# DEVELOPMENT PROJECT SWAZILAND 200353

| FOOD BY PRESCRIPTION | |
|---|---|
| Number of beneficiaries | 119 400 |
| Duration of project | 36 months<br>(January 2012- December 2014) |
| Food tonnage | 6 367 mt |
| Cost (United States dollars) | |
| WFP food cost | US$2 881 078 |
| WFP cash/voucher cost | n/a |
| Total cost to WFP | US$6 743 487 |

# EXECUTIVE SUMMARY

Swaziland has the highest prevalence rate of HIV in the world with 26 percent of the adult population and 38 percent of pregnant women infected. Around 80,000 people living with HIV require anti-retroviral treatment and 9,300 are estimated to need prevention of mother-to-child transmission treatment. Of these, 59 percent and 88 percent respectively are currently receiving medication. A malnutrition baseline survey, undertaken in October 2010, found that 24 percent of those receiving anti-retroviral treatment and 57 percent of those initiating tuberculosis treatment were acutely malnourished.[1] Wasting is strongly associated with poor treatment outcomes and is a reliable predictor of mortality.

The objective of this development project is to improve the client's nutritional recovery, treatment success and survival rate as well as improve food consumption within the targeted households. Under the leadership of the Ministry of Health, WFP will implement a Food by Prescription programme in the main health facilities across the country targeting: (i) undernourished clients undergoing anti-retroviral treatment; and (ii) tuberculosis treatment and women enrolled into the prevention of mother-to-child transmission/ante-natal care. WFP will provide individual monthly take-home ration of Supercereal and a household ration. In addition, moderately malnourished children in supplementary feeding programmes, many of whom are HIV positive or exposed, will also be assisted.

This project was designed taking into consideration the lessons learnt from WFP's previous

[1] World Food Programme and Ministry of Health, Malnutrition Baseline Survey, 2010. Preliminary results.

supplementary feeding programme and the recommendations from the 2010 comprehensive programme review and appraisal. The use of cash and voucher transfers will be explored through a feasibility and market analysis study for potential scale-up of the project.

Throughout the lifespan of the project, WFP will work to develop the capacity of the Ministry of Health's National Nutrition Council with the view to handing over the implementation of the Food by Prescription programme in the future. In particular, capacity development efforts will focus on project management, procurement, storage and inventory management.

The Food by Prescription programme is aligned with WFP Strategic Objectives 4 (Reduce chronic hunger and undernutrition) and 5 (Strengthen the capacities of countries to reduce hunger), and the Swaziland's National Multi-sectoral HIV and AIDS Policy. The project also contributes towards the implementation of the Government's National Comprehensive Package of HIV Care and is an integral component of the United Nations Development Assistance Framework pillar 1 (HIV and AIDS), specifically the outcome relating to increasing access to comprehensive HIV treatment, care and support. Food security and nutrition support also form key priority areas within the Treatment, Care and Support and Impact Mitigation outcomes of the Joint United Nations Programme of Support on HIV and AIDS. The project will contribute to the achievement of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases).

## SITUATION ANALYSIS

1. Swaziland, a small, landlocked nation in Southern Africa, ranks at 140 out of 187 countries on the 2011 Human Development Index.[2] It is considered a lower middle-income country with a gross national income per capita of US$4,484.[3] However, the wealth is not equally distributed. The Gini Coefficient stands at 51 and the wealthiest 10 percent of the population hold the vast majority of the wealth (41 percent) compared with the poorest 10 percent that hold under 2 percent of the income share.[4] As a result, 63 percent of the population lives below the poverty line of US$1.25 per day.[5]

2. The country's economic performance has been on a downward trend for the past two decades, with an average annual growth in gross domestic product declining from 3.9 percent in the 1990s to 2.4 percent in 2008.[6] This is 2.6 percentage points lower than the minimum required growth rate to reduce poverty.[7] The lowest ever growth was recorded in 2009 at just 0.4 percent. Declining revenues, particularly from the South African Customs Union as well as reduced foreign direct investment and the global financial crisis, have forced the Government to adopt a fiscal adjustment roadmap which threatens civil servant jobs and social services.[8] With each Swazi wage earner reportedly supporting 10 people, job losses will have far reaching consequences.

3. The population of 1 million has grown by just 0.9 percent since 1997 and growth can be expected to remain low as a result of declining fertility and increasing crude death rates.[9] Life expectancy at birth is one of the lowest in the world, at just 43 years, down from 60 years in 1997.[10] The main contributory factor to these poor indicators is HIV and AIDS. Swaziland has the highest HIV prevalence rate in the world with 26 percent of the adult population and 38 percent of pregnant women infected with the virus.[11] Approximately 80,000 people living with HIV and AIDS (PLHIV) are currently in need of anti-retroviral therapy (ART)[12] though only 59 percent receive it. The number of PLHIV requiring ART is predicted to approach 97,000 by 2015.[13] The number of HIV-positive pregnant women requiring prevention of mother-to-child transmission (PMTCT) treatment is estimated to be 9,300 (88 percent of whom are currently receiving treatment).[14]

4. Swaziland also suffers the burden of one of the highest tuberculosis (TB) incidence rates in the world. In 2007, 14,000 new cases of TB were detected, 11,000 of which were in HIV-positive people. The incidence rate stands at 812 cases per 100,000 population and 80 percent of TB clients are HIV-positive.[15] In addition, there is an unacceptably high

