GUINEA BISSAU DEVELOPMENT PROJECT 200322

Food and nutrition assistance to malnourished children and HIV and TB affected people	
Number of beneficiaries	11,300
Duration of project	12 months (January - December 2012)
WFP food tonnage	990
Cost (United States dollars)	
WFP food cost	US$573,903
Total cost to WFP	US$1,402,641

EXECUTIVE SUMMARY

Guinea Bissau has a population of 1.6 million, of whom 30 percent live in urban areas. It is one of the poorest countries in the world, ranking 176 out of 187 countries in the 2011 Human Development Index. Two-thirds of the population live on less than US$2 per day.

Guinea Bissau's infrastructure and social services have suffered from more than 20 years of socio-political unrest and related destruction, looting and neglect. Schools, health facilities and transport infrastructure are in very poor condition. Access to basic services - including clean and safe water, health, education and electricity - is extremely limited. Only 53 percent of the rural population have access to potable water, 5 percent to latrines, and 38 percent to health care.

The HIV prevalence in Guinea Bissau of 2.6 percent is one of the highest in West Africa. The incidence of tuberculosis is also high (203 cases per 100,000 people) and co-infection with HIV is 38 percent. Adherence to treatment remains low with high default rates and high mortality in the first weeks of initiation of treatment due to inadequate access to food. Twenty-five percent of households with people living with HIV and tuberculosis are food-insecure, while 19 percent of clients on anti-retroviral therapy and 42 percent of clients being treated for tuberculosis are under-nourished.

While the prevalence of acute malnutrition in children under 5 is decreasing, it is still

classified as “poor” by the World Health Organization (6 percent in 2010), and the prevalence varies between 4-8 percent regionally. Chronic malnutrition remains serious at 32 percent, with regional prevalence ranging from 20-42 percent.

The proposed development project will focus on: i) providing nutrition support to 2,200 people living with HIV and people affected by tuberculosis, accompanied by nutrition assessment, education and counselling activities pre- and post-treatment and supplementary food support for their households; ii) supporting the treatment of moderate acute malnutrition in 2,000 children aged 6-59 months and 1,000 pregnant and lactating women through targeted supplementary feeding; and iii) building national capacity towards full national ownership of hunger solutions.

This development project is part of WFP’s transition from humanitarian assistance in Guinea Bissau towards development action. It is aligned to WFP Strategic Objectives 4 and 5, moving towards full national ownership of hunger solutions in support of the Government’s National Poverty Reduction Paper. This 12-month project will serve as a transition between the protracted relief and recovery operation 2009-2011 and a future country programme that will be aligned with the next United Nations Development Assistance Framework cycle (2013-2017). The project directly contributes towards Millennium Development Goals 1, 4, 5 and 6.

SITUATION ANALYSIS

The Overall Context

1. Guinea Bissau is located on the west coast of Africa, between Senegal and Guinea (Conakry). It covers 36,000 km^2 and has a population of 1.6 million, of whom approximately 30 percent live in urban areas, including 25 percent in the capital city of Bissau.[1] Per capita gross domestic product is US$580, and 66 percent of the population lives on less than US$2 per day. The country is one of the poorest in the world, ranking 176 out of 187 countries in the 2011 Human Development Index.[2]

2. Since 1980, Guinea Bissau's economy has suffered greatly from civil war and political instability. Despite abundant natural resources, favourable climate and rainfall patterns, and potential for fishing and tourism, the economy still relies heavily on foreign aid (80 percent of the budget). Agriculture employs 95 percent of the population and is dominated by cashew nut production for export, but also includes rice and other cereals, fruits, fishing, livestock, and forestry products. The economy is predominantly informal and industrial activity is almost non-existent.

3. Schools, health facilities and transport infrastructure are in very poor condition. Access to basic services - including clean and safe water, health, education, electricity - is extremely limited: only 38 percent of the population has access to health care; 6 percent has access to electricity; 53 percent of the rural population to potable water and 5 percent to latrines.

