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Full Report of the Evaluation of the Burkina Faso PRRO 10541.0

"Reversing Growing Under Nutrition in Food Insecure Regions"

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Responsibility for the opinions expressed in this report rests solely with the authors. Publication of this document does not imply endorsement by WFP of the opinions expressed

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Fact Sheet

Title:	"Reversing Growing Under Nutrition in Food Insecure Regions"				
Number of the Operation	PRRO 10541.0				
Approval Date	28 December 2006				
Operation objectives	(i) Reduce levels of moderate acute under nutrition among children under three, pregnant women and lactating mothers (SO3, MDG 4, 5 and 6); (ii) Enhance the Government's capacity to implement the National Plan of Action for Nutrition, in particular the aspects related to strengthening household food security and setting up a nutrition surveillance system (SO5, MDG 1 and 6).				
Operation specs	Start Date	End Date	Beneficiaries	Metric tons	USD
Design at the start	1 Jan 2007	31 Dec 2008	668,500	24,211	18,337,142
Design at the time of the evaluation	1 Jan 2007	31 Dec 2009	832,600	30,147	28,560,891
Planned activities			Beneficiaries	Metric tons	USD
Supplementary Feeding			832,147	30,147	28,560,891
Main Partners					
Government	MoH				
NGO	Hellen Keller International, MSF, CRS, Africare, Civil Society Organizations				
Bilateral					
Multilateral	UNICEF, FAO				
Main Donors	USA, ECHO, Germany, UN-CERF, Multilateral funds				
Other ongoing WFP Operations	Burkina Faso – Country Programme (2006-2010) EMOP 10773.0 -"Emergency response to High Food Prices in Burkina Faso main cities"				

ACONYMS

ALNAP	Active Learning Network for Accountabilty and Performance in Humanitarian Action
BCG	Bacille Calmette Guérin
BKF	Burkina Faso
BMI	Body Mass Index
CCA	Common Country Assessment
CD	Capacity Development
CDC	Centers For Disease Control
CFA	CFA Franc
CILSS	Comité permanent Inter-Etats de lutte contre la sécheresse dans le Sahel
CMR	Crude mortality rate
CNCN	National Council of Nutrition
CO	WFP Country Office
CP	Country Programme
CREN	Centre de Réhabilitation et Education Nutritionnelle
CSB	Corn Soya Blend
CSPS	Centre de Santé et Protection Sociale
CTC	Community Therapeutic Care
CT-CNSA	Technical Committee of the National Food Security Council
DAC	Development Assistance Committee
DFID	Department for International Development
DGPSA	Direction Générale des Prévisions et de Statistiques Agricoles
DHS	Demographic & Health Survey
DNA	Direction Nationale de l'Activité
DS	Direction de la Santé
DTC3	Diphtheria, Tetanus, Whooping Cough Vaccine Dose 3
ECHO	European Commission Humanitarian Office
ECHUI	Ending Child Hunger and Undernutrition in the Sahel
EM	Evaluation Manager
EMOP	Emergency Operation
EPA	Enquête Permanente Agricole
EQAS	Evaluation Quality Assurance System
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FBF	Fortified Blended Food
FEWS	Famine Early Warning System
GAM	Global Acute Malnutrition
Gvt	Government
HKI	Helen Keller International
IEC	Information, education, communication
IFCR	International Federation of the Red Cross and Red Crescent Societies
IMF	International Monetary Fund

INGO	International Non Governmental Organizations
IPs	Implementing Partners
IPC	Integrated Food Security Phase Classification
IRD	Institut de Recherche pour le Développement
LBW	Low birth weight
MDG	Millennium Development Goals
MoA	Ministry of Agriculture
MoH	Ministry of Health
MSF	Médecins sans Frontières
MUAC	Mid Upper Arm Circumference
NE	Nutrition Expert
NGO	Non Governmental Organization
NNSS	National Nutrition Surveillance System
OECD	Organization for Economic Co-operation and Development
OCADES	Organisation Catholique pour le développement et la solidarité
PDM	Post Distribution Monitoring
PDM1, PDM2	Post Distribution Monitoring 1…..2…..
PHC	Primary Health Care
PNDS	Plan Nationale de Dévelopment de la Santé
PRRO	Protracted Relief and Recovery Operation
PRSP	Poverty Reduction Strategy Paper
REACH	Renewed Effort against Child Hunger and Undernutrition
Q&A	Questions and Answers
RUSF	Ready to Use Supplementary Food
SASDE	Strategie d'Acceleration de la Survie et du Développement de l'Enfant.
SMART	Standardized Monitoring Assessment of Relief and Transitions
SNU	Systeme des Nations Unies
SO3, SO5	WFP Strategic Objective 3, 5
TL	Team Leader
TOR	Terms of Reference
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
VIH	Virus Immune Insufficience Humaine
WFP	World Food Programme
WHO	World Health Organization

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Executive Summary

Burkina Faso is amongst the poorest countries in the world, ranking 173rd out of 179 in the UNDP's 2008 Human Development Index. Roughly half of the country's population does not have sufficient access to the food needed to meet minimum energy requirements. From the early 1990s, there was worrying evidence of increasing prevalence and incidence of undernutrition in Burkina Faso. Between 1993 and 2003, the prevalence of stunting increased from 31% to 39%, while underweight rose from 30% to 38%. Most significantly, in the context of renewed concerns about wasting following the Niger crisis of 2004/05, the prevalence of wasted children was found to be almost 19% (representing over 450,000 children). That rate was well above the emergency threshold defined by WHO and other humanitarian agencies as indicative of a crisis situation.

The problems of Burkina are shared with its neighbours—Mali, Mauritania, Niger and Chad. The region plays host to roughly 1.4 million wasted children under 5, and its environmental, public health and economic challenges remain serious. As part of a broader regional strategy for the northern Sahel, WFP, UNICEF and many other partners decided to support the Burkina Faso government with interventions designed to reverse recent trends in undernutrition. It was decided that the precarious nutrition situation could not be addressed piecemeal, through small scale, development interventions in the context of regular country programmes. Instead, an integrated multi-sectoral and multi-country approach was formulated that includes both curative and preventive measures.

PRRO 10541.0 targets 426,000 children aged 3 years and under, as well as 242,500 undernourished pregnant and lactating women. While government policy targets children under 5 years as the priority group for nutrition intervention, younger children (less than 3 years) are a) more at risk of mortality linked to acute undernutrition, and b) the priority target group for investing in longer-term nutrition by preventing nutritional deterioration early in their life. Thus partners in the PRRO jointly decided to focus on the under-3 years age group for this time-bound intervention. In many recent nutrition assessments the north-eastern parts of the country had higher than average rates of undernutrition and food insecurity; but the South-West region is also affected by high rates, linked to high migration, seasonal food-insecurity, low health-seeking behaviour and certain local caring and feeding practices that may contribute to nutritional deterioration of infants. A 13-point weighted scoring system by the inter-agency assessment mission in 2006 resulted in the geographical focus of the PRRO on the 5 most affected regions. This number of regions was increased to 7 during a revision of the PRRO.

The objectives of the PRRO were as follows:

- Reduce levels of moderate acute undernutrition in children under three, pregnant and lactating women (Strategic Objective (SO3, MDG 4, 5, and 6).
- Enhance the Government's capacity to implement its National Plan of Action for Nutrition and to develop a National Nutrition Surveillance System.

The PRRO was planned for 1st January 2007 to 31st December 2008. An extension was approved in November 2008 to take the PRRO to 31st Dec. 2009. A total of 668,500 individuals were expected to benefit directly from the PRRO's activities. The total cost to WFP at the outset was established as US$18.3 million, of which US$ 9,1 million represented food costs (24,211 metric tons (MT)). However, a budget revision was approved in 2008 that increased the budget to US$ 28.9 million and pushed up the

number of beneficiaries to 832,600. As of December 4th 2008, $16.6 million had been received, representing 57 % of the needed financial resources.

The output and outcome indicators established in the log-frame are detailed, mainly focused on measurable changes in nutritional status at both individual and population levels. The outcomes are defined as:

- Prevalence of wasting among children <3 years in target areas
- Incidence of children born with Low birth weight (LBW)
- Recovery rates of children treated for malnutrition
- Credibility and timeliness of reporting on nutrition derived from a nutrition surveillance established under government auspices.

The PRRO involves many stakeholders. There are important actors in the government of Burkina Faso (BKF), including the National Council of Nutrition (CNCN), the Direction Nationale (DN) in the Ministry of Health (MoH), and the DGPSA in the Ministry of Agriculture (MoA) at central level, and health staff at regions and health centres

The evaluation focuses on the implementation period running from June 2007 through August 2008, representing a period when the PRRO was most adequately resourced.

Main Findings

The design of PRRO 10541.0 is appropriate to addressing the problems it sets out to resolve. The objectives of the intervention are well-defined, realistic and relevant to the priority concerns of BKF's government. The PRRO activities are targeted to regions with the highest levels or risks of food insecurity, which conforms with WFP's internal policies.

The PRRO was designed with three principal components: i) a set of interventions following a 'twin track' concept of treatment of undernutrition combined with its prevention (which is consistent with current thinking on meeting immediate needs of vulnerable populations while simultaneously building longer-term resilience against food and nutrition insecurity), ii) supporting capacity development at a national level in terms of appropriate policy formulation and iii) the establishment of simple, reliable and useful surveillance and diagnostic systems that will permit closer monitoring, and forecasting, of nutrition conditions around the country throughout the year. These elements are appropriate to the needs of the country and consistent with government and donor concerns.

The PRRO does not operate in a vacuum. It builds on the WFP country programme (CP) for 2006–2010, both in terms of design elements (learning from local experience) and shared logistics (operating in many of the same food insecure parts of the country). The PRRO's objectives were developed collaboratively, with input from government ministries, UN partners and NGOs—building directly on the findings of a multi-agency assessment mission in 2006. The activity is well integrated with other medium and longer-term strategies and investments that underpin UNDAF, the PRSP, and other broad policy initiatives of the government.

PRRO 10541.0 is unique in that it was not preceded by an EMOP. Thus, it represents new, rather creative, thinking within WFP on how to address problems like malnutrition that have characteristics of both emergency and non-emergency intervention settings.

This PRRO not only treats conditions that are symptomatic of high mortality risk during EMOPs (high prevalence rates of child wasting), but also seeks to change underlying conditions (knowledge and behaviour at household level) that are more commonly addressed through CPs.

In its overall conceptualization and technical design, the PRRO earns high marks for its innovation and appropriateness. Its design builds not only from what was formerly done under the CP but takes on board current thinking related to, a) the importance of community level interventions in resolving widespread nutrition problems, b) the synergistic potential of combining treatment (particularly involving community management of malnutrition) with prevention, c) the importance of developing an enabling policy environment, not just programming interventions, and d) bringing attention to low birth weight as a 'neglected' issue in nutrition policy and programming that relates not only to maternal welfare but also to the future burden of malnutrition.

For the period of the PRRO under consideration by this evaluation (June 2007 through August 2008), 519,920 individuals received at least one ration. Beneficiaries included 584,282 children <3 years of age (compared with a target of 272,000), 201,504 pregnant women (compared with a target of 130,000), and 353,312 lactating women (versus a target of 112,500). This seemingly extraordinary high achievement is explained by the larger than expected number of beneficiaries who were enrolled in PRRO activities but who dropped-out before completing a full 'treatment' (see below). This means that more individuals benefitted at least from WFP food rations than benefitted from the entire package of PRRO interventions, but it does not represent a dilution of rations. This project had a high rate of voluntary food contribution in the culinary demonstration sessions, and unrecorded overall impact on improved weaning practices despite a considerable resource gap.

Post distribution monitoring (PDM) reports that the number of clients in the health system increased because of the nutrition-centred activities, even if occasionally no food distribution took place because of pipeline breaks. There is no doubt that CSB is shared within households, but this is much less the case in relation to Plumpy'nut used in therapeutic treatment since products more clearly defined as 'medicinal' are less shared.

Community-based activities started on a small scale, because there were few NGOs and other partners working in nutrition per se. During the period from June 2007 to August 2008 the number of collaborating NGOs increased from 5 to 19. Health education concentrated on culinary demonstrations with fortified WFP rations and locally available ingredients. A total of 334,000 food rations were distributed during these sessions, catering to more than 34,000 children. This increase in community level activities is a clear indication that ownership of longer-range 'nutrition-change' programmes on population level is a successful approach and attracts NGO appreciation. A first 'hands-on' appreciation during the field visits has led the evaluators to postulate that the reported figures suggest also very high cost-efficiency.

The major constraints reported by government health staff working both at clinic level and at regional and district health level were: i) insufficient time, ii) difficulties with report formats, iii) insufficient and cumbersome tools (anthropometry) and iv) insufficient training and supervision. It is estimated that only 50 % of health staff had substantial pre-service formal nutrition education. No additional professionally trained staff is currently available to address the new focus on nutritional rehabilitation.

In this context, reducing what were high and increasing rates of moderate acute malnutrition in the worst-affected regions represented a significant challenge. The

baseline survey in March/April 2007 documented prevalence rates for moderate wasting of 17.7% in children <3 --above the 15% 'crisis' threshold normally defined by WHO and used by WFP to initiate emergency blanket supplementary feeding activities--as well as around 5% for severe acute under nutrition.

Nevertheless, the rates in follow-up surveys were lower. By the time of follow-up No.3 in August 2008, moderate acute malnutrition prevalence was down to 15.5%, and severe acute wasting was stable at around 5%. Thus, while the 10% target level has not yet been reached a major positive impact has already been achieved in the targeted regions and a continuation of the PRRO activities can realistically achieve seethe 10% goal within another 12 to 18 months, if all activities are implemented and required resources are forthcoming.

BKF government statistical services estimated that 19% of live births in 1999 to 2005 were LBW. The WFP baseline of target regions found a rate of 16.2% (in 2007). During the period of PRRO implementation that rate fell to around 12% in follow-ups No. 1 (late 2007) and No. 2 (early 2008), down to 11% in follow-up No. 3 (late 2008).

The target for rehabilitation of children through supplementary feeding was set at >70% recovery, but no target was set for the rehabilitation of mothers. Overall, the rates of child rehabilitation were good, averaging around 65% for the PRRO period as a whole. Strong follow-up by WFP led to the recruitment of several new NGOs in the spring of 2008. The result was a sharp improvement in rehabilitation rates for children and also pregnant women reaching 90% by August 2008.

Rehabilitation of undernourished mothers was somewhat better than for children; overall, almost 70% of pregnant women and 58% of lactating women receiving nutrition support, successfully exited the programme. However, a high default rate among targeted beneficiaries has serious implications for the cost of the programme, since many more rations and services are delivered than 'complete treatments', and to the recovery of individuals (because a large share of the target population is non-compliant with the rehabilitation protocols).

In all regions, there has been a progressive improvement in, a) the capacity of implementing partners (IPs) to manage the PRRO, b) the number of partners conducting activities (and often helping each other), and c) the awareness of local populations of the importance of the programme. The mission concluded that these apparent changes during the programme implementation were a key to long-term behaviour adaptation, but require a longer timeframe within the overall development process to be fully appreciated . However, these issues would be monitored during forthcoming establishment of surveillance.

A National Nutrition Surveillance System (NNSS) is programmed by the government to start in 2009. For this reason, any nutritional status measurements of populations covered by the PRRO cannot be measured against national norms. However, the various efforts to establish some measure of nutritional status among vulnerable groups at various times of the year across regions allows to establish trends in undernutrition, which have been used to prioritize interventions areas Most members of the nutrition community in BKF would give preference to a nutrition surveillance system that builds on existing systems rather than creating a large infrastructure from scratch. Given current scarcity of technical capacity in nutrition in BKF, it would be preferable for WFP to improve the existing mechanisms for data collection, rather than to investment in the development a new stand-alone surveillance system.

Beyond the outcomes defined in the log-frame, it is important to recognize the high value of the behaviour change communication components of this PRRO with regard to breastfeeding (mothers) and necessary priority in feeding during the weaning period (under 3s) and during pregnancy and lactation (women, mothers).

Conclusions

PRRO 1054.0 is relevant to the overall nutrition and food security problems in the country as well as to the urgent needs of its targeted beneficiaries since it responds to high rates of child wasting and an apparent deterioration in the nutritional status of pregnant women and lactating mothers through preventive and curative activities. The activities of the programme are appropriate in their flexible design to be applied in villages/communities and through administrative structures of the health system.

The linking of food inputs with key non-food medication and services (the elements of an 'essential package') of the PRRO reflects current professional consensus on potential for efficient implementation for this kind of intervention.

The effectiveness of the PRRO is clearly demonstrated by overall improving nutritional trends documented by a variety of data sources, achieved through a combination of resources applied through health centre and community activities. However, technical capacity in nutrition is limited in the country among all IPs and operational capacity is constrained in the parts of the country where the problems are most severe. WFP has done well to implement an ambitious activity in a short time frame, but the logistical hurdles remain.

In terms of impact the PRRO looks positive—particularly in terms of short-term outcomes - although a sustained "reversal" in negative nutrition trends (the overarching goal of the PRRO) needs to be confirmed over the longer run.

The collaboration of WFP with a large range of civil society organisations and partners with a large spectrum of different development priorities has a development potential to connect the current aftermath of the 2005 crisis with durable development planning in nutrition. The process of defining and implementing the PRRO has helped WFP play a more active role in the country and in the regions in promoting dialogue on nutrition problems and comprehensive solutions over the longer-term.

Recommendations

Since the evaluation mission found the objectives to improve the current nutritional situation and the development of capacities in nutrition and food security on all levels highly relevant, it is recommended that the PRRO be adequately supported by WFP, its donors and its partners since is a critically needed intervention, broadly successful in its first phase.

It is recommended to the management of the PRRO that the achievements in areas currently covered be strengthened prior to major expansion into new zones. The proposed consolidation is required in view of the slow growth of nutrition capacity documented on all levels of the management pyramid.

Analytical capacity among implementing partners in: a) assessment of local nutrition problems, b) improved recording and reporting of anthropometric data, c) enhanced capacity for both case-finding and follow-up of defaulters should be improved.

The mission recommends to evaluate the behaviour change aspects of the intervention through 1) the assessment of communication approaches that work best, 2) sharing of best practices across the many IPs involved, and 3) greater attention to measuring outcomes of this particular dimension of the intervention.

Data requirements, collection methods and analysis should be reviewed at implementation level, and recording and transcribing errors must be minimized. At programme management level, WFP needs to adopt the Minimum Reporting Package for Emergency Supplementary Feeding Programmes, currently being finalized by partners of the Emergency Nutrition Network. There is a need for better reporting on default rates, on coverage, on LBW outcomes, and on the characteristics of individuals who do not respond to treatment.

The mission recommends, that at national level, a review of data requirements is needed to assess the nature and volume of information required for 1) appropriate nutrition surveillance in the current situation and 2) permanently required activity changes for nutrition interventions.

While current food basket is adequate to achieve nutrition rehabilitation in the majority of cases, the mission recommends in view of the seemingly successful multiple productions of weaning formulas in the country and the currently fast growing international experience in this field to explore the use of alternative foods. This concerns specifically, the possibility of using a ready-to-use supplementary food such as 1) Plumpy'doz in the rehabilitation of children who are moderately wasted and 2) testing an enriched CSB or enriched flour complemented by powdered home fortificants which is central to the current international discussion on this issue.

There is a need for well-designed operational studies on i) Costs and effectiveness of different intervention models (particularly in relation to types of foods used), ii) What is the appropriate metric to assess cost-effectiveness in a programme of this nature—analysis is needed of unit costs per 'treatment' (rehabilitation) versus cost per ration or price per beneficiary. An attempt should be made to pilot the REACH costing model to the PRROs various activities, and in this context the potential for locally-produced supplementary foods should be re-considered.

1. Background

1.A. Context

1. Burkina Faso is amongst the poorest countries in the world, ranking 173rd out of 179 in the UNDP's 2008 Human Development Index. Roughly half of the country's population does not have sufficient access to the food needed to meet minimum energy requirements. Just over 1 million of these people are children under 5 years of age, a high proportion suffer poor nutritional status.

2. From the beginning of the 1990s there was worrying evidence that the prevalence and incidence of undernutrition and micronutrient deficiencies were increasing in Burkina Faso, as across much of the Sahel region. A Demographic and Health Survey of 2003 indicated that between 1993 and 2003, the prevalence of stunting increased from 31% to 39%, while underweight rose from 30% to 38%. Around 90% of children under-five were affected by anaemia. Most significantly in the context of renewed concerns about wasting in the context of the Niger crisis during 2004 and 2005, the prevalence of wasted children was found to be almost 19% (representing over 450,000 children). That rate was well above the emergency threshold defined by WHO and other humanitarian agencies as indicative of a crisis situation.

3. A nutrition survey conducted in August 2006 by MSF (with WFP) in two regions (the North and East) confirmed the seriousness of the nutrition situation, also noting that the crude mortality rate (CMR) of 1.27/10,000/day was also above the internationally accepted threshold. Also in 2006, a joint Government/UNICEF/FAO/WFP/WHO nutrition and food security assessment mission concluded that despite relatively good cereal production in recent years, seasonal droughts in food insecurity linked to local crop failures, a continuing threat of crop pests and diseases, and high post-harvest crop losses translated to inadequate food consumption in many regions (in quality as well as quantity), which, linked to widespread infectious diseases and lack of access to appropriate clean water and sanitation, was contributing to the high, and still-growing, levels of undernutrition.

4. The problems of Burkina are shared with its neighbours—Mali, Mauritania, Niger and Chad which together make up the Northern Sahel. The region plays host to roughly 1.4 million wasted children under 5, and its environmental, public health and economic challenges remain serious. What is more, the relationships among severe undernutrition, poverty and food insecurity are complex and not always predictable. For example, in Burkina Faso some of the highest levels of wasting are found in the South West, a region of relatively good rainfall, relatively plentiful harvests, local gold mining and easy migration to plantation agriculture in coastal West African states. Similarly, in Niger, Zinder region had both the lowest proportion of food insecure households in 2005, and some of the highest rates of severe acute undernutrition. Child undernutrition is also not limited to rural areas in the Sahel, since recent surveys in Ouagadougou, Niamey and N'Djamena show that as many as 16% of <5s suffer moderate acute wasting.

5. Nevertheless, despite these high, and in many cases increasing, rates of malnutrition, the problem of wasting has been largely invisible to donors, governments and even non-governmental agents of change. While the Niger crisis stirred up considerable attention and controversy in some circles, a concerted response to tackle such problems at scale across the Sahel was not an immediate outcome. That is not to say that governments ignored nutrition completely. Since 2001, the Government of Burkina Faso, for

example, has been actively engaged in formulating policies, plans and protocols to deal with undernutrition in the framework of health, food security and agricultural policies. The country's National Plan of Action for Nutrition was revised, based on the Poverty Reduction Strategy Paper (PRSP) of 2003, to become a national nutrition policy in October 2006.

The latter includes 5 major objectives:

- Reduce mortality and morbidity due to malnutrition
- Reduce the prevalence of chronic disease due to poor nutrition
- Improve nutrition activities in health facilities
- Enhance community level nutrition activities
- Reinforce intersectoral nutrition programme coordination and integration.

6. This policy was enhanced by a Presidential Decree that established a National Nutrition Coordination Council in early 2008, with the Ministry of Health as overall nutrition programme coordinator. National protocols for the management of severe acute malnutrition were formalized during 2007. In other words, the policy environment for action on the ground was enhanced in the past 5 years, making it possible for WFP, WHO, UNICEF and other partners to craft a large-scale field intervention aimed at addressing both the causes and effects of moderate and severe acute malnutrition. The Burkina Faso activity was planned and implemented as part of a broader regional strategy for the governments in the northern Sahel. It was decided that the precarious nutrition situation across the region could not be addressed piecemeal, through small scale, development interventions in the context of regular country programmes. Thus, an integrated multi-sectoral and multi-country approach was agreed, to include both curative and preventive measures, and food and non-food inputs, to be targeted to the most affected demographic groups; namely, under 3s, pregnant and lactating women.

1.B Description of the Operation

7. PRRO 10541.0 was designed to assist 426,000 children aged 3 years and under, as well as 242,500 undernourished pregnant and lactating women in 5 highly affected regions of BKF. Although nutrition problems can be found in all parts of the country, a Government/United Nation assessment mission identified 5 priority regions—the Sahel, North, Centre-North, East and South-West regions. The 2 objectives of the PRRO are as follows:

    - Reduce levels of moderate and acute undernutrition in children under three, pregnant and lactating women (Strategic Objective (SO3, MDG 4, 5, and 6)
    - Enhance the Government's capacity to implement its National Plan of Action for Nutrition, including the development of national nutrition surveillance.

8. Recognizing the need for large-scale therapeutic interventions (to reduce the incidence and prevalence of both severe acute and moderate acute wasting), but also preventative actions to tackle underlying causes, WFP and its partners developed a three-pronged approach: a) targeting beneficiaries for therapeutic treatment (supported by UNICEF and the government, mainly through the health-care system, but also with the assistance of medically-competent non-governmental organisations such as MSF); b) offering supplementary feeding and additional services to resolve moderate acute malnutrition (recovery of those who had been severely malnourished and those who were found before they became more than moderately acutely malnourished)—again through a combination of health facilities and community-level interventions supported by NGOs; and c) preventive actions based on awareness raising, education and demonstrations.

