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PROJECTS FOR EXECUTIVE BOARD APPROVAL

Agenda item 9

For approval

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DEVELOPMENT PROJECT— CAMBODIA 10170.2

Support for Mother-and-Child Health	
Number of beneficiaries	63,520
Duration of project	36 months (January 2008–December 2010)
Cost (United States dollars)	
Total cost to WFP	7,216,180
Total food cost	4,216,250
Total cost to the Government	43,200

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NOTE TO THE EXECUTIVE BOARD

This document is submitted to the Executive Board for approval.

The Secretariat invites members of the Board who may have questions of a technical nature with regard to this document to contact the WFP staff focal points indicated below, preferably well in advance of the Board's meeting.

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EXECUTIVE SUMMARY

Despite recent progress, Cambodia still suffers the effects of 30 years of war, internal displacement and political instability. Continued poverty also results from high population growth, low agricultural productivity, social exclusion, poor access to health services and high exposure to natural disasters.

Cambodia ranks 129th out of 177 countries in the 2006 United Nations Development Programme Human Development Index. Per capita gross domestic product was US$350 in 2005.[1] The country is also classified as a least developed,[2] low-income food-deficit country.[3] About 35 percent of Cambodians live below the poverty line and 20 percent live below the food-poverty line, unable to meet a minimum food requirement of 2,100 calories per day; 91 percent of the population below the food-poverty line live in rural areas and spend 65 percent of their total expenditure on food.[1]

Reports show that infant mortality is 83 deaths per 1,000 live births[4] and that maternal mortality is 437 deaths per 100,000 live births.[5] Malnutrition in Cambodian children under 5 is a silent emergency: stunting prevalence is 37 percent, the rate of underweight is 36 percent and wasting is 7 percent. Poor diet diversity with 65 percent of calories provided by cereals[1] results in severe micronutrient inadequacy: 46 percent of women of reproductive age and 62 percent of children under 5 suffer from anaemia.[4]

Preliminary results of the 2005 Cambodia Demographic and Health Survey suggest some improvements in the health and nutritional status of the population since the previous survey in 2000. However, the situation still warrants continued inter-sectoral interventions addressing nutrition and improvements in food security, health services and access to water and sanitation.

Improved maternal health and nutrition during pregnancy promote foetal development and reduce the risk of low birthweight, stunting and wasting; reduction of micronutrient deficiency in pregnant women is linked to reduced risk of death during childbirth. Children between 6 and 24 months are most vulnerable to malnutrition because of poor childcare and increased risk of infection; in this age group particularly, improved childcare, health and nutrition practices promote healthy development and increase catch-up growth.

This project is in line with the Government's health and nutrition plans, including the

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[1] Royal Government of Cambodia, Ministry of Planning. 2006. *A poverty Profile of Cambodia 2004*. Phnom Penh.

[2] United Nations Development Programme. 2006. *Human Development Report 2006*. New York.

[3] WFP. 2006. *World Hunger Series 2006 – Hunger and Learning*. Rome.

[4] Cambodia Demographic and Health Survey (CDHS). 2005. Phnom Penh.

[5] CDHS. 2000.

Cambodia Nutrition Investment Plan 2003–2007, which is soon to be revised. The project takes into account the results of the baseline and evaluation surveys conducted by WFP in 2004 and 2005 and builds on the progress achieved under the previous phases.

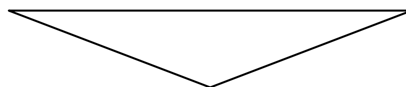
Target provinces are determined using poverty and stunting prevalence combined with the current or expected presence of suitable cooperating partners (see map in Annex III). The provinces targeted are Pursat, Kampong Speu, Kampong Thom, Preah Vihear and Siem Reap, which have either the highest poverty and/or the highest stunting rates. The poorest and most food-insecure rural communes in these provinces will be targeted in collaboration with the Ministry of Health and non-governmental organizations that will join in selecting the most food-insecure and vulnerable households at the village level.

The major objectives of the project are to improve the nutritional status of: (i) children between 6 and 24 months; children under 6 months are supported indirectly through the support given to their mothers, who are encouraged to breastfeed infants exclusively for at least 6 months; (ii) women six months before giving birth; and (iii) lactating women up to 6 months after giving birth. This is to be achieved by providing a fortified food ration to enrich the beneficiaries' diet. The secondary objectives are: (i) participation of pregnant and lactating women and mothers of children of 6–24 months in health and nutrition education; and (ii) increased use of healthcare and community development services.

Rice will be used as an incentive for women to attend health centres and for village volunteers to carry out growth monitoring, health and nutrition education and food distribution.

Cooperation between the Ministry of Health, non-governmental organizations and WFP through health centres and outreach teams will increase the effectiveness of health and nutrition services. In addition to supplementary feeding, services such as vaccination programmes and distribution of vitamin A capsules, iron, folate and deworming tablets will be delivered by these partners.

DRAFT DECISION*



The Board approves development project Cambodia 10170.2 "Support for Mother-and-Child Health" (WFP/EB.A/2007/9-A/1) subject to the availability of resources.

* This is a draft decision. For the final decision adopted by the Board, please refer to the Decisions and Recommendations document (document WFP/EB.A/2007/15) issued at the end of the session.

SITUATION ANALYSIS

1. Despite recent socio-economic progress, Cambodia remains one of the poorest countries in South-East Asia, ranking 129th of 177 countries in the 2006 United Nations Development Programme (UNDP) Human Development Index. Cambodia is a least developed, low-income food-deficit country: 35 percent of Cambodians live below the poverty line; per capita gross domestic product (GDP) was US$350 in 2005. Economic growth has benefited a small proportion of society only: it is limited to Phnom Penh, where it is driven by the construction and textile industries, and Siem Reap and Sihanoukville, where it is driven by tourism; it has not yet led to widespread reduction in poverty. The 2006 UNDP Gender-Related Development Index (GDI) ranks Cambodia 97th of 136 countries and highlights the plight of Cambodian women, who have less access to education, paid employment and land ownership and who lack acceptable health services during pregnancy and maternity. The proportion of households headed by women is 29 percent. Annual population growth of 1.7 percent is among the highest in the region.

2. The health and nutrition status of the population is precarious. Infant mortality is 83 per 1,000 live births[4] and maternal mortality is 437 per 100,000 live births.[5] The 2005 results indicate that the Government's target of reducing under-5 mortality to 85 deaths per 1,000 live births by 2010 has been achieved. These figures are national averages, however, and include the most developed areas of the country, which is not where WFP operates; only 44 percent of births are attended by qualified medical staff and the true figures are likely to be much higher. Reaching the 2010 target in the intervention areas and progressing towards a reduction to 65 deaths per 1,000 live births by 2015 will require a major commitment.

3. The increase in stunting evident between 12 and 23 months tends to remain high as children grow older. Catch-up growth through improved childcare, health and nutrition is most effective in children under 24 months. Rates of stunting, wasting and underweight are shown in Table 1.

TABLE 1. PREVALENCE OF STUNTING, WASTING AND UNDERWEIGHT IN CHILDREN (%)

Age	Stunting	Wasting	Underweight
6–11 months	14.5	6.8	21.5
12–23 months	42.1	11.9	41.0
24–59 months	43.0	6.0	40.0
Under 5 years	37.0	7.0	36.0

4. Twenty percent of Cambodians live below the food-poverty line, unable to meet a minimum food requirement of 2,100 calories per day; 91 percent of these people live in rural areas and spend 65 percent of their total expenditure on food. Insufficient food intake combined with poor diet diversity – 65 percent of calories are provided by cereals[1] – results in high levels of malnutrition. Other factors include low levels of education among mothers, poor awareness of good health and nutrition practices, inadequate childcare, inappropriate weaning practices, high exposure of children to diseases and limited access to basic healthcare services. Access to safe drinking water and acceptable sanitation will

continue to be addressed by the current cooperating partners, in particular World Vision Cambodia, Caritas and the Reproductive and Child Health Alliance (RACHA).

5. During the last ten years, Cambodia has been rebuilding its healthcare system and other infrastructure destroyed by war; the aim is to improve financial and geographical accessibility to essential health services. Lack of funds for salaries, supplies and maintenance severely limits the quality and availability – and hence the use – of public health services. Households seek care with traditional and private health service providers. The HIV/AIDS prevalence rate, which at 1.9 percent is one of the highest adult HIV prevalence rates in Asia,[6] has put a further strain on the health sector.

6. The project is in line with: (i) WFP's Strategic Objective 3: Support for improved nutrition and health status of children, women and other vulnerable people; (ii) WFP's Strategic Plan and the Enhanced Commitments to Women (ECW); (iii) Cambodian Millennium Development Goal (CMDG) 4: Reduced Child Mortality; (iv) CMDG 5: Improved Maternal Health; and (v) the United Nations Development Assistance Framework (UNDAF) 2006–2010, which commits the United Nations to supporting the Cambodia Nutrition Investment Plan (CNIP) to improve the nutritional status of women and children.

7. The Government's National Strategic Development Plan (NSDP) for 2006–2010, which aims to reduce poverty through economic growth, envisages further investments in human capital to increase economic development. The Government is committed to improving access to health and education services, especially for women and girls, and increasing the participation and empowerment of the poor.

8. As part of its pro-poor approach, the Government is committed to achieving CMDG targets for health and nutrition through healthcare activities to reduce child malnutrition and improve maternal health. These are integrated into national and community development plans and will use existing health structures.

PAST COOPERATION AND LESSONS LEARNED

9. WFP has been continuously present in Cambodia since 1979, since when its assistance has gradually shifted from relief to rehabilitation and recovery.

10. In 1999, WFP started a quick-action development project (QAP) to address the nutritional needs of mothers and young children in food-insecure areas, followed by a mother-and-child health (MCH) development project from April 2002 to May 2005 in which children of 6–59 months and pregnant and lactating women received supplementary food rations and benefited from growth monitoring, health and nutrition education and training in basic healthcare and prevention; capacity-building for local volunteers was also provided. This project was replaced by the current June 2005–December 2007 MCH project.

11. A baseline survey at the start of the MCH project in 2002 established benchmarks for measuring progress, including anthropometric indicators, child and maternal haemoglobin levels, health and nutrition knowledge and diet. Follow-up surveys were conducted in 2004 and 2005.

[6] Ministry of Health, National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (STDs). 2006. *Report on HIV Sentinel Surveillance in Cambodia, 2003*.

12. The review of 2005 found that stunting among children had fallen by 1.9 percentage points in comparison with the baseline 55.6 percent; in the control group of villages where the project had not yet started, it had increased by 0.2 percentage points. Chronic energy deficiency among women had been reduced by 11.5 percentage points to 5.3 percent from a 16.8 percent baseline; in the control group it remained 14 percent. Underweight among children fell by 4.5 percentage points against a baseline of 50 percent. Vitamin A deficiency among children fell by 1.6 percentage points; among pregnant women it fell by 4.2 percentage points. Iron deficiency anaemia (IDA) among pregnant women fell by 23 percentage points, among lactating women by 12.1 percentage points and among children by 17.2 percentage points. Widespread sharing of rations in households was also noticed.

13. The 2005 survey found that among vulnerable groups poor hygiene, unsuitable breastfeeding and infant feeding, inadequate attention to health and lack of knowledge of healthcare were common. As a direct result of the project, 26.7 percent of mothers came to understand that colostrum was good for newborns, 25.2 percent more women started breastfeeding within an hour of birth, 12.2 percent more mothers gave more liquid to children with diarrhoea and 14.6 percent more mothers boiled drinking water. Increased utilization of health services cannot be solely attributed to the project, but 20.2 percent more pregnant women had visited a health centre and 14.5 percent more had received ante-natal care.

14. The 2004 review and the 2005 survey concluded that the project is technically feasible and socially acceptable. It is incorporated into the health and nutrition development plans of the Government, which supports mobilization and health and nutrition awareness at the village and community levels. The report recommended continued support for the MCH project.

15. The project will be implemented in synergy with the new PRRO to address the needs of people in crisis through food for education, food for assets and food for health; the latter supports tuberculosis patients, people living with HIV (PLHIV), orphans and vulnerable children. Food aid monitors will follow both projects. Implementation of programmes is limited in some areas by the absence of partners with adequate capacity.

PROJECT STRATEGY

16. The long-term objective of the project is to contribute to the Millennium Development Goals (MDGs) of reducing child mortality and improving maternal health.

17. The immediate objectives are to reduce the incidence of stunting and underweight among young children and improve the health and nutrition of mothers, in line with WFP's Strategic Plan (2006–2009) and corporate indicators (see Annex II).

18. Targets are based on standard nutritional benchmarks for a feeding programme with complementary activities.

19. The following monthly outputs are anticipated in target areas (see Annex II):

- 20,900 infants of 6–24 months receive a monthly take-home ration of fortified blended food, oil and sugar;
- 13,480 pregnant and lactating women receive a monthly take-home ration of fortified blended food, oil and sugar for six months before giving birth and six months afterwards;

- 20,220 pregnant and lactating women and mothers of children of 6–24 months participate in healthcare and nutrition counselling and training and receive a complementary monthly ration of rice; and
- 1,500 village health volunteers, of whom at least 50 percent are women, receive health and nutrition education and a ration of rice.

20. The total number of beneficiaries is estimated at 63,520, taking into account enrolment and graduation from beneficiary groups over the 36 months: 41,800 children of 6-24 months, 20,220 pregnant and lactating women and mothers of young children, and 1,500 village health volunteers. A child may be counted as beneficiary for up to 18 months; a woman may be enrolled for up to 30 months in relation to a single child. A mother who is not pregnant or lactating and who has more than one child enrolled in the programme will receive a ration for each child and one for herself.

21. Children of 6–24 months and pregnant and lactating women from vulnerable households in target areas will be identified by health centre and non-governmental organization (NGO) staff, traditional midwives and village health volunteers.

22. NGO partners will register village health volunteers, who will often be members of village development committees, in collaboration with local authorities. Women will be encouraged to register; the target is at least 50 percent women volunteers.

23. To maximize coverage, the project will be implemented at the village level by outreach teams consisting typically of two health centre staff, one NGO staff member and one or two village health volunteers. Services include ante-natal care, nutrition and health education for targeted women and as growth monitoring for targeted children; additional services will be provided by the NGO and Government partners through ongoing programmes such as vaccination and distribution of vitamin A capsules and iron/folate and deworming tablets. The current cooperation between the MCH outreach teams and the home-based care teams for HIV/AIDS will continue to support MCH beneficiaries affected by HIV/AIDS.

24. The food basket consists of fortified blended food, vegetable oil, sugar and rice, taking into account the sharing expected in households as recommended by the latest survey mission. Sugar is pre-mixed with the fortified blended food and packaged in monthly rations to enhance hygiene, avoid losses at distribution and prevent the use of sugar to produce rice wine.

25. The aim of supplementary feeding with fortified food rations is to improve the nutritional status of young children and pregnant and lactating women by providing a micronutrient supplement in their diet.

26. The distribution of rice will (i) serve as an incentive to targeted women to take part in health and nutrition education, (ii) minimize the sharing of fortified food in households, (iii) promote the use of healthcare and community development services and (iv) compensate volunteers who conduct growth monitoring, provide health and nutrition education and distribute food.

27. The fortified food ration, excluding rice, provides at least 77 percent of a child's energy requirement and most of the micronutrient requirement; it provides at least one third of the requirements of a pregnant and lactating woman. The combination of the fortified ration and rice in the household food basket will enhance the nutrition of beneficiaries even if food is shared.

28. Growth monitoring under the current phase of the project has taken place monthly. Village health volunteers discuss growth charts with mothers and refer faltering cases to health centres. The results are compiled monthly and reported every quarter to WFP.

29. The health and nutritional status of recipients of supplementary food rations is expected to improve through a combination of enhanced diet and the interventions described above. The accompanying health and nutrition education will give mothers the knowledge to combat the inter-generational effects of malnutrition. As the capacity of volunteers and health centre staff improves, communities in the project area will benefit from improved health and nutrition services.

30. More pregnant and lactating women are expected to improve their nutrition and health through diet diversification, improved ante-natal and post-natal care, improved knowledge of hygiene and spacing of births. Improved dietary diversity is expected to result from eating fortified foods, nutrition education and better feeding practices.

31. The supplementary and complementary food rations for women should help to enhance their position as primary health carers and managers of household resources.

32. Under the Minimum Package of Activities, the Ministry of Health has implemented a national training programme for health staff that includes growth monitoring and growth promotion. A package of information on education and communication (IEC) has been developed for use in communities, at health centres and in outreach services to promote good health and nutrition among children under 5. The growth-monitoring charts and nutrition and health material used in this project are in line with national and international standards.

33. The Government will ensure acceptable levels of personnel for health centres and will organize monthly activities for outreach teams facilitated by partner NGOs.

34. WFP will support capacity-building for Government health centre staff, outreach teams and village health volunteers through annual refresher training and IEC materials.

35. WFP’s collaboration with NGOs such as World Vision Cambodia, Caritas and RACHA has been important in reaching the intended beneficiaries, integrating the MCH activities into development interventions, maximizing resource utilization and minimizing costs.

36. The current implementation modalities will continue in the new project phase. WFP will continue to use standard tripartite partnership agreements with the Ministry of Health and NGOs. New partnerships will be considered according to the interest and capacity of the Government and NGO partners.

37. Partnerships with NGOs will be extended without excluding new NGO partners. The health centres covered in the current phase of the project will continue to receive support to provide continuity and increased awareness of project objectives.

38. NGOs are responsible for technical assistance related to health, nutrition education, vegetable gardening and distribution of Vitamin A, iron, folate and deworming tablets provided by the Government with the support of the World Bank, The United States Agency for International Development (USAID), the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF).

39. Coordination with other agencies is important to achieving the desired impact of WFP food aid. Supplementary feeding alone is not sufficient to address the underlying causes of malnutrition: it should be integrated with other health and nutrition interventions. Poor provision of ante-natal and child health services will negate the expected benefits.

40. WFP has a central warehouse in Phnom Penh and three provincial warehouses, to which imported food, transported from the port of Sihanoukville, and locally purchased food will be delivered. To ensure hygiene, workers hired by WFP will re-pack the corn-soya blend (CSB) into bags containing one month's rations. Contracted commercial companies will transport the food to final distribution points.

41. The landside transport, storage and handling (LTSH) rate for the expansion phase of the project is estimated at US$85/mt, including discharge and handling at the port of entry and transport. The Commodity Movement Processing and Analysis System (COMPAS) will track consignments and report losses and damage.

42. Implementation of NSDP is being hindered by the shortage of internal resources. Continued international support for Cambodia is essential in helping the Government to develop the capacity of the healthcare system.

43. From 2010, however, Cambodia expects to benefit from recently discovered oil and gas reserves. WFP will advocate for national policies that include the vulnerable poor in the benefits of the new wealth; this project therefore emphasizes ownership by the Government and communities and capacity-building to enable them to take responsibility for its implementation.

MONITORING AND EVALUATION

44. NGO partners will be primarily responsible for monitoring and reporting project activities; WFP will provide support to increase the involvement of Government staff, for example by organizing more regular meetings of all stakeholders. WFP monitors regularly visit project sites and distributions, using standard checklists to verify that all components of the project are carried out.

45. The review of the current phase of the project concluded that reporting forms capture all the information needed to track progress. Quarterly reporting on output and process indicators was found to enable rapid response if project adjustments are needed.

46. A baseline survey of the implementation areas will be carried out at the beginning of the project; a follow-up survey will take place in the second quarter of 2010. Project outcomes measured include stunting and underweight in children of 6–24 months and prevalence of under-nourishment among pregnant and lactating women with a mid-upper arm circumference (MUAC) of less than 22 cm;[7] measurement of low birthweight as a reflection of maternal malnutrition will be gradually introduced as a pilot initiative.

47. Output and process indicators will be measured and reported in the quarterly progress reports produced by cooperating partners.

48. Successful implementation depends on the assumptions that political stability will be maintained, that the Government will continue to implement its reform agenda, that there are no unusually severe droughts or floods and that there are no pipeline breaks because of lack of funding.

49. There will be no environmental changes resulting from this project.

50. The project will be implemented in areas with high levels of food insecurity; it will target communities with little or no purchasing power or ability to grow enough of the

[7] WFP. 2005. *Food and Nutrition Handbook*. Rome.

foods necessary for a healthy diet. The project does not envisage any risk of disincentives to local production or the displacement of local markets.

51. Continuous coordination during the previous and current phases of the project has secured the involvement of all stakeholders from the planning stage; this has been enhanced by the involvement of the Ministry of Planning, which chairs the National Council for Nutrition, the Ministry of Health, the Technical Working Group on Food Security and Nutrition, co-chaired by WFP, other United Nations agencies – UNICEF in particular – and NGO partners.

ANNEX I-A

BREAKDOWN OF PROJECT COSTS			
	Quantity (mt)	**Average cost per mt**	**Value (US$)**
WFP COSTS			
A. Direct operational costs			
Commodity *			
– Rice	3 721.68.	254.12	945 753
– CSB	7 426.08	343.32	2 549 522
– Vegetable oil	371.31	720.00	267 343
– Sugar	928.26	488.69	453 631
Total commodities	**12 447.33**		**4 216 249**
External transport		**63.57**	**791 277**
LTSH		**84.61**	**1 053 189**
Other direct operational costs		**13.63**	**169 620**
Total direct operational costs			**6 230 335**
B. Direct support costs[1] (see Annex I-B for details)			
Total direct support costs		**41.27**	**513 758**
C. Indirect support costs[2] (7.0 percent)			**472 087**
TOTAL WFP COSTS			**7 216 180**
Government contribution			43 200
* This is a notional food basket used for budgeting and approval. The contents may vary.			

[1] Indicative figure for information purposes. The DSC allotment is reviewed annually.

[2] The ISC rate may be amended by the Board during the project.

ANNEX I-B

DIRECT SUPPORT REQUIREMENTS (US$)	
Staff	
National professional officers	85 500
National general service staff	184 500
Temporary assistance	45 292
International consultant	30 000
Staff duty travel	60 000
Staff training	7 500
Subtotal	**412 792**
Office expenses and other recurrent costs	
Rental of facility	25 760
Utilities	11 200
Office supplies	4 500
Communication and IT services	12 000
Equipment repair and maintenance	2 400
Vehicle maintenance and running costs	26 500
Other office expenses	6 000
United Nations organizations services	3 000
Subtotal	**91 360**
Equipment and other fixed costs	
Furniture, tools and equipment	1 729
TC/IT equipment	7 877
Subtotal	**9 606**
TOTAL DIRECT SUPPORT COSTS	**513 758**

ANNEX II – RESULTS AND RESOURCES MATRIX

Results chain	Performance indicators	Risks, assumptions	Resources required
UNDAF outcome 1. By 2010 improved health, nutritional and educational status and gender equity of rural poor and vulnerable groups.	**UNDAF outcome indicators** 1.1 Increased equitable access to and utilization of quality social services. 1.2 Increased awareness and empowerment of the population, particularly women, children and youth, to claim their rights to social services.		
Development projects outcomes Improved nutrition and health status among targeted pregnant and lactating women and children between 6 and 24 months of age: 1. Prevalence of underweight among young children is prevented and reduced. 2. Prevalence of stunting among young children is prevented and reduced. 3. Practice of measurement of Low Birth Weight in neonates is increased. 4. Prevalence of undernourished pregnant and lactating women is reduced.	**WFP Development project outcome indicators** 1. Decreased prevalence of underweight (< 2SD) in children 6-24 months of age. 2. Decreased prevalence of stunting (< 2SD) in children 6-24 months of age. 3. Increased practice of measuring neonates' weight at birth. 4. Reduced prevalence of under nutrition in pregnant and lactating women (MUAC <22cm).	➢ Political stability is maintained. ➢ Government is committed to implement Cambodian Nutrition Investment Plan. ➢ No floods or droughts of unusual severity. ➢ All stakeholders involved in the project fulfil their responsibilities, as food aid alone, will not be able to achieve intended outcomes.	US$7,216,180

ANNEX II – RESULTS AND RESOURCES MATRIX

Results chain	Performance indicators	Risks, assumptions	Resources required
Outputs Increased participation of pregnant and lactating women and young children in food-supported nutrition interventions: 1. 20,900 children from 6–24 months of age (10,450 boys and 10,450 girls) received a monthly take-home ration of fortified, blended food. 2. 13,480 pregnant and lactating women received a monthly take-home ration of fortified blended food. 3. 20,220 pregnant and lactating women and mothers of children aged 6 to 24 months, participated in health care and child nutrition training sessions. 4. At least 90% of village volunteers and health staff completed basic or refresher training on growth monitoring and MCH.	**Output indicators** 1. Number of children from 6-24 months of age having received a monthly take-home ration of fortified blended food. 2. Number of pregnant and lactating women having received a monthly take-home ration of fortified blended food. 3. Number of targeted women having participated in health care and child nutrition counselling/training sessions. 4. Number of village volunteers and health staff having completed a basic or refresher training on growth monitoring and MCH.	➢ Fortified ration is shared with family members. ➢ Partners provide appropriate basic training. ➢ Partners provide appropriate refresher training.	Total: US$7,216,180 (as per budget: US$513,758 DSC and US$169,620 ODOC)

ANNEX III

MCH Target Provinces for 2008–2010

Otdar Mean Chey
Banteay Mean Chey
Siem Reab
Preah Vihear
Stueng Traeng
Rotanak Kiri
Krong Pailin
Bat Dambang
Kampong Thum
Kracheh
Mondol Kiri
Pousat
Kampong Chhnang
Kampong Cham
Kampong Spueu
Phnom Penh
Kaoh Kong
Kandal
Prey Veaeng
Svay Rieng
Takaev
Kampot
Krong Preah Sihanouk
Krong Kaeb

Legend
WFP MCH Target (Provinces) 2005-2007
WFP MCH Target (Provinces) 2008-2010
Current PRRO Target (Communes) 2004-2007
Svay Rieng Province Name

Produced by the WFP VAM Unit, Feb. 2007

The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the World Food Programme (WFP) concerning the legal status of any country, territory, city or area or of its frontiers or boundaries.

ACRONYMS USED IN THE DOCUMENT

CDHS	Cambodia Demographic and Health Survey
CMDG	Cambodian Millennium Development Goal
CNIP	Cambodia Nutrition Investment Plan
CSB	corn-soya blend
COMPAS	Commodity Movement Processing and Analysis System
DOC	direct operational costs
DSC	direct support costs
ECW	Enhanced Commitments to Women
IDA	iron deficiency anaemia
IEC	Information, Education and Communication
ISC	indirect support costs
GDI	Gender-related Development Index
GDP	gross domestic product
LTSH	landside transport storage and handling
MCH	mother-and-child health
MDG	Millennium Development Goal
MUAC	mid-upper arm circumference
NGO	non-governmental organization
NSDP	National Strategic Development Plan
ODB	Asia Regional Bureau
ODOC	other direct operational costs
ODP	Latin America and the Caribbean Regional Bureau
PLHIV	people living with HIV
QAP	quick-action development project
RACHA	Reproductive and Child Health Alliance
STDs	sexually transmitted diseases
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization