HNP DISCUSSION PAPER

Nutrition Beyond the Health Sector

A Profile of World Bank Lending in Nutrition from 2000 to 2006

James Garrett and Safinaz El Hag El-Tahir

January 2008

HNP
HEALTH, NUTRITION, AND POPULATION
THE WORLD BANK

NUTRITION BEYOND THE HEALTH SECTOR:

A Profile of World Bank Lending in Nutrition from 2000 to 2006

James Garrett and Safinaz El Hag El Tahir

January 2008

Health, Nutrition and Population (HNP) Discussion Paper

This series is produced by the Health, Nutrition, and Population Family (HNP) of the World Bank's Human Development Network. The papers in this series aim to provide a vehicle for publishing preliminary and unpolished results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual author(s) whose name appears on the paper.

Enquiries about the series and submissions should be made directly to the Managing Editor, Nicole Klingen (Nklingen@worldbank.org). Submissions should have been previously reviewed and cleared by the sponsoring department, which will bear the cost of publication. No additional reviews will be undertaken after submission. The sponsoring department and author(s) bear full responsibility for the quality of the technical contents and presentation of material in the series.

Since the material will be published as presented, authors should submit an electronic copy in a predefined format (available at www.worldbank.org/hnppublications on the Guide for Authors page). Drafts that do not meet minimum presentational standards may be returned to authors for more work before being accepted.

For information regarding this and other World Bank publications, please contact the HNP Advisory Services at healthpop@worldbank.org (email), 202-473-2256 (telephone), or 202-522-3234 (fax).

Health, Nutrition and Population (HNP) Discussion Paper

Nutrition Beyond the Health Sector:
A Profile of World Bank Lending From 2000 To 2006

James Garrett[a] and Safinaz El Tag El Tahir[b1]

[a] International Food Policy Research Institute (IFPRI), Washington, DC, USA
[b] Europe and Central Asia Region, The World Bank, Washington, DC, USA

Paper prepared for the Health, Nutrition and Population Unit, Human Development Network
The World Bank,

Abstract: The World Bank report *Repositioning Nutrition as Central to Development* (2006) explicitly recommended improving nutrition by not only working through the health sector, but also in non-health sectors such as agriculture and education. This report provides descriptive and financial profiles of the Bank's recent portfolio in nutrition (from FY2000 to late FY2006) to note the extent to which the Bank has actually gone outside the health sector to work on nutrition.

In this period, 41 projects were assigned a theme of "food and nutrition security." Just over half of them (22 out of 41) had nutrition-related components or activities. Of these 22 projects, half fell within the health sector, and half fell outside.

Because current monitoring tools are inadequate, the exact amount of Bank support for nutrition in this period cannot be determined. Current tools often do not allow managers to identify the actual amounts each project invested in nutrition. Sector-wide investments cause the most problems because they often bundle nutrition with other activities and do not clearly specify amounts allocated to each.

Initially excluding 3 sector-wide projects where amounts invested by the project or the Bank in nutrition are uncertain, confirmed total Bank investment in nutrition in the period was US$332.89 – 362.69 million, with US$115.89 – 116.69 million channeled through non-health sectors. Assuming all Bank investment in these 3 projects went to nutrition would increase Bank investment by US$500 million (total Bank investment was US$200 million in 2 projects in Peru and US$300 million in a project in Bangladesh).

In a positive light, the amounts invested in nutrition are substantial and the Bank is, perhaps surprisingly, already pursuing a good deal of nutrition investment through non-health sectors. But opportunities for synergy are being missed, and amounts do not come close to demonstrated need. For instance, the Bank invested in 16 countries in non-emergency situations. Of these, all

[1] James Garrett is a Research Fellow at the International Food Policy Research Institute (IFPRI). He is formerly a Senior Economist in the Health, Nutrition, and Population (HNP) unit of the World Bank, under the Staff Exchange Program. Safinaz El Hag El Tahir is a Rural Development Specialist in the Europe and Central Asia Region of the World Bank. First authorship is not assigned.

but 3 were countries with a “high burden” of malnutrition. Unfortunately, the Bank has identified 80 countries as “high burden,” so much more remains to be done. In addition, current methods of tracking investment and impact are inadequate, and without modification, deficiencies will increase over time.

Keywords: lending, multisectoral, nutrition, World Bank

Disclaimer: The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

Correspondence Details: Safinaz El Tag El Tahir, World Bank, 1818 H Street, NW, Washington, DC 20433, USA, Tel: +(202)458-1826, email: seltahir@worldbank.org.

Table of Contents

Tables

Figure

ACRONYMS AND ABBREVIATIONS

AIN-C	Atención Integral en Nutrición a Nivel Comunitario (Integrated Care for Children)
APLs	Adaptable Program Loans
BW	World Bank Business Warehouse
CAS	Country Assistance Strategy
CBO	Community Based Organization
CSW	Commercial Sex Workers
DAA	Division of Agricultural Affairs
DHC	District Health Center
CHW	Community Health Worker
C-IMCI	Community Integrated Management of Childhood Illness
CRDS	Regional Sustainable Development Council
DOTS	Directly Observed Treatment-Short Course
DRC	Democratic Republic of Congo
ECD	Early Childhood Development
ED	Education
EPI	Expanded Program for Immunization
ERLs	Emergency Recovery Loans
ESD	Essential Services
ESSD	Environmentally and Socially Sustainable Development
GAIN	Global Alliance for Improved Nutrition
Ha	Hectare
HE	Health
HH	Health House
HNP	Health, Nutrition and Population
ICR	Implementation Completion Report
IDA	International Development Association
IDD	Iodine-deficiency Disorder
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
INF	Infrastructure
INI	National Indigenist Institute
LGU	Local Government Units
M&E	Monitoring and Evaluation
MCH	Maternal-Child Health
MEF	Ministry of Economy and Finance
MOA	Ministry of Agriculture
MOH	Ministry of Health
MSM	Men Having Sex with Men
MT	Metric Ton
NCD	Non-Communicable Diseases
NEP	Nutrition Enhancement Program
NGO	Non-Governmental Organization
NHP	National Health Plan
PAD	Project Appraisal Documents
PBHS	Package of Basic Health Care Services
PCU	Project Coordinating Unit
PDOs	Project's Development Objectives
PDPLs	Programmatic Development Policy Loans
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PID	Project Information Documents
PLWHA	People Living With HIV/AIDS
PO	Poverty
PREM	Poverty Reduction and Economic Management
PRONAA	Programa Nacional de Asistencia Alimentaria (National Food Assistance Program)
PRSC4	Forth Reduction Support Credit
PRSPs	Poverty Reduction Strategy Papers
PSALs	Programmatic Structural Adjustment Loans
PSNP	Productive Safety Net Project
PWPs	Public Work Projects
RHC	Rural Health Center
RDV	Rural Development
SILs	Specific Investment Loans
SIML	Sector Investment and Maintenance Loan
SP	Social Protection
SSP	Social Support Projects
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STP	Secretariat of the Presidency
SVPs	Primary Care Centers
SWAps	Sector-Wide Approaches
TA	Technical Assistance
TAP	Treatment Acceleration Project
TB	Tuberculosis
TR	Transportation
UHC	Urban Health Center
UNECA	United Nations Economic Commission for Africa
WHO	World Health Organization

ACKNOWLEDGEMENTS

The authors are grateful to Meera Shekar (Senior Nutrition Specialist, Health, Nutrition and Population) for her support and guidance in the production of this report. We are also thankful for very helpful comments from Yi-Kyoung Lee (Health Specialist, Africa Region 2); Nwanze Okidegbe (Adviser, Agriculture and Rural Development); and Richard Heaver, who served as peer reviewers of the paper.

The authors would also like to thank our colleagues in the Health, Nutrition, Population unit and at IFPRI who supported the data and information gathering, organization, and editing of this report, including Ayanna Anderson-Bellard, Melinda Elias, Rifat Hasan, Jessica St. John, Nelly Tioco, and Jacques Wright.

EXECUTIVE SUMMARY

The World Bank report *Repositioning Nutrition as Central for Development* (2006) explicitly recommends working to improve nutrition not only through the health sector but also through appropriate actions in other sectors, including agriculture and education. The Bank's 2007 Health, Nutrition, and Population strategy calls for an integrated multisectoral approach to achieve results. Utilizing data on projects approved at the Bank from Fiscal Year 2000 through late Fiscal Year 2006[2], this report reviews the extent to which the Bank has actually gone outside the health sector to work on nutrition, profiling the Bank's recent portfolio in nutrition and providing examples of how operational staff can integrate nutrition into projects outside the health sector. This information, which includes thumbnail descriptions of all projects, allows the report to serve as a quick initial reference for recent projects in nutrition.

OBJECTIVES OF THE REVIEW

The report has two primary aims and audiences:

- To describe the nutrition-related components of projects to operational staff who are or could potentially be working on nutrition, and provide examples of ways to integrate nutrition activities into non-health-sector projects;
- To present an overview of the nutrition portfolio outside health to managers and directors, giving insight into operational and strategic concerns regarding the current state of lending for nutrition.

Specifically, the review provides:

1) an overview and descriptive profile for all nutrition projects approved at the World Bank from Fiscal Year 2000 to late Fiscal Year 2006 in health and other sectors (including the number of projects as well as kinds of activities, sectors, and countries);
2) a financial profile for these projects (including total Bank investment, total project investment, and type of lending instrument);
3) suggestions for follow-on analyses and activities to strengthen the Bank's inter-sectoral work in nutrition.

DESCRIPTIVE PROFILE

How many nutrition projects were there? In what sectors?

From FY2000 to FY2006, 41 projects were assigned a theme of "food and nutrition security." Just over half of them (22 out of 41) actually had nutrition-related components or activities. Of these 22 projects, half fell within the health sector, in terms of sector classification, and half fell outside. Of the 11 projects under sector boards other than Health, 5 fell under Social Protection, 4 under Education, and 2 under Rural Development. No projects with nutrition components came under sector boards for Transportation or Poverty.

[2] The project list was generated in May 2006.

How did Project Development Objectives reflect attention to nutrition?

The project's development objectives (PDOs) should describe the project's main objectives in terms of expected outcomes. Only 15 of the 22 projects specifically mentioned nutrition in their PDOs. PDOs of projects in the health sector were much more likely to note the focus on nutrition (9 of 11 projects) than projects outside the health sector (only 6 of 11). Mention of nutrition in PDOs is not systematic, even when nutrition activities are part of the project, and the statements are sometimes rather vague, precluding a clear translation of the project objectives into project indicators. More explicit attention to nutrition in PDOs would enable reviewers to better assist monitoring, evaluation, and learning activities of the project, and would provide a guiding focus for the team during the design phase.

What nutrition activities were in non-health-sector projects?

Focusing specifically on the projects carried out under sector boards other than health, we found that the 11 non-health-sector projects carried out 28 activities or interventions. These projects were in 3 sectors: social protection, education, and rural development. The most common activities were nutrition education, micronutrient supplementation, capacity building, and growth monitoring and counseling. Social marketing, specific training activities, school feeding, and cash transfer activities also appeared.

Some types of activities appear in projects in all the sectors—even activities normally thought of as primarily health-based. For instance, growth monitoring and counseling and micronutrient supplementation were elements of projects in all 3 non-health sectors (social protection, education, and rural development). This may suggest substantial, relatively easy opportunities for cross-sectoral integration.

Within a sector, we found that social protection projects appear broad enough in terms of content and institutional linkages that they can provide numerous points for sectoral connections with nutrition. In education, early childhood development programs may provide a good entry point. Rural development has as-yet unrealized opportunities to incorporate nutrition, through investment in biofortification research, for example. But emergency recovery programs, which here were designated as part of the rural development sector projects, may also provide good opportunities, as protecting food and nutrition security is often a prime objective of disaster relief.

Who was responsible for implementing nutrition projects?

The Ministry of Health (or Ministry of Health and Social Welfare) was the government partner for all health-sector nutrition projects. But partners for the non-health-sector activities varied, and included a range of government ministries, agencies and local government bodies. However, these institutions are usually only named as the agency responsible for oversight, and primary responsibility for implementation may be given to another unit, or even to multiple units. The implications of these institutional arrangements for effective nutrition programming remain to be explored.

Interestingly, there is a broad overlap in the components of projects implemented by non-health actors with those of projects carried out by the health sector. The non-health-sector projects described above often incorporated a *broader* range of activities, such as reform of social services, than those found in a health-based project.

How were the results framework and output/impact indicators used?

Only 4 of the 11 projects had nutrition-related indicators for the overall project development objectives as well as for the nutrition-related project components. Indicators were sometimes vague and not consistent

across projects. A brief review suggested no project set out sufficiently comprehensive indicators to measure operational efficiency and effectiveness as well as impact. The need for multisectoral action in nutrition, including support for institutional development and for actions with indirect routes to improving nutrition, can further complicate monitoring and assessment.

What about impact?

Only 4 projects of the 11 non-health-sector projects had Implementation Completion Reports (ICRs) available at the time of the review. ICRs are internal reports of the Bank that provide an initial assessment of the project at project end. One of the projects (Yemen Child Development Project) was rated as Unsatisfactory, given some delay in the project. All others were Satisfactory. Staff should be able to turn to ICRs to gain insight into issues of design and management as they integrate nutrition into Bank projects, but currently such insight is weak and not especially timely.

This report gives some guidance regarding the opportunities for integrating nutrition activities into projects outside the health sector, but as yet we have no systematic or comprehensive analysis of experiences to answer key operational questions such as: What kinds of multisectoral approaches and arrangements are most effective? Which interventions offer the best returns? Do they offer better returns than a more traditional single-sector intervention? Of course, many findings would be country-specific, but application of a shared analytical framework across a select set of projects could begin to shed light on these questions.

Efforts are being made to answer some of these questions. Countries are pursuing successful multisectoral and intersectoral approaches to reducing malnutrition from which we can learn. The Bank is producing a number of documents relevant to this issue, including a study on lessons for multisectoral action on nutrition, a series of case studies on country experiences, and guidelines and studies on how to link nutrition with prevention and treatment of HIV/AIDS and with agricultural activities.

FINANCIAL PROFILE

How much did the Bank invest in nutrition?

The 22 projects with nutrition components had a total investment of US$5819.04 million. Eighty-six percent of the total, or US$5029.58 million, corresponded to the health sector, and 14 percent, or US$789.46 million, to the non-health sectors. But these figures are misleading as an indicator of the global reach of the Bank's investment as US$4306.2 million of the total investment was for a single Health, Nutrition and Population Sector Program in Bangladesh. Without this project, the figure for project amounts channeled through the health sector was about the same or even slightly less than investment through other sectors.

Of course, estimates of total project amounts are not reflections of the actual spending on nutrition, because they include investment in multiple activities (especially when the investment is through a sector-wide approach or when nutrition interventions are packaged with others). Sector reform projects in Bangladesh (US$4306.2 million) and Peru (2 projects totaling US$200 million) did not specify the amount allotted to nutrition and their inclusion, being large, could bias the figures. Excluding these projects, confirmed total project investment in nutrition amounted to US$493.03 million, with US$190.57 million, or 39 percent, through non-health sectors. Bank investment totaled US$332.89 – 362.69 million (Bank contribution was uncertain in some cases) of this amount, with Bank investment through non-health sectors at US$115.89 – 116.69 million. This represents the minimum investment in nutrition by the Bank in this period, not yet accounting for spending through the Peru or Bangladesh sector-wide projects.

Inclusion of the Peru sector reforms or the Bangladesh sector support for health, nutrition, and population would increase this amount of total Bank investment substantially. However, as indicated, the lack of information on how much each of these projects actually invested in nutrition makes the exact figure very difficult to quantify. As before, if we assume that none of the project's money went to nutrition (an admittedly unrealistic assumption) then the figures above hold. If we assume all of the Bank investment in the project was spent on nutrition, then the summary amounts increase by US$500 million (US$200 million for the Peru programs and US$300 million for the Bangladesh program), giving a potential Bank investment in nutrition between US$832.89 – US$862.59 million for the period.

Promising news is that all but 3 countries with investments (Dominican Republic, El Salvador, Iran) were countries with a "high burden" of malnutrition, where stunting or underweight affected more than 20 percent of children under 5 years old. And at 19 percent of children under five, stunting was nevertheless very near to "high-burden" levels in El Salvador. Of greater concern is that the Bank financed nutrition projects in *only* these 18 countries, when the Bank has identified 80 countries as being "high-burden."

What instruments were used for lending in nutrition?

Half of lending to projects with nutrition activities was through Specific Investment Loans (SILs). Emergency Recovery Loans (ERLs) financed 3 projects. Other nutrition lending was through a variety of instruments, including Programmatic Development Policy Loans (PDPLs), Programmatic Structural Adjustment Loans (PSALs), and Adaptable Program Loans (APLs). This suggests that financing for nutrition is not limited to one instrument, but the instrument can be adapted to need.

CONCLUSIONS

The Bank has made a start in integrating nutrition into projects outside the health sector, reflecting an understanding, as well as the possibilities, of having a multisectoral approach to reducing malnutrition. In addition, the Bank is beginning to produce tools and studies to support further integration. Furthermore, the Bank's investment in nutrition is primarily through investment projects and policy and program loans, which indicates a level of confidence and commitment greater than if the Bank were financing nutrition through, say, significant numbers of emergency or learning loans.

On the other hand, the Bank invests a relatively small amount in nutrition, whether through health or other sectors, and coverage in terms of countries and population is limited.

Various weaknesses in Bank spending on nutrition remain. Some deficiencies are methodological and others are programmatic.

- The total number and lending amounts of multisectoral nutrition projects do not come close to demonstrated need.
- Current methods of tracking investment and effectiveness in nutrition are inadequate. Without modification, deficiencies will grow over time, especially as the Bank's policy lending or use of sector-wide approaches grows.
- ICRs are reasonable summaries but more comprehensive analyses of project effectiveness, including operational evaluations and impact assessments, are needed, as is a more systematic way for staff to collect and easily access lessons in project design and management.
- Many projects do not have clear nutrition goals, and those that do fail to incorporate indicators adequate to monitor nutrition activities and evaluate their performance.

Clearly, the Bank is missing opportunities to incorporate nutrition into activities outside the health sector, but without a more solid evidence base, it is difficult to confidently guide Bank staff, policymakers, or program officials. Recommendations to "do more work multisectorally" stem mainly from individual case studies and expert perception of what seems to be working. Systematic analyses of these experiences, including insights on impacts, costs, benefits, and political and organizational issues, still need to be carried out, as does the consequent development of tools for partners and staff to more effectively and efficiently integrate nutrition into a wide range of sector activities. Actions should not overlook the importance of identifying the challenges internal to the Bank, including individual incentives, awareness, and organizational structure, that promote or inhibit intersectoral collaboration on nutrition.

PART I – INTRODUCTION

The World Bank report *Repositioning Nutrition as Central to Development* (2006) argues that the most effective initiatives to reduce malnutrition require a multisectoral framework, if not necessarily a multisectoral program. The report explicitly recommends working to improve nutrition not only through the health sector but also through appropriate actions in other sectors, including agriculture and education, and establishing links with cross-cutting issues such as gender. The 2007 strategy for the World Bank in Health, Nutrition, and Population also calls for an integrated multisectoral approach to the Bank's lending activities in these areas (World Bank 2007a).

This report reviews the extent to which the Bank has actually gone outside the health sector to work on nutrition in support of this strategy. It examines the Bank's recent portfolio in nutrition and gives examples of how operational staff in the Bank can integrate nutrition into projects outside the health sector.

OBJECTIVES OF THE REVIEW

This report is an initial step in supporting the Bank's efforts to work cross-sectorally in nutrition. The report has two primary aims and audiences:

- To describe the nutrition-related components of projects to operational staff who are or could potentially be working on nutrition, and provide examples of ways to integrate nutrition activities into non-health-sector projects;
- To present an overview of the nutrition portfolio outside health to managers and directors, giving insight into operational and strategic concerns regarding the current state of lending for nutrition.

Specifically, the review provides:

1) an overview and descriptive profile for all nutrition projects approved at the World Bank from Fiscal Year 2000 to late Fiscal Year 2006 in health and other sectors (including the number of projects as well as project components and countries);[3]
2) a financial profile for these projects (including total Bank investment, total project investment, and type of lending instrument);
3) suggestions for follow-on analyses and activities to strengthen the Bank's inter-sectoral work in nutrition.

The descriptive profile asks the following questions:

- How many nutrition projects were there? In what sectors?
- How did a project's development objectives reflect attention to nutrition?
- What nutrition activities did non-health-sector projects have?
- Who was responsible for implementing nutrition projects?
- How were the results framework and output/impact indicators used?
- What can we say about impact?

[3] The project list was generated in May 2006.

The financial profile asks:

- How much did the Bank invest in nutrition?
- What instruments were used for lending in nutrition?

CONTEXT OF THE REVIEW

This report complements other recent reports on nutrition at the Bank (Cardemil 2006; Claeson, Mawji, and Walker 2000; Heaver 2006; Rutabanzibwa-Ngaiza and Shekar 2006; Shekar and Lee 2006). It differs from them in that it collects information on all nutrition projects since 2000, offers more detailed descriptions of all projects being undertaken outside the health sector, and provides a succinct project and financial profile for each of them. This report can thus serve as a quick basic reference for recent projects in nutrition.

The genesis of each of these earlier reports accounts for other differences as well. For instance, Cardemil (2006) reviews only projects in countries with high prevalence of malnutrition ("high-burden countries") and examines aspects of monitoring and evaluation not covered in this report. Heaver (2006) considers lending only to 2003, with less attention than this report to projects outside health. Rutabanzibwa-Ngaiza and Shekar (2006) focus mostly on monitoring and evaluation indicators. Shekar and Lee (2006) summarize how the Poverty Reduction Strategy Papers (PRSPs) incorporate the issue of nutrition. This last does specify proposed nutrition activities, but, as it reviews PRSPs and not projects, it does not describe what projects were actually undertaken. Claeson, Mawji, and Walker (2000) review the HNP portfolio, but only for FY 1993-99. In addition, as a review of "best buys," they simply note whether the Bank was at that time investing in "best buys" in different categories. They do not describe projects.

It should also be noted what this report does not do. The report's main focus is on providing an overview of nutrition projects within the Bank, with special attention to how projects in sectors other than health incorporate nutrition activities. Although the report can make a useful contribution to a broader analysis, it does not itself pretend to analyze, summarize, or evaluate all the Bank's activities in nutrition – its analytical, technical, or advisory work, or the quality, quantity, and structure of human resources to support nutrition, for instance. Nor does it examine how the Bank's global and country-level partnerships, with organizations such as WHO and GAIN or trust-fund donors, such as the Netherlands, contribute to the Bank's work in nutrition, although these partnerships may themselves support inter- or cross-sectoral analyses and action.

METHODOLOGY

We began with data from the World Bank Business Warehouse (BW), an integrated database that allows Bank staff to generate management reports and perform informational analyses. The Business Warehouse allows task team leaders to assign up to 5 descriptive codes to a project, at their discretion. Initially, we selected all projects that had "food and nutrition security" as one of the primary or secondary themes and had been approved beginning in FY2000 up to late FY2006. We chose FY2000 as a starting date since we primarily wanted a picture of recent conditions at the Bank, and this would cover projects for at least the past five years.

The "food and nutrition security" theme was the code closest to our objective. Bank guidance points to this code as the appropriate one for "programs that include objectives and specific activities related to improving nutritional status or food security at the household level." But, of course, this code includes projects on food security and not just nutrition.

The distinction between food security and nutrition security is important. Food security is generally concerned with provision of food alone, but often includes attention to energy. Nutrition security focuses more on ensuring the availability of a diverse diet consisting of both macro- and micro nutrients, such as

vitamins or minerals. Nutrition security for a child would include access to health and a healthy environment and appropriate caring and feeding practices, in addition to an adequate diet (food). A food-security-related intervention, however, could pay more attention to food production or marketing activities, which may have only an indirect connection to nutrition. For example, a food security project could improve agricultural technologies or otherwise support agricultural production and marketing, and so raise producer incomes or lower consumer prices for food. The direct impact on child nutritional status of higher incomes or lower food prices, however, is likely to be rather modest, given the importance of other determinants in the causal chain with closer relationships to nutrition (child breastfeeding, for example). Still, we would include such projects if they had a specific objective of improving nutrition. For instance, an investment to develop new agricultural technologies would qualify if it specifically attempted to improve bioavailability of nutrients in the crop, or if a marketing campaign had an explicit objective of improving food choices and dietary quality.

Along these lines, since we were most interested in seeing how nutrition-related activities were integrated into projects in sectors outside health, we looked for projects that had specific nutrition objectives, with activities or components clearly directed to improving nutrition, not those that might affect nutrition in a more indirect way.

The Business Warehouse, however, does not allow this level of definition. Because the code combines food and nutrition, task team leaders could use it for a project that impacted food security, whether or not the project had any specific component dealing with nutrition. For instance, they might assign this code to a project involving the construction of rural roads. While the roads may increase food security, their direct nutrition impact would be tenuous. If the road construction project targeted women for employment and provided nutrition education or childcare, the potential impact on nutrition would be clearer, and could be included as a "project with a nutrition-related component."

The system is further complicated because each project is allowed up to 5 codes, at least 1 of which is primary. The others may be primary or secondary. The system automatically assigns weights to the themes to assist in tabulating the allocation of investment, with each primary theme (there can be more than one) given twice the weight of the secondary themes. Because the task team leader determines the assignment of the codes, and because the weighting between primary and secondary themes is arbitrary, data on investments from Business Warehouse need not reflect actual investment. Furthermore, projects with similar attention to nutrition may differ because the task team leader does not use the food and nutrition security code or allocates primary and secondary themes differently.

Clearly, the data available from Business Warehouse are not adequate to identify the projects that are directly relevant to nutrition, and one cannot accurately perform the descriptive or financial analyses on a project- or Bank-wide basis using only that data. To see which projects actually had nutrition-related activities or interventions required a manual review of project documents.

To gather this information, we reviewed, wherever possible, Project Appraisal Documents (PAD), Project Information Documents (PID), Implementation Completion Reports (ICR), and grant agreements and other supporting documents. The documents selected for review provide the most information available on the different phases of the World Bank project cycle—from identification, preparation and appraisal to implementation, supervision, conclusion, and evaluation. Even so, and even though likely more accurate than Business Warehouse, most of these documents cannot provide exact figures either. Only the ICR provides actual amounts invested.

Nevertheless, the information collected for this review establishes a baseline of recent projects in nutrition at the World Bank. The data are significantly more accurate and complete than those available from Business Warehouse. The database we have produced should be updated periodically. Given the lack of information in available documents, particularly in terms of project quality and impact, this would require some but not extensive effort.

PART II – DESCRIPTIVE PROFILES OF NUTRITION PROJECTS

This section profiles the content of the various nutrition projects in this study, in particular their components and their relation to stated development objectives.

HOW MANY NUTRITION PROJECTS WERE THERE? IN WHAT SECTORS?

From FY2000 to FY2006, 41 projects were assigned the "food and nutrition security" theme (Table 2.1). These projects fell under the organizational parameters of various sector boards, depending on the primary thrust of each project. The sector board is a coordinating committee of individuals internal to the Bank, drawn from the regional staff and global networks that deal with specific thematic topics. These projects were categorized under sector boards for health, education, poverty, rural development, social protection, and transportation. About 5 "food and nutrition" projects per year were approved in this period. Of the 41 projects, about 18 projects, or nearly half, were approved under the health-sector board. The remaining 23 projects came under other sector boards including education (4 projects), poverty (1 project), rural development (9 projects), social protection (6 projects), and transportation (3 projects).

Just over half of the "food and nutrition" projects (22 out of 41) actually had nutrition-related components or activities (Table 2.2). Of these 22 projects, half fell within the health sector, in terms of sector classification, and half fell outside. As might be expected, proportionally more of these came from the health sector (11 of 18, or 61%) than from sector boards outside health (11 of 23 projects, or 48%). Of the 11 projects under sector boards other than health, 5 fell under social protection, 4 under education, and 2 under rural development.

No project listed under the transportation or poverty board turned out to have any identifiable nutrition component. Projects under transportation or poverty might include components potentially related to food and nutrition security through, for example, investment in road construction, maintenance and safety; development of a rural transport strategy; or delivery of social services. Improvements in food security, and ostensibly in nutritional status, could be seen as outcomes of the improvements in roads or service. Nevertheless, while improved transportation may facilitate access to health care and raise incomes we did not consider such projects to have a specific enough nutrition 'component' and so do not cover them in detail. Annexes 1 and 2 do, however, present thumbnail summaries of all projects assigned the food and nutrition security theme in health and non-health sectors, respectively.

HOW DID PDOS REFLECT ATTENTION TO NUTRITION?

A project's development objectives (PDOs) should describe the project's main objectives in terms of expected outcomes. They can reveal a great deal about the emphasis given to nutrition in the project, as later project evaluations will assess the project based on its stated PDOs.

Fifteen of the 22 projects with nutrition-related components specifically mentioned nutrition in their PDOs. PDOs of projects in the health sector were much more likely to do so (9 of 11 projects) than projects outside the health sector (only 6 of 11). Outside the health sector, the projects that mentioned nutrition in their PDOs were mostly in social protection and education. Only 1 project out of 4 in the rural development sector mentioned nutrition in its PDOs (Table 2.3).

Table 2. 1. Projects with Food and Nutrition Security Theme, FY00-FY06

FY	Project ID	Project Title	Country	Sector Board
FY00	P050483	Child Development Project	Yemen	ED
	P050751	National Nutrition Project	Bangladesh	HE
	P051741	Second Health Sector Support Project	Madagascar	HE
	P057530	Rural Development in Marginal Areas Project - APL II	Mexico	RDV
	P058842	Mindanao Rural Development Project (APL)	Philippines	RDV
	P068739	Second Social Development Project - Health & Nutrition - Supplemental Loan	Ecuador	HE
	P069943	Second Primary Health Care and Nutrition Project	Iran	HE
	P070533	Agricultural Rehabilitation Project	Timor-Leste	RDV
FY01	P035672	National Transport Program Support Project	Chad	TR
	P068463	Integrated Early Childhood Development Project	Eritrea	ED
	P073307	National Fertilizer Sector Project - Supplemental Credit	Ethiopia	RDV
FY02	P050383	Food Security Project	Ethiopia	RDV
	P067986	Earthquake Emergency Recovery & Health Services Extension Project	El Salvador	HE
	P070541	Nutrition Enhancement Program	Senegal	HE
	P073911	Second Agriculture Rehabilitation Project	Timor-Leste	RDV
	P075956	Institutional Strengthening of National Indigenist Institute	Mexico	SP
FY03	P054937	Early Childhood Education Project	Dominican Republic	ED
	P057296	Emergency Multisector Rehabilitation and Reconstruction Project	Dem. Rep. of Congo	TR
	P070542	Health Sector Support Project	Cambodia	HE
	P073817	Programmatic Social Reform Loan Project (02)	Peru	SP
	P080368	Emergency Drought Recovery Project	Malawi	RDV
	P080612	Emergency Drought Recovery Project	Zambia	RDV
	P081773	Emergency Drought Recovery Project	Ethiopia	RDV
	P082395	Programmatic Human Development Reform Loan Project	Ecuador	HE
FY04	P050740	Health Sector Reform Project	Sri Lanka	HE
	P082335	Second Health Sector Development Project	Tanzania	HE
	P082613	Regional HIV/AIDS Treatment Acceleration Project	Africa	HE
	P084601	Nutrition II - Supplemental Credit	Madagascar	HE
FY05	P051370	Health 2 Project	Uzbekistan	HE
	P070823	Education Sector Support Project 1	Malawi	ED
	P074841	Health Nutrition and Population Sector Program	Bangladesh	HE
	P076799	HIV/AIDS Prevention and Control	St Vincent & the Grenadines	HE
	P078523	Integrated Human Development Project	Maldives	SP
	P078991	Health Services Extension and Modernization (2nd APL)	Nicaragua	HE
	P083968	Programmatic Social Reform Loan IV	Peru	SP
	P087707	Productive Safety Nets Project (APL 1)	Ethiopia	SP
	P088729	Supplemental Credit for Second Health Project (CRESAN II)	Madagascar	HE
FY06	P077756	Maternal and Infant Health and Nutrition	Guatemala	HE
	P088642	Social Protection Project	El Salvador	SP
	P090881	Poverty Reduction Support Credit 5	Uganda	PO
	P096305	CD-Emergency Multi Sectoral Rehab & Recovery ERL Supplemental (FY06)	Dem. Rep. of Congo	TR

Sector Board

HE = Health SP= Social Protection

TR = Transportation ED= Education

PO = Poverty RDV = Rural Development

Table 2. 2. Projects with Nutrition Components, FY00-FY06

FY	Project ID	Project Title	Country	Sector Board
FY00	P050483	Child Development Project	Yemen	ED
	P050751	National Nutrition Project	Bangladesh	HE
	P051741	Second Health Sector Support Project	Madagascar	HE
	P068739	Second Social Development Project - Health & Nutrition - Supplemental Loan	Ecuador	HE
	P069943	Second Primary Health Care and Nutrition Project	Iran	HE
FY01	P068463	Integrated Early Childhood Development Project	Eritrea	ED
FY02	P050383	Food Security Project	Ethiopia	RDV
	P067986	Earthquake Emergency Recovery & Health Services Extension Project	El Salvador	HE
	P070541	Nutrition Enhancement Program	Senegal	HE
FY03	P054937	Early Childhood Education Project	Dominican Republic	ED
	P070542	Health Sector Support Project	Cambodia	HE
	P073817	Programmatic Social Reform Loan Project (02)	Peru	SP
	P080368	Emergency Drought Recovery Project	Malawi	RDV
	P081773	Emergency Drought Recovery Project	Ethiopia	RDV
FY04	P084601	Nutrition II - Supplemental Credit	Madagascar	HE
FY05	P070823	Education Sector Support Project 1	Malawi	ED
	P074841	Health Nutrition and Population Sector Program	Bangladesh	HE
	P078523	Integrated Human Development Project	Maldives	SP
	P078991	Health Services Extension and Modernization (2nd APL)	Nicaragua	HE
	P083968	Programmatic Social Reform Loan IV	Peru	SP
FY06	P077756	Maternal and Infant Health and Nutrition	Guatemala	HE
	P088642	Social Protection Project	El Salvador	SP

Sector Board
HE = Health SP= Social Protection
TR = Transportation ED= Education
PO = Poverty RDV = Rural Development
Health Sector Projects are *shaded.*

Table 2. 3. Nutrition and Project Development Objectives: Non-Health Sector Projects

Project Title	Country	Nutrition in Development Objectives
Social Protection (SP)		
Programmatic Social Reform Loan Project (02)	Peru	**No**: (1) Establish pro-poor social expenditure regime and adequate social protection mechanism (2) Improve access of the poor to critical social programs (better targeting improved efficiency and rationalization of expenditures) (3) Improve transparency in social programs and expenditures and empower beneficiaries to participate in the policy and budget process
Programmatic Social Reform Loan IV	Peru	**No:** Same objectives as for the project above
Social Protection Project	El Salvador	**Yes**: Improve the education, health and nutrition of children living in the rural areas of 100 poorest municipalities
Integrated Human Development Project	Maldives	**Yes**: Improve social outcomes and promote economic growth by strengthening the delivery of social services (education, health and nutrition)
Educational Development (ED)		
Early Childhood Education Project	Dominican Republic	**Yes**: (1) Increase availability of high-quality educational services for young children (0-5) (2) Expand access to and improve the quality of integrated services that address young children's basic needs, including preprimary education, psycho-social stimulation, health care and nutrition
Child Development Project	Yemen	**Yes:** An area-based program (ABP) to improve health and nutrition of children < 5 and educational status of girls in primary schools in 30 districts under-served in health and education
Education Sector Support Project 1	Malawi	**No:** (1) Increase number of qualified teachers (2) Improve quality and capacity of education services (3) Improve learning outcomes at all levels
Integrated Early Childhood Development Project	Eritrea	**Yes**: (1) Promote the healthy growth and holistic development of children (2) Expand access to and improve the quality of services that address young children's basic needs (health care, nutrition, social protection, psycho-social stimulation, affection and early childhood education)
Rural Development (RDV)		
Emergency Drought Recovery Project	Malawi	**No**: (1) Allow the government to maintain key commitments to economic priorities and investment consistent with the PRSP (2) Restore productive capability of the population (3) Support longer-term disaster management by the government
Emergency Drought Recovery Project	Ethiopia	**No:** (1) Enable the government to help affected families survive the emergency, retain productive assets, and develop sustainable livelihoods (2) Contribute to the stabilization of the macro economy
Food Security Project	Ethiopia	**Yes**: (1) Build the resource base of poorer rural households (2) Increase their employment and income (3) Reduce real costs of food (4) Improve nutrition of children < 5, and pregnant & lactating women

The specific mention of nutrition in the PDOs of the different projects varies. The development objective of El Salvador's social protection project ("Improve the education, health and nutrition of children living in the rural areas of 100 poorest municipalities") is an example of a project that mentions nutrition clearly. The Yemen child development project ("Improve health and nutrition of children under 5") and the Ethiopia food security project ("Reduce real costs of food and improve nutrition of children under 5 and of pregnant and lactating women") are as well. However, the PDOs of some projects, such as the Maldives's integrated human development project, are less specific, mentioning nutrition within a collective group of services such as education and health ("Improve social outcomes and promote economic growth by strengthening the delivery of social services").

All the projects that mentioned nutrition in their PDOs had clearly defined nutrition activities, but not all projects with nutrition activities mentioned nutrition in their PDOs. For example, the Malawi educational sector support project did not mention nutrition in its PDO or in the sections of documents that referred to the Country Assistance Strategy (CAS), yet the project supported a wide range of nutrition activities, including distribution of vitamin A and iron-folic acid to school children and promotion of good health and nutrition practices.

Such variation in the treatment of nutrition in PDOs suggests the Bank is sometimes rather improvisational in its approach. Concrete statements of nutrition objectives in the PDOs of projects with nutrition components could guide staff to clearly identify which nutrition-related activities are needed to achieve those goals. Staff would have a clear target for their actions.

It would also assist monitoring, evaluation, and learning, since reviewers will refer to these objectives to guide their analyses of the project, from the development of the concept note to the completion report. If nutrition is not mentioned, even when the project itself includes some nutrition-related activities, the project team may pay less attention during project design to how they will achieve nutrition objectives. Evaluators, too, are less likely to be concerned about whether nutrition objectives were achieved.

A toolkit is available to help Bank staff incorporate nutrition into project design (Elder, Kiess, and DeBeyer 1996). It suggests that at the identification stage task team leaders should (1) determine the presence and extent of malnutrition; (2) investigate determinants of malnutrition; (3) critically evaluate existing nutrition programs and national nutrition strategies; and (4) assess institutional capacity to carry out activities in a sustainable way. At the preparation stage, staff need to (1) select intervention strategies; (2) begin project design through the selection of priority interventions in consultation with the community or beneficiary groups; (3) plan for monitoring and evaluation; and (4) initiate the economic analysis of intervention options. The publication further details tasks at the pre-appraisal, appraisal, implementation and supervision and evaluation stages.

WHAT NUTRITION ACTIVITIES WERE IN NON-HEALTH-SECTOR PROJECTS?

Outside the health sector, 11 projects carried out 28 activities or interventions. As noted, these projects were in 3 sectors: social protection, education, and rural development. Because most non-health-sector projects were funded through investment loans rather than policy lending, they focused on specific activities (sometimes multiple interventions) rather than a broad strategy. The number of projects outside the health sector that included nutrition was relatively small, but these projects can provide some initial ideas about how to incorporate nutrition into non-health sectors in future projects.

The most common nutrition activities in non-health-sector projects were nutrition education, micronutrient supplementation, capacity building, and growth monitoring and counseling. Social marketing, specific training activities, school feeding, and conditional cash transfers with nutrition objectives were only present in 1 project each. Figure 2.1 summarizes the types of activities and the number of projects with each. Table 2.4 notes the nutrition components in each of the 11 non-health-sector projects. Annex 2 provides more detailed descriptions of each of these projects.

Figure 2.1. Nutrition Activities in Non-Health-Sector Projects

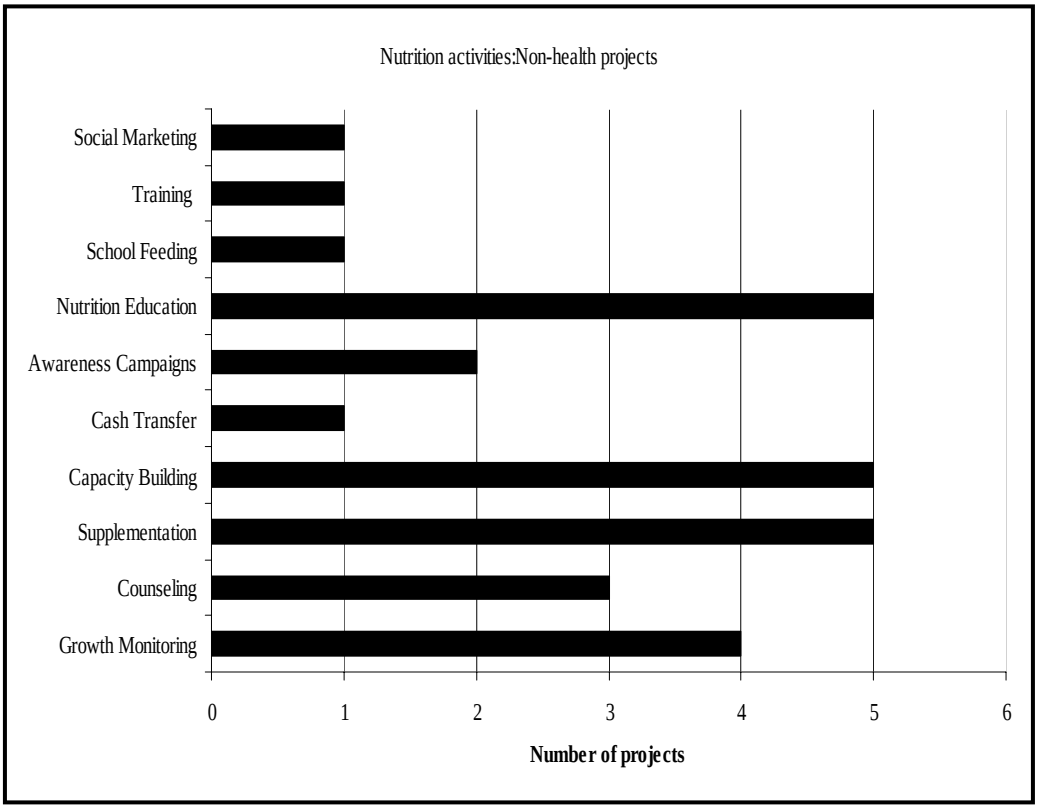

Table 2. 4. Nutrition Project Components (Non-Health Sector)

Project Name	Country	Growth Monitor-ing	Coun-seling	Supple-mentation	Capacity Building	Cash Transfer	Awareness Campaigns	Nutrition Education	School Feeding	Training	Social Market-ing	Others
Human Development Network (HDN)												
Social Protection (SP)												
Programmatic Social Reform Loan Project (02)	Peru			**X**				**X**				Admin and fiduciary reform for food distribution
Programmatic Social Reform Loan IV	Peru											Admin and fiduciary reform for food distribution
Social Protection project	El Salvador	**X**	**X**		**X**	**X**						
Integrated Human Development Project	Maldives				**X**		**X**					
Educational Development (ED)												
Early Childhood Education Project	Dominican Republic				**X**		**X**	**X**		**X**	**X**	
Child Development Project	Yemen	**X**	**X**	**X**				**X**				
Education Sector Support Project 1	Malawi			**X**	**X**			**X**				
Integrated Early Childhood Development Project	Eritrea	**X**		**X**	**X**			**X**				Therapeutic feeding, support for availability of low cost complementary feeding
Environmentally and Socially Sustainable Development (ESSD)												
Rural Development (RDV)												
Emergency Drought Recovery Project	Malawi								**X**			
Emergency Drought Recovery Project	Ethiopia			**X**								
Food Security Project	Ethiopia	**X**	**X**									

The number of nutrition activities carried out in each project varied from as little as 1 to as many as 5. While projects in the social protection and the education sectors contained a mix of activities, projects in the rural development sector usually had only 1 nutrition activity at a time. This is perhaps related to the fact that 2 of the 3 are emergency projects, with a focus on relief rather than longer-term development.

Just as the number of activities varied, so did the approach, with some interventions being specifically targeted to nutrition and others affecting it only indirectly. For example, the Yemen Child Development project supported direct nutrition interventions such as nutrition education, counseling, growth monitoring, and micronutrient supplementation. On the other hand, the Peru Programmatic Social Reform loan only indirectly supported nutrition, through efforts to increase program impact on nutrition by consolidating and rationalizing existing food distribution programs.

ACTIVITIES ACROSS SECTORS

Some types of activities appeared in projects *across* sectors—even ones normally thought of as primarily health-based. This may suggest substantial, relatively easy opportunities for cross-sectoral integration. For instance, growth monitoring and counseling and micronutrient supplementation were elements of projects in all 3 non-health sectors.

Growth monitoring activities were among the nutrition interventions adopted in 4 projects. In El Salvador, activities were part of a social protection project that expanded the provision of basic health and nutrition services in association with a conditional cash transfer program. In Yemen and Eritrea, growth monitoring and counseling were part of community-based activities in early childhood development. In Ethiopia, the food security project targeted poor rural households, but included grants to support community-based child-growth activities.

Micronutrient supplementation was incorporated in all but 1 of the education projects, but part of only 1 social protection project. All supplementation interventions targeted iron deficiency with a few projects targeting vitamin A deficiencies. Supplementation was either direct or through the provision of fortified foods delivered through educational institutions.

Although not present in rural development projects (again likely due to the short-term nature of those projects), capacity building was a fairly common activity in both social protection and education projects (5 of 11 projects). Technical and organizational capacity is critical to effectiveness and sustainability. Capacity to understand the issue, to identify and design appropriate interventions, and to implement, monitor, and manage them is needed regardless of sector or activity. The Integrated Human Development Project in the Maldives built capacities of community-based organizations to provide nutrition services. The education project in Malawi built capacity of the Ministry of Education and other relevant ministries to plan, implement, and evaluate a national school health and nutrition program. It also supported selected training and study tours to increase awareness and knowledge about how to design and implement school health and nutrition programs. The early childhood education project in the Dominican Republic strengthened cross-sectoral linkages among institutions involved in delivering early childhood development services and provided grants for NGOs, local governments, and the private sector to implement innovative child development projects.

ACTIVITIES BY SECTOR

As noted, some activities frequently appear in more than 1 sector. Alternatively, we can look at the frequency of activities *within* sectors. For example, while the conditional cash transfer program in El Salvador incorporated a number of nutrition interventions, the *social protection sector* did not otherwise show any particular tendency toward a specific type of nutrition activity. Social protection projects appear broad enough in terms of content and institutional linkages that they can provide numerous points

for connections with nutrition. In these examples, social protection projects included nutrition education, nutrition awareness campaigns, and policy reform, in addition to interventions already mentioned.

Within the *education sector*, most projects that incorporated nutrition were early childhood development (ECD) projects. Unsurprisingly, nutrition education activities were also common, often as part of ECD activities. In general, ECD projects frequently do share types of activities (education) and target groups (mothers and young children) with nutrition programs. Given commonalities, ECD interventions may represent an underutilized opportunity for connections. In Malawi the early childhood project financed a health and nutrition package targeting school children under 10 years old. It comprised micronutrient supplementation, de-worming, treatment of malaria and fever, and the promotion of good health and nutrition practices. In Yemen the project targeted the nutrition and health education of health workers and community volunteers, including religious leaders, school teachers, district council members, and health staff. It also financed the procurement of iron supplements. The early childhood project in the Dominican Republic funded events to bring parents and communities together to communicate specific needs and interests to the school and to enable family members to learn more about the hygiene, health, nutrition, and overall physical and emotional development of their child.

Despite a well-established link between agriculture and nutrition, only 3 projects in the *rural development sector* incorporated nutrition activities, and 2 of those were emergency projects. The third project was a food security project concerned with building the resource base of poor rural households in Ethiopia and improving the nutritional status of mothers and children.

Nutrition should be a priority area for emergency projects, and such projects may provide another important avenue for integration of nutrition with projects outside health. The Ethiopian project, for instance, provided assistance to families affected by drought, and supported nutrition by distributing a supplementary "food package" targeted at small children and pregnant and lactating mothers.

WHO WAS RESPONSIBLE FOR IMPLEMENTING NUTRITION PROJECTS?

The Ministry of Health (or Ministry of Health and Social Welfare) was the government partner for all health-sector nutrition projects. But partners for the non-health-sector projects varied, and included a range of government ministries, agencies, and local government bodies. For social protection-sector projects, the partner tended to be the Ministry of Economy or Finance. For projects linked to the education sector, it was the Ministry of Education.

Importantly, these institutions, named on the summary cover sheet of the PAD, are the government agencies responsible only for the oversight of the project. Responsibilities for implementation might be given to another unit, or even multiple units. In the Republic of Yemen, for instance, the Higher Council for Motherhood and Childhood implemented the program, even though the project included micronutrient supplementation, which typically is implemented through the Ministry of Health.

Ministries of Local Government or regional governments took the lead in projects in Eritrea and in Ethiopia. These projects included a range of activities that covered multiple sectors. In Eritrea, for example, the project included nutrition education, community-based growth and monitoring, and micronutrient supplementation. In Ethiopia, regional governments coordinated with the Ministry of Rural Development on growth promotion and counseling, which is most commonly thought of as a prerogative of the Ministry of Health. Such intergovernmental collaboration outside the health ministry was also present in the Emergency Drought Recovery project for Ethiopia.

In actuality, the components of projects implemented by non-health sectors overlap a surprising amount with those of projects carried out by the health sector. In fact, the non-health-sector projects described above often incorporated a *broader* range of activities, such as reform of social services, than those found in a health-based project. Agencies outside the health sector, such as the Ministry of Finance, can find

themselves acting as the main partner for projects with clear "health" components. For example, conditional cash transfer programs, often implemented by ministries of social welfare or finance, condition on health behaviors, growth monitoring, or promotion of breastfeeding practices. These examples demonstrate that even when project components are largely and directly health-related, implementation need not be confined to the health sector. Their more comprehensive scope of action may even be an advantage.

HOW WERE THE RESULTS FRAMEWORK AND OUTPUT/IMPACT INDICATORS USED?

The results framework of World Bank projects is an integral part of the project design. The framework is meant to help structure the institutional and data collection arrangements for monitoring and evaluation of outcomes and results (both intermediate and end-of-project) as part of project management. The framework should capture answers to questions such as:

- Institutional issues: How will monitoring and evaluation complement project management?
- Data collection: If the project uses data collected by Government statistical offices or line agencies, which statistics will be used and what is their reliability? If more specific information is needed to measure project results and outcomes, what are the associated costs and institutional responsibilities?
- Capacity: If capacity to acquire the information is limited, how will local capacity be supplemented through the project, and what will be the costs of doing this?

Table 2.5 shows the results framework for all the projects outside the health sector with nutrition components, and suggests weaknesses on the application of the framework and in potential learning from it. Only 4 of the 11 projects had nutrition-related indicators for the overall project as well as for the nutrition-related project components. The nutrition-related indicators for PDOs varied from indicators that targeted only underweight, to those that targeted both underweight and stunting (low height-for-age), and to others that targeted only stunting among a specific age group. Of course, the appropriate indicator should reflect aims and context, so this variation in choices is perhaps reasonable, but it may also reflect confusion among task team leaders about the appropriate indicator for each project.

Nutritional status impacts are often many steps removed from the specific interventions funded by the project and their associated outputs or outcomes. Project actions can contribute to improvements in nutritional status, but are never the sole factor. Thus, different sets of indicators are needed to measure the operation and effectiveness of the various components, not just final impact. It is essential to be aware of the context and what the project's plausible outputs and direct impacts are when determining appropriate indicators for the different levels of interest (input, output, impact, and outcome). Table 2.6 provides some recommended, illustrative indicators for some specific nutrition interventions.

Table 2. 5. Results Framework: Non-Health-Sector Projects

	Country	Project development objective indicator	Component indicator
Social Protection			
Programmatic Social Reform Loan Project (02)	Peru	-	
Programmatic Social Reform Loan IV	Peru	-	
Social Protection project	El Salvador	reduced malnutrition rates (underweight)	(1) % families satisfied with primary care and nutrition services
Integrated Human Development Project	Maldives	-	(1) 30% reduction in the number of children showing faltering growth between ages 6-12 months
Educational Development			
Early Childhood Education Project	Dominican Republic	-	
Child Development Project	Yemen	20% reduction in wasting	(1) prevalence of wasting and micronutrients deficiencies decreased (2) knowledge of breastfeeding practices increased (3) proportion of mothers who implement proper nutrition and feeding practices increased by at least 20% (4) prevalence of iron, anemia and vitamin A deficiency reduced by 30% for children
Education Sector Support Project 1	Malawi		no. of primary pupils covered by the program increased
Integrated Early Childhood Development Project	Eritrea	20% decrease in malnutrition - both stunting and wasting	(1) no. of workers and home and extension agents from MOH, MOA and Ministry of Fisheries who received special training in nutrition (2) no. of communities monitoring growth of children (3) % of communities that received locally adapted infant and maternal dietary counseling (4) no. of food-insecure children (5) no. of children weighed by growth monitoring and promotion program at the community level (6) no. and % of mothers and caregivers practicing proper feeding practices
Rural Development			
Emergency Drought Recovery Project	Malawi	-	(1) endorsed food security and nutrition strategy statement within one year of the project
Emergency Drought Recovery Project	Ethiopia		
Food Security Project	Ethiopia	reduced stunting among children < 2 in project area	(1) 90% of children < 2 in participating areas regularly monitored and their caretakers counseled

Table 2. 6. Illustrative Nutrition Indicators

Type of Project	Type of Indicator	Indicators
Vitamin A supplementation (for children aged 6 months to 5 years)	Input	•Quantity of supplements delivered on time to the project site / Total quantity expected to be delivered to the project site •Number of quality checks* conducted per year •Quantity of supplements found to be unusable / Total quantity of supplements checked
	Output	•Number of targeted children who received the supplement / Total number of targeted children
	Impact	•Number of children with clinical signs of night blindness* (proxy) / Total number of targeted children
Growth Promotion and Nutrition Counseling	Input	•Number of community nutrition workers who received training* / Total number of community nutrition workers slated for training
	Output	•Number of women who were counseled* by nutrition educator / Total number of targeted women •Number of children 6-24 months who were weighed / Number of children 6-24 months in project area •Average "knowledge and attitudes" score of targeted women
	Outcome	•Average number of months of exclusive breastfeeding* of targeted women •Number of mothers who exclusively breastfed for at least 4 months / Total number of mothers interviewed with children aged > 4 months •Number of mothers who introduced complementary foods* to their infants before 9 months of age. / Total number of mothers interviewed with children aged > 6 months
	Impact	•Number of underweight (WAZ < -2) children aged 6-24 months / Total number of children aged 6-24 months who were weighed
School feeding	Input	•Quantity of commodities delivered on time to the project site / Total quantity expected to be delivered to the project site •Number of days that school was actually in session / Number of days that school was scheduled to be in session
	Output	•Number and percentage of children who actually received meals each day •Number of meals received per child per school year
	Outcome	•Number of student absences* (proxy) / Total number of student school days •Number of drop-outs* (proxy) / Total number of school children
	Impact	•Literacy rate* •Primary school completion rate*

*Terms need to be more clearly defined by M&E staff. For example, literacy would be linked to a test of ability to read and comprehend (e.g., standardized test scores measuring school performances). Primary school completion rates might be percent of children enrolled in first grade 6 years ago who completed primary school.

Source: Levinson and others (1999).

The need for multisectoral action and for support of actions with indirect routes to improving nutrition can further complicate monitoring and assessment. For example, Eritrea's Integrated Early Child Development Project had 6 detailed indicators, measuring progress on training, growth monitoring, infant and maternal dietary counseling, food security, and feeding practices. On the other hand, the Salvadoran Social Protection Project had only 1 indicator throughout the project, the "percent of families satisfied with the nutrition services," despite the fact that it had at least 4 wide-ranging nutrition components. Multiple indicators seem necessary to ensure proper monitoring and assessment of integrated projects.

Projects that focus on institutional strengthening and alignment are important, but may pose difficult challenges for assessment. The Malawi Emergency Drought Recovery project had as its indicator simply the endorsement of a food security and nutrition strategy statement within 1 year of project implementation. The strategy was seen as a key element to have in place to reduce the likelihood of future food crises in the country. Similarly, the Peru Programmatic Social Reform loan supported the consolidation and coordination of existing food programs in order to reduce administrative costs and to better focus programs on mothers and young children in low-income groups. While institutional development and policy reforms are often essential to sustainable action on nutrition, work remains to be done to identify the appropriate impact and process indicators in such projects. Similar challenges may arise when nutrition interventions are part of a sector-wide approach (SWAp) or a poverty-reduction strategy credit (PRSC) that incorporates multiple activities.

WHAT ABOUT IMPACT?

This desk review provides a brief overview of the Bank's investment portfolio in nutrition, especially outside the health sector. It does not answer important questions of whether these investments were appropriate in magnitude or in type (whether the intervention was effective in removing identified key constraints or reaching the target population, for instance). This is because looking at each country's needs in-depth (demand side) would require much more extensive and context-specific analysis and because we have little or no information on the relative cost-effectiveness or the institutional arrangements and incentives needed for different interventions, individually or as an integrated package (supply side).

Still, the Implementation Completion Reports (ICRs) can give an idea of the effectiveness of a particular project, if not an overall assessment of the impact of the investment portfolio.[4] But even then most projects do not have strong enough evaluation designs to allow for measurement of impact, and in any case they often fail to revisit key questions about whether, at the end of the project, the investment was appropriate. (Because of the Bank's procedures for project identification and appraisal, one assumes that the investment was deemed appropriate at the beginning.)

Unfortunately, only 4 projects out of 11 non-health-sector projects had ICRs available at the time of the review. All other projects but one (Ethiopia emergency) were ongoing. Table 2.7 summarizes the principal performance ratings for these projects, providing separate ratings for the overall outcome as well as sustainability, institutional development impact, and Bank and borrower performance. Obviously these few examples do not allow us to draw any general conclusions about what components should or should

[4] The World Bank prepares Implementation Completion Reports (ICR) for each lending operation undertaken. The ICR is prepared at the time of project completion and marks the transition from implementation to project operation. It assesses (a) the degree to which the project achieved its development objective and outputs as set out in the project documents; (b) other significant outcomes and impacts; (c) prospects for the project's sustainability; and (d) Bank and borrower performance, including compliance with relevant Bank safeguard and business policies. It also provides the data and analysis to substantiate these assessments, and it identifies the lessons learned from implementation (based on OP 13.55- Implementation Completion Reporting, July 1999.)

not be integrated into which sectors or project types. However, review of a project's ICR can give staff some insights into issues of design and management of nutrition-related project components.

Four of the 11 non-health-sector projects have ICRs. The Peru sector reforms were both judged satisfactory, with likely sustainable substantial or moderate impact on institutional development. The child development project in Yemen was rated marginally unsatisfactory because implementation started late and therefore coverage was limited: only 10 districts instead of 30 were eventually covered. Reviewers also found the nutrition program was not fully integrated into the Integrated Management of Childhood Illnesses framework as planned. This was partly due to the fact although output and impact indicators were well set, the project did not actually collect the data needed to gauge impact The Malawi emergency project was judged satisfactory despite the fact that it did not ultimately support the government in developing a food and nutrition strategy during the period of the project. This was due to high staff turnover at the Ministry of Health and the Ministry of Planning, the two ministries involved in the implementation of the project. However, the strategy was developed in the year after the completion of the project.

BUILDING EVIDENCE FOR OPPORTUNITIES IN CROSS-SECTORAL WORK

This report gives some guidance regarding the opportunities for integrating nutrition activities into projects outside the health sector, but unfortunately we have no systematic analyses of these experiences to answer key operational questions such as: What kinds of multisectoral approaches and arrangements are most effective? Which interventions offer the best returns? Do they offer better returns than a more traditional single-sector intervention? Of course, many findings would be country-specific, but application of a shared analytical framework across a select set of projects could begin to shed light on these questions.

Fortunately, efforts are being made to do so. Country governments, for instance, are going ahead and creating successful institutions and initiatives that work cross-, inter-, or multisectorally, even as common wisdom at the international level holds that effective institutional arrangements and incentives to support such coordination are practically impossible. These country experiences suggest a variety of promising new modalities for integrating nutrition across sectors.

The Bank is beginning to look at these experiences. More in-depth studies of the Senegal Nutrition Enhancement Program, Madagascar's SEECALINE Project, and Colombia's MANA Initiative could provide further insights. Although work with or through the health sector is an important component of each of these, they are also multisectoral in nature and coordinate nutrition activities with non-health ministries or sectors.

The Bank has also produced a report that looks at the institutional arrangements needed to promote multisectoral action on nutrition (Bassett, Levinson and Garrett 2007). Using examples from general national efforts at coordination as well as from agriculture, social protection, and other sectors, the report noted that successful modalities to promote multisectoral action on nutrition vary according to the different contexts—there is no "one size fits all" arrangement. The study consistently emphasized the need for nutrition managers and policymakers to respect institutional boundaries and missions while thinking strategically about how to make partnerships with nutrition attractive to the various sectors.

Table 2. 7. Principal Performance Ratings from ICR Reports: Non-Health Sector

Project	Country	Fiscal Year (FY)	Closing Date of Project[a]	Principal Performance Ratings from ICR Report				
				Outcome	Sustainability	Institutional Development Impact	Bank Performance	Borrower Performance
Non-Health Sectors								
Social Protection								
Programmatic Social Reform Loan Project (02)	Peru	FY03	Dec 2002	S	L	M	S	S
Programmatic Social Reform Loan IV	Peru	FY05	Dec 2005	S	L	SU	S	S
Social Protection Project	El Salvador	FY06	Jan 2011					
Integrated Human Development Project	Maldives	FY05	June 2010					
Educational Development								
Early Childhood Education Project	Dominican Republic	FY03	June 2008					
Child Development Project	Yemen	FY00	Dec 2005	U	UL	N	U	U
Education Sector Support Project 1	Malawi	FY05	Sept 2010					
Integrated Early Childhood Development Project	Eritrea	FY01	March 2007					
Rural Development								
Emergency Drought Recovery Project	Malawi	FY03	Nov 2004	S	L	SU	S	S
Emergency Drought Recovery Project	Ethiopia	FY03	Dec 2006					
Food Security Project	Ethiopia	FY02	June 2009					

[a] Closing date figures downloaded from the World Bank's project data base by country/area.

Note: Ratings were available for only 4 projects. Possible ratings are: HS=Highly Satisfactory; S=Satisfactory; M=Moderate; MU=Moderately Unsatisfactory; U=Unsatisfactory; N= Low or Negligible; L= Likely; UL= Unlikely; SU=Substantial.

Whatever the chosen modality, integrating nutrition into sectors other than health appears easiest where there is broad political commitment and an understanding that malnutrition requires a multisectoral response. For this reason, the Bank is currently undertaking a range of activities to understand and support the political and institutional aspects of action on nutrition. The Africa region, for instance, has produced a series of "country experience briefs" in nutrition (Mulder-Sibanda 2006a, Mulder-Sibanda 2006b, Mulder-Sibanda 2006c), and is now conducting a set of comparative case studies in 4 African countries to examine how political and institutional factors have affected nutrition policy reform and operations. Similarly, HNP is supporting strategies to build political commitment for action on nutrition in 4 pilot countries.

At the same time, the Bank is producing information on how specific sectors can better integrate nutrition into their activities. For example, the Bank has produced a synthesis of international guidance on how to integrate nutritional considerations into programs for the prevention and treatment of HIV/AIDS (World Bank 2007b). And the Bank's Agriculture and Rural Development department has prepared a report on links between agriculture and nutrition. For example, governments and producer groups could collaborate to promote fruit and vegetable consumption, and international donors and governments could invest in research to produce and promulgate micronutrient-rich crops, such as orange-fleshed sweet potatoes or biofortified legumes (World Bank 2007c).

Transportation is another area where projects could integrate nutrition activities. For instance, worksites may be good places for nutrition awareness campaigns or could be encouraged to include childcare facilities for working mothers. In another example, no poverty-reduction sector projects had any nutrition components, yet we know that better nutrition is not just an outcome of economic growth and poverty reduction but also a critical *input*. Increased awareness of this fact could encourage those who design projects for poverty reduction to include activities that focus specifically on improving nutrition.

Problems of organization, incentives, and perceptions of capacities, roles, and commitments also exist within the Bank and can impede integration even if staff know *what* to do. On the operational side, for instance, nutrition is grouped with health, making health a usual starting point for action. Yet nutrition could also easily be tied into agriculture, education, infrastructure, and social protection, to name just a few sectors. The Bank's imperative to have a single official oversight partner can also complicate cross-sectoral collaboration. The Bank has, of course, connected with Ministries of Economy and Finance when an interministerial committee is required, but often the institutional commitment to nutrition in these ministries is not strong, and ability to coordinate other sectors is weak. The experience within the Bank of mainstreaming gender and HIV/AIDS may be instructive. These initiatives provided task team leaders with resources such as project examples and toolkits to help them understand the issues and guide them in taking action.

PART III – FINANCIAL PROFILES OF NUTRITION PROJECTS

HOW MUCH DID THE BANK REALLY INVEST IN NUTRITION?

Table 3.1 provides a financial profile of the 22 projects with nutrition activities. These projects had a total investment, from all sources, of US$5819.04 million. Of this, the Bank provided US$1402.36 million. As explained below, this figure overstates the amount of Bank investment in nutrition because these project investment amounts included funding from Bank as well as other sources and because these projects financed other activities in addition to nutrition. In any case, 86 percent of this total, or US$5029.58 million, corresponded to the health sector, and 14 percent, or US$789.46 million, to the non-health sectors. These figures, however, are also somewhat misleading as an indicator of the reach of global project activity and of the allocation between health and non-health sectors because US$4306.2 million was for a single Health, Nutrition and Population Sector Program in the health sector of one country, Bangladesh. Without this project, the total project amount in the health sector was actually slightly less than investment through non-health sectors: US$723.38 million.

For reasons noted above, total project amounts overstate actual spending on nutrition. As Heaver (2006) notes, "It is only when the entire project finances are supporting nutrition activities, a rare occurrence such as the case of Bangladesh National Nutrition Program, for a total loan amount of $92 million,…that it is possible to give an actual estimate for nutrition spending. When the project is supported through different activities associated with different sectors, the exact amounts spent on nutrition-related activities become very difficult to estimate…."

Unfortunately, the Business Warehouse cannot clearly break out the amounts for nutrition activities. Therefore, to determine project and Bank spending on nutrition components, we had to review individual project documents, and even then we could not always determine the amounts dedicated specifically to nutrition.

One problem is that in some projects, nutrition activities are (often understandably) bundled with other components, such as delivery of a basic health and nutrition package. In this case, the exact amounts for nutrition activities cannot be determined. For example, the Malawi Education Sector Support Project provided a package including distribution of micronutrients, de-worming, treatment of malaria and fever, and the promotion of good health and nutrition practices. Many of these activities certainly have impacts on nutrition, but within the project the components specific to nutrition, and their investment amounts, are not easy to separate out. The analysis in this paper, however, assumes that the full amount of the transfer in such "packages" represents an investment in nutrition, so figures for amounts spent on nutrition include the full amounts of these packages, or transfers, when known.

In other cases (the project in the Maldives in the non-health sector, and projects in Ecuador and El Salvador in the health sector), the project amount for nutrition was known, but not the corresponding amount of Bank investment. Because of this, the summary figures for total Bank amounts invested in nutrition in Table 3.1 show a minimum (which assumes none of the Bank's contribution on these projects was spent on nutrition) and a maximum figure (which assumes the Bank's contribution covered the full amount dedicated to nutrition in these projects).

Table 3. 1. Estimated Amounts of Investment in Nutrition (FY2000-FY2006)

Project	Country	Bank amount for nutrition ($ mlln)	Total Project amt for nutrition ($ mlln)	Bank amount ($ mlln)	Total Project amount ($ mlln)
Non-Health Sector Projects					
Social Protection					
Programmatic Social Reform Loan Project (02)	Peru	n/a	n/a	100	100
Programmatic Social Reform Loan IV	Peru	n/a	n/a	100	100
Social Protection Project	El Salvador	15	71.4.*	21	160.6
Integrated Human Development Project	Maldives	n/a	0.8	15.76	18.5
Educational Development					
Early Childhood Education Project	Dominican Republic	5.96*	7.44.*	42	62
Child Development Project	Yemen	0.2	1.5	28.9	45.3
Education Sector Support Project 1	Malawi	3*	3*	32.2	32.2
Integrated Early Childhood Development Project	Eritrea	4	5.2	40	49
Rural Development					
Emergency Drought Recovery Project	Malawi	8*	8*	50	50
Emergency Drought Recovery Project	Ethiopia	15*	16.5*	60	61.7
Food Security Project	Ethiopia	64.73*	76.73*	85	110.16
Subtotal 1 (excluding Peru projects)	**9 projects**	**115.89-116.69****	**190.57**	**374.86**	**589.46**
Subtotal 2 (non-emergency projects, excluding Peru projects)	**8 projects**	**92.89-93.69****	**166.07**	**264.86**	**477.76**
Subtotal 3 (all non-emergency)	**9 projects**	**n/a**	**n/a**	**464.86**	**677.76**
Total Non-Health	**11 projects**	**n/a**	**n/a**	**574.86**	**789.46**

* Exact amounts are not available (either not available or uncertain). This includes educational and other combined transfers.

****** Lower figure assumes 0% Bank contribution to the nutrition amount; higher figure assumes 100% Bank contribution.

Table 3. 1. Estimated Amounts of Investments in Nutrition (FY2000-FY2006) cont.

Project	Country	Bank amount for nutrition ($ mlln)	Total Project amt for nutrition ($ mlln)	Bank amount ($ mlln)	Total Project amount ($ mlln)
Health-Sector Projects					
National Nutrition Project	Bangladesh	92	124.46	92	124.46
Second Health Sector Support Project	Madagascar	1.5	1.5	40	44.38
Second Social Development Project - Health & Nutrition – Supplemental Loan	Ecuador	n/a	12.5*	20.2	21.6
Second Primary Health Care and Nutrition Project	Iran	19	21.5	87	124
Earthquake Emergency Rec. & Health Services Extension Project	El Salvador	n/a	16.5*	142.6	165.7
Nutrition Enhancement Program	Senegal	48.7	69.2	48.7	69.2
Health Sector Support Project	Cambodia	2	2	27	31.84
Nutrition II - Supplemental Credit	Madagascar	10	11	10	11
Health Nutrition and Population Sector Program	Bangladesh	n/a	n/a	300	4306.2
Health Services Extension and Modernization (2nd APL)	Nicaragua	21.9	21.9	11	82.2
Maternal and Infant Health and Nutrition	Guatemala	21.9	21.9	49	49
Subtotal 4 (excluding Bangladesh Sector Program)	**10 projects**	**217-246****	**302.46**	**527.5**	**723.38**
Subtotal 5 (excluding Bangladesh Sector Program and Emergency)	**9 projects**	**217-229.5**	**285.96**	**384.9**	**557.68**
Subtotal 6 (all non-emergency)	**10 projects**	**n/a**	**n/a**	**684.9**	**4863.88**
Total Health	**11 projects**	**n/a**	**n/a**	**827.5**	**5029.58**

* Exact amounts are not available (either not available or uncertain). This includes educational and other combined transfers.

** Lower figure assumes 0% Bank contribution to the nutrition amount; higher figure assumes 100% Bank contribution.

Table 3. 1. Estimated Amounts of Investments in Nutrition (FY2000-FY2006) cont.

Project	Country	Bank amount for nutrition ($ mlln)	Total Project amt for nutrition ($ mlln)	Bank amount ($ mlln)	Total Project Amount ($ mlln)
Non-Health and Health-Sector Projects					
Total Non-Health and Health Projects	22 projects	n/a	n/a	1402.36	5819.04
Subtotal 7 (excluding Bangladesh sector program)	21 projects	n/a	n/a	1102.36	1512.84
Subtotal 8 (excluding Bangladesh and Peru sector programs)	20 projects	332.89-362.69**	493.03	902.36	1312.84
Subtotal 9 (excluding Bangladesh and Peru sector programs, and non-emergency programs)	17 projects	309.89-323.19**	452.03	649.76	1035.44

* Exact amounts are not available (either not available or uncertain). This includes educational and other combined transfers.

** Lower figure assumes 0% Bank contribution to the nutrition amount; higher figure assumes 100% Bank contribution.

More problematic were the sector-wide programs in Peru (two projects) and Bangladesh (one project).[5] These projects did not specify the amounts invested in nutrition, whether financed by the Bank or by others, including the government. It is particularly troublesome as the figures for these projects are not small (a total of US$200 million in Peru and US$4306.20 million in Bangladesh), and so the inclusion or exclusion of these projects, or misestimation of the proportion actually spent on nutrition, could significantly change the picture regarding Bank or project investment in nutrition. Such sector-wide programming poses a challenge that is likely to grow in the future. Without careful attention to budgeting procedures, it will become increasingly difficult to determine exactly how much is being spent on nutrition because these investments are embedded in the program as a whole.

Because of uncertainty regarding the amounts invested by the Bank or the project as a whole in nutrition in these 3 sector projects, we exclude them from the initial calculations. Nevertheless, the resulting figures provide a good general sense of the scope of Bank investment in nutrition, since excluding these projects eliminates only 3 projects (of 22), and only 2 countries (of 16).

Excluding these projects for the moment, total project investment in nutrition from FY2000 to late FY2006 was US$493.03 million, with US$190.57 million, or 39 percent, channeled through the non-health sector. The World Bank contributed between US$332.89 – 362.69 million to these projects.[6] This

[5] Note that this problem occurs in Bangladesh only with the more recent sector-wide program. The figures for the Bangladesh National Nutrition Project, begun in FY2000, were known.

[6] As explained, the Bank amounts for nutrition cannot be determined for 3 projects with a total investment of US$ 33.9 million, a relatively small proportion of the total. The figures in the table and text represent the range of the Bank's possible contribution, from having contributed nothing to the funding for nutrition to having covered the total amount of project investment in nutrition.

represents the minimum investment by the Bank in nutrition in this period, not yet accounting for spending through the Peru or Bangladesh sector projects.

Based on these figures, the Bank financed approximately 70 percent of the amount of the nutrition projects on average, but the proportion varied greatly from project to project, from as low as 13 percent to as high as 100 percent. This proportion was higher for projects financed under the health sector. The average amount per project was about $US17.5 – 19 million, although the amounts for the 9 non-health-sector nutrition projects were, on average, smaller than those for the 10 health-sector projects. For example, Bank financing exceeded US$15 million in only 1 of the non-health nutrition projects, whereas Bank contributions greatly exceeded US$15 million in 5, or half, of the health-sector nutrition projects.

It is impossible to tell from these general figures whether these per-project amounts represent "significant" investment or not, in terms of the amounts of investment it would take to have real impact on levels of malnutrition. The size of the target population, the cost to reach them, and the nature of need and of the intervention itself would all affect that assessment, and that information is not available.

We should, however, note that 2 of the projects in Rural Development (Malawi, Ethiopia) and 1 of the projects in Health (El Salvador) were actually intended to address emergencies. While they can be classified as investments in nutrition, they clearly do not represent a sustained commitment. On the other hand, these 3 projects, a small proportion of the 22 total, account for only US$41 million in nutrition investment. Moreover, the total number of countries with nutrition projects – or global scope of the Bank's investment – remains unchanged because in each of the countries with an emergency project there was also a separate nutrition project.

Inclusion of the Peru sector reforms or the Bangladesh sector support for health, nutrition, and population would increase this amount of total Bank investment substantially. However, as indicated, the lack of information on how much each of these projects actually invested in nutrition makes the exact figure very difficult to quantify. As before, if we assume that none of the project monies went to nutrition (an admittedly unrealistic assumption) then the figures above hold. If we assume all of the Bank investment in the project was spent on nutrition, then the summary amounts increase by US$500 million (US$200 million for the Peru programs and US$300 million for the Bangladesh program), giving a potential Bank investment in nutrition between US$832.89 – US$862.59 million for the period.

Another way to look at the magnitude of Bank investment is the number of countries that have nutrition projects. The Bank financed nutrition projects in non-emergency situations in 16 countries in FY00-06. There were projects in 6 countries in Latin America-Caribbean, 5 in Africa, 2 each in South Asia and Middle East-North Africa, and 1 in East Asia Pacific.

Promising news is that all but 3 of these countries (Dominican Republic, El Salvador, Iran) were countries with a "high burden" of malnutrition, where stunting or underweight affected more than 20 percent of children under 5 years old. And with a stunting rate of 19 percent, stunting was nevertheless very near to "high-burden" levels in El Salvador. Of greater concern is that the Bank financed nutrition projects in *only* these countries, when the Bank has identified 80 countries as being "high-burden."

Further investigation should seek to map projects to need in greater detail in order to determine how well projects have responded to conditions or policy constraints. For example in Malawi, where anemia affects 80 percent of the children, the country's emergency project supported school-based feeding interventions focused on total energy provision, with little emphasis on micronutrient deficiencies. Without more information about what the government or other donors and agencies are doing, it is difficult to say whether such action is appropriate, but every project should be reviewed to determine if it

is responding to needs, is reflective of current policy, and, in comparison with other demands, merits fiscal space.

WHAT INSTRUMENTS WERE USED FOR LENDING IN NUTRITION?

As shown in Table 3.2, half of lending to projects with nutrition activities was through Specific Investment Loans (SILs). As the name implies, SILs finance specific expenditures identified in the project preparation process. Disbursement must be made to specific organizations for specific, usually predetermined, expenditures.

Emergency Recovery Loans (ERLs) financed 3 projects. The main objective of ERLs is to restore assets and economic and social activities after an emergency, such as a war or natural disaster. ERLs are intended for limited-term efforts, and so do not indicate long-term support for nutrition.

Other nutrition lending was financed through a variety of instruments, including Programmatic Development Policy Loans (PDPLs), Programmatic Structural Adjustment Loans (PSALs), and Adaptable Program Loans (APLs). These instruments generally provide a framework to support policies and programs and so can finance a more flexible range of items or activities. Disbursement is usually tied to program and policy achievements, rather than specific investment items. Use of these lending instruments could potentially encourage greater integration of nutrition into other sectors, since they tend to support programmatic, multisectoral, and therefore more holistic, operations.

Table 3. 2. Lending Instruments for Nutrition

Project	Country	Lending Instrument
Non-Health-Sector Projects		
Social Protection		
Programmatic Social Reform Loan Project (02)	Peru	PSAL
Programmatic Social Reform Loan IV	Peru	PDPL
Social Protection Project	El Salvador	SIL
Integrated Human Development Project	Maldives	SIL
Educational Development		
Early Childhood Education Project	Dominican Republic	SIL
Child Development Project	Yemen	SIL
Emergency Drought Recovery Project	Malawi	SIL
Integrated Early Childhood Development Project	Eritrea	SIL
Rural Development		
Emergency Drought Recovery Project	Malawi	Emergency loan
Emergency Drought Recovery Project	Ethiopia	Emergency loan
Food Security Project	Ethiopia	SIL
Health-Sector Projects		
National Nutrition Project	Bangladesh	SIL
Second Health Sector Support Project	Madagascar	SIL
Second Social Development Project - Health & Nutrition - Supplemental Loan	Ecuador	n/a
Second Primary Health Care and Nutrition Project	Iran	SIL
Earthquake Emergency Rec. & Health Services Extension Project	El Salvador	Emergency loan
Nutrition Enhancement Program	Senegal	APL
Health Sector Support Project	Cambodia	SIML
Nutrition II - Supplemental Credit	Madagascar	Supplemental Credit
Maternal and Infant Health and Nutrition	Guatemala	SIL
Health Nutrition and Population Sector Program	Bangladesh	SIML
Health Services Extension and Modernization (2nd APL)	Nicaragua	APL

APL = Adjustable Program Loan
PDPL = Programmatic Development Policy Loan
PSAL = Programmatic Structural Adjustment Loan
SIL = Specific Investment Loan
SIML = Sector Investment and Maintenance Loan

On the other hand, policy loans are typically connected to a particular sector, and nutrition activities often do not rank highly in the overall sectoral approach. Even when the loan agreement inserts nutrition-relevant conditionalities (or "triggers") for disbursement that imply coordination with *other* sectors, the lead sector involved is unlikely to consider activities based in other sectors a high priority. More commonly that sector will consider it a bureaucratic burden. Unless the team putting the loan together is aware of these concerns and makes them a priority, nutrition activities will take a back seat to activities with a sectoral base. In this sense, multisectoral approaches present just as much a challenge to integration of nutrition across sectors as does a single-sector approach.

This analysis shows there is a range of lending instruments that can be used for nutrition. There is no cause-effect between choice of lending instrument and integration of nutrition, and so the type of lending instrument should be the one that best supports the project's development objectives. Interestingly, except for the programmatic loans for Peru, and the emergency loans, SILs were used for each of the other non-health-sector projects. Lending instruments in the health sector were more of a mix. One potential reason for this is that nutrition investments are more easily considered as *part of* the health sector, and staff and governments better understand how to incorporate nutrition activities into sector-wide approaches based in health. To encourage greater integration, the Bank should seek to provide staff with improved support for integrating nutrition into sector-wide approaches outside health, perhaps by documenting successful examples or by developing tools to help them think through and implement the integration process. Without clear conceptual models, systematic logical frameworks that link action to expected outputs, close attention to institutional arrangements and incentives, and careful monitoring of investment and impact, what happens in nutrition is likely to get lost regardless of lending instrument.

PART IV – CONCLUSIONS

The Bank has made a start in integrating nutrition into projects outside the health sector, indicating an understanding of the importance of a multisectoral approach to nutrition. The extent to which nutrition has been integrated into sectors outside its usual home in the health sector is even rather surprising, with half of all nutrition projects based in sectors other than health. In addition to these experiences, which can help build knowledge about what to do and how to do it, the Bank is beginning to produce tools and studies to support further integration.

The Bank's investment in nutrition is primarily through investment projects and policy and program loans, which indicates a level of confidence and commitment greater than if the Bank were financing nutrition through, say, significant numbers of emergency or learning loans.

On the other hand, the Bank invests a relatively small amount in nutrition, whether through health or other sectors, and average project amounts also seem small. Moreover, the coverage in terms of countries and population is limited.

Various weaknesses in Bank spending on nutrition also remain. Some deficiencies are methodological and others are programmatic.

- The total number and lending amounts of multisectoral nutrition projects do not come close to demonstrated need.

- Current methods of tracking investments in nutrition and the effectiveness of these investments are inadequate. The coding systems in Business Warehouse mean the Bank cannot accurately determine overall investment in nutrition. But the problem is not only one of software: Often the PADs themselves do not specify the amount allocated for nutrition activities. Without modification, deficiencies will grow over time, especially as the Bank's policy lending or use of sector-wide approaches (SWAps or PRSCs) grows.

- ICRs are intended to summarize effectiveness, without significant burden on staff, but they cannot replace more comprehensive analyses of project effectiveness, including operational evaluations and impact assessments that in fact should serve as *inputs* into the ICR. Unfortunately, these complementary assessments are generally not performed, and the lessons that could be learned from them are lost.

- Many projects do not have clear nutrition goals, and those that do fail to incorporate indicators that would permit nutrition activities to be monitored and their performance evaluated.

Clearly, the Bank is missing opportunities to incorporate nutrition into activities outside the health sector, but without a more solid evidence base, it is difficult to confidently guide Bank staff, policymakers, or program officials. Recommendations to "do more work multisectorally" stem mainly from individual case studies and expert perception of what seems to be working. Systematic analyses of these experiences, including insights on impacts, costs, benefits, and political and organizational issues, urgently need to be carried out. In brief:

- We cannot confidently state whether multi- or inter-sectoral approaches to malnutrition are more effective than single-sector approaches, and we don't have sufficient data on cost or relative cost-effectiveness.

- Even if multi- and inter-sectoral approaches plausibly improve effectiveness of nutrition interventions, we know little about how to design them or scale them up effectively in a particular country or local context.

- We do not know how to balance, sequence, or integrate investment in nutrition appropriately—that is, what proportion should go to actual interventions and policy reform, or organizational restructuring.

- We also do not fully understand organizational incentives or barriers within the Bank or within a country's political environment that lead to low nutrition lending, nor do we have systematic analyses to suggest how to overcome them.

This paper has sought mainly to describe nutrition lending in the Bank, especially lending outside the health sector. At the same time, it has provided background for future, more strategic examination of lending in nutrition. Future reports and studies should seek to understand why the structure of nutrition lending in the Bank is as it is. Work could proceed along the following lines:

- Document experiences of current projects, including:
  - analysis of effectiveness of cross- and multisectoral action;
  - identification and analysis of institutional and organizational issues; and
  - costs and cost-effectiveness.

- Develop tools for identifying appropriate opportunities and designing projects that utilize an inter-, cross-, or multisectoral framework for nutrition investments.

- In collaboration with regional staff, identify the internal operations, such as mission, incentives, and organizational structure, of the Bank that promote or inhibit inter-, cross-, or multisectoral action on nutrition. This analysis can be performed perhaps by choosing a small number of projects in high-burden countries as cases for joint reflection and learning.

And, finally,

- Develop a strategy, which includes developing briefs and toolkits and promoting better use of those that exist, to support a more multisectoral approach to nutrition. The emphasis should be on greater integration of nutrition into sectors outside health and on incorporation of appropriate indicators for monitoring, evaluation, and learning.

ANNEX 1. FOOD AND NUTRITION PROJECT DESCRIPTIONS: *HEALTH SECTOR*

1) AFRICA - REGIONAL HIV/AIDS TREATMENT ACCELERATION PROJECT (TAP)

Development Objective

To pilot strategies for strengthening each country's capacity to scale up comprehensive programs providing care and treatment that is effective, affordable, and equitable. The TAP will pilot treatment systems which ensure that people living with HIV/AIDS (PLWHA) and their immediate families benefit from care and treatment.

Components

- **Testing Approaches for Scaling-Up Service Delivery for HIV/AIDS Care and Treatment ($38.82 million) (Burkina Faso $13.48 million; Ghana $9.86 million; and Mozambique $15.48 million):** The TAP activities comprise: (a) piloting scale-up of existing care and treatment programs managed by selected implementing partners to ensure the delivery of the full continuum of care, and (b) piloting efforts to significantly increase the number of patients needing care and treatment at different stages. The focus is on five elements of treatment: voluntary counseling and testing; home-based care; prevention of opportunistic infections; anti-retroviral treatment; and prevention of mother-to-child transmission.
- **Strengthening Institutional Capacity for HIV/AIDS Care and Treatment ($16.51 million) (Burkina Faso $4.63 million; Ghana $5.72 million; and Mozambique $6.16 million):** Ensure effective public oversight of the treatment scale-up process, by: (i) strengthening the capacity of the National Treatment Committee, established in each country by the MOH, to provide technical guidance and quality control; (ii) coordinating program expansion through improved planning of infrastructure, human resource development, and drug procurement; and (iii) monitoring the accessibility, quality, and results of treatment with particular attention to the poor.
- **Facilitating Regional Learning from the TAP Country Experiences ($6.0 million) (World Health Organization (WHO) $4.0 million and United Nations Economic Commission for Africa (UNECA) $2.0 million):** Support in-country learning by funding WHO technical support activities, through its headquarters and regional offices, and within each MOH TAP unit. Refine and implement treatment guidelines and protocols; develop national standards, criteria and assessment tools for accrediting laboratories and treatment sites; and set up quality assurance systems for drug procurement and testing. WHO to also provide additional technical assistance in: (i) developing curricula and pedagogical methods for the training of medical and paramedical staff; (ii) strengthening program monitoring and evaluation; and (iii) establishing methods for managing patient compliance and evaluating treatment outcomes and potential drug resistance.

2) BANGLADESH - HEALTH NUTRITION AND POPULATION SECTOR PROGRAM

Development Objective

The Health Nutrition and Population Sector Program for Bangladesh will increase availability and utilization of user-centered, effective, efficient, equitable, affordable and accessible quality services, be it the Essential Services Package, improved hospital services, nutritional services or other selected services.

Components

- **Accelerate the Achievement of Health-Related MDGs and PRSP Strategies and of Population Policy Objectives:** This project supports the delivery of essential services that focus on:
  (i) Reducing maternal mortality through (a) public information campaigns to raise awareness about the importance of antenatal care and maternity services to reduce problems during pregnancy, labor and the postnatal/neonatal period and obstetric complications; (b) expanding the skilled birth attendance program; (c) strengthening emergency obstetric services by equipping and staffing these services; and piloting a voucher program to increase demand for maternal and neonatal health services.
  (ii) Reducing neonatal mortality through the above interventions and a program on home care.
  (iii) Reducing childhood morbidity and mortality by: strengthening the routine EPI program, including supplementary immunization activities, as needed, and scaling up IMCI to a national level after evaluation of the pilots.
  (iv) Improving the nutritional status of the people in Bangladesh with particular emphasis on maternal and children through: (a)social mobilization (b) supporting the important role of proper nutrition at national and community level and incorporation o f such information in the school curricula; (c) counseling of families on nutritional needs and proper household-level feeding of children; (d) strengthening of existing breastfeeding and complementary feeding activities and linking up with the global Infant and Young Child Feeding interventions (e) strengthening the community IMCI package including nutritional counseling and linking it with regular health services; (f) further improving the coverage o f vitamin-A supplementation every six month for all children 1-5 years of age and promote increased consumption of micronutrient and anti-oxidant-rich food by all; (g) improving iron folate supplementation for adolescent girls and pregnant women; (h) IDD control through salt iodization; (i) increasing coverage of de-worming; (j) preventing chronic diet-related NCD; and (k) food quality and safety.
  (v) Reducing fertility to the replacement level (by 2010) through public information campaigns, inclusion in secondary school curricula and service quality improvements.
  (vi) Reducing the burden of TB and malaria and preventing and controlling HIV/AIDS by increasing case detection while maintaining a high cure rate, improving the compliance of the private sector and academic institutions with the DOTS strategy, and ensuring uninterrupted supplies of drugs and laboratory supplies for TB; supporting the implementation o f the Revised Malaria Control Strategy for malaria; and continuing to focus on high-risk group interventions, communication and advocacy, blood safety and institutional strengthening for HIV/AIDS.
- **Meeting Emerging HNP Sector Challenges:** This component will support the development of policies and strategies for emerging challenges, and possibly implementation at a later stage, with a focus on:
  (i) Reduction of injuries and implementing improvements in emergency services;
  (ii) Prevention and control of major Non-Communicable Diseases (NCDs);
  (iii) Urban health service development; and

(iv) Improving the HNP response to disasters.

- **Advancing HNP Sector Modernization.** This component will deal with HNP reforms: (a) Public health-sector management and stewardship capacity; (b) Health sector diversification in order to diversify service provision; (c) Stimulating demand for HNP services.

Note
This project is one of the most comprehensive in terms of nutrition activities and interventions.

3) BANGLADESH - NATIONAL NUTRITION PROJECT

The National Nutrition Project for Bangladesh will be the first of a series of investments which will support the Government's 15-year vision to extend community nutrition services to the entire country.

Development objective

The development objective of the National Nutrition Project is to significantly reduce malnutrition, especially among women and children, through adoption of changes in behavior and appropriate use of nutrition services.

Components

- **Services Component:**
  (i) Area-based community nutrition services (US$71.6 million; 57.5% of total cost) which would: (a) improve behavior practices in critical areas such as breastfeeding, timely introduction of complementary food and adequate food intake during pregnancy; (b) increase awareness and treatment of malnutrition in the primary health care system; and (c) provide food security and income generating activities for the poorest households in the community. This sub-component was implemented through non-governmental organizations (NGOs).
  (ii) National-level nutrition services (US$11.7 million; 9.4% of total cost) which aim to promote and protect breastfeeding practices; promote salt iodization; and provide iron folate and vitamin A capsules supplementation to specific target groups.

- **Project Support and Institutional Development Component:**
  (i) Project management and development (US$8.70 million; 7% of total cost) through
  (a) the establishment of NNP Program Management Unit within the Ministry of Health and Family Welfare;
  (b) an NGO contract management system;
  (c) effective linkages between NNP and Health and Population Sector Program; and
  (d) strengthening the management capacities of communities and NGOs.
  (ii) Monitoring and Evaluation (US$8 million; 6.4% of total cost) that would (a) establish an effective project Management Information System; (b) establish an Independent Quality Assurance Group; (c) conduct baseline, mid-term and final evaluations; and (d) contract project-based operations research.
  (iii) Training and Behavioral Change Communications (US$24.46 million; 19.7% of total cost) to build capacity and to foster positive behaviors and nutritional practices.

Key Performance Indicators

Key outcome indicators for measuring and monitoring progress are reduced prevalence of severe and moderate child malnutrition, reduced prevalence of vitamin-A deficiency and iron deficiency anemia, increased use of iodized salt, increased pre-pregnancy and pregnancy weight gains, reduced low birth weight, and increased practice of exclusive breastfeeding followed by timely introduction of complementary food.

4) CAMBODIA - HEALTH SECTOR SUPPORT PROJECT

Development Objective

To 1) develop affordable quality health services with emphasis on primary health care and first referral services in rural areas; 2) increase the utilization of health services by the poor; 3) mitigate the effects of infectious disease epidemics and malnutrition; and 4) improve the health sector's capacity and performance.

Components

- **Improved Delivery of Health Services** (for the benefit of the poor and rural population). There are two subcomponents: (i) to provide support to increase the accessibility and quality of health services by rehabilitating and constructing civil works, financing equipment and maintenance, funding training for the minimum and complementary package of activities and funding to help solve current problems with drug quality, utilization, and availability throughout the health services; and (ii) to finance an alternative means to increase the affordability of health care services for the poor and under-served populations.
- **Improved Programs Addressing Public Health Priorities:** Support will be given for infectious diseases control programs for TB, Malaria, Dengue and STIs/H1V/AIDS consistent with the World Bank Strategy for Health, Nutrition and Population in the East Asia and Pacific Region, 2000. Support will also be given for nutritional activities proven to be cost-effective such as (i) exclusive breast-feeding for infants 0-6 months; (ii) timely and adequate complementary foods for children from six months to two years of age with continued breast-feeding until two years of age and promotion of an adequate diet for women of reproductive age, particularly pregnant women; (iii) appropriate care of sick and malnourished children; (iv) provision of iron-folate supplements for women and children; (v) provision of vitamin A for women and children; and (vi) availability of iodized salt for all members of the household.
- **Strengthened Institutional Capacity:** Under this component, the project will provide appropriate support to ongoing efforts at central, provincial, and district levels to strengthen key health sector functions, including: (a) oversight of the policy, legislative and regulatory framework for health service administration; (b) sector planning and program coordination of health care delivery; and (c) management of sector resources (human, financial, and material including infrastructure, drugs, etc.). An additional function, monitoring and evaluation of sector performance and health status, will be financed jointly by external donors.

Key Performance Indicators

The nine key performance indicators monitored on an annual basis are: the MOH recurrent budget (salary excluded) as a proportion of the total Government recurrent (salary excluded) budget; the % of the population with access to Health Centers providing a minimum package of activities services (as defined by MOH); per capita consultations (or visit rate) for curative care in public facilities, especially by the poor; the % of patients satisfied with services received in public health facilities; the % of Provincial Health Departments and Operational Districts producing annual health plans/Health Management Agreements (as specified in the MOH manual); the incidence of malaria per 100,000 inhabitants in areas at risk and the malaria case fatality rate in public facilities per 100 patients; pulmonary TB smear (+) case detection rate and cure rate; HIV sero-prevalence rate among women attending antenatal care; and malnutrition (weight-for-age) rate in children < 2 and children 2-5 years of age.

5) ECUADOR - PROGRAMMATIC HUMAN DEVELOPMENT REFORM LOAN PROJECT

Development Objective

(i) protecting and enhancing Ecuador's public sector investment in social sectors by supporting rationalized institutional budgets and financing for key social programs; (ii) increasing the efficiency and effectiveness of social programs through refocusing program objectives, improving targeting of social services, raising consistency in their administration, and promoting resource sharing among institutions; and (iii) enhancing the public consultations, transparency and accountability in the implementation of social programs.

6) ECUADOR - SECOND SOCIAL DEVELOPMENT PROJECT - HEALTH & NUTRITION - SUPPLEMENTAL LOAN

Development objectives

The main objective of the supplemental loan is to support the delivery of basic health services, including nutrition and basic water and sanitation, for the poor, particularly women and children and indigenous groups.

Components

- **Basic Health Care:** Infrastructure rehabilitation and supply of equipment to some health facilities will be financed. Basic drugs, including vaccines, micronutrients and other medical supplies, will also be financed.
- **Basic Sanitation and Safe Water:** Water and sanitation services will be extended to those rural communities not being served at present, and existing water supply systems will be upgraded.
- **Malaria Prevention and Control**: This component concentrates on improving the capacity to diagnose and treat infected population in high risk areas, particularly in the coastal region affected by El Niño Phenomenon, by integrating malaria prevention and control into the local health systems with an active participation of the affected communities. The supplemental loan would finance prevention and control activities by supporting field operations including

information, communication and education campaigns, purchase of pharmaceuticals and other medical inputs, elimination of vector reservoirs, and strengthening of local capacity (laboratories, health facilities and community organizations in affected areas) for diagnosis and treatment of malaria and other tropical diseases.

- **Monitoring, Evaluation and Auditing:** Overall monitoring and evaluation of the project is a responsibility of the MOH's PCU. Specific tasks include: (i) management and monitoring of key project activities to ensure implementation is done according to the agreed schedule; (ii) ensuring that the target population is receiving health care, nutrition and basic sanitation services; and (iii) monitoring timing of budget allocations and expenditures to ensure adequate and timely use of resources. Independent auditors would audit project accounts.

7) El Salvador - Earthquake Emergency Rec. & Health Services Extension Project

Development Objective

Restore hospital operations, and improve the provision of health assistance, specifically to vulnerable groups in the country's earthquake-damaged areas, in particular the underserved populations of the poverty-stricken Northern Region. This will be achieved by 1) rebuilding and improving health sector infrastructure damaged or destroyed by the earthquakes; 2) extending the coverage of essential health and nutrition services through a community based outreach approach; and 3) strengthening the institutional capacity of MOH to develop and implement policies and priority programs for the health sector.

Components

- **Emergency Reconstruction of MOH Hospital Network in Earthquake-Affected Areas ($127.0 million):** An emergency reconstruction of the MOH hospital network in the earthquake affected areas, through a phased construction that will meet current seismic structural codes. Equipment supply will include computers, medical waste disposal equipment, and medical equipment. Technical assistance (TA) will be financed to cover environmental impact studies, topographical analyses, and engineering drawings.
- **Strengthening Essential Health and Nutrition Services in Earthquake-Affected and Extremely Poor Areas (US$16.5 million):** The extension of essential health and nutrition services to damaged and poor areas by forming partnerships with nongovernmental organizations and local government agencies to strengthen MOH capacity, towards an integrated service delivery of health and nutrition services. Participatory outreach programs with communities will be established, including the development of management reforms in those reconstructed hospitals, to establish accountability systems, and health coverage in rural areas.
- **MOH Institutional Development for Policy Formation, National Priority Programs, and Support Systems (US$16.0 million):** Strengthening of MOH's capacity to perform public health programs, with improved quality and disease surveillance, regulation and performance-based monitoring stewardship functions related to quality enhancement, health promotion, public health programs, disease surveillance, regulation, and performance-based monitoring and evaluation. This will be achieved by supporting investments linked to the adoption and implementation of an institutional strengthening and decentralization strategy.
- **Project Management (US$4.8 million):** Project management, including the project's overall impact evaluation, and financial audits.

Key Performance Indicators

Hospital reconstruction/rehabilitation: facilities constructed/rehabilitated, services fully functioning, increased efficiency, and patient satisfaction; Preventive and corrective maintenance: maintenance staff trained, protocols/manuals produced, and facilities with functioning programs; Essential health: vaccination rates, malnutrition, growth monitoring, prenatal care, tetanus vaccination rates, and utilization; National priority programs: entomological surveillance, incidence of dengue and HIV/AIDS, toxic medical waste management, and environmental health; and MOH stewardship role: contracting and forming partnerships with NGOs, foundations, cooperatives and government agencies such as ISSS and municipalities, performance agreements with MOH providers, national health policy formation, information technology, communication strategies, and monitoring and evaluation.

Note
Nutrition in this project was supported through the purchasing of basic services implemented through the signing of contracts with NGOs, foundations, and cooperatives in Northern region affected by the earth-quake.

8) GUATEMALA - MATERNAL AND INFANT HEALTH AND NUTRITION

Development Objective

To improve maternal and infant health in the project's 40 areas of intervention and also reduce chronic malnutrition among children younger than 2 years of age in 70 municipalities targeted by the project.

Components

- **Strengthen Maternal and Infant Health Network (US$22.8 million):** This component supports the development of a Maternal and Infant Health Referral Network, promotes the demand for maternal and infant health care, and contributes to increasing the proportion of safe institutional deliveries, the referral of obstetric emergencies directly from the community, and access to a referral system for children with acute respiratory and digestive diseases. This component is divided into three sub-components: (i) maternal and infant health promotion from the community; (ii) strengthening capacity of the secondary health level; and (iii) strengthening the referral system.
- **Nutrition - Implementation of the AINM-C and "Creciendo Bien" Strategy (US$21.9 million):** This component aims to address the problem of child malnutrition in the selected 70 municipalities by expanding coverage of community-based growth promotion and basic health services. In addition, this component will expand community-based capacity-strengthening of mothers and families in the most vulnerable and indigenous communities. This component consists of three sub- components: (i) Strengthening the basic AINM-C package of services; (ii) Extending the Creciendo Bien Program in the most vulnerable communities; (iii) Supervision of nutrition activities.
- **Communication, Monitoring, Evaluation and Continuous Auditing Systems ($2.4 million):**This component seeks to: (i) provide support to poor families to learn about nutrition and health programs, encourage poor and indigenous population to utilize health and nutrition services, promote pattern behavior, and disseminate the populations' right to utilize services; (ii)

design and implement a comprehensive monitoring and evaluation system for the nutrition and health interventions; and (iii) measure the project's impact on targeted population welfare. This component is comprised of three sub-components: a communication strategy, a monitoring and evaluation system, and the impact evaluation of the project.

- **Institutional Strengthening ($1.7 million).** Supports the institutional capacity of the Ministry of Health to implement and administer basic health and nutrition services.

Note: The nutrition component in this project is quite comprehensive.

9) IRAN - SECOND PRIMARY HEALTH CARE AND NUTRITION PROJECT

Development objective

The objective of the proposed project is to assist the Government of Iran in improving health conditions in rural and urban areas through: (i) sustaining access to, and the quality of, primary health care; and (ii) improving the nutritional status of children under 2 years of age and of pregnant and lactating women.

Components

- **Sustain Access to, and the Quality of, Primary Health Care (US$91.2 million;74 percent of project costs):** The project will physically rehabilitate selected Health Houses (HHs), Rural Health Centers (RHCs), Urban Health Centers (UHCs), District Health Centers (DHCs), and Behvarz Training Centers that are more than 10 years old; replace and provide additional equipment in some cases; replace older vehicles in order to sustain the effectiveness of the PHC program.
- **Improve Nutritional Status of Children under 2 years of age and Pregnant and Lactating Women (US$21.5 million; 17 percent of project costs):** The project proposes to improve the effectiveness of the ongoing nutrition services in the health sector through: (i) an extensive training component that focuses on interpersonal counseling; the Information, Education, and Communication program; and social marketing as means of changing behavior; (ii) strengthening of the growth monitoring program, shifting the focus from monitoring to the promotion of growth; (iii) institutional strengthening of the nutrition department; and (iv) baseline studies, operational studies, situation analyses, and strategy development.
- **Capacity Building (US$11.3million; 9 percent of project costs):** This component will: (i) improve management training; (ii) conduct evaluation activities and operational research; and (iii) strengthen project management.

Key Performance Indicators

Physical progress of civil works by HHs, RHCs, and UHCs; number of re-equipped, newly-renovated HHs and RHCs; number of selected UHCs with operable X-ray; improved compliance– from 40 to 80 % –with iron supplementation programs; improved functional nutrition literacy at the household level and proportion of Behvarzes and CHWs and other health personnel trained; number of management trainers trained; number of management courses offered; and number of operational studies undertaken.

10) MADAGASCAR - NUTRITION II - SUPPLEMENTAL CREDIT

Development Objective

Reduce chronic malnutrition among children under three and improve the nutritional status of school-aged children, pregnant and lactating mothers.

Components

- Training
- Institutional strengthening
- Rehabilitation of nutrition centers

11) MADAGASCAR - SECOND HEALTH SECTOR SUPPORT PROJECT

Development objectives

The project's overall development objective is to contribute to the improvement of the health status of the population through more accessible and better quality health services.

Specific development objectives are to:
(i) improve quality of and access to primary health care services with a focus on rural areas;
(ii) support priority health programs with emphasis on endemic infectious diseases, reproductive health (including family planning, sexually transmitted diseases and HIV/AIDS) and nutrition; and
(iii) strengthen sector management and administrative capacity within the MOH and at provincial and district levels, to enable successful decentralization and sector reform.

While the project's main focus is on primary health services and malaria reduction (which will benefit from about 65% of the proceeds of the credit), the project will also contribute to reproductive health and nutrition activities, and to the strengthening of health sector capacity, by supporting the implementation of the health sector's Policy and Development Plan.

Components

- **District Health Services:** Finances civil works for health centers and district hospitals, re-equipping newly constructed or rehabilitated health facilities; and carries out studies, trains personnel, provides medicines; supports supervision activities, decentralized health administrations, sanitation activities; and helps maintain buildings, equipment, and vehicles.
- **Infectious Diseases:** Finances transport and other logistical expenditures, drugs and insecticides, equipment, studies, and training to diagnose, prevent, treat, and monitor malaria, tuberculosis, plague, and schistosomiasis.
- **Family Planning and Reproductive Health (including STD/HIV/AIDS):** Funds information, education, and communication efforts to improve reproductive health service delivery; training to raise standards in health interventions like child survival and safe motherhood; and prevention

campaigns to improve STD/HIV/AIDS services, particularly among prostitutes and other groups at risk.

- **Nutrition Rehabilitation and Knowledge Management:** Provides a package of institutional strengthening and child treatment support to enable the health ministry to enhance the effectiveness of nutrition programs and to develop a multi-sectoral operational nutrition information system.
- **Institutional Strengthening:** Finance reform by improving sector coordination; increasing service coverage, financial access, and equity; and enhancing efficiency.

Key Performance Indicators

1. Increased accessibility to health facilities (primary health care facility within a 5 km radius) from 65% to 85% by 2006; 2. Increased outpatient health facility utilization rates from 0.2 contacts per year to 0.6 contacts per year by 2006; 3. Increased district hospital utilization rates from 50% to 80% by 2006; 4. Increased contraceptive prevalence rates from 9.7% to 17% by 2006; 5. Increased child immunization rates from 40% to 75% by 2006; 6. Reduced hospital fatality rate in malnourished children hospitalized for nutrition rehabilitation from 20% to 10% by 2006; and 7. Maintain the HIV prevalence rate in pregnant women below 0.25 per 100.

12) MADAGASCAR - SUPPLEMENTAL CREDIT FOR SECOND HEALTH PROJECT (CRESAN II)

Development Objective

To contribute to the improvement of the health status of the population through more accessible and better quality health services.

Components

Same as the ones for **Madagascar – Second Health Sector Support Project** above.

13) NICARAGUA - HEALTH SERVICES EXTENSION AND MODERNIZATION (2ND APL)

Development Objective

To improve health outcomes in Nicaragua, particularly among the poor, by raising the efficiency, effectiveness, equity and sustainability of the Nicaraguan health system.

Components

- **Extension of Access to the Basic Package of Health Services (PBHS) for the Poorest and Most Vulnerable Populations - US$36.5 million (IDA - US$ 7.5 million):** Package of basic health care services (PBHS), focusing on maternal and child health, offered to the most deprived population of Nicaragua. Vulnerable populations and localities for the extension of coverage have been identified based on the following criteria: current access to health services, level of poverty, and health status.

- **Strengthening the Network of Services in Targeted Areas to Support the Implementation of the PBHS (US$27.8 million):** Sector Wide Approach (SWAp) designed to support the extension of coverage, and to complement its Maternal-Child Health (MCH)-related activities. Activities in this area are aimed at creating an effectively structured and functioning referral system that will provide a more complete continuum of MCH care to rural communities, while increasing access to secondary care and improving the overall quality of health care. This component includes physical rehabilitation of health centers and hospitals, expansion of the Women's Center Network and strengthening the management of public providers.
- **Improving Stewardship, Institutional Strengthening and Decentralization (US$ 17.8 million):** The Ministry of Health (MOH) recognizes that to fulfill the vision set forth in the National Health Plan (NHP) and effectively lead the SWAp, the following institutional reforms need to be undertaken: (i) strengthening the Ministry's management capacity necessary for planning, contracting and supervising the expansion of the PBHS (e.g., programming and planning, information and reporting) and the rest of the institutional fiduciary systems (financial accounting, procurement, auditing) so the SWAp can progressively adopt these national systems instead of donors' procedures; (ii) strengthening the Government of Nicaragua's capacity to monitor and evaluate health sector performance, efficiency and equity; (iii) supporting the Government of Nicaragua's coordination role as executor and overseer of the Government of Nicaragua's population policy; and (iv) developing a strong purchasing function at the MOH, including the identification of beneficiaries for the expansion of essential services, adjusting payment mechanisms, overseeing service quality, contract design and monitoring.

Key Performance Indicators

Results related to improved access to maternal and child essential services in targeted areas: 1. Coverage of complete prenatal care; 2. Institutional delivery rate; 3. Child immunization rates; 4. Coverage of early prenatal care; 5. Coverage of complete prenatal care; 6. Utilization rates of safe family planning methods. Results related to strengthening the health services network in targeted areas: *7.* Number of pregnant women admitted to Women's Centers; 8. Hospital discharge rate; 9. Number of hospitals with critical path services certified by MOH; 10. Percentage of providers satisfying targets set in their service agreements; and 11. Percentage of maternal deaths audited. Results related to improved sector stewardship and institutional strengthening: 12. Percentage of MOH budget transferred to local systems as purchase of services; 13. Percentage of MOH budget directly administered by the MOH executing units of the Autonomous Atlantic Regions; and 14. Per-capita public health expenditure in the targeted areas.

14) SENEGAL - NUTRITION ENHANCEMENT PROGRAM (NEP)

Development objective

Improve the growth of children under three in poor rural and urban areas and also help build up the institutional and organizational capacity to carry out and evaluate nutrition interventions.

Components

- **Community Nutrition and Growth Promotion:** Finance a large-scale community-based intervention that emphasizes behavior change communication for nutrition and establish growth monitoring and promotion in poor urban neighborhoods and rural villages. Support the delivery

of nutrition and health education through female community nutrition aides, who put the principles of Community Integrated Management of Childhood Illnesses (C-IMCI) into practice. Basic health services will be provided by District Health personnel in collaboration with the community nutrition aides.

- **Capacity Building and Monitoring and Evaluation:** Empower communities to establish and manage a system for growth monitoring and promotion. Focus on institutions as well as organizations, in particular inter-organizational collaborations and the capacity to manage the program based on results. Training and other types of capacity building activities will be provided.
- **Program Management:** Program Management: The National Executive Bureau is responsible for the daily management of the program. It will ensure financial management, reporting and auditing systems, and procurement.

Key Performance Indicators

Project outcome indicators: 1. Increased overall program coverage of under-five year old children in rural areas from 15% in 2006 to 40% in 2011; 2. Increase in the percentage of infants exclusively breastfed for the first six months by 30% in the intervention areas by 2011; and 3. At least 40% of pregnant women and children under five years of age sleep under insecticide-treated bed nets in the intervention areas by 2011.

15) Sri Lanka - Health Sector Reform Project

Development Objective

Improve efficiency, equity, and quality of health care by strengthening planning, management and monitoring capacity at the district, provincial and central level with specific focus on supporting preventive care services at the district and divisional level.

Components

- **Support District Health Agencies in Improving Service Delivery and Outreach:** Support existing District health programs, especially the MCH network that has delivered outstanding results in the past, as well as those associated with the emerging needs of NCDs. The focus is on preventive health care and service delivery to poor communities and underserved areas.
- **Support to Central Programs and Hospitals:** Promote synergy across selected central programs and their convergence at the provincial and district level as well as address some of the structural deficiencies in the hospital network.
- **Support Policy Making, Budget Formulation, and Monitoring and Evaluation:** Strengthen the capacity for stewardship of the Central MOH and increase the credibility, transparency and accountability of the public health system. This component would also support the collection of baseline, mid-term and endline data and issue-specific studies related to seeking solutions to implementation problems.

Key Performance Indicators

Outcome indicators addressing equity, quality and efficiency of the health sector include: 1. % of districts with infant mortality rate of 12.1/1,000 live births or lower; 2. % of districts with maternal mortality rate of 46.9/100,000 live births or lower; 3. Prevalence of anemia among pregnant women; 4. % of districts

with injection-site abscess rate of 10/100,000 doses of DTP3 or less; 5. % of institutional deliveries in teaching, general and specialist maternity hospitals; and 6. Budget allocated to health is aligned with explicit sector objectives and targets.

16) St. Vincent and the Grenadines - HIV/AIDS Prevention and Control

Development Objective

To support the national program aimed at preventing and controlling the spread of HIV/AIDS, and to mitigate the socio-economic impact of the disease. The project uses a two pronged strategy: targeting interventions at high-risk groups, and implementing non-targeted activities for the general population. Successful achievement of the development objective will: (a) increase the practice of safe sex among high-risk groups; (b) enhance knowledge in the general population of the negative societal and family impact of the disease; (c) prolong the lives of infected persons and provide care and support to their families; and, (d) reduce the degree of stigma and discrimination associated with the disease.

Components

- **Scaling-up HIV/AIDS Response by Civil Society Organizations (US$0.98 million):** Empowering civil society groups to respond effectively to the HIV/AIDS epidemic by providing support to communities and groups difficult to reach through regular public services, particularly high-risk commercial sex workers (CSW), men having sex with men (MSM), prisoners and vulnerable groups (orphans and youth).
- **Scaling-up the Response by Line Ministries (US$1.60 million):** Scale-up responsiveness of line ministries by supporting them in the expansion of HIV/AIDS initiatives, namely on information, education, communication/ behavior changes, condom distribution; care for the infected and affected families; and workplace policy formulation, including reduction of stigma and discrimination.
- **Strengthening the Health Sector Response to HIV/AIDS (US$3.48 million):** Strengthen the health sector response to HIV/AIDS by upgrading and expanding HIV/AIDS prevention, treatment (including anti-retroviral therapy) and care services delivered through the health care system.
- **Strengthening Institutional Capacity for Program Management and Monitoring & Evaluation (US$2.55 million):** Support institutional capacity building for the coordination and management of the National HIV/AIDS Program, including strengthening program monitoring and evaluation.

Key Performance Indicators

The following output indicators are planned to be monitored frequently: 1. Positive HIV cases identified, counseled and treated; 2. STI cases traced and treated; 3. Number of condoms distributed; 4. Pregnant women testing positive and receiving antiretroviral therapy; 5. Blood units screened before transfusion; 6. Physicians and nurses trained in managing HIV/AIDS patients; 7. Orphans identified and cared for; 8. HIV/AIDS IEC messages aired in the mass media; and 9. Civil Society Organizations actively engaged in the national HIV/AIDS response.

17) TANZANIA - SECOND HEALTH SECTOR DEVELOPMENT PROJECT

Development Objective

To achieve improvements in the provision of quality health services through continuing to support reforms, capacity development, and improved management of resources, while placing a greater emphasis on quality.

Components

- **Improving District Level Health Services:**
- **Strengthening Management of Secondary and Tertiary Hospital Care**
- **Strengthening Central Level Stewardship Role**

Key Performance Indicators

Agreed upon indicators for assessing the long-term impact of the Health Sector Development Program: 1. Infant Mortality Rate (IMR); 2. Ratio of the IMR of the poorest quintile to the IMR of the least poor quintile; 3. Under-five mortality rate; 4. Life expectancy at birth; 5. Total fertility rate 15-49; and 6. Maternal Mortality Ratio.

18) UZBEKISTAN - HEALTH 2 PROJECT

Development Objective

To improve the quality and overall cost-effectiveness of health care services through 1) completion of the primary care program in 8 regions; 2) extension of financing and management reforms related to efficiency and effectiveness of service delivery; 3) improving public health services, including surveillance, training in public health and control of communicable disease; 4) building capacity of the MOH to better monitor and evaluate reforms.

Components

- **Primary Health Care Development:** Extend further support for development of Primary Health Care (PHC) services. In concert with the Asian Development Bank, all Primary Care Centers (SVPs), as well as some remaining SVPs not covered under Health I, will be supplied with a package of equipment. More remote SVPs will be supplied with telecommunication equipment and transport to improve patient services, referrals, and overall management of these facilities.
- **Financing and Management Reforms:** Support broad activities to continue to improve the health care financing and management system, to improve efficiency in the delivery of services and to help increase sustainability of primary health care reforms. Activities to improve the health care financing and management system will comprise the scaling up of financing and management pilots initiated under the first Health project, and extending and geographically expanding the rural PHC financing model of the first project nation-wide following some adaptations.

- **Improving Public Health Services:** Contribute to the control of communicable and non-communicable diseases, and to improve public health services, including surveillance, and health promotion. Three main areas are supported in this component: (i) capacity building, through development of a national public health strategy, development of a School of Public Health, scaling-up health promotion and health education programs under Health I, and local community-driven and nutrition programs; (ii) upgrading and strengthening of essential public health infrastructure and manpower; and, (iii) contributing to scaling-up activities to prevent HIV/AIDS and STIs, and control TB.
- **Project Management, Monitoring and Evaluation**: This component would finance the Central Project Implementation Bureau staff salaries, technical assistance, travel costs, annual project audits and limited upgrade of office equipment and vehicles.

Key Performance Indicators

Primary Health Care Development: 1. Increase number of pregnant women covered by prenatal care by 10%; 2. Increase number of newborns who receive hepatitis B immunization by 10% and increase primary health care utilization and access by 10%; 3. Training of 2,700 general practitioners who work in SVPs; 4. Increase availability of essential pharmaceuticals at primary care level as measured by number of essential drugs stocked; Financing and Management Reforms: 5. Decrease hospital referrals and admissions by 10%; 6. Training of 520 health policy experts and financial managers; 7. Recurrent expenditures for primary care is at least 20% of total public expenditures for health; 8. Share of expenditures for primary and outpatient care at least 40%; Improving Public Health Services: 9.100% of pregnant women have access to HIV testing and have access to Mother-to-Child treatment prevention; 10. Increase of coverage of groups at risk by HIV prevention activities by 10%; 11. Adoption of a National Strategic Plan and scaling-up DOTS throughout the country; 11. Training of at least 50 public health specialists and public health nurses; 12. Number of community-based grant projects implemented; Project Management, Monitoring and Evaluation: 13. M&E system established with a minimum of 2 facility surveys and 2 household surveys.

ANNEX 2. FOOD AND NUTRITION PROJECT DESCRIPTIONS: *NON-HEALTH SECTORS*

SOCIAL PROTECTION (SP)

1) EL SALVADOR - SOCIAL PROTECTION PROJECT

Development Objective

Support El Salvador's Red Solidaria program to initiate a conditional cash transfer intervention for very poor families and their most vulnerable children in the country's poorest municipalities.

Components

- **Establishing a Conditional Cash Transfer Program (US$63.6 million financed by government counterpart funds):** Support the implementation of a conditional cash transfer program to encourage extremely poor families to send their children 5-15 years old to pre-school and primary education, maintain the full immunization scheme in children younger than 5 years, and regularly monitor the growth and development of children aged 0-24 months.
- **Expanding Provision of Basic Health and Nutrition Services (US$15.0 million World Bank financing; US$20 million total external financing):** Support the expansion of the existing basic package of health services with a focus on maternal and child health, as well as the strengthening of nutritional interventions based on the AIN-C integrated community nutrition model in the 100 poorest municipalities where the conditional cash transfer program will be implemented.
- **Strengthening Legal Access to Services through Expanding the Civil Registry (US$4 million):** Support the National Registry of Persons to broaden legal access to the basic education and health services of the Red Solidaria by expanding the coverage o f the civil registry system.
- **Monitoring, Evaluation and Social Awareness Strategy (US$2 million World Bank financing; US$6 million total external financing):** Provide institutional strengthening to the Technical Secretariat of the Presidency (STP) to ensure the adequate design and implementation of the operational rules and norms of the Red Solidaria Program, effective inter-institutional and inter-sectoral coordination, an effective social communication and dissemination strategy, and appropriate supervision and monitoring of the Program. This component will also support the development of a small technical team in the Red Solidaria Unit of the STP, including an Executive Director (already hired from within the STP) and a small core staff, as well as provide technical support, training, and the equipment necessary to fulfill its coordinating, supervisory and monitoring functions.

2) ETHIOPIA - PRODUCTIVE SAFETY NETS PROJECT (APL 1)

Development Objective

This project is part of a larger national Food Security Program, which utilizes many other instruments and gets funds from many other donors. The development objectives of phase I of the Program are to assist

the Government to shift from a relief-oriented to a productive and development-oriented safety net by (i) providing predictable, multi-annual resources, (ii) replacing food with grants as the primary medium of support, and (iii) making resources available for critical capital, technical assistance, and administrative costs.

Components

The main components of this APL (Phase I) are: Safety Net Activities (labor intensive public works, direct transfers) and Institutional Support (local-level capacity building, development of M&E, procurement of goods and services).

3) MALDIVES: INTEGRATED HUMAN DEVELOPMENT PROJECT

Development Objective

The development objectives of this project are to: (i) improve social outcomes and promote economic growth by strengthening the delivery of social services (education, health and nutrition services) available to the population; (ii) reduce poverty and promote regional equity by strengthening social service delivery and increasing economic opportunities in atolls remote from the prosperous Male region; and (iii) promote ecologically sustainable development by concentrating services and populations on ecologically viable islands within these atolls.

Components

- **Strengthen Education Service Delivery:** This project component supports the following activities: (a) enhance cost-effective access to secondary education through (i) the implementation of a school rationalization framework for focus atolls that expands and concentrates secondary schools on focus islands (ii) reduce transport constraints faced by students (particularly poor and female students) who need to travel to focus islands to attend school, by establishing community-managed residential learning centers on focus islands; (b) improve the quality of education on focus islands by: (i) improving the capabilities and skills of teachers, including for multi-grade teaching where necessary, (ii) raising the quality of school leadership and administration on the part of principals, headmasters, and headmistresses, (iii) expanding education facilities such as IT centers, science laboratories, multi-purpose rooms, library and teacher resource centers, and (iv) increasing the supply of teaching material and learning resources; and (c) conduct whole school evaluations including assessments of (i) student learning achievements, (ii) teaching, (iii) school management and effectiveness of in-service training.
- **Strengthen Health Service Delivery:** The project component supports the following activities: (a) rationalizing care for NCDs by: (i) establishing standard treatment protocols for risk factor management, (ii) setting standard operating procedures, (iii) improving access to specialist services for focus island residents through telemedicine, and (iv) improving access to essential medicines at low cost by supporting community pharmacies, and (v) training staff in using the protocols and monitoring their use; (b) enhancing support for nutrition promotion to address the widespread problem of childhood malnutrition through: (i) communication of strategic behavioral changes, (ii) improved nutrition surveillance, and (iii) greater use of locally relevant complementary foods.
- **Strengthen Employment Services:** This project component will enhance employment prospects of individuals, particularly those residing in remote atolls by (a) supporting cost effective job

information and job counseling services through (i)a national jobs information network, (ii)establishing job centers on focus islands, (iii)career and employment counseling through job centers and (iv) business centers to facilitate business development; and (b) expanding existing microfinance programs to all of the focus islands.

- **Strengthen Community Services:** The project will improve service delivery by strengthening community services, i.e. public administration and local government, on focus islands. The project will strengthen and improve community groups by providing: (a) leadership and management skills training to community-based organizations; (b) financial support to community groups, through a community development fund and cooperatives offering community-wide services; (c) support to the development of multi-purpose buildings to consolidate the provision of services; and (d) the development of broad networks on each focus island.

Key Performance Indicators

The key performance indicators are: 1. Increase in citizen satisfaction with social services on focus islands, as measured by Citizen Report Cards and Community Score Cards, by 30% by end of project; 2. Increase in secondary (grade 8-10) enrollments on focus islands by 25% by end of project; 3. Female students account for at least 40% of the student residents in the Residential Learning Centers on the four focus islands by end of project; 4. Reduction in the gender gap in 0-level pass rates on focus islands by 25% by end of project; 5. Reduction in job search waiting time on focus islands by 20% by end of project; 6. Increase from zero to 50% in the use of Standard Treatment Protocols on Focus Island hospitals by end of project; 7. Reduce the number of children showing growth faltering during weaning period (6 to 12 months) by 30% on the focus islands by end of project; and 8. 20% increase in number or value of local development initiatives undertaken by CBOs on focus islands by end of project.

4) MEXICO - INSTITUTIONAL STRENGTHENING OF NATIONAL INDIGENIST INSTITUTE- MEXICO

Development Objective

The purpose of the Grant is to strengthen the capacity of the Recipient's National Indigenist Institute (INI) to play an effective role in indigenous development.

Components

- **Technical assistance and training for**: (i) INI's staff at the regional and national level; and (ii) selected indigenous organizations.
- **Diagnostic workshops**: including, *inter alia*: (i) a field workshop with key regional coordination offices to analyze the outcome of a draft diagnostic document and to initiate discussions within INI to design an indigenous development strategy; (ii) a multi-agency workshop with relevant agencies involved in indigenous development issues to discuss a draft diagnostic document and propose strategic activities; (iii) a consultative workshop with indigenous municipalities, communities and organizations to present the proposed strategy and get feedback to develop a work program; and (iv) a consolidation workshop with key stakeholders, including government agencies, indigenous professionals and regional offices to disseminate the proposed strategy.

5) PERU - PROGRAMMATIC SOCIAL REFORM LOAN PROJECT (02)

Development Objective

a) Establish a pro-poor social expenditure regime and an adequate social protection mechanism for the poor;
b) Improve access of the poor to critical social programs, through better targeting, improved efficiency and rationalization of expenditures; and
c) Improve transparency in social programs and expenditures, as well as empower beneficiaries to participate in the policy and budget process.

Components

- **Improve Anti-Poverty Focus of Public Expenditure:** Identify and monitor a set of key social programs of demonstrated efficacy, whose medium-term funding would be protected; and consolidate and rationalize the many existing food distribution programs. Reorient aggregate fiscal expenditures away from defense and internal security in favor of education, health, social protection, and rural infrastructure; Unify the management and improve the anti-poverty targeting of rural infrastructure programs; Initiate an emergency employment program; and Improve the finances of the public pension system, while exploring options for redirecting subsidy elements toward the poor.
- **Improve Access of the Poor to Health and Education:** Components include the expansion of the maternal and infant component of the Integrated Health Insurance Program; the expansion and capacity building of community-administered health facilities; the rationalization of health expenditures by better coordination and separation and greater efficiency and transparency of activities; the reduction of inefficiencies in nutrition expenditures by consolidation and better targeting of food distribution programs, and by more systematic efforts to improve the access of poor mothers to nutritional information and education as well as micronutrients for pregnant women and young children; and the improvement of initial and primary education, with particular attention to rural teacher incentives, qualifications, and performance.
- **Increase Transparency and Social Control over Public Expenditur**e: Make social programs more transparent and accountable, to promote collaborative planning and budgeting processes, and to improve the systems of public financial administration and procurement. In addition, it is intended to make statistical information generally more reliable and timely by providing administrative and financial autonomy.
- **Macroeconomic Management.**

6) PERU - PROGRAMMATIC SOCIAL REFORM LOAN IV

Development Objective

This project is a continuation of earlier programmatic social reform loans (I, II, III), so the main objectives are the same. Reforming Food Programs IV suggested that the food programs are to be decentralized, but they lack clear objectives, monitoring and evaluation are weak, and both targeting and transparency need further strengthening.

Components

- **Improving the Anti-Poverty Focus of Public Expenditures by Protecting Funding Levels and Promoting Better Targeting:** This component includes formalizing the government's commitment to poverty reduction through the inclusion of social spending priorities and objectives in the Multiannual Macroeconomic Framework, and by enacting the legal norms to govern related management agreements between MEF and the sector ministries and other entities of the national, regional, and local governments; Improving the protection of budgetary expenditures for six priority social programs; Establishing a normative framework to ensure the pro-poor targeting of food distribution programs, and their transparency and monitoring, as both resources and implementing responsibility are transferred to the municipal governments; and Continuing reform of the public pension system through the publication of a strategy for increasing its coverage and efficiency, the initiation of a time-bound action program for achieving the specified objectives, and an information system to monitor and disseminate the results.
- **Increasing the Access of Poor Families to Quality Health and Educational Services:** This component includes continuing the expansion of the Integrated Health Insurance program's coverage of infant and maternal care, and strengthening the focus of expenditures on primary health care facilities; Strengthening the monitoring of management agreements between the Ministry of Health and the Regional Health Departments and introducing quarterly reporting of their goals and results to the public; Progress in rationalizing human resource management in the public education system, extending coverage of the Unified Payroll System for teachers to provide sector authorities a long-missing information base and a mechanism to control the growth and allocation of sector resources, eliminate improper payments, and shift teaching positions from over-staffed schools to areas of need; and Continued pilot testing, consultation, and evaluation of a system of incentives for rural teachers and the initiation of pilot testing of merit incentives.
- **Increasing the Transparency of Social Programs and Enhancing the Participation of the Poor in their Design, Monitoring and Evaluation:** The implementation of a transparent and participatory, results-oriented M&E system for the PSPs adapted to the process of decentralization; effective implementation of the Law of Transparency and Access to Information, with dissemination of information on the decentralized social programs reaching the local communities and the latter increasingly involved directly in program targeting and monitoring; and improved regulation and transparency of the procurement of foodstuffs for the food distribution programs.

EDUCATION (ED)

7) DOMINICAN REPUBLIC - EARLY CHILDHOOD EDUCATION PROJECT

Development Objective

To assist the Government of the Dominican Republic in its efforts to increase the availability of high quality educational services for young children age zero through five by means of targeted early childhood interventions. With a particular focus on the poor, the project will expand access to and improve the quality of integrated services that address young children's basic needs, including preprimary education, psycho-social stimulation, health care and nutrition.

Components

- **Expanding Preprimary Education Services:** This component consists of two sub-components: the establishment of Regional Model Centers (including new teacher salaries) and the establishment of new classrooms for pre-primary education (including new teacher salaries).
- **Increasing ECD Education Quality:** This component consists of six sub-components: teacher training and staff development programs, application of the pedagogical model, creation of educational resource centers in each regional model center, provision of educational materials for all preprimary classrooms, renovation of preprimary classrooms and the family-based initiative.
- **Institutional Strengthening in Education Sector:** This component consists of two-subcomponents, and it is the component with the likeliest connection to nutrition. The sub-components are: (a) (i) support for policy and strategy development and institutional organization; and (ii) support for practical, formal, cross-sectoral linkages between initiatives involved in delivering ECD services; and (b) establish a grant program for inter-institutional support for ECD, to stimulate NGOs, municipal governments and the private sector to implement innovative projects targeting educational quality, health or other social services that benefit children living in poor communities between the age of zero and five (also other beneficiaries are involved, including parents, teachers and care givers of children). Expected activities are training, social marketing, and educational campaigns promoting the importance of child development and proper health and nutrition for young children.
- **Project Administration and Monitoring:** This component consists of two sub-components: project administration and project monitoring and evaluation contingencies.

Key Performance Objectives

1. Increase the enrollment rate of five-year-olds in pre-primary education from 71.8% to 86%; 2. Increase the enrollment rate of the poorest five-year-olds in pre-primary education from 51% to 86%; 3. Carry out 200 initiatives involving cross-sectoral and public-private collaboration in the provision of early childhood services, benefiting 20,000 children directly and 80,000 others indirectly; 4. Decrease the percentage of time during which children in pre-primary classrooms are not actively engaged, by 5 percentage points; and 5. Achieve significant difference in grade repetition and dropout rates in grades 3 and 4 for children that attended Regional Model Centers as compared to those rates for the total population in grades 3 and 4.

8) Eritrea - Integrated Early Childhood Development Project

Development Objective

Promote the healthy growth and holistic development of Eritrean children. It will expand access to and improve the quality of services that address young children's basic needs: health care, nutrition, social protection, psycho-social stimulation, affection and early childhood education. The program covers about (1) 560,000 children under 6 years (2) 310,000 primary school-age children (3) 32,000 children facing especially difficult circumstances (orphans).

Components

- **Improving Child Health (US$ 11.90 million):** The objective of this component is to reduce childhood morbidity and mortality by improving case management and preventive skills of health staff and empowering communities and caregivers to improve family/child health care practices.
- **Improving Child and Maternal Nutrition (US$5.20 million):** The objective of this component is to improve the nutritional status of children under 5 years, and pregnant and nursing mothers. Nutritional interventions include:
    - (i) Parent/care provider nutrition education;
    - (ii) Institutionalizing a community-based growth-monitoring system;
    - (iii) Targeted supplementary feeding;
    - (iv) Improving the referral system for sick and malnourished children;
    - (v) Reducing micro- and macro-nutrient deficiency by vitamin A and iron supplementation and increasing iodized salt consumption, therapeutic feeding for growth-faltering children within a limited period of time (approximately 3 months);
    - (vi) Increasing availability of low-cost complementary food for children;
    - (vii) Training women with skills in improving household level nutrition and in a selected income-generating activity. This also includes training of home extension agents to teach women to include fish in household diets; and
    - (viii) Building capacity within ministries to implement the nutrition component, as well as the capacity for research, analysis and development of new approaches.
- **Improving Early Childhood Education and Care US$ 13.60 million:** This component seeks to improve access to and quality of early childhood education, improve primary school health environment and enhance the institutional capacity of all administrative levels to undertake early childhood education and care.
- **Support to Children in Need of Special Protection Measures US$12.40 million:** The objective of this component is to strengthen the traditional safety nets for child care and protection through community-based reintegration and psycho-social support for orphans.
- **Strengthening Overall Project Management, Supervision and Strategic Communications US$5.90 million** This component will support the over-all management of the multi-sectoral program; all the other components have their respective budgets and activities to support institutional strengthening.

Key Performance Indicators

The outcome/impact indicators (by June 2005 in project areas) are: 1. 20% decrease in case fatality in children from the combined 5 major causes: malaria, acute respiratory infections, diarrhea, measles and malnutrition; 2. 20% decrease in malnutrition (measured by prevalence of underweight in children <6 years of age); 3. 20% decrease in repetition and drop-out rates between grades 1 and 2; and 3. reunification of 32,000 orphans with their nearest relative. Key indicators to monitor implementation progress (monitored in July and December of each year) are: 1. Percentage of actual vs. projected disbursement by component; 2. Number of health workers trained in the integrated management of childhood illnesses case management; 3. Number of health facilities stocked with essential IMCI drugs; 4. Number of mothers who received special training in food security and nutrition through the Ministry of Agriculture's training program with support from the Ministry of Health; 5. Number of kindergarten schools established, and the number of children enrolled in the kindergarten schools; 6. Number of kindergarten teachers, assistants, directors and community care givers trained and inducted into the early

childhood education (ECE) program; 7. Number of social workers trained; 8. Number of group homes established and the number of orphans enrolled in such homes; 9. Number of villages reached by the project relative to goal; and 10. Number and percent of supervision and evaluation reports completed/submitted as planned.

9) MALAWI - EDUCATION SECTOR SUPPORT PROJECT 1

Development Objective

To improve education quality by improving the conditions and processes of teaching and learning at the school level and the capacity for education service delivery across the education system.

Components

- **Teacher Capacity Development (IDA allocation of US$15.5 million at base cost):** Refurbishment of education facilities, construction of new teacher training college, student assessment survey to function as a baseline for the project.
- **Quality Improvement and Inputs (IDA allocation of US$3.7 million at base cost):** Secondary schools refurbishment, provision of textbooks for teachers, and teacher training.
- **Mitigating Externalities Affecting Quality of Education (IDA allocation of US$3.0 million at base cost):** Providing school health and nutrition package to all primary schools, which include the following interventions: distribution of Vitamin A, iron-folic acid to school children under 10 years, de-worming, treatment of malaria and fever, and promotion of good health and nutrition practice.
- **Direct Support to Primary Schools (IDA allocation of US$3.7 million at base cost):** Supply basic learning materials directly to schools while strengthening the participation of communities in school management.
- **Capacity Building and Policy Development (IDA allocation of US$1.4 million at base cost):** Includes the following two sub-components: (i) national education policy consolidation and capacity building, and (ii) support to the implementation of the government's decentralization policy in education.
- **Project Implementation Unit and Contingencies** (IDA allocation o f US$4.9 million). This component will support the physical implementation and management of fiduciary and procurement issues.

10) YEMEN - CHILD DEVELOPMENT PROJECT

Development Objective

To assist the government of Yemen in the implementation of a coordinated area based program for improving the health and nutritional status of children under five and educational status of girls in primary schools in 30 targeted districts that are underserved in the areas of health and education.

Components

- **Community Readiness Program (US$1.33 million):** Improve community readiness for project inputs through training in assessing needs and planning and through social mobilization (institution building activity).
- **Health Activity (US$25.76 million) (physical building activity):** This has 5 subcomponents: district health system, integrated management of childhood illnesses, immunization program, safe motherhood and water and sanitation. It is a capacity-building activity to improve the health status of children under age 5 in 9 governorates in general and in 30 selected districts in particular.
- **Nutrition Activity (US$1.51 million):** Institution-building activity to reduce malnutrition and growth failure in the selected districts using sustainable and effective approaches. This is through community activities such as nutrition education, counseling, growth monitoring and rehabilitation and micro-nutrient supplementation.
- **Education Activity (US$9.12 million):** To expand girls' access to quality primary education through innovative and effective community-based schools, women teacher training and textbooks/educational material availability. This is a physical institution-building activity.
- **Pilot Early Childhood Development Activities (US$0.52 million):** This is an institution-building activity to improve education ability of young children through pilot community-based ECD models, which will be carefully evaluated for future expansion.
- **Project Management (US$2.26 million):** To support the direct cost management of the project by the Yemen high council for mothers and children.

Key Performance Indicators

Key performance indicators include reduced child mortality, improved nutritional status of young children, and increased enrollment and learning achievement of girls up to grade six.

ENVIRONMENTALLY AND SOCIALLY SUSTAINABLE DEVELOPMENT (ESSD)

11) ETHIOPIA - NATIONAL FERTILIZER SECTOR PROJECT - SUPPLEMENTAL CREDIT

Development Objective

(a) Supporting policy reform to create an enabling environment for the growth of a competitive fertilizer sector;
(b) Supporting institutional strengthening and human resource development; and
(c) Promoting initiatives to maintain and improve the long-term fertility of the Ethiopian soils and ensuring environmental conservation.

Components

- Capacity building and institutional strengthening and human resources development.
- Addressing fertilizer supply and demand constraints, including the construction of rural soil-testing facilities.
- Soil fertility management and environmental conservation.

12) ETHIOPIA - EMERGENCY DROUGHT RECOVERY PROJECT

Development Objective

To enable the government to help affected families survive the crisis, retain productive assets and develop sustainable livelihoods as well as contribute to stabilizing the macroeconomy.

Components

- **Community Interventions (US$16.5 million):** These activities are aimed at improving coping mechanisms, reducing malnutrition in children, protecting productive assets of the affected population and enabling them to recover their productive capacity. Under this component the project will build on the Gratuitous Relief program, seeking to improve nutrition by financing the inclusion of supplementary, enriched food targeted at small children and pregnant and lactating mothers in the "food package". The community intervention is also concerned with education through funding of food-for-education, especially for girls.
- **Quick Disbursing Assistance (US$43.5 million):** Imports of items essential to support the recovery of the economy, and the agriculture sector in particular.
- **Project Management (US$1.7 million)**: Support and specialized staff provided for program management, monitoring and evaluation, finance, procurement, and rural engineering at the Federal level. Funding provided for capacity-building programs at the Region and Woreda levels. Select studies would be carried out in drought-prone parts of Ethiopia, on program effectiveness and impact.

Key Performance Indicators

The main indicator of project impact would be reduced levels of outmigration of affected families from their homes.

13) ETHIOPIA - FOOD SECURITY PROJECT

Development Objective

Build the resource base of poorer rural households, increase their employment and income, reduce their real costs of food and improve nutrition levels for their children under five years of age, and pregnant and lactating mothers.

Components

- **Funds to Communities/Kebeles:** Under this component, 12 woredas (akin to districts) will be selected to: (i) Receive grants as fixed sum of money to support food insecure woredas so as to increase incomes or assets of the community; and (ii) obtain grants up to $2500 for each kebele to support child-growth activities. Child-growth promotion animators, working with mothers, will monitor the growth of infants on a monthly basis from birth until the age of 24 months. A portion of the project funds would be also used for food-security related capacity building at Woreda,

Region and Federal levels, and for initiatives designed to increase the efficiency of food marketing, and reduce real food prices.

- **Community-Based Child Growth Promotion - community funds and capacity building.**
- **Capacity Building Funds to Woredas, Regions, and Federal Ministries for Specific, Project-Related Activities.**
- **Investments Undertaken at the Federal and Regional Levels to Study and Launch Initiatives and Policies to Lower Transaction Costs in Food Marketing.**
- **Investments in Communications to Ensure Transparency.**
- **Administration of the Flow of Funds, Monitoring and Evaluation.**

Key Performance Indicators

Communities themselves propose how they will measure progress on their projects. To the maximum extent possible, monitoring of performance will emphasize outcome indicators rather than process indicators. The precise indicators communities will select are not known in advance and as a result are not mentioned in the Project Appraisal Document.

14) MALAWI - EMERGENCY DROUGHT RECOVERY PROJECT

Development Objective

The objectives of the Emergency Drought Recovery Project are: (a) to allow the Government to maintain key commitments to economic priorities and investments consistent with the PRSP process while at the same time fulfilling its immediate obligations to avert famine; (b) to help restore the productive capability of the populations; and (c) to support longer term disaster management by the Government.

Components

- **Quick disbursement of import items linked to the drought (US$40.0 million):** This component provides foreign exchange for the importation of: petrol and fuel products; agricultural inputs; construction equipments, livestock, animal products and vet, medical and school supplies.
- **Expanding the Malawi Social Action Fund Public Work Projects and the Social Support Projects (US$8.0 million):** Public works supported will include those that reduce the isolation of rural communities in need of assistance (primarily repair of rural roads and bridges), and also that reduce the likelihood of recurrence.
- **The project also includes support for implementation, technical assistance, and studies (US$ 2.0 million):** The technical assistance and studies will have the following objectives: (i) to support full public discussion and consideration of the causes of the present crisis and measures to prevent recurrence, including the work of the technical sub-committees of the Inter-Ministerial Task Force; (ii) to support Malawi's participation in the SADC-wide efforts to craft a regional approach to prevention and management of crises; (iii) to diagnose the key problems with agricultural statistics and how to fix them; (iv) to finance regular meetings of a technical steering committee to monitor implementation of the present program; (v) to put in place a mechanism for monitoring and evaluation of the impact of the crisis and mitigation efforts; and (vi) to provide short-term support to strengthen the agricultural advisory services available to small farmers as they rebuild following the present catastrophe, and to focus on ways of improving water and soil management, mitigating the impact of future disasters.

15) MEXICO - RURAL DEVELOPMENT IN MARGINAL AREAS PROJECT - APL II

Development Objective

To improve the wellbeing and income of small land holders in targeted marginal areas, who are among the country's poorest inhabitants, through sustainable increases in productivity and better food security.

Components

- **Productive Investments (US$46 million):** Financing demand-driven investment sub-projects for agricultural production, natural resources management, processing and minor productive infrastructure through matching grant system. The subprojects are in the areas of: improvements in existing farming system for basic grains, home gardens production, rearing of small animals (birds, sheep, goats, and pigs), dissemination of sustainable grain production technologies that would improve soil and moisture conditions, improvement of coffee productivity and expansion of organic production, intensification of livestock activities such as dual-purpose cattle raising (dairy and meat).
- **Community Development (US$6.0 million):** Preparation and implementation of simple plans for community-based natural resource management, using participatory rural assessment methods.
- **Technical Support (US$17.0 million):** Technical support and training for farmers and producers organizations required for the implementation of sub-projects, the establishment of demonstration plots, and the organization of workshops and training.
- **Institutional Strengthening and Project Administration (US$4.0 million):** Support to project management and administration and include (i) the establishment and operations of the technical support teams for each CRDS; (ii) capacity building and training for the CRDS and Coffee Councils; and (iii) institutional strengthening at the central and state level for project management, monitoring and evaluation, and auditing.

Key Performance Indicators

Key performance indicators include: (i) the adoption of new technology, increases in yields and income, and better food security; (ii) the successful integration of sustainable natural resource management practices; and (iii) the promotion of off-farm activities and employment opportunities.

16) PHILIPPINES - MINDANAO RURAL DEVELOPMENT PROJECT

Development Objective

It is a targeted poverty reduction program for the rural poor and indigenous communities of Mindanao aimed at improving incomes and food security in the targeted rural communities within the 24 provinces of Mindanao. Through the implementation of better-targeted agricultural and fisheries-related rural development and biological diversity conservation programs and improved local government units' institutional, management and financial systems.

Components

- **Rural Infrastructure Improvement (US$27.4 million (66% of total costs including contingencies))**: Rehabilitate rural roads, support for communal irrigation (local government units to take over), and provision of safe potable water.
- **Community Funds for Agricultural Development (US$6.5 million (15.7% of total costs including contingencies))**: Community Funds for Agricultural Development set up at the municipal level. The Community Funds will finance demand-driven sub-projects which are consistent with the Department of Agriculture's programs and priorities for supporting agricultural and fisheries development. Poor communities will be targeted, and preference given to women and indigenous peoples groups.
- **Institution/Implementation Support (US$5.4 million (13% of total costs including contingencies)):** Initiatives to increase local capacity include support for microfinance institutions, support for enhancing rural development planning and resource allocation capacity at the Local Government Unit through TA for rural development planning and on-the-job training on assessment of agricultural potential and constraints, poverty mapping, and M&E. The component also includes skill upgrading for fisheries technicians, support for mini-projects to demonstrate new skills learned, training, study tour, equipment and vehicles.
- **Costal/Marine Biodiversity Conservation to Increase Productivity (US$1.7 million (4% of total costs including contingencies)):** Establish community-based management of marine biodiversity resources; strengthen local capacity to address marine ecosystem management issues; M&E; develop policy and action plans for marine biodiversity conservation and mainstreaming it into coastal development plans.

17) TIMOR-LESTE - AGRICULTURAL REHABILITATION PROJECT

Development Objective

The project was an emergency recovery project aiming at:
a) Improving food security of selected poor households; and
b) Increasing agricultural production in selected areas and promoting rural growth.

Components

- **Priority Productive Asset Restoration:** Activities included providing cattle vaccinations, old chicks and chicken feed to rural families to improve household nutrition and income, replacement for lost buffaloes to farmers who lost theirs so they can prepare for rice planting, provision of simple farming tools, and conducting farmer information campaigns.
- **Irrigation/Rural Infrastructure Rehabilitation and Maintenance:** Finance (i) pre-feasibility design, hydrological and engineering studies; (ii) reconstruction, rehabilitation and maintenance of irrigation drain schemes covering up to 7,000 ha; and (iii) rehabilitation and maintenance through community participation of a minimum of 100 km of agricultural access roads.
- **Pilot Agriculture Services Centers:** Activities include: establishment of pilot agricultural centers to support university's faculty of agriculture, radio procurement and establishment of radio station to provide information to farmers, local and international training, workshops and study tours, and technical assistance.

- **The Project Management Unit:** Finance the recruitment of East Timorese and expatriate consultants, technical assistance, training for East Timorese staff, as well as equipment, vehicles and operating costs in order to implement the project.

Key Performance Indicators

The following indicators will used to follow up on project implementation progress and to evaluate the achievement of its development objectives and eventually its impact. Key project outcome indicators: 1. Nutrition of project beneficiaries improve (1st grant): Increased availability of eggs, poultry, and rice at the household level; 2.Off-farm employment opportunities increase in the project areas (1st grant and whole project); 3. Area under irrigation and access to main roads improve in project areas (whole project); and 4. Yields of rice and maize increase by about 10 percent at full development. Key project output indicators: 1. Cattle, buffalo, small ruminants mortality rates decline by 50 percent (1st grant); 2. Length of access roads rehabilitated by communities is at least 100 km (1st grant and whole project); 3. Irrigation schemes covering a total area of at least 7000 ha are maintained and rehabilitated (whole project); 4. Eight Pilot Agriculture Services Centers established (1st grant = 5 and whole project = 8); 5. Five community radio stations established (1st grant = 2 and whole project = 5); and 6. A minimum of twenty research, extension, Pilot Agriculture Services Center staff trained in country and/or abroad (1st grant = 15 and whole project = 20).

18) TIMOR-LESTE - SECOND AGRICULTURE REHABILITATION PROJECT

Development Objective

The improvement of food security of rural families and increased agricultural production in selected areas of Timor-Leste.

Components

- **Pilot Participatory Development and Natural Resources Management (appraisal estimates US$0.89 million):** Establishment of facilitation teams in 14 pilot villages in seven Districts selected; training for the Ministry of Agriculture, Forestry and Fisheries staff, NGO partners, and farmers; facilitation of community proposals; provision of community grants to farmers; and monitoring and evaluation of the progress of village activities.
- **Rapid Infrastructure Rehabilitation (appraisal estimates US$2.71 million):** Rehabilitation of 2,100 hectares of community-based irrigation schemes and seven irrigation schemes with light- to medium-damage; feasibility study for three irrigation schemes with major damage; rehabilitation of 100 km of farm-to-market access roads; establishment of 11 Water User Associations in irrigated areas rehabilitated by the project; and irrigation training.
- **Services to Farmers (appraisal estimates US$3.10 million):** The component consists of three sub-components: information to farmers, sustainable animal health and pilot agricultural services.
- **Program Management Unit (appraisal estimates US$2.21 million):** The component consists of: policy and strategy development aimed at producing agricultural policy, rural development, and forestry strategy papers; and project management and capacity building, which includes operational support, training, workshops and study tours, project support and monitoring and evaluation and general management operations.

Key Performance Indicators

The Project has the following key performance indicators: 1. Average rice yields increased from 1.5 MT/ha. to 3.0 MT/ha in 5 years in irrigated areas rehabilitated by the project; 2. Production of other food crops such as maize, cassava, and beans at 120 percent of pre-conflict (1999) levels by the end of the project; and about 20 percent reduction in the number of household with critically low food reserves by end of the project. Key project output indicators: 1. 14 pilot upland and coastal villages assisted (up to 30 if the initial pilot villages are successful by mid-term review); 2. 1,400 and 2,100 hectares of irrigated area resulting from the rehabilitation of, respectively, large and small irrigation schemes, and 100 km of farm-to-market access roads rehabilitated; 3. Liaison Secretariat for Consultative Group on International Agricultural Research established; 4. 80 percent of adult cattle, buffaloes, and pigs vaccinated annually; 5. 3 Pilot Agriculture Service Centers fully operational and 2-3 new centers established (if initial 3 are successful at mid-term); Policy options papers on agricultural policy, rural development, and forestry strategy prepared and
discussed with key stakeholders; 6. 30 DAA staff and NGO partners trained on project management skills, participatory rural appraisal techniques and selected technical topics; and 7. Overall, about 30 percent of the trained farmers and other beneficiaries are women.

19) ZAMBIA - EMERGENCY DROUGHT RECOVERY PROJECT

Development Objective

To assist the government in maintaining key commitments to its economic and investment priorities laid out in the PRSP while meeting the exigencies of the food crisis, and to help restore productive capability of the affected population. It is aimed at helping the government to respond effectively to the current drought, and to supplement government's efforts and resources: (a) to prevent starvation and malnutrition in the affected human population; (b) to support other identified drought mitigation measures such as providing drinking water, improving critical transport and logistics links, supporting health and sanitation services, providing support to keep children in school and protecting the threatened livestock population; (c) to support farmers to raise crops in the next agricultural season; and (d) to enhance government capacity for longer-term disaster management, including through support for developing an effective early warning system.

Components

- **Quick Disbursing Assistance to Finance a Positive List of Imports (US$ 35 million):** This includes: (i) machinery and equipment; (ii) agricultural inputs; (iii) petroleum products; (iv) construction materials; (v) transport vehicles, motor bicycles, bicycles; (vi) livestock and animal health products and veterinary supplies and equipment; (vii) school supplies and equipment; (viii) medical supplies and equipment.
- **Safety Net Interventions Aimed at Improving Access to Markets for Essential Commodities and Services by Vulnerable Groups (US$7 million):** The project will support some government efforts in providing employment and improving access to markets by expanding its public works programs under ongoing projects such as the Road Sector Investment Program, and to invest in removing critical transport bottlenecks.
- **Distribution of a Package of Agricultural Inputs and Technologies (US$7 million)**: Agriculture rehabilitation through delivery of agricultural input package to vulnerable but viable

farmers (packs of seeds, planting materials and training), who cultivate less than a hectare of land, lost their crop to drought, lost their cattle and draft animals, households with those living with HIV/AIDS and who support orphans and the handicapped, come from child-headed households, and/or women-headed households.

- **Improving the Early Warning System and Disaster Management and Mitigation Capacity (US$1 million):** Includes technical assistance, training, and studies.

INFRASTRUCTURE (INF)

20) CHAD - NATIONAL TRANSPORT PROGRAM SUPPORT PROJECT

Development Objective

To support Chad's national transport program, which has the objective of reducing poverty and rural isolation, by improving year-round access to market and services (both social and administrative), especially in the rural areas where more than 90% of the poor live.

Components

- Road investments.
- Road maintenance.
- Road safety.
- Institutional support.
- HIV/AIDS support.
- Rural transport strategy.

21) DEMOCRATIC REPUBLIC OF CONGO - EMERGENCY MULTISECTORAL REHAB & RECOVERY EERL SUPPLEMENTAL (FY06)

Development Objective

The specific objectives are to assist the DRC to (a) start rebuilding agricultural production and enhance food security, (b) rehabilitate and reconstruct critical infrastructure, (c) restore essential social services and build community infrastructure, and (d) strengthen capacity of government to formulate, implement, and manage medium- and long-term development programs.

Components

- **Rehabilitation and Reconstruction of Critical Infrastructure (US$1,148 million, of which IDA US$292 million):** Finance the rehabilitation and reconstruction of critical transportation infrastructure, electricity services, water supplies, and urban infrastructure. It comprises five subcomponents: transportation, roads, electricity, water supply, and urban services and infrastructure.
- **Agriculture, Social Services and Community Development (US$372 million of which IDA US$96 million):** Finance the emergency priorities relating to agriculture, social services (health, education, and social protection) and community development. The health services subcomponent will assist the government to (a) develop and disseminate laws and regulations governing the

health system; (b) reinforce partnership and community participation and reestablish health planning structures; (c) rehabilitate and equip health centers and other health facilities in 100 health zones; (d) increase the number and upgrade skills of health care workers; (e) establish central medical purchasing and distribution offices to improve the availability of medicines and other essential medical supplies throughout the country; (f) strengthen programs to prevent and treat the DRC's most serious diseases, including HIV/AIDS, malaria, tuberculosis, and sleeping sickness; and (g) provide health care services targeted to specific groups, notably mothers, children, orphans, and victims of war.

- **Development of the Medium and Long Term Sector Development Strategies, Capacity Building and Institutional Reform (US$24 million, of which IDA US$11million):** Finance the preparation of the development strategies for the DRC's most important sectors: agriculture, education, health, transportation (covering all modes), water and sanitation, electricity, and social protection. It also covers the costs of implementing sector and institutional reforms and of building human and institutional capacity.
- **Management, Monitoring and Evaluation of the Implementation of the Program and the IDA-Financed Project (US$ 22 million of which IDA US$10 million):** Finance project management, and monitoring and evaluation of the implementation of the project. This involves technical assistance, expertise, consultant services, operating costs, logistical support and equipment.

22) Democratic Republic of Congo - Emergency Multisector Rehabilitation and Reconstruction Project

Development Objective

To initiate a long-term process of reconstruction and economic rehabilitation. Specific objectives of the IDA finance are to assist the DRC to: a) Start rebuilding agricultural production and enhance food security; b) Reconstruct and rehabilitate critical infrastructure; c) Restore essential social services and build community infrastructure; and d) Strengthen capacity of government to formulate, implement and manage medium and long term development.

Components

- **Agriculture**: Finance reconstruction of rural roads, establish agriculture information system for farmers, strengthen the operations of producers, NGOs, and key public service providers, and support the development of a policy framework that improves the investment climate in agriculture.
- **Rehabilitation and construction** of critical infrastructure, including transportation infrastructure, electricity, water and urban infrastructure.
- **Social and community development**: Finance essential services in health, education and social protection. It will also finance community development projects. In the health services subcomponent the project will help the government to develop and disseminate laws and regulations governing health systems and rehabilitate and equip health systems.
- **Development of medium and long term sector development strategies, capacity building and institutional reforms:** Sectors include agriculture, education, health, transportation, water and sanitation, electricity and social protection.

POVERTY (PO)

23) UGANDA - POVERTY REDUCTION SUPPORT CREDIT 5

Development Objective

The overall objective of the proposed Poverty Reduction Support Credit (PRSC4) will be to support the implementation of Uganda's revised Poverty Eradication Action Plan (PEAP)/ PRSP. The credit/grant provides budget support, and much technical assistance and advice in formulating policy reforms for selected areas of the PEAP/PRSP where the institution has a comparative advantage.

Components

Support implementation of the revised PEAP of 2004.

ANNEX 3. NUTRITION PROJECT PROFILES (NON-HEALTH SECTOR)

Project Title	Country	Implementing Agency	Nutrition in Development Objectives	Nutrition in CAS	Project Components	Nutrition Components	Beneficiaries	Outcome/Impact Indicators
Human Development Network (HDN)								
Social Protection (SP)								
Programmatic Social Reform Loan Project (02)	Peru	Ministry of Economy and Finance	**No**: (1) Establish pro-poor social expenditure regime and adequate social protection mechanism (2) Improve access of the poor to critical social programs (better targeting, improved efficiency and rationalization of expenditures) (3) Improve transparency in social programs and expenditures and empower beneficiaries to participate in the policy and budget process	**No**: Bank assistance will help the country maintain economic stability, identify sources for growth, and competitiveness, ensure access of the poor to basic social programs, provide social protection and move forward toward strengthening an open, democratic system ensuring participation and empowerment of the poor.	(1) Improve anti-poverty focus of public expenditure (2) Improve access of the poor to health and education (3) Increase transparency and social control over public expenditure (4) Macro-economic management	(1) Reform food distribution programs with focus on nutrition (2) Package of services including nutrition education and promotion of dietary supplementation through local health clinics (i.e., nutrition education and iron supplements for pregnant mothers and children < 2)	Children 5-17 years old, infants and mothers	Not known

Project Title	Country	Implementing Agency	Nutrition in Development Objectives	Nutrition in CAS	Project Components	Nutrition Components	Beneficiaries	Outcome/Impact Indicators
Programmatic Social Reform Loan IV	Peru	Ministry of Economy and Finance	**No:** Same objectives as for the project above	Not mentioned in project documents	Same objectives as for the project above	Same as project above.	Same as above.	Not known
Social Protection Project	El Salvador	Unclear	**Yes**: Improve the education, health and nutrition of children living in the rural areas of 100 poorest municipalities	**Yes**: Service outreach and delivery to combat chronic malnutrition also needs to be strengthened by moving away from traditional programs that focus on food distribution and toward community-based programs orientated towards improving family knowledge and nutritional practices, promoting child growth, and preventing malnutrition.	(1) Conditional cash transfer (2) Expanding provision of basic health and nutrition services	(1) Health and nutrition transfer of $15 per month/family, for three years, to have children <5 immunized and pregnant women participate in health and nutrition monitoring (2) Growth monitoring for children < 2, pregnant women and mothers (3) Counseling for child care (4) Check-ups for micronutrient deficiencies (5) Capacity building for Ministry of Health to supervise the NGOs in implementing these activities	Pregnant women, lactating mothers and children < 5 (Total of 100,000 families and 300,000 children)	(1) % of families satisfied with basic education and primary health care and nutrition services (2) % covered with the basic health and nutrition package, along with % satisfied with this package

Project Title	Country	Implementing Agency	Nutrition in Development Objectives	Nutrition in CAS	Project Components	Nutrition Components	Beneficiaries	Outcome/Impact Indicators
Integrated Human Development Project	Maldives	Ministry of Finance and Treasury	**Yes**: Improve social outcomes and promote economic growth by strengthening the delivery of social services (education, health and nutrition)	**Yes**: Maldives suffers from unexpectedly high rates of malnutrition and micronutrient deficiencies as well as a disease burden caused by prenatal mortality and a slow decline in maternal mortality. Malnutrition rises sharply after the first 12 months, likely because of inadequate weaning practices and foods. Vitamin A deficiency and iron deficiencies among women are also high.	Enhance support for nutrition promotion	(1) Capacity building for family health workers and households on growth monitoring (2) Awareness campaigns for breastfeeding and healthy feeding practices	Children < 5 and pregnant and lactating women	Reduction by 30% of number of children showing growth faltering during weaning period (6-12 months)

Project Title	Country	Implementing Agency	Nutrition in Development Objectives	Nutrition in CAS	Project Components	Nutrition Components	Beneficiaries	Outcome/Impact Indicators
Educational Development (ED)								
Early Childhood Education Project	Dominican Republic	Ministry of Education	**Yes**: (1) Increase availability of high-quality educational services for young children (0-5) (2) Expand access to and improve the quality of integrated services that address young children's basic needs, including preprimary education, psycho-social stimulation, health care and nutrition	**Yes**: The three leading causes of childhood death in the Dominican Republic are intestinal infectious diseases, nutritional deficiencies, and acute respiratory infections.	A grant program of inter-institutional support for early childhood development	(1) Capacity building for NGOs, municipalities and private sector to carry out training (2) Social marketing and educational campaigns to promote the importance of child development and proper health and nutrition for young children	Children 0-5 from disadvantaged backgrounds (40,000 5-year olds, plus 20,000 0-5) and 168,000 5-year olds already at school	None

Project Title	Country	Implementing Agency	Nutrition in Development Objectives	Nutrition in CAS	Project Components	Nutrition Components	Beneficiaries	Outcome/Impact Indicators
Child Development Project	Yemen	Higher Council for Motherhood and Childhood	**Yes:** An area-based program (ABP) to improve health and nutrition of children < 5 and educational status of girls in primary schools in 30 districts under-served in health and education	**Yes**: At least 30% of Yemeni children are protein-energy malnourished. In addition, micronutrient deficiencies (iodine, Vit A and iron) are also widespread.	Nutrition activities	(1) Nutrition education (2) Counseling, growth monitoring and rehabilitation (3) Micro-nutrient supplementation	Children < 5 and girls of primary school age in the 30 target districts. Some of the interventions are targeted towards families in general.	(1) Prevalence of wasting and micronutrient deficiencies decreased (2) Knowledge of breastfeeding practices increased (3) Proportion of mothers who implement proper nutrition and feeding practices increased by at least 20% (4) Prevalence of iron, anemia and vitamin A deficiency reduced by 30% for children

Project Title	Country	Implementing Agency	Nutrition in Development Objectives	Nutrition in CAS	Project Components	Nutrition Components	Beneficiaries	Outcome/ Impact Indicators
Education Sector Support Project 1	Malawi	Education Management Development Unit	**No:** (1) Increase number of qualified teachers (2) Improve quality and capacity of education services (3) Improve learning outcomes at all levels	Not mentioned in project documents	Provide a school health and nutrition package to all primary schools	(1) Distribution of Vitamin A, iron-folic acid to school children < 10 (2) De-worming (3) Treatment of malaria and fever (4) Promotion of good health and nutrition practices	Unclear	The number of children reached by the program
Integrated Early Childhood Development Project	Eritrea	Ministry of Local Government	**Yes**: (1) Promote the healthy growth and holistic development of children (2) Expand access to and improve the quality of services that address young children's basic needs (health care, nutrition, social protection, psycho-social stimulation, affection and early childhood education)	Not mentioned in project documents	Improving child and maternal nutrition	(1) Nutrition education (2) Establish a community-based growth monitoring system (3) Micronutrient supplementation	560,000 children < 6, 310,000 primary school-age children, and 32,000 children facing especially difficult circumstances (orphans)	(1) 20% reduction in case fatality rate from malaria, acute respiratory infections, diarrhea, measles and malnutrition (2) 20% decrease in malnutrition - both stunting and wasting

Project Title	Country	Implementing Agency	Nutrition in Development Objectives	Nutrition in CAS	Project Components	Nutrition Components	Beneficiaries	Outcome/Impact Indicators
Environmentally and Socially Sustainable Development (ESSD)								
Rural Development (RDV)								
Emergency Drought Recovery Project	Malawi	Ministry of Agriculture and Irrigation and Malawi Social Action Fund	**No**: (1) Allow the government to maintain key commitments to economic priorities and investment consistent with the PRSP (2) Restore productive capability of the population (3) Support longer term disaster management by the government	Not mentioned in project documents	Include action funding in the Malawi Social Action Fund (MASAF), Public Work Projects (PWPs) and the Social Support Projects (SSP).	School feeding (provision of porridge meals twice a day at school)	Grade 1 through 6 pupils in 145 schools	Stakeholder-endorsed food security and nutrition strategy statement
Emergency Drought Recovery Project	Ethiopia	Ministry of Rural Development, Food Security Department through Regional and Woreda Governments	**No:** (1) Enable the government to help affected families survive the emergency, retain productive assets, and develop sustainable livelihoods (2) Contribute to the stabilization of the macro economy	**Yes**: Pillar of CAS is the enhancement of human development outcomes by improving governance, which includes the expansion of coverage and quality of all health services, especially preventive health care including nutrition and HIV/AIDS prevention	(1) Community interventions (2) Quick disbursing assistance for the import of items essential to supporting the recovery of the economy and the agricultural sector in particular (3) Project management	Financing the inclusion of supplementary enriched food targeted at small children, pregnant women and lactating mothers in the "food package"	Small children, pregnant women and lactating mothers	None

Project Title	Country	Implementing Agency	Nutrition in Development Objectives	Nutrition in CAS	Project Components	Nutrition Components	Beneficiaries	Outcome/Impact Indicators
Food Security Project	Ethiopia	Regional Government of Amhara, Oromiya, Southern Nations, Tigray/Ministry of Rural Development	**Yes**: (1) Build the resource base of poorer rural households (2) Increase their employment and income (3) Reduce real costs of food (4) Improve nutrition of children < 5, and pregnant and lactating women	Not mentioned in project documents	Growth promotion in communities/ kebeles	Growth promotion and counseling	Chronic food deficit households, children, pregnant women and lactating mothers	(1) Improved nutrition for children < 5 (stunting among children < 2 reduced) (2) 90% of children < 2 in participating kebeles are regularly monitored and their caretakers are counseled

REFERENCES

Bassett, L., J. Levinson, and J. Garrett. 2007. Multisectoral Approaches in Nutrition: Lessons Emerging from a Review of Processes and Mechanisms. Washington D.C.: World Bank. Processed.

Cardemil, C. 2006. A Review of the World Bank Projects Addressing Maternal and Child Undernutrition in High Burden Countries. Washington D.C.: World Bank. Processed.

Claeson, M., T. Mawji, and C. Walker. 2000. *Investing in the Best Buys: A Review of the Health, Nutrition, and Population Portfolio, FY1993-99. HNP Discussion Paper.* Washington, D.C.: World Bank.

Elder, L., L. Kiess, and J. De Beyer. 1996. *Incorporating Nutrition into Project Design*. Washington, D.C.: World Bank.

Heaver, R. 2006. *Good Work–But Not Enough of It: A Review of the World Bank's Experience in Nutrition. HNP Discussion Paper*. Washington, D.C.: World Bank.

Levinson, F., B. Rogers, K. Hicks, T. Schaetzel, L. Troy, and C. Young. 1999. *Monitoring and Evaluation: A Guidebook for Nutrition Project Managers in Developing Countries.* Washington, D.C.: World Bank.

Mulder-Sibanda, M. 2006a. Halving Benin's Malnutrition by 2015: What are the Chances? Washington, D.C.: World Bank. Draft.

Mulder-Sibanda, M. 2006b. Burkina Faso: How to Go Beyond Vitamin A? Washington, D.C.: World Bank. Draft.

Mulder-Sibanda, M. 2006c. Madagascar: From Pilot to Project to Program. Washington, D.C.: World Bank. Draft.

Rutabanzibwa-Ngaiza, J. and M. Shekar 2006. A Review of Monitoring and Evaluation Initiatives in Health, Nutrition, and Population Projects 1999-2005. Washington D.C.: World Bank. Processed.

Shekar, M and Lee, Y. 2006. *Mainstreaming Nutrition into Poverty Reduction Strategy Papers: What Does it Take? A Review of the Early Experience. HNP Discussion Paper*. Washington D.C.: World Bank. Processed.

World Bank. 2006. *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*. Washington, D.C.: World Bank.

World Bank. 2007a. *Healthy Development: The World Bank Strategy for Health, Nutrition and Population Results*. Washington, D.C.: World Bank.

World Bank. 2007b. *HIV/AIDS, Nutrition, and Food Security. What we can do. A synthesis of international guidance.* Washington D.C.: World Bank.

World Bank. 2007c. *From Agriculture to Nutrition. Pathways, synergies and outcomes*. Report No.40196 – GLB. Washington, D.C.: World Bank.

HEALTH, NUTRITION,
AND POPULATION

HUMAN DEVELOPMENT NETWORK

THE WORLD BANK

About this series...

This series is produced by the Health, Nutrition, and Population Family (HNP) of the World Bank's Human Development Network. The papers in this series aim to provide a vehicle for publishing preliminary and unpolished results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual authors whose name appears on the paper.

Enquiries about the series and submissions should be made directly to the Managing Editor Nicole Klingen (Nklingen@worldbank.org) or HNP Advisory Service (healthpop@worldbank.org, tel 202 473-2256, fax 202 522-3234). For more information, see also www.worldbank.org/hnppublications.

THE WORLD BANK

1818 H Street, NW
Washington, DC USA 20433
Telephone: 202 473 1000
Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org