[2] UNDP (2011) Human Development Report 2011, http://hdr.undp.org/en/statistics
[3] In purchasing power parity terms (constant 2005 international) http://hdrstats.undp.org/en/countries/profiles/SWZ.html
[4] UNDP (2009) Human Development Report.
[5] World Bank (2009) Swaziland at a Glance.
[6] *Ibid.*
[7] Ministry of Finance (2010) Fiscal Adjustment Roadmap 2010/2011-2014/15.
[8] Ibid.
[9] Swaziland Central Statistics Office (2010) 2007 Population and Housing Census.
[10] *Ibid.*
[11] Swaziland Central Statistics Office (2008) Demographic and Health Survey 2006-2007.
[12] Estimate based on World Health Organization (WHO) 2010 guidelines "Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress Report", 2010.
[13] UNAIDS (2010) Swaziland HIV estimates and projections report, July 2010.
[14] WHO (2010) Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2010.
[15] World Health Organisation (2007) Swaziland TB Country Profile. Accessed 09.11.10 www.who.int

multi-drug resistant TB rate of 8 percent among new cases and 34 percent among previously treated cases.

5. Agriculture is the traditional mainstay of the economy contributing 9 percent to gross domestic product in 2008 and is the main source of livelihood for the Swazi population.[16] However, successive years of drought, the multi-dimensional impact of HIV and AIDS, dependence on rain-fed agriculture, high cost of farm inputs and low use of improved agricultural technology have resulted in declining food production since the 1990s. The impact of HIV and AIDS has reduced the area of cultivated land by 44 percent (resulting in a 54 percent reduction of maize production) due to the gradual loss of manpower, with a diversion of 31 percent of labour to care for the sick.[17] Swaziland consistently fails to produce enough food to cover domestic requirements and is increasingly dependent on imports to fill the gaps. Since 2006, between 20 and 38 percent of annual domestic maize consumption requirements have been imported through commercial imports and food aid to meet the shortfalls.[18] Food imports constitute over 12 percent of total imports.[19]

6. Low agricultural productivity, the negative impact of HIV and AIDS and poverty have rendered approximately 25 percent of the population food-insecure.[20] Most of the food consumed in Swaziland is derived from cash purchases and since income is a major determinant of food security, many poor people cannot access adequate nutritious food. The number of people requiring government food aid during the "lean season" (October to March) peaked at 345,000 in 2006 and was 161,000 in 2010.[21] Vulnerable households are mostly located in the dry Middleveld and Lowveld livelihood zones.[22]

7. Hunger and malnutrition, a direct result of food insecurity, are widespread in Swaziland. While levels of acute malnutrition have remained low at just over 1 percent, rates of chronic malnutrition have risen steadily over the past 25 years and currently 40 percent of children under 5 are stunted.[23] This indicates a "very high prevalence" according to the World Health Organization (WHO) standards.[24] The causes of malnutrition include food insecurity, poverty and poor infant feeding practices but are also understood to be a consequence of HIV exposure.

8. Furthermore, among acutely malnourished children, the mortality rate for those who are HIV positive is much higher (34 percent) compared to those that are not infected (26 percent). Recognizing that, in the context of high HIV prevalence, timely and effective management of acute malnutrition saves lives, the Ministry of Health (MOH) launched the Integrated Management of Acute Malnutrition (IMAM) programme in 2008 as a standardized national approach. It provides integrated management of severe and moderate acute malnutrition for children and adolescents at health centre and community level, through inpatient and outpatient therapeutic feeding, supplementary feeding and community mobilisation for early case detection. WFP has been supporting the supplementary feeding component of the IMAM programme, while other partners have focused on the therapeutic feeding component.

[16] Ministry of Finance (2010) Fiscal Adjustment Roadmap 2010/2011-2014/15.
[17] United Nations System in Swaziland (2010) Complementary Country Analysis.
[18] Swaziland Vulnerability Assessment Committee (2008, 2009 & 2010) Annual Vulnerability Assessment and Analysis Report.
[19] World Bank (2009) Swaziland at a Glance.
[20] United Nations System in Swaziland (2010) Complementary Country Analysis.
[21] Swaziland Vulnerability Assessment Committee (2010) Annual Vulnerability Assessment and Analysis Report July 2010.
[22] Swaziland is divided into four regions and seven livelihood zones.
[23] Ministry of Health (2009) National Nutrition Survey 2008.
[24] WHO (2010) Nutrition Landscape Information System (LNIS) Country Profile Indicators: interpretation guide.

9. While the overall rate of undernutrition among adults is low (3 percent in women and 10 percent in men[25]), a recent malnutrition baseline survey[26] found that 17 percent of HIV clients and 46 percent of TB clients initiating treatment are suffering from mild and moderate acute malnutrition.[27] A further 6 percent of ART and 11 percent of TB-Directly Observed Treatment Short-course (TB-DOTS) initiators are suffering from severe acute malnutrition.[28]

10. Based on current estimates of the number of adults enrolled in ART,[29] the malnutrition baseline survey results suggest that a total of 11,200 HIV-positive people on ART are acutely malnourished. Wasting is strongly associated with poor treatment outcomes and is a reliable predictor of mortality, independent of CD4 count[30] or other indicators of immune performance.[31]

11. The Government recognises the seriousness of the situation and has placed food and nutrition security high on its development agenda. The National Development Strategy (NDS) launched in 1999 is a long-term framework to guide development until 2022. It presents the country's vision of advancing human capital and quality of life through sustainable socioeconomic development which addresses agricultural development and food security, social justice and political stability. The Poverty Reduction Strategy and Action Programme (PRSAP; 2007-2015) operationalizes the NDS and is based around five pillars. The three pillars that are relevant for this project are: i) Empowering the poor to generate income and reduce inequalities; ii) Human capital development; and iii) Improving the quality of life of the poor. The Programme of Action (2008-2013) identifies government priorities in healthcare, education and food security that align with the PRSAP.

12. For HIV and AIDS, Swaziland's response is based upon the National Multi-sectoral Strategic Framework for HIV and AIDS (2009-2014) which comprises four main areas: i) prevention; ii) treatment, care and support; iii) impact mitigation; and iv) response management. The United Nations Development Assistance Framework (UNDAF 2011-2015) is directly aligned with this strategic framework and includes the provision of nutritious food supplements to clients under treatment, care and support.

13. Acutely malnourished HIV and TB clients have been recognised by the Swaziland National Nutrition Council (SNNC - within the MOH) as particularly vulnerable to poor adherence to treatment, which is associated with poor outcomes. This group has been specifically highlighted as requiring nutrition assistance within the treatment protocols currently being finalised. WFP will target malnourished ART, TB and PMTCT/ante-natal care (ANC) clients, while children will continue to receive supplementary feeding as outlined in the IMAM guidelines. The Government is to start implementing this 'Food by Prescription' approach in the main health facilities across the country, with WFP support.

[25] Central Statistics Office (2008) Swaziland Demographic and Health Survey 2006-2007.
[26] World Food Programme and Ministry of Health (2010) Malnutrition Baseline Survey. Preliminary results.
[27] Based on the following cut-off points: body mass index (BMI) of 16-18.5 and/or mid-upper arm circumference (MUAC) 19-23 cm.
[28] Based on the following cut-off points: BMI under 16 or MUAC under 19 cm.
[29] WHO estimates that 47,241 adults are enrolled in ART. WHO, Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2010.
[30] CD4 cells are a type of white blood cell that fights infection. The CD4 count measures the number of CD4 cells in a sample of blood. Along with other tests, the CD4 count indicates the strength of the immune system, the stage of HIV disease, guides treatment, and predicts how the disease may progress.
[31] WFP (2010) Food by Prescription: An Orientation Paper (draft 13.10.2010)

## PAST COOPERATION AND LESSONS LEARNED

14. A recent evaluation of the current protracted relief and recovery operation 106020 highlighted key issues and provided important lessons learned for future interventions.

15. Programmatic lessons learned include: (i) moving away from treating symptoms to addressing the underlying causes of food insecurity and targeting responses to those in greatest need; (ii) ensuring programmes always take a problem-based approach to ensure they address a clearly defined hunger problem in a comprehensive way; and (iii) consolidating WFP's own systems with those of the Government while providing technical assistance to the Government to take over leadership of national systems - or WFP be contracted to run programmes on the Government's behalf.

16. Areas recognised as strengths for WFP include expertise on hunger and programme design; operational efficiency; strong logistical capacity; and recognised ability to build capacity on hunger issues.

17. For food and nutrition support to ART, TB and PMTCT clients, lessons learned included: (i) blanket supplementary feeding to all clients regardless of their nutritional status contributed to increased dependency; and (ii) the food basket did not allow for the inevitable sharing of rations, reducing the impact on client outcomes. To improve the cost-efficiency and effectiveness of WFP food assistance, the Ministry of Health and WFP re-designed the on-going programme along the Food by Prescription approach.

## STRATEGIC FOCUS OF THE DEVELOPMENT PROJECT

18. The overall project goal is to contribute to improving the quality of life of persons infected and affected by HIV by improving the client's nutritional recovery, treatment success and survival rate as well as improving food consumption within the household. The project is aligned with WFP Strategic Objectives 4 (Reduce chronic hunger and undernutrition) and 5 (Strengthen the capacities of countries to reduce hunger), UNDAF Pillar 1 (HIV and AIDS), and national policies including the National Multi-sectoral HIV and AIDS Policy. The project will contribute to the achievement of Millennium Development Goal 6 - Combat HIV/AIDS, malaria and other diseases,

19. WFP aims to achieve its goal by implementing a Food by Prescription programme providing malnourished ART, TB and PMTCT clients with Supercereal to improve their treatment outcomes, while also supporting their families through a monthly food ration to prevent them from sliding into food insecurity and deeper vulnerability. In addition, moderately malnourished children, many of whom are HIV positive or exposed, will be given Supercereal through a supplementary feeding programme under the IMAM programme.

20. WFP has conducted several cash and voucher studies which indicated that food prices in Swaziland are considerably higher than in neighbouring South Africa, Swaziland being a net importer of food. WFP will continue to provide in-kind food until there is a favourable change in market conditions but will continue to explore the feasibility and appropriateness of cash and voucher transfers for the family support component.

