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PROJECT PERFORMANCE ASSESSMENT REPORT

SENEGAL

A Decade of World Bank Support to Senegal's Nutrition Program

Report No. 110290
DECEMBER 21, 2016

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Report No.: 110290

PROJECT PERFORMANCE ASSESSMENT REPORT

SENEGAL

NUTRITION ENHANCEMENT PROGRAM
(IDA CREDIT NO. 36190)

NUTRITION ENHANCEMENT PROJECT IN SUPPORT OF THE SECOND PHASE OF THE NUTRITION ENHANCEMENT PROGRAM
(IDA CREDIT NO. 42450)

ADDITIONAL FINANCING FOR THE SECOND PHASE OF THE NUTRITION ENHANCEMENT PROGRAM
(IDA CREDIT NO. 50840)

RAPID RESPONSE CHILD-FOCUSED SOCIAL CASH TRANSFER AND NUTRITION SECURITY PROJECT
(IDA CREDIT NO. 46050) &

AND MULTIDONOR TRUST FUND FOR THE GLOBAL FOOD PRICE CRISIS RESPONSE PROGRAM
(TF 94372)

DECEMBER 21, 2016

Human Development and Economic Management
Independent Evaluation Group

Currency Equivalents (Annual Averages)

Currency Unit = CFA Franc (CFAF)

2002	US$1.00	CFAF 664.54
2003	US$1.00	CFAF 628.93
2004	US$1.00	CFAF 551.27
2005	US$1.00	CFAF 516.19
2006	US$1.00	CFAF 539.44
2007	US$1.00	CFAF 503.03
2008	US$1.00	CFAF 447.77
2009	US$1.00	CFAF 479.02
2010	US$1.00	CFAF 473.00
2011	US$1.00	CFAF 481.81
2012	US$1.00	CFAF 490.53
2013	US$1.00	CFAF 507.49
2014	US$1.00	CFAF 483.60
2015	US$1.00	CFAF 500.67

Abbreviations and Acronyms

APL	Adaptable Program Loan
CAS	Country Assistance Strategy
CEA	Community Executing Agency
CLM	Cellule de Lutte contre la Malnutrition
CNP	Community Nutrition Project
CPS	Country Partnership Strategy
DHS	Demographic and Health Survey
HNP	Health, Nutrition, and Population
ICR	Implementation Completion and Results Report
IEG	Independent Evaluation Group
IMCI	Integrated Management of Childhood Illness
KPC	Knowledge, Practice, Coverage
NEP	Nutrition Enhancement Program
NGO	nongovernmental organization
PAD	Project Appraisal Document
PDO	project development objective
PPAR	Project Performance Assessment Report
PRSP	Poverty Reduction Strategy Paper
SDR	special drawing rights
SMART	Standardized Monitoring and Assessment of Relief and Transitions
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

Fiscal Year

Government: January 1 – December 31

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Contents

This report was prepared by Denise Anne Vaillancourt, who assessed the project in April 2016, with the technical input of Amadou Hassane Sylla, Senegalese consultant. The report was peer reviewed by Ziauddin Hyder and panel reviewed by Judyth Twigg. Aline Dukuze provided administrative support.

Boxes

Tables

Principal Ratings

Nutrition Enhancement Program

	ICR*	ICR Review*	PPAR
Outcome	Highly Satisfactory	Satisfactory	Highly Satisfactory
Risk to Development Outcome	Negligible to Low	Moderate	Moderate
World Bank Performance	Satisfactory	Highly Satisfactory	Highly Satisfactory
Borrower Performance	Highly Satisfactory	Highly Satisfactory	Highly Satisfactory

* The Implementation Completion and Results (ICR) report is a self-evaluation by the responsible global practice. The ICR Review is an intermediate IEG product that seeks to independently validate the findings of the ICR.

Nutrition Enhancement Project in Support of the Second Phase of the Nutrition Enhancement Program

	ICR	ICR Review	PPAR
Outcome	Satisfactory	Satisfactory	Satisfactory
Risk to Development Outcome	Moderate	Significant	Significant
World Bank Performance	Satisfactory	Satisfactory	Satisfactory
Borrower Performance	Satisfactory	Satisfactory	Satisfactory

Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project

	ICR*	ICR Review*	PPAR
Outcome	Highly Satisfactory	Satisfactory	Highly Satisfactory
Risk to Development Outcome	Moderate	Moderate	Significant
World Bank Performance	Satisfactory	Satisfactory	Satisfactory
Borrower Performance	Satisfactory	Satisfactory	Satisfactory

Key Staff Responsible

Nutrition Enhancement Program

Project	Task Manager/Leader	Division Chief/ Sector Director	Country Director
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Completion	Menno Mulder-Sibanda	Eva Jarawan	Madani Tall

Nutrition Enhancement Project in Support of the Second Phase of the Nutrition Enhancement Program

Project	Task Manager/Leader	Division Chief/ Sector Director	Country Director
Appraisal	Menno Mulder-Sibanda	Eva Jarawan	Madani Tall
Completion	Menno Mulder-Sibanda	Trina Haque	Vera Songwe

Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project

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IEG Mission: Improving World Bank Group development results through excellence in independent evaluation.

About this Report

The Independent Evaluation Group (IEG) assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the World Bank's self-evaluation process and to verify that the World Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEG annually assesses 20–25 percent of the World Bank's lending operations through fieldwork. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or World Bank management have requested assessments; and those that are likely to generate important lessons.

To prepare a Project Performance Assessment Report (PPAR), IEG staff examine project files and other documents, visit the borrowing country to discuss the operation with the government, and other in-country stakeholders, interview World Bank staff and other donor agency staff both at headquarters and in local offices as appropriate, and apply other evaluative methods as needed.

Each PPAR is subject to technical peer review, internal IEG panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible World Bank country management unit. The PPAR is also sent to the borrower for review. IEG incorporates both World Bank and borrower comments as appropriate, and the borrowers' comments are attached to the document that is sent to the World Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

About the IEG Rating System for Public Sector Evaluations

IEG's use of multiple evaluation methods offers both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. IEG evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (additional information is available on the IEG website: http://ieg.worldbankgroup.org).

Outcome: The extent to which the operation's major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. *Relevance* includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project's objectives are consistent with the country's current development priorities and with current World Bank country and sectoral assistance strategies and corporate goals (expressed in poverty reduction strategy papers, Country Assistance Strategies, sector strategy papers, and operational policies). Relevance of design is the extent to which the project's design is consistent with the stated objectives. *Efficacy* is the extent to which the project's objectives were achieved, or are expected to be achieved, taking into account their relative importance. *Efficiency* is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared with alternatives. The efficiency dimension is not applied to development policy operations, which provide general budget support. *Possible ratings for Outcome:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Risk to Development Outcome: The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). *Possible ratings for Risk to Development Outcome:* High, Significant, Moderate, Negligible to Low, and Not Evaluable.

Bank Performance: The extent to which services provided by the World Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan or credit closing, toward the achievement of development outcomes). The rating has two dimensions: quality at entry and quality of supervision. *Possible Ratings for Bank Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, and Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. *Possible ratings for Borrower Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, and Highly Unsatisfactory.

Preface

This is the Project Performance Assessment Report (PPAR) for the Nutrition Enhancement Program, the Nutrition Enhancement Project in Support of the Second Phase of the Nutrition Enhancement Program, and the Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project.

A credit (IDA-3619) to support the first phase of the Nutrition Enhancement Program was approved on March 14, 2002, in the amount of special drawing rights (SDR) 11.8 million (US$14.7 million equivalent).[1] Government counterpart financing in the amount of US$1.5 million equivalent was planned, along with parallel financing from the World Food Program of US$4 million equivalent. The credit became effective on June 27, 2002, and closed on July 15, 2006, six months after the original closing date. The total cost at closing was US$19.1 million equivalent. The credit amount disbursed was SDR 11.4 million: 96 percent of the original credit amount and 100 percent of the revised credit amount after SDR 0.4 million was canceled.

An SDR 10.1 million (US$15 million equivalent) credit for the Nutrition Enhancement Project in Support of the Second Phase of the Nutrition Enhancement Program (Second Nutrition Enhancement Project) was approved by the World Bank on November 13, 2006, and became effective on January 29, 2007. Government counterpart financing was planned in the amount of US$16.3 million equivalent and an additional $11.1 million was envisaged from other sources.[2] Additional financing for this project in the amount of SDR 6.5 million (US$10 million equivalent) was approved by the World Bank on March 29, 2012, and became effective on May 23, 2012. The original credit and the additional financing both closed on June 14, 2014, and were fully disbursed.

A credit of SDR 6.8 million (US$10 million equivalent) was approved on May 6, 2009, to finance the Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project and became effective on September 11, 2009. A Global Food Crisis Response Program multidonor trust fund grant (TF 94372) of US$8 million equivalent provided cofinancing to the project. No government counterpart was envisaged. The credit was closed on August 31, 2012, and was 100 percent disbursed. The Trust Fund was also closed on August 31, 2012; 99 percent of its original value was disbursed and US$97,218 was canceled.

This report is based on a review of project documents; the Implementation Completion and Results Reports (ICRs) on each project; aide-mémoires and supervision reports; and other relevant material, data, and studies. A mission to Senegal was undertaken by Denise Anne Vaillancourt, international consultant, and Amadou Hassane Sylla, Senegalese consultant in April 2016, during which interviews were conducted with government officials and technical staff, service delivery personnel, local government authorities,

[1] This amount was for the first of three phases of an Adaptable Program Loan. Total envisaged International Development Association support for the three phases was SDR 39 million (US$48.7 million equivalent).

[2] Projet Sante II/African Development Bank, World Food Programme, United Nations Children's Fund, and Micronutrient Initiative.

civil society organizations, beneficiaries, relevant development partners and other involved persons. The team visited relevant offices, facilities, and communities in Dahra, Sagatta Djoloff, Sagatta-Affe, Darou Mousty (Region of Louga); Guinguineo, Gagnick Tibou (Region of Kaolack); and Mbar and Mbam Djigane (Region of Fatick), chosen in consultation with the government and the World Bank's team. The beneficiary perspective was enhanced by beneficiary assessments commissioned by the program. Interviews were also conducted in Washington, D.C, with additional relevant staff. The Independent Evaluation Group (IEG) gratefully acknowledges all those who made time for interviews and provided documents and information and expresses its gratitude to the World Bank's office in Dakar for the logistical and administrative support provided to the mission. A list of persons met is provided in appendix E.

This report serves an accountability purpose by evaluating the extent to which the operations achieved their intended outcomes. It also seeks to draw lessons to inform and guide future investments in the health and social protection sectors. This assessment also complements, respectively, the Implementation Completion and Results Reports, prepared by the World Bank's operations teams with borrower contributions, and IEG's desk review (ICR Reviews) of these reports, by providing an independent, field-based assessment some two years after the last of these projects' closings.

Following standard IEG procedures, a copy of the draft report was sent to the relevant government officials and agencies for their review and feedback. No comments were received.

Summary

This report assesses the performance of three projects: (1) the Nutrition Enhancement Program, (2) the Nutrition Enhancement Project in Support of the Second Phase of the Nutrition Enhancement Program, and (3) the Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project.

At the start of the new millennium, malnutrition in Senegal was of great concern. Among children under five years of age almost one-third (30 percent) were stunted (low height for age), 10 percent were wasted (low weight for height), and 20 percent were underweight (weight for age), each of these levels categorized as high severity by the World Health Organization. Rates vary greatly, with the poor and rural, and residents of the north, south and central zones, suffering disproportionately. Malnutrition contributes to child and maternal mortality and morbidity, undermines children's prospects of reaching their physical and intellectual potential, and undercuts income-earning potential for households and overall productivity and economic development. Its two principal causes are inadequate food intake and illness. Underlying factors are poverty; inadequate access to quality food; inadequate knowledge and behaviors favoring the health of mothers and children; and inadequate services, especially health, clean water, and sanitation.

In 2001, the government of Senegal issued a new nutrition policy, supporting a 10-year goal to improve nutrition through a community-based, multisectoral approach. The policy was translated into the 10-year Nutrition Enhancement Program (NEP), financed by the government of Senegal, the World Bank, and eventually others. The government of Senegal also created the Cellule de Lutte contre la Malnutrition (Agency in Charge of the Fight against Malnutrition; CLM), attached to the prime minister's office, responsible for policy oversight and evaluation.

Nutrition Enhancement Program

This project was designed as the first of three planned World Bank operations, packaged as a 10-year Adaptable Program Loan (APL) to support NEP implementation. Its objectives were to assist the Borrower in building the institutional and organizational capacity required to enable the Borrower's CLM and its partners in the public and private sectors to develop, implement and monitor multisectoral nutrition activities in both rural and urban areas. It supported two components: (1) community-based nutrition and growth promotion (growth monitoring and promotion, health and nutrition education, integrated management of childhood illness, basic health services provision and promotion, micronutrients, and grants for community projects); and (2) capacity building for program management (technical assistance, training, and health and education sector support).

The credit became effective on June 27, 2002, and closed on July 15, 2006. Objectives were not changed, and there were no restructurings. Total project cost was US$19.1 million equivalent or 118 percent of the original estimate.

The project's outcome rating is **highly satisfactory.** Its objectives are highly relevant to current country conditions, national strategies and priorities and the World Bank's current Country Partnership Strategy, as well as its Health, Nutrition and Population Strategy. The design is also highly relevant, with clear and logical results chains supporting the objectives to build capacity to develop, monitor, and oversee the NEP and to build capacity to implement NEP activities. The objective to build capacity to develop, monitor, and oversee multisectoral nutrition activities was highly achieved. The CLM fully assumed its role of setting the policy agenda for nutrition, overseeing its implementation through the NEP, and fostering cooperation across sectors. A solid monitoring and evaluation system, with mechanisms and structures for reviewing data at every level, has fostered a strong results focus, transparency and accountability, and learning by doing. The objective to build capacity to implement multisectoral nutrition activities was highly achieved. Community-based nutrition services were established and delivered in the targeted areas exceeding most targets. Knowledge and behaviors of target groups improved significantly in the intervention areas. Ninety-one percent of children participating in growth promotion sessions in the intervention areas showed adequate weight gain, a notable achievement given the 90 percent participation rate. Project efficiency is substantial, with highly cost-effective, well-targeted interventions culminating in low median costs per child

Risk to development outcome is rated **moderate.** Most risks are rated low, including technical, social, political, institutional, and government ownership. But financial risk is high. The government of Senegal has substantially increased its financial contribution to the NEP since project closure, but NEP costs and financing need to be better assessed. Moreover, the remuneration of nutrition aides is an emerging issue, with innovative financing sources and solutions under discussion and experimentation.

Overall World Bank performance is rated **highly satisfactory.** Quality at entry is **highly satisfactory,** the APL being an appropriate instrument and the design and the institutional arrangements exceptionally strong. Quality of supervision is **highly satisfactory,** with well-staffed missions highly focused on the project development objective (PDO).

Overall borrower performance is rated **highly satisfactory.** Government performance is **highly satisfactory,** marked by its strong ownership of the NEP, generous counterpart, and the placement of the CLM in the office of the prime minister. Implementing agency performance was **highly satisfactory.** The CLM was well staffed and recognized for its transparent management style.

Nutrition Enhancement Project in Support of the Second Phase of the NEP

The project's objective was to improve nutritional conditions of vulnerable populations, in particular children under five years of age in poor urban and rural areas. It was supported by three components: (1) community-based nutrition activities; (2) multisectoral support for nutrition; and (3) support for implementation, monitoring and evaluation of the nutrition policy. While originally envisaged as the second in a series of three projects, packaged as a 10-year APL, the World Bank decided that this would be the last phase of support under the APL.

The International Development Association (IDA) credit became effective on January 29, 2007. Although the objective did not change, additional financing was approved in 2012, adding two years and SDR 6.5 million for project implementation. And most targets were raised. Total project cost was US$25.3 million equivalent or 169 percent of the original estimate.

The project's outcome rating is **satisfactory.** The project's objective is highly relevant to country conditions, Senegal strategic priorities, the World Bank's strategies for Senegal, and the World Bank's sectoral strategies. The relevance of design is high. Its results chain is well-articulated and plausible—as strong as the one for the first project, with both the original and additional financing designs further refined based on emerging evidence and lessons. Efficacy is substantial. All outcome targets were surpassed, both the original and the revised ones. Although none of the outcome indicators directly measured the objective of improved nutritional conditions, they show strong performance in intervention areas in the coverage of these cost-effective services and changes in behaviors, which are strongly linked in the literature to improved nutritional status. Moreover, very high rates of children showing adequate weight gain and successful screening and rehabilitation of moderate and severe acute malnutrition cases also provide reassuring evidence that nutrition status was improved. Efficiency is substantial with evidence of strong value for money and strong operational and implementation efficiency.

Risk to development outcome is **significant.** As for the first project, technical, social, political, and institutional risks are all assessed to be low. Likewise, financial and natural disaster risks are still assessed to be substantial. But more weight has been given to the financial risk at the end of this World Bank project, given that available national and international financing does not cover needs for full coverage of the NEP. Creative discussions and experimentation are under way to find ways and means to provide more adequate remuneration of nutrition aides.

Overall World Bank performance is rated **satisfactory.** Quality at entry is **satisfactory.** Building on the first project's success, the NEP was very well designed, its sound institutional framework refined to support a growing role for local government in line with decentralization policy. A shortcoming in an otherwise very solid monitoring and evaluation design was the absence of a strong indicator to measure the PDO. Quality of supervision is **satisfactory.** Widespread feedback acknowledged the quality of the World Bank's technical work and collaboration and its strong support and advocacy. The World Bank also mobilized development partners to conduct semiannual joint coordination and supervision missions of the NEP and was successful in mobilizing additional resources when IDA financing of the 10-year APL fell short of original commitments.

Overall borrower performance is rated **satisfactory.** Government performance is rated **satisfactory.** The CLM successfully worked with seven prime ministers since 2001, who are reported to have provided strong and unequivocal support, once briefed on the NEP. The global Scaling Up Nutrition movement cited Peru and Senegal for strong government ownership. Counterpart financing exceeded plans, although initial years experienced a shortfall because of the global economic crisis. The implementing agency

performance is rated **highly satisfactory.** The CLM's inclusive and transparent management style continued to be very effective in nurturing ownership and partnerships at all levels of the program and stimulating a truly multisectoral approach.

Rapid Response Child-Focused Social Cash Transfer and Nutrition Security

The objective is to reduce the risk of nutrition insecurity of vulnerable populations, in particular children under five in poor rural and urban areas by scaling up the NEP and providing cash transfers to vulnerable mothers of children under five. Three components supported NEP implementation: (1) community-based nutrition; (2) sectoral support for nutrition results; (3) support to implementation, monitoring, and evaluation of nutrition development policy. The fourth, Child-Focused Social Cash Transfers, sought to use the NEP structure to deliver to eligible beneficiaries (mothers of young children in vulnerable families in 10 districts) bimonthly cash payments over six months to mitigate the effects of the food price crisis, accompanied by messages about maternal and child nutrition.

The IDA credit became effective on September 11, 2009. Objectives did not change, and there was no restructuring. The credit closed on August 31, 2012, eight months after the original closing date. Total project cost was US$18.2 million, close to the original estimate of US$18.0 million.

The outcome rating is **highly satisfactory**. The relevance of objective is high, with the PDO well focused on addressing immediate issues, as well as building resilience for the future. Relevance of design is also high, as the interventions and approaches drew on best practices as well as lessons learned from program experience. The cash transfer pilot was well and expeditiously designed as an emergency operation, with a very well-developed process and criteria for targeting the most vulnerable and a beneficiary assessment and impact evaluation. The objective to reduce nutrition insecurity through the scaling up of the NEP was substantially achieved. Critical behaviors changed in the intervention areas, and child outcomes were good, with 81 percent of children attending monthly weighing sessions showing adequate weight gain—exceeding the 75 percent target. The objective to reduce nutrition insecurity by enhancing the food-buying power of mothers with cash transfers was highly achieved. The targeting process was effective, more beneficiaries than planned were reached, and they all received intended benefits. A beneficiary assessment documented good use of the funds; and an impact evaluation confirmed a positive effect on the nutrition and well-being of targeted children. Efficiency was substantial. The project used existing institutions and focused on simplicity in building new ones, and interventions were cost-effective.

Risk to development outcome is **significant.** For the community nutrition components, the assessment of risks under NEP II applies, since this project's time frame falls within NEP II's time frame. The child-focused cash transfer has proven to be an effective low-cost means of mitigating vulnerability. Although social protection is high on Senegal's policy agenda and public budget has been allocated to this end, a major challenge is the still limited capacity to manage safety net and cash transfer schemes.

Overall World Bank performance is rated **satisfactory.** Quality at entry is **satisfactory**. The World Bank proactively pulled together an emergency operation to address nutrition insecurity in Senegal, the design of which built on and expanded the successful NEP. The new cash transfer mechanism design drew on extensive knowledge and experience acquired under NEP and was highly appropriate for the emergency, pilot nature of this intervention. Quality of supervision is **highly satisfactory**. Supervision continued to be characterized by close collaboration between the CLM and the World Bank team, a strong results focus and continuous emphasis on problem-solving and learning.

Overall borrower performance is rated **satisfactory**. Government performance is **satisfactory.** The government was and remains committed to the PDO, with child nutrition featured as a major priority in poverty alleviation and economic development strategies. Commitment and involvement are broad, deep, and growing, encompassing a wide range of relevant sectors and local government. The implementing agency performance is **highly satisfactory.** The highly satisfactory assessment of the CLM's performance under NEP II applies here. Its performance on the social cash transfer component was also very strong, as it found workable mechanisms for the payment system, smoothed and consolidated implementation, and successfully absorbed this new component into its service delivery platform.

More Than a Decade of Support in Perspective

Chapters 2, 3 and 4 have documented the success of these three individual projects, but the achievements of these projects (greater knowledge, healthier behaviors and practices, and improved nutrition outcomes) in their intervention areas, did not culminate in substantial declines in malnutrition nationwide. The majority of the original 10-year objectives and targets of the APL (which were also the objectives and targets of the NEP), set in 2001, were not met. Underweight among children was reduced, but not by 40 percent; severe underweight was also reduced but not to less than 1 percent.

The main reason that the three projects performed so well but the 10-year program goals were not met centers on program coverage. The APL initially aimed to achieve nationwide coverage of Senegal's NEP. But these targets were scaled back when the World Bank scaled back its financing. Financial constraints limited the number of intervention areas that the NEP was able to support and also the frequency and intensity of interventions. On the other hand, there are an increasing number of national and international partners in Senegal, who provide substantial financial and technical support over and above government of Senegal financing. This support has not culminated in adequate coverage of target groups with the full package of cost-effective services, nor is this support yet fully aligned with the highest priority areas of the country. Although some may interpret these findings as weaknesses in the program, this evaluation acknowledges CLM's proactivity in commissioning a well-designed, sophisticated survey, which uncovered and explained for the first time detailed data on program wide coverage and efficiency, which paves the way for improving program effectiveness.

In conclusion, the NEP deserves its strong reputation as a well-run, evidence-based, community-focused program that has piloted and demonstrated its effectiveness in

intervention areas and managed to increase its coverage, although not to the level initially anticipated in 2001. Its success and experience provide useful guidance and insights for other countries attempting to establish or improve nutrition programs. In addition, this evaluation reveals opportunities for the CLM and its partners to further enhance program performance and results.

A well-earned reputation. Among many strong features of the NEP, this evaluation highlights three in particular that have been the result of extremely good design work and ongoing refinement over the past 15 years. They are (1) a service delivery scheme that is community-oriented, highly participatory, and well managed and overseen; (2) an increasingly multisectoral approach, taking root at every level of the program and culminating in improved program effectiveness; and (3) an approach to behavior change communication that is evidence-based, cognizant, and respectful of local tradition, culture, and practices; benefiting from the involvement of opinion leaders and other critical family and community members; and complemented with the provision of other means to effect behavior change.

Challenges and opportunities. The increasingly large and diverse number of partners supporting nutrition in Senegal presents both a challenge and an opportunity for improved program performance. Senegal has already put in place many of the required building blocks for enhanced aid effectiveness: a well-defined national policy; a very capable institutional and organizational framework responsible for policy oversight and program implementation; well-established protocols for strong monitoring and evaluation and its use in decision making and tracking accountabilities for performance and results; an increasingly multisectoral approach and leadership role of the local governments; a strong focus on results; and widespread ownership.

And other critical elements still need to be put into place: (1) a medium-term strategic program, grounded in national policy, with estimated costs; (2) a medium-term projection of resource availability; (3) a move by all partners toward the use of well-proven NEP systems, rather than parallel project systems; and (4) fuller strengthening of systems for coordination and collaboration across partners, including joint missions and coordination meetings, chaired by the CLM. Given that there is a range from 12 to 21 partners (both national and international) in each of Senegal's 14 regions, coordination efforts also need to happen at regional, departmental, and local levels.

Lessons

- Formidable results (establishment of a new program, behavior change, and outcomes) can be achieved within the time frame of a four-year project. At the same time, capacity and institution building is a medium-term incremental process. The gradual decentralization of program oversight, evolving roles and involvement of local-level and other sectors take time. But they are well worth the quality of this program's mature design and capacity.
- A truly multisectoral approach is the result of a shared objective and the sense of mandate and accountability to contribute to that objective. At local and central levels alike, cross-sectoral coordination and teamwork coalesce around shared objectives.

- A management style that supports an evidence-based, participatory learning culture will culminate in strong ownership of the program and the continual improvement of its performance and effectiveness.
- The measurement of coverage is complex but critical to assess program efficacy.

Zeljko Bogetic
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1. Background and Context

1.1 This section summarizes the background and context covering the period during which the three projects under review were designed and implemented, 2001–2015.

General Background

1.2 Senegal's total estimated population of 14.4 million in 2015 is inequitably distributed across its territory of 196,722 square kilometers. Densities range from a high of 5,735 inhabitants per square kilometer in the region of Dakar to a low of 16 in the Tambacounda region in the northeast. Forty-five percent of the population resides in urban areas and 55 percent in rural areas. Total fertility rate is five children per woman, with higher rates in rural areas (6.3 children) than urban (4 children). Forty-two percent of the population is under 15 years of age.[3]

1.3 According to the government of Senegal's first Poverty Reduction Strategy Paper (PRSP), at the start of the new millennium Senegal had returned to a path of economic growth, with an annual average of over 5 percent growth in gross domestic product between 1995 and 2001. However, improved economic performance did not culminate in better social indicators and living standards for the population or in reductions in poverty. Weak investments and stagnation in agriculture and industry underlie the modest number of jobs created despite economic growth, which did not particularly benefit the poorest segments of the population. Climate change, low agricultural productivity and investments not well aligned to rural, rain-fed agriculture practiced by the poor also contributed to poverty, along with inefficient public expenditures on social programs. In 2001, 54 percent of households were estimated to be living below the poverty line, showing negligible change over the 1994 estimate of 58 percent (core welfare indicators household surveys). Poverty is much higher in the rural areas, especially in the center, south, and northeast.

1.4 A decade later, the annual rate of gross domestic product growth per capita was 0.5 percent during 2005–11.[4] During this same period the poverty rate declined but the number of absolute poor increased. Between 2001 and 2005, economic growth was inclusive and poverty declined from 55 percent to 48 percent. However, this rate of decline slowed after 2005, reaching 47 in 2011. This slowdown was consistent with the macroeconomic environment and the series of shocks that affected welfare over this same period: poor rains, global food and fuel price shocks, floods, and some deterioration in governance. Extreme poverty dropped more slowly from 17 to 15 percent between 2001 and 2011 and the poverty gap between Dakar and rural areas widened.[5] In 2011, 57 percent of the rural population was poor compared with 26 percent of the population in urban Dakar and more than a third lived in Kolda or Ziguinchor regions of the Casamance. Poverty levels were higher (62 percent) in

[3] Data in the "General Background" section are from the "Government of Senegal Poverty Reduction Strategy Paper, 2002" at https://www.imf.org/External/NP/prsp/2002/sen/01/100502.pdf.

[4] National Strategy for Economic and Social Development (2013–17), November 8, 2012

[5] Extreme poverty is defined as the portion of the population whose total consumption is less than the cost of a food basket providing minimum calorie requirements.

households relying on agriculture as the main occupation than those relying on other occupations (33 percent). Factors contributing to poverty include no formal education of head of household and large household size. Natural disasters such as droughts and flooding add to the vulnerability of the poor.

1.5 Senegal enjoys considerable political stability and has strengthened its democratic structures. Senegal has had four presidents.[6] Power was handed over peacefully from Senghor to Diouf in 1981. The 2000 election of Wade was contested but resulted in a democratic political transition from the traditional Socialist Party of Senghor and Diouf to the Senegalese Democratic Party of Wade. The 2012 election of former Prime Minister Sall benefited from high transparency and universal acceptance of the results, notwithstanding deadly protests preceding the first round of voting. Civil society played an important role in bringing about political change in Senegal in 2012, contributing to Senegal's second democratic transition. The media was also instrumental in fostering election transparency and integrity. The 1982 separatist movement of the Casamance region has precipitated a sense of abandonment and distance from Dakar and conflict has undermined economic performance (agricultural production, trade, and tourism) and displaced 30,000–60,000 people. Resolving this crisis is a priority of current President Sall.

1.6 Senegal's is ranked 170 out of 188 countries in United Nation's Development Progamme's Human Development Index in 2014. Between 2000 and 2014, life expectancy at birth increased from 58 to 67 years; mean years of schooling increased from 1.9 to 2.5 years; expected years of schooling increased from 5.4 to 7.9 years; and gross national income per capita increased from US$1,878 to US$2,188. Health status has been improving but remains unacceptable. According to Demographic and Health Survey (DHS) data infant mortality has fallen from 61 in 2005 to 39 in 2015, under age five years mortality has also fallen from 121 in 2005 to 59 in 2015, and maternal mortality was 392 in 2011. These rates reveal inequities across urban/rural divides, regions, and income quintiles. Coverage and quality of health services remain issues. Only two-thirds (68 percent) of children are fully vaccinated; both modern contraceptive prevalence and use of maternal and child health services are low and inequitable across urban/rural areas, regions, and income quintiles, albeit slowly improving. Adult female illiteracy was 60 percent in 2013.

1.7 As expressed in its 2002 PRSP, Senegal's three development priorities (and relevant sectors or targets for action) were (1) creation of wealth within a healthy macroeconomic framework (agriculture, infrastructure, livestock, fisheries, handicraft, industry, energy, mining, trade, tourism, information technology, private sector, and employment); (2) capacity building and promotion of basic social services (education, health, drinking water, natural resources and environment, sanitation, good governance); and (3) improving living conditions of vulnerable groups (children, women, handicapped, elderly, youth, and displaced). Senegal's PRSP for 2013–17 is articulated around three pillars (and areas for intervention): (1) growth creation, productivity, and wealth (viability of macroeconomic framework, employment, private sector, productive sectors, integrated development of rural economy, industry and agri-food processing, mines, and quarries); (2) human capital, social protection, and sustainable development (population and sustainable human development,

[6] Senghor (1960–80); Diouf (1981-2000); Wade (2000–12); and Sall (2012–Present).

universal education and skills development, improved healthcare and nutritional status, improved access to drinking water and sanitation, housing and living conditions, social protection, risk and disaster prevention and management, environment); and (3) governance, institutions, peace, and security (peace and security, rule of law, human rights and justice, gender equity and equality, state reform and public administration, and governance).

Nutrition

1.8 **Issues and challenges**. Malnutrition remains a significant problem today in Senegal, notwithstanding some improvement over the past 15 years. Between 2000 and 2015, among children under age five years the prevalence of stunting (height for age) declined from 29.5 percent to 20.5 percent, the prevalence of wasting (weight for height) declined from 10 percent to 7.8 percent, and the prevalence of underweight (weight for age) declined from 20.3 percent to 15.5 percent (see appendix D, figures D.1, D.2, and D.3). None of these trends have been smooth, with important setbacks in progress in certain years, especially in 2010–11, likely linked to the food price crisis and poor harvests due to droughts. Levels vary across regions. DHS data from 2014 reveal that two zones in Senegal (south and central) register the highest levels of stunting as well as the highest number of stunted children, with the south exceeding 30 percent (the "serious" threshold for the World Health Organization [WHO]). At 9.6 percent, the north zone has the highest prevalence of wasting, also approaching WHO's "serious" threshold of 10 percent. But the greatest number of wasted children are found in the center (37,142). Lowest income quintiles suffer higher levels of malnutrition than their richer counterparts, as do rural residents, compared with their urban counterparts, notwithstanding pockets of poor, vulnerable populations in the urban areas. Although declining, anemia remains high with 60 percent of children 6–59 months old and 54 percent of women 15–49 years old anemic in 2014. About half of school-age children (6–12 years old) and women (15–49 years old) are deficient in iodine. Vitamin A deficiency is also an issue.

