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For consideration

SUMMARY REPORT OF THE MID-TERM EVALUATION OF THE PROTRACTED RELIEF AND RECOVERY OPERATION ETHIOPIA 106650 (2008–2010)

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NOTE TO THE EXECUTIVE BOARD

This document is submitted to the Executive Board for consideration

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

This report evaluates WFP's ongoing protracted relief and recovery operation in terms of relevance, results and factors explaining the performance. The evaluation was conducted by three independent evaluators with fieldwork in Ethiopia in November 2009.

The evaluation found that the operation had responded effectively to a significant increase in demand for food aid transfers. Resources were quickly mobilized and distributed to millions of poor households. This saved lives, prevented acute hunger, reduced the risk of chronic hunger and addressed undernutrition. The relief component responded to the series of national economic and climate shocks and improved access to food for populations affected by insecurity and drought. The Productive Safety Net Programme addressed the increased demand for food transfers resulting from a sharp increase in the price of food and had a positive impact on food security. The targeted supplementary feeding component provided support to those suffering from malnutrition or at risk of becoming malnourished. The urban HIV/AIDS component demonstrated significant beneficial outcomes for people living with HIV/AIDS on anti-retroviral therapy and for orphans and other vulnerable children.

The factors that positively influenced the operation's efficiency and effectiveness included: resources quickly mobilized, resulting in food distributed; efficient targeting under the relief, Productive Safety Net Programme and HIV/AIDS components; the introduction of new operating systems to WFP relief operations in Somali region; and innovative partnership models developed in the HIV/AIDS component.

The efficiency and effectiveness of the operation was negatively influenced by food transfers that lacked predictability and/or were delayed. These delays caused households to adopt negative coping strategies that impacted their livelihoods and reduced their capacity to address vulnerability.

The evaluation recommends that WFP: i) devote resources to the establishment of a food management system capacity building strategy and task force comprising the Government, relevant donors and WFP; ii) work with donor agencies to commission an impact evaluation framework for all relief-related programmes; iii) strengthen the relevance and appropriateness of the targeted supplementary feeding programme by improving links across sectors; iv) seek ways of improving the targeted supplementary feeding programme's targeting and its response to emergency requirements; and v) continue and expand, if funding allows, the urban HIV/AIDS component.

DRAFT DECISION*

The Board takes note of "Summary Report of the Mid-Term Evaluation of the Protracted Relief and Recovery Operation Ethiopia 106650 (2008–2010)" (WFP/EB.2/2010/6-E) and the management response in WFP/EB.2/2010/6-E/Add.1 and encourages further action on the recommendations, taking into account considerations raised by the Board during its discussion.

* This is a draft decision. For the final decision adopted by the Board, please refer to the Decisions and Recommendations document issued at the end of the session.

BACKGROUND

Context

1. Ethiopia experienced a period of rapid economic growth from 1998 to 2007, with national gross domestic product (GDP) growing at almost 8 percent per year. However, the rate of rural poverty remains high, with 38 percent of rural households living below the food poverty line.[1] In 2005, 34 percent of rural households had suffered food shortages in the previous 12 months and 15 percent of rural households had a food gap of longer than four months.[2] Access to markets is a critical constraint, with 43 percent of households in rural areas having to travel more than 15 km to access transport services. Ten percent of the population (7.5 million people) participates in the largest public works programme in Africa.[1] In addition, millions more people are affected by climate, economic and social shocks.

2. Since 2007 Ethiopia has had two major droughts that affected 6.4 million people.[3] Poor households were also impacted by the food price crisis, which caused a sharp increase in the price of staple foods across the country.[4] An International Food Policy Research Institute (IFPRI) report showed the lowest price increase was found for maize in Tigray, which increased by "only" 75 percent over this two-year period. The highest price increase was maize in Southern Nations and Nationalities and Peoples Region (SNNPR), which increased by 187 percent.[4]

3. Recurrent drought and military activity have combined to create a complex emergency in Somali region that affects an additional 2 million people.

4. Ethiopia has high malnutrition levels, particularly in rural areas.[5] At the national level, the recorded rates in 2005 were over 10 percent for wasting (global acute malnutrition or GAM) and 47 percent for stunting (chronic malnutrition).[6] The Demographic and Health Survey (DHS) found considerable malnutrition among women of childbearing age; the national average was over 26 percent of women being undernourished, with a body mass index (BMI) of less than 18.5. Low birthweight prevalence was found to be a high 13.5 percent. Information at the *woreda*[7] level on 2008 and 2009 nutrition conditions is provided through standard nutrition surveys. Consistently high malnutrition levels (GAM > 20 percent) were found in surveys undertaken in Afar and Somali regions and some pockets in SNNPR. In Amhara and Oromiya regions and the other parts of SNNPR reported GAM rates were all <15 percent (in about half of the cases < 10 percent) and in Tigray all well below 10 percent.

5. The main causes of the high levels of both acute and chronic malnutrition in Ethiopia are poverty combined with deficiencies in maternal and child care, inadequate health services,

[1] World Bank. 2009. PSNP, Project Appraisal Document. Washington, DC.

[2] Ethiopia Central Statistical Agency. Welfare Monitoring Survey, 2004-2005. Addis Ababa.

[3] World Bank. Country Assistance Strategy – Ethiopia 2006. Washington, DC.

[4] IFPRI. 2008. An Impact Evaluation of Ethiopia's PSNP. Washington, DC.

[5] Central Statistical Agency (Ethiopia) and ORC Macro (2006). Ethiopia DHS 2005. Addis Ababa.

[6] Somali region showed an alarmingly high GAM rate of 23.7 percent (with 5.1 percent SAM), followed by Amhara and Benishangul-Gumuz (14.2 percent and 16.0 percent, respectively). The lowest rates were found in SNNPR (6.5 percent) and Gambella (6.89 percent but with 3.8 percent severe acute malnutrition (SAM) rate).

[7] A *woreda* is a sub-regional administrative unit.

unsafe water supply and lack of sanitation facilities. Food-secure households or regions in Ethiopia can still be highly affected by both acute and chronic malnutrition. Augmented acute malnutrition levels occur during times of (recurrent) natural disasters and other acute external food security shocks in Ethiopia.[8]

6. Ethiopia is severely affected by the HIV epidemic. In 2009 HIV prevalence among adults 15–49 years was 2.3 percent (7.7 percent in urban and 0.9 percent in rural areas). The number of people living with HIV (PLHIV) was 1.1 million. There were 855,720 orphans and other children made vulnerable by AIDS (OVC) among a total of 5.4 million OVC. During the year there were 131,000 new infections, and AIDS caused the deaths of 44,751 adults and 7,214 children.[9] In 2008 anti-retroviral therapy (ART) was available at 400 sites for 132,379 PLHIV, and an estimated 18 percent of the pregnant women with HIV received ART for prevention of mother-to-child transmission (PMTCT).[10] In 2006 AIDS was the leading cause of mortality in 15–49-year-olds (43 percent of all deaths) and life expectancy was falling as a result of the epidemic; it was expected to drop from 59 to 50 years by 2010.[11]

Description of the Operation

7. The protracted relief and recovery operation (PRRO) runs from January 2008 to December 2010. It was originally designed to address the food needs of up to 3.8 million beneficiaries a year with a total proposed food allotment of 959,327 mt, at a total cost estimated at US$561.9 million. Owing to drought and the international food and oil price crises in 2008, a prolonged emergency significantly increased numbers of relief beneficiaries. Following eight budget increases, the total food allotment in November 2009 was nearly 1.6 million mt, with a total cost of almost US$1.3 billion.

8. The four programme components of this PRRO are similar to those of the previous programme. These are:

- **Relief programmes**. The relief programmes support government efforts to respond to acute and transitory food insecurity, beyond the people covered by the Productive Safety Net Programme (PSNP). WFP's contribution to these efforts includes: logistical support, livelihoods-based needs assessments, technical backstopping to early warning systems and seasonal assessments, rapid-assessment teams in disaster-affected areas, determination of required assistance, monitoring of distributions and assistance in targeting. WFP staff provide technical assistance and strategic input from the United Nations and national levels through to the local government and community levels. Original plans were to assist a maximum of 792,000 people; the figure was later revised to 6.4 million people.
- **Productive Safety Net Programme**. The PSNP is a multi-year, multi-donor programme that provides predictable and timely food and cash transfers to chronically food-insecure beneficiaries. WFP supports the Government in the management of food transfers. In the original approval document, the Government and WFP targeted a maximum of 2.46 million people for food transfers in 2009; PSNP reached 7.5 million people with food and/or cash transfers and other support. It seeks to help

[8] IFPRI. 2005. An assessment of the causes of malnutrition in Ethiopia. November. Washington, DC.

[9] Federal HIV/AIDS Prevention and Control Office, Ethiopia. 2009. National Fact Sheet 2009. Addis Ababa.

[10] WHO/UNAIDS/UNICEF. 2009. Towards Universal Access. Progress Report 2009.