4. Life expectancy in Guinea-Bissau is low at 49 years, with infant and child mortality (223 per 1,000) and maternal mortality (800 per 100,000) among the highest in sub-Saharan Africa.[3] The human immunodeficiency virus (HIV) prevalence of 2.6 percent is one of the highest in West Africa, reaching up to 7 percent in Bafata, Bissau and Cacheu, and 5 percent in Gabu. While the HIV epidemic shows signs of stabilizing in the capital city and in the North, it remains dynamic in the East and South, especially in Gabu. HIV prevalence is still increasing among specific groups, especially sex workers and their partners. The potential for a rapid increase in prevalence is high due to a combination of vulnerability factors, such as economic dependency of young girls and women, mobility and its links to commercial sex, little knowledge about HIV prevention among the youth, and risky behaviours such as unprotected sex with multiple partners.

5. About 22,000 people are estimated to live with HIV, including 12,000 women and 2,100 children.[4] The incidence of tuberculosis (TB) is also high: 203 cases per 100,000 people, with TB and HIV co-infection estimated at 38 percent.[5] Despite the high directly observed treatment with short-course chemotherapy (DOTS) coverage (97 percent), adherence

[1] The Government of Guinea Bissau. 2009. *Inquérito Ligeiro para Avaliação de Pobreza II* (ILAP).
[2] United Nations Development Programme. 2011 Human Development Report.
[3] Government of Guinea-Bissau. *Documento de Estratégia Nacional de Redução da Pobreza 2011-2015,* DENARP II, p. 18.
[4] Joint United Nations Programme on HIV/AIDS (UNAIDS) 2010 *Report on the Global acquired immune deficiency syndrome (AIDS) Epidemic 2010.*
[5] WHO, Tuberculosis Country profiles 2010.

remains low with high default rates and high mortality in the first weeks of treatment due to inadequate access to food.

Food Security and Nutrition

6. Guinea Bissau is a low-income food-deficit country. Rice, the main staple, represents 75 percent of the local cereal production, followed by millet (12 percent), sorghum (8 percent) and maize (5 percent). Despite good agricultural potential and a rapid increase in domestic cereal production between 2000-2008, only 50 percent of domestic requirements could be covered by the 106,000 mt produced in 2010[6] with the remainder met through rice imports. The high dependency on the export of one cash-crop (cashew nut) and food imports, combined with a deteriorating rate of exchange between cashew and rice are a significant cause of vulnerability.[7] This is being exacerbated by falling revenues associated with the global economic crisis.[8]

7. The WFP comprehensive food security and vulnerability assessment (CFSVA) in late-2010 found that 20 percent of the rural population was food-insecure, 8 percent of whom were severely food-insecure. The most food-insecure regions are Quinara (47 percent of households are food-insecure), Bolama (30 percent), Oio (25 percent), and Cacheu (22 percent). Food insecurity is more likely to affect the poorest households and households headed by women or by less-educated parents.[9]

8. The CFSVA also revealed that food insecurity in Guinea Bissau is a result of both structural causes and transient shocks including: poverty, chronic political instability and related conflicts, low levels of literacy (particularly amongst women), market fluctuations of main food exports/imports, inadequacy of road infrastructure, and the recent global food and financial crises.

9. Data from the latest multiple-indicator cluster survey (MICS) indicate that 6 percent of children under 5 are acutely malnourished (wasted), with rates varying between 4-8 percent. Chronic malnutrition (stunting) is 32 percent, reaching critical levels (41 percent) in Cacheu, Gabu and Oio districts. The World Health Organization (WHO) classifies chronic malnutrition rates as "serious" in all regions and acute malnutrition rates as "poor". Both forms of malnutrition have higher prevalence in the eastern and northern areas than in the southern areas.[10] Malnutrition is linked to the three major underlying causes: maternal and child health, food insecurity, and caring practices - including infant and young child feeding.