1.9 Malnutrition has devastating consequences on individuals, their households and the country at large. It is one of the principal causes of child and maternal mortality and morbidity in Senegal. It prevents a child from reaching his or her full potential, both physical and intellectual. This, in turn, undermines the income-earning opportunities for households, as well as the overall productivity and economic development of the country. Its two principal causes are inadequate food intake (both quality and quantity) and illness, which can cause or exacerbate malnutrition. Underlying factors are inadequate access to a sufficient quantity of quality food; inadequate knowledge and behaviors promoting the well-being of mothers and children; and inadequate services, especially health, clean water and sanitation.

1.10 **National priorities**. In 2001, the government of Senegal took major steps to step up its fight against malnutrition. In April of that year, a "Letter of Nutrition Development Policy" was issued (République du Sénégal 2001). This policy (outlined in appendix B, box B.1) included a range of innovative strategies supporting a 10-year goal to improve the nutritional status of poor and vulnerable groups, including a community-based and multisectoral approach; capacity building to monitor and manage nutrition programs; strengthened partnerships with local government, civil society, and the private sector; and social mobilization and behavior change. By Decree 2001-770 of May 10, 2001, government

of Senegal created the Cellule de Lutte contre la Malnutrition (Agency in Charge of the Fight against Malnutrition; CLM), attached to the Prime Minister's office, responsible for the oversight and evaluation of the new nutrition policy. The policy was translated into the 10-year Nutrition Enhancement Program (NEP), whose implementation was financed by government of Senegal, the World Bank, and eventually other development partners supporting nutrition.

1.11 Some 14 years later, the government of Senegal has issued its National Development Policy for Nutrition (2015–25), which builds on the lessons and experience to date (République du Sénégal, Primature 2015). Its overarching objective is to ensure a satisfactory nutritional status for all, particularly children under five years of age, women of reproductive age, and adolescents (see appendix B, box B.2). It supports six intermediate objectives: (1) adequate coverage of essential nutrition services; (2) improved access to and use of quality health services; (3) improved knowledge and behaviors supporting good nutrition; (4) the production of foods high in nutritional value; (5) sufficient and sustainable financing; and (6) strengthened program capacity for management and implementation. The new policy articulates four strategic pillars: (1) production of food with high nutritional value; (2) transformation, distribution and pricing of primary outputs into quality food that is affordable and accessible; (3) a multisectoral approach to nutrition education focused on behavior change and adequate, equitable access to clean water and sanitation; and (4) integration and complementarity of basic health, nutrition, and water and sanitation services. Cross-cutting themes include a lead role for local government, adequate and sustainable financing, social and behavior change, multisectoral approach, participation, equity, and continued capacity building.

1.12 **World Bank and other support to nutrition.**[7] The World Bank first invested in nutrition in Senegal over 20 years ago with the approval in 1995 of the Community Nutrition Project (CNP). Its objectives were to (1) halt a further deterioration in the nutritional status of the most vulnerable groups (malnourished children under three and pregnant and nursing mothers); (2) provide potable water to under-serviced neighborhoods; and (3) enhance household food security in poor rural and urban areas during critical periods of vulnerability (World Bank 1995). Its total actual cost was US$51 million, and its outcome was rated moderately satisfactory by Independent Evaluation Group. Moreover, this project provided a wealth of experience and lessons, which influenced the design of subsequent nutrition support.[8] In 2002, the World Bank approved the first project of a planned series of three designed as an Adaptable Program Loan (APL) to support Senegal's 10-year NEP. The World Bank's second phase of support was approved in 2006, with additional financing approved in 2012. Although the World Bank decided against financing the third phase, a Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project was approved in 2009. It is these three projects (NEP Phase I, NEP Phase II, and Rapid Response) that are the subject of this Project Performance Assessment Report (PPAR). An

[7] Appendix B provides an overview of the World Bank's support to nutrition efforts in Senegal from 1995 to the present.

[8] Completed in 2000, this project succeeded in halting a further deterioration of the nutritional status of young children in the highly vulnerable urban neighborhoods targeted by the project. However, the approach was very costly, and there were low levels of capacity strengthening. Lessons reveal that the project could have benefited from more substantial use of local women's groups, nongovernmental organizations, and other local structures and capacity (World Bank 2001).

ongoing health operation (Health and Nutrition Financing) has a nutrition component and a project to Build Resilience to Food and Nutrition Insecurity Shocks is under preparation. Over and above the World Bank's long tradition of lending for nutrition in Senegal, it has also supported analytic work and technical assistance (see appendix B, table B.1).

1.13 In early 2002, at the time of approval of the World Bank's first phase of support to NEP, various development partners provided ad hoc support to nutrition in Senegal. According to the project appraisal document (PAD), the United Nations Children's Fund (UNICEF) was providing support to national nutrition strategy implementation, salt iodization and Integrated Management of Childhood Illness (IMCI) activities (World Bank 2002b). The U.S. Agency for International Development (USAID) was also supporting IMCI, including at the community level. IMCI was also supported by WHO, specifically through training of service providers. In addition, KfW Development Bank was financing water and sanitation interventions. As Senegal's NEP and the CLM became better established, especially from 2009 onward, more development partners joined the World Bank in channeling their nutrition support to and through these vehicles, notably the Micronutrient Initiative, World Food Programme, UNICEF, Spanish Cooperation and Global Alliance for Improved Nutrition. Their financial contributions to the NEP over time are itemized in appendix C, table C.12). USAID and many others continue to finance nutrition activities through other sectors and programs.

2. Nutrition Enhancement Program

Objectives, Design, and Relevance

PROJECT DEVELOPMENT OBJECTIVES

2.1 As stated in the Development Credit Agreement of March 29, 2002, "The objectives of the Project are to assist the Borrower in building the institutional and organizational capacity required to enable the Borrower's CLM and its partners in the public and private sectors to develop, implement and monitor multisectoral nutrition activities in both rural and urban areas" [9] (World Bank 2002a, 13). For the purposes of analysis, the PDO will be subdivided into two objectives. Objective 1: Building institutional and organizational capacity to enable CLM and its partners to develop and monitor multisectoral nutrition activities in both rural and urban areas. Objective 2: Building institutional and organizational capacity to enable CLM and its partners to implement multisectoral nutrition activities in both rural and urban areas. Assessment of the first objective will center on capacity built for strategic management of the Program, including monitoring and evaluation. Assessment of the second objective will focus on the results chain of service delivery and behavior change interventions and their relevant outcomes.

[9] The PAD of February 20, 2002, states this same PDO but also adds another one: "to consolidate and sustain the results gained with the earlier (Community Nutrition) project, which contributed to reversing the negative trend in nutritional status among children under three in the urban areas" (World Bank 2002b, 3). In line with harmonized guidelines, this project will be evaluated against the PDO, as stated in the Development Credit Agreement. Nevertheless, trends in nutritional status among children under age three years will also be assessed.

2.2 This project was the first of three planned World Bank operations, packaged as a 10-year Adaptable Program Loan (APL), to support the implementation of Senegal's Nutrition Development Policy. The overarching objective of the 10-year APL (the NEP) was "to improve the growth of children under three in poor rural and urban areas and help build the institutional and organizational capacity to carry out and evaluate nutrition interventions." (World Bank 2002b, 3) The first project (Phase I of the NEP, and the subject of this chapter) was a preparatory phase meant to consolidate and sustain results gained with the previous CNP, refine and extend interventions to rural areas, and initiate capacity building of the newly established CLM. Phase II was intended to further scale up interventions and refine implementation capacity, and Phase III was to achieve nationwide coverage of a cost-effective nutrition system responsive to local needs, and working cooperatively with communities and local government. Outcome indicators for the 10-year program and for each of the three phases are presented in box 2.1.

2.3 The geographic scope of nutrition interventions to be supported under the project comprised (1) continued support (albeit with design changes) of the urban zones supported under the previous CNP,[10] and (2) rural areas in Kaolack, Fatick, and Kolda regions. The targeting of geographic zones and populations were thorough, participatory, and sound.[11] The project's support to nutrition program capacity building targeted national agencies and their regional branches as well as actors and stakeholders in the project intervention areas.

RELEVANCE OF OBJECTIVE

2.4 The relevance of objectives is rated **high.**

2.5 First, the PDO is responsive to country conditions at the time of appraisal, project completion, and currently. Although declining over time, malnutrition remains a serious problem among Senegal's poor, especially in the rural areas where most of the poor live and among the very young (six months to three years old), who are the most vulnerable. Malnutrition wreaks havoc on a country's socioeconomic development prospects: Stunted children are more susceptible to death and disease and have diminished cognitive capacity, undermining their learning and future earning capacities. Anemia impairs women's health and economic productivity and, for pregnant women, can lead to maternal death and serious health consequences for infants (stillbirths, prematurity, and low birth weight). Low breastfeeding rates undermine a child's immune system, protection from disease, and their potential for healthy growth and intelligence. Although Senegal had supported programs and initiatives to fight malnutrition prior to the launch of this project, they were neither

[10] Specifically: neighborhoods in the cities of Dakar, Pikine, Diourbel, Kaolack, and Ziguinchor.

[11] For the urban zones: The PAD on the CNP devotes an entire appendix to the targeting methodology. In short, four types of targeting were used: geographic targets (neighborhoods with high poverty and poor or no basic services), demographic targets (specific target groups, for example, pregnant and nursing women and children ages 6–36 months), nutritional status of children and "at-risk" children, and food security. A range of sources (including household survey data and malnutrition data) and techniques (local level participation) was also envisaged. For the rural areas: The regions of Kaolack, Fatick, and Kolda were selected because they were determined (based on available poverty data and studies) to be the three poorest regions in Senegal. Within these regions, 34 health districts were selected with the assistance of Regional Health Officers on the basis of social indicators and, within these districts, communities were selected with Health District and nongovernmental organization input on the basis of malnutrition data.

sufficiently coordinated nor cost-effective and offered many lessons for their consolidation and improvement. Indeed, the rationale for maintaining support to the urban zones supported under the CNP was precisely to reform the approach there in light of lessons learned, both to consolidate gains there as well as to achieve greater cost-effectiveness. These urban populations were highly vulnerable, residing in very poor squatter neighborhoods, targeted on the basis of multifaceted criteria (see paragraph 2.3).

Box 2.1. Key Performance Indicators for 10-Year APL and Each of Its Phases

Outcome indicators for 10-year APL (nationwide)

- underweight (weight for age <−2 s.d.) among children under age three years reduced by 40 percent
- severe underweight (weight for age <−3 s.d.) reduced to less than 1 percent
- virtual elimination of vitamin A deficiency
- at least 80 percent of rural communities made aware that malnutrition is a development problem and know of actions to address the determinants of malnutrition
- the accelerated decline in under age five years mortality, due in part to the program

Specific outcome indicators for Phase I, 2002–05 (in the intervention areas)

- program coverage has reached 35 percent of the target population in the targeted rural areas and 50 percent of the target population in the targeted urban areas
- severe underweight is reduced by half in the targeted areas
- underweight among children under three is reduced by 25 percent in the targeted areas
- proportion of children exclusively breastfed until six months increased from 8 to 15 percent in the targeted areas
- use of prenatal care (at least three visits) increased by 30 percent in the targeted areas
- proportion of caregivers (mothers and other caregivers) who recognize at least two danger signs in sick children has increased by 25 percent in targeted areas

Specific outcome indicators for Phase II, 2005–10 (in the targeted areas in seven of Senegal's 10 regions)

- program coverage has increased to 60 percent of the target population in 7 of 10 regions
- severe underweight is reduced to less than 1 percent
- underweight among children under age three is reduced by 25 percent
- proportion of exclusively breastfed children up to six months increases to 45 percent in the first 3 (Phase I) regions and to 15 percent in the 4 regions added under Phase II
- use of prenatal care increased by 30 percent in all seven regions
- local authorities work cooperatively to take over and manage basic nutrition interventions

Specific outcome indicators for Phase III, 2010–12

- program coverage has extended to all regions
- the performance indicators of the 10-year program are achieved
- local authorities have taken over and are managing basic nutrition services cost-effectively
- the *Lettre de Politique de Dévéloppement de la Nutrition* has been evaluated and updated as necessary

Sources: World Bank 2002b, 4; and World Bank 2002a for Phase I indicators.
Note: s.d. = standard deviation.

2.6 Second, the PDO has remained highly relevant to Senegal's strategic priorities over the years. Senegal's 2002 PRSP recognized the importance of nutrition interventions to attaining Senegal's overarching objective of alleviating poverty and included budgetary provisions for nutrition. It also advocated more active partnership among the government of Senegal, civil society, and communities. The PRSP, issued just after the project's closing,

supported access to basic social services, with an explicit commitment to improving nutrition, protecting vulnerable groups, and supporting greater transparency and participation. Senegal's Strategie Nationale de Developpement Economique et Social 2013–17 articulates a Priority Action Plan linked with the national budget framework, which aims to improve access to basic services, with emphasis on strengthened resilience and social protection for vulnerable groups. In short, the reduction of malnutrition was both explicit and budgeted for. The PDO is directly supportive of Senegal's Nutrition Policy of April 2001, which sought to improve the nutritional status of poor, vulnerable groups and reproductive women.

2.7 Third, the PDO was and remains relevant to the World Bank's strategies for Senegal over the years. Poverty alleviation was at the center of the World Bank's 1998 Country Assistance Strategy (CAS), which included an objective to improve the nutritional status of women and children under age five. The CAS issued just after the project's closing included a human development/shared growth pillar emphasizing access to social services and enhanced opportunities for the poor and vulnerable (World Bank 2007 b). It also set a target to reduce malnutrition. The current World Bank Group Country Partnership Strategy (CPS) for FY2013–17 is focused on one foundation—strengthening the governance framework and building resilience—and two pillars: accelerating inclusive growth and creating employment and improving service delivery, with an emphasis on social sector governance, access, and equity (World Bank 2013a). Although the PDO is relevant to this CPS's emphasis on health-related services and outcomes, its nutrition-specific content is not as strong as the previous CAS. Phase II was ongoing, covering the first two years of the five-year CPS. But a Phase III nutrition follow-on project was no longer envisaged. Moreover, the CPS did not include nutrition-specific targets or indicators.

2.8 Fourth, the PDO is also very relevant to the World Bank's series of Health, Nutrition, and Population (HNP) Global Practice strategies. The 1997 HNP strategy set three objectives: (1) improve HNP outcomes of the poor, (2) enhance health systems performance, and (3) secure sustainable health financing (World Bank 1997). The 2007 HNP strategy sought to improve the level and distribution of HNP outcomes, particularly for the poor and vulnerable; prevent poverty due to illness; improve financial sustainability; and improve sector governance, accountability, and transparency (World Bank 2007a). Aligned with selected Sustainable Development Goals[12] and the World Bank's twin goals, the 2016 updates to the priority directions for the HNP Global Practice (2016–20) articulate three strategic areas to which the PDO responds: fair, efficient, and sustainable financing for HNP outcomes; equitable access to affordable, quality services; and harnessing the potential of other sectors to strengthen results (World Bank 2016). In 2006, a World Bank advocacy document laid out a strategy for large-scale action for nutrition: strengthening global and national commitment and capacity; mainstreaming and prioritizing nutrition in development strategies; reorienting ineffective programs; action research and learning by doing for strengthened evidence base and action (World Bank 2006c). Most recently, World Bank President Jim Kim's Investing in Early Years for Growth and Productivity initiative has identified Senegal, along with 21 other countries, for scaled-up financing focusing on child

[12] 1. No Poverty; 2. Zero Hunger; 3. Good Health; 5. Gender Equality; 10. Reduced Inequalities; 11. Sustainable Cities and Communities; 13. Climate Action; and 16. Peace and Justice.

nutrition, early learning, and early stimulation to support the development of the child to reach full potential.

PROJECT DESIGN

2.9 Designed as an APL, this project was the first of a series of three anticipated World Bank operations, which together would support implementation of Senegal's new 10-year NEP. This Phase I project (NEP I) supported three components (box 2.2).

Box 2.2. Nutrition Enhancement Program Phase I Components

Component 1. Community-based nutrition and growth promotion: This component supported a package of five community-based interventions, to be delivered by nutrition aides selected from communities, aimed at promoting adequate growth to prevent malnutrition:

- growth monitoring and promotion, comprised of monthly weighing sessions and follow-up home visits to vulnerable children (who either did not participate or showed inadequate weight gain);
- nutrition and health group education for the delivery of key messages;
- IMCI, including the promotion of healthy behaviors and design and implementation of guidelines for management of severe malnutrition cases in health facilities;
- basic health services provision, including commodities (micronutrients, deworming tablets, impregnated bed nets, and oral rehydration salts) and promotion of prenatal care and other health services; and
- grants for community-based nutrition projects.

Component 2. Capacity building and monitoring and evaluation: This component was designed to strengthen

- institutional and organizational capacity, including the (1) technical support and learning opportunities for the CLM; (2) technical support, training, equipment, materials, and other support for the functioning of the national executive bureau and its regional offices; (3) support for the operations of Ministry of Health divisions in charge of nutrition and health education; (4) the recruitment and strengthening of local NGOs to be contracted to promote and oversee local-level nutrition activities; (5) training of service providers (nutrition aides), supervisors, and program administrative staff in contract management and accounting; (6) establishment of small community for program design and oversight, district-level consultative committees for the development of regional nutrition plans; and local committees for the monitoring of program interventions; (7) retraining of urban nutrition development centers; and
- monitoring, evaluation, operational research, routine program reporting and special studies.

Component 3. Project management and reporting: This component supported the establishment and operation of the national executive bureau and technical advisory services.

Source: World Bank 2002b.
Note: Planned versus actual costs by component are presented in appendix C, table C.1.

RELEVANCE OF DESIGN

2.10 The relevance of design is rated **high**.

2.11 The results chain for PDO 1 (to build the institutional and organizational capacity to develop and monitor multisectoral nutrition activities) is well conceived. It supports a range

of activities centered on building capacity for strategic management of the program, including monitoring and evaluation capacity.

2.12 First, it is designed to support and further strengthen the technical, managerial, and material capacities of all key actors in the newly established institutional and organizational framework: the CLM (responsible for the definition and implementation of national nutritional policy); the national executive bureau and its regional offices (serving as secretariat to the CLM and responsible for management and oversight of the NEP); nongovernmental organizations (NGOs) recruited as community executing agencies (CEAs) to guide, facilitate and supervise local-level activities and provide the interface among communities, local government, and the program; and community-level nutrition aides, selected by their peers to carry out growth monitoring and nutrition education and promotion.

2.13 Second, it facilitates the "vertical" and "horizontal" interaction and collaboration of all key actors through the establishment and support of various committees and forums, which include (1) at the central level, the multisectoral CLM and its technical and monitoring and evaluation committees; (2) at decentralized levels, the district-level consultative committees for the development of multisectoral regional nutrition plans and local-level committees for the monitoring of program interventions; and (3) at the community level, small community forums for program design and oversight.[13]

2.14 Third, it provides targeted support to the health sector, in recognition of its critical role at the central or policy level, and in guiding, supervising, and directly participating in prevention and treatment at the community level as a part of its primary health care agenda. Lastly, and perhaps most importantly, the PDO to improve program strategic management is greatly supported by the development and implementation of a results-based, learning-by-doing approach, underpinned by routine program monitoring and evaluation and strategic studies and operations research. The regular review, discussion, and use of program data for decision making at each level of the system is designed to be both transparent and participatory, serving the purposes of learning and accountability.

2.15 The results chain for PDO 2 (to build the institutional and organizational capacity to implement multisectoral nutrition activities) is equally well conceived. The results chain is clearly laid out, encompassing supply- (service delivery) and demand-side (awareness-raising, information, education, and behavior change) interventions targeted to the most vulnerable groups, which are plausibly expected to culminate in healthier behaviors (breastfeeding, improved diets, proper use of health services, and so on), and ultimately lead to improved nutrition and health outcomes for vulnerable women and children. Interventions appropriately emphasize prevention and promotion but also include treatment of severe cases of malnutrition, also important for achieving program goals. The grants for community-based nutrition projects support innovative activities, family gardens and other relevant activities to enhance communities' abilities to improve their nutrition practices and outcomes. The locus of action is the community and the nutrition aides. Both the credibility of the nutrition aide

[13] Vertical interaction means the collaboration and exchange across the multiple levels of the NEP: central, regional, district, and local levels. Horizontal interaction and collaboration means a multisectoral approach, which seeks to involve all relevant sectors and public or private actors at each level of the system.

among her peers and her knowledge of the local community and its issues and challenges provide her with leverage to effect change. Supply- and demand-side interventions focus on issues of highest relevance and priority, reflecting best practices from the literature and accumulated experience, as well as the needs and priorities of specific communities, thanks to a communications program that is based on listening, as well as information transmission.[14] An evidence-based focus enables continuous learning and improvement. The design was a positive shift away from Senegal's previous efforts (supported under the CNP), which focused primarily on the mitigation of acute malnutrition by means of food supplementation and toward the prevention of chronic malnutrition through growth monitoring and behavior change.

2.16 **Implementation arrangements.** Starting at the community level, the nutrition aides were responsible for the nutrition and growth promotion activities under component 1. NGOs and local associations were contracted to facilitate social mobilization and the selection, training, and supervision of nutrition aides and to ensure the availability of other program support. The health post was the first level at which program activities were formally integrated with the health system. The regional executive bureau was responsible for the mobilization of NGOs and for regional-level coordination, monitoring and evaluation, with a plan for their eventual assumption of contracting and financing responsibilities. The national executive bureau was responsible for day-to-day program management and served as secretariat of the CLM. The CLM was responsible for policy development, ensuring a multisectoral approach, and approving strategies, annual work plans, and budgets.[15]

Implementation

2.17 **Key dates.** Approved by the Board of Executive Directors on March 14, 2002, the International Development Association (IDA) credit became effective on June 27, 2002. The midterm review took place in February 2005. The project was not restructured, but its closing date was extended by six months to July 15, 2006, to allow the community-level subprojects to complete a full two-year cycle.

2.18 **Planned versus actual costs, financing and disbursements.**[16] The total cost estimated at appraisal was US$16.20 equivalent, net of planned World Food Programme (WFP) support to be provided through parallel financing. The actual cost of the project reported in the Implementation Completion and Results Reports (ICR; US$23.10 million)

[14] See IFPRI 2016, World Bank 2006c, and *The Lancet* Maternal and Child Nutrition Series (2008). Components capture (1) the "short routes" to improved nutrition advocated in *Repositioning Nutrition as Central to Development* (community-based health and nutrition services, facility-based services, micronutrient supplements, nutrition education and behavior change interventions including: maternal nutrition, knowledge and care-seeking during pregnancy and lactation; infant and young child feeding, hygiene education, and promoting healthy diets); and (2) are cognizant of and serve to stimulate a multisectoral approach to the "long routes to improved nutrition (health, water and sanitation, supportive food and agricultural policies, fruit and vegetable production, poverty alleviation, purchasing power for food, women's status, workload and education."

[15] Technical divisions within Ministry of Public Health and other line ministries are represented in the technical committee, which assists the CLM with policy development and expert advice. A monitoring and evaluation committee evaluates the performance of the national executive bureau.

[16] Detailed data are provided in appendix C, tables C.1, C.2, and C.3.

appears to be inclusive of WFP support (World Bank 2007c). The actual cost of the project net of WFP's US$4.0 million in support is US$19.1 million or 118 percent of the original estimate. Actual costs of component 1 (inclusive of WFP support) were twice the appraisal estimate and program management actual costs also exceeded the original estimate. On the other hand, actual costs of institutional capacity building and monitoring and evaluation and research were less than original estimates.

2.19 Although in principal they should add up, there is a discrepancy between actual costs and actual financing. This is due to the different sources used, an actual increase in the US$ value of the SDR over the life of the project and different calculations of the exchange rate. In terms of US$, actual IDA financing ($16.5 million) exceeded the original estimate ($14.7 million) by 112 percent. Government counterpart financing (US$1.8 million equivalent) also exceeded its obligation (US$1.5 million) by 120 percent (appendix C, table C.2).

2.20 Of the originally approved World Bank financing of SDR 11.8million,[17] SDR 0.422 was canceled and 11.378 was used (96 percent of the original amount and 100 percent of the adjusted amount after cancelation). Actual use of IDA funds (1) exceeded original allocations for consultants and training and operating costs and (2) fell short of original allocations for works, goods, pharmaceuticals, subprojects and the project preparation facility. This is largely a reflection of the time and resources invested during the first full year of the project to establish capacity and broad-based ownership at the local and community levels.

FACTORS AFFECTING IMPLEMENTATION

2.21 **Outside the government's control.** There was a severe drought in 2002, the first year of implementation, and another drought in 2004, compounded with a plague of locusts. This affected cereal production and food availability for the population, especially the poorest and most vulnerable.

2.22 **Within the government's control.** With President Wade's election in March 2000, both he and the First Lady became strong advocates for nutrition. Newly created in 2001, the CLM was appropriately housed in the office of the prime minister, given its multisectoral mandate. Strong government support and commitment were reflected in its overall development policies, which focused on poverty alleviation, including the improved nutritional status of the population; in the appointment of highly qualified staff to serve in the CLM; and in its counterpart financing, which exceeded its initial commitment.

2.23 **Within the CLM's control.** During the project's four-year implementation period, the CLM served under three prime ministers.[18] The CLM was proactive in ensuring the full briefing of each new prime minister, successfully securing the appreciation and support of this critical program and its importance for achieving the country's development goals with

[17] Of which 8.4 million is an IDA credit and 3.4 million a multilateral debt relief initiative. The latter calls for 100 percent cancelation of IDA, African Development Fund, and International Monetary Fund debt for countries that reach the heavily indebted poor countries completion point.

[18] Mame Madior Boye (2001–02); Idrissa Seck (2002–04); Macky Sall (2004–07)

each new prime minister. The CLM style of management was collaborative across sectors, participatory in including all actors and stakeholders at each level of the system, results-based, transparent, and focused on learning. The NGOs/CEAs contracted under the project provided a very effective interface between the program, local authorities, and the communities, in terms of social mobilization, communication, social cohesion, operational support, supervision, and reporting.

2.24 **Safeguards compliance.** No safeguards were triggered under this project.

2.25 **Fiduciary compliance.** Financial management has been exemplary, with project financial management reports having been rated highly by the World Bank. External financial audits were completed on time, with no qualifications, and were satisfactory to IDA. Procurement performance was also fully satisfactory, due to the high quality of staff. Some financial management and procurement tasks were carried out by the 12 NGOs operating at the local level. Their good performance was a result of initial capacity building efforts to strengthen their fiduciary competencies.

Achievement of Objectives

2.26 Appendix D, table D.1, presents the baselines, targets, and actual achievements of all outcome and intermediate outcome indicators and all the sources of these data. Although the PDO makes specific reference to rural and urban areas, these results are not disaggregated by urban/rural residence. The ICR provides no such breakdown. Moreover, the mission was informed by the CLM monitoring and evaluation expert that this information was not possible to provide.

OBJECTIVE 1

2.27 Objective 1 of NEP I was to build institutional and organizational capacity to enable CLM and its partners in the public and private sectors to develop and monitor multisectoral nutrition activities in both rural and urban areas. The achievement of objective 1 is rated **high.**

2.28 **Outputs and intermediate outcomes.** Project provision of technical assistance, training, material, equipment, and operating costs culminated in the establishment of capacity at every level of the system for program planning, management, oversight, and course correction. At the central level, the CLM, which was responsible for policy advice, oversight of policy implementation, and multisectoral coordination, was established in 2001 just six months prior to project effectiveness. The project was instrumental in building the CLM's capacity to fulfill its mandate and in guiding it in the launch of the NEP, the main vehicle for implementing nutrition policy. The newly established national executive bureau, serving as the CLM secretariat and as the project implementation unit, was staffed (with about 20 staff), trained, and equipped with project support and guided in its initial action planning, budgeting, and quarterly reporting to the CLM on program progress.[19] Support was also extended to the six regional executive bureaus (each staffed with 2 technical staff, 2 financial

[19] The chair of national executive bureau was the director of the NEP.

staff, and 2 support staff), responsible for providing technical support to and overseeing community-level activities and organizations, especially the NGOs/CEAs.

2.29 At the local level, a system for contracting local NGOs and associations to operate as CEAs was developed and implemented. CEAs were chosen on a competitive basis for their experience, credibility, and good reputations with local communities; and their staff were recruited or trained to further strengthen their capacities in community mobilization and in the oversight, supervision, monitoring and evaluation, reporting on local-level progress, procurement, and financial management.[20,21] The CEAs were mandated to involve local government officials and district health personnel. At the community/service delivery level, over and above their training in the technical aspects of service delivery (see paragraph 2.34) nutrition aides, selected by their communities, were trained by the CEAs in the collection and recording of program performance data and in using these data as a vehicle for dialogue and behavior change interventions targeted to mothers and other caregivers and for communicating results to their communities.

2.30 At the sectoral level, the project supported the Ministry of Public Health and Ministry of Education in the preparation of work plans and budgets specific to their mandates and comparative advantages in the delivery of key nutrition inputs and interventions, and in the monitoring and oversight of their implementation, at every level of the system. This was a strategic first step in working toward the development of a truly multisectoral approach.

2.31 A viable monitoring and evaluation system was established with project support, which documents program baselines and targets for the various components of the program results chains. The data is widely shared with actors and stakeholders. A system of committees has been established to discuss and improve program performance in light of regular reporting. At the community level, the Local Steering Committee supports nutrition aides in mobilizing community interest and action, managing nutrition commodities, and general troubleshooting and problem-solving.[22] At the district and departmental levels, the Local Monitoring Committees meet on a quarterly basis to discuss the results and action plans presented by the CEA.[23] At the regional level, the Regional Monitoring Committee meets semiannually to hear and discuss regional reports on activity plans and results.[24] In short, the monitoring and evaluation system provides for the analysis of program and special studies' data and feedback to stakeholders at the community, district, regional, and national levels.

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[20] Project leader, community supervisor, fiduciary staff, and others.

[21] Thirty-six CEA staff (100 percent of staff responsible for administrative and financial management) were trained in procurement and financial management. All 34 subproject coordinators were trained in monitoring and evaluation.

[22] Members include community representatives selected by the community. These committees are typically led by village chiefs or spiritual leaders

[23] Chaired by the local authority (*sous-prefet* at the district level and *prefet* at the departmental level), members include the district health officer other relevant sector representatives and representatives from beneficiary communities.

[24] Chaired by the governor, members include district and regional medical officers, representatives from local collectivities and CEAs.

2.32 **Outcome.** In the space of the four-year implementation period, thanks to the direct project support to capacity building and applied experience, CLM fully assumed its central role of setting the policy agenda for nutrition in Senegal, overseeing its implementation through the NEP, fostering cooperation across sectors and with the nongovernmental sector, and, increasingly, sector wide monitoring and coordination of donor support to nutrition. The NEP has evolved into a nationally owned nutrition program (and not a World Bank project), which is the main vehicle for national policy implementation. The national executive bureau and its regional offices have been successful in functioning as the operational arm of the CLM, thanks to their very capable and experienced team and good management practices. CEAs were effective in ensuring that the program is well grounded in the needs/priorities of the communities and that local authorities are increasingly committed and involved. The NEP has strong ownership at the community level. The community-based service delivery structure and decentralized implementation have catalyzed a range of actors and contributors at the local level, so critical for a multisectoral approach. Its monitoring and evaluation system and mechanisms for discussing and utilizing the data at every level of the system have promoted rigorous tracking, discussion of data, fostering a strong results focus, transparency and accountability and learning by doing.