[11] WFP Country Office. 2005/06 Annual HIV/AIDS Monitoring and Evaluation Report. Addis Ababa.

households meet basic needs through monthly transfers and to build more resilient livelihoods through community public works and environmental management.

- **Targeted supplementary feeding**. The TSF programme is the only large-scale food-based programme in support of the Government's Child Survival Initiative and operates in conjunction with the Enhanced Outreach Strategy (EOS) programme supported by the United Nations Children's Fund (UNICEF). The TSF, established in 2004 following the 2002/03 emergency response, is a system of targeted nutritional support to treat moderate malnutrition in rural Ethiopia. The TSF targets were reduced from 737,000 to 597,000 people.
- **Urban HIV/AIDS**. This programme supports food-insecure PLHIV at a critical point in HIV management by using food support when commencing ART or PMTCT. It also supports children made vulnerable by AIDS and infants of women participating in PMTCT. It complements allied health and community services and is implemented through government and non-governmental organization (NGO) partners. It was envisaged to scale up from 155,000 to 164,000 over the three years.

Evaluation Features

9. The evaluation serves accountability and learning purposes; it took place from October 2009 to February 2010, with fieldwork in November 2009. The evaluation team comprised three independent international evaluators. The methodology included a literature review, stakeholder interviews, focus group sessions and site visits to Amhara, SNNPR, Somali regions and Addis Ababa. The evaluation followed WFP's Evaluation Quality Assurance System.

PERFORMANCE HIGHLIGHTS

Operation Design: Relevance and Appropriateness

10. The PRRO's newly introduced strategic objectives, corresponding to WFP's Strategic Objectives 1, 2, 4 and 5, are to:

- save lives and protect livelihoods in emergencies;
- prevent acute hunger and invest in disaster preparedness and mitigation measures;
- reduce chronic hunger and undernutrition; and
- strengthen the capacities of countries to reduce hunger, including through hand-over strategies and local purchase.

11. These objectives are coherent with the strategic and policy priorities of the Government and many donors. They also reflect the needs of groups targeted by the programme.

12. **Programme Design.** The design of the relief component allowed it to expand in response to the impact of both economic and climate shocks. The PSNP design allows for variability in the balance between cash and food provided to beneficiaries. In 2008, increased food prices reduced the value of cash transfers, so the programme increased the volume of food transfers. The TSF component is highly relevant because it targets young children and pregnant and lactating women; and increases coverage of TSF programmes. The relevance of the HIV/AIDS component's design is demonstrated by evidence that a high percentage of initiating ART patients were malnourished according to clinical criteria; most PLHIV came from highly food-insecure and economically poor groups; and, food insecurity was an urban problem.

13. However, the mid-term evaluation found that the design of the PRRO would have been more relevant and appropriate if the approach towards building the capacity of the food management system had improved levels of strategic problem analysis, increased accountability, and provided clearer indicators of progress at output and/or outcome level.

14. **Progamme Coherence.** All the programme components have strong internal and external coherence with key policies and programmes. In the current United Nations Development Assistance Framework (UNDAF), WFP leads the Humanitarian Response, Recovery and Food Security thematic group. It is well placed to coordinate and influence links between the PRRO and other relevant initiatives.

Outputs and Implementation

15. **Outputs**. In 2007, the PRRO design estimated that approximately 1 million people would be vulnerable to rapid-onset shocks. However, in 2008 over 7 million people benefitted from general food distributions. In 2009, WFP once again had to scale up its operations to provide support to over 6 million beneficiaries.

16. The cost of operating the PRRO has been adjusted seven times since its inception.[12] Mobilizing the resources to cover these rapid increases in beneficiary numbers has been a challenge. WFP has been effective in ensuring the PRRO is well financed. However, mobilizing the volume of resources to meet the increased demand has placed significant strain on the capacity of the food management systems.

17. **Efficiency.** The evaluation concluded that the PRRO appears to have efficiently targeted activities under the relief, PSNP, and HIV/AIDS components, although some delays occurred in food distributions. The targeting efficiency for the TSF was less optimal (see paragraph 27).

18. The introduction of new operating systems for WFP relief operations in the Somali region had a significant and positive impact on programme coverage. In October 2008, WFP, in coordination with the Government, established the “hubs and spokes” system for food distribution. Prior to use of the system, 30 percent of food allocated was delivered, compared to 94 percent in the period October 2008 to September 2009.

19. Since the inception of PSNP there has been evidence of delays of food and cash transfer deliveries. In 2007, an estimated three out of four PSNP beneficaries (71 percent) had encountered delays in transfers, according to their own reports. The situtation was no better in 2008, when less than 50 percent of households received all the transfers they were due in the first five months (see Table 1).

[12] In January 2010 the budget was revised again.

TABLE 1: PSNP HOUSEHOLDS RECEIVING TRANSFERS, BY PERCENT OF DUE TRANSFERS (9 JANUARY–9 JUNE 2008)					
Region	**Number of households**	**0–50%**	**50–80%**	**80–100%**	**100%**
Tigray	422	51	30	4	15
Amhara	289	25	35	20	21
Amhara II*	374	37	30	10	23
Oromiya	286	24	16	11	49
SNNPR	360	9	32	14	45

Source: IFPRI

* The IFPRI study divided Amhara assistance into two groups depending on the support provided.

20. The first phase of TSF (2005–2007) was marked by sharp increases in geographical and beneficiary coverage. However, as Table 2 shows, the trend has been reversed since the inception of the current PRRO.

TABLE 2: COVERAGE UNDER TSF (2005–2009)					
	PRRO 103620			**PRRO 106650**[13]	
	2005	**2006**	**2007**	**2008**	**2009**[14]
Regions[15]	7	10	10	7	7
Woredas	165	260	342	166	202
Pregnant/lactating women	173 000	228 000	369 000	289 000	356 000
Under-5s	301 000	484 000	783 000	615 000	756 000
Total beneficiaries	**474 000**	**712 000**	**1 152 000**	**904 000**	**1 112 000**

Source: Evaluation team

21. Ideally, TSF coverage would be needs-based and not resource-based. The WFP country office, the Government and other stakeholders face a major challenge in securing the contributions required to ensure acceptable coverage, in terms of both number of *woredas* and total number of beneficiaries.[16] In addition, high fuel and food prices limited the purchasing power of available donor funds.

22. The HIV/AIDS component did not reach its target for the output on the timely provision of food in sufficient quantities. At 12,320 mt the overall tonnage of food distributed was

[13] WFP country office. 2009, Standard Project Report 2008 Ethiopia; Project 106650. Addis Ababa.

[14] Figures refer to round one only, which was undertaken in 167 *woredas* in the period May–August, and ad hoc screening results in 35 additional *woredas* in Amhara, SNNPR and Oromiya. Owing to operational problems, no screening/distribution took place in this round in Afar and Gambella regions.

[15] In 2006 and 2007 all regions in Ethiopia were covered. In 2008–2009 seven regions were covered: Somali region, Oromiya, Amhara, Tigray, SNNPR, Gambella and Afar.

[16] Nationwide around 780,000 under-5s are estimated to be in need of treatment for moderate acute malnutrition. At first sight, this target figure seems to be closely matched by the total coverage achieved in 2007. However, there has been a considerable level of false inclusions (see the Results section) and only a certain proportion of all rural *woredas* in Ethiopia were covered by the TSF. This means that there were many malnourished children in Ethiopia who were not reached by the TSF.

56 percent of the target and one in five beneficiaries reported not receiving food on time. However, for outputs of capacity development of HIV counterpart staff, the project managed to reach its beneficiary training targets.

23. **Partnerships and coordination.** All components utilize government systems for both logistics and procurement. Operationally WFP is a crucial player in enabling the food management system to function. There is broad recognition that the Government has significant gaps in capacity. WFP's partnership provides it a unique role in supporting the Government to identify needs and develop its capacity. The evaluation found that positive lessons can be learned from the relief component's approach to establishing multi-stakeholder steering committees to coordinate humanitarian support to Somali region. In PSNP, WFP should continue to play its role in the donor coordination mechanisms. The HIV/AIDS component has established a framework of partnerships with formal and non-formal institutions. This allows the programme to be strategically placed and maximizes its value added.

24. The evaluation found that the TSF needs to expand its coordination and partnerships, specifically to establish a better link with those sectors related to the underlying causes of malnutrition, especially the health and food security sectors.

25. **Targeting.** The relief component targeting uses National Food Aid Targeting Guidelines issued in 2000. Since the introduction of the guidelines, a range of innovations has been introduced in the humanitarian sector. The Government and WFP are reviewing the guidelines to identify gaps and limitations that hinder the timeliness of relief and the proper utilization of resources. [17]

26. The PSNP uses a combination of administrative and community-based targeting to select beneficiaries. The evaluation found this approach to be broadly appropriate.

27. The geographical targeting for TSF is coherent with government systems for prioritizing humanitarian assistance. However, the component struggles to keep pace with an expanding demand for coverage. The evaluation assessed whether the average number of TSF beneficiaries per *woreda* is in line with peak malnutrition rates in the three regions visited. It found a substantial inclusion error in Amhara and SNNPR while generally there was still under-coverage in Somali region.[18] These findings underscore the importance of improving EOS screening procedures as is currently being done in response to the 2008 TSF outcome evaluation study that highlighted the same issue. In 2009, WFP initiated a pilot study of the gatekeeper approach, which might also help to reduce targeting errors. This approach, first piloted in SNNPR and now being expanded to Afar region, uses the EOS screening to make a referral to a second screening done by health workers.[19]

28. Overall the evaluation found that the HIV/AIDS component: i) targets food support appropriately; ii) strengthens beneficiary referral, promotes use of services and encourages graduation; iii) improves partnership and networking among services that enhance sustainability; and iv) develops the local integrated response to HIV in a strategic manner.

29. **Monitoring and evaluation.** The evaluation found weaknesses in the PRRO's approach to evaluating the relief component. The frequency of humanitarian crises, the high

[17] WFP country office. 2010. Terms of Reference, Targeting of Relief. Addis Ababa.

[18] Peak malnutrition levels were based on the Standard Nutrition Survey findings plus a certain margin for particularly bad years. For SNNPR, a level of 20 percent was taken, for Amhara 15 percent and for Somali region 25 percent.

[19] According to the WFP country office, the new approach works well.

probability that a crisis will repeatedly impact certain geographical areas, and the levels of resources invested in humanitarian response, suggest that resources could and should be applied to establishing a robust monitoring and evaluation framework.

30. In contrast, PSNP has established a comprehensive framework for monitoring and evaluation. The programme has established a comprehensive, in-depth and continuous system that includes various types of evaluation, including impact evaluation.

31. The design of the TSF includes the choice to do large-scale coverage – up to 1.15 million/year – without using monitoring of weight gain of each individual beneficiary as an outcome indicator. Instead, annual outcome monitoring studies and post-distribution beneficiary interviews are performed on a sample of beneficiaries.

32. The HIV/AIDS component has created an excellent results-based system. It provides detailed analysis of operations and beneficiary impacts, and identifies best practices and challenges.

Results

33. **Effectiveness.** Overall progress towards achieving the strategic objectives is mixed. Under the relief, PSNP and TSF components the programme has delivered transfers to millions of people. This has saved lives, prevented acute hunger, reduced the risk of chronic hunger and addressed undernutrition. However, delays in the delivery of transfers have restricted household investments in protecting livelihoods and risk mitigation measures. The evaluation found the delays in transfers are, in part, related to the need to develop further capacity. WFP's approach to capacity development should be more output– and outcome–focused and be linked to indicators that reflect improvements in timeliness.

34. A sample of WFP's post-distribution monitoring (PDM) reports indicates that households normally use 80–90 percent of food aid transfers for consumption. There is evidence from an Institute of Development Studies (IDS) study to suggest that the vast majority of PSNP beneficiaries use food transfers for the intended purpose (see Table 3).

TABLE 3: USE OF PSNP FOOD (PREVIOUS 12 MONTHS)		
Use of food	**PSNP Beneficiaries**	
	number	**percent**
Ate all the food	431	73.7
Sold some food, ate the rest	74	12.6
Gave away some food, ate the rest	26	4.4
Sold the food to buy other food	21	3.6
Gave some food as payment, ate the rest	13	2.2
Sold all the food for cash	13	2.2
Gave all the food to livestock for feed	1	0.2
Gave all the food as payment	1	0.2
Other	5	0.9
Total	**687**	**100**

Source: IDS, 2008

35. However, progress in supporting households to develop risk mitigation strategies is less positive. Transfers through PSNP are meant to discourage households from using negative coping strategies such as selling assets. The evaluation highlighted that timeliness and predictability of transfers are critical factors in reducing negative coping strategies. Studies show that households that receive lower than the intended level of transfers are much more likely to sell assets because of distress.

36. Studies undertaken in 2007 and 2008[20] found that the TSF component was not highly effective (recovery rates of only 50 to 62 percent). The programme was found to have high inclusion errors, significant delays between screening and actual food distribution, and problems with compliance because of substantial sharing of food among household members.

37. The evaluation found that the HIV/AIDS component is achieving its outcomes by establishing effective systems and processes for providing food support and improving nutritional status and quality of life for PLHIV and by increasing school enrolment and attendance of OVC.

38. The HIV/AIDS component annual results survey demonstrated significant beneficial outcomes and achievement of targets for PLHIV on ART and OVC, but not for PMTCT. Most indicators showed a positive trend (see Table 4 below) and met between 84 and 108 percent of their targets. The project reached only 49 percent of its PMTCT target owing to factors beyond its influence; for example, pregnant women often do not use health services, and those who do are reluctant to be tested for HIV because of the stigma associated with the virus. The component's contribution to ART programming is shown by a three-fold increase in the number of clients enrolled in ART from 2007 to 2008.[21]

[20] WFP country office. 2007. TSF Performance Study Report. Addis Ababa; and Skau, J., Belachew, T., Girma, T. and Woodruff, B. 2009. Outcome evaluation study of the targeted supplementary food program in Ethiopia. Addis Ababa.

[21] WFP Urban HIV/AIDS Project. Results Report for 2007 and 2008. Addis Ababa.

TABLE 4: INDICATOR PERFORMANCE FOR URBAN HIV/AIDS COMPONENT (%)			
Outcome indicators	**Baseline (June 2006)**	**Actual (Nov 2008)**	**Percent of target**
PLHIV gaining weight by at least 10% six months after starting ART	24.6	47.4	84
Percent of beneficiaries on ART taking 95% of medication in last month	76.7	96.4	101.3
PLHIV with improving/stabilizing health condition	85.6	95.1	99.9
PLHIV with improved functional status	73.2	92.4	108
School enrolment of OVC	80.1	98.8	104
School attendance of OVC	90.9	98.4	N/A

39. The stigma associated with HIV has a profound influence on the project: it is a major factor in the food insecurity of beneficiaries and prevents them from accessing services.

40. **Impact.** The evaluation team could find no comprehensive and statistically valid evaluations of the impact of the relief component. As noted above, households utilize almost all their food transfers for household consumption, suggesting that transfers are sufficient to meet household demand and address the "saving lives" objective. However, there is no evidence of how the relief component is impacting livelihoods and achieving the timeliness requirements as compared with the safety net programme.[22]

41. The PSNP food and cash transfers have had a positive impact on food security. However, the IFPRI impact evaluation and the IDS assessments vary in their assessment of the extent of the programme's impact. In 2009, IFPRI stated that the impact of PSNP would be greater if transfers – both cash and food – were predictable and households had access to livelihood support programmes. Unpredictable transfers cause households to sell assets.[23] The IDS report's more positive assessment found that PSNP is stabilizing livelihoods and improving the food security of beneficiary households.[24]

42. The TSF outcome studies focus on changes in the nutritional status of beneficiaries. In terms of impact, it would be interesting to measure the contribution of the programme to stabilization or reduction of malnutrition rates in Ethiopia, but the information base for such assessments is not available.

43. The HIV/AIDS component makes a valuable contribution to the response to HIV in Ethiopia at many levels. Through the component design and capacity development it assists the government HIV response by helping the national agency, the Federal HIV/AIDS Prevention and Control Office, to fulfill its leadership, coordination and technical roles. Through the partnership model it strengthens HIV health services. It strengthens NGOs' ability to provide support to beneficiaries and also to conduct HIV education and sensitization about PLHIV with the general population. By assisting PLHIV to return to social and community life, and by engaging with community groups, it improves social attitudes about HIV and toward PLHIV, thus reducing stigma and discrimination.

[22] The PDM report does not disaggregate the impact of food transfers on diet by programme component (relief and safety net).

[23] IFPRI. 2009. An Impact Evaluation of PSNP. Washington, DC.

[24] IDS. 2008. Ethiopia's PSNP, Assessment Report. Brighton, UK.

44. **Sustainability.** The hand-over strategy for the PRRO relies on reduced need for food transfers and sufficient capacity development with the Government. There have been positive trends in phasing out of food assistance. Examples include the emergence of cash transfers in PSNP, the introduction of new mechanisms such as drought risk financing, and the general policy drive toward improved disaster management. However, in practice, food aid has remained the preferred response to major economic and climatic shocks. WFP has an important role to play in ensuring that the Government delivers extensive and substantial food resources to millions of food-insecure, often very remote, households. The evaluation found WFP's current approach to developing capacity to be inadequate. This role could be more clearly defined, and benchmarks and indicators that demonstrate increased capacity could be used more frequently.

Cross-Cutting Issues

45. **Gender.** WFP has focused on appropriate gender initiatives such as increased efforts to ensure greater participation of women in local-level decision-making bodies that affect relief and PSNP components.

46. **Protection.** This is a highly relevant issue. The insecurity in the Somali region highlighted the need for a stronger focus on protection. WFP has initiated a process of incorporating protection into its staff training programme. Multiple priorities are restricting the resources and staff time devoted to developing and implementing protection protocols.

47. **Mainstreaming HIV.** It is appropriate for WFP to contribute to government efforts to augment coverage of HIV prevention information dissemination, particularly in rural areas. The WFP-supported projects Managing Environmental Resources to Enable Transitions to More Sustainable Livelihoods Programme and TSF are successful in mainstreaming HIV components. Although WFP facilitated an inter-agency process – including the Joint United Nations Programme on HIV/AIDS (UNAIDS) – to develop a package of rapid interventions to address HIV/AIDS in emergency situations, it remains necessary to mainstream HIV within the relief component.

CONCLUSIONS AND RECOMMENDATIONS

Overall Assessment

48. The overall assessment of the PRRO is that it has effectively responded to a significant increase in demand for food transfers. Resources have been quickly mobilized and distributed to millions of food-insecure households. Numerous reviews and evaluations conclude that the PSNP is having a positive impact on food security. The PRRO appears to have efficiently targeted activities under the relief, PSNP and HIV/AIDS components. The HIV/AIDS component, in particular, achieves its outcome targets and provides important positive lessons on how WFP can build and maintain strong partnerships. The evaluation team came to the conclusion that progress towards sustainability and phasing out of food assistance will be incremental. The introduction of PSNP, with its focus on shifting from food to cash transfers and resources to make multi-annual investments in capacity development, demonstrates a positive trend as part of WFP's hand-over strategy.

49. The evaluation concluded that delays in the delivery of transfers have restricted household investments in protecting livelihoods and risk-mitigation measures. It found the delays in transfers are related, in part, to the need to develop further capacity. Furthermore, the evaluation team found that WFP's approach to building food management systems capacity is necessary but insufficient.

50. WFP, as the leading humanitarian agency, and the PRRO, as the largest and most strategic humanitarian initiative in Ethiopia, need to set new standards in monitoring and evaluation. Specific attention needs to be given to regular impact evaluations of relief and TSF components.

51. The evaluation also concluded that WFP and the Government will have to make changes in the TSF design to improve the targeting and operational effectiveness of this important programme. TSF should ultimately become part of a more developmental health and nutrition framework, as part of Ethiopia's Community-Based Nutrition (CBN) programme currently being rolled out.

Issues for the Future

52. The country office needs to apply a more integrated and appropriate approach to addressing malnutrition in Ethiopia. Over the next five to ten years WFP (and donors) should be prepared to provide large-scale targeted nutrition support in Ethiopia, as part of the government nutrition policy framework and in line with existing needs.

53. WFP needs to work with partners to strengthen the conceptual framework and definition of target groups for the relief and PSNP components. The current application of acute versus chronic food insecurity does not accurately reflect the complex nature of vulnerability in Ethiopia.

54. The HIV/AIDS component provides insights for WFP HIV policy and programming in other countries where the response to HIV is resource-poor and has limited institutional and programming capacity. In such settings, WFP, working in partnership, can create innovative food assistance programming in ways that best contribute to the broader response to the epidemic.

Recommendations

55. **Recommendation 1:** WFP should devote resources immediately to the establishment of a food management system capacity development strategy and task force. The strategy should include in-depth problem analysis, a clear and concise action plan and indicators to highlight improvements in performance. The task force should comprise the Government, relevant donors and WFP.

56. **Recommendation 2:** WFP should work with donor agencies to commission the establishment of an impact evaluation framework for all relief-related programmes. The design of the framework should draw on lessons obtained from PSNP.

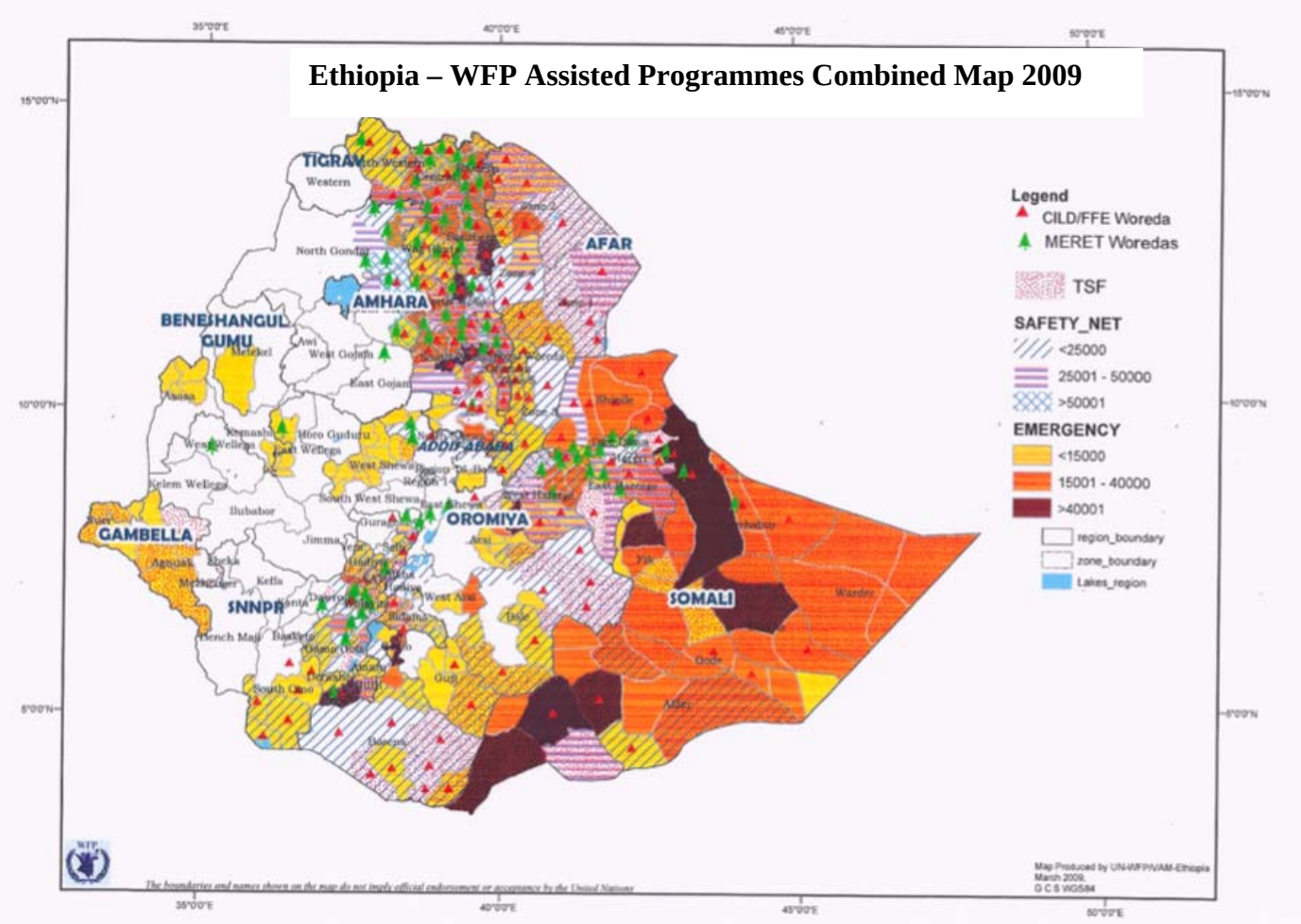
57. **Recommendation 3:** WFP should partner with the Office for the Coordination of Humanitarian Affairs (OCHA) and use its position as chair of the UNDAF Humanitarian Response, Recovery and Food Security thematic group to be a leading voice in the process of establishing a joint impact evaluation of all future humanitarian activities in Ethiopia. This evaluation should cover humanitarian assistance provided by the Government, the United Nations and NGOs.

58. **Recommendation 4:** WFP should strengthen the relevance and appropriateness of the TSF programme through: i) improved targeting; ii) development of a mechanism to adequately respond to emergency requirements; and, ii) better links and communication across sectors – including basic health care workers and water and sanitation – and within the food/food security sector (PSNP and relief interventions).

59. **Recommendation 5:** The urban HIV/AIDS component has been very successful; it should continue and, if funding allows, expand to new towns.

60. **Recommendation 6:** The critical importance of WFP's role and contribution to advocacy and the institutional and programming response to HIV in Ethiopia should be acknowledged and the HIV team should be supported with the technical capacity to continue this work.

61. **Recommendation 7:** The country office should increase its commitment to HIV mainstreaming to ensure programming interventions are implemented.



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

ART	anti-retroviral therapy
BMI	body mass index
DHS	Demographic and Health Survey
EOS	Enhanced Outreach Strategy
GAM	global acute malnutrition
HAPCO	Federal HIV/AIDS Prevention and Control Office
HBC	home-based care
HBCV	home-based care volunteer
IDS	Institute of Development Studies
IFPRI	International Food Policy Research Institute
NGO	non-governmental organization
NNP	National Nutrition Programme
ODOC	other direct operational costs
OVC	orphans and other vulnerable children
PEPFAR	United States President's Emergency Plan For AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
PRRO	protracted relief and recovery operation
PSNP	Productive Safety Net Programme
SAM	severe acute malnutrition
SNNPR	Southern Nations and Nationalities and Peoples Region
TSF	targeted supplementary feeding
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation