REPUBLIC OF CONGO DEVELOPMENT PROJECT 200211 SAFETY NET PROGRAMME	
Number of beneficiaries[1]	23,436
Duration of project	12 Months (1 July 2011 – 30 June 2012)
WFP food tonnage	109.3 mt
Cost (United States dollars)	
WFP food cost	415,340
WFP cash/voucher cost	1,202,880
Total cost to WFP	2,591,144

[1] In principle the beneficiary total should reflect the number of individuals to be assisted during the life of the operation (including through food, cash and vouchers interventions). If this is too difficult to estimate, provide the yearly maximum: do not add up the totals for each year or average them out.

EXECUTIVE SUMMARY

This pilot project aims at strengthening capacities of the government of the Republic of Congo to reduce hunger by implementing a safety net programme in main suburban areas of Brazzaville and Pointe Noire.

The Safety net project will be operationalized through the distribution of electronic vouchers targeting extremely vulnerable households, who will be able to exchange them for basic food products in authorized shops. Beneficiaries will be targeted according to pre-established criteria so to include households whose monthly income is less than 60 USD, female-headed households, especially those headed by pregnant and nursing women caring for People Living with HIV (PLHIV) and Tuberculosis (TB) patients. The monthly vouchers will enable beneficiaries to fill the gap that deprives them from food, forces them to take children out of school and to sacrifice health care. Vouchers will be distributed on the conditions of regular school enrolment and use of health services. The project will ensure, as well, that PLHIV and/or TB patients as well as malnourished children under 2 years and pregnant or lactating women will adhere to their treatment and receive in addition to the vouchers, a nutritional supplement at their local health centre.

This project is based on the results of the WFP safety net feasibility study based on surveys carried out between May and September 2010. The study recommended the use of vouchers specifically because they would permit a saving US$ 10 per household, per month compared to distribution of food rations. The project is strongly supported by the Congolese government which is committed to invest more in social protection, as outlined in the 2013 social security policy aiming at ensuring the poorest access basic social services. It is also in line with Poverty-Reduction Strategy Paper (PRSP) 2008-2013 and United Nations Development Assistance Framework (UNDAF) 2009-2013.

The project, which will be executed by the Ministry of Social Affairs and Humanitarian Action (MoSAHA) with WFP assistance through implementing NGOs and in coordination with UNICEF and WHO will contribute to the following objectives:

i)To strengthen the capacity of the Government of Congo to reduce hunger by providing training and capacity building to government staff in implementing safety net programmes in the main suburban areas of Brazzaville and Pointe Noire (Strategic Objective (SO) 5);

ii). To support the Government of Congo in reducing under-nutrition to below critical levels, and break the intergenerational cycle of chronic hunger

iii) To meet the food and nutrition needs of HIV and/or TB affected population (SO 4);

iv) To improve enrolment and school attendance in the urban areas of Brazzaville and Pointe Noire for children 6-12 years (SO4).

The project is a pilot and it is expected that to be integrated into government future social protection programmes. The pilot Project will present a tranfer model whose integration is expected under the National Social Protection Strategy which is being formulated with the assistance of African Development Bank (AfDB). National empowerment will be guaranteed by the fact that government is committed to cover the total voucher costs of the project. At the end of the project, the MoSAHA is expected to set-up an inter-ministerial unit to coordinate the implementation of the National Social Protection Strategy including safety nets programmes.

The Deputy Executive Director and Chief Operating Officer approves, under the Executive Director's delegated authority, the proposed Development Project to the Republic of Congo; 200211, subject to availability of resources.

SITUATION ANALYSIS

1. The Republic of Congo covers an area of 342,000 square kilometres with a population of 3.7 million people. The economy of the Republic of the Congo is mainly based on oil and timber. Oil exports contribute to approximately 70 percent of government revenues and account for about 78 percent of the government budget and about 95 percent of Congo's export earnings. Despite the Congo being classified as a middle income country - with a GDP per capita of approximately US$ 1,262, considerably higher when compared to other countries in the region - the 2010 United Nations Development Programme (UNDP) Human Development Report ranked the Country 126th out of 169 based on the human development index. Approximately half of the Congolese (50.7 percent) live on less than one dollar per day. Poverty in Congo is multidimensional but is most pronounced in the household's access to quality food, education and health services. The Country is also characterized by urbanization[2]: 61.8 percent of the population in Congo lives in urban areas of Brazzaville and Pointe Noire (Annex IV for location of these cities). According to the Inter-Ministerial 2010 thematic analysis report on household poverty, cities concentrate 51.2 percent of Congo's poverty against 41.6 percent for rural areas. Brazzaville alone contributes to 32 percent of the whole poverty in the Country. Rural Households who migrated to urban areas are confronted with extremely high unemployment rates which results in high levels of poverty.

