Fighting Hunger Worldwide

Operation Evaluation

Mid-Term Evaluation of the Ethiopia Protracted Relief and Recovery Operation 10665.0 (2008-2010): An Operation Evaluation

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Disclaimer

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Title of the Operation	Responding to Humanitarian Crises and Enhancing Resilience to Food Insecurity.				
Number of the Operation	10665.0				
Approval Date	September 2007				
Objectives	• Stabilise and/or reduce acute malnutrition among people affected by acute food insecurity resulting from natural disasters or conflict; • Increase the ability of PSNP beneficiaries to manage shocks and invest in activities that enhance their resilience; • Rehabilitate children under 5 with moderate acute malnutrition and pregnant and lactating women identified during the EOS screening in food-insecure districts; • Enhance the basic nutrition knowledge of mothers and other women in communities targeted by EOS/TSF; • Improve the nutritional status and quality of life of food-insecure people living with HIV/AIDS through HBC, ART and PMTCT; • Increase school enrolment and attendance of OVC in HIV/AIDS affected urban communities; • Increase the capacity of government, particularly at local levels, and communities to identify food needs, develop strategies and carry out hunger and disaster risk reduction programmes				
Operation specs	**Start Date**	**End Date**	**Beneficiaries**	**Metric tons**	**US$**
Approved design	1 Jan 2008	31 Dec. 2010	3.8 million (yearly maximum)	959,327	561,324,284
At the time of the evaluation	1 Jan 2008	31 Dec 2010	4.9 million	1,591,312	1,295,291,546
Main Partners					
Government	Government: Food Security Coordination Bureau, Disaster Prevention and Preparedness Agency, Ministry of Health, Federal HIV/AIDS Prevention and Control Office, Ministry of Agriculture and Rural Development, and regional and district bureaus and offices of these Ministries				
Bilateral	Canada, European Commission, Germany, Japan, Spain, UK, USA				
Multilateral	UN CERF, Multilateral,				
Other ongoing WFP Operations	CP 10430.0 - Ethiopia Country Programme PRRO 10127.3 - Food Assistance to Sudanese, Somali, Kenyan and Eritrean Refugees Special Operation 10721.1 – Logistics Augmentation for Somali region operations Special Operation 10713.0. Inter-Agency Passenger Services for the Somali region of Ethiopia				

Executive Summary

Background

Context

1. Ethiopia experienced a period of rapid economic growth from 1998 to 2007, with national gross domestic product (GDP) growing at almost 8 percent per year. However, the rate of rural poverty remains high, with 38 percent of rural households living below the food poverty line.[1] In 2005, 34 percent of rural households had suffered food shortages in the previous 12 months and 15 percent of rural households had a food gap of longer than four months.[2] Access to markets is a critical constraint, with 43 percent of households in rural areas having to travel more than 15 km to access transport services.[3] Ten percent of the population (7.5 million people) participates in the largest public works programme in Africa.[4] In addition, millions more people are affected by climate, economic and social shocks.

2. Since 2007 Ethiopia has had two major droughts that affected 6.4 million people.[5] Poor households were also impacted by the food price crisis, which caused a sharp increase in the price of staple foods across the country.[6] An International Food Policy Research Institute (IFPRI) report showed the lowest price increase was found for maize in Tigray, which increased by "only" 75 percent over this two-year period. The highest price increase was maize in Southern Nations, Nationalities and Peoples Region (SNNPR), which increased by 187 percent.[7]

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

4. Ethiopia has high malnutrition levels, particularly in rural areas.[8] At the national level, the recorded rates in 2005 were over 10 percent for wasting (global acute malnutrition or Global Acute Malnutrition [GAM]) and 47 percent for stunting (chronic malnutrition).[9] The Demographic Health Survey (DHS) found considerable malnutrition among women of childbearing age; the national average was over 26 percent of women being undernourished, with a Body Mass Index (BMI) of less than 18.5. Low birthweight prevalence was found to be a high 13.5 percent. Information at the *woreda*[10] level on 2008 and 2009 nutrition conditions is provided through standard nutrition surveys. Consistently high malnutrition levels (GAM > 20 percent) were found in surveys undertaken in Afar and Somali regions and some pockets in SNNPR. In Amhara and Oromiya regions and the other parts of SNNPR reported GAM rates were all <15 percent (in about half of the cases < 10 percent) and in Tigray all well below 10 percent.

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

[1] World Bank. 2009. PSNP, Project Appraisal Document. Washington, DC.
[2] Welfare Monitoring report, 2004/05
[3] World Bank, Project Appraisal Document, 2009
[4] World Bank, PSNP, Project Appraisal Document, 2009.
[5] World Bank. 2006. Country Assistance Strategy – Ethiopia 2006.
[6] IFPRI. 2008. An Impact Evaluation of Ethiopia's PSNP. Washington, DC.
[7] IPFRI. 2009. Impact Report
[8] Central Statistical Agency (Ethiopia) and ORC Macro (2006). Ethiopia DHS 2005. Addis Ababa.
[9] Considerable regional variation existed with regard to GAM rates. Somali region showed an alarmingly high rate of 23.7 percent (with 5.1 percent SAM), followed by Amhara and Benishangul-Gumuz (14.2 percent and 16.0 percent, respectively). The lowest rates were found in SNNPR (6.5 percent) and Gambella (6.89 percent but with 3.8 percent SAM).
[10] A *woreda* is a sub-regional administrative unit.

inadequate health services, unsafe water supply and lack of sanitation facilities. Food-secure households or regions in Ethiopia can still be highly affected by both acute and chronic malnutrition. Augmented acute malnutrition levels occur during times of (recurrent) natural disasters and other acute external food security shocks in Ethiopia.[11]

6. Ethiopia is severely affected by the Human Immunodeficiency Virus (HIV) epidemic. In 2009 HIV prevalence among adults 15–49 year-olds was 2.3 percent (7.7 percent in urban and 0.9 percent in rural areas). The number of People Living with HIV (PLHIV) was 1.1 million. There were 855,720 orphans and other children made vulnerable by Acquired Immune Deficiency Syndrome (AIDS), orphans and vulnerable children (OVC) among a total of 5.4 million OVC. During the year there were 131,000 new infections, and AIDS caused the deaths of 44,751 adults and 7,214 children.[12] In 2008 Anti-retroviral therapy (ART) was available at 400 sites for 132,379 PLHIV, and an estimated 18 percent of the pregnant women with HIV received ART for prevention of mother to child transmission (PMTCT).[13] In 2006 AIDS was the leading cause of mortality in 15–49-year-olds (43 percent of all deaths) and life expectancy was falling as a result of the epidemic; it was expected to drop from 59 to 50 years by 2010.[14]

Description of the Operation

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

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

- **Relief programmes**. The relief programmes support government efforts to respond to acute and transitory food insecurity, beyond the people covered by the Productive Safety Net Programme (PSNP). WFP's contribution to these efforts includes: logistical support, livelihoods-based needs assessments, technical backstopping to early warning systems and seasonal assessments, rapid-assessment teams in disaster-affected areas, determination of required assistance, monitoring of distributions and assistance in targeting. WFP staff provide technical assistance and strategic input from the United Nations and national levels through to the local government and community levels. Original plans were to assist a maximum of 792,000 people; the figure was later revised to 6.4 million people.