9. The prevention component encourages women to monitor the weight of their children and seek health care as appropriate, it encourages home production of enriched porridge as an improved complementary food for young children, and it seeks to raise women's understanding of the importance of exclusive breastfeeding and appropriate weaning practices, vaccination, family planning, avoidance of food taboos, improved hygiene and food handling, etc. Eligibility for inclusion in the programme, and exit (successful rehabilitation) is based on anthropometric measures.

10. The PRRO was planned for implementation from 1st January 2007 to 31st December 2008. An extension of the end date, to Dec 31st 2009, was approved in November 2008. A total of 668,500 individuals were expected to benefit directly from the PRRO's activities. The total cost to WFP at the outset was established as US$18,337,142, of which US$ 9,101,330 represented food costs (24,211 metric tons (MT)). However, a budget revision was approved in mid-2008 taking the total budget to US$ 28.9 million. A resourcing update of December 4th 2008 shows that US$16.6 million had been received against the appeal, representing 57 % of the required resources.

11. The PRRO's logical framework is framed around an overriding goal which is "to reverse current nutritional trends". Under that heading, two major objectives are defined:

    - Reduce levels of moderate and acute undernutrition among children under 3 years of age and
    - Enhance Governments capacity to implement the National Plan for Nutrition, in particular the aspects related to strengthening household food security and setting up a National Nutrition Surveillance System (NNSS).

12. The logframe has a number of activities for each of the objectives, each with its own outputs and expected outcomes. On the one hand, the field intervention revolves around supplementary feeding and supports for information, education and communication (IEC) activities. The intent is to deliver appropriate food rations to target beneficiaries for the requisite periods of time to achieve optimal outcomes in terms of rehabilitation rates for those previously undernourished, and a concomitant reduction in prevalence rates of wasting as well as low birth weight (a measure of successful reduction in undernutrition among mothers).

13. Naturally, food alone would have only limited impact unless accompanied by complementary non-food inputs and services. These are brought together to form an 'essential package', comprising, i) promotion of hygiene, ii) promotion of breastfeeding and sound weaning practices with locally available foods, iii) reduction of micronutrient deficiencies in both groups of beneficiaries (through reinforced food items in the supplementary food basket) but also through collateral measures like de-worming and improvement of malaria prevention, iv) access to basic Primary Health Care (PHC) services, access to potable water and improved sanitation, v) improved household food security and vi) improved status of women.

14. On the other hand, there are additional capacity enhancement, policy dialogue and information management goals to be pursued at the national level. This includes the training of individuals in nutrition skills among health institutions, NGOs and at community level; technical support by WFP to partners in government and in civil society on data management, surveillance systems, assessment methods, etc; and active engagement in national policy dialogue on nutrition.

15. The output and outcome indicators established in the logframe are elaborate (compared with many other PRROs), but appropriate for an activity that seeks to bring about measurable changes in nutritional status at both individual and population levels. The outcomes of interest are defined as:
    - Prevalence of wasting among children <3 years in target areas
    - Incidence of children born with LBW
    - Recovery rates of children treated for malnutrition
    - Credibility and timeliness of reporting on nutrition derived from a nutrition surveillance established under government auspices.

16. Assumptions made regarding the feasibility of these outcomes revolved around, a) the potential for negative influences on nutrition and health from crop failures (linked, say, to drought or locust attack), epidemic diseases (like a meningitis or measles outbreak), or socio-political instability (linked, potentially, to the impact of high food prices); and b) appropriate funding for, and implementation of, all aspects of the PRRO. The latter would include constraints to policy implementation and funding for the establishment of a nutrition surveillance system.

17. All output indicators for the first objective are quantifiable. They concern nutritional status improvements, beneficiaries, logistics, storage and distribution of supplementary food, as well as implementation of IEC sessions. The verification of these indicators is pursued through a combination of monthly reporting requirements, post-distribution monitoring, ad hoc visits from WFP staff, and periodic surveys.

18. The PRRO involves many different stakeholders. There are many important actors within the government of BKF, including the CNCN, the DN in the MoH, and the DNSPA in the MoA at central level, and then health ministry staff at other levels from the regional, through district, down to health centre (CSPS). These institutions and individuals interact quite closely with other stakeholders, particularly, on the one hand, with the main beneficiaries themselves—the undernourished enrolled in the programme. Health centre staff works with and for the beneficiaries, enrolling, offering curative and preventive care, and delivering key elements of the essential package.

19. On the other hand, health centre staff interact regularly with stakeholders at the community level—be they village volunteers (bénévoles) who help with the culinary demonstrations, or staff from collaborating non-governmental organisations (today numbering 20). These organisations are trained in specific tasks from beneficiary targeting, management of food supplies and distribution, anthropometric measurement, activity recording and reporting, and capacity building. Their staff often understands local customs and taboos that may influence the preparation of complementary foods, exclusive breastfeeding, and traditional coping mechanisms during drought and lean periods.

20. The other main set of stakeholders is the international donor and development assistance community. A number of major donors, such as the EC and the World Bank, have embraced not only the idea of a regional approach to pervasive Sahel-wide nutrition challenges, but to country-specific operations that combine the treatment of severe acute malnutrition with rehabilitation of moderately undernourished women and children, and with actions that seek to prevent future undernutrition from taking hold. Collaborating agencies in the UNCT (particularly UNICEF, WHO and FAO), and bilateral agencies (USAID, DFID, etc.) play an important role in national policy dialogue on nutrition and food security more broadly, in sharing resources for needs assessments and surveys, and in capacity development.

21. Representatives of all stakeholder groups were actively involved in the evaluation of PRRO 10541.0, from conceptualization, through the sharing of ideas and data in the context of separate briefings and group meetings, and in offering feed-back on preliminary thoughts and findings.

1.C Evaluation features

22. This evaluation was undertaken in compliance with WFP's corporate evaluation policy, according to which "any operation longer than 12 months should be evaluated". The first phase of the PRRO, based on its original timeline, came to an end on 31st December 2008, and the course of the evaluation ran from September 2008 through February 2009. However, the evaluation also serves as a mid-term reality check for the PRRO given that it has been formally both extended in time (to the end of 2009) and expanded in scope (by adding 2 new regions to the original 5). In other words, although the evaluation focused primarily on implementation of the PRRO up to September 2008, the findings and recommendations can also serve to adjust and refine design and operational features in the expanded phase.

23. The (external) evaluation of PRRO 10541.0 offers independent conclusions in line with accepted international standards of accountability, while simultaneously highlighting features of the operation that may have a bearing on WFP programming more broadly, even beyond BKF (that is, lessons learned that may be of pertinence at least across the Sahel).

Scope

24. The evaluation focuses on the implementation period running from June 2007 through August 2008. This is because, a) the operation did not become active in terms of food distribution until May/June 2007 (and the baseline survey was only conducted in March/April 2007), b) this represents a period when the PRRO was most adequately resourced, allowing for a viable assessment of effectiveness, and c) the mission arrived in country in November 2008, which allowed for field data to be compiled covering the whole period in question.

25. Field visits were made to a representative sample of implementing partners/sites in all 5 of the original regions (see Pre Mission Report). The additional 2 regions added to the PRRO in late 2008 were not included in the evaluation, because they have been added only recently and no longitudinal data collection for the evaluation is as yet available. The evaluation took into account all aspects of the PRRO, including the supplementary feeding, nutrition education/sensitization, service provision of other elements of the essential package (malaria treatment, deworming…..), and capacity enhancement/policy dialogue on central level.

Methodology

26. A pre-mission review was undertaken of available documentation of the situation at the beginning of the project (baseline survey, prior vulnerability assessments, agricultural production and food security surveys) and through the period of implementation (PDMs, monthly reporting, market price monitoring, IP surveys, etc). Based on such information it was determined that the PRRO could be effectively evaluated in terms of its implementation (inputs and outputs) and in terms of measurable impacts.

27. Three weeks prior to the main field mission, a 10-day pre-mission was undertaken to the country by TL and EM in order to, a) conduct preliminary interviews with stakeholders on key issues to be considered, b) establish a logistics plan for the field mission, with precise time allocations for field visits and partner discussions, c) formulate and field tested a standardized interview format/checklist to facilitate discussions during the main mission, and d) interact with WFP CO and evaluation staff on details of process and intended outcomes of the mission.

28. The full field mission took place from 22 November to 9 December 2008.. A briefing/consultation meeting was held with several dozen stakeholders at the CO prior to the field visits. A maximum of time was spent in the field with various government, NGO and village stakeholders.

29. Discussions were held with all regional medical officers and most district level staff, with health staff in clinics, and with NGO staff, village leaders and beneficiary groups in villages. Focus group discussions were had in communities, and representatives of partner NGOs were interviewed with a pre-tested interview guideline. In Ouagadougou, group and individual meetings were held with a range of UNCT partners, donor agency representatives, local and international academics, and NGOs.

Limitations

30. The short time-frame for the mission, given its desire to focus on the field operations, meant that discussions with government and donor institutions in the capital were held to a minimum. While this was unavoidable, it limited the depth to which capacities of national institutions could be assessed (in relation to the establishment of a national surveillance system), as well as exploration of what is known or not known (in detail) about the factors contributing to the 'crisis' of wasting that the PRRO addresses. For example, the mission uncovered wide variance in terms of contributing factors to undernutrition, their manifestations and required solutions across districts, ethnic groups and ecologies. Gaining an understanding of how well the various PRRO activities effectively address such specificities was a challenge in the short time available at each field site.

31. The short timeframe of the PRRO itself represents a limitation in terms of the goal that is set—reversing trends. While much can be (and apparently has been) done in a short time period to addressing wasting, 2 years is too short to determine if population-wide changes in prevalence rates of wasting or low birth weight have been, or can be, sustained. Only a longer-term monitoring and evaluation period can provide concrete evidence for sustained effectiveness (protecting and maintaining gains achieved). This also applies to assessing institutional capacity development and changes to the policy environment.

32. The environment in which the PRRO was implemented was challenging. The global food price crisis accelerated and peaked during the period under consideration. Local market price monitoring for cereals showed unusual and higher than usual seasonal variations. This had most likely a negative effect on pre-harvest buying of the rural poor and might have resulted in seasonal acute undernutrition levels. This kind of limitation to the evaluation remains currently speculative but needs mentioning since it should certainly be picked up by nutrition surveillance in the future.

Quality assurance

33. WFP has developed an Evaluation Quality Assurance System (EQAS) based on UNEG norms, and standards and good practice defined by the international evaluation community (ALNAP and OECD/DAC). It elaborates process maps with in-built steps for quality assurance, and provides templates for all evaluation outputs. It also includes checklists for feedback on quality for each product, including the TOR. EQAS was systematically applied during the course of this evaluation. Both team members are external consultants to WFP, with no conflict of interest perceived.

Main Findings

2.A Operation design: relevance and appropriateness.

2.A1 Objectives of the Operation including targeting and their relevance/appropriateness.

34. The design of PRRO 10541.0 is appropriate to addressing the problems it sets out to resolve. The objectives of the intervention (namely, achieving a reduction in prevalence rates of moderate wasting among children aged less than 3 years (and other nutritionally vulnerable groups), as well as capacity development in nutrition and food security policy formulation, surveillance and programming, are well-defined, realistic and relevant to the priority concerns of BKF's government.

35. Large numbers of Burkinabé households continue to be faced with the combined threats of ill health, limited formal education, chronic poverty and environmental shocks, all of which lay communities open to vagaries of global market conditions, the cross-border spread of epidemics or the traumas linked with regional conflicts.[1] While some progress has been made in the West African region in gradually reducing the prevalence of child stunting (impaired linear growth) and underweight (low weight for age), progress has been slow and uneven, while the prevalence of wasting (acute and moderate rates of low weight for height which carry elevated mortality risks) have been increasing. Every sub-region of Africa saw rising levels of wasting between 1990 and 2005, but Sahelian countries like BKF, led the pack[2].

36. There have been many contributing causes. The Interagency Assessment Mission on the food security and nutrition situation of September 2006 [3] established that around 40% of households in BKF are at-risk of food insecurity. While the drought-prone North of the country is at highest risk (with over 50% of the population affected), other regions are also at risk, particularly including the Eastern and South-Western parts of the

1 OCHA (Bureau de la Coordination des Affaires Humanitaires). 2008. Rapport de situation mensuel. Bureau régional pour l'Afrique de l'Ouest. 8 juin 2008. Dakar, Senegal. Mimeo.; FAO. 2008. BKF : Initiative sur la flambée des prix agricoles. Initiative on Soaring Food Prices (ISFP). Mission d'évaluation de la situation, de consultation des partenaires et identification préliminaire d'un plan d'actions (7 – 18 avril 2008). Rapport de fin de mission. Mai 2008. Mimeo.

2 UN Standing Committee on Nutrition. 2004. 5th Report on the World Nutrition Situation. Geneva, Switzerland; World Bank. 2006. Repositioning Nutrition. Washington, DC.
DHS. 2004. Enquête Démographique et de Santé : BKF, 2003. Institut National de la Statistique et de la Démographie, Ministère de l'Économie et du Développement. Ouagadougou/ORC Macro, Calverton, Md

3 Rapport technique de la Mission Conjointe (Gvt/PAM/UNICEF/FAO/OMS) sur l'evaluation et la planification des interventions du Systeme des Nations Unies en matière de lutte contre la malnutrition au BKF (11 – 22 September 2006).
(4) OCHA. 2008. West Africa Consolidated Appeal – Mid-Year Review. New York, July 2008.

country. Most at-risk are farming families reliant on rainfall to produce cereals, rather than cash crops, who have limited mechanized assets (tractors/animal plowing), and who, as a result, purchase more than 40% of their food during the lean season. Overall, these kinds of households allocate more than 60% of their expenditures on food, compared with roughly 40% of spending on food by non-poor households.4 The most food insecure households are obliged to sell their output soon after harvest since they have little or no storage capacity and they have an urgent need for cash to service debt, education and health expenditures. As in most other parts of the Sahel region, the result is sales when food prices are at their lowest, followed in a few months by purchases when prices are much higher.

37. In addition, repeated shocks during recent decades (mainly droughts and pest attacks) have resulted in an erosion of traditional coping mechanisms, particularly with regard to use of wild growing plants in the hardship seasons [5]. Aggravating these traditional cycles was a recent steep rise in cereal prices during the pre-harvest seasons of 2007 and 2008 6 . While cereal prices moderated in the second half of 2008, thanks to relatively good harvests in several parts of the country, this was offset for many by a much lower than usual cotton crop.[7]

38. The targeting of PRRO activities to regions inhabited by people with the highest levels or risks of food insecurity conforms with WFP's internal policies. However, the PRRO's particular focus on nutrition injected a further dimension. Prevalence rates of undernutrition do not always correlate with levels of highest food insecurity because of the multi-causal nature of malnutrition (i.e. food and income levels are not the only determinants of nutritional status outcomes) [8]. For example, national food-security assessments (EPA) [9] do not show regions of low cereal production to be the same as those of high rates of undernutrition. Indeed, some of Burkina's cereal surplus regions sometimes have high levels of undernutrition. This supports the conclusion made by the Copenhagen Consensus that nutritional objectives cannot be met through income growth alone--rather, focus should be given to child and reproductive health programmes with emphasis on reducing the incidence of low birth weight, promotion of exclusive breastfeeding and infant and child nutrition, reducing anaemia and deficiencies of vitamin A, iodine, and zinc [10]. For such reasons, the PRRO targeted its initial 5 priority provinces using a combination of indicators that included multiple aspects of health concerns as well as various indicators of macro- and micronutrient

4 OCHA. 2008. West Africa Consolidated Appeal – Mid-Year Review. New York, July 2008

5 Ouédraogo, F. C. 2006. La vulnérabilité alimentaire au BKF.,L'Harmattan, BKF; Kazianga, H, and C. Udry. 2006. Consumption smoothing? Livestock, insurance and drought in rural BKF. Journal of Development Economics 79: 413– 4

6 Maxwell, D., P. Webb, J. Coates and J. Wirth. 2008. Rethinking Food Security Responses in Humanitarian Crises. Background Paper for the Food Security Forum, Rome, April 16-18 ……..

7 Rapport Mission Conjointe d'Evaluation de la Situation Alimentaire, des Marchés et des Flux Transfrontaliers au Sud Ouest du Burkina Faso, CILSS/PRA Marché, FEWS NET, SONAGESS-SIM/Burkina Faso, Février 2008, Mimeo

8 CSAO-CILSS (Club du Sahel et de l'Afrique de l'Ouest- Comité Inter Etats de Lutte contre la Sécheresse au Sahel). 2008. Profil sécurité alimentaire Burkina Faso. Rapport Final (April 2008). Report to the Ministère des Affaires Étrangères de la France and l'Union Européenne. Ouagagadougou. ; Poulsen, L., M. Michael, and N. Pearson. 2007. Drought and Vulnerability – A review of context, capacity and appropriate interventions with respect to drought and the problem of acute malnutrition in the Sahel Region of West Africa. Final Version of report to DG ECHO. Cardno Agrisystems Limited. Mimeo

9 Governement of Burkina Faso. 2004. Plan d'action système d'information sur la sécurité alimentaire., Ministry of Agriculture, Ouagadougou.

10 Behrman, Jere R et al. .2004. Hunger and Malnutrition. Copenhagen Consensus – Challenges and Opportunities, Copenhagen

malnutrition [11]. This permitted multi-agency and government consensus on what were the top priority regions requiring intervention focused on both treatment and prevention of malnutrition, in a context of high food insecurity and vulnerability to shocks.

39. Based on survey data from multiple sources, including crop and food needs assessment missions (FAO and multi-agency), comprehensive (WFP) vulnerability assessments, surveys of nutritional status, mortality and health (DHS, MSF, UNICEF, WFP), and estimates of micronutrient deficiencies (DHS, WHO, UNICEF), priority provinces were identified as having highest prevalence rates of nutrition deficiencies, lowest rates of health service/vaccination coverage, highest levels of risk to environmental shocks, and highest rates of food insecurity.

40. Responding to the multi-causal, multisectoral nature of the problem to be addressed, the PRRO was designed with three principal components. On the one hand, a set of interventions following a 'twin track' concept of treatment of undernutrition combined with its prevention--which is consistent with current thinking on meeting immediate needs of vulnerable populations while simultaneously building longer-term resilience against food and nutrition insecurity [12]. The second activity consists in targeting the moderately and chronic malnourished population in order to avoid an epidemic of acute malnutrition in crisis periods. The third principal thrust of such strategy pursues simultaneously capacity development at a national level in terms of appropriate policy formulation and the establishment of simple, but reliable and useful, surveillance and diagnostic systems that will permit closer monitoring, and potentially forecasting, of conditions around the country. These elements are appropriate to the needs of the country and consistent with government and donor concerns. The PRRO incorporates all these elements, which are part of the international agenda in designing the new intersectoral nutrition architecture.

2.A.2 Internal coherence of project objectives.

41. The approaches pursued by this PRRO are consistent with WFP policies on nutrition, as well as its policies and operational guidelines relating to intervention in the context of chronic emergencies. For example, the policy paper on 'Transition from Relief to Development' [13] stresses the importance of coordinating transition situations at the country level and focusing WFP efforts on providing support as required. WFP's policies for PRROs clearly indicate the importance of developing national capacities to analyze, monitor and appropriately respond to food insecurity as part of the overall objective of helping governments to manage food assistance programmes. Capacity development featured in all WFP Strategic Plans since 1997, focusing on capacities of countries at national and local levels.

42. All partners interviewed during the current evaluation mission acknowledged the strong comparative policy advantage of WFP, particularly through its VAM capabilities, in needs assessment and vulnerability analysis, as well as in contributing to national dialogue on national food and nutrition policies and plans of action. PRRO 10541.0 is designed to optimize these comparative advantages, giving appropriate emphasis to

11 Rapport technique de la Mission Conjointe (Gvt/PAM/UNICEF/FAO/OMS) sur l'évaluation et la planification des interventions du Système des Nations Unies en matière de lutte contre la malnutrition au Burkina Faso (11 – 22 Septembre 2006).
12 HLTF (High-Level Task Force On The Global Food Crisis). 2008. Comprehensive Framework For Action. Final Report. JULY 2008. Mimeo. United Nations. New York
13 WFP/EB.A/2004/5-B

capacity development in multiple technical areas mentioned in policy document. [14] While WFP's 2004-2007 Strategic Plan focused on strengthening government capacities to manage food assistance programmes, the more recent 2006–2009 plan speaks of countries and regions, in the context of hunger-reduction activities [15]. PRRO 10541.0 even foreshadowed the current 2008-2011 plan, which argues not only that WFP needs to go beyond the traditional dichotomy between emergency and development assistance—focusing on issues like malnutrition and risks to food insecurity that cut across conventional funding windows—but also that it should adopt a more preventative approach to hunger reduction, a major part of which involves capacity development, policy dialogue and transfer of skills and knowledge, not just commodity resources [16].

43. Similarly, the design of PRRO 10541.0 conforms to guidance laid out in WFP's three policy papers dealing with nutrition, particularly with regard to a) delivering appropriate food and non-food resources needed to achieve intended nutrition objectives, b) focus carefully on the delivery of essential micronutrients, not just macronutrients, c) pay more attention in programming in emergencies (EMOPs and PRROs) to underlying causes of malnutrition, not just acute outcomes, and d) active engagement in national policy dialogues on malnutrition problems and solutions, in collaboration with appropriate partners, including offering support for capacity development in technical and policy domains [17].

44. The PRRO does not operate in a vacuum. It builds on the WFP country programme (CP) for 2006–2010, both in terms of design elements (learning from local experience) and shared logistics (operating in many of the same food insecure parts of the country). The CP supports several activities that seek to: (i) satisfy the nutritional needs of vulnerable groups; ii) promote education, (iii) make it possible for poor families to gain and preserve assets and; (iv) contribute to mitigating the effects of natural disasters. Within these goals, the CP already supported improved access to quality health care – curative, preventive and promotional – in particular for women and children and nutritional support.

45. Food assistance has been offered in this context to preventing severe malnutrition and low birth weight—two of the core goals of the PRRO. At the same time, such interventions are used to trigger activities aimed at encouraging community participation in development activities in general, and identification and prevention of undernutrition, in particular. Village-level communication of nutrition, health and hygiene education is a key element of prevention activities. Such activities are expected to be implemented in collaboration with a range of partners engaged in broader health and nutrition interventions, including UNICEF and NGOs such as Helen Keller International and Africare. PRRO 10541.0 takes these same operational features and partners and expands them in scope.

14 These include: i) vulnerability assessments, ii) co-ordination of food related humanitarian assistance iii)commodity tracking and logistics, iv) community participation, empowerment, strengthening traditional coping mechanisms and v) local procurement and markets, storage and transport, milling and fortification.

15 WFP and Food-based Safety Nets: Concepts, Experiences and Future Programming Opportunities EB.3/2004/4-A., Exiting Emergencies, EB.1/2005/44-B.

16 WFP/EB.A/2008/5-A/1/Rev.1

17 WFP/EB.A/2004/5-A/1, A2 and A3

46. As consequence of the food price crisis impacting Burkina since 2007, the UNCT fielded a vulnerability assessment mission in April 2008[18]. The food price index had increased by 23% between end 2007 and early 2008, leading to **demonstrations** against the rising cost of living ("la vie chère") in all major towns of the country. Government measures implemented in response included exoneration from VAT for a basic food basket, export restrictions on cereals, price controls for commercial cereal sales, subsidies on some consumer food prices, and subsidized agricultural inputs. The UN recommended the establishment of a social safety net for the most vulnerable rural and urban people.[19] In this context, the Ministry of Social Affairs requested WFP to prepare an intervention that would be targeted to the poorest population of two major towns. With the assistance of the Red Cross and IRD, roughly 140,000 urban households were screened based on criteria set by a joint Government/UN/NGO steering committee. Of those households, 30,000 were selected (about 180,000 people) to receive a cash transfer for 6 months to compensate for loss of purchasing power. In addition, all pregnant and lactating women, and children aged between 6 and 24 months, are to receive a supplementary food ration in the form of a ready-to-use food (for children) and micronutrient-fortified flour (for women). After 6 months the project "EMOP – 10773.0 – Burkina Faso – Emergency response to High Food Prices in Burkina Faso Main Cities" will be evaluated and further activities determined.

2.A.3. External coherence of project activities.

47. In September 2006, the UNCT and government agencies conducted a joint vulnerability assessment in BKF with a view to responding to rising undernutrition and rural food insecurity. It was estimated that 49% of rural families produce insufficient food for their own requirements. The severity of the situation is supported by data on high and rising undernutrition among children <5. It was estimated that 38% of <5s (950 000 children) were undernourished at any one time. The aim of the vulnerability assessment was to analyze the nutrition situation nationally, in part through a comprehensive desk-study and in part through field visits and interaction with partners in the field. The capacity for social mobilization and nutrition and health communication were also assessed.

48. The Conclusion was immediate action was necessary, based on an integrated package of activities targeted to selected high priority regions (developed jointly through a weighted 13 point priority ranking process) . Given the scale and complex nature of the problem, the response effort would require close collaboration among government institutions, UNCT members, NGOs and other civil society partners. The activities would need to target nutritional rehabilitation as well as prevention, taking into account underlying causes as well as immediate threats to health. The strategy would also include poverty reduction measures, including literacy projects. Implementation would be conducted both through line ministries and at community level through NGOs. The regions selected for immediate roll-out were the North, Sahel ,Centre North and Eastern regions. In all 4 regions projects were already underway with FAO, WFP, UNICEF and WHO support. The South-West region was quickly added to the list given its high prevailing levels of undernutrition, thought to be due to very high seasonal labour migration rates abroad, and consequent destabilisation of traditional family fabric. The conclusion was that immediate action was necessary in all 5 regions based on an integrated package of activities targeted to these selected high priority regions.

18 Mission Conjointe Gouvernement/Agences du SNU/ONG Save The Children UK. 2008. Impact De La Hausse Des Prix Sur Les Conditions De Vie Des Menages Et Les Marches De Ouagadougou Et De Bobo-Dioulasso. Rapport de synthèse de fin de mission Ouagadougou, Juillet 2008. Mimeo Réponse du SNU à la flambée des prix. Mimeo: WFP, October 2008.

19 Réponse du SNU à la flambée des prix. Mimeo: WFP, October 2008

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50. In addition to the periodic assessments of the urban food security problem [20] additional activities relating to vulnerability assessment have been strengthened in response to the food price crisis in the form of more regular analysis and sharing of price and purchasing power information. Monitoring the impact of the global prices on domestic markets and purchasing power has been a useful tool for supporting dialogue among partners on these issues[21].

51. The PRRO's objectives were developed collaboratively, with input from government ministries, UN partners and NGOs—building directly on the findings of a multi-agency assessment mission in 2006 [22]. That mission had its origins in regional, as well as national level, discussions on lessons to be learned from the Niger crisis of 2004/05.[23] It was realized at that time that, a) many countries across the Sahel faced similar issues as Niger, particularly with regard to high rates of wasting, b) the problem cut across conventional operational windows (having features of both emergency and development issues), and c) any response would require a consolidated strategy that linked treatment to rehabilitation and prevention. As a result, a set of multisector interventions were quickly implemented in multiple countries of West Africa, each having several common strategic and design features needed to address the scope and scale of undernutrition that had only recently been acknowledged.

52. That WFP, UNICEF and several donor agencies have adopted common (linked) approaches to programming in the northern Sahel and are trying to learn lessons that may apply from one Sahelian country to others, represents a positive step forward compared with past programming decisions that often followed agency-specific, country-specific and sector-specific isolated programming.

20 Mission Conjointe Gouvernement/Agences du SNU/ONG Save The Children UK. 2008. Impact De La Hausse Des Prix Sur Les Conditions De Vie Des Menages Et Les Marches De Ouagadougou Et De Bobo-Dioulasso. Rapport de synthèse de fin de mission Ouagadougou, Juillet 2008. Mimeo

21 CILSS/Fewsnet/FAO/WFP. 2008. West Africa: Markets, Hazards And Food Security October 2008; See also USAID's Price Watch: Urban Food Markets (www.fews.net)

22 Rapport technique de la Mission Conjointe (Gvt/PAM/UNICEF/FAO/OMS) sur l'evaluation et la planification des interventions du Systeme des Nations Unies en matière de lutte contre la malnutrition au Burkina Faso (11 – 22 September 2006) p.18 ff,. p.23ff.

23 For example, the meeting of WFP and UNICEF Regional Bureaux in Dakar during February 2006, led to the development of a multi-agency common approach to resolving child undernutrition in the Sahel.

53. Just as one example, in its funding of humanitarian actions around the world, the European Commission not only makes increasingly specific distinctions among actions supportive of improved nutrition versus food security or food availability [24]) in the context of the Sahel it has also focused squarely on understanding the causes of moderate and severe malnutrition, and innovative approaches to "nutritional recovery", as clear priorities [25]. More specifically, the EC has supported a strategic region-wide approach that would seek to better combine EC resources with those of other donors and recipient governments, while combining relief and prevention activities in realms specific to nutrition[26]. The EC's Sahel Decision on early detection and response to malnutrition (developed in consultation with many services of the commission as well as multiple donors and government counterparts), and its Sahel Global Plan, have been important in focusing donor attention on, a) malnutrition as a 'crisis' in itself, b) the regional nature of this problem (across the Sahel), and c) the importance of embedding actions that link food security, nutrition and health together in broader country Development Programmes.[27] Based on its own 'needs assessment' (framed as an ex ante evaluation in 2007), the EC's approach includes "nutritional feeding programmes and improved access to basic health care for the most vulnerable children and lactating and pregnant mothers [and] assisting the short-tern rehabilitation of household coping mechanisms/livelihoods will help reducing the risk of child malnutrition" [28]. Such objectives, which are intended for BKF as well as for the Sahel as a whole, support the activities undertaken by WFP and others in the context of PRRO 10541.0. Similarly, new wide ranging policy initiatives are emerging in US-funded assistance programmes as a long-term consequence of many years experience in Famine Early Warning Systems (FEWS) on the African continent.

54. Within BKF, the PRRO is well integrated with other medium and longer-term strategies and investments that underpin UNDAF, the PRSP, and other broad policy initiatives of the government.[29] For example, PRSP IV mentions improved nutrition of poor communities in several places, but nutrition outcomes do not feature among the performance indicators in the logframe that sees poverty reduction as the overall goal. It sees stabilization of macro-economic conditions as contributing—having "a direct impact on reduction of malnutrition among children" [30]

24 EC. 2008. Commission Decision on the financing of humanitarian operations from the general budget of the European Communities to provide food aid, short-term food-security support, nutritional support and short-term livelihood support for vulnerable populations in humanitarian crises. ECHO/-FA/BUD/2008/01000. Brussels

25 EC. 2008. Humanitarian Aid Decision 23-02-02. ECHO/-FA/BUD/2008/01000. Brussels.

26 EC. 2007. Commission Decision on the financing of a Global Plan for humanitarian operations from the general budget of the European Communities in the Sahel Region of West Africa. ECHO/-WF/BUD/2007/01000. Brussels.

27 The Decision, adopted in 2007, was unusual for DG ECHO, in that it addresses disaster preparedness and risk reduction in the health domain, but going beyond preparedness for Epidemics. It adopted the principle that it makes sense to address malnutrition at its roots and so prevent children from slipping into severe malnutrition, before it is too late. The Sahel Decision allocated € 15million for implementation in five countries (Burkina Faso, Chad, Mali, Mauritania and Niger), for a period of 20 months (this 'long' funding duration is also a novelty for ECHO). Several Food Aid Decisions, also in the Sahel, are designed to be complementary.

28 EC. 2006 Operational Strategy 2007. Commission Staff Working Document SEC (2006) 1626. Directorate-General for Humanitarian Aid – ECHO. Brussels.; Harnmeijer, J. And W. Meeus. 2007. An Evaluation of DG ECHO-Financed Activities in the Health Sector. Final Report. DG ECHO/Adm/Bud/2007/01209. Leusden, Netherlands. Mimeo

29 A recent report on aid harmonization and effectiveness in Burkina suggests that compared with 2005 donor assistance in 2007 was already significantly more aligned with government priorities (rising from 68% alignment to 92% alignment during that period): OECD. 2008.

30 ADB. 2008. Fourth Poverty Reduction Strategy Support Programme, Burkina Faso. Appraisal Report, May 2008. Mimeo

It can be argued that in fact the main contribution of PRSP-based investments to nutrition are indirect, but they are not, for all that, negligible. Government investments linked to the PRSP's Axis 2: Ensuring access to basic social services and social protection for the poor increased by 17 points between 2005 and 2007, with actions that promote better access to health services and nutrition programs to the poor reported as showing "the best performance" . [31]

55. The increased resource commitment to this domain can be linked, on the one hand, to the government's 2006 support for the Programme National de Développement Sanitaire (PNDS), which seeks: (i) to increase national medical cover; (ii) to improve the quality and use of health services; (iii) to support the fight against transmissible and non-transmissible diseases; (iv) to reduce the transmission of the HIV; (v) to develop human resources in health; (vi) to improve the public's financial access to health services; (vii) to increase health sector financing; and (viii) to strengthen the institutional capacities of the Ministry of Health. Investments in each of these sectors(all of which continued a growth in public spending since the mid-1990s) has been supportive of more functional CSPSs around the country, and hence has contributed positively to the functioning of the PRRO directly, and to nutrition gains as well [32]. On the other hand, more resources are also flowing into the health sector as part of the PRSP and related World Bank and IMF back-stopping. According to the IMF, for example, investments in "poverty-reducing social expenditures" such as health are projected to increase from 56 billion CFAF in 2005 to 88 billion in 2010 [33].

56. The World Bank's objectives and strategies in BKF are based on an agreed Country Assistance Strategy, which supports the pillars of the Poverty Reduction Strategy Paper (PRSP) of 2004 34. The PRSP's strategic objective responds to improved access to basic social services and reduction of child and maternal mortality, to improved nutrition through community-based activities. The revised country assistance strategy for BKF mentions specifically that it will seek to strengthen multi-sectoral interventions to address persistent child malnutrition, as well as increase use and quality of PHC, enhance the coverage and effectiveness of HIV/AIDS prevention and care, and scale up malaria prevention and treatment. Of particular relevance for the PRRO are: i) a focus on strengthening the community-based approaches, and, ii) technical capacity development in 4 of the 7 regions targeted by the PRRO. Indeed, most interventions target the same beneficiary group as does WFP. It is now argued by the World Bank that economic returns to investment in nutrition rank among the highest compared with other developmental interventions including roads, irrigation, water and sanitation35. Many other major donors are also bringing more attention to bear on nutrition problems in the Sahel, including the World Bank, which is considering expanding nutrition programming in BKF along the lines of Senegal. The US has long been concerned with food insecurity and under nutrition in the Sahel, providing Title II food aid for development activities in BKF through US private voluntary organisations, as well as supporting emergency operations, including those of WFP.

31 Government of Burkina Faso. 2007. Progress Reports on the Implementation of the PRSP – Priority Action Programme for year 2006. Ministry Of The Economy And Finance. Ouagadougou. June 2007.

32 Nougtara,A., S. Haddad, J. Ouédraogo, S. Ky-Ouédraogo, V. Ridde, and P. Fournier. 2004. Health Sector Reform under Macroeconomic Adjustment in Burkina Faso: Lost Opportunities? http://www.crdi.ca/fr/ev-118489-201-1-DO_TOPIC.htm

33I International Monetary Fund. 2008. Second Review Under the Three-Year Arrangement Under the Poverty Reduction and Growth Facility, and Requests for Waiver of Non observance of Performance Criterion, and Deletion of Performance Criteria. Prepared by the African Department, June 12, 2008 Ouagadougou

34 Cadre Stratégique de Lutte contre la Pauvreté. Gvt, BKF., 2004.

35 World Bank. 2008. Project Paper on a Proposed Additional Financing Grant in the Amount of SDR 9.2 Million to BKF for the Health Sector Support (May). Mimeo

2.A.4. Project Design

57. Moderate malnutrition contributes more to the nation's disease burden in numbers than severe malnutrition, even if the risk of death is lower, since it affects many more children [36]. As a result, responding to, and preventing, to all forms of malnutrition (mild and moderate as well as severe, as well as micronutrient and macronutrient deficiencies) remains a top priority. It is now recognized internationally that targeting alone severe acute malnutrition in major policy- and programming initiatives has not reduced the "burden of disease" (morbidity and mortality due to malnutrition). Many children become severely malnourished even when prevention programmes are in place, and these children require treatment followed by rehabilitation if they are not to revert to the more severe condition once discharged from therapeutic care. Hence, high quality 'curative' interventions are still needed, but they should be a) treated through national health and nutrition programmes (rather than implemented by non-governmental organisations on an ad hoc basis), and b) should be dove-tailed with rehabilitation and prevention activities so that a complete nutrition "safety net" is set in place.[37]

58. For a PRRO, the logical framework used in programme 10541.0 is unusually elaborate in terms of the range and specificity of outcomes defined. This can in part be put down to the fact that it builds (appropriately) on processes and targets already defined in the on-going CP. PRRO 10541.0 is unique in that it was not preceded by an EMOP. It thus represents new, rather creative, thinking within WFP on how to address problems like malnutrition that have characteristics of both emergency and non-emergency intervention settings. This PRRO not only treats conditions that are symptomatic of high mortality risk during EMOPs (high prevalence rates of child wasting), but also seeks to change underlying conditions (knowledge and behaviour at household level) that are more commonly addressed through CPs. A multisectoral approach is pursued that defines specific roles for each agency in the UNCT as well as for government and civil society partners. A series of goal-specific, but mutually-supportive, interventions is implemented aimed at: i) nutritional treatment and rehabilitation, ii) prevention of undernutrition, (addressing underlying causes of undernutrition linked to health-seeking and behaviour change), iii) development of a supportive health environment (access to clean drinking water, sanitation provision, hygiene promotion, primary health care services, links to education, etc), and iv) enhancing institutional and technical capacity of government to better monitor and respond to nutrition and food security problems when and where they arise. In its overall conceptualization and technical design, the PRRO is fully in line with similar current programme experiences and innovations elsewhere.

59. Given such needs in a country like BKF (which has relatively weak institutional and transportation infrastructures), PRRO 10541.0 has been well designed as a combined health service and community – based delivery system, focused on treatment as well as prevention. The programme's activities are fully supportive of the recent National Policy in Nutrition and its associated protocols for the treatment of severe acute malnutrition, and promote further dialogue on nutrition among stakeholders, which strengthens its chances of success.

36 Pelletier, D. and E. Frongillo. 2002. Changes in Child Survival Are Strongly Associated with Changes in Malnutrition in Developing Countries. Washington, D.C.: Food and Nutrition Technical Assistance Project United Nations System Standing Committee on Nutrition and the United Nations Children's Fund; Gross, R. and P .Webb. 2006. Wasting time for wasted children: severe child undernutrition must be resolved in non-emergency settings . The Lancet , 367 (9517):1209-11

37 World Health Organization, the World Food Programme, the United Nations System Standing Committee on Nutrition and the United Nations Children's Fund; Gross, R. and P . Webb. 2006. Wasting time for wasted children: severe child undernutrition must be resolved in non-emergency settings . Lancet , 367 (9517):1209-11.

60. The result is a PRRO logical framework that is both realistic and ambitious. It is realistic in that it clearly defines the critical problem needing to be addressed (reducing child wasting and mothers' undernutrition), and sets precise targets that relate to both individual recovery and population-wide prevalence rates. It also defines indicators that relate to the preventive aspects of the programme; that is, outputs are defined in terms not only of appropriate products delivered (balanced rations including micronutrient fortified commodities), but also low birth weight (which reflects mothers' nutritional status), and aspects dealing with behaviour change communication, such as awareness-raising sessions (nutrition and health education) and culinary demonstrations (preparation of improved complementary foods at home). One logframe deficiency that might be highlighted is the lack of any objective measures of behaviour change linked to the IEC interventions. Actions linked to national capacity building are defined in terms of the desired outputs of a reporting system established for nutrition and food security surveillance. While timeliness of reporting can certainly be documented, there is some vagueness in the use of a term like "credibility" as an outcome measure of surveillance system reporting.[38]

61. An external evaluation of the previous (2000-2005) CP in 2003 concluded that the WFP's prevailing strategic focus on the most vulnerable zones and groups was coherent with government concerns while also conforming to priority objectives of the Common Country Assessment (CCA). However, that evaluation also noted a lack of coherence between the CP and its basic components in terms of their objectives, target populations and expected results. That is, the CP and its components lacked a logical framework agreed by all parties, and, as a result, it was difficult to determine how far the basic components of the CP would contribute to its success. Any potential synergy between components, which should be the core of any programme, remained slight. The current CP (2006-2010) and PRRO 10541.0 have sought to avoid that problem by preparing elaborate, widely discussed, logical frames for their operations that help all partners clearly identify a) WFP's niche activities within a broader national framework of priorities, and b) the specific actions and intended outcomes of WFP-supported interventions.

2.A.5. Appropriateness of planned activities with respect to needs.

62. In terms of the appropriateness of planned activities, the PRRO's design builds not only from what was formerly done under the CP but takes on board cutting-edge thinking relating to a) the importance of community level interventions in resolving widespread and profound nutrition problems, b) the synergistic potential of combining treatment (particularly involving community management of malnutrition) with prevention, c) the importance of developing an enabling policy environment, not just programming interventions, and d) bringing attention to low birth weight as a 'neglected' issue in nutrition policy and programming that relates not only to maternal welfare but also to the future burden of malnutrition [39]. Each of these is important in the Burkinabe context and well-defined in terms of the PRRO's composite strategy.

38 Since there exists a National Plan of Action for Nutrition, the logframe ought to spell out what government capacities need to be enhanced, at which level (institutional, organizational, individual), and how these capacities would translate into measureable improvements in nutrition and food security.

39 Van der Velden. E and S. van der Kam. 2008. Key factors underlying defaulting in MSF ambulatory therapeutic feeding programmes. MSF Scientific Day Report. 'Research shaping the way we work'. 5th June 2008. http://www.msf.org.uk/scientificday.event; Navarro-Colorado, C. 2007. A ((

63. While each of these elements is sound—they are conceptually coherent and measurable in terms of SMART methodology--the intentions of this PRRO were arguably over-ambitious given the time-frame permitted. That is, the broad goal of not merely slowing rates of undernutrition but reversing trends in a 12-24 month period is more aspirational than concrete, and the targets set (reducing rates of global acute malnutrition and low birth weight to less than 10%) would normally be expected to take several years to attain. Indeed, it could be argued that it is often easier to bring operations up to full speed in a post-emergency setting than in one where no emergency has actually been declared. WFP's roles in promoting nutritional recuperation, behaviour change, and institutional change, are challenging in themselves, but success in this case also relies on the resources and actions of collaborating partners involved in complementary treatment and prevention actions.

2.B Outputs and implementation processes: elements of efficiency[40]

64. PRRO 10541.0 was designed to offer nutritional and other forms of support to a total of 668,500 beneficiaries over two years, of which 426,000 would be children under 3 and 242,500 would be pregnant or lactating women. The specific objectives of the PRRO were twofold:

65. Reduce levels of moderate acute undernutrition among children less then 3 years of age, pregnant women and lactating mothers.

66. Enhance the government's capacity to implement its National Plan of Action for Nutrition, in particular the aspects related to strengthening household food security and setting up a nutrition surveillance system.

2.B.1. Levels of Outputs. Comparison of planned versus actual

67. Five separate indicators were established as measures of outputs to be generated under the first major activity of the PRRO, which was framed in terms of the "timely provision of food to supported nutrition interventions for targeted beneficiaries in appropriate quality and quantity." The output measures allowed for consideration of, i) beneficiaries reached, ii) the number of sensitization sessions and culinary demonstrations actually completed, iii) the percent of food delivered through nutrition interventions that was micronutrient-fortified, iv) the quantities of food delivered (by commodity), and v) how much of the food distributed to implementing partners was finally delivered to beneficiaries.

68. There was a steady increase in food distributed and beneficiaries reached since PRRO inception. The total number of people in the programme has risen from just 76 beneficiaries in April 2007 to almost 100,000 (97,600) in August 2008 (the single month with the highest activity so far since the start of the PRRO).

69. For the period of the PRRO under consideration by this evaluation (June 2007 through August 2008), the total number of individuals who have received at least one monthly ration reached 620 020. That included 248 673 children <3 years of age (compared with a target of 272,000), 114 733 pregnant women (compared with a target of 130,000), and

40 Sources of information used by the evaluation team in determining outputs and outcomes: a) Bi-annual WFP surveys; b) Monthly reporting from IPs (compiled by WFP) on implementation and outcomes; c) PDM reports; d) Interviews with NGO staff, CSPS staff, beneficiary groups, individual beneficiaries; e) Individual surveys and reports generated by IPs; f) Data collected at DS and CSPS level (fed into monthly reports to MoH).

156 514 lactating women (compared with a target of 112,5000). The 'over-achievement' of almost all targets (see table) is explained by the CO and partners through the enormous popularity of the program, in particular the community-based part; in addition private sector partners (OCADES, Red Cross) were able to mobilize from the beginning 'self-help' activities in form of locally donated food and firewood by the beneficiaries themselves and the village committees. (This was particularly important in many localities during the rainy season, when for months the local road net becomes impassable and regular food deliveries cannot be made.). The mission found that defaulters returning to the programme received new registration numbers in some locations. This explains also the relatively high total number of beneficiaries despite overall resource deficit.

70. Additionally roughly 1,000 individuals per month - who are mainly women from the communities served by the PRRO -- support CSPS-based culinary demonstrations and nutrition education sessions. These 'bénévoles' also receive rations (6 kg of cereals plus 1.05kg of pulses, small amounts of salt and oil were also received by the volunteers in some locations). The total WFP food allocated as remuneration/incentive to these volunteers amounted to roughly 1,050 tons during the evaluation period. In every site visited, this ration to volunteers was reported as being a) very well received and appreciated, but b) very little compared with the time and effort put in by these volunteers to support the programme.

Table Levels of Output June 2007 – August 2008

INDICATOR	TARGET	ACHIEVED (Aug. 2008)
Be <3 years	426 000	248 673
Pregnant and women	130 000	114 733
Lactating Mothers	112 500	156 514
Total Beneficiaries	668 500	620 020
Nut. Education & culinary sessions	9 300	30 000
Fortified Food delivered	13 400 MT	5 700 MT
Total Food delivered to clinics and communities	24 210 MT	11 100 MT
Total Food delivered to beneficiaries	11 000 MT	10 705 MT
No. of children in 'wet feeding' (1-2 times/week)	142 000	1.2 million portions
Clinics	500	504

71. WFP food (around 600 tons) was programmed as an input to the cooking sessions, in community-level activities as well as through the clinics. Almost 30,000 individual sessions took place during the evaluation period, with increasing attendance over time. By August 2008, around 20,000 women were attending cooking sessions once or twice a week, compared with 12,000 in June 2007.

72. Undernourished children brought by their mothers to these sessions consume the 'enriched porridge' made on the spot—a product typically based on WFP-provided CSB, vegetable oil, salt and pulses, to which mothers are typically asked to contribute condiments and other inputs in kind or via a small cash donation. From June 2007 to August 2008, more than 1.2 million 'rations' of wet feeding were delivered to children in this context. By August 2008, roughly 23,250 children were benefitting from this form of wet feeding once or twice a week, compared with 13,000 at the start of the programme.

During the evaluation period as a whole, slightly more girls than boys benefitted from the wet-feeding activity: a total of 593,876 boys being registered relative to 676,737 girls. The PRRO target for the number of children to receive the porridge during sensitization sessions was 71,000 per year—thus, the target has been amply exceeded.

2.B.2 Channels of Delivery

73. In tonnage and commodity terms, the PRRO has, on the one hand, suffered difficulties in terms of delayed start-up, weak implementing capacity among some partners, extremely challenging logistics, pipeline breaks at various points in time—and, of course, a serious shortfall (around 50%) in resourcing of the activity. On the other hand, it has done well to deliver what it had in a timely and appropriate fashion.

74. The goal of the programme was to distribute 24,210 MT of food, of which CSB represented an unusually high share (13,400 MT, with cereals accounting for 6,760 MT and the remaining 4,000 MT taking the form of vegetable oil, pulses, sugar and salt, in that order). During the evaluation period just over 11 000 MT of food was distributed—a level that reflects the 50% resource gap. Some commodities were 'protected' slightly more than others. Cereals were distributed at a rate just above the planned target (with 3,520 MT distributed), perhaps reflecting good cereal availability in-country and very large commitment to local purchases. The distribution of pulses (659 MT) and salt (150 MT) were only slightly below target levels, however CSB, vegetable oil and sugar were all distributed at levels lower than planned (in the case of CSB only 5,700 MT were available, in large part due to global shortages).

75. In terms of distribution by activity, the bulk of WFP's food was intended for delivery as supplementary feeding rations in the context of nutritional rehabilitation interventions. Just over 23,000 MT was allocated to this purpose and in fact 10,705 MT were distributed to such activities—again, matching the 50% shortfall. Of the 628 MT designated for use in the culinary demonstrations, roughly 215 MT was the quantity distributed—in this case well below the 50% of target level.

76. As discussed elsewhere, the bulk of implementation/distribution during the evaluation period was undertaken by the health centres. Roughly 66% of the caseload of undernourished children and 80% of the undernourished pregnant women was carried by the CSPSs. Reflecting that fact, roughly 70% of the food delivered during the evaluation period was done so through the CSPS infrastructure. In the Sahel, for example, CSPS sites handled around 1.3 MT of food, while community partners only dealt with 0.6 MT in the same reference period. It should, of course, be highlighted that the number of community-level partners has increased steadily over time (today reaching 20), and that their capacity to deliver food has grown such that the share of food distributed via NGOs during the last months of 2008 was considerably higher than during the evaluation period (which only accounts for conditions through August 2008). For example, in the South-West region more food was distributed through community partners than through the CSPSs. And the plan for October 2008 (outside of the evaluation's frame of reference) anticipated that community partners in the Centre-North region, as well as the South-West, would deliver more food than the CSPSs in their region. That said, the importance of the government's health structures in underpinning the success of this PRRO should not be underestimated. Logistically, the food was delivered through the WFP store in Ouagadougou and the 3 regional warehouses, depending on the best road network and shortest circuits in the target regions. Deliveries to communities were done in monthly intervals through locally hired transport circuits with fixed price/tonnage arrangements.

77. Initially the choice was made to deliver services in priority through all health structures in the target regions, and develop community-based activities in areas beyond walking distance to health centres (areas currently not effectively covered by health services). The very positive response by civil society through the traditional Burkinabé social rural 'association' culture is seen by the mission as key element for long-term inclusion of nutrition as basics issue in rural development. The concept, including also moderate undernutrition as major element of the 'safety net' strategy, requires that the community-based part of the programme is further strengthened. (see comments in paragraph 119 below).

2.B.3. Implementation mechanisms

78. The National Plan for Nutrition is coordinated by the MoH and outlines in its medium term (2015) perspective the following priorities: i) nutrition therapy and rehabilitation, ii) nutrition and chronic diseases, iii) HIV/AIDS and nutritional problems, iv) nutrition and basic education, v) nutrition and community participation, vi) IEC for nutrition, vii) institutional capacity development in nutrition [41]. The PRRO targets all medical institutions in the project areas, which are charged with nutrition treatment, -rehabilitation and –education. While inpatient treatment of complicated cases of severe acute undernutrition is undertaken in 16 CRENs in the project areas and supported by UNICEF within the PRRO frame, all 504 CSPS are rehabilitating severe and moderate malnourished children. The registration of beneficiaries, food demonstrations and IEC activities are an additional burden for the already overcharged staff of the basic health system. In all district- and regional health administrations initial training courses have been organized to facilitate the logistic support of the system. However, the system was unable to employ new staff, so that in all health centres auxiliary staff has been charged with registration, anthropometric measurement, food storage and distribution as well as with reporting. Nutritional statistics are integrated in the monthly health reports and channelled through the regional hierarchy to the MoH/DNA.

79. The MoH has provided a template for the formulation of regional and District health plans, which are elaborated in December 2008 for 2009. Regional WFP staff and NGO leaders are invited to attend these sessions.

80. In logistics and commodity terms, the PRRO has, on the one hand, suffered difficulties in terms of delayed start-up, weak implementing capacity among some partners, extremely challenging logistics, pipeline breaks at various points in time—and, of course, a serious shortfall (around 50%) in resourcing of the activity. On the other hand, it has done well to deliver what it had in a timely and appropriate fashion. Most of the monthly deliveries of PRRO food requirements are made through the 4 sub-offices and the main WFP food store in Ouagadougou to health centres and community projects. The delivery to an increasing number of villages is subcontracted by local transport through a standard WFP tender process, who foresees monthly rounds for the relative small quantities of food delivered to community projects. Health Centre staff and village committee members as well as staff from local NGOs have been trained in basic administrative procedures of storekeeping and reporting. Since a large number of remote villages are inaccessible during the rainy season, some partner organisations (Red Cross, SOS Sahel) have organized village 'self help' transport schemes, by organizing bicycle transport caravans from local storage sites. While the rainy season cut-off is an annual event, no systematic solution was found for 2008 (already the second rainy season) to avoid temporary pipeline breaks.

41 Politique Nationale de Nutrition., 2007., pp 12 – 13;.

The mission was informed by health centre staff and village committees, that local market purchases and voluntary donations were used in some instances to continue culinary demonstrations, when the stores ran dry.

81. It has been often suggested that there are large surpluses in Burkina to be tapped into. While that may be true in some years, the converse has also been argued, namely, that since so many households barely attain minimum required consumption levels in most years that 'surpluses' are mainly consumed (either at home or in local markets), thereby reducing the amounts available for 'export' to other regions or countries [42]. As noted by Ruijs and. al. (2006), "As long as farmers in BKF do not succeed in escaping from their subsistence situation, there is no reason to believe that the inelasticity of cereal supply will change since they will continue supplying only a small part of their harvest."[43] The implication is that while encouraging communications on reliable demand (e.g. through Purchase for Progress) and investing in road infrastructure are both attractive because they imply the freeing up of more 'surplus' cereals for use outside of Burkina's North-West and West, substantial improvements in food trade are only likely if market institutions, including rural financing and storage are reformed.

82. It is estimated that in the agricultural season 2006-7 there was a surplus of 570000 mt of cereals[44] , which is more than 6% than in 2006. Since 2001-2, WFP has purchased 49.000mt of food , with an average of 9.800 mt /year.

83. Production analyses have shown that the cereal production in 2006 – 7 had increased by 18 %, and was above the 5-year-running average, like in the preceding year. Similar estimates were made by CILSS in most countries of the sub-region. While BKF is a net exporter for millet and sorghum, it is estimated that external market demands for grain will fall, due to export restriction. In 2007, average consumer prices were lower than in the same month in the preceding year, although monthly and seasonal fluctuations remained. The price hike 2007 – 8 affected mainly rice, a net import crops, but self sufficiency in sorghum and millet acted somehow as buffer on the supply and demand schedule on local markets [45]). In 2008, WFP estimates to purchase between 11000 and 18000 mt of sorghum, and 21000 MT maize (final figures not yet available), according to availability and price schedules provided by the National Society for Food Security Stocks.

84. Post distribution monitoring (PDM) reports show clearly that the number of clients in the health system increased because of the nutrition- centred activities, even if occasionally no food distribution took place (because of pipeline breaks). The increase in clinic visits had positive effects on vaccination coverage, malaria and other infectious disease treatments as well as pre-and post-natal monitoring. (The mission reviewed monthly statistical reports in a number of Clinics, and regional health staff confirmed the statements by health staffs and the findings of the mission.)

85. Community-based activities started on a small scale, because there were few NGOs working in nutrition per se. As a result, other (non-health) NGO partners who had the capacity and willingness to work with WFP and the government in PRRO activities had

42) Sirpe´, G., 2000. Transport Routier et Ecoulement des Produits Agricoles: une Analyse Economique de l'Influence des Transports sur les Mouvements Interre´gionaux de Cereales au Burkina Faso. PhD thesis. Universite´ de Ouagadougou, Burkina Faso; De Janvry, A., Fafchamps, M. And E. Sadoulet. 1991. Peasant household behaviour with missing markets: some paradoxes explained. Econ. J. 101: 1400–17

43 Ruijs, A., C. Schweigman and C. Lutz. 2004. The impact of transport- and transaction-cost reductions on food markets in developing countries: evidence for tempered expectations for Burkina Faso. Agricultural Economics 31: 219–28

44 Procurement locale WFP,Mimeo p.2

45 WFP evaluation of cereal prices on 41 local markets in BKF, CD data base for PRRO evaluation. 2008.

to be identified and trained (in food and warehouse management as well as in nutrition/health education activities), before they could engage with village level interventions. During the period from June 2007 to August 2008 the number of collaborating NGOs increased from 5 – 19. The rapid increase in community activities meant that by May 2008 the distribution target of supplementary food was reached and exceeded in the following months. Also, more than 90 % of 256,000 beneficiaries were reached during this month. in August 2008 the number of beneficiaries dropped slightly, due to inaccessibility of a number of villages in the rainy season, but still an impressive 84 % were reached. Health education concentrated on culinary demonstrations with fortified WFP rations AND locally available ingredients, and it seems, they became the centrepiece of village-based operations. A total of over 5000 such meetings were held, children and their mothers fed on the spot and the variability of local differences in customs and taboos of weaning practices discussed; A total of 334,000 beneficiaries attended these sessions

86. All health centres (504) in the target regions assess the nutritional status of all attending children between 6 – 35 months, as well as pregnant and lactating women with anthropometric measurements. All selected beneficiaries receive a supplementary ration monthly for 5 months. In all clinics a weekly culinary demonstration is organized, and the attendants are fed a supplementary meal. Due to large distances from health care points and other unknown reasons, about 30 % of beneficiaries abandon the programme temporarily, and are 'restarted' if and when they are coming back, until they have achieved 5 consecutive months in the programme.

87. A similar system is employed in community-based project sites (179), although the assessment for children is based on MUAC and not on weight/height. Women are nutritionally assessed by BMI. Severe acute undernourished patients are referred to the health system, where they are treated in CREN or hospitals if they are severely malnourished and have complications. Both types of activities include an 'essential package' (providing health education, de-worming and treatment for malaria).

88. While the village projects are assisted by 20 local partner associations, 8 NGO groups supervise these projects [46] monthly and report to WFP.

89. All projects are supervised by staff from partner organisations on a monthly basis. A regular post distribution monitoring scheme (PDM) visits a 10 % sample of project points in the health system and interviews health staff and beneficiaries [47]) to i) verify the projected activities (selection criteria, ration size, rehabilitation time, nutrition status assessment methods…), ii) to evaluate constraints and bottle necks in the project routine, iii) assess access of beneficiaries to the food aid, iv) evaluate proper use of rations, and v) evaluate the impact of the supplementary rations.

90. The expected outcome is a better understanding of the purpose of food aid, quantitative output information on implemented activities and results of recommended activity modification during previous PDM visits.

91. In 2008, over 98 % of health centres followed the guidelines for beneficiary selection correctly, over 97 % of all health staff knew ration composition for the different types of beneficiaries, while selection criteria for the wet feeding were less known. The mission estimated that in usual crowded clinic settings, it is very difficult to restrict communal consumption of enriched porridge to <3 children. In this context, and given

46 Map: "Localisation des partenaires communautaires", WFP,CO
47 Post Distribution Monitoring 2: Fevrier 2008., WFP/CO Mimeo

the cultural communal feeding habits in the country, it should be considered to establish the wet feeding practice as blanket coverage for all <5 children. The strict (and unusual) selection process (<3s and women <18.5 BMI) is very difficult to understand for beneficiaries and the public and can have a serious negative impact on desired food habit changes [48]).

92. The second PDM assessment in February 2008 found also, that parts of the 'essential package' (nutrition education, weight/height assessment of <3s, and culinary demonstrations with CSB) had been substantially reduced, particularly in the Sahel region. On the other hand, other activities like de-worming, supply with Vit. A and iron had increased in all regions. The major constraints felt by health staff concern i) insufficient time, ii) difficulty with report formats, iii) insufficient and cumbersome tools (anthropometry) and iv) insufficient training and supervision. The evaluation field mission confirmed these data, particularly with regard to essential skills in assessment, storage and report writing. It is estimated that only 50 % of health staff had substantial pre-service nutrition education.

93. The community-based care model showed similar constraints, although the mission concluded that MUAC assessments were easier understood by the population, and that key issues particularly with regard to breastfeeding and weaning were understood better outside the "medical" setting of a health centre.

94. The mission concluded that in an extended phase of the PRRO, more attention will be needed for i) supervision, ii) discussions of constraints and solutions with partners in the field and iii training and retraining of essential skills for health-care providers.

2.B.4. External Institutional Arrangements.

95. The MoH has provided a template for the formulation of regional and District health plans, which are elaborated in December 2008 for 2009. Regional WFP staff and NGO leaders are invited to attend these sessions. Detailed annual plans provide updates on healthcare infrastructure developments, and also new district-specific initiatives by donors. WFP has made arrangements that effective linkages are made in future through the MoH planning mechanisms. In this respect, the early creation of the DNA in the MOH is a major asset and also control mechanisms.

2.B.5. Internal Institutional arrangements.

96. While the PRRO is the result of the regional Sahel initiative after the 2005 Niger crisis, the CO has created an internal management structure, centred on the complex monitoring data base, which has been established for the project. There is a large VAM component, and the periodic PDM rounds as well as the 6-monthly nutrition survey rounds provide the project management framework. Together with logframe the mission estimates that there is a strong technical capacity in the CO, although the number of specialized staff needs to be reviewed. The enormously detailed and growing task load of M&E cannot be mechanized further due to the many experimental facets of the program. The existing linkages to the regional bureau of WFP and the Nutrition and VAM specialists in WFP headquarters need to be further strengthened to enhance the capacity of the CO.

48 COLLINS S. et. al., 2006, Key issues in the success of community-based management of severe malnutrition., in: Food and Nutrition Bulletin., 27.,3., pp.S49

2.B.6. Cost and Funding of the Operation.

97. PRRO 10541.0 was approved on 28 December 2006 for 2 years with a total budget of 18,337,142 US$., of which food cost was just under 50 % with 9,101,330 US$. By 30th June 2008 10.8 million USD had been mobilized and a shortfall of 26 % was documented. In November, during the evaluation, the project was extended until 31 December 2009 with a total project cost of 28.9 million US$. The shortfall was indicated with 13 million US$. The major donors of the PRRO are Germany, the UN, ECHO, Multilateral and the USA.

2.B.7. Cost Efficiency

98. The monthly cost of a ration per beneficiary has been calculated by the CO as being between US$7.2 in June 2007 and US$ 9.0 in August 2008. Bénévoles (volunteers for registration, measuring and food storage maintenance) have been given a monthly ration as compensation. In some district clinics, some monthly cash remuneration/volunteers between 5000 and 13000 CFA (US$12. 5 and US$32.5) have been made instead of the monthly food ration. From this simple calculation it is clear, that food as incentive for volunteers is more cost efficient that a cash emolument. Very recently, lipid-based supplementary foods have been employed for treatment of acute severe undernutrition with results that indicate faster recovery rates overall. While currently various evaluations in this approach are under study, cost efficiency implications for such programmes need to be explored as a matter of urgency. Likewise, trials are under way, to use lipid-based supplements, enriched with micronutrients, for the systematic treatment of moderate malnutrition. As has been said elsewhere in this report, the high default rates in the PRRO impact negatively on the cost efficiency overall (since cost per rehabilitated beneficiary increase proportionally with the defaulter rate). It is urgently needed therefore to analyze reasons for defaulting and adapt the programme to minimize these rates. After appropriate studies this might require possibly a shift to lipid-based supplements, in view of numerous advantages (no cooking required, less problems with storage and bacterial pollution etc), resulting in improved cost efficiency.

2.C Results: outcomes achieved, unintended effects

99. Three distinct outcomes indicators were defined in the log-frame relating to Outcome 1, which is defined in terms of “reduced levels of acute undernutrition among targeted children and women”. These indicators are 1.1) prevalence of wasting among children <3; 1.2) prevalence of low birth weight in targeted regions; and 1.3) recovery rates of children ‘treated for malnutrition’ (meaning having undergone nutritional rehabilitation through supplementary feeding and other complementary activities).

100. Prevalence rates for wasting in targeted areas was assessed by nutrition surveys undertaken twice each year (during and after the lean season), allowing for comparison of findings with baseline conditions. These surveys are conducted following WFP guidance, in collaboration with multiple partners in the country [49]. Data on a range of topics are collected, including dietary diversity and the nutritional status of mothers, although they were not included in the logframe as specific target group.

49 . 2006. A Manuel: the Design and Implementation of Nutrition and Mortality Surveys. Rome.

101. Outcome 1.1 has as a target bringing the prevalence of moderate wasting (global acute malnutrition) among children aged less than 3 to less than 10%. This conforms to national targets, which are themselves based on international norms[50] Wasting has been increasing in all regions of Africa in recent decades, not only in BKF. Some have argued that high levels of wasting in African countries could relate to HIV/AIDS. This is not the case in most of the Sahel[51]. Prevalence rates of HIV/AIDS in BKF, for example, are relatively low (national rates have fallen from around 7% in the late 1990s to 4.2% in 2002, to <3% in 2008), and according to UNICEF are declining in the main urban areas rather than increasing[52].

102. By contrast, one factor that may in part explain this has been the significant progress made, including in Burkina since 2000, in reducing infant mortality (dropping from 105 per thousand in 2000 to 81 per thousand in 2006) and child mortality (falling from 219 to 151 per thousand over the same period) [53]. This has been possible thanks to increased availability of, and accessibility of, health systems, improvements in access to clean drinking water, and some progress in reducing mortality linked to communicable diseases, particularly malaria and meningitis [54]. However, paradoxically, improved survival rates of children in the absence of dramatic improvements in broader living conditions (via income growth and improved diet quality and food consumption levels) can lead to higher rates of wasting.

103. In this context, reducing what were high and increasing rates of moderate acute malnutrition in the worst-affected regions of BKF represented a significant challenge. The baseline survey in March/April 2007 documented prevalence rates for moderate wasting of 17.7% in children <3 using WHO 2006 reference standards--above the 15% 'crisis' threshold normally defined by WHO and used by WFP to initiate emergency blanket supplementary feeding activities--as well as around 5% for severe acute undernutrition[55]8). Nevertheless, the rates in follow-up surveys were lower, other than in the first follow-up which took place in September/October 2007 when conditions are usually worse. That is, by the time of follow-up No.3, moderate acute malnutrition prevalence was down to 15.5% (against WHO reference), and severe acute wasting was stable at around 5%.[56] Thus, while the 10% target level has not yet been reached it can be argued that a major positive impact has already been achieved at population level in the targeted regions and that a continuation of the PRRO activities could realistically achieve the 10% goal within another 12 to 18 months, assuming all activities are implemented effectively and resources required are forthcoming.

50 For example, the multiagency Integrated Phase Classification activity defines a rate of global acute malnutrition above 10% as reflecting an 'acute food and livelihood crisis'. Getting rates below that level is an important humanitarian goal. (See IPC Global Partners. 2008. Integrated Food Security Phase Classification Technical Manual. Version 1.1. FAO. Rome.) IPC Global Partners. 2008. Integrated Food Security Phase Classification Technical Manual. Version 1.1. FAO. Rome

51 Gross, R. and P. Webb. 2006. Wasting Time: Severe Child Undernutrition Must Be Resolved in Non-Emergency Settings. The Lancet. 367 (4): 1209-11

52 UNICEF. 2007. Faire reculer le VIH au Burkina Faso, au Cameroun, en Gambie et au Niger dans le context de la lutte contre la pauvrete. Division of Policy and Planning. Working Paper. New York, UNICEF

53 ADB/OECD. 2008. African Economic Outlook. Chapter on Burkina Faso. Paris, pp. 167-79.

54 Tshilolo, L., E. Kafando, M. Sawadogo, F. Cotton, F. Vertongen, A. Ferster, and B. Gulbis, 2008. Neonatal screening and clinical care programmes for sickle cell disorders in sub-Saharan Africa: Lessons from pilot studies. Public Health. 122: 933-41

55 WFP survey data

56 If one reverts to the pre-2006 convention of using NCHS (1978) references for anthropometric status then GAM fell from 16.5% at baseline to only 13% in follow-up No.3.

104. The same can be said in relation to output indicator 1.2, focused on rates of low birth weight. It is well known that low birth weight is an important indicator of human wellbeing, in part because neonatal mortality is higher when a baby is born well below 2,500g, in part because the mortality risk of older children is also higher for those who were born with LBW than for those born with a normal weight (>2,500g) [57]. Yet, LBW also represents an indication of the mother's own wellbeing--her health and nutrition status during pregnancy and the effectiveness of ante-natal care.

105. In BKF, it is estimated that 19% of live births in 1999–2005 were LBW [58]. The WFP baseline of the 5 target regions found a rate of 16.2% (in 2007). During the period of PRRO implementation that rate fell to around 12% in follow-ups 1 and 2, down to 11% in August 2008. While not quite reaching the 10% target, this again represents a very important gain with the trend clearly in the right direction.

106. A positive correlation was found, through analysis of follow-up data against the baseline, between undernutrition rates in pregnant women and the prevalence of low birth weight, which supports the view that this indicator offers a view on impacts that affect more than just one demographic group. Indeed, although undernutrition of women was not defined in the logframe gains were documented among mothers. Although the share of pregnant women with MUAC measures <22cm did not vary much during the course of the PRRO, a statistically significant difference was noted in the mean MUAC over time (with the mean of actual MUAC measures improving in each follow-up season over the preceding season).

107. Output 1.3 relates to the recovery rates of children admitted into supplementary feeding activities based on their poor nutritional status. The target rate was set at >70% recovery for children, no target was set for the rehabilitation of mothers.

108. Overall, the rates of child rehabilitation have reasonably good, averaging around 65% for the PRRO period as a whole. It can be noted that while the SPHERE guidelines set a standard of >75% recovery in targeted supplementary feeding interventions (with <15% defaulting), a recent review of the effectiveness of such interventions reported a median recovery rate of 62% for 27 programmes in "chronic situations", which allows for some level of comparison with Burkina's achievements [59]. While this PRRO has not achieved its own target of 70% recovery (among children) let alone the SPHERE standard, its performance under difficult conditions has been reasonably good.

109. The strongest performance was posted by the Centre-North and Eastern regions (70% recovery in both cases) and Sahel region (64%), the lowest overall rates of rehabilitation are posted by the South-West (35% for children). Why the particularly poor performance of the South-West? On the one hand, the region is burdened with some of the highest numbers and prevalence rates for undernourished children, while means that a region of particularly poor infrastructure and weak capacity among local IPs is burdened with a high and complex problem.

57 Kabore P, Potvliege C, Sanou H, Bawhere P, Dramaix M. 2004. Growth velocity and survival of full-term low birth weight infants in an African rural area (Burkina Faso). Arch Pediatr. 11(7):807-14

58 Roberfroid, D., L. Huybregts, H. Lanou, M.-C. Henry, N. Meda, J. Menten, and P. Kolsteren. 2008. Effects of maternal multiple micronutrient supplementation on fetal growth: a double-blind randomized controlled trial in rural Burkina Faso. Am J Clin Nutr 88:1330–40.; Zombre, S., M.-M. Hacen, G. Ouango, S. Sanou, Y. Adamoud, B. Koumar´e, and M. K. Kond´. 2007. The outbreak of meningitis due to Neisseria meningitidis W135 in 2003 in Burkina Faso and the national response: Main lessons learnt. Vaccine 25S: A69–A71

59 Navarro-Collorado-C., F. Mason and J. Shoham. 2008. Measuring the effectiveness of Supplementary Feeding Programmes in emergencies. Humanitarian Practice Network Paper No. 63. London.

It is complex because of the animist traditions of the majority ethnic groups in the South-West, leading to their limited use of health facilities coupled with traditional beliefs that run counter to appropriate feeding of infants and children.

110. On the other hand, a closer look at the evolution of the programme uncovers two salient facts: i) the lack of accessibility of a large share of the target population in the region led to a steep decline in rehabilitation rates recorded by CSPS facilities (from close to 100% in June 2007 to barely around 40% in the soudure (post-rains) period of October 2007 through March 2008. After that time, accessibility and a stronger reinforcement of the PRRO from the CO caused rehabilitation rates to climb again to around 70% where they stayed through the rest of the evaluation period (to September 2008). Similarly, for the first part of the evaluation period there were few NGOs involved (the first started distributing food around October 2007), meaning that the first rehabilitation data (5 months later for children receiving the allotted 5 successive rations) would not appear until early in 2008. Until July 2008, the rehabilitation rates for children through NGO IPs stayed below 50% for reasons of weak technical implementing capacity. However, strong follow-up by WFP CO staff led to the recruitment of several new NGOs in the spring of 2008 having strong health and nutrition competencies. The result was a sharp improvement in rehabilitation rates for children and also pregnant women reaching 90% (ninety) by August 2008.

111. In other words, while it is important to consider rehabilitation rates averaged out over the whole PRRO period, it is equally important to consider trends as well. In all regions, including the 'worst case' of the South-West, there has been a progressive improvement in, a) the capacity of IPs to implement the PRRO, b) the number of partners conducting activities (and often helping each other), and c) the awareness of local populations of the importance of engagement with the programme. The result has been a slow ramping up of rehabilitation rates, with the most recent rates standing very high indeed: data (from monthly IP reports) for August 2008 show 90% rehabilitation of children and pregnant women in NGO activities in the South-West; between 90% and 100% for children and lactating women in NGOs activities in the North; and between 75% and 100% for children in CSPS and NGO interventions, respectively, the Eastern region. These data support the mission's finding that the PRRO's partners have become more technically competent, reached more people, and had much greater impact as the programme has unfolded.

112. It should also be pointed out that there are particularly strong, versus weak, implementation records among CSPSs and NGOs. Among the health facilities, the best rehabilitation records for children were recorded by CSPSs in the East (74%), Centre-North (71%) and Sahel regions (71%), while CSPSs in the North and South-West record much lower rates for children (between 62 and 67%). It should be pointed out, however, that the North (and Centre-North) had to content with significantly higher number of children than, say, the Sahel (two to three times the caseload of children). The same appears to be true among the NGO implementing partners, where the highest success in rehabilitation rates was recorded by those agencies with the lowest caseloads. Those agencies dealing with 3,000 or more children posted recovery rates as low as 40%, while those with only 300 or so cases recorded recovery rates around 99% [60].

113. In terms of rehabilitation of undernourished mothers rates were somewhat higher than for children. Overall, almost 70% of pregnant women and 58% of lactating women receiving nutrition support successfully exited the programme, ranging in terms of CSPS rates (for pregnant women only) from 77% in the Eastern region to 65% in the

60 WFP Monthly report on PRRO 10541.0 for September 2008. Ouagadougou. Mimeo

South-West and Sahel, and for the NGOs from 100% down to 42%. Among the NGOs carrying the highest caseloads of pregnant women, rates were below 60%, while those with the smallest number reached 100% recovery. In other words, in all cases it appears that very high caseloads represent, i) a higher burden on the health facilities in such regions (since there is no additional staffing made available to such facilities to deal with the higher numbers of clients), and ii) in many cases the high incidence of undernutrition is also associated with higher severity of many cases, which in itself adds burdens in terms of diagnosis, referral and follow-up subsequent to any recovery from severe acute malnutrition. Thus, the effectiveness of treatment of some facilities can be compromised by overwhelming demand for services generated by the PRRO.

2.C.1. Effectiveness

114. There are, however, two other important aspects to be considered in assessing the effectiveness of rehabilitation activities. The Navarro-Colorado et. al. (2008) paper reported default rates of 19.1% and 'non-response' (unsuccessful recovery) of 10%. Both of these rates were much higher than that in the Burkina experience. This means that if WFP is to improve its recovery rates then the default rate must be reduced and the treatment itself may need to be improved, if defaulter tracing would show high rates of non-responders; this being in itself the reason for defaulting.

115. In terms of default rates, the total number of people enrolled in the programme is very large and continues to grow, but only around 40% of the total complete the programme—that is, children <3 must complete 5 sequential monthly visits to be weighed/measured and receive 5 monthly rations of food. Some appear only once on the books and disappear, usually due to sickness of the child or mother over extended periods of time, migration to another region/country, or travel linked to social events (marriages, burials, etc.), inaccessibility (literally, an inability to reach a health centre during the rainy season because of flooding or road damage), or cost avoidance. Many others enter the programme for a few months, only to suspend for a month or two, and then return later. In such cases, the individuals retain their original enrolment number (i.e. they are not re-registered as a 'new' beneficiary), but they must start the sequence from scratch. And when sickness or new cost demands come along they may chose yet again not to complete the programme.

116. Where costs are concerned, a report from the early 2000s reported that the cost of medication represents 80% or more of the cost of each illness episode for people who attend health clinics during an illness; 70% of households surveyed at that time reported "having difficulty meeting such health expenses during illness." [61] However, the price of transportation and opportunity costs of time also play a role, particularly in communities located up to 20km from a health centre.[62] (see also 45).

117. The high default rate has serious implications for the cost of the programme (since many more rations and services are delivered than 'complete treatments') and to the recovery of individuals (since a large share of the target population is non-compliant with the rehabilitation protocols. Ways need to be found to gain a deeper understanding of causes of defaulting (including the possibility that some mothers withdraw as soon as

61 Nougtara,A., S. Haddad, J. Ouédraogo, S. Ky-Ouédraogo, V. Ridde, and P. Fournier. 2004. Health Sector Reform under Macroeconomic Adjustment in Burkina Faso: Lost Opportunities? http://www.crdi.ca/fr/ev-118489-201-1-DO_TOPIC.html

62 UNICEF talks of the economic "ravine" that separates the wealthiest 20% of households in Burkina Faso from the poor 80%: "dans les groupes les plus riches, l'utilization des services de santé est plus elevée el la malnutrition plus basse." UNICEF 2007. Faire reculer le VIH au Burkina Faso, au Cameroun, en Gambie et au Niger dans le context de la lutte contre la pauvrete. Division of Policy and Planning. Working Paper. New York.

they seen gains in their child's status), and establish systems that allow for improved follow-up on such cases where they remain in their home community (i.e. the cause is not migration). This would require more human and financial resources at community level to support not just case-finding but case-follow up. It may also be necessary to redefine the treatment protocol to allow for exit from the supplementary feeding activity as soon as an individual has attained the required minimum anthropometric cut-off, not waiting until the end of a 5 month (for children) or 3 month (for women) sequence.

118. In terms of improving the effectiveness of the treatment itself, and reducing rates of 'non-response' (i.e. unsuccessful rehabilitation), both the essential package and the food components bear further scrutiny. On the one hand, the mission found considerable evidence to support a need for further location-specific problem analyses at region and even district levels that would support a tailoring of the essential package to problems that are not found everywhere. That is, some regions still require greater attention to clean water provision, but not all. Some have had limited availability of bed-nets despite a serious local problem of malaria. In others, the importance of local faith healers among animists should not be ignored (i.e. efforts need to be made to engage traditional healers into the programme as potential referral agents rather than dismiss them as part of the problem). It is also important, in assessing location-specific causes to malnutrition, to assess what Hampshire et. al. (2008) note as critical hurdles to appropriate caring and feeding practices in the region, including "risk aversion, the need to maintain self-identity and status, and constrained decision making."[63]).In conclusion: while treatment protocols for undernutrition are available, appropriately detailed local analysis of underlying causes needs to be included in problem analysis in an adapted fashion.

119. On the other hand, the food products themselves deserve some consideration, particularly since this is a PRRO with nutritional rehabilitation (resolution of malnutrition) defined as its primary outcome. This carries some controversy, in part because while the physiological and metabolic processes associated with severe acute malnutrition are well described, and the progress of children under going treatment (and potential complications) are well known, the same is not true of moderate acute malnutrition. Much less attention has been focused on this domain until very recently (the last 5 years), so the normative guidance remains in its infancy.

120. At the same time, there is increasing agreement that since moderate malnutrition is part of a continuum leading from severe acute conditions towards normality it is crucial that the consumption of a specific high quality diet or foods should continue until the condition has not just improved but been resolved. The corollary of this is that while fortified blended foods such as CSB have been provided for a wide range of purposes over the past 30 years or more, it is increasingly recognized that CSB "is not a good product for very young or moderately malnourished children." [64]. While CSB is not a 'bad' product, particularly in terms of cost-effective delivery of key nutrients in a form that is widely acceptable, it may not be the ideal commodity to achieve rapid resolution of malnutrition. This is because, a) it does not contain all required nutrients at levels that can make an impact on already undernourished children, b) CSB contains a

63 Hampshire K, Casiday R, Kilpatrick K, and C. Panter-Brick. 2008 May 29. The social context of childcare practices and child malnutrition in Niger's recent food crisis. Disasters. 33 (1): 132-51.

64 de Pee, S. and M. Bloem. 2008. Current and potential role of specially formulated foods and food supplements for preventing and treating malnutrition among young (6-23 mo) and moderately malnourished children. Paper prepared for Moderate Malnutrition meeting, 30 Sept – 3 Oct, GenevaWFP. 2008. Ready-to-Use Foods (RUFs) and WFP's Approach to Treating and Preventing Malnutrition. Ten Minutes to Learn About… 1 (5); WFP. 2008. Improving Corn Soy Blend and other fortified blended foods, Why and How. Ten Minutes to Learn About… 1 (4).

relatively large amount of anti-nutrients, particularly when it derives from non de-hulled and non de-germed soy beans and maize kernels or wheat grains; c) it does not provide sufficient energy per serving, d) its essential fatty acid content is low, and e) there is no animal source content (milk powder) in the product which increasingly appears to be critical to the growth of young children.

121. WFP has been reviewing nutrient specifications for past 5 years and now moving towards piloting new and/or adapted products that are a) modified to meet current scientific norms for requirements of different demographic groups, b) better tailored to the intended nutritional goal (treatment, recuperation or prevention), and c) cost-effective [65]56). Thus, the potential exists in the context of this PRRO's extension to consider testing some alternative products, be they enriched CSBs or RUSFs, including those to be used in the 2009 urban EMOP, to assess acceptability, rapidity of resultant weight gain, duration of required treatment, etc.[66])

122. Outcome Indicator 2.1 is defined as "credibility and timeliness of reports from the nutritional surveillance system". A National Nutrition Surveillance System (NNSS) is programmed by the Gvt to start only in 2009. For this reason, any nutritional status measurements of populations from the regions covered by the PRRO cannot be measured against national norms, originating from random sample survey rounds .

123. Most nutritional data collected in BKF originate from 'passive' surveillance i.e. measurements taken on a population attending health services of some kind or another. One exception are MUAC measurements taken during the annual agricultural production surveys, which target 3 population strata (pastoralists, staple crop producers and cash crop producers) together with data collection on food consumption. Other exemptions are nutrition surveys were conducted in various regions at various seasons of the year and cannot provide a 'national baseline'. However, the various efforts to establish some measure of nutritional status in various vulnerable groups at various times of the year in various regions, allows to establish some notion of trends in malnutrition, which has been used to prioritize interventions areas (such as the PRRO) and justification for nutritional components in rural development programmes such as SASDE, the advanced strategy for child survival, in which UNICEF is active in the East and Centre east regions. UNICEF and WHO provide institutional support for nutritional surveillance to the MoH. On regional and local level, health staff trained in nutrition status assessment skills is a very important element of capacity development for a future NNSS. WHO provides technical support to MoH, in particular through the use of the 2005 Nutrition manual, which contains techniques for nutritional surveillance.

124. The National Nutrition Policy which had been finalized in 2006 highlights 3 activities in relation to nutritional surveillance: i) improving nutrition activities in health facilities, ii) enhancing community-level nutrition activities and iii) reinforcing inter- and intra-sectoral nutrition coordination and collaboration.

125. The current and periodic nutritional assessments have given rise to required programme changes and are therefore regarded by the mission as links in an ongoing effort for the establishment of a more periodic surveillance scheme; the lack of periodic national data collections has not impeded on policy advancement. As argued earlier (

65 (56) WFP. 2008. Improving the Nutrition Quality of WFP's Food Basket—An overview of nutrition issues, commodity options and programming choices. Ten Minutes to Learn About

66WFP. 2008. Ready-to-Use Foods (RUFs) and WFP's Approach to Treating and Preventing Malnutrition. Ten Minutes to Learn About… 1 (5); WFP. 2008. Improving Corn Soy Blend and other fortified blended foods, Why and How. Ten Minutes to Learn About… 1 (4).

paragraph 27) many partners in BKF would favour currently to "add on" the current assessment rounds instead of building a totally new surveillance system from scratch, which would absorb an extraordinary amount of nutrition skills available in BKF, a capacity much needed in the field of prevention and rehabilitation

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2.C.2. Impact/Connectedness

126. Beyond the outcomes defined in the logframe, it is important to recognize the high value of the behaviour change communication components of this PRRO. It would have been good to incorporate into the logframe some measures of information retention and perhaps also behaviours changed.[67] The importance of this aspect of the PRRO's work is underlined by the fact that even basic health and nutrition knowledge among beneficiary groups simply cannot be assumed. The 2003 DHS survey noted that 20% of Burkina's children aged 6 to 11 are illiterate and more than 60% of those aged 10 to 11 report having had no formal schooling at all [68]. In other words, while literacy and schooling (not the same thing) are at critically low levels in BKF, gross enrolment in primary schools in Burkina has only increased by around 1% per annum since 2000[69]. This makes the work of communicating even simple facts about health and nutrition quite a challenge, but makes the effort through awareness raising sessions and culinary demonstrations all the more important.

127. The sensitization activities involve regular sessions of what can broadly be termed 'nutrition and health education', with mothers of malnourished children comprising the main target audience, but additional women in targeted communities are also regularly involved, as are some adult men (albeit a small and irregular number). The degree to which these sessions comprise 'lectures', interactive auto-problem solving, or Q&A varies by implementing organisation (the NGO IPs have a tendency to engage in more participatory, inter-active sessions while the clinic-based sessions appear to have more of a 'lecture' format. The content of these sensitization sessions appears to be fairly standardized around core messages focused on health and hygiene, food groups and food hygiene, preparation of appropriate complementary foods, etc.

128. The outcome of such sessions, in terms of information successfully communicated (i.e. understood and retained) or leading to behaviour change (acted upon with measurably results), cannot at this point be assessed. However, the mission did gain a sense that, a) the quality of communication approaches varies considerably among IPs and requires more attention to standardization of delivery, and not just standardization of content; b) most messages are widely understood and remembered, at least in the short term (based on questions posed to groups and individual women during the mission); and c) the perceived value of such activities as reported by beneficiaries is extremely high.

129. Discussions with individual women and with focus groups suggested that there is a strong demand for informal education that can help women (particularly young mothers) become more empowered. Weaning practises, breastfeeding practises, health care practises all need improvement in Burkina, and longer-term behaviour change in

67 Although diet diversity was included in the follow-up surveys as a marker of enhanced knowledge of the importance of diet quality, this is not sufficient to gain understanding of how health and nutrition knowledge is being understood and applied by knowledge recipients.

68 Parent. D. 2006. Youth Labour Market in Burkina Faso: Recent Trends. Social Protection Working Paper No. 0607. Washington, D.C. World Bank

69 UNICEF 2007. Faire reculer le VIH au Burkina Faso, au Cameroun, en Gambie et au Niger dans le context de la lutte contre la pauvrete. Division of Policy and Planning. Working Paper. New York

such domains is at the core of the 'preventive' goal of the PRRO [70](Indeed, the potential for multipliers in terms of improved health and reduced health care costs to the country are large. The mission was repeatedly told by health ministry staff at all levels that the PRRO had significantly increased the numbers of rural people coming to use health services.

130. For example, in the DS of Sebba (Sahel Region) the 'taux de consultation' (share of overall visits to health centres) for "malnutrition", where this was recorded at the principle reason for the consultation, ranked in the top ten for each year from 2005 through 2007. The numbers of children 0-4 years old consulting for reason of malnutrition jumped from around 180 in 2005 and 2006 to 319 in 2007—arguably because of enhanced health seeking behaviour rather than because of an increase in rates of malnutrition in that region[71] (63). Similarly, data provided by the MoH's liaison with WFP on the PRRO (i.e. the Chef of project from the government's side), show that the rate of use of health facilities increased in all PRRO regions since the start of the programme—for example, rising in the Eastern region from 29% use (taux de fréquentation) in 2005 to 38% in 2007, and in the North region from 25% to 36% in the same period[72].

131. These kinds of positive impacts are confirmed through WFP's post distribution monitoring (PDM), which shows that the number of clients in the health system increased, even if occasionally no food distribution took place due to pipeline breaks. The increase in clinic visits (by 100% across all regions, according to PDM reporting) had positive effects on vaccination coverage, malaria and other infectious disease treatments as well as pre-and post-natal monitoring. This is especially important for public health as re-emerging diseases come to play a growing role in Burkina (e.g. certain forms of meningitis, TB and yellow fever), as many other contagious diseases remain to be successfully contained on a population-wide level [73]. Cross-checks with health statistics from regions not assisted by the PRRO, show clearly, that the effect is related to the food-aid programme.

132. For example, increased vaccination coverage was reported universally by CSPS staff. It was widely stated that since more women came for antenatal and postnatal care the coverage rates of BCG and DTC3 had risen, and not only among women involved in the PRRO; that is, it was reported that word of mouth was helping spread demand for

70 Traore´, T., M.-C. Vieu, T. Alfred, and S. Tre`che. 2005. Effects of the duration of the habituation period on energy intakes from low and high energy density gruels by Burkinabe` infants living in free conditions. Appetite 45: 279–86; Tre`che, S. (2002). Complementary foods in developing countries: Importance, required characteristics, constraints and potential strategies for improvement. In P. Kolsteren, & T. Hoere´e (Eds.),
Avallone S, Brault S, Mouquet C, Treche S. 2007. Home-processing of the dishes constituting the main sources of micronutrients in the diet of preschool children in rural Burkina Faso. Int J Food Sci Nutr. 58 (2):108-15; Lestienne, I., M. Buisson, V. Lullien-Pellerin, C. Picq, and S. Treche. 2007. Losses of nutrients and anti-nutritional factors during abrasive decortication of two pearl millet cultivars (Pennisetum glaucum). Food Chemistry 100: 1316–23; Tou, E., C. Mouquet-Rivier, I. Rochette, A. Traore´, S. Treche, and J. Guyot. 2007. Effect of different process combinations on the fermentation kinetics, microflora and energy density of ben-saalga, a fermented gruel from Burkina Faso. Food Chemistry 100:935–43.
Direction de la Nutrition. 2006. Analyse complementaire de la situation nutritionelle au Burkina Faso. Ministere de la Sante. Ouagadougou. Mimeo.

71 Based on documention shared by the Direction Regionale de la Sante du Sahel. DS de Sebba. 2008. Les 10 Principales Maladies Dominantes Dans le District. DS de Sebba. 2008. Les 10 Principales Maladies Dominantes Dans le District

72 Dabire, A. 2008. Transmission of data from the Ministry of Health relating to health outcomes in the regions served by PRRO 10541.0. Document No. 226/MS/SG/DGS/BKF 6129. Dated November 4, 2008

73 Teyssou, R. and E. Muros-Le Rouzic. 2007. Meningitis epidemics in Africa: A brief overview. Vaccine 25S: A3–7.; Koumare, B., R. Ouedraogo-Traore, I. Sanou, A. Yada, I. Sow, P.-S. Lusamba, E. Traore, M. Dabal, M. Santamaria, M.-M. Hacen, A. Kabore, and D. Caugant.. 2007. The first large epidemic of meningococcal disease caused by serogroup W135, Burkina Faso, 2002. Vaccine 25S ;A37–41

vaccination from those in the PRRO to those who were not. Measles vaccination also increased significantly in some regions—from 80% coverage in the North in 2005 to 100%, and from 89% in East to 100% in the same period [74]. This increased acceptance (and demand for) vaccination was also reported (by mobile clinicians met at several locations in the field) to have improved coverage of the 2008 national yellow fever vaccination campaign since rural populations in the PRRO zone were now more sensitized a) to the importance of vaccinations of all kinds, and b) comfortable with attending CSPS sites (which is where the mobile teams set up for the yellow fever sessions).

133. At the same time, the increased use of health services has had important household-level and individual level impacts through greater demand for curative services. The Eastern region, for example, saw a rise in curative consultations of 70% by August 2007 (PDM1), over pre-PRRO levels, and of 90% by Feb 2008 (PDM2). Similarly, attendance of post-natal consultations in the North region rose by 93% and 100% in the same period. There is also evidence from all regions that pre-natal consultations rose by 50 to 100%. These are significant changes that have positive multipliers for the health system in terms of a likely reduction, in coming years, in the burden of diseases and hence in costs to the health system (let alone in terms of reduced burden and costs to families).

134. It can also be reported that more visits to health facilities and more awareness of the importance of family planning gained through sensitization sessions at community level, may have contributed to an increased in levels of contraceptive use, assisted births (at the CSPS), and vaccination coverage rates in the 5 target regions increased markedly after the start of the PRRO. For example, after being stable at low levels for many years, contraceptive use (through CSPS facilities) doubled in the Sahel region from 9% in 2005 to 18% in 2007, while also doubling in the South-West region from 14% to 28% in the same period. The other 3 regions reported smaller gains, but all 3 did see sharp rises in demand for contraception compared with 2005 and earlier [75]. Assisted deliveries in 2005 were in the 25% to 35% range across the regions, rising in most regions to a 45% to 55% level by 2007 (the exception being the Sahel which traditionally has lower levels of assisted deliveries, but still rose from 14% to 26%).

135. In recognition of the infrastructural and capacity constraints within the public health system, the MoH recently adopted an approach of contracting out to the implementation of community-based health and nutrition interventions. This new approach has the potential to rapidly scale up nutrition activities at community level, provided adequate funding is available. The World Bank, in recognition that the donor community in BKF for nutrition is too small, has decided to support community-based health and nutrition in 3 of the regions (Sahel, North and South West) where the PRRO is located. The programme is planned for 4 years and will support at least 10 % of <5s .

74 Dabire, A. 2008. Transmission of data from the Ministry of Health relating to health outcomes in the regions served by PRRO 10541.0. Document No. 226/MS/SG/DGS/BKF 6129. Dated November 4, 2008

75 Dabire, A. 2008. Transmission of data from the Ministry of Health relating to health outcomes in the regions served by PRRO 10541.0. Document No. 226/MS/SG/DGS/BKF 6129. Dated November 4, 2008

2.C.3. Sustainability and Exit Strategy

136. The new focus on nutrition as essential element for development has resulted in new approaches to scale up efforts reduce under nutrition.(see above). Since the activities of the PRRO are also consistent with the regional WFP/UNICEF strategy for fighting high levels of acute undernutrition in the northern Sahel countries, the mission concluded that sustainability is not a priority concern, provided that WFP funding continues in the current economic crisis. Partnership with 3 large NGOs and a national organisation, which by definition is auxiliary to the MoH (Burkinabé Red Cross) creates further synergies in 'localising' the community element of the PRRO. The ownership created through focus on village-level monitoring of health- and nutrition status of children, points clearly in this direction.

137. Phasing-out decision making is obviously linked closely to the results of the rolling nutrition status surveys in the target regions. However, the mission concluded, that the timing for an exit strategy must be determined by the reduction of prevalence of wasting among young children in the community below the critical threshold established by WHO. Only then, decisions on the sustainability on the 'reversing of trends in undernutrition' are justified.

138. Improvements themselves can only be sustained with continued investments in a) dépistage, b) capacity to implement rehabilitation and treatment, and c) greater investment in prevention activities, sustained with other activities supportive of improved health, food security and income generation.

139. Capacity to do all of these things has been greatly enhanced as a direct result of the PRRO, in combination with government efforts to mainstream nutrition in national policy and programming. The focus on nutrition at national and community levels is today significantly higher than it was 2 years ago.

2D. Cross Cutting Issues

140. There has been a rapid growth in the number of partner organisations on field level, in particular local associations, who enlarged substantially the number of needy communities to be included in the PRRO, outside the current coverage by the CSPS system. The initiation of the collaboration with the project had many faces: in some cases, like in the Red Cross, the ubiquitous network of village-based volunteers allows this organisation a rapid overview and micro-analysis of an emerging special vulnerability anywhere in the country due to natural hazards through a finely meshed information network. The mission found that there is a much larger scope to exploit such comparative advantages of an inbuilt organisational culture, and to bring to fruit local ownership of the program. This is not to say, that for example the Red Cross could or would 'impose' it's basic principles and modes of action, but the realm of the negotiation and compromise-finding activities remain to be codified and to be integrated into day-to-day management of the PRRO.

Similarly, the comparative advantage and success of targeting elderly women in the rural society as change-agents with regard to eating and feeding habits of younger women by an organisation like HKI [76] merits further exploration in the context of IEC strategy for the PRRO in a second phase.

141. On the other hand, local development association are well codified by customary law in BKF and follow strictly established policy principles of rural development. The mission was unable to determine during the brief stays in villages, whether such groupings with varying objectives (from small-credit unions for women to promoting first-aid training) represent non-ambiguously the interests of all households. What was impressive is the fact, that everywhere strict meeting rules prevailed; seemingly giving all members speaking opportunities and distributing practical tasks, although still less women than men presided the mission's meetings with focal discussion groups.

142. Currently it is not fully clear, how community level activities of social dimension are constitutionally represented in District and Regional Committees, since these groups are overwhelmingly composed of Gvt appointed officials, posted in the Regions as a career step.

143. Since the activities of the PRRO touch increasingly on an ever-growing range of concerns for children and women simply by being firmly anchored in the most peripheral zones in five regions, the mission considers it necessary to formulate and negotiate formally the project's representation on district and regional level to establish firm ownership. This question touches also on questions like capacity and capability of WFP's sub-office staff, who will need nutrition- and nutrition rehabilitation skills, in order to represent WFP in regional- and district planning meetings. More general, if community-based nutrition projects are further enlarged by the MoH, the question arises, whether the WFP management will not need some capacity in medical nutrition, to be able to engage fully in a health/nutrition dialogue with the MoH staff.

144. The mission found a number of district- and local research poles (Gagna, Sahel), which in collaboration with the University of Ouagadougou have explored questions of integrated development with regard to food insecurity in a systematic way. The mission concluded that the CO should explore in a systematic way opportunities to include questions of evaluation and monitoring of the PRRO in applied research projects [77].

3. Conclusions and Recommendations

3A. Overall Assessment

145. PRRO 10541.0 is relevant to the priority concerns of the country, as well as to the urgent needs of its targeted beneficiaries. It responds to government concerns with worrying trends in child wasting and an apparent deterioration in the nutritional status of mothers. The PRRO represents an ambitious activity in its scale and design, incorporating treatment with prevention, and the delivery of products and services as well as information and empowerment. The PRRO is appropriately designed in that it supports national policy priorities, but also in that it serves as a bridge between emergency responses to malnutrition (treatment) and longer-term development goals of preventing nutritional deterioration in the next generation of children, while also

76 Démarche de Mise en Oeuvre de l'Approche "Partenariat avec les Grand-Merès dans la Promotion des Savoirs Locaux et modernes en Matière de la Santé/Nutrition et Bien-être des Enfants et des Femmes, D. Ouoba, HKI, mimeo.

77 Cadre Stratégique de Lutte contre la Pauvreté., Ministère de l'Economie et du Dévelopment, 2004, pp 86 – 87

building capacity at national level for monitoring the situation and responding to future problems as they arise. The combined use of health facilities and a community-level approach is entirely consistent with government aims and it has achieved reasonable coverage and commendable results in a very short period of time.