2. It is estimated that only two percent of the country's arable land is cultivated thus producing only 30 percent of the population's food needs and forcing the country to import 70 percent of basic food products. The national food production is dominated by cassava and tubers, while cereals, livestock products and oilseeds are almost totally imported. According to the 2007 Food and Agricultural Organisation (FAO) Food Balance Sheet, national average consumption is 2512 Kcal per person per day, but the 2009/2010 Comprehensive Food Security and Vulnerability Analysis (CFSVA) highlighted the fact that the diet of most of the population is poor in quality if not quantity. WFP safety nets feasibility surveys, carried out between May and August 2010 in suburban areas of Brazzaville and Pointe Noire, estimated that 43 percent of households earn less than US$ 60 a month and have an average size of 6.15. Total daily expenditure on food for an average household amounts to US$ 2.75. The survey also reveals that most households settle on one and a half meal per day and rely on coping strategies that sometimes involve illegal or risky activities. This leads to additional difficulties to find food especially when the wage earner cannot work due to illness and doesn't have proper access to health care. In large urban areas, the quasi-total dependency on importations has made the population vulnerable to shocks on international market prices: due to inflation, households are unable to cover their vital needs and turn to coping strategies that deprive them from access to education and health care.

3. Health and nutrition are particularly linked by a double-way cause-effect relationship: 60 percent of the population do not have access to primary health care and 60 percent of the population are micronutrient deficient[3]The 2008/2009 Ministry of Health/UNICEF

[2] 2010 Spatial repartition of population survey
[3] PRSP 2008 – 2010.

nutritional assessment in the departments of Brazzaville, Pointe Noire, Likouala and Plateaux measured Severe Acute Malnutrition (SAM) at 3.8 percent, Global Acute Malnutrition (GAM) at 9.5 percent and stunting at 15.4 percent. A comparison of nutritional indicators from 2005 to 2009 indicates that stunting and underweight of children under five increased by 15 and 10 percent respectively. Micronutrient deficiency is even more alarming: according to the 2005 Demographic and Health Survey (DHS), and the joint UNICEF/ Ministry of Health (MoH) assessment, 65 percent of the children under five years, 69.8 percent of pregnant women, 60 percent of nursing women and 54 percent of the women of reproductive age were anaemic. Forty seven percent of children under five years and pregnant and nursing women were vitamin A deficient and 12.5 percent of the population were iodine deficient. The Congo is one of the five countries in the world where children under-five's mortality has increased dramatically: 104 deaths per 1000 live births per day in 1990 against 128 deaths per 1000 live births per day in 2009[4]. Fifty two percent of children are deprived of education because of their parents' or tutors' poverty[5]. Although government of Congo has promoted universal education and health, consultation in a local health centre costs range from US$ 2[6] to US$ 4 and a school inscription amounts to US$ 1 per child. About 50 percent of households living under the poverty line can't afford these services.

4. The 2009-2013 Strategic Framework for the fight against HIV and AIDS identifies poverty and food insecurity as major factors in the transmission of HIV. In 2009 it was estimated that Congo has a national prevalence of 3.2 percent. However, the national prevalence is not equally distributed and it is higher in urban areas than in rural areas (3.3 and 2.8 percent respectively). Pointe Noire has the highest number of PLHIV with a prevalence of 4.6 percent. The prevalence in Brazzaville reaches 2.4 percent. On the whole, women are more affected than men: at 4.1 percent against 2.1 percent respectively on national average. The national Strategic Framework focuses on the populations most at risk, including transporters, sex workers, youth not attending school, widows and other women heads of households and indigenous people and recommends the provision of nutritional care to the affected people. According to the National Council for the fight against HIV and AIDS 2010 report, 39.6 percent of PLHIV at an advanced stage were under Anti-Retroviral Therapy (ART) in 2007. The situation improved in 2009 with a treatment coverage reaching 96.4 percent of advanced stage clients. This can be explained by the Government policy to ensure PLHIV access to free treatment. However, most of the clients coming from vulnerable families cannot afford adequate or appropriate food and may thus have a poor diet, and suffer from malnutrition making it harder for them to adhere to treatment.

5. According to the 2009 MoH annual report, 9,935 TB cases were identified. 76 percent of TB infected people were successfully treated but 18 percent of them stopped the treatment and were lost in the follow up. TB patients who are also infected by HIV represent 19.5 percent of the caseload. As with PLHIV, the most vulnerable TB patients are not able to adhere to treatment due to the difficulty to afford adequate and appropriate food.

[4] UN Inter Agency Group for Child Mortality Estimation, UNICEF, 2010 Report, Child Mortality report; trend and challenges
[5] 2009 UNICEF White Book on Social Protection of Children in Congo
[6] I US$ is equivalent to 500 Central African (CFA) franc

PAST COOPERATION AND LESSONS LEARNED

6. Over the last 20 years WFP's development portfolio was limited due to the civil conflict and the long period of instability that followed the end of hostilities. Between 2000 and 2010 WFP implemented three Emergency Operations (EMOPs): two of them from 1999 to 2002 targeted internally displaced people (IDPs); one, in 2010, targeted refugees from the Democratic Republic of Congo. Three protracted relief and recovery operations supported early recovery interventions to assist populations affected by conflict and poverty through school feeding, food for work and nutrition support for PLHIV. The current PRRO 103121, ends in June 2011

7. An evaluation of PRRO 103120 in 2008 observed that the projects were indeed targeted to assist the poor but the efficiency of operations was highly hampered by poor coordination and cooperation mechanisms that needed to be put in place to ensure effective participation and coordination from key donors, ministries and other relevant government bodies. The relief outputs met the targets but the recovery interventions performed badly. It also recommended the need for increased government commitment.

8. A Programme Review by the RB carried out in 2009 observed that WFP's engagement in coordination was strengthened through its participation in the thematic working groups but decentralized structures are still lacking. The review observed the need for: strengthened monitoring and reporting, assessment of partner capacity, and improved targeting and programme design WFP has always targeted the most vulnerable people affected by hunger. Priority was given to women heads of household, pregnant and nursing women, households with children under five years, elderly people, refugees from DRC in particular pygmies and PLHIV and/or TB patients. All the people benefited from access to WFP rations and nutritional support through targeted food distribution or food for work activities.

9. Difficulties in the food supply chain, coupled with the vulnerable populations' lack of access to food, education and health drove the government to new policies in social security. WFP is offering to support these efforts and to fill the gaps observed in the field to guarantee minimum social security to the most vulnerable households in Brazzaville and Pointe Noire.

STRATEGIC FOCUS OF THE DEVELOPMENT PROJECT

10. Social protection has increasingly been considered a policy-level intervention for reducing vulnerability, extreme poverty and food insecurity and to achieve the MDGs, that Congo undersigned. This project intends to enhance poorest households' food security through a voucher programme while promoting at the same time access to health and education with the aim at addressing MDGs 1 ("Eradicate extreme poverty and hunger"), 2 ("Attain universal primary education"), 4 ("reduce child mortality"), 5 ("improve maternal health") and 6("fight HIV and AIDS, malaria and other diseases"**)**. The main aim of the safety net programme is to build government's capacity to implement a successful safety net activity in order to reduce hunger in the most vulnerable urban populations in the country. Furthermore, it will aim at improving access to schools by school age children, access to health services by pregnant and lactating women as well as children under two and improving treatment outcomes for clients under ART or TB-Directly Observed Treatment Short-course (DOTS). This project is aligned to WFP SO 4 (Reduce chronic hunger and under nutrition) and SO 5 (Strengthen the capacities of countries to reduce hunger, including through hand-over strategies and local purchase).

11. The Republic of Congo has no real social protection system[7]: modern mechanisms of social transfers are absent or do not reach the most part of poor people. The need for such an intervention is recognised by a number of governmental documents, in particular the Poverty Reduction Strategy Paper of 2008; its third pillar being the improvement of access to basic services and social protection[8] to be achieved through the inclusion of vulnerable groups, and the reinforcement of actions against HIV/AIDS. In particular, the same document identifies the priority actions in social protection, including: 1) the creation of an integrated and universal social protection system, 2) an information system for social protection and 3) the reinforcement of NGOs' capacities. The fifth pillar of the Strategy "Stepping up the fight against HIV/AIDS", drives the focus of this intervention to include the assistance of PLHIV.

12. This proposal is aligned to the UNDAF 2009-2013[9], specifically outcomes 4 and 3: "Improvement of population access to basic social services" and "Improvement of population food security and nutritional status".

Project Objectives

13. This project aims:

    i) To strengthen the capacity of the Government of Congo to reduce hunger by providing training and capacity building to government staff in implementing safety net programmes in the main suburban areas of Brazzaville and Pointe Noire (SO5)

[7] http://www.unicef.org/sitan/files/wcaro_congo_poverty-resized.pdf
[8] http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/Congo_PRSP_2008-2010.pdf and http://siteresources.worldbank.org/INTPRS1/Resources/Country-Papers-and-JSAs/CongoRep-IPRSP.pdf
[9] http://www.undg.org/docs/9062/UNDAF-2009-2013-R%C3%A9publique-du-Congo.pdf

ii). To support the Government of Congo in reducing chronic hunger and under-nutrition to below critical levels and break the intergenerational cycle of chronic hunger.

iii) To support the Government of Congo to meet the food and nutritional needs of HIV and/or TB affected populations.

iv) To improve school enrolment and attendance in the urban areas of Brazzaville and Pointe Noire for children 6-12 years.

14. As an Organization for Intellectual Development (OID) case study stresses[10], despite the Country's lack of a consistent strategy for social protection, a synergy among the various interventions in the sector is possible and necessary. Other institutions share this view and are active in this sector. The African Development Bank (AfDB) is currently assisting the MoSAHA in formulating a National Social Protection Strategy. While UNICEF is engaged in assisting the set-up of a National Medical Insurance scheme, the International Monetary Fund (IMF) has recently advised government of Congo to address the impacts of high market prices in ensuring transfers to the poorest through implementation of social protection projects as the current inflation rate stands at 5.5 percent (IMF Revenue Report, April 2011). WFP and UNICEF are currently supporting an AfDB consultant in putting in place the intra-ministry unit that will ensure the implementation of the national strategy. WFP has been requested to promote safety net models and help in setting up capacities that could implement and monitor safety net programmes. Under the project framework, WFP will work in close collaboration with the Congolese government, in particular with the MoSAHA that has just engaged in a budgetary readjustment to promote social protection policies. WFP will contribute in familiarising government staff with food, and cash/vouchers safety nets models. WFP intends to support the current reform in collaboration with other development partners, particularly AfDB, International Labour Organisation (ILO), UNICEF and the World Health Organisation (WHO) who are engaged in activities that promote quality of education and health in suburban areas.