OBJECTIVE 2

2.33 Objective 2 of NEP I was to build institutional and organizational capacity to enable CLM and its partners in the public and private sectors to implement multisectoral nutrition activities in both rural and urban areas. The achievement of this objective is rated **high.**

2.34 **Intermediate outcomes.** With project support, community-based nutrition services were established and delivered in the targeted urban and rural areas.[25] One hundred percent (or 2,459) of nutrition aides (selected from and by their communities) were trained in the promotion of basic health care and in community-based IMCI, far exceeding the target of at least 25 percent. They also received on-the-job technical support and guidance from health providers and CEAs in the organization of monthly growth promotion sessions and in social mobilization. Against a target of 820 (for 80 percent coverage of targeted communities), 924 nutrition sites were established and equipped. Children under three were regularly monitored and their caretakers counseled. A total of 200,000 children under three and their mothers were mobilized for monthly growth monitoring and promotion, exceeding the target of 171,000, reflecting a high participation of 90 percent of targeted mothers and children. In 2006, 94 percent of established sites held monthly nutrition and health education sessions (exceeding the 80 percent target), and these sessions were well attended by 89 percent of targeted groups. With targets surpassed both for the number of nutrition sites established and the number children under three served by the program, program coverage appears to have exceeded plans. But there were no data to assess the program's aim to have reached 35 percent of the targeted population in rural and 50 percent in urban areas.[26]

[25] Urban zones covered under the CNP and selected local collectivities in rural areas of three priority regions: Fatick, Kaolack, and Kolda.

26 While this was stated in the PAD as a target, it was not among the key performance indicators. Moreover, the CLM has noted difficulty in disaggregating data by urban/rural residence.

2.35 Greater responsiveness and involvement of local health services were achieved through training of 1,122 health post and district personnel in the promotion of basic care and in IMCI (100 percent and 78 percent, respectively), exceeding the target of 40 percent. Forty-six percent of health posts were adequately equipped to manage severely malnourished children, almost achieving the 50 percent target. Reinforcing the IMCI content at the community level was the training of 23 trainers and staff of all CEAs supporting and overseeing community-level activities. Micronutrient coverage in the intervention areas was significantly increased. By the project's end (2005), vitamin A supplementation coverage for children ages 6–59 months achieved a level of 85 percent, up from 42 percent in 2003, exceeding the national average of 75 percent that same year; and vitamin A supplementation of mothers within eight weeks postpartum achieved 51 percent (up from 27 percent in 2003), exceeding the 2005 national average of 27 percent.[27]

2.36 **Outcomes.** Most targets for knowledge and behavior changes of priority groups were exceeded in the intervention areas, culminating in much higher levels than national averages. Knowledge, Practice, Coverage (KPC) surveys show that the proportion of caregivers who recognize at least two danger signs in sick children increased from 55 to 77 percent (a relative increase of 40 percent, exceeding the 25 percent target) (CLM 2006b). The proportion of children exclusively breast fed until six months almost doubled from a 30 percent baseline to 58 percent, comparing very favorably to the end-of-project average for Senegal of 34 percent. KPC surveys also show that the use of prenatal care (at least three visits) increased from 52 to 67 percent (a relative increase of 29 percent, essentially achieving the 30 percent target).[28] The proportion of children under five sleeping under insecticide-treated bed nets more than doubled from 28 to 59 percent, far exceeding the 2005 national average of 10 percent.[29] Consumption of iodized salt also increased from 46 to 59 percent (an increase of 28 percent), exceeding the national average in 2005 of 41 percent. Moreover, program activities in the intervention areas, established and supported with project support, culminated in improved nutrition outcomes for children under three years of age. Ninety-one percent of children participating in monthly growth promotion sessions in the intervention areas showed adequate weight gain, and this constituted the vast majority of targeted children, whose participation rate in these sessions exceeded 90 percent.

2.37 In short, the program's capacity to implement multisectoral, community-based nutrition activities in the intervention areas was highly achieved, exceeding targets and expectations. With project support, service delivery targets were exceeded in terms of both their coverage and their intensity (see paragraphs 2.34 and 2.35). In turn, this very strong performance culminated in improvements in the knowledge and behaviors of target groups,

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[27] The low coverage in 2003 was the result of a sudden policy change on campaign-style delivery of services, which was rectified in 2004 (World Bank 2007c).

[28] Preliminary results from an impact evaluation suggested it increased from 65 to 78 percent in intervention areas, and from 64 to 70 percent in control areas. But these results were appropriately discounted because there were really no control areas in Senegal, given the wide range of partners and interventions promoting maternal and child health care, covering (in their own different ways) most of the country (see also paragraph 2.56).

[29] Malaria and malnutrition combine in a vicious circle: malnourished children have weak immune systems, so their bodies are less able to fight diseases such as malaria, and children sick with malaria are more likely to become dangerously malnourished.

which were significantly higher than national averages, and also in the adequate weight gain of most children under three targeted by the program. The program set targets for reductions in underweight in the intervention areas, which were ambitious for the project's short time frame (see paragraph 2.54) and, moreover, not a fair or accurate measure of the project's more immediate objective to build program implementation capacity. Still, it is interesting to report progress against these. Two data sources reveal that the prevalence of underweight and severe underweight among children was indeed reduced in the intervention areas. Program monitoring data shows a 44 percent drop in underweight among children under three in the intervention areas during the project period (from 18 to 10 percent). This exceeds the project target of a 25 percent drop. The impact evaluation also shows a reduction in intervention areas, albeit a smaller one: 14 percent (from 26.8 to 23.1 percent), but still larger than the 10 percent reduction in control areas.[30] According to WHO's Global Data, national prevalence of underweight among children under five declined by 29 percent from 20.3 percent in 2000 to 14.5 percent in 2005. Field visits revealed the strong opinion of actors and stakeholders that the counterfactual for the intervention areas would have been worse without the project, as it prioritized and targeted areas with the highest malnutrition rates, poverty, and vulnerabilities, among whom results are more difficult to achieve.[31] The impact evaluation also shows a drop in severe underweight among children under three in the intervention areas from 5.7 to 4.5 percent. WHO Global Database on Child Growth and Malnutrition shows a nationwide drop from 7.0 to 3.9 percent (WHO 2014).

2.38 **Assessment of contribution or attribution.** The high efficacy of the program in achieving both objectives is a direct result of the project's investments in program capacity and in the World Bank team's technical support to the program, both during its design and implementation. World Bank took on the lead role among donors in encouraging and supporting the formulation of the government of Senegal's nutrition policy and the definition of the 10-year NEP. Multiple assessments of the launch and implementation of this program, as well as interviews with a range of national and international actors, give full credit to the World Bank as a leader to this end. Although there were donors supporting maternal and child health interventions in the three regions where the project was active, the project was the main source of technical and financial support for this first phase of community-based NEP implementation. The program capacity built and the services delivered during 2001–06 (paragraphs. 2.34 and 2.35) were the result of the project's support; and it was this newly developed capacity, which culminated in the program's excellent results (see paragraphs 2.36–2.37). WFP provided parallel financing in the amount of US$4.0 million but only for a very specific intervention: food supplementation in the urban areas supported by the project. KfW and UNICEF were also supporting nutrition activities, but not specifically in the intervention areas. The Ministry of Public Health and its development partners may have made some contribution to improved outcomes in the intervention areas through their

[30] The reduction was from 24 percent to 21.7 percent. Again, both the CLM / National Executive Bureau (secretariat to the CLM) and the PPAR understand the methodological challenges of defining true control groups for this study in Senegal (para. 256).

[31] The national improvements in underweight are likely linked to the strong, inclusive economic growth and especially to the poverty reduction achieved between 2001 and 2005 (see paragraph 1.3). But the project's intervention areas remained extremely poor even during this period of strong economic performance, highly dependent on rain-fed agriculture and vulnerable to unfavorable environmental and climatic conditions.

provision of maternal and child health services. But without the project's discrete support to the health sector, it is unlikely that local-level health services would have (1) provided the technical oversight and support to community-level interventions and (2) been sufficiently equipped to receive, properly rehabilitate, and follow up on acutely malnourished children referred by the program. The establishment and successful implementation of the NEP would eventually provide a strong foundation for improved collaboration and coordination among development partners under the second phase, with the World Bank playing an important catalytic role (see paragraph 3.30).

Efficiency

2.39 Efficiency is rated **substantial**.

2.40 The fight against malnutrition is a highly cost-effective investment in a country's development. A large body of scientific evidence shows that improving nutrition during the critical 1,000 day window has the potential to save lives, help children to develop fully and reach their full potential both in school and ultimately in the workforce, and thus enable them to contribute more effectively to a country's economic prosperity. Senegal's choice to develop and invest in a nutrition program is a sound investment in its development. The program is efficient in that it targets the right categories of the population with the right interventions: weighing of children under two and counseling of their mothers, promotion of exclusive breastfeeding of children under a six months, improved feeding practices and IMCI for children under age five years, essential health commodities for women and children; more effective use of maternal and child health services, and promotion of healthy pregnancies and childbirth.[32]

2.41 The delivery of community-based nutrition and growth monitoring and promotion activities under this project had a very reasonable median cost per child per year of US$4.3 (US$3.7 in rural areas and US$5.0 in urban areas), substantially lower than the costs of the previous CNP project, whose per child annual costs were estimated at US$80, net of food supplementation. A big reason for the higher cost of the CNP was its reliance on paid nutrition workers, in contrast with the NEP, which is delivered by volunteer nutrition aides. And even with these substantially lower costs, the intervention areas demonstrated significant improvements in knowledge and behaviors and a decline in the prevalence of underweight.

2.42 Implementation efficiency was substantial. The CLM successfully established itself as a capable, evidence-based manager and coordinator of program implementation. The national executive bureau and its regional offices were highly capable and effective in backstopping community-based activities. Thanks to a rigorous and transparent process, very capable local NGOs were contracted to provide a viable interface between the program and the beneficiary communities, and to forge a stronger link and collaboration with local government authorities and local-level services of various key sectors (see paragraph 2.32). The start of project activities was delayed by about six months while several essential success factors were put into place, including the establishment and training of local-level oversight

[32] Under Phase I, children ages 0–36 months were targeted for growth promotion; under Phase II, the target age was amended to ages 0–24 months.

committees, service delivery protocols, and a competitive process for recruiting NGOs. This slight delay was an investment in efficiency: when activities did start, the ground had been prepared for a smooth and accelerated implementation. A six-month project extension allowed for the completion of a two-year subproject cycle.

Ratings

PROJECT OUTCOME

2.43 The project's outcome rating is **highly satisfactory.** The project's objectives are highly relevant to current country conditions, national strategies and priorities (both higher-order development objectives and health and nutrition-specific objectives) and the World Bank's current CPS, as well as its HNP strategy. The design is also highly relevant, with clear and logical results chains supporting, respectively, the first objective to build capacity to develop, monitor, and oversee the NEP and the second objective to build capacity to implement NEP activities. The institutional and organizational setup, the community-based approach, the pivotal role of the nutrition aides and the NGOs, and the evidence-based, learning-by-doing management style were all very strong features of this innovative design, built on the lessons of the previous project. The objective to build capacity for the development and monitoring multisectoral nutrition activities was highly achieved, and the objective to build capacity for the implementation of those activities was also highly achieved. Most outcome and intermediate outcome targets were surpassed. Although they did decline, prevalence of underweight and severe underweight may not have fully achieved the targets. Nevertheless, this impact indicator is not a fair measure of the PDO, which focused on capacity building. Project efficiency was substantial because of good value for money and a very efficient implementation.

RISK TO DEVELOPMENT OUTCOME

2.44 The risk to development outcome is **moderate.**

2.45 Technical risk is **low** because the design has been validated as best practice in the literature, which has emerged over the past five years (almost a decade after the project was designed).[33] Financial risk is **substantial.** The government of Senegal has substantially increased its financial contribution to the NEP over the ensuing years since project closure. But both the costs and the financing need to be better assessed. The issue of whether and how much to remunerate nutrition aides and with what financing source(s) is raised among actors and stakeholders and needs more assessment and creative solutions. Further discussed in chapter 5, it is worth noting here the strong dedication of nutrition aides to their mandates. Throughout field visits, the remuneration of nutrition aides was consistently raised but not always by the aides themselves. Local government officials, NGOs, NEP staff, and communities all raised this concern, demonstrating the value they place on their work. Innovative financing sources and solutions are under discussion and experimentation.

[33] Such literature includes *Scaling up Nutrition: A Framework for Action* (2013), *The Lancet* Maternal and Child Nutrition Series (2008), *The First 1,000 Days*, and *From Promise to Impact* (IFPRI 2016).

Despite very low remuneration, nutrition aides derive great satisfaction in serving their communities and receive great respect and admiration for their work and results.

2.46 Social risk is **low.** Stakeholder awareness and support is extremely high across a range of groups: beneficiaries, communities, traditional and religious leaders, local government, district, regional and national program staff and oversight committees. Political risk is **low.** Nutrition figures prominently among the country's development goals and indicators. The placement of the CLM in the office of the prime minister is a statement of political commitment. The CLM has been successful in briefing new prime ministers so as to maintain the prominence at the highest levels of government. Risk of waning government ownership and commitment is **low** because the program's success, and it's still untapped potential is recognized, nationally, and internationally, and increasingly by local governments and other sectors, whose support and involvement continue to grow. Institutional risk is **low.** CLM gained acceptance as the national focal point for nutrition and its secretariat (National Executive Bureau) is recognized for its very strong performance. Local governments, with NGO contractual assistance, continue to assume growing responsibility for the nutrition program, in line with Senegal's decentralization policy. Risk of natural disasters is **substantial.** Senegal is prone to drought and locust infestation, which, while exogenous to the program, could compromise, at least temporarily, gains in nutrition status.

WORLD BANK PERFORMANCE

2.47 Overall World Bank performance is rated **highly satisfactory.**

2.48 Quality at entry is rated **highly satisfactory.** The project design was grounded in government of Senegal nutrition policy, which had been developed through a participatory process involving all stakeholders in nutrition and with World Bank technical assistance. The policy reflects Senegal's commitment to reduce and prevent malnutrition through a multisectoral approach and is appropriately focused on a sound assessment of issues and determinants of malnutrition. The 10-year NEP was developed, with World Bank technical assistance, as the vehicle for implementing government of Senegal nutrition policy. Not only was it technically sound (see the Relevance of Design section), it also very pragmatically reflected the lessons of previous nutrition interventions (both in Senegal and elsewhere)[34] culminating in a new, improved approach focused on sustainable nutrition interventions at the community level with an emphasis on prevention and promotion. The program was appropriately targeted to the poorest, most vulnerable geographic areas, and within these areas, to the most vulnerable segments of the population: children under five and mothers. The institutional and organizational framework was very sound. The placement of the CLM in the office of the prime minister reflected high commitment on the part of the government of Senegal to the program and provided the needed authority for coordinating a multisectoral approach. Implementation arrangements were extremely well thought out and highly appropriate, ensuring that the locus of the program was the community level, communities would be adequately supported by CEAs and local-level sector services, local governments

[34] International lessons were drawn from the World Bank's nutrition investments in Madagascar, Bangladesh, India, and other community-based multisectoral nutrition experiences.

would be increasingly involved and committed, results would be shared and discussed at every level of the program, and decision making and management would be transparent and results based. These arrangements have proven themselves and stood the test of time. Fiduciary aspects were well designed, including an assessment and strengthening of fiduciary capacity of all actors (including NGOs) to permit decentralized management. The monitoring and evaluation design was sound overall, with indicators measuring each link in the results chain. Nutrition outcome indicators established to track impact were not an appropriate measure of the project's capacity building objective but kept the program focused on medium-term results (see paragraph 2.54). Arrangements for its use of data for management and decision making were explicit and well developed. Potential risks were assessed and appropriate mitigation measures outlined. The World Bank's team had solid expertise in nutrition and communication. The APL instrument was an appropriate choice for the launch and scale up of this brand new 10-year program

2.49 Quality of supervision is rated **highly satisfactory.** The focus on development impact was very strong. World Bank missions and their aide-mémoire were highly focused—both in their content and in their process—on the PDO: to build a capable institutional and organizational framework for NEP implementation at every level of the system. The missions' close supervision and guidance ensured the successful implementation of the various components of the monitoring and evaluation system. The task team was also flexible and wise in allowing the national executive bureau the time needed for its own capacity building before rolling out interventions at the community level. Although this slightly delayed the launch of community-level activities, the strategy was well worth it because the rollout was smooth and efficient. Fiduciary aspects of the project were well supervised, with intensive oversight and support in the project's first year. Supervision inputs and processes were strong and well appreciated by the Borrower. Two supervisions per year, complemented by additional technical missions from Dakar-based staff, provided ample support. The transition of responsibility to a new task team leader (task team leader) at the start of implementation was smooth; and both task team leaders were seasoned nutrition experts. Both the World Bank's dialogue during these missions and subsequent report writing were candid and of high quality. Feedback from the client on the World Bank's performance was very strong and broad. Great appreciation was expressed for the quality of the team and its continued contributions to improved performance, both on the technical and implementation fronts. The government of Senegal' contribution to the ICR characterized the World Bank's support as "tremendous," and this was echoed throughout the PPAR mission, at all levels of the program.

BORROWER PERFORMANCE

2.50 Overall borrower performance is rated **highly satisfactory.**

2.51 Government performance is rated **highly satisfactory.** Its ownership and commitment to achieving the PDO was strong because the PDO was fully supportive of government of Senegal nutrition policy and objectives.[35] It provided an enabling environment for the

[35] Initially, there were some elements of government of Senegal who had misgivings about the transition from the food supplementation (CNP) approach to the community-based approach. But these faded as the program demonstrated its effectiveness.

project's success, as evidenced by its management structure placed in the prime minister's office; a generous counterpart provision, which exceeded its commitment; and a well-developed policy and explicit objectives, which have also been captured in its overarching development strategies. Under the oversight and guidance of the director of cabinet (in prime minister's office) the CLM convened regular meetings of representatives from all relevant sectors to support and nurture an increasingly multisectoral approach. The government of Senegal supported the decentralized, community-based structure, which left much flexibility and decision making to the local level and it supported the beneficiary assessments commissioned by the project. The government's actions to recruit very highly qualified experts to staff the CLM and the national and regional executive bureaus were pivotal to the success of project implementation and learning by doing. Transition arrangements were well embedded in the APL design.

2.52 The performance of the CLM, as implementing agency, is rated **highly satisfactory.** This assessment of the CLM includes its secretariat (the National Executive Bureau and its regional offices). The CLM has been and remains highly committed to achieving the PDOs, which are fully supportive of national policy. It both encouraged and facilitated beneficiary stakeholder consultations through: regular monitoring committee meetings held at every level of the program; and a monitoring and evaluation system that included studies to seek the beneficiary perspective. All key staff were highly qualified, well trained, and have stayed in their positions for a long institutional memory and accumulated experience. Some staff were drawn from the CNP and still remain with the program (some 10 years later) because of their high motivation to make a difference. There was a change in the CLM coordinator, but he was replaced with an equally qualified, well-performing leader and manager. Its fiduciary performance has been exemplary. The National Executive Bureau has successfully managed day-to-day project management, effectively handled the community subcontracts, and provided capacity strengthening for NGOs in financial management procedures. It was instrumental in clarifying institutional arrangements established between CLM and sector ministries and was successful in improving the collaboration between the NEP and the Ministry of Public Health. Systematically, during field trips for this evaluation, the CLM was recognized for its rigorous and transparent management style, grounded in a monitoring and evaluation system, which promotes the sharing of performance data and its use for decision making by stakeholders up and down the system. Over time, the CLM has established itself as the focal point for nutrition policy development and its good reputation has attracted more development partners to work through this institution. It was instrumental in involving other sector ministries in planning, managing and monitoring nutrition program activities. It held quarterly meetings to review progress and approve annual action plans and budgets, conducted regular supervision missions, and approved sector and community-based projects.

MONITORING AND EVALUATION

2.53 The quality of monitoring and evaluation is rated **substantial**.

2.54 **Monitoring and evaluation design**. The monitoring and evaluation design of this first phase of the APL laid out targets and indicators for the entire 10-year program and for each of the three individual phases. The 10-year indicators reflected objectives to improve the growth of children under age three, specifying targets for improved knowledge of caregivers, better nutrition outcomes, and the expected acceleration of child mortality, as an

effect. The first phase indicators (relevant to this project) specified targets for improved program coverage, improved knowledge of mothers and other caregivers, adoption of healthier behaviors (exclusive breastfeeding and increased use of prenatal care), and better nutrition outcomes (underweight and severe underweight prevalence among children under three years). Although ambitious for the project's short time frame and not a fair measure of the project's capacity building objectives, the nutrition outcome indicators were reflective of the program's ultimate intent. Moreover, the design included triggers for moving from the first to second phase, which included measures of capacity built (appendix D, table D.2).

2.55 The indicators were measurable and some baselines were available and documented in the PAD, largely drawn from DHS. Other baselines specific to intervention areas were established by KPC surveys and an impact evaluation. The program coverage targets (35 percent of the targeted population in the rural areas and 50 percent in the urban areas) might have been more specific in defining the denominator: population in the targeted regions, districts, or within these, communities directly receiving interventions. The numerator might also have been better specified: children under age three or five years, pregnant and lactating women, or mothers of children under age three or five years. An appropriate mix of data collection methods and analysis was proposed, including national anthropometric surveys, micronutrient prevalence survey, awareness and beneficiary assessments, DHS, performance assessments, routine project data and an impact evaluation.

2.56 The monitoring and evaluation design was well embedded institutionally and emphasized stakeholder ownership and use for the purposes of learning, accountability and decision making. The PAD specifies output and outcome indicators, monitoring and evaluation roles and responsibilities, and participatory events for the discussion and use of data for each level of the system: community, district, region, and central. Performance against the triggers, under the APL design, for transition to Phase II was to be assessed on the basis of results provided by this system and independent evaluation.

2.57 **Monitoring and evaluation implementation**. Monitoring and evaluation activities were implemented largely as planned. Routine collection and reporting of data started with the nutrition aides, who reported monthly trends in target populations attending growth monitoring and behavior change sessions and in healthy weight gains of children under age three years. These and other program data were reviewed and compiled by NGOs into district-level reports, then submitted to the regional offices for further compilation and analysis, and finally to the national level for programwide compilation and analysis. This routine reporting was supplemented by special surveys and studies, including beneficiary assessments, KPC surveys, and an impact evaluation. Although the results of the impact evaluation provide some insight, discussions with program staff confirm doubts raised by this evaluation that "control groups" really existed in Senegal when that evaluation was undertaken.[36] Both then (2006) and now, Senegal has numerous partners supporting a whole

[36] Indeed, the CLM and the task team leader have indicated that (1) the project did not operate in isolation: there was a lot of institutional communication around the new approach, which trickled to other actors, service providers and beneficiaries; and (2) the random selection could not be controlled at 100 percent due to local political economy issues. Moreover, the time allowed for impact (two years) was too short given that the age range of children for growth monitoring and promotion (0–36 months old). Not much influence could be expected among the "older" children and the enrollment or observation of

variety of maternal and child health and nutrition interventions. Results focus and transparency in the sharing and use of information were highly appreciated by respondents. A solid monitoring and evaluation plan was produced and implemented. Monthly, quarterly, and annual reporting on project implementation performance and on FM was timely and cited by World Bank for its quality.

2.58 **Monitoring and evaluation use**. There is strong evidence, already documented in this chapter, of the use of data for decision making. The initial selection of target districts, regions, and communities were based on poverty and malnutrition data. The satisfaction of triggers for moving from Phase I to Phase II were contingent on results and thus provided strong incentive to ensure monitoring and evaluation system operating satisfactorily. Throughout implementation, positive results from regular monitoring data provided important feedback, which encouraged communities, NGOs and government of Senegal to remain committed to the project. Moreover, cost-effectiveness data provided a basis for comparing various approaches developed by NGOs. The impact evaluation, as well as other program data, fed into the refinements of the Phase II design.

3. Nutrition Enhancement Project in Support of the Second Phase of the Nutrition Enhancement Program

Objectives, Design, and Relevance

PROJECT DEVELOPMENT OBJECTIVES

3.1 **Original PDO.** The financing agreement of December 5, 2006, states, "The objective of the Project is to improve nutritional conditions of vulnerable populations, in particular children under five years of age in poor urban and rural areas" (World Bank 2006a, 6).[37] Specifically, and as noted in the PAD, the program (with project support) aims to reduce underweight malnutrition in children under the age of five by 25 percent in the intervention areas by 2011.

3.2 **Revised PDO.** On additional financing, approved on March 29, 2012, the PDO was reworded. As reflected in the April 20, 2012, Financing Agreement, "The objective of the Project is to improve nutritional conditions of vulnerable populations, in particular children under five years of age in the Intervention Areas." The original and revised objectives statements are essentially the same: the revised objective merely clarifies that the "poor urban and rural areas" are the project intervention areas. Although most outcome indicators remained the same under this restructuring, outcome targets were increased, and a new

only newborns may have revealed the true effect of the project. The impact evaluation also confirmed that the impact was most significant among those under age one.

[37] The PAD (World Bank 2006b, 5) states essentially the same objective but also mentions expansion of access (to program services), "The second phase objective is to expand access to and enhance nutritional conditions of vulnerable populations, in particular those affecting growth of children under five in poor urban and rural areas." It also mentions that while "the first phase was meant to explore, learn and identify best practices on a limited scale," the second phase is "…dedicated to scaling up interventions and refining strategies and implementation capacity for the provision of appropriate, cost-effective nutrition services in collaboration with communities and local government."

outcome indicator and target were added to reflect additional activities aimed at anemia control. Itemized in table 3.1, these changes do not warrant a split rating methodology.[38]

3.3 The geographic scope of interventions to be supported under the project comprised (1) continued support of the intervention areas covered under the first phase (NEP I) and rural areas in an additional three regions.[39,40] Data-based targeting methodology and criteria and a multiple-tiered participatory process employed under Phase I (see paragraph 2.3) were also applied for this project.

Table 3.1. Key Performance Indicators for NEP II: Original and Revised

Original Targets and Indicators	*Revised Targets and Indicators*
• An increase in overall program coverage of children under age five in rural areas from 15 percent in 2006 to 40 percent in 2011	• **Target increased.** Target was raised to 62 percent, which was the level of progress achieved at the time of restructuring
• An increase in the prevalence of exclusive breastfeeding among 0–6 months old children by 30 percent	• **Target increased.** Target was raised to 65 percent in light of the achievement 63 percent at the time of restructuring
• The attainment of at least 40 percent of pregnant women and children under five years of age sleeping under insecticide-treated bed nets	• **Target increased**. Target was raised to 75 percent, in light of the achievement of 71 percent at the time of restructuring
• An increase in the number of people with access to a basic package of health, nutrition and population services from 265,073 to 709,124	• **Target increased**. Target was raised to 1.1 million, which was the level of progress achieved at the time of restructuring
	• **New outcome indicator.** An increase in the share of children aged 6–23 months receiving yearly a minimum of 90 micronutrient sprinkles sachets for three months in intervention areas from 0 to 30 percent

Sources: World Bank 2006b for original targets; World Bank 2012a for revised targets.

RELEVANCE OF OBJECTIVE

3.4 The relevance of the objective is rated **high.**[41]

3.5 First, it is highly responsive to country conditions, characterized by unacceptable rates of underweight among children under age five years and pregnant and lactating women,

[38] Strictly speaking, the logic of the split rating as outlined in the harmonized guidelines do apply. However, in this case, targets were revised upward, and both original and revised ones were met or exceeded. Therefore, for the sake of elegance and simplicity, this evaluation does not go through the mechanisms of a split.

[39] Urban areas: five *quartiers* in Dakar, one in Diourbel, four in Kaolack, and four in Ziguinchor. Rural areas in three regions: Kaolack, Fatick, and Kolda.

[40] This project thus continued support in the urban areas provided under the first phase and scaled up its coverage of rural areas, selected on the basis of their levels of poverty and malnutrition, to include 7 regions. At the time of project design and through the early years of implementation, there were 10 regions in Senegal.

[41] This rating is not split across original and revised objectives because the PDO did not change under the restructuring.

as well as stunting rates among children under age five years that were known at the time of project design.[42]

3.6 Second, it is highly responsive to Senegal's strategic priorities, whose 2006 PRSP identified a decrease in malnutrition as critical for achieving Millennium Development Goal 1, specifically halving the number of people who suffer from hunger between 1990 and 2015. Senegal's National Nutrition Policy was a clear articulation of the importance it placed on the fight against malnutrition, and the NEP was the vehicle for supporting and implementing those high-level policy goals. As such, the project builds seamlessly on the first phase of the APL.

3.7 Third, the objective is highly relevant to the World Bank's strategies for Senegal over the years. The 2003 CAS included a human development, shared growth pillar emphasizing access to social services, and enhanced opportunities for the poor and vulnerable. As is already noted in paragraph 2.7, the current CPS (2013–17) focuses on two pillars emphasizing inclusive growth and equitable social services delivery but does not include a nutrition follow-up operation or nutrition-specific targets or indicators. It does emphasize reducing food insecurity as part of its agriculture sector program. As discussed in paragraph 2.8, the objective is very relevant to the World Bank's HNP strategies.

PROJECT DESIGN

3.8 Although originally envisaged as the second of three phases of support under a 10-year APL, the PAD notes that this project would be the second and last phase.[43] The first project period of four years (2002-2006) and the projected five-year, implementation period of the second project (2007 to early 2012) would cover almost the entire original 10-year period. The PAD states that the second phase would bring best practices "to scale" but does not specify the APL's 10-year objective of achieving nationwide coverage. Follow-on support was expected to come from the national budget and other funding sources, and "possibly other more consolidated financing mechanisms from the World Bank," including budget support, community-driven development, and sector wide approaches .

3.9 **Components**. Box 3.1 presents (1) the components, as originally designed, built on the accomplishments and lessons from the first phase; and (2) changes made at the time of the additional financing and restructuring of March 2012.

RELEVANCE OF DESIGN

3.10 The relevance of design is rated **high**.

3.11 In keeping with the incremental approach of the APL, this project's PDO (aimed at improving nutritional conditions) is more ambitious than NEP I, which aimed to build capacity for implementing this newly established program. Still, it follows the same sound

[42] According to the 2000 Multiple Indicator Cluster Survey (MICS), 23 percent of children under five and 15 percent of women aged ages 15-49 years were underweight; and 19 percent of children under age five years were stunted (MICS 2000).

[43] As detailed in chapter 5, the World Bank cut back substantially on its initial financial commitment under the APL.

program logic as under the initial project: the delivery of cost-effective community-based nutrition interventions, supporting and nurturing both supply- and demand-side responses; the strategically prioritized and incremental involvement of key sectors for an increasingly synergistic and multisectoral approach to nutrition; continued strengthening of the ownership, involvement and leadership of local-level and community-based actors and stakeholders, both public sector and civil society; and a professional, transparent, participatory, evidence-based approach to management that supports and nurtures a learning-by-doing approach at every level of the system. All of these together are logically and plausibly and linked to expected changes in the knowledge of caregivers and in their behaviors and practices, culminating in improved nutritional status of women and children. Already deemed as highly relevant under the first phase, the results chain under this project's design was further improved based on experience and lessons learned under the first operation. It (1) placed stronger emphasis on the dissemination of information on dietary diversification, micronutrient supplements, fortified foods, and deworming medication; (2) added support for the intake of iron supplements by pregnant and postpartum women; and (3) included the referral of children at risk to health centers.

3.12 The 2012 additional financing added further refinements, making the program logic even stronger, particularly in terms of community-level screening, rehabilitation, and follow-up of acute malnutrition of children ages 6–59 months; expansion of multisectoral support to include public agencies responsible for agriculture and childhood development (in addition to Ministries of Health and Education); promotion of food security at community level through livestock development; household production of fruits and vegetables; and creation of village grain banks for food storage.

3.13 **Implementation arrangements.** Implementation arrangements built on the experience and lessons of NEP I. Roles and responsibilities remain the same for the most part: nutrition aides deliver community-based interventions; NGOs/CEAs guide, oversee, and report on community-level activities on a contractual basis; the Ministry of Public Health and Ministry of Education implement key interventions that fall within their mandates and are included in strategic work plans supported under the project; and the CLM assumes oversight responsibility, in keeping with its mandate to coordinate government of Senegal nutrition policy implementation through a multisectoral approach. There were refinements to implementation arrangements under this project. First, as envisioned from the start, the secretariat to the CLM, the national executive bureau and its regional offices have evolved from being more of a time-bound project management unit to a fully nationally owned structure, accountable to the CLM. Second, the CLM created a National Committee for Food Fortification to look into technical and operational aspects of food fortification with essential micronutrients. Third, and probably most significantly, in keeping with new responsibilities transferred to the local governments under the decentralization process, including nutrition, health, and education, the local governments were responsible for selecting a CEA (with regional executive bureau assistance) to which it will contract out community-based interventions; submitting a subproject proposal to CLM for funding; signing a contractual agreement with the national executive bureau after subproject approval; monitoring and reporting on activities; and incorporating nutrition activities and indicators in local development plans. Regional executive bureaus were to guide and support local governments to this end.

Box 3.1. Nutrition Enhancement Program Phase II Components: Original and Revised

Component 1. Community-based nutrition

- Promotion of community-based IMCI and monitoring of growth through
  - monthly growth monitoring of children under two, counseling feedback to mothers, home visits to children requiring special attention and cooking demonstrations;
  - promotion of infant and young child feeding practices, disease preventive measures, particularly malaria, by promotion of bed net use by children and pregnant women, home-based care, recognition of danger signs, and timely care-seeking for sick children; and
  - **added under additional financing**, community screening, nutritional rehabilitation, and follow-up of acute malnutrition of children ages 6–59 months.
- Promotion of micronutrient intake through
  - dissemination of information on dietary diversification, vitamin supplements, fortified foods such as iodized salt, and de-worming medication;
  - referral of children at risk to health centers; and
  - support for the intake of iron supplements by pregnant and post-partum women—**revised under additional financing** to include distribution of iron supplements and promotion of their use by **children under age five years** and pregnant and post-partum women.
- **Added under additional financing:** Promotion of food security at community level through
  - development of small livestock herds and backyard gardens for household fruits and vegetables; and
  - development of village grain banks for staple food storage for lean season.

Component 2. Multisectoral support for nutrition

- Support involves
  - updating and strengthening of the annual work plans of the Ministry of Public Health and Ministry of Education—**revised under additional financing** to add ministries responsible for agriculture and childhood development;
  - identification of areas of collaboration between the Ministry of Public Health and Ministry of Education—**revised under additional financing** to add ministries responsible for agriculture and childhood development, with an emphasis on strategic planning; updating of nutrition-relevant norms for the promotion of a strategy to fight anemia; health and education sector advocacy for nutrition; health and nutrition education; and delivery of essential health and nutrition services.
  - technical assistance or coordination with sector ministries for child growth at community level;
  - support to the HIV/AIDS and nutrition strategy.

Component 3. Implementation and monitoring and evaluation of the nutrition policy

- Support for implementation and monitoring and evaluation of the nutrition policy through
  - updating of the monitoring system and of community nutrition activities (and its tools) to include the role of **targeted** local government and sector ministries;
  - institutionalization of ad hoc studies, both quantitative and qualitative, regarding child growth, the hungry season, and client satisfaction within the monitoring system—**changed under additional financing** to children's nutritional status, household food security, and client satisfaction with the monitoring system; and
  - strengthening of the decision-making process by enhancing analytic capacity and accountability at local, district and central levels—**under additional financing**, this expanded to include carrying out of a household survey to strengthen the information base for monitoring and evaluation; and provision of goods required for the purpose.

Sources: World Bank 2006b for original components; World Bank 2012 a and b for revised.
Note: Planned versus actual costs by component are shown in appendix C.

Implementation

3.14 **Key dates**. The project was approved on November 13, 2006, and became effective on January 29, 2007. Funds were reallocated twice (June 2008 and December 2011). On March 1, 2012, the original closing date was extended from May 14, 2012, to June 14, 2013, and targets for indicators that had been achieved (or almost achieved) were revised upward. On March 29, 2012, the World Bank approved additional financing of SDR 6.5 million (US$10 million equivalent) to increase program coverage and intensity. On May 15, 2013, the closing date was extended by one year (from June 14, 2013, to June 14, 2014).

3.15 **Planned versus actual costs, financing and disbursements.**[44] The PAD estimated the total cost of the entire Phase II of the program (2007–11) to be $42.4 million equivalent, with 70 percent of the funds allocated to community-based nutrition (component 1). Within the program was the project, whose estimated cost at appraisal (US$15 million equivalent) was 100 percent World Bank–financed and allocated (as for the program) largely to community-based nutrition. Actual program costs were tracked by the CLM in CFA francs and presented in appendix C, table C.13. Actual project costs were US$25.3 million equivalent or 169 percent of the original estimate (World Bank 2014). This cost increase was entirely attributable to the additional financing secured in 2012. Both the original IDA allocation (SDR 10.1 million) and the additional financing (SDR 6.5 million) were fully disbursed. An amount of SDR 3.0 million was reallocated to the grants subprojects categories, because other partners were supporting some of the expenses in the other disbursement categories, especially: drugs, other commodities, technical assistance and training. Government financing of the program was $23.4 million equivalent, significantly more than the $16.3 million equivalent estimated at appraisal. Other partners contributing to program financing included Micronutrient Initiative, WFP, UNICEF, Spanish Cooperation, and Global Alliance for Improved Nutrition, whose annual contributions are shown in appendix C, table C.12.

FACTORS AFFECTING IMPLEMENTATION

3.16 **Outside the government's control.** A series of droughts and the global food price and financial crisis caused significant challenges to the population. Sharp increases in food prices in 2008 and 2009 had a direct and negative influence on access to food, especially for the poorest and most vulnerable. Given that Senegal imports 80 percent of its rice consumption, many were unable to afford their basic food needs. Moreover, inadequate rainfall undermined local food production. There was a full-on drought in 2010, and low, erratic rainfall during the two following years culminated in poor harvests for 2011 and 2012. All of these had their negative repercussions on the nutritional status of the poor and vulnerable, who were the target of the project.

3.17 **Within the government's control.** National elections in 2007 resulted in a brief, temporary reduction in ownership of the program at the highest levels of government. This resulted in the CLM being moved from the prime minister's office to a newly created Ministry of National Solidarity. Thanks to the advice and input provided by the project

[44] Detailed data are provided in appendix C, tables C.4, C.5, and C.6.

coordinator and the World Bank to the prime minister, the unit was subsequently reinstated at the prime minister's office. The increasingly precarious economic and budgetary situation of the country, linked with the global financial crisis, caused the government of Senegal not to provide the agreed counterpart funding for this program, in the initial years of Phase II.[45] This setback was, however, temporary, and the government of Senegal has continued to increase its allocations to the program (see paragraph 3.15). During the project period, administrative regions were redrawn and increased from 10 to 14 regions. The number of local collectivities also increased from 384 in 2005 to 552 in 2016. Health districts also increased from 52 in 2005, to 69 in 2008, to 76 currently. This made it difficult both to plan and measure coverage.

3.18 **Within the CLM's control.** Because of budget constraints (due to initially low counterpart funding from the government of Senegal and to the World Bank's reneging on its initial financial commitment to support three phases under the APL), the CLM was obliged to scale back the coverage and intensity of program interventions. Actual disbursements of IDA funds in the initial years were higher than estimates making up for temporary lack of government of Senegal counterpart funding (of the program). In response, CLM increasingly played a catalytic role in mobilizing resources from international development partners and in promoting more and better partnerships within the country (multisectoral and public-private). This was facilitated by the World Bank, which encouraged the coordination and collaboration of development partners around the NEP.

3.19 **Safeguards compliance**. No safeguards were triggered under this project.

3.20 **Fiduciary compliance**. As was the case for the first project, financial management was of high quality, thanks to a stable and capable staff. All audit reports were unqualified and submitted on time and accepted by the World Bank. There was a five-month delay in setting up a disbursement mechanism for new activities added under the additional financing, but this did not have a major effect on implementation. Procurement also continued to be satisfactory, as it had been under the first project, and the internal control system continued to perform well. One exception to the strong procurement performance was a delay of over a year for the procurement of sprinkles sachets, due to a complex procurement process among the CLM, UNICEF, and the World Bank. Once resolved, the distribution of the entire stock was undertaken in under three months.

Achievement of Objectives

3.21 Appendix D, table D.3, presents the baselines, targets, and actual achievements of all outcome and intermediate outcome indicators and all the sources of these data.

[45] Indeed, the government of Senegal did not provide the agreed counterpart funding for any of the World Bank's projects in the country for a period of time, due to its financial constraints.

OBJECTIVE 1

3.22 Objective 1 was to improve nutritional conditions of vulnerable populations, in particular children under five years of age in poor urban and rural areas or intervention areas.

3.23 The achievement of the PDO is rated **substantial**.

3.24 **Outputs or intermediate outcomes.** The project supported the continuation of activities launched under NEP I and the expansion of these activities into additional communities, located in all regions in the country. From a 2005 baseline of 924, by 2013 2,243 community nutrition sites were established.[46] The number of trained nutrition aides increased from 3,271 in 2006 to 4,922 in 2014. The project also provided essential program commodities, including micronutrient supplements, deworming medication, insecticide-treated bed nets, and other small materials (scales, pans for cooking demonstrations).

3.25 Community-based nutrition aides delivered a range of critical services to protect and promote the nutritional status of target populations in the intervention areas. Ninety percent of mothers of targeted children participated in monthly information and education sessions, surpassing the original target of 60 percent and fully achieving the revised target of 90 percent. A total of 272,796 children under age 24 months benefited from improved infant and young child feeding practices in the intervention areas, surpassing the (unchanged) target of 222,500. By the project's end in 2014, 91 percent of children ages 6–59 months in intervention areas (or about 1.5 million children) were screened on a quarterly basis for acute malnutrition, a new activity introduced under this project. This resulted in 19,799 children under age five years treated for moderate or severe acute malnutrition (according to the project monitoring system).

3.26 Ninety-five percent of children ages 6–59 months in intervention areas received high preventive doses of vitamin A twice yearly (according to lot quantity assurance sampling [LQAS] surveys), surpassing the original and revised targets. This translated into about 2.2 million children. By the project's end, 1.94 million children, or 89 percent, of the target population received deworming medication twice yearly, surpassing the original (then dropped) target of 80 percent (according to the project monitoring system). Forty percent of children ages 6–23 months received a minimum of 90 micronutrient sprinkles sachets for three months in intervention areas, exceeding the target. A total of 500,000 insecticide-treated bed nets were distributed to target populations in intervention areas to protect against malaria (which can cause anemia), meeting the target. Behavior change communications, disseminated by nutrition aides and health staff, encouraged knowledge and practices that would benefit both pregnant and lactating mothers and their children.[47] Moreover, new community-based activities to promote food and dietary diversification were supported with

[46] The number of nutrition sites has decreased somewhat in the ensuing years, due to financing constraints (see chapter 5).

[47] Areas covered: healthy pregnancies (husband's support, antenatal care, iron supplementation, danger signs), infant care (danger signs in newborn, postnatal care, early initiation of breastfeeding, exclusive breastfeeding until 6 months), infant and young child supplemental feeding and diet, and feeding the sick child.

the establishment of 1,321 backyard gardens and livestock projects, close to four times the target of 350 (according to the project monitoring system).

3.27 The health, education and agriculture sectors complemented the community-based interventions to contribute to the goal of improving nutrition status of vulnerable groups. The Ministry of Public Health developed a strategy for child growth promotion in children under two years of age and revised the anemia prevention and control strategy, both of which were subsequently adopted. The local-level health system (both district and post levels) carried out regular supervisions of nutrition aides, participating in the key nutrition events, guiding the technical aspects of the work and reinforcing critical messages. Moreover, local health services took on the management of severe acute cases of malnutrition, screened at the community level and referred to them, while moderate cases were managed at the community level, under the supervision of the health system. Thanks to interventions undertaken by the Ministry of Education (1) 99 percent of targeted children in primary schools receive weekly micronutrient supplements during the school year in the intervention areas, surpassing both the original (80 percent) and revised (90 percent) targets; (2) 80 percent of targeted children in primary school received deworming medication twice a year in the intervention areas, fully achieving the target; and (3) school vegetable gardens were established in 60 schools in 2013; one year later 850 schools had vegetable gardens.

3.28 In collaboration with the Ministry of Agriculture, 64 local governments in the eight districts most affected by chronic malnutrition were targeted to address resilience factors at the household and community level.[48] Backyard livestock and garden activities, backstopped by local agricultural extension workers and livestock experts, were put in place and successfully implemented with a view to reducing food insecurity of the most vulnerable families within those communities. A field visit to Mbar to observe firsthand the effects of a herd of goats provided to the poorest households was very revealing. In this very poor village, the villagers themselves decided which 10 households would benefit from three goats each. They also decided that when the goats multiplied they would be given to the next-poorest households in the village. The goats are well managed by the village and used only to benefit the mothers and children. They cannot be sold or slaughtered unless it is for supporting the costs of treating a sick child, feeding a child, registering births, or vaccinating children. The goats have served as household and village assets that have generated income and benefited the health of children. The local-level livestock agent visits often to vaccinate the goats, care for the sick ones, and strengthen the breed. Beneficiary feedback said this intervention reduced poverty, stimulated women to weigh their children, changed behaviors in feeding and caring for their children, stimulated the interest and involvement of men in preserving child well-being, and stimulated women to launch income-generation activities used to buy millet and establish grain storage for feeding children during drought periods.

3.29 Program interventions appear to have precipitated substantially healthier behaviors. The share of infants exclusively breastfed for the first six months increased from a national baseline of 34 percent (DHS 2005) to 65 percent among target groups in the intervention areas (LQAS surveys). This level surpassed the original target of 44 percent and fully

[48] Target districts (regions): Gossas (Fatick), Kongheul (Kaffrine), Koumpentoum (Tambacounda), Medina Yoro Foula (Kolda), Bambey (Diourbel), Ranerou (Matam), Linguere (Louga), and Podor (Saint-Louis).

achieved the revised target of 65 percent. National DHS data show a more-than-doubling of the share of mothers who initiate breastfeeding within an hour of the birth (from 23 percent in 2005 to 48 percent in 2010–11). Unfortunately, there are no trend data for the following years. By the project's end, 86 percent of pregnant women and children under age five years were sleeping under insecticide-treated bed nets in the intervention areas (LQAS surveys). There was also a substantial increase in the share of pregnant women making at least four prenatal care visits, from a baseline of 40 percent (DHS 2005 for all of Senegal) to 61 percent, surpassing both the initial target of 52 percent and the revised target of 56 percent. Nationwide breastfeeding peaked at 39 percent in 2010 and then declined to 33 percent in 2015 (DHS 2015). Despite advocacy and information, education, and communication, unsatisfactory levels nationwide persist because of the unavailability of mothers (whether working or sick), cultural beliefs/practices, and the mixing of breast milk with other liquids. According to the 2015 DHS, only 58 percent of children ages 6–9 months received food in complement to breast milk. Although the NEP maintains a strong focus on behavior change interventions for improved infant and young child feeding, its coverage is not yet sufficient to have made a significant impact countrywide. Corroborating the quantitative data, which reveal changes in child nutrition practices in the intervention areas, mothers interviewed during field visits were emphatic and consistent in noting that their younger children (those born after the start of the program) were much healthier and better nourished than their older children, who either were too old to have benefited from the program or whose benefit was having been rehabilitated after being screened for acute malnutrition. These mothers noted that their younger children would never reach the undernourished state that their older children suffered.

3.30 By the end of the project, coverage of children under age five years with community-based services in rural areas was at 73 percent, exceeding both the original (40 percent) and revised (62 percent) targets (according to the project monitoring system). This translates into about 1.6 million children under age five years reached by the project, including the regular weighing and growth promotion sessions for children under age two years and their mothers, who are counseled on feeding and care practices and more than a million children under age five years who are screened for acute malnutrition every month. In 2014, there were an estimated 2.2 million children under age five years in Senegal (appendix D, table D.6). Coverage of the program by local collectivity has substantially increased. In 2005, the program (97 of a total of 384) covered only 25 percent of the local collectivities. This increased to 72 percent (400 of 552) by 2015, then declined slightly in 2016 to 70 percent (385 of 552; appendix D, table D.7).[49] It is important to note that local collectivities "covered" by the program are not covered 100 percent. Rather, it means that certain communities, identified within the local collectivities as highly vulnerable, have nutrition sites, which deliver interventions. In addition, information gathered from a range of respondents and field visits has introduced some uncertainty about the real coverage of the program. Essentially, because of financial constraints, there are indications that the program has cut back on the range and intensity of its coverage, compared to the package of interventions implemented under Phase I. Villages with populations under 1,000 were slated

[49] This decline in coverage was due to the elimination from the program of local collectivities in the Dakar region as a result of financial constraints.

under Phase II of the NEP to receive less intensive (quarterly) interventions than villages with greater populations, which were to benefit from monthly interventions. Although no precise numbers were offered, it was noted that some of the nutrition sites were closed and that not all sites deliver the full range of interventions. Program staff expressed the concern that that growth monitoring and promotion activities may not be affordable to implement across the country. In short, there is a tension between the goals of increased coverage on the one hand, and enhanced quality and intensity of services on the other; and the desire to extend coverage as much as possible within the resource constraints is strong. Field visits and interviews also revealed that scaling back the intensity and range of interventions was considered critical for continuing the program, especially in anticipation of the end of the World Bank's financing.

3.31 The CLM has recognized that the measurement and tracking of program coverage needs to be both more precise and more systematic. Thus in 2014 it commissioned a massive survey of national and international partners supporting nutrition activities in the country.[50] The survey sought to assess the coverage of 25 specific nutrition interventions delivered by the program to various target groups (different age tranches of children; different subcategories of women: pregnant, reproductive age, lactating, mothers of young children; adolescents; care givers; grandmothers; households; communities; and health providers).[51] The response rate was high at 95 percent (50 of 52 partners). The survey results reveal low coverage, countrywide, of essential nutrition interventions (Appendix D, Table D-8). This explains why that, notwithstanding the project's coverage targets being surpassed in intervention areas, the nationwide coverage of certain target groups with certain key interventions is still modest. The CLM intends to repeat this survey periodically as a tool for prioritizing interventions, setting coverage targets by intervention and by target group and tracking progress more systematically.

3.32 **Outcomes**. In 2014, 83 percent of children under age two years participating in monthly growth promotion interventions showed adequate weight gain every month. This is a significant outcome, given the very high rate of participation in this program (90 percent of all target children in the intervention areas). This outcome continues post project: in 2015, 82 percent of all children weighed (or 1.5 million children) showed adequate weight gain. There are no data on the success rate of community-based rehabilitation of wasted children. But mothers or caregivers, nutrition aides, and other stakeholders interviewed during field trips spontaneously spoke of these services as saving the lives of children. High levels of anemia have not subsided with most recent DHS data available showing two-thirds of children and more than half of all women as anemic. During the project period, national prevalence of underweight in children under age five years (weight for age) fluctuated but culminated in a 13 percent decline: from 14.5 percent in 2005 to 12.6 percent in 2014.

[50] Some 50 partners responded to the surveys, including government ministries, research institutions, local and international NGOs, and bilateral and multilateral partners.

[51] Vitamin A supplementation; iron and folic acid supplementation; household fortification; screening for acute malnutrition and severe acute malnutrition and rehabilitation of these cases; deworming; growth monitoring and promotion; small-scale community fortification; exclusive breastfeeding; infant and young child feeding practices; development of family agriculture; food bio fortifiers; social protection; nutrition education; behavior change interventions; functional literacy; promotion of handwashing with soap; promotion of latrine use; treatment of drinking water; diarrhea treatment; treatment of upper respiratory infection; reproductive health; safe pregnancy, antenatal care; and IMCI.

Likewise, there were fluctuations and an overall decline in severe cases: from 3.9 to 2.2. However, 2015 levels have risen to slightly higher than the project baseline. Again, program coverage targets (and actuals) had to be curtailed when the World Bank cut back on the initial commitments made under the APL and so could not be expected to have a significant impact on nationwide trends.

3.33 **Attribution**. Various development partners and donor agencies provide support to parallel nutrition projects implemented by the same implementing agency, the CLM. These partner organizations include UNICEF, WFP, USAID, the Micronutrient Initiative/CIDA, the Spanish Millennium Development Goal Achievement Fund and the Global Alliance for Improved Nutrition. Since 2007 these partners participate in joint supervision missions, organized by the World Bank; since 2010 a nutrition donor support group has been set up; and since 2011, Senegal has joined the Scaling Up Nutrition movement, which calls for governments to provide institutional leadership for large-scale nutrition policies and programs and for the donor community to provide coordinated support. In addition, in response to the 2008 food and financial crisis, the World Bank mobilized US$8 million from the Global Food Price Crisis Response Program Multidonor Trust Fund and an additional US$10 million of canceled IDA resources to support an emergency operation, which aimed to channel these funds directly into the NEP for its continued expansion and into a pilot effort to provide cash transfers to highly vulnerable mothers to mitigate the effect of the food price crisis on the nutrition of children. The project, evaluated in Chapter 4, had an implementation period that fell fully within the period of NEP II, thus contributing to its outcomes. The efficacy of the project in the project intervention areas is certainly attributable to the World Bank's support—but not exclusively. There are a number of other national and international development partners working across the country, including in the project intervention areas, who have also likely contributed to these outcomes. The CLM's first-ever survey of all partners contributing to nutrition (cited above) is an effort to map all of the activities, interventions, and sources of support across the country. Its purpose is not only to inventory but also to assess and improve nutrition program coverage and effectiveness

Efficiency

3.34 Efficiency is rated **substantial.**

3.35 **Economic efficiency and cost-effectiveness**. The ICR undertook an economic analysis, which reveals high value for money. The economic analysis used a conservative scenario, showed high benefits-costs ratio (20:1), and a resulting net present value of around US$1 billion. Moreover, the project fully disbursed both credits and most intermediate outcome and outcome targets were surpassed, even after they were increased under the restructuring.

3.36 Technical efficiency was strong. Community-based service delivery of prevention and promotional activities supported under the project are among the most cost-effective for improving nutrition outcomes (notably stunting) and have some of the highest cost-benefit ratios in terms of poverty reduction and economic development. These activities built on the positive findings from the Phase I impact evaluation and on robust evidence on the effectiveness of community nutrition programs, as documented by the World Bank and other

leading institutions in the world.[52] Planned activities were identified to generate maximum impact based on the evidence.

3.37 Operational efficiency was also strong. The project had impressive control over planning cycle, in which activities, expenses and disbursements were fully linked and integrally managed. The original credit of US$15 million was fully disbursed by original closing date and the additional financing of US$10 million disbursed in just two years. The subsidiarity principle applied all throughout the implementation framework resulting in a lean management structure that kept management costs at less than 12 percent and overhead at just 3 percent of total budget expenditures. On two separate occasions, the CLM was awarded by the Ministry of Economy and Finance the Alpha prize for the best performing project management unit. No other implementing agency has this level of recognition.

Ratings

PROJECT OUTCOME

3.38 The project's outcome rating is **satisfactory**. The project's objective is highly responsive to country conditions, Senegal's strategic priorities, the World Bank's strategies for Senegal, and the World Bank's sectoral strategies. The relevance of design is high. Its results chain is well-articulated, plausible, and as strong as the one for the first project, with both the original and additional financing designs further refined based on emerging evidence and lessons. Efficacy is substantial. All outcome targets were surpassed, both the original and the revised ones. While none of the outcome indicators directly measured the objective of improved nutritional conditions, these outcome indicators do show strong performance (in the intervention areas) in the coverage of these cost-effective and proven services and in changes in key behaviors, which are strongly linked in the literature to improved nutritional status. Moreover, very high rates of children showing adequate weight gain and successful screening and rehabilitation of children with moderate and severe acute malnutrition also provide reassuring evidence that nutrition status was improved. Efficiency was fully substantial, with evidence of strong value for money and strong operational and implementation efficiency.

RISK TO DEVELOPMENT OUTCOME

3.39 The risk to development outcome is rated **significant**.

3.40 As was the case for the first phase project (see paragraphs 2.45–2.46), technical, social, government ownership and commitment and institutional risks are all assessed to be low for the same reasons initially discussed. Likewise, financial and natural disaster risks are still assessed to be substantial. However, more weight has been given to the significant financial risk at the end of this World Bank project, given the following: no follow-on project is currently under implementation, not all development partner support to nutrition is

[52] See World Bank 2006; *Scaling up Nutrition: What Does it Cost?* (2013); *The Lancet* Maternal and Child Nutrition Series, 2008. Moreover, the World's top economists placed these activities among the top 10 of any global development solution in two rounds of the Copenhagen Consensus, based on the latest cost-effectiveness evidence (2008; 2012).

channeled through the CLM and into the program, local government budgets have very limited capacity to absorb the costs of implementation, and there is a need to assess and address fair remuneration for the work of the nutrition aides, with some promising initiatives being explored. In the meantime, field visits, including direct exchanges with nutrition aides and the populations they serve, point to their strong sense of mission, the high respect and appreciation they receive from their villages and local authorities, and the satisfaction they receive from their results. This is further discussed in chapter 5.

WORLD BANK PERFORMANCE

3.41 Overall World Bank performance is rated **satisfactory.**

3.42 Quality at entry is rated **satisfactory.** Phase II built on lessons learned from Phase I, which showed that community-based communication can effect behavior change and a reduction in malnutrition, and that engagement with local governments supports local ownership and sustainability. The World Bank also ensured that the technical advice and recommendations emanating from the 2006 strategy, outlined in "Repositioning Nutrition as Central to Development," were reflected in project design, especially the importance of community-level interventions. The World Bank coordinated with other agencies and partners to share knowledge and improve implementation arrangements. It identified relevant risk factors during preparation, especially the risk of waning government of Senegal ownership following national elections in 2007. It was ultimately successful in supporting the CLM in stimulating high-level interest and ownership and financing of the NEP. But this took some time. The World Bank might have ensured that there would be more specificity and measures of the objective to improve nutrition conditions. At the time of project design, the World Bank's Country Management Unit made a decision not to honor the commitment of IDA funds to the second and third phases of the APL, made at outset of the three phases. It canceled the third phase of the World Bank's commitment, and though it did support the second phase, it did so with significantly less IDA funding than originally committed. As a consequence, the coverage targets of the program had to be scaled back. Although this was a setback for the NEP, the CLM was emphatic in conveying to the PPAR mission that the financial contribution was not the only valued contribution from the World Bank. Its technical advice and leadership were also highly valued; and ultimately the World Bank managed to attract and coordinate significant additional resources for the program.

3.43 Quality of supervision is rated **satisfactory.** During implementation, the task team was highly proactive in mobilizing resources to compensate for the World Bank's decision to provide less financing than originally committed under the APL. In 2009, the World Bank's team prepared, on an emergency basis, the Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project, which infused more resources into the NEP and supported the piloting of non-conditional cash transfers to poor, vulnerable mothers to mitigate worsening malnutrition brought about by the food price crisis. Moreover, in 2012, the World Bank's team succeeded in acquiring additional financing for the NEP. It also mobilized support through analytic work and technical assistance tasks, notably an Institutional Development Fund Grant approved in 2009 to strengthen operational evaluation in program implementation; and (currently under way) analytic work to assess program performance with a view to fine-tuning strategy and action for greater impact. Supervision

missions were carried out biannually, and were well staffed with qualified experts. Significant positive feedback was provided by actors and stakeholders at every level of the program about the quality of the technical work of the World Bank, the collegial nature of its collaboration with the CLM, and the strong support and advocacy that its missions brought to bear. The World Bank's focus on results was strong, with joint troubleshooting and problem-solving with a view to enhancing PDO achievement, in line with the comparative advantages of the various actors on the World Bank's and the government of Senegal sides. Thanks to its sound risk mitigation plan, the World Bank was able to reallocate 15 percent of the credit to ensure implementation of core project activities when government of Senegal was unable to make its planned counterpart contribution on time. Still, several project activities had to be scaled back. The World Bank's team worked closely with the CLM and government of Senegal to ensure release of government of Senegal funds.

3.44 Late in 2008, World Bank supervision reports raised the concern that the PDO may not be achieved because of the fast burn rate of IDA funding and the absence of counterpart funds. This candid report downgraded project performance ratings. The World Bank was proactive in improving collaboration and coordination of an increasing number of development partners with a view to reducing fragmentation of donor assistance. The World Bank mobilized development partners to conduct semiannual joint coordination and supervision missions of the NEP. Indeed, this served to enhance coordination in the early years of the project (2007–09). In 2010, a turnover of development partner staff stationed in Dakar, combined with a push (among some development partners) for humanitarian responses resulted in somewhat of a setback in donor coordination in the ensuing years.

BORROWER PERFORMANCE

3.45 Overall borrower performance is rated **satisfactory.**

3.46 Government performance is rated **satisfactory.** The government of Senegal was highly committed to project implementation. The only exception was immediately after the 2007 election when commitment changed, albeit briefly. At that point in time, the CLM was moved out of the prime minister's office and into the newly created Ministry of National Solidarity. Based on information provided to the prime minister by the project coordinator and the World Bank (task team and the Country Management Unit), the prime minister appreciated the strategic importance of keeping the CLM in his office and the decision was quickly overturned. Different levels of government collaborated closely with the World Bank, which had a positive impact on the decentralization of project implementation to the local governments. The government of Senegal's support was also evident in the strong and stable staffing of the CLM.

3.47 The CLM has successfully worked with at least seven prime ministers since its inception in 2001. All of them are reported to have all provided strong and unequivocal support to the nutrition policy and programs. Counterpart funding was temporarily withheld during the 2007–08 budget crisis, but this was not exclusive to the NEP. Rather, the budget crisis affected counterpart funding of the entire portfolio of World Bank-financed projects. Once the budget crisis was solved, the NEP, because of its outstanding performance, was first to receive the counterpart funding, including 100 percent of all arrear payments. And

government of Senegal financing of the program exceeded initial plans (see paragraph 3.15). The global Scaling Up Nutrition movement singled out Peru and Senegal as two model countries with strong government ownership. The Minister of Economy and Finance is highly appreciative and supportive of Senegal's NEP. During the World Bank's Spring Meetings, he gave a speech on the importance of investing in nutrition and on the success of Senegal's NEP. A Ministry of Economy and Finance official in charge of human development oversight, who met with the PPAR mission, stated that it was the best performing program in government. During project implementation, there has been a growing recognition and commitment, across an expanding range of sectoral actors, of the importance of the nutrition program to Senegal's economic development and poverty reduction prospects and of their roles and comparative advantages in contributing to NEP objectives. This was evident both in meetings with the various sector representatives and during field visits, where local-level sector agents are already contributing to the program and local government officials are increasingly recognizing, nurturing and supporting these critical inputs (see also the chapter 5 discussion on the multisectoral approach).

3.48 Implementing agency performance is rated **highly satisfactory.** The CLM (including the national executive bureau and its regional offices) continued the highly satisfactory performance it exhibited under the first project. The CLM had a clearly defined mandate, which it fulfilled very well. Its staff had well-specified roles for which they were fully qualified. Over and above their high qualification were their high level of commitment to the program and their long institutional memories.[53] The project became effective earlier than planned due to efficient preparation by the CLM and the World Bank. The CLM worked across sectors and built effective partnerships with Ministries of Education and Agriculture, as well as other sectors (in addition to the Ministry of Public Health). The CLM creatively overcame the monitoring and evaluation challenges related to striking health districts holding back data. The conduct of LQAS surveys, a Standardized Monitoring and Assessment of Relief and Transitions survey in 2012 (producing departmental-level data) and household surveys all served to fill this void and provide vital information on project performance, over and above program data reported from the intervention areas. Fiduciary performance continued to be exemplary (as under the first project). Indeed, CLM's financial management was often used as example for other projects to follow. The one exception to superlative performance was the procurement of sprinkles sachets (see paragraph 3.20). But the delay in procuring these sachets was mitigated with their very rapid and efficient distribution nationwide.

3.49 CLM, supported by the prime minister, proactively searched for additional resources to scale up interventions. It did so by building partnerships with local development partners and by participating at several international events on maternal newborn and child health at which they showcased their work. Additional financing was used to widen the intervention area, but it was not sufficient to include all districts. The Minister of Economy and Finance

[53] Changes in the CLM Coordinator were smoothly implemented because the Coordinator was replaced with an equally capable leader, who had been with the program from the outset. Most staff had been with the Program for many years, many for a decade or more and some recruited from the CNP. They spontaneously noted to the PPAR team that they had no intention of ever leaving the program because they believed so strongly in their mission and that they aspire to achieve even greater impact based on unfolding evidence and lessons.

awarded CLM with the Alpha prize for best performing program management unit on two separate occasions. The World Bank's internal reporting system continually pointed out CLM's mastery of planning, implementation oversight, and monitoring, which also earned the praise of other development partners and the government of Senegal. The CLM was successful in smoothly integrating new activities into its core program, including: bed net distribution, therapeutic care of acute malnutrition, social cash transfers, salt iodization and household food security, each of which became a success story by themselves. This is the mark of a well-established, well-performing program. The CLM pointed out, itself, another key management skill, corroborated by other evidence: its ability to adapt proactively to a rapidly changing environment (changes in financing, CLM's institutional home, country leadership, high-level government of Senegal ownership, exogenous factors, such as economic crisis, drought among others). The CLM has also been recognized for the evidence base and transparency of its management and its strong focus on results and learning. This was raised consistently throughout the PPAR mission, ranging from the highest levels of government to the local-level actors and stakeholders. The mission was overwhelmed with very positive feedback about the performance of the CLM.

MONITORING AND EVALUATION

3.50 The quality of monitoring and evaluation is rated **substantial.**

3.51 **Monitoring and evaluation design** included indicators (with baselines and targets) for key elements of the results chain: institutional development and stakeholder ownership and involvement (local governments incorporating nutrition objectives into their annual development plans); integration of nutrition into government of Senegal PRSP and Millennium Development Goal documents); adoption of enabling health sector policies and strategies; various measures of service coverage and use (by target group, type of intervention, geographic area); and resulting behavior change (exclusive breastfeeding, bed net use, prenatal visits). It did include indicators to track achievement of the PDO—improvements in the nutritional status of target groups (adequate weight gain of children under 2 years of age). But complementary indicators might have included measures of severe and moderate underweight among children under age five years; severe and moderate stunting among children under age five years; and women's health and nutritional status.[54]

3.52 The monitoring and evaluation system, already well established under the first project, was functioning well, as managed by the CLM and coordinated with CEAs, who collected and reported community-level program information. It was further refined to integrate with CEAs and health and education sector plans. Monitoring and evaluation activity was to rely on a multiplicity of complementary data sources: bottom-up program data, baseline and end line KPC surveys for each subproject and other studies of project impact.

3.53 **Implementation of monitoring and evaluation**. The monitoring and evaluation design, grounded in the well-established system under the first phase, was implemented

[54] The PAD mentions a *program* objective of reducing undernutrition by 25 percent in the intervention areas by 2011. But this is not included as a key outcome indicator for the project.

largely, as planned. But there were challenges. First, the tracking of coverage was complex, given that the number of administrative regions, local collectivities, and health districts changed over the life of the project. The monitoring of coverage by target group (children under age two years, children under age five years, mothers and caregivers among others) in intervention areas overcame this constraint somewhat. But the establishment of trends in geographic coverage is tricky.[55] Second, between 2010 and 2014, health districts had been holding back the reporting of critical data, motivated by a partial strike. To compensate for this lack of data, CLM commissioned LQAS surveys to provide additional quality monitoring information on indicators. These surveys also provided a cheaper, but good quality alternative to the KPCs.[56] In 2012, a good quality national SMART (Standardized Monitoring and Assessment of Relief and Transitions) survey was undertaken, the first to have data representative at the level of the Department. This survey focused on the underlying determinants of under-nutrition and provided the basis for the design of the additional financing.

3.54 Drawing on the above studies, the 2012 restructuring and additional financing documented the very strong performance of the project against the original outcome targets and raised those targets as a consequence. It also added a new outcome indicator to measure coverage of micronutrient sachets for children ages 6–23 months for anemia control. The adding and dropping of indicators and changes in targets are itemized in appendix D, table D. 3.

3.55 **Monitoring and evaluation use.** Results from various surveys informed decision making. Regular feedback to regional and local stakeholders encouraged adjustments in project implementation when necessary. Thanks to the already strong results-based management focus of the program, information generated by the monitoring and evaluation system was discussed and used at all levels of the program (community, local, regional, and central levels) to monitor progress and to make adjustments where progress was stalling. Project support missions to operational levels were organized around the findings of monitoring and evaluation systems, thus giving them a distinctly issues-oriented, problem-solving focus. As a result, stakeholders at all levels were fully informed of implementation progress and actively oriented around ways and means to further enhance program performance.

[55] Moreover, in recognition of this challenge, the CLM has since (after project closing) commissioned REACH to undertake a survey of all partners to assess coverage of key interventions across the country. REACH (Renewed Efforts Against Child Hunger and undernutrition) is a country-led approach to scale-up proven and effective interventions addressing child undernutrition through the partnership and coordinated actions of UN agencies, civil society, donors, and the private sector, under the leadership of national governments. REACH cofacilitates the UN network for Scaling-Up Nutrition (SUN) together with the UN Standing Committee on Nutrition.

[56] KPC surveys require large household sample sizes and are therefore expensive. LQAS require very small sample sizes and provide accurate information on categorical hypotheses. Since LQAS is implemented at the local level, aggregating data from multiple LQAS allows the calculation of KPC estimates on specific indicators.

4. Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project

Objectives, Design, and Relevance

PROJECT DEVELOPMENT OBJECTIVES

4.1 As stated in the financing agreement between Senegal and IDA of June 12, 2009, "The objective of the Project is to reduce the risk of nutrition insecurity of vulnerable populations, in particular children under five in poor rural and urban areas in the Recipient's territory, by scaling up the Recipient's Nutrition Enhancement Program and providing cash transfers to vulnerable mothers of children under five" (World Bank 2009a, 5).[57] The project paper also states that the overarching objective of government of Senegal's NEP is to contribute to the attainment of the first Millennium Development Goal of eradicating extreme poverty and hunger through implementation of the Nutrition Development Policy, aimed at improving the nutrition status of vulnerable groups, notably children and pregnant and lactating women (World Bank 2009c, 5). For the purposes of this evaluation, two objectives and results chains will be assessed: (1) to reduce the risk of nutrition insecurity of vulnerable populations by scaling up the NEP (community nutrition monitoring, promotion activities and other services leading to improved nutrition-related knowledge and behaviors) and (2) to reduce the risk of nutrition insecurity of vulnerable populations by providing cash transfers to vulnerable mothers of children under age five years , improving their ability to procure essential foods and other investments in their children's well-being.

Box 4.1. Key Performance Indicators for Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project

- An increase from 22 to 45 percent in the target population (children under age five years) reached by the NEP
- A 30 percent increase in share of mothers providing exclusive breastfeeding for the first six months
- Number of beneficiaries of the cash transfer program: 50,000
- Percentage of selected beneficiaries who receive all intended cash transfers: 80 percent

Source: World Bank 2009c.

4.2 **Geographic coverage and targeting.** The project infuses additional World Bank financing to support the nationwide expansion of the NEP and the intensification of program activities (scope and targeting described in paragraph 3.3). The new child-focused social cash transfer component applied three targeting mechanisms to reach intended beneficiaries: categorical targeting (limiting eligibility to mothers of children under five years of age); geographical targeting (based on the most up-to-date data on poverty, malnutrition, and household food security), culminating in the selection of 10 "critical districts" and community-based household targeting (assessing the presence of children under age five

[57] The financing agreement's PDO statement is consistent with the statement in World Bank 2009c.

years, inadequate food consumption, and limited possessions), with the involvement of community-level organizations.[58, 59]

RELEVANCE OF OBJECTIVES

4.3 The relevance of objectives is rated **high**.

4.4 First, the objectives are highly relevant to country conditions. Already high rates of malnutrition in Senegal increased further following a series of shocks to the economy, leading to a sharp rise in food prices and deteriorating living conditions. This especially affected the poorest and most vulnerable, whose food insecurity and nutritional risks were worsening under these conditions. Two years of inadequate rainfall (2006–07 and 2007–08) resulted in a 25 percent reduction in cereal production, whereas prices for imported cereals were rapidly rising due to the global food crisis.

4.5 Second, the objectives were highly relevant to Senegal's strategic priorities. Both Senegal's poverty reduction and social protection strategies highlight the goal of better nutritional outcomes. Moreover, Senegal's nutrition policy supports the goals of improved health and nutrition and reduced nutritional insecurity, which it seeks to achieve through the scaling up of its main implementation mechanism—the NEP. In addition, the project is highly relevant to government of Senegal's search for new ways and means to accelerate its essential poverty alleviation programs and to provide more effective and efficient safety nets to those most in need, especially during a time of food price crisis.

4.6 Third, the objectives are also highly relevant to the World Bank's strategies for Senegal, both (1) the 2007 CAS, which was in effect at the design of the project (whose second pillar aimed at "improving human development through better delivery of social services, notably to the most vulnerable groups" [World Bank 2007b]); and (2) the current 2013 CPS, which includes technical assistance for continued strengthening of nutrition policy and program implementation, as well as support for establishing an efficient safety net system, which was to be tested through pilot cash transfer programs (World Bank 2013a).

4.7 Fourth, the project is highly relevant to the World Bank's poverty alleviation mission and strongly supportive and reflective of its thematic strategies for health and nutrition and for social protection.

PROJECT DESIGN

4.8 The project was designed around four components, the first three aimed at scaling up and intensifying the package of NEP activities and the fourth being the new child-focused social cash transfer.

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[58] These districts are Bakel, Darou Mousty, Dianke Makha, Kidira, Louga, Goudiry, Goudoump, Guinguineo, Kebemer, and Matam

[59] The Local Selection Committeee of the Social Affairs Commission of local government; the CEA involved in NEP implementation; and the *Arronissement*-Level Monitoring Committee

Box 4.2. Rapid Response Child-Focused Social Cash Transfer and Nutrition Security

Component 1. Community-based nutrition: This component supported community-based nutrition activities to be carried out monthly in targeted communities with a population over 1,000 and quarterly in targeted communities with a population under 1,000. The following are key activities:

- **Growth monitoring and promotion of child health and nutrition:** (1) community-based growth promotion and integrated management of childhood illnesses sessions for children under age two years and for all children under age five years: improved infant and young child feeding practices, recognition of danger signs during illness and home-based care; (2) mobilization of extended caregivers to take part in social and behavior change communication, including grandmothers, in-laws, men and other relatives important for the survival of infants and young children; (3) screening of acute malnutrition and support for the management of identified cases at the community level; (4) training and supervision of nutrition aides.
- **Micronutrients provision and promotion:** (1) provision of iron and vitamin A supplements, deworming medication, and insecticide-treated bed nets along with behavior change communication and counseling addressed micronutrient needs of mothers and pregnant women, as well as children; (2) community-level communication activities to create demand for fortified foods (especially iodized salt), vitamin A, iron supplements, and dietary diversification.

Component 2. Sectoral support for nutrition results: This component aimed to support health and education sector efforts in agreed annual work plans to improve growth and nutrition. Activities included periodic distribution of micronutrient supplements and deworming medicines in schools; supervision of nutrition services; and scaling up of food fortification.

Component 3. Support to implementation and monitoring and evaluation of nutrition development policy: This component aimed to strengthen the implementation and monitoring performance of the CLM, local governments, and line ministries, with a particular focus on integrating the adapted the cash transfer program. Technical assistance, training and workshops supported continued promotion of ownership and accountability of stakeholders, especially local government.

Component 4. **Child-focused social cash transfers:** The cash transfer component was to use the NEP community organization structure to identify eligible beneficiaries (mothers of young children in vulnerable families), who would receive small bimonthly payments (in the amount of CFAF 14,000) for six months. For a total of CFAF 42,000) The cash transfer would be accompanied by a strong communication campaign emphasizing messages about maternal and child nutrition and close monitoring of process and effect. Beneficiaries were identified through geographical (most vulnerable districts), categorical (mothers of children under age five years), and community-based (most vulnerable households) targets, with oversight and verification provided by local selection and regional monitoring committees as well as the CEAs.

Sources: World Bank 2009a, 2009c.
Note: Planned versus actual costs by component are shown in appendix C, table C-7.

RELEVANCE OF DESIGN

4.9 The relevance of design is rated **high**.

4.10 The project design in support of the first objective (to reduce nutrition insecurity through the scaling up of the NEP) is strong. As laid out in paragraphs 3.11–3.12, the underlying logic of the NEP is strong. It comprises cost-effective, well-targeted, community-based interventions, commodities and services, which are directly supportive of improvements in knowledge and behaviors, which, in turn, are expected to culminate in improved nutritional status. The design promotes key activities, ownership, and accountability for nutrition results of key sectors, including health (provision of maternal and child health and nutrition services and supervision of community activities), education (provision of micronutrients and deworming activities in schools) and food fortification (with iodine, iron, and vitamin A), among other sectors. The involvement of communities, local government and a range of other sectors, combined with a monitoring and evaluation system

that is used at each level of the system, enhances awareness and monitoring of nutrition efforts by communities and all levels of government.

4.11 The project design in support of the second objective (to reduce nutrition insecurity by enhancing the food-buying power of mothers with cash transfers) is also strong. It targeted the most vulnerable families with children under the age of five years in 10 high-poverty districts with high levels of malnutrition as a means of increasing household consumption. The cash transfers were unconditional, based on the evidence of international studies, which show that additional cash provided to female household members is spent on family welfare, especially the well-being of the children. Its pilot design sought to test and refine a feasible and replicable instrument that could effectively mitigate adverse effects of shocks on populations most in need, and it relies on a delivery system (the NEP), which has been proven.

4.12 **Implementation arrangements**. Implementation arrangements for the first three components were the same as for the World Bank's second phase support to NEP (see paragraph 3.13). In summary, the CLM, through its secretariat (the national executive bureau and its regional offices), is responsible for coordinating and supervising the various implementing actors: line ministries, local governments, CEAs, decentralized public services, communities, and nutrition aides. Sector ministries formulate policies, norms, and protocols; undertake quality assurance; and implement discrete activities agreed in work programs. On behalf of the local governments, responsible for program design and implementation at the local level, CEAs (selected and contracted by local government) assume primary responsibility for subgrant proposals, implementation, oversight, and financial management. To this end, a grant agreement is cosigned by CEAs and local government under which CEAs report to local authorities and the health district. Communities choose nutrition aides, determine sites for program activities, and establish committees to oversee those activities. CEAs, in collaboration with health service providers and local authorities, provide technical support to communities.

4.13 The cash transfer component was to rely on the NEP structures and processes for its implementation, including the overall coordination and oversight of the CLM. In non-NEP areas, the same cash transfer mechanisms were to be used, accompanied by nutrition communication activities, but without the monthly NEP activities. The first set of beneficiary communities were to be deliberately selected from areas where community-level interventions had been implemented for at least six months. Over time, other communities where NEP was not operating would also be selected. Cash transfers to families in these communities would be accompanied by nutrition communication activities. The two implementation models were to be assessed and compared. The distribution of funds was contracted out to a financial institution with local outlets as close to the beneficiaries as possible. In the interest of transparency, whistleblowers were to be set up at different stages of the process, particularly targeting and payment, and the eligibility criteria and list of selected beneficiaries were to be publicly disclosed.

Implementation

4.14 **Key dates**. The IDA credit was approved on May 6, 2009, became effective on September 11, 2009, and closed on August 31, 2012. The original closing date (December 31, 2011) was extended because of implementation delays in the cash transfer program due to the absence of payment outlets in remote areas and the consequent need to develop ad hoc distribution arrangements.

4.15 **Planned versus actual costs, financing, and disbursements.**[60] The actual cost of the project was calculated at US$18.2 million at the time of project completion, or 101 percent of the original estimate of US$18.0 million (World Bank 2013b). Because there was no government counterpart planned or provided for in this particular project, the total estimated cost of the project (US$18.0 million) was equal to the total estimated financing, which comprised an IDA credit of US$10 million equivalent and a multidonor trust fund of US$8 million equivalent. Actual financing data, retrieved from the World Bank's information system in October 2016, reveals total financing of US$18.5 million, of which US$10.6 equivalent was provided by the IDA credit and US$7.9 million was provided by the multidonor trust fund. The difference between the actual cost of the project and its actual financing in US$ equivalents is likely a function of different calculations of the exchange rate.[61]

4.16 Both the IDA credit and the multidonor trust fund were fully disbursed, according to World Bank system data. There was a reallocation of the IDA credit proceeds in December 2011, which increased allocations for sub grants for community nutrition activities and reduced the allocations in the two other categories (commodities, consulting fees, training, audits; and operating costs). This reallocation was in response to contributions by development partners, which covered some of the costs under these two categories and thus liberated funds for subproject financing (World Bank 2011).

FACTORS AFFECTING IMPLEMENTATION

4.17 **Within the government's control.** PRSPs for 2002 and 2007 highlighted the development of a national social protection strategy as an integral step for the country's development and poverty alleviation goals. This provided an enabling environment for the piloting of the cash transfer scheme. Also enabling the success of this project, and within control of the CLM, were: a well-established intersectoral, community-based platform for the delivery of services; the strong commitment and participation of a range of actors at every level of the system; a transparent, trustworthy management style; and an evidence-based approach.

4.18 **Safeguards compliance**. No safeguards were triggered under this project.

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[60] Detailed data are provided in appendix C, tables C.7, C.8, C.9 and C.10.

[61] The IDA credit amount is designated in SDRs, and the multidonor trust fund is designated in a number of different currencies provided by its various contributors.

4.19 **Fiduciary compliance**. Fiduciary compliance was rated **satisfactory** throughout the project period. Annual audit reports were submitted on time with unqualified audit opinions and were acceptable to IDA. The procurement plan was in place at the beginning of the project. Implementation was **satisfactory,** and the internal control system performed well.

Achievement of Objectives

4.20 Appendix D, table D.4 presents the baselines, targets, and actual achievements of all outcome and intermediate outcome indicators and all the sources of these data.

OBJECTIVE 1

4.21 Objective 1 was to reduce the risk of nutrition insecurity of vulnerable populations, in particular children under age five years, in poor rural and urban areas, by scaling up the NEP.

4.22 The achievement of objective 1 is rated **substantial**.

4.23 **Outputs.** Project support was largely channeled through the negotiation and award of subgrants for community nutrition interventions, focused on mobilizing and supporting new health districts with high malnutrition rates and on increasing coverage in districts already mobilized. Project support also included the contracting and training of CEAs, who animated and oversaw implementation on behalf of local governments. Intensity of interventions was tailored to the size of communities, with those with over 1,000 inhabitants having monthly activities and those with populations under 1,000 having quarterly activities. Activities supported under subprojects included: community-based growth promotion, health, and nutrition education; provision of essential micronutrients and other commodities and related behavior change interventions; outreach to caregivers in addition to mothers (grandmothers, in-laws among others); screening of acute malnutrition and education on community management of moderate cases, with severe cases referred to the health post; and training and supervision of nutrition aides by the Ministry of Public Health.

4.24 **Intermediate outcomes and outcomes**. The program was successfully scaled up in terms of both its overall coverage of the main target group and of the expansion of the menu of interventions delivered. From a baseline of 22 percent, program coverage of children under age five years increased to 65 percent, exceeding the target of 45 percent. This translated into 1.34 million children, of whom 453,997 were urban and 886,878 were rural (according to the project monitoring system). Moreover, as the program gained a strong reputation and increasingly involved local government in implementation, monitoring, and evaluation, local-level ownership and leadership continued to grow. Thirty percent of local governments incorporated nutrition objectives and interventions in their local development plans at the end of the project, surpassing the target of 25 percent, and this level has been maintained each year thereafter (2013–2015; according to the CLM project monitoring system).

4.25 With project support key, proven nutrition and child well-being services were delivered to vulnerable populations and their use was high. Growth promotion and monitoring activities covered close to 90 percent of children ages 0–24 months. A very high 95 percent of mothers of children under age five years participated in monthly information

and education sessions, or a total of 1.73 million mothers (according to the project monitoring system). This exceeded the project target of 80 percent (1.5 million mothers) and encompassed both the newer, harder-to-reach areas as well as more established NEP communities. The share of children ages 6–59 months receiving vitamin A supplementation was 94 percent in 2012, surpassing the target of maintaining a level of 80 percent. This high level was continued post-project: 96 percent in 2013, 95 percent in 2014, and 95 percent in 2015. Although there were no end-of-project data for the share of children ages 12–59 months receiving deworming medication twice annually, program data show high coverage post project: 89 percent in 2014; 86 percent in 2015. Under this project, a new intervention—the quarterly screening of children under age five years for acute malnutrition and their rehabilitation at the community level—was introduced. By the project's end, 90 percent of children were screened on a quarterly basis, surpassing the target of 80 percent.

4.26 Multisectoral interventions improved the supply of, and access to, micronutrient supplements, other essential medication, and fortified foods. Ministry of Education interventions culminated in 95 percent of children in primary schools receiving weekly micronutrients supplements and 95 percent receiving deworming medication twice annually. These levels surpassed the target of 80 percent and translate into about 300,000 school children reached. Through support to the private sector, small producers adequately iodized 73,300 tons of salt, falling below both the 87,000 baseline and the 139,000 target. This was due to seasonal shocks and a six-fold increase in the price of the fortifier. Since the project has closed, there has been a trend of improvement, although still short of the target, with 89,209 tons adequately iodized in 2014 and 112,022 in 2015 (CLM 2012c, 2013, 2014). With project support, an increasing quantity of oil was fortified with vitamin A by the oil industry: at the end of the project, 107,178 liters were fortified, surpassing the target of 80,000 liters.[62] Under this public-private partnership, the government of Senegal bought oil from local producers, which was subsequently fortified by the oil industry. This reduced the amount of unfortified oil that would be sold to the population. In 2014, 124,465 liters of oil were fortified. The quantity of iron-enriched flour produced by local industry was 164,710 tons in 2015, surpassing the project target for 2011.

4.27 Critical behaviors changed in the intervention areas, particularly the share of mothers practicing exclusive breastfeeding of children up to age six months, which exceeded the project target. But these have not yet translated into substantial changes at the national level. Baseline and end line LQAS surveys show an increase in the share of mothers exclusively breastfeeding their children under age six months from 34 percent to 62 percent over the project period, surpassing the target of 44 percent. However, available data show very little change at the national level: 34.1 percent in 2005, 39.0 percent in 2010–11, 37.5 in 2012–13, and 33 percent in 2014. The share of pregnant women making at least four prenatal care visits rose from a baseline of 39 percent (national level DHS data from 2005; USAID 2006) to 51 percent (end-of-project LQAS), achieving the 30 percent target increase. Intervention-level areas show slightly higher levels than national DHS data for 2014 (48 percent) and 2015 (47 percent). Field visits benefited from discussions with mothers or clients of the community-based program. They noted that the program informed them and incited them to

[62] The end-of-project, full-year production estimate is made up of production data from the fourth quarter of 2011 and the first three quarters of 2012.

adopt improved infant and child feeding practices. And they asserted that their younger children would never reach the level of malnutrition of their older children, some having been screened for acute malnutrition and rehabilitated by the program.

4.28 Child outcomes were good. Eighty-one percent of children under age two years were showing adequate weight gain, exceeding the target of 75 percent. This already high level continued to improve: 82 percent in 2012, 83 percent in 2013, 83 percent in 2014, and 84 percent in 2015. In 2012, the CLM conducted a national anthropometric survey using the SMART (Standardized Monitoring and Assessment of Relief and Transitions) methodology, which showed that stunting levels had been further reduced, measuring at 16 percent in 2012. This is the lowest rate of stunting seen in Sub-Saharan Africa. Although national trends are positive overall, progress nationwide is slower than progress in the intervention areas (see appendix D, figures D.1, D.2, and D.3).

OBJECTIVE 2

4.29 Objective 2 was to reduce the risk of nutrition insecurity of vulnerable populations, in particular children under age five years in poor rural and urban areas, by providing cash transfers to vulnerable mothers of children in that age group.

4.30 The achievement of objective 2 is rated **high**.

4.31 **Outputs**. The cash transfer pilot was successfully set up and implemented. Local payment service providers with strong local presence were contracted to deliver the payments to beneficiaries in the target districts. In difficult to reach areas, mobile units were created to extend their reach. The project also invested in the design and delivery of an elaborate communication strategy, linked with the cash transfers, comprised of: large community meetings with discussions, drama and songs; group education; orientation and decision meetings with local authorities; and counseling and other forms of inter-personal communication.

4.32 **Intermediate outcomes and outcomes**. The targeting process was effective, more beneficiaries than planned were reached, and they virtually all received intended benefits. Only 2.5 percent of selected beneficiaries did not meet eligibility criteria (inclusion error), far below the project target of 20 percent. This is a significant indicator of the very appropriate design, verification, and implementation of the targeting mechanism.[63] By the second year of implementation, all transfers were made by local payment service providers. Both the social cash transfer to mothers of vulnerable children and the community targeting system have been adopted by Government. The number of beneficiaries (mothers of children under five) receiving the cash transfers was 54,512 (CLM project monitoring system, 2012 data), exceeding the target of 50,000. The transfers are estimated to have benefited at least 300,000 people, including those living in the households of the direct beneficiaries. Virtually all beneficiaries (96 percent) received all intended cash transfers. This is substantially higher than the 80 percent target.

[63] A combination of geographic, categorical, and community-based targeting was used. The CLM has undertaken a detailed analysis of the targeting mechanism applied under the project and it's very positive results, which were instrumental in government of Senegal's adoption of the case transfer scheme.

4.33 The beneficiary assessment documented good use of the funds (CLM 2012a). Over three-quarters (77 percent) of mothers spent some of the cash on their child (ren) under age five years, and 22 percent spent the cash exclusively on the child. Six percent spent part of the funds on an income-generation activity. In order of frequency, the type of expenses covered by the transfer included: food (99 percent); clothes for the child (77 percent); health care and medicines (70 percent); shoes for the child (66 percent); and donation of a part of the transfer to another person (27 percent). This validates the project's assumption (based on evidence) that unconditional cash transfers culminated in appropriate use of the funds.

4.34 The impact evaluation revealed that the cash transfers had a positive effect on the nutrition and well-being of children in targeted households (Institut Fondamental d'Afrique Noir n.d.). The share of households in which children received at least four meals or snacks per day increased from 26 to 54 percent of beneficiary households, compared to a smaller increase in control groups (from 21 to 37 percent). General food insecurity remained largely unchanged (31 percent before and after intervention) for beneficiary households, compared to worsening food insecurity (from 35 to 42 percent) in control areas. Health benefits in beneficiary households were also noted, compared to control areas: cases of diarrhea cases decreased, while the likelihood of the child having a vaccination card and receiving regular vaccinations were slightly higher. The impact evaluation points to a significant increase (from 36 percent to 60 percent) in women participating in nutrition information and education sessions after they receive cash transfers, with no such increase in control areas. The beneficiary assessment revealed good use of the funds.

Efficiency

4.35 Efficiency is rated **substantial.**

4.36 **Economic efficiency and cost-effectiveness**. For the community nutrition component, efficiency discussions for NEP II from chapter 3 apply, which highlight the low annual cost per child of approximately US$5. This section thus focuses on the new cash transfer component. Although neither the Emergency Project Paper (World Bank 2009c) nor the ICR (World Bank 2013b) included an economic or financial analysis, the project design did contain features that enhanced its efficiency.

4.37 **Operational and implementation efficiency**. Only 2.5 percent of selected beneficiaries did not meet eligibility criteria (inclusion errors), versus the 20 percent target. Technical efficiency was high. The project included some of the most cost-effective nutrition interventions (household and community-focused behavior change communications, screening, simple treatment protocols). Project management for the NEP elements drew on existing national structures and well-established partnerships at the local level. The management structure for the cash transfer was kept purposefully light, amounting to only 3 percent of total project costs.

Ratings

PROJECT OUTCOME

4.38 The outcome rating is **highly satisfactory**. The relevance of objective is high, with the PDO well focused on addressing immediate issues, as well as building resilience for the future. Relevance of design is also high, as the interventions and approaches drew on best practices, as well as lessons learned from program experience. The first objective was substantially achieved, with NEP reaching some 65 percent of the target population. The second objective was highly achieved, with the cash transfers reaching 96 percent of beneficiaries with all intended payments with very low inclusion errors. Moreover, the funds were indeed used for investments in child nutrition and protection with positive effects on children's health and well-being. The efficacy of this second objective is heavily weighted because this was the main thrust of this emergency operation. Efficiency was substantial. The project took advantage of existing institutions and focused on simplicity in building new ones, and interventions were cost-effective.

RISK TO DEVELOPMENT OUTCOME

4.39 The risk to development outcome is **significant.**

4.40 For the community nutrition component, the assessment of risk to development outcome for NEP II (see paragraph 3.40) applies, since this component's time frame falls within that project's time frame. The pilot cash transfer has proven to be an effective low-cost means of adding to the government of Senegal's instruments for mitigating future economic risks in the face of economic crisis. It remains to be seen whether it actually will become a permanent safety net instrument and how affordable it really is. Support of NEP continues with government of Senegal and donor funding. The CLM continues to play its critical role in the coordination of nutrition policy and increasingly serves as the entry point for nutrition policy dialogue with development partners, thanks to its strong technical and organizational capacity. The World Bank continues its policy dialogue on health, nutrition, and social safety nets with the government of Senegal in general (and the CLM in particular) through its portfolio of technical assistance, analytic work, and projects (planned and ongoing).

4.41 Social protection programs are high on the policy agenda, and budgetary allocations have been made to continue safety net operations. In addition, the World Bank continues to provide IDA financing to social protection policy implementation. The CLM's analysis of the importance of targeting mechanisms and distillation of other lessons is being used to adjust and guide safety net programs. A major challenge is the coordination of a large number of public institutions, many with limited or no capacity to manage safety net or cash transfer schemes. The government of Senegal's plans for a third phase of NEP will position the CLM at the center of a new partnership for nutrition development and further strengthen its role in coordination and policy oversight.

WORLD BANK PERFORMANCE

4.42 Overall World Bank performance is rated **satisfactory**.

4.43 Quality at entry is rated **satisfactory.** The World Bank deserves credit for pulling together an emergency operation to address nutrition insecurity in Senegal, especially given the underfinancing of the APL. The project focused on child welfare, and in particular, responded to nutritional risks that children were facing as a result of domestic climate shocks and the global food crisis. It included a fast track response, benefiting from Operational Policy 8.0. A pre-project survey informed the selection of districts to target for scaling up, and community-level screening of children was undertaken before project effectiveness. Design built on and expanded the successful NEP, which was already performing to international standards in achieving healthy child measurements. Design of the cash transfer mechanism was able to draw on extensive local field-level knowledge from the NEP experience to identify risks and incorporate mitigating measures into the design of the cash transfer. A strong project monitoring system already existed for the NEP, which allowed a mix of monitoring data and independent evaluation studies to measure results. The project was to be implemented by the CLM, which was already implementing the NEP. With the introduction of the cash transfer, emphasis was placed on adequate reporting, flow of funds, and auditing processes for this component. There was a slight delay at the level of the World Bank's loan department in setting up and activating the trust fund that was to be disbursed prior to the IDA funds. This minor shortcoming delayed the start of implementation.

4.44 Quality of supervision is rated **highly satisfactory.** The supervision process was characterized by close collaboration between the CLM and the World Bank team. The World Bank provided technical assistance and encouraged the CLM to develop its own solutions to implementation challenges. During implementation, the local payment service provider for the cash transfer did not have sufficient coverage in all target areas. This did delay implementation and required a project extension of some eight months, but the delay was an investment in an operation that was prepared as an emergency intervention and was still seeking to pilot test a major intervention. Success in extending the reach of the program to the most remote populations serves to demonstrate the viability and reach of the program. The World Bank's internal reporting system and aide-mémoires document broad consultation with stakeholders and were focused on learning and results.

BORROWER PERFORMANCE

4.45 Overall borrower performance is rated **Satisfactory**.

4.46 Government performance is rated **satisfactory.** The government was and remains committed to the PDO. Child nutrition has been a major priority for over a decade, and this is reflected in government of Senegal's poverty and social strategies. It has developed and maintained the NEP—an innovative community-focused mechanism—to pursue this objective. The NEP involves a broad segment of public and private stakeholders at the national and subnational level and is supported by donors. During project preparation and implementation, the government of Senegal provided continuous support through the prime minister's office. As documented in paragraphs 3.46 and 3.47, the highest levels of government, a wide range of relevant sectors, and local governments are all very committed to NEP's success and increasingly involved in its implementation. Striking health workers retained data as a means of protest during 2010–13.

4.47 Implementing agency performance is rated **highly satisfactory.** This project's time frame falls within the (longer) time frame of NEP II, so the highly satisfactory performance of the CLM, described in paragraphs 3.48–3.49, also applies here. The CLM also performed very well on the new social cash transfer component. It was instrumental in finding workable mechanisms for the cash transfer payment system. Selection of the local payment service provider to manage the distribution of the cash transfers was well implemented and monitored very closely during implementation. When it took longer than the agreed 15 days for the local payment service provider to check the transfer balance and submit the report of a completed region, the CLM formed a team to assist in the verification process to submit the transfer balance and report in a timely manner.

MONITORING AND EVALUATION

4.48 The quality of monitoring and evaluation is rated **substantial.**

4.49 Monitoring and evaluation design was grounded in the already well-established monitoring and evaluation system for the NEP. In keeping with the sound design of NEP (ongoing at the same time as this operation) and the NEP program objectives, outcome indicators appropriately sought to track increased coverage of the program (percent of children under age five years reached by the nutrition program) and behavior change (an increase in exclusive breastfeeding). As well, project intermediate outcome indicators were also consistent with those already tracked by the NEP (and under the World Bank's second-phase operation): service delivery indicators, weight gains of children under age two years, crucial behavior changes, food fortification measures, and local government involvement. Baselines and targets were specified. One shortcoming was the lack of specificity of the coverage indicator.[64]

4.50 New indicators added for the cash transfer component were also appropriate, monitoring both process and programmatic outcomes: the number of beneficiaries, any errors of inclusion, the extent to which they received benefits, the degree to which payments were made by local-level entities, and the development and adoption by government of Senegal of a social cash transfer scheme as a part of its social protection strategy. The already established monitoring and evaluation system and processes will ensure the transparency, availability, and discussion of performance data at every level of the system to support and nurture learning by doing. Two types of evaluation of the cash transfer pilot were envisaged: a process evaluation focused on the delivery system, beneficiary satisfaction, service use, validity of targeting and effectiveness of communication; and an impact evaluation, focussed on positive externalities of the project, such as household food and iodized salt consumption, birth registration, prenatal care, and immunizations. Baseline and six-monthly LQAS surveys were also envisaged.

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[64] The outcome indicator tracks the share of the target population (children under age five years) reached by the community nutrition program (baseline: 22 percent; target: 65 percent). However, different interventions targeted different age groups, and (because of underfinancing) villages with populations under 1,000 would benefit from fewer interventions, delivered less frequently, than those for villages with populations greater than 1,000. Moreover, the program sought to expand interventions to harder-to-reach populations as well as to intensify activities where the program was already intervening. More precision in measuring these various types of program expansion and coverage would have brought more clarification and certainty.

4.51 **Implementation of monitoring and evaluation.** Thanks to the well-established monitoring and evaluation system for NEP, data was collected on a monthly basis permitting the close monitoring of community-level activities, service quality, outcome indicators and costs. The system also integrates the tracking of progress of health and education sectors against their agreed plans. Data quality is good and reports have been completed on time. This good implementation performance is due in significant part to the roles of the CEAs in closely monitoring activities; the strong demand of stakeholders at all levels of the system, who were accustomed to and highly interested in tracking performance in their respective catchment areas; and the technical support and managerial capacity of the CLM (including the National Executive Bureau and its regional offices), whose management was strongly grounded in the evidence and emphasized continued learning. The CLM creatively overcame the monitoring and evaluation challenges related to striking health districts holding back data (see paragraph 3.48). New tools were integrated into the monitoring and evaluation system to monitor the cash transfers and proved to be effective in tracking performance. A number of evaluation studies were implemented to exploit the experience and lessons of the cash transfer pilot: an impact evaluation (comparing baseline and endline data) in randomly selected intervention areas and control areas; a process evaluation, which assessed the effectiveness of cash delivery to the beneficiaries, service utilization and the validity of the targeting process; and an assessment of the beneficiaries' appreciation of the intervention. No rigorous impact evaluation was undertaken for the NEP because one had been done in 2004–06 during the Phase I of the NEP.

4.52 **Monitoring and evaluation use**. The data generated from the NEP's monitoring system and related surveys monitored project outcomes and is still being used to evaluate the need for shifts in NEP design. Regular feedback is provided to regional stakeholders. Data on the cash transfer are used to evaluate processes, impact, and beneficiary satisfaction for adjusting program features as necessary.

5. A Decade of Support in Perspective

10-Year Program Results: An Overview

5.1 Chapters 2, 3, and 4 documented the success of three individual projects, with two culminating in highly satisfactory outcomes and one culminating in a fully satisfactory outcome. But the individual assessments of each project do not reveal the full experience and lessons of the last 15 years. A broader look at these investments together reveals a number of key findings and messages.

5.2 First, the majority of the 10-year objectives and targets of the APL (which were also the objectives and targets of Senegal's NEP) were not met. Underweight among children was reduced—but not by 40 percent; severe underweight was also reduced but not to less than 1 percent; vitamin A deficiency was not eliminated; and, because declines in malnutrition have been modest (see appendix D, figures D.1, D.2, and D.3), their impact on declining trends in under age five years mortality is not likely to be significant.

5.3 Second, the main reason that the three projects performed so well but the 10-year program goals were not met centers on program coverage. The APL initially aimed to achieve nationwide coverage of Senegal's NEP. But these targets were scaled back

considerably when the World Bank scaled back its financing. The projects performed well in their intervention areas, culminating in greater knowledge, healthier behaviors and practices, and improved nutrition outcomes. But, even though these intervention areas extended to all of Senegal's 14 regions and 45 departments, they did not achieve sufficient coverage of at-risk communities (within regions and departments) to effect major improvements in nutrition outcomes at the national level that were initially anticipated.

5.4 Third, the World Bank's strategic and technical contributions to the NEP have been highly acclaimed, but the retraction of its commitment under the APL to provide substantial financial and technical support to three phases of the program was a factor in the failure to achieve a level of coverage that would have a significant effect on nationwide trends. Indeed, fieldwork and interviews have revealed that financial constraints not only limited the number of intervention areas that the NEP was able to support, they also had an effect on the frequency and intensity of interventions. Already in the Phase II design, it was decided that villages with a population under 1,000 would receive services less frequently (quarterly) than those with a population over 1,000 (with monthly service). Field visits also revealed, anecdotally, that some nutrition centers were closed and others were scaling back their activities, especially in anticipation of the end of the World Bank's financing. There were even echoes of concern that (highly effective) growth monitoring and promotion may no longer be affordable.

5.5 Fourth, although the World Bank has been the major source of external financing for the NEP, an increasing number of development partners provide financial and technical support to nutrition activities in Senegal over and above the financial support provided by the government of Senegal. A recent survey of over 50 national and international partners supporting nutrition in Senegal (commissioned by the CLM and undertaken by REACH [See footnote 55]) has revealed two important findings:

- The support of all of these partners together does not culminate in the adequate coverage nationwide of critical categories of at-risk populations (women and children) with an essential package of cost-effective, community-based services appropriate to the type(s) of malnutrition they are suffering. As detailed in appendix D, table D.7, the NEP, with support from all of its partners together, covers all of Senegal's 14 regions and 45 departments. There is a strong presence of multiple partners in each region, ranging from a low of 12 partners in Ziguinchor to a high of 21 partners in Tambacounda. But coverage of target groups with key interventions is still somewhat modest (appendix D, table D.8).
- This support reveals some degree of alignment of interventions and intensity of support with needs across regions: the high levels (>30 percent) of stunting in Tambacounda and Kolda, for example, appear to be matched with strong support. But there is room for improvement, with other regions in the south, also suffering from equally high stunting rates (Ziguinchor, Sedhiou, and Kedougou) receiving lighter support than still other regions with lower stunting rates receiving more support.

5.6 Some may interpret these findings as weaknesses in the program. But this evaluation acknowledges CLM's proactivity in commissioning this survey with a view to gathering information that puts it in a position to improve program effectiveness and efficiency.

Indeed, this has been a hallmark of the CLM's excellent and transparent management style: to be on a continual quest for opportunities to learn and improve through the gathering, sharing, analysis, and use of evidence. And it is timely, given that Senegal is preparing a new 10-year nutrition program.

5.7 In conclusion, the NEP deserves its strong reputation as a well-run, evidence-based community-focused program that has piloted and demonstrated its effectiveness in intervention areas and managed to increase its coverage, although not to the level initially anticipated. Its success and experience are useful to highlight for the benefit of other countries attempting to establish or improve programs to enhance the nutritional status of their respective populations. In addition, this evaluation reveals opportunities for the CLM and its partners to enhance further program performance and results. Both the strengths and the challenges of the NEP are briefly reviewed below.

A Well-Earned Reputation

5.8 Among many strong features of the program, this evaluation highlights three in particular, which have been the result of both extremely good design work and their ongoing refinement over the past 15 years. They are service delivery, an increasingly multisectoral approach, and behavior change communication.

5.9 **Service delivery.** The program has set up a top-notch institutional and organizational structure that is highly focused on community services responsive to the needs of target groups and embraces the roles, responsibilities, and comparative advantages of a range of actors and stakeholders. Box 5.1 lists the multiple strengths of nutrition service delivery, as designed and nurtured under the program, which were directly observed by the evaluation mission to be very good practice and pivotal to the program's success.

5.10 A multi-sectoral approach has truly taken hold. The Phase I project judiciously and strategically limited its initial support to two sectors: health and education. The project successfully strengthened these sectors' capacities and involving them in critical activities for which they had the comparative advantage. The health sector now contributes in a number of ways to the nutrition agenda, including preparing and enforcing service standards; training, supervising, and supporting nutrition aides in the delivery of services; reinforcing health and nutrition messages of the nutrition aides; and taking on cases of severe acute malnutrition referred to health facilities by the nutrition aides and other community members. The education sector delivers micronutrients and deworming services to school children, delivers health and nutrition messages for students and their families, promotes girls' education, and is serving as an innovative vehicle for promoting the NEP messages and agenda in communities. As local governments became more involved in the financing, coordination, and implementation of the nutrition program, and as the goal of the NEP became more strongly understood and owned at the local level, an increasing number of sectors became active and involved. Field visits demonstrated how this is taking hold. Local authorities were eloquent in appreciating NEP progress to date but quick to add that other sectors must become increasingly involved, especially clean water and sanitation. An agriculture extension agent who was interviewed expressed his strong sense of responsibility when he mentioned that he provides mothers with the best (drought-resistant) seeds for their family gardens and stated that if he sees a malnourished child in his area, it is a signal that he is not

doing his job well. Livestock agents have become key in keeping village/family herds of goats safe, well, and fully vaccinated by frequent visits, caring for sick goats and seeking to upgrade the breeds. Indeed, beneficiaries interviewed expressed their appreciation of multisectoral support under the project (family gardens, family livestock projects, and cash transfers), which were pivotal in allowing them to fully apply the knowledge and behaviors promoted by the program.

Box 5.1. Service Delivery Features of the NEP

- Services are linked to a clear objective around which all service providers are united and for which the clients have strong ownership and appreciation.
- Sound understanding and strong involvement of key local actors supports and facilitates the use of services and application of knowledge by the targeted clients.
- Roles, responsibilities, and complementarities of all actors and stakeholders are clear and understood and their synergies exploited.
- Room is provided for supporting and nurturing innovation in the prioritization and delivery of services.
- Service delivery standards are established, clear, adhered to, and validated by technical support and data.
- The service pyramid is turned upside down, putting clients at the top. Service providers are accountable to the clients (and to the authorities that represent them) and the CLM and policy makers are in a supportive role.
- Good governance pervades every level of the program and every dimension of the strategic management cycle (starting and ending with monitoring and evaluation for learning, accountability, and improvement).
- Program management is transparent and credible, underpinned by strong and recurrent communications; validation, discussion, and use of data for decision making at the point of data collection; regular, bottom-up meetings for candid assessments of program performance and continual improvements; involvement of local and traditional authorities and opinion leaders; and strong appropriation of objectives by local authorities.
- A strong interface between local-level technical services and community level actors and stakeholders is achieved through contracts with NGOs possessing both technical expertise and the trust of the communities. Contracting evolved from first project, under which NGOs were contracted directly by the NEP, to three signatories (NGOs, NEP, and local collectivities responsible for nutrition financing and implementation under the decentralization policy).
- Community-level structures, whose members are chosen by the community for troubleshooting, problem-solving, prioritization, and targeting of services, provide an enabling environment, evidence-based management, and learning to allow communities to lead where they have the comparative advantage.
- Communities choose community-based nutrition aides who are trusted, respected, and accountable to deliver services.
- A creative, innovative focus on evolving toward services sustainability allows exploration of ways and means of remunerating nutrition aides.
- The "horizontal integrity" of the institutions and actors ensures coordination of actors at each level of the program through joint oversight of financing and performance, thereby nurturing and supporting an increasingly multisectoral approach.
- The "vertical integrity" of the institutions and actors ensures the collaboration of resources up and down the system to ensure the delivery of quality services.
- Strong program leadership delegates responsibilities to the level or actors closest to the target populations and then supporting them, addressing only those problems that cannot be resolved locally.
- Systems and structures support a participatory process of learning and fine-tuning, which has been institutionalized at every level of the program.

Source: Compilation of evaluation mission's direct observations, field visits, and other assessments.

5.11 A meeting with the focal points of all sector Ministries and public agencies, who are members of the CLM representing all relevant sectors, revealed a strong and still increasing commitment to a multisectoral approach. Indeed, many respondents (inside and outside of the CLM) noted that the building of this multisectoral approach has been nothing short of a revolution. Sectors' contributions are increasingly less about what money they receive and

more about what they understand to be a national objective, which they have the mandate and accountability to effect. Moreover, this meeting highlighted plans and opportunities for joint work, for example, between Agriculture and Industry, and Industry and Commerce, among others. While at the time of the CLM's creation, focal points attended meetings somewhat reluctantly, this meeting exhibited a true reform in the way this forum works. There is a unanimous demand for meetings to continue their evolution toward being more technical, operational, creative and entrepreneurial in nature, rather than institutional. There is widespread consensus that the ongoing development of a new strategic plan is an important vehicle and opportunity to continue this evolution. Rather than (merely) preparing sectoral plans for insertion into a multisectoral nutrition plan, each sector now sees its nutrition contributions as an integral part of its own sector plans.

5.12 **Behavior change interventions.** Behavior change communication was designed at the outset based on studies documenting local-level knowledge, beliefs, and practices, which undermined the health and nutrition of mothers and children. During implementation, and thanks to the results-focused learning by doing, refinements were made as experience was gained. Communication efforts are not only about sending messages to target populations but also about listening to them. Knowledge and behaviors should be understood and addressed as well as the roots and rationale behind them. A behavior is not likely to change if it is deeply embedded in religion, tradition, and culture. The involvement of religious, traditional, and cultural leaders turned out to be an effective approach both to mobilize populations to attend education sessions and to encourage changes in behaviors. The involvement and support of other people with strong influence on mothers' behaviors were also important, especially mothers-in-law and husbands. Moreover, changes in behaviors are contingent on more than just knowledge and the support of community and family. Some are only possible with the provision of means. Beneficiaries were unanimous across all field visits in noting that proper nourishment of children and their basic health care were greatly facilitated by family gardens, family livestock projects, grain storage projects, and cash transfers. Behavior change was also greatly stimulated by data and group discussions. Trends documented in individual growth charts (both good and bad), and then discussed in a group, incited mothers to adopt practices to improve their children's growth trajectories.

Challenges and Opportunities

5.13 Both the success of the NEP (including its effective management by the CLM) and the high priority of addressing malnutrition in Senegal (and elsewhere) have attracted a large number of national and international partners who are supporting nutrition interventions, some channeled through, and others bypassing, the NEP and CLM. According to a recent survey, over 50 partners are supporting nutrition in Senegal, with a strong presence of multiple partners in each of the 14 regions. Although they all support nutrition policy objectives, they are not fully coordinated around the national strategic plan, and this undermines the effectiveness of this support. The design of numerous projects by partners, not necessarily in sync with national needs and priorities, risks undermining local ownership and commitment. This can result in resource allocation and priority setting driven by partners and their projects, instead of government. It also makes it difficult to track fully and routinely total expenditures on nutrition. The bypassing (by some projects and financiers) of well-

established, strong institutional and organizational structures for nutrition is inefficient and can create high transaction costs and duplication of efforts.

5.14 Empirical evidence from reviews of the sector wide approach in the health sector around the world have much to offer in guiding government of Senegal in general and the CLM in particular to achieve greater aid effectiveness for nutrition (Vaillancourt 2009 and 2012). Senegal has already put in place many of the required building blocks for enhanced aid effectiveness: a well-defined national policy, a very capable institutional and organizational framework responsible for policy oversight and program implementation, well-established protocols for strong monitoring and evaluation and its use in decision making and tracking accountabilities for performance and results, an increasingly multisectoral approach and leadership role of the local governments, a strong focus on results, and widespread ownership at all levels of the program. Other critical elements still need to be put into place.

5.15 First, a medium-term strategic program grounded in national policy needs to be defined. Indeed, the definition of a new medium-term program was being launched around the time of the PPAR mission. It is not enough to define the program, however. The full costing of the program is critical for attracting financing. The program needs to be realistic in terms of its relevance to needs and issues, its ambition, time frame, implementability, and affordability, and it needs to be sufficiently prioritized and phased. Growth monitoring (or any other critical activity) should not be eliminated because of fear it may not be affordable.

5.16 Second, the preparation of a medium-term projection of resource availability and expenditure plans would provide an inventory of available resources, sources of financing, and earmarks. Reconciling the program costs and available financing would provide a basis for mobilizing additional resources, negotiating reallocations for greater equity, efficiency, coverage, and complementarity among the partners and financiers.

5.17 Third, government of Senegal and development partners have the opportunity to rally together to use, to the extent feasible, well-proven country systems rather than parallel project systems. This could apply to fiduciary systems. But this evaluation emphasizes the further strengthening and full use of the very capable program monitoring and evaluation system, which has oversight responsibility for all nutrition activities. Fourth, fuller strengthening and exploitation of systems and processes already in place for development partner coordination might be pursued. The practices of joint missions and coordination meetings, chaired by the CLM, could be strengthened and become more regular. Fifth, all of these recommendations apply equally to the local level, as well as to the central level. Given that, there is a range from 12 to 21 partners in each of Senegal's 14 regions; coordination of the wide range of partners – both national and international – needs to happen at regional, departmental and local levels.

6. Lessons

- These three projects demonstrate that formidable results can be achieved within the time frame of a four-year project. Phase I was highly successful in establishing a new innovative program, a strong capacity for its successful management and

implementation, and tangible results in the intervention areas. The three projects together also demonstrate that capacity and institution building is a medium-term, incremental process. The gradual decentralization of program oversight, the evolving roles and involvement of local governments, CEAs, and other sectors could not have happened all at once. The time invested is well worth the quality of this program's mature design and capacity.

- Cross-sectoral coordination and teamwork coalesce around shared objectives. A truly multisectoral approach cannot be achieved solely through an organigram or sectoral work plans with resource allocations. Rather, a shared objective and sense of mandate and accountability to contribute to that objective light the way. This applies to local and central levels alike.
- A management style that supports an evidence-based, participatory learning culture will culminate in strong ownership of the program and the continual improvement of its performance and effectiveness. The evidence base of the program has been strong and continues to grow with new evidence about sector wide coverage and support of other partners. There is scope for the further enhancement of evidence and learning by prioritizing and supporting research. Senegal has untapped technical capacity in nutrition that could be exploited.
- Senegal's nutrition policy and program have attracted many partners, both national and international, but inadequate coordination of this financial and technical support has undermined its overall effectiveness. Considerable scope exists for enhancing the aid effectiveness of nutrition interventions by preparing and brokering a fully costed, prioritized multiyear program with a fully developed inventory of available financing and technical support.
- The measurement of coverage is complex but critical to assess program efficacy. It was difficult to reconcile the robust outcomes in the intervention areas with modest trends at the national level, in the absence of detailed data on program coverage. It is not enough to measure geographical coverage. Even program coverage by target group (for example, children under age five years) does not provide sufficient detail. The REACH survey is a landmark in the program's capacity to define and assess coverage by specific intervention and by specific age group.

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Appendix A. Basic Data Sheet

Nutrition Enhancement Project (Credit 3619 -SE)

Table A.1. Key Project Data *(US$ million)*	***Appraisal estimate***	***Actual or current estimate***	***Actual as percent of appraisal estimate***
Total project costs	14.70	16.48	112
Loan amount	14.70	16.48	112
Cancelation	0.00	0.00	0

Source: Project portal

Table A.2. Cumulative Disbursements Estimated and Actual

	FY03	***FY04***	***FY05***	***FY06***	***FY07***
Appraisal estimate (US$, millions)	2.26	7.19	10.75	13.76	14.70
Actual (US$, millions)	1.45	5.15	10.42	14.96	16.47
Actual as percent of appraisal (percent)	64	72	97	109	112
Date of final disbursement: November 14, 2006					

Source: SAP—Project disbursement data.
Note: FY = fiscal year

Table A.3. Key Project Dates

Project stage	***Original date***	***Actual date***
Concept review	01/16/01	01/16/01
Appraisal	01/22/02	01/22/02
Board approval	03/14/02	03/14/02
Signing	03/29/02	03/29/02
Effectiveness	06/27/02	06/27/02
Closing date	01/15/06	07/15/06

Table A.4. Task Team Members

Name	*Title*	*Unit*
Harold H. Alderman	Adviser	AFTHD
Siaka Bakayoko	Sr Financial Management Specialist	MNAFM
Demba Balde	Social Development Specialist	AFTS4
Laurent Mehdi Brito	Procurement Specialist	AFTPC
Flavia Bustreo	Sr Public Health Specialist	HDNHE
Willyanne DeCormier Plosky	E T Consultant	AFTHD
Aissatou Diack	Sr Public Health Specialist	AFTH2
Bourama Diaite	Sr Procurement Specialist	AFTPC
Astou Diaw-Ba	Team Assistant	AFCF1
Eleonora Genovese	Consultant	HDNHE
Meri Paula K. Helleranta	Consultant	AFTH3
Alessandra Marini	Economist	LCSHS
Menno Mulder- Sibanda	Sr Nutrition Specialist	AFTH2
Claudia Rokx	Lead Health Specialist	EASHD
Fily Sissoko	Sr Financial Management Specialist	LCSFM
Julia Van Domelen	Consultant	MNSHD

Table A.5. Staff Time Budget and Cost for World Bank

Stage or Year of project cycle	*Staff weeks (no.)*	*Finance (including travel and consultant costs) (US$, thousands)*
Lending		
FY01	16	118.63
FY02	36	169.70
FY03	8	28.03
FY04	0	0.00
FY05	0	0.00
FY06	0	0.00
FY07	0	0.00
Total	60	316.36
Supervision and Implementation Completion and Results Report		
FY01	0	0.00
FY02	0	0.00
FY03	14	51.06
FY04	27	103.90
FY05	23	97.77
FY06	21	137.64
FY07		0.86
Total	85	391.23

Note: FY = fiscal year.

Nutrition Enhancement Project II (Credit 4245-SE and Credit 5084- SE)

Table A.6. Key Project Data (US$ million)

	Appraisal estimate	*Actual or current estimate*	*Actual as percent of appraisal estimate*
Total project costs	15.0	25.3	169
Loan amount	15.0	24.7	165
Cofinancing	0.0	0.0	0.0

Source: Project portal.

Table A.7. Cumulative Disbursements Estimated and Actual

	FY07	*FY08*	*FY09*	*FY10*	*FY11*	*FY12*	*FY13*	*FY14*	*FY15*
Appraisal estimate (US$, millions)	3.3	7.0	10.8	12.8	13.7	14.7	15.0	15.0	15.0
Actual (US$, millions)	3.4	7.3	11.2	13.2	13.8	15.2	17.2	23.8	25.4
Actual as percent of appraisal	101	103	105	103	100	104	115	158	169
Date of final disbursement: October 14, 2014									

Source: SAP—Project disbursement data.
Note: FY = fiscal year.

Table A.8. Key Project Dates

Project stage	*Original*	*Actual*
Concept review	12/06/2005	12/06/2005
Appraisal	06/06/2006	06/13/2006
Board approval	11/13/2006	11/13/2006
Signing	12/05/2006	12/05/2006
Effectiveness	12/18/2006	01/29/2007
Closing date	05/14/2012	06/14/2014

Table A.9. Task Team members

Names	*Title*	*Unit*
Lucy Katherine Bassett	Social Protection Specialist	GSPDR
Wolfgang M. T. Chadab	Senior Finance Officer	CTRLA
Alain W. D'Hoore	Senior Economist	GMFDR
Astou Diaw-Ba	Executive Assistant	AFCF1
Saidou Diop	Senior Financial Management Specialist	GGODR
Maimouna Mbow Fam	Senior Financial Management Specialist	GGODR
Ronnie W. Hammad	Senior Operations Officer	GPSOS
Mamadou Mansour Mbaye	Consultant	GGODR
Nathalie S. Munzberg	Senior Counsel	LEGEN
Mademba Ndiaye	Senior Communications Officer	AFRSC
Mamadou Ndione	Senior Country Economist	GMFDR
Fatou Fall Samba	Financial Management Officer	GGODR
Afroditi Smagadi	E.T. Consultant	GHNDR
Ludovic Subran	Senior Social Protection Economist	GSPDR
Moukim Temourov	Senior Human Development Economist	GEDDR
Marietou Toure Diack	Senior Human Resource Assistant	HRDTA
Cheick Traore	Senior Procurement Specialist	GGODR
Menno Mulder-Sibanda	Senior Nutrition Specialist	GHNDR
Aissatou Diack	Senior Health Specialist	GHNDR
Boury Ndiaye	Program Assistant	AFCF1
Demba Balde	Senior Social Development Specialist	GSURR
Maya Abi Karam	Senior Counsel	LEGAM
Nicole Hamon	Language Program Assistant	GHNDR
Sariette Jippe	Program Assistant	GHNDR

Table A.10. Staff Time Budget and Cost for World Bank

Stage or Year of project cycle	***Staff weeks*** (no.)	***Finance (including travel and consultant costs)*** (***US$, thousands***)
Lending		
FY 07	6.43	25,347.45
Total	6.43	25,347.45
Supervision		
FY 07	2.82	9, 743.15
FY08	8.15	49, 319.55
FY09	5.09	34, 115.74
FY10	6.68	59, 037.38
FY11	4.91	44, 049.24
FY12	3.40	33, 948.86
FY13	4.45	44, 080.63
FY14	7.11	80, 664.04
FY 15	1.05	9, 061.30
Total	43.66	364,019.89

Note: FY = fiscal year.

Rapid RESPONSE Child-Focused Social Cash Transfer and Nutrition Security Project (CREDIT 4605-SN)

Table A.11. Key Project Data (US$ million)

	Appraisal estimate	*Actual or current estimate*	*Actual as percent of appraisal estimate*
Total project costs	18.00	18.62	103
Loan amount	10.00	10.62	106
Cofinancing	8.00	8.00	100
Cancelation	0.00	0.00	0

Source: Project portal.

Table A.12. Cumulative Disbursements Estimated and Actual

	FY10	*FY11*	*FY12*	*FY13*
Appraisal estimate (US$, millions)	1.58	5.94	9.75	10
Actual (US$, millions)	2.67	4.65	7.84	10.62
Actual as percent of appraisal	169	78	80	106
Date of final disbursement: December 31, 2012				

Source: SAP—Project disbursement data.
Note: FY = fiscal year.

Table A.13. Key Project Dates

Project stage	*Original*	*Actual*
Concept review	02/10/2009	02/10/2009
Appraisal	02/20/2009	02/20/2009
Board approval	05/06/2009	05/06/2009
Signing	06/12/2009	06/12/2009
Effectiveness	09/11/2009	09/11/2009
Closing date	12/31/2011	08/31/2012

Table A.14. Task Team members

Names	*Title*	*Unit*
Lending or supervision		
Lucy Katherine Bassett	Social Protection Specialist	LCSHS
Wolfgang M. T. Chadab	Senior Finance Officer	CTRLA
Alain W. D'Hoore	Lead Economist	AFTP1
Astou Diaw-Ba	Program Assistant	AFCF1
Saidou Diop	Sr. Financial Management	AFTME
Maimouna Mbow Fam	Sr. Financial Management	AFTME
Ronnie W. Hammad	Senior Operations Officer	ECSSD
Mamadou Mansour Mbaye	Consultant	AFTPE
Nathalie S. Munzberg	Senior Counsel	LEGEN
Mademba Ndiaye	Senior Communications Officer	AFRSC
Mamadou Ndione	Senior Economist	AFTP4
Fatou Fall Samba	Financial Management Analyst	AFTME
Afroditi Smagadi	E T Consultant	LEGAF
Ludovic Subran	Social Protection Economist	LCSHS
Moukim Temourov	Resident Representative	MNCDZ
Marietou Toure Diack	Program Assistant	HRSER
Cheick Traore	Senior Procurement Specialist	AFTPE

Table A.15. Staff Time Budget and Cost for World Bank

Stage or year of project cycle	*Staff weeks* (no.)	*Cost (including travel and consultant costs)* (US$, thousands)
Lending		
FY09	0.0	26.1
FY10	0.0	0.00
Total	0.0	26.1
Supervision or Implementation and Completion Review Report		
FY09	0.0	0.0
FY10	9.9	61.4
FY11	4.8	45.4
FY12	3.0	40.4
FY13	2.6	40.6
Total	20.3	187.8

Note: FY = fiscal year.

Appendix B. National Nutrition Policies and World Bank's Nutrition Portfolio

Box B.1. Government of Senegal Letter of Nutrition Development Policy

Principles

- Equality: with particular attention to more vulnerable groups living in poor areas
- Decentralization and deconcentration: supporting local authorities involvement in nutrition through identifying, implementing, and monitoring strategies applicable to the social, economic, and cultural environment
- Partnership: ensuring harmonization of interventions and synergies among stakeholders involved in nutrition, coordinated at local, regional, and central levels
- Know-how: ensuring effective, adequate interventions for improved performance and outcomes
- Community appropriation: fostering participation at all levels to support sustainability
- Transparency in management: emphasizing clarity in management and decision making at all levels and a monitoring system to ensure efficiency
- Sustainability: including commitment of beneficiaries and stakeholders and effective, long-term financing mechanisms.
- Ethics: ensuring morale and human dignity in actions to be undertaken

Objectives

The broad purpose of this policy is to improve the nutritional status of poor vulnerable groups, reproductive women and old people. It will specifically consist of reducing underweight among children over the next 10 years. To this end, the state will support efforts to (1) ensure availability and accessibility of food for all Senegalese people, (2) address, and prevent poor feeding practices. All development sectors will be involved.

Strategic steps

- Strengthening the Community Approach: including growth monitoring promotion, exclusive breastfeeding, and food supplementation from 6-24 months, micronutrient supplementation, and nutrition during and after illness, deworming, disease prevention and wellness visits.
- Food Security Enhancement: through improvement of agricultural production, Agribusiness Research and Food Supply which will play a paramount role in programs for food product enrichment in the control of micronutrient deficiencies.
- Improvement of water and sanitation conditions of households: focusing on the combination of nutrition programs with efforts to improve access to drinking water and sanitation for poor households.
- Restructuring and institutional capacity building to monitor and manage nutrition programs: including nutrition policy development and a multisectoral approach, requiring the establishment of operational and strategic forums of coordination, planning, implementation and program monitoring and evaluation.
- Strengthening Partnership with Local Government, NGOs, Associations, Executing Agencies and Private Sector: to promote interactions among the different actors, develop contracting arrangements, improve communication and coordination.
- Improve Systems of Data Collection, Analysis, Reporting, Promoting Studies, and Research: to allow for the development of targeted interventions, and including the definition of nutrition-related indicators.
- Enhancement of Human Resource Capacity at National and Community Levels: to ensure sustainability of activities at the community level and to ensure expertise at the national level.
- IEC, Behavior Change and Social Mobilization: with a focus on local-level leaders and organizations and the testing of innovative communication methods.
- Promotion of Income Generation: especially for women.

Source : République du Sénégal, Gouvernement du Sénégal. 2001. "Lettre de Politique de Développement de la Nutrition," Avril.

Box B.2. Republic of Senegal's National Development Policy for Nutrition (2015–25)

Vision

A country in which each individual enjoys an optimal nutritional status for having adopted the proper behaviors and practices.

Overarching objective

Ensure a satisfactory nutritional status for all citizens, particularly children under five years of age, women of reproductive age, and adolescents.

Intermediate objectives

- Ensure adequate coverage of essential nutrition services for children under age five years, women of reproductive age, and adolescents
- Improve access to and use of quality health services
- Improve nutritional knowledge of the populations leading to the adoption of behaviors supporting good nutrition
- Promote research and the production of foods high in nutritional value
- Secure sufficient and sustainable financing for nutrition interventions
- Strengthen the coordination, monitoring and evaluation of nutrition interventions in the context of a multisectoral approach

Four strategic pillars

- Production of food with the highest nutritional value
- Transformation, distribution and pricing of primary outputs from agriculture, livestock, and fisheries into high-quality food that is affordable and accessible; this involves a range of multisectoral actors, both governmental and private sector
- A multisectoral approach to nutrition education focused on behavior change and adequate, equitable access to clean water and sanitation
- Effective integration and complementarity of basic health, nutrition, and water and sanitation services, covering a range of elements, including community-based services, social protection, adequate access to and utilization of basic services, with local collectivities playing a catalytic role in the mobilization and coordination of actors and resources

Cross-cutting support for four pillars

- Local governance and administration
- Adequate and sustainable financing with contributions by the State, local collectivities, private sector and other partners
- Advocacy and communication for social change and behavior change
- Strengthening of multisectoral approach; participation and equity in coverage and outcomes
- Coordination, research, monitoring and evaluation, and capacity strengthening of all actors.

Source: République du Sénégal, Primature 2015.

Table B.1. Timeline of Approval and Closing Dates of Nutrition Interventions in Senegal

	Year																							
Interventions, by type	***95***	***96***	***97***	***98***	***99***	***00***	***01***	***02***	***03***	***04***	***05***	***06***	***07***	***08***	***09***	***10***	***11***	***12***	***13***	***14***	***15***	***16***	***17***	***18***	***19***
Projects																									
Community Nutrition Project	A						C																		
APL Phase I: Nutrition Enhancement Program								A				C													
APL Phase II: Nutrition Enhancement Program II																									
Initial IDA Credit												A						C							
Additional Financing																		A		C					
Rapid Response Child-Focused Social Cash Transfer and Nutrition Security															A			C							
Health and Nutrition Financing																			A					C	
Building Resilience to Food and Nutrition Insecurity Shocks																						A			C
Analytic Work and Technical Assistance																									
Strengthening Operational Evaluation in Program Implementation (Institutional Development Fund Grant)															A			C							
Health Results-Based Financing Impact Evaluation (linked to H & N Financing project)																					A	C			
Health and Nutrition Financing (w/ same objectives as Country Nutrition Status Report)																					A		C		

Note: For projects (green), *A* refers to approval by the World Bank's Board of Executive Directors and *C* refers to the closing date. For analytic work and technical assistance (blue), *A* refers to activity sign off and *C* refers to the completion of the task.

Appendix C. Costs, Financing, and Disbursements*

Table C.1. NEP I: Planned versus Actual Costs by Project Component

Component	***Planned* (including contingencies)*** (US$, millions)	***Actual***† (US$, millions)	***Actual/ planned*** (percent)
Community-Based Nutrition and Growth Promotion Program	7.70	16.7	217
Institutional and Organizational Capacity Building	4.50	1.20	27
Monitoring and Evaluation and Research	1.50	0.70	47
Program Management	2.50	4.50	180
Total Project Costs	16.20	23.10	143

Source: World Bank 2002b for planned; World Bank 2007c for actual.
Note: *Total project cost estimated at appraisal equaled the sum of International Development Association financing (estimated at $14.7 million) and government of Senegal financing (estimated at $1.5 million). It was presented net of anticipated World Food Programme parallel financing estimated at $4.0 million.† It is assumed that total actual costs presented in the Implementation Completion and Results Report are inclusive of World Food Programme parallel financing, because this estimate is very close to the end-of-project financing provided by International Development Association, government of Senegal and World Food Programme (Table C.2).

* — Means not available; n.a. means not applicable and 0 means zero.

Table C.2. NEP I: Planned versus Actual Financing (US$, million equivalent)

Financing source	**Planned***	**Actual**†
IDA Credit	14.70	16.47
MDRI (IDA 3619A)	4.28	4.97
IDA Credit (IDA 36190)	10.42	11.50
Government of Senegal	1.50	1.80
Subtotal Project Financing for Phase I APL	16.20	18.27
World Food Programme (parallel financing)	4.00	4.00
Total Phase I Support including WFP Parallel Financing	20.20	22.27

Sources: World Bank 2002b. ; World Bank project system for IDA credit; World Bank 2007 for government and World Food Programme financing.
Note: The MDRI calls for 100 percent cancelation of International Development Association, African Development Fund, and International Monetary Fund debt for countries that reach the heavily indebted poor countries completion point. IDA = International Development Association; MDRI = Multilateral Debt Relief Initiative.

Table C.3. NEP I: Planned versus Actual Disbursements by Disbursement Category (Special drawing rights [SDRs], thousands) *

Disbursement category	*Original allocation*	*Fall 2006 restructuring*	*Actual*
(1) Works	150	28	23
(2) Goods	700	575	575
(3) Pharmaceuticals	600	425	415
(4) Consultants/Training	7,450	8,914	8,941
(5) Subprojects	400	195	294
(6) Operating Costs	600	978	994
(7) Refund of Project Preparation Advance	700	263	263
(8) Unallocated	1,200	0	0
Designated account A	n.a	n.a	-115
Designated account B	n.a	n.a	-12
Total disbursements	11,800*	11.378	11,378
Amount of credit canceled	n. a	422	422

Note: * Of which an International Development Association credit of 8.363 million SDRs and a MDRI of 3.437 million SDRs. The MDRI calls for 100 percent cancellation of International Development Association, African Development Fund, and International Monetary Fund debt for countries that reach the heavily indebted poor countries completion point.

Table C.4. NEP II: Planned versus Actual Costs by Project Component

	Entire Phase II (2007–11) (All financing, including World Bank)		***Project NEP II project***† (World Bank financing only)			
Component	***Planned**** (US$, millions)	***Actual*** (US$, millions)	***Planned***† (US$, millions)	***Additional Financing*** (US$, millions)	***Actual*** (US$, millions)	***Actual/ planned*** (percent)
Community-based nutrition	29.5	—	10.4	7.6	18.3	176
Multisectoral support	3.9	—	1.4	1.3	2.7	193
Support to national policy and monitoring and evaluation	2.2	—	3.2	1.1	4.3	134
Program management	5.4	—	0	0	0	n.a
Unallocated	1.4	—	0	0	0	n.a
Total	42.4	—	15.0	10.0	25.3	169

Sources: World Bank 2006b for all planned financing; World Bank 2014 for the rest.

Table C-5: NEP II: Planned versus Actual Financing of Project (US$, millions equivalent)

Financing source	***Original plan*** (US$, millions)	***Additional financing*** (US$, millions)	***Actual*** (US$, millions)	***Actual/ original*** (percent)
IDA credit	15.0	10.0	25.3	167%
Government of Senegal	16.3	n.a	23.4	144%
Others (Projet Sante II/AfDB, WFP, UNICEF, Micronutrient Initiative)	11.1	n.a	—	—
Total	42.4	10.0	—	—

Sources: World Bank 2006c for original;, World Bank 2011 for additional financing; World Bank 2014 and World Bank's disbursement data for actual.

Note: UNICEF = United Nations Children's Fund; WFP = World Food Programme.

Table C-6: NEP II: Planned versus Actual Disbursements by Category (SDR, thousands)

Category	***Original allocation***	***Additional financing***	***Most recent allocation***			***Actual disbursements***
			Original	***AF***	***Original + AF***	
(1) Drugs and pharmaceutical equipment	2,690	1,850	1,720	1,830	3,550	3,550
(2) Grants subprojects	3,500	4,650	6,400	4,700	11,100	11,100
(3) Consultants services, training and audits	1,950	0	1,550	0	1,550	1,550
(4) Operating costs	470	0	300	0	300	300
(5) Refund of Project Preparation Advance	410	0	120	0	120	120
(6) Unallocated	1,080	0	0	0	0	0
Total	10,100	6,500	10,100	6,500	16,600	16,600

Source: World Bank 2006a for original allocation, 2012a for additional financing, and World Bank's project information system for actual disbursements.
Note: AF = additional financing.

Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project

Table C.7. Rapid Response: Planned versus Actual Costs by Project Component (US$ million)

Component	***Planned*** (US$, millions)	***Actual*** (US$, millions)	***Actual/planned*** (percent)
Community-based nutrition	9.7	10.8	111
Sectoral support	1.3	0.7	54
Implementation and monitoring and evaluation	0.7	0.9	129
Child-focused cash transfers	6.3	5.8	92
Total	18.0	18.2	101

Sources: World Bank 2009c for planned; World Bank 2013b for actual.

Table C.8. Rapid Response: Planned versus Actual Financing of Project

Component	***Planned*** (US$, millions)	***Actual*** (US$, millions)	***Actual/planned*** (percent)
IDA credit	10.0	10.62	106
Global Food Crisis Response Program, Multi-Donor Trust Fund	8.0	7.90	99
Government of Senegal	0.0	0.0	n.a
Total	18.0	18.52	103

Sources: World Bank 2009a, 2009b; World Bank's project information system and operations portal for actual financing.

Table C.9. Rapid Response: Planned versus Actual Disbursements of IDA Credit by Disbursement Category

Disbursement category	***Original allocation*** (SDR, thousands)	***12/2011 reallocation*** (SDR, thousands)	***Actual disbursements*** (SDR, thousands)	***Actuals/ original*** (percent)
1. Subgrants for subprojects under Part 1	3,520	5,320	5,250	99
2. Drugs, pharmaceutical equipment, consultants, audits, training	2,800	1,200	1,200	100
3. Project operating costs	480	280	0.260	93
Total	6,800	6,800	6,800*	100

Sources: World Bank 2009a, 2009b; World Bank 2011 for reallocation; World Bank's project information system and operations portal for actual disbursements.
Note: *Total may not add up due to rounding. Bank's system shows that SDR 6.8 million were fully disbursed.

Table C.10. Planned versus Actual Disbursements of Multidonor Trust Fund by Disbursement Category

Disbursement category	***Original allocation*** (US$, thousands)	***12/2011 reallocation*** (US$, thousands)	***Actual disbursements*** (US$, thousands)
1. Grants for subprojects for Regions A under Part 1 of the Project	3,100	2,940	99
2. Cash transfers for Part 4 of the Project	4,900	4,640	100
Total*	8,000	7,580	100

Source: World Bank 2009b, 2011 and World Bank project information system.
Note: The multidonor trust fund grant agreement shows original amount as US$8 million equivalent, whereas the World Bank's system shows original amount as US$7.9 million (World Bank 2009). By the same token, actual disbursements shown in the World Bank's system add up to $7.58 million. But the World Bank's system also shows that the trust fund was fully disbursed. These numbers are reflected here, with the assumption that discrepancies are due to exchange rate fluctuations in the various currencies of the donors' contributions.

Table C.11. Planned versus Actual World Bank Support for 10-Year APL

World Bank–Financed Operations	***Initially committed for APL*** (SDR, millions)	***Actual commitments*** (SDR, millions)	***Actual/initial*** (percent)
Phase I	11.8	11.8	100
Phase II	19.2	16.6	86
*Initial credit**	*n.a*	*10.1*	*n.a*
Additional financing	*n.a*	*6.5*	*n.a*
Phase III	8.0	0.0	0
Rapid Response†	0	6.8	(unanticipated)
Total	39.0	35.2	90
Total net of non-NEP support	39.0	30.8	79

Sources: World Bank 2002b for initial APL commitments; World Bank 2002a, 2006a, 2009a, 2009b, and 2012a for actual commitments.
Note: * Of which SDR 3.4 million (or US$5 million) was from Malaria Booster Program. †Of which SDR 1.0 million (or US$1.4 million) was for Social Cash Transfers pilot.

Table C-12: Program-Wide Financing, 2004–15(CFAF, billions)

	Year											
Financiers	***2004***	***2005***	***2006***	***2007***	***2008***	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***
World Bank	2.664	2.693	0.654	2.575	2.535	2.776	1.416	5.252	1.589	3.852	0.961	0.961
Government of Senegal	0.176	0.176	1.076	1.810	1.307	3.143	1.427	0.274	2.738	1.613	3.023	2.190
Micronutrient Initiative						0.131	0.194	0.211	0.187	0.145	0.088	
World Food Programme						0.005	0.478	0.016	0.088	0.098	0.163	0.147
UNICEF						0.049	0.056	0.529	0.533	0.132	0.123	0.558
Spanish Cooperation										0.180	0.328	
GAIN							0.514				0.203	0.131
Total	2.840	2.869	1.730	4.386	3.842	6.105	4.086	6.282	5.135	6.019	4.888	3.987

Source: CLM/Program Financial Data

Table C-13: Program-Wide Expenditures, 2004–15(CFAF, billions)

	Year											
Expenditures	***2004***	***2005***	***2006***	***2007***	***2008***	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***
Nutrition/IMCI	2.002	1.961	1.039	2.470	3.250	2.991	2.586	2.768	3.162	3.896	4.701	3.071
Multi-sectoral interventions				0.179	0.095	0.177	0.294	0.515	0.227	0.157	0.247	0.159
Policy support and oversight	0.397	0.166	0.147	0.109	0.149	0.181	0.501	0.361	0.642	0.599	0.317	0.173
Program management	0.542	0.487	0.434	0.655	0.595	0.640	0.788	0.690	0.790	0.784	0.822	0.797
Cash Transfers	0	0	0	0	0	0.144	0.933	1.326	0.522	0	0	0.054
Total	2.940	2.614	1.620	3.414	4.091	4.132	5.101	5.661	5.343	5.437	6.087	4.255

Source: CLM/Program Financial Data

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Appendix D. Statistical Data and Results

I. Project-Level Results

Table D.1. First Nutrition Enhancement Project: Results Framework/Achievement of Objectives

Objectives or indicators*	**Outcomes**
Project Development Objective	
PDO 1: To assist the Borrower in building the institutional and organizational capacity required to enable the Borrower's CLM and its partners in the public and private sectors to develop and monitor multisectoral nutrition activities in both rural and urban areas. PDO 2: To assist the Borrower in building the institutional and organizational capacity required to enable the Borrower's CLM and its partners in the public and private sectors to implement multisectoral nutrition activities in both rural and urban areas.	
End-of-Phase I Outcome Indicators:	
PDO 1: the prevalence of severe underweight is reduced by half in the targeted areas Baseline: Target: 50 percent reduction	2006 Impact evaluation shows a drop from 5.7% to 4.5% (a 21% relative decrease) in target areas, not meeting the target and less than the 28% relative decrease (from 5.3% to 3.8%) in control areas. 2005 shows severe underweight nationwide at 3.0%. Target not achieved at end of first phase project. Target achieved nationwide by the end of the program, with severe underweight among children under five falling by 54 percent: from 7.0 percent in 2000 to 3.2 percent in 2015. (Source: WHO and DHS data; see Graph in Chapter . . .).
PDO 2: the prevalence of underweight among children under three is reduced by 25 percent in targeted areas Baseline: Target: 25 percent reduction	Decreased from 18% to 10% or a drop of 44%, according to program monitoring data. Impact evaluation shows a 14% reduction in intervention areas (from 26.8% to 23.1%) and a 10% reduction in control areas (from 24% to 21.7%). National average in 2005 was 17.3% (DHS). Achievement of target not clear at end of first phase project. Target essentially achieved nationwide by the end of the program, with underweight prevalence among children under five falling by 24 percent: from 20.3 percent in 2000 to 15.5 percent. (Source: WHO and DHS data; see Graph in Chapter . . .)
	Proportion of children gaining weight, compared to the month before, increased from 84% to 91% Very strong performance, albeit no specific target.
PDO 3: the proportion of children exclusively breastfed until 6 months has increased in the targeted areas Baseline: 8 percent Target: 15 percent	Increased from 30 percent to 58 percent, virtually doubling, comparing favorably to 2005 national level of 34%. Absolute increase of 28 percentage points, compared to target of 7 percentage points. (KPC surveys) (Impact evaluation showed increase from 17% to 49% in intervention areas.) Target surpassed at end of first phase project. However, nationwide prevalence has not substantially changed (34 percent in 2005; and 33 percent in 2014). (Source: DHS data)
PDO 4: The use of prenatal care (at least three visits) has increased by 30 percent Baseline:	Increased from 52% to 67%, a relative increase of 29% (KPC surveys). Impact evaluation shows an increase from 65% to 78% in intervention areas and from 64 to 70 percent in control areas. In retrospect, and as discussed/agreed with CLM experts, there are no true control areas in Senegal because of multiple interventions and efforts to stimulate improved maternal and child health through enhanced service delivery and utilization.

Target: increase of at least 30 percent	Nationwide, since project completion the percentage of women having at least 3 prenatal visits rose from 40 percent to 50 percent in 2010 and then regressed slightly to 48 percent in 2014 and 47 percent in 2015. Target essentially achieved.
PDO 5: the proportion of caregivers who recognize at least two danger signs in sick children has increased by 25 percent in targeted areas Baseline: Target: increase of at least 25 percent	Increased from 55% to 77% (a relative increase of 40%) (KPC surveys) **numerator/denominator? Target surpassed.
Component Outputs	
Community-Based Nutrition and Growth Promotion Program	
Component 1.1 Growth Monitoring and Promotion	
Children under three regularly monitored and their caretakers counseled Baseline: Target: 171,000	200,000 and their mothers mobilized for monthly growth monitoring and promotion, as of last six months of project Target exceeded. Participation in growth monitoring was high at over 90%
	Vitamin A supplementation coverage in last six months for children 6-59 months: 85%, exceeding the national average (75%)
	Vitamin A supplementation of mothers w/in 8 weeks post-partum: 51% (up from 27 percent in 2003), exceeding the national average (27%)
Component 1.2: Nutrition and Health Group Education	
Monthly nutrition and health education sessions are held in 80 percent of established sites Baseline: Target: 80 percent of established sites	94 percent of established sites in 2006. This high rate has been maintained, as recorded in program monitoring reports: 96 percent in 2008; 97 percent in 2011; 91 percent in 2013 and 88 percent in 2015. The percent of target group/mothers who attended these sessions was also high: 89 percent in 2006; 93 percent in 2009; 97 percent in 2011; 91 percent in 2013; 89 percent in 2015 (Source: CLM Progress Reports)
Component 1.3 IMCI	
% of health staff in targeted areas trained in IMCI Baseline: Target: at least 40 percent	1,122 health post and district personnel trained (100% and 78 percent, respectively); and 163 staff from the NGOs/community-level executing agencies and 23 trainers also received C-IMCI training. (Source: CLM Progress Reports) Target surpassed.
% of sites where training sessions for nutrition aides were held Baseline: Target: at least 25 percent of sites	

Component 1.4 Basic Health Services	
% of health staff in targeted areas trained in promotion of basic health services Baseline: Target: at least 40 percent	1,122 health post and district personnel trained (100% and 78 percent, respectively) Target surpassed.
% of sites where training sessions for nutrition aides were held Baseline: Target: at least 25 percent of sites	2,459 nutrition aides were trained in the promotion of basic health care or 100% vs. 25% Target surpassed.
	Proportion of children sleeping under insecticide-treated bed nets more than doubled from 28% to 59%, far surpassing 2005 national average (10%)
Component 1.5 Fighting the Roots of Malnutrition % of sites having successfully applied for small grants Baseline: Target: at least 40 percent	Not reported
	Consumption of iodized salt increased from 46% to 59% (an increase of 28%), surpassing 2005 national average (41%)
Capacity Building and Monitoring and Evaluation	
Component 2.1 Institutional and Organizational Capacity Building	
Comprehensive Growth Monitoring and Promotion strategy and materials developed Baseline: Target: Growth Monitoring and Promotion Strategy Developed	Target achieved.
Number of nutrition sites which are functional Baseline: Target: 820 (80 percent community coverage)	924 nutrition sites were established and equipped and delivered growth monitoring and promotion services to the communities. New sites were gradually added reaching 5105 in 2013, and slightly reduced to 4922 in 2014. Target surpassed.
% of health posts adequately equipped to manage severely malnourished children Baseline: Target: at least 50 percent	48 percent Target almost achieved.

Component 2.2 Monitoring and Evaluation and Research	
% of the sites where learning events are held Baseline: Target: 50 percent	monitoring and evaluation learning events held in 100% of communities Target surpassed.
Studies conducted and recommendations integrated into Phase II work plan	Phase II work plan benefited from the program performance data, as well as from the impact evaluation. Target achieved.
Program Management (central and regional)	
Staff in place and trained	100% of National Executive Bureau (secretariat to the CLM) staff were recruited and received training; and they played an important role in clarifying the institutional arrangement between the CLM and the sector ministries 36 staff of NGO Executing Agencies (100 percent of staff responsible for administrative and financial management) were trained in procurement and financial management. Target achieved.
	NGO staff were trained in financial management and procurement; and 34 subproject coordinators (100%) were trained in monitoring and evaluation
Management cost less than 15 percent of total budget	Target achieved.
At least 80 percent of activities in annual plan completed within cost estimates.	92 percent of activities in annual action plan were completed w/in cost estimates. Target surpassed.

Note: *As outlined in World Bank 2002, "Appendix 1: Project Design Summary."

Table D.2. First Nutrition Enhancement Project: Triggers for moving from the first to the second phase

Trigger	*Degree of achievement at the project's end*
Both urban and rural nutrition interventions show positive impact on child growth in targeted regions.	The monitoring system shows a considerable drop in the prevalence of malnutrition in both urban and rural areas and an increase in the proportion of children demonstrating weight gain from one month to the other.
The CLM effectively coordinates the application of the Lettre de Politique de Dévéloppement de la Nutrition measured by (1) at least three sectors having proposed work programs that have been approved; and (2) the performance of the national executive bureau is evaluated by an independent bureau and satisfactory to International Development Association.	(1) The CLM approved four proposals from three sector Ministries (health, education and literacy) and one agency (early childhood development) and signed technical agreements with each. (2) The audit firm "Coopers and Lybrand" audited the national executive bureau in 2002, 2003, 2004 and 2005. Results of each audit have been judged satisfactory to International Development Association.
An independent evaluation of Phase I is completed and its recommendations incorporated into the design of Phase II.	Two KPC surveys (November 2003 and November 2005) were conducted in all intervention areas and preliminary results were used in preparing the Phase II project. An independent impact evaluation was under way at the time of project closing, with a first round of data collection completed in April 2004 and the second in April 2006. These results, as well, were used in to guide the implementation of Phase II.
Reasonable sustainability is reached with the implementation of the nutrition interventions (cost per child less than US$8 direct implementation cost in urban areas and US$4 per child in rural areas).	The median cost per child per year for both zones is US$4.3 (US$5.0 in urban areas and US$3.7 in rural areas). Eighty percent of community-based projects have a cost per child per year below the norms fixed in the trigger.

Source: World Bank. 2007c. *Senegal—Nutrition Enhancement Program Project*. Washington, DC: World Bank.
Note: CLM = Cellule de Lutte contre la Malnutrition; KPC = Knowledge, Practice, Coverage.

Table D.3. Nutrition Enhancement Project II: Results Framework or Achievement of Objectives

Original objectives, indicators, or targets*	***Revised objectives/2013 targets for additional financing and restructuring (approved in 2012)***	***Outcomes against original targets, as of 2014 (60% weight)***	***Outcomes against revised targets, as of 2014 (40% weight)***
Project Development Objective			
Original Objective: To improve nutritional conditions of vulnerable populations, in particular children under five years of age in poor urban and rural areas. Revised Objective (under 2012 restructuring/Additional Financing): To improve nutritional conditions of vulnerable populations, in particular children under five years of age in the Intervention Areas.			
Outcome Indicators			
PDO 1: Increased overall program coverage of children under the age of five in rural areas Baseline: 14% (preliminary DHS 2005 results) Target for 2011: 40%	Target increased: 62% (ICR notes revised target of 70%) Achieved at end-2011: 50%	73%Target surpassed. (CLM Project Monitoring System)	73% Target surpassed. Coverage of 387/552 local collectivities (72%) and 74% coverage of children under age five in 2015. (CLM Project Monitoring System)
PDO 2: Increase in percentage of infants exclusively breastfed for first six months by 30 percent in intervention areas Baseline: 34% (preliminary DHS 2005 results) Target for 2011: 44%	Target increased: 65% Achieved at end-2011: 63%	65% Target surpassed. (LQAS Surveys)	65% Target achieved. (LQAS Surveys)
PDO 3: At least 40% of pregnant women and children under five years of age sleeping under insecticide-treated bed nets in intervention areas Baseline: 12% (preliminary DHS 2005 results) Target for 2011: 40%	Target increased: 75% Achieved at end-2011: 71%	86% Target surpassed. (LQAS Surveys)	86% Target surpassed. (LQAS Surveys)
PDO 4: CORE INDICATOR: Not in PAD, but shown as original indicator in Additional Financing/Restructuring Paper: People with access to a basic package of health, nutrition and population services (Core Indicator; refers to number of children reached by the community nutrition activities) Baseline: 265,073 Target: 709,124	Target increased: 1.1 million Achieved at end-2011: 1.1 million	1.64 million children (CLM data) Target surpassed (CLM Project Monitoring System)	1.64 million children Target surpassed. (CLM Project Monitoring System)

	Added: PDO#5: Children aged 6-23 months receiving yearly a minimum of 90 micronutrient sprinkles sachets for three months in intervention areas Reflecting new activities on distribution and promotion of supplemental iron.Target: 30% Achieved at end-2011: 0	Not applicable	40% Target surpassed. Only 20 percent was achieved by the project's closing, but the 40 percent was achieved soon after. (CLM Project Monitoring System)
Intermediate Outcome Indicators			
Intermediate Outcome 1: Adequate child growth in targeted children			
IOI 1: At least 75% of targeted children aged 0-24 months show adequate monthly weight gain (Additional Financing added: ". . . in intervention areas.") Baseline: 50% (preliminary DHS 2005 results) Target for 2011: 75%	Target increased: 80% Achieved at end-2011: 80%	83% Target surpassed. (CLM Project Monitoring System)	83% (CLM data) Target surpassed. In 2015 1.5 million children under 2 years showed adequate weight gain or 82% of all weighed. (CLM Project Monitoring System)
IOI 2: Increase in percentage of pregnant women making at least four prenatal care visits by 30% in intervention areas Baseline: 40% (preliminary DHS 2005 results) Target for 2011: 52% (ICR notes target of 50%)	Target increased: 56% (ICR notes revised target of 60%) Achieved at end-2011: 52%	61% Target surpassed. (LQAS Surveys)	61% Target surpassed. (LQAS Surveys) Also exceeds nationwide level of 48 percent (2014 DHS) and 47 percent (2015 DHS)
IOI 3: At least 80% of mothers of targeted children participate in monthly information and education sessions Baseline: 60% (preliminary DHS 2005 results) Target for 2011: 80%	Target increased: 90% Achieved at end-2011: 95%	90% Target surpassed. (CLM Project Monitoring System)	90% Target achieved. 89% in 2015 (CLM Project Monitoring System)
Number of children under 24 months benefitting from improved infant and young child feeding practices in the target area Baseline: 200,000 Target: 222,500	Target maintained.	272,796 Target surpassed. (CLM Project Monitoring System)	272,796 Target surpassed. This number fell to 207,365 in 2015. (CLM Project Monitoring System)

Children 6-59 months screened on a quarterly basis for severe malnutrition			73 percent (2009); 86 percent (2010); 90 percent (2012); 91 percent (2014); 84 percent (2015)/1.5 million children quarterly
Targeted children under 5 treated for moderate or severe acute malnutrition. No target set, since aim was to treat the maximum number of cases, while reducing malnutrition prevalence		19,799 (CLM Project Monitoring System)	19,799 (CLM Project Monitoring System)
Intermediate Outcome 2: Improved micronutrient status in targeted children aged 6-59 months			
IOI 4: At least 80% of children aged 6-59 months in intervention areas receive high preventive doses of Vitamin A supplements twice yearly Baseline: 79% (preliminary DHS 2005 results) Target for 2011: 80%	Target increased: 90% (Baseline shown as 70% in Project Paper) Achieved at end-2011: 120	95% Target surpassed. (LQAS Surveys)	95% Target surpassed. (LQAS Surveys)
IOI 5: CORE INDICATOR: Not in PAD, but shown as original indicator in Additional Financing/Restructuring Paper: Number of children receiving a dose of vitamin A (Core indicator – information derived from IOI immediately above) Baseline: 1.58 million	Target: 1.58 million Achieved at end-2011: 2.15 million	2.3 million Target surpassed. (Health Information System, as reported in ICR)	In 2014, 2.2 million children 6-59 months received Vitamin A supplements or 91 percent of the target group. Target achieved. In 2015 the number of children was reduced to 1.5 million. (CLM Project Monitoring System, as reported to PPAR mission)
At least 80% of children aged 12-59 months receive deworming medication twice yearly Baseline: 79% (preliminary DHS 2005 results) Target for 2011: 80%	Dropped: This indicator is tied to vitamin A supplements as both interventions are coupled	1.94 million children or 89% of the target population; 86% coverage in 2015. Target surpassed. (CLM Project Monitoring System)	1.94 million children or 89% percent of the target population; 86% coverage in 2015. Target surpassed. (CLM Project Monitoring System)
At least 90% of target number of insecticide-treated bed nets distributed Baseline: 0% Target for 2011: 90%	Target increased: 100% (according to page 14 of Project Paper, while p. 11 notes the target did not change). Achieved at end-2011: 100%	100% Target exceeded. This activity carried out in 2011 only. (CLM Project Monitoring System)	100% Target achieved. (CLM Project Monitoring System)

CORE INDICATOR: Not in PAD, but shown as original indicator in Additional Financing/Restructuring Paper: Long-lasting insecticide-treated malaria nets purchased and/or distributed (number) Baseline: 0	Target: 500,000 Achieved at end-2011: 500,000	500,000 Target achieved. (CLM Project Monitoring System)	500,000 Target achieved. (CLM Project Monitoring System)
	Added: Backyard gardens in intervention areas (number) Reflecting new activities on promotion of food and dietary diversification Target: 350. Achieved at end-2011: 0	Not applicable	1,321 backyard gardens Target exceeded. (CLM Project Monitoring System)
Intermediate Outcome #3: Sectoral ownership and accountability for nutrition results, particularly in health and education			
Adoption of child growth promotion in children under two years of age and revision of anemia prevention and control strategy by Ministry of Public Health by 2009. Target: Updated in 2009	Target maintained Achieved at end-2011	Targets achieved. (CLM Project Monitoring System)	Targets achieved. (CLM Project Monitoring System)
At least 75% of planned supervision activities by implicated health districts conducted Baseline: 0 Target for 2011: 75%	Dropped: This indicator is not even an output indicator, but more an input indicator	Not available	Not available
At least 80% of targeted children in primary education receive weekly micronutrient supplements in school-year period in the intervention areas Baseline: 0 Target for 2011: 80%	Target increased: 90% Achieved at end-2011: 95%	99% Target surpassed. (CLM Project Monitoring System)	99% Target surpassed. (CLM Project Monitoring System)
		80% targeted children in primary education received weekly iron supplements in 2015 (CLM Project Monitoring System)	80% targeted children in primary education received weekly iron supplements in 2015 (CLM Project Monitoring System)
At least 80% of targeted children in primary education receive deworming medication twice in one-year period in the intervention areas Baseline: 0 Target for 2011: 80%	Dropped: This indicator is closely tied to IOI on vitamin A as both interventions are coupled	80% in 2015 Target achieved. (CLM Project Monitoring System)	80% in 2015 Target achieved. (CLM Project Monitoring System)

Intermediate Outcome #4: Government, at all levels, is aware of importance of nutrition in development and effectively monitors implementation progress of National Nutrition Policy			
Nutrition indicators are integrated in monitoring tools and documents of poverty reduction strategy and Millennium Development Goals Baseline: (not quantified) Target for 2011: (not quantified)	Target maintained Achieved at end-2011	Targets achieved. (CLM Project Monitoring System)	Targets achieved. (CLM Project Monitoring System)
At least 25% of targeted local governments have incorporated nutrition objectives and interventions in Local Development Plans Baseline: 0 Target for 2011: 25%	Target increased: 35% Achieved at end-2011: 31%	34% Target surpassed. (CLM Project Monitoring System)	34% (135 local governments) Target achieved. (CLM Project Monitoring System)
	Added – Core Indicator: Direct project beneficiaries (number), of which female (percent) While data on total number will be available, data on the proportion female will not. Target: 2.3 million Achieved at end-2011: 2.0 million		2.1 m in 2012; 2.2 in 2013; 2.2 m in 2014; 1.9 million in 2015. Target almost achieved, but declining slightly post-project. (CLM Project Monitoring System, as reported to PPAR mission; ICR reported 2.3 million in 2014, also citing CLM)

Note: *As outlined in World Bank 2006, "Appendix 3: Results Framework." Percent of total disbursements: under original project: 10.0/16.6 = 60% weight; under restructured project/additional financing: 6.6/16.6 = 40% weight. IOI = intermediate outcome indicator.

Table D-4: Rapid Response Child-Focused Social Cash Transfer and Nutrition Security Project: Results Framework/Achievement of Objectives

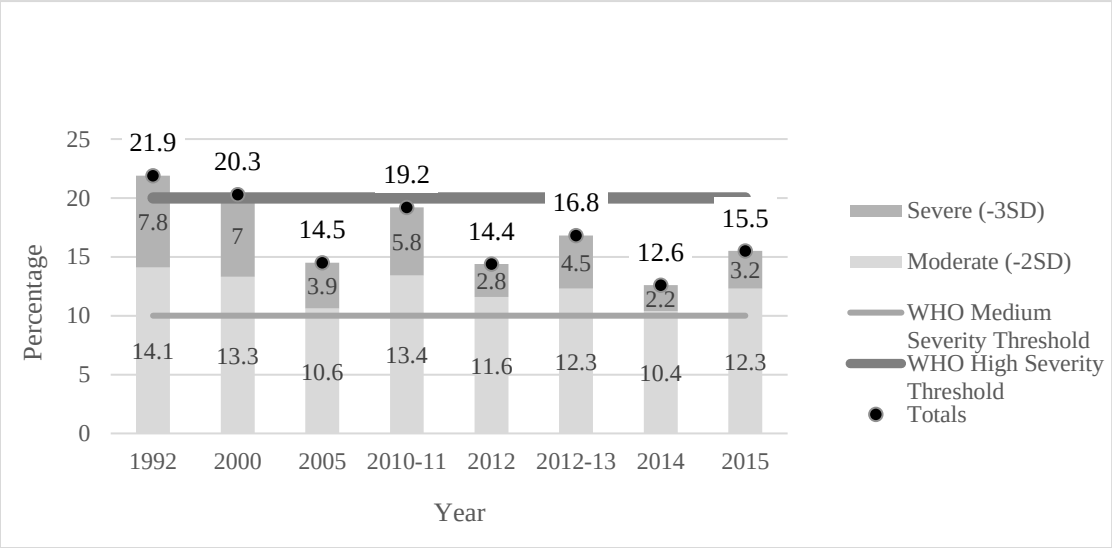
Objectives or indicators*	Outcomes†
PDO	
Project Development Objective: To reduce the risk of nutrition insecurity of vulnerable populations, in particular children under five in poor rural and urban areas, by scaling up the Government Nutrition Enhancement Program and providing cash transfers to vulnerable mothers of children under five.	
Project Outcome Indicators:	
PDO#1: % of the target population (children < 5) reached by the community nutrition program Baseline: 22% Target for 2011: 45%	65% (CLM Project Monitoring System) Target surpassed.
PDO#2: % of targeted mothers providing exclusive breastfeeding for the first six months Baseline: 34% (PAD notes that this baseline refers to national level data from 2005. Area-specific data was to become available within four months of effectiveness.) Target for 2011: +30%	62% (Source: LQAS, commissioned by CLM) Target surpassed.
PDO#3: the number of beneficiaries (individuals) of the cash transfer program Baseline: 0 Target for 2011: 50,000	49,315 in 2011; 54,512 in 2012 (Source: CLM Project Monitoring System) Target surpassed.
PDO#4: % of selected beneficiaries who receive all intended cash transfers Baseline: 0 Target for 2011: 80%	96% (Source: CLM Project Monitoring System) Target surpassed.
Intermediate Outcome Indicators	
IOI#1: % children 6-59 months screened for acute malnutrition Baseline: 0 Target for 2011: 80%	90% (Source: CLM Project Monitoring System) Target surpassed.
IOI#2: % children 0-24 months showing adequate weight gain Baseline: 60% Target for 2011: 75%	82% (2012); 83% (2013); 83% (2014); 84% (2015) (Source: CLM Project Monitoring System) Target surpassed.
IOI#3: % pregnant women making at least 4 prenatal care visits Baseline: 39% (PAD notes that this baseline refers to national level data from 2005. Area-specific data was to become available within four months of effectiveness.) Target for 2011: +30% (or 51%)	51% (Source: LQAS, commissioned by CLM) 48% (2014); 47% (2015) (Source: Continuous DHS) Target surpassed.
IOI#4: % mothers of target children who participate in monthly information and education sessions Baseline: 80% Target for 2011: 80%	95% (Source: CLM Project Monitoring System) Target surpassed.
IOI#5: % targeted children 6-59 months receiving vitamin A supplementation	94% (2012); 96% (2013); 95% (2014); 95% (2015)

Baseline: 80% Target for 2011: 80%	(Source: LQAS commissioned by CLM) Target surpassed.
% targeted children 12-59 months receiving deworming medication twice in a one-year period (no baseline or target)	89% (2014); 86% (2015)
IOI#6: % targeted children in primary education receiving weekly micronutrient supplements Baseline: 80% Target for 2011: 80%	95% (Source: CLM Project Monitoring System) Target surpassed.
IOI#7: % targeted children in primary education receiving deworming medication twice in a one-year period Baseline: 80% Target for 2011: 80%	95% (2012); 80% (2015) (Source: CLM Project Monitoring System) Target surpassed at end of project, then fully met post-project.
IOI#8: Quantity of salt adequately iodized by small producers (tons) Baseline: 87,000 tons Target for 2011: 139,000 tons	73,299 (2012); 89,209 (2014); 112,022 (2015) (Source: CLM Project Monitoring System) Target not achieved, reflecting seasonal shocks and six-fold increase in price of fortificant)
IOI#9: Quantity of adequately fortified oil with vitamin A by oil industry (liters) Baseline: 0 Target for 2011: 80,000 litres	107,178 (2012); 124,465 (2014) (Source: CLM Project Monitoring System) Target surpassed.
Quantity of iron-enriched flour produced by local industry Target for 2011: 150,000 tons	164,710 tons (2015) (Source: CLM Project Monitoring System) Post-project (2015) target surpassed.
IOI#10: % local governments incorporating nutrition objectives and interventions in Local Development Plans Baseline: 0 Target for 2011: 25%	30% (2012) and each year thereafter (2013-2015) (Source: CLM Project Monitoring System) Target surpassed.
IOI#11: % selected beneficiaries not meeting eligibility criteria (inclusion error) Baseline: 0 Target for 2011: < 20%	2.5% (Source: CLM Project Monitoring System) Target surpassed.
IOI#12: % transfers made by local payment service providers Baseline: 0 Target for 2011: 80%	76% (2010); 100% (2011); 100% (2012) (Source: CLM Project Monitoring System) Target surpassed.
IOI#13: Development and adoption by the Government of an efficient child-focused social cash transfer scheme as part of the National Social Protection Strategy Baseline: Not done Target for 2011: Done	Both the social cash transfer to mothers of vulnerable children and the community targeting system have been adopted by Government. Target achieved.

Note: *As outlined in World Bank 2009, "Appendix 1: Project Design Summary." †Mid-2012 data reported in Implementation and Completion Results Report (World Bank 2013), revalidated by the CLM, and CLM's updates for recent years.

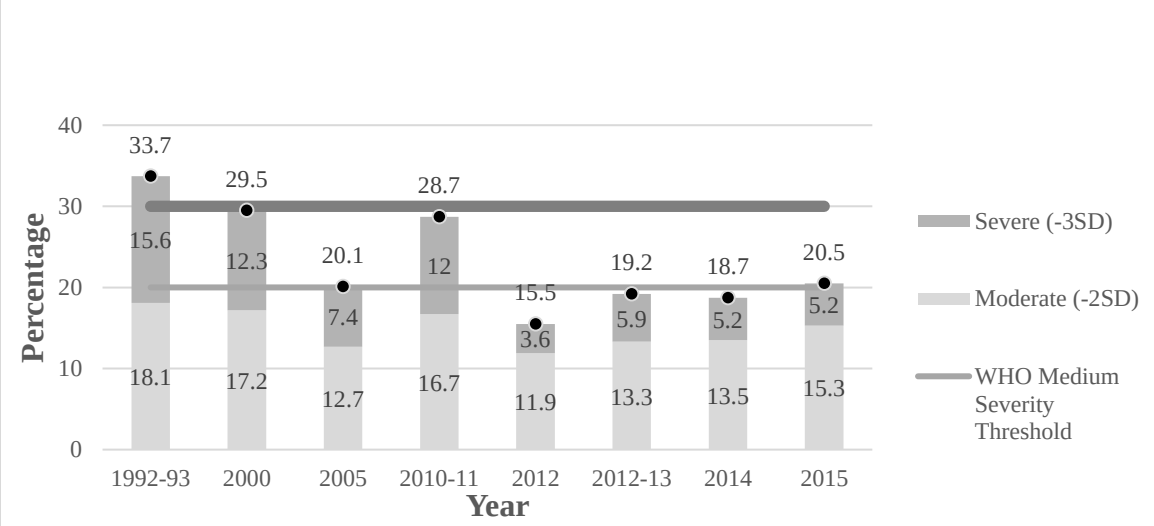
II. National Trends

Figure D.1. Prevalence of Underweight in Children under Age Five Years (Weight for Age), "Insuffisance Pondéral"



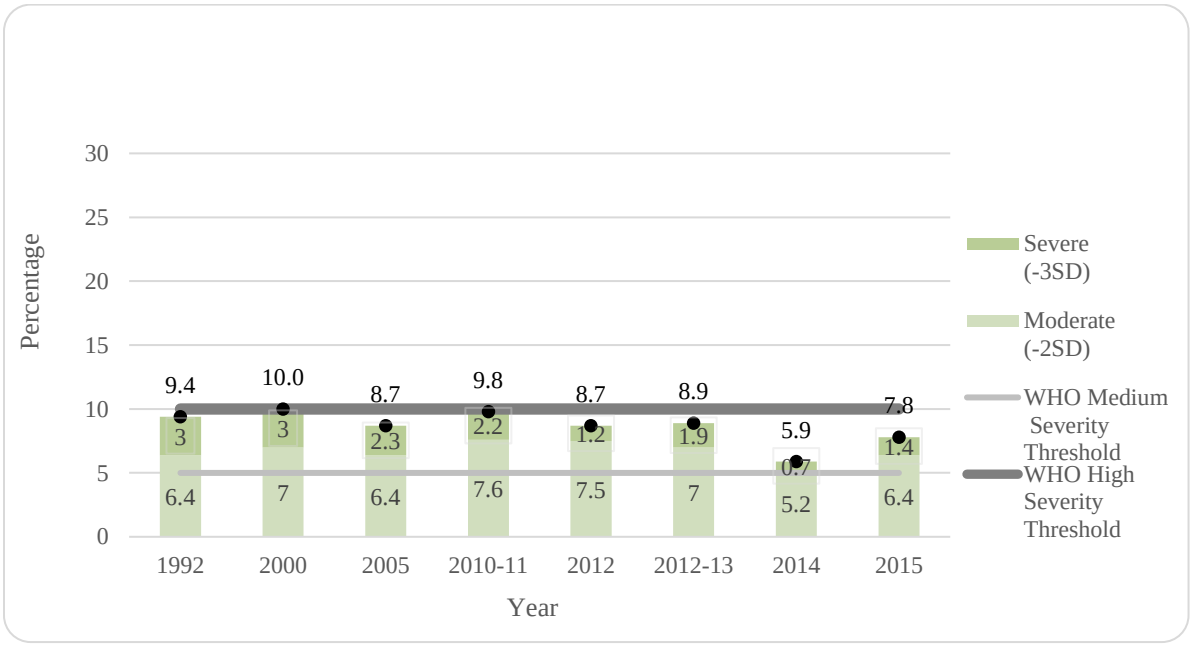
Sources: World Health Organization, Global Nutrition Data (for 1992–2012/13), which recalculates DHS data based on new comparator groups and definitions (WHO 2014, DHS 1992—93, DHS 1999, DHS 2005, DHS 2010—11, DHS 2012—13, DHS 2014, DHS 2015).

Figure D.2. Prevalence of Stunting in Children under Age Five Years (Height for Age), "Malnutrition Chronique"



Sources: World Health Organization, Global Nutrition Data (for 1992 –2012/13), which recalculates DHS data based on new comparator groups and definitions; (WHO 2014, DHS 1992—93, DHS 1999, DHS 2005, DHS 2010—11, DHS 2012—13, DHS 2014, DHS 2015).

Figure D.3. Prevalence of Wasting in Children under Age Five Years (Weight for Height), "Malnutrition Aigüe"



Sources: World Health Organization, Global Nutrition Data (for 1992 –2012/13), which recalculates DHS data based on new comparator groups and definitions; (WHO 2014, DHS 1992—93, DHS 1999, DHS 2005, DHS 2010—11, DHS 2012—13, DHS 2014, DHS 2015).

III. Program Coverage

Table D.5. NEP II Targets

Region	***Children ages 0–5 years*** (no.)	***Underweight prevalence (ages 0–5 years)*** (percent)	***Coverage target***		***Children to be reached (Rural And Urban)***	
			Rural (percent)	***Urban*** (percent)	percent	no.
Kolda	155,413	32	70	39	61	96,121
Matam	69,572	29	70	50	62	42,923
Saint Loius	96,644	28	70	45	57	55,395
Tambacounda	105,442	25	70	42	60	63,584
Louga	105,771	21	55	44	51	53,703
Diourbel	155,101	20	55	32	50	77,670
Fatik	100,649	16	45	23	41	41,523
Thies	236,749	13	45	26	37	86,850
Kaolack	184,318	11	45	17	38	69,827
Dakar	350,699	6	15	30	29	102,820
National	1,629,326	17	53	32	43	706,789

Table D.6. Population under Age Five Years, 2002–16

Year	*Total population* (*millions*)	*REACH*	*Under age five years (14.7%)*	*REACH*	*Urban under age five years*		*Rural under age five years*	
					percent	*no.*	*percent*	*no.*
2002	10.4		1.53		40.64	621,792	59.36	908,208
2003	10.7		1.57		40.78	640,246	59.22	929,754
2004	11.0		1.62		40.94	663,228	59.06	956,772
2005	11.3		1.66		41.12	682,592	58.88	977,408
2006	11.6		1.71		41.31	706,401	58.69	1,003,599
2007	11.9		1.75		41.52	726,600	58.48	1,023,400
2008	12.2		1.79		41.74	747,146	58.26	1,042,854
2009	12.6		1.85		41.98	776,630	58.02	1,073,370
2010	13.0		1.91		42.23	806,593	57.77	1,103,407
2011	13.4		1.97		42.50	837,250	57.50	1,132,750
2012	13.8		2.03		42.78	868,434	57.22	1,161,566
2013	14.2	13.9	2.09	2.09	43.08	900,372	56.92	1,189,628
2014	14.7		2.16		43.39	937,224	56.61	1,222,776
2015	15.1		2.22		43.72	970,584	56.28	1,249,416

Sources: World Bank *World Development Indicators* (http://data.worldbank.org/data-catalog/world-development-indicators); Dankoko, Dr. Boubacar Samba, "The Evolution of the Population in Senegal," Dakar, Senegal, May 2011; Index Mundu (http://www.indexmundi.com/facts/senegal/urban-population).

Note: REACH (Renewed Efforts Against Child Hunger and undernutrition) is a country- led approach to scale-up proven and effective interventions addressing child undernutrition through the partnership and coordinated actions of UN agencies, civil society, donors and the private sector, under the leadership of national governments. REACH cofacilitates the UN network for Scaling-up Nutrition (SUN), together with the UN Standing Committee on Nutrition.

According to REACH in 2013, these were totals of each target group:

- Women of reproductive age (15–49 years): 3,427,417
- Children under age 6 months: 225,708
- Children ages 6–24 months: 670,854
- Children ages 6–59 months: 1,864,180
- Children under five years: 2,089,888

Table D.7. Program Coverage by Local Collectivity

Region	Dept	Local collectivities	2005*	2013	2014		2015	2016	
			no.	no.	no.	%		no.	%
Dakar	4	52	8	29	29	56	29	0	
Diourbel	3	40	4	36	36	90	40	40	
Fatick	3	40	21	28	28	70	28	29	
Kaffrine†	4	33	12	26	26	79	26	26	
Kaolack	3	41	17	25	25	61	25	26	
Kedougou†	3	19	1	14	14	74	19	19	
Kolda	3	40	10	27	27	68	27	27	
Louga	3	55	1	39	39	71	39	39	
Matam	3	26	0	26	26	100	26	26	
Saint-Louis	3	38	3	33	33	87	38	38	
Sedhiou†	3	43	19	26	26	61	26	27	
Tambacounda	4	46	1	46	46	100	46	46	
Thies	3	49	0	30	30	61	30	29	
Ziguinchor	3	30	0	1	1	3	13	13	
Senegal	45	552	97	386	386		400	385	
Number of local collectivities			384	552	552		552	552	
Geographic coverage of NEP (percent)			25	70	70		72	70	

Note: *. In 2005 Senegal was made up of communes and rural communities and the regions of Kaffrine, Kedougou and Sedhiou did not yet exist. This table has taken into account the communes and rural communities of Kaolack, Tambacounda and Kolda and allocated them to the yet to be created regions of Kaffrine, Kedougou and Sedhiou for the purpose of trend analysis

Table D.8. Coverage of Key Interventions by Department and by Target Group

Interventions	***Departments Covered*** (no.)	***Target groups or age groups***	***Coverage***			
			<25%	***25–50%***	***50–75%***	***>75%***
Nutrition						
Vitamin A supplementation	45/45	Children ages 6–59 months				■
Iron and folic acid supplementation	42/45	Pregnant women	■			
Household fortification	45/45	Children ages 6–23 months		■		
Screening for acute malnutrition	45/45	Children ages 6–59 months				■
Rehabilitation of severe acute malnutrition	45/45	Children ages 6–59 months	■			
Rehabilitation of moderate acute malnutrition	45/45	Children ages 6–59 months		■		
Deworming	45/45	Children ages 12–59 months				■
	45/45	School children ages 5–14 years				■
Growth monitoring and promotion	45/45	Children ages 0–23 months	■			
Small scale/community fortification	19/45	Children ages 6–59 months	■			
Promotion of Infant and Young Child Feeding Practices						
Exclusive breastfeeding for under ages 6 months child	45/45	Lactating mothers of children <6 months	■			
	45/45	Pregnant women	■			
Proper feeding of children ages 6–23 months	45/45	Lactating mothers of children ages 6–23 months		■		
	45/45	Lactating mothers of children <6 months	■			
Food Security						
Development of family agriculture, livestock, fishing	45/45	Households	■			
Biofortification of food consumed in household	8/45	Households	■			
Social assistance for vulnerable groups	33/45	Households	■			
Communication for Behavior Change						
Nutrition education	45/45	Mothers or other child care providers for children under five	■			
Promotion of behavior change for good nutrition	45/45	Mothers or other child care providers for children under five	■			
Gender						
Functional literacy program	12/45	Women 15–49 years	■			

Health and Environmental Services (Promotional Activities)						
Promotion of hand washing with soap	45/45	Mothers or other child care providers for children under five				
Promotion of latrine use	43/45	Households				
	43/45	Mothers or other child care providers for children under five				
Treatment of drinking water in households	29/45	Mothers or other child care providers for children under five				
	29/45	Households				
Proper care of diarrhea	45/45	Mothers or other child care providers for children under five				
Proper care of upper respiratory infection	45/45	Mothers or other child care providers for children under five				
Reproductive health and birth spacing	19/45	Women 15–49 years				
	19/45	Pregnant women				
Healthy pregnancy monitoring (antenatal care, assisted deliveries, post-natal visits)	45/45	Pregnant and lactating women				
Disease prevention (vaccination, IMCI)	45/45	Children ages 0–59 months				
	45/45	Pregnant and lactating women				

Note: IMCI = Integrated Management of Childhood Illness.

Appendix E. List of Persons Met

Government of Senegal, National Level

Ministry of Economy and Finance

Ms. Ndeye Maye Diouf, Officer in Charge of Health and Social Development

CLM/National Level Staff

Mr. Abdoulaye Ka, National Coordinator
Mr. El Hadji Momar Thiam, monitoring and evaluation Specialist
Mr. Makick Faye, Financial Management and Accounting Specialist
Ms. Aminata Ndoye, Director of Operations
Mr. Ibrahima Gaye, Manager of the Food Fortification Program
Ms. Adama Cisse, Communication Adviser
Mr. Ousseynou Diakhate, Communication Officer
Ms. Ndeye Rokheya Seck, Thies Regional Office

CLM Focal Points Representing Various Sectors Contributing to Nutrition Efforts

Ms. Sophie Gyeye Sow, Focal Point, National Agency for Young Children (ANPECTP)
Mr. Mouhamadou Lamine Sow, Ministry of Industry and Mines
Ms. Ramatoulaye Aidara, Ministry of Commerce
Ms. Khady Mbaye, Ministry of Commerce
Mr. Ismaila Ba, Familyt Directorate, Ministry of the Family
Ms. Seynabou Tuore Laye, Ministry of Agriculture and Rural Equipment
Ms. Khady Diallo, Ministry of National Education
Dr. Maty Diagne Camara, Ministry of Health

Former Focal Points

Dr. Mame Mbayame Dione, Deputy of National Assembly, former Focal Point for Ministry of Health
Prof Galaye Sall, Pediatrics Department, Hospital Aristide Le Dantec, former Focal Point for Ministry of Health

Local Level Actors and Stakeholders

Field Visit to Louga Region-Dahra Actors

Mr. Moussa Yatte, Sous-Prefet, Sagatta Djoloff, Dahra
Mr. Mamadou War, Chief of Project, ADEV, Dahra
Mr. El Hadji Faye, Supervisor, ADEV, Dhara
Mr. Serigne Ndiaye Beye, Community Agent, ADEV, Sagatta Djoloff
Mr. Aliou Ndao, Community Agent, ADEV, Deali
Mr. Semou Diop, Community Agent, ADEV. Sagatta-Affe
Ms. Coumba Diaw, Mayor, Local Collectivity, Sagatta Djioloff
Ms. Bator Ndiaye, President, Local Pilot Committee, Sagatta Djioloff
Mme Oumou Diop, Vice President, Local Pilot Committee, Sagatta Djioloff
Ms. Fatou Ndiaye Diaw, Assistant Treasurer, Local Pilot Committee, Sagatta Djioloff
Mr. El Hadji Bassirou Ndao, Village Chief, Local Collectivity, Sagatta Djioloff
Ms. Fatou Ndiaye Faye, Nurse Chief of Municipal Health Post, Dahra

Darou Mousty Actors

Mr. Gallo Cisse, Chief of Project, Plan-Senegal, Darou Mousty
Mr. Pape Ly, Deputy Sous-Prefet, Darou Mousty Arrondissement
Ms. Fatou Fall Dieye, Chief of Service, CADL, Darou Mousty

Mr. Wagane Faye, Representative of Village Chief, Darou Mousty
Mr. Madiop Biteye, Mayor, Local Collectivity, Darou Mousty
Mr. Mamadou Sambou, Overseer of agriculture component, ANCAR, Darou Mousty
Mr. Mamadou Gaye, Village Chief, Local Collectivity, Darou Mousty
Mr. Mansour Diop, Health Educator, Local Collectivity, Ndoyene
Mr. Moustapha Badji, Nurse Chief of Health Center, Darou Mousty
Ms. Astou Toure, President, Association of Nutrition Aides, Darou Mousty
Mr. Alioune Mbaye, Director, Centre of Social Reintegration/Directorate of Social Action, Ministry of Health and Social Development, (visiting) Darou Mousty
Ms. Adja Seynabou Diop, Nutrition Aide, Local Collectivity, Darou Mousty
Ms. Ndeye Sokhna Thiam, President C.G., Local Collectivity, Darou Mousty
Ms. Cina Hosny, Nutrtrition Aide, District, Darou Mousty
Ms. Astou Toure, President, Association of Aides, Darou Mousty
Ms. Ndeye Diagne, Treasurer, Local Pilot Committee, Darou Mousty
Ms. Rokheya, Community Health Educator, Local Collectivity, Mbadiane
Mr. Modou Dema Seck, President, Local Pilot Committee, Local Collectivity, Darou Mousty
Mr. Mansour Ndoye, Community Health Educator, Local Collectivity, Ndoyene
Ms. Aissatou Sow, ECS, Health District, Darou Mousty
Mr. Amadou Ndiagne Diagne, Plan-Senegal, Darou Marnane
Mr. Ibra SEck Ba, Deputy Mayor, Local Collectivity, Darou Marname
Mr. Mor Seck, Municipal Secretary, Local Collectivity, Darou Marnane
Beneficiaries/Mothers of Dahra-Ndiayene/Dahra Djoloff
Ms. Mboyo Ka, Nutrition Aide
Ms. Hawa Sow
Ms. Oumou Sow
Ms. Farimal Sow
Ms. Toylaye Dia
Ms. Binta Diallo
Ms. Gueda Ba
Ms. Ndeye Coumba Guisse
Ms. Mareme Guisse
Ms. Fama Diaw
Ms. Diarra Ndiaye
Ms. Astou Toure, President ARC

Beneficiaries/Mothers of Darou Marnane Local Collectivity
Ms. Ndeye Diop
Ms. Fatou Ba
Ms. Anta Sock
Ms. Ndeye Sow
Ms. Kokhna Gaye
Ms. Bomba Sylla
Ms. Awa Ngom

Field Visit to Kaolack Region Actors
Mr. Cheikh Seye, Accountant, ARAF, Gossas
Mr. Momar Mbodji, Chief of Project ARAF, Gossas
Mr. Ibrahima Diallo, Chief of Project, ARAF, Guinguineo
Mr. Mamadou Sarr, President, ARAF, Gossas
Mr. Waly Faye, Secretary General ARAF, Gossas
Ms. Fatou Ndiaye, President, Local Pilot Committee, Gagnick Tibou
Ms. Oumy Ndiaye, Vice President, Local Pilot Committee, Gagnick Tigou

Ms. Awa Faye, Secretary, Local Pilot Committee, Gagnick Tibou
Ms. Ndioba Sow, Treasurer, Local Pilot Committee, Gagnick Tibou
Ms. Awa Mbaye, Nutrition Aide, Local Collectivity, Gagnick Tibou
Ms. Diaw Samb, Nutrition Aide, Local Collectivity, Gagnick Tibou
Ms. Soda Mareme Kane, Nutrition Aide, Local Collectivity, Gagnick Tibou
Mr. Mbaye Ndiaye, Nurse Chief of Health Post, Gagnick Khodjil
Mr. Falou Ndour, Chief of Departmental Livestock Service, Gossas

Beneficiaries/Mothers of Gagnick Tibou/Guinguineo Local Collectivity

Ms. Fatou Dkouf
Ms. Ramatoulaye Diop
Ms. Mboye Badiane
Ms. Ndeye Fatou Top
Mr. Aly Ndiaye, Chief of Village
Ms. Amy Ndiaye, Traditional Midwife
Mr. Mbaye Sakho, President, Association of Polyvalent Community Aides

Field Visit to Fatick Region Actors Nutri-Ecole Project

Mr. Babacar Diop, Principal, Secondary School, Mbar
Mr. Lamine Barro, Professor, Secondary School, Mabar
Ms. Cecile Man Dione, Professor, Secondary School, Mbar
Mr. Barra Dieng, Student/President Nutri-Ecole Project
Mr. Ndiaye Seye, Student/Secretary, Nutri-Ecole Project
Ms. Amy Diouf, Student/Organizer, Nutri-Ecole Project
Mr. Modou Diouf, Student/Treasurer, Nutri-Ecole Project
Ms. Racky Ane Ndiaye, Student/External Relations Officer, Nutri-Ecole Project
Ms. Aida Kane, Student/Vice-President, Nutri-Ecole Project
Mr. Alassane Sy, Student/External Relations Officer, Nutri-Ecole Project
Mr. Khadim Diouck, Student/Organizer, Nutri-Ecole Project
Mr. Aziz Seye, Student/External Relations Officer, Nutri-Ecole Project
Ms. Khady Gueye, Student/Deputy Treasurer, Nutri-Ecole Project

Mbar Actors

Mr. Mbaye Samb, Mayor, Local Collectivity, Mbar
Mr. Pape Makhtar Lo, Community Agent, Local Collectivity, Mbar
Mr. Seydou Seye, Municipal Secretary, Local Collectivity, Mbar
Ms. Mougnane Ka, Municipal Adviser, Local Collectivity, Mbar
Ms. Asou Niane, Nutrition Aide/President, Village Management Committee, Mbam Djigane
Mr. Adama Sow, Shepherd/village flock, Village Management Committee, Mbam Djigane
Mr. Aly Dieng, Village Chief/Treasurer, Village Management Committee, Mbam Djigane
Mr. Mamadou Niang, Secretary General, Village Management Committee, Mbam Djigane

World Bank

Ms. Eva Jarawan *(retired)*, Former Sector Manager, Human Development, Africa
Ms. Claudia Rokx, Former Task Team Leader, Senegal Nutrition
Mr. Menno Mulder-Sibanda, Task Team Leader, Senegal Nutrition
Ms. Leslie Elder, Senior Nutrition Specialist
Mr. Christophe Lemiere, Task Team Leader, Senegal Health
Ms. Aminata Bop Ndiaye, Administrative Assistant
Mr. El Hadji Mamadou Cisse, Financial Management and Accounting Officer

Other International Development Partners and International Experts

Ms. Aissatou Dioum, Nutrition Specialist, UNICEF

Mr. Ibrahima Mbodji, Communication Expert, UNICEF
Ms. Yaikah M. Jeng Joof, Program Director, Childfund
Dr. Balla Moussa Dhiedhiou, Director for the Sahel, Micronutrient Initiative
Ms. Megan Kyles, Nutrition Leader, USAID
Ms. Maria E. Garcia Noguera, Officer for Humanitarian Programs, AECID/Spanish Cooperation
Ms. Marieme Diaw, Nutrition Program Officer, World Food Programme
Ms. Aida Gadiaga Facilitator, REACH
Ms. Sophie Cowppli-Bony, International Facilitator, REACH
Ms. Elodie Becquey, Research Officer, International Food Policy Research Institute (IFPRI)