- **Productive Safety Net Programme**. The PSNP is a multi-year, multi-donor programme that provides predictable and timely food and cash transfers to chronically food-insecure beneficiaries. WFP supports the Government in the management of food transfers. In the original approval

[11] IFPRI. 2005. An assessment of the causes of malnutrition in Ethiopia. November. Washington, DC.
[12] Federal HIV/AIDS Prevention and Control Office, Ethiopia. 2009. National Fact Sheet 2009. Addis Ababa.
[13] WHO/UNAIDS/UNICEF. 2009. Towards Universal Access. Progress Report 2009.
[14] WFP country office. 2005/06 Annual HIV/AIDS Monitoring and Evaluation Report. Addis Ababa.

document, the Government and WFP targeted a maximum of 2.46 million people for food transfers in 2009; PSNP reached 7.5 million people with food and/or cash transfers and other support. It seeks to help households meet basic needs through monthly transfers and to build more resilient livelihoods through community public works and environmental management.

- **Targeted supplementary feeding**. The Targeted Supplementary Feeding (TSF) programme is the only large-scale food-based programme in support of the Government's Child Survival Initiative and operates in conjunction with the Enhanced Outreach Strategy (EOS) programme supported by the United Nations Children's Fund (UNICEF). The TSF, established in 2004 following the 2002/03 emergency response, is a system of targeted nutritional support to treat moderate malnutrition in rural Ethiopia. The TSF targets were reduced from 737,000 to 597,000 people.

- **Urban HIV/AIDS**. This programme supports food-insecure PLHIV at a critical point in HIV management by using food support when commencing ART or PMTCT. It also supports children made vulnerable by AIDS and infants of women participating in PMTCT. It complements allied health and community services and is implemented through government and non-governmental organization (NGO) partners. It was envisaged to scale up from 155,000 to 164,000 over the three years.

Evaluation Features

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

Performance Highlights

Operation Design: Relevance and Appropriateness

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

- save lives and protect livelihoods in emergencies;

- prevent acute hunger and invest in disaster preparedness and mitigation measures;

- reduce chronic hunger and under nutrition; and

- strengthen the capacities of countries to reduce hunger, including hand-over strategies and local purchase.

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

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

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

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

Outputs and Implementation

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

16. The cost of operating the PRRO has been adjusted seven times since its inception.[15] Mobilizing the resources to cover these rapid increases in beneficiary numbers has been a challenge. WFP has been effective in ensuring the PRRO is well financed. However, mobilizing the volume of resources to meet the increased demand has placed significant strain on the capacity of the food management systems.

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

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

19. Since the inception of PSNP there has been evidence of delays of food and cash transfer deliveries. In 2007, an estimated three out of four PSNP beneficaries (71 percent) had encountered delays in transfers, according to their own reports. The

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

situtation was no better in 2008, when less than 50 percent of households received all the transfers they were due in the first five months (see table below).

PSNP Households receiving transfers by percent of due transfers (9 January – 9 June 2008)

Region	Number of households	0–50%	50–80%	80–100%	100%
Tigray	422	51	30	4	15
Amhara	289	25	35	20	21
Amhara II*	374	37	30	10	23
Oromiya	286	24	16	11	49
SNNPR	360	9	32	14	45

Source: IFPRI
Table PSNP report = Comparison of original and new Strategic Objectives and Outcomes of Logframe
* The IFPRI study divided Amhara assistance into two groups depending on the support provided

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

Coverage under TSF (2005–2009)

	PRRO 10362.0			PRRO 10665.0[16]	
	2005	**2006**	**2007**	**2008**	**2009[17]**
Regions[18]	7	10	10	7	7
Woredas	165	260	342	166	202
Pregnant/lactating women (000)	173	228	369	289	356
Under-5s (000)	301	484	783	615	756
Total beneficiaries (000)	**474**	**712**	**1 152**	**904**	**1 112**

Source: Evaluation team
Summary of Outputs 2008

21. Ideally, TSF coverage would be needs-based and not resource-based. The WFP country office, the Government and other stakeholders face a major challenge in securing the contributions required to ensure acceptable coverage, in terms of both number of *woredas* and total number of beneficiaries.[19] In addition, high fuel and food prices limited the purchasing power of available donor funds.

[16] WFP country office. 2009, SPRt 2008 Ethiopia; Project 10665.0. Addis Ababa.
[17] Figures refer to round one only, which was undertaken in 167 *woredas* in the period May–August, and ad hoc screening results in 35 additional *woredas* in Amhara, SNNPR and Oromiya. Owing to operational problems, no screening/distribution took place in this round in Afar and Gambella regions.
[18] In 2006 and 2007 all regions in Ethiopia were covered. In 2008–2009 seven regions were covered: Somali region, Oromiya, Amhara, Tigray, SNNPR, Gambella and Afar.
[19] Nationwide, around 780,000 under-fives are estimated to be in need of treatment for moderate acute malnutrition. At first sight, this target figure seems to be closely matched by the total coverage achieved in 2007. However, there has been a considerable level of false inclusions (see the Results section) and only a certain proportion of all rural *woredas* in Ethiopia were covered by the TSF. This means that there were many malnourished children in Ethiopia who were not reached by the TSF.

22. The HIV/AIDS component did not reach its target for the output on the timely provision of food in sufficient quantities. At 12,320 mt the overall tonnage of food distributed was 56 percent of the target and one in five beneficiaries reported not receiving food on time. However, for outputs of capacity development of HIV counterpart staff, the project managed to reach its beneficiary training targets.

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

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

25. **Targeting.** The relief component targeting uses National Food Aid Targeting Guidelines issued in 2000. Since the introduction of the guidelines, a range of innovations has been introduced in the humanitarian sector. The Government and WFP are reviewing the guidelines to identify gaps and limitations that hinder the timeliness of relief and the proper utilization of resources. [20]

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

27. The geographical targeting for TSF is coherent with government systems for prioritizing humanitarian assistance. However, the component struggles to keep pace with an expanding demand for coverage. The evaluation assessed whether the average number of TSF beneficiaries per *woreda* is in line with peak malnutrition rates in the three regions visited. It found a substantial inclusion error in Amhara and SNNPR while generally there was still under-coverage in Somali region.[21] These findings underscore the importance of improving EOS screening procedures as is currently being done in response to the 2008 TSF outcome evaluation study that highlighted the same issue. In 2009, WFP initiated a pilot study of the gatekeeper approach, which might also help to reduce targeting errors. This approach, first piloted in SNNPR and now being expanded to Afar region, uses the EOS screening to make a referral to a second screening done by health workers.[22]

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

[20] WFP country office. 2010. Terms of Reference, Targeting of Relief. Addis Ababa.
[21] Peak malnutrition levels were based on the Standard Nutrition Survey findings plus a certain margin for particularly bad years. For SNNPR, a level of 20 percent was taken, for Amhara 15 percent and for Somali region 25 percent.
[22] According to the WFP country office, the new approach works well.

29. **Monitoring and evaluation.** The evaluation found weaknesses in the PRRO's approach to evaluating the relief component. The frequency of humanitarian crises, the high probability that a crisis will repeatedly impact certain geographical areas, and the levels of resources invested in humanitarian response, suggest that resources could and should be applied to establishing a robust monitoring and evaluation framework.
30. In contrast, PSNP has established a comprehensive framework for monitoring and evaluation. The programme has established a comprehensive, in-depth and continuous system that includes various types of evaluation, including impact evaluation.