21. The nutritious food provided will complement nutritional assessment, education and counselling (NAEC) to be conducted for all clients attending ART, TB and PMTCT

clinics at supported sites as part of regular consultations. Each client will undergo a nutrition assessment by a trained clinician to determine the most appropriate nutrition intervention (which may, but not necessarily, include a prescription for food). NAEC will continue throughout the client's treatment period, irrespective of enrolment in the Food by Prescription programme in order to promote sustainable optimum nutrition practices.

22. The Food by Prescription programme contributes to the Government's National Comprehensive Package on HIV Care. It forms an integral component of UNDAF pillar 1 and the outcome related to increasing access to comprehensive HIV treatment, care and support. More specifically, food security and nutrition support form key priority areas within the Treatment, Care and Support and Impact Mitigation outcomes of the Joint United Nations Programme of Support on HIV and AIDS.[32] Food and nutrition support is recognised as a vital part of the comprehensive package, as well as part of impact mitigation efforts for vulnerable households and as support to people infected and affected by the pandemic to regain their strength and re-build their livelihoods.

23. The main outcomes of the programme, as outlined in the logical framework in Annex II, include:
    - improved nutritional recovery rate;
    - improved adherence rate; and
    - adequate food consumption reached over assistance period for targeted households.

24. In addition, through this project, WFP intends to improve:
    - the capacity of MOH to provide nutrition support by providing training on relevant NAEC skills; and
    - awareness of nutrition issues among community health workers, including increased ability to provide nutrition education and nutrition-related referrals to the health system and other service providers.

25. There are two target groups within the Food by Prescription programme:
    - moderately acutely malnourished ART, TB and PMTCT/ANC clients and their households[33]; and
    - moderately acutely malnourished children aged between 6 months and 18 years.[34]

26. To avoid stigmatisation, ANC clinics are to be used as a means to target all malnourished mothers, many of whom are enrolled in PMTCT. Similarly, the IMAM programme will be used to target malnourished children and adolescents, many of whom are HIV-positive, exposed, or do not know their status.

27. Clinicians will take anthropometric measurements of clients and if necessary initiate the client onto the Food by Prescription programme. Anthropometric indicators have already been added to client paperwork, as nutrition assessment is now a standard procedure at participating health facilities. A ration card will enable the client to receive their rations

[32] United Nations in Swaziland (2009) Joint United Nations Programme of Support on HIV and AIDS 2009-2015.

[33] Will be considered moderately acutely malnourished, ART and TB clients with a BMI below 18.5 or a MUAC below 23 cm or loss of at least 5 percent bodyweight in previous month. PMTCT/ANC clients with a MUAC below 23 cm will be targeted.

[34] They will be referred from the IMAM programme or will show a weight per height of 70-79 percent, or (for children 6-59 months only) a MUAC of 11-11.9cm, as per the criteria outlined in the IMAM guidelines.

themselves, or to send a family member to pick them up on their behalf. Trained staff will provide nutrition counselling to the client and stress the importance of drug adherence.

28. Clients will be discharged when anthropometric measurements reach and are maintained at satisfactory levels for two consecutive monthly measures.[35] The anticipated length of treatment for adults is 6 months, based on programme protocols and evidence from other countries. Children will benefit from supplementary feeding for 3 months in line with the IMAM guidelines.

29. An estimated total of 20,400 ART, TB and PMTCT/ANC clients will be targeted over the 3-year period as well as 650 malnourished children enrolled in 11 health facilities across the country (see Table 1). Based on the malnutrition baseline survey, a larger proportion of adult clients are expected to be women due to greater health-seeking behaviours demonstrated by women in Swaziland as compared to men.

**TABLE 1: BENEFICIARIES BY ACTIVITY TYPE**

| Activity | 2012 | 2013 | 2014 | TOTAL | Gender balance (%) | |
|---|---|---|---|---|---|---|
| | | | | | Male | Female |
| Rehabilitation of moderate malnourished ART clients | 2 035 | 2 405 | 2 867 | **7 307** | 32 | 68 |
| Rehabilitation of moderate malnourished TB clients | 2 775 | 2 960 | 3 330 | **9 065** | 29 | 71 |
| Rehabilitation of moderate malnourished women enrolled in PMTCT/ANC | 740 | 1 110 | 1 573 | **3 423** | 0 | 100 |
| Rehabilitation of moderate malnourished children and adolescents | 185 | 185 | 278 | **648** | 47 | 53 |
| Moderate malnourished TB/ART clients' household support | 33 300 | 38 850 | 46 620 | **118 770** | 47 | 53 |
| **ADJUSTED TOTAL**[36] | **33 500** | **39 035** | **46 898** | **119 418** | 47 | 53 |

30. There are two components under the Food by Prescription programme: an individual client ration and a household ration. All ART, TB and PMTCT/ANC clients, regardless of their food security status, receive both the individual ration and the household ration whereas the moderately acutely malnourished children and adolescents receive the individual ration only, in line with the national IMAM guidelines.

[35] Beneficiaries will be discharged when BMI is above 18.5 or MUAC is above 23cm or when there is no further weight loss.

[36] The total number of beneficiaries has been adjusted to avoid double-counting adult clients who receive both an individual and household rations. Children and adolescents do not receive household ration, in line with the National IMAM Guidelines.

31. *Individual client ration:* The individual client ration will consist of Supercereal and will provide the required energy, protein, fat and essential micronutrients and minerals required by the chronically ill and acutely moderately malnourished children. Supercereal is easy to prepare, palatable and easy to digest. The ration size accounts for increased energy requirements of between 20-30 percent for symptomatic HIV and TB clients and recommended increased dietary intake for pregnant and lactating women. ART, TB and PMTCT/ANC clients will receive 10 kg of Supercereal per month as will moderately malnourished children enrolled in IMAM. These rations take into consideration the inevitable sharing of the ration at household level and will allow pre-packaging.*Malnourished ART/TB clients' household support:* The household food ration will provide balanced variety of commodities that meet beneficiaries' needs and cultural and taste preferences in line with WFP decision tree for response options in HIV and AIDS, TB, PMTCT and orphan and vulnerable children programmes. This complementary ration is based upon the average family size of six and provides each household member with 45 percent[37] of daily energy requirements.

32. Considering both the individual and household rations, ART and TB clients will receive approximately 78 percent[38] and PMTCT/ANC clients will receive 90 percent[39] of daily recommended energy requirements.

**TABLE 2: DAILY FOOD RATION BY ACTIVITY *(g/person/day)***

| | Rehabilitation of moderate malnourished ART/TB clients, adolescents and children | Malnourished ART/TB clients' household support | Total daily ration for malnourished ART/TB clients |
|---|---|---|---|
| Supercereal | 333 | - | 333 |
| Maize meal | - | 200 | 200 |
| Pulses | - | 28 | 28 |
| Vegetable oil | - | 12.5 | 12.5 |
| **Total** | **333** | **240.5** | **573.5** |
| ***Total kcal/day*** | ***1 332*** | ***938*** | ***2 270*** |
| % Kcal from protein | 18.0 | 10.2 | 14.8 |
| % Kcal from fat | 13.5 | 15.6 | 14.4 |

[37] Based on whole population requirements (NutVal 2006).
[38] Based on 20-59 years age group plus an additional 30 percent to allow for increased requirements associated with HIV infection (NutVal 2006).
[39] Based on average of requirements for pregnant and for lactating women (NutVal 2006).

| TABLE 3: TOTAL FOOD REQUIREMENTS BY ACTIVITY *(mt)* | | | |
|---|---|---|---|
| | Rehabilitation of moderate malnourished ART/TB clients, adolescents and children | Malnourished ART/TB clients' household support | **Total (mt)** |
| Supercereal | 1 225 | 0 | 1 225 |
| Cereals | 0 | 4 276 | 4 276 |
| Pulses | 0 | 599 | 599 |
| Vegetable oil | 0 | 267 | 267 |
| **Total** | **1 225** | **5 142** | **6 367** |

33. *Gender:* WFP's Gender Policy will be integrated into the management and evaluation of the Food by Prescription programme. WFP aims to increase awareness of gender-based violence (GBV) and the links between HIV and gender inequality through the following:
    - printing messages on food bags promoting awareness of how to deal with GBV and listing available GBV services;
    - supporting partnerships to create awareness of the links between HIV and gender inequality; and
    - promoting the use of fuel-efficient stoves that save on time and labour, which is particularly important for pregnant and immune-compromised women.
34. *Capacity development:* WFP will provide technical assistance to the MOH/SNNC throughout the project period, with a view to handing-over key aspects by the end of the project. A detailed handover strategy is being developed with the SNNC and a memorandum of understanding between WFP, the MOH and SNNC is being drafted to outline the key short and longer-term responsibilities of each partner to facilitate a smooth transition to government ownership. WFP will provide technical assistance, capacity development support as well as relevant training to clinicians and health staff in the following areas: programme management and implementation, anthropometric measurements, admission criteria, food distribution, and nutrition education and counselling to clients.
35. *Cash and voucher transfers:* In collaboration with partners, WFP will explore the feasibility of cash/voucher transfers in support of programme objectives and will undertake new market analyses in areas marked for potential scale-up of the project but where the demand for food is too low and infrastructure inadequate to make typical storage and distribution procedures viable. If cash or voucher transfers are found to be appropriate, WFP will consider introducing them through a budget revision to this project.

## PROGRAMME MANAGEMENT, MONITORING AND EVALUATION

36. *Partnerships:* This project is embedded in the MOH and coordinated by the SNNC. WFP will act as the sole implementing partner for food provision and will be the main technical lead for the project fortraining the Food by Prescription assistants and other health staff on relevant NAEC skills. Partnerships have been established with the United Nations

Children's Fund (UNICEF), Action Against Hunger (AAH) and Clinton Health Access Initiative to ensure synergies with the IMAM programme. There are also partnerships with the International Centre for AIDS Care and Treatment Programmes and AAH concerning the provision of technical and training support to facilitate the roll-out of the project. Future partnerships, particularly with AAH and Elizabeth Glazer Paediatric AIDS Foundation, are anticipated to enhance the monitoring the project as well as strengthen routine NAEC. There are coordination meetings and information-sharing with all aforementioned partners and others.

37. Peace Corps Volunteers (PCVs) actively promote food and nutrition security at WFP target sites by offering nutrition education and advice to beneficiaries and their communities, as well as suggesting referrals to service providers. There is at least one PCV in the area of each WFP supported health facility.

38. Partnership opportunities with the Food and Agricultural Organization of the United Nations (FAO) will be explored to link the Food by Prescription programme to sustainable livelihood opportunities once clients have graduated from the programme to ensure a continuum of sustainable support for clients and their families and to help prevent clients relapsing to a poor nutritional status. This work will be supported by a partnership with the Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA) to create linkages with the communities hosting Food by Prescription clients.

39. WFP is closely engaged with the Global Fund for AIDS, TB and Malaria (GFATM) in Swaziland, providing technical assistance to the Principle Recipient to include food and nutrition into the proposals and has received funding to implement the PMTCT component of the Food by Prescription programme. It is anticipated that the Global Fund through the SNNC (the sub recipient) will fund part of this project.

40. *Procurement:* Swaziland produces less than 50 percent of its cereal requirements and imports the bulk of its commodities. Commodities will therefore be purchased regionally or internationally unless local purchase is possible according to yearly estimates of local production by the Swaziland Vulnerability Assessment Committee. In line with the Swaziland Biosafety Policy and Southern Africa Development Community and Common Market for Eastern and Southern Africa guidelines on genetically modified organisms food aid, pre-milled maize meal will be procured instead of whole grain maize. About 14 percent of food commodities will be purchased internationally and 86 percent regionally.

41. *Logistics:* WFP is responsible for the delivery of food to the health facilities. All food commodities will be directly delivered from the point of origin to the field warehouses to reduce both transportation and handling costs. The SNNC is responsible for storing, handling and distributing the food commodities at the sites through Central Medical Stores systems. It will also submit monthly beneficiary reports. Clients will collect their food rations on a monthly basis when they come for their regular check-ups and drug replenishment. Distributions for malnourished children will also take place monthly, even though visits to the health facility may be more frequent. WFP will cover the costs of two Food by Prescription assistants per health facility on the understanding that at the end of this project, these costs will be covered by Government.

42. *Monitoring and evaluation (M&E):* To enable regular progress tracking and reporting, key performance indicators have been developed with set baselines and targets. Nutrition indicators related to the Food by Prescription programme have already been integrated into the health management information system (HMIS) and related protocols and

existing data collection tools used in the ART, TB and PMTCT/ANC units have been revised accordingly. This will ensure that the Food by Prescription programme is fully incorporated into the regular MOH monitoring system for future sustainability and handover to the Government. The monitoring of this project will also be integrated into the UNDAF M&E framework, which is tracked in collaboration with the United Nations Joint Programme on Strategic Information and Data.

43. Regular monitoring will be done jointly by WFP field monitors, cooperating partners (AAH and PCVs) and the MoH through field visits, data collection and progress reports. Effective monitoring of both outputs and outcomes will generate essential first-time data and lessons on nutrition HIV and TB interventions.

44. Annual evaluations of the project, based on consolidated monthly reports and tracking of outcome level data will be part of the United Nations Joint Annual Review. This information will also be presented in the WFP Standard Project Report. At mid-term and at the end of the project, WFP, in conjunction with MOH, will undertake an in-depth evaluation of the project. Should a cash or voucher component be introduced, the evaluations will include a review of the comparative advantages of cash and voucher transfers over in-kind food.

45. *Risk assessment:* With regards to potential risks to the project, in the wider context there is the risk of political instability in the wake of the financial crisis that has taken hold in Swaziland. For a number of reasons, the Government has been unable to secure loans from institutions such as the International Monetary Fund and the African Development Bank and bilateral loans including from South Africa. This has impacted on the provision of social services and payment of civil servants, including doctors and nurses, leading to repeated protests and strikes.

46. Programmatically, while concerted efforts have been made to integrate the programme into MOH protocols to ensure its sustainability, the MOH still requires WFP support to implement the programme. There is the institutional risk that WFP will receive inconsistent funding for this project because of the middle-income status of the country which deters many traditional donors. This would not only harm WFP's reputation in the country and potentially jeopardise chances of receiving government funds (e.g. through the Global Fund), but would pose a serious risk to the substantial gains made in establishing the Food by Prescription programme. By closely monitoring the progress of the programme and its impact on malnourished HIV/TB/ANC clients and their families, WFP will demonstrate the benefits of such a programme and thereby mitigate some of the risks related to sustainability and funding.

## RECOMMENDATION

The Development Project Swaziland 200353 is recommended for approval by the Deputy Executive Director under the Executive Director's delegated authority.

## APPROVAL

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

## PROJECT COST BREAKDOWN

| **Food**[40] | **Quantity** *(mt)* | **Value** *(US$)* | **Value** *(US$)* |
|---|---|---|---|
| Cereals | 4 276 | 1 677 365 | |
| Pulses | 597 | 305 287 | |
| Oil and fats | 267 | 310 258 | |
| Mixed and blended food | 1 225 | 588 169 | |
| Others | - | - | |
| **Total food** | **6 367** | **2 881 078** | |
| Cash transfers | | - | |
| Voucher transfers | | - | |
| Subtotal food and transfers | | | 2 881 057 |
| External transport | | | 425 002 |
| Landside transport, storage and handling | | | 586 393 |
| Other direct operational costs | | | 504 193 |
| Direct support costs[41] (see Annex I-B) | | | 1 905 658 |
| Total WFP direct costs | | | 6 302 324 |
| Indirect support costs (7.0 percent) [42] | | | 441 163 |
| **TOTAL WFP COSTS** | | | **6 743 487** |

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

| DIRECT SUPPORT REQUIREMENTS (*US$*) | |
|---|---|
| **Staff and staff-related costs** | |
| International professional staff | - |
| International general service staff | - |
| Local staff - national officers | 299 106 |
| Local staff - general service | 928 345 |
| Local staff - temporary assistance | 24 748 |
| Local staff – overtime | - |
| Hazard pay and hardship allowance | - |
| International consultants | - |
| Local consultants | - |
| United Nations volunteers | - |
| Commercial consultancy services | - |
| Staff duty travel | 99 390 |
| **Subtotal** | **1 351 589** |
| **Recurring expenses** | |
| Rental of facility | 173 924 |
| Utilities | 5 963 |
| Office supplies and other consumables | 74 726 |
| Communications services | 81 500 |
| Equipment repair and maintenance | 8 468 |
| Vehicle running costs and maintenance | 119 500 |
| Office set-up and repairs | - |
| United Nations organization services | 70 511 |
| **Subtotal** | **534 592** |
| **Equipment and capital costs** | |
| Vehicle leasing | - |
| Communications equipment | 6 000 |
| Local security costs | 13 477 |
| **Subtotal** | **19 477** |
| **TOTAL DIRECT SUPPORT COSTS** | **1 905 658** |

**ANNEX I-B**

**ANNEX II**

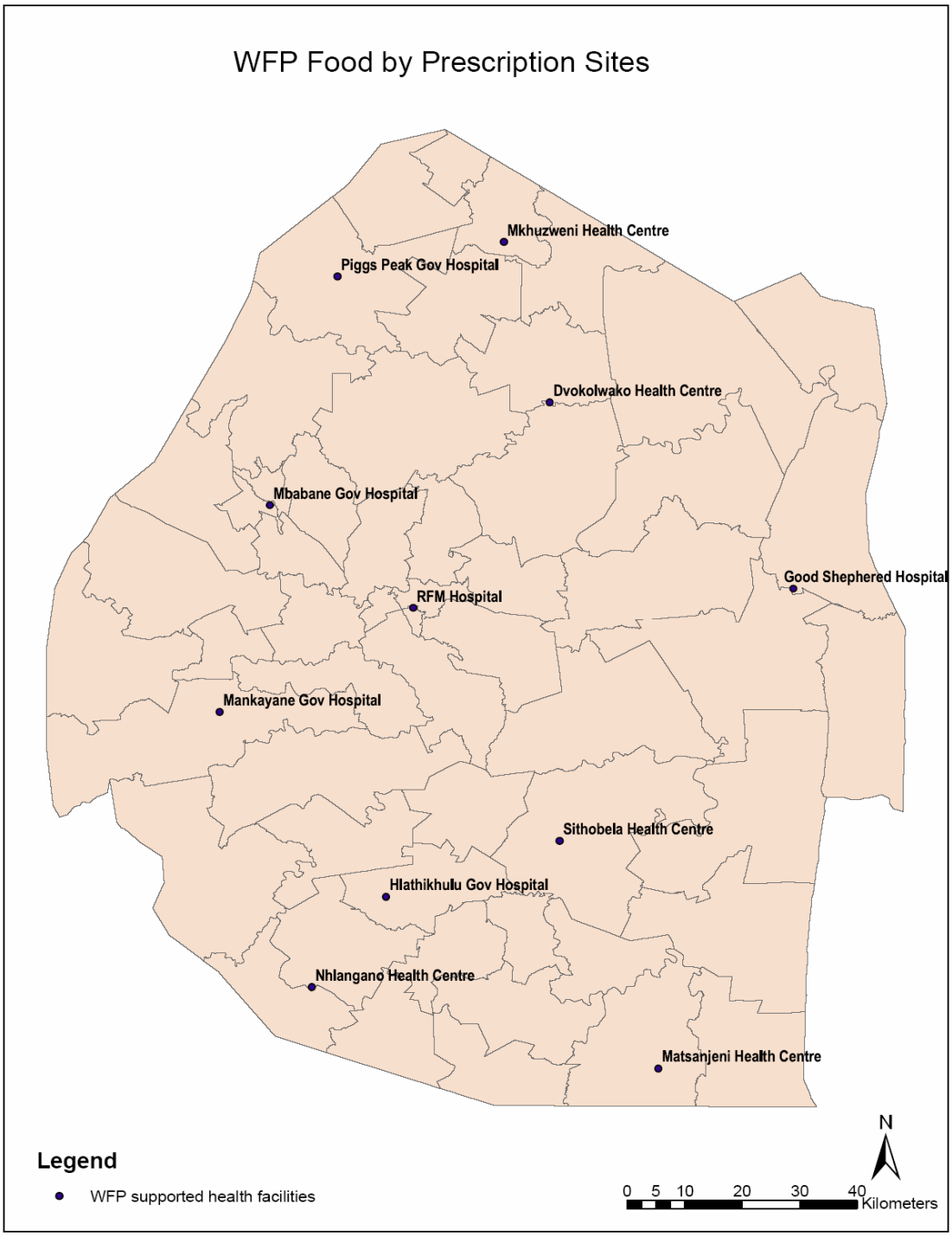
# Summary of Logical Framework of Swaziland Food by Prescription Development Project (200353), 2012-2014

| Results | Performance indicators | Risks, assumptions | Resources required |
|---|---|---|---|
| **UNDAF OUTCOME: Pillar 1, Outcome 2** *Capacity of the health sector for comprehensive HIV treatment, care and support services strengthened* | **UNDAF Outcome Indicators**<br>*# of facilities with capacity to provide nutritional support to HIV and/or TB clients* | ***Assumptions***<br>• Availability of funds<br>• Implementation capacity, funds and motivation in place at the Ministry of Health<br>• Availability of adequate and well motivated human resources in the health sector<br>***Risks***<br>Insufficient financial and human resources | US$3 500 000 |
| **Strategic Objective 4: Reduce Chronic Hunger and Undernutrition** | | | |
| ***Outcome 4.1a:***<br>Improved ART/TB/PMTCT Nutritional Recovery | - *Nutritional Recovery Rate for Clients on ART, TB and PMTCT programs*<br><br>Target: *80% of targeted clients* | ***Assumptions:***<br>• Availability of funds<br>• Implementation capacity, funds and motivation in place at the Ministry of Health<br>• Availability of adequate and well motivated human resources in the health sector<br><br>***Risk:***<br>• Insufficient financial and human resources | US$3 000 000 |
| ***Outcome 4.1b:***<br>Improved Adherence to ART/TB Treatment | - *ART Adherence rate*<br><br>- *TB Treatment Success rate*<br><br>Target: *80% adherence rate for ART and 85% success rate for TB treatment for clients on FBP.* | | |

| | | | |
|---|---|---|---|
| **Output 4.1**<br><br>Nutrition Assessment, Education and Counselling Undertaken | - *Number of women, girls, boys and men participating in nutrition education*<br><br>- *Number of women, girls, boys and men that have received nutrition counselling*<br><br>- *Number of women, girls, boys and men that received prescription for nutrition* | | |
| ***Outcome 4.2***<br>Adequate food consumption reached over assistance period for targeted households | - *Household food consumption score*<br>Target: *35/42 for targeted households* | | |
| **Output 4.2**<br><br>Food and non-food items distributed in sufficient quantity and quality to target groups under secure conditions | - *Number of women, men, girls and boys receiving food and non-food items by category as a % figure*<br><br>- *Tonnage of food distributed by activity type as a % of Planned distribution*<br><br>- *Quantity of fortified foods, complementary foods, and special nutritional products distributed, by type, as % of planned distribution*<br><br>- *Number of institutional sites (health facilities) assisted* | | |
| **Strategic Objective 5: Strengthen The Capacities of Countries to Reduce Hunger, including through Handover Strategies and Local Purchase** | | | |
| ***Outcome 5.1:***<br>Progress made towards nationally owned hunger solutions | - *National Capacity Index (NCI) by hunger solution*<br><br>Target: *12/20* | ***Assumptions:***<br>• Adequate funding available for capacity building activities.<br>• Government commitment and support for capacity building will continue.<br>***Risks:***<br>• Inadequate funding for capacity building<br>•<br>• Staff movement within government , leaving with acquired skills. | US$500 000 |

| | | | |
|---|---|---|---|
| **Output 5.1**<br><br>- Capacity and awareness developed through WFP led activities. | - *Number of people trained in programme design ad panning, implementation procedures and practices, disaggregated by category.*<br><br>Target:<br>- *60 people trained*<br>- *WFP expenditure for technical assistance to strengthen national capacity*<br><br>Target: *US$ 477 000* | | |

## ANNEX 3 - Map of Food by Prescription sites



**ANNEX 4 - List of acronyms**

| | | |
|---|---|---|
| AAH | - | Action Against Hunger |
| AIDS | - | Acquired Immune Deficiency Syndrome |
| ANC | - | Ante-natal Care |
| ART | - | Anti retroviral therapy |
| BMI | - | Body mass index |
| FAO | - | Food and Agricultural Organization of the United Nations |
| GBV | - | Gender-based violence |
| GFATM | - | Global Fund for AIDS, TB and Malaria |
| HIV | - | Human Immunodeficiency Virus |
| IMAM | - | Integrated Management of Acute Malnutrition |
| M&E | - | Monitoring and evaluation |
| MDG | - | Millennium Development Goal |
| MOH | - | Ministry of Health |
| MUAC | - | Mid-upper arm circumference |
| NAEC | - | Nutrition Assessment Education and Counselling |
| NDS | - | National Development Strategy |
| PCV | - | Peace Corps Volunteers |
| PLHIV | - | People living with HIV/AIDS |
| PMTCT | - | Prevention of mother-to-child transmission |
| PRSAP | - | Poverty Reduction Strategic Action Programme |
| SNNC | - | Swaziland National Nutrition Council |
| TB | - | Tuberculosis |
| TB-DOTS | - | TB Directly Observed Treatment Short-course |
| UNDAF | - | United Nations Development Assistance Framework |
| WHO | - | World Health Organization |