10. Twenty-five percent of households with people living with HIV (PLHIV) and TB are food-insecure, while 19 percent of anti-retroviral therapy (ART) clients and 42 percent of DOTS clients are under-nourished.[11] According to ART and DOTS service providers, mortality is high during the first weeks of treatment, and inadequate access to food is a

[6] DENARP II, p. 27; WFP. 2010. Comprehensive food security and vulnerability assessment (CFSVA). p. 31.
[7] Previously, cashew nuts had been traded for rice on kg/kg basis. The 2010 CFSVA reports that the exchange rate reached 1:2.5 in 2008.
[8] DENARP II, p. 39.
[9] WFP. 2010. Comprehensive food security and vulnerability assessment (CFSVA).
[10] The United Nations Children's Fund (UNICEF) Guinee Bissau, MICS 2010.
[11] *Rapport de l'étude de vulnérabilité des PVVIH en Guinée Bissau*, Mai 2011.

main cause of low uptake or adherence to ART and DOTS treatments. Analysis of the HIV, malnutrition and food insecurity mapping in Guinea Bissau shows that Cacheu is the most affected as it presents high rates of both HIV, malnutrition, and food insecurity.

11. Differences between regions for stunting and global acute malnutrition, are outlined in Table 1 below.

TABLE 1: BREAKDOWN OF FOOD INSECURITY AND MALNUTRITION BY REGION

	Food insecurity	Chronic malnutrition (stunted children < 5)	Acute malnutrition (Wasted children < 5)
Region	**%**	**%**	**%**
Bafatá	14	32	5
Biombo	19	29	4
Bolama/Bijagós	30	26	4
Cacheu	22	40	6
Gabú	15	41	6
Oio	25	42	8
Quinará	47	24	7
SAB	0	20	5
Tombali	5	28	5
Guinea-Bissau		**32**	**6**

Source: MICS 2010 and CFSVA March 2010

Government Programmes for HIV/AIDS, TB and Nutrition

12. Following the discovery of the first HIV cases in 1985, a nationwide concerted response started in 1986, implemented through short- and medium-term plans. In 2002, a National HIV/AIDS Strategic Framework (2003-2005) was developed to address the pandemic, and a second framework (2007-2011) integrated and strengthened the role of nutrition, with WFP support. National guidelines for food and nutrition support for PLHIV and TB clients were prepared in 2011 with WFP technical support. For TB, a second national strategic plan (2009-2013) is being implemented, but although the importance of food and nutrition is mentioned, they are not yet adequately mainstreamed in the plan.

13. The treatment of acute malnutrition has been integrated into government plans, with support from the United Nations Children's Fund (UNICEF) for the treatment of severe acute malnutrition (in-patient and out-patient) and from WFP for the treatment of moderate acute malnutrition (MAM) in children under 5 and in malnourished pregnant and lactating women (PLW). A national protocol for the treatment of acute malnutrition was adopted in 2007 and revised in 2011. These activities are well-integrated into centres run by the Government, non-governmental organizations (NGOs) and faith-based organizations.

PAST COOPERATION AND LESSONS LEARNED

14. WFP has been active in Guinea-Bissau since 1974. In 2011, WFP assistance in Guinea Bissau reached 340,000 beneficiaries through school feeding, rural development, nutrition, and HIV activities.

15. A three-year United Nations joint programme funded by the Millennium Development Goal (MDG) Fund started in 2009 to support integrated nutrition programme implementation in the regions most severely affected by acute and chronic malnutrition. More specifically, nutrition activities from WFP's protracted relief and recovery operation (PRRO 106090) have been linked with other nutrition recuperation and prevention activities to maximise synergies with other partners and to develop government and community capacities.

16. An evaluation of PRRO 106090 in 2010 concluded that WFP activities in Guinea Bissau were too geographically dispersed, fragmenting operational response and making adequate monitoring and reporting difficult. The evaluation recommended that WFP (i) transition from relief to development interventions by building on existing potential and strengthening national capacities; (ii) refocus assistance on the poorest and most food-insecure areas using the 2010 CFSVA and increase the synergy among activities; and (iii) strengthen collaboration and synergies with other United Nations agencies and bilateral partners.

17. WFP's monitoring of its HIV activities has shown that:
    - ART and DOTS centres assisted with food have higher treatment adherence rates, but this drops sharply when food assistance ceases or during pipeline breaks.
    - Beneficiaries exiting food assistance support activities are not systematically referred to livelihood promotion programmes. If feasible, these clients should be referred to safety net programmes run by partners or the Government.

STRATEGIC FOCUS OF THE DEVELOPMENT PROJECT

18. This nutrition and HIV development project is part of WFP's shift from recovery to development activities in Guinea-Bissau. It seeks to support the Government in achieving MDGs 1, 4, 5 and 6[12] through the provision of basic services in the area of food and nutrition. WFP has also prepared a separate development project focused on supporting basic education (project 200274). From 2013, both development activities will fall under a single country programme aligned with the new United Nations Development Assistance Framework (UNDAF) cycle (2013-2017).

19. The project aims to:
    - Provide a comprehensive package of food and nutrition services to PLHIV and TB clients, including nutritional assessment, education and counselling (NAEC); food and

[12] MDG 1: Eradicate extreme poverty and hunger; MDG 4: Reduce child mortality; MDG 5: Improve maternal health; MDG 6: Combat HIV/AIDS, malaria & other diseases

nutrition; and food support for food-insecure households affected by HIV. This project has a strong focus on strengthening national capacities to progress towards nationally-owned hunger solutions for PLHIV.

- Support improved nutrition for the most vulnerable groups, including PLW and children under 5. WFP is moving towards adopting a more holistic approach to address malnutrition in Guinea Bissau, aiming to encompass both preventive and curative approaches and transition to improved nutrition products to ensure maximum effectiveness. This project will focus on continuing to provide a nutrition safety net by treating MAM among children 6-59 months and PLW in 2012.

20. The project's objectives are aligned to WFP Strategic Objectives 4 and 5, specifically to:
    - improve the treatment adherence rate of ART and DOTS clients (Strategic Objective 4 "Reduce chronic hunger and undernutrition");
    - improve the success rate of TB treatment (Strategic Objective 4);
    - improve the nutritional status of children 6-59 months and malnourished PLW (Strategic Objective 4); and
    - pave the way for progress towards full national ownership of hunger solutions, which will be pursued in the next country programme (Strategic Objective 5 "Strengthen the capacities of countries to reduce hunger through hand-over strategies and local purchase").

21. In line with the evaluation findings and the CFSVA, the project will focus HIV activities in Bafata, Biombo, Bissau,and Cacheu and nutrition activities in Bafeta, Cacheu, Gabu, and Oio. Synergies will be achieved by working with partners (Government, United Nations and NGOs) on sensitizing and training materials and on graduation of ART or TB clients to safety net programmes.

TABLE 2: BENEFICIARIES BY ACTIVITY

Activity	Men/boys	Women/girls	Total
Nutrition Support of ART clients	100	700	800
Nutrition Support of DOTS clients	700	700	1 400
Food support of populations affected by HIV*	3 050	3 050	6 100
SuFP for children 6-59 months of age with moderate acute malnutrition[13]	1 000	1 000	2 000
Treatment of malnourished PLW[14]		1 000	1 000
TOTAL	**4 850**	**6 450**	**11 300**

*Family ration is based on family size of 7 people.

[13] Estimated beneficiary figures for MAM treatment are based on estimated population figures, most recent prevalence rates, an estimated low incidence of new cases, and a coverage rate based on recent programme data from existing centres.

[14] Estimated beneficiary figures for malnourished PLW are based on estimated population figures and a coverage rate based on recent programme data.

HIV Activities

22. All ART and DOTS health facilities in targeted areas will be equipped with scales, height boards, mid-upper arm circumference tapes, body mass index (BMI) wall charts, calculators and registers to enable them to assess the nutrition status of PLHIV and TB clients based on anthropometric measurements. In addition, staff will be trained in NAEC techniques.

23. To improve adherence to ART and success of TB treatment, an annual average of 800 ART clients and 1,400 TB clients with a BMI <18.5 will receive nutritional support, consisting of a fortified blended food (Supercereal with sugar) and vegetable oil for their nutritional rehabilitation.

