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

Concept Stage | Date Prepared/Updated: 15-Mar-2018 | Report No: PIDISDSC24049

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Benin	P166211		Early Years Nutrtion and Child Development Project (P166211)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Nov 12, 2018	Jan 22, 2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Economy and Finance	Permanent Secretariat of the national Food and Nutrition Council (SP/CAN)	

Proposed Development Objective(s)

The development objective is to increase the coverage and utilization of early nutrition and child development interventions in selected areas in the Recipient's territory

Financing (in USD Million)

SUMMARY

Total Project Cost	32.00
Total Financing	32.00
Financing Gap	0.00

DETAILS

Total World Bank Group Financing	32.00
World Bank Lending	32.00

Environmental Assessment Category	Concept Review Decision
C-Not Required	Track II-The review did authorize the preparation to continue

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Other Decision (as needed)

B. Introduction and Context

Country Context

1. Benin is a small coastal country with a growing population of about 10.9 million people, including many young people between the age of 0-14 years (approximately 43 percent). Economic growth has increased from 2012-2016 to around 4.9 percent, and further increased in 2017 to 5.4 percent. This trend is expected to continue, with an average of 6.3 percent economic growth estimated for the period of 2018-2020. Despite steady growth, Benin remains a low-income country with a per capita income of US$ 771 in 2016. Per the 2015 Human Development Index, Benin ranks 167th out of 187 countries. While poverty improved marginally from 2006 to 2015, given the rapid population growth (about 3.2 percent), the absolute number of the poor in Benin increased from 5.0 to 5.3 million people. The average annual growth in GDP per capita is about 1 percent, below the Sub-Saharan African average and far below the best performing economies. A substantial portion of the population live in high vulnerability, especially in rural areas, which account for 56 percent of the population, and 65 percent of the poor population (World Bank, 2016).

2. Benin's economy is concentrated around agriculture production, informal transit trade to Nigeria and a few large formal enterprises. Most rural poor are smallholder farmers, cultivating maize and yams for their own consumption and selling cotton, oil-palm and fruits and vegetables as cash crops. Agricultural yields are low and below those of other countries in the region. Agricultural GDP growth has been the result of acreage expansion and increased labor effort as opposed to increases in productivity due to the use of improved inputs and technologies. Benin also has a large and growing informal economy linked to the transit of goods from and to Nigeria by land and water.

3. Benin is widely regarded as one of the more successful cases of democratic transition within Africa. Since 1991, elections have been held on peaceful terms without incident. In 2016 the Presidential election was won by Patrice Talon, a prominent businessman, and Benin adopted an ambitious reform program called "*Programme d'Actions du Gouvernement 2016-2021*" structured to improve the productivity and living conditions of the population. The program includes a focus on improving human capital development and decentralization, and nutrition is a transversal priority. While the government has widespread population support, there are high expectations. Pressure is mounting to accelerate efforts to reduce high youth unemployment, accelerate economic growth, and improve the quality of public services. In addition, the government faces political opposition to some of the proposed reforms in governance structures. Economic growth in Benin also has shown to be volatile to political cycles (for example, in 2005, 2010, and 2015 economic performance worsened).