15. The government of Congo intends to implement a social protection strategy that includes and takes advantage of the outputs of WFP pilot safety net project. WFP's added value will be emphasised by capacity-development activities in the areas of food assistance to vulnerable people, PLHIV, nutrition and school feeding. The Government plans to create an inter-ministerial coordination committee under the leadership of MoSAHA to facilitate the implementation of the project and take an active engagement in decision making and project monitoring. The proposed intra-ministerial unit will be responsible for managing the project. Although the Government spending in social protection represents only 0.7 percent of the budget the funding of the voucher system demonstrates the interest for such programmes and the will to take ownership. It is worth noting that after gaining independence food vouchers were distributed by the government in the framework of programmes targeting the most vulnerable people.

16. The following outputs are expected:

a) Capacities of 80 government agents:
   - Ten agents for each of the 3 selected Social Action Centres (SAC) and 10 Ministry representatives in each targeted urban area will be trained to manage a successful urban safety net programme

[10] http://www.odi.org.uk/resources/download/3478-full-report.pdf

- Thirty SACs agents will be trained on the set-up of a data base to collect, store and analyse data on beneficiaries.

b) 3,906 households (6 persons per household) among the most vulnerable households of suburban areas in Brazzaville and Pointe Noire will receive vouchers to access a sufficient food diet and to basic social services during the year. This will help them meet their food and non-food gap. The households comprise:
   - 1,200 households with school age children, i.e. at least 2 children per household in targeted areas currently out of school.
   - 506 households - 100 with pregnant and lactating women and 406 with children under two identified as malnourished (i.e. with a height-for-age (HFA) score below -2 z- from the reference median for that sex and age).
   - 2,200 households with malnourished clients on ART or TB-DOTS. The ART or DOTS clients will receive supplementary nutrients, vital to their nutritional wellbeing and treatment success for the period of their nutritional recovery.

17. The selected geographic areas are the suburban neighbourhoods of Brazzaville and Pointe Noire with the largest number of poor households. This situation is mainly caused by the rural - urban migration that has resulted in households to settle down in the suburban areas of the main cities. In Brazzaville, these areas are Makélékélé, Talangai and Mfilou, in Pointe Noire Loandjili and Tiétié.

TABLE 1: BENEFICIARIES BY ACTIVITY

Activity	Men/boys	Women/girls	Total
Support to education*	**3,600**	**3,600**	**7,200**
- School children	1,200	1,200	2,400
- family	2,400	2,400	4,800
HIV/AIDS and TB impacted**	**6,336**	**6,864**	**13,200**
- treatment & care (clients)	1,056	1,144	2.200
- family	5,280	5,720	11,000
MCHN***	**607**	**2,429**	**3,036**
- mother & child care	182	730	912
- family	425	1699	2,124
TOTAL****	**10,544**	**12,892**	**23,436**

* Each of the 1,200 household sends two children to school
** Each of the 2,200 households has at least either HIV/AIDS client or a TB patient
*** Assume from each household a mother and one child
**** All the 23,436 (3,906 households, each six members) are beneficiaries of vouchers

Justification for a conditional voucher modality as part of this project:

18. WFP feasibility surveys carried out in September 2010 showed that poor households' average monthly income amounts to US$ 60[11] while the average monthly food expenses are about US$ 82, i.e. US$ 2.75 per household per day. This implies a gap of US$ 22 to purchase food items exists and households try to address this by resorting to different coping strategies.

19. School fees in public schools amount to an insurance payment of US$ 0.50 per child per month. Through the nanny grouping system, families could also afford to cover the costs to watch their children at home for US$ 0.60 to US$ 1 per month and per family. A consultation at a local health centre costs between US$ 2 and 4. This means that for a household to make school insurance payment for two children, and afford nanny services and two medical consultations a month in case a family member gets sick, a household would require about US$10 per month.

20. The project will aim at enabling household meet all their food needs and creating a saving by distributing monthly transfer vouchers valued at US$ 40 (20 000XAF) per month – US$ 30 for food[12] and US$ 10 for social obligations. WFP vouchers will be used for food and will help households to save money they originally spent on food which then can be used to cover other costs. It would therefore allow poor households to improve both their purchasing power to cover food expenses and the most urgent social costs in terms of education and health.

System of implementation

21. In order to guarantee that the transfers will be devoted to the desired needs, beneficiaries will receive a monthly voucher which will enable beneficiaries to choose among the authorized products they most need (salt, oil, rice, beans, smoked fish etc.). The 2010 Feasibility Study tested the diet driven by consumption habits for different categories of beneficiaries (according to gender, age, sedentarily, etc.) and found that when consumers are not constrained by cash, locally available food stuff can provide a balanced diet for the whole family.

22. Beneficiaries will be able to exchange their vouchers in selected shops that will be registered for a determined time. Priority will be given to the selection of women traders. Selected shops will be equipped with a bar code reader to register the code of each voucher that will be automatically sent to the operator, who in turn will send the information to the implementing NGO. This system will allow day to day follow-up on the use of the vouchers.

23. The NGO and MoSAHA unit in charge will then validate the purchase and authorise payments to agreed bank accounts.

[11] I US$ is equivalent to 500 CFA
[12] US$ 22 food gap plus US 8 to buffer any commodity price fluctuations.

24. MoSAHA is selecting traders that will be closely monitored by WFP and its partners to guarantee their integration, understanding and acceptance of the programme, particularly for not under-valuing vouchers allowing beneficiaries to procure the same products they would have obtained with cash.

25. Standard Memoranda of Understanding (MoU) will be signed with selected partners. These agreements will include the guidelines essential for project implementation such as the selection of authorized traders, the small trader's agreement content, the vouchers numbering and formatting system, the vouchers printing and safety system, the control and follow-up procedures, the financial arrangement, report mechanisms, etc.

26. The use of vouchers is less expensive than direct food distribution: the feasibility study estimates a net saving of more than US$ 10 per household per month compared to direct food distribution. This represents a US$ 39,060 savings per month and US$ 468,720 for the whole project duration.

27. The extra food demand represented by vouchers will have no impact on local market prices because in terms of quantity, it is a very small proportion of the food transacted in the two main markets of the country. However, the project will have a positive impact on small trade in suburban areas by creating a dynamic network of small traders, in particular women, who will be authorized to sell their products to the project beneficiaries.

28. The beneficiaries list will be established jointly by SAC and the implementing NGO and will then be approved by WFP and the MoSAHA. Vouchers will specify the household's size, its address, authorized traders and the name of the household head. The voucher value will be prorated to household size – a US$ 40 voucher is the standard reference value for a household of six i.e. about US$ 6.7per person per month. Vouchers will be issued to the female head of the household, except for vulnerable households represented by a single man.

29. Clients on ART and TB-DOTS will be referred to the SAC from selected clinics upon confirmation of malnutrition or concerns of household vulnerability affecting treatment success. The SAC together with the implementing NGO will consider their eligibility for social assistance. Those found to be malnourished will also receive a ready-to-use-food (RUF)[13] for the duration of their recovery. RUFs are preferred over the use of Fortified Blended Foods (FBF) because of their longer shelf life and unit size packaging, both conducive for product handling in the health sector. Their nutritional density will facilitate a faster recovery than with the use of FBFs. Palatability and utilization by the target group will be closely monitored.

30. A survey will be carried out at the inception of the project to target and preselect the beneficiaries as well as the participating traders. The survey will set parameters/indicators for selection of eligible beneficiaries under RUF which will be reinforced by routine nutrition assessments of patients attending clinics. A data base will then be set up and used to monitor activities throughout the project.

31. To select the beneficiaries, the following criteria will be used (households combining the majority of these criteria will be selected first):

[13] Choice for therapeutic or supplementary RUFs will follow further consultation with technical partners and easy procurement availability.

i) To receive the vouchers:

- Households whose monthly income amounts to US$ 60 or less and spend US$ 0.50 for food on average per person per day
- Women-headed households with pregnant or lactating women and children under two
- Households with at least one school age child who doesn't go to school
- Households whose head is a widow
- Households with malnourished family members accessing ART and/or TB-DOTS.

ii) To receive nutritional supplements

- Individuals accessing ART and/or TB-DOTS who are confirmed to be malnourished[14], for the duration of their recovery (discharge at second consecutive measurement of adequate nutritional status).

TABLE 2: FOOD RATION/TRANSFER BY ACTIVITY

	Support to Education	**HIV/AIDS and TB treatment care**	**MCHN**
RUF (g/person/day)		276	
Voucher (*US$/household/month*)	40	40	40
TOTAL	**-**	276	**-**
Total kcal/pers/day		**630**	
Number of feeding days for year 1 (Jul- Dec 2011		**180**	
Number of feeding days for year 2 (Jan-Jun 2011)		**180**	
Total kcal/pers/day		**530**	

TABLE 3: TOTAL FOOD/CASH AND VOUCHER REQUIREMENTS BY ACTIVITY

	Support to education	**HIV/AIDS and TB treatment care**	**MCHN**	**Total**
Food requirements (mt)		109.30		109.30
Food requirements (US$)		415,340		
Voucher (*US$*)	432,000	528,000	242,880	1,202,880
TOTAL	**432,000**	**943,340**	**242,880**	**1,618,220**
% of total requirements[15]	**27**	**58**	**15**	**100**

[14] Dependent on client age and condition, nutritional status will be measured using BMI, MUAC, BMI/age, W/H using internationally agreed cut off points.

[15] Requirements allocated to each project activity as percentage of total requirements

32. In order to support the government to implement safety nets programmes on its own in the future, a set of activities are conceived to develop capacities in the SACs, the critical foci of provision of social service. In particular the necessary capacities will be built by the distribution of telecommunication and measurement equipment to make social workers operational, on-the-job training and more specific training on data collection, storage and analysis,, follow-up of criteria, procedures and beneficiaries' monitoring. A study tour will be organised for senior managers of the MSA to visit similar safety nets experiences.

33. A database will be established to assist the project management and follow up the beneficiaries. The implementing NGO will train SACs on the database function. This will help evaluate the change and orient the household to the most adapted safety net available type. This orientation will be done in agreement between the beneficiary household and the local structure implementing the project. It will materialize through a memorandum of understanding between the two parties.

34. Households meeting the eligibility criteria will have to agree to certain conditionalities. The distribution of vouchers will be linked to enrolment of children in school or apprenticeship, attendance of Integrated Health Centres (IHC) where women will be expected to follow prenatal services, deliver their babies, and access growth monitoring and vaccination for children under two and/or attendance of scheduled clinic visits for ART and/or TB-DOTS. The regular update of the database will enable the NGO and the SACs to suspend vouchers for households who don't respect the conditions they agreed upon.

35. WFP will monitor the voucher distribution and traders supply chain and will keep a direct contact with beneficiaries to ensure that their obligations are met. WFP will meet regularly with the MoSAHA in order to discuss the project implementation and challenges. WFP will organize trainings and workshops on the planning and the implementation of safety net projects.

36. Work will be divided as follows:

- The NGO will contribute to build the capacities of SAC on the establishment and use of a data base and beneficiaries follow-up. It will issue the vouchers provided for by the operator to the SAC that will distribute them to the beneficiaries.

- Vouchers will then be presented in an authorized shop and be exchanged for basic food products. Beneficiaries will be able to choose the ration they need from a variety of authorized products (salt, oil, rice, beans, smoked fish etc.). Within the household, responsibility will be given to women who usually manage the household's expenses on a daily basis.

- WFP will provide technical support to the government to ensure the transparency of fund management as well as all involved parties' accountability.

- WFP will organize training and workshops to strengthen Government capacities to take over the project in the years to come and integrate it fully to its social protection reform

- In collaboration with all partners, WFP will develop clear implementation guidelines covering the different levels involved: central government/district/shops etc. These guidelines will serve the government to expand the project further and to evaluate the project impact in the end.

37. WFP will work with WHO and other health sector partners to support the MoH to develop appropriate nutrition rehabilitation protocols for people accessing HIV and TB-related care and treatment programmes, supply adequate equipment and materials to participating clinics, and strengthen the Nutrition Assessment, Education and Counselling (NAEC) activities within which context the nutrition supplement will be used. Appropriate roles and responsibilities will be identified among existing health personnel who will receive training to adopt new tasks, while infrastructure will be strengthened to manage supplementary food products. Participating clinics will be established as model and training sites for possible future replication of the programme under Government leadership.

PROGRAMME MANAGEMENT, MONITORING AND EVALUATION

The institutional framework of the project implementation will be organized at 3 levels:

(i) Technical Coordination Committee

38. WFP will be in charge of the technical coordination committee in collaboration with one or two NGOs that will be selected in agreement with the MoSAHA and the Department Directors of Social Affairs in Brazzaville and Pointe Noire. The technical coordination committee will examine and validate all chosen beneficiaries' files in agreement with the SAC. It will also confirm shops authorization, payment to participating small traders and will ensure the monitoring of activities linked to the exit strategy in order to favour national ownership of the project. The committee will also validate and authorize the use of micro finance institutions where small traders will be invited to withdraw their payments.

39. All small traders will have to open a bank account if they don't yet have one in one of the two main micro finance institutions in RoC, namely Caisse de Participation à la Promotion des entreprises et au Développement (CAPPED) and *Mutuelle Congolaise d'Epargne et de Credit* (MUCODEC). Voucher payments will be directly issued by WFP on each small trader's bank account.

(ii) Running of the project

40. WFP and the MoSAHA will manage jointly the programme. The running Committee will include WFP representative as well as representative from the MoSAHA and the Ministry of Plan. It will decide on the project's activities and orientation, adopt the work plan, approve the budgets and will follow up on the project's implementation. WFP will exploit its added value in terms of technical assistance, logistics support and resources mobilisation among multilateral donors to support the government's social protection

reform as planned in the PRSP, while actively pursuing complementary partnerships for assistance to ARTs and TB-DOTS clients

(iii) Implementation in the field

41. In the field, SACs are the operational arm of the intervention. They will be supervised by the implementing NGO in charge of following up on the beneficiary households. The SACs will report regularly to the technical coordination committee. SACs already deployed in the targeted areas will follow the family recipients of vouchers and monitor children access to schools as well as family members' access to primary health services and report accordingly to WFP and partners to ensure that recipient families are meeting the project admittance/selection conditions.

42. Nutrition rehabilitation will be supported by selected implementing NGOs working in partnership with MoH. They will manage the supply and handling of the nutritional supplement provided by WFP, provide on the job training and support to health staff, oversee the implementation of appropriate NAEC approaches and the strict application of anthropometric criteria in the initiation and termination of nutrition supplementation.

Reporting:

43. Implementation, monitoring and ongoing evaluation will be consistent with WFP Results Based Management (RBM) Policy. Each activity's results will be subjected to quarterly, biannual and annual narrative and financial reports and will have to comply with WFP procedures. The database will be the primary tool to follow-up and report on the respect of vouchers conditionality, children enrolment in school, medical consultations and food items purchased by each household. The MoSAHA will be responsible for the transmission of project reports and evaluations.

44. WFP will explore possibilities to enhance existing health information systems to include nutrition related information to strengthen data management at client and programme levels. Complementary data collection and analysis may be put in place while full integration is pursued.

Evaluation:

45. An evaluation will be carried out at the end on the project in order to assess the final impact of this pilot phase and to draw some recommendations to extend its scope to a higher number of beneficiaries and/or other locations. Small traders' performance will be evaluated as well. Strategic discussions will then take place with the government to integrate this project to the country's social protection policy.

Resource mobilisation:

46. One million US$ has been secured to support the project activities. The MoSAHA, co-in-charge of the implementation of the project has created a coordination unit that includes the Ministries of Education and health with the aim of insuring their contribution and participation to the pilot project. The MoSAHA just conducted a field visit in Brazil and to visit a similar project currently executed in Brasilia and Rio.

47. The CO has appealed to donors with interest in supporting social protection programme in Congo.

48. Lastly, the MoSAHA has arranged a meeting with the President to ensure remittance of Government contribution. WFP met the special adviser of the President on food security who should finalize the briefing kit for the President attention prior to the meeting scheduled for January 2011. The president will be invited to launch officially the first voucher through MTN.

49. As the project addresses the need of PLHIV and TB patients, partnership with national counterparts could be explored in accessing dedicated funding, such as the Global Fund (GF). Besides local funding efforts with the donors represented in the country, the CO will therefore also work closely with the joint UN team on including the national capacity building component as well as costs of continued nutrition care and support into future proposals to the GF.

ANNEX I-A

PROJECT COST BREAKDOWN			
Food[16]	**Quantity** ***(mt)***	**Value** ***(US$)***	**Value** ***(US$)***
Cereals	0	0	
Pulses	0	0	
Oil and fats	0	0	
Mixed and blended food (RUF)	109.3	415,340	
Others	00 000	00 000	
Total food	**109.3**	**415,340**	
Cash transfers		0	
Voucher transfers		1,202,880	
Subtotal food and transfers			1,618,220
External transport			11,203
Landside transport, storage and handling			29,630
Other direct operational costs			266,820
Direct support costs[17] (see Annex I-B details)			495,757
Total WFP direct costs			**2,421,630**
Indirect support costs (7%) [18]			**169,514**
TOTAL WFP COSTS			**2,591,144**

[16] This is a notional food basket for budgeting and approval. The contents may vary.
[17] Indicative figure for information purposes. The direct support costs allotment is reviewed annually.
[18] The indirect support cost rate may be amended by the Board during the project.

ANNEX I-B

DIRECT SUPPORT REQUIREMENTS (*US$*)	
Staff and staff-related costs	
International professional staff	178,782
International general service staff	0
Local staff - national officers	0
Local staff - general service	157,351
Local staff - temporary assistance	0
Local staff – overtime	0
Hazard pay and hardship allowance	15,000
International consultants	0
Local consultants	0
Non staff HR: UNV	0
Commercial consultancy services	0
Staff duty travel	24,000
Subtotal	**375,133**
Recurring expenses	
Rental of facility	10,000
Utilities general	13,750
Office supplies and other consumables	15,500
Communications and IT services	14,900
Equipment repair and maintenance	11,400
Vehicle running cost and maintenance	12,299
Office set-up and repairs	3,500
UN organization services	2,000
Subtotal	**83,349**
Equipment and capital costs	
Vehicle leasing	20,400
TC/IT equipment	13,125
Local security costs	3,750
Subtotal	**37,275**
TOTAL DIRECT SUPPORT COSTS	**495,757**

ANNEXE II- Log Frame

Government Priority: Improvement of population access to basic social services		
UNDAF Objective: Within 2013, the population will have equal access to qualitative social protection, Education, health, water, sanitation services		
UNDAF OUTCOME 4: Vulnerable and Poor population access to social services protection is improved	**UNDAF OUTPUT 4.1:** Special programs of prevention and reintegration of vulnerable household's and those affected by HIV/AIDS and TB are reinforced and made effective.	**Partners:** UNICEF, WHO, Ministry of Social Affairs
Government Priority: Improvement of population food security and nutritional status		
UNDAF Objective:: Within 2013 the population will access to food security and will have nutritional status improved		
UNDAF OUTCOME 3: Food insecure households should be detected and support provided	**UNDAF OUTPUT 3.1:** To carry out vulnerability assessments (To be implement by WFP) **UNDAF OUTPUT3.3:** Support to HIV/AIDS affected people and malnourished children (To be implemented by WFP, UNICEF and UNAIDS)	**Partners:** UNICEF, FAO, Ministry of social affairs and Health, Ministry of Agriculture and NGOs **Partners:** WHO, Ministry of Health, Ministry of Social Affairs, NGOs

Outcome 4.5 to increase attendance to MCHN activities for <2 years, pregnant and lactating women	**Indicator:4.5.1** Attendance rate to MCHN for pregnant and lactating women	80% of targeted beneficiaries attend health centres	Source : Annual Monitoring
Outcome	**Indicator:4.5.2** Attendance rate to MCHN for **Indicators** **Indicators: 4.5.3** Percentage of supported lactating women who received a post-natal check-up **Indicator: 4.5.4** Percentage of children 9-15 months who completed all vaccinations according to the schedule in the national protocol	**Corporate target and performance measure**	**Project Target and data source**
Outcome 4.1: Improved Adherence **Outcome 4.2**: Improved success of TB treatment	**Indicator 4.1.1** ART adherence rate (% adhering clients on ART achieving 95% of adherence to their medication during the previous month). **Indicator 4.2**: Improved success of TB treatment		Source: Annual Reporting
	Indicator4.2.1 TB success rate (% TB clients on DOTS in a given year that have successfully completed treatment		
Outcome4.3 ART/TB Nutrition recovery	**Indicator 4.3.1:** Nutrition recovery Rate (% ART clients found to be malnourished at initiation of food support, who are considered to have recovered from malnutrition upon completion of food	Score exceeded the threshold for 80% of the beneficiaries	Food consumption score exceeded 35/42 in targeted households Source: Annual household survey or monitoring data
Outcome 4.4 Increase access to Education Increase Attendance to school	**Indicator 4.4.1.**: Attendance rate: Number of schooldays in which girls and boys attended class, as % of total number of schooldays.	Attendance rate of 80% met or exceeded for	Increase the attendance rate at 80% for the targeted beneficiaries Source: Annual monitoring 80% of targeted out-of-school children newly enrolled Source: Annual monitoring

Output 4..: Food and/or non-food items distributed in sufficient quantity and quality to targeted beneficiaries	**Indicator:** Actual metric tons (MT) of food distributed as a percentage of planned by commodity. **Indicator:** Number of clients on ART who received individual supplements **Indicator:** Number of clients on TB treatment who received individual supplements **Indicator:** Number of children <2who received individual supplements **Indicator:** Number of PLW who received individual supplements **Indicator:** Number of women and men receiving voucher as % of planned **Indicator:** Number of Voucher distributed as % of planned **Indicator**: Number of shops participating in the voucher activity **Indicator**: Number of vouchers issued in men's name **Indicator**: Number of vouchers issued in women's name

WFP STRATEGIC OBJECTIVE5: STRENGTHEN THE CAPACITIES OF COUNTRIES TO REDUCE HUNGER, INCLUDING THROUGH HAND-OVER STRATEGIES AND LOCAL PURCHASE			
Outcome	**Indicators**	**Corporate target and performance measure**	**Project Target and data source**
Outcome 5.1: Develop capacity to manage safety net programmes and awareness through WFP organized training	**Indicator:5.1.1** Capacities of 80 government agents (10 agents for each of the 3 selected SAC and 10 Ministry representatives in each city) are enhanced to manage a successful urban safety net programme		
Outcome 5.2 To improve Government capacities to follow up on beneficiaries and extend the project in the future	**Indicator: 5.2.1** 30 SAC government agents are trained on the set up of a data base to follow up on beneficiaries in the future.		
Output; 5.1 Agreed hand-over strategies in place	**Indicator: 5.1.1** Number of hand-over strategies agreed to between WFP and the Government		

ANNEX III: List of Acronyms

AfDB	African Development Bank
AIDS	Acquired immunodeficiency syndrome
ART	Anti-retroviral therapy
BMI	Body mass index
CAPPED	*Caisse de Participation à la Promotion des entreprises et au Développement*
CFA	Central African Franc
CFSVA	Comprehensive Food Security and Vulnerability Analysis
CO	Country Office
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
FAO	Food and Agriculture Organization
FBF	Fortified blended **foods**
GDP	Gross domestic product
GFD	General Food Distribution
HH	Households
HIV	Human immunodeficiency virus
IDP	Internally Displaced Person
IFPRI	International Food Policy and Research Institute
IHC	Integrated Health Centres
ILO	International Labor Organization
IMF	International Monetary Fund
MCHN	Mother and Child Health and Nutrition
MDG	Millennium development goal
MoH	Ministry of Health
MoU	Memorandum of Understanding
MoSAHA	Ministry of Social Affairs and Humanitarian Action
MTN	Mobile Telephone Network
MUAC	Mid-upper arm circumference
MUCODED	*Mutuelle Congolaise d'Epargne et de Credit*
NAEC	Nutrition Assessment, Education and Counselling
NGO	Non-governmental organization
OID	Organization for Intellectual Development
PLHIV	People Living with HIV
PLW	Pregnant and Lactating Women
PRRO	Protracted relief and recovery operation
PRSP	Poverty-Reduction Strategy Paper
RBM	Results Based Management
RoC	Republic of Congo
RUF	Ready to use food
SAC	Social Action Centres
SAM	Severe acute malnutrition
SO	Strategic Objective
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

ANNEX IV: Map of the Republic of Congo and the intervention locations