with the government's decentralization policy. The program will build capacity to equip the administration with the appropriate tools and systems to implement the program effectively. These include the URB, MIS, and revisions to the payment mechanism. Communities will continue to play a key role in the management and monitoring of interventions, cementing their ownership, which is key to contributing to sustainability of the program's effects. • **Sustainability of Impact at the HH Level.** Interventions covered by this program should enable beneficiary HHs to take advantage of other opportunities, reverse any decline in livelihood, and move on a positive trajectory. Furthermore, this program actively supports HHs' efforts to invest in the future through investments in health and education for children (through the VCT); investment in labor-intensive public works (through the PWP) and savings (through the COMSP). The results of these investments will continue to have positive impacts on HHs and their communities after the HHs exit the program.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	PSSN is linked to the national monitoring system. The primary data are collected by the village council, with technical assistance from the extension workers at the ward and PAA levels and the specialized nongovernmental organizations working in the PAA areas. Data are consolidated at the PAA for analysis and sharing at the regional and national levels for further aggregation and dissemination. The data analysis is then done at two levels, first at the PAA level and then at the national level. At the PAA level, all data are entered into a simple computerized MIS. The necessary computing capacities and technical know-how are strengthened through the capacity-building program. In addition, a village-level paper-based system is also in place, strengthened by the institutional support component. A quick assessment conducted by the project indicates that PSSN has achieved significant enhancements to targeting and enrollment. Most important are: (a) updating PMT and improving related operational tools (such as targeting questionnaires and the data entry interface); (b) increased compatibility with other national databases through incorporation of the National Bureau of Statistics geographical coding system in the MIS and the URB; (c) increased capacity of the data entry center at the TASAF Management Unit; and (d) the tracking of daily data entry productivity to facilitate an increase in workload as the project grows.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	The PSSN M&E system incorporates data collection, processing, and information management into an integrated data system to facilitate the operation of PSSN components through the program's cycle, across all levels of government. A comprehensive impact evaluation and regular process evaluations to assess program operations are also included. These evaluations are carried out for both the CCT and PWP, starting one year after expansion. Beneficiary surveys and qualitative evaluation are also conducted. A grievance mechanism has been designed and tested to enhance program accountability. Field-based sampling verifications, in the form of spot checks, and financial and technical audits are conducted.
3. OUTCOME/IMPACT INDICATORS	Project development objectives: • Direct beneficiaries supported by the program (PWP, CCT) • Benefits reaching the poorest 20 percent of the population • Proportion of beneficiaries and caretakers who know their rights and coresponsibilities under the program's rules and entitlements; • Proportion of registered HH with updated information on compliance with coresponsibilities • Transfers of benefits to HHs within five days of their due dates, according to the annual payment calendar issued by TASAF in January each year.
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	In order to explore the possible expansion of the CCT pilot, its performance and impact have been assessed and measured using several instruments: A process evaluation completed in September 2011, a targeting assessment carried out between April and July 2011, an impact evaluation based on a quantitative analysis of a baseline and two follow-up surveys (baseline in February 2009, follow-up survey in September 2011, end-line survey in October 2012), a qualitative assessment based on focus groups convened in August and December 2011, and a social accountability exercise using community score cards finalized in August 2011. Different results can be observed regarding the impact of the pilot on health status and use of health services. The evaluation shows that children participating in the program are 5 percent less likely to be sick or injured in the previous month compared with children in control villages. There is no evidence, however, that participating in the program has had any impact on adults or the elderly for the same indicator. In control villages there is no significant difference between children and adults, and the elderly population is more likely to be sick or injured. Also in the health sector, children and the elderly are more likely to seek care when sick (11 and 13 percent more than the same groups in control villages, respectively). Adults in treatment villages are less likely to seek care, and in control villages, children and the elderly are less likely to seek care when sick than adults in the same villages (–6 and –15 percent less likely, respectively).

MONITORING AND EVALUATION	
5. HARMONIZATION WITH OTHER PROGRAMS	PSSN is linked to CHF, a community-based health insurance scheme, under which beneficiaries can access local health services for an annual payment of $3 to $5. So far, 80 percent of beneficiaries are taking part in CHF. The aim of linking PSSN to CHF would be to enhance, through free access, beneficiaries' use of local health services. PSSN is also linked to WASH projects and is implemented in coordination with and with the technical support of UNICEF, UNDP, and UNFPA for issues related to family planning. PSSN is also linked to the Ministry of Health and Social Welfare's Most Vulnerable Children program, implemented by the Department of Social Welfare.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The objectives of the CCT are increasing HH consumption throughout the year and improving food consumption (quantity and quality of meals), thus helping to reduced food insecurity, while creating an incentive for extremely poor HHs to invest in the education and health of their children and pregnant women and prevent chronic malnutrition. In addition, cash (for both CCT and PWP) is disbursed only to women, giving them control over income. If this is not feasible, a guardian receives the benefit. The livelihood component of the project, particularly the community savings program, provides necessary skills and technical support to the groups (mainly women) and assists HHs in diversifying income and consumption.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The program's coresponsibilities promote health, nutrition, and caring practices. For example: • Children under 24 months old must be brought for routine health services once per month • Children 24–60 months old must be brought for routine health services once every six months • In areas where no health services are available, primary care providers for children under 60 months old must attend community health and nutrition sessions every two months • Pregnant women must attend at least four prenatal visits, deliver at health facilities or be assisted by skilled personnel, and attend a postnatal checkup; • In areas where no health services are available, pregnant women must attend community health and nutrition sessions every two months • Parents or guardians must attend community workshops every two months on topics such as nutritional practices, childcare, home hygiene, and water safety
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The program targets poor and food insecure HHs based on the following targeting steps and mechanisms: • **Geographic targeting:** Selection of areas of intervention (regions, PAAs, and villages) is done on the basis of a poverty index and is designed to support the poorest areas first (although consideration is also given to the ability to deliver the program). As villages are selected, the poverty index, combined with information about poverty levels and the population of the village determine quotas for the number of expected beneficiary HHs in each village. The final list of villages is approved by the corresponding PAA. • **Community targeting:** The community, through their chosen representatives on a CCTMC and under the oversight of the village council, identifies potential beneficiary HHs using predetermined criteria agreed upon at a Village Assembly meeting. The community representatives identify HHs representing up to 120 percent of the set quota. Once potential beneficiaries have been identified, key data are collected for each HH and entered in the URB at PAA level. • **PMT and verification:** Each HH entered in the URB receives a welfare score based on the PMT weights that are used to reduce inclusion errors. HHs whose welfare scores fall below the extreme poverty line are considered eligible

NUTRITION-SENSITIVE RATIONALE	
	for the program. If the welfare scores of all HHs selected by the community fall below the extreme poverty line, then all HHs are eligible for the program. The resulting list is sent back to the village, where it is ratified at a Village Assembly meeting. The Village Assembly meeting can add or remove only those HHs that had been identified through community targeting. However, the Village Assembly meeting provides an opportunity for HHs not listed by the CCTMC to complain directly to the PAA, which then facilitates a fast-track grievance process. • Additional transfers target HHs with children.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	Subprojects under the PWP are implemented to address the special needs of women. PLW (if considered able to work according to the criteria set for the project) are assigned appropriate lighter work. Timing and settings are allotted to avoid interfering with their roles as care providers; in particular, flexible working hours and the possibility of working half-days are offered to women. In some cases childcare may be brought to the workplace to facilitate participation of women who are breastfeeding. Some women are employed as caregivers and paid at the same rate as other workers. The program also properly ensures the participation of women in decision making for the PW program, in particular through membership on the CMC. Beneficiary HHs register all eligible members in the program (that is, children younger than 18 and pregnant women).
5. THE PROGRAM HAS NUTRITION INDICATORS	Proportion of beneficiaries and caretakers who know their rights and coresponsibilities under the program's rules and entitlements.
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The program promotes access to food through regular and longer-term support using both cash transfers and PWPs in the lean season, but also focuses on promoting access to health care facilities through compliance with health-related conditions. Compliance facilitates access to health services for people in very vulnerable situations, which reduces their vulnerability to poor health. Cash benefit distribution takes place every two months in community-based health sessions. Beneficiaries' compliance with set conditions is cross-checked and transfers are disbursed accordingly. Sessions focus on delivering key educational messages to participants on issues related to hygiene, nutrition, and household health. The simultaneity between cash distribution and community-based health sessions increases the effectiveness of community sessions for women, who are the direct recipients of CTs. The scale of the program is notable because it covers nearly the entire country, reaching more than 1.1 million HHs living below the poverty line.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Overall, the program is making significant contribution to the improvement of HH consumption and enhancing positive, nutrition-sensitive behavior.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The program intends to strengthen its links with other national nutrition programs.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects /P124045/tanzania-third-social-action-fund-productive-safety-nets-program-tasaf-iii -psnp?lang=en
2. METHODS OF DOCUMENTATION	**Desk-based research:** WBG resources: *Project Appraisal Document (PAD) 67116-TZ March 2012* **Interview with Task Team Leader**
3. WEB SOURCES	The list of project documents can be found at http://www.worldbank.org/projects/P124045/tanzania-third-social-action-fund -productive-safety-nets-program-tasaf-iii-psnp?lang=en

East Asia & Pacific

Indonesia – PNPM Generasi Program

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Robert Wrobel, Senior Social Development Specialist[a] Ali Winoto Subandoro, Health Specialist[b]
ORGANIZATION	World Bank Groups (WBG)
ROLE WITHIN THE PROGRAM	[a]Task Team Leader [b]Health and Nutrition Focal Point

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Program Nasional Pemberdayaan Masyarakat (PNPM) Generasi Program
2. COUNTRY	Indonesia
3. TYPE OF PROGRAM	Community Driven Development (CDD)
4. PROGRAM DURATION	2007 to 2017
5. PROGRAM OBJECTIVE(S)	To empower local communities in poor, rural subdistricts in the project provinces to increase use of health and education services.
6. FUNDING AGENCY/ IES	Government of Indonesia: $242 million PNPM Support Facility (WBG): $197 million
7. IMPLEMENTING AGENCY/IES	Directorate General (DG) Village Development and Empowerment, Ministry of Villages, Disadvantaged Areas and Transmigration (responsible institution)
8. TOTAL COST	$440 million
9. TARGET GROUP(S)	Poor, rural subdistricts in selected provinces. In particular, target beneficiaries are pregnant women and those who have recently given birth, children under 5, and primary school–age children.
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	4.9 million women and children in 5,400 villages in 499 rural subdistricts (kecamatans) in 11 provinces.

PROGRAM OVERVIEW		
11. NUMBER OF REACHED BENEFICIARIES	4.9 million women and children under 5 years old	
12. PROGRAM CROSS-CUTTING THEMES	☐ Double burden of malnutrition (DBM) ☒ Multisectoral collaboration ☒ Integrated approach ☒ Governance ☒ Decentralization ☒ Performance-based financing ☒ Community participation ☐ Agriculture and local procurement ☐ Urban	☒ Rural ☐ Resilience ☐ Conflict-affected setting ☐ Harnessing nutrition data ☐ Use of mobile technology ☐ Behavior change communication (BCC) ☐ Life-cycle approach ☒ Gender and women's empowerment ☐ Early child development (ECD)

CONTEXT OVERVIEW	
1. CONTEXT	The Indonesian economy has experienced positive economic growth, and the poverty rate has fallen from 23.4 percent in 1999 to 12.0 percent in 2011. Nonetheless, 32.5 million Indonesians lived below the national poverty line of Rp 233,700 per person per month (approximately $1.19 per day PPP) in 2011. Forty percent of the population was clustered just above this line and earned about $2.37 PPP per day. Of the poor, 65 percent lived in rural areas. Despite strong macroeconomic fundamentals, modest gains have been observed in health and education relative to other East Asian countries. Within Indonesia, substantial variations in poverty, health, and education outcomes exist across regions, with rural areas lagging. *WBG Project Information Document Appraisal Stage PIDA807 March 2013* *WBG Project Information Document Additional Financing PIDA2466 December 2013* *WBG Implementation Completion and Results Report ICR00003281 January 2015*
2. COUNTRY INCOME LEVEL	Lower-middle-income
3. KEY CONTEXT DATA	2011 data: • GDP growth: 6.2 percent • Gini index: 35.6 (WBG estimate, 2010) • Population living below national poverty line ($1.19 per day PPP): 12.5 percent • Share of population with access to improved sanitation facilities: 56 percent • Population clustered just above the national poverty line (earning $2.37 per day PPP): 40 percent • Share of poor living in rural areas: 65 percent *World Development Indicators (WDI) and WBG project appraisal document (PAD)*
4. KEY SOCIAL PROTECTION DATA	2013 data: • Public spending on social assistance programs, percent of GDP: 0.7 percent 2011 data: • Coverage of Social safety nets (SSNs) in total of population: 53.9 percent • Coverage of SSNs in extreme poor: 81.7 percent • Incidence of beneficiaries of SSNs in extreme poor: 27.9 percent *ASPIRE database*

CONTEXT OVERVIEW	
5. NUTRITION CONTEXT	Indonesia has made great strides in improving key human development indicators over the past several decades. However, infant mortality, child malnutrition, maternal mortality, junior secondary school enrollment, and educational learning quality continue to lag, and regional disparities reveal poorer outcomes in rural and remote areas compared to urban areas. Stunting, or low height for age, affects around 37 percent of Indonesian children under 5 years old, a rate equal to that of many Sub-Saharan countries. There has been no progress in reducing underweight or stunting in children under 5 years old since 2007. In 2013, almost 9 million children in Indonesia from birth to 48 months old were stunted, making it the country with the fifth highest number of stunted children. The prevalence of underweight in children under 5 years old decreased from 31 percent to 17.9 percent between 1989 and 2010, but increased to 19.6 percent in 2013. Nationally, in 2013, 5.3 percent of children were severely wasted and 6.8 percent were moderately wasted. The total number of children suffering from wasting in 2013 approached 3 million, the fourth highest in the world. Significant disparities in stunting prevalence persist among provinces and wealth quintiles. Until recently, there have been a limited number of interventions in Indonesia that specifically target reductions in child stunting. Since 2014, PNPM Generasi has been part of the Community-Based Stunting Reduction Program, an integrated, multisector package of demand- and supply-side interventions designed to improve maternal and child nutrition. The government's 2012–25 Master Plan for Accelerating Poverty Reduction identifies improved access to basic quality health and education services for the poor and vulnerable as a key pillar of an overall poverty reduction strategy. PNPM Generasi also contributes directly to this pillar of the poverty reduction strategy by targeting demand-side financing to improve access to basic services in rural, underserved areas. *WBG Project Information Document Appraisal Stage PIDA807 March 2013* *WBG Project Information Document Additional Financing PIDA2466 December 2013* *WBG Implementation Completion and Results Report ICR00003281 January 2015* *National Medium Term Development Plan 2014 (RPJMN, 2014)* *National Long-Term Development Plan (RPJPN 2005-2025) http://www.indonesia-investments.com/projects/government-development-plans/national-long-term-development-plan-rpjpn-2005-2025/item308* *Basic Health Research Survey 2013 (RISKEDAS, 2013)*
6. KEY NUTRITION DATA	<u>2013 data:</u> Children under 5 years old suffering from • Stunting: 37.2 percent • Severe wasting: 5.3 percent • Moderate wasting: 6.8 percent • Underweight: 19.6 percent Prevalence of undernourishment: 9 percent of population Rural HHs with stunted children: 42 percent <u>2012 data:</u> Pregnant women receiving prenatal care: 96 percent <u>2011 data:</u> Children under 5 years old suffering from anemia: 33 percent Prevalence of undernourishment: 11 percent of population *WDI and WBG PAD*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	Program Nasional Pemberdayaan Masyarakat (PNPM) Generasi is an innovative adaptation of the PNPM-Rural CDD platform. Through the PNPM Generasi pilot, the government tested the hypotheses that (a) PNPM-Rural's community driven development (CDD) approach could be adapted to enable communities to address a broad set of demand and small-scale supply constraints to accessing health and education services more effectively than the standard PNPM-Rural model; and (b) that it could do so in ways that other programs, like conditional cash transfers (CCTs), could not because of the supply constraints that exist in remote parts of Indonesia. PNPM Generasi is a hybrid model that incorporates performance incentives from CCT programs with the flexibility and adaptability of CDD, which allows communities to address supply constraints, demand constraints, or some combination thereof. In PNPM Generasi, communities are given incentives to reach targets for each of 12 health and education indicators. Communities can use the funds to improve service quality and performance directly and contract with private providers if public provision of services is considered suboptimal. This ability addresses supply-side deficits that limit poor HH's and communities' use of basic health and education services. Communities identify the poor and vulnerable through social mapping, particularly focused on reaching out to "nonusers." A share of the funds specifically targets those not yet receiving the relevant health and education services. **Kecamatan Grants.** • Provide grants to Kecamatan for investment activities (including the provision of scholarships for poor children, transportation and other in-kind subsidies, contract teachers, supplies for health and education facilities) that improve use and access of health and education services. The block grants are conditional on achieving 12 key health and nutrition target indicators. • Provide support for the financing of administrative costs associated with planning and preparation for subproject proposals and training and for building capacity within communities. **Community Empowerment and Facilitation Support**. Includes training to improve community skill levels in identifying and overcoming constraints to the use of health and education services; strengthening community health volunteer activities; improving communication between local government health and education offices and service providers and communities"; and management of the management information system (MIS) database. **Implementation Support and Technical Assistance.** To provide (a) support for strengthening the management and oversight capacity of the PNPM Generasi Secretariat, including workshops, coordination with line ministries, and field supervision; (b) technical assistance for health and education planning and database management, including PNPM Generasi national specialists and PNPM Generasi provincial specialists, with expertise in health, education, financial management, complaints handling, procurement, and information management and support for field supervision; and (c) training for PNPM Generasi facilitators at all levels of program delivery, including refresher training for existing staff, preservice training for new staff, specialized training for district database operators, and regional evaluation workshops.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	$10,000 per village per year The size of a village's Generasi block grant is based in part on the performance of that village in achieving targeted indicators in the previous year, thereby motivating communities to prioritize the most effective policies in their spending and activities.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	In the initial stage, the size of a block grant at the subdistrict level is determined based on composite socioeconomic and health and education indicators. Within a subdistrict, in the project's first year funds are divided among villages in proportion to the number of target beneficiaries in each village, that is, the number of children of varying ages and the expected number of pregnant women.

PROGRAM DETAILS	
	In the project's second and subsequent years, 80 percent of the subdistrict's kecamatan grant funds are divided among villages in proportion to the number of target beneficiaries. The remaining 20 percent is a performance bonus pool that is divided among villages based upon their previous year's performance on the 12 Generasi indicators. Villagers monitor the indicators and are not dependent on third parties, such as service providers.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Block grants to communities are provided upon the achievement of 12 education and health indicators related to maternal and child health and primary and junior secondary enrollment and attendance: • Four prenatal care visits for pregnant women • Taking iron tablets during pregnancy • Delivery assisted by a trained professional • Two postnatal care visits • Complete childhood immunizations • Ensuring monthly weight increases for infants • Monthly weighing for children under three and biannual weighing for children under 5 years old • Vitamin A twice a year for children under 5 years old • Participation by pregnant women in monthly pregnancy and nutrition classes (kelas ibu hamil) • Participation by parents of children from birth to 2 years old in monthly parenting and nutrition classes (kelas balita) • Enrollment in school of all primary and junior secondary school–aged children who have not previously been enrolled or who have dropped out, including children with disabilities • Enrollment in junior secondary school of all children who have graduated from primary school, including children with disabilities
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	*Costs by category can be estimated as follows: Investment 80 percent; Administrative support 10 percent; TA 10 percent. On average, other CDD programs feature 85 percent actual investment and 15 percent administration and TA. However, PNPM Generasi focuses on TA more than do other programs.*

PROGRAM DETAILS	
9. INSTITUTIONAL ARRANGEMENTS	Institutional and implementation arrangements for PNPM Generasi build on the successful elements of the existing structure of PNPM Rural. Responsibility for the implementation of PNPM Generasi remains with Directorate General (DG) Village Development and Empowerment (VDE), the Ministry of Villages, Disadvantaged Areas and Transmigration. VDE continues to mobilize additional TA for PNPM Generasi in the form of dedicated specialists in health, education, and financial management of MIS. facilitators; and database managers at the national, provincial, district, and subdistrict levels. Communities identify interventions and are responsible for implementation and oversight.
10. COMMUNITY PARTICIPATION	PNPM Generasi uses a flexible community poverty targeting mechanism. PNPM Generasi's targeting system applies geographical targeting combined with a local participatory process that does not rely on central statistical systems. Indonesia's poverty profile indicates that a large portion of the near poor is clustered around the poverty line. These near-poor groups fall in and out of poverty with seasonal fluctuations and external shocks. PNPM Generasi takes a flexible and localized approach to creating the list of beneficiaries through a village-level participatory social mapping process. Unlike central statistical targeting systems, the beneficiary lists generated through the community poverty targeting mechanism can be adjusted as needed to deal with economic and other shocks. Recent analytical work conducted by the WBG together with the Vice President's Office for Accelerating Poverty Reduction shows that community targeting methods selected more of the very poor and led to higher levels of satisfaction in targeting outcomes than methods that rely solely on centralized statistical data. The PNPM Generasi impact evaluation found that the program was successful at targeting assistance, particularly in-kind assistance, to households in the two lowest income quintiles. Through social mapping and in-depth discussion groups, villagers identify problems and bottlenecks in reaching the 12 indicators. Village facilitators organize hamlet-level meetings as well as hamlet-level women's focus groups to identify constraints on the use of services. Intervillage meetings and consultation workshops with local health and education service providers allow community leaders to obtain information, TA, and support from the local health and education offices. Each village prepares a proposal for discussion at a village meeting where village representatives determine collectively which proposals will be financed. Subdistrict and village facilitators will facilitate wide and inclusive community participation. PNPM Generasi trains community empowerment cadres to collect data on and monitor local health and education status, thereby expanding the depth and scope of community planning exercises beyond the small-scale infrastructure projects that are included in village medium-term development plans. In addition, PNPM Generasi promotes transparency in the use of local health and education budgets. Local service providers have an interest in knowing how communities will invest their block grants for health and education purposes and therefore have an incentive to share information on local health and education budgets during project planning and monitoring meetings. At the subdistrict and village levels, PNPM Generasi operates through existing user groups and service delivery structures, such as integrated community health posts (Posyandu) and school committees, rather than by creating new structures.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	PNPM Generasi piggybacks on the architecture for community-level targeting, participatory planning, block grant transfers, local-level facilitation, and accountability mechanisms put in place by its parent project, PNPM-Rural, thereby achieving important economies of scale. PNPM Generasi uses the existing PNPM-Rural implementation structure with additional technical assistance (TA) and capacity-building support provided to government, specialist, consultant, and facilitator teams operating at the national, provincial, district, subdistrict, and village levels. In addition, PNPM Generasi takes full advantage of the social capital built through PNPM-Rural, enabling communities to act collectively to tackle common demand-side and supply-side problems to improve access to services.

PROGRAM DETAILS	
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	Because PNPM Generasi is a CDD program, it builds communities' capacity to plan, implement and monitor health and nutrition programs. PNPM Generasi may evolve into a sustainable delivery platform that can address the typical sustainability problems that arise when programs are discontinued due to lack of funding.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	PNPM Generasi developed a comprehensive monitoring and evaluation (M&E) system that provides stakeholders with timely information to track the progress of project implementation, assess the effectiveness of the project in achieving its objectives, guide daily operations, and make decisions to improve results. The backbone of PNPM Generasi's M&E system is the web-based MIS, which provides stakeholders with real-time access to information on project beneficiaries, participation of women and the poor in project meetings, subprojects financed, and community progress toward achieving target health and education indicators. PNPM Generasi uses village-level committees to conduct effective community monitoring within the village, as well as to undertake intervillage audits on a regular basis. In 2013 and 2014, Performance Monitoring Surveys (PMSs) were conducted to measure key performance indicators using a rapid quantitative method. The PMS uses small cluster sampling to report on the performance of the program on average across all participating villages. The results of the first survey, delivered in October 2013, show that in 2013, PNPM Generasi met or exceeded performance targets for five out of seven key performance indicators.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	Rigorous evaluations are built into the project design through several rounds of randomized evaluation: • Baseline in 2007 • One-year follow-up in 2008 • Two-year follow-up in 2010 • Eight-year follow-up planned in 2016 To facilitate a rigorous evaluation, the Indonesian government incorporated random assignment into the selection of PNPM Generasi locations to ensure randomized evaluation techniques. Within the districts selected by the government for the program, entire subdistricts were randomly allocated either to participate in PNPM Generasi or to be in a control group. The control group, although not participating in PNPM Generasi, received an equivalent amount of funding under the PNPM-Rural program. Each PNPM Generasi location was further randomly allocated to one of two versions of the program: Treatment A, which provided incentives using the pay-for-performance component, or treatment B, otherwise identical but without the pay-for-performance incentives. To assess whether financial incentives encouraged communities to achieve better outcomes, villages in subdistricts in which treatment A was applied and which achieved higher than average results were rewarded with a share of a bonus block grant.
3. OUTCOME/IMPACT INDICATORS	<u>Project Development Objectives:</u> • Improved access to and use of selected health and education services that contribute to the improvement of maternal and child health and basic education outcomes in targeted villages • Improved community capacity to provide feedback to front-line providers on the status of health and education service delivery in targeted areas (villages and subdistricts) • Improved community capacity to facilitate the delivery of basic services through the provision of training and operational support in targeted villages • Improved involvement by women and the poorest community members in project planning and decision-making meetings

MONITORING AND EVALUATION	
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	The evaluation was conducted in three rounds from 2007 to 2010 with quantitative and qualitative components. The Wave 3 impact evaluation found that, on average over the 30-month implementation period, PNPM Generasi had a statistically significant positive impact on all 12 indicators. The most significant long-term impact was a decrease in malnutrition. Childhood malnutrition fell by 2.2 percentage points, a 10 percent reduction from baseline levels in treatment areas. Education indicators also improved with the largest improvement observed in school participation rates among primary school students. On average, the project was about twice as effective in areas with very low health and education status (10th percentile of service provision). The project had the greatest impact in areas with low baseline health and education indicators, like East Nusa Tenggara province, where underweight and severe underweight rates fell by 20 percent and 33 percent against control, respectively. Stunting was decreased by 21 percent against control. The junior secondary school gross enrollment rate increased by 29 percent relative to control, while gross primary school attendance rates increased by 4 percent for children 7–12 years old against control. Overall, impact evaluation findings show that the PNPM-Rural mechanism was successfully modified to increase the use of basic services and fill small-scale supply gaps. Community performance incentives improved project performance in health. Project impacts were not affected by differences in ease of access to health and education facilities. PNPM Generasi increased the probability that a junior secondary school was located in a village. Midwives also worked longer providing services in villages that received incentive-based block grants.
5. HARMONIZATION WITH OTHER PROGRAMS	PNPM Generasi is part of an integrated, multisector package of demand- and supply-side interventions to improve maternal and child nutrition, referred to as the Community-Based Stunting Reduction Program. PNPM Generasi is one of the key nutrition-sensitive programs under the SUN framework. Four ministers from the Ministries of People's Welfare, Development and Planning, Health, and Women's Empowerment and Child Protection, launched the First 1,000 Days of Life Movement. Presidential Decree 42 signed in May 2013 led to the launch of the SUN movement in October 2013 and the establishment of a multistakeholder high-level task force under the Ministry for People's Welfare, which acts as the convening body for 13 ministries and UN agencies. The government's 2012–25 Master Plan for Accelerating Poverty Reduction, which is currently being drafted, identifies improved access to basic quality health and education services for the poor and vulnerable as a key pillar of an overall poverty reduction strategy. PNPM Generasi contributes directly to this strategy by targeting demand-side financing to improve access to basic services in rural, underserved areas.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	No information available.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The program focuses on providing health services using grants and training and capacity-building activities for communities. Communities use PNPM Generasi block grants to provide small-scale health and nutrition services, such as bringing midwives to houses more frequently and strengthening activities that promote growth monitoring. Given the renewed focus on the reduction of stunting, supply-side activities must be intensified and expanded. Thus, since 2014, PNPM Generasi has been part of the Community-Based Stunting Reduction Program, an integrated, multisector package of demand- and supply-side interventions aimed at improving maternal and child nutrition. In particular, supply-side activities relating to maternal and child health and nutrition that are delivered through the Community-Based Stunting Reduction Program consist of: (a) mother, infant and young child feeding or Modul Pelatihan Pemberian Makan Bayi dan Anak (PMBA) for health providers; (b) distribution of micronutrient supplements; (c) a national awareness campaign for stunting reduction; (d) provision of anthropometric equipment; (e) sanitation and hygiene behavioral change activities; and (f) private-sector engagement. Moreover, the program now goes beyond enhancing the quality of service delivery and focuses on influencing the day-to-day behavior at the community level.

NUTRITION-SENSITIVE RATIONALE	
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	Poor communities targeted by the program receive block grants that are conditioned on compliance with performance indicators measured on monthly, biannual, and annual bases. The program requires that 10 percent of the total funds for each village in Java and 25 percent of those outside Java specifically target those not yet receiving the relevant health and education services, and who are performing poorly against the 12 health and education indicators, such as out-of-school children and malnourished children. PNPM Generasi targeting systems apply geographical targeting combined with a local-level participatory process that does not rely on central statistical systems. It takes a flexible and localized approach in creating the list of beneficiaries through a village-level participatory social mapping process. Unlike central statistical targeting systems, the community poverty targeting mechanism is flexible in adjusting the beneficiary list as needed to mitigate economic shocks. Moreover, community-based targeting also appears to be more appropriate for Indonesia, where a large share of the population hovers around the poverty line, making centralized statistical targeting more prone to error.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	PNPM Generasi has innovative and effective ways to involve groups, such as women, that tend to be excluded from traditional institutions but who are particularly relevant to nutrition and health outcomes. In PNPM Generasi, these include the mobilization of mother's groups (kolompok ibu) in each participating subvillage. In particular, PNPM Generasi is designed to specifically engage women as participants in program planning and decision making and respond to women's basic needs by increasing access to health and education services. The project MIS shows that women have been the dominant participants in village-level participatory planning and decisionmaking, averaging over 60 percent of participants since 2007.
5. THE PROGRAM HAS NUTRITION INDICATORS	• Four prenatal care visits for pregnant women • Taking iron tablets during pregnancy • Delivery assisted by a trained professional • Two postnatal care visits • Complete childhood immunizations • Ensuring monthly weight increases for infants • Monthly weighing for children under 3 years old and biannual weighing for children under 5 years old • Vitamin A twice a year for children under 5 years old • Participation by pregnant women in monthly pregnancy and nutrition classes (kelas ibu hamil) • Participation by parents of children from birth to 2 years old in monthly parenting and nutrition classes (kelas balita)
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	PNPM Generasi is one of the first health and education programs worldwide that combines community block grants with explicit performance bonuses for communities. PNPM Generasi demonstrates that village governments and communities can play an important role in delivering improved basic services using the principles of transparency, accountability, and inclusion, and this has resulted in improved health and nutrition indicators. Participatory process and community empowerment with adequate support from local government and relevant sectors are key factors to the success of achieving the goal.

NUTRITION-SENSITIVE RATIONALE	
	In particular, PNPM Generasi addresses supply-side as well as demand-side obstacles through collective action. Using a community participatory and collective-action model, PNPM Generasi tries to address both small-scale supply and demand issues. Demand-side problems may be addressed through providing village-based scholarships, covering costs for health services, and covering transportation costs to access services for the poor. Activities addressing small-scale supply side problems may range from providing a transportation allowance to a midwife to regularly visit a village, improving living and housing conditions for a midwife to convince her to stay in the village, and improving infrastructure and facilities for schools and teachers. Communities can also use the funds to contract with private providers or NGOs if the public provision of services is considered suboptimal. PNPM Generasi is an incentivized community block grant program that focuses on many of the same targets as traditional CCT programs—individuals who comply with certain education and health requirements. Communities receive a bonus kecamatan grant allocation during the second and subsequent years of participation in the program, based on progress toward improving target health and education indicators. PNPM Generasi's impact evaluation found that, after 30 months, the incentive-based kecamatan grants improved program performance in health. The PNPM Generasi program was designed to facilitate a rigorous evaluation of its effects, with random assignment incorporated into the selection of the locations and control groups to test the effects of both the incentive-based and nonincentive-based versions of the program. The approach adopted by the program is extremely innovative, with few precedents anywhere in the world on this scale. Currently, a PNPM Generasi Long Term Impact Evaluation is being planned. It is a panel survey, tracking those who first participated in 2007 as well as beneficiaries in the expanded areas. The control group is relatively intact; therefore, this is a rare opportunity to measure total impact and the mechanisms through which the effects are accomplished.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	PNPM Generasi, the Millennium Challenge Corporation compact, and the Program Keluarga Harapan (PKH) have been recognized as the three most relevant projects for nutrition outcomes. This acknowledgment could represent an opportunity to work with the government to use the performance-based model that has proven to be effective in improving health and nutrition outcomes and building local capacity to manage and implement the program. Furthermore, PNPM Generasi has demonstrated that, once the structure is established, the community model developed through PNPM-Rural is flexible and adaptable. PNPM Generasi may be able to improve health and education indicators in supply-deficient areas, where the traditional CCT model may not be as effective because of supply constraints. Similar models may be developed to achieve other goals, particularly in lagging areas such as access to water and sanitation facilities. The most recent evaluation shows that community-level incentives work well in some contexts. Specifically, it shows that under the PNPM Generasi pilot, these incentives had a greater impact on health (as defined by the specific indicators for the pilot) than on educational outcomes. The evaluation suggests that the Indonesian government should continue to experiment with the use of community-level incentives, perhaps extending their use into interventions in other lagging areas, such as access to water and sanitation.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	PNPM Generasi is part of Program Kesehatan dan Gizi Berbasis Masyarakat (PKBM), an integrated demand- and supply-side intervention. One of the key challenges ahead relates to multisectoral coordination among different stakeholders of PKBM. Clear roles, responsibilities, and accountability of stakeholders are essential for ensuring the smooth program implementation to reach the intended goals and objectives. In particular, stakeholders at the national and subnational levels are often not fully informed of their expected roles or updated on the progress of the complementary supply-side activities, both of which create obstacles for implementation.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
	A second challenge relates to community-level BCC activities. Thus far, BCC activities are limited only to mothers. At the community and HH levels, other actors, such as husbands, grandmothers, and religious leaders, play an important role in influencing mothers' decisions regarding prenatal and childcare. One of the main challenges of behavior change is to get husbands and fathers to support and encourage breastfeeding. If mothers work outside the home, grandmothers and other caregivers play a key role in childcare and feeding practices. The BCC activities have not explicitly reached out to these caregivers. For effective behavioral change, international experience shows that interpersonal communication is essential in influencing mothers to adopt recommended healthy behaviors. To this end, interpersonal communications that take place through home visits focus on curative care. Posyandu cadres (similar to Community Health Workers or Village Health Volunteers) generally visit only those who are diagnosed as malnourished or those who do not attend Posyandu session (a process called "sweeping"). Home visits are currently done at a low intensity, and could benefit if Posyandu cadres receive clearer mandates and incentives, as well as information on preventive care.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects/P147658?lang=en
2. METHODS OF DOCUMENTATION	**Desk-based research:** WBG resources: *Project Information Document Appraisal Stage PIDA807 March 2013* *Project Information Document Additional Financing PIDA2466 December 2013* *Implementation Completion and Results Report ICR00003281 January 2015* External resources: *National Medium Term Development Plan. 2014. http://www.indonesia-investments.com/projects/government-development-plans/national-long-term-development-plan-rpjpn-2005-2025/item308* *Basic Health Research Survey 2013 (RISKEDAS, 2013)* **Interview with Task Team Leader and Health Specialist**
3. WEB SOURCES	http://www.worldbank.org/projects/P147658?lang=en

Indonesia – Program Keluarga Harapan Prestasi

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Pungkas Bahjuri Ali, Ministry of National Development Planning/Bappenas, Directorate for Health and community Nutrition Theresia Ronny Andayani, Ministry of National Development Planning/Bappenas
ORGANIZATION	Government of Indonesia (GOI)
ROLE IN THE PROGRAM	Planning and monitoring coordination

PROGRAM OVERVIEW		
1. NAME OF PROGRAM	The Family Hope Program: Program Keluarga Harapan (PKH) Prestasi	
2. COUNTRY	Indonesia	
3. TYPE OF PROGRAM	Conditional Cash Transfer (CCT)	
4. PROGRAM DURATION	2012 to March 2016	
5. PROGRAM OBJECTIVE(S)	To strengthen the PKH Program and to scale up nutrition to reduce the prevalence of stunting as mandated in the National Medium Term Development Planning and National Action Plan on Nutrition and Food	
6. FUNDING AGENCY/IES	GOI UNICEF Australia Department of Foreign Affairs and Trade	
7. IMPLEMENTING AGENCY/IES	GOI: Bappenas (responsible institution), Ministry of Social Affairs (MOSA), Ministry of Health (MOH), Ministry of Home Affairs, local (provincial and district) governments Faith-based organization Journalist organization	
8. TOTAL COST	$1.8 million	
9. TARGET GROUP(S)		
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	11,000 Households (HHs) (10,000 children under 2 and 11,034 women) Indirectly about 595,000 individuals	
11. NUMBER OF REACHED BENEFICIARIES	HHs with pregnant and lactating women HHs with children age 0 to 6 years old HHs with children age 7 to 15 years old HHs with children age 16 to 18 years old with incomplete education	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM ☒ Multisectoral collaboration ☒ Integrated approach ☐ Governance ☐ Decentralization ☐ Performance-based financing ☒ Community participation ☒ Agriculture and local procurement ☐ Urban	☐ Rural ☐ Resilience ☐ Conflict-affected setting ☐ Harnessing nutrition data ☒ Use of mobile technology ☒ BCC ☒ Life-cycle approach ☒ Gender and women's empowerment ☒ ECD

CONTEXT OVERVIEW	
1. CONTEXT	In Indonesia, recent economic gains have not led to corresponding gains in nutritional status. Poverty and potential threats, including climate change, have led to the introduction of large-scale social protection programs to protect those at risk from economic insecurity and poverty. PKH is a nationwide government-funded CCT program with health and education conditions that is designed to alleviate poverty and improve social welfare by providing CTs to vulnerable HHs. Evidence indicates that PKH has improved the use of health services but not nutritional status.

CONTEXT OVERVIEW	
	The program aims to: • Improve intersectoral coordination between government institutions and between government and nongovernment institutions and community organizations • Increase demand for nutrition and health services • Increase coverage and quality of nutrition and health services • Improve knowledge and practices of beneficiaries *MOH. 2010. National Basic Health Survey* *List of PKH program beneficiaries starting from 2012.* *Baseline survey 2012.* *The number of pregnant and lactating women (PLW) and children under the age of five, District Health Office 2015.*
2. COUNTRY INCOME LEVEL	Lower-middle-income
3. KEY CONTEXT DATA	2011 data: • GDP growth: 6.2 percent • Gini index: 35.6 (WBG estimate, 2010) • Share of population with access to improved sanitation facilities: 56 percent *WDI*
4. KEY SOCIAL PROTECTION DATA	2013 data: • Public spending on social assistance programs, percent of GDP: 0.7 percent 2011 data: • Coverage of SSNs in total of population: 53.9 percent • Coverage of SSNs in extreme poor: 81.7 percent • Incidence of beneficiaries of SSNs in extreme poor: 27.9 percent *ASPIRE database*
5. NUTRITION CONTEXT	No information available.
6. KEY NUTRITION DATA	2012 data: Children under 5 years old suffering from • Stunting: 31 percent • Anemia: 80 percent Pregnant women suffering from • Chronic energy deficiency: 27 percent • Anemia: 58 percent Pregnant women receiving prenatal care[a]: 96 percent
	2013 data[a]: Prevalence of undernourishment: 9 percent of population 2011 data[a]: Children under 5 suffering from anemia: 33 percent Prevalence of undernourishment: 11 percent of population [a]*WDI*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**PKH:** Provided nutrition and health services to PLW and children under 5; training of health personnel at subdistrict level and below. **PKH Prestasi:** PKH Prestasi is a pilot project designed to demonstrate whether increasing the coverage and quality of nutrition services results in improved knowledge, behavior, and practices of beneficiary HHs. It includes the training of non–health personnel, down to the village level, on nutrition and health topics and of community facilitators on facilitation skills; distribution of multiple-micronutrient supplements to children 6 to 59 months; and development of reference materials to support the trainings.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	$107 annually per family with a pregnant or lactating woman, a child under 5 years old, or both. Payments are disbursed four times a year.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	Set by MOSA, with annual adjustment.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Local procurement of multiple-micronutrient powder for children is fully supported by the district.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Health and education conditions—pregnancy checkups, monthly weighing for children under 5 years old, and school attendance
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	No information available.
9. INSTITUTIONAL ARRANGEMENTS	Under the Ministry of National Development Planning (BAPPENAS), district planning agencies, are responsible for overall coordination. MOH, the District Health Office, MOSA, a faith-based organization, and various experts are responsible for training sessions. The training of PKH facilitators will be carried out by MOSA. The training of religious leaders will be carried out by the faith-based organization. MOH supplies the multiple-micronutrient powder.
10. COMMUNITY PARTICIPATION	Community participation takes place in several innovative ways. First, mothers who head CCT groups facilitate monthly education sessions with CCT facilitators and are expected to encourage their group members to actively participate in the monthly FDSs. Through PKH, young people are selected from the village to serve as community journalists, which strengthens the capacity of local journalists to report on child health and nutrition-related issues and raises the awareness of the community of journalistic and nutrition issues. Religious leaders are enabled to disseminate knowledge and awareness of maternal child health and nutrition (MCHN) in their villages.

PROGRAM DETAILS	
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The training of PKH facilitators, religious leaders, and community journalists on nutrition and health topics has the potential to be scaled up.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	District regulations have been established. Good collaboration and networks between local stakeholders have been established. Local funding and commitment will continue because the Bappena acts as the leading institution at the local level.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	Implementation is monitored through self-reporting and spot checks. Mobile technology will be used by the facilitator to report monthly sessions.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	Process evaluation as well as impact evaluation will be conducted using a consistent logical framework. The impact on nutrition and health will be measured in 2016.
3. OUTCOME/IMPACT INDICATORS	No information available.
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	Improved services by implementing agencies are reported.
5. HARMONIZATION WITH OTHER PROGRAMS	No information available.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	Women have control over the cash from the CCT program. Although the size of the Cash transfer (CT) is not enough to support adequate daily nutritious food for a pregnant woman, the amount could support the adequate daily nutrition needs of a child.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The program has a counseling component, knowledge that is passed on by trained health and nonhealth personnel to the mothers and the community. The counseling would ideally increase knowledge and improve good behavior of the mothers, including purchasing of more good quality food and consumption of more nutritious food. PKH has firm conditions linked to the use of health services. PKH Prestasi seeks to improve the impact of the health-based conditions by increasing the coverage and quality of evidence-based nutrition services, including counseling on maternal nutrition and infant and young-child feeding and micronutrient supplementation. The demand created may enhance better delivery of health services. The trainings accommodate the need for increased knowledge of reproductive health, nutrition, and childcare.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The program targets at-risk age groups in the poorest HHs, PLW and children under 5 years old, who are most at risk of food insecurity and undernutrition.

NUTRITION-SENSITIVE RATIONALE	
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	No information available.
5. THE PROGRAM HAS NUTRITION INDICATORS	• Frequency of antenatal care (ANC) and consumption of iron pills during pregnancy • Frequency of postnatal care visits • Delivery at a health facility • Breastfeeding initiation within 1 hour after birth • Rate of exclusive breastfeeding for the first 6 months after birth • Timely and good quality complementary feeding • Complete immunization by 12 months old • Vitamin A supplementation twice a year • Washing hands with soap • Open defecation free • Conducting or receiving counseling
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	The program adopts a multisectoral approach to overcoming anemia and increasing nutrition, including the distribution of multiple micronutrients, and empowering community journalists, community facilitators, heads of mothers' groups, religious leaders, health personnel, and community volunteers. Increased coordination between social protection, health, and nutrition stakeholders at all levels enhances policy and program coherency across the sectors.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	PKH Prestasi incorporates the following practices: • Collaboration between stakeholders at the central and local levels, including government, nongovernment, and a faith-based organization • Interagency collaboration at the local level among government, nongovernment and a faith-based organization • Support from the heads of the local governments through, for example, laws, regulations, and finance • Field trials of references, books, and teaching modules; the final forms are used for scaling up at the national level • Field trials of monitoring and evaluation tools; the final forms are used for scaling up at the national level

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The impact on nutrition and health will be measured in 2016.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	• Production of local multiple micronutrients supplements • Training costs • Monitoring of program activities

FURTHER REFERENCES	
1. DOCUMENTS	Baseline report Five reference books as training materials, some of which include video, puzzles, cards, and games M&E tools for the various trainings and implementation
2. METHODS OF DOCUMENTATION	Field work for the baseline survey Desk-based resources for creating the reference books
3. WEB SOURCES	pkh.kemsos.go.id

Myanmar – Tat Lan Program: Maternal and Child Cash Transfer (MCCT) Pilot

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Mathew Tasker, Food Security, Livelihoods and Social Protection Advisor Andrea Menefee, Senior Nutrition Advisor
ORGANIZATION	Save the Children International (SCI)
ROLE IN THE PROGRAM	Coleaders

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Tat Lan Program: Maternal and Child Cash Transfer Pilot
2. COUNTRY	Myanmar
3. TYPE OF PROGRAM	Unconditional Cash Transfer (UCT)
4. PROGRAM DURATION	August 2014 to September 2016 (pilot), scale up through December 2018
5. PROGRAM OBJECTIVE(S)	To improve health and nutrition outcomes of mothers and young children during the critical window of the first 1,000 days from conception through 24 months
6. FUNDING AGENCY/IES	Livelihoods and Food Security Trust Fund
7. IMPLEMENTING AGENCY/IES	SCI. With the anticipated program expansion, other Tat Lan Program partners (the International Rescue Committee and Oxfam through a local nongovernmental organization (NGO), the Better Life Organization) may assist implementation starting in 2016.
8. TOTAL COST	$623,775 for the pilot program With the anticipated program expansion, the total cost will increase substantially
9. TARGET GROUP(S)	Pregnant mothers and mothers of children under 6 months old from 30 villages. Women in the 15 villages targeted for cash intervention receive both CTs and BCC on child and women's nutrition and care; women in the remaining 15 villages will receive BCC only. The rationale for this target group is to cover as much of the 1,000-day window as possible given the budget limitations and timing of the intervention within the current overall program timeframe

10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	1,096 total individuals, scaling up to 80 villages from 2016, to cover approximately 4,000 women by December 2018. Based on the average monthly enrollment rate, approximately 571 pregnant women and mother and child pairs receive CTs and BCC, and 525 mothers will be provided with BCC only for the duration of the pilot. Female beneficiaries: 100 percent	
11. NUMBER OF REACHED BENEFICIARIES	696 total beneficiaries 395 pregnant women and mother and child pairs are receiving CTs and BCC, and 301 mothers are provided with BCC only	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM	☒ Rural
	☒ Multisectoral collaboration	☒ Resilience
	☒ Integrated approach	☒ Conflict-affected setting
	☐ Governance	☐ Harnessing nutrition data
	☐ Decentralization	☐ Use of mobile technology
	☐ Performance-based financing	☒ BCC
	☒ Community participation	☒ Life-cycle approach
	☐ Agriculture and local procurement	☒ Gender and women's empowerment
	☐ Urban	☒ ECD

CONTEXT OVERVIEW	
1. CONTEXT	The Tat Lan Program is a large, integrated Food Security and Livelihoods Program in four townships in Rakhine State, Myanmar. Rakhine State has a predominantly poor rural population residing in remote villages and is characterized by political tension and periodic bouts of ethnic conflict. The region is moderately food insecure, with high exposure to nutrition insecurity. Poverty is widespread, and poor and very poor households in all three livelihood zones are unable to afford both a nutritious diet and essential nonfood expenditures. In two livelihood zones, even wealthy and better-off households are unable to afford both a nutritious diet and essential nonfood expenditures. The Tat Lan Program has nutrition security as one of its main components, and since late October 2014, SCI has been operating a pilot program to test the viability and impact of a nutrition-sensitive social protection intervention—an MCCT for pregnant women and children within the first 1,000-day window. The MCCT pilot was designed using a rigorous analysis based on • Household Economy Assessment; • Tat Lan Program baseline; • MCCT baseline; • Infant and Young Child Feeding Qualitative Assessment; and • Cost-of-diet analysis. These studies and the resulting data were used to analyze the local context and identify the main nutritional issues for rural HHs.
	An Integrated Household Living Conditions Assessment provided an estimate of monetary poverty, as measured by consumption expenditures on food and nonfood items. According to this measure, about 44 percent of the population was living below the poverty line in Rakhine State. This is considerably higher than the 26 percent estimated as being poor nationwide. Preschool attendance among children 3–5 years old is quite low nationally (23 percent), but it is lowest in Rakhine (about 5 percent). The primary school enrollment rate in Rakhine is also much lower than the national average, with almost 30 percent of children not enrolled.

CONTEXT OVERVIEW	
	Barely a third of all children attending primary school in the Rakhine complete their studies on time. The outbreak of violence in 2012 has worsened access to and quality of education for thousands of children (MICS 2010). With a rate of only about 12 percent, children in Rakhine State are much less likely than the average Myanmar child to be born in a health facility, where lifesaving obstetric care would be available for mother and child in case of complications during birth. This also reflects the low level and quality of ANC received by pregnant women in the State. Immunization rates appear high and comparable to the national average, but routine immunization, as well as several other essential services, has been interrupted since the outbreak of violence in the State in 2012. The use of oral rehydration therapy to prevent life-threatening dehydration associated with diarrhea among children is used in only 60 percent of cases. Among those reached by the public health system, only 21 percent of pregnant women in Rakhine are tested for HIV and receive the test result. Of pregnant women identified as HIV-positive, at least 16 percent are not receiving antiretroviral therapy for prevention of mother-to-child transmission. Only 6 percent of infants born to HIV-positive women in the State are tested for HIV within the prescribed two months after birth. Rakhine ranks worst among all states and regions in Myanmar. Fifty-two percent of HHs in the State do not have access to improved sanitation, and 41 percent practice open defecation. Prevalence of diarrhea among children from birth to 59 months in Myanmar has increased from about 4 percent in 2003 to almost 7 percent in 2009–10. In Rakhine, diarrhea prevalence stands at 8 percent. *Multiple Indicator Cluster Survey (MICS) 2009-2010. UNICEF*
2. COUNTRY INCOME LEVEL	Lower-middle-income
3. KEY CONTEXT DATA	<u>Integrated Household Living Conditions Assessment for Rakhine State:</u> • Population living below the poverty line: 44 percent • Preschool attendance of children 3–5 years old: about 5 percent • Children attending primary school who complete on time: about 30 percent • Children born in a health facility: 12 percent • Diarrhea cases among children using oral rehydration therapy: about 60 percent • Pregnant women tested for HIV: 21 percent • Infants born to HIV-positive women tested for HIV within two months after birth: 6 percent • HIV-positive women not receiving antiretroviral therapy for prevention of mother-to-child transmission: at least 16 percent • HHs without access to improved sanitation: 52 percent • HHs practicing open defecation: 41 percent • Prevalence of diarrhea among children from birth to 59 months old: 8 percent

CONTEXT OVERVIEW	
	2013 data[a]: • GDP growth: 8.2 percent • Life expectancy: 66 years • Infant mortality rate: 42 per 1,000 live births • Share of population with access to improved sanitation facilities: 80 percent [a] *WDI*
4. KEY SOCIAL PROTECTION DATA	No information available.
5. NUTRITION CONTEXT	Undernutrition among children is particularly pronounced in Rakhine State, as evidenced by stunting, poor infant and young-child feeding practices, and low dietary diversity. Based on findings from the Baseline Nutrition Assessment and SCI Infant and Young Child Feeding Assessment published in January 2013, suboptimal feeding practices are found to be a major contributing factor to undernutrition in the Tat Lan area. Food availability differs by market level but, in general, is not a key barrier to HHs obtaining a nutritious diet. Key barriers include the economic access and affordability of nutritious foods, and many HHs believe that nutritious foods are expensive because the prices of these foods are "high" compared to rice. Other contributing factors to nutrition insecurity include food taboos for child feeding. Rakhine State has the second highest percentage of moderately to severely stunted children under 5 years old in the country at nearly 40 percent. Rakhine State also has the highest wasting rate nationally at 10.8 percent of children under 5 years old. Tat Lan's Baseline Nutrition Assessment found that stunting within the first 1,000 days is 18.4 percent (21.7 percent for boys and 15.3 percent for girls) in the sampled Rakhine townships. For all children under five, the rate jumps to 39.1 percent (41 percent for boys and 37.2 percent for girls)—over one-third of young children. Infant and young-child feeding indicators are poor—only 12 percent of children under 6 months old are exclusively breastfed (12 percent of boys and 13 percent of girls). Dietary diversity is low among younger children, with only 29 percent of children 6–23 months old (30 percent of boys and 28 percent of girls) consuming a minimum adequate diet.
	SCI's cost-of-diet analysis found that household dietary diversity in three different livelihood zones is poor regardless of wealth group, with rice being consumed in large quantities at least twice a day. Cultural taboos for children under 2 years old exacerbate poor dietary diversity. Suboptimal feeding practices strongly contribute to undernutrition in the Tat Lan areas. Exclusive breastfeeding is very low and the introduction of foods and liquids other than breastmilk before the age of 6 months strongly contributes to childhood illness and undernutrition.
6. KEY NUTRITION DATA	Rakhine State: Children under 5 years old suffering from • Stunting: 39.1 percent • Wasting: 10.8 percent Children under 6 months old exclusively breastfed: 12 percent Children 6–23 months old consuming a minimum adequate diet: 29 percent

CONTEXT OVERVIEW	
	2009 data[a]: Children under 5 years old suffering from • Stunting: 35.1 percent • Wasting: 7.9 percent • Underweight: 23 percent • Anemia: 40 percent Prevalence of undernourishment: 23 percent of population [a] *WDI*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**BCC on optimal MIYCF behaviors, health seeking, hygiene, and maternal care during the first 1,000-day window.** BCC activities and materials are used to improve community level nutrition and MIYCF behaviors. The focus of BCC activities will be expanded from MMSGs to include fathers and husbands of PLWs, grandmothers of children from birth to 2 years of age, mothers or mothers-in-law of PLWs, and "key influencers"—village leaders, midwives, and traditional birth assistants. **Hygiene promotion is also being integrated into all project components to ensure that the existing gap in hygiene and sanitation is addressed.** In particular, promoters will work alongside water, sanitation, and hygiene (WASH) infrastructure sector teams in order to mobilize and educate community members about sanitation and hygiene practices. **Mothers in target areas receive MCCTs during the 1,000-day window.** The MCCT-BCC intervention study is being conducted in 30 selected villages through 2016, after which all 30 villages will receive the MCCT-BCC package. A soft condition will be applied to encourage close links to the health infrastructure and to ensure an adequate degree of nutrition promotion. If funding is available, SCI is proposing to scale up to 80 villages with a more innovative implementation model that leverages and strengthens local capacity and governance, and engages local government and policy.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	K13,000 ($14) monthly for a maximum of 24 months
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	To facilitate consumption of a nutritious diet for a targeted mother and child pair, Save the Children UK's cost-of-diet tool was used to calculate the size of the CT needed to cover the gap between (1) HH incomes and expenditures and (2) the cost of a locally appropriate and nutritious diet, which varied across three livelihood zones. The cost-of-diet assessment found that the cost of a locally acceptable nutritious diet for a child 12 to 23 months old ranged from K94,445 to K156,619 (approximately $75 to $125) across livelihood zones. At present the cost-of-diet software is not able to calculate amounts for a child 6 to 11 months old or a separate additional cost for a PLW. We therefore took the cost of complementary foods for a child 12 to 23 months old as a proxy for the extra food a PLW would need in addition to her normal diet. Averaging the monthly costs of food across the three livelihood zones gave a monthly total of K9,875.30 (approximately $7.90). As highlighted in the cash programming review, food is not the only important cost during this period; health care costs are also important. Based on estimates from the Household Economy Assessment, HHs in the Tat Lan Program area spend about K3,000 (approximately $2.40) per month on health care and medicines. The transfer amount was rounded up to K13,000 (approximately $10.40) per month to include support for accessing health care. The transfer amount is calculated to provide the resources needed to meet the nutritional needs of the mother and child pair and is not designed to address a HH consumption gap, which will be addressed in Tat Lan through other livelihood activities.

PROGRAM DETAILS	
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Receipt of the CT will be conditional on attendance by targeted mothers at nutrition education and Mother-to-Mother Support Groups (MMSG) sessions, attendance at ANC services, and the immunization of children according to the national immunization schedule. This is a soft condition, meaning that nonattendance does not prohibit the beneficiary from receiving the CT. The reason for this soft condition is to ensure strong links between cash programming and BCC on optimal feeding and care, as highlighted in the review of the CT program SCI previously implemented in the Delta region of the country. Ensuring that mothers are accessing basic preventive health care for themselves and their infants and young children will also maximize the benefits of CTs by making sure mothers and babies are healthy and can make best use of the foods they buy.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	*Costs by category have been calculated as follows: Administrative and human resources (targeting, implementation, management, and monitoring): $359,741 (58 percent); Operational and payment and distribution (processing, logistics, and associated travel costs): $98,154 (16 percent); Direct costs of cash transfers: $119,600 (19 percent); BCC: $46,280 (7 percent).* *The remote location, the need for a manual distribution system, and the intensive nature of the BCC component and continuous monitoring necessitate a very high initial investment in administration and human resources and operations. These costs should fall gradually as we explore options to test new technology (such as mobile money) and compare the findings of this pilot with other pilots we are conducting that use much less BCC. The M&E would also be far less intensive once the pilot phase is completed.*
9. INSTITUTIONAL ARRANGEMENTS	**Community level:** Village Development Committee members are trained and actively involved in the cash payment and recipient verification process. Paid community volunteers are trained in BCC and take the lead on completing monthly beneficiary lists and conducting home visits to beneficiary HHs to share and discuss nutrition issues. **Government engagement:** Government engagement is difficult, but SCI is attempting to engage midwives who provide ANC cards to pregnant mothers.
10. COMMUNITY PARTICIPATION	Communities participate in the pilot directly through their Village Development Committees. SCI also engages motivated community members to deliver BCC and support other aspects of the pilot, such as monthly updates of beneficiary lists. All members of the community, as well as traditional birth assistants and midwives, are encouraged to participate in BCC sessions. MMSGs also act as a forum for the dissemination of nutrition-related information, discussion, and sharing experiences. Through these community-level mechanisms, key behaviors are targeted, such as exclusive and continued breastfeeding, timely introduction of a complementary diet, maternal nutrition, optimal hygiene, and sanitation practices.

PROGRAM DETAILS	
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	It is planned that the program will scale up from 2016–18, but the limitations of technology and the remote nature of the intervention area necessitate considerable up-front investment and staffing for the manual distribution of payments and interpersonal BCC activities at the village level. However, the pilot is being used to inform our advocacy strategy with the government to develop a modified model that is more cost-effective and can be scaled up at a national level. The pilot was a blueprint for the development of two larger-scale programs that are testing technology and government capacity to deliver similar first 1,000-day CT programs in different regions of the country.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	The pilot was used to generate evidence for a cost-effective model for scaling up the project nationally and as a catalyst for convincing major donors and the government of Myanmar of the merits of developing two, much larger first 1,000-day CT program. In its current form the pilot is not sustainable by the individual communities or the government. Sustainability of the pilot can be achieved only by: • Using the intervention study to build a clear and robust evidence base that will demonstrate to the government the effectiveness of the intervention in reducing the incidence of stunting and the potential socioeconomic impact over the mid- to long term. • Clearly linking the pilot with two similar first 1,000-day CT programs under which SCI will test technology and intervention models that are nimbler, more adaptable, use fewer human resources, and have lower administrative costs.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	**Activity monitoring**: Project staff will submit payment forms and documentation to finance teams after each round of payment for verification. Using a tally sheet form for the MCCT, a beneficiaries list, and a CT database, the team completes a monthly activity summary detailing: how many mothers receive CTs each month; the percentage of target beneficiaries reached; the number of new mothers added and the number of mothers who have graduated; and the percentage of HHs targeted for postdistribution monitoring (PDM) that have been successfully visited (see below). This information is entered into the program M&E database and reviewed by SCI staff to capture any emerging issues that require follow-up and response. **PDM**: Village paid volunteers, with supervision from SCI staff, conduct monthly PDM for a subsample of beneficiary HHs. The PDM focuses on the HHs' experience of, and satisfaction with, the payment delivery process, the use of cash received, and control of the cash within HHs. Each round of PDM will cover 10 percent of the beneficiaries (approximately 40 HHs), which will be selected at random from the beneficiaries list. PDM data will be entered into a database and reviewed by SCI staff.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	The evaluation of the pilot involves the study of two intervention arms, each with 15 villages. Arm 1 consists of intensive CTs and BCC for all eligible women. Arm 2 is the control, which has intensive BCC but no CT. To set up this two-arm process, 30 villages were allocated into two groups, based on their distance to a formal health facility (less than 2.5 kilometers away or 2.5 kilometers away or more). Once the villages were allocated, random assignment to the control group or the intervention group was done separately for each allocation. After the random assignment, the control and intervention groups were assessed for average population size, distance to a health facility, livelihood zone, distance to the nearest cereal, vegetable, and fish markets, and percentage with a resident midwife in village to ensure that control and intervention groups were largely comparable.
3. OUTCOME/IMPACT INDICATORS	The main impact indicator being studied in the pilot is linear growth of children from birth to age two. The key secondary impact indicators are dietary diversity for children 6 to 23 months of age and PLWs. Indicators of feeding and caring, such as exclusive breastfeeding, appropriate complementary feeding, and vaccination coverage, are also measured. The main process indicators are those measured using the PDM process described above and focus on beneficiary experience with the program.

MONITORING AND EVALUATION	
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	Data collection is ongoing, and the sample size of mother and child pairs who have received the CT since birth is still small, but preliminary analysis of the data collected from October 2014 to March 2015 showed higher rates of growth among children whose mothers received CTs compared to those who received only BCC. Dietary diversity also showed positive trends, though increases in neither growth nor diversity were statistically significant at that time. Exclusive breastfeeding rates between intervention and control groups were significantly higher at three measurement points. At delivery, 89.3 percent of intervention mothers practiced exclusive breastfeeding, compared with 76.2 percent of control mothers. At three months, 89.4 percent of intervention mothers continued to breastfeed exclusively, compared to 64.9 percent of control mothers. At six months, the rates dropped for both groups: 23.6 percent of intervention mothers and 22.0 percent of control mothers were breastfeeding exclusively, indicating that mothers were introducing complementary foods. Individual dietary diversity was poor in both groups at six and nine months, but improved in the intervention group at 12 and 18 months. 23.5 percent, and 40 percent of children consumed four or more food groups in the Intervention villages at 12 and 18 months respectively, versus 14.3 percent, and 0 in the control villages. 'Height for age' z scores', measured at five intervals to assess stunting in children, show children in cash intervention villages had less stunting compared to children in control villages.
5. HARMONIZATION WITH OTHER PROGRAMS	Currently this is a stand-alone pilot, but we will link it to a similar first 1,000- day CT program we are launching in the Delta and potentially the Dry Zone regions of the country. The pilot also is well aligned with the government's recently launched National Social Protection Strategic Plan.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	Using SCI's cost-of-diet tool, the size of the CT is calculated to cover the affordability gap between (1) HH incomes and expenditures and (2) the cost of a locally appropriate and nutritious diet across three different livelihood zones. The CTs are universal to address widespread poverty, and delivered monthly basis to ensure that mothers have access to a frequent and reliable source of income to support the purchase of essential nutritious food and health care. Preliminary findings indicate that women have control over—and are empowered by—the CT, use it for nutritious food and health care, and see it as an incentive for behavioral change.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	CTs are disbursed in the context of a wider BCC strategy that encourages community participation through the formation of MMSGs, interpersonal counseling and support from trained community volunteers, mass media messaging, and community-level awareness raising, all targeted at influential members of the community. The program has soft conditions linked to the use of health and nutrition services, training and promotion of behavioral change through MMSGs, interpersonal counseling and support from trained community volunteers, mass media messaging, and community-level awareness raising. BCC activities deliver targeted and relevant messages to increase the awareness and practice of consuming nutritious foods, accessing essential health services during pregnancy and lactation, and promoting optimal infant and young-child feeding and care during the critical first 1,000 days. The pilot promotes capacity building of village volunteers and Village Development Committee members in nutrition-sensitive interventions and practices. SCI hopes to extend this to more government counterparts, such as midwives, starting in 2016.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	Because nutrition is critical to infant health during the first 1,000 days, income poverty is widespread in rural areas, and the wealthiest quintile in Myanmar exhibit chronic malnutrition rates of over 20 percent, the pilot takes a universal approach to beneficiary selection making all pregnant women eligible.

NUTRITION-SENSITIVE RATIONALE	
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	Weaknesses in financial services and technology and telecommunications in Myanmar necessitate that all CT payments currently be made manually. Therefore, the pilot ensures that CTs are distributed at the village level so women do not have to spend time and money traveling to receive them. The pilot provides village-level BCC on nutrition, but mothers are specifically supported through the establishment of MMSGs for information dissemination, discussion, and the sharing of experiences on key behaviors, such as exclusive and continued breastfeeding, timely introduction of a complementary diet, maternal nutrition, and optimal hygiene and sanitation practices. Focus group discussions indicate that women are empowered by the cash.
5. THE PROGRAM HAS NUTRITION INDICATORS	The pilot has the following core indicators: • percent of stunted children 6 months–2 years old • percent of children under 2 years old who have minimum adequate diet • percent of infants from birth to 6 months old in target villages being exclusively breastfed • percent of caregivers demonstrating knowledge of optimal MIYCF practices • number of mothers participating in MMSG meetings
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	The pilot is being actively used to build an evidence base to advocate to the government on the effectiveness of nutrition-sensitive social protection mechanisms at a national scale.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	Although this is a small pilot, SCI has created a strong advocacy platform to inform and influence the government. Using preliminary findings from the pilot and global evidence, SCI has successfully ensured that the intervention is included in the government's new National Social Protection Strategic Plan. SCI has also advocated that nutrition-sensitive social protection interventions be made a priority by donors in future rural development programs. As a result of this advocacy work, SCI is now testing a scaled-up approach using government systems in another region of the country and may also implement a third 1,000-day CT in the central Dry Zone with a large-scale randomized controlled trial.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Preliminary analysis of monitoring data shows that children whose mothers were enrolled during pregnancy had mean height-for-age (HAZ) scores at delivery of 0.76 compared with –1.5 in controls. Similarly, mothers who received CTs had a mean dietary diversity score of 4.8 food groups compared to 4.1 food groups in controls. These trends will be analyzed further as more data become available from the pilot.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	• Demonstrating a more cost-effective model for delivering the pilot at scale through government systems (particularly a BCC component). • Ensuring that government and other relevant national organizations can continue to carry out the program and implement a similar intervention at scale while maintaining high quality standards (particularly for M&E and antifraud mechanisms). • The use of technology (particularly telecommunications) is rapidly emerging in Myanmar as a viable alternative to manual CT mechanisms. This is a nascent industry, however, which will face a steep learning curve before it can effectively harness and use technology to scale up a nonmanual system.

FURTHER REFERENCES	
1. DOCUMENTS	Internal SCI case studies, Kamayut Media story on the pilot (video in Burmese only).
2. METHODS OF DOCUMENTATION	Case studies and media coverage were collected through field visits using observation and interviews with beneficiaries and other relevant stakeholders.
3. WEB SOURCES	No information available.

Philippines – Philippines Social Welfare Development and Reform Project

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Aleksandra Posarac, Program Leader
ORGANIZATION	World Bank Group (WBG)
ROLE WITHIN THE PROGRAM	Task Team Leader

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Philippines Social Welfare Development and Reform Project (4Ps)
2. COUNTRY	Philippines
3. TYPE OF PROGRAM	CCT
4. PROGRAM DURATION	January 2010 to December 2015 (WBG) 2007 to present (Government of the Philippines [GOP])
5. PROGRAM OBJECTIVE(S)	To strengthen the effectiveness of the DSWD as a social protection agency in efficiently implementing the CCT program (the 4Ps) and to expand an efficient and functional National Household Targeting System for Poverty Reduction (NHTS-PR) for social protection programs.
6. FUNDING AGENCY/IES	WBG (International Bank for Reconstruction and Development [IBRD]) $502 million GOP $1.5 billion annually (2015)
7. IMPLEMENTING AGENCY/IES	GOP: Department of Social Welfare & Development (DSWD) (responsible institution)
8. TOTAL COST	$502 million $1.5 billion annually for the overall program
9. TARGET GROUP(S)	CCT program rules require that grantees be mothers **Health grant**: Poor HHs with children from birth to 18 years old, or pregnant women, or both. **Education grant**: Poor HHs living in selected areas with children 6–18 years old.
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	**CCT[a]:** 617,293 HHs in 2014 905,731 HHs in 2013; 594,356 HHs in 2012; 608,611 HHs at baseline in 2009. Female beneficiaries: 90 percent *Targets pertain only to the CCT grants to which the WBG loan contributes. The overall program has a target number of 4.3 million beneficiary HHs as of late 2015. **Targeting component:** 11 million HHs from 2010 to 2015 (60 percent of all HHs in the Philippines) and 15.3 million HHs in 2015 (75 million people or 75 percent of the population of the Philippines).
	Family development session (FDS): 4.3 million HHs (24 million people). All beneficiary HHs are required to attend monthly FDSs

PROGRAM OVERVIEW		
11. NUMBER OF REACHED BENEFICIARIES	**CCT:** 4.3 million HHs (24 million people). **Targeting component:** 15.3 million HHs (75 million people).	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM ☐ Multisectoral collaboration ☐ Integrated approach ☐ Governance ☐ Decentralization ☐ Performance-based financing ☐ Community participation ☐ Agriculture and local procurement ☐ Urban	☐ Rural ☐ Resilience ☐ Conflict-affected setting ☐ Harnessing nutrition data ☐ Use of mobile technology ☒ BCC ☐ Life-cycle approach ☒ Gender and women's empowerment ☒ ECD

CONTEXT OVERVIEW	
1. CONTEXT	After posting strong economic growth for several years, the Philippines is experiencing an economic slowdown from the effects of the global economic crisis. Available data at the project development stage showed that the food and fuel price shock in 2008, the global economic crisis, and the typhoon-related disaster had taken their toll on HH welfare and the economy as a whole, which reduced the employment and incomes of Filipino households. The unemployment rate increased slightly, from 7.4 percent in January 2008 to 7.5 percent in April 2009, and the growth of remittances from overseas Filipino workers slowed dramatically, from 13.7 percent growth in 2008 to 2.8 percent growth from January to May 2009. Moreover, a growing number of Filipinos consider themselves poor. Of the 1.1 million entrants to the labor force in 2009, only 22 percent got jobs in the domestic formal sector. The recent contraction in agricultural sector employment, where most of the poor still find their livelihoods, may risk undermining the government's poverty reduction efforts. Many Filipinos still live just above the poverty line ("near poor"), cycling in and out of poverty because of their high vulnerability to climatic disaster, and financial and price shocks. It has been estimated that a 20 percent increase in the poverty line following a major food shock would increase the poverty incidence by over 9 percent. Between 2003 and 2009, 44 percent of the population was poor at least once, one in three Filipinos was persistently poor, and two out of three households moved in and out of poverty. Perennial typhoons and flooding are most devastating in their economic and social impact. *WBG Project Appraisal Document PAD47175-PH October 2009* *WBG Project Information Document, Concept Stage PIDC22250 March 2015*
2. COUNTRY INCOME LEVEL	Lower-middle-income
3. KEY CONTEXT DATA	<u>2009 data:</u> • GDP growth: 1.1 percent • Gini index: 42.9 (WBG estimate) • Poverty rate: 26.3 percent • Unemployment rate: 7.5 percent • Share of population with access to improved sanitation facilities: 56 percent • Growth of received remittances: 13.7 percent in 2008 and 2.8 percent from January to May 2009 • Share of poor population: between 2003 and 2009, 44 percent of the population was poor at least once, 33 percent was persistently poor, 67 percent households moved in and out of poverty. *WDI and WBG PAD*

CONTEXT OVERVIEW	
4. KEY SOCIAL PROTECTION DATA	2013 data: • Coverage of SSNs in total of population: 27.4 percent • Coverage of SSNs in extreme poor: 58.5 percent • Adequacy of benefits of SSNs in total population: 11.6 percent • Adequacy of benefits of SSNs in extreme poor: 22.8 percent • Incidence of benefits of SSNs in extreme poor: 37.5 percent • Incidence of beneficiaries of SSNs in extreme poor: 34.3 percent • Public spending on social assistance programs, percent of GDP: 0.6 percent *ASPIRE database*
5. NUTRITION CONTEXT	Despite progress in some social indicators, several challenges remain. Although the prevalence of underweight children from birth to 5 years has declined from 27.4 percent in 1989 to 19.9 percent in 2013, stunting rates have declined only by about 3 percentage points over the last decade (from 33.9 percent in 2003 to 30.3 percent in 2013), and at this rate of improvement, the Philippines is unlikely to achieve the Millennium Development Goal target for nutrition. Immunization rates are low and barely improving (rising from 72.2 percent in 1993 to 76.6 percent in 2013), and obesity among children and adults has also been steadily increasing, along with the associated risk factors for diabetes, hypertension, and cardiovascular disease. Faced with the financial crisis in 2007, the GOP embarked on the reform of its social assistance system to assist the poor and vulnerable more effectively. These reforms were spearheaded largely by the DSWD and included, among other actions, the adoption of a national definition and framework for social protection; the establishment of a unified national system to target poor households; and the creation of the 4Ps CCT program, which plays a central role in the government's overall strategy to address poverty and vulnerability among Filipinos. *WBG Project Appraisal Document PAD47175-PH October 2009;* *WBG Project Information Document, Concept Stage PIDC22250 March 2015*
6. KEY NUTRITION DATA	2013 data: Children under 5 years old suffering from • Stunting: 30.3 percent • Underweight: 19.9 percent Immunization rate: 76.6 percent *WDI and WBG PAD*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**Support for the NHTS-PR**. Support the DSWD in developing and implementing NHTS-PR to better deliver to the poor key social assistance and social protection programs of DSWD and other government agencies. **Support to the 4Ps**. Support the 4Ps through provision of health and education grants to poor and eligible HHs living in the selected municipalities. **Building Institutional Capacity to Lead in Social Protection**. Support the strengthening of basic institutional capacity of DSWD to undertake policy analysis and strategic planning and the installation of a technically sound M&E system.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	**Health grant:** ₱500 ($11) monthly (for a period of 12 months per year) per HH with children from birth to 18 years old and pregnant women, regardless of the number of children under 18. **Education grant:** ₱300 ($6) monthly per child 6–14 years old; ₱500 ($11) per child 14–18 years old for a period of 10 months per year, up to a maximum of 3 children.

PROGRAM DETAILS	
	HHs with both children younger than 5 years old and children 6–18 years old receive both transfers in one payment if conditions are met, according to the number and age of their children. HHs receive the transfers as long as they have eligible children and meet the conditions.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The average transfer per HH under 4Ps was calculated during the program design in 2006–07 to equal approximately 23 percent of the estimated average annual income of HHs. This proportion was within the range of that used in successful CCT programs in Latin America. However, based on empirical evidence from HH and impact evaluation surveys, the transfer represented about 17 percent of estimated average annual income of HHs in 2009 and has steadily declined since then to about 11 percent in 2013.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	The health grant requires that HHs fulfill the following conditions: • All children from birth to 5 years old attend a health center or rural health unit to get the services appropriate for their age, as established by the DOH • Pregnant women attend a health center or rural health unit for pre and post natal services according to DOH protocol • All children 6–14 years old comply with the deworming protocol in school • For HHs with children from birth to 14 years old, the grantee (usually the mother) or spouse attend family development sessions at least once a month Beneficiary HHs receive the education transfer for each child 6–18 years old so long as they are enrolled in primary or secondary school and maintain a class attendance rate of 85 percent every month.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	(WBG project only): • **Support for the NHTS-PR:** $55.3 million • **Support to the 4Ps:** $447 million (including $100 million AF) • **Building Institutional Capacity to Lead in Social Protection:** $1.7 million *Costs by category (WBG project only) can be estimated as follows: administrative costs 10 percent; cash grants 90 percent.*
9. INSTITUTIONAL ARRANGEMENTS	The institutional arrangements for project implementation are aligned with the government structure. At the central level, DSWD, DOF, Department of Budget and Management and the Commission of Audit are responsible for ensuring that project resources are budgeted for and that project accounts are audited.

PROGRAM DETAILS	
	The DSWD is the executing agency, with overall responsibility for accounting for project funds and coordinating activities under the project. Although overall oversight and management is placed with the office of the Undersecretary for Policy and Program Group, two discrete implementation units are supported by the project: (a) the National Project Management Office (NPMO) NHTS, charged with implementing the NHTS-PR and (b) the NPMO-4Ps, charged with implementing the 4Ps component. DSWD has established a sophisticated and well-functioning CCT implementation structure with about 13,000 staff.
10. COMMUNITY PARTICIPATION	The program features a built-in and comprehensive community participation: • Initial lists of HHs identified as poor by the national targeting system are vetted by communities • Beneficiaries of the CCT program are known to community members • CCT beneficiaries are organized in groups of 35, each of which is led by a parent leader (99 percent of whom are women) • Civil society organizations (CSOs) are involved in the monitoring of the CCT and in identifying hard-to-reach potential beneficiaries (such as the homeless, and indigenous populations in remote areas) • FDSs are often open to other community members, and in many cases more than half of the community benefits from the program • The CCT program has a sophisticated grievance redress system
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	Since 2010, the program has scaled up from 0.7 million to 4.3 million poor HHs with children from birth to 14 years old (18 years old as of 2014), as identified by the national HH targeting system, representing 100 percent of the target population.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	The program has had the full political and financial support of the current administration, which has expanded it from 0.7 million HHs in 2010 to 4.3 million in 2015 and increased its budget from 0.1 percent to 0.5 percent of GDP. The program critically depends on political commitment. It is not guaranteed that the next administration will be as supportive as the current one. Because it is a program, not a legal mandate, it is vulnerable to a lack of political will.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	The information used by DSWD project administrators in monitoring project outputs comes from three main sources: • Program administrative records and the MIS produce the information required for informed and timely policy decisions and adjustments • Spot checks to monitor targeting and 4Ps program implementation processes and outputs are undertaken regularly through technical and social audits. Spot checks have been shown to provide valuable operational guidance in similar projects implemented by other countries. DSWD is responsible for ensuring that the data generated by the audits are gathered and used for policy decisions.
	• Some aspects of monitoring, such as targeting effectiveness, are also based on data collected by the regular national household surveys, particularly the Food and Income Expenditure Survey.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	The 4Ps established a methodologically rigorous impact evaluation. The evaluation is based on an experimental design using randomly selected treatment and control groups. The objectives are to determine whether 4Ps had any significant impact on the main project outcomes: health; education; and well-being. So far two rounds of the IE have been carried out and the third round is currently in the field. In addition to the quantitative IE, a round of qualitative assessment was conducted in 2013.

MONITORING AND EVALUATION	
3. OUTCOME/IMPACT INDICATORS	Project Development Objective indicators: • Share (percentage) of all poor HHs registered in the NHTS-PR • Share (percentage) of children 6–14 years old in poor beneficiary HHs with a school attendance rate of at least 85 percent • Share (percentage) of children from birth to 5 years old receiving growth monitoring and checkups in accordance with DOH protocol.
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	According to the available information, all Project Development Objective Indicators have been achieved or exceeded. The program has helped improve the long-term nutritional status of children from 6–36 months old, a positive impact not seen in other CCT impact evaluations so early in program implementation. The improvement represented a 10-percentage-point reduction in severe stunting compared to barangays that did not receive the program, where 24 percent of children 6–36 months old were severely stunted. The program enabled parents to provide consistently better care for their children and to feed them more protein-rich food, such as eggs and fish, which improved their long-term nutritional status. Reduction in severe stunting among this young age group is expected to have strong long-term benefits. The program has also encouraged poor women to use maternal and child health services such as ANC, postnatal care, regular growth monitoring, and vitamin A and deworming pills. In addition, it has helped increase health care–seeking behaviors among beneficiaries when their children become ill. The program is also achieving its objective of enabling poor HHs to increase their investment in meeting the health and education needs of their children. The 4Ps is changing the spending patterns of poor HHs, with beneficiary HHs spending more on health and education than poor HHs who had not participated in the program. The study also found that beneficiary HHs spent less on adult goods such as alcohol and that the program may have contributed to increased savings among beneficiary HHs. Although the study found that the cash grants were reaching beneficiaries, it did not find an overall increase in per capita consumption among the poor benefiting from the program, although there was some evidence that poor HHs are saving more in certain provinces. The lack of impact on mean consumption is not unusual for CCT programs at a relatively early stage of implementation; evaluations of other programs have found an effect on mean consumption as the programs mature. *Philippines Conditional Cash Transfer Program Impact Evaluation 2012; Published in January, 2013, and revised in April 2014*
5. HARMONIZATION WITH OTHER PROGRAMS	The impact evaluation found that 4Ps has had positive effects beyond its originally targeted objectives. For example, the program has contributed to increased coverage under the PhilHealth health insurance program. Growth monitoring serves and is used by many local communities as an indication of nutrition status of the CCT children and a means of targeting the supplemental feeding program of DSWD. DSWD has a separate, government-budget financed "supplemental feeding" program for small children and a separate public works program in case of disasters.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	Payments are bimonthly and regular to support expenditures for covering daily necessities. HHs remain in the program until all children eligible to be enrolled in the program exit the education system.

NUTRITION-SENSITIVE RATIONALE	
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The program has firm conditions, requiring participation of the targeted HHs in health and growth monitoring sessions, in particular: • All children from birth to 5 years old must attend a health center or rural health unit to get the services appropriate for their age, as established by the DOH; • Pregnant women must attend a health center or rural health unit according to DOH protocol; • All children 6–14 years old must comply with the deworming protocol in school; and • For HHs with children from birth to 18 years old, the HH grantee (usually the mother) or spouse shall attend an FDS at least once a month. The FDSs include several sessions on nutrition ranging from breastfeeding to proper food preparation practice. They also include extensive WASH instruction to raise awareness and inform CCT beneficiaries about proper WASH practices. FDSs also tackle topics such as family relations, family violence and abuse, and reproductive health.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	4Ps targets poor HHs with children from birth to age 18 and pregnant women. Poverty status is a necessary condition that is established through the national targeting system using a Proxy Means Testing (PMT) targeting method combined with community verification to identify the poor. Ninety percent of HH members receiving grants are mothers; more than 90 percent of parent leaders are women.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	No information available.
5. THE PROGRAM HAS NUTRITION INDICATORS	Project Development Objective indicators: • Share (percentage) of children from birth to 5 years old receiving growth monitoring and checkups in accordance with DOH protocols
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The reduction in severe stunting rates found in the impact evaluation indicates that the 4Ps is enabling HHs to better care for their children in a sustained and consistent manner. The provision of cash coupled with education on good parenting practices provided during the program's FDSs have improved parents' feeding practices for their children. More parents in 4Ps barangays, compared to nonparticipating parents were feeding their children more high-protein foods, including eggs and fish, leading to the improved long-term nutritional status of young children.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The 2012 impact evaluation found that 4Ps is meeting the objective of keeping children healthy, as evidenced by a reduction in the rates of severe stunting among poor children 6–36 months old, which is expected to have long-term benefits. Notably, impact evaluations of CCT programs around the world have not proven to reduce stunting at such early stages of program implementation; 4Ps appears to be an exception. Although there was no measured impact on the mean height-for-age score or other anthropometric measures, the program lowered the rate of severe stunting among poor children 6–36 months old by 10.1 percentage points from the baseline of 24 percent in non-4P barangays.

2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The 4Ps is designed primarily to increase demand among poor families for education and health services. The study findings show, however, that achieving overall improvement in education and health outcomes requires intensified efforts to improve access to and quality of health and education services for CCT beneficiaries. For example, although more children are visiting health centers to meet the program conditions of regular growth monitoring, the study did not find an increase in childhood immunization coverage which, although not uncommon in impact evaluations around the world, suggests that health providers are not yet able to fully capitalize on the opportunities to provide basic child health services to CCT HHs.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects/P082144/ph-social-welfare-development-reform?lang=en
2. METHODS OF DOCUMENTATION	**Desk-based research:** WBG resources: *Project Appraisal Document PAD47175-PH October 2009* *Project Information Document, Concept Stage PIDC22250 March 2015* *Philippines Conditional Cash Transfer Program Impact Evaluation 2012; January 22, 2013 (revised April 2014) Report Number 75533-PH* **Interview with Task Team Leader**
3. WEB SOURCES	http://www.worldbank.org/projects/P082144/ph-social-welfare-development-reform?lang=en http://www.worldbank.org/en/news/video/2013/06/10/philippines-conditional-cash-transfers-good-investments-in-health-and-education http://www.worldbank.org/en/news/feature/2013/06/10/conditional-cash-transfers-pay-off-in-the-philippines

Europe & Central Asia

Kyrgyz Republic – Optimizing Primary School Meals Programme

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Ashimbaeva Toktobubu Abasovna, Deputy Minister of Education and Science[1] Carlo Scaramella, Deputy Regional Director, World Food Programme MENA Region[2] Maria Lukyanova, Head of World Food Programme Tunisia and Morocco Country Offices[2] Nadya Frank[2] Ram Saravanamuttu[2]
ORGANIZATION	[1]The Kyrgyz Republic [2]World Food Programme
ROLE IN THE PROGRAM	Coordination and cooperation with World Food Programme-funded pilot project "Optimizing Primary School Meals Programme in the Kyrgyz Republic"

PROGRAM OVERVIEW		
1. NAME OF PROGRAM	Optimizing Primary School Meals Programme (pilot)	
2. COUNTRY	The Kyrgyz Republic	
3. TYPE OF PROGRAM	In-kind transfer (school feeding)	
4. PROGRAM DURATION	January 2013 to December 2016, with the possibility of extension.	
5. PROGRAM OBJECTIVE(S)	Provide technical support to the government to improve the quality, efficiency, and sustainability of the national School Meals Programme.	
6. FUNDING AGENCY/IES	Government of the Kyrgyz Republic (state resources) World Food Programme (donor contributions, primarily from the Russian Federation)	
7. IMPLEMENTING AGENCY/IES	World Food Programme The Kyrgyz Republic: Ministry of Education & Science (responsible institution); MOH NGOs: Social and Industrial Food Services Institute; Roza Otunbaeva's Initiative; Agency for Development Initiatives; Center for Activation and Development of Rural Initiatives	
8. TOTAL COST	$10.4 million	
9. TARGET GROUP(S)	Primary school children, grades 1 to 4.	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	56,000 individuals Female beneficiaries: 28,000 (50 percent)	
11. NUMBER OF REACHED BENEFICIARIES	*As of May 2015:* 44,518 individuals	
12. PROGRAM CROSS-CUTTING THEMES	☐ Double burden of malnutrition (DBM) ☒ Multisectoral collaboration ☐ Integrated approach ☒ Governance ☐ Decentralization ☐ Performance-based financing ☒ Community participation ☐ Agriculture and local procurement ☐ Urban	☐ Rural ☐ Resilience ☐ Conflict-affected setting ☐ Harnessing nutrition data ☐ Use of mobile technology ☒ Behavior change communication (BCC) ☐ Life-cycle approach ☒ Gender and women's empowerment ☐ Early child development (ECD)

CONTEXT OVERVIEW	
1. CONTEXT	Since 2006, the government of the Kyrgyz Republic has implemented a national School Meals Programme for almost 400,000 primary school children. The government spends approximately $10 million per year on this program from state budget resources. In most schools, however, gaps in program design and implementation make the quality of the meals nutritionally inadequate, providing children with only an unfortified bun, a cup of black tea, and in many cases empty calories, such as cookies or sweets. Access to primary education is high, with minimal disparities between genders and between urban and rural areas. The overall primary net enrollment rate is 95 percent for both girls and boys. However, learning achievement is low in comparison to other countries in the region, with the Kyrgyz Republic performing last of the 74 countries and territories participating in the Programme for International Student Assessment in 2009. Attendance is an issue, especially in the autumn and spring months, when many children are involved in income-generating activities, including agriculture, which forces them to drop out of school on a seasonal basis.

CONTEXT OVERVIEW	
	World Bank. 2012. World Development Indicators *World Bank. 2010. Kyrgyz Republic 2010: Lessons from the Programme for International Student Assessment* *UNICEF. 2011. Situation Assessment of Children in the Kyrgyz Republic*
2. COUNTRY INCOME LEVEL	Lower-middle-income

3. KEY CONTEXT DATA	According to a 2013 World Food Programme School Meals Baseline Assessment of selected schools, under the existing national School Meals Programme and prior to implementation of the School Meals Optimization project:
	• 87 percent of schools provided children with only a bread roll and tea
	• School meals provided only 58 percent of the calories and 36 percent of the protein values recommended by the government for breakfast
	• Procurement efficiency rate was 70 percent (that is, the actual expenditure on food was 30 percent higher than local market prices for the same food)
	• Only 10 percent of parents contributed cash towards school meals
	2012 data[a]:
	• gross domestic product (GDP) growth: –0.1 percent
	• Gini index: 27.8 (World Bank Group [WBD] estimate)
	• Poverty rate (at national poverty lines): 38 percent
	• Poverty rate, by location (at national poverty lines):
	  • rural 39.6 percent
	  • urban 35.4 percent
	• Life expectancy: 70 years
	• Infant mortality rate: 23 per 1,000 live births
	[a]*World Development Indicators (WDI)*

4. KEY SOCIAL PROTECTION DATA	2013 data: • Public spending on social assistance programs, percent of GDP: 3.0 percent 2011 data: • Coverage of social safety nets (SSNs) in total of population: 8.5 percent • Coverage of SSNs in extreme poor: 17.3 percent • Adequacy of benefits of SSNs in total population: 9.9 percent • Adequacy of benefits of SSNs in extreme poor: 26.8 percent • Incidence of benefits of SSNs in extreme poor: 14.2 percent • Incidence of beneficiaries of SSNs in extreme poor: 14.4 percent *ASPIRE database*
5. NUTRITION CONTEXT	Preventable nutritional challenges—particularly stunting and anemia—cost the Kyrgyz Republic approximately $32 million annually in lost productivity that results from increased mortality and reduced cognitive and physical development. Although Kyrgyz diets typically provide sufficient energy, they are not nutritionally diverse and are particularly lacking in micronutrients. A World Food Programme Household Food Security Assessment in 2014 found that in the surveyed households, 60 percent of energy came from bread and potatoes. Such diets cannot provide sufficient micronutrients, increasing the risk of malnutrition and susceptibility to disease.

CONTEXT OVERVIEW	
	About 18 percent of children under 5 years old are stunted, and the prevalence of anemia is 43 percent among children 6–59 months old. Balanced diets with increased micronutrient intake must be promoted. Health disorders directly linked to nutrition quality in the Kyrgyz Republic include iron deficiency anemia, iodine deficiency disorders, and hyperthyroidism. Nearly 17 percent of children 8–13 years old have been diagnosed with stunting, and 52.5 percent of school children have been reported to have chronic diseases, most often of the digestive system. *World Bank/UNICEF. 2011. Situation Analysis: Improving Economic Outcomes by Expanding Nutrition Programming in the Kyrgyz Republic* *Government of the Kyrgyz Republic. 2012. Demographic and Health Survey.* *World Food Programme. School Meals Optimization in Kyrgyzstan, 2013–14*
6. KEY NUTRITION DATA	2012 data: Children under 5 years old suffering from • Stunting: 18 percent (of which 6 percent is severe) • Wasting: 3 percent Children 6–59 months old suffering from anemia: 43 percent *Government of the Kyrgyz Republic. 2012. Demographic and Health Survey*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	World Food Programme established the Optimizing Primary School Meals in the Kyrgyz Republic program to provide technical support to the government's effort to improve the quality, efficiency, and sustainability of the national School Meals Programme through: • Development of a national school meals policy and implementation strategy and building government capacity to manage an optimized school meals program • Implementation of a pilot to construct and renovate school canteens and water and sanitation facilities and introduce more nutritious meals at 250 schools in selected food-insecure areas of the country. The pilot program is effective, accountable, sustainable and efficient in terms of costs.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	School meals with a value of $0.13–$0.19 (som7–10) daily per child (depending on the geographic location of the school). One meal is served each school day from a diverse range of menus. About 96 percent of schools serve hot meals; 10 percent serve fresh salads, and 58 percent include meat on the menu. For example, sample menus include: milk-based oat porridge, compote, and a fortified bread roll; rice pilaf, cabbage-stuffed fortified buns, and fruit compote; and pea soup with potatoes, a fortified bread roll, and fruit compote.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	In order to ensure fiscal sustainability, the project aims to provide nutritious meals at a cost as close as possible to som7–10 per child per day, which is the level of national budget resources allocated to the project annually by the Kyrgyz government. The pilot is designed to provide food with nutritional values as close as possible to the Kyrgyz government's recommended values for breakfast. The food distributed under the pilot provides an average of 30 percent of the children's daily energy requirements (547 Kcal energy out of the 1,850 Kcal recommended by WHO/FAO for this age group).
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Food is procured both locally and internationally. About 83 percent of pilot schools use locally produced milk or dairy products, and 58 percent serve meat from local farmers. Under the pilot, food is provided both by the government of the Kyrgyz Republic and by World Food Programme. Suppliers are selected through the procurement systems of the government and World Food Programme.