24. Duration of support will be for a maximum of six months for ART and eight months for DOTS, or until nutritional recovery is complete (BMI >18.5 at two consecutive monthly assessments).[15] This will be accompanied by NAEC pre- and post-treatment.

25. Household food support – a ration of cereals, pulses, oil and sugar - will also be provided to food-insecure families of ART or DOTS clients assisted under the nutritional support activity. Selection criteria will be developed jointly by WFP, the Ministry of Health, the National AIDS Commission, and cooperating partners to identify the most food-insecure households. In total, 6,100 beneficiaries will be reached under this activity.

26. Regions with the highest HIV burden will be targeted, including Bafata, Biombo, Bissau, and Cacheu. Activities will be targeted in one or two centres in each region which have the highest concentration of affected people.

Nutrition Activities

27. High levels of poverty, food insecurity and HIV in Guinea Bissau make it a risky context for a rapid deterioration in the nutrition situation. In agreement with other key actors working in the nutrition sector in-country, this project will continue supporting improved nutrition for the most vulnerable groups, including PLW and children under 5 through a supplementary feeding programme (SuFP) in Bafeta, Cacheu, Gabu, and Oio regions.

28. Moderately malnourished children between 6-59 months will receive an individual ration of Supercereal plus to ensure a rapid recovery. Malnourished PLW will receive a ration of Supercereal with sugar (pre-mix) and vegetable oil.

29. This activity will continue to be conducted through existing health structures and in conformity with the modalities in the National Protocol for the Treatment of Acute Malnutrition, with admissions and exits from the activity based on the nutritional status of the child.[16] Centres will also support the treatment of malnourished PLW from the point beneficiaries are screened – as early in the pregnancy as possible – until 6 months after

[15] Planned beneficiary figures are calculated based on the total number of people receiving ART, the prevalence of malnutrition among ART and DOTS clients and expected resources.
[16] Entry criteria: children between 70% and 80% of the median weight-for-height or discharged from therapeutic feeding programmes. Discharge criterion: when children reach and maintain > 85% weight-for-height for 2-4 consecutive weeks.

birth, to limit the risk of intra-uterine growth restriction and low birth weight affecting the nutritional status of new-born children.

TABLE 3: FOOD RATION BY ACTIVITY (g/person/day)

Commodity	Supplementary Feeding for treatment of Moderate Acute Malnutrition		Nutrition support	Food support
	Children 6-59 months	PLW	ART and TB clients	Households affected by HIV
Cereals				200
Pulses				60
Supercereal with sugar		270	270	
Supercereal plus	200			
Vegetable oil		25	25	20
Salt				5
TOTAL	**200**	**295**	**295**	**285**
Total kcal/day	840	1 300	1 300	1 098
% kcal from protein	13.5	14.1	13	9.5
% kcal from fat	18	24.7	35	17.8
# feeding days	90	360	180	180

30. Nutrition support and food rations for ART and DOTS clients and populations affected by HIV will be distributed to beneficiaries at health centres each month. WFP and the Government will ensure that all health facilities have adequate storage facilities and that staff are properly trained in food management and distribution.

31. Supplementary feeding for moderately malnourished children and PLW will be at mother-and-child health and nutrition clinics managed by the Government, NGOs, or faith-based organizations. Those enrolled in nutrition centres will be consulted at least every two weeks and will receive their target ration, systematic treatment and counselling according to the national protocol guidance.

TABLE 4: TOTAL FOOD REQUIREMENTS BY ACTIVITY (*mt*)

	Cereals	Pulses	Supercereal with sugar	Supercereal plus	Vegetable oil	Salt	Total
Nutrition Support of ART and DOTS clients			214		20		234
Food support of populations affected by HIV	439	132			44	11	626
SuFP for children 6-59 months of age with MAM				24			24
Treatment of malnourished PLW			97		9		106
TOTAL	**439**	**132**	**311**	**24**	**73**	**11**	**990**
% of total requirements	45	13	31	3	7	1	100

32. WFP will continue to work with the Government and other partners to put nutrition at the top of the national agenda, with particular attention to PLHIV. To ensure improved quality of nutrition activities, initiatives will include improved joint monitoring with the Government and key partners, and training and refresher courses for health centre staff in programme implementation.

33. WFP will partner with WHO, UNICEF and the NGO *Projecto de Saude de Bandim* to assist the Government to design nutrition promotion and sensitization materials, develop training modules and roll out training of staff at central, regional and community levels. The training sessions are intended to develop capacities of staff to perform nutrition promotion activities (NAEC) at ART and DOTS facilities and eventually at the community level (i.e., community workers). WFP, its partners and the Government will design short-, medium- and long-term training strategies and ensure that adequate budget is allocated to ensure completion of training cascades and progressive roll out of NAEC in all ART and DOTS facilities by end of 2013.

34. Activities will be closely coordinated with the Food and Agriculture Organization of the United Nations, UNICEF and the Network of Associations of PLHIV of Guinea Bissau. (*Rede Nacional das Associações das Pessoas Viventes com VIH* - RENAP+) to facilitate the graduation of food-insecure ART or TB clients to safety net programmes run by partners or the Government.

PROGRAMME MANAGEMENT, MONITORING AND EVALUATION

35. *Coordination*. WFP's cooperation with partners will be based on field-level agreements following standard WFP requirements for budgeting, operations, and monitoring and evaluation. The overall coordination of support to nutrition will be managed by the Ministry of Health, with its partners including WFP, UNICEF, World Health Organization (WHO) and NGOs. A United Nations volunteer will be out-posted to the Ministry of Health to strengthen capacities of the Department of Nutrition and ensure effective support to nutrition and HIV programmes assisted by WFP.

36. *Procurement*. In accordance with WFP standard procurement procedures, WFP will be responsible for the procurement and transport of food to extended distribution points (health centre facilities), where it will be stored and distributed to beneficiaries.

37. Financial support will be provided to the Government by WFP and UNICEF to purchase non-food items and assist in the procurement and delivery of weighing scales, height boards, mid-upper arm circumference tapes, and registers to the health centres.

38. *Monitoring*. Health centres participating in the project will be responsible for data collection. Cooperating partner monitoring reports will be submitted each month. WFP will undertake monitoring visits, consolidate and analyse monitoring data based on the indicators included in the Logical Framework (Annex II), and report quarterly. There will be a particular focus on ensuring improved monitoring and evaluation of supplementary feeding activities to improve the quality of service provision and to limit treatment time and relapses. The focus on improved quality will include: training for all centres based on the national protocol and WFP's reporting system; regular training to ensure new recruits are trained, since staff rotation is frequent in health centres; and frequent in-depth supervision missions to ensure that best practices are shared with all centres and any specific problems are immediately addressed. When possible, missions will be held jointly with government counterparts and other partners.

39. A joint (internal) review of progress and achievements will be undertaken at the end of 2012.

Risk Assessment:

40. *Contextual risks.* Although the security situation has been stable for the past two years, early presidential elections will take place in March 2012 and legislative elections are foreseen for November 2012, which might cause temporary disruptions. WFP participates in the United Nations security group which closely monitors developments. Formalised agreements on the major areas of work will facilitate continuity.

41. *Programme Risks.* Strikes by health providers and shortfalls of treatment drugs are identified risks. If malnutrition rates increase, adjustments will be made to the project through a budget revision.

42. *Institutional risks*. These are mainly related to the increasing global food prices which would increase the costs of the project. Market monitoring will continue through

improved food security and nutrition monitoring. WFP will continue to advocate with public and private donors both nationally and regionally to raise the required funds, recognising that this must be sustained during the period of project implementation.

RECOMMENDATION

The Deputy Executive Director for Operations approves, under the Executive Director's delegated authority, the proposed development project for Guinea Bissau 200322, at a total cost to WFP of US$1.4 million, subject to availability of resources.

APPROVAL

…… *Dat*e: ……..