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

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

Results

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

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

Use of PSNP Food (previous 12 mths)

Use of food	PSNP Beneficiaries	
	Number	percent
Ate all the food	431	73.7
Sold some food, ate the rest	74	12.6
Gave away some food, ate the rest	26	4.4
Sold the food to buy other food	21	3.6
Gave some food as payment, ate the rest	13	2.2
Sold all the food for cash	13	2.2
Gave all the food to livestock for feed	1	0.2
Gave all the food as payment	1	0.2
Other	5	0.9
Total	**687**	**100**

Source: IDS, 2008

35. However, progress in supporting households to develop risk mitigation strategies is less positive. Transfers through PSNP are meant to discourage households from using negative coping strategies such as selling assets. The evaluation highlighted that timeliness and predictability of transfers are critical factors in reducing negative coping strategies. Studies show that households that receive lower than the intended level of transfers are much more likely to sell assets because of distress.
36. Studies undertaken in 2007 and 2008[23] found that the TSF component was not highly effective (recovery rates of only 50 to 62 percent). The programme was found to have high inclusion errors, significant delays between screening and actual food distribution, and problems with compliance because of substantial sharing of food among household members.

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

38. The HIV/AIDS component annual results survey demonstrated significant beneficial outcomes and achievement of targets for PLHIV on ART and OVC, but not for PMTCT. Most indicators showed a positive trend (see table below) and met between 84 and 108 percent of their targets. The project reached only 49 percent of its PMTCT target owing to factors beyond its influence; for example, pregnant women often do not use health services, and those who do are reluctant to be tested for HIV because of the stigma associated with the virus. The component's contribution to ART programming is shown by a three-fold increase in the number of clients enrolled in ART from 2007 to 2008.[24]

Indicator performance for urban HIV/AIDs component (%)

Outcome indicators	Baseline (Jun 2006)	Actual (Nov 2008)	Percent of target
PLHIV gaining weight by at least 10% six months after starting ART	24.6	47.4	84
Percent of beneficiaries on ART taking 95% of medication in last month	76.7	96.4	101.3
PLHIV with improving/stabilizing health condition	85.6	95.1	99.9
PLHIV with improved functional status	73.2	92.4	108
School enrolment of OVC	80.1	98.8	104
School attendance of OVC	90.9	98.4	n/a

TSF achieved coverage 20005-2009

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

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

[23] WFP country office. 2007. TSF Performance Study Report. Addis Ababa; and Skau, J., Belachew, T., Girma, T. and Woodruff, B. 2009. Outcome evaluation study of the targeted supplementary food programme in Ethiopia. Addis Ababa.
[24] WFP Urban HIV/AIDS Project. Results Report for 2007 and 2008. Addis Ababa.

and achieving the timeliness requirements as compared with the safety net programme.[25]

41. The PSNP food and cash transfers have had a positive impact on food security. However, the IFPRI impact evaluation and the IDS assessments vary in their assessment of the extent of the programme's impact. In 2009, IFPRI stated that the impact of PSNP would be greater if transfers – both cash and food – were predictable and households had access to livelihood support programmes. Unpredictable transfers cause households to sell assets.[26] The IDS report's more positive assessment found that PSNP is stabilizing livelihoods and improving the food security of beneficiary households.[27]

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

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

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

Cross-Cutting Issues

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

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

[25] The PDM report does not disaggregate the impact of food transfers on diet by programme component (relief and safety net).
[26] IFPRI. 2009. An Impact Evaluation of PSNP.
[27] IDS. 2008. Ethiopia's PSNP, Assessment Report. Brighton, UK.

restricting the resources and staff time devoted to developing and implementing protection protocols.

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

Conclusions and Recommendations

Overall Assessment

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

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

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

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

Issues for the Future

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

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

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

Recommendations

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

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

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

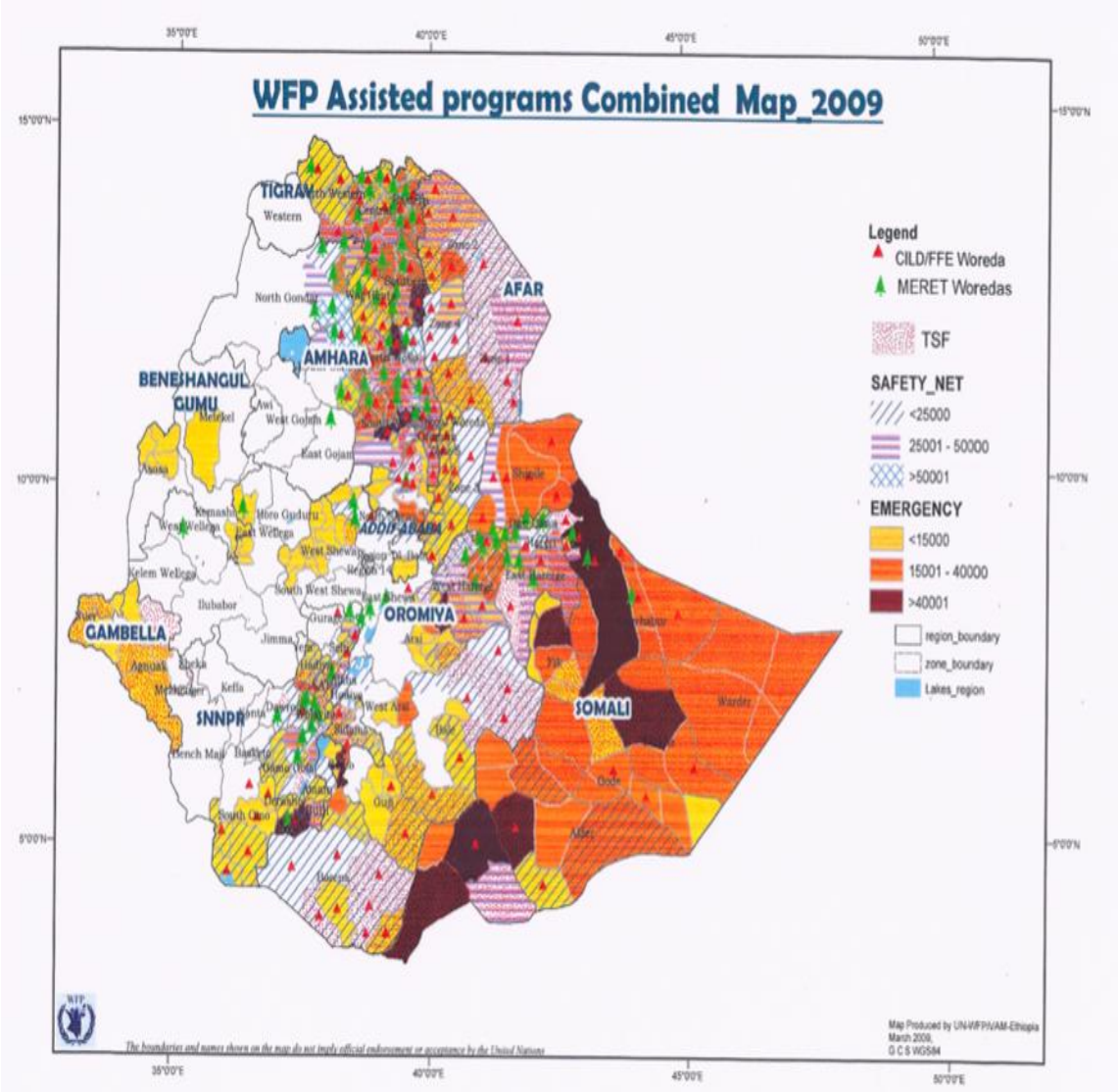
58. WFP should strengthen the relevance and appropriateness of the TSF programme through: i) improved targeting; ii) development of a mechanism to adequately respond to emergency requirements; and, ii) better links and communication across sectors –including basic health care workers and water and sanitation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

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

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

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

Map


WFP Assisted programs Combined Map_2009
TIGRAY
AFAR
AMHARA
BENESHANGUL GUMU
GAMBELLA
SNNPR
OROMIYA
SOMALI
ADDIS ABABA
Legend
CILD/FFE Woreda
MERET Woredas
TSF
SAFETY_NET
<25000
25001 - 50000
>50001
EMERGENCY
<15000
15001 - 40000
>40001
region_boundary
zone_boundary
Lakes_region
Map Produced by UN-WFP/AM-Ethiopia
March 2009.
G C S WGS84
The boundaries and names shown on the map do not imply official endorsement or acceptance by the United Nations
35°00'E
40°00'E
45°00'E
50°00'E
15°00'N
10°00'N
5°00'N

1. Background

1.1. Context

1. Ethiopia experienced a period of rapid economic growth from 1998 to 2007, with national GDP growing at almost eight percent per year. However, the rate of rural poverty remains high, with 38.5 percent of rural households living below the food poverty line.[28] In 2005, 34.2 percent of rural households suffered food shortages in the previous 12 months and 15.2 percent of rural households had a food gap of longer than four months.[29] The Livelihood Information Unit (LIU) reports rural households in food-insecure areas are net cereal buyers, purchasing around 30 percent of their food needs from market.[30] However, access to markets is a key constraint, with 43 percent of households in rural areas having to travel more than 15 kilometres to access transport services.[31]Ten percent of the population (7.5 million people) participate in the largest public works programme in Africa.[32] In addition, millions more people are affected by climate, economic and social shocks.

2. Since 2007, Ethiopia has had two major droughts that affected over 6.4 million people.[33] Poor households were also impacted by the food price crisis, which caused a sharp increase in the price of staples across the country.[34] An IFPRI report showed the lowest price increase was found for maize in Tigray, which increased by "only" 75.3 percent over this two-year period. The highest price increase was maize in SNNPR, which increased by 186.7 percent. In addition, except in Tigray, food prices increased much more rapidly than the wages paid for agricultural labour.[35]

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

4. The most recent DHS[36] in 2005 showed that Ethiopia has high malnutrition levels, particularly in rural areas. At the national level, the recorded rates were 10.5 percent for GAM and 47 percent for stunting (chronic malnutrition).[37] The DHS survey found considerable malnutrition among women of childbearing age; the national average was 26.5 percent of women being undernourished (BMI < 18.5).[38] Low birth weight prevalence was found to be a high 13.5 percent. *Woreda*-level information on 2008 and 2009 nutrition conditions is provided through Standard Nutrition surveys (see Annex

[28] World Bank, PSNP, Project Appraisal Document, 2009.
[29] Welfare Monitoring report, 2004/05.
[30] World Bank, Project Appraisal Document, 2009.
[31] World Bank, Project Appraisal Document, 2009.
[32] World Bank, PSNP, Project Appraisal Document, 2009.
[33] World Bank, Country Assistance Strategy-Ethiopia, 2006.
[34] IPRI, An Impact Evaluation of Ethiopia's PSNP, 2008.
[35] IFPRI, Impact Report, 2009.
[36] Central Statistical Agency (Ethiopia) and ORC Macro (2006), Ethiopia Demographic and Health Survey 2005, Addis Ababa/Calverton.
[37] Considerable regional variation existed with regard to GAM rates. Somali region showed an alarmingly high rate of 23.7 percent (with 5.1 percent SAM), followed by Amhara and Benishangul-Gumuz (14.2 percent resp. 16.0 percent). Other regions like Tigray, Afar, Oromiya, Dire Dawa and Harari were in the middle ranges with GAM rates around 10 percent. The lowest rates were found in SNNP (6.5 percent) and Gambella (6.89 percent but with 3.8 percent SAM).
[38] The national average was 8.8 percent of women being moderately or severely thin (BMI <17).

5).[39] Consistently high malnutrition levels (GAM > 20 percent) were reported for Afar and Somali region and some pockets in SNNPR while in Amhara and Oromiya regions and the other parts of SNNPR reported GAM rates were all <15 percent (in about half of the cases < 10 percent) and in Tigray all well below 10 percent.

5. The main causes of the high levels of both acute and chronic malnutrition in Ethiopia are poverty combined with deficiencies in the non-food factors of nutrition like maternal and child care, inadequate health services, unsafe water supply and lack of sanitation facilities. Food-secure households or regions in Ethiopia can still be highly affected by both acute and chronic malnutrition. Augmented acute malnutrition levels occur during times of (recurrent) natural disasters and other acute external food security shocks in Ethiopia. [40]

6. Ethiopia is severely affected by the HIV epidemic.[41] In 2009, HIV prevalence among adults 15-49 years was 2.3 percent (7.7 percent in urban areas and 0.9 percent in rural). The total number of People Living with HIV (PLHIV) was 1,116,216. There were 855,720 orphans and other children made vulnerable by Acquired Immune Deficiency Syndrome (AIDS) and OVC within a total of 5.4 million OVC. During the year, there were an estimated 131,145 new infections, and AIDS caused the deaths of 44,751 adults and 7,214 children.[42] In 2008, ART was available at 400 sites for 132,379 PLHIV, and an estimated 18 percent of the pregnant women with HIV received ART for PMTCT.[43] In 2006, it was estimated that AIDS was the leading cause of mortality in 15-49 year olds (43 percent of all deaths) and that life expectancy in Ethiopia was falling as a result of the epidemic; it was expected to drop from 59 to 50 years by 2010.[44]

7. In general, Ethiopian women and girls hold unequal status in society relative to males. This is reflected in their limited ownership of resources, access to education (secondary school gross enrolment is 17 percent of secondary-school-age females compared to 28.3 percent of males; in rural areas it is 8.8 percent females, compared with 14.7 percent males), decision-making power and political representation (32 percent female representation among parliamentarians).[45]

8. Rain-fed agriculture remains the key source of livelihood for the majority of the population. Yet Ethiopia's annual variability in rainfall across different zones is among the highest in world.[46] In recent years there has been a growth in the agricultural sector. However, analysis suggests the increase is related to the expansion of land under cultivation and not to a significant intensification of crop production.[47] Ensuring significant and sustainable growth increases in the agricultural sector will require

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[39] As the surveys are normally undertaken in *woredas* for which a nutrition problem has been signalled or as follow-up in *woredas* with nutrition programmes, the survey results cannot be used as basis for aggregation at regional level. Nevertheless, the findings do give some insight into the magnitude of acute malnutrition problems.

[40] Benson T (2005), An assessment of the causes of malnutrition in Ethiopia; A contribution to the formulation of a National Nutrition Strategy for Ethiopia, IFPRI, Washington DC, November 2005.