PROGRAM DETAILS	
5. IS THE TRANSFER LINKED TO CONDITIONS?	Food is served to all children enrolled in and attending grades 1–4 at the pilot schools.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	*Costs (annual) by category have been calculated as follows: For World Food Programme, Food and related costs: $260,000; Capacity development (including equipment, training, and monitoring): $1.6 million; Administrative and indirect support costs: $1 million. For Government of the Kyrgyz Republic, Food and related costs: $1.3 million. The above figures do not include government funding of cooks' salaries or local authority and community contributions toward canteen rehabilitation, maintenance, and food.*
9. INSTITUTIONAL ARRANGEMENTS	The Ministry of Education & Science has overall responsibility for the program. District Departments of Education determine menus and procure food in coordination with Ministry of Education & Science. The Ministry of Health (MOH) monitors all health-related issues and conducts regular sanitary and hygiene inspection of schools.
10. COMMUNITY PARTICIPATION	Community participation is promoted at every stage in the project cycle. Parents are systematically engaged prior to the start of the pilot at each school in the design of menus and school meal development plans, in sharing and discussing results and lessons learned, and in making contributions to the program. Communities also contribute financially. In 2014, parents contributed $42,000 toward rehabilitation and maintenance of canteens and $48,000 toward food and bonuses for cooks.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The pilot is designed as a model that could be expanded by the government to cover all primary schools in the Kyrgyz Republic. Already many schools outside the pilot schools and districts have begun to replicate the optimized school meals model on their own initiative or with the support of local authorities.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	The government of the Kyrgyz Republic allocates an annual budget (from state resources) of som7–10 per child per day (varying by geographic area) to the national School Meals Programme for almost 400,000 children (including 44,000 children at the optimization pilot schools). The program is expected to be sustainable by national funding as it enjoys strong political support and legal foundations. The School Meals Optimization Pilot aims to improve the quality of the national program while—for the sake of fiscal sustainability—maintaining expenditures as close as possible to the national budget of som7–10 per child. Additional investments would, however, be needed, for example, to improve canteen infrastructure and equipment. World Food Programme is working to improve institutional capacity and community participation, which are also critical elements for sustainability. In 2014, support for school meals was further institutionalized when the government launched a national School Meals Policy developed with technical assistance from World Food Programme.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	Currently the government has monitoring systems to prevent corruption and enable auditing, but not for monitoring implementation. World Food Programme field monitors visit each pilot school at least twice per month to monitor progress at the process level (quality control) and the output level (immediate results). World Food Programme and partners currently conduct the monitoring, but the government plans to take over this role in increments. The program does not monitor anthropometric data of beneficiaries, but the nutritional value of the food provided before, during, and after the project are monitored against national recommended nutritional values.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	Outcomes are evaluated through assessments at the school level, including stakeholder surveys and participatory lessons-learned sessions. A comprehensive program evaluation is planned for the first half of 2016. In addition, a participatory outcome evaluation exercise was recently carried out by the Ministry of Education & Science, World Food Programme, and the WBG, in which stakeholders assessed the program against the five standards of the Systems Approach for Better Education Results. A report is currently being prepared.
3. OUTCOME/IMPACT INDICATORS	The pilot program has a logical framework specifying several outcomes, outputs, and related indicators. The project does not monitor nutritional outcomes or anthropometric data. The government is currently discussing with the World Food Programme the possibility of measuring and assessing nutritional outcomes in the future.
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	A comprehensive evaluation is planned for the first half of 2016.
5. HARMONIZATION WITH OTHER PROGRAMS	The School Meals Optimization pilot program is integrated into the existing national School Meals Programme. The optimization pilot current assists 44,000 children within the broader umbrella of the national school meals program, which reaches almost 400,000 children at all primary schools in the country. World Food Programme, the Ministry of Education & Science, and partners hope to expand the pilot model to cover all schools under the national program. Efforts have already begun to replicate and share information and know-how with nonpilot schools. In the future, World Food Programme is planning to link the pilot with a proposed Productive Safety Net pilot program, to be implemented with the Ministry of Social Development and the Ministry of Labour, Youth & Migration. World Food Programme proposes to develop home-grown school meals, through building the capacity of smallholder farmer groups (under the proposed Productive Safety Net pilot) to sell fresh local produce to the government for distribution under the School Meals Programme.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The optimized school meals model enables children to eat a healthier, more balanced diet than was the case under the existing national school meals model. Under the pilot, schools switch from the national program's typical menu of tea and unfortified buns (often accompanied by sweets or cookies) to more nutritious menus, including items such as milk, fruit compote, vegetables, and salads. Children eat more healthfully today and may develop lifelong habits of eating more-balanced meals. In addition to the immediate benefit of improved nutrition for children, over the long term, improved micronutrient intake is expected to lead to increased productivity and better health during the adult years. A School Feeding Investment Case study in 2014 by World Food Programme and Boston Consulting Group estimated that for every $1 invested in the Optimized School Meals model in the Republic of Kyrgyz, there is a lifelong return of $2 of increased productivity and a healthier and longer life. The food provided also saves poor HHs from having to purchase school lunches for their children, freeing up their scarce resources to invest in other areas, such as the family's health and productive assets.

NUTRITION-SENSITIVE RATIONALE	
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	World Food Programme and partners are working to improve children's knowledge, attitudes, and practices on nutrition through a number of complementary activities: • More than 5,000 children have been trained through child-friendly interactive games to promote awareness of healthy, balanced diets • School hygiene facilities have been improved and children are trained in basic hygiene, especially handwashing • School gardens have been developed on a pilot basis at five schools, providing children with an opportunity, among other things, to learn more about growing vegetables World Food Programme supported a 2014 MOH survey on consumption of junk food and sodas by school children in an effort to better understand and address this issue.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The pilot program geographically targets the most food-insecure districts in the country. Within selected schools, all children in grades 1–4 receive food.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	The program ensures that women are fully represented in designing and making decisions on the project through community engagement mechanisms, particularly consultations with parent-teacher groups. Currently 70 percent of parent-teacher group members at pilot schools are women. Female members play an important role in project planning, oversight of spending, and mobilization of community involvement in the program.
5. THE PROGRAM HAS NUTRITION INDICATORS	Formal, regularly monitored indicators related to nutrition: • Percent of schools serving hot meals • Energy value of meals (Kcal) measured against recommended requirements for breakfast for children 6–11 years old • Protein content of school meals (including animal protein) Additional indicators, monitored on an ad hoc basis: • Micronutrient values of meals (vitamins A, B1, B2, and C, and iron) • Number of children trained in interactive games on healthy nutrition • Percent of children who believe they should eat fruit and vegetables to remain healthy
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The program demonstrates that it is possible to provide high quality, nutritious meals at a low cost, approximately within the limits of the available national state resources of a country at the level of development of the Republic of Kyrgyz. Most internationally recognized high-quality school meals programs are being implemented in high-income or upper-middle-income countries such as Brazil. Programs in lower-middle-income or low-income contexts are in many cases partially dependent on external funding, and school meals funded primarily through national resources (such as the current national program in the Republic of Kyrgyz) are often undermined by quality issues. The optimized school meals pilot in the Republic of Kyrgyz demonstrates that high-quality, nutritious meals can be provided for $0.13–0.19 per child, per day, in hygienic conditions with strong community participation, mostly within the limits of the relatively low budget available to a lower-middle-income country.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The program has introduced milk, fruit compote, and vegetables for students, improving typical school meals featuring tea and unfortified buns.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Challenges to scaling up include the perception that it is not possible to introduce improved or hot meals within the government's budget allocation. The pilot demonstrates that it is indeed possible. Other challenges include inadequate technical capacity, canteen equipment, and water and sanitation infrastructure. Capital investment will be needed in order to expand the model to sites outside the current pilot.

FURTHER REFERENCES	
1. DOCUMENTS	*World Food Programme. 2015. School Meals Optimization in Kyrgyzstan 2013–14* *Optimising School Meals in the Kyrgyz Republic (Progress Reports issued quarterly by World Food Programme)* *World Food Programme Ministry of Education & Science. 2014. Implementation Strategy for Developing School Meals in 250 Pilot Schools of the Kyrgyz Republic* *School Feeding Investment Case—Kyrgyzstan (presentation; World Food Programme Boston Consulting Group, 2014)*
2. METHODS OF DOCUMENTATION	Information has been collected through regular World Food Programme monitoring, participatory stakeholder consultations and surveys, and Ministry of Education & Science reports.
3. WEB SOURCES	No information available.

Latin America & the Caribbean

Brazil – National School Feeding Programme

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Christiani Amaral Buani, Head of Programme[1] Eliene Sousa[2]
ORGANIZATION	[1]World Food Programme Centre of Excellence against Hunger (WFP COE) [2]Government of Brazil
ROLE IN THE PROGRAM	Supporting South-South cooperation with African countries

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	National School Feeding Program (PNAE)
2. COUNTRY	Brazil

PROGRAM OVERVIEW		
3. TYPE OF PROGRAM	In-kind transfer (school feeding)	
4. PROGRAM DURATION	1940 to present (universal in 1972)	
5. PROGRAM OBJECTIVE(S)	Provide fresh and nutritious daily meals to all students in public schools.	
6. FUNDING AGENCY/ IES	Fundo Nacional de Desenvolvimento da Educação (FNDE)	
7. IMPLEMENTING AGENCY/IES	FNDE (responsible institution)	
8. TOTAL COST	$2 billion	
9. TARGET GROUP(S)	Students of all ages enrolled in public preschool, primary, secondary and high school, and adults enrolled in special education (such as literacy) programs and regular courses for the elderly.	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	45 million students Female beneficiaries: 60 percent	
11. NUMBER OF REACHED BENEFICIARIES	45 million students	
12. PROGRAM CROSS-CUTTING THEMES	☒ Double burden of malnutrition (DBM)	☐ Rural
	☒ Multisectoral collaboration	☐ Resilience
	☒ Integrated approach	☐ Conflict-affected setting
	☒ Governance	☐ Harnessing nutrition data
	☒ Decentralization	☐ Use of mobile technology
	☐ Performance-based financing	☐ Behavior change communication (BCC)
	☒ Community participation	☐ Life-cycle approach
	☒ Agriculture and local procurement	☐ Gender and women's empowerment
	☐ Urban	☐ Early child development (ECD)

CONTEXT OVERVIEW	
1. CONTEXT	Nearly 44 million people in 9.3 million HHs earned less than a dollar a day in 2003. A large proportion of this vulnerable population lives in rural areas, and the most insecure groups are women, children, and the elderly. Although child mortality remains high, Brazil achieved the Millennium Development Goal for childhood mortality reduction, decreasing the rate from 53.7 per 1,000 in 1990 to 17.7 per 1,000 in 2011. A recent diagnosis of the hunger problem in Brazil suggests that the demand for food is insufficient, preventing commercial agriculture and agro-industry from increasing food production. Research indicates that farmers in Brazil have the potential to produce all the food required to meet the population's needs. The insufficient demand is attributed to excessive income concentration, low wages, high rates of unemployment, and low growth rates, particularly in sectors that could hire more people. That is, hunger persists not for lack of food, but rather for lack of income among vulnerable groups to purchase it. As these conditions are deemed to be inherent to the current economic growth pattern, there is a twin-track approach toward improving income and economic inclusion of, and support for, smallholder farms, the main suppliers of food to the Brazilian population. Since 2003, the eradication of poverty and hunger in Brazil has been a top priority. The strategy, known as Fome Zero or Zero Hunger, was launched in the first days of former President Lula's term and has received international

CONTEXT OVERVIEW	
	recognition as an effective public policy. It assumes that hunger in Brazil is an outcome of poverty and that sound social policies are not governmental costs but rather investments in inclusive growth. The Zero Hunger strategy was the outcome of civil society mobilization and top-level political will. In the early days of his new term, President Lula stated that fighting hunger would be at the core of his administration. The Zero Hunger strategy has translated into Brazilian foreign policy through South-South cooperation. Internally, the promotion of food and nutrition security became the basis for a long-term cross-cutting strategy, which included a set of complementary programs. Within the Zero Hunger context, Brazil has fulfilled the commitment of Millennium Development Goal 1 to "eradicate extreme poverty and hunger" and halved, between 1990 and 2015, the proportion of people living on less than R$2.75 ($1.25) per day. Over the past 10 years, approximately 20 million Brazilian people left the condition of absolute poverty. The percentage of underweight children under 5 years old (weight-for-age) decreased from 13 percent in 2003 to 5 percent in 2008. School feeding was first introduced to Brazil in the early 1940s when the then–Institute of Nutrition proposed to the federal government that food be provided in schools. The name was changed from the School Meals Campaign in 1955 to the National School Lunch Campaign in 1956, with the intention of making it a universal program. By 1965, the name had been changed again to the National School Feeding Campaign. The National Institute for Food and Nutrition was created in 1972 to administer the program and was attached to the Ministry of Health. The program was highly centralized, and states and municipalities were responsible only for storage and delivery of food to schools. In 1979, the program was given its current name, the Programa Nacional de Alimentação Escolar (PNAE). It is Brazil's oldest ongoing food program. Until 1993, the implementation of school feeding in Brazil was centralized at the federal level. The logistics were complex and expensive due to long distances. Controlling program implementation and monitoring were major challenges. PNAE was redesigned in the 1990s, and again after the launch of the Zero Hunger strategy in 2003 established universal and nutrition-sensitive school feeding as a key program for tackling hunger. Brazil now has the second-largest national school feeding program in the world, behind India, and has customized the school feeding experience to its own realities and challenges. The program has its own national law and, in 2010, the social right to food was included in the Constitution of Brazil, consolidating the role of school feeding in the promotion of food and nutrition security in the country.
2. COUNTRY INCOME LEVEL	Upper-middle-income
3. KEY CONTEXT DATA	<u>2013 data:</u> • gross domestic product (GDP) growth: 2.7 percent • Gini index: 52.9 (World Bank Group [WBG] estimate) • Poverty rate (at national poverty lines): 8.9 percent • Poverty headcount ratio at $1.90 a day (2011 PPP): 4.9 percent of population • Share of population with access to improved sanitation facilities: 51 percent • Life expectancy: 74 years • Infant mortality rate: 14 per 1,000 live births *WDI*
4. KEY SOCIAL PROTECTION DATA	<u>2012 data:</u> • Coverage of social safety nets (SSNs) in total of population: 19.5 percent • Coverage of SSNs in extreme poor: 26.1 percent • Adequacy of benefits of SSNs in total population: 9.1 percent

CONTEXT OVERVIEW	
	• Adequacy of benefits of SSNs in extreme poor: 56.7 percent • Incidence of benefits of SSNs in extreme poor: 2.1 percent • Incidence of beneficiaries of SSNs in extreme poor: 4.5 percent <u>2011 data:</u> • Public spending on social assistance programs, percent of GDP: 2.4 percent *ASPIRE database*
5. NUTRITION CONTEXT	School feeding is a central pillar of the Zero Hunger Strategy, guaranteeing access to a minimum calorie intake for children in school—with special attention to vulnerable populations and younger children—and improving food security and education indicators. In 2014, the PNAE reached 42,333,722 school children—approximately a quarter of the Brazilian population—in 163,000 public communitarian and philanthropic institutions in kindergarten, preprimary and secondary education, ensuring children's right to nutritious food. The current legal framework mandates that all schools have nutritionists on staff for planning meals, taking into account costs, nutritional needs, and diverse, fresh, and healthful foods that are aligned with cultural habits and approved by students. These regulations are based on the school feeding federal law and the Human Right to Adequate Food, which is enshrined in the Federal Constitution and the basis of all policies related to food and nutrition security and sovereignty. Since its exit from the Hunger Map in 2014, Brazil faces new challenges to ensure food and nutrition security. The country is experiencing a rocketing increase in overweight and obesity and is taking action both to increase the quality and supply of fresh and healthful food and to reduce consumption of ultraprocessed food, as recommended by WHO. The Brazilian government is also implementing, through its Intersectoral Chamber of Food and Nutrition Security, the Intersectoral Strategy of Obesity Prevention and Control, with the broad participation of civil society through the National Council of Food and Nutrition Security. The strategy has six goals: • Availability of and access to healthful and adequate food • Education, communication, and awareness-raising actions • Promotion of healthy habits in specific environments such as schools, workplaces, social care, and health care networks • Nutrition monitoring systems • Thorough care for individuals suffering from overweight and obesity at the health care system • Regulation of quality and safety of food
6. KEY NUTRITION DATA	No information available.

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	PNAE provides school meals from nurseries to high schools. Each institution receives a daily per capita value, depending on education level and the time students spend at school, to be used exclusively for food purchases. PNAE has four main components: nutrition, local purchase, social development, and community participation. All of the components are embedded in the educational framework and the pedagogical objective, which are the basic pillars of the program.

PROGRAM DETAILS	
	The objectives of the PNAE are to: • Provide in-school meals (breakfast, lunch, and/or snack) that respect local eating habits to all public school children and students • Provide at least 20 percent of the daily nutritional needs of students • Promote healthy eating habits through food and nutrition education • Contribute to the growth, development, and learning capabilities of students • Support sustainable development through the acquisition of food from local and family farmers
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	$0.15 to $0.50 daily per child for the entire school year The number of meals and the calorie intake are determined by the type of school, level of education, and other factors.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The resolution that established PNAE has clear criteria for building a menu based on the minimum composition of the meals and including macro- and micronutrient guidelines: • A minimum of 20 percent of daily nutritional needs for one meal served to students enrolled in primary school in one school-period shift (morning or afternoon) • A minimum of 30 percent of daily nutritional needs for two or more meals served to students enrolled in primary school, except for kindergartens, in one school period shift (morning or afternoon) • A minimum of 30 percent of daily nutritional needs of students enrolled in schools in indigenous and slave-descendant communities, except for kindergartens • A minimum of 70 percent of the daily nutritional needs of students enrolled in full-time primary school • A minimum of 30 percent of daily nutritional needs for two or more meals served to children in kindergarten in one school period shift (morning or afternoon) • A minimum of 70 percent of daily nutritional needs for three or more meals served to children in full-time kindergarten, including those located in indigenous and slave-descendant communities • A minimum of three portions of fruits and vegetables per week (200 grams per student per week) Resource allocation is based on data provided by the National Institute for Educational Studies and Research, which collects information at the school level through a yearly census. The most critical information for school feeding is the number of students in different schools and at different levels. Once the census data is communicated to the FNDE, the calculation is: Number of days X number of students X amount per capita = total amount transferred. This methodology is established by regulations of the Ministry of Education, which is responsible for determining the number of school days, whether schools are full time or on a shift (morning or afternoon), the curriculum, and other pedagogical issues. Whether schools are full time or on a shift basis affects the number of meals offered and the percentage of nutritional needs to be reached for each school level.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	All institutions must purchase at least 30 percent of the food for school meals from local smallholder farming, a measure proven to improve access to fresh and healthful food, especially vegetables and fruits. This mandate was established by Law No. 11.947 of 2009.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Provision of meals is based on enrolment and attendance.

PROGRAM DETAILS	
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	No information available.
9. INSTITUTIONAL ARRANGEMENTS	The Ministry of Social Development and Fight against hunger was created in 2004 and played a key role in the coordination of the Zero Hunger strategy. An Interministerial Chamber of Food and Nutrition Security, consisting of some 20 ministries, was created and formalized by presidential decree in 2007, under the law that established the national food and nutrition security system in 2006. Sectoral policies are discussed among stakeholders in the chamber to coordinate all participant ministries' efforts. The FNDE is responsible at the federal level for the PNAE's implementation. Currently, the PNAE is implemented in all 163,000 public schools and has a budget of R$3.8 billion ($1.7 billion) solely for the purchase of food. States and municipalities complement the amount transferred from the federal level and provide all necessary infrastructure and logistics for program implementation. Three levels of government (federal, state, and municipal) share the responsibility for implementing PNAE. Institutional capacity has been developed and reinforced at the three levels in order to manage program implementation. The FNDE is the operational arm of the Ministry of Education, which provides technical and financial assistance to improve the quality of education. The FNDE serves as a resource in the implementation of public policies. Its functions include (1) providing funding to states, municipalities, and schools for the PNAE; (2) supervising the application of financial resources and taking action in the event of mismanagement of funds; and (3) establishing guidelines, overseeing program implementation, and evaluating program effectiveness. FNDE funding covers only the cost of food. Its funding is complementary financial assistance to the states and municipalities, which are expected to cover the other associated costs. FNDE funding covers a period of 200 school days. The allocated funds are automatically transferred in 10 monthly installments (starting in February) to the states and municipalities, which are charged with managing the funds. Resources are allocated to the municipal- or state-level Secretariat of Education, into a specific budget line for receiving these funds. Funds are transferred to a specific bank account opened by the FNDE. States and municipalities may choose whether to transfer the money to schools (decentralized) or administer the funds (semidecentralized). At the state level, the state Secretariat of Education or the municipal government is responsible for food procurement. Complementary resources are available for complying with menus; hiring and training staff; storage; making logistical arrangements for the delivery of foods to schools; and providing school meals (breakfast, lunch, and/ or a snack) to all beneficiaries of the program. Successful implementation requires funding beyond that provided by the government, which is most often provided by the implementing bodies themselves. In certain cases, supplementary financial assistance may be provided to schools by the Direct Money in Schools Programme. To improve institutional capacity, especially at the local level, the FNDE has established partnerships with federal universities in eight different states and created Centro Colaborador em Alimentação e Nutrição Escolar (CECANEs). The rationale was to provide more technical support to local PNAE managers in nutrition, monitoring, and program implementation. The work of the CECANEs is monitored by FNDE staff.

PROGRAM DETAILS	
10. COMMUNITY PARTICIPATION	Every state or municipality, by law, must establish a Conselho de Alimentação Escolar (CAE), which consists of one representative of the government and two elected members from each of the following groups: parents (usually from the parent-teacher group); teachers, students, and other educational professionals; and civil society (such as the church or rural union). The members of the CAE are elected for four years, after which they can either be replaced or have their membership renewed if they are reappointed. Community participation takes place through the CAE, which oversees the use of funds and ensures the quality of the PNAE's implementation. CAE counselors help to supervise program implementation, although schools must develop the capacity to implement the program. The CAE increasingly assumes program tasks when funds are decentralized and implementation takes place at the school level. The Brazilian National Council of Food and Nutrition Security represents community participation in the policy making process at national and local levels because two-thirds of its members are drawn from civil society.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The program is universal and already reaches all public schools in the country. The number of meals served and calorie intake provided can be scaled up if funding is provided by municipalities or states, or both.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	School feeding is a right for students guaranteed by the Federal Constitution (Chamber of Deputies, 2010), which guarantees funding for PNAE. The PNAE is funded by national treasury revenues, through taxes and contributions, such as the Federal lottery taxes and the income tax, and is part of the annual budget legislation.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	The CAE is a central part of the PNAE and functions as an autonomous monitoring and supervisory unit. As described in Article 34 of Resolution No. 26 of 2013 (FNDE, 2014) its responsibilities include: (1) ensuring that states and municipalities comply with the PNAE guidelines; (2) overseeing the application of financial resources provided by the FNDE; (3) ensuring food quality, hygienic conditions, and suitability and acceptability of menus according to the nutritional guidelines; (4) conducting regular meetings and visits to the schools; (5) evaluating the execution of the PNAE based on the annual management report; and (6) reporting to the FNDE and other control bodies, such as the Brazilian Court of Audit, any irregularities or mismanagement in the use of funds. M&E of the PNAE is carried out by FNDE technical staff and the CAE, with the participation of individuals and other entities, such as parent-teacher groups. FNDE technicians at the national level supervise program implementation by states and municipalities annually following predetermined criteria established by the national co-ordination of the program. These technicians guide those involved directly or indirectly with the implementation of the school feeding program, such as Secretariats of Education, nutritionists, managers, and representatives of the CAE. The technicians conduct onsite visits and request updated information about the program. Any irregularities or improprieties are reported to the external control bodies as well as to the FNDE internal audit unit. The role of supervision has proven crucial to successful program implementation. In 2008, the System for Monitoring the PNAE was developed and implemented by the FNDE in collaboration with CECANE, which works regionally. The system is developing gradually, according to continuous evaluation of its results, and has been implemented in all municipalities since 2008. The System for Monitoring the PNAE assesses program implementation (other than budget transfers) for each beneficiary school, such as food procurement procedures, school menu, and food safety.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	Implementation of a new and integrated system for reporting and accountability beginning in 2012 will facilitate access to this data and make it possible to measure the overall costs of PNAE. A study is currently being prepared.

MONITORING AND EVALUATION	
3. OUTCOME/IMPACT INDICATORS	No information available.
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	There is no national data as yet on the effect of PNAE other than the improvement of educational indicators for each municipality or State where PNAE is implemented.
5. HARMONIZATION WITH OTHER PROGRAMS	Daily meals reinforce school attendance, improve performance of students, and guarantee provision of minimum calories, the benefits of which are reflected in ongoing evaluations by community health programs. The Zero Hunger Strategy comprises a set of complementary programs: Bolsa Familia: Brazil's CCT for the extreme poor is conditioned primarily on school attendance. School feeding enables families to more easily benefit from both programs. Food Acquisition Program: PNAE requires purchases of food from local smallholder farms to provide healthful and fresh food, which promotes higher prices for organic production. Nutrition-sensitive regulations guide the composition of meals and snacks served to schoolchildren. Specific regulations requiring purchase of food from smallholder farmers results in assistance to those farmers. National Program for Strengthening Smallholder Farming: Provides access to credit, technical assistance, and rural extension and Insurance for crops and harvest. Promotes organic production with specific incentives. National Program for Rural Production: Transfers cash in fixed installments to smallholder farmer households in situations of social risk, such as low income, emergency victims, and food insecurity. Human Milk Network: Created in 1998 by the Ministry of Health (MOH) to scale up human milk banks and outreach to the food-insecure population, in partnership with federal entities, the private sector, and civil society. In 1981, Brazil introduced the National Program of Breastfeeding, which contributed to an increase of breastfeeding. The country currently has a network of some 300 hospitals providing human milk, 212 human milk banks, and 128 human milk collection points. Micronutrient supplementation: Iron for children from 6–24 months old, and women during and after pregnancy, distributed through the health care system, and mandatory fortification with iron and folic acid by producers of wheat and maize flour.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	Two of the objectives of PNAE are nutrition-related—providing at least 20 percent of the daily nutritional needs of students, and promoting healthy eating habits through food and nutrition education The menus are developed and supervised at the local level by qualified nutritionists appointed by the state or municipality who prepare menus for different school levels and groups (special education needs, kindergarten, preprimary, primary and secondary education, youth and adult education, and indigenous and slave-descendant communities). Menus are based on the nutritional needs of the targeted age group and guidelines for micronutrients, limits on sodium, fats and sugar, and restrictions on food with low nutrition content, such as soft drinks, sausages, sweets, and canned, processed, or concentrated foods. The nutritional restrictions promote the consumption of healthful food, respect local eating habits, and avoid the use of industrialized or poor-quality food.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	Pedagogical gardens are also widely used in schools. They serve as food and nutrition-education tools and encourage participation by families, farmers, and the school community.

NUTRITION-SENSITIVE RATIONALE	
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	Although PNAE is a universal program that does not specifically target vulnerable groups, the overwhelming majority of Brazil's vulnerable students are in public schools. It is no coincidence that the poorest population corresponds to the most nutritionally vulnerable population. In some areas, the only meals children have are the ones they receive at school, justifying the nutrition-based design of PNAE. The minimum nutrition requirements, number of meals, and per capita funding provided by PNAE is higher in full-time schools, as well as in schools located in indigenous and traditional-community areas, as compared to other types of schools.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	By its universal coverage, PNAE can be a key factor of inclusion for women, especially single mothers whose children attend kindergarten in full-time schools.
5. THE PROGRAM HAS NUTRITION INDICATORS	Monitoring of nutrition indicators is done by the health services, not through the PNAE. However, all school menus are designed by nutritionists who are responsible for verifying the quality of the food purchased by the schools.
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	PNAE menus are diverse and vary according to regions and local habits within the standard composition of nutritional need per child per day. The school menu is planned at the beginning of the fiscal year and reflects the local eating habits and preferences of the various communities.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	**School feeding is included within the framework of the human right to adequate food:** Since 2010, Brazil has included in its Constitution the human right to adequate food as a social right. This was a benchmark for the consolidation of the National Food and Nutritional Security System (SISAN in its Portuguese acronym) and the programs related to the fight against poverty and hunger. **Intersectoral coordination and collaboration:** The PNAE involves stakeholders from education, agriculture, health, social development, planning, and program implementation. Cross-cutting discussions occur at the federal level to ensure collaboration between ministries and civil society. **The PNAE is part of national policy and legislation:** A major hallmark of Brazil's experience is that Law No. 11.947 of 2009 guarantees that information on school feeding is available for all stakeholders at all levels of government. **Strengthened links between school feeding and local purchases from smallholder farmers:** Legislation guarantees that at least 30 percent of funding is earmarked for local purchases from smallholder farmers. Despite the challenges in implementation, the legislation has created a large demand for produce by smallholder farmers and has resulted in healthier and nutritious food for students. **Community involvement and awareness:** Community oversight through the CAE is another successful component of the Brazilian experience.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Despite its vast size, which contributes to a diversity of experience, Brazil has developed a successful national school feeding program. PNAE is complex and is constantly adapted and adjusted to the Brazilian context. PNAE has contributed to intersectoral coordination among different ministries, especially agriculture and education. PNAE has shown how a sustainable and nationally led school feeding program can be built over time. The sharing of Brazil's experience and lessons with other countries is a major advantage for South-South cooperation. Activities of this kind are being carried out in partnership between the World Food Programme Centre of Excellence against Hunger and the FNDE.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL	School feeding in Brazil has become universal through a successful process of decentralization, under which resources for food procurement are transferred from federal states to municipalities and schools. The establishment of operational guidelines for program implementation and Monitoring & Evaluation (M&E) are at the heart of the FNDE's role in school feeding.

PROTECTION AND NUTRITION OBJECTIVES	PNAE is a decentralized program that is implemented by local entities, which use different means of accomplishing the program's purposes. Some states and municipalities face infrastructure gaps and a limited ability to supplement the resources available for school feeding. Day-to-day implementation of the program is constrained by problems of supply chain logistics, such as inadequate transport and storage systems. Food quality and monitoring were also important issues of concern.

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2. METHODS OF DOCUMENTATION	Desk-based resources, field work observations and reports, participatory methodology, official reports, and censuses
3. WEB SOURCES	Conditional cash transfer (CCT), Food Acquisition Programme "PAA" and other programs targeting smallholder farmers: http://www.wwp.org.br CCT, Food Acquisition Programme "PAA", School Feeding Program "PNAE" and other programmes related to the Zero Hunger Strategy (reports, working papers and studies): http://www.ipc-undp.org/?q=publications History of the Zero Hunger Strategy by a leading decision-maker: http://www.fao.org /docrep/016/i3023e/i3023e00.htm

Dominican Republic – Progresando Con Solidaridad

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Jorge Fanlo, Country Director, World Food Programme Dominican Republic[1] Elisabet Fadul, Programme Officer, World Food Programme Dominican Republic[1] Maria Altagracia Fulcar, Nutrition Officer, World Food Programme Dominican Republic[1] Altagracia Suriel, General Director, Progresando Con Solidaridad
ORGANIZATION	[1]World Food Programme
ROLE IN THE PROGRAM	Implementing and partner organization supporting Progresando con Solidaridad, the national social protection program

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Progresando con Solidaridad
2. COUNTRY	Dominican Republic
3. TYPE OF PROGRAM	Conditional Cash Transfer (CCT) with Food/Nutrition Supplement
4. PROGRAM DURATION	2009 to August 2016
5. PROGRAM OBJECTIVE(S)	Overall objective of the nutrition component: • Develop a component within *Progresando con Solidaridad*, the national social protection program, to improve its effect on the nutritional status of the targeted beneficiary population, especially the groups most vulnerable to undernutrition and micronutrient deficiencies Specific objectives: • Prevent and control micronutrient deficiencies in children under 5 years old by increasing the rate of exclusive maternal breastfeeding and providing micronutrient powders • Contribute to the prevention and control of micronutrient deficiencies in PLW by providing a complementary fortified food specific to this group • Contribute to the prevention and control of acute undernutrition in vulnerable children to 6–59 months old by providing complementary fortified food • Contribute to guaranteeing adequate food and nutrition security among the elderly beneficiaries of Progresando con Solidaridad by providing a complementary fortified food • Contribute to strengthening the national and local capacity to monitor the growth and development of children under 5 years old, deliver prenatal care, and provide nutrition counseling to the elderly. • Contribute to behavior change in nutrition and feeding practices by increasing community knowledge of and empowerment for healthful eating through community mobilization and a network of local nutrition counselors.
6. FUNDING AGENCY/IES	Nutrition component: Government of the Dominican Republic (GODR) Progresando con Solidaridad: GODR, World Bank Group (WBG), and Inter-American Development Bank
7. IMPLEMENTING AGENCY/IES	Programme Progresando con Solidaridad (responsible institution) of the Social Cabinet of the Vice President of the Dominican Republic World Food Programme
8. TOTAL COST	$1.5 million annually
9. TARGET GROUP(S)	Children from birth to 59 months old, pregnant and lactating women (PLW), and elderly adults in beneficiary HHs of Programme Progresando con Solidaridad.

PROGRAM OVERVIEW		
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	Targeted CCT: 700,000 poor HHs. From these HHs, from January 2014 to August 2016: 121,706 beneficiaries of the nutrition component and special nutritious foods (micronutrient powders, Supercereal Plus or Supercereal), including 88,348 children 6–59 months old, 23,665 PLW, and 9,693 elderly adults; 20,000 community employee and public health practitioners participating in capacity-development activities; and 40,000 women heads of HH targeted for undernutrition counseling through community education and mobilization activities. November 2010 to December 2013: 78,882 children 6–59 months old; 354,118 children indirectly provided with micronutrient powders through the MOH's primary health care system; 15,000 PLW provided with calcium tablets and micronutrients; 15,000 HHs received deworming tablets; 4,500 practitioners participating in capacity-development activities.	
11. NUMBER OF REACHED BENEFICIARIES	Annually: • 79,982 children 6–59 months old received micronutrient powders • 9,366 children 6–59 months old received complementary fortified food (Progresina Infantil) to prevent and control acute undernutrition • 10,513 PLW received complementary fortified food (Progresina for PLW) • 7,838 elderly beneficiaries received complementary fortified food (Progresina for elderly) • 100,000 HHs received education on nutrition and child feeding practices Progresina is used generally to refer to complementary fortified food.	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM	☐ Rural
	☒ Multisectoral collaboration	☐ Resilience
	☒ Integrated approach	☐ Conflict-affected setting
	☒ Governance	☐ Harnessing nutrition data
	☐ Decentralization	☐ Use of mobile technology
	☐ Performance-based financing	☒ BCC
	☒ Community participation	☒ Life-cycle approach
	☐ Agriculture and local procurement	☐ Gender and women's empowerment
	☐ Urban	☒ ECD

CONTEXT OVERVIEW	
1. CONTEXT	Although self-sufficient for basic food production, the Dominican Republic suffers from marked income inequality. Inequity in distribution of family income stood at 45.7 in 2014 in the WBG Gini index. With an inflation rate of 3.7 percent and a poverty rate of 41.1 percent in 2013, the poorer half of the population receives less than 20 percent of GDP, while the richest receive nearly 40 percent. Income inequality combined with sustained inflation result in a decline in purchasing power for poor HHs, affecting their consumption of food. In 2004, the GODR, through the Social Policy Cabinet, rolled out the social protection program, then known by the shorthand Solidaridad, to assist its most vulnerable citizens, improve human capital, and spur economic growth. In 2009, the program was revamped to include components focusing on human development, of which nutrition was an essential element. World Food Programme designed the nutrition component.

CONTEXT OVERVIEW	
	A new vice president was elected in the presidential election in 2012 who was instrumental in prioritizing social protection programming in the Dominican Republic. She combined Solidaridad with the social program Progresando to form a broader, multisector safety net program called Progresando con Solidaridad. Progresando con Solidaridad comprises the following areas of intervention related to human development: integrated health; education; nutrition and food security; environment; training; and access to information and communication technology. Relevant Progresando con Solidaridad activity components are: • **Comer es Primero** addresses hunger by providing economic assistance of approximately $16 per month (RD$700) to each beneficiary HH to supplement the basic foods eaten in families living in extreme poverty. Additionally, the program seeks to improve the overall health status of children through access to vaccines, growth monitoring, and health education. The World Food Programme-led nutrition component, including the distribution of micronutrient powders to children 6–59 months old, is a condition of the cash transfer (CT). • **Incentivo a la Asistencia Escolar** addresses education by providing monthly financial assistance of $7–$13 (depending on the number of children) for each child 6–16 years old who attends school, in order to increase school attendance and decrease attrition rates. • **Dominicanos con Nombres y Apellido** facilitates and promotes the registration of births and improves the process of obtaining documentation. The program has been expanded to include income-generating activities, actions focusing on livelihoods of beneficiaries, and a stronger community outreach and mobilization network. Under this new phase, the nutrition component has been broadened to include PLW and the elderly and a more detailed targeting of children vulnerable to undernutrition and micronutrient deficiencies.
2. COUNTRY INCOME LEVEL	Upper-middle-income
3. KEY CONTEXT DATA	2013 data: • GDP growth: 4.8 percent • Gini index: 47.1 (WBG estimate) • Poverty rate (at national poverty lines): 41.1 percent • Poverty headcount ratio at $1.90 a day (2011 PPP): 2.3 percent of population • Share of population with access to improved sanitation facilities: 83 percent • Life expectancy: 73 years • Infant mortality rate: 22 per 1,000 live births 2009 data: • GDP growth: 0.9 percent • Gini index: 48.9 (WBG estimate) • Poverty rate (at national poverty lines): 42.1 percent • Poverty headcount ratio at $1.90 a day (2011 PPP): 3.3 percent of population • Share of population with access to improved sanitation facilities: 82 percent • Life expectancy: 73 years • Infant mortality rate: 28 per 1,000 live births *WDI*
4. KEY SOCIAL PROTECTION DATA	2013 data: • Public spending on social assistance programs, percent of GDP: 0.8 percent

CONTEXT OVERVIEW	
	2011 data: • Coverage of SSNs in total of population: 26.6 percent • Coverage of SSNs in extreme poor: 44.9 percent • Adequacy of benefits of SSNs in total population: 4.5 percent • Adequacy of benefits of SSNs in extreme poor: 13.0 percent • Incidence of benefits of SSNs in extreme poor: 10.1 percent • Incidence of beneficiaries of SSNs in extreme poor: 13.3 percent *ASPIRE database*
5. NUTRITION CONTEXT	The food security and nutrition situation of the Dominican Republic is characterized by persistent poverty, lack of dietary diversity, micronutrient deficiencies, poor quality of public health services, weak agricultural structure, and recurrent natural and economic shocks. Though a middle-income country, poverty still affects the food and nutrition security of many Dominicans and leads to insufficient food consumption and micronutrient deficiencies in the vulnerable. The family members most vulnerable to malnutrition, including micronutrient deficiencies, are young children, PLW, elderly Haitian immigrants, and people suffering from chronic illnesses. The prevalence of chronic undernutrition was 7 percent nationally as of 2013, but some provinces present rates two to three times higher. According to the 2009 National Micronutrient Survey of the Ministry of Health, the prevalence of anemia reached 34 percent in nonpregnant women, 37 percent in women who had given birth in the past 12 months, 28 percent in children 6–59 months old, and 61 percent in children from 6–11 months old. With the objective of ensuring food and nutrition security of the population, World Food Programme and Progresando con Solidaridad have added a nutrition-sensitive component to the safety net program by the inclusion of activities guaranteeing improved nutrition of vulnerable populations; providing nutritional surveillance and increasing the attendance of children and their families to primary health care centers; improving the eating habits of children, PLW, and the elderly; and strengthening the capacity of community health practitioners and community leaders in nutrition. The baseline survey of the nutrition component in 2011, focused on beneficiaries of the Progresando con Solidaridad program only, found anemia prevalence of 60.9 percent in children 6–59 months old. The survey was representative of the Progresando con Solidaridad households and was conducted by World Food Programme and the MOH in coordination before the implementation of the nutrition interventions.
6. KEY NUTRITION DATA	2013 data: Children under 5 years old suffering from • Stunting: 7.1 percent • Underweight: 4 percent Prevalence of undernourishment: 15 percent of population 2012 data: • Children under 5 years old suffering from wasting: 2.4 percent 2011 data: • Children under 5 years old suffering from anemia: 33 percent 2007 data: Children under 5 years old suffering from • Stunting: 10.1 percent • Underweight: 3.4 percent • Wasting: 2.3 percent Prevalence of undernourishment: 20 percent of population *WDI*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	The World Food Programme-supported nutrition component is carried out at the national level as part of the Nutrition and Food Security element of Progresando con Solidaridad and the health condition of the CT Comer es Primero. The nutrition component comprises the following core areas of intervention: • **Prevention and control of undernutrition**, including provision of fortified food for children 6–59 months old at risk or vulnerable to undernutrition; and the strengthening of national capacity, enhancement of public health programs, and activities related to the nutritious food products • **Provision of complementary fortified food for the elderly** • **Prevention and control of micronutrient deficiencies**, including provision of micronutrient powders to children 6–59 months old, and provision of complementary fortified food for PLW • **Nutrition education for improved dietary diversity**, including education materials and activities for BCC • **Community participation and nutritional vigilance**, including community participation and the establishment and training of community nutrition counseling networks • **Field monitoring and evaluation**, including follow-up, field monitoring, field visits, and community mobilization activities and coordination to ensure that activities are implemented at the community level according to planned objectives; ensuring coordination among all actors; and monitoring of indicators and reporting • **Strengthening national capacity**, including the MOH's program for vigilance and promotion of growth of children under 5 years old and the program for attention to pregnancy and maternity. The nutrition component encompasses training; capacity development; promotion of growth monitoring and preventive care for children through access to primary health care; and the provision of micronutrient powders and Progresina to beneficiary children 6–59 months old, children 6–59 months at risk of acute or chronic undernutrition, PLW, and the elderly. It promotes nutritional care of targeted beneficiaries, with the emphasis on prevention and control of malnutrition and micronutrient deficiencies, and ensures the application of nutrition interventions within a framework of public health norms, by: • Including cash-based health conditions to the provision of micronutrient powders and Progresina that address specific nutrition requirements of the targeted vulnerable groups • Strengthening existing capacity and interventions at the community level of both Progresando con Solidaridad and the MOH • Including activities guaranteeing improved nutrition for vulnerable populations, nutritional surveillance, and increased attendance of children and their families at primary health care centers. In addition, the component incorporates interventions focusing on empowerment and ownership of community leaders.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	$16 (RD$700) monthly per Household (HH). The ration and frequency of the transfers are: • For children 6–59 months old—after an assessment of a child's nutritional state at a growth-monitoring consult at the community's primary health care center, caregivers are provided 60 sachets of micronutrient powders containing 1 gram each to be consumed 1 sachet a day for two months. After 60 days, the child receives a second 60-day sachet ration to be consumed over 4 months.

PROGRAM DETAILS	
	• For children 6–59 months old at risk or vulnerable to undernutrition—after an assessment of a child's nutritional state at a growth-monitoring consult at the community's primary health care center, caregivers are provided 6 kg of the complementary fortified food Progresina Infantil for 60 days' use (enough to enable HH sharing). After 60 days, the child must be taken to the health center, where the doctor will assess his or her nutritional state and determine whether a second ration is necessary. • For PLW—after an assessment of her nutritional state at a pregnancy consult at the community primary healthcare center, and if seen at the start of the fourth month of pregnancy, a woman is provided 18 kg of Progresina for 180 days (enough to enable HH sharing). If the woman is seen after the beginning of her fourth month, the ration is adjusted accordingly so she receives 100 grams per day until the end of the second month after the birth of her child. • For PLW: after an assessment of their nutritional state and if captured at the start of the fourth month of pregnancy, 3 kg of Progresina for 60 days is provided during their attendance to the consult at the community primary healthcare center as a complementary food support.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The CT level is determined by the government based on the cost of the basic food basket per month for the standard HH. For 2015, the CT per family and month represented 14 percent of the basic food basket.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	GODR purchases micronutrient powders and complementary fortified products internationally. Feasibility studies showed that local procurement is a less cost-effective option. World Food Programme and Program Progresando con Solidaridad have worked to strengthen the national capacity of the Dominican Republic as a potential supplier of Progresina.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Food transfers and supplements are subject to the health conditions of the CT program, Comer es Primero. Beneficiaries must comply with the conditions of Comer es Primero to receive the nutrition component of the program. The primary condition is regular participation in preventive medical care, such as vaccinations and attendance at child growth and development checkups as established by the MOH for children from birth to 5 years old and PLW. Other conditions include regular school attendance for school-age children, obtaining of identity documents and attendance by heads of HHs at community education sessions.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	• **Prevention and control of acute malnutrition and chronic undernutrition:** $133,850.15 • **Prevention and control of micronutrient deficiencies:** $327,036.87 • **Complementary and health feeding:** $24,951.97 • **Nutrition education for healthy feeding habits:** $11,200.00 • **Community participation and nutrition surveillance:** $308,500.00 • **M&E:** $583,971.23 • **Capacity strengthening:** $63,740.00 • **Coordination and administration:** $118,200.00

PROGRAM DETAILS	
9. INSTITUTIONAL ARRANGEMENTS	The Social Policy Cabinet administers Progresando con Solidaridad with the MOH and World Food Programme as essential partners in its health condition and nutrition component. Intersector coordination with other government entities is carried out under the framework of intergovernmental arrangements and agreements between the Cabinet of Social Policies and the government ministries for the implementation of the social protection policy and Progresando con Solidaridad. The nutrition component is also based on Progresando con Solidaridad's operational manual and public health norms. They have proven to be critical organizational tools that provide clear roles and responsibilities within a complex program. The partnership with World Food Programme in relation to nutrition expertise, field presence, special nutritious products, and capacity strengthening supports the enhancement of the quality of the nutrition-sensitive interventions and national efforts to promote nutrition-sensitive activities that change the behavior of the targeted population. The partnership is embodied in a memorandum of understanding between Progresando con Solidaridad and World Food Programme. World Food Programme is responsible for nutrition technical assistance, procurement and logistics for micronutrient powders and complementary fortified foods, and support for M&E. Progresando con Solidaridad is supported by two government entities. Targeting of beneficiaries is accomplished through the surveillance systems of the Unique System of Beneficiaries, and CTs are processed by the Social Services Administration.
10. COMMUNITY PARTICIPATION	The nutrition component is implemented at the community level through the community outreach and education network of Progresando con Solidaridad and through community basic health care provided by the MOH's primary healthcare system, combined with a community nutrition mobilization strategy coordinated by World Food Programme. The strategy calls for the formation and training of a national community-based network of nutrition counselors composed of community leaders and Progresando con Solidaridad beneficiary HHs, who assist beneficiary families in meeting commitments to nutrition, promote beneficiary attendance at the health centers, and conduct monitoring of food consumption and nutrition of the targeted children, PLW, and elderly. The World Food Programme trained Progresando con Solidaridad staff to provide nutrition education in the sessions for beneficiaries, focusing on the themes of healthful eating, nutrition, and hygiene. The nutrition counselors contribute to behavior change in nutrition and feeding practices of the beneficiaries and help to increase community knowledge and empowerment regarding healthy eating through capacity-building activities and mobilization.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The nutrition component of Progresando con Solidaridad has the technical, human, and financial resources for scaling up, if necessary. HHs are periodically added to the beneficiary database of the program after periodic HH surveys. The children, PLW, and elderly of the new HHs benefit from the nutrition component. The program's coverage and design enable it to scale up to respond to the effects of weather shocks and price fluctuations.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	Progresando con Solidaridad is the government's main strategy to ensure human development and combat poverty. The nutrition component is integral to the Dominican Republic's main safety net program and funded by the government. Furthermore: • Interventions are based on government structures and processes • The nutrition component is implemented under national health norms and processes • Beneficiary targeting is based on a government database that has been in existence since 2004 • Government commitment at all levels is high • Progresando con Solidaridad has agreements with most government ministries and entities

PROGRAM DETAILS	
	• Through field monitoring, education for behavior change, and household visits, World Food Programme and Progresando con Solidaridad ensure household awareness and ownership of the nutrition status of children, PLW, and the elderly • The nutrition component supports the community primary health consultation and enables nutrition surveillance

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	World Food Programme is responsible for monitoring, which is supported by a consistent logical framework. Monitoring includes: field visits to primary health care centers to collect distribution reports; organization of health education sessions; coordination with local actors; local training and coordination meetings; and weekly reports that compile output indicators for the implemented activities. Ten field monitors cover 10 regions of the country. Community employees of Progresando con Solidaridad trained as nutrition counselors monitor HH consumption post distribution using a monitoring and reporting kit, which is regularly collected and the information analyzed. Health centers have monthly reporting requirements for beneficiaries reached and supplement or complementary fortified food distribution. These are collected on a monthly basis for consolidation and analysis.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	World Food Programme applies the business rules of the corporate Strategic Results Framework for the measurement of performance indicators, at baseline, midterm and final stages. Through surveys, regular monitoring and coordination meetings, progress toward objectives is assessed. Weekly field monitor reports on project output and process indicators from all 10 regions of the country follow up on project performance and build evidence on effective program approaches. The midterm evaluation was performed by external institutions to ensure the results. The collected information has been useful for sharing the best practices of the project at national and international levels. In addition, the capacity building of government counterparts at all levels and collecting beneficiary feedback are part of the project and field monitoring activities.
3. OUTCOME/IMPACT INDICATORS	• Reduced prevalence of undernutrition and micronutrient deficiency in children 6–59 months old and PLW • Improved food and nutrition security of the elderly • Improved dietary diversity of targeted families • Enhanced national and local capacity to reduce undernutrition
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	In 2010, World Food Programme and Progresando con Solidaridad conducted a pilot program to test the feasibility of the proposed nutrition component by distributing micronutrient powders in one region of the country, Cibao Central. The positive results led to the incorporation of the nutrition component and inclusion of micronutrient powders in Solidaridad nationally in 2011. The first phase of the implementation included: • Training staff at all levels, including World Food Programme field monitors, in nutrition and raising awareness of the importance of distributing micronutrient powders; • Conducting a cost analysis of local production options for micronutrient powders; • Establishing the conditions for beneficiaries to receive benefits; • Developing a logistics plan; • Establishing a monitoring system; and • Introducing the nutrition component to regional and provincial level authorities of Solidaridad and the Ministry of Health.

MONITORING AND EVALUATION	
	The midterm evaluation of the nutrition component of Progresando con Solidaridad program, conducted in 2013, reported a 50 percent reduction in the prevalence of anemia in the enrolled beneficiary children, most notably those 6–24 months old, when the window of opportunity for impact is greatest. In addition, results showed an increase in attendance at the primary health care consultation, as more than 83 percent of families stated that their children received the micronutrient powders at the community healthcare center. Results also reported an over 90 percent positive perception from doctors, staff of the Progresando con Solidaridad program, and children's parents regarding the effects of micronutrient powders on the children's development (increases in attention to learning, appetite, and energy) and the impact of the nutrition component.
5. HARMONIZATION WITH OTHER PROGRAMS	The nutrition component of Progresando con Solidaridad must be harmonized with public health programs related to nutrition surveillance and growth monitoring of children under 5 years old, attention to pregnancy and maternity, and with other areas of Progresando con Solidaridad that promote food security and income generation, such as setting up and maintaining community gardens, which is implemented with the Ministry of Agriculture. In addition, interventions are harmonized with other government programs focusing on nutrition and with local NGOs in order to maximize effort and avoid duplication. Periodic coordination and information meetings are held with this objective.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The nutrition component promotes nutritional care of the targeted beneficiaries, with the emphasis on prevention and control of malnutrition and prevention of micronutrient deficiencies. Doctors and World Food Programme field monitors provide an information session on nutrition with emphasis on the importance and use of the micronutrient powders. Caregivers have the opportunity to taste the micronutrient powders and share their impressions and experiences. The rations, frequency, and delivery method of the micronutrient powder and the complementary fortified food have been determined according to the nutrition standards and policy of World Food Programme, defined based on scientific research, best practices, and programming guidelines developed in conjunction with other international organizations. As part of its other areas of intervention, Progresando con Solidaridad targets women of beneficiary HHs with income-generating activities and training.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The nutrition component places conditions on the provision of micronutrient powders and Progresina and strengthens existing capacity and interventions at community level of both Progresando con Solidaridad and the MOH. The nutrition component is generally implemented within the primary health care system in accordance with public health norms, thereby promoting proper health care practices and services. Health sessions are conducted in primary health care centers in accordance with the requirements set out by the MOH as the main strategy for addressing beneficiaries and promoting demand for primary health care as an essential element for guaranteeing adequate nutrition at the community level. The nutrition component consists of a complete package of interventions including capacity development for community leaders and health practitioners; coordination among actors; community nutrition education; promotion of preventive care for children through the provision of primary health care; provision of micronutrient powders to children 6–59 months old; and distribution of complementary nutritious foods to children at risk of chronic or acute malnutrition, to PLW, and the elderly. The World Food Programme, Progresando con Solidaridad and the MOH jointly organize health sessions at the primary health care centers two to four times a year. These sessions include regular appointments for child growth monitoring, nutrition counseling, preventive care checkups for children, nutrition education sessions, and provision of micronutrient powders and guidance on their proper use and preparation.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The nutrition component targets children from birth to 5 years old, but emphasizes children from birth to 2 years old, and PLW. The nutrition component also targets the elderly.

NUTRITION-SENSITIVE RATIONALE	
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	In order to accommodate women's needs and to facilitate their participation into the component activities, their family responsibilities and time availability are taken into account.
5. THE PROGRAM HAS NUTRITION INDICATORS	The program is aligned with the strategic objectives of the World Food Programme's normative instrument and indicators. The component also includes impact indicators related to anemia levels, stunting, acute malnutrition, and dietary diversity. The outcome and impact indicators ensure the reporting on achievements related to strengthening government and community capacity to manage effective nutrition programs within their safety-net systems; and addressing micronutrient deficiencies and nutrition among children of 6–59 months old and PLW.
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	The nutrition component includes integrated nutrition interventions, empowers and encourages ownership by community leaders of nutritional vigilance, and enhances government programs through capacity-strengthening activities and training.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	Progresando con Solidaridad's alliances for achieving its safety net and multisector objectives provide an important and feasible network for implementation of nutrition activities with community reach and empowerment that ensures the fulfillment of public health norms and national nutrition and development objectives. The Progresando con Solidaridad nutrition component demonstrates how World Food Programme can work with governments to implement nutrition-sensitive programming for improving the nutritional status of the population and the economic outlook of the country. This success is largely made possible by the strong partnership between GODR and World Food Programme. Without the political, financial, and administrative commitment of GODR, this program would not have been so successful in its first phase of implementation and its sustainability would not be guaranteed.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	• Improved nutritional surveillance and increased attendance by children and their families at local health centers • Improved eating habits by children who consume micronutrient powders • Completion of a baseline study and midterm evaluation in the project's intervention areas on weight, height, and hemoglobin levels of children 6–59 months old • Training in nutrition of community health practitioners and leaders of Progresando con Solidaridad • Increased attendance at and quality of preventive consultations for child growth and development of the MOH • Increased quality and frequency of reporting by the MOH • Incorporation of nutrition into medical students' university curriculum by the MOH • Awareness of the impact and importance of nutrition, among national, regional, and provincial government decision makers • Increased fulfillment of the health conditions of Progresando con Solidaridad.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	**Increasing capacity for implementation:** Front-line medical workers require continual training and support in nutrition. Primary care center doctors had limited nutrition training and limited ability to respond to cases of malnutrition. Seventy-five percent of primary care centers are managed by interns as part of their medical training. The interns are posted at a center usually for no more than one year, after which they rotate to a new center. This high turnover of medical personnel makes it difficult to maintain nutrition capacity at the primary care centers.
	Motivating staff and community participation: Continual changes in time and innovative strategies are required to inspire and motivate the medical staff and community HHs to participate in the nutrition component, especially as custom dictated that a child be brought to a health center only if he or she was sick. **Improving use of micronutrient powder:** Appropriate use of micronutrient powders by beneficiaries requires the implementation of compliance strategies. Micronutrient powders were a novel product for Solidaridad beneficiaries, which caused confusion and a number of misconceptions.

FURTHER REFERENCES	
1. DOCUMENTS	*Baseline evaluation 2011* *Impact Evaluation 2013* *Case Study Dominican Republic (http://www.wfp.org/content/how-government-dominican-republic-and-wfp-reduced-anemia-50-percent-children)*
2. METHODS OF DOCUMENTATION	Desk-based resources, fieldwork observations and reports.
3. WEB SOURCES	http://progresandoconsolidaridad.gob.do/ https://www.wfp.org/content/how-government-dominican-republic-and-wfp-reduced-anemia-50-percent-children https://www.youtube.com/watch?v=U1KxQhqRgvw&list=UUr4fTZGRsJrXzTbrIlUc5Ug http://progresandoconsolidaridad.gob.do/multimedia/youtube/ https://www.youtube.com/watch?feature=player_embedded&v=FEhpMWeq_iw

Haiti – Kore Lavi

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Afurika Juvenal, Kore Lavi Chief of Party[a] Julien Morel, Nutrition Security and Social Protection Senior Advisor[b]
ORGANIZATION	[a]Care Haiti [b]Action Against Hunger (AAH)
ROLE IN THE PROGRAM	[a]Chief of Party [b]Advisor, supported the design of the program, now providing technical advice and follow-up

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Kore Lavi - Appui au Programme National de Sécurité Alimentaire et de Nutrition (Support for the National Food Security and Nutrition Program)
2. COUNTRY	Haiti
3. TYPE OF PROGRAM	In-kind transfer (unconditional food voucher) with Food/Nutrition Supplement
4. PROGRAM DURATION	October 2013 to September 2017
5. PROGRAM OBJECTIVE(S)	• Strengthening national systems for targeting vulnerable populations • Increasing the access of extremely vulnerable HHs to local and nutritious foods • Improving maternal and child nutritional status • Improving Haitian institutions' capacity to effectively lead and manage safety net programs
6. FUNDING AGENCY/IES	USAID
7. IMPLEMENTING AGENCY/IES	CARE Ministère des Affaires Sociales et du Travail (MAST) (responsible institution) AAH World Food Programme World Vision (WV)

PROGRAM OVERVIEW		
8. TOTAL COST	$79,996,200	
9. TARGET GROUP(S)	**Food voucher:** Poorest, most-deprived, and vulnerable people using the Haiti Deprivation and Vulnerability Indicator **Food supplement:** PLW and all children under 2 years old	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	**Food voucher:** 90,750 individuals (18,150 vulnerable HHs) **Food supplement:** 87,190 PLW; 109,674 children 6–23 months old	
11. NUMBER OF REACHED BENEFICIARIES	11,259 HHs enrolled 57,152 children under 5 years old reached 71,577 individuals receiving supplementary, conditional rations 6,208 children under 5 years old referred to health facilities for treatment of moderate acute malnutrition (MAM) 33,534 HHs reached through care groups	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM	☒ Rural
	☒ Multisectoral collaboration	☐ Resilience
	☐ Integrated approach	☐ Conflict-affected setting
	☒ Governance	☒ Harnessing nutrition data
	☐ Decentralization	☒ Use of mobile technology
	☐ Performance-based financing	☒ BCC
	☒ Community participation	☒ Life-cycle approach
	☒ Agriculture and local procurement	☒ Gender and women's empowerment
	☒ Urban	☐ ECD

CONTEXT OVERVIEW	
1. CONTEXT	Haiti is disaster prone and one of the most food-insecure countries in the world. Fifteen major natural disasters have befallen Haiti in the last six years, affecting nearly 5 million people. These events have further strained the coping capacity of the country and have contributed to placing Haiti among the most vulnerable countries in the world. The FAO, World Food Programme and International Fund for Agricultural Development (IFAD) produce an annual report on the state of food insecurity in the world. In the 2012, an estimated 44.5 percent of the population of Haiti was undernourished, placing Haiti 89th among the 92 countries for which data are available. In a second analysis, the Index for Food Security produced by the Economist Intelligence Unit placed Haiti 4th from the bottom for the 105 countries listed, and, in a third analysis, the Global Hunger Index produced by the IFPRI placed Haiti third from the bottom among the 79 countries for which data were available. The underlying causes of food insecurity in Haiti are: *Income poverty:* Nearly half of the Haitian population is undernourished and unable to access sufficient food because of low incomes. They do not have sufficient cash in their pockets to feed themselves adequately. *Declining agricultural productivity and increasing dependence on imported foods:* Despite the substantial growth potential of its agriculture sector, Haiti currently imports more than 50 percent of the staple foods it requires. Most producers are no longer food self-sufficient and, to cover the food needs of their families, they have to spend more to buy imported food on the local market. *Poor use of food:* Access to basic services related to nutrition, public health, and treated water is very low generally among the population. Knowledge of positive behaviors is also insufficient, and, as a result, the capacity of people to effectively use the food consumed is constrained.

CONTEXT OVERVIEW	
	Price instability also contributes significantly to food insecurity in Haiti. For example, price instability on international markets in July 2012 combined with poor national harvests resulted in increasing food prices for consumers in Haiti, exacerbating food insecurity for those HHs that are most vulnerable. According to the last Humanitarian Needs Overview published by the UN Office for the Coordination of Humanitarian Affairs, 171,000 people in Northwest, 148,500 people in Artibonite, 68,500 people in Southeast, 675,000 people in the West, and 175,500 people in the Center are in need. *PDNA du tremblement de terre. Evaluation des dommages, des pertes et des besoins généraux et sectoriels, juin 2010;* *Direction de Protection Civile (Thomas), Ministère de la santé (choléra), récoltes (FAO et CNSA), sécheresse, Isaac et Sandy (CNSA)*
2. COUNTRY INCOME LEVEL	Low income
3. KEY CONTEXT DATA	2012 data: • GDP growth: 2.9 percent • Gini index: 60.8 (WBG estimate, 2012) • Poverty rate (at national poverty lines): 58.5 percent • Poverty headcount ratio at $1.90 a day (2011 PPP): 53.9 percent of population • Share of population with access to improved sanitation facilities: 27 percent • Life expectancy: 62 years • Infant mortality rate: 56 per 1,000 live births • Pregnant women receiving prenatal care: 90 percent *WDI*
4. KEY SOCIAL PROTECTION DATA	2001 data: • Coverage of SSNs in total of population: 0.8 percent • Coverage of SSNs in extreme poor: 0.7 percent • Adequacy of benefits of SSNs in total population: 0.6 percent • Adequacy of benefits of SSNs in extreme poor: 0.8 percent • Incidence of benefits of SSNs in extreme poor: 17.6 percent • Incidence of beneficiaries of SSNs in extreme poor: 54.8 percent *ASPIRE database*
5. NUTRITION CONTEXT	Malnutrition prevalence was considerably reduced in Haiti between 1995 and 2012, but remains a major public health issue. Between 1995 and 2012, acute malnutrition was reduced from 7.6 percent to 4.1 percent, chronic malnutrition from 38.2 percent to 23.4 percent, and underweight from 23.1 percent to 10.6 percent. The national Study on Mortality, Morbidity and Use of Services in Haiti, done in 2012 with the technical assistance of the Demographic and Health Surveys Program and funded by USAID, showed that 22 percent of children under 5 years old suffer from chronic malnutrition (stunting or low height-for-age), 5 percent from acute malnutrition (wasted or low weight-for-height), and 11 percent from underweight. Although the trend in malnutrition rates has improved (for example, from 2000 to 2012, a reduction of 3 percentage points in underweight and a reduction of 7 percentage points in growth retardation), prevalence levels in 2005–06 were higher than or the same as they had been in 2000, and there was no trend toward sustained improvement. In addition, about two-thirds of all children in Haiti are anemic and 32 percent were deficient in vitamin A.

CONTEXT OVERVIEW	
	Malnutrition in Haiti has many causes. Recurrent infections, poor health, and inadequate food intake are the immediate causes of malnutrition, but the underlying causes include the lack of drinking water, poor hygiene and inadequate sanitation, food insecurity, gender inequality, and poverty. Malnutrition in Haiti is a complex problem that persists because its many causes are rooted in various social sectors. Therefore, nutrition-specific interventions, which are usually multisectoral, are essential to the reduction and eradication of malnutrition in Haiti. Behavior change formative research identified several key barriers to effective nutrition in the first 1,000 days from conception to 2 years old. PLW do not have enough support to implement good nutrition behaviors, and are not aware of, or do not have access to, foods that would provide a healthier diet for themselves and their children. Based on this research, there are four key recommendations that Kore Lavi can implement to improve nutrition in its target zones: • Create messaging that is more targeted to the local realities and constraints and that focuses on the key problem areas • Focus behavior change messaging and support on people or institutions that influence women's ability to make good nutrition decisions for themselves and their children and who can help lift some labor burdens from pregnant women • Identify solutions for diets and nutrition that take into account the availability and acceptability of local foods, as well as local practices • Work with communities to increase women's empowerment and value in the community. *Ministry of Public Health and Population [MSPP]/UNICEF 2005.* *Cayemittes, Michel, et al. 2013. Enquête Mortalité, Morbidité et Utilisation des Services, Haïti, 2012. Calverton, MD, USA : MSPP, IHE, and ICF International*
6. KEY NUTRITION DATA	National SMART (Standardized Monitoring and Assessment of Relief and Transitions) Survey, March 2012: • Global Acute Malnutrition: 4.1 percent • Severe Acute Malnutrition (SAM): 1 percent • Chronic malnutrition: 23.4 percent • Severe chronic malnutrition: 7.1 percent • Underweight: 10.6 percent • Severe underweight: 3.2 percent 2012 data[a]: Children under 5 years old suffering from • Stunting: 21.9 percent • Wasting: 5.2 percent • Underweight: 11.6 percent Prevalence of undernourishment: 51 percent of population 2011 data[a]: • Children under 5 suffering from anemia: 62 percent [a]*WDI*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**Strengthening of national systems for targeting vulnerable populations.** MAST-led equitable vulnerability targeting methodology developed, tested and implemented. **Increasing access of extremely vulnerable HH to local and nutritious foods.** MAST-led, gender-responsive, food voucher–based safety net model developed and implemented. Increase inclusion of local foods in the voucher-based safety net. Increase access to complementary services for safety net households. **Improving maternal and child nutritional status.** Increased practice of appropriate nutrition behaviors to prevent malnutrition. Improving of the capacity of community-based entities to promote appropriate nutrition practices to prevent malnutrition. Strengthening the capacity of health facilities to deliver appropriate nutritional services. **Improving Haitian institutions' capacity to effectively lead and manage safety net programs.** Reinforcement of the institutional capacity of various levels of government to lead, coordinate, and implement safety net programs and the capacity of civil society to monitor and support safety net programs. Expansion of government capacity to respond to food emergencies.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	**Food voucher:** The food voucher is valued at G1,100 ($25) monthly. There are two different vouchers: (a) an electronic voucher of G700 (approximately $14 at program start October in 2013) to buy staple food products and (b) A paper voucher of G400 (approximately $8) to buy fresh foods. A transaction limit of G250 (approximately $5) per product stimulates the diversity of food purchases. The fresh food products include meat, fish, eggs, tubers, vegetables, and fruits. **Food supplement:** Each beneficiary receives a preventive ration of food and an accompanying ration. The accompanying ration is not meant to cover specific food needs, but to protect an individual's benefit from being reduced by the sharing practices of the HH. It also encourages mothers to come to the Kore Lavi food distribution sites by offering compensation for the time spent at the sites and for participating in behavior change activities with mother leaders. The food supplements are distributed to PLW and children under 2 years old.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The value of the food voucher represents between 25 percent and 35 percent of the monthly consumption of the HH and enables the beneficiary HHs to have a balanced diet. This amount was determined through consultation among the MAST Kore Lavi Consortium members, the Coordination Nationale de Sécurité Alimentaire (CNSA), and other specialized national actors. A technical group defined and approved a staple food basket consisting of rice, maize, pearl millet, peas, beans, flour, and cooking oil. All products are local except for cooking oil. The basket provides nutritious food products to the beneficiaries, promotes diversification, and supports local production.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	**Food voucher:** Kore Lavi works with local food vendors and petty traders to supply a food basket that contains primarily locally produced foods (other than cooking oil). This approach, coupled with community-managed savings, is intended to have a positive influence on rural markets and incomes. Kore Lavi recruited both staple food vendors and fresh food vendors. As of August 2015, close to 790 local vendors were involved in the program. Staple food vendors must meet basic criteria, such as having been a recognized vendor in the area for at least 6 months, having adequate storage capacity, and holding a license. Identified vendors are preselected by the social safety net technical officer, subjected to an assessment, and trained. Fresh food vendors are small rural vendors with much less logistic capacity than staple food vendors. Social protection agents, working with the local authorities and community representatives, select the markets in the targeted communities. Fresh food vendors meeting basic criteria are preselected and ranked according to their ability to meet the following criteria: selling mainly or exclusively fresh food products; diversity of the fresh food products sold; and personal motivation. One vendor is selected for 30 beneficiaries and is trained.

PROGRAM DETAILS	
	Food supplement: The preventive and accompanying food rations distributed to PLW and children 6–23 months old in order to prevent malnutrition consist of U.S. government–funded, imported food commodities. Kore Lavi is planning the introduction, on a limited pilot scale, of conditional food vouchers for nutritious foods to prevent malnutrition in HHs in extreme poverty.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Food vouchers are unconditional, but can be used only to purchase specified locally produced foods (meat, fish, eggs, tubers, vegetables, fruits, rice, corn, and flour) and cooking oil. Preventive rations are conditioned on beneficiaries' seeking health services (antenatal care [ANC] and postnatal care) and participating in behavior-change activities. Beneficiaries must have their health cards filled out showing ANC, postnatal, and growth follow-up visits to the health center and accept visits from the Care Group Lead Mothers. The objective is to promote the use of health services and effect sustainable behavior change in order to prevent malnutrition of children under 2 years old.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	• **Social assistance:** $40.8 million • **MCHN:** $16.6 million • **Capacity building, preparedness, and planning:** $6.3 million
9. INSTITUTIONAL ARRANGEMENTS	MAST is the leader of the program and works in close collaboration with the Ministry of Public Health and Population (MSPP) and the Ministry of Women's Affairs and Women's Rights. MSPP is a key member of the Kore Lavi Steering Committee. A memorandum of understanding between the MAST and MSPP is meant to ensure that, at the institutional level, the long-term social safety net for food security integrates prevention of malnutrition as a core objective. Interministerial and interagency working groups on targeting, food vouchers, and MCHN have been established to enable coordination at the national level. At the departmental level, government ministries and other actors across multiple sectors of social protection are brought together, under the leadership of MAST, to support the government-led social protection agenda and plans. CARE: Signatory of the cooperative agreement, Lead of the Consortium, Technical Lead of the Safety Net (food voucher) component, and leader of implementation in South East and Central Plateau geographic departments. World Food Programme: Technical lead on Vulnerability Targeting and Institutionalization. In charge of Commodity Management. Member of the Kore Lavi Consortium, Technical Lead on Institutionalization and Commodity Management. ACF: Member of the Kore Lavi Consortium, Technical Lead of the MCHN component, and leader of implementation in Artibonite and North West geographic departments. WV: leader of implementation at La Gonâve Island. Kore Lavi staple food vouchers are transferred electronically through a platform operated under a contract with Digicel, a nationwide cell phone company. The electronic platform enables timely refilling of vouchers, proper tracking of voucher redemption, and collection of information on amounts that were redeemed toward vendor payments.

PROGRAM DETAILS	
10. COMMUNITY PARTICIPATION	Kore Lavi uses the Essential Nutrition Actions (ENA) framework for behavioral change messages, and formative research has been undertaken to identify the specific behaviors to be targeted for behavioral change by the program. PLW are the priority, but messages and approaches are tailored to reach other women of reproductive age. The use of care groups is a community-based strategy to promote behavioral change. The methodology is based on the creation of groups of lead mothers who represent, serve, and individually promote good health and nutrition among women (and men) in 10 HHs in their community. Care groups are different from typical mothers' groups because each lead mother is responsible for regularly reaching a group of neighbors to share what she has learned and facilitate behavior change in these targeted HHs in her neighborhood. A dozen of lead mothers constitute a care group. They meet at least once a month for a training session hosted by an Multidsciplinary Community Health Agent (ASCP). Each lead mother visits the women and HHs in her neighborhood for whom she is responsible. As part of these home visits, she provides support, advice, and education to promote behavior change. The program is supporting lead fathers, men who are supportive partners, promoting good health and nutrition and BCC initiatives. ASCPs provide key resources. Ideally, each ASCP is responsible for four to six groups of about 10 lead mothers. These lead mothers are volunteers working in and for the community to provide important messages on health and nutrition. Each lead mother educates about ten HHs targeted in her neighborhood. The Kore Lavi Program relies on a Participatory Development Support Council in each commune to perform various functions for the program (including community outreach, overseeing the community preselection step of the vulnerability targeting system, selection of vendors, management of complaint mechanisms for the vulnerability targeting systems, the food voucher–based safety net, and vendor selection) and to facilitate the evaluation of the impact and quality of the program through social audits. Locally elected bodies, civil society, the Directorate for Civil Protection, the private sector, and other informal leaders are represented on the Councils.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	Kore Lavi has been designed and implemented as the initial, foundational phase of a GOH–led nationwide social protection program to reduce chronic food insecurity with nutrition prevention assistance and services for PLWs and infants. Before the end of its current four-year phase, Kore Lavi will begin to establish within MAST the procedures and capacity required to scale up a nationwide nutrition-sensitive social safety net mechanism for food security targeting at least 10 percent of the most deprived and vulnerable HHs.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	All activities are implemented in close collaboration with the GOH, especially MAST and MSPP, in order to ensure the best institutionalization of the program. An objective of Kore Lavi is the strengthening of the institutional capacity of the GOH at different levels of civil society (central, departmental, and communal), including: implementation of the social safety net; formalizing the partnership between the CNSA and Social and Economic Action Funds; commitment of central authorities to the follow-up and implementation of activities; progressive transfer of capacity; and training of intermediate senior staff at the departmental and communal levels.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	Kore Lavi performance management plan includes 42 indicators measured and reported on annually. Program progress monitoring includes monthly and quarterly implementation reports that are reviewed by the program management team and the program steering committee. Safety net monitoring includes beneficiary registration and a database that tracks the beneficiaries of the nutrition prevention and food voucher components. Kore Lavi context monitoring includes market prices, quality of food distribution, and post distribution monitoring of food and voucher distribution. Based on the INPV, vulnerability lists are produced, organized, and stored in a database, which enables centralized information requests and sharing. Kore Lavi is working with other stakeholders to create a single national registry of social protection beneficiaries in order to ensure the effectiveness of MAST.

MONITORING AND EVALUATION	
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	Kore Lavi conducted a baseline assessment; the midterm evaluation will take place toward the end of 2015. Kore Lavi has 17 indicators that are measured at both baseline and endline.
3. OUTCOME/IMPACT INDICATORS	• Prevalence of households with moderate or severe hunger using the Household Hunger Scale • Average Household Dietary Diversity Score (HDDS) • Mean depth of poverty • Prevalence of underweight children under 5 years old • Prevalence of stunted children under 5 years old • Prevalence of underweight women of reproductive age
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	No information available.
5. HARMONIZATION WITH OTHER PROGRAMS	No information available.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	A key feature of the Kore Lavi safety net mechanism is the monthly $25 food voucher for the purchase of a locally produced food basket. Forty percent of the value of the monthly transfer is earmarked for fresh food (including vegetables, fruit, and meat products). The Bureau of Nutrition of the MOH took a lead role in a working group that defined the composition of the food basket to ensure it is nutrition-sensitive. Supplementary food distributions are provided to all HHs that participate in nutrition-related activities. These supplementary rations target PLW and children from 6–23 months old. In addition, a family ration is provided to the families of these women and children to ensure that the targeted rations are consumed by the intended recipients. The program also makes supplemental rations available through health facilities for children diagnosed with moderate acute malnutrition. Kore Lavi mobilizes self-selected and self-managed savings groups to promote self-reliance and opportunity. These groups are a key community-based informal safety net that reduces vulnerability and prevents loss of livelihood.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	Kore Lavi implements a food-assisted first 1,000-days approach to prevent childhood undernutrition. This component of the program uses conditional monthly rations of nutritious foods to complement the interventions that build the capacity of: • Child caregivers, including mothers, fathers, grandparents, and siblings, to understand good behavior for ensuring that children are born healthy and nurtured effectively • Community-based informal health service providers and community leaders to understand and be able to support the behavioral change promoted by the program • Health facilities to provide high quality health and nutrition services Kore Lavi supports the ASCP and health centers with essential health materials and trains the ASCP, the health agents, the lead mothers and local civic organizations on nutrition and health topics according to the MSPP. Kore Lavi works with the health agents of the targeted communities to reinforce their knowledge of nutrition of infants and young children, to strengthen their capacity to monitor growth, and to improve care services, especially for the treatment of childhood diseases and severe or moderate malnutrition.

NUTRITION-SENSITIVE RATIONALE	
	At the facilities level, the program supports the strengthening of health and nutrition services including birth preparedness and maternity services, immunization, vitamin A and iron supplementation for children, and iron and folic acid supplementation for PLW. Facilities-based growth monitoring and promotion services are also strengthened to enable more effective identification and monitoring of children with severe or moderate acute malnutrition. A total of 107 health centers in 19 communes are targeted for the strengthening of capacity to improve the quality of nutrition and health services.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The five departments of Northwest, Artibonite, Southeast, Center, and La Gonâve and the 23 communes have been selected because they are the most vulnerable to food insecurity. Kore Lavi targets food voucher beneficiaries using the Haiti Deprivation and Vulnerability Indicator, which consists of 21 indicators grouped in 7 categories: demography, health, education, labor conditions, food security, home resources, and life conditions. These indicators are assessed through home visits and HHs are ranked according to an index between 0 and 1, with 1 indicating the greatest deprivation. The program targets at-risk age groups (mainly children in the first 1,000 days and pregnant women). The distribution of preventive rations targets PLW and children under two. The care group approach targets all HHs with a beneficiary receiving nutrition rations. MAST and Kore Lavi, with the support of their partners, are implementing the INPV, a new, harmonized approach to vulnerability targeting that focuses on chronically food insecure HHs. Kore Lavi will implement this approach in 16 communes. Kore Lavi targeting uses existing census data and data collected from a census conducted in partnership with the CNSA.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	The targeted beneficiaries of the preventive food rations are all PLW in the areas of intervention who meet the conditionality criteria. A preliminary gender analysis has been undertaken in the design of Kore Lavi. Kore Lavi provides support to the Ministry of Women's Affairs and Women's Rights to strengthen its regulatory, advocacy, and technical guidance roles for gender integration specifically in food security and social assistance and protection programming. In addition to gender training for frontline staff, local leadership, and government stakeholders, the program also engages men as supportive partners and agents of change, working with men's and women's groups to promote changes in social norms, particularly around violence and nutrition, HH decision making, and livelihoods. Kore Lavi provides support to GOH institutions and Civil Society Organizations (CSOs) at various levels that have responsibility for gender-sensitive social assistance and the implementation of food security programs.
5. THE PROGRAM HAS NUTRITION INDICATORS	GOAL indicators: • Average HDDS • Prevalence of underweight in children under 5 years old • Prevalence of stunted children under 5 years old • Prevalence of underweight women of reproductive age Outcome indicators: • Prevalence of children 6–23 months old who receive a minimum acceptable diet • Women's Dietary Diversity Score (WDDS): Mean number of food groups consumed by women of reproductive age • Prevalence of exclusive breastfeeding of children under 6 months old • Percent of children under 5 years old with diarrhea treated with oral rehydration therapy

NUTRITION-SENSITIVE RATIONALE	
	• Percentage of people reached by BCC messages • Percentage of MDAs receiving remedial training • Percentage of Community Advocacy and Development Projects or other civil society programs supporting public awareness campaigns for ENA, mother, infant and young child feeding (MIYCF), Growth Monitoring & Promotion (GMP) or Community Management of Acute Malnutrition (CMAM) • Percentage of eligible children in a health center catchment enrolled in GMP services • Percent of children identified with MAM receiving food who have met Government of Haiti recuperation standards Output indicators: • Number of children under five reached by USG-supported programs • Number of community public awareness campaigns for ENA, MIYCF, GMP, and CMAM implemented • Number of HHs reached through care groups • Number of individuals receiving supplementary, conditional rations • Number of trainings on ENA, MIYCF, GMP, and CMAM • Number of MDAs trained on gender-based violence and gender-based violence referral processes • Number of people trained in child health and nutrition through USG-supported program • Number of children from 6–59 months old referred to health facilities for treatment of MAM • Number of MDAs completing MSPP nutrition training curricula
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The Kore Lavi program is the first comprehensive social safety net and social protection project implemented in Haiti at its scale. It implements a specific and new targeting methodology and plans to have centralized data on population vulnerabilities under MAST supervision. The electronic food voucher system designed to stimulate local markets and the strategic objective of institutionalizing the program can also be considered best practices for Haiti.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The midterm evaluation will take place toward end of 2015.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The Kore Lavi program is currently studying the possibility of introducing, on a limited pilot scale, conditional food vouchers to prevent malnutrition in HHs living in extreme poverty. Kore Lavi is keen to evolve and see institutionalized a nutrition-focused food security safety net. The original design and experience thus far confirm that, to be effective in Haiti, a food security–focused safety net must be adequately integrated with nutrition services. It is difficult to imagine the GOH managing a safety net that integrates U.S. government–funded imported commodities.

FURTHER REFERENCES	
1. DOCUMENTS	Pending official publication: Vulnerability Information System Strategy and operational plan Operational Guidelines (food voucher–based transfers, MCHN strategic objectives) Gender analysis Formative Research and Strategy Recommendations for Social and Nutrition Behavior Change and Communication
2. METHODS OF DOCUMENTATION	The program uses technical and practice briefs to document its strategic objectives and approaches.
3. WEB SOURCES	No information available.

Mexico – Mexico Program of Social Inclusion PROSPERA

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Francesca Lamanna, Senior Economist
ORGANIZATION	World Bank Group (WBG)
ROLE WITHIN THE PROGRAM	Task Team Leader for a WBG operation in support to PROSPERA, Program for Social Inclusion.

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Mexico Program of Social Inclusion PROSPERA
2. COUNTRY	Mexico
3. TYPE OF PROGRAM	Conditional Cash Transfer (CCT) with Food and Nutrition Supplement
4. PROGRAM DURATION	1997 Progresa, 2002 Oportunidades, 2014 PROSPERA
5. PROGRAM OBJECTIVE(S)	To strengthen the social rights of the poor by improving their capabilities, especially their nutrition, health, and education capabilities, and contributing to breaking the cycle of intergenerational poverty.
6. FUNDING AGENCY/IES	Government of Mexico WBG (IBRD) $350 million (effective February 2015) Inter-American Development Bank $600 million
7. IMPLEMENTING AGENCY/IES	*Secretaria de Desarrollo Social* (SEDESOL) and PROSPERA (responsible institution)
8. TOTAL COST	$2,340 million
9. TARGET GROUP(S)	PROSPERA beneficiaries Children under 5 years old and pregnant and lactating women (PLW)
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	*As of April 2015:* 6.1 million HHs (25.5 million people), including 293,060 pregnant women attending breastfeeding workshops; 1,453,382 children under 5 years old attending health workshops. Female beneficiaries: 96.4 percent *Matrix of Indicators from Government (Matriz de Indicador Resultados, MIR).*
11. NUMBER OF REACHED BENEFICIARIES	*As of June 2015:* 6,077,944 HHs receiving direct transfers for nutrition, health, or education

12. PROGRAM CROSS-CUTTING THEMES	☐ DBM	☐ Rural
	☒ Multisectoral collaboration	☐ Resilience
	☒ Integrated approach	☐ Conflict-affected setting
	☐ Governance	☐ Harnessing nutrition data
	☐ Decentralization	☐ Use of mobile technology
	☐ Performance-based financing	☒ BCC
	☒ Community participation	☒ Life-cycle approach
	☐ Agriculture and local procurement	☒ Gender and women's empowerment
	☐ Urban	☒ ECD

CONTEXT OVERVIEW	
1. CONTEXT	Significant segments of the Mexican population face food insecurity and nutrition challenges. SEDESOL documents that in 2012, as many as 27.4 million people, 23.3 percent of the total population, reported some deprivation related to food access. The prevalence of deprivation related to food access is especially high among indigenous population (35.4 percent), youth (28.1 percent), and people with disabilities (31.2 percent). The southern region of Mexico—which includes the poorest states of the country, such as Oaxaca, Guerrero, Yucatan and Chiapas—has the highest stunting rates. In the rural areas of Chiapas as many as 44.2 percent of children under 5 years old are stunted, more than twice the national average for rural areas. The malnutrition problem in Mexico is multifaceted and characterized by the coexistence of high rates of chronic malnutrition with high and increasing rates of overweight and obesity. Obesity rates in Mexico are the highest in the hemisphere and among the highest in the world at 32.8 percent for adults. Obesity is more common among the poor and less educated, and it is increasing even among children. The government of Mexico recognizes food security and improved nutritional status as fundamental elements of its poverty reduction strategy, because of their impact on the long-term productivity of the population. At the same time, international evidence points to the importance of multisectoral solutions for greater impact on the nutritional status of the population. Access to income, health and nutrition services, food diversity, and health care are among the critical elements of a successful strategy to tackle malnutrition. Many programs and resources are directed at addressing this important challenge in Mexico. For example, PROSPERA, the national flagship CCT program, provides reliable CTs to over 25 million poor with proven effects on nutrition status (for example, a reduction of 22.2 percentage points in the prevalence of stunting and of 11.8 percentage points in the prevalence of anemia in children under 2 years old). However, program fragmentation and lack of coordination have been issues. According to the Consejo Nacional de Evaluación de la Política de Desarrollo Social (CONEVAL), in 2014 there were as many as 278 federal programs directed at improving socioeconomic welfare, each using different targeting and delivery mechanisms, coexisting with as many as 2,849 state and 1,883 local programs. Recently, the government has increased its efforts to improve coordination, reduce fragmentation and duplication of programs, and implement integrated approaches. *Working Document, Política Social de Nueva Generación y Cruzada Nacional Contra el Hambre, CNCH), 2013* *ENSANUT 2012* *United Nation Food and Agricultural Organization, 2013.* *Obesity Update, Organization for Economic Co-operation and Development (OECD).* *Programa Desarrollo Humano Oportunidades. Documento Compilatorio Evaluaciones Externas (2008).*

CONTEXT OVERVIEW	
2. COUNTRY INCOME LEVEL	Upper-middle-income

3. KEY CONTEXT DATA	2012 data:
	• GDP growth: 4.0 percent
	• Gini index: 48.1 (WBG estimate)
	• Poverty rate: 52.3 percent
	• Poverty rate, by population group:
	  • Indigenous people, 72.3 percent
	  • Children from birth to 17 years old, 53.8 percent
	• Extreme poverty, rural areas: 21.6 percent
	• Severely food-insecure HHs: 10.5 percent
	• Moderately food-insecure HHs: 17.7 percent
	• Food deprivation, total population: 23.3 percent
	• Food deprivation, by population group:
	  • Indigenous people, 35.4 percent
	  • Youth, 28.1 percent
	  • People with disabilities, 31.2 percent

4. KEY SOCIAL PROTECTION DATA	2012 data: • Coverage of SSNs in total of population: 58.9 percent • Coverage of SSNs in extreme poor: 91.4 percent • Adequacy of benefits of SSNs in total population: 10.2 percent • Adequacy of benefits of SSNs in extreme poor: 60.8 percent • Incidence of benefits of SSNs in extreme poor: 7.9 percent • Incidence of beneficiaries of SSNs in extreme poor: 6.3 percent 2010 data: • Public spending on social assistance programs, percent of GDP: 0.7 percent *ASPIRE database*
5. NUTRITION CONTEXT	The proportion of HHs with a perception of food security at the national level is approximately 30 percent; the remaining HHs are classified into one of three categories of food insecurity: mild insecurity (41.6 percent), moderate food insecurity (17.7 percent), and severe food insecurity (10.5 percent). Malnutrition has maintained a steady decline over almost a quarter of a century. Acute malnutrition (low weight for height) has nearly been eliminated as a public health problem, although there are still pockets of acute malnutrition in certain regions and age groups. Chronic malnutrition (low height for age) fell to about half that found in 1988. In spite of the decline in the prevalence of chronic malnutrition, currently almost 14 of every 100 preschool children, almost 1.5 million children under 5 years old, have low height for age, an indicator of chronic malnutrition. Anemia is a public health problem that affects people at all socioeconomic levels; it has important consequences on the cognitive and physical development of children and on the physical performance and labor productivity of adults. The prevalence of anemia remains a serious problem in Mexico, especially in children under 5 years old and particularly in children 12–24 months old.

CONTEXT OVERVIEW	
	The government has also recently launched integrated strategies directed specifically at preventing malnutrition and food insecurity, such as the CNCH and the ESIAN. The CNCH is an integrated strategy to bring together and coordinate existing resources at the federal, state and municipal levels to fight malnutrition and hunger. In 2014, more than 19 different institutions of the federal government were operating in the targeted municipalities with over 90 different programs, initiatives, and actions. The impact of the CNCH is being measured according to CONEVAL's multidimensional poverty indicators. The government of Mexico is working in closely with the WBG on a recently approved project and a recently approved grant to ensure that the social protection system is nutrition-sensitive. *Encuesta Nacional de Salud y Nutrición (ENSANUT - National Survey on Health and Nutrition) 2012*
6. KEY NUTRITION DATA	2012 data: Children under 5 years old suffering from • Stunting: 14 percent • Stunting in the rural areas of Chiapas: 44.2 percent • Anemia: 26 percent Adult obesity rate: 32.8 percent Share of pregnant women receiving ANC: 98 percent

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	PROSPERA comprises three components and four lines of action designed to contribute to capacity building, increase access to social rights and improve the welfare of the population in poverty. PROSPERA was designed to solve three problems: low use of health services, high level of chronic malnutrition, and low school attendance. Components: • **Food—**Direct monetary support to beneficiary families to improve the quantity, quality, and diversity of their food intake • **Health—**Disease prevention and the promotion of access to quality health care services • **Education—**Greater education coverage, with scholarships as an incentive to school progress and retention Lines of Action: • **Productive Inclusion—**Interagency coordination to provide information and advice to members of HHs about programs that promote production and income generation. • **Labor Inclusion—**Interagency coordination agreements that promote access for HH members to training and employment programs that would facilitate entry into the formal labor market • **Financial Inclusion—**Providing program beneficiaries with access under preferential conditions to financial services for financial education, savings, life insurance, and credit • **Social Inclusion—**Interagency coordination to provide priority access for beneficiaries to programs that facilitate access to social rights Within the framework of the ESIAN, PROSPERA has three main areas of nutrition intervention: (1) providing new supplements; (2) supporting the provision of basic equipment to measure the growth of children; and (3) a communication strategy and training in nutrition for personnel and beneficiary families.

PROGRAM DETAILS	
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	**Food:** $130 to $315 per month per HH; $115 per month per child from birth to 9 years old (maximum three transfers). **Health:** Basic nutrition package and nutrition supplements for children under 5 years old and PLW; $345 per month for the elderly who are members of PROSPERA households and who don't receive SEDESOL transfers. **Education:** Scholarships ranging from $165–$330 for primary school, to $810–$1,055 for secondary or professional school, to $4,500 for university students. Transfers are distributed bimonthly to beneficiaries' bank accounts and withdrawn using a bank card. If bank services or branches are not available, transfers are given in "smart cards". There is no predetermined time limit for participation. Beneficiaries remain in the program as long as they continue to meet eligibility requirements.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	• Protection of basic consumption of a family (20 percent of the income per capita of the family) • Opportunity cost of the use of health and education services to reduce the gap in attendance and the drop-out rate; starting in secondary school, girls receive an additional amount because their rate of dropping out was higher than that for boys • The nutrition supplement for reducing anemia among children and PLW was changed to improve cost and acceptability, and to increase their consumption.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Conditions include: • Regular visits to health centers by all HH members (at least twice a year, and more frequently for pregnant women and children under 2 years old, in accordance with established protocols) • Attendance at monthly health information sessions workshops by at least one adult member of the family • Children and youth under 21 years old must be enrolled in school, and those between the 3rd grade of primary and the 3rd grade of secondary school must have an attendance rate of at least 85 percent. For youth that complete high school before the age of 22, a one-time incentive is provided.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	*For each peso of program direct and indirect costs, 95 centavos go directly to the beneficiaries. The health and nutrition interventions and support provided to each family cost Mex$835.*

PROGRAM DETAILS	
9. INSTITUTIONAL ARRANGEMENTS	The National Coordination Agency of PROSPERA is responsible for the implementation and day-to-day oversight of the program, as defined in the operating rules for the program. The strategic guidance of the program is the responsibility of a multisectoral technical committee at the national level. At the state level, the state technical committees and regional committees guide the effective implementation of the program.
10. COMMUNITY PARTICIPATION	From its beginning, PROGRESA was designed to encourage a high level of participation from the community, particularly for self-support on health and nutrition. The program set up community committees composed of representatives of the program for health, nutrition, education, and, more recently, on social accountability. The representatives of the program responsible for nutrition support beneficiary families to ensure access to and consumption of nutrition supplements and that families attend regular health checkups and behavioral change workshops, at which nutrition is an important topic.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The program is already implemented on a national scale.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	The project is fully aligned with Mexico's National Development Plan, current social strategy, and long-standing agenda on poverty reduction. The project supports the government's efforts to reduce poverty and increase shared prosperity. Support for Oportunidades, which has been the main vehicle to achieve this goal, has been consistent across administrations as demonstrated by increased coverage. The project now supports Mexico's commitment to a new generation of social policy to ensure more coordinated and effective access to social and productive programs for the poor while reducing fragmentation and duplication of programs. It is expected that these efforts will improve support for the poor and increase efficiency in spending in the long term.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	From its beginning in the late 1990s, PROSPERA designed a monitoring system that would serve the multiple needs of its stakeholders. The information for the various stakeholders' needs is supplied by different data collection and reporting tools, including the MIS, the appeals and control system, social accountability systems, and beneficiary assessments. An operational component informs frontline and midlevel managers whether planned tasks are fulfilled using measures of quantity, quality of service, and efficiency. A strategic, results-based monitoring component informs upper-level management and external stakeholders whether beneficiaries' outcomes are improving.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	The government has established a performance-evaluation system for all social programs, based on an MIR, which is agreed upon for each program every year, including PROSPERA. PROSPERA has been one of the most evaluated programs in the world and will continue to be so in the future.
3. OUTCOME/IMPACT INDICATORS	*Indicators are revised every year. This list may be incomplete.* • Percentage of children malnourished • Percentage of the population that is food-insecure • Difference in schooling between fathers and children • Percentage of scholarships for secondary school by composition per grade and by gender • Percentage of completion of basic education for the youth in the program • Anemia prevalence of PLW beneficiaries 12–49 years old • Percentage of students in secondary school that transition to higher education • Percentage of students enrolled basic education by sex and gender in comparison to the national enrollment

MONITORING AND EVALUATION	
	• Percentage of students in primary education that transition to secondary school • Girls and boys that receive basic education scholarships at the secondary level • Percentage of students in basic education that receive support for school goods • Percentage of students at the primary and secondary levels that receive an education benefit • Percentage of beneficiaries that finished secondary education and receive support from the program *Joves PROSPERA* in the first 6 months of secondary education • Percentage of coverage of families with health programming • Percentage of coverage of girls and boys with nutrition supplements • Percentage of coverage of PLW with nutrition supplements • Percentage of coverage of prenatal care for women • Percentage of elderly that comply with health responsibilities and receive economic support • Percentage of coverage of children with nutrition programming • Percentage of female beneficiaries that receive economic support for food • Perception of beneficiaries of the treatment received from program personnel • Percentage of schools that participate in the program and show better school quality with beneficiaries of PROSPERA • Percentage of beneficiary HHs in which the head of the HH is female • Percentage of coverage of PROSPERA beneficiary HHs • Percentage of localities participating in the program that are in Crusade against Hunger municipalities • Number of family beneficiaries of the program • Percentage of coverage for prenatal visits for the first trimester of pregnancy • Percentage of medical units that have at least 80 percent of the necessary medications • Percentage of the elderly that are certified as complying with the coresponsibilities • Average of treatment with nutrition supplement for women beneficiaries and for children • Percentage of beneficiaries for whom timely and complete health reports are received
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	Extensive qualitative and quantitative data have been collected since PROSPERA started in 1997. Selected key health and nutrition results are summarized for the most recent surveys (2007 for rural areas; 2009 for urban areas). • Increased use of health services, especially preventive services • Increases use of prenatal care, reduced likelihood of adolescents to engage in risky behavior, and reductions in obesity and chronic illness among program participants • Increases in both overall and food consumption, sustained over time • In the case of nutrition, in children under 2 years old, a reduction of 22.2 percentage points in the prevalence of stunting and of 11.8 percentage points in the prevalence of anemia • Reductions of 5.4 percentage points and 14.2 percentage points in urban and rural areas, respectively, in the prevalence of anemia in pregnant women 17–22 years old

MONITORING AND EVALUATION	
	• A recent evaluation of supplements shows reductions in anemia of 16.3 percentage points and 2.4 percentage points in rural areas and urban areas, respectively, in children 6–59 months old • The greatest changes in health and education were observed in women and indigenous populations • The longer the participation by beneficiaries in the program the better the health and education outcomes • The program still faces significant challenges in reaching its objective of breaking the intergenerational cycle of poverty. Nutrition, health, education, and job indicators for the target population still lag significantly behind. *Conditional Support Program—Impact Evaluation and Key Results of PROSPERA*
5. HARMONIZATION WITH OTHER PROGRAMS	A total of 17,519,703 beneficiaries of PROSPERA receive access to the health insurance program, Seguro Popular (as of April 2015), and several other programs in different ministries.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The size of the cash transfer is set to have an impact on nutrition, that is, it is set at 20 percent of family per capita income to guarantee basic consumption for poor families. Payments are frequent (every two months) and reliable to support expenditures for daily necessities.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	CTs are given to beneficiaries based on specific coresponsibilities relating to the use of health and nutrition services and attendance at health and nutrition education sessions. Specifically, these coresponsibilities include: • Regular visits to health centers by all HH members (at least twice a year, and more frequently for pregnant women and children under 2 years old, in accordance with established protocols) • Attendance at monthly health information sessions by at least one adult member of the HHs PROSPERA also provides a basic package of health services free of charge, including the delivery of food supplements to vulnerable groups and education to support infant and PLW's nutrition. Within the framework of Estrategia Integral de Atención a la Nutrición (ESIAN), the program seeks to promote good nutrition habits starting from pregnancy, during lactation and for children under 5 years old. There are three fundamental components: • Distribution of supplements for women from pregnancy until the child turns 1 year old and for children 6–59 months old generally, as part of an integrated strategy to improve the health and nutrition status of priority groups • Providing specific equipment to health centers for the evaluation of nutrition status and diagnosis of anemia (including audiovisual support for the promotion of key messages of the ESIAN) • Plans for (1) building the awareness and capacity of PROSPERA health and community personnel to carry out the basic interventions of the ESIAN and of counseling to mothers using best practices; and (2) communication to and training of PROSPERA health and community personnel to carry out the elements of the program and improve the attitudes and practices of the personnel at all levels toward women beneficiaries of the program. From January to April 2015, 567,299 workshop sessions were held, focusing, among other themes, on nutrition and health, adolescence and sexuality, overweight and obesity, and early child development.

NUTRITION-SENSITIVE RATIONALE	
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	PROSPERA beneficiaries are selected through a three-tiered mechanism: (1) the selection of marginal communities according to a specially developed marginality index; (2) the selection of poor HHs using a multidimensional poverty line; and (3) community validation of the list of beneficiaries at a town meeting. The nutrition intervention uses categorical targeting—women of reproductive age with children under 5 years old. The program uses indigenous language communication strategies to target nutrition messages.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	The program interventions are flexible to address specific vulnerability gaps, particularly in health, nutrition, and education, for subgroups of women. For example, 20 percent of pregnant women have anemia, and 75 percent of adult women are overweight or obese. Specific interventions are designed for each subgroup of the population.
5. THE PROGRAM HAS NUTRITION INDICATORS	MIR for PROSPERA related to nutrition are: • Prevalence of malnutrition in infants, measured as small height for age of the PROSPERA population • Percentage of coverage of prenatal care of women • Percentage of children beneficiaries in the nutritional workshops • Percentage of coverage of children provided with nutritional supplements • Percentage of coverage of PLW receiving supplements. • Percentage of health coverage among beneficiary HHs • Percentage of adults that comply with the coresponsibilities for health
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	According to the results of Encuesta Nacional de Salud y Nutricion (ENSANUT) 2012, PROSPERA, supported by this WBG intervention, has the widest coverage, best targeting, and best results for closing the gap in health and nutrition. Almost 25 percent of HHs in Mexico receive benefits from one or more programs for social development or nutrition. For each beneficiary family of the program in urban areas there are five in rural areas, which is appropriate given the higher prevalence of malnutrition in rural areas. Also, given the extent of the malnutrition of children under 5 years old in Mexico, the program coverage is adequate for its purpose to improve nutrition in that age group.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Based on the impact evaluation of the program, a number of adjustments were made, and results were achieved in these three areas: • Improved quality of services, particularly in nutrition though the ESIAN • Strengthened provision of services of Seguro Popular • Enhanced communication strategies to improve nutrition through counseling, workshops, and messages appropriate to the population, with special attention to indigenous languages to reach a population that faces cultural and linguistic barriers
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The adequate use of nutrition supplements and the consequent reduction in anemia continue to be a challenge. Additional challenges include how to achieve better practices in terms of breastfeeding, nutritional content of food, reduction of obesity, and overweight in school. To that end, ensuring an appropriate counseling for better nutrition is a priority for the program. The monitoring of the health system is not digitalized, which would providing contemporaneous follow-up of growth monitoring at the national level.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects /P147212?lang=en
2. METHODS OF DOCUMENTATION	**Desk-based research:** WBG resources: *Project Appraisal Document PAD933-MX October 2014* *Project Information Document PIDA8034 August 2014* External resources: *Encuesta Nacional de Salud y Nutrición (ENSANUT - National Survey on Health and Nutrition) 2012* Program and SEDESOL resources: *Decree PROSPERA: https://www.prospera.gob.mx/Portal/work/Web20132 /-documentos/05092014_DOF_Decreto_de_Creacion_Prospera.pdf* *Operating Rules for the program: http://www.normateca.sedesol.gob.mx/work /-models/NORMATECA/Normateca/Reglas_Operacion/2015/rop_prospera.pdf* **Interview with Task Team Leader**
3. WEB SOURCES	http://www.sedesol.gob.mx/en/SEDESOL/Prospera https://www.prospera.gob.mx/Portal/wb/Web/inicio https://www.prospera.gob.mx/EVALUACION/es/matriz/matriz2015.php http://www.worldbank.org/projects/P147212?lang=en https://www.worldbank.org/en/news/feature/2014/11/19/un-modelo-de-mexico-para-el-mundo

Peru – Juntos Results for Nutrition SWAp

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Alessandra Marini, Senior Economist
ORGANIZATION	World Bank Group (WBG)
ROLE WITHIN THE PROGRAM	Co-Task Team Leader

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Juntos Results for Nutrition Sector Wide Approach (SWAp)
2. COUNTRY	Peru
3. TYPE OF PROGRAM	Conditional Cash Transfer (CCT)
4. PROGRAM DURATION	March 2011 to September 2016
5. PROGRAM OBJECTIVE(S)	• Increase demand for nutrition services by strengthening the operational effectiveness of the Juntos CCT program • Improve coverage and quality of the supply of basic preventive health and nutrition services in the communities covered under the PAN, including the Juntos program.

PROGRAM OVERVIEW		
6. FUNDING AGENCY/ IES	WBG (IBRD) $25 million Peru: $29.0 million	
7. IMPLEMENTING AGENCY/IES	Ministry of Economy and Finance (MEF) (responsible institution)	
8. TOTAL COST	$54 million	
9. TARGET GROUP(S)	**CCT:** Juntos program beneficiary HHs with children under 36 months old The intervention targets 3 of the 14 poorest regions of the country where the Juntos program is operating: Amazonas, Cajamarca, and Huánuco. These are mainly rural areas with an estimated 370,262 HHs totaling about 5.8 percent of Peru's population. Supply-side interventions would benefit most of the population of these target districts.	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	**Juntos CCT program:** 58,076 Juntos program beneficiary HHs. **Densification of enrollment of newborns in the Juntos CCT program:** 12,979 new enrollments	
11. NUMBER OF REACHED BENEFICIARIES	*As of June 2015:* Percent of Juntos children under 12 months old that have received the complete CRED scheme appropriate to their age: 78.7 percent (baseline 63.9 percent; end target 80 percent) Percent of children under 36 months old that have received the complete CRED scheme appropriate to their age: 72.7 percent (baseline 71.70 percent end target 73 percent) (estimated)	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM	☒ Rural
	☒ Multisectoral collaboration	☐ Resilience
	☒ Integrated approach	☐ Conflict-affected setting
	☒ Governance	☒ Harnessing nutrition data
	☐ Decentralization	☐ Use of mobile technology
	☒ Performance-based financing	☒ BCC
	☒ Community participation	☒ Life-cycle approach
	☐ Agriculture and local procurement	☒ Gender and women's empowerment
	☐ Urban	☐ ECD

CONTEXT OVERVIEW	
1. CONTEXT	In the years preceding project preparation, Peru experienced its strongest period of rapid growth of the last decades, which led to a significant reduction in poverty. However, poverty and entrenched inequalities remained a critical challenge for the country's long-term economic and social prospects. Despite improvements, Peru's human development outcomes continued to lag behind the country's economic impetus. Health inequalities were large and persistent between socioeconomic groups and regions, particularly in rural areas and among indigenous communities. Although Peru is a middle-income country with near-universal coverage of primary education, coverage for secondary education remained below desired levels, and ultimately less than 20 percent of second grade students reached full sufficiency in literacy (almost half were unable to read at all) and basic arithmetic. *WBG Project Appraisal Document (PAD) 51149-PE January 2011*
2. COUNTRY INCOME LEVEL	Upper-middle-income

CONTEXT OVERVIEW	

3. KEY CONTEXT DATA	2008 data:
	• GDP growth: 9.1 percent
	• Gini index: 48.6 (WBG estimate)
	• Poverty rate, national: 36.2% percent
	• Poverty rate, by location:
	  • Costa urban 23.4 percent, Costa rural 34.8 percent
	  • Sierra urban 31.3 percent, Sierra rural 65.6 percent
	  • Selva urban 31.3 percent, Selva rural 49.1 percent
	  • Metropolitan Lima 17.7 percent
	• Extreme poverty rate, national: 12.6 percent
	• Extreme poverty rate, by location:
	  • Costa urban 2.4 percent, Costa rural 7.9 percent
	  • Sierra urban 9.2 percent, Sierra rural 37.4 percent
	  • Selva urban 7.2 percent, Selva rural 20.7 percent
	  • Metropolitan Lima 0.7 percent
	• Maternal mortality ratio: 164 per 100,000 live births
	WDI and WBG PAD

4. KEY SOCIAL PROTECTION DATA	2013 data: • Public spending on social assistance programs, percent of GDP: 0.8 percent 2012 data: • Coverage of SSNs in total of population: 86.6 percent • Coverage of SSNs in extreme poor: 88.2 percent • Adequacy of benefits of SSNs in total population: 9.8 percent • Adequacy of benefits of SSNs in extreme poor: 27.0 percent • Incidence of benefits of SSNs in extreme poor: 6.4 percent • Incidence of beneficiaries of SSNs in extreme poor: 2.2 percent *ASPIRE database*
5. NUTRITION CONTEXT	In 2006, stunting affected 28 percent of Peruvian preschool children, and the rate of chronic malnutrition had been stagnant for a decade. A remarkable advocacy effort in 2006 led to a major multisectoral nutrition initiative, coordinated at the highest political level and with the support of the country's president, which led to an impressive reduction in chronic malnutrition and stunting in the districts reached. At the time of project design, stunting affected 23.8 percent of Peruvian preschool children. The Ministry of Economy and Finance (MEF) formalized the political commitment to achieving results and accountability for nutrition by including the Articulated Nutrition Program (PAN) in the key strategic programs to be monitored within the Performance-Based Budgeting (PBB) pilots. Through PAN MEF started assigning budgetary resources based on the achievement of better results in nutrition rather than on the basis of historical allocation. The Government of Peru (GOP) has strengthened the child growth promotion sessions (CRED). Demand-side interventions like the CCT program Juntos were also prioritized, based on the success of similar programs in other countries in reducing chronic malnutrition when accompanied by adequate coverage and quality of health and nutrition services.

CONTEXT OVERVIEW	
	WBG supported the GOP nutrition efforts over the last 10 years in a variety of ways, to include promoting visibility of the issue, developing communications material, providing analytical work, and building commitment. In addition, WBG aimed to build technical capacity around reduction of malnutrition through effective links between the Juntos CCT program and the supply of nutrition and health services. The Japanese Social Development Fund (JSDF) Participatory Intervention Model to Improve Child Nutrition was used to assist in this process and helped pilot innovative tools, such as communication materials targeted to indigenous communities and local-level monitoring of nutrition outcomes. The TA highlighted that the Juntos program, despite its achievements in poverty reduction and facilitation of access to health services, had not produced the expected reduction in chronic malnutrition. This was related partly to the lack of coverage and quality of the associated health and nutrition services, and partly to shortcomings in the program's design and implementation, such as the verification of compliance with health and nutrition coresponsibilities. The shortcomings identified by the TA were used to identify the key investment areas of the current Juntos SWAp project. Finally, the WBG supported key reforms needed to promote nutrition results through a Programmatic Reform Loan Series (REACT 2007-2011) which contributed to strengthen the results and accountability framework for better nutritional outcomes. Peru has also joined the SUN initiative. As a result, the nutrition efforts of the GOP have been recognized by a platform consisting of CSOs, international organizations, government agencies, and academia and have been presented in international forums. *WBG Project Appraisal Document (PAD) 51149-PE January 2011* REACT/RECURSO/NLTA final reports As of 2014, chronic malnutrition (stunting) affects 14.6 percent of preschool children in Peru, while 50 percent of children under 5 years old and 69 percent of children under 2 years old suffer from anemia. Chronic malnutrition is more than three times higher among children living in the rural areas (28.8 percent) as it is in children living in urban areas (8 percent). Thirty-four percent of the extreme poor children are stunted, compared to only 4 percent of children in the first quintile. There is great variation in malnutrition rates across regions. The regions of Huancavelica, Cajamarca and Amazonas are among the poorest of Peru and have the highest stunting levels (above 30 percent).

6. KEY NUTRITION DATA	<u>2014 data:</u>
	
	Children under 5 years old suffering from
	• Stunting: 14.6 percent
	• Stunting, by location:
	  • rural, 28.8 percent
	  • urban, 8 percent
	• Stunting, by quintile:
	  • Q5, 34 percent
	  • Q1, 4 percent
	• Anemia: 50 percent
	
	Children under 2 years old suffering from anemia: 69 percent
	
	<u>2011 data:</u>
	
	Share of pregnant women receiving ANC: 95 percent

CONTEXT OVERVIEW	

	2008 data:
	• Children under 5 years old suffering from stunting: 27.5 percent
	• Children under 5 years old suffering from stunting, by location:
	  • rural, 36.0 percent
	  • urban, 11 percent
	  • Costa, 15.5 percent
	  • Sierra, 32.3 percent
	  • Selva, 20 percent
	  • Metropolitan Lima, 6.9 percent
	WDI and WBG PAD

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	The WBG Juntos Results for Nutrition program has been designed to support the demand, supply, and governance of nutrition services provided by the GOP, as articulated in the Programa Articulado Nutricional (PAN). **Support to the demand of nutrition services.** This component supports an incentive mechanism to the GOP through output payments based on: (a) the affiliation of children younger than 12 months old with Juntos; and (b) the verification of the health coresponsibilities of children younger than 36 months old already affiliated with Juntos. **Support to the supply of nutrition services.** This component creates incentives for MOH providers to increase coverage and improve the quality of basic health and nutrition services through additional funding for PAN, using capitation payments, which enables beneficiaries of the Juntos CCT to comply with their health and nutrition coresponsibilities. **Support to the governance of nutrition services.** This component supports an incentive mechanism to strengthen GOP budgetary planning and monitoring capacity for the PAN through output payments for: (a) the implementation of a monitoring system and planning and monitoring capacity for health facilities; (b) the establishment of a social monitoring of nutrition results at the municipal level; (c) technical verification of the capacity of health facilities to provide nutrition services; (d) early affiliation of newborns to the SIS; and (e) verification of CRED information.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	S/200 ($66) every two months per mother for at least 3 years.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The transfer amount was established by the GOP before the WBG began to support the Juntos CCT program. The amount was based on a combination of budget availability and resources needed by poor HHs to acquire a minimum basket of resources. The transfer amount corresponds to approximately 80 percent of the cost of the minimum basket at 2008 prices.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	• Regular health and nutrition visits for pregnant women and children under 5 years old • School attendance rate of at least 85 percent for children 6–14 years old who have not completed elementary education • Identification documents required for women beneficiaries to open a bank account • Beneficiaries must be targeted through the Household Targeting System

PROGRAM DETAILS	
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	• **Strengthening and consolidating the Juntos CCT program for families with children under 36 months old:** $6.8 million ($5.5 million WBG funding) • **Improving coverage and quality of basic preventive health and nutrition services in the Juntos areas:** $29.8 million ($5.5 million WBG funding) • **Strengthening the GOP's capacity to influence nutritional outcomes by improving budgetary planning and monitoring of results for selected activities of the PAN:** $17.5 million ($14 million WBG funding)
9. INSTITUTIONAL ARRANGEMENTS	The PBB unit in the Dirección Nacional Presupuesto Público (DGPP) in MEF is responsible for the technical coordination of the implementation of the program. In addition, the PBB unit is responsible for assigning and transferring the budget resources to the sectors and agencies involved in the implementation of the program based on their progress in implementing the activities supported by the program. The Sectoral Loan Coordination Unit (UCPS) in MEF coordinates the administration of the Juntos CCT program, including procurement for key activities that support the achievement of outputs defined for agencies involved in the project. In addition, UCPS conduct procurement audits and audits financial statements. The Juntos CCT program, the Integral Health Insurance system (SIS), and the regional health directorates are the critical subexecuting agencies of this project and are responsible for carrying out the activities to achieve the expected results of the project. The relationship between the three agencies and the MOF is regulated through result-based agreements.
10. COMMUNITY PARTICIPATION	The WBG project supported the establishment of a social monitoring mechanism to be run by local governments with the participation of local CSOs, media, users, and service providers. The social monitoring oversees nutrition results and the quality of primary health and nutrition services at the district level through (a) the local provision of user-friendly information on key nutrition services and outcomes and the capacity of health facilities to meet minimum conditions of effectiveness in providing the guaranteed package of services; and (b) the use of this information in multistakeholder forums for municipal authorities, service providers, and local CSO representatives, organized by the local governments to oversee progress in the achievement of local nutrition goals.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The MEF is currently undergoing an internal process to request additional financing to support the expansion of the WBG project to the more vulnerable Amazon population.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	The WBG project supports an existing and well established government RBB program of the MEF, which assigns resources to activities and programs that are considered cost-effective in reducing child malnutrition. None of the activities or programs depend directly on WBG financing. The WBG project aims at strengthening results by disbursing funds directly to the MEF on the basis of achieved output and outcomes. In order to strengthen its sustainability, the MEF has included the implementation and updating of the Nominal Registry for Children (Padron Nominado), a key activity supported by the project, as one of the targets measured by the Municipal Incentives Plan for accessing the budget incentives allocated by this program to local governments.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	Results are monitored regularly and are the basis of disbursement. Specifically, three activities supported by the project have shown to be critical to improving local planning and monitoring: the Padrón Nominado, the social monitoring mechanism, and the Encuesta a Establecimientos de Salud sobre Calidad Técnica del Crecimiento y (ENCRED) survey on the capacity of health facilities. The project supported the development of the Padron Nominado, a platform administered by the national identity registry (RENIEC), which contains information on children under 6 years of age at the local level for the 1,851 districts nationwide. The database is fed by reports of local governments and other government entities (such as RENIEC, Ministry of Health, Ministry of Education). The registry provides indicators that allow monitoring the coverage of: children under 3 years of age in accessing health as well as identity and other social programs; and children under 3 years attending pre-primary school by region, province and district. This information is then used by the RBB instruments implemented by MEF, including the Municipal Incentives Plan, and at the district level to monitor children's attendance at checkups as well as their enrollment with Juntos and SIS The WBG project introduces an innovative social monitoring mechanism to oversee nutrition results and the quality of health and nutrition services at the local level. The Social Monitoring is a mechanism led by local governments with participation of indigenous organizations, local civil society, service providers, etc., directed at monitoring nutrition outcomes and verifying the quality of primary-level health services in the district. The Project has contributed to provide technical assistance to 159 ***Juntos*** districts in the target regions towards the development of the social monitoring. The project financed the implementation of the Survey to Health Facilities to assess their minimum capacity to carry out nutrition and health services, such as CREDs and immunizations.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	The monitoring and evaluation activities supported by the WBG project are designed to strengthen the capacity of MEF, Juntos, and MOH and are critical element of the RBB framework that MEF uses to disburse funds to the agencies and sectors on the basis of results. The results framework supporting M&E disaggregates data by indigenous and nonindigenous populations, particularly for the Project Development Objective indicators and other indicators that are considered critical for indigenous populations
3. OUTCOME/IMPACT INDICATORS	<u>Project Development Objective indicators:</u> • Percentage of Juntos children under 12 months old that have received the complete CRED scheme appropriate for their age in the areas of intervention of the Juntos program targeted by this operation • Percentage of children under 36 months old that have received complete CRED scheme appropriate for their age in the areas of intervention of the Juntos program targeted by this operation
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	An impact evaluation conducted in 2009 using nonexperimental evaluation techniques suggested that the Juntos program was associated with an improvement in a number of key welfare indicators for program beneficiaries. Juntos had a moderate impact in reducing poverty and increasing monetary measures of both income and consumption. In addition, and similar to evidence from other countries, the program was shown to increase the use of health services for both children and women and to improve nutritional intake of program HHs. Despite these positive effects, no effect was found on final outcome indicators such as malnutrition or anemia. This result was consistent with the international experience, which suggests that, to produce these effects, CCT schemes needed to be complemented by an adequate supply of health services (in both quantity and quality) and interventions to better promote health and education practices. In this sense, the evidence served as an additional basis for the design of the project. *Perova, E., and R. Vakis. 2009. Welfare Impacts of the "Juntos" Program in Peru: Evidence from a Nonexperimental Evaluation. Washington DC: World Bank.*

MONITORING AND EVALUATION	
5. HARMONIZATION WITH OTHER PROGRAMS	• PAN: Articulated Nutrition Program. One of the Results Based Budgeting Programs of the MEF – assigns budgetary resources to programs and regions on the basis of their cost effectiveness and needs • Juntos CCT program and CRED growth promotion activities. Directly supported by the project and included in the PAN framework • SIS: Integral Health Insurance. Free health insurance covering basic health services for the poor population • EuroPAN: Budget support program financed by the European Union that supports the strengthening of Juntos and CRED in the regions of Ayacucho, Apurimac, and Huancavelica.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The size of the Juntos CCT transfer is set to have an impact on nutrition, and frequent and reliable payments support expenditures for daily necessities. Transfers are given bimonthly to mothers, which gives women control over the income and consumption decisions.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	This WBG project, which supports both the demand and supply of health and nutrition services, has an explicit nutrition focus, that is, improving the coverage and quality of the basic preventive health and nutrition services in the Juntos areas and increasing the use of such services through health and nutrition coresponsibilities. Also, the project is designed to increase the enrollment of newborns into Juntos to ensure that children are monitored during the critical nutrition window of opportunity. The project also supports the verification of health and nutrition co-responsibilities, which include regular health visits for pregnant women and children under 5 years old.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The Juntos CCT program explicitly targets children in the first 1,000 days. An important element is the registration of the youngest children in the CCT program to make sure that health and nutrition coresponsibilities are monitored. In addition, efforts are being made to increase the enrollment of newborns (from birth to 30 days old) in SIS. Overall, the WBG project targets 3 of the 14 poorest regions of the country where Juntos operates (Amazonas, Cajamarca, and Huánuco), where poverty and malnutrition rates are highest and the provision of basic services is limited.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	The payment of the Juntos transfer was changed from monthly to bimonthly to minimize the opportunity cost of traveling to receiving the transfer. Payments are disbursed through bank accounts at Banco de la Nación and associated debit cards.
5. THE PROGRAM HAS NUTRITION INDICATORS	Project Development Objective indicators: • Percentage of Juntos children under 12 months old that have received the complete CRED scheme appropriate for their age in the areas of intervention of the Juntos Program targeted by this operation • Percentage of children under 36 months old that have received complete CRED scheme appropriate for their age in the areas of intervention of the Juntos Program targeted by this operation Outcome indicators: • Number of newborns (children under 12 months old) enrolled in the Juntos program Coverage indicators: • Complete coverage of CRED in Juntos population • Complete immunization coverage in Juntos population • Coverage of collective activities in Juntos population

NUTRITION-SENSITIVE RATIONALE	
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	The program adopts a multisectoral approach.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	**Integrated approach.** The project features an integrated approach to nutrition that finds its roots in the WBG's long-term efforts to support the GOP's commitment to prevent malnutrition across the country. The lack of understanding of the problem was evidenced by large government expenditures on nutrition-related interventions that focused on providing a remedy rather than prevention. Before the project was prepared, WBG TA focused on building political and technical consensus on the need for restructuring, relaunching, and consolidating the Juntos CCT. The NLTA Program supported high-level and technical meetings among key policy makers to design and implement a strategy to effectively determine the demand and supply sides of Juntos with emphasis on the provision of health and nutrition services. These efforts led to the preparation of a project that aimed at addressing challenges at the level of demand, supply and governance of nutrition services. **Social monitoring.** Given the strong emphasis in promoting good governance and social accountability to monitor the impact of GOP programs, the WBG project promoted the establishment of a district-based social accountability mechanism to oversee nutritional outcomes led by local government. Outputs produced so far provide a good indication of the sense of ownership and relevance of the mechanism for improving local planning and management of basic health and CRED services, such as CRED coverage maps, warning reports on gaps and progress, and timing and costs of nutritional service delivery flows. **Multisectoral collaboration.** The program found a strong counterpart in the MEF, which helped address malnutrition multisectorally through sound coordination of collaborating ministries. The DGPP in the MEF was selected by the GOP as the most appropriate technical agency for coordinating the different sectors' agencies because: (a) the operation complements its ongoing efforts to maintain the focus of government programs, especially multisectoral ones, on results by introducing PBB pilots; and (b) PAN is part of the first five key strategic programs to be monitored within the PBB pilots, with the objective of concentrating budgetary, logistical, and organizational efforts in the regions with the highest malnutrition rates. **Performance-based financing.** WBG's experience in supporting health sector interventions indicates that financing should be closely linked to results, both outputs (such as enrollment of beneficiaries), and, when appropriate, outcomes (such as improvement of final or intermediary health indicators). The introduction of capitation payment mechanisms and performance agreements, along with effective monitoring and information systems, has helped create incentives to achieving measurable improvements in access to health services in underserved communities in other countries in the region.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Data show increased use of health and nutrition services in the areas of the project and specifically among beneficiaries of the Juntos CCT program. In addition, several useful tools have been developed as part of the project. Many institutions have used the Padron Nominado as a tool to help both design and organize health facilities. The Padron Nominado helps early identification of coverage gaps and, in turn, improves the government's capacity to influence nutritional outcomes. The project also contributed to the strengthening of the governance of nutrition services through the social monitoring tool. In the second part of 2014, 80 districts created local committees that were trained by consultants from the MEF in the use of basic indicators that help monitor results that are expected to have an impact on nutrition outcomes. In addition, by 2014, 75 of the 80 districts organized accountability forums in their communities to present key nutrition-related results and receive feedback from local decision makers on actions that could be taken to improve nutrition results.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The main challenge the project faces in the future is the low participation of indigenous communities in the Juntos CCT program and in the use of health and nutrition services, particularly in the Amazon region. The main factors affecting lower early enrollment rates among Amazonian children seem to be: (a) late registration of children in the Civil registry, particularly those born at home; (b) inability of some mothers to get a National Identification Document because, for example, digital registration systems are incompatible with the phonograms of some native languages, HHs are located in remote areas, registration errors have been made; and (c) the mononuclear HH structure underlying the Juntos procedures does not match the multinuclear HH structure of some Amazonian groups. Also, low compliance of coresponsibilities linked to complete CRED was associated with: (a) limited capacity of health centers to deliver CRED services to remote and dispersed areas; and (b) cultural barriers (mothers opting out of attending CRED consultations because of fear of immunizations). Finally, Amazonian mothers from remote communities have to travel long distances to get to the mobile payment facilities and often face the risk of being robbed or assaulted by thieves. In order to address the persistent gaps affecting Indigenous communities in the highland rural areas of Huánuco and Cajamarca, and especially in the Amazon region, it will be necessary to identify interventions that take into account the challenges posed by the cultural diversity, a weaker presence of public institutions, and a poor infrastructure in those territories. Second, ENCRED findings showing poor availability of critical inputs for health facilities (such as soap, washbasins, proper storage of vaccines, and a moderately unsatisfactory performance of health personnel in delivering the prioritized PAN services) reinforce the necessity of measuring not only service coverage but also minimum quality standards to ensure positive effects on the nutritional status of children. This observation may be corroborated by the high levels of anemia in the territories where the program is implemented. Services like CRED still have room to improve their quality.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects/P117310/results-nutrition-juntos-swap?lang=en&tab=overview
2. METHODS OF DOCUMENTATION	**Desk-based research:** WBG resources: *Project Appraisal Document (PAD) 51149-PE January 2011* *Perova, E., and R. Vakis. 2009. Welfare Impacts of the "Juntos" Program in Peru: Evidence from a Nonexperimental Evaluation. Washington, DC: World Bank* Results and Accountability (REACT) Development Policy Loan (DPL) series program documents RECURSO AAA program documents **Interview with Co-Task Team Leader**
3. WEB SOURCES	http://www.worldbank.org/projects/P117310/results-nutrition-juntos-swap?lang=en&tab=overview https://www.youtube.com/watch?v=mJieb2Xgt9U

Middle East & North Africa

Djibouti – Social Safety Net Project

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Stefanie Koettl-Brodmann, Senior Economist[a] Kevin Hempel, Consultant[b]
ORGANIZATION	World Bank Group (WBG)
ROLE WITHIN THE PROGRAM	[a]Task Team Leader [b]Interim Co-Task Team Leader

PROGRAM OVERVIEW	
1. NAME OF PROGRAM	Social Safety Net (SSN) Project
2. COUNTRY	Djibouti
3. TYPE OF PROGRAM	Public Works Program (PWP) with Food/Nutrition Supplement
4. PROGRAM DURATION	August 2012 to September 2018
5. PROGRAM OBJECTIVE(S)	• Provision of short-term employment opportunities in community-based labor-intensive works for the poor and vulnerable • Improvement of nutrition practices among participating HHs focusing on preschool children and pregnant and lactating women (PLW).
6. FUNDING AGENCY/IES	WBG (IDA) $10 million (expanded to $14 million) Japan Social Development Fund (JSDF) $3.6 million (pilot)
7. IMPLEMENTING AGENCY/IES	Agence Djiboutienne de Développement Social (ADDS) (responsible institution) in collaboration with local civil society organizations (CSOs) (including Union Nationale des Femmes de Djibouti, Association Ecologie du Village d'Adailou), and community-based associations Djibouti MOH World Food Programme
8. TOTAL COST	$13.6 million (expanded to $17.6 million)
9. TARGET GROUP(S)	HHs that participate in the nutrition sessions, i.e. HHs with PLW or children under 2 years old, or both, in Djibouti Ville and all intervention areas (except in the towns of Dikhil and Obock, where the target includes families with children up to 5 years old). Beneficiaries of the nutrition sessions are eligible to register one HH member for the workfare program once a year.
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	**Nutrition activities:** 7,000 individuals (expanded to 15,000 individuals in 2016) Female beneficiaries: 100 percent **PWP:** 5,000 HHs (expanded to 8,000 HHs in 2016) Female beneficiaries: 85 percent
11. NUMBER OF REACHED BENEFICIARIES	**Nutrition activities:** 7,152 individuals (expanded to 12,170 individuals)

PROGRAM OVERVIEW		
12. PROGRAM CROSS-CUTTING THEMES	☐ Double burden of malnutrition (DBM)	☐ Rural
	☒ Multisectoral collaboration	☐ Resilience
	☐ Integrated approach	☐ Conflict-affected setting
	☐ Governance	☒ Harnessing nutrition data
	☐ Decentralization	☐ Use of mobile technology
	☒ Performance-based financing	☒ Behavior change communication (BCC)
	☒ Community participation	☐ Life-cycle approach
	☐ Agriculture and local procurement	☒ Gender and women's empowerment
	☐ Urban	☒ Early child development (ECD)

CONTEXT OVERVIEW	
1. CONTEXT	Djibouti is constantly affected by droughts, which contribute to severe food crises domestically and across neighboring countries and trading partners, such as Somalia, Kenya, and Ethiopia. Income and consumption patterns of the urban and rural poor are severely strained by increases in food prices. Unemployment hovers at 50 percent. Data from 2012 estimated that 48 percent of the population lived in poverty and 23 percent in extreme poverty. In 2009, the infant and under-5 mortality rates were still among the highest in the region, at 75 and 94 per 1,000 live births, respectively. *WBG Report 67605-DJ May 2012, Project Appraisal Document PAD985 October 2014* *WBG Project Information Document Concept Stage AB6994 February 2012* *Poverty and Social Impact Analysis AUS7544 February 2015*
2. COUNTRY INCOME LEVEL	Lower-middle-income
3. KEY CONTEXT DATA	2012 data: • Gross domestic product (GDP) growth: 3.0 percent • Gini index: 45.1 (WBG estimate) • Poverty rate: 48 percent • Extreme poverty rate: 23 percent • Unemployment rate: 50 percent • Share of population with access to improved sanitation facilities: 47 percent 2009 data: • Infant mortality rate: 75 per 1,000 live births • Under-5 mortality rate: 94 per 1,000 live births *World Development Indicators (WDI) and WBG Project Appraisal Document (PAD)*
4. KEY SOCIAL PROTECTION DATA	2014 data: • Public spending on social assistance programs, percent of GDP: 0.2 percent 2012 data: • Coverage of SSNs in total of population: 10.8 percent • Coverage of SSNs in extreme poor: 33.6 percent • Adequacy of benefits of SSNs in total population: 11.9 percent • Adequacy of benefits of SSNs in extreme poor: 21.5 percent • Incidence of benefits of SSNs in extreme poor: 47.3 percent • Incidence of beneficiaries of SSNs in extreme poor: 52.9 percent *ASPIRE database*

CONTEXT OVERVIEW	
5. NUTRITION CONTEXT	Despite recent efforts, malnutrition remains high in Djibouti, with 29.7 percent of children under 5 years old chronically malnourished, 29.6 percent underweight, and over 17.8 percent of children acutely malnourished. Children between the critical ages of 12–36 months old have the highest prevalence of malnutrition. Food insecurity is high, with 55,000 to 70,000 poor and vulnerable people relying regularly on food assistance during the dry season. In addition to increasing the risk of mortality, malnutrition increases the susceptibility to and the duration of severity of various morbidities. Djibouti ranks number 165 out of 187 countries with comparable data in the 2011 HDI. *HDI 2011* *Djibouti SMART survey 2013*
6. KEY NUTRITION DATA	2013 data: Children under 5 years old suffering from • Stunting: 33 percent • Underweight: 29.6 percent 55,000 to 70,000 people rely on regular food assistance during the dry season 2012 data: • Children under 5 suffering from wasting: 21.5 percent *WDI and WBG PAD*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**Community-based labor-intensive PWPs and services**. This component finances the community-based labor-intensive work and service activities of the nutrition-based social safety net program to provide short-term employment to able-bodied members of vulnerable and poor HHs. Under the AF, the maximum number of days of the program was increased from 50 to 75. Each workfare beneficiary receives a card that provides access to a bank account at the local microfinance institution. **Nutrition-based social assistance to support investments in human capital**. This component supports innovative community interventions aimed at preventing malnutrition in preschool children and PLW and enhancing child development. Community-based interventions consist of training and sensitization sessions for mothers, growth monitoring and promotion of children, and provision of food supplements during the lean season. Local community associations, nongovernmental organizations (NGOs) and facilitators provide the interventions directly at the community level through trained community volunteers and facilitators who also provide peer-training and sensitization. **Targeting, monitoring and evaluation**. This component is designed to improve the targeting and monitoring of social programs in Djibouti. The project finances (a) the development of a social registry housed at the SEAS; and (b) the consolidation of an integrated monitoring system (including monitoring surveys) at the ADDS to evaluate the outcome of the program financed by the project. **Project management and administration**. This component provides support to the ADDS in the management, implementation, and coordination of the project.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	DF1,000 ($5.60) daily in urban areas and DF800 ($4.50) daily in rural areas for 75 days. Wages are below the market wage. Payments were intended to be disbursed weekly, but, in practice, they are disbursed biweekly.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The transfer represents an increase of about 15 percent over annual total consumption for beneficiary HHs or about 45 percent of the budget needed to eliminate the food consumption deficit of poor HHs.

PROGRAM DETAILS	
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	**PWP:** The key condition is being enrolled in the nutrition sessions.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Work is performed 6 days per week, from Saturday to Thursday (the typical work week). Work hours are from 7:30 a.m. to noon, including a one-hour breastfeeding break for lactating women.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	PWPs are carried out using labor-intensive construction techniques that mostly rely on an unskilled workforce. Services consist of artisanal activities, street cleaning, garbage collection at the community level, routine and periodic maintenance of feeder roads, production of stone blocks to be used for labor-intensive construction, and rehabilitation of community infrastructure. Under the AF, more emphasis is placed on identifying nutrition-sensitive works and services, such as the development of microgardens in urban Djibouti for growing vegetables and fruits. The scope of activity has been expanded under the AF to include development of manual skills and life-related skills, such as coaching and literacy, for beneficiaries of the PWP.
8. COST BREAKDOWN BY PROGRAM COMPONENT	(WBG): • **Community-Based Labor-Intensive Works and Services:** $4.87 million • **Nutrition-Based Social Assistance to Support Investments in Human Capital:** $1.52 million • **Targeting, monitoring and evaluation (M&E):** $2.93 million • **Project management and administration:** $0.68 million *Total WBG contribution expanded to $14 million in 2016* (JSDF): • **Community-Based Labor-Intensive Works and Services:** $2.14 million • **Nutrition-Based Social Assistance to Support Investments in Human Capital:** $0.76 million • **Targeting, M&E:** $0.38 million • **Project management and administration:** $0.30 million *Costs by category (WBG PWP) can be estimated as follows: Direct costs of transfers (cash wages): 70 percent; Input costs (tools, materials): 13 percent; Administrative costs (component management): 17 percent. Costs of transfers and inputs constitute approximately 35 percent and 7 percent, respectively, of the entire project expenditure.*
9. INSTITUTIONAL ARRANGEMENTS	The project is implemented by the ADDS in cooperation with the MOH and local organizations. The ADDS is an autonomous administrative public institution, which is overseen by the SEAS. The multisectoral design of the project requires strong technical cooperation among institutions with different degrees of involvement, in particular: the MOH, the Ministry of Agriculture, the Ministry for the Promotion of Women, the Ministry of the Interior (regarding the social registry), and the Statistics Office (Department of Statistics and Demographic Studies). Various agreements establish the standards, roles, and responsibilities of the different partner institutions (for example World Food Programme, UNICEF, and FAO) in providing technical support and delivering services through the project.

PROGRAM DETAILS	
10. COMMUNITY PARTICIPATION	The planning of community works and services is collaborative and responds to community needs and potential workforce availability as determined by the registration process. The local development committee, a community-led council, identifies public works to be carried out under the project that will create sustainable community assets. Community works are selected and given priority by the communities from a list of eligible works and a catalogue of standard designs for eligible works of limited size and scope for the upgrading and maintenance of small-scale community assets. These may include the upgrading of community infrastructure such as the paving of footpaths, the construction or rehabilitation of small containment walls for flood control, and small pedestrian bridges and stairs. The project continues to strengthen existing community structures in order to promote sustainability of interventions. Nutrition services are delivered by trained volunteers and facilitators from the community or local associations. Community-based support groups for women are created under the project. Additionally, local leaders organize quarterly community reviews of the implementation of both the nutrition and public works interventions.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The project is a scaling up of the original Djibouti Crisis Response Social Safety Net Project (January 2013 to September 2016). The scale-up of the nutrition-based social safety net program incorporates the following lessons learned during the implementation of the pilot phase (financed through a JSDF grant) and the parent project. First, beneficiaries must be made aware of the link between the nutrition and the workfare programs at the community level. This will be accomplished through short sessions on child malnutrition that will be organized for all beneficiaries of the workfare component, including men, as well as for Community Village Committees, to promote the use of additional income from temporary employment for child nutrition. Second, it is necessary to identify projects that have the potential to improve either food security in the communities (agriculture, water management) or health outcomes (sanitation) in order to maximize the results of the project on nutritional status. Third, it is also necessary to identify work and services that are both gender sensitive and suitable for PLW. Given the high participation of women in the program, more diversified light work and services beyond handicrafts and street cleaning will be identified and work conditions monitored to ensure compatibility with women's schedules. Fourth, workfare will be increased from 50 to 75 days to support women in building assets and gaining skills (such as basic literacy and artisan skills) during their participation in the program. Finally, income-generation support strategies for beneficiaries, such as links with microcredit institutions and training in handicraft activities, will be designed and implemented.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	Strategies to foster a lasting impact beyond the program itself include: (a) using the knowledge gained from the existing program to inform the development of a longer-term national strategy to prevent malnutrition; (b) ensuring the sustainability of the program by committing government resources; and (c) continued strengthening of cooperation between the MOH and the Ministry of Health and Social Affairs, in particular to find a sustainable mechanism to provide incentives for and reward the work of local volunteers (mères conseillères). A second AF was signed in mid-2016 with the explicit objective of promoting the institutionalization of the community-based approach to preventing malnutrition in collaboration with the MOH and to make a preventive approach sustainable over the course of the AF. A second objective will be to adapt the nutrition-sensitive social safety net program to complement a national CT program that will be piloted in 2016.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	The backbone of the project's monitoring system is an MIS, which registers and tracks every project beneficiary and the benefits he or she receives. Beneficiaries are registered when they start participating in the nutrition sessions, and their information (such as attendance, prenatal consultations, and child weight) is regularly updated over the course of the project. The MIS also tracks the payments for the PWP component. In addition, monitoring of the nutrition component includes a supervision plan which defines the schedule of site visits by the ADDS, partner NGOs, and joint visits with representatives from the MOH. At the community level, checklists are distributed at each project location and filled out by supervision staff during their field visits. Monitoring of the PWP is conducted through weekly site visits to monitor progress and collect and register beneficiary attendance in the MIS as a basis for payment. Quarterly meetings with local development committees are conducted in each area of intervention to discuss the progress of both components.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	The primary evaluation of the project is a rigorous impact evaluation to assess the relative effectiveness of the combined nutrition–public works intervention compared to the nutrition intervention alone. To this end, surveys are conducted during the period of the labor-intensive activities as well as nine months later. Focus groups were conducted to better understand beneficiary attitudes and satisfaction with the project.
3. OUTCOME/IMPACT INDICATORS	Outcomes of interest include HH consumption, dietary diversity, time use, labor market participation, and intrahousehold decision making. Project Development Objective indicators: • Direct project beneficiaries • Female beneficiaries • Proportion of women participating in the nutrition sessions who exclusively breastfeed during the first 6 months of an infant's life • Number of person-days of labor intensive community works provided to able-bodied members of poor or vulnerable HHs
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	The process evaluation (from data collected in May 2014) showed that 96 percent of women decide how to spend the money they earned in the workfare program, and 93 percent of them invest it in child nutrition and health. The workfare program has evolved toward more specifically targeting women (services, street cleaning, and artisanal activities) and adapting working hours to their needs. The process evaluation showed that over 90 percent of women are satisfied with the organization of the workfare program. One qualitative survey and a number of quantitative surveys were carried out prior to the start of the program (a baseline in September 2011 in Djibouti Ville and in September 2013 in the towns of Dikhil and Obock) and during the program (May 2013 in two neighborhoods in Djibouti Ville and in January 2014 in one neighborhood of Djibouti Ville). The last survey serves as the baseline for a rigorous impact evaluation to measure the impact of combining the workfare component with the nutrition intervention. These surveys show a consistent trend toward improved nutrition practices. For example, the 2011 baseline survey recorded that in Hayableh (a poor neighborhood in Djibouti Ville), 23.3 percent of PLW and 32.1 percent of children from 6–24 months years followed a diversified diet (defined as consuming foods from at least four different food categories within the last 24 hours). Among beneficiaries of the nutrition-based social safety net program in Hayableh who followed the nutrition component only, the corresponding rates in April 2015 were 70.1 percent and 77.1 percent. Exclusive breastfeeding increased from 14.7 percent to 59.8 percent. These changes will be further monitored as the beneficiaries gain access to the workfare program and the impact evaluation is being carried out. These preliminary results are promising as they point to a potentially high impact intervention, which can, over time, reduce chronic malnutrition.

MONITORING AND EVALUATION	
5. HARMONIZATION WITH OTHER PROGRAMS	The social registry helps the government of Djibouti identify the poor and vulnerable population and where they live. It provides accurate and transparent information on potential beneficiaries, links potential beneficiaries to social safety net programs for which they are eligible, and ensures improved coordination across programs. The project has been liaising with the MOH to generate synergy and ensure the institutional ownership of the program by relevant authorities and stakeholders in the area of nutrition. Specifically, the collaboration seeks to ensure the project's compliance with national rules and procedures related to nutrition while also fostering the active involvement of representatives from the MOH in the planning and implementation of project activities. In December 2015, the WB's Social Protection and Health teams and client counterparts launched a pilot under which "mères conseillères," who support the implementation of the nutrition sessions, will receive the same incentives and rewards for referring pregnant women and malnourished children to the health facilities as do the community workers from the MOH. The pilot targets two health facilities in two urban neighborhoods in Djibouti Ville (Arhiba and Bache á Eau) as well as the two community-based associations in these neighborhoods that implement the nutrition sessions and the workfare program. The pilot program's use of incentive-based rewards from the MOH to the communities who use the funds to run the malnutrition prevention sessions will be an important factor in achieving sustainability of the community-based preventive approach. The pilot will be evaluated in August 2016.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The size of transfer is set to have an impact on nutrition. It represents an increase of about 15 percent over annual total consumption for beneficiary HHs or about 45 percent of the budget needed to eliminate the food consumption deficit of poor HHs. Payments are frequent (in principle weekly, in practice biweekly) and reliable to support the purchase of daily necessities. Women control the income. The great majority of labor-intensive work and service participants are women, who receive the funds and own the bank accounts.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	The program has firm conditions linked to use of services. Only those who are enrolled in the nutritional assistance program are eligible for the PWP. The AF increased the nutrition sensitivity of the program. Nutrition services are offered at the community level to poor HHs with PLW and children from birth to 24 months old, addressing the first 1,000 days. These nutrition services include: • Sensitization and community-based growth monitoring through: (a) sessions on the importance of good nutrition practices; the appropriate use of key micronutrients; the importance of education; improved care practices for children; and cooking demonstrations using available nutritious foods; and (b) home visits by a community worker or facilitator • Distribution of food supplements such as micronutrient supplements (sprinkles) and food supplementation during the lean season for children 6–24 months old • Developing and conducting training on the prevention of malnutrition and promoting growth and child development through sensitization in partnership with the MOH • Providing support to the MOH with respect to the prevention of malnutrition at the community level through training, workshops, and provision of goods for the health centers; cases of acute malnutrition will be referred to the appropriate MOH agency • Support for early identification of pregnancy and promotion of health-seeking behavior, such as prenatal visits, use of iron and folic acids, and vaccinations; adapted BCC on nutrition, health and hygiene promotion, and handwashing; monthly follow-up of weight gain for women; and accompanied referral to health centers and free hemoglobin testing • Activities to stimulate early childhood development for children 3–5 years old in selected areas, through referral to and support of childcare centers

NUTRITION-SENSITIVE RATIONALE	
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The project applies a dual targeting mechanism. Geographical targeting is based on poverty rates. Within the target geographic areas, the beneficiary HHs are selected based on nutrition vulnerability, which identifies HHs with pregnant women and children under 2 years old.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	The PWP specifically targets women by providing light tasks, such as services, street cleaning, and artisanal activities, and adapts working hours to their needs. Moreover, the work hours incorporate regular breaks to accommodate breastfeeding. Low intensity work is provided for PLW, and PLW receive nutritional support.
5. THE PROGRAM HAS NUTRITION INDICATORS	<u>Project Development Objective indicators:</u> • PLW, adolescent girls, and children under 5 years old reached by basic nutrition services • Among women who participated in the nutrition sessions, the percentage who breastfeed exclusively for 6 months <u>Intermediate Result indicators:</u> • Among women who attended the nutrition sessions, the percentage who attended at least three prenatal consultations during their last pregnancy • Among HHs that participated in the nutrition sessions, the proportion of children 6–24 months years old who have a diversified diet • Among those who participated in the nutrition sessions, PLW who have a diversified diet
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	The project is accompanied by a range of M&E activities to inform project implementation and generate knowledge on the effectiveness of linking social protection and nutrition interventions, including: an MIS to capture data on eligible HHs, HHs attending nutrition sessions, and worker data; monitoring and qualitative surveys; and a rigorous impact evaluation. The emphasis on evaluation and learning is helping to establish a stronger focus on results and value for money within the relevant government agencies.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The program is targeted to those populations for which the prevention of malnutrition is particularly important. Geographical targeting is based on poverty rates but within the targeted areas, HHs are eligible if they contain nutritionally vulnerable members, such as PLW and children under 2 years old. By combining behavior change intervention with an income transfer, the program addresses multiple barriers to improved nutrition. The cash-for-work component includes community service and light labor. Each beneficiary can apply for up to 75 days of work that provides a small daily wage. Workfare is available only to HHs that have attended the nutrition interventions, with the female caregiver having first right to decide whether she wants to take the work or delegate it to another HH member. Women are empowered through knowledge about optimal child-care practices and financial transfers. The additional income they earn allows them to apply the recommended nutrition practices. BCC during monthly group sessions and individual home visits is designed to effect change at both the HH and community levels. Growth monitoring sessions for children under 2 years old are organized monthly. Children 6–24 months old receive micronutrient powders and targeted supplements. The program also promotes healthy behavior and accompanies patients referred to health centers for free diagnoses of hemoglobin levels during prenatal care. Community-based nutrition complements the work of the MOH, which focuses on the treatment of acute malnutrition. Moreover, the public works are becoming increasingly nutrition-sensitive, with a focus on hygiene and access to water and income-generating interventions for women. The selection of works and services is adapted to women.

NUTRITION-SENSITIVE RATIONALE	
	The MIS has been designed to fully integrate the two components and conditionality to ensure that individuals recruited for small PWPs and services actually belong to the targeted HH. By helping to build the infrastructure and processes for a social registry, which will allow a broader identification of poor and vulnerable populations for social programs, the project is contributing to the establishment of a national social protection system.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY NUTRITION-RELATED ACCOMPLISHMENTS OF THE PROGRAM	• The project is at the forefront of a longer-term social protection strategy. At the onset of the food crisis in 2008, Djibouti had no social safety net that could be scaled up, and the government focused on food delivery in rural areas. To date, the initial pilot project has turned into a flagship social safety net program for the country and is currently being scaled-up. The multisectoral nature of the project has led to a breakdown of traditional barriers between ministries, fewer turf battles, and an effort to promote the prevention of malnutrition rather than just treating it with curative care. • Traditionally, targeting efficiency has been low in Djibouti, with eligibility criteria based mostly on rigid categories often times ad hoc, and not based on poverty-focused criteria developed using proxy means testing (PMT). By developing the necessary concepts and tools for a social registry that will feed into a national ID system, the project laid important ground for a robust system of identifying, classifying, and targeting HHs to improve the delivery of assistance to them. Moreover, the project's targeting mechanism has been innovative by making attendance at nutrition learning sessions a condition to access to labor-intensive work thereby reducing vulnerability among HHs with children and PLW.
2. INDICATE KEY NUTRITION-RELATED CHALLENGES FOR THE FUTURE OF THE PROGRAM	• The decentralized, community-based delivery model of the nutrition component through local volunteers puts a premium on quality assurance. A continued emphasis on monitoring and training of the local volunteers and facilitators is essential to ensure that the core concepts of the nutrition sessions are consistently delivered. • Although the focus on M&E is a strength of the program, ensuring the timeliness of data collection, entry, and analysis remains a challenge because the decentralized delivery model involves a variety of stakeholders (community volunteers, community-based organizations, and NGOs). Establishing and adapting appropriate protocols for data collection, data quality control, and analysis will be required.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects/P149621?lang=en
2. METHODS OF DOCUMENTATION	**Desk-based research:** WBG resources: *Report 67605-DJ May 2012* *Project Appraisal Document PAD985 October 2014* *Project Information Document Concept Stage AB6994 February 2012* *Poverty and Social Impact Analysis AUS7544 February 2015* External resources: *Human Development Index (HDI) 2011* *Djibouti SMART Survey 2013* **Interview with Interim Co-Task Team Leader**
3. WEB SOURCES	http://www.worldbank.org/projects/P149621?lang=en http://www.worldbank.org/en/news/feature/2014/10/28/developing-a-nutrition-based-social-safety-net-program-in-djibouti

Syrian Arab Republic – Fresh Food Vouchers for Pregnant & Lactating Internally Displaced Women

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Mona Shaikh, Nutrition Advisor
ORGANIZATION	World Food Programme
ROLE IN THE PROGRAM	Strategic planning and technical supervision

PROGRAM OVERVIEW		
1. NAME OF PROGRAM	Fresh Food Vouchers for Pregnant and Lactating Internally Displaced Women	
2. COUNTRY	Syrian Arab Republic	
3. TYPE OF PROGRAM	In-kind transfer (unconditional food voucher)	
4. PROGRAM DURATION	July 2014 to December 2015 (pilot), expected to be scaled-up in 2016	
5. PROGRAM OBJECTIVE(S)	• Improve diet diversity among PLW of internally displaced families in Syria • Raise awareness of beneficial nutrition and health practices	
6. FUNDING AGENCY/IES	World Food Programme	
7. IMPLEMENTING AGENCY/IES	Local NGO partners: Al-Ikhaa (Lattakia), Al-Birr (Homs)	
8. TOTAL COST	$5.9 million per year	
9. TARGET GROUP(S)	PLW with children up to 6 months old in internally displaced and food-insecure HHs receiving World Food Programme emergency food assistance	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	15,000 individuals Female beneficiaries: 100 percent	
11. NUMBER OF REACHED BENEFICIARIES	*As of December 2015:* 10,500 individuals	
12. PROGRAM CROSS-CUTTING THEMES	☐ DBM ☒ Multisectoral collaboration ☐ Integrated approach ☐ Governance ☐ Decentralization ☐ Performance-based financing ☒ Community participation ☒ Agriculture and local procurement ☐ Urban	☐ Rural ☐ Resilience ☒ Conflict-affected setting ☐ Harnessing nutrition data ☐ Use of mobile technology ☒ BCC ☒ Life-cycle approach ☒ Gender and women's empowerment ☐ ECD

CONTEXT OVERVIEW	
1. CONTEXT	World Food Programme is providing emergency food assistance to 4.25 million highly vulnerable and food insecure people affected by the civil conflict in Syria, many of whom are resorting to extreme coping strategies like reducing the number and quality of meals consumed. Nutritious fresh foods are available in the markets, but have become unaffordable for poor HHs because livelihoods have been affected and prices have increased sharply. The World Food Programme voucher program launched in July 2014 aims at improving the dietary diversity of displaced and food-insecure vulnerable PLW, who can use vouchers to purchase fresh fruit, vegetables, dairy products, and meat at participating retail shops. The conflict in the Syrian Arab Republic has entered its fifth year with increasing scale and intensity. Security risks and deteriorating socioeconomic conditions have resulted in large-scale and widespread internal displacement within Syria and an exodus of refugees to neighboring countries. Overall, it is estimated that approximately 4 million women and children in Syria are vulnerable and in need of preventive and curative nutrition services. Markets function in areas that are less affected by the crisis, although food prices have increased during the conflict. Locally produced and nutritionally rich food items, including vegetables and other fresh food items, are readily available in main markets but they are out of reach for poor HHs. The average retail price of wheat flour in Syria increased 388 percent over pre crisis prices (measured in 2011) and increased by an average of 1 percent per month in 2015. The purchasing power of daily wage earners, as reflected by the terms of trade, decreased by 14 percent from November 2014 to May 2015. A combination of price increases and reduction of income-generating opportunities has resulted in reduced access to and consumption of nutritious foods for the most vulnerable segments of the Syrian population. The average HH is spending more than 50 percent of its total expenditures on food. Moreover, at least half of the population is unable to meet basic food needs with its own resources. The most common coping mechanisms adopted by HHs are the reduction in food consumption and the substitution of lower-quality, cheaper food. Low-quality diets, combined with reduced access to health services, increase the population's vulnerability to malnutrition, illness, and disease. *Syria Strategic Response Plan, 2015* *Special Report: FAO/WFP Crop and Food Security Assessment Mission to the Syrian Arab Republic, July 2013* *Syria Food Security Assessment,* World Food Programme*, 2015* World Food Programme *Syria Market Price Watch, November 2015* *Joint Rapid Food Security Needs Assessment II, Syria Ministry of Agriculture/FAO/* World Food Programme*, December 2012* *Rapid Nutrition Assessment, MoH/CBS/UNICEF, 2013* *Syria Humanitarian Assistance Response Plan 2014*
2. COUNTRY INCOME LEVEL	Lower-middle-income
3. KEY CONTEXT DATA	<u>2014 data:</u> • Share of population with access to improved sanitation facilities: 96 percent • Life expectancy: 75 years • Infant mortality rate: 12 per 1,000 live births *WDI*
4. KEY SOCIAL PROTECTION DATA	<u>2010 data:</u> • Public spending on social assistance programs, percent of GDP: 1.0 percent *ASPIRE database*

CONTEXT OVERVIEW	
5. NUTRITION CONTEXT	The overall nutrition situation before the crisis was reported as poor with an estimated prevalence of stunting at 23 percent, wasting at 9.3 percent, and underweight at 10.3 percent. Infant and young-child feeding practices are far from optimal with exclusive breastfeeding rates at 42 percent, while the proportion of newborns introduced to breastfeeding within first hour stood at 43 percent. Micronutrient deficiencies were also recorded in Syria, with the prevalence of anemia in children from birth to 59 months and women of childbearing age at 22.3 percent and 44 percent, respectively, indicating a moderate public health situation. In separate surveys, vitamin A deficiency was reported at 8.7 percent, and iodine deficiency was reported at 12.9 percent. In Deir Ezor, Hama, Al-Raqqa, Damascus, Rural Damascus and Al-Hassakeh, wasting rates were above 10 percent. Recent data indicate a continued poor public health and nutrition situation, poor infant and young-child feeding practices, moderate to severe micronutrient deficiency, and an overburdened health system. PLW are also increasingly vulnerable due to the disrupted delivery of basic services, growing nutrition needs, and increasing health risks, with an estimated 300,000 at risk of micronutrient deficiencies. PLW require nutrition support and education on appropriate feeding practices. After nearly five years of the crisis, during which the public services (health, water, and sanitation) have been significantly compromised and food security of the population negatively affected, nutrition indicators are likely to have deteriorated further. Baseline results of the CT nutrition support program also revealed that 58 percent of those surveyed consumed only two meals a day, while 18 percent consumed just one meal a day. It further showed that 42 percent had poor food consumption and 52 percent had low to medium dietary diversity. *Syria Family Health Survey, 2009* *Ministry of Health, Nutrition Surveillance System data 2011* *Http://Whqlibdoc.Who.Int/Publications/2008/9789241596657_Eng.Pdf* *Syria Nutrition Sector Strategy (MOH, 1998)*
6. KEY NUTRITION DATA	• Prevalence of stunting in children: 23 percent • Prevalence of wasting in children: 9.3 percent • Prevalence of underweight in children: 10.3 percent • Prevalence of anemia in children from birth to 59 months old: 22.3 percent • Prevalence of anemia in women of childbearing age: 44 percent • Vitamin A deficiency: 8.7 percent • Iodine deficiency: 12.9 percent 2011 Data[a]: • Prevalence of anemia in children under 5 years old: 37 percent [a] *WDI*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**Targeting.** Geographic locations targeted have a large concentration of displaced families and a high prevalence of food insecurity. Targeted locations are also relatively stable and safe for beneficiaries and implementers and have functioning markets. At the beneficiary level, targeting is based on household vulnerability to food insecurity. **Voucher delivery.** Two methods of voucher delivery are currently in place—paper vouchers that can be redeemed every other week and e-vouchers, delivered monthly to a debit card, which can be redeemed as required. **Designated retailers.** Selected shops have access to fresh food items (fruits, vegetables, dairy, and meat products) at all times and are easily accessible by beneficiaries. They also have the capacity to administer the World Food Programme voucher system. **Raising beneficiary awareness.** A number of key health and nutrition messages are delivered to beneficiaries through onsite briefings as well as printed materials. **Partnerships.** A partnership has been formed with UNFPA to enhance the health and nutrition benefits to the beneficiaries. On days when vouchers are distributed or recharged, UNFPA mobile clinic teams conduct group education sessions on reproductive health care, maternal nutrition and mother, infant and young child feeding (MIYCF) and facilitate referrals to available programs run by for PLW, such as for antenatal care (ANC), vaccinations, delivery, and family planning services, partners.
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	The food voucher is valued at LS4,800 ($18) monthly and is provided from the confirmation of pregnancy through six months of lactation. Registered beneficiaries may enter the program at any point during this 15 months period. Paper vouchers are redeemable every other week, and the e-voucher is redeemable as required. As the exchange rate is prone to rapid fluctuation, the value of the voucher is reviewed and adjusted periodically.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	Although the objective of the vouchers is to improve diet diversity, it is difficult to prescribe a standard food basket that improves diet diversity for all HHs. The voucher value was determined using the micronutrient requirements of pregnant women as a reference point. According to the joint WHO-WFP-UNICEF statement, the micronutrients that are of particular importance for this target group are iron, calcium, vitamin C, folic acid, vitamin A, and zinc. A reference food basket was created, designed to meet at least 50 percent of the daily intake gap of the six key micronutrients in World Food Programme food rations. Food items that are commonly consumed in Syria and that are richest in the micronutrients were chosen to create the basket. The cost of this reference basket in the local markets determined the voucher value. Beneficiaries can choose any item from the four food categories—fruit, vegetables, dairy, and meat.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	The fresh food voucher provides access to locally produced food, thereby stimulating demand for local production and supporting the local economy.
5. IS THE TRANSFER LINKED TO CONDITIONS?	The food voucher is unconditional. It is provided to all women that meet the beneficiary selection criteria. Although the food vouchers are not conditional, they can be used only to purchase specified fresh foods (fruit, vegetables, dairy products, and meat) from participating retail shops.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.

PROGRAM DETAILS	
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	*Costs by category can be estimated as follows: Administrative costs (targeting, implementation, management, and monitoring): 4 percent of transfer value; Operational and payment and distribution costs (processing, logistics, and cash payments to retailers): 9% of transfer value, including one-off equipment purchase cost; Direct costs of transfers: $18 per woman.*
9. INSTITUTIONAL ARRANGEMENTS	World Food Programme: Program development; advocacy and fund raising; overall management and coordination; implementing partner selection; retail shop selection; voucher management; M&E NGO partners: Selection, verification, and enrollment of beneficiaries; distribution of vouchers; monitoring of shops; and reconciliation of redeemed vouchers Retail partners: Provision of food supplies from specified list; voucher redemption; reporting.
10. COMMUNITY PARTICIPATION	During each voucher distribution, both women and accompanying men attend nutrition-sensitization sessions to raise their awareness of the importance of good nutrition during pregnancy and lactation and of appropriate MIYCF practices. These sessions include both group discussions and dissemination of information and education communication (IEC) materials, including simple graphics for those who are illiterate.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The ability to scale up the program is primarily dependent on the overall security situation and the function of markets. In addition, the availability of partners and retailers meeting the minimum criteria is essential. The program started in two governorates (Homs and Lattakia) with two NGO partners and retailers and is currently scaling up to include additional partners and retailers in the existing locations and to introduce the project into other governorates such as Tartous. In a stable security environment, the program has the flexibility to be scaled up quickly.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	The program provides lifesaving food support for a vulnerable, conflict-affected population and is currently dependent on continued donor support. However, it provides a good working model for a social safety net program with developed capacity in both the NGO and private sectors, which will facilitate scale-up and ownership by national leadership and institutions in the recovery phase.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	Monitoring is conducted continuously from the distribution process of the voucher at the selected distribution centers, to the shop level, to market monitoring and PDM. There are three categories of monitoring: process monitoring, output monitoring, and outcome monitoring. Process monitoring examines how well the voucher system is implemented in targeted areas, whether cooperating partners are complying with World Food Programme guidelines and signed agreements and checks the accuracy of the information reported in partner distribution reports. This involves field visits to voucher distribution sites and conducting household interviews. Output monitoring involves collection of information on the number of beneficiaries assisted and the number of vouchers distributed on a monthly basis to verify the extent to which World Food Programme intervention provided assistance, as set in both the project logical framework and in the partner agreements. Outcome monitoring is conducted systematically to collect and analyze data, the results of which facilitate management decision making on voucher implementation, to identify effects (intended or unintended) of voucher activity on beneficiaries, and to demonstrate accountability at the project and corporate levels. Data collected for outcome monitoring include food consumption, coping strategies, and income sources of targeted HHs.

MONITORING AND EVALUATION	
	Market monitoring is also conducted for selected food items in targeted areas to assist in determining the voucher value and decision making on program adjustments.
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	Evaluation is planned in 2016 after the two-year pilot phase concludes.
3. OUTCOME/IMPACT INDICATORS	Program impact is measured using the individual dietary diversity score of targeted beneficiaries, calculated using standard methodology. The baseline is July 2014 and the project follow-up results will be included in the 2015 project report.
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	Evaluation is planned in 2016 after the two-year pilot phase concludes.
5. HARMONIZATION WITH OTHER PROGRAMS	A partnership has been entered into with UNFPA that will improve access of the beneficiaries to health and nutrition-related services being offered in the area by UNFPA and other partners. These include awareness sessions on health and nutrition topics from mobile health teams; referral to reproductive health clinics for prenatal and postnatal care and vaccinations; referral to free delivery services in selected hospitals; and distribution of hygiene kits.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The voucher can be used only to purchase items from a list of fresh, nutritious foods, which directly encourages beneficial dietary practices. The value of the voucher is based on a reference food basket expected to cover nutritional intake gaps in pregnant women and is reviewed periodically. Vouchers are distributed on a regular monthly schedule and nutrition and health awareness sessions are held on distribution days. Women are the registered beneficiaries of the program, and the vouchers are delivered only to them, which gives them control over the food purchase choices and caters to their needs.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	World Food Programme collaborated with UNFPA and NGOs to ensure consistency in the delivery of complementary health and nutrition benefits to beneficiaries, such as community education sessions on voucher distribution days with information on reproductive health care, maternal nutrition, and MIYCF, and referrals to available services run by partners for PLW, such as micronutrient supplementation, ANC, vaccinations, and delivery and family planning services. Beneficiaries confirmed to be pregnant are referred to reproductive health services provided by other partners, where they can receive micronutrient supplements and vaccinations. This facilitates multisectoral collaboration and partnership in service delivery that includes NGOs and the private sector. In addition, beneficiaries and their accompanying HH members are included in education sessions on appropriate MIYCF practices and the importance of various micronutrients for the health of both child and mother. These sessions, at which IEC materials are distributed, target both men and women to raise their awareness of issues related to mother and child health and recognize both women's and men's influences on child-feeding practices.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	The program targets women from the internally displaced HHs already identified as extremely vulnerable to food insecurity and receiving unconditional World Food Programme food assistance. The program targets PLW during the critical first 1,000 days of life, during which inadequate nutritional intake can lead to lifelong harm.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	The program specifically targets women in their most vulnerable stage of the life cycle and provides nutritional support by providing the diversified diet required for the proper growth and development of the unborn child and health of the mother.

NUTRITION-SENSITIVE RATIONALE	
5. THE PROGRAM HAS NUTRITION INDICATORS	The individual dietary diversity score is used to assess the impact of vouchers on dietary diversity among target beneficiaries.
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The program is an innovative approach by World Food Programme to promote good nutrition among vulnerable and food-insecure women, in particular PLWs. Furthermore, this form of food assistance enables beneficiaries to maintain a level of nutrition similar to what they had before the crisis.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Monitoring reveals that the program has had notable success in meeting its primary objective of increasing dietary diversity. The proportion of PLWs with low dietary diversity decreased from 48 percent during the baseline survey in July 2014 to 1 percent for the first quarter of 2015. During the same period, the proportion of households with a poor food-consumption score decreased to 3 percent in the first quarter of 2015, down from 8 percent in the fourth quarter of 2014, a marked improvement on the 42 percent figure noted in the July 2014 baseline survey.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	The main challenges of the program relate to operational issues resulting from the highly unstable security situation. These include the availability of partners and retailers with the required capacity, electricity, and Internet access, and the fluctuating cost of food, which necessitates frequent market price surveys to determine whether the monetary value of the voucher should be changed. Nutrition-related challenges include the availability and capacity of partners to deliver quality health and nutrition information and referrals to relevant services.

FURTHER REFERENCES	
1. DOCUMENTS	*Syria FFV Concept Note* *Fresh Foods Vouchers Fact Sheet 2015*
2. METHODS OF DOCUMENTATION	World Food Programme Internal documentation
3. WEB SOURCES	No information available.

South Asia

Bangladesh – Income Support Program for the Poorest

INFORMATION ON THE RESPONDENT	
NAME, POSITION & CONTACT	Iftikhar Malik, Senior Social Protection Specialist[a] Aneeka Rahman, Social Protection Economist[b]
ORGANIZATION	World Bank Group (WBG)
ROLE WITHIN THE PROGRAM	[a]Task Team Leader [b]Co-Task Team Leader

PROGRAM OVERVIEW		
1. NAME OF PROGRAM	Income Support Program for the Poorest (ISPP)	
2. COUNTRY	Bangladesh	
3. TYPE OF PROGRAM	Conditional cash transfer (CCT)	
4. PROGRAM DURATION	December 2014 to June 2020	
5. PROGRAM OBJECTIVE(S)	To provide income support to the poorest mothers in selected Upazilas while (a) increasing the mothers' use of child-nutrition and cognitive development services, and (b) enhancing local government capacity to deliver safety net programs	
6. FUNDING AGENCY/IES	WBG (IDA) $300 million Government of Bangladesh (GOB) $3.37 million	
7. IMPLEMENTING AGENCY/IES	Local Government Division	
8. TOTAL COST	$303.37 million	
9. TARGET GROUP(S)	Poor households (HHs) with pregnant women, or mothers of children under 5 years old, or both. Poor HHs are those that fall in the bottom two expenditure quintiles. They will be selected based on their poverty scores in the National Household Database, being developed by the Bangladesh Bureau of Statistics.	
10. NUMBER OF TOTAL TARGETED BENEFICIARIES & SHARE OF FEMALE BENEFICIARIES	600,000 mothers 2.7 million indirect beneficiaries Female beneficiaries: 100 percent	
11. NUMBER OF REACHED BENEFICIARIES	Not yet available.	
12. PROGRAM CROSS-CUTTING THEMES	☐ Double burden of malnutrition (DBM) ☒ Multisectoral collaboration ☐ Integrated approach ☐ Governance ☒ Decentralization ☐ Performance-based financing ☐ Community participation ☐ Agriculture and local procurement ☐ Urban	☐ Rural ☐ Resilience ☐ Conflict-affected setting ☐ Harnessing nutrition data ☐ Use of mobile technology ☐ Behavior change communication (BCC) ☒ Life-cycle approach ☒ Gender and women's empowerment ☒ Early child development (ECD)

CONTEXT OVERVIEW	
1. CONTEXT	Despite remarkable progress in the fight against poverty, reducing extreme poverty is a key development challenge for Bangladesh. Poverty fell from 48.9 percent in 2000 to 40 percent in 2005 to 31.5 percent in 2010. Coupled with this progress was consistent improvement in well-being measured by asset ownership, better-quality homes, improved access to amenities, and increased caloric intake and educational attainment across all income groups. Nevertheless, the latest available data at the time of program design (2014) show that an estimated 26 million HHs (about 18 percent of the population) remain extremely poor. Extreme poverty in Bangladesh is mainly a rural phenomenon: 60 percent of the poor in rural areas are also extremely poor.

CONTEXT OVERVIEW	
	Annually Bangladesh spends over 2 percent of its gross domestic product (GDP) on social protection programs, but there are high levels of leakage and the bulk of the resources go to the nonpoor. To accelerate its poverty reduction rates, Bangladesh needs to make better use of its social protection expenditures. The GOB has set a target poverty rate of 14 percent by 2021. Assuming population growth continues to decline at the same rate as that from 2000–10, achieving this poverty target will require lifting approximately 15 million people out of poverty in the next eight years. Currently, expenditures for social protection within the country are skewed toward a few large programs that primarily address emergencies and seasonal shocks. Programs that target pregnant women and young children are severely limited. Poor targeting of safety net benefits, along with inadequate average transfer amounts at the beneficiary level, also limit the potential of the safety net to reduce poverty. Social protection programs in Bangladesh at present cover only one-third of the poor population. *WBG ISPP Project Appraisal Document PAD957 November 2014.* *WBG Project Information Document Appraisal Stage PIDA11276 August 2014*
2. COUNTRY INCOME LEVEL	Lower-middle-income
3. KEY CONTEXT DATA	<u>2010 data:</u> • GDP growth: 5.6 percent • Gini index: 32.0 (WBG estimate) • Poverty rate: 31.5 percent • Extreme poverty rate: 18 percent • Share of extremely poor living in rural areas: 21 percent *World Development Indicators (WDI) and WBG project appraisal document (PAD)*
4. KEY SOCIAL PROTECTION DATA	<u>2014 data:</u> • Public spending on social assistance programs, percent of GDP: 1.1 percent <u>2010 data:</u> • Coverage of social safety nets (SSNs) in total of population: 24.6 percent • Coverage of SSNs in extreme poor: 34.3 percent • Adequacy of benefits of SSNs in total population: 8.8 percent • Adequacy of benefits of SSNs in extreme poor: 10.6 percent • Incidence of benefits of SSNs in extreme poor: 28.0 percent • Incidence of beneficiaries of SSNs in extreme poor: 39.0 percent *ASPIRE database, Household Income and Expenditure Survey 2010*
5. NUTRITION CONTEXT	The prevalence of undernutrition in Bangladesh is among the highest in the world. Although there has been significant progress in reducing the prevalence of underweight children under 5 years old (from 60 percent in 1990 to 36.8 percent in 2011), progress in reducing wasting and stunting has been less encouraging. The annual rate of reduction in stunting from 2004 to 2011 was only 1.3 percentage points, while the rate of prevalence of wasting stagnated. The latest data available in 2014 showed that, among countries with the largest numbers of stunted children, Bangladesh ranks 6th in the number of stunted children and 17th in prevalence of stunting. The prevalence of low birth weight in Bangladesh is also among the highest in the world at 22 percent as of 2006, and maternal undernutrition is about 24 percent. The high prevalence of infectious disease poses an additional challenge for Bangladeshi children—the interaction between undernutrition and common infections creates a potentially harmful cycle of worsening illness and deteriorating nutritional status resulting in long-term irreversible adverse effects.

CONTEXT OVERVIEW	
	Although the problem of undernutrition affects the whole population in Bangladesh, the poor primarily bear its burden. Poverty also interferes with the access to knowledge and services related to nutrition and proper eating. In addition, both wealth and mother's education are positively correlated with higher vaccination rates among children. Poverty can also hamper school achievement: poor children in Bangladesh exhibit worse educational attainment compared to their nonpoor counterparts. Yet none of the major social safety net programs focus on child nutrition and cognitive development. *Bangladesh Demographic and Health Survey (BDHS) 2011*
6. KEY NUTRITION DATA	2011 data: Children under 5 years old suffering from • Stunting: 41.4 percent • Underweight: 36.8 percent • Wasting: 15.7 percent 2006 data: • Low-birthweight babies: 22 percent • Maternal undernutrition: 24 percent *WDI and WBG PAD*

PROGRAM DETAILS	
1. PROGRAM CORE COMPONENTS	**Cash transfers for beneficiary mothers.** This component finances quarterly CTs to eligible households. Each beneficiary mother is entitled to benefit payments only for the first- and second-born children. Beneficiary mothers receive cash benefits if they fulfill the following coresponsibilities linked to the growth and development of their young children: (a) use of antenatal care (ANC) services up to four times during pregnancy; (b) use of growth monitoring and promotion (GMP) services; and (c) attendance at Child Nutrition and Cognitive Development (CNCD) awareness sessions. **Enhancing local level government capacity.** This component provides the necessary inputs to the Local Government Division (LGD) to facilitate the implementation of the cash transfers (CTs). This includes strengthening the capacity of: (a) Union Parishads (union-level elected councils) to develop a beneficiary list based on the National Household Database (NHD) and register their enrollment into ISPP; (b) community clinics to deliver ANC and GMP services and CNCD awareness sessions; and (c) Union Post Offices to make electronic payments using postal cash cards to beneficiaries who comply with their coresponsibilities. **Monitoring and evaluation.** A robust monitoring and evaluation (M&E) framework is critical to assess the achievement of the program's objectives and the impact of CTs on household poverty and on CNCD outcomes. This component provides the necessary inputs to help LGDs monitor ISPP beneficiary selection, enrollment, compliance with coresponsibilities, payments, case management, and any grievances or appeals. To ensure that activities are being carried out effectively, this component also supports third-party operational review, which will cover: (a) an annual evaluation of program-cycle processes to assess administrative issues and constraints for a sample of locations; and (b) biannual spot checks, including knowledge, attitudes and practices (KAP) assessments on CNCD issues for a random sample of beneficiaries, to confirm that implementation is carried out in accordance with the Operations Manual and to track outcomes.

PROGRAM DETAILS	
2. INDICATE THE TRANSFER - LEVEL - DENOMINATION - FREQUENCY - DURATION	Tk1,200 ($15.50) to Tk1,800 ($23.25) The transfer level varies by type of beneficiary and compliance with specific conditions. There is a natural exit mechanism—the maternal benefit ends once the mother gives birth, and the CT linked to child growth and development ends when the child reaches 5 years old.
3. HOW WAS THE TRANSFER LEVEL DETERMINED?	The transfer represents approximately 15–23 percent of the estimated average monthly per capita expenditure of the target population, who are expected to consume near the lower national poverty line. Evidence from similar conditional cash transfer (CCT) programs suggests limited labor disincentive effects, especially when the level of benefits is within 20 percent of HH income. The proposed benefit amount is adequate without creating an adverse impact on labor supply.
4. IN CASE OF FOOD, IS IT PROCURED LOCALLY?	Not applicable.
5. IS THE TRANSFER LINKED TO CONDITIONS?	Four coresponsibilities are required, depending on the demographic composition of the beneficiary HH. CTs are conditioned on the use of the following services: • Tk200 paid after each visit for up to four quarterly ANC visits by pregnant beneficiaries • Tk500 per visit paid quarterly to mothers for monthly GMP of their children from birth to 24 months old, for up to a total of Tk1,500 in one quarter, plus a bonus of Tk500 if all three visits are completed in a single quarter • Tk1,000 paid quarterly to mothers for quarterly GMP for their children from 2–5 years old • Tk500 per visit paid quarterly for monthly attendance at CNCD awareness sessions by all eligible pregnant women and mothers, for a total of Tk1,500 in one quarter irrespective of the number of children enrolled The incentive structure emphasizes the relative importance of GMP for children from birth to 24 months old and that of CNCD awareness for mothers for all children under 5 years old.
6. IN CASE OF PUBLIC WORKS PROGRAM, INDICATE - WORKING HOURS - DURATION - PERIOD OF THE YEAR IN WHICH WORKS TAKE PLACE	Not applicable.
7. IN CASE OF PUBLIC WORKS PROGRAM, SPECIFY WHICH ARE THE MAIN PW TASKS/ SUB-PROJECTS	Not applicable.
8. COST BREAKDOWN BY PROGRAM COMPONENT	• **Cash transfers for beneficiary mothers:** $267 million • **Enhancing local government capacity:** $32.87 million • **M&E:** $3.5 million

PROGRAM DETAILS	
9. INSTITUTIONAL ARRANGEMENTS	A Project management unit (PMU) has been set up at the LGD to conduct day-to-day project management, specifically the administration of the CTs, and to oversee the coordination with partner agencies and various stakeholders at the District, Upazila and Union levels. The PMU is advised and guided by a Project Steering Committee (PSC), chaired by the secretary of the LGD, which provides oversight to ensure that project activities are well coordinated across the various partner ministries. The secretaries of the partner ministries (Health and Family Welfare, Post and Telecommunications, Statistics and Informatics, and Disaster Management and Relief) are members of the PSC. A Project Implementation Committee, headed by a project director and consisting of representatives from partner ministries, assists in the supervision of the project at all levels to ensure that it follows both GOB and WBG rules and regulations. At the district level, the district commissioner provides overall supervision and guidance of project activities, assisted by the Deputy Director-Local Government. At the Upazila level, the Upazila Nirbahi Officer is the primary official responsible for all project-related processes, assisted by the safety net program supervisor hired for the project. At the Union level, the project has safety net program assistants to manage the SNC at the Union Parishad office.
10. COMMUNITY PARTICIPATION	Community participation is integral to the program. Public outreach, social mobilization, and regular follow-up with mothers are conducted in close collaboration with the Community Support Groups which are linked to the CCs and consist of members of the local community. These groups mobilize the community to raise beneficiaries' awareness and encourage the use of health services offered by the GOB.
11. SCALE UP, SCALE DOWN & SHOCK-RESPONSIVENESS	The National Social Security Strategy (NSSS) 2015 recommends the consolidation of the numerous SSNs into fewer outcome-based life-cycle programs with improved pro-poor coverage. Although Income Support Program for the Poorest (ISPP) is in its very early phase, successful implementation could position it as a flagship SSN that can be scaled up incrementally while nonperforming programs are crowded out.
12. HOW IS THE PROGRAM'S SUSTAINABILITY ADDRESSED?	There is strong country ownership of project activities, as evidenced by the support offered by the LGDs and Ministry of Health and Family Welfare (MOHFW) during the implementation and scale-up of the Shombhob pilot. Public expenditures for SSNs continue to receive priority by the Ministry of Finance (MOF), as shown by the consistent spending of about 2 percent of GDP since fiscal 2008. This emphasis is unlikely to diminish with any change in government. There is an increased recognition among policy makers of the importance of improving the quality of SSN expenditures. The recommendations of the NSSS include setting up a child-focused safety net and developing a single safety-net beneficiary registry—both of which are being initiated by the project.

MONITORING AND EVALUATION	
1. HOW IS MONITORING PERFORMED/ CARRIED OUT?	Project performance monitoring is expected to use the automated MIS in combination with independent assessments, including both third-party monitoring and program impact evaluations. The M&E will include: • Beneficiary data monitoring and compliance verification using the management information system (MIS) • Internal audits of Bangladesh Post Office (BPO) payments by LGDs • Third-party monitoring to (a) conduct an annual evaluation of the project cycle to assess administrative issues and constraints for a sample of locations; and (b) carry out biannual spot checks and KAP assessments on a random sample of beneficiaries on a continual basis • Focus group discussions with participants and nonparticipants to conduct a qualitative evaluation of project outcomes
2. HOW IS EVALUATION PERFORMED/ CARRIED OUT?	Trust Fund resources will be used to finance HH surveys of program participants and nonparticipants to assess the effect of the project on HH poverty and CNCD outcomes over the short and long terms. Both qualitative and quantitative evaluations will be conducted.

MONITORING AND EVALUATION	
3. OUTCOME/IMPACT INDICATORS	Project Development Objective indicators: • Number of ISPP beneficiaries registered to receive cash transfers; • Proportion of ISPP beneficiary HHs in the bottom two expenditure quintiles; • Proportion of ISPP beneficiaries receiving at least 70 percent of their maximum benefit; • Number of unions maintaining a single beneficiary registry for at least five SSNs. The IE study will also look at the effect of cash transfers on • Socioeconomic conditions and food security of beneficiary HHs; • Child nutrition and cognitive development outcomes; and • Readiness for school.
4. AVAILABLE EVALUATION(S) AND KEY FINDINGS	Not yet available. However, ISPP draws on lessons learned from the Shombhob pilot, implemented between 2011 and 2013, to test mechanisms for delivering CCTs through local government to improve human development outcomes for the poorest HHs. The Shombhob pilot provided monthly allowances for 20 months to poor mothers as long as they attended regular monthly sessions on nutrition education and monitored the growth of their children under 3 years old. Another objective of the Shombhob pilot project was to identify a modern service delivery mechanism at the local level. Beneficiary mothers were selected using PMT to ensure the participation of the poorest HHs. Payments were made electronically using debit cards and monitored by an automated MIS. The process evaluation of Shombhob, funded by the South Asia Food and Nutrition Security Initiative (SAFANSI), shows that the targeting system based on proxy means testing (PMT) worked well. Beneficiary HHs have lower per capita consumption levels than those who applied and were rejected. Regular cash transfers made directly to beneficiary mothers using electronic cash cards proved successful. Ninety-five percent of beneficiary mothers reported having received the full amount of their regular payments without incurring any additional costs. The impact evaluation of this project showed that not only were the poorer HHs selected, but also that after having received CCTs for 12 months, beneficiary households experienced a significant increase in monthly household food consumption of 11 percent. Moreover, food expenditures on proteins—meat, eggs, dairy, fish, and pulses—increased dramatically for beneficiary HHs that received the nutrition package. The analysis also finds that the intervention had a significant impact on the incidence of wasting among children who were 10–22 months old when the program started, reducing the prevalence of child wasting by 40 percent. Moreover, the intervention increased the number of mothers with nutrition-related knowledge regarding the importance of exclusive breastfeeding by 8 percent. Encouraged by these results, the Ministry of Local Government, Rural Development and Cooperatives, through its LGD, requested International Development Association (IDA) support to scale up the Shombhob pilot project nationally as part of the country's overall social protection system. *Ferré, C., and I. Sharif. 2014. "Can Conditional Cash Transfers Improve Education and Nutrition Outcomes for Poor Children in Bangladesh? Evidence from a Pilot Project." Policy Research Working Paper 7077, World Bank, Washington, DC.*
5. HARMONIZATION WITH OTHER PROGRAMS	ISPP complements the nutrition services offered under the Ministry of Health and Family Welfare's universal NNS program, which is supported by the Health Sector Development Program, by giving the poorest pregnant women and mothers incentives to regularly use services that are important for child nutrition and growth.

NUTRITION-SENSITIVE RATIONALE	
1. THE PROGRAM PROMOTES INCOME/ CONSUMPTION	The size of the cash transfer is set to have an impact on nutrition. It represents approximately 15–23 percent of the estimated average monthly per capita expenditure of the target population. Payments are frequent and reliable to support expenditures for daily necessities. Because mothers are the recipients of the transfers, women have control over the income.
2. THE PROGRAM PROMOTES CARING AND HEALTH PRACTICES/SERVICES	CTs are given to beneficiaries upon compliance with firm conditions consisting of the use of health and nutrition services and attendance at nutrition and health education sessions. Specific conditions include: • **ANC services:** CCs offer basic ANC services. These services include measuring blood pressure and weight; detection of anemia, jaundice, edema, albumin in urine, and sugar in urine; and counseling on birth planning and recognition of danger signs. Beneficiary pregnant mothers are given an incentive of Tk200 per visit to encourage at least four ANC visits at the CC. Third-party monitoring will be conducted on a regular basis to ensure these services are available in the project locations. • **GMP services:** All children under 24 months old in beneficiary HHs must have their height and weight recorded every month and plotted on a growth chart according to age, while beneficiary children 2–5 years old must have their height and weight monitored quarterly. The mothers receive a copy of the GMP chart that they bring to every GMP session held at the CC. Partner NGOs support the CCs by ensuring follow-up with mothers to discuss the growth of their children and to help them understand the overall health of their child. • **CNCD sessions:** These sessions focus on combining selected growth-promotion activities with early-childhood development issues. To help mothers with a limited educational background, these sessions introduce a single nutrition and child cognitive development topic each month. Flipcharts, posters, and other media materials will be used to help reinforce key ideas and concepts. The sessions will provide general age-specific nutrition information. Having one key topic each month will provide an incentive for families to come back and ensure that they are not getting the same information each time. During these sessions, child cognitive development topics will be presented in interactive scenarios. Discussions will be tailored to different groups of mothers and families.
3. THE PROGRAM TARGETS NUTRITIONALLY VULNERABLE POPULATION	ISPP is implemented in 42 of the poorest Upazilas (subdistricts), which have a high probability of malnutrition of children under 5 years old. Within the selected locations, the program targets at-risk groups having the following two characteristics: (a) HHs in the bottom two expenditure quintiles; and (b) HHs with pregnant women, or mothers of children under 5 years old, or both.
4. THE PROGRAM ACCOMMODATES WOMEN'S NEEDS	Payments are made electronically to beneficiary mothers so as to minimize the time spent traveling to get the transfer.
5. THE PROGRAM HAS NUTRITION INDICATORS	Intermediate Results indicators: • Proportion of ISPP beneficiary pregnant women and mothers who fulfill CNCD coresponsibility • Proportion of ISPP beneficiary pregnant mothers who fulfill ANC coresponsibility • Proportion of ISPP beneficiary mothers who fulfill GMP coresponsibility
6. OTHER ASPECTS MAKING THE PROGRAM NUTRITION-SENSITIVE	No information available.
7. DOES THE PROGRAM CONSTITUTE A BEST PRACTICE?	The program supports local government administration through the establishment of SNCs, using global good practices in building an integrated and comprehensive social protection system. Data, monitoring, and policy objectives are synchronized across programs. The successful implementation and functioning of the SNCs would create the necessary local-level mechanisms to integrate existing safety nets, initially through a common beneficiary registry, and over time through the use of common administrative platforms, for beneficiary identification, enrollment, payments, and grievance procedures. Eventually, numerous cash-based safety net programs in Bangladesh could be consolidated into an integrated system to provide social protection to the poorest.

PROGRAM'S ACCOMPLISHMENTS AND CHALLENGES	
1. INDICATE KEY ACCOMPLISHMENTS OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Not yet available. The program is expected to start in the field in late 2016 with initial assessments expected from 2017.
2. INDICATE KEY CHALLENGES FOR THE FUTURE OF THE PROGRAM IN COMBINING SOCIAL PROTECTION AND NUTRITION OBJECTIVES	Not yet available. The program is expected to start in the field in late 2016 with initial assessments expected from 2017.

FURTHER REFERENCES	
1. DOCUMENTS	WBG Project Appraisal Documents, WBG Project Information Documents, WBG Implementation Status Reports can be found at http://www.worldbank.org/projects/P146520?lang=en
2. METHODS OF DOCUMENTATION	**Desk-based research:** WBG resources: *Project Appraisal Document PAD957 November 2014* *Project Information Document Appraisal Stage PIDA11276 August 2014* *Ferré, C., and I. Sharif. 2014. "Can Conditional Cash Transfers Improve Education and Nutrition Outcomes for Poor Children in Bangladesh? Evidence from a Pilot Project." Policy Research Working Paper 7077, World Bank, Washington, DC* External resources: *Bangladesh Demographic and Health Survey (BDHS) 2011 http://dhsprogram.com /pubs/pdf/PR15/PR15.pdf* **Interview with Task Team Leader and Co-Task Team Leader**
3. WEB SOURCES	http://www.worldbank.org/projects/P146520?lang=en

Notes

1. Households whose food security status has improved sufficiently that they no longer need transfers are expected to graduate from the Program. The key criteria for graduation is that "households achieve food sufficiency in the absence of external support".
2. Direct Support beneficiaries are labor-constrained households, which generally include female-headed HH and those headed by orphans or the elderly.

Appendix A. Case Study Briefs

Africa

Cabo Verde – National School Food and Nutrition Programme

RESPONDENT(s)	Felisberto Moreira, President of Ministry of Education and Sports (FICASE) João Semedo, Director of the National School Food and Nutrition Programme Charlotte Dufour, Nutrition Policy and Programme Officer, Nutrition Division, FAO
TYPE OF PROGRAM	In-kind transfer (school feeding)
PROGRAM DURATION	2010 to present (Government of Cabo Verde) 1979 to 2010 World Food Programme
PROGRAM OBJECTIVE(S)	Encourage school attendance, improve food security and provide a safety net to poor families. The programme aims to provide every preprimary and primary school child with one hot meal per day. The objectives are currently being reviewed, with greater emphasis on nutrition, improving the diversity and quality of the food ration, while promoting local agriculture and enhancing nutrition education.
FUNDING AGENCY/IES	Government of Cabo Verde FICASE: 65 percent External donors (in-kind food donations): 20 percent Parents: 5 percent Ministry of Education and Sports (district-level staff salaries): 4 percent UN Joint Program Support to Food and Nutrition Security in Schools financed by the Luxembourg Development Cooperation: (technical assistance and piloting of diversifying school meals through local procurement)
IMPLEMENTING AGENCY/IES	FICASE and Ministry of Education, with key partners: • Ministry of Health • Ministry of Rural Development • UN Joint Program Support to Food and Nutrition Security in Schools (FAO, World Food Programme, WHO, UNICEF) financed by the Luxembourg Development Cooperation • Local farmers, cooperatives, and traders
TOTAL COST	$5,149,684 (CVEsc 489,200,000)
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	All children in public pre-primary and primary schools, that is, nationwide blanket coverage). Approximately 80 percent are in public primary schools and 20 percent are in public preprimary schools. Additional beneficiaries include poor women, likely unable to obtain any other formal employment, who will be trained and paid as cooks, local farmers from whom food is procured locally, and traders. Targeted: 90,000 children; 1,078 cooks.
PROGRAM CROSS-CUTTING THEMES	Double burden of malnutrition (DBM); multisectoral collaboration; integrated approach; governance; community participation; Agriculture and local procurement; BCC; gender and women's empowerment

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CONTEXT	Cabo Verde is a state composed of 10 arid islands in the Atlantic Ocean, off the coast of Senegal. When the school feeding program was initially launched in 1979 with the support of the World Food Programme, the country was facing extensive drought, malnutrition and mass emigration. The initial objectives were to reduce food insecurity and poverty and encourage school enrolment and attendance. The program was operated with World Food Programme financial and technical assistance until 2010, when, after a transition phase, the government took over its management and funding. Since then, the government has been exploring how to expand the program, in particular for the prevention of noncommunicable disease, which has become a government priority. The government is establishing pilot programs to improve the nutritional composition of the food ration by diversifying it with fresh produce and improving the quality of health and nutrition education in schools.
NUTRITION-SENSITIVE RATIONALE	The program promotes nutrition through the provision of diversified school meals (for current consumption and to shape future healthy eating habits) and through nutrition education in schools and the community. The school meal is an in-kind transfer that can reduce households' expenses on food; create income for farmers and traders involved in local procurement; and create income through employment of school cooks, who are primarily women. The school nutrition program includes the integration of nutrition education into the school curriculum and the use of school gardens for educational purposes. Nutrition education is integrated into the teacher-training program. Nutrition education and courses on healthful food preparation is also provided to cooks. The schools are used as entry points for broader education on nutrition in local communities. The program provides universal coverage of primary school children. The targeting is based on a life-cycle approach: healthful eating habits in school not only enhance the learning capabilities of school-age children but also contribute to better eating habits in adolescence and later life, helping prevent the intergenerational cycle of malnutrition. The provision of school meals can reduce women's workload of food preparation at home. The school cooks are vulnerable women whose jobs represent an important source of income. The program has nutrition indicators. Strong multisectoral coordination involving public and private stakeholders working in agriculture, health, and education makes the program nutrition sensitive. The effective collaboration between these stakeholders creates incentives for the production and consumption of healthful diets.

Ethiopia – Productive Safety Net Program

RESPONDENT(s)	Laura Campbell, Social Protection Specialist, World Bank Group (WBG)
TYPE OF PROGRAM	Public Works Program (PWP) and Unconditional Cash Transfer (UCT) or in-kind transfer (unconditional food transfer)
PROGRAM DURATION	2015 to 2020 Productive Safety Net Program Phase 4 (PSNP4)
PROGRAM OBJECTIVE(S)	Increased access to safety net and disaster risk-management systems, complementary livelihood services and nutrition support for food-insecure HHs in rural Ethiopia.
FUNDING AGENCY/IES	GOE, WBG, DfID, USAID, GAC, Irish Aid, Swedish International Development Authority (SIDA), EKN, the European Union, Danish International Development Agency (DANIDA), UNICEF, World Food Programme

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IMPLEMENTING AGENCY/IES	Ministry of Agriculture (MOA) Ministry of Labor and Social Affairs (MOLSA) Ministry of Health (MOH) USAID channels support to the PSNP4 through NGOs, such as Catholic Relief Services (CRS), Save the Children International (SCI), and Relief Society of Tigray (REST)
TOTAL COST	$3.6 billion
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Chronic and transitory food-insecure households (HHs) in rural Ethiopia. Targeted: 10 million individuals. Starting with the existing PSNP3 caseload, PSNP4 will increase coverage to become a national program.
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; integrated approach; community participation; rural; resilience; BCC; gender and women's empowerment
CONTEXT	Ethiopia, one of the world's poorest countries, has made substantial progress on social and human development over the past decade. Ethiopia is ranked 173 out of 187 countries in the HDI of the UNDP. Strong economic growth has helped reduce poverty in both urban and rural areas. Since 2005, 2.5 million people have been lifted out of poverty, and the share of the population below the poverty line has fallen from 38.7 percent in 2004–05 to 29.6 percent in 2010–11 (using a poverty line of close to $1.25 per day). Ethiopia met its Reduce Child Mortality Millennium Development Goal several years early, slashing the number of child deaths by two-thirds from one of the highest mortality rates in Africa. The country has also made dramatic progress in its Improve Maternal Health Millennium Development Goal, reducing the maternal mortality ratio by 70 percent. Today, 49 percent of the rural population has access to safe drinking water, up from just 3 percent in 1990, and 28 percent has access to improved sanitation facilities—up from less than 1 percent in 1990. Twenty-five years ago, only 20 percent of primary school–age Ethiopian children attended school. Today, 80 percent are in school. Nearly 60 percent of Ethiopian children finish primary school, up from just 20 percent in 1999. Ethiopia's impressive poverty reduction has been credited to three primary factors: economic growth; infrastructure investments; and the PSNP. PSNP has had substantial household and community-level effects. Through transfers alone, PSNP has reduced poverty by 7 percent. Public works have contributed significantly to the gains outlined above, transforming many rural communities. More rural communities have access to health posts, where they can obtain critical primary care and antenatal checkups. The building of roads and schoolrooms enables rural families to send their children to school. In addition, land rehabilitation, irrigation, and road construction have improved the livelihoods of small-scale farmers and entrepreneurs and have made markets more accessible.
NUTRITION-SENSITIVE RATIONALE	PSNP transfers are designed to reinforce HH income during the agricultural slack season to help HHs smooth their consumption and avoid asset depletion. A recent impact evaluation concluded that the program is smoothing HH consumption and protecting assets even during times of crisis. Evidence from 2012 shows that HHs tend to spend 75 percent of CTs on consumption and 25 percent on investments. PSNP previously provided 15 kg of cereals per person per month (or its cash equivalent). PSNP4 provides 15 kg of cereals plus 4 kg of pulses per person per month (or its cash equivalent), which supplies the recommended caloric requirement of 2,100 kcal per day. For food beneficiaries, this means a direct nutritional benefit from the consumption of pulses. For cash beneficiaries, it means an increased CT to purchase pulses or other nutritious foods. Actions to enhance women's control over the use of cash or food transfers include the development of community conversation manuals and guidelines to promote awareness of the use of transfers for improved HH food and nutrition security;

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	education of communities and kebele Appeals Committees (PSNP's grievance redress mechanism) on the issue of inappropriate use of transfers; piloting of approaches to ensure that women benefit equally from transfers; and training on intrahousehold dynamics regarding transfers and PW. PSNP4 will facilitate the formation of development groups comprising 20–30 village members to participate in livelihood interventions. These groups can promote nutrition-sensitive income-generation activities. For example, in areas where critical nutrition-related services (such as milk marketing or the processing of complementary foods for young children) are identified as a potential income-generation activity, PSNP4 may support their inclusion as off-farm enterprises eligible for program support. These groups will also provide an entry point for supporting active link to the health and nutrition education and training provided by HEWs and for nutrition and health related BCC. Increased focus on livelihoods might increase household income, which can lead to improved caring practices if combined with nutrition and health care BCC. The program has nutrition indicators.

Kenya – Cash Transfers for Orphans and Vulnerable Children

RESPONDENT(s)	Emma Mistiaen, Social Protection Specialist, World Bank Group (WBG) Michael Mutemi Munavu, Social Protection Specialist, WBG Cornelia Tesliuc, Senior Social Protection Specialist, WBG
TYPE OF PROGRAM	Unconditional Cash Transfer (UCT) with Food/Nutrition Supplement
PROGRAM DURATION	October 2013 to December 2016 (AF) 2009 to December 2015 (parent project)
PROGRAM OBJECTIVE(S)	To increase access to the social safety net for extremely poor orphans and vulnerable children (OVC) HHs and to build the capacity of the government to more effectively deliver the NSNP
FUNDING AGENCY/IES	WBG (IDA) $10 million WBG (IDA) $50.0 million (parent project) DfID $56.40 million
IMPLEMENTING AGENCY/IES	Government of Kenya: MLSSS (Department of Children's Services) - now the Ministry of East African Community Affairs, Labour and Social Protection
TOTAL COST	$66.4 million (AF) $126 million (parent project)
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	HHs that (a) include as permanent members OVC from birth to 17 years old; (b) are extremely poor; and (c) are not the beneficiary of other cash transfer programs that directly support OVC beneficiaries Targeted: 500,000 HHs having approximately 5 members per households (HHs) on average, for a total of 2,500,000 individual beneficiaries
PROGRAM CROSS-CUTTING THEMES	Use of mobile technology; BCC
CONTEXT	In spite of a decade of relatively strong economic growth, high rates of poverty persist in Kenya. Latest available data show that poverty rates tend to be higher among vulnerable groups such as children (53.5 percent), including OVC (54.1 percent), older people (53.2 percent), and people with disabilities (57.4 percent).
NUTRITION-SENSITIVE RATIONALE	The size of the cash transfer is set to have an impact on consumption and represents approximately 20 percent of estimated average monthly households (HHs) expenditures.

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	The transfer payment is linked to attendance at growth-monitoring appointments and to the use of vitamin A supplements, as well as attendance at health and education awareness-raising activities at the community level. Health education covers the importance of good diet, locally available resources, the need for well-child visits, and broader health issues such as HIV/AIDS. The program targets at-risk groups. Eligibility is determined in each area using the characteristics of extreme poverty, such as availability or lack of resources, and number of meals per day. The CT-OVC pilot conditions the transfer payments on compliance with coresponsibilities to test the extent to which penalties improve the behavior of beneficiaries with respect to the health and education outcomes of the children under their care. Use of biometric smart cards and local "agency banks" in communities have the potential to reduce the time beneficiaries spend collecting their transfer payments.

Mali – Emergency Safety Nets project (Jigisèmèjiri)

RESPONDENT(s)	Philippe George Leite, Senior Social Protection Economist, World Bank Group (WBG)
TYPE OF PROGRAM	Unconditional Cash Transfer (UCT)
PROGRAM DURATION	April 2013 to June 2018
PROGRAM OBJECTIVE(S)	To provide targeted cash transfers to poor and food-insecure HHs and to establish building blocks for a national safety net system in Mali
FUNDING AGENCY/IES	WBG (IDA)
IMPLEMENTING AGENCY/IES	Government of Mali: Unité Technique de Gestion Filets Sociaux (UTGFS) attached to the Ministry of Economy and Finance and Budget (MEFB)
TOTAL COST	$70 million
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Chronically food-poor HHs in rural areas of the five regions in the south of the country and in the urban areas of the Bamako district. The UCT targets HHs according to their poverty levels, needs, characteristics and capabilities, such as HHs having fewer than 2 meals a day, with children or elderly, or no source of income. Targeted **UCT:** 62,000 HHs. Targeted **Social Registry:** 122,000 HHs at the end of the fifth year.
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; community participation; urban; rural; resilience; BCC
CONTEXT	Mali is a landlocked country in the Sahel with a narrow natural-resource base, rapid population growth, and high poverty levels (43.6 percent in 2010). Recent political events, combined with Mali's vulnerability to environmental, social, political and economic shocks (including from both international prices and climate), have aggravated the living conditions of a large majority of the country's population.
NUTRITION-SENSITIVE RATIONALE	The size of the CT is set to have an impact on nutrition. The level of transfer is calculated to be: (a) commensurate with available international evidence on CT (below 15 percent of a national poverty line and below 20 percent of beneficiary HHs' expenditure levels); (b) likely to have a significant impact on the level and quality of households (HHs) food consumption; and (c) likely to reduce the food-poverty headcount by 4.6 percent and the food-poverty gap by 5.8 percent.

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	The Pilot Preventive Nutrition Package (PPNP) provides flour, soy, peanuts, sugar, iodized salt, minerals, and vitamins. The PPNP also provides fortified nutritional supplements (farine enrichie) that are approved by the Comité Technique National, which includes members of the MEFB, the MOH, the Ministry of Education, the Ministry of Rural Development, the Ministry of Women, Family and Children, and the Ministry of Social Affairs and Solidarity. This fortified supplement is designed for preventive care, and other partners may consider complementary interventions to address the acute malnutrition in the selected areas. All children under 5 years old in the selected areas are eligible for this component. The program has an explicit nutrition component, AM linked to health and nutrition through soft conditions. That is, it aims to promote behavioral changes through AM sessions focused on health and nutrition delivered by NGOs. AM sessions are open to all adults who would like to learn good human development practices. Program implementers are monitoring actual attendance of beneficiaries to determine whether to make attendance a firm condition. The program also has a PPNP as a complementary intervention to AM sessions focusing on preventive care for children and pregnant women that will be tested in a few villages. About 20 villages out of the 106 selected for the CT have been identified for this pilot according to the AM agencies' capacity to deliver in-kind nutrition packages. In selected villages, an information campaign has been carried out to inform the communities that the nutrition packages would be provided to all children from birth to 59 months old and pregnant women during the AM sessions. The AM agencies that are providing the education sessions distribute the nutrition packages and inform attendees during the sessions how to use the products. The nutrition packages are tailored to each zone of intervention according to the population's needs. The program has been implemented in all five regions in the south (Sikasso, Segou, Mopti, Koulikoro, and Kayes) and in the district of Bamako, but these regions can be ranked (if necessary) according to an index that combines poverty levels from the Institute of Statistics (INSTAT) poverty map and the SAM index from UNICEF. Within each region, districts are ranked based on a weighted index that combines poverty and infrastructure indicators from INSTAT. Within each district, communes are ranked based on a poverty index that combines poverty and infrastructure indicators from INSTAT and a community level infrastructure index from the Observatory for Sustainable Human Development. UTGFS started implementation in a few of the poorest communes of the country, selected from up to three of the poorest districts in each of five regions (plus Bamako) in the southern part of the country. The selection of areas of intervention (regions, districts, and communes) was done on the basis of a geographic-targeting process that combined socioeconomic indicators. As communes were selected, quotas for the number of expected beneficiary HHs in each village were determined, but all villages in the commune are deemed eligible. The final list of HHs is approved by the villagers, and the community committee is responsible for informing the selected HHs. Once a commune has been selected, the community committee, district regional staff, regional staff and UTGFS sign an agreement endorsing the program and defining the specific institutional responsibilities for the operation. Once potential beneficiaries have been identified, key data are collected by a third party (most likely staff from National Statistics Office) for each of these HHs and entered in the unified registry of beneficiaries at the district level. The program has nutrition indicators.

Niger – Niger Safety Net Project

RESPONDENT(s)	Ali Mory Maidoka, Coordinateur National, Cellule Filets Sociaux, Government of Niger Patrick Premand, Senior Economist, World Bank Group (WBG) Carlo del Ninno, Senior Economist, WBG
TYPE OF PROGRAM	Unconditional Cash Transfer (UCT) and Public Works Program (PWP)
PROGRAM DURATION	September 2011 to June 2017 Additional Financing (AF) to further expand the project is under preparation.
PROGRAM OBJECTIVE(S)	Establish and support an effective safety net system that will increase access of poor and food-insecure people to CT and cash-for-work programs
FUNDING AGENCY/IES	WBG (IDA)
IMPLEMENTING AGENCY/IES	CFS of the Office of the Prime Minister, in collaboration with many local NGOs
TOTAL COST	$70 million
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	UCT – target group: Chronic poor HHs Targeted UCT: 80,000 HHs (targeted to the first wife in polygamous HHs) PWP – target group: HHs in communities affected by temporary food insecurity caused by unpredictable events The project is implemented in the regions of Dosso, Maradi, Tahoua, Tillabery, and Zinder, which have the highest incidence of poverty and where 95 percent of the poor of Niger live. Targeted PWP: 60,000 individuals (at most one individual per HH)
PROGRAM CROSS-CUTTING THEMES	Community participation; rural; resilience; BCC; gender and women's empowerment; ECD
CONTEXT	Niger is one of the poorest countries in the world and faces severe challenges in early childhood nutrition and development. In 2011, when the project was designed, it was estimated that 48.9 percent of the population in Niger lived on less than $1.25 per day, and 75.23 percent on less than $2 per day. More than 50 percent of Niger's population was food insecure, with 22 percent of the population suffering from chronic food insecurity (per capita consumption of less than 1,800 kcal/person/day) in any given year. Human development indicators are particularly alarming for children. The infant mortality rate was 66.4 per 1,000 live births in 2010. Seasonal and acute malnutrition are also very high. Recent food crises (for example in 2001, 2005, 2008, and 2010) brought on by local droughts and international high prices, have exacerbated the vulnerability of the poor to food insecurity. Historically, most of the safety net programs operated in Niger provided ad hoc emergency assistance. The effectiveness of these programs in reducing chronic food insecurity is limited.
NUTRITION-SENSITIVE RATIONALE	UCT payments are designed to address food insecurity by providing small, yet regular and predictable transfers over a relatively long period of time (24 months). This contrasts with the approach of many humanitarian interventions that provide larger amounts but for a shorter period of time, usually after a crisis or temporary shock. The UCT is given to women representing the HH, typically the first wife of the head of HH. The CT program includes the soft conditions of parenting training and activities for beneficiaries. The UCT is accompanied by soft conditions of parenting training and activities for beneficiaries. The parenting training is a BCC (volet comportemental). The training curriculum builds on the "essential family practices" package developed by UNICEF and adopted by the government of Niger, but goes beyond the package to provide a holistic approach to children's development by promoting improvements in parenting practice on nutrition, psychosocial stimulation, health and sanitation.

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	As part of the coresponsibilities of the UCT, each beneficiary HH participates in three activities per month: a village assembly led by an NGO operator, a small-group meeting led by a community educator, and a home visit by the community educator. One village assembly is organized for every 50 beneficiary HHs on average. The village assembly is open to nonbeneficiary households in those villages as well. The community educator leads one small-group meeting (causerie) for a group of 25 beneficiaries each month. The community educator also visits each HH in the group each month. The household visit lasts two hours and includes educational content. The curriculum covers child nutrition (such as exclusive breastfeeding for the first 6 months, complementary feeding after 6 months, recognizing signs of malnutrition and referring malnourished children to health services, vitamin A supplementation, deworming, and iron absorption); health (the use of preventive health services to protect children against disease, health visits for children at the onset of illness, hygiene and hand washing, and family planning); psychosocial stimulation (language stimulation, stimulation through play, school readiness, brain development, and sleep management); and child protection (birth registration, discipline, punishment and conflict management, attachment, and psychosocial development). The program targets chronically food-insecure HHs, in areas where chronic poverty and food insecurity are prevalent. Geographical targeting is used to select the poorest regions and communes to participate in the CT program. Within the five regions, departments and communes eligible for the CT program are selected based on information available as to poverty, vulnerability, and food insecurity and validated through stakeholder assemblies. In the selected communes, many more villages are eligible than the project could serve. To ensure full transparency and equal chances of participation for all villages, public lotteries are implemented to select beneficiary villages from among all equally eligible villages. In each commune, the public lotteries were carried out in the presence of village chiefs, commune authorities, and program staff. Within selected villages, proxy means testing is used to identify the most chronically poor HHs. The community validates the final list of beneficiaries. The schedule of the AM is determined after consultation with beneficiaries to ensure that their timing does not conflict with other activities. The program does not include nutrition indicators in its results framework, but the impact evaluation will measure effects on nutrition indicators. As part of the proposed AF, the project is being restructured to be more adaptive, efficient, and responsive to strengthen the ability of poor and vulnerable HHs to respond to shocks and build their resilience. Adaptive social protection programs can protect poor HHs from climate and other shocks before they occur (through predictable transfers, building community assets, and other programs that help them cope).

Nigeria – Child Development Grant Program

RESPONDENT(s)	Kerina Zvogbo, Social Protection Advisor, Save the Children International (SCI) Mercy Jibrin, Nutrition/BCC Advisor, SCI Solomon Bahiru, Deputy Program Manager, SCI
TYPE OF PROGRAM	Unconditional Cash Transfer (UCT)
PROGRAM DURATION	April 2013 to March 2018
PROGRAM OBJECTIVE(S)	Goal/Impact • Improved nutritional status of children under five in Jigawa and Zamfara States.

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	Purpose/Outcome • A scalable program showing how cash transfers can bring cost-effective immediate and long-term food security and nutrition benefits to poor households with young children in northern Nigeria.
FUNDING AGENCY/IES	UK AID
IMPLEMENTING AGENCY/IES	SCI Action Against Hunger (AAH) Government of Nigeria: Ministry of Local Government and Economic Planning Stanbic IBTC (service provider for the delivery of CTs)
TOTAL COST	$78 million
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Pregnant women in randomly selected villages in five local government areas in Zamfara and Jigawa States. Targeted: 90,000 pregnant women
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; community participation; rural; resilience; use of mobile technology; BCC; life-cycle approach; gender and women's empowerment
CONTEXT	Poverty, hunger and malnutrition are widespread in northern Nigeria and affect the potential for children to survive and thrive. Sixty-four percent of Nigeria's 158 million people live on less than $1.25 per day. Approximately, 77 percent of the population is poor. Nationally, nearly one in five children under the age of 5 dies each year. In the north the rate is 40 percent higher, and about one-third of the deaths are caused by malnutrition. Maternal mortality rates are three times the national rate. More than two-thirds of girls 15–19 years old cannot read, and only 3 percent finish secondary school. Development efforts will have limited impact until the root causes of food insecurity and malnutrition are addressed. Poverty, social exclusion, a growing sense of injustice, and frustration with corrupt and chronically weak governments have been exploited by radical religious ideologues. This has led to instability and conflict that are growing worse and spreading elsewhere in the country. If it continues, progress in reducing poverty will remain beyond reach. Inclusive broad-based and poverty-focused development in the north is an essential part of the solution to this problem. Compared to other African countries, Nigeria's social sector spending as a percentage of GDP is relatively low, and the allocation to social protection is even lower.
NUTRITION-SENSITIVE RATIONALE	The size of the CT was determined by the cost of an easily accessible nutritious diet. Payments are reliable and delivered on a monthly basis. The CT is delivered to women; the PDM and impact evaluation will determine whether women maintained control over the income or whether they had input into the use of the cash. Although the Child Development Grant Program (CDGP) is primarily a CT program, it has the potential to improve the food and nutrition security of the beneficiary HHs. The program is strongly linked to BCC activities (soft conditions) and promotes behavioral changes through exposure to MIYCF trainings, support groups, one-on-one counseling, food demonstrations, drama groups and mass media focused on BCC. CDGP food demonstration sessions provide guidance on how to prepare nutritious meals for beneficiaries and their children 6–23 months old. They also receive educational information to promote handwashing, personal hygiene, and health-seeking behavior. The program promotes capacity building through maternal, infant, and young child feeding trainings at the community level. The program universally targets an at-risk age group, children in the first 1,000 days and pregnant women. Support starts when a pregnancy is confirmed and continues until the child reaches the age of 2. The program is implemented in the northern Nigeria, which has high numbers of malnourished children. The states and local government areas that are participating in the program were selected in part based on high malnutrition indicators.

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	Payment agents deliver the cash to the communities in which the women live, which minimizes the participants' travel time and cost of transport. As mobile payments develop within northern Nigeria, the program will transition to a community-agent-based model, which will enable women to access their payments at a convenient time during the month. The nutrition indicators for the program are built into the program's logical framework and carry the same weight as the CT component. At outcome levels, the program indicators measure dietary diversity and the rate of exclusive breastfeeding. The output indicators measure the reach of the BCC activities. The program also measures involvement of beneficiaries in support groups and support group activities, the coverage of mass media, and improvement in knowledge and practice on health and nutrition. The program is research-oriented. An impact evaluation will be conducted by an external evaluation team under contract with DfID that will assess the impact of high intensity and low intensity nutrition BCC in two different treatment groups and a control. CDGP improves resilience by providing support throughout the year, especially during the hunger season, which typically runs from March until September.

Republic of Congo – Nutrition-Sensitive Urban Safety Net Program

RESPONDENT(s)	Gautier Massamouna, Assistant Vulnerability Analysis and Mapping Officer, World Food Programme David Bulman, Country Director, World Food Programme Koffi Akakpo, Deputy Country Director, World Food Programme Angele Ayenoue, Programme Officer and HIV/Nutrition, Focal Point, World Food Programme Thibaut Ackondjo, Senior Programme Assistant, Safety Net, World Food Programme
TYPE OF PROGRAM	In-kind transfer (conditional food voucher) with Food/Nutrition Supplement
PROGRAM DURATION	January 2015 to December 2018 April 2012 to December 2014 (pilot)
PROGRAM OBJECTIVE(S)	Strengthen the capacity of the government to implement a safety net program to reduce hunger and improve access to basic and social services for the most vulnerable populations by • Improving food consumption of vulnerable populations • Ensuring access to care for pregnant and lactating woman (PLW) and children under 2 years old • Improving the living conditions of households affected by HIV or TB or both • Supporting treatment adherence with antiretroviral therapy or directly observed treatment, short course, by people living with HIV (PLHIV) and people with TB, respectively
FUNDING AGENCY/IES	Government of the Republic of Congo (60 percent) World Food Programme (40 percent)
IMPLEMENTING AGENCY/IES	World Food Programme Ministry of Social Affairs, Humanitarian Action and Solidarity
TOTAL COST	$24,223,139

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TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Households (HHs) with less than $60 income per month, and one of: (a) a PLW; or (b) a PLHIV or person with TB under treatment and malnourished; or (c) at least two school-age children not attending school. Targeted: 117,600 individuals (19,600 HHs), including 81,600 PLW (69.39 percent of targeted individuals).
PROGRAM CROSS-CUTTING THEMES	Double burden of malnutrition (DBM); integrated approach; urban; resilience; harnessing nutrition data; use of mobile technology; BCC; gender and women's empowerment
CONTEXT	Although the Republic of Congo is an oil-rich, middle-income country, more than half of the population live below the poverty line. Food insecurity affects 5 percent of the population (approximately 216,000 people), while high undernutrition has produced a stunting prevalence of 30 percent among children under 5 years old. The mortality rate of children is 128 per 1,000 live births, one of the highest rates in the world. The UNDP Human Development Index of 2013 ranked the Republic of Congo at 140 out of 187 countries, placing it in the "low" category for human development. Poverty affects 46.5 percent of the population. The Gini coefficient is 0.43, indicating significant inequalities. Of the estimated 4.2 million inhabitants, 64 percent live in urban areas, mainly in Brazzaville and Pointe-Noire. According to the index of world hunger, the score of the Republic of Congo, rose from 18.4 in 2005 to 20.5 in 2013. The Republic of Congo imports 75 percent of its food. In 2011, food imports exceeded $400 million.
NUTRITION-SENSITIVE RATIONALE	The electronic voucher is sent to beneficiary HHs using mobile money, providing access to a selected range of food commodities with a ceiling on cereals to ensure a nutritious balanced diet. The voucher can be used to purchase of fresh products including fruits, vegetables, and meat. Through this nutrition-sensitive approach, the program addresses the immediate determinants of undernutrition (such as inadequate dietary intake and disease), and targets the complex and interrelated underlying determinants (such as poor practices for food use, insufficient health services, and inadequate care for children and women). World Food Programme food and nutrition assistance to vulnerable HHs provides incentives for the use of and access to basic social services provided by the government. The use of conditional voucher transfers not only reduces hunger and immediate poverty, but also promotes positive behaviors that increase resilience to food insecurity and undernutrition in the long term. A program for BCC supports the project through campaigns to promote better feeding and hygiene practices for infants, children, PLW, PLHIV, and persons with TB. Training for health workers and awareness workshops conducted on the benefits of a balanced and diversified diet and the importance of health monitoring and vaccinations. Brochures and publications are provided on these topics. The program targets PLHIV and TB malnourished-vulnerable individuals. They are assisted in a supplementary feeding program for the treatment of MAM. Along with PLW, these groups are followed through awareness programs for balanced diets, to fight against all forms of malnutrition during pregnancy, and to ensure the nutritional status of children in the first 1,000 days. PLW are trained in food practices through BCCs and nutrition education sessions. Food vouchers are delivered electronically through mobile money. The program has nutrition indicators. The project contributes to the Republic of Congo's capacity to address hunger reduction, which will lead to the development of a national social protection policy. The program has created strategic partnerships (including for the nutritional health training of FEFA and health workers) with UNICEF and the Ministry of Health's National Nutrition Service. FAO and IFAD expertise assist the program in rural areas and support a multi-sectoral approach to the implementation of exit strategies for HHs in the project.

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	The project includes exit mechanisms that can increase household resilience. Beneficiary HHs are assessed for participation in livelihood-related projects such as income-generating activities, training for trades and cooperatives, and other group activities. Contracts have been signed between the Ministry of Social Affairs, World Food Programme and partners with expertise in the establishment of microbusiness training and support for income-generating activities.

Tanzania – Tanzania Productive Social Safety Net

RESPONDENT(s)	Muderis Abdulahi Mohammed, Senior Social Protection Specialist, World Bank Group (WBG)
TYPE OF PROGRAM	Conditional Cash Transfer (CCT) and Public Works Program (PWP)
PROGRAM DURATION	August 2012 to December 2017 (extended to December 2019)
PROGRAM OBJECTIVE(S)	To create a comprehensive, efficient, well-targeted productive social safety net for vulnerable sections of the Tanzanian population.
FUNDING AGENCY/IES	WBG (IDA) $220 million (expanded to $420 million in 2016) Government of Tanzania $4 million DfID $16 million (expanded to $186 million in 2016) Government of Spain $0.9 million (expanded to $75.90 million in 2016)
IMPLEMENTING AGENCY/IES	Tanzania Social Action Fund
TOTAL COST	$240.90 million (expanded to $685.90 million in 2016)
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Poor and vulnerable households (HHs) living in Project Area Authorities (PAA) and villages identified as being worst affected by poverty. In addition to the direct beneficiaries, HHs living in selected villages benefit from the creation of community assets under the labor- intensive public works component of the program. Targeted: 1,100,000 extremely poor HHs (comprising 6 million people) living in selected villages. The program is implemented in all districts. (expanded to 1,700,000 HHs in 2016)
PROGRAM CROSS-CUTTING THEMES	Integrated approach; community participation; BCC; gender and women's empowerment
CONTEXT	The latest available data in 2007 showed that income poverty in Tanzania was very high, with 33.6 percent of the population living below the basic needs poverty line and 16.6 percent, or 6.4 million people, living below the food poverty line. The poor in Tanzania remain overwhelmingly rural. Eighty-four percent of the vulnerable poor are in rural HHs, highly dependent on agriculture (74 percent) both for income and food consumption. The average rural HH is larger than its urban counterpart (6.7 members compared to 5.7 members), has a higher proportion of dependents (children under 15 years old and elderly over 61 years old) than its urban counterpart, and has less adult labor force capacity, further limiting income earning opportunities and exacerbating poverty.
NUTRITION-SENSITIVE RATIONALE	The objectives of the CCT are increasing HH consumption throughout the year and improving food consumption (quantity and quality of meals), thus helping to reduced food insecurity, while creating an incentive for extremely poor HHs to invest in the education and health of their children and pregnant women and prevent chronic malnutrition. In addition, cash (for both CCT and PWP) is disbursed only to women, giving them control over income. If this is not feasible, a guardian receives the benefit. The livelihood component of the project, particularly the community savings program, provides necessary skills and technical support to the groups (mainly women) and assists HHs in diversifying income and consumption.

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	The program coresponsibilities promote health, nutrition, and caring practices. For example: • Children under 24 months old must be brought for routine health services once per month • Children 24–60 months old must be brought for routine health services once every six months • In areas where no health services are available, primary care providers for children under 60 months old must attend community health and nutrition sessions every two months • Pregnant women must attend at least four prenatal visits, deliver at health facilities or be assisted by skilled personnel, and attend a postnatal checkup • In areas where no health services are available, pregnant women must attend community health and nutrition sessions every two months • Parents or guardians must attend community workshops every two months on topics such as nutritional practices, childcare, home hygiene, and water safety The program targets poor and food insecure HHs based on the following targeting steps and mechanisms: • **Geographic targeting:** Selection of areas of intervention (regions, PAAs, and villages) is done on the basis of a poverty-index and is designed to support the poorest areas first (although consideration is also given to the ability to deliver the program). As villages are selected, the poverty-index, combined with information about poverty levels and the population of the village determine quotas for the number of expected beneficiary HHs in each village. The final list of villages is approved by the corresponding PAA. • **Community targeting:** The community, through their chosen representatives on a Community Cash Transfer Management Committee (CCTMC) under the oversight of the village council, identifies potential beneficiary HHs using predetermined criteria agreed upon at Village Assembly meeting. The community representatives identify HHs representing up to 120 percent of the set quota. Once potential beneficiaries have been identified, key data are collected for each HH and entered in the unified registry of benficiaries at PAA level. • **PMT and verification:** Each HH entered in the URB receives a welfare score based on the PMT weights that are used to reduce inclusion errors. HHs whose welfare scores fall below the extreme poverty line are considered eligible for the program. If the welfare scores of all HHs selected by the community fall below the extreme poverty line, then all HHs are eligible for the program. The resulting list is sent back to the village, where it is ratified at a Village Assembly meeting. The Village Assembly meeting can add or remove only those HHs that had been listed during the community targeting. However, the Village Assembly meeting provides an opportunity for HHs not listed by the CCTMC to complain directly to the PAA, which then facilitates a fast-track grievance process. Additional transfers target HHs with children. Subprojects under the PWP are implemented to address the special needs of women. pregnant or lactating women (if considered able to work according to the criteria set for the project) are assigned appropriate lighter work. Timing and settings are allotted avoid interfering with their roles as care providers; in particular, flexible working hours and the possibility of working half-days are offered to women. In some cases childcare may be brought to the workplace to facilitate participation of women who are breastfeeding. Some women are employed as caregivers and paid at the same rate as other workers. The program also properly ensures the participation of women in decision making for the PW program, in particular through membership on the CMC. Beneficiary HHs register all eligible members in the program (that is, children younger than 18 and pregnant women). The program has nutrition indicators.

East Asia & Pacific

Indonesia – PNPM Generasi Program

RESPONDENT(s)	Robert Wrobel, Senior Social Development Specialist, World Bank Group (WBG) Ali Winoto Subandoro, Health Specialist, WBG
TYPE OF PROGRAM	Community Driven Development (CDD)
PROGRAM DURATION	2007 to 2017
PROGRAM OBJECTIVE(S)	To empower local communities in poor, rural subdistricts in the project provinces to increase utilization of health and education services.
FUNDING AGENCY/IES	Government of Indonesia: $242 million PNPM Support Facility (WBG): $197 million
IMPLEMENTING AGENCY/IES	DG Village Development and Empowerment, Ministry of Villages, Disadvantaged Areas and Transmigration
TOTAL COST	$440 million
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Poor, rural subdistricts in selected provinces. In particular, target beneficiaries are pregnant women and those who have recently given birth, children under 5 years old, and primary school–age children. Targeted: 4.9 million women and children in 5,400 villages in 499 rural subdistricts (kecamatans) in 11 provinces.
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; integrated approach; governance; decentralization; performance-based financing; community participation; rural; gender and women's empowerment
CONTEXT	The Indonesian economy has experienced positive economic growth and the poverty rate has fallen from 23.4 percent in 1999 to 12.0 percent in 2011. Nonetheless, 32.5 million Indonesians lived below the national poverty line of Rp233,700 per person per month (approximately $1.19 per day PPP) in 2011. Forty percent of the population was clustered just above this line and earned about $2.37 per day PPP. Of the poor, 65 percent lived in rural areas. Despite strong macroeconomic fundamentals, modest gains have been observed in health and education relative to other East Asian countries. Within Indonesia, substantial variations in poverty, health, and education outcomes exist across regions, with rural areas lagging.
NUTRITION-SENSITIVE RATIONALE	The program focuses on providing health services using grants and training and capacity-building activities for communities. Communities use Generasi block grants to provide small-scale health and nutrition services, such as bringing midwives to houses more frequently and strengthening activities that promote growth monitoring. Given the renewed focus on the reduction of stunting, supply-side activities must be intensified and expanded. Thus, since 2014, PNPM Generasi has been part of the Community-Based Stunting Reduction Program, an integrated, multisector package of demand- and supply-side interventions aimed at improving maternal and child nutrition. In particular, supply-side activities relating to maternal and child health and nutrition delivered through the Community-Based Stunting Reduction Program consist of: (a) maternal, infant, and young child feeding or *Modul Pelatihan Pemberian Makan Bayi dan Anak* (Training Module for Feeding Infants and Children) for health providers; (b) distribution of micronutrient supplements; (c) a national awareness campaign for stunting reduction; (d) provision of anthropometric equipment; (e) sanitation and hygiene behavioral change activities; and (f) private sector engagement. Moreover, the program now goes beyond enhancing the quality of service delivery and focuses on influencing the day-to-day behavior at the community level.

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	Poor communities targeted by the program receive block grants that are conditioned on compliance with performance indicators measured on monthly, biannual, and annual bases. The program requires that 10 percent of the total funds for each village in Java and 25 percent of those outside Java specifically target those not yet receiving the relevant health and education services, and who are performing poorly against the 12 health and education indicators, such as out-of-school children and malnourished children. PNPM Generasi targeting systems apply geographical targeting combined with a local-level participatory process that does not rely on central statistical systems. It takes a flexible and localized approach in creating the list of beneficiaries through a village-level participatory social mapping process. Unlike central statistical targeting systems, the community poverty targeting mechanism is flexible in adjusting the beneficiary list as needed to mitigate economic shocks. Moreover, community-based targeting also appears to be more appropriate for Indonesia, where a large share of the population hovers around the poverty line, making centralized statistical targeting more prone to error. PNPM Generasi has innovative and effective ways to involve groups, such as women, that tend to be excluded from traditional institutions but who are particularly relevant to nutritional and health outcomes. In PNPM Generasi, these include the mobilization of mother's groups (*kolompok ibu*) in each participating subvillage. In particular, PNPM Generasi is designed to specifically engage women as participants in program planning and decision making and respond to women's basic needs by increasing access to health and education services. The project MIS shows that women have been the dominant participants in village-level participatory planning and decision-making, averaging over 60 percent of participants since 2007. The program has nutrition indicators.

Indonesia – Program Keluarga Harapan (PKH) Prestasi

RESPONDENT(s)	Pungkas Bahjuri Ali, Ministry of National Development Planning/ Bappenas, Directorate for Health and Community Nutrition Theresia Ronny Andayani, Ministry of National Development Planning/Bappenas
TYPE OF PROGRAM	Conditional Cash Transfer (CCT)
PROGRAM DURATION	2012 to March 2016
PROGRAM OBJECTIVE(S)	To strengthen the PKH Program and to scale up nutrition to reduce the prevalence of stunting as mandated in the National Medium Term Development Planning and National Action Plan on Nutrition and Food.
FUNDING AGENCY/IES	Government of Indonesia (GOI) UNICEF Austraila Department of Foreign Affairs and Trade
IMPLEMENTING AGENCY/IES	GOI: Bappenas, Ministry of Social Affairs, MOH, Ministry of Home Affairs, local (provincial and district) governments Faith-based organization Journalist organization
TOTAL COST	$1.8 million
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Targeted: 11,000 households (HHs) (10,000 children under 2 years old and 11,034 women) Indirectly about 595,000 people

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PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; integrated approach; community participation; Agriculture and local procurement; use of mobile technology; BCC; life-cycle approach; gender and women's empowerment; ECD
CONTEXT	In Indonesia, recent economic gains have not led to corresponding gains in nutritional status. Poverty and potential threats, including climate change, have led to the introduction of large-scale social protection programs to protect those at risk from economic insecurity and poverty. PKH is a nationwide government-funded CCT program, with health and education conditions that is designed to alleviate poverty and improve social welfare by providing CTs to vulnerable HHs. Evidence indicates that PKH has improved the use of health services but not nutritional status.
NUTRITION-SENSITIVE RATIONALE	Women have control over the cash from the CCT program. Although the size of the CT is not enough to support adequate daily nutritious food for a pregnant woman, the amount could support the adequate daily nutrition needs of a child. The program has a counseling component, knowledge that is passed on by trained health and nonhealth personnel to the mothers and the community. The counseling should ideally increase knowledge and improve good behavior of the mothers, including purchasing of more good quality food and consumption of more nutritious food. PKH has firm conditions linked to the use of health services. PKH Prestasi seeks to improve the impact of the health-based conditions by increasing the coverage and quality of evidence-based nutrition services, including counseling on maternal nutrition and infant and young-child feeding and micronutrient supplementation. The demand created may enhance better delivery of health services. The trainings accommodate the need for increased knowledge of reproductive health, nutrition, and childcare. The program targets at-risk age groups in the poorest households, PLW and children under 5, who are most at risk of food insecurity and undernutrition. The program has nutrition indicators.

Myanmar – Tat Lan Program: Maternal and Child Cash Transfer (MCCT) Pilot

RESPONDENT(s)	Mathew Tasker, Food Security, Livelihoods and Social Protection Advisor, Save the Children International (SCI) Andrea Menefee, Senior Nutrition Advisor, SCI
TYPE OF PROGRAM	Unconditional Cash Transfer (UCT)
PROGRAM DURATION	August 2014 to September 2016 (pilot), scale-up through to December 2018
PROGRAM OBJECTIVE(S)	To improve health and nutrition outcomes of mothers and young children during the critical window of the first 1,000 days from conception through 24 months old.
FUNDING AGENCY/IES	Livelihoods and Food Security Trust Fund
IMPLEMENTING AGENCY/IES	SCI. With the anticipated program expansion, other Tat Lan Program partners (the International Rescue Committee and Oxfam through a local NGO, the Better Life Organization) may assist implementation starting in 2016.
TOTAL COST	$623,775 for the pilot program
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Pregnant mothers and mothers of children under 6 months old from 30 villages. Targeted: 1,096 total beneficiaries. Scaling up to 80 villages from 2016, covering approximately 4,000 women by December 2018.

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PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; integrated approach; community participation; rural; resilience; conflict-affected setting; BCC; life-cycle approach; gender and women's empowerment; ECD
CONTEXT	The Tat Lan Program is a large integrated Food Security and Livelihoods Program in four townships in Rakhine State, Myanmar. Rakhine State has a predominantly poor rural population residing in remote villages and is characterized by political tension and periodic bouts of ethnic conflict. The region is moderately food insecure, with high exposure to nutrition insecurity. Poverty is widespread, and poor and very poor households in all three livelihood zones are unable to afford both a nutritious diet and essential nonfood expenditures. In two livelihood zones, even wealthy and better-off households are unable to afford both a nutritious diet and essential nonfood expenditures. The Tat Lan Program has nutrition security as one of its main components, and since late October 2014, SCI has been operating a pilot program to test the viability and impact of a nutrition-sensitive social protection intervention—a maternal and child cash transfer (MCCT) for pregnant women and children within the first 1,000-day window. The MCCT pilot was designed using a rigorous analysis based on • Household Economy Assessment; • Tat Lan Program baseline; • MCCT baseline; • Infant and Young Child Feeding Qualitative Assessment; and • Cost-of-diet analysis. These studies and the resulting data were used to analyze the local context and identify the main nutritional issues for rural HHs. An Integrated Household Living Conditions Assessment provided an estimate of monetary poverty, as measured by consumption expenditures on food and nonfood items. According to this measure, about 44 percent of the population living below the poverty line in Rakhine State. This is considerably higher than the 26 percent estimated as being poor nationwide. Pre-school attendance among children 3–5 years old is quite low nationally (23 percent), but it is lowest in Rakhine (about 5 percent). The primary school enrollment rate in Rakhine is also much lower than the national average, with almost 30 percent of children not enrolled. Barely a third of all children attending primary school in Rakhine complete their studies on time. The outbreak of violence in 2012 has worsened access to and quality of education for thousands of children (*Multiple Indicator Cluster Survey (MICS) 2009–2010. UNICEF*). With a rate of only about 12 percent, children in Rakhine State are much less likely than the average child in Myanmar to be born in a health facility, where lifesaving obstetric care would be available for mother and child in case of complications during birth. This also reflects the low level and quality of antenatal care received by pregnant women in the State. Immunization rates appear high and comparable to the national average, but routine immunization, as well as several other essential services, has been interrupted since the outbreak of violence in the State in 2012. The use of oral rehydration therapy to prevent life-threatening dehydration associated with diarrhea among children is used in only 60 percent of cases. Among those reached by the public health system, only 21 percent of pregnant women in Rakhine are tested for HIV and receive the test result. Of pregnant women identified as HIV-positive, at least 16 percent are not receiving antiretroviral therapy for prevention of mother-to-child transmission. Only 6 percent of infants born to HIV-positive women in the State are tested for HIV within the prescribed two months after birth. Rakhine is the worst among all states and regions in Myanmar.

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	Fifty-two percent of households in the State do not have access to improved sanitation, and 41 percent practice open defecation. Prevalence of diarrhea among children from birth to 59 months in Myanmar has increased from about 4 percent in 2003 to almost 7 percent in 2009–10. In Rakhine, diarrhea prevalence stands at 8 percent.
NUTRITION-SENSITIVE RATIONALE	Using SCI's cost-of-diet tool, the size of the CT is calculated to cover the affordability gap between (1) HH incomes and expenditures and (2) the cost of a locally appropriate and nutritious diet across three different livelihood zones. The CTs are universal to address widespread poverty, and delivered monthly basis to ensure that mothers have access to a frequent and reliable source of income to support the purchase of essential nutritious food and health care. Preliminary findings indicate that women have control over—and are empowered by—the CT, use it for nutritious food and health care, and see it as an incentive for behavior change. CTs are disbursed in the context of a wider BCC strategy that encourages community participation through the formation of MMSGs, interpersonal counseling and support from trained community volunteers, mass media messaging, and community level awareness raising, all targeted at influential members of the community. The program has soft conditions linked to the use of health and nutrition services, training and promotion of behavioral change through mother to mother support groups (MMSGs), interpersonal counseling and support from trained community volunteers, mass media messaging, and community-level awareness raising. BCC activities deliver targeted and relevant messages to increase the awareness and practice of consuming nutritious foods, accessing essential health services during pregnancy and lactation, and promoting optimal infant and young-child feeding and care during the critical first 1,000 days. The pilot promotes capacity building of village volunteers and Village Development Committee members in nutrition-sensitive interventions and practices. SCI hopes to extend this to more government counterparts, such as midwives, starting in 2016. Because nutrition is critical to infant health during the first 1,000 days, income poverty is widespread in rural areas, and the wealthiest quintile in Myanmar still exhibit chronic malnutrition rates of over 20 percent, the pilot takes a universal approach to beneficiary selection making all pregnant women eligible. Weaknesses in financial services and technological and telecommunications in Myanmar necessitate that all CT payments currently be made manually. Therefore, the pilot ensures that CTs are distributed at the village level so women do not have to spend time and money traveling to receive them. The pilot provides village-level BCC on nutrition, but mothers are specifically supported through the establishment of MMSGs for information dissemination, discussion, and the sharing of experiences on key behaviors, such as exclusive and continued breastfeeding, timely introduction of a complementary diet, maternal nutrition, and optimal hygiene and sanitation practices. Focus group discussions indicate that women are empowered by the cash. The program has nutrition indicators. The pilot is being actively used to build an evidence base to advocate to the government on the effectiveness of nutrition-sensitive social protection mechanisms at a national scale. Recent data shows significant differences between intervention and control groups for exclusive breastfeeding, individual diet diversity, and height-for-age z score.

Philippines – Philippines Social Welfare Development and Reform Project

RESPONDENT(s)	Aleksandra Posarac, Program Leader, World Bank Group (WBG)
TYPE OF PROGRAM	Conditional Cash Transfer (CCT)

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PROGRAM DURATION	January 2010 to December 2015 (WBG) 2007 to present (Government of Philippines [GOP])
PROGRAM OBJECTIVE(S)	To strengthen the effectiveness of the Department of Social Welfare and Development (DSWD) as a social protection agency in efficiently implementing the CCT program (the 4Ps) and to expand an efficient and functional National Household Targeting System for Poverty Reduction (NHTS-PR) for social protection programs.
FUNDING AGENCY/IES	WBG (IBRD) $502 million GOP $1.5 billion annually (2015)
IMPLEMENTING AGENCY/IES	GOP: DSWD
TOTAL COST	$502 million $1.5 billion annually for the overall program
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	CCT program rules require that grantees be mothers. **Health grant**: Poor households (HHs) with children from birth to 18 years old, or pregnant women, or both. **Education grant**: Poor HHs living in selected areas with children 6–18 years old. **Targeted CCT*:** 617,293 HHs in 2014. *Target pertains only to the CCT grants to which the WBG loan contributes. The overall program has a target number of 4.3 million beneficiary HHs as of late 2015.
PROGRAM CROSS-CUTTING THEMES	BCC; gender and women's empowerment; ECD
CONTEXT	After posting strong economic growth for several years, the Philippines is experiencing an economic slowdown from the effects of the global economic crisis. Available data at the project development stage showed that the food and fuel price shock in 2008, the global economic crisis, and the typhoon-related disaster had taken their toll on HH welfare and the economy as a whole, which reduced the employment and incomes of Filipino households. The unemployment rate increased slightly, from 7.4 percent in January 2008 to 7.5 percent in April 2009, and the growth of remittances from overseas Filipino workers slowed dramatically, from 13.7 percent growth in 2008 to 2.8 percent growth from January to May 2009. Moreover, a growing number of Filipinos consider themselves poor. Of the 1.1 million entrants to the labor force in 2009, only 22 percent got jobs in the domestic formal sector. The recent contraction in agricultural sector employment, where most of the poor still find their livelihoods, may risk undermining the government's poverty reduction efforts. Many Filipinos still live just above the poverty line ("near poor"), cycling in and out of poverty because of their high vulnerability to climatic disaster, and financial and price shocks. It has been estimated that a 20 percent increase in the poverty line following a major food shock would increase the poverty incidence by over 9 percent. Between 2003 and 2009, 44 percent of the population was poor at least once, one in three Filipinos was persistently poor, and two out of three households moved in and out of poverty. Perennial typhoons and flooding are most devastating in their economic and social impact.
NUTRITION-SENSITIVE RATIONALE	Payments are bimonthly and regular to support expenditures for covering daily necessities. HHs remain in the program until all children eligible to be enrolled in the program exit the education system. The program has firm conditions, requiring participation of the targeted HHs in health and growth monitoring sessions, in particular: • All children from birth to 5 years old must attend a health center or rural health unit to get the services appropriate for their age, as established by the Department of Health (DOH); • Pregnant women must attend a health center or rural health unit according to DOH protocol;

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	• All children 6–14 years old must comply with the deworming protocol in school; and • For HHs with children from birth to 18 years old, the HH grantee (usually the mother) or spouse shall attend an Family Development Session (FDS) at least once a month. The FDSs include several sessions on nutrition ranging from breastfeeding to proper food preparation practice. They also include extensive WASH instruction to raise awareness and inform CCT beneficiaries about proper WASH practices. FDSs also tackle topics such as family relations, family violence and abuse, and reproductive health. 4Ps targets poor HHs with children from birth to 18 years old and pregnant women. Poverty status is a necessary condition that is established through the national targeting system using a PMT combined with community verification to identify the poor. Ninety percent of HH members receiving the grant are mothers; more than 90 percent of parent leaders are women. The program has nutrition indicators.

Europe & Central Asia

Kyrgyz Republic – Optimizing Primary School Meals Programme

RESPONDENT(s)	Ashimbaeva Toktobubu Abasovna, Deputy Minister of Education and Science Carlo Scaramella, Deputy Regional Director, World Food Programme MENA Region Maria Lukyanova, Head of World Food Programme Tunisia and Morocco Country Offices Nadya Frank, World Food Programme Ram Saravanamuttu, World Food Programme
TYPE OF PROGRAM	In-kind transfer (school feeding)
PROGRAM DURATION	January 2013 to December 2016, with the possibility of extension.
PROGRAM OBJECTIVE(S)	Provide technical support to the government to improve the quality, efficiency and sustainability of the national School Meals Programme.
FUNDING AGENCY/IES	Government of the Kyrgyz Republic (state resources) World Food Programme (donor contributions, primarily from the Russian Federation)
IMPLEMENTING AGENCY/IES	World Food Programme The Kyrgyz Republic: Ministry of Education & Science; Ministry of Health (MOH) NGOs: Social and Industrial Food Services Institute; Roza Otunbaeva's Initiative; Agency for Development Initiatives; Center for Activation and Development of Rural Initiatives
TOTAL COST	$10.4 million
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Primary school children, grades 1 to 4. Targeted: 56,000 individuals
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; governance; community participation; BCC; gender and women's empowerment

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CONTEXT	Since 2006, the government of the Kyrgyz Republic has implemented a national School Meals Programme for almost 400,000 primary school children. The government spends approximately $10 million per year on this program from state budget resources. In most schools, however, gaps in program design and implementation make the quality of the meals nutritionally inadequate, providing children with only an unfortified bun, a cup of black tea, and in many cases empty calories, such as cookies or sweets. Access to primary education is high, with minimal disparities between genders and between urban and rural areas. The overall primary net enrollment rate is 95 percent for both girls and boys. However, learning achievement is low in comparison to other countries in the region, with the Kyrgyz Republic performing last of the 74 countries and territories participating in the Programme for International Student Assessment in 2009. Attendance is an issue, especially in the autumn and spring months, when many children are involved in income-generating activities, including agriculture, which forces them to drop out of school on a seasonal basis. *World Bank. 2012. World Development Indicators* *World Bank. 2010. Kyrgyz Republic 2010: Lessons from the Programme for International Student Assessment* *UNICEF. 2011. Situation Assessment of Children in the Kyrgyz Republic*
NUTRITION-SENSITIVE RATIONALE	The optimized school meals model enables children to eat a healthier, more balanced diet than was the case under the existing national school meals model. Under the pilot, schools switch from the national program's typical menu of tea and unfortified buns (often accompanied by sweets or cookies) to more nutritious menus, including items such as milk, fruit compote, vegetables, and salads. Children to eat more healthfully today, and may develop lifelong habits of eating more-balanced meals. In addition to the immediate benefit of improved nutrition for children, over the long term, improved micronutrient intake is expected to lead to increased productivity and better health during the adult years. A School Feeding Investment Case study in 2014 by World Food Programme and Boston Consulting Group estimated that for every $1 invested in the Optimized School Meals model in the Kyrgyz Republic, there is a lifelong return of $2 of increased productivity and a healthier and longer life. The food provided also saves poor households from having to purchase school lunches for their children, freeing up their scarce resources to invest in other areas, such as the family's health and productive assets. World Food Programme and partners are working to improve children's knowledge, attitudes, and practices on nutrition through a number of complementary activities: • More than 5,000 children have been trained through child-friendly interactive games to promote awareness of healthy, balanced diets • School hygiene facilities have been improved and children are trained in basic hygiene, especially handwashing • School gardens have been developed on a pilot basis at five schools, providing children with an opportunity, among other things, to learn more about growing vegetables World Food Programme supported a 2014 MOH survey on consumption of junk food and sodas by school children in an effort to better understand and address this issue. The pilot program geographically targets the most food-insecure districts in the country. Within selected schools, all children in grades 1–4 receive food. The program ensures that women are fully represented in designing and making decisions on the project through community engagement mechanisms, particularly consultations with parent-teacher groups. Currently 70 percent of parent-teacher group members at pilot schools are women. Female members play an important role in project planning, oversight of spending and mobilization of community involvement in the program. The program has nutrition indicators.

Latin America & the Caribbean

Brazil – National School Feeding Programme

RESPONDENT(s)	Christiani Amaral Buani, Head of Programme, World Food Programme Center of Excellence (WFP COE) Eliene Sousa, Government of Brazil (GoB)
TYPE OF PROGRAM	In-kind transfer (school feeding)
PROGRAM DURATION	1940 to present (universal in 1972)
PROGRAM OBJECTIVE(S)	Provide fresh and nutritious daily meals to all students in public schools.
FUNDING AGENCY/IES	National Fund for Education Development (FNDE)
IMPLEMENTING AGENCY/IES	FNDE
TOTAL COST	$2 billion
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Students of all ages enrolled in public preschool, primary, secondary and high school, and adults enrolled in special education (such as literacy) programs and regular courses for the elderly. Targeted: 45 million students
PROGRAM CROSS-CUTTING THEMES	Double burden of malnutrition (DBM); multisectoral collaboration; integrated approach; governance; decentralization; community participation; Agriculture and local procurement
CONTEXT	Nearly 44 million people in 9.3 million households (HHs) earned less than a dollar a day in 2003. A large proportion of this vulnerable population lives in rural areas, and the most insecure groups are women, children, and the elderly. Although child mortality remains high, Brazil achieved the Millennium Development Goal for childhood mortality reduction, decreasing the rate from 53.7 per 1,000 in 1990 to 17.7 per 1,000 in 2011. A recent diagnosis of the hunger problem in Brazil suggests that the demand for food is insufficient, preventing commercial agriculture and agro-industry from increasing food production. Research indicates that farmers in Brazil have the potential to produce all the food required to meet the population's needs. The insufficient demand is attributed to excessive income concentration, low wages, high rates of unemployment and low growth rates, particularly in sectors that could hire more people. That is, hunger persists not for lack of food, but rather for lack of income among vulnerable groups to purchase it. As these conditions are deemed to be inherent to the current economic growth pattern, there is a twin-track approach toward improving income and economic inclusion of, and support for smallholder farms, the main supplier of food to the Brazilian population. Since 2003, the eradication of poverty and hunger in Brazil has been a top priority. The strategy, known as Fome Zero or Zero Hunger, was launched in the first days of former President Lula's term and has received international recognition as an effective public policy. It assumes that hunger in Brazil is an outcome of poverty, and that sound social policies are not governmental costs but rather investments in inclusive growth. The Zero Hunger strategy was the outcome of civil society mobilization and top-level political will. In the early days of his new term, President Lula stated that fighting hunger would be at the core of his administration. The Zero Hunger strategy has translated into Brazilian foreign policy through South-South co-operation. Internally, the promotion of food and nutrition security became the basis for a long-term cross-cutting strategy, which included a set of complementary programs.

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	Within the Zero Hunger context, Brazil has fulfilled the commitment of Millennium Development Goal 1 to "eradicate extreme poverty and hunger" and halved, between 1990 and 2015, the proportion of people living on less than R$2.75 ($1.25) per day. Over the past 10 years, approximately 20 million Brazilian people left the condition of absolute poverty. The percentage of underweight children under 5 years old (weight-for-age) decreased from 13 percent in 2003 to 5 percent in 2008. School feeding was first introduced to Brazil in the early 1940s when the then–Institute of Nutrition proposed to the federal government that food be provided in schools. The name was changed from the School Meals Campaign in 1955 to the National School Lunch Campaign in 1956 with the intention of making it a universal program. By 1965, the name had been changed again to the National School Feeding Campaign. The National Institute for Food and Nutrition was created in 1972 to administer the program and was attached to the Ministry of Health. The program was highly centralized, and states and municipalities were responsible only for storage and delivery of food to schools. In 1979, the program was given its current name the *Programa Nacional de Alimentação Escolar* (PNAE). It is Brazil's oldest ongoing food program. Until 1993, the implementation of school feeding in Brazil was centralized at the federal level. The logistics were complex and expensive due to long distances. Controlling program implementation and monitoring were major challenges. PNAE was redesigned in the 1990's, and again after the launch of the Zero Hunger strategy in 2003 established universal and nutrition-sensitive school feeding as a key program for tackling hunger. Brazil now has the second-largest national school feeding program in the world, behind India, and has customized the school feeding experience to its own realities and challenges. The program has its own national law and, in 2010, the social right to food was included in the Constitution of Brazil, consolidating the role of school feeding in the promotion of food and nutrition security in the country.
NUTRITION-SENSITIVE RATIONALE	Two of the objectives of PNAE are nutrition-related—providing at least 20 percent of the daily nutritional needs of students, and promoting healthy eating habits through food and nutrition education. The menus are developed and supervised at the local level by qualified nutritionists appointed by the state or municipality who prepare menus for different school levels and groups (special education needs, kindergarten, preprimary, primary and secondary education, youth and adult education, and indigenous and slave-descendant communities). Menus are based on the nutritional needs of the targeted age group and guidelines for micronutrients, limits on sodium, fats and sugar, and restrictions on food with low nutrition content, such as soft drinks, sausages, sweets, and canned, processed, or concentrated foods. The nutritional restrictions promote the consumption of healthful food, respect local eating habits, and avoid the use of industrialized or poor-quality food. Pedagogical gardens are also widely used in schools. They serve as food and nutrition-education tools and encourage participation by families, farmers, and the school community. Although PNAE is a universal program that does not specifically target vulnerable groups, the overwhelming majority of Brazil's vulnerable students are in public schools. It is no coincidence that the poorest population corresponds to the most nutritionally vulnerable population. In some areas, the only meals children have are the ones they receive at the school, justifying the nutrition-based design of PNAE. The minimum nutrition requirements, number of meals, and per capita funding provided by PNAE is higher in full-time schools, as well as in schools located in indigenous and traditional-community areas, as compared to other types of schools. By its universal coverage, PNAE can be a key factor of inclusion for women, especially single mothers whose children attend kindergarten in full-time schools. Monitoring of nutrition indicators is done by the health services, not through the PNAE. However, all school menus are designed by nutritionists who are responsible for verifying the quality of the food purchased by the schools.

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	PNAE menus are diverse and vary according to regions and local habits, within the standard composition of nutritional need per child per day. The school menu is planned at the beginning of the fiscal year and reflects the local eating habits and preferences of the various communities.

Dominican Republic – Progresando Con Solidaridad

RESPONDENT(s)	Jorge Fanlo, Country Director, World Food Programme Dominican Republic Elisabet Fadul, Programme Officer, World Food Programme Dominican Republic Maria Altagracia Fulcar, Nutrition Officer, World Food Programme Dominican Republic Altagracia Suriel, General Director, Progresando Con Solidaridad
TYPE OF PROGRAM	Conditional Cash Transfer (CCT), in-kind transfer with Food and Nutrition Supplement
PROGRAM DURATION	2009 to August 2016
PROGRAM OBJECTIVE(S)	Overall objective of the nutrition component: • Develop a component within Progresando con Solidaridad, the national social protection program, to improve its effect on the nutritional status of the targeted beneficiary population, especially the groups most vulnerable to undernutrition and micronutrient deficiencies. Specific objectives: • Prevent and control micronutrient deficiencies in children under 5 years old by increasing the rate of exclusive maternal breastfeeding and proving micronutrient powders; • Contribute to the prevention and control of micronutrient deficiencies in pregnant and lactating women (PLW) by providing a complementary fortified food specific to this group; • Contribute to the prevention and control of acute undernutrition in vulnerable children 6–59 months old by providing complementary fortified food; • Contribute to guaranteeing adequate food and nutrition security among the elderly beneficiaries of Progresando con Solidaridad by providing complementary fortified food; • Contribute to strengthening the national and local capacity to monitor the growth and development of children under 5 years old, deliver prenatal care, and provide nutrition counselling to the elderly; • Contribute to behavior change in nutrition and feeding practices by increasing community knowledge of and empowerment for healthful eating through community mobilization and a network of local nutrition counselors.
FUNDING AGENCY/IES	Nutrition component: Government of the Dominican Republic (GODR) Progresando con Solidaridad: GODR, World Bank Group (WBG), and Inter-American Development Bank
IMPLEMENTING AGENCY/IES	Programme Progresando con Solidaridad of the Social Cabinet of the Vice President of the Dominican Republic World Food Programme
TOTAL COST	$1.5 million annually

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TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Children from birth to 59 months old, PLW, and elderly adults in beneficiary households (HHs) of Programme Progresando con Solidaridad. Targeted CCT: 700,000 poor HHs. From these HHs, from January 2014 to August 2016: 121,706 beneficiaries of the nutrition component and special nutritious foods (micronutrient powders, Supercereal Plus or Supercereal), including 88,348 children 6–59 months old, 23,665 PLW, and 9,693 elderly adults; 20,000 community employee and public health practitioners participating in capacity-development activities; and 40,000 women heads of HH targeted for undernutrition counseling through community education and mobilization activities.
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; integrated approach; governance; community participation; BCC; life-cycle approach; ECD
CONTEXT	Although self-sufficient for basic food production, the Dominican Republic suffers from marked income inequality. Inequity in distribution of family income stood at 45.7 in 2014 in the WBG Gini index. With an inflation rate of 3.7 percent in 2013 and a poverty rate of 41.1 percent in 2013, the poorer half of the population receives less than 20 percent of GDP, while the richest receive nearly 40 percent. Income inequality combined with sustained inflation result in a decline in purchasing power for poor HHs, affecting their consumption of food. In 2004, the GODR, through the Social Policy Cabinet rolled out the social protection program then known by the shorthand Solidaridad, to assist its most vulnerable citizens, improve human capital, and spur economic growth. In 2009, the program was revamped to include components focusing on human development, of which nutrition was an essential element. World Food Programme designed the nutrition component. A new vice president was elected in the presidential election in 2012 who was instrumental in prioritizing social protection programming in the Dominican Republic. She combined Solidaridad with the social program Progresando to form a broader, multisector safety net program called Progresando con Solidaridad. Progresando con Solidaridad comprises the following areas of intervention related to human development: integrated health; education; nutrition and food security; environment; training; and access to information and communication technology. Relevant Progresando con Solidaridad activity components are: • **Comer es Primero** addresses hunger by providing economic assistance of approximately $16 per month (RD$700) to each beneficiary HH to supplement the basic foods eaten in families living in extreme poverty. Additionally, the program seeks to improve the overall health status of children through access to vaccines, growth monitoring, and health education. The World Food Programme led nutrition component, including the distribution of micronutrient powders to children 6–59 months old is a condition of this CT. • **Incentivo a la Asistencia Escolar** addresses education by providing monthly financial assistance of between $7–$13 (depending on the number of children) for each child 6–16 years old that attends school, in order to increase school attendance and decrease attrition rates. • **Dominicanos con Nombres y Apellido** facilitates and promotes the registration of births and improves the process of obtaining documentation. The program has been expanded to include income-generating activities, actions focusing on livelihoods of beneficiaries, and a stronger community outreach and mobilization network. Under this new phase, the nutrition component has been broadened to include PLW and the elderly and a more detailed targeting of children vulnerable to undernutrition and micronutrient deficiencies.
NUTRITION-SENSITIVE RATIONALE	The nutrition component promotes nutritional care of the targeted beneficiaries, with the emphasis on prevention and control of malnutrition and prevention of micronutrient deficiencies. Doctors and World Food Programme field monitors provide an information session on nutrition with emphasis on the importance and use of the micronutrient powders. Caregivers have the opportunity to taste the micronutrient powders and share their impressions and experiences.

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	The rations, frequency, and delivery method of the micronutrient powder and the complementary fortified food have been determined according to the nutrition standards and policy of World Food Programme, defined based on scientific research, best practices, and programming guidelines developed in conjunction with other international organizations. As part of its other areas of intervention, Progresando con Solidaridad targets women of beneficiary HHs with income-generating activities and training. The nutrition component places conditions on the provision of micronutrient powders and Progresina and strengthens existing capacity and interventions at community level of both Progresando con Solidaridad and the Ministry of Health (MOH). The nutrition component is generally implemented within the primary health care system in accordance with public health norms, thereby promoting proper health care practices and services. Health sessions are conducted in primary health care centers in accordance with the requirements set out by the MOH as the main strategy for addressing beneficiaries and promoting demand for primary health care as an essential element for guaranteeing adequate nutrition at the community level. The nutrition component consists of a complete package of interventions including capacity development for community leaders and health practitioners; coordination among actors; community nutrition education; promotion of preventive care for children through the provision of primary health care; provision of micronutrient powders to children 6–59 months old; and distribution of complementary nutritious foods to children at risk of chronic or acute malnutrition, to PLW, and the elderly. The World Food Programme, Progresando con Solidaridad and the MOH jointly organize health sessions at the primary health care centers two to four times a year. These sessions include regular appointments for child growth monitoring, nutrition counseling, preventive care checkups for children, nutrition education sessions, and provision of micronutrient powders and guidance on their proper use and preparation. The nutrition component targets children from birth to 5 years old, but emphasizes children from birth to 2 years old, and PLW. The nutrition component also targets the elderly. In order to accommodate women's needs and to facilitate their participation into the component activities, their family responsibilities and time availability are taken into account. The program has nutrition indicators. The nutrition component includes integrated nutrition interventions, empowers and encourages ownership by community leaders of nutritional vigilance, and enhances government programs through capacity-strengthening activities and training.

Haiti – Kore Lavi

RESPONDENT(s)	Afurika Juvenal, Kore Lavi Chief of Party, Care Haiti Julien Morel, advisor (previously Action Against Hunger (AAH))
TYPE OF PROGRAM	In-kind transfer (unconditional food voucher) with Food/Nutrition Supplement
PROGRAM DURATION	October 2013 to September 2017
PROGRAM OBJECTIVE(S)	• Strengthening of national systems for targeting vulnerable populations • Increasing the access of extremely vulnerable households (HHs) to local and nutritious foods • Improving maternal and child nutritional status • Improving Haitian institutions' capacity to effectively lead and manage safety net programs
FUNDING AGENCY/IES	USAID

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IMPLEMENTING AGENCY/IES	CARE Ministry of Social Affairs and Labor (MAST) AAH World Food Programme WorldVision (WV)
TOTAL COST	$79,996,200
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Food voucher – target group: Poorest, most-deprived and vulnerable people using the Haiti Deprivation and Vulnerability Indicator Targeted: 90,750 individuals (18,150 vulnerable HHs) Food supplement – target group: pregnant and lactating women (PLW) and all children under 2 years old Targeted: 87,190 PLW; 109,674 children 6–23 months old
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; governance; community participation; agriculture and local procurement; harnessing nutrition data; use of mobile technology; BCC; life-cycle approach; gender and women's empowerment
CONTEXT	Haiti is disaster prone and one of the most food-insecure countries in the world. Fifteen major natural disasters have befallen Haiti in the last six years, affecting nearly 5 million people. These events have further strained the coping capacity of the country and have contributed to placing Haiti among the most vulnerable countries in the world. The FAO, World Food Programme and IFAD produce an annual report on the state of food insecurity in the world. In the 2012, an estimated 44.5 percent of the population of Haiti was undernourished, placing Haiti 89th among the 92 countries for which data are available. In a second analysis, the Index for Food Security produced by the Economist Intelligence Unit placed Haiti 4th from the bottom for the 105 countries listed, and, in a third analysis, the Global Hunger Index produced by the International Food Policy Research Institute placed Haiti third from the bottom among the 79 countries for which data were available. The underlying causes of food insecurity in Haiti are: *Income poverty:* Nearly half of the Haitian population is undernourished and unable to access sufficient food because of low incomes. They do not have sufficient cash in their pockets to feed themselves adequately. *Declining agricultural productivity and increasing dependence on imported foods:* Despite the substantial growth potential of its agriculture sector, Haiti currently imports more than 50 percent of the staple foods it requires. Most producers are no longer food self-sufficient and, to cover the food needs of their families, they have to spend more than before to buy imported food on the local market. *Poor use of food:* Access to basic services related to nutrition, public health and treated water is very low generally among the population. Knowledge of positive behaviors is also insufficient, and as a result, the capacity of people to effectively use the food consumed is constrained. *Price instability* also contributes significantly to food insecurity in Haiti. For example, price instability on international markets in July 2012 combined with poor national harvests resulted in increasing food prices for consumers in Haiti, exacerbating food insecurity for those HHs that are most vulnerable. According to the last Humanitarian Needs Overview published by the UN Office for the Coordination of Humanitarian Affairs, 171,000 people in Northwest, 148 500 people in Artibonite, 68 500 people in Southeast, 675,000 people in the West and 175,500 people in the Center are in need.
NUTRITION-SENSITIVE RATIONALE	A key feature of the Kore Lavi safety net mechanism is the monthly $25 food voucher for the purchase of a locally produced food basket. Forty percent of the value of the monthly transfer is earmarked for fresh food (including vegetables, fruit, and meat products). The Bureau of Nutrition of the MOH took a lead role in a working group that defined the composition of the food basket to ensure it is nutrition-sensitive.

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	Supplementary food distributions are provided to all HHs that participate in nutrition-related activities. These supplementary rations target PLW and children from 6–23 months old. In addition, a family ration is provided to the families of these women and children to ensure that the targeted rations are consumed by the intended recipients. The program also makes supplemental rations available through health facilities for children diagnosed with moderate acute malnutrition. Kore Lavi mobilizes self-selected and self-managed savings groups to promote self-reliance and opportunity. These groups are a key community-based informal safety net that reduces vulnerability and prevents loss of livelihood. Kore Lavi implements a food-assisted first 1,000-days approach to prevent childhood undernutrition. This component of the program uses conditional monthly rations of nutritious foods to complement the interventions that build the capacity of: • Child caregivers, including mothers, fathers, grandparents, and siblings, to understand good behavior for ensuring that children are born healthy and nurtured effectively • Community-based informal health service providers and community leaders to understand and be able to support the behavioral change promoted by the program • Health facilities to provide high quality health and nutrition services Kore Lavi supports the Multidisciplinary Community Health Agent (ASCP) and health centers with essential health materials and trains the ASCP, the health agents, the lead mothers and local civic organizations on nutrition and health topics according to the MSPP. Kore Lavi works with the health agents of the targeted communities to reinforce their knowledge of nutrition of infants and young children, to strengthen their capacity to monitor growth, and to improve care services especially for the treatment of childhood diseases and severe or moderate malnutrition. At the facilities level, the program supports the strengthening of health and nutrition services including birth preparedness and maternity services, immunization, vitamin A and iron supplementation for children, and iron and folic acid supplementation for PLW. Facilities-based growth monitoring and promotion services are also strengthened to enable more effective identification and monitoring of children with severe or moderate acute malnutrition. A total of 107 health centers in 19 communes are targeted for the strengthening of capacity to improve the quality of nutrition and health services. The five departments of Northwest, Artibonite, Southeast, Center, and La Gonâve and the 23 communes have been selected because they are the most vulnerable to food insecurity. Kore Lavi targets food voucher beneficiaries using the Haiti Deprivation and Vulnerability Indicator, which consists of 21 indicators grouped in 7 categories: demography, health, education, labor conditions, food security, home resources, and life conditions. These indicators are assessed through home visits and HHs are ranked according to an index between 0 and 1, with 1 indicating the greatest deprivation. The program targets at-risk age groups (mainly children in the first 1,000 days and pregnant women). The distribution of preventive rations targets PLW and children under 2. The care group approach targets all HHs with a beneficiary receiving nutrition rations. MAST and Kore Lavi, with the support of their partners, are implementing the National Privation and Vulnerability Index, a new, harmonized approach to vulnerability targeting that focuses on chronically food-insecure HHs. Kore Lavi will implement this approach in 16 communes. Kore Lavi targeting uses existing census data and data collected from a census conducted in partnership with the *Coordination Nationale de Sécurité Alimentaire* (National Food Security Coordination).

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	The targeted beneficiaries of the preventive food rations are all PLW in the areas of intervention who meet the conditionality criteria. A preliminary gender analysis has been undertaken in the design of Kore Lavi. Kore Lavi provides support to the Ministry of Women's Affairs and Women's Rights to strengthen its regulatory, advocacy, and technical guidance roles for gender integration specifically in food security and social assistance and protection programming. In addition to gender training for frontline staff, local leadership, and government stakeholders, the program also engages men as supportive partners and agents of change, working with men's and women's groups to promote changes in social norms, particularly around violence and nutrition, household decision-making, and livelihoods. Kore Lavi provides support to GOH institutions and CSOs at various levels that have responsibility for gender-sensitive social assistance and the implementation of food security programs. The program has nutrition indicators.

Mexico – Mexico Program of Social Inclusion PROSPERA

RESPONDENT(s)	Francesca Lamanna, Senior Economist, World Bank Group (WBG)
TYPE OF PROGRAM	Conditional Cash Transfer (CCT) with Food and Nutrition Supplement
PROGRAM DURATION	1997 Progresa, 2002 Oportunidades, 2014 PROSPERA
PROGRAM OBJECTIVE(S)	To strengthen the social rights of the poor by improving their capabilities, especially their nutrition, health, and education capabilities, and contributing to breaking the cycle of intergenerational poverty.
FUNDING AGENCY/IES	Government of Mexico WBG (IBRD) $350 million (effective February 2015) Inter-American Development Bank $600 million
IMPLEMENTING AGENCY/IES	*Secretaria de Desarrollo Social* (SEDESOL) and PROSPERA
TOTAL COST	$2,340 million
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	PROSPERA beneficiaries Children under 5 years old and pregnant and lactating women (PLW) Targeted: 6.1 million housholds (HHs) (25.5 million people), including 293,060 pregnant women attending breastfeeding workshops; 1,453,382 children under 5 years old attending health workshops.
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; integrated approach; community participation; BCC; life-cycle approach; gender and women's empowerment; ECD
CONTEXT	Despite important progress in poverty reduction, significant segments of the Mexican population still face food insecurity and nutrition challenges. Ministry of Social Development (SEDESOL) documents that in 2012, as many as 27.4 million people, 23.3 percent of the total population, reported some deprivation related to food access. The prevalence of deprivation related to food access is especially high among indigenous population (35.4 percent), youth (28.1 percent), and people with disabilities (31.2 percent). The southern region of Mexico—which includes the poorest states of the country, such as Oaxaca, Guerrero, Yucatan and Chiapas—has the highest stunting rates. In the rural areas of Chiapas as many as 44.2 percent of children under 5 years old are stunted, more than twice the national average for rural areas. The malnutrition problem in Mexico is multifaceted and characterized by the coexistence of high rates of chronic malnutrition with high and increasing rates of overweight and obesity. Obesity rates in Mexico are the highest in the hemisphere and among the highest in the world at 32.8 percent for adults. Obesity is more common among the poor and less educated, and it is increasing even among children.

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	The government of Mexico recognizes food security and improved nutritional status as fundamental elements of its poverty reduction strategy, because of their impact on the long-term productivity of the population. At the same time, international evidence points to the importance of multisectoral solutions for greater impact on the nutritional status of the population. Access to income, health and nutrition services, food diversity and health care are among the critical elements of a successful strategy to tackle malnutrition. Many programs and resources are directed at addressing this important challenge in Mexico. For example, PROSPERA, the national flagship CCT program provides reliable CTs to over 25 million poor with proven effects on nutrition status (for example, a reduction of 22.2 percentage points in the prevalence of stunting and of 11.8 percentage points in the prevalence of anemia in children under 2 years old). However, program fragmentation and lack of coordination have been issues. According to the National Council for the Evaluation of Social Development Policy (CONEVAL), in 2014 there were as many as 278 federal programs directed at improving socioeconomic welfare, each using different targeting and delivery mechanisms, coexisting with as many as 2,849 state and 1,883 local programs. Recently, the government has increased its efforts to improve coordination, reduce fragmentation and duplication of programs, and implement integrated approaches.
NUTRITION-SENSITIVE RATIONALE	The size of the cash transfer is set to have an impact on nutrition, that is, it is set at 20 percent of HH per capita income to guarantee basic consumption for poor HHs. Payments are frequent (every two months) and reliable to support expenditures for daily necessities. CTs are given to beneficiaries based on specific coresponsibilities relating to the use of health and nutrition services and attendance at health and nutrition education sessions. Specifically, these coresponsibilities include: • Regular visits to health centers by all HH members (at least twice a year, and more frequently for pregnant women and children under 2 years old, in accordance with established protocols); • Attendance at monthly health information sessions by at least one adult member of the HH. PROSPERA also provides a basic package of health services free of charge, including the delivery of food supplements to vulnerable groups and education to support infant and PLW's nutrition. Within the framework of the Integrated Nutrition Strategy (ESIAN), the program seeks to promote good nutrition habits throughout life, starting from pregnancy, during lactation, and for children under 5 years old. There are three fundamental components: • Distribution of a new set of supplements for women during pregnancy and until that child turns 1 year old and for children from 6–59 months old, as part of an integrated strategy to improve the health and nutrition status of priority groups; • Providing specific equipment to health centers for the evaluation of nutrition status diagnosis of anemia (including audiovisual support for the promotion of key messages of the ESIAN); • Plans (1) building awareness and capacity of PROSPERA health and community personnel to carry out the basic interventions of the ESIAN and of counseling to mothers using best practices; (2) communication to and training of PROSPERA health and community personnel to carry out the elements of the program and improve the attitudes and practices of the personnel at all levels and toward women beneficiaries of the program. From January to April 2015, 567,299 workshop sessions were held, focusing, among other themes, on nutrition and health, adolescence and sexuality, overweight and obesity, and early child development.

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	PROSPERA beneficiaries are selected through a three-tiered mechanism: (1) the selection of marginal communities according to a specially developed marginality index; (2) the selection of poor HHs using a multidimensional poverty line; and (3) community validation of the list of beneficiaries at a town meeting. The nutrition intervention uses categorical targeting—women of reproductive age with children under 5 years old. The program interventions are flexible to address specific vulnerability gaps, particularly in health, nutrition, and education, for subgroups of women. For example, 20 percent of pregnant women have anemia, and 75 percent of adult women are overweight or obese. Specific interventions are designed for each subgroup of the population. The program has nutrition indicators.

Peru – Juntos Results for Nutrition SWAp

RESPONDENT(s)	Alessandra Marini, Senior Economist, World Bank Group (WBG)
TYPE OF PROGRAM	Conditional Cash Transfer (CCT)
PROGRAM DURATION	March 2011 to March 2016
PROGRAM OBJECTIVE(S)	• Increase demand for nutrition services by strengthening the operational effectiveness of the Juntos CCT program • Improve coverage and quality of the supply of basic preventive health and nutrition services in the communities covered under the Articulated Nutrition Program (PAN), including the Juntos program
FUNDING AGENCY/IES	WBG (IBRD) $25 million Peru $29 million
IMPLEMENTING AGENCY/IES	Ministry of Economy and Finance (MEF)
TOTAL COST	$54 million
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	**CCT target group:** Juntos program beneficiary HHs with children under 36 months old. Targeted **Juntos CCT program:** 58,076 Juntos program beneficiary HHs. Targeted **Densification of enrollment of newborns in the Juntos CCT program:** 12,979 new enrolments.
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; integrated approach; governance; performance-based financing; community participation; rural; harnessing nutrition data; BCC; life-cycle approach; gender and women's empowerment;
CONTEXT	In recent years, Peru experienced its strongest period of rapid growth of the last decades, which led to a significant reduction in poverty. However, poverty and entrenched inequalities remained a critical challenge for the country's long-term economic and social prospects. Despite improvements, Peru's human development outcomes continued to lag behind the country's economic impetus. Health inequalities were large and persistent between socioeconomic groups and regions, particularly in rural areas and among indigenous communities. Although Peru is a middle-income country, with near-universal coverage of primary education, coverage for secondary education remained below desired levels, and ultimately less than 20 percent of second grade students reached full sufficiency in literacy (almost half were unable to read at all) and basic arithmetic.

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NUTRITION-SENSITIVE RATIONALE	The size of the Juntos CCT transfer is set to have an impact on nutrition, and frequent and reliable payments support expenditures for daily necessities. Transfers are given bimonthly to mothers, which gives women control over the income and consumption decisions. This WBG project, which supports both the demand and supply of health and nutrition services, has an explicit nutrition focus, i.e. improving coverage and quality of the provision of basic preventive health and nutrition services in the Juntos areas, and increasing the use of such services through health and nutrition coresponsibilities. Also, the project is designed to increase the enrolment of newborns into Juntos to ensure that children are monitored during the most critical nutrition window of opportunity. The project also supports the verification of health and nutrition co-responsibilities, which include regular health visits for pregnant women and children under 5 years old. The Juntos CCT project explicitly targets children in the first 1,000 days. An important element is the registration of the youngest children in the CCT program to make sure that health and nutrition coresponsibilities are monitored. In addition, efforts are being made increase the enrollment of newborns (from birth to 30 days old) in Integral Health Insurance Program (SIS). Overall, the WBG project targets 3 of the 14 poorest regions of the country where the Juntos program operates (Amazonas, Cajamarca, and Huánuco), where poverty and malnutrition rates are highest and the provision of basic services is limited. The payment of the Juntos transfer was changed from monthly to bimonthly to minimize the opportunity cost of traveling to get the transfer. Payments are disbursed through bank accounts at Banco de la Nación and associated debit cards. The project has nutrition indicators. The project adopts a multisectoral approach.

Middle East & North Africa

Djibouti – Social Safety Net Project

RESPONDENT(s)	Stefanie Koettl – Brodmann, Senior Economist, World Bank Group (WBG) Kevin Hempel, Consultant, WBG
TYPE OF PROGRAM	Public Works Program (PWP) with Food/Nutrition Supplement
PROGRAM DURATION	August 2012 to September 2018
PROGRAM OBJECTIVE(S)	• Provision of short-term employment opportunities in community-based labor-intensive works for the poor and vulnerable • Improvement of nutrition practices among participating HHs focusing on preschool children and pregnant or lactating women
FUNDING AGENCY/IES	WBG (IDA) $10 million (expanded to $14 million in 2016) JSDF $3.6 million (pilot)
IMPLEMENTING AGENCY/IES	Agence Djiboutienne de Développement Social in collaboration with local CSOs (including Union Nationale des Femmes de Djibouti, Association Ecologie du Village d'Adailou), and community-based associations. Djibouti Ministry of Health (MOH) World Food Programme
TOTAL COST	$13.6 million (expanded to $17.6 million in 2016)

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TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Households (HHs) that participate in the nutrition sessions, i.e. HHs with PLW or children under 2 years old, or both, in Djibouti Ville and all intervention areas (except in the towns of Dikhil and Obock, where the target includes HHs with children up to 5 years old). Beneficiaries of the nutrition sessions are eligible to register one HH member for the workfare program once a year. Targeted **Nutrition activities:** 7,000 individuals (expanded to 15,000 individuals in 2016). Targeted **PWP:** HHs (expanded to 8,000 individuals in 2016).
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; performance-based financing; community participation; harnessing nutrition data; BCC; gender and women's empowerment; ECD
CONTEXT	Djibouti is constantly affected by droughts, which contribute to severe food crises domestically and across neighboring countries and trading partners, such as Somalia, Kenya and Ethiopia. Income and consumption patterns of the urban and rural poor are severely strained by increases in food prices. Unemployment hovers at 50 percent. Data from 2012 estimated that 48 percent of the population lived in poverty and 23 percent in extreme poverty. In 2009, the infant and under 5 mortality rates were still among the highest in the region, at 75 and 94 per 1,000 live births, respectively.
NUTRITION-SENSITIVE RATIONALE	The size of transfer is set to have an impact on nutrition. It represents an increase of about 15 percent over annual total consumption for beneficiary HHs or about 45 percent of the budget needed to eliminate the food consumption deficit of poor HHs. Payments are frequent (in principle weekly, in practice biweekly) and reliable to support the purchase of daily necessities Women control the income. The great majority of labor-intensive work and service participants are women, who receive the funds and own the bank accounts. The program has firm conditions linked to the use of services. Only those who are enrolled in the nutritional assistance program are eligible for the PWP. The AF increased the nutrition sensitivity of the program. Nutrition services are offered at the community level to poor HHs with PLW and children from birth to 24 months old, addressing the first 1,000 days. These nutrition services include: • Sensitization sessions and community-based growth monitoring • Distribution of food supplements • Developing and conducting training on the prevention of malnutrition and promoting growth and child development • Providing support to the MOH with respect to the prevention of malnutrition at the community level • Support for early identification of pregnancy and promotion of health-seeking behavior; adapted BCC; monthly follow-up of weight gain for women; and accompanied referral to health centers and free hemoglobin testing • Activities to stimulate early childhood development for children 3–5 years old in selected areas The project applies a dual targeting mechanism. Geographical targeting is based on poverty rates. Within the target geographic areas, the beneficiary HHs are selected based on nutrition vulnerability, which identifies HHs pregnant women and children under 2 years old. The PWP specifically targets women by providing light tasks, such as services, street cleaning, and artisanal activities, and adapts working hours to their needs. Moreover, the work hours incorporate regular breaks to accommodate breastfeeding. Low intensity work is provided for PLW, and PLW receive nutritional support. The program has nutrition indicators. The project is accompanied by a range of M&E activities to inform project implementation and generate knowledge on the effectiveness of linking social protection and nutrition interventions, including: an MIS to capture data on eligible HHs, HHs attending nutrition sessions, and worker data; monitoring and qualitative surveys; and a rigorous impact evaluation. The emphasis on evaluation and learning is helping to establish a stronger focus on results and value for money within the relevant government agencies.

Syrian Arab Republic – Fresh Food Vouchers for Pregnant & Lactating Internally Displaced Women

RESPONDENT(s)	Mona Shaikh, Nutrition Advisor, World Food Programme.
TYPE OF PROGRAM	In-kind transfer (unconditional food voucher)
PROGRAM DURATION	July 2014 to December 2015 (pilot), expected to be scaled-up in 2016
PROGRAM OBJECTIVE(S)	• Improve diet diversity among PLW of internally displaced families in Syria • Raise awareness of beneficial nutrition and health practices
FUNDING AGENCY/IES	World Food Programme
IMPLEMENTING AGENCY/IES	Local NGO partners: Al-Ikhaa (Lattakia), Al-Birr (Homs).
TOTAL COST	$5.9 million per year
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Pregnant and lactating women (PLW) with children up to 6 months old in internally displaced and food-insecure families receiving World Food Programme emergency food assistance. Targeted: 15,000 individuals
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; community participation; agriculture and local procurement; conflict-affected setting; BCC; life-cycle approach; gender and women's empowerment
CONTEXT	World Food Programme is providing emergency food assistance to 4.25 million highly vulnerable and food insecure people affected by the civil conflict in Syria, many of whom are resorting to extreme coping strategies like reducing the number and quality of meals consumed. Nutritious fresh foods are available in the markets, but have become unaffordable for poor HHs because livelihoods have been affected and prices improving the dietary diversity of displaced and food insecure vulnerable PLW, who can use vouchers to purchase fresh fruit, vegetables, dairy products, and meat at participating retail shops. The conflict in the Syrian Arab Republic has entered its fifth year with increasing scale and intensity. Security risks and deteriorating socioeconomic conditions have resulted in large-scale and widespread internal displacement within Syria and an exodus of refugees to neighboring countries. Overall, it is estimated that approximately 4 million women and children in Syria are vulnerable and in need of preventive and curative nutrition services. Markets function in areas that are less affected by the crisis, although food prices have increased during the conflict. Locally produced and nutritionally rich food items, including vegetables and other fresh food items, are readily available in main markets but they are out of reach for poor households. The average retail price of wheat flour in Syria increased 388 percent over pre-crisis prices (measured in 2011) and increased by an average of 1 percent per month in 2015. The purchasing power of daily wage earners as reflected by the terms of trade, decreased by 14 percent from November 2014 to May 2015. A combination of price increases and reduction of income-generating opportunities has resulted in reduced access to and consumption of nutritious foods for the most vulnerable segments of the Syrian population. The average household is spending more than 50 percent of its total expenditures on food. Moreover, at least half of the population is unable to meet basic food needs with its own resources. The most common coping mechanisms adopted by families are the reduction in food consumption and the substitution of lower-quality, cheaper food. Low-quality diets combined with reduced access to health services increase the population's vulnerability to malnutrition, illness and disease.

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NUTRITION-SENSITIVE RATIONALE	The voucher can be used only to purchase items from a list of fresh, nutritious foods, which directly encourages beneficial dietary practices. The value of the voucher is based on a reference food basket expected to cover nutritional intake gaps in pregnant women, and is reviewed periodically. Vouchers are distributed on a regular monthly schedule and nutrition and health awareness sessions are held on distribution days. Women are the registered beneficiaries of the program, and the vouchers are delivered only to them, which gives them control over the food purchase choices and caters to their needs. World Food Programme collaborated with UNFPA and NGOs to ensure consistency in the delivery of complementary health and nutrition benefits to beneficiaries, such as community education sessions on voucher distribution days with information on reproductive health care, maternal nutrition, and maternal, infant, and young child feeding (MIYCF), and referrals to available services run by partners for PLW, such as micronutrient supplementation, antenatal care (ANC), vaccinations, and delivery and family planning services. Beneficiaries confirmed to be pregnant are referred to reproductive health services provided by other partners, where they can receive micronutrient supplements and vaccinations. This facilitates multisectoral collaboration and partnership in service delivery that includes NGOs and the private sector. In addition, beneficiaries and their accompanying family members are included in education sessions on appropriate MIYCF practices and the importance of various micronutrients for the health of both child and mother. These sessions, at which information and education communication materials are distributed, target both men and women to raise their awareness of issues related to mother and child health and recognize both the women's and men's influences on child feeding practices. The program targets women from the internally displaced families already identified as extremely vulnerable to food insecurity and receiving unconditional World Food Programme food assistance. The program targets PLW during the critical first 1,000 days of life, during which inadequate nutritional intake can lead to lifelong harm. The program specifically targets women in their most vulnerable stage of the life cycle and provides nutritional support by providing the diversified diet required for the proper growth and development of the unborn child and health of the mother. The individual dietary diversity score is used to assess the impact of vouchers on dietary diversity among target beneficiaries.

South Asia

Bangladesh – Income Support Program for the Poorest

RESPONDENT(s)	Iftikhar Malik, Senior Social Protection Specialist, World Bank Group (WBG) Aneeka Rahman, Social Protection Economist, WBG
TYPE OF PROGRAM	Conditional Cash Transfer (CCT)
PROGRAM DURATION	December 2014 to June 2020
PROGRAM OBJECTIVE(S)	To provide income support to the poorest mothers in selected Upazilas, while (a) increasing the mothers' use of child nutrition and cognitive development services, and (b) enhancing local level government capacity to deliver safety net programs.
FUNDING AGENCY/IES	WBG (IDA) $300 million Government of Bangladesh (GOB) $3.37 million

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IMPLEMENTING AGENCY/IES	Local Government Division
TOTAL COST	$303.37 million
TARGET GROUP(S) & NUMBER OF TOTAL TARGETED BENEFICIARIES	Poor households (HHs) with pregnant women, or mothers of children under 5 years old, or both Targeted: 600,000 mothers; 2.7 million indirect individual beneficiaries.
PROGRAM CROSS-CUTTING THEMES	Multisectoral collaboration; decentralization; life-cycle approach; gender and women's empowerment; ECD
CONTEXT	Despite remarkable progress in the fight against poverty, reducing extreme poverty is a key development challenge for Bangladesh. Poverty fell from 48.9 percent in 2000 to 40 percent in 2005 to 31.5 percent in 2010. Coupled with this progress was consistent improvement in well-being measured by asset ownership, better-quality homes, improved access to amenities, and increased caloric intake and educational attainment across all income groups. Nevertheless, the latest available data at the time of program design (2014) show that an estimated 26 million HHs (about 18 percent of the population) remain extremely poor. Extreme poverty in Bangladesh is mainly a rural phenomenon: 60 percent of the poor in rural areas are also extremely poor. Annually Bangladesh spends over 2 percent of its GDP on social protection programs, but there are high levels of leakage, and the bulk of resources go to the nonpoor. To accelerate its poverty reduction, rates Bangladesh needs to make better use of its social protection expenditures. The GOB has set a target for a poverty rate of 14 percent by 2021. Assuming population growth continues to decline at the same rate as that from 2000–10, achieving this poverty target will require lifting approximately 15 million people out of poverty in the next eight years. Currently, expenditures for social protection within the country are skewed toward a few large programs that primarily address emergencies and seasonal shocks. Programs target pregnant women and young children are severely limited. Poor targeting of safety net benefits, along with inadequate average transfer amounts at the beneficiary level, also limit the potential of the safety net to reduce poverty. Social protection programs in Bangladesh at present cover only one-third of the poor population.
NUTRITION-SENSITIVE RATIONALE	The size of the cash transfer is set to have an impact on nutrition. It represents approximately 15–23 percent of the estimated average monthly per capita expenditure of the target population. Payments are frequent and reliable to support expenditures for daily necessities. Because mothers are the recipients of the transfers, women have control over the income. CTs are given to beneficiaries upon compliance with firm conditions consisting of the use of health and nutrition services and attendance at nutrition and health education sessions. Specific conditions include antenatal care services; growth monitoring and promotion services; and attendance at child nutrition and cognitive development (CNCD) sessions. ISPP is implemented in 42 of the poorest Upazilas (subdistricts), which have a high probability of malnutrition of children under 5 years old. Within the selected locations, the program targets at-risk groups having the following two characteristics: (a) HHs in the bottom two expenditure quintiles; and (b) HHs with pregnant women, or mothers of children under 60 months old, or both. Payments are made electronically to beneficiary mothers so as to minimize the time spent traveling to get the transfer. The program has nutrition indicators (impact evaluation).


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