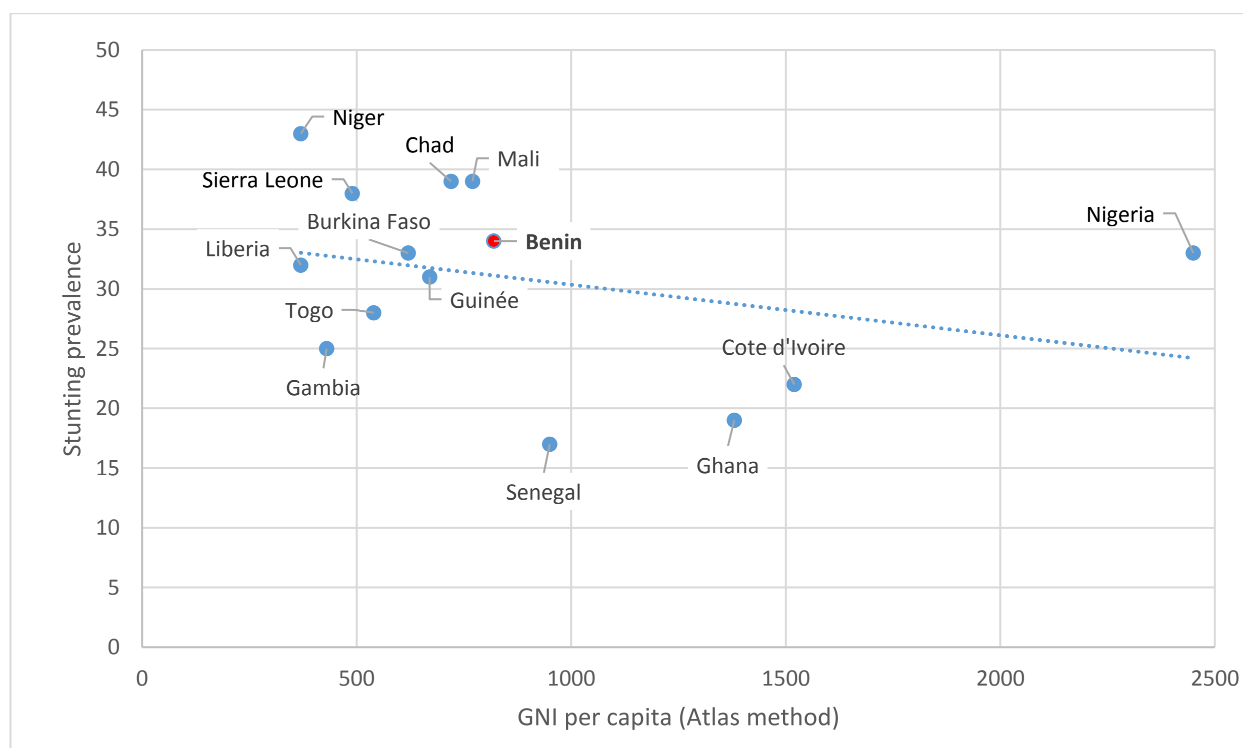
Sectoral and Institutional Context

4. **Benin has made some progress on child health, but child malnutrition remains a major impediment to ensuring optimal accumulation of human capital in the country, and one of the key markers of poverty and vulnerability.** Benin has about 3.3 million children between 0-8 years of age, including 1.8 million children 0-4 years (World Bank 2015). The healthy development of these children is critical for human capital accumulation. Child under-five mortality rates in Benin dropped from 160 (per 1000 live births) in 2001 (Demographic Health Survey or DHS 2001) to 115 in

2014 (Multiple Indicator Cluster Survey or MICS 2014). This is mainly due to improvements in the use of bed nets in households (81 percent, MICS 2014), children receiving vitamin A supplementation (95 percent, Ministry of Health 2016), and immunization coverage (63 percent of children are vaccinated for measles, MICS 2014). Child malnutrition, however, including fetal growth restriction, suboptimum breastfeeding, stunting, wasting, iron and other vitamin and mineral deficiencies continues to cause up to 45 percent of under-five deaths annually (Black et al, 2013).

5. **Childhood stunting remains high compared to other West African countries, and poses considerable risk of human develop loss for the country.** Stunting prevalence among children under-five, which is among the best markers to assess child development, increased sharply from 36 percent to 43 percent (DHS 2001; 2006), but then dropped to 34 percent (MICS 2014), yielding only a marginal improvement in stunting rates since 2001. Compared to other countries in the region and their Gross National Income, Benin is not faring all too well (Figure 1). Moreover, due to population growth and continued high fertility (per the 2014 MICS, 5.7 children per women nationally and 6.0 in rural areas), the total number of stunted children has increased since 2001. Childhood stunting is the result of inadequate food intake and repeated disease incidence, particularly in the first 1,000 days of life and below the age of five. Adequate food and care, birth spacing, clean water, sanitation, a nurturing environment and health care during early childhood years are important factors for good nutrition and child development, but access to these factors is limited in Benin. Exclusive breastfeeding of children 0-5 months similarly increased to 41 percent in 2014 (MICS), likely due to the increased emphasis on nutritional programming. In 2012, exclusive breastfeeding dropped to 32 percent, from 43 percent in 2006 (DHS). Only 25 percent of children 6-24 months in Benin have the minimum required food diversity for their development (MICS 2014).

Figure 1: Stunting rates and Gross National Income per Capita in various West-African countries



6. **The first 1,000 days which is conception to two years of age is a critical window to address stunting.** There is strong global evidence showing that the "first 1,000 days" of a child's life is the most critical for addressing malnutrition; this

is the segment of the life cycle when most physical growth, brain development, and human capital formation occurs. If a child does not receive proper nutrition during this critical period, irreversible damage occurs. In Benin, growth retardation starts during pregnancy with 19% of Beninese children born stunted. The rate of stunting rapidly increases to approximately 40% at the age of 24 months after which it levels off. Maternal nutrition, particularly maternal anemia, is an important cause. Equally important is the fact that one in five women aged 20-24 years have experienced a life birth before the age of 18 years.

7. **Stunting prevalence is highest for the 40 percent of poorest households and in northern regions, implying potentially lower prospects for their future income.** Per the 2014 MICS, stunting is more than twice as high among the poorest population quintile (46 percent) than among the wealthiest quintile (18 percent). Stunting is also higher in children where the mother has no education (39 percent), compared to 30 percent in children of mothers with primary education. Geographically, prevalence is highest in the northern departments, like poverty incidence. Malnutrition in the early years is known to impair cognitive, physiological and socioemotional development, thereby undermining educational performance during school age, health, and earning potential as an adult. Poverty, malnutrition, and low educational attainment tend to be mutually reinforcing and self-perpetuating as a poverty trap. Chronic malnutrition (manifested as stunting) is estimated to cost Sub-Saharan African countries an average GDP reduction of about 9 percent annually. Benin's per capita income is about 12 percent less than it would have been if none of its workforce had been stunted in childhood (Galasso 2017).

8. **Children vulnerable to the multiple risk factors for stunting are the same children most at risk for long-term disadvantages in learning associated with poor early childhood development (ECD).** There is limited support for parents to adequately stimulate the cognitive development of their children; only 13 percent of children 36-59 months nationally and 2 percent in the poorest income quintile attend early childhood education. This is against a 98 percent new primary school enrollment rate with the onset of universal education. Parents often lack the knowledge to provide stimulation and learning support to prepare their young children for school, even when children formally attend early childhood education. Only 28 percent of children 36-59 months nationally and 18 percent in the poorest income quintile are engaged in four or more activities for their learning. Hence, even if learning and stimulation is not organized in a formal setting, parents are often not supported or engaged, to simulate this learning in their home or community environment. Changing the engagement of parents in early learning is critical to results. An estimated 34 percent of children under five years of age are left in inadequate care, affecting their food intake, emotional and physical development (MICS 2014).

9. **Health and social services have improved but often do not reach vulnerable women and children.** Maternal mortality fell from 498 (per 100,000 live births) in 1996 to 347 in 2014. The rate of assisted delivery in health facilities is relatively high at 77 percent (MICS 2014), but there remain inequities in access to care between regions and wealth quintiles. However, many families do not use facility-based health services, due to distance, knowledge, gender constraints, cost, among other factors. Only 35 percent of women in the poorest quintile have the minimum recommended number of four pre-natal visits during their pregnancy, compared to 59 percent nationally (MICS 2014). Further, the quality of services to provide a continuum of care for women and children from pregnancy and birth through ECD remains weak. In addition, only about 76 percent of births in rural areas are registered by the local administration (UNICEF 2012), although a right under the Children's Act in the Republic of Benin. Further, 20 percent of women give birth before the age of 18, increasing the health and nutrition risks for mother and child (MICS 2014). The utilization of contraceptive to space births or delay pregnancy has changed minimally for women aged 15-49, from 17 percent in 2006 to 18 percent in 2014 (DHS 2006; MICS 2014). Table 1 gives an overview of relevant early years indicators at three points in time in as far as data is available.

Table 1: Outcomes on selected early years indicators (2006 DHS; 2012 DHS; 2014 MICS)

INDICATORS	2006	2012	2014	Change since 2006
Health and Nutrition Status				
Infant Mortality Rate (per 1,000 live births)	67	42	67	NC
Under Five Mortality Rate (per 1,000 live births)	125	70	115	NC
Total Fertility Rate	5.7	4.9	5.7	NC
% women age 15-49 who are anemic	61	41	-	++
% undernourished women	9	6	-	++
% overweight and obese women	19	27	-	---
% low birth weight babies	13	13	13	NC
Anemia (% of children under 5)	78	58	-	++
Stunting (% of children under 5)	43	-	34	++
Health Services				
% married women using modern contraceptives	6	8	13	++
% unmet demand for family planning	30	33	18	++
% women 20-24 years who gave live birth before age 18	23	23	19	++
% women who receive at least 4 antenatal care visits	61	58	59	NC
% of children age 6-59 months receiving vitamin A supplementation in the previous 6 months	61	49	-	---
% children 12-23 months completely vaccinated by age 12 months	40	43	42	NC
Feeding/Care behaviors				
% children 0-24 months initiating breastfeeding within 1 hour after birth	-	50	47	NC
% children 0-5 months exclusively breastfeeding	43	33	41	NC
% children 0-5 months bottle feeding	7	13	11	---
% children 6-23 months consuming a minimum acceptable diet by age	-	-	14	
% children 6-23 months having received minimum meal frequency	49	42	53	++
% children 0-59 months in household consuming adequately iodized salt	60	-	39	---
Early Learning				
% children 36-59 months in preschool program	-	-	13	
% children 36-59 months with adult member engaged in at least 4 learning activities in last 3 days	-	-	28	
Water and Sanitation				
% households with access to improved water source	35	77	72	++
% households with improved toilet	15	16	33	++

NC = No change; ++ = Relative improvement by 10% or more; --- = Relative deterioration by 10% or more

10. **Ensuring a healthy and nurturing environment for young children is a critical challenge to Benin's human capital development.** Although there is still limited evidence on the best approach to deliver these services at scale, early experiences indicate that incorporating early stimulation interventions into community-based health and nutrition services is more cost effective than delivering ECD interventions alone (Gowani et al., 2014). An integrated community-based platform also provides a natural entry point to access vulnerable families, such as for engaging mothers (and other family members) in responsive breastfeeding and complementary feeding. Moreover, it is more cost-effective to intervene early in life as the brain is still in the process of developing and development trajectories can be influenced to establish a positive developmental track. Ensuring disadvantaged children are on-track from a young age can address underlying constraints and inequalities which limit opportunities for human capital accumulation later in life. A key aspect of the effectiveness of these integrated community-based programs is there influence on multiple aspects of behavioral change in families when tailored to the local context, e.g., Reach Up and Learn and the Care for Child Development (UNICEF/WHO; Britto et al, 2017).

11. **The Government has demonstrated strong commitment to multisectoral and stakeholder coordination to address complex challenges underlying nutrition and child growth.** The Government of Benin expressed their commitment when joining the global Scaling Up Nutrition (SUN) movement in 2011 and has taken strong leadership in developing multisectoral policy and actions for nutrition since 2009. At the national level, a multisectoral coordination forum has been established. This National Food and Nutrition Council (CAN) is the multisectoral policy coordination platform with a Permanent Secretariat (SP/CAN). The CAN brings together different sectors (including agriculture, health, social protection, finance, planning, decentralization, industry sectors, national associations, academia and civil society) under the auspices of the President to develop and coordinate multisectoral nutrition policies and programs for enhanced human development. Each of these authorities is expected to take actions to address nutrition strategically. This is a new paradigm for all sectors and building the capacity of the CAN to effectively coordinate actions horizontally (between sectors) as well as vertically (between levels of administration) is a long but high priority process.

12. **The CAN is leading the development of a harmonized approach for the promotion of improved nutrition in the first 1,000 days, involving a multitude of actors at different levels.** This approach is actively supported in 40 out of the nation's 77 districts with all 77 districts expressing commitment to nutrition in the new generation of their Development Plans (PDC).[1] These 40 districts have established multisectoral coordination platforms (i.e., *"Cadre Communal de Concertation"* or CCC) to deliver nutrition and child growth promotion services. These CCCs bring together all the actors at the district level including district council member, representatives from line ministries at the decentralized level, public service providers, representatives of NGOs and local associations, and prominent community members, including traditional and religious authorities. Each CCC is housed in and chaired by the Mayor's office, which in turn is assisted by a full-time Nutrition Focal Point. Performance of the CCCs varies according to local leadership but is improving across the board as the CCCs gain experience but also receive ongoing coaching support from the SP/CAN and the National District Association (ANCB which stands for "*Association Nationale des Communes du Bénin")*.

13. **The CCCs are at the heart of the decentralized platform for multisectoral community-based service delivery for nutrition development** that also includes the "*Groupe d'Assistance en Nutrition" (GAN)* or Nutrition Care Groups at community level across the 40 districts. The GANs are community-based groups of approximately 20-25 members who are trained to deliver services with a particular focus on social and behavior change communication. Each GAN member takes around 10-15 households under his/her wings. Depending on the size of the community, there can be multiple GANs in one community which together ensure complete household coverage to deliver services. This is an inclusive form of community mobilization that is still relatively new to Benin.

14. **There is an opportunity to reinforce the existing multisector platform on nutrition and form new synergies in areas of education, communication, social and legal protection, and others.** The National Policy for the Integrated Development of Young Child in Benin was developed in 2010 by a multisectoral committee chaired by the Ministry of Planning and Development with the support of UNICEF. The policy calls for integrated actions in areas of parenting education, child stimulation, sanitation, child rights, food production, access to health services, communication and education. Investing in the early years has however been complex because of the compartmentalization of child nutrition and development efforts. Multiple authorities bring a piece of the puzzle, each with their own approach. Moreover, across the multiple sectoral policies there is limited selectivity around what is most needed to ensure the on-track development of young children, as well as lacking vision around how to integrate interventions at the

[1] Benin is subdivided in 12 administrative regions (Département) and 77 districts (communes). The districts are local authorities with legal status and financial autonomy and are governed freely by an elected council. The Mayor is the head of the district.

community-level. Interventions, in particular early learning interventions, remain fragmented, lacking coordination. For example, the Ministry in charge of social affairs has developed some resources for parenting education. The Ministry of Pre-School and Primary Education looks after pre-school education in only a few selected communities due to budget limitations. Most (sectoral) policies have not mainstreamed ECD strategies or actions specifically. The Ministry of Planning and Development, also a member of CAN, has chaired a second related but separate committee for the development of a policy on child protection.

15. **The conditions are ripe for targeted investments in the early years with high returns on human capital formation.** Mainstreaming ECD would require strengthening the CCC platforms to include parenting education and child stimulation and other evidence based approaches. The current package already engages agriculture, health and social protection. The reinforced package would need to address multiple constraints faced by disadvantaged children: inadequate access to enough diversified foods of high nutrient value throughout the year; poor infant and young child feeding practices sustained by inadequate knowledge on these issues; near-absence of family-level services to monitor growth; parents having inadequate knowledge to support child stimulation; inadequate hygiene and sanitation practices; are all constraints in Benin that irreversibly damage the outcomes of child development and nutrition status.

16. **In Benin, various non-governmental organizations have piloted operational experiences with early learning activities for the development of young children.** These experiments are often small-scale and short-lived, and therefore have limited benefit and often do not appear in the statistics. Among the major challenges of the many activities implemented so far are: (i) the high cost of extending them to all Benin municipalities; (ii) weak knowledge sharing and strategic collaboration between the government and NGOs with relevant field experiences; and (iii) the weak implication of parents in early learning activities. Therefore, there is a need to better capitalize the various models that are effective at lower cost and can be replicated at the district level to ensure greater coverage. In addition, to improve the spatial prioritization of which communities receive specific interventions to maximize results, resource allocation, and the address of the multiple underlying factors influencing nutrition and child development.

17. **Strengthening community service delivery is needed to expand the utilization and coverage of services.** The sectoral services at the district level, such as health, social protection and education lack sufficient outreach to deliver services outside the physical facilities (health centers, social action centers, primary and nursery schools). Moreover, the weak but existing outreach lacks structure and support to deliver quality services as well as a sustainable business model to ensure motivation and incentives to sustain services. Strengthening the CCC platform of public service providers to deliver nutrition and ECD services is a critical challenge. Similarly, the capacity of the GAN networks to engage in effective social and behavior change communication needs harnessing.

18. **Successful community-level programs need to transform behaviors and gender roles, engaging community leaders, men and women.** Gender analysis identified the patrimonial influence of the male partner and his family as a main constraint to empowering women’s decision-making in regards to the use of nutrition and child development services and decisions in the household (CAN, 2016). Despite the predisposition of women to participate in community activities, they are often excluded from decision-making at family and community level. The absence of women among the 3,743 village chiefs is expressive of this situation, in addition to their under-representation in other elective and professional positions, including within the civil society organizations. The man’s family establishes a women’s schedule and influences decisions over activities, from food preparation to decisions to use health care and discipline children, especially in the case of less educated women. Communication, community mobilization and the delivery of services needs to address this constraints, targeting the co-responsibility of the mother and the father, in a transversal way: to encourage men's participation in nutrition and child development activities; to improve the involvement of women in food production; to encourage influential community leaders to promote co-empowerment of the father

and the mother on household issues; and encourage women's effective participation in local committees to improve services. Key is a process of transforming social relationships and roles in the community.

19. **Reinforcing leadership and decision-making capacity at the decentralized levels is required to effectively expand services in districts**. Most child development and nutrition programs in Benin have been planned, monitored and managed by and from the central level, influencing the scale, scope, effectiveness, ownership, and sustainability of the programs. With the emphasis on local governance there is an opportunity to reverse this constraint, and empower local government, civil society and community groups, anchored in the CCC, to manage early years investment programs. Districts now systematically include nutrition in their local development plans (PDC which stands for "Plan de Développement Communal") and have started to foresee financial contributions to the program through their annual budgets. To enhance the ownership by districts, the Government is in the process of adjusting the district budget framework as well as "*Fonds d'Appui au Développement des Communes*" (FADeC), which is the mechanism by which national resources are transferred to the districts, to better enable the districts to invest in the district-level nutrition activities.

20. There is also the challenge of decentralizing data collection and use for monitoring and evaluation (M&E) to inform the implementation of interventions. The data to inform early years investments is spread across sectors, and not used at the district level. Community groups such as parents' groups also lack participation in government decisions to influence services for young child development, while parent groups for older children may be active. Moreover, these groups often lack knowledge and organization to effectively promote the rights of families in terms of actual benefits to expect from services, limiting the opportunity for meaningful collaboration, i.e., within the CCC structure, to improve the quality and tailoring of services.

Relationship to CPF

21. **Benin is joining the list of priority countries under the World Bank's commitment to invest in human capital development in the early years of life, given its pioneering role in developing multisectoral policy and services for nutrition.** The new operation builds on the Benin Multisectoral Food Health Nutrition Project (2014-2019), which enabled the President's office, led by the CAN to develop the multisectoral coordination structure for nutrition and enhanced human development programs in Benin. The new operation will broaden the focus on key actions for human development in the early years of life, such as parenting skills including positive discipline, stimulation of children to prepare them for lifelong learning, and child protection including the right to birth registration, in addition to promoting nutrition and healthy growth.

22. **The proposed operation is thus fully aligned with the focus area of investing in human capital of the new Country Partnership Framework (CPF) FY18-FY22.** The CPF identifies investing in human capital as one of three focus areas for reversing Benin's slow progress towards the goals of eliminating extreme poverty and boosting shared prosperity. Through investing in human capital, the CPF aims at increasing the inclusion of the poorest 40 percent of the population by improving their capacity, productivity and resilience to achieve a higher level of human capital development. The CPF calls for improved education for formal sector employment (objective 5) as well as improved social protection, health and nutrition (objective 6) to invest in human capital. The operation fall under objective 6 in its support of holistic efforts for young children in beneficiary households to achieve their full physical and cogitative potential, and to communities to become more resilient and protected from malnutrition. The project also contributes to the Sustainable Development Goals (SDGs) targeted by the CPF: SDG 2, end hunger, achieve food security and improved nutrition and promote sustainable agriculture; SDG 3, ensure healthy lives and promote wellbeing for all at all ages, and SDG 5, achieve gender equality and empower all women and girls.

23. **The operation will also contribute to results in cross-cutting CPF themes of governance and women's economic empowerment, reinforcing the achievement of all development outcomes in Benin.** The operation will build collaborative leadership across sectors nationally, focusing especially on the capacity of district-level government to coordinate, plan, implement, finance and monitor multisectoral social services, reinforcing Benin's system of decentralized governance. In targeting parents, the operation will also influence social norms and gender roles that lead to suboptimal child development and nutrition outcomes and foster women's leadership in community and district level decision making, in relation to the quality delivery of services.

C. Proposed Development Objective(s)

The development objective is to increase the coverage and utilization of early nutrition and child development interventions in selected areas in the Recipient's territory

Key Results (From PCN)

24. At the impact level, the project will contribute to more children being able to reach their full potential by promoting healthy growth, stimulation and early learning. Together these activities will improve children's readiness for human capital accumulation throughout their life course.

25. The proposed outcome indicators of the PDO are as follows:

	Indicator	Explanation
i)	Children 0-59 months who benefit from a package of early child nutrition and development interventions	The indicator will assess the increased utilization of a package of early child nutrition and development services in targeted communities.
ii)	Caregivers educated on parenting practices based on parenting modules in last 3 months	The indicator will assess the increased coverage of parenting education in targeted communities.
iii)	Children 6-23 months with a minimal acceptable diet	The indicator will assess social and behavioral change catalyzed by the increased utilization of nutrition services.
iv)	Districts rated satisfactory in the execution of the package of family services per a scorecard	The indicator will assess the increased coverage of the package of early child nutrition and development interventions for families by providing information on the extent of delivery of the services in the district level government programs across the targeted areas.
v)	Nutrition Care Group members trained and providing services to households	This indicator will assess the extent to which Nutritional Care Groups or GAN are reinforced to expand the coverage of services at the community level. Training includes knowledge to deliver the defined services as well as skill building to manage services over the longer-term.

D. Concept Description

26. The project beneficiaries will be children under five years of age as well as their mothers and caretakers (including men) in the targeted districts. The activities will be implemented in selected areas of the country, focusing on the poorest communities. The operation will engage government ministries and agencies involved in nutrition and enhanced human development policies and programs to become key drivers of change at the national level. The National District Association (***ANCB)*** and non-government partners with expertise in early nutrition and child development interventions are among those drivers of change at the national level. At the decentralized level, change agents will include the local government structures and the CCCs, while at community-level, these are the GANs as well as community leaders (including traditional and religious leaders) and women's and parents' associations.

27. The development objective to increase coverage and utilization of nutrition and other early years interventions will be achieved through a multi-pronged change strategy across three components: 1) Leadership for Human Capital Formation during the Early Years; 2) Community Nutrition and Child Development Service Delivery; and 3) Multi-Stakeholder Monitoring, Evaluation and Learning. What follows is a short description of the proposed components.