[41] There is no single source for comprehensive current HIV/AIDS data and statistics: these must be gathered from a range of documents.

[42] Federal HIV/AIDS Prevention and Control Office. *National Fact Sheet 2009*. http:www.etharc.org

[43] Towards Universal Access. Scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2009. WHO. UNAIDS. UNICEF.

[44] 2005/06 Annual HIV Monitoring and Evaluation Report Ethiopia.

[45] Contextual Gender Analytical Study for PSNP, Helm consultants, 2008.

[46] World Bank, PSNP, Project Appraisal Document, 2009.

[47] Rethinking Agriculture and Growth in Ethiopia: A Conceptual Discussion, 2009.

continuing infrastructure investments, increasing market linkages and ensuring access to improved technologies.

9. Land degradation poses a significant challenge to the prospects for sustainable growth and poverty reduction. Estimates suggest that erosion from cropland involves a loss of two to three percent of agricultural GDP per year in Ethiopia, and degradation of watersheds exacerbates the impact of droughts.[48]

10. Land degradation has also been directly related to population growth. The country is currently expanding by more than two million people every year. The World Bank concludes, "As a result, land holdings per rural person have been more than halved over the past 40 years and a land-poor class is emerging—20 percent of the rural households have not enough land to produce half of their caloric needs". Pressure on the land could be reduced by urbanization. According to the World Bank World Development Report 2009, Sub-Sahara Africa is 30 percent urbanised, whereas Ethiopia is only 10.9 percent urbanised. However, there is already growing evidence that poor households in urban areas experience vulnerability and shocks including food insecurity.[49]

11. Over the past five years the Government has been testing, developing and innovating institutional responses to humanitarian crises. The most significant institutional change has been the establishment of the PSNP in 2005. This programme seeks to provide predictable and timely food and/or cash transfers to 7.5 million people. The introduction of PSNP has provided an additional tool for The Government and donors to respond to food insecurity. In addition, the programme has created institutional standards against which donors and government can measure the effectiveness, efficiency and impact of their response to vulnerability.

12. Ethiopia is a pilot country for the Organisation for Economic Co-operation and Development/Development Assistance Committee harmonisation agenda. This process is redefining the way development agencies work with the Government. Key indicators of progress towards harmonisation include ownership (focusing on the Government), alignment (specifically with government systems), harmonisation (including joint missions and analytical work) and managing for results.

13. The harmonisation agenda features strongly in the current UNDAF. This document focuses heavily on improving the capacity of key stakeholders including government agencies operating in the humanitarian sector in Ethiopia. WFP heads the UNDAF Humanitarian Response, Recovery and Food Security thematic group. WFP has endorsed the Paris Principles and Accra Agenda for Action.[50] In this context, Ethiopia has the potential to be at the leading edge of how humanitarian actors effectively apply harmonisation principles.

14. The Government has recently undergone a major Business Process Reengineering. As a result of this process, departments within ministries have been restructured and there have been significant adjustments to staff numbers.

15. Humanitarian assistance, and food aid in particular, operates within Ethiopia's complex political environment. There are, for example, periodic accusations of food aid

[48] World Bank, Country Assistance Strategy-Ethiopia, 2006.
[49] World Bank, Country Assistance Strategy-Ethiopia, 2006.
[50] Building Regional and Country Capacity, 2004.

being used for political purposes, such as this charge by Prime Minister Meles Zenawi: "Some agencies were reporting exaggerated numbers of affected people for the sake of their ideological, economic and political interests."[51] Internationally, the media plays a role in projecting images of starving children and drought-ravaged landscape. These types of events create additional pressures on all humanitarian programmes and the donors that support them.

1.2. Description of the operation

16. The current PRRO 10665.0 is a three-year programme running from 01 January 2008 to 31 December 2010. It was originally designed to address the food needs of up to 3.7 million beneficiaries a year with a total proposed food allotment of 959,327 Metric Ton (MT), and a total cost estimated at US$561,947,745.[52] Due to drought and the international food and oil price crises in 2008, a prolonged emergency significantly increased numbers of relief beneficiaries. Following eight budget increases, the total food allotment in November 2009 stands at 1,591,312 mt, with a total cost to WFP of US$1,295,291,545.[53]

17. The four programme components of this PRRO are broadly similar to those of the previous programme. Specifically, these are:

- WFP Relief Programmes. These programmes support government efforts to respond to acute and transitory food insecurity, outside of the PSNP caseload. WFP's support to these efforts includes logistical support, livelihoods-based needs assessments, technical back-stopping to early warning systems and seasonal assessments, rapid-assessment teams in disaster-affected areas, and determination of required assistance. WFP staff provide technical assistance and strategic input from the United Nations (UN) and national levels down to the local government level. Originally a maximum of 792,000 people expected in this component later significantly revised.

- PSNP. The PSNP is a multi-year, multi-donor programme that provides predictable and timely transfers to a chronically food-insecure caseload of approximately 7.5 million people. It seeks to help household's meet basic needs through monthly transfers and to build more resilient livelihoods through community public works and environmental management. WFP targeted a maximum of 2.46 million people in the original proposal.

- TSF. The TSF programme is the only large-scale food-based programme in support of the Government Child Survival Initiative and operates in conjunction with the Enhanced Outreach Strategy (EOS) programme supported by UNICEF. The TSF was established in 2004 (after the 2002/03 emergency response was over) with the aim of setting up a system of targeted nutritional support that can effectively treat moderate malnutrition in large parts of rural Ethiopia.
- Urban HIV/AIDS Initiative. This programme supports food insecure PLHIV at a critical point in HIV management by using food support to facilitate commencing ART or PMTCT, and supports children made vulnerable by AIDS and infants of

[51] Voice of America, Peter Heinlein, 11 October 2009
[52] WFP PRRO Ethiopia 10665.0
[53] WFP, WFP 2008 (27-30 Oct Executive Board meeting - Budget increases - Agenda Item 9); WFP 2009 (8-12 June Board meeting - budget increases to PRRO).

women participating in PMTCT. It complements allied health and community services and is implemented through government and NGO partners. The design increased coverage from 155,000 to 164,000 people over the three years.

18. The implementation of the PRRO has been supported by Special Operation 10721.1 in the Somali region. This programme focused supporting logistics for the Somali region.

19. This PRRO, entitled 'Responding to Humanitarian Crises and Enhancing Resilience to Food Insecurity,' is one of WFP's three programmes in Ethiopia. The country programme seeks to support environmental sustainability and rural livelihoods, and universal access and gender equality in primary education. An additional PRRO helps Somali, Sudanese and Eritrean refugees maintain nutritional status.

20. A summary of the key PRRO stakeholders, both nationally and internationally, is found in Annex A. The evaluation team sought to engage as many stakeholders as possible in each stage of the evaluation.

1.3. Evaluation features

21. The evaluation took place between 28 October 2009 and mid-February 2010 with the field work in Ethiopia from 8 November to 4 December 2009.There were two objectives for this evaluation:

- To provide an avenue for accountability to the stakeholders by reporting on the work that has been carried out and the results achieved, using the planned objectives and targets as the benchmark against which to assess performance. Providing space for accountability to the donors, in terms of reporting on the results of their contributions, is also an important element.

- To draw lessons from the experience gained from the implementation of this PRRO. Given that WFP has been providing support to the large food-insecure populations in Ethiopia for over two decades, particular emphasis should be placed on identifying those practices, under the safety net component, that are indeed increasing the resilience of these populations to food insecurity.

22. The evaluation team structured the evaluation questions to ensure: a) the inclusion of WFP's key evaluation criteria, e.g. relevance, effectiveness, efficiency, impact and sustainability; b) that comparisons could be made across each of the PRRO components; and c) that focus was on both the strategic and operational elements of the PRRO. A summary of the evaluation questions is found in Annex 4.

23. The team undertook a comprehensive review of programme documents, previous evaluations, impact evaluations, monitoring reports, studies, and policies. Given the scale of the programme, priority was given to evaluations and studies whose methodologies ensure a reasonable sample of the programme components. The evaluation has considered other sources of data including the WFP Ethiopia's own Post Distribution Reports.

24. The evaluation included site visits in three regions (Amhara, SNNPR, Somali Region) and in Addis Ababa. These sites were selected because: a) the key components of the PRRO are, to varying degrees, operational in these regions; b) these regions (and their

capitals) are relatively accessible; and c) the regions were illustrative of the range of environments in which the PRRO is functioning.

25. Strong emphasis was placed on stakeholder participation in the evaluation process. Specifically, the team held a series of workshops and interviews with WFP staff, donors, civil society and government at both the start and conclusion of the mission. There were three principal objectives behind this process: to share lessons learned, validate findings, and build ownership over the evaluation's findings and recommendations.

26. The strategic objectives for the PRRO were adjusted in October 2009. The scale of PRRO operation, specifically, the scope of its geographical coverage, the vast population it covers and the complexity of its implementation were constraining factors on the evaluation. For example, the evaluation team did not have the time or resources to undertake a complete analysis of the systems that deliver food aid. The team sought to address these limitations by focusing its time and resources on issues of strategic significance to the overall programme.

27. The evaluation followed the Evaluation Quality Assurance System (EQAS)of WFP, applying the principles developed for operations evaluations conducted by the Office of Evaluation. It involved presenting initial findings at debriefings to stakeholders from WFP, the Government and the donor community, the review of the report by the same stakeholders.

2. Performance highlights

2.1. Operation design: relevance and appropriateness

28. This section reviews the PRRO objectives and provides evidence and findings of lessons learned and issues of accountability since the inception of the PRRO.

Logframe

29. At the time of the evaluation, the logical framework (logframe) for the PRRO was in a transitional phase. Specifically, in October 2009 the strategic objectives were adjusted. The justification was to ensure greater consistency with the revised corporate performance requirements. The changes are summarised in Table 1.

Table 1: Comparison of original and new Strategic Objectives and Outcomes of Logframe

	Original Strategic Objective and Outcomes	New Strategic Objectives and Outcomes
SO 1	**Save lives in crisis situations**	**Save lives and protect livelihoods in emergencies**
Outcome 1.1	Stabilised and/or reduced acute malnutrition among people affected by unpredictable acute food insecurity as a result of natural disasters or conflict	Reduced or stabilised acute malnutrition in children under-five in targeted emergency affected populations
Outcome 1.2		Improved food consumption over assistance period for targeted emergency affected households.
Outcome 1.3		Reduced or stabilised moderate/acutely malnourished children under five and pregnant and lactating women identified during EOS screening in food-insecure districts.
SO 2	**Protect livelihoods in crisis situations and enhance resilience to shock**	**Prevent acute hunger and invest in disaster preparedness and mitigation measures**
Outcome 2.1	Increased ability of PSNP beneficiaries to manage shocks and invest in activities that enhance their resilience	Increased ability of PSNP beneficiaries to manage shocks and invest in activities that enhance their resilience
Outcome 2.2		Adequate food consumption over assistance period for target households at risk of falling into acute hunger
SO 3	**Support the improved nutrition and health status of children, mothers and other vulnerable people**	
Outcome 3.1	Rehabilitated moderate/acutely malnourished children under 5 and pregnant and lactating women identified during EOS screening in food-insecure districts	
Outcome 3.2	Enhanced basic knowledge on nutrition-related issues for mothers and other women in communities targeted by EOS/TSF	
Outcome 3.3	Improved nutritional status and QOL of food-insecure people living with HIV/AIDS on HBC, ART therapy and PMTCT	
SO4	**Support access to education and reduce gender disparity in access to education and skills training**	**Reduce chronic hunger and under-nutrition.**
Outcome 4.1	Increased school enrolment and attendance of OVC in HIV/AIDS-affected urban communities	Enhanced basic knowledge on nutrition-related issues for mothers and other women in communities targeted by EOS/TSF.
Outcome 4.2		Improved nutritional status and QOL of food-insecure people living with HIV/AIDS on HBC, ART therapy and PMTCT
Outcome 4.3		Increased school enrolment and attendance of OVC in HIV/AIDS-affected urban communities.
SO 5	**Strengthen the capacities of countries and regions to establish and manage food assistance and hunger reduction programmes**	**Strengthen the capacities of countries to reduce hunger, including through hand over strategies and local purchase**
Outcome 5.1	Increase the capacity of government, particularly at local levels, and communities to identify food needs, develop strategies and carry out hunger and disaster risk reduction programmes	Increase the capacity of government, particularly at local levels, and communities to identify food needs, develop strategies and carry out hunger and disaster risk reduction programme.
Outcome 5.2		Increased marketing opportunities at national level with cost effective WFP local purchases.

30. The evaluation team finds these changes to the logframe (see Annex 5 for full logframe) strategically relevant. These objectives are coherent with the strategic and policy priorities of the Government and many donors. They also reflect the needs of food insecure households. However, the new objectives are broader and more ambitious than the original objectives. Objective One, for example, was focused on stabilising malnutrition and now has been expanded to saving lives and protecting livelihoods. Adding the protection of livelihoods to the objectives adds a new complexity. Specifically, those receiving food aid must be confident that the food will arrive in a timely and predictable manner. If this confidence does not exist, intended recipients of food aid start to sell or consume household assets in a manner that may undermine livelihoods. The Mid-Term Evaluation (MTE) finds that the food management system is generally unable to provide food aid in a timely or predictable manner.

Objectives

31. *Relief and Productive Safety Net Programme Components*. The new objectives are relevant and appropriate policy priorities of the Government and donors and to the needs of the majority of rural households who rely on rain-fed subsistence agriculture and are vulnerable to the extreme variability of weather patterns. Population pressures continue to decrease farm size and cause further degradation of the land. Access to irrigation, inputs and improved seeds remains limited. Households are vulnerable and unable to meet their consumption needs even in years when rain is adequate.[54]

32. The new PRRO strategic objectives are ambitious. The logframe contains a cluster of outputs that focus on the timeliness of transfers. The MTE found evidence that Ethiopia's food management system does not, in general, deliver transfers in a timely manner. The lack of predictability and timeliness in the delivery of transfers (both cash and food) negatively impacts progress towards achieving logframe objectives. Specifically, because delays have a negative impact on household's capacity to protect assets, strengthen livelihoods and develop improved risk management strategies.

33. The objectives seek to strengthen disaster risk management and chronic food insecurity. The MTE finds that progress in these areas will continue to be positive, specifically through WFPs contributions to PSNP (e.g. the dissemination of approaches to community based resource management and its strategic support to the donor consortium).

34. In general, measuring progress towards the strategic objectives and outcomes is possible. Stronger alignment between indicators, outcome, and objectives would improve the logic in the framework (e.g. introducing indicators for timeliness).

35. The progress of TSF component towards achieving its outcomes and outputs is mixed. Transfers are being delivered; however, design features undermine the effectiveness, efficiency and impact of the programme.

36. The HIV/AIDS Component is achieving its outcomes by establishing effective systems and processes for providing food support and improving nutritional status and QOL for PLHIV and by increasing school enrolment and attendance of OVC.

[54] World Bank, PSNP, Project Appraisal Document, 2009

Programme Design

37. *Relief Component*. Given the combination of sharply increasing food prices, drought and restricted access to inputs, ensuring access to food was a relevant and appropriate approach to the crisis. Utilizing food aid as the primary mechanism appears to have been the preferred Government policy response. However, alternative policy pathways, such as lifting restrictions on private commodity imports, may have been a more efficient mechanism. However, the policy environment is not in place to support this approach. In this context, utilizing a proven method for distributing food aid directly to poor households was an appropriate decision.

38. MTE found the relief component design allowed the programme to: a) support accurate assessments of food requirements; b) facilitate rapid mobilization of a significant increase in resources; and c) implement the distribution of food resources to millions of households. WFP Post Distribution Monitoring (PDM) reports consistently show 70-90 percentage of the households surveyed used the food aid for consumption. [55]

39. *Productive Safety Net Programme Component*. The PSNP aims to provide chronically food insecure households with food and cash transfers for up to five years, allowing households to bridge their annual food consumption gap and build their resilience until they are no longer chronically food insecure and are better able to cope with moderate shocks. The two "principles" of the PSNP are: predictability and avoiding dependency. Predictability is achieved by delivering cash or food transfers every month to eligible households for five-six months each year until the household graduates or the programme ends.

40. The introduction of PSNP has brought new institutional ways of working and standards to the humanitarian sector in Ethiopia. Donors, WFP and the Government of Ethiopia have established a stronger coordination mechanism to support the implementation of the programme. The mechanisms have introduced new governance structures (such as multiple audits, fiduciary risk assessments, regular system performance reports, etc). These design features enable PSNP stakeholders to track programme progress towards objectives. WFP, as part of the donor coordination group, has played a role in the design of these processes.

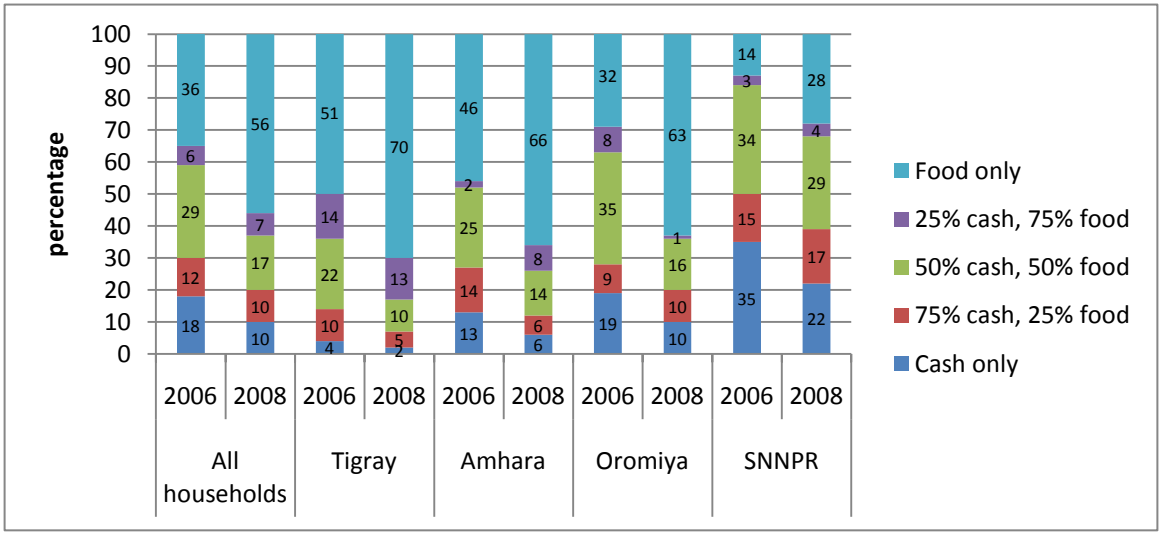
41. The design of PSNP allows for variability in the balance between cash and food provided to beneficiaries. Annually, communities and regional government have the opportunity to determine whether they require cash, food or a mixture of transfers. This flexible approach enables the programme to be more responsive to needs of the communities. For example, Figure 1 highlights the differences in preference for food transfers in PSNP between 2006 and 2008. The food price crisis is widely seen as the driver in this trend. The combination of PSNP's flexibility and the PRRO contributions allow this programme to respond to the increasing demand for food transfers as the value of cash diminished.

42. At the household level, transfers (both cash and food) would be relevant if they ensure: a) there is sufficient food for consumption to bridge production deficits in chronically food-insecure households; b) poor households are able to protect household assets and are therefore prevented from falling further into poverty; and c) if households

[55] WFP, Post distribution monitoring reports, 2008-2009

are able to reduce vulnerability from future shocks. These assumptions rely on the capacity of the institution to deliver the required volume of transfers in a timely and predictable manner. Unfortunately, poor predictability and delays in transfers (both cash and food) are obstacles to the effectiveness of PSNP and the wider food management system. Building institutional capacity is widely seen by stakeholders, including WFP, as critical to addressing these challenges.

Figure 1: Highlighting food versus cash preferences in PSNP 2006-2008



Source: IFPRI 2009

43. The approach to capacity-building outlined in the PRRO states that WFP will, through the logistics and information and communications technology clusters and the Food Management Task Force, (FMTF) support the government's capacity for fast, efficient and large-scale response to unpredictable multiple hazards. The approach focuses on the mechanism for coordinating capacity-building. However, it does not provide clarity of: a) what capacity will be developed; b) who will lead and deliver capacity-building initiatives; c) specifics on the expected outcomes of the capacity-building efforts; and d) how these initiatives will be harmonised with other capacity-building programmes. The Network of Ethiopian Positives (MTE) finds the design of the PRRO would have been more relevant and appropriate if there was a specific focus given to building the capacity of the food management system at output and/or outcome level.

44. The design of the PRRO enables WFP to play a critical role in supporting the public works component of the PRRO. Specifically, WFP brings its experience from the implementation of the Managing Environmental Resources to Enable Transitions (MERET) programme, which aims to support physical asset creation and watershed rehabilitation. The focus on increased water availability, soil productivity, and income-earning opportunities among participating households is highly relevant to the needs of poor households.

45. *Targeted Supplementary Feeding Component*. The objective of the TSF component is to improve the nutrition status of acutely malnourished children under five and pregnant and lactating women, and to enhance mothers' basic knowledge of nutrition. This is highly relevant for two reasons: (a) it targets population subgroups that are the

most vulnerable from a nutrition point of view[56]; and (b) it ensures increased coverage of TSF programmes in Ethiopia, providing support for the treatment of moderate to acute malnutrition (MAM).[57]

46. The design of this component is based on linking nutritional screening through bi-annual EOS at (sub) *kebele* level with targeted community-based food distribution ('*at the door step*') by local FDA.[58,59] The TSF provides supplementary food for malnourished children 6 – 59 months of age and for malnourished pregnant and lactating women and is primarily a curative programme but also contains a (small) education component on child feeding practices which is more preventative.[60,61]

47. The PRRO combines the PSNP, relief and TSF components in one single WFP operation. This approach is logical. However, there is a need to improve the integration between the different components. The PRRO document does not make reference to the links between the TSF and WFP-supported general food distributions as part of the PSNP and emergency relief interventions. However, in the areas with chronic and acute food insecurity, the TSF obviously is a complementary programme alongside these other programmes.

48. The relief/TSF hybrid model has been used in some *woredas* in Somali region from April 2008 onwards. [62] The new model aims at blanket coverage of all children under five years of age and pregnant and lactating women in the community through the TSF dispatch and distribution structures (with many more delivery points than for the regular relief food distribution). Blanket supplementary feeding for nutritionally

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[56] See e.g., World Bank (2006), Repositioning Nutrition as Central to Development; A Strategy for Large-Scale Action, Washington, 2006: '*The critical periods of pregnancy and lactation and the first two years of life pose special nutritional challenges because these are when nutrition requirements are greatest and when these population subgroups, in many parts of the world, are most vulnerable to inadequate caring behaviours, inadequate access to health services, and inappropriate feeding practices.' (p. 56).*

[57] A rough estimate of current nation-wide needs for treatment of MAM amounts to around 775,750 children 6-59 months of age. The needs for MAM treatment are only to a small extent being met by NGO-run Supplementary Feeding Programmes. The estimate is indicative only; the calculation is based on a total rural population of 53.5 million, a proportion of 14.5 percent of this population falling in the 6-59 months age bracket and an average MAM prevalence of 10 percent. Likewise, there is a definite need in Ethiopia for nation-wide targeted nutrition support for pregnant and lactating women, as malnutrition is also common among them.

[58] The EOS is implemented by the Ministry of Health with support from UNICEF and delivers an integrated package of child and maternal health interventions (Vitamin A supplements, measles vaccination, insecticide treated bed nets, de-worming, MUAC screening).

[59] In total, at the time of the evaluation there were 1231 FDC that are operated by 2462 FDAs.

[60] Cut-off points for malnutrition are 12.0 cm for children under five and 21.0 cm for pregnant and lactating women. The TSF provides two (one for '*ad hoc*' *woredas)* consecutive 3-monthly rations of 25 kg CSB and 3 l. of oil which equals a food transfer of 1338 kcal per beneficiary per day (same for children and women) and allows for some sharing with other household members. Because of problems around the supply and availability of CSB due to increasing global food prices and limited local production capacity, WFP Ethiopia is currently testing an alternative Ready-to-use food (Supplementary Plumpy) that is suitable to treat moderate malnutrition and can replace the traditional CSB/oil rations.

[61]The TSF replaced the provision of supplementary food rations to 35 percent of the needy population alongside the general food distribution under the 2002/03 EMOP. With the new shocks of 2008/09, the 35 percent CSB distribution was revived in Somali region.

[62] These *woredas* in principle were selected for being worst affected. Standard nutrition surveys conducted in April – May '09 discovered very high levels of malnutrition (GAM > 20 percent) in two of the six *woredas*. For the other *woredas* however no nutrition information was available to substantiate the inclusion under the relief/TSF hybrid model. It appears that two *woredas* were included because of the intended collaboration with an NGO. Five *woredas* were Priority 1 in the October '09 hotspot classification, one *woredas* was Priority 2.

vulnerable groups indeed is an appropriate relief response in situations with high malnutrition levels (GAM > 15 percent). The relief/TSF hybrid model was developed as an alternative distribution channel in response to accessibility problems for the General Food Distribution (GFD) due to insecurity. On top of the TSF and the relief/TSF hybrid model programmes, in Somali Region the GFD also contains blanket distribution of CSB which is targeted to 35 percent of the population (the vulnerable demographic groups: children under five years, pregnant and lactating women, the elderly and disabled people). [63]

49. A thorough analysis on why malnutrition exists in Ethiopia pointed out that all of these food-oriented responses are necessary but not sufficient to address the various underlying causes of malnutrition in Ethiopia. [64, 65] As further discussed below under External coherence, there is a need for more multi-sectoral approaches.

50. *Urban HIV/AIDS Component*. The relevance of the HIV/AIDS component's design is demonstrated by: the project's needs assessment showing a high percentage of initiating ART patients were malnourished according to clinical criteria; most PLHIV came from highly food-insecure and economically poor groups; and, food insecurity was an urban problem.[66] Studies, whilst few, reinforce the observational data gathered by the component that, in food-insecure urban areas, where moderate malnutrition is common, PLHIV have severe malnutrition.[67-69] Most beneficiaries have no employment; others have low-wage unskilled occupations.[70] Many people infected with or affected by HIV suffer from the consequences of stigma: rejection from partners and families; loss of employment; and internalised stigma causing social isolation and despair. Hence the shock of the impacts of HIV and AIDS cause many PLHIV, their families, and OVC to become acutely food insecure and some to become chronically food insecure. Beneficiaries and partners confirmed this during the MTE.[71] Adherence to ART is a

[63] For the 5th round in July 2009, a total of 2119 MT of CSB has been distributed in 45 *woredas* in Somali region as part of an overall distribution of relief food for two months in 54 *woredas* for 1.59 million people. Ration size was 4.5 kg CSB per person per month. The ration size for the relief/TSF hybrid was also 4.5 kg CSB per person per month.

[64] This is based on the implicit assumption that nutritional improvement will automatically follow if utilization aspects of the food security strategy are well implemented.

[65] Benson T (2005), An assessment of the causes of malnutrition in Ethiopia; A contribution to the formulation of a National Nutrition Strategy for Ethiopia, IFPRI, Washington DC, November 2005.

[66] WFP Ethiopia. *Second scale-up of the Urban HIV/AIDS Food and Nutrition Assistance Project*. 2009.

[67] Federal HAPCO. *Strategic Plan II for Multi Sectoral HIV and AIDS Response in Ethiopia*. (SPM II 2009-2010/11). P. 16. 'Households in Addis Ababa experiencing an HIV/AIDS death are poorer than those experiencing a non-HIV/AIDS death. In addition, poorer households experience a greater decline in socioeconomic status following the death of a household member…the difference between AIDS and non-AIDS mortality in terms of direct costs is minimal; the indirect costs of an AIDS death per household exceeds that of non-AIDS death by 58 percent…poor households are more likely to experience an AIDS death and in turn are more vulnerable to the socioeconomic impact of death. Therefore, it is justifiable to target HIV-impact programmes on poorer households.'

[68] WFP Ethiopia. *Second scale-up of the Urban HIV/AIDS Food and Nutrition Assistance Project*. 2009.

[69] B.Tadesse. *Food Security in the Era of HIV and AIDS – a Policy Analysis of Food Security and HIV and AIDS in Sub-Saharan Africa: the case of Ethiopia*. Panos Global AIDS Programme. 2008

[70] WFP Ethiopia. *Results Report for 2007 and 2008*. Supporting households, women and children infected and affected by HIV/AIDS. 2009. Most beneficiaries are in the productive years of their lives (95.1 percent aged 15-49) with 45 percent having no formal education and most having either no employment or engaged