Ramiro Lopes Da Silva
Deputy Executive Director for Operations
United Nations World Food Programme

ANNEX I-A

PROJECT COST BREAKDOWN			
Food[17]	**Quantity** ***(mt)***	**Value** ***(US$)***	**Value** ***(US$)***
Cereals	439	173,484	
Pulses	132	117,266	
Oil and fats	73	85,446	
Mixed and blended food	335	196,474	
Iodised salt	11	1,232	
Total food	**990**	**573,903**	
Cash transfers		0	
Voucher transfers		0	
Subtotal food and transfers			573,903
External transport			148,176
Landside transport, storage and handling			131,049
Other direct operational costs			176,552
Direct support costs[18] (see Annex I-B)			281,200
Total WFP direct costs			**1,310,880**
Indirect support costs (7.0 percent) [19]			91,762
TOTAL WFP COSTS			**1,402,641**

[17] This is a notional food basket for budgeting and approval. The contents may vary.
[18] Indicative figure for information purposes. The direct support costs allotment is reviewed annually.
[19] 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	
Local staff - national officers	54 000
Local staff - general service	97 000
Staff duty travel	21 000
Subtotal	**172 000**
Recurring expenses	
Rental of facility	7 000
Utilities	30 000
Office supplies and other consumables	3 000
Communications services	10 000
Equipment repair and maintenance	15 000
Vehicle running costs and maintenance	5 000
Office set-up and repairs	3 000
United Nations organization services	7 000
Subtotal	**80 000**
Equipment and capital costs	
Vehicle leasing	10 200
Communications equipment	25 000
Local security costs	2 000
Subtotal	**29 200**
TOTAL DIRECT SUPPORT COSTS	**281 200**

ANNEX II: LOGICAL FRAMEWORK		
Results	**Performance indicators**	**Risks, assumptions**
UNDAF OUTCOME **National institutions and Civil Society provide quality basic services to the population, specifically to the most vulnerable groups**	**UNDAF INDICATOR** **Percentage of health structures that provide a comprehensive package of services for mother-and-child health, nutrition and HIV**	**Assumptions:** **i) Availability of resources;** **ii) Support the development partners to strengthen national capacity and resource mobilization.** **Risks:** **i) Political and institutional instability,** **ii) Withdrawal of development partners;** **iii) Lack of resources.**
Strategic Objective 4: Reduce chronic hunger and undernutrition		
Outcome 4.1: Improved success rate of TB treatment for target cases	➢ TB treatment success rate Baseline 58.1% (WFP monitoring data 2010) Target: 85% TB treatment success rate Source: Monitoring data and/or survey data	Assumptions: i) No shortfall/supply break of treatment drugs, ii) Adequate functioning of health centres for treatment of malnutrition and support to ART and DOTS clients iii) Government and partners' continuous support iv) No major outbreak of disease/epidemics v) Political and institutional stability vi) Effective functioning of government nutrition coordination mechanisms
Outcome 4.2 : Improved adherence to ART	➢ ART adherence rate Baseline and target to be determined (this is a new indicator for the country office)	
Outcome 4.3: Improved nutritional recovery of ART and TB clients	➢ ART clients nutritional recovery rate Target – > 70% TB clients nutritional recovery rate Target - > 70% Source: Monitoring data (no baseline available yet)	
Outcome 4.4 Improved nutritional status of target groups of women, girls and boys.	➢ Prevalence of wasting among target children under 5 (weight-for-height as %) Baseline: Guinea Bissau 5.8% (Bafata 5.4, Cacheu 7.1, Gabu 6.0 and Oio 8.0) MICS 2010 Target: reduction of 10% per year in targeted groups Source: nutrition survey data ➢ Supplementary feeding Recovery rate (%), death rate (%), non-response rate (%) and default rate (%) Baseline: recovery rate 76%, defaulter rate 17.7% Target recovery rate: >80%, Target defaulter rate : <15% Source: WFP monitoring data 2010	

Output 4.1 to 4.4 : Food and non-food items distributed in sufficient quantity and quality to target groups of women, men, girls and boys under secure conditions	➢ Number of institutional sites assisted ➢ Number of women, men, girls and boys receiving food and non-food items, by category and as percent of planned figures ➢ Quantity of food and NFI distributed, by type, as percent of planned distribution ➢ Quantity of fortified foods, complementary foods and special nutritional products distributed, by type, as percent of planned distribution ➢ Number of health centres assisted	Assumption: Resources are available Risk: Shortfall of treatment drugs, ii) health care providers strike
Strategic Objective 5: Strengthen the capacities of countries to reduce hunger, including through hand-over strategies and local purchase		
Outcome 5.1: Progress made towards nationally owned hunger solutions	➢ National Capacity Index for HIV/TB and nutrition programs (Baselines to be determined)	Risks: i) Political and institutional instability, ii) Relaxation of the commitment of policymakers to carry out reforms, iii) Withdrawal of development partners; iv) Lack of resources. Assumption: An irreversible commitment of policy makers to pursue ownership of hunger solutions
Output 5.1: Capacity and awareness developed through WFP-led activities	➢ Number of people trained in nutrition assessment, education and counselling; assessments, targeting, food management in terms of quantity and quality, information management, local tendering processes; disaggregated by gender and category (WFP, national government and partner staff)	Assumptions: i) Availability of resources; ii) Support the development partners to strengthen national capacity and resource mobilization.


GUINEA-BISSAU
SENEGAL
GUINEA
ATLANTIC OCEAN
Canal do Géba
CACHEU
OIO
BAFATÁ
GABÚ
BOLAMA
QUINARA
TOMBALI
BIOMBO
BISSAU
Arquipélago dos Bijagós
Kolda
Kounkané
Bignona
Sédhiou
Salikénié
Koumbakara
Wassadou
Ziguinchor
Diattakounda
Tanaf
Dungal
Cuntimaco
Jumbembem
Cambaju
Sare Bácar
Canhámina
Pirada
Bajocunda
Canquelifá
Kandika
Oussouye
Mpak
São Domingos
Farim
Bigene
Ingoré
Barro
Olossato
Mansaina
Mansabá
Gamamudo
Contuboel
Sonaco
Canjufa
Paunca
Buruntuma
Camajábá
Pitche
Gabú
Kabrousse
Varela
Susana
Cacheu
Jolmete
São Vicente
Bissorã
Bafatá
Uacaba
Gâba
Cabuca
Foula Mori
Caliquisse
Canchungo
Bula
Binar
Encheia
Mansôa
Safim
Nhacra
Porto Gole
Ximo
Bambadinca
Galomaro
Caió
Quinhámel
Prábis
Bissau
Enxudé
Tite
Fulacunda
Dulombi
Chê Chê
Béli
Koumbia
Boé
Vendu Leidi
Xitole
Buba
Bolama
Empada
Quebo
Kambera
Féliné
Dabalaré
Caravela
Abu
Madina de Baixo
Bubaque
Uno
Eticoga
Orango
Catió
Tombali
Bedanda
Sangonha
Cacine
Campeane
Kandiafara
Sansalé
Dobali
Ilhas Tristão
GUINEA-BISSAU
National capital
Regional capital
Town, village
Airport
International boundary
Regional boundary
Main road
Secondary road
0 10 20 30 40 50 60 km
0 10 20 30 40 mi
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
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Department of Peacekeeping Operations
Cartographic Section

LIST OF ACRONYMS USED IN THE DOCUMENT

AIDS	acquired immune deficiency syndrome
ART	anti-retroviral therapy
BMI	body mass index
CFSVA	comprehensive food security and vulnerability assessment
DOTS	directly observed treatment with short-course chemotherapy
HIV	human immunodeficiency virus
MAM	moderate acute malnutrition
MDG	Millennium Development Goal
MICS	multiple-indicator cluster survey
NAEC	nutrition assessment, education and counselling
NGO	non-governmental organization
PLHIV	people living with HIV
PLW	pregnant and lactating women
PRRO	protracted relief and recovery operation
RENAP+	*Rede Nacional das Associações das Pessoas Viventes com VIH* (Network of Associations of PLHIV of Guinea Bissau)
SuFP	supplementary feeding programme
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