28. **Component 1: Leadership for Human Capital Formation during the Early Years (estimated financing: USD 4 million).** This component will support the development of an integrated approach to coordinate the multitude of stakeholders involved in early years' nutrition and child development interventions, and build leadership to collaboratively communicate and implement a holistic package of family services. This will include the strengthening and improvement of the framework for multisectoral policy coordination and implementation at central and decentralized levels. Typical expenditures will include training, supervision, monitoring, workshops, operating costs of coordinating structures at the district and central levels, consultants, reproduction of material, and equipment and material.

29. At the national level, the project will reinforce the existing coordination platforms of the CAN and in the Ministry of Planning and Development. Consensus will be built around an integrated policy framework, and cascading roadmap and results indicators for a holistic package of decentralized nutrition and child development interventions for families. This will build on the existing nutrition and child development policies to coordinate and prioritize interventions across the network of stakeholders from government ministries and agencies (including those in charge of social protection, education, health, agriculture, communication) and non-government (including NGOs, academia, national associations, etc.) involved in early years' nutrition and child development. The roadmap and results indicators will be anchored at the district level to support decentralized stakeholders to lead implementation of the family services. The national level support will include learning materials and coordination activities to structure the decentralized services across districts.

30. At the decentralized level, leadership to deliver multisectoral services will be strengthened. The project will support activities to reinforce the role of Mayors and the multisectoral CCC platforms in developing annual work plans and engage sector, non-government and community stakeholders collaboratively to coordinate and implement a package of key family services. The work plans will align to a medium-term strategy integrated in the district's development plan or PDC and reinforce the use of FADeC resources. Each district will also plan an accompanying program (results-based leadership coaching, training, tools, etc.) to strengthen the implementation of the family services. The results-based leadership coaching will support multisectoral implementation teams from the CCC members to work together to demonstrate progress on the cascading results indicator. The coaching will be organized with quarterly targets to progress results indicators in each district, and support CCC teams implementing interventions to analyze bottlenecks and tailor local innovations to the set-up of the services in the districts. Other accompanying activities will provide the districts with knowledge, tools and technical support to ensure the quality of the family services.

31. **Component 2: Community Nutrition and Child Development Service Delivery (estimated financing: USD 24 million).** At the community level, nutrition and child development service outcomes will be improved by strengthening the network of GAN to deliver family services (including nutrition, parenting support and child stimulation); as well as through strategic communication and stakeholder mobilization to influence social norms, gender roles and behaviors. The GAN will be equipped to deliver household- and community-based services across the villages that are complementary to and reinforce facility-based services (of health, social protection, education, other), enabling broader coverage and utilization, even in remote villages. The community voice and ownership of services will be reinforced through a citizen scorecard, which will engage women's groups to steer service improvements. The component will consist of two subcomponents: 1) Expansion of Early Years Nutrition and Child Development Service Delivery in Communities; and 2) Community Behavior Change and Voice of Women.

32. **Subcomponent 2.1. Expansion of Early Years Nutrition and Child Development Service Delivery in Communities.** The financing under this subcomponent will support the delivery of a package of family services by GAN in villages. The project will engage NGOs using a performance-based contracting model to mentor GAN groups to structure the delivery of the family services. The activities will equip and develop the knowledge and know-how of a network of GAN across rural villages to manage and deliver a package of services for i) growth promotion and monitoring, ii) education and coaching parents in positive approaches, and iii) child stimulation. The services will be delivered through family visits to households in the community, and the development of informal community spaces for child feeding, breastfeeding, as well the stimulation of children and the education of mothers, fathers and caregivers. Each GAN member will cover about 10-15 households. The GAN services will be synergistic to the sectoral services in the district (of health, social protection, agriculture, education, other), enabling broader coverage, even in remote villages.

33. In the target districts, CCCs will develop joint action plans to strengthen the GAN network to manage the family services over the medium-term, in collaboration with the district administration. The project will pilot innovative low-cost interventions to reinforce the ownership of communities and GAN members in quality service provision. Experience of projects in Benin (by NGOs and other donors) and evidence from other countries will inform the selection of the innovations. The piloting process will be supported by an external agency to evaluate the learning from the different innovations and develop recommendations for broader scale-up.

34. **Sub-component 2.2. Community Behavior Change and Voice of Women.** The ownership of the nutritional and child development services in districts will be reinforced through strategic messaging and mobilization of influential leaders (political leaders, community leaders, women, parent's associations, among others). These activities will accelerate behavioral change among women and caregivers, such as child feeding and stimulation practices. Each district will develop and implement a community mobilization and communication strategy to strategically identify stakeholders who can play influential local roles, as well as clear communication messages. The focus will be on influencing changes in social, cultural and gender norms, which may otherwise constrain results or even inhibit decision-making by women and caregivers to take-on new behaviors to ensure their children's development is on track. Implementation of the strategy will involve developing a participatory action program to engage key groups to intensify the results at the district level.

35. Social mobilization will also include the development of a citizen scorecard to monitor community feedback on the delivery of the nutritional and child development services, focusing on the voice of women's and parent's groups. The score card will assess satisfaction with service delivery at the sector level, as well as at the community-level. It will also include an assessment process to improve services, based on the community feedback, followed by re-assessment of the services after identified improvements were made.

36. **Component 3: Multi-Stakeholder Monitoring, Evaluation and Learning (estimated financing: USD 4 million).** Monitoring, evaluation and learning will improve decision-making at the national and decentralized level to guide the effective implementation of nutritional and child development programs. The triangulation of quantitative and qualitative information will be used to inform implementation, including: data from service delivery by the CCC (sectors, GAN, NGOs, other); information on implementation bottlenecks; evidence on the piloting of innovations with the GAN; and citizen feedback on services. Knowledge management and sharing will support the scale-up of results by translating information on successes across districts. Geo-spatial analysis will help aggregate data to reinforce management decisions across districts. What follows are some of the proposed knowledge management strategies that the project intends to apply.

37. *Learning about effective delivery models.* The project will develop an operational research agenda to gather evidence on interventions in the Benin context, including studies on the cost-effectiveness of different services and delivery approaches to inform the investment case for the long-term delivery of the services in the government program to advance key nutritional and child development outcomes. The agenda will engage national stakeholders, from sectors, NGOs and academia as well as districts.

38. *Capitalization of experiential knowledge*. The SP/CAN and ANCB will engage national stakeholders in a knowledge management strategy. This is critical given the pioneering nature of the project, and need for cross-fertilization of experiences across districts, as well as countries implementing similar approaches. Multiple qualitative methods of process learning and knowledge capture, such as outcome harvesting (i.e., collecting evidence of what has changed and, then, working backwards, determining whether and how an intervention has contributed to these changes) and positive deviance approach, will be systematically employed to create a toolkit to share implementation knowledge and lessons, which can guide nutritional and child development services in the districts. The ANCB will be reinforced to lead the knowledge sharing including peer-to-peer learning across districts to support the CCCs in the implementation of the multisector services.

39. *Strengthening multi-stakeholder decision-making*. The project will strengthen decision-making by national stakeholders and districts by developing a package of tools for result management. This will include triangulating different data sources to inform implementation decisions: data on community satisfaction with services from citizens' scorecards; data on community knowledge and behaviors from knowledge attitude and practice (KAP) surveys; data from targeted qualitative analyses conducted to understand implementation bottlenecks at the district level; data from community services delivered by the GAN and NGOs; data from sectoral services (health, social protection, education, agriculture); data from a project baseline and end line survey. Each district will develop a dashboard with key indicators, and Mayors and CCC stakeholder will be supported to use the data for decisions on the development and tailoring of the family service package. Data sources will also be aggregated nationally and regionally to compare the situation across communes, including using geo-spatial analysis to visually compare progress on key indicators in different communities. The results-based leadership coaching (in Component 1) will reinforce the capacity of districts to engage local stakeholders from CCCs to use the available data to inform course corrections to progress targeted results indicators.

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SAFEGUARDS

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

The project will be nationwide.

B. Borrower's Institutional Capacity for Safeguard Policies

There are no Safeguard Policies triggered by the project.

C. Environmental and Social Safeguards Specialists on the Team

Abdoul Wahabi Seini, Social Safeguards Specialist
Africa Eshogba Olojoba, Environmental Safeguards Specialist
Abdoulaye Gadiere, Environmental Safeguards Specialist

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	No	The project is rated as "C" as it is not expected that project activities will impact the environment in an adverse manner.
Natural Habitats OP/BP 4.04	No	The project does not involve or affect natural habitats.
Forests OP/BP 4.36	No	The project does not involve or affect forests.
Pest Management OP 4.09	No	The project does not involve pest management.
Physical Cultural Resources OP/BP 4.11	No	The project does not affect physical cultural resources
Indigenous Peoples OP/BP 4.10	No	there are no indigenous people as defined by the World Bank in the project targeted areas
Involuntary Resettlement OP/BP 4.12	No	There are no civil works that might induce land acquisition, economic impacts or restriction of access to resources
Safety of Dams OP/BP 4.37	No	The project will not finance dams, not rely on dams.
Projects on International Waterways OP/BP 7.50	No	The project is not expected to affect international waterways
Projects in Disputed Areas OP/BP 7.60	No	The project will not be located in a Disputed Area.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Nov 29, 2018

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

There are no Safeguard Policies triggered by the project, thus no safeguards instruments are expected.

CONTACT POINT

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