146. The linking of food inputs with key non-food products and services (the elements of an 'essential package') reflects current professional consensus on best practice for this kind of intervention. The food aid used is appropriate in that a) an unusually high share of commodities distributed are purchased within the country (and there are very few reports of problems with such food in terms of quality, type, ration composition or availability), and b) the lion's share of commodities used is accounted for by CSB and other micronutrient-fortified commodities which are targeted to the nutritionally vulnerable. While the potential for using alternatives or complements to CSB should be explored in the PRRO extension (particularly RUSFs or enriched CSB that would arguably be more appropriate for the treatment dimension of moderate malnutrition), the achievement of positive results so far suggests that nutrition gains have been possible with the current ration formulation.

147. Among the principal challenges facing this PRRO throughout its implementation have been hindrances linked to a) resource inadequacy, b) weaknesses in implementing capacity, and c) logistical hurdles impairing timeliness of delivery. Resourcing has been relatively poor throughout the PRRO, despite its visibility in the local (in-country) donor community as well as internationally (due to two cost and beneficiary extensions). The level of 50% resourcing may not be out of the ordinary for many PRROs, but for one unusually focused on nutrition outcomes this is a very serious problem that has only partly been overcome through the sharing of logistics with the Country Programme, slower than expected start-up, and falling prices for domestic purchases during 2008. Partners (government and civil society) have also faced resourcing constraints in the context of delivering non-food inputs to meet the needs of the essential package. The actual extent to which such resourcing failures impacted on desired outcomes can only be guessed—but a negative impact can be assumed. In other words, the net results achieved could have been greater still. Most of the problems identified by the mission can be traced not to design flaws, but to constraints (funding, capacity and other) to a full and effective implementation of that design.

148. Weak implementing capacity has been one of the constraints to effective roll-out of the PRRO during its first months. Identifying appropriate NGO implementing partners, training them, and securing the first deliveries took considerably more time than expected due to the weak civil society base in most remote rural regions of Burkina Faso. The civil society partners that have been found have proved their worth very quickly, achieved considerable improvement in programming as the PRRO progressed, and some have the potential to increase their case-load and geographic coverage in the PRRO's extension phase. Nevertheless, the PRRO faces a lack of technical and implementing expertise across the board (including within regional and local government) as it seeks to both enhance current effectiveness and expand its reach. Weak capacity in nutrition does not only affect the PRRO, of course, since it represents a constraint to the country's own Health Development Plan. To be successful, the latter needs a critical mass of expertise in community-based health and nutrition and project management at regional and district levels to mobilize implementing organisations, facilitate and guide the development of local plans and subprojects, and ensure close monitoring and follow-up of implementation.

149. The logistical hurdles relating to rainy season inaccessibility of large numbers of beneficiaries were far greater than anticipated. Whole districts can be cut off from normal transportation arteries during the rains simply because unpaved tracks become impassable (or indeed disappear altogether). WFP responded by attempting as far as possible to pre-position stocks of food (based on estimates of need) in locations that would not be reached for several months at a time, as well as promoting blanket feeding of nutritionally vulnerable demographic groups in participating communities. Nevertheless, there were many unforeseen costs relating to transportation of rations across bodies of water by canoe and barge, 'extra incentives' needing to be paid to private transporters to reach beneficiary villages and not just extended delivery points—some of these costs had to be borne by WFP, others by implementing partners, and others still by beneficiary groups themselves. Overall, despite such problems, leading to some pipeline breaks for some activities in some locations, WFP made commendable efforts to predict such problems and seek solutions that would reduce the impact on beneficiaries.

150. Coordination has been good at all levels. WFP has collaborated well with government health services in this process, as well as with its 20 or so NGO implementing partners. The activities of the PRRO are increasingly well synchronized with national health protocols, and they support ongoing reform of nutrition policy reform of the government. WFP responded quickly and appropriately to what was recognized as a growing nutrition emergency in Burkina Faso. In addition, the PRRO might have provided some assistance for seriously food insecure households during the food price rises of 2007 and early 2008, which not only affected urban areas, but all those, who during harvest times are forced to sell cereals, only buy them back in the lean season. This period was, according to all reports, particularly tough between 2007-8, when the food price crisis hit.

151. The impact of the PRRO has been measurably positive—particularly in terms of short-term outcomes. While the two year life of the current activity is too short to definitively confirm a "reversal" in nutrition trends, multiple sources of data suggest that positive outcomes have been achieved and that an extension of time (to further extend coverage and consolidate current interventions) is warranted. While final targets have not been attained, there is sufficient evidence from a triangulation of data sources to suggest that a) considerable progress has been made overall in the face or many serious logistical, implementation and environmental hurdles, b) targets have been achieved in some locations by some implementing partners, confirming feasibility but also suggesting a need to undertake constraints analysis of those locations and partners still dragging down the average.

152. The PRRO has achieved, or nearly achieved, most of the goals relating to 'treatment' (that is, rehabilitation) of moderately malnourished children and mothers (both in terms of outputs as well as many of the outcomes). It managed this through effective dovetailing with the referral and treatment of severe acute malnutrition as well as links to activities promoting behaviour change. For example, the PRRO has encouraged a marked increase in health-seeking behaviour among beneficiaries in all regions, but particularly in those geographical areas with poor road infrastructure, limited vehicular transport opportunities, and hence long walking distances to health service points. Health system personnel at all levels (from staff at CSPS posts to regional medical directors) report a surge in numbers of clients for preventive, as well as diagnostic/curative, services.

This in itself has had a positive impact on the coverage of childhood vaccinations, regular pre- and post-natal consultations, as well as early treatment of malaria, diarrhoeal disease and respiratory infections. There is also some evidence (from monthly health system reports and verbal interviews with clinic staff) of lower numbers of low birth-weight.

153. Similarly, the PRRO has offered strong and sustained support to IEC activities framed around demonstrations of how to prepare enhanced complementary foods for small children. Demand for information on health, nutrition, and family planning has grown, and this offers a platform for more sustained (post-PRRO) changes in family practices that can lead to improved nutritional outcomes in the longer term. However, success in the longer-term, including sustainability of results so far generated, will depend on improved delivery of all components of the essential package, a reduced default rate/higher rehabilitation rate, and a clear strategy for transitioning PRRO activities into some other form of medium-term development plan. The activities and partnerships put in place under the PRRO should be sustained beyond its funding horizon as part of a wider series of actions that track and respond to nutrition problems, and promote nutrition awareness and wellbeing, across the entire country.

154. Thus, the overall conclusion of this mission is that PRRO 10541.0 is relevant, appropriate and innovative, and that it has succeeded reasonably well in reaching defined objectives despite many constraints. Its collaborative design and implementation have generated considerable goodwill in the donor and development community—a common desire to make it work. The novel approach (for Burkina) of linking government services with a community approach in delivering services, inputs and information needed to achieve success offers a new platform for future forms of collaboration. What is more, the mission concludes (in a preliminary fashion) that it is making effective and efficient strides towards the goals defined. There is evidence of positive progress toward targets set in the log-frame. That said, the PRRO suffers from a short time-horizon (compared with the scale of problems needing to be addressed), and a serious shortfall in funding to make things work. The mission recommends that all efforts are being made to extend the time-frame of the project and to increase the funding level of the operation.

3B Key issues for the future

155. The greatest challenge faced by WFP and its partners in pursuing an operation of this nature resides in securing the resources that are appropriate to achieving defined goals. A large-scale nutrition intervention that combines treatment of acute malnutrition with prevention requires, a) the right kinds of foods to be delivered (meaning higher cost than usual), b) a close linkage with complementary non-food inputs (meaning cash resources from donors, not simply food commodities), c) appropriate human capacity to ensure quality programming, including careful application of enrolment and discharge criteria, high level community mobilization (information, education and communication of nutrition and health messages), and competent health care provision. The available funding level of 50% is insufficient for consolidating/improving current programming, let alone expansion into new regions. A key challenge for the future will therefore be deciding on what not to do if funding remains only at its current level. Trade-offs will be needed between ensuring full implementation in some areas and partial implementation in all. A strategic decision will need to be taken early in 2009 on how to deal operationally with a continued short-fall in funding, including a resultant reduction in target objectives.

156. During 2009, the activity will face the problem of how to integrate more fully with national government policies and agendas. On the one hand, this will involve changing the target age group among children from <3y to <5y to fall in line with government policy, which would increase the caseload quite considerably; on the other hand, it could involve expansion to additional provinces where moderate acute malnutrition is also high. Today, the PRRO covers 7 of 13 regions in Burkina Faso, reaching approximately 43% of the total population. Since national health policy is based on equitable access for all citizens, and that under nutrition is widespread in the country, an argument has been made that the activities undertaken by the PRRO (if not the PRRO itself), should at some point cover all regions of the country—a mater of equity and rights. The cost implications of both demands for extended coverage are huge.

157. A solution has to be found in dialogue with government and donor partners to map out the strategic steps needing to be taken by ALL stakeholders in the coming 5 and even 10 years. The PRRO itself is a vehicle for achieving goals that are by definition limited in space and time, but the problems it tackles are neither. The challenge for WFP will be to engage in a dialogue that allows it to dovetail with alternative investments in nutrition treatment and prevention that will bring the PRRO to an end and be replaced by other forms of intervention that sustain and extend its achievements. Fortunately, the PRRO has attained a sufficiently large 'critical mass' to leverage both the strategic dialogue and further investments.

158. An operational challenge that continues to hamper the PRRO is the duration of time needed for successful 'treatment' of individuals prior to their discharge from supplementary feeding. The duration issue has clear cost and cost-effectiveness implications. There are two areas that require much more attention during 2009 if this challenge is to be met. The first is the default rate has to be reduced. A reduction of the period during which a child or mother receives rations is important since it determines the food (and other) cost per person rehabilitated. Many 'additional' rations are given prior to rehabilitation (whether successful or not) since there are many defaulters. These are, in the main, not total defaulters who enter the programme then leave and never return. Most default on the monthly visits for one or two months, then return, but then still have to receive 5 consecutive monthly rations (as a child) to be considered for discharge. There is limited understanding of the causes of such temporary defaulting (which vary by province and time of year), and little capacity to follow up with such families. Active defaulter tracing would not require a lot of training or infrastructure (in either of programme components (clinics and villages)), and while it would represent an added cost the net savings to the intervention as a whole (through considerable reduction in ration distribution and potentially more rapid rehabilitation), could be large. Active defaulter tracing is by definition part and parcel of community participation and responsibility, and a novel design element that WFP should consider introducing in the PRRO extension.

159. The second element relates to the kind of supplementary foods used. The new urban EMOP is to use a form of ready-to-use supplementary food that offers considerable potential for increasing the cost-effectiveness of the PRRO. While such foods typically carry a higher unit cost than, say, CSB, the potential exists for more rapid rehabilitation since a) the product is better tailored to the role of reducing malnutrition (i.e. less than 5 months of distribution would likely be needed to meet exit criteria, so the '5 sequential ration' rule could be made more flexible); and b) differently packaged, more 'medicalised' form of supplementary foods (along the lines of RUSFs) may reduce intra-household sharing and hence dilution of effects. As a result, a challenge for the PRRO will be to better analyze costs, cost-effectiveness and potential trade-offs among elements of the food basket.

160. In some areas, many people (particularly the Peul) appear to be nutritionally sound and healthy but present as undernourished according to anthropometric cut-offs. The clinical diagnosis of 'acute and severe malnutrition and/or pitting oedema' seems clear enough to be included as criteria for selection, but the discharge of healthy-but-thin individuals needs to be systematically considered in some areas. Currently, the project does not have sufficient nutritional know-how among all its partners to deal with such very real and pertinent questions. This is a 'grey area' in program management that needs urgent attention if operational quality is to improve.

161. The PRRO collects a large amount of monitoring information on a highly disaggregated scale. The complexity of internal data checks, transcription of data and data analysis is costly in terms of time and attention to detail. A review and potential revision of data capture mechanisms, information flows, and how analyses are used (or not) for changes in day-to-day programming is essential as part of the consolidating the PRROs operational effectiveness. WFP should, in tandem with partners, review all the kinds of data collected and consider a) where to reduce, b) how to optimize the analysis of relevant monitoring (not just periodic survey) data, c) how to improve the analysis and dissemination of survey data, and d) how the various WFP datasets could feed into, or serve as a basis for, any future nutrition and food security surveillance system.

162. A cost and benefit assessment is needed of blanket feeding of stranded populations in relation to PRRO goals during the rest of the year. WFP faces serious logistical challenges in pre-positioning stocks into areas usually cut off for many months during the rainy season. An assessment is needed of storage requirements that are appropriate to the scale of operations served, training in storage protection (not just management), but more important is an understanding of the impact of NOT achieving effective blanket feeding on the specific goals of the PRRO; that is, was malnutrition in areas that had effective pre-positioning and good storage, allowing for appropriate blanket feeding less, or more quickly treated after the rains, than in areas that were cut off? This has important programme design implications, with potential lessons for other WFP operations that may include blanket with targeted supplementation distributions in areas of already high malnutrition.

163. Better understanding is needed of constraints to adoption of new knowledge and practices, as well as hurdles to health-seeking behaviour[78]. While these are known in a broad, generic sense, local specificities are important to understanding why some children are malnourished in a community and others are not (controlling for income or food security status), why some mothers are willing and able to adopt new behaviours and others are less so, why some households demand improved health care and others appear less concerned. Such understand will be an important part of tailoring interventions that can sustain gains made by the PRRO into succeeding.

78 De Allegri,M., M.Sanon, J. Bridges, and R. Sauerborn. 2006. Understanding consumers' preferences and decision to enrol in community-based health insurance in rural West Africa. Health Policy 76:58–71

3.C Recommendations

164. The PRRO should be adequately supported by WFP, its donors and its partners. It is a critically needed intervention, broadly successful in its first phase, that requires sufficient funding and appropriate staffing to succeed.

165. That said, given a likely continuation of less than full-funding during 2009, it is recommended that the PRRO consolidate its achievements in areas currently covered. Trade-offs will be inevitable in relation of numbers of beneficiaries served (via expansion of geographic coverage) versus quality and quantity of inputs and services provided. While keeping numbers of beneficiaries served to a 'manageable' level is of course not acceptable in terms of the overall intent of the intervention (which is to achieve a population-wide reduction in undernutrition), the reality is such that actual targets will only be achieved if the appropriate foods are delivered in combination with a full complement of non-food inputs and services that are essential to achieving the nutritional outcomes desired. That is, translating limited donor funds into maximum rehabilitation rates, minimum default rates, and optimum delivery of information and services needed for effective prevention.

166. Context-specific tailoring of the essential package may be necessary, based on a deeper critical assessment of specific needs by locality. While it is important that all elements of the package be delivered simultaneously, some components appear to be relatively more important than others depending on location-specific contributors to undernutrition. For example, more attention should be paid to understanding where and why, a) severe nutrition problems persist, including 'pockets' of acute wasting within districts that may otherwise be doing well, and b) where rehabilitation rates lag behind the average, such that adaptations can be made to the programming that address local problems and/or special programming constraints.

167. A major weakness that could impede further gains relates to low levels of analytical and technical capacity among all partners in responding to nutrition problems. Thus, a key element in future success relates to enhancing capacity among implementing partners in: a) assessment of local nutrition problems, b) improved recording and reporting of anthropometric data, c) enhanced capacity for both case-finding and follow-up of defaulters, and d) enhanced delivery of nutrition and health education—and measurement of its impact. Efforts invested in developing institutional as well as human capacities and capabilities (among health delivery staff as well as NGOs) will have high returns. WFP should define what skill-sets and knowledge bases are necessary to conform to the demands of implementing the PRRO, but also to sustaining and expanding activities once the PRRO ends. Some of WFP's own nutrition training materials could be adapted and shared, and funding for broader nutrition training should be sought, in collaboration with government, UNCT and other partners.

168. More effort is needed in strengthening the behaviour change component aspects of the intervention among some partners and in some locations. What are the most effective methods of delivering nutrition and health knowledge, the best tools for measuring effective dissemination of such knowledge, and optimal ways for determining the impact (outcomes) of such activities? WFP's logframe requires that partners measure outcomes of behaviour change, while also expanding the audience of knowledge dissemination activity to include more a) mothers in law and grandmothers, and b) husbands. The latter are critical to framing what scope exists for effective behaviour change by young mothers.

169. Data requirements, collection methods and analysis should be reviewed. First, at implementation level, there is a need to continually review the appropriate application of eligibility and exit requirements (data collection on MUAC, BMI, weight and height, etc). Recording and transcribing errors should be minimized, but this can only happen with good (and reinforced) training, high levels of supervision on the ground, and cross-checking of monthly reporting data (rates of, and trends in, rehabilitation or defaulting rates relative to weights and measures taken).

170. Secondly, at programme management level, WFP management should seriously consider adopting (and hence piloting) the Minimum Reporting Package for Emergency Supplementary Feeding Programmes, currently being finalized by partners of the Emergency Nutrition Network [79]. At a minimum, there is a need for PRRO 10541 to include: a) better tracking of, and reporting on, default rates. Do defaulters who return to the programme subsequently defaulting again (serial defaulting)? What is the sequence of defaulting (i.e. how many rations taking prior and after one or more months default), What are major reasons for default by district and season?; b) coverage data should be included in an expanded log-frame. WFP has moved to include 'coverage' in its indicator compendium as a key element in the assessment of supplementary feeding programmes [80] This would improve understanding of the PRRO's impact in the second phase; c) critical analysis needed out positive and negative outcomes as part of monthly monitoring and reporting. What characteristics define the children or mothers who complete the treatment but are not rehabilitated? Are higher rehabilitation rates linked to specific seasons, or ethnic groups, the severity of wasting at the outset (i.e. controlling for actual weight for height at enrolment), or the caseload managed at each location?); d) sharing of WFP analysis from the centre back to the field. The regular communication of data trends, including identification of positive and negative outliers, is widely desired at field level (both by NGOs and health facility staff), and this could serve as a strong incentive for greater engagement in, and consolidation of, local actions; and e) health district (DS) data on low birth weight, from the monthly reports delivered up to Ministry of Health, should become part of the systematic monitoring of logframe outcomes.

171. Thirdly, at a national level, a review of data needs should include the question of the nature of information required for nutrition and food security surveillance. WFP should continue its dialogue with the government and other partners on ways to develop a system of nutrition data collection, analysis and dissemination that would not require a major investment of new resources or institutional capacity. Given the resource constraints of the PRRO and CP, and the limited capacity at all levels of the health system, the creation of a new NNSS 'project' currently seems both infeasible and potentially distracting, despite the urgency expressed in recent nutrition policy declarations. WFP should join with its UNCT partners (particularly UNICEF and the World Bank), to discuss with the government what data management systems are essential to achieve stated objectives of national policy, and determine if existing data collection efforts can, as a first step, be adapted to the purpose and knitted together from multiple sources.

79 Emergency Nutrition Network Steering Group. 2008. Minimum Reporting Package for Emergency Supplementary Feeding Programme. London, December 2008. Mimeo.
WFP. 2008. Indicator Compendium. Optional Indicators - Coverage of supplementary feeding. Responsible Technical Units: Nutrition, MCH, HIV/AIDS (OMXD). Rome
80 WFP. 2008. Indicator Compendium. Optional Indicators - Coverage of supplementary feeding. Responsible Technical Units: Nutrition, MCH, HIV/AIDS (OMXD). Rome

172. The potential should be explored for using alternative (or additional) foods in the ration; specifically, the possibility of using a ready-to-use supplementary food such as Plumpy'doz in the 'rehabilitation of children who are moderately wasted. There is also potential for testing an enriched CSB or enriched flour complemented by powdered home fortificants. There is no doubt that CSB is shared within households (admitted to by beneficiary mothers), but this is already much less the case in relation to Plumpy'nut used in therapeutic treatment, or even in the consumption of locally produced FBFs (products intended for weaning or as supplements for pregnant women made by Nutrifaso or Misola). In other words, products more clearly defined either as 'medicinal' or as having demographic traits (by age and gender) may be less shared. Defining the appropriate food and its form will be important to enhancing the speed (and hence programme costs) of rehabilitation.

173. There is an urgent need for well-designed operational studies are needed in a unique PRRO of this kind, on: i) Costs and effectiveness of different intervention models. Does the cost per rehabilitation differ in different locations based on case load, on modality (CSPS versus NGO delivery), on severity of wasting at enrolment, on degree of undernourishment of the mother (in relation to recovery rate of the child), or on the use of CSB versus other forms of foods in the rehabilitation component, etc.; ii) What is the appropriate metric to assess cost-effectiveness in a programme of this nature—analysis is needed of unit costs per 'treatment' (rehabilitation) versus cost per ration or price per beneficiary. An attempt should be made to pilot the REACH costing model to the PRROs various activities 81, and in this context the potential for locally-produced FBFs should be re-considered, not in terms of cost per ton but in terms of cost per child/mother rehabilitated and in terms of cost per percentage point reduction in population-wide wasting; iii) Tools to monitor effective nutrition and health education in terms of delivery and outcomes—what are the most appropriate metrics to assess content retention among beneficiaries (what do they remember), content usage (changed behaviours resulting from new information), and content impact (outcomes plausibly linked to improved knowledge). There is an opportunity to empirically demonstrate the importance of the prevention aspect of this multidimensional PRRO, and the potential to develop measures that could in future be added to WFP's indicator compendium relating to nutrition.

174. WFP should ensure that it is prepared for an active, sometimes lead, role in strategic dialogue at country level on the future of nutrition planning, policy directions and investment priorities in Burkina Faso plans. WFP should support medium-term planning in the context of the next PRSP, reviews and recommitments to the MDGs, and in raising awareness of nutrition problems beyond wasting. WFP should also raise its capacity to have effective interaction with stakeholders at regional and district levels, in terms of dialogue on nutrition and public health.

81 Boston Consulting Group. 2008. REACH: Successful practice compilation & country pilots. High-level cost estimates for REACH-promoted interventions. Report and presentation to WFP- August 2008

Annexes

Annex 1 Terms of Reference

COMPLETION EVALUATION OF BURKINA FASO – PRRO 10541.0
"Reversing Growing Undernutrition in Food Insecure Regions"
TERMS OF REFERENCE

1. Background

A Context of the Evaluation

Burkina Faso, a least-developed country with a population of 13.2 million (2005 estimate), is among the poorest countries in the world, ranking 174th out of 177 in the United Nations Development Programme's 2006 Human Development Index. Forty-nine percent of the rural population is not able to produce and/or access enough food to meet their minimum energy intake requirements. Almost one million of these are children under five.

Prior to the WFP operation implementation, the Demographic, health and nutrition surveys and studies indicated that under nutrition and micronutrient deficiency in Burkina Faso had worsened reaching precarious levels. Ninety percent of children under-five were affected by anaemia. Between 1993 and 2003, the prevalence of stunting had increased from 31 to 39 percent and underweight risen from 30% to 38%. The prevalence of wasted children was found to be 18,6% (over 450,000 children)3, which is critical according to WHO criteria.

The above situation was prevailing also in other Sahelian countries and more specifically in the northern Sahel countries. In 2005, it had resulted in an unanticipated acute humanitarian crisis called "The Niger crisis". In order to be better prepared to respond to this category of "hidden" crisis WFP decided to develop in the Sahel its support to nutrition by joining forces with local partners.

In Burkina Faso, WFP, UNICEF and the World Bank have been playing a leading role in: i) enhancing the knowledge base on the relationship between nutrition and food security; ii) identifying the underlying causes of malnutrition; iii) ensuring that acute under nutrition is not mistaken for a famine problem.

WFP plays this leading role through the implementation of PRRO 10541.0 whose action is complementary to that of the on-going Country programme (2006-2010) which addresses longer-term factors contributing to under nutrition and food insecurity. The PRRO 10541.0 has been approved for a period of 2 years (1 January 2007 - 31 December 2008) with a food tonnage of 24,211 Mt corresponding to a total WFP cost of 18,337,142. On 1st April a budget revision was requested in order to compensate for increase in food and transport prices. This brought the WFP cost to US 21,919,089. Currently another Budget Revision is in process. The rationale for this revision is for the PRRO to provide assistance in supplementary feeding to two extra regions, namely: Central South and Central East.

Specific objectives of the PRRO:

(i) Reduce levels of moderate acute under nutrition among children under three, pregnant women and lactating mothers (SO3, MDG 4, 5 and 6);

(ii) Enhance the Government's capacity to implement the National Plan of Action for Nutrition, in particular the aspects related to strengthening household food security and setting up a nutrition surveillance system (SO5, MDG 1 and 6).

Activities of the operation:

The PRRO is designed to assist some 668.500 beneficiaries out of which 426,000 children under-three and 242.500 pregnant and lactating mothers, It builds from the findings of a joint nutrition and food security assessment which recommended an integrated nutrition programme including both rehabilitation and prevention of acute under nutrition for children under three, pregnant and lactating women.

The rehabilitation component includes therapeutic and supplementary feeding programmes. Within this framework, the PRRO provides supplementary feeding rations for the rehabilitation of moderately undernourished children under three (Therapeutic feeding for the severely malnourished children is provided by UNICEF). It also provides a nutritionally balanced food ration to malnourished pregnant women and lactating mothers with the objective of reducing the incidence of low-weight births and promoting exclusive breastfeeding during the first 4 to 6 months after birth.

The prevention component consist in delivering a minimum essential package including: 1) promotion of good hygiene and child feeding practices; 2) access to age-appropriate complementary foods; 3) reduction of micronutrient deficiencies among children and pregnant and lactating women; 4) deworming; 5) access to basic health services; 6) access to potable drinking water and adequate sanitation; 7) improved household food security and 8) improved status of women.

This prevention component focuses more specifically on activities such as encouraging women to monitor the weight of their children, demonstrating preparation of enriched porridge, and conducting nutrition education sessions on breastfeeding and weaning practices, vaccination, family planning, food taboos, hygiene issues, etc.

WFP's role is to facilitate and encourage women's attendance to nutrition education sessions, and to partner with the Nutrifaso project, which promotes the use of adequate complementary foods locally produced at lower cost.

Through the existing close collaboration with UNICEF, the information and communication campaigns reinforce and expand thus playing a key role together with local NGOs and women associations to promote nutrition awareness and education among women.

Finally, to complement the above preventive action and fully take into account the priorities identified through in-country discussions with the Government, World Bank, NGOs and other UN agencies, the Country Office VAM expertise is made available to work with the food security and nutrition working groups on the set up of a surveillance system.

Delivery channels:

Food assistance is provided to selected beneficiaries through more than 400 health centres distributed across five priority regions. Previous experience indicates that the presence of food is an incentive for women to take their children to the closest health centre.

Since the limited and irregular use of health facilities makes it difficult to reach and properly treat many cases of under nutrition WFP has developed its partnership with three large NGOs working in the health sector in Burkina Faso, namely: Africare, Plan International and Helen Keller International.

Through this partnership WFP attempts to reinforce and scale-up the NGOs' respective community-based nutrition and child survival activities. This consists of identifying cases of child-care best practices available in the communities and using them as good examples. Cases of moderate acute under nutrition are treated and followed-up by trained personnel from within the community itself.

Similar activities implemented by organisations from the civil society, though at a lower scale, are also reinforced in order to enhance the operation.

B Stakeholders

The following stakeholders will be closely involved in the evaluation through interviews and/or briefings conducted by the evaluation team. Most of them will be invited to actively participate in the review of evaluation outputs, in particular the draft of the full report. (For further details, please see stakeholder analysis matrix in annex 7).

(i) External Stakeholders

The PRRO activities aim at assisting the government at national (MoH and MoA) and sub-national levels (Health centres), international and national non-governmental organisations (in particular: Africare, Plan International, Helen Keller International and MSF), communities and beneficiaries. At each level, individuals are involved. Their stake in the process is that they are the key implementing agents whose performance will determine whether WFP assistance achieved its objectives. They will be providing feedback to the evaluators on their views, experiences and suggestions for improvements and change.

Other stakeholders external to WFP are partners from within the UN and bilateral agencies or donors, who cooperate with WFP in particular in funding food security and nutrition assistance in Burkina Faso (World Bank, USA, EC, France and Netherlands), as well as bodies focusing on food security and nutrition in the country and the region such as the CT-CNSA and the CILSS. All these stakeholders will be consulted by the evaluation mission on questions of partnerships, co-ordination and comparative advantage.

(ii) Internal Stakeholders

The Country office in Burkina Faso, its related sub-offices as well as the West Africa regional bureau located in Senegal (OMD) play an important role in the conception and implementation of the PRRO.

At headquarters, the main stakeholders are the OMX division (more especially the OMXD and OMXF units)82 and the OEDP units which have participated in the design of the operation and provide technical support to the Country Office for the implementation of the PRRO. The OMLP unit (Food procurement) can be also regarded as a stakeholder, more specifically regarding the issue of the local food procurement issue.

Although these units were not existing at the time the operation was designed, there are currently dealing with issues directly related to the operation.

The stake of WFP colleagues consist in their role of defining and implementing policies and operations and reporting back on achievements. They are key informants to understanding achievements and areas in which improvements are needed and how they can be achieved.

WFP Management and the Executive Board are key stakeholders in the evaluation, as they review the summary evaluation report and decide on policy directions, strategies, and thus indirectly decide on resources for the operation.

2. Reason for the Evaluation

A. Rationale

This evaluation is conducted to comply with stipulations of the WFP's corporate evaluation policy, according to which "any operation longer than 12 months should be evaluated".

The current PRRO implementation phase is expected to come to an end in December 2008. The evaluation will be conducted a few months before the completion of the current phase so as to obtain recommendations for improvement in the framework of an eventual future extension in time of the operation.

The evaluation will be managed by the WFP Office of Evaluation (OEDE) at the request of the Regional Bureau and the Country Office. As such, this decision is also in compliance with the current evaluation policy which stipulates that "OEDE will manage evaluations identified and proposed as part of its biennium work-planning exercise; these being undertaken with the agreement of the regional bureau and the country office".

B. Objectives

The objective of the evaluation of the PRRO 10541.0 is to contribute to accountability and learning in the context of the provision of an independent evaluation service:

> (i) Accountability is the obligation to account for (and report on) the level of implementation of the PRRO 10541.0. In this respect, the mission will report on the results achieved by the PRRO regarding the reduction of levels of moderate acute nutrition or further deterioration avoided among children and women in the country, as well as the extent to which the operation was able to enhance the Government capacity to implement its National Plan for Nutrition. Looking at the performance level of the PRRO, the mission will also report on the level of aid expenditures vis-à-vis the degree of success and/or failure of the above-mentioned PRRO's objectives as well as the achievement level of the outputs.
>
> (ii) Learning: The mission will take advantage of this evaluation to see whether lessons can be drawn in order to be applied at the design phase of an eventual new phase of the PRRO 10541.0. These lessons should help improve future performances of the operation or facilitate the decision-making regarding the continuation or discontinuation of the assistance provided by the PRRO 10541.0. Given that PRRO 10151.0 is part of the WFP regional strategy against malnutrition, these lessons could also serve for other operations with the same objectives in the region.

3. Scope of the Evaluation

A. Scope

The evaluation will cover the period under which the PRRO has been implemented (i.e. 1 January 2007 till the evaluation field mission that is expected to take place in August 2008) . The main period of analysis for the evaluation will be mid-2007 to August 2008, representing the period when the operation was the most adequately resourced.

The evaluation will cover the two major components of the operation, namely: relief and recovery.

In this respect, the evaluation will examine the various activities supported by the PRRO in the five priority regions: Sahel, North, Centre-North, east and South-west.

All regions assisted by the PRRO will be visited by the evaluation team and all major partners will be interviewed (Government, UN Agencies, Local donor representatives, NGOs, etc…).

B. Evaluability Assessment

Evaluability is the extent to which an activity or a program can be evaluated in a reliable and credible fashion. It necessitates that an operation provides: (a) a clear description of the situation before or at its start that can be used as reference point to determine or measure change; (b) a clear statement of intended outcomes, i.e. the desired changes that should be observable once implementation is under way or completed; (c) a set of clearly defined and appropriate indicators with which to measure changes; and (d) a defined timeframe by which outcomes should be occurring.

(i) Baseline Information Availability

The section on the context stresses that a number of assessments, studies and surveys have been conducted before the implementation of the operation. The PRRO has also been built on the findings of a joint nutrition and food security assessment conducted in 2006. The Country Office has also indicated that baseline information has been collected at the start of the project and recorded in a database designed by the country office. This information will be made accessible to the evaluation mission.

Regarding the baseline information relative to the second major objective of the PRRO (i.e. enhancement of the Government capacity in implementing its National Plan on Nutrition), the Country Office has reported that information relative to the Government's capacity on nutrition can easily be obtained through interviews with partners.

Consequently, it appears that baseline information available from various sources could be used to determine or measure change resulting from the operation implementation.

(ii) Clarity of Intended Outcome

The project document provides clear outcomes for the operation. Likewise the logical framework annexed to the document appears to be usable in the sense that it specifies expected outputs, outcomes and associated indicators. Clear and measurable outputs and objectives seem to have been set at the inception of the operation. Outputs and outcomes could be revisited by the evaluation team and eventually better defined should there be a need. In this vein, the two issues of the incentive role of food aid to have women attending training courses, as well as the objective to promote use of foods locally produced will have to be clarified to be better addressed in the logical framework.

(iii) Appropriate Indicators

The logical framework presented in the project document contains specific indicators at each level of the result chain. Chosen indicators set in the operation logic model seem to be appropriate and SMART.

(iv) Data Availability and Reliability

The Country Office has indicated that a special effort has been made regarding the monitoring system of the operation that is reported to be appropriately implemented. Data are reported to exist for all indicators set in the logical framework. Most of these data are recorded in an access database that will be made available to the evaluation team.

The Country Office has also indicated that analysis of the above data has been conducted and reports issued. These reports will be made available for the mission.

(v) Access to Sites and Stakeholders

Burkina Faso is a secured country where no particular problem can be expected regarding circulation in the country and access to sites and stakeholders.

The Field mission is anticipated to take place out of the rainy season in order to facilitate the sites visits to the evaluation team. The Country Office will ascertain that stakeholders will be present in the country at the time of the field evaluation mission.

In light of the above, the level of evaluability seems adequate. However, an in-depth evaluability assessment will be conducted by the team leader during the preparatory phase of the evaluation and decision made on the evaluability, evaluation techniques, and limitations to the evaluation resulting from these assessments. More especially, the team leader will assess the extent to which evaluation criteria such as Effectiveness and Impact can be assessed. The team leader will be assisted in this task by a data analyst. The evaluability assessment will be completed well before the preparatory mission in order to give the team leader the opportunity to study during the preparatory mission with the Country Office how to increase the data reliability.

4. Key Issues/Key Evaluation Questions

In compliance with the report template developed by OEDE (see annex 1) the evaluation team will assess and analyse the PRRO 10541.0 trough the various evaluation criteria that are usually used for evaluation, namely: relevance and appropriateness, coherence, efficiency, effectiveness, impact and connectedness (see generic issues to be assessed by evaluation team in annex 8). It will also look into cross-cutting issues such as gender and partnership. (see generic issues to be assessed in annex 8).

From a quick preliminary desk review, it appears that the mission will more particularly place emphasis on the following key issues:

A. Operation Design: Relevance and Appropriateness

Project Design:

In this respect, the evaluation team will assess the strengths and weaknesses of the project's logical framework and the potential consequences for evaluation.

The mission will also study whether, in the light of previous evaluations made in the country as well as discussions having taken place at the PRC stage, assumptions made in the logical

framework were appropriate; If it is deemed that risks were underestimated at the design stage of the operation, the mission will assess the extent to which this impacted on the operation performance.

- Objectives of the Operation including targeting (relevance/appropriateness)

Relevance: is about assessing the extent to which the objectives of the operation are consistent with beneficiary needs, country needs, organisational priorities, and partners and donors policies.

The evaluation team will assess whether the PRRO objectives are in line with national set priorities as well as donors decided policies for the country.

It will also study whether these objectives should be in some way adjusted/fine-tuned in order to better match the national authorities priorities.

- Appropriateness is about assessing whether the planned inputs and activities of the operation are in line with local needs and priorities.

The evaluation will examine whether the PRRO activities are in line with national needs and priorities and the extent to which these activities have the institutional/political support of the national authorities.

- External coherence: is about assessing whether the project objectives are consistent with government, partners and other donors policies and interventions (cf. UNDAF, PRSP, initiatives from other agencies, etc);

The evaluation team will also study the extent to which the PRRO is coherent with the Government's decided strategies and policies (PRSP and the National Nutrition policy

Coherence must also be checked regarding the policy set by major donors for this sector in Burkina Faso (World Bank, US, EC, France and Netherlands).

B. Outputs and Implementation Processes: Elements of Efficiency

Implementation Mechanisms:

The team will also look into the issue of regional and local food procurement in order to check whether the same or higher level of efficiency could have been achieved at lower costs.

In this respect it will also check whether this mechanism is financially viable and thus has some sustainability.

External Institutional Arrangements: partnerships, coordination and transfer of competencies (capacity building and participation)

Institutional arrangements with partners will be examine in order to see whether these arrangements were made on time and were effective.

The mission will look into the issue of coordination and see whether the extent to which the coordination between the implementing partners was sufficient and effective (Government, WFP, IPs, Donors, etc…).

Cost and Funding of the Operation

The team will assess the extent to which WFP was able to provide the planned level of food resources for PRRO 10541.0. The resource pipeline of the PRRO as well as the resourcing

update of the operation will be studied in order to see whether resourcing impacted on the performance of the PRRO.

C. Results

Effectiveness: Measured outcomes achieved, unintended effects, how outcomes led (or are likely to lead) to the achievement of the objectives

The mission will evaluate the extent to which the both planned objectives of the PRRO have been reached. Like for any other evaluation exercise, this will be done on the basis of results and performance indicators outlined in the logical framework or the revised and adjusted version of logical framework of PRRO 10541.0.

The mission will pay special attention to the nutritional status of beneficiaries which, according to the nutritional study issued in September 2005, was far from being satisfactory.

Taking into consideration that some weaknesses might exist regarding the adequacy of implementing partners, the mission will more particularly assess the extent to which this eventual inadequacy has impacted on the level of performance of the PRRO 10541.0

The evaluation team will review the effectiveness of the operation, including, adjusting the food basket, need for fresh food, use of micronutrients such as fortified blended products, and if deemed necessary/appropriate will identify areas in which effectiveness can be improved.

As regards the second objective of the PRRO, the evaluation team will attempt to assess the extent to which the eventual insufficiency of institutional support might have impacted on the achievement of planned outcome.

In both areas (inadequacy of implementing partners and insufficient institutional support) the mission will make sure that appropriate recommendations are made so as to provide sufficient guidance regarding the design of an eventual extension in time of PRRO 10541.0

Connectedness:

The mission will assess the extent to which there is hope to have a continuation of the PRRO benefits after its completion. In this respect, the mission will more especially study whether the assistance in building local capacity has been sufficient to expect local partners to be able to supply an appropriate level of assistance.

It will also assess whether there is sufficient hope to get some sustainability regarding the mechanism of procurement of local food put in place by the PRRO 10541.0

D. Cross cutting issues

- Partnership

In view of the type of activities to be implemented by the PRRO, clearly partnership is a key element of the operation implementation. The evaluation will have an in-depth look at the partnership dimension and assess its value added.

In this connection it is expected that the mission will study whether:

(i) adequate IPs (in number and quality) are present in the country.

(ii) the number and nature of IPs under the PRRO is adequate and appropriate for implementing the PRRO range of activities.

(iii) the capacities and comparative advantages of potential implementing partners (IPs) are assessed by the Country Office prior to entering into partnerships and agreements.

(iv) the team will assess to what extent have partnership arrangements successfully or negatively contributed to the implementation of the PRRO. If weaknesses are noted, the mission should indicate what are specific weaknesses and make appropriate recommendations for eventual future phase of the PRRO.

(v) what are the mechanisms for coordination with government, donors, UN agencies, NGOs, etc.? Are these being used to the PRRO's maximum benefit?

(vi) are appropriate and suitable mechanisms in place to ensure strategic co-ordination at the national policy level regarding relief and recovery issues?

(vii) a sufficient consultation and effective coordination exist between the WFP country office in Burkina and the other WFP Country Offices participating in the WFP fight against nutrition problem in the northern Sahel countries.

5. Evaluation Design

A. Methodology

To address the issue of evaluability, the evaluation will use stakeholder discussions and secondary data, to verify existence and validity of baseline information and collected data. A data analyst will be recruited to assist the evaluation team leader in assessing the evaluability of the PRRO.

The evaluation will draw on traditional evaluation methods based on programme theory and logical framework approaches. At the start of the preparatory evaluation phase, an in-depth review of the logical framework will be conducted in consultation with the Country Office. Should the indicators placed in the logical framework not be regarded as sufficiently appropriate, other relevant indicators – quantitative and qualitative, as appropriate – will be defined by the evaluation team during the preparatory phase.

The evaluation will use a range of data collection techniques such as key informant interviews, focus group discussions.The evaluation will also use a mix of quantitative and qualitative information to address the key issues identified in the preparatory phase. Since the Country Office has indicated that data were collected all along the operation implementation, no survey is expected to be conducted. A sampling method based on selection criteria will be used to decide on sites to be visited by the evaluation team.

The evaluation will also ensure that stakeholders with diverse views will be consulted in order to have findings and recommendations based on a comprehensive understanding of diverse perspectives on issues, performance and outcomes. To the extent possible, all information collected will be triangulated before being presented as a finding. Where triangulation is not possible, the evaluation will be explicit about it and use the information with caution.

In compliance with EQAS standards, the evaluation matrix will present structured issues and sub-issues to be raised to reach the evaluation objectives as clarified during the discussions on the logic model in consultation with the country office. It will also include information on indicators to be used to address these issues and on the main sources of information. The evaluation matrix will serve as a guide throughout the evaluation process; it will be updated as appropriate on the basis of stakeholders' comments on the logic model.

In compliance with EQAS standards, in order to assess the performance of the operation the evaluation team will use the filter of internationally agreed evaluation criteria of relevance, coherence (internal and external), efficiency, effectiveness, impact and sustainability. As a complementary exercise, the evaluation will also look into cross-cutting issues of particular interest to WFP, namely: gender, and partnership.

B. Evaluation Quality Assurance System

The evaluation will be exposed to a quality assurance process that will entail internal review by OEDE (for quality check) and the creation of an internal stakeholders group, who will provide an independent assessment of the quality of the evaluation. The quality assurance process will draw on the OEDE quality pro-forma which have been developed on the basis of those adopted by ALNAP and OECD/DAC.

Concerning the quality of data and information, under the leadership of the team leader, the evaluation team will ensure systematic check on accuracy, consistency and validity of collected data and information.

C. Phases and Deliverables

To obtain the greatest utility value, the evaluation aims at being completed in time for presentation to the Executive Board meeting in February 2009. During the course of the evaluation process, regular feedback and interaction is planned with internal stakeholders from WFP to ensure lessons can be used as they become available.

The evaluation will be undertaken in the phases mapped out below. These are the EQAS typical steps for an operation's evaluation process. The detailed scheduled will be developed by the evaluation manager during the preparatory phase in consultation with the evaluation team and the Country Office.

i) Initial Phase

Final Terms of Reference (TORs)

Based on the available documentation (See annex 2 – Bibliography) and in consultation with the Country Office, the evaluation manager will issue a first draft of the evaluation TORs. Based on these TORs, which will provide the profiles of consultants to be recruited, a team leader will be identified and recruited as well as the other evaluation team members.

A brief will be provided by OEDE to the evaluation team on the process to be followed for the evaluation.

The evaluation team will conduct a desk review of all available information and data, and identifies areas to be clarified and addressed during the team leader's preparatory mission.

The team leader will undertake a preparatory field visit in Burkina Faso to obtain any complementary information and have a first contact with the major local stakeholders and more especially the Country Office. The purpose of this preparatory visit is to review all material available, identify issues to be addressed during the field visits and ensure appropriate preparedness of the evaluation team.

At the end of this phase the evaluation manager, in consultation with the team leader and the CO, will adjust the TORs and provide a final version of these TORs.

ii) Desk research and pre-mission phase Pre- mission Report

Based on the above final TORs, the evaluation team will review the documentation made available and assist the team leader in issuing a **pre-mission report**, whose purpose is three fold: (i) document the above set choices (ii) Review and clarify the TOR (including an in-depth review of the logical framework) and present the methodology to be used to undertake the evaluation; and (iii) Present the preliminary findings of the desk review and identify information gaps to be filled with data collected during the evaluation mission.

The pre-mission report will be produced by the evaluation team under the responsibility of the team leader and will be shared with stakeholders for comments.

iii) Field Research Stage Aide-Memoir & Debriefing at CO level

Fieldwork will be undertaken for a selected sample of sites. For the time being it is estimated that the field visit will take some 17 days. This timing will be adjusted after the team leader preparatory mission.

Prior to leaving the country the evaluation mission will issue an aide-memoir (Maximum 10 pages in English) that will be presented through a PowerPoint presentation in English to the Country Office and HQs stakeholders (in attendance by conference call). This internal stakeholder debriefing session will be followed by a debriefing session in French organized for external stakeholders (Government, implementing partners, local donor representatives, etc…).

The aide-memoir will provide the preliminary findings; point out to major issues noted by the evaluation team as well as the preliminary conclusions and eventual broad recommendations which could be made in the final report. The PowerPoint presentation will summarize the information contained in the aide-memoir. A copy of the issued aide-memoir will be shared with all attendees.

iv) Evaluation Report Writing Full Evaluation Report and EB Summary Report

The findings of the evaluation team will be brought together, by the team leader, in an analytical evaluation report (Full Evaluation Report) that will (a) respond to the objectives set out in this evaluation; and (b) report against evaluation criteria specified in these terms of reference (and those in the evaluation matrix).

The format used for this report will be in compliance with the EQAS template, and will go through a quality check exercise conducted by the WFP's office of evaluation.

The draft report will then be shared with the internal stakeholders group for comments. The draft report will be revisited by the evaluation team in the light of the comments received, in order to issue the final evaluation report.

Another deliverable is the EB Summary Report. This report is to be presented to the Executive Board. It will be drafted by the team leader with the assistance of the evaluation team. This report will also be shared with stakeholders for comments, prior for the team leader to issuing the final version of the Summary Report.

v) Presentation to the Executive Board

The EB Summary Report will be presented to the Executive Board by the WFP's Office of Evaluation (OEDE) in February 2009. Taking into consideration that the editorial process for an EB presentation takes usually three months, the final version of the EB Summary Report will thus have to be ready for process at the latest by the end of October 2008.

6. Organisation of the Evaluation

A. Expertise of the Evaluation Team

The team leader for the evaluation requires evaluation experience and an extensive knowledge of Nutrition (including new developments in this field) as well as National Nutritional Plan and Nutritional Surveillance System (PRRO's objective 2). In view of the PRRO key implementing partners, he/she should have a good knowledge of UN health activities especially in nutrition (UNICEF, WHO) and have some experience with the UN system. Taking into consideration, the eventual weakness in the institutional support, he/she should have good communication and diplomatic skills and have a good knowledge of French. As the main report writer, he/she should also have good writing skills in English. Preferably, the team leader should have some knowledge of WFP operations.

The evaluation team will be completed with a technical expert in nutrition whose work should more particularly focus on the rehabilitation component of the PRRO. The expert should have evaluation experience, good writing skills in English and be able to conduct interviews in French. In order to decrease on costs, and gain in knowledge on local context, it would be preferable to have this expertise recruited locally.

The above team will be assisted by a data analyst, having good experience in data gathering and analysis, with good communication and writing skills in English and with good working knowledge of French language. In order to decrease costs, preserve independence and ease communication with OEDE and team leader, this expertise will be mobilized in Rome.

A preliminary set of tasks is included in Annex 4. More specific qualifications and requirements will be determined in the preparatory phase of the evaluation and specified in the final terms of reference, once the evaluability has been more appropriately assessed.

The recruited evaluators will act impartially and independently, and will respect the code of conduct referred to in Annex 1.

B. WFP Stakeholders Roles and Responsibilities

As previously indicated in section 1.B, the external stakeholders are : the Government at national and sub-national levels, as well as international and international NGOs. As key implementing agents, both are expected to provide feedback to evaluators on their views, experience and suggestions for improvement and change.

Concerning other external stakeholders such as UN agencies, local donor representatives and national or regional bodies focusing on food security and nutrition, they are expected to assist the evaluators in getting a good grasp on policies, strategies applying to Burkina Faso, as well as the constraints encountered by the country in these two areas.

As internal stakeholders, the Country office in Burkina Faso, its related sub-offices as well as the West Africa regional bureau located in Senegal (OMD) will play an important role in facilitating/arranging the access of the evaluation team to information and data, and in ensuring an appropriate logistical support to the mission and introduction to the Government

and other local stakeholders. Both the CO and the RB will be part of the internal review group commenting on the evaluation deliverables.
At headquarters, the main stakeholders are the OMX division (OMXD and OMXF units more especially) and the OEDP unit. In a less extent, OMLP is also to be regarded as a stakeholder more particularly with regard to local procurement of food. The three entities will assist the evaluation team in getting a good understanding on how WFP designs PRROs and apply policies, and will be part of the internal review group commenting on the evaluation deliverables.

As key stakeholders, the WFP Management and the Executive Board will review the evaluation summary report and will make appropriate decisions.

C. Communication

To ease the direct contact of the evaluation team with beneficiaries, translators in local languages will be made available for the field mission.

To facilitate the feedback process, the evaluation will set up an internal stakeholder group consisting of a cross-section of WFP stakeholders who will receive deliverables (TORs, Pre-mission report, aide-memoir as well as draft full and summary reports) specified above for comments and verbal feedback at other stages in the process. The group will be composed of staff from a cross-section of functional areas (programme design and support division, operations, etc…) and location (headquarters, regional bureaus, country offices). A tentative composition of this review group is provided in annex 6. The final composition of this group will be decided during the preparatory phase. In order to preserve the independence and impartiality of the evaluation team, the internal stakeholder group will be confined to an advisory role.

As previously indicated, the final summary report of the evaluation will be presented to the Executive Board, most likely in February 2009 although the detailed schedule will be developed during the preparation phase. After finalization, the full technical and summary reports will be made available online as is the case for all WFP evaluation reports.

In addition, OEDE will determine and maximize opportunities for drawing lessons from the evaluation and disseminating them verbally (PRC sessions) or through a website to be developed by OEDE at a later stage.

D. Budget

At this stage, it is still not possible yet to provide a definitive and detailed budget for the evaluation. The maximum budget for the evaluation is US$100,000 out of which US$ 60.000 would be funded through untied funds and US$ 40,000 from the PRRO DSC budget..

At the time of drafting these TORs, it is deemed that if a local/regional[83] consultant could be found to cover the nutrition issue, the overall cost of the evaluation could probably be decreased to the amount of US$ 83.000). Contacts have been taken with the Country Office in order to obtain résumés of local/regional evaluators with expertise in nutrition.

Another mean to save on costs will be for the evaluation manager not to accompany the evaluation team during its field mission. However, should the nutrition expert be directly recruited in Burkina Faso, the savings resulting from the cancellation of the budget line for international travel currently attached to this expertise in the estimated budget (US$ 5.000), will be used by the evaluation manager to accompany the team leader during the preparatory visit in Burkina Faso.

83 To be on a safe side, the budget is still taking into consideration travel cost for a consultant recruited in the region. Travel cost estimates are calculated with the cost of an airplane ticket Dakar- Ouagadougou and return. Corresponding DSA costs are also taken into account. Should a local consultant be identified, all these costs would be removed.

A preliminary budget has been drawn up and is provided below:

Honorarium:

Team Leader	39.000
Nutrition Expert	20.000
Data Analyst	2.500
Translators	2.000
(for interviews with Beneficiaries)	

International Travel + DSA: (domestic transportation costs by road - drivers, cars, petrol - to be funded from CO budget)

Team Leader	11.500
Nutrition Expert	5.000
Contingencies	4.000

Total: (estimate) …… **83.000**

The above estimated budget will be finalised and the revised version will be provided in the final Terms of Reference.

Annexes

1. Background documentation on evaluation concepts

While conducting the evaluation, the evaluation team will apply the concepts developed in the following documentation. This documentation will be provided to the evaluation team at the very start of the evaluation process.

UNEG - Norms 2005 - Eng.pdf
UNEG - Norms 2005 - FR.pdf
UNEG - Standards 2005 - Eng.pdf
UNEG - Standards 2005 - FR.pdf
UNEG - Code of Conduct 2007 draft.pdf
TN - evaluation criteria

2. Bibliography

To date the identified bibliography is listed below. It is expected that this listing will be fleshed out with extra information expected from the Country Office. The data analyst will organized this library in order to make it more user-friendly and will complete it with the documents relative to data.

- Poverty Reduction Strategy Paper for Burkina Faso
- Demographic and Health Survey – 2003 (DHS)
- National Nutrition Policy – MoH (October 2006)
- National Strategic Plan for Nutrition
- Protocole National de Prise en Charge de la Malnutrition Aigue (GVT/Unicef/OMS) 2007
- Décret National sur la Création du Conseil National de Concertation en Nutrition, 2007
- Nutrition Survey in the Sahel and East regions in Burkina Faso– MSF/WFP (August 2006)
- Studies promoted by the World Bank, UNICEF, WFP and WHO (2006)
- Joint Government/UNICEF/FAO/WFP on malnutrition trend in Burkina (September 2006)
- Annual household Survey (EPA) 2004 and 2005
- Status Report of joint evaluation mission GVT/SNU on nutrition (used for designing the PRRO) September 2006
- Joint Action Plan on Nutrition GVT/SNU, document utilisé pour la formulation du PRRO, décembre 2006
- Report on baseline information for the PRRO, (used for designing the PRRO) 2007
- Rapport d'Etude 'Liens entre diversité alimentaire et situation nutritionnelle des enfants de moins de trois ans en milieu rural au Burkina Faso', Mémoire de Master en Nutrition, co-encadré par le PAM et l'IRD, septembre 2007
- Project Document, such as approved by PRC, December 2006
- SPA Nfr on session relative to PRRO 10541.0
- Project Document PRRO 10541.0 (as presented and approved by the Executive Board)
- Project Document of the Burkina Faso Country Programme
- Resource Update – PRRO 10541.0
- 2006 SPR report
- 2007 SPR report

- WFP Policy Documents on Gender, Capacity Building, Partnership and Transition from Relief to Recovery.
- List of UN Millenium Development Goals
- List of WFP's Strategic objectives
- Monitoring data + Monthly reports (to be gathered and presented in a user-friendly library by the data analyst)
- PDM Report on the PRRO Nutrition component, August 2007
- Follow-up report on the PRRO Nutrition component, September 2007
- Rapport sur l'analyse des systèmes de suivi-évaluation des programmes du PAM, y compris le PRRO Nutrition, novembre 2007
- Various maps relative to geographical regions/departments as well as on health centres and community assistance by partners.

3. Report Templates

While drafting the various evaluation deliverables, the evaluation team will use and comply with the following templates which have been developed by the WFP Office of Evaluation (OEDE).

T - OpEv - Pre-mission report
T - OpEv - Evaluation report
T - OpEv - Summary Report

4. Preliminary Tasks of the Evaluation Team Members

See table attached

5. Group of Internal Reviewers

Ms. Annalisa Conte	Country Director, BKF
Ms. Olga Keita	Deputy Country Director, BKF
Ms. Paola Dos Santos	Programme Officer, BKF
Mr. David Bulman	Head Programming, RB Dakar
Ms. Britta Schumacher	Evaluation Focal Point, RB Dakar
Ms. Margot Van der Velden	Technical Unit Support, RB Dakar
Ms. Tina van den Briel (OMXD)	Chief Nutrition, MCH & HIV/AIDS, Mr.
Martin Bloem	Director, OEDP (Nutrition & HIV/AIDS)
Ms. Isatou Jallow (OEDP)	Chief, Women, Children, Gender Policy Ms.
Joyce Luma	Director, OMXF (Food Security)
Mr. Paul Turnbull	OMXD (Operations Design)
Ms. Hildegard Tuttinghoff	OMXD (M & E)
Ms. Nicole Menage	Chief, OMLP (Procurement)
Quality check:	
Caroline Heider	Director, OEDE
Alain Cordeil	Senior evaluation manager, OEDE

6. Stakeholder Analysis (See Attachment)

7. Generic Evaluation Questions/Issues (See Attachment)

8. Job Descriptions (See Attachment)

9. Overall Evaluation Timeline (broken down by team members)

Annex 2: Bibliography

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Annex 3: List of persons met and places visited

Location	Institution	Persons met	Function
Rome	WFP	Caroline Heider	Director OEDE
Rome	WFP	Alain Cordeil	Sr Evaluation Manager OEDE
Rome	WFP	Martin Bloem	Director OEDP
Rome	WFP	Joyce Luma	Director OMXD
Rome	WFP	Paul Turnbull	OMXD (Ops. Design)
Rome	WFP	Hildegard Tuttinghoff	OMXD (M&E)
Ouagadougou	WFP	Annalisa Conte	Country Director BKF
Ouagadougou	WFP	Olga Keita	Programme Officer BKF
Ouagadougou	WFP	Olga Ninon	Programme Assistant BKF
Ouagadougou	WFP	Paola Dos Santos	VAM/M&E Officer BKF
Ouagadougou	WFP	Maria Luigia Perenze	JPO VAM M&E BKF
Ouagadougou	FAO	Jean-Pierre Renson	Country Representative
Ouagadougou	UNICEF	Biram Ndiaye	Nutritionist
Ouagadougou	UNICEF	Ilarid Bianchi	Programme officer
Ouagadougou	UNICEF	Ambroise Nanema	Administrator, Nutrition
Ouagadougou	WHO	Djamila Cabral	WHO Representative
Ouagadougou	WHO	Jean Gabriel Ouango	Family Health programme manager WHO
Ouagadougou	WHO	Alhousseini Maiga	Regional Officer, Guinea Worm Eradication
Ouagadougou	MSF France	Mohamed Morchid	Coordinator
Ouagadougou	MSF France	Sylvie Goosens	Medical officer
Ouagadougou	GRET	Claire Kabore	Director, Nutrifaso
Ouagadougou	ECHO	Henriette Nikiema	Humanitarian Project Coordinator
Ouagadougou	ECHO	Jan Eijkenaar	Regional Director, DG ECHO, Dakar
Ouagadougou	University	François de Charles Ouedraogo	Geography Department
Ouagadougou	IRD	Yves Martin-Prevel	Research officer
Ouagadougou	DNA/MoH	Alfé Dabiré	Director
Ouagadougou	DS/MoH	Sylvestre Tapsoba	Director
Ouagadougou	IMF	Isabell Adenauer	Resident Representative
Ouagadougou	World Bank	Tsiya Subayi	Operations Officer
Ouagadougou	Belgian Red Cross	Rosine Jourdain	Country Representative
Ouagadougou	Belgian Red Cross	Albert Tshiula Lubanga	Medical Nutritionist
Ouagadougou	UN - OCHA	Félix Sanfo	National Representative Humanitarian Affairs
Geneva	WHO	Francesco Branca	Director, Nutrition
Geneva	WHO	Monika Bloessner	Technical Officer, Surveillance
Geneva	WHO	André Briand	Medical Officer, Child Health
Geneva	MSF International	Susan Shepherd	Medical Advisor Nutrition
Geneva	MSF Switzerland	Valerie Captier	Nutritionist
Geneva	UN OCHA	Mark Cousins	Technical Officer Food Price Crisis
Gaoua	Direction régionale de la santé du Sud Ouest	• Dr. Y. Isidore Moyenga • Ki Pascal • Dr	• Directeur Régional de la santé • Coordonnateur de région • Médecin Chef de Gaoua
CSPS de Kpueré	Direction régionale de la santé du Sud Ouest	Diallo	Agent itinérant de santé
Village COM Dokita	Croix Rouge Belge/Burkinabé Section de Batié		Infirmière et logisticien

Location	Institution	Persons met	Function
Village COM Bobera	Plan International		
Village COM Tiossera	Croix Rouge Belge/Burkinabé Section de Gaoua		
CSPS Bonko	Direction régionale de la santé du Sud Ouest		
CSPS de Dolo	Direction régionale de la santé du Sud Ouest		
COM Sœurs de Dissin	Organisation Catholique pour le développement et la solidarité (OCADES) Section Sud Ouest		Responsable de la communauté, 4 gestionnaires de l'activité au niveau du centre
Village COM Benvar	Association pour la valorisation des ressources naturelles par l'autopromotion (Varena Asso)		Hygiéniste et les membres du comité de gestion
Com Néma	Africare		
Com Kangrin	Association appui moral et intellectuel à l'enfant (AMMIE)		
DRS Ouahigouya	Direction régionale de la santé du Nord	Dr. Moussa Dadfjoari	Direction régionale de la santé du Nord
CSPS You	Direction régionale de la santé du Nord		Infirmier chef de poste et une accoucheuse auxilliaire et 1 agent inténerant de santé
CSPS Selbonga	Direction régionale de la santé du Nord		Infirmier chef de poste
COM Tansalga	Christian Relief and development organization (CREDO)		Superviseuse et animatrice
Com Soussou	Association pour le secours et aide à l'orphelin (APSAO)		
Com Tavoussé	Association pour la promotion de la femme Ouahigouya (ZOODO)		
Com Bani	Croix Rouge Belge/Burkinabé Section du Nord		2 Infirmières + les membres du comité villageois de nutrition et un animateur
Com Thou	Association pour la promotion des œuvres sociales (APROS)		2 bénévoles à Thou et le président à Kain
CSPS Banh	Direction régionale de la santé du Nord		Infirmier chef de poste et une accoucheuse auxilliaire et 1 agent inténerant de santé
District de Djibo	Direction régionale de la santé du Sahel	• Sawadogo • Dr Dembélé Philibert	• Responsable des statistiques et épidémiologie • Médecin Chef de District

Location	Institution	Persons met	Function
Com Ouré	Hunger Project /Section Sahel		Gestionnaire de l'épicentre de Bougué
COM Botonou, Tingou, Aoura	Croix Rouge Belge/Burkinabé Section du Sahel		1 Infirmière + un animateur+ un logisticien
CSPS de Baraboulé	Direction régionale de la santé du Sahel		
District de Sebba	Direction régionale de la santé du Sahel	• Onadja • Dr Diallo	• Coordonnateur de district • Médecin Chef de District intérim
Direction Régional de la Santé	Direction régionale de la santé du Sahel	• Sanou Abdoulaye	• Coordonnateur de district
CSPS de Oursi	Direction régionale de la santé du Sahel		
COM soeurs de Gorom	Organisation Catholique pour le développement et la solidarité (OCADES) Section Sahel		
COM Village de Katchari/ Soffokel	Reach Italia		Coordonnateur de projet+ comité de suivi de projet+ 2 animatrices
COM de Bolaré	Le Projet de lutte contre la malnutrition dans la région du Sahel (APRODEB)		Coordonnatrice de projet+directeur exécutif+ 1 animatrice
COM Darkoa	Organisation Catholique pour le développement et la solidarité (OCADES) Section Centre North		
CSPS de Dibilou	Direction régionale de la santé du Centre Nord		
CSPS Secteur 7	Direction régionale de la santé du Centre Nord		
Billakardié	SOS Sahel International		
CMA de Boulsa	Direction régionale de la santé du Centre Nord		Infirmier chef de poste+ la coordonnatrice de district
CSPS Liligou	Direction régionale de la santé du Centre Nord		Infirmier chef de poste+ la coordonnatrice de district
COM Goenga	Hunger Project Section Centre North		Gestionnaire de l'épicentre de Bougué+ bénévole
COM Nanioagou	Association d'appui à la Promotion du Développement Durable des Communautés (APDC)		
Direction Régional de la Santé	Direction régionale de la santé de l'Est	Dr Robert Kargougou	Directeur régional de la Santé
CSPS Dinalaye	Direction régionale de la santé de l'Est		
CSPS village de Tankwarou	Direction régionale de la santé de l'Est		Infirmier chef de poste
COM de Bassiéri	Hellen Keller International		Infirmier chef de poste + responsable du comité villageois
CSPS de Tambarga	Direction régionale de la santé de l'Est		Infirmier chef de poste+ accoucheuse

Annex 4: Methodology / evaluation matrix

Nutrition Issues

(relevant to Outcome 1: Reduced level of acute undernutrition among targeted children and women)

1. Reversing trends in malnutrition: can it be/has it been done?

    - Underlying etiology of recent trends—causes and implications for longer-term programming. Regional dimensions to sub-national crises. Are the causes being reversed, not just the symptoms?
    - Challenges of simultaneously treating and preventing undernutrition
    - Challenges of narrow targeting while seeking universal coverage
    - Are the metrics and methods used appropriate to demonstrate success in turning around population-wide (prevalence) versus individual malnutrition (recovery rates)?
    - Implications of current debate concerning the appropriateness of the WHO 'emergency threshold' for public action against wasting.

2. Roles of food in treatment and prevention

    - Does this kind of PRRO need different kinds of rations/commodities?
    - What implications are there from the ongoing debate on ready-to-use foods (RUFs as well as RUTFs) for such a PRRO. Should more animal-source foods be present? What of home fortificants?
    - Current experience of local production (WFP/Nutrifaso). What are the logistical, cost and technical issues concerned? Potential for expansion into energy dense RUSFs?
    - How 'protected' has the pipeline been for this 'nutrition'-focused PRRO versus any other PRRO
    - How well was non-ration consumption assessed (to determine actual role of commodities delivered)?
    - How has diet diversity been used in understanding needs, programming of commodities, assessment of impact?

3. Micronutrient issues:

    does nutrient composition make as much a difference in prevention as in treatment?

    - Measuring % fortified food delivered tells us…..what exactly?
    - Any shelf-life issues appearing given scale of operations (hence more logistic, warehousing and pipeline complexity)?
    - What role, if any, for home fortificants, multi micronutrient supplements, double/triple fortified salt, etc?
    - Potential for direct measurement of micronutrient deficiency and/or impacts in micronutrient status?
    - Some evidence exists of secular shifts in BF dietary patterns towards higher reliance on cereals with less on tubers and animal source protein. Can this be documented? Is higher cereal consumption a factor in diet quality deterioration leading to wasting?

4. Low birth weight: a relatively new indicator for WFP success

    - Use of this measure requires strong partnership with health sector actors—any constraints to such partnership?
    - Is the number of births linked to period of actual food distribution large enough to have statistical significance?
    - Given low coverage of primary health care services, what is the quality of measurement of low-birth weight in target areas? How well are potentially confounding issues (problems causing complications for the mother) tracked and accounted for?
    - Is there sufficient evidence to make plausible inference on role of food?
    - Do implementing partners and mothers themselves understand the implication of this metric to nutrition outcomes?
    - Are there potential trade-offs in terms of LBW and wasting prevalence? That is, since the odds ratio of prenatal mortality are much higher with LBW, achieving gains in BW should result in higher survival rates, which could in turn contribute to higher prevalence of wasting among survivors

5. Nutrition Surveillance: What should be done, how, by whom, for what purpose?

    - Relative mandates (UNICEF, WHO, WFP) and competitive advantages
    - Human and financial capacity of BF/MOH
    - Functions of INGOs in early warning, surveillance and monitoring
    - Appropriate metrics?
    - Quality of sentinel sites—capacity for delivering appropriate data, location in relation to what kinds of 'need', links with non-nutritional data?
    - Track record of linking 'warning signals' with appropriate responses
    - Implications of experiences of Integrated Phase Classification (IPC) on surveillance design.
    - Credibility of data:

        - Training approaches, survey methodologies, analytical capabilities
        - Ownership and dissemination of information
        - Evidence-based programming (more principle than practice?)

6. Behaviour Change: evidence of information/education having effect?

    - Using cutting edge content and delivery?
    - Are culinary demonstrations valued by implementing partners or beneficiaries? Are they assessed in terms of worth?
    - Metrics for measurable impact?
    - Are energy and nutrient dense complimentary foods available? Is nutrition education focused on the critical 4 to 6 months weaning period?

7. Malnutrition as 'development crisis'

    - How to transition from emergency to development modes when malnutrition cuts across such programming/funding windows?
    - Resolving malnutrition in a vacuum? Potential for improved nutrition surrounded by deterioration in poverty/food security.
    - What are the plans for funding of future treatment of wasting in a more developmental context?
    - Cost-benefit issues (treatment versus prevention/targeted versus universal)
    - If trends shown to have been reversed, what implications are there for sustained action to prevent future moderate undernutrition again turning to severe?

Broad Policy Issues

(relevant to overall goal: Improve nutritional status of the most vulnerable populations)

8. National nutrition strategy development: next steps
    - Given the relatively recent political recognition of nutrition in the BF gvt, is this actually translating into authority and resources for action?
    - Functional lines of authority among BF ministries—where does the power really lie for a) policy change and b) implemented programmes?
    - Moving strategy to plan of action—what process, whose responsibility?
    - How is the experience of implementing (and design) of the PRRO informing thinking on national planning for nutrition?
    - Is nutrition now more prominent in the PRSP process? What resource windows are opening in government recurring budget to deal with needs laid out by national nutrition strategy?

9. Global food and fuel price crisis: implications for the medium term?

    - Likely winners/losers in BF if food prices stay 'higher' over the next 3 to 5 years (by region and demographic).
    - Rural to urban shifts in locus of nutrition problems? Or are investment resources now moving back 'into agriculture'?
    - What political credibility does the BF Cost of Living Coalition (a group of civil society organisations and unions) have in government circles? That is, if strikes and demonstrations continue what policy changes could be effected, with what potential implications for nutrition in coming years?
    - Cost of delivering products and services in coming years (due to fuel prices, commodity costs, potential tariff changes, etc)
    - How is the 'nutrition crisis' discussed and framed in the context of CAP appeals (emergency nutrition cluster), UN country team discussions and crisis prevention community (lessons from the Niger emergency).

10. Linking nutrition to food security

    - Implications for development programming of a push for 'community nutrition interventions'. What outreach support, training needs, institutional backing needed?
    - Are programmatic/sectoral links between elaborated for actions in agriculture and livelihoods security that may dovetail with investments in health and nutrition?
    - Seasonal dimensions of malnutrition closely track food insecurity. What potential for non-food supported safety net interventions to buffer consumption and purchasing power on a seasonal basis?

11. Health and nutrition interactions

    - Facilities for primary care are still rudimentary. Referral facilities for severe acute malnutrition are not yet functional in all regions, and some have low performance of counter-reference. Few accommodate accompanying family members, who will not receive any meals. Although nutrition is part of IMCI/c-IMCI, coverage is low. Nutrition is not well integrated into PMTCT programmes. What plans are in motion to build this kind of infrastructure that will be an essential foundation for effective nutrition actions in the coming years?

- Recent rise in <5 mortality in some parts of West Africa (and no improvement in rates for BF for past 15 years) raises concerns about underlying malnutrition rates, epidemics, etc. Can actions needed to bolster the effectiveness of child survival interventions support and synergize nutrition interventions?
- What role of malaria and meningitis in the process and trend patterns of malnutrition? What plans and investments are targeted to these major health risks?

Process and Capacity Issues

(relevant to outcome 2: Enhance Government's capacity to implement the National Plan of Action for Nutrition, in particular the aspects related to setting up a nutrition surveillance system.)

12. WFP processes:

- Has WFP has the appropriate skill sets and human capacity to implement such an ambitious, large scale activity?
- To what extent have operations been able to count on appropriate non-food resources (cash) as necessary?
- Given the nutrition focus of the PRRO, has the necessary nutrition backstopping been forthcoming from regional and HQ units?
- How different are the needs and problems of the 5 target provinces? Is more nuanced tailoring of operations desirable in coming years?
- How can differences of opinion and understanding surrounding the meaning of, and motivation for, 'nutrition surveillance' best be resolved?
- What functions should WFP pursue and decline in the context of setting up an effective national surveillance system?
- In addition to Nutrifaso should WFP explore support for local production of additional fortified blended foods, particularly RUSFs, potentially in collaboration with UNICEF?

13. UN processes:

- Institutional and personal interactions with UNICEF—has the MOU helped or hindered?
- What non-food resources have not been forthcoming from other UN agencies due to lack of funds or other constraints?
- How can OCHA, UNHCR (active in the broader region), and UNDP become more active champions of the nutrition problematic in, and through, their own work?
- With common premises and 'One UN' promises high on the international agenda, how is the joint UN agenda affected by the growing attention to nutrition in BF? What (otherwise hidden) capacities do other potential partners have to contribute.

14. Institutional capacity of BF government

- What day-to-day constraints most hamper the work of public sector nutritionists?
- How might a decentralized DN (CNCN) structure at regional and/or district level help bolster human capacity for programme implementation, collection and interpretation of data, and enhance the political stature of nutrition among other sectoral players?
- If underlying constraints linked to low exclusive breastfeeding, epidemic disease outbreaks, poor hygiene and sanitation, etc, what strategic plans of operation need to be in place to ensure that underlying causes of malnutrition are appropriately tackled in a sustained fashion? What capacity, funding streams, offices, programme staff, training regimens, etc are needed?

Stakeholder Issues

(relevant to output 1.1: Timely provision of food- to supported nutrition interventions (supplementary feeding) for targeted beneficiaries in appropriate quality and quantity)

15. Partners' capacity: critical to success

    - What are partners' constraints to scaling up coverage (in terms of parcelling of spatial domains among INGOs, limits to UN operational funding, etc.)
    - Trade-offs between offering quantity versus quality of service and inputs. At present, health centre stocks of supplies and equipment that are all essential to nutrition programming and surveillance, including Information-Education-Communication (IEC) materials, vitamin A capsules, iron-folic acids, growth charts (and scales) and therapeutic foods, are limited, often depending on the presence of an INGO. What plans are developed for enhanced stocking, pipeline priming, and training in use of, such inputs?
    - What investments/training are made in partner capacity enhancement (other than MoH)? For example, knowledge and capacity of PMTCT, CTC approaches, new protocols for zinc distribution, etc.

16. Credibility of surveillance and warning information

    - Are nutrition data of various kinds better/increasingly a) understood by more people, b) demanded, c) used to inform decisions and actions?
    - What disagreements about methods or analysis constrain acceptance of results?
    - Who is training whom in MOH and among INGOs, using what protocols? Is training quality appraised?
    - Do ad hoc or regular field mission reports have credibility issues?
    - What are donors demanding in terms of credible information to help them prioritize responses—more representative data, more frequent reporting, better collected and compiled data, more transparent methodologies, etc?

17. Donor funding priorities

    - The EC states that it is "ready to increase its aid to fight malnutrition in Burkina Faso if current…nutrition projects prove to be "success stories" (Sept 2008). What do they need to see for it to qualify as 'success'? What are EC and other donors plans for investment in nutrition assuming success is demonstrated?
    - What levels of investment (in $ terms) might be needed to replicate and sustain any progress demonstrated by the PRRO?
    - Few 'new' INGOs have arrived in BF on the heels of the 2005 drought/locust crisis, in stark contrast to Niger. How does BF's status as a 'stable, non-emergency country' affect priority-setting in donor capitals. Does/should the gvt and its partners seek to change the nature of the funding priority debate by highlighting acute malnutrition as a hidden emergency?
    - What role may exist for private sector partners in the nutrition agenda? Nutrifaso is just one example, would P4P have a major role in BF? With national expanded coverage, what transportation hurdles will be faced? Could elements of a surveillance system be commissioned/outsourced when it is beyond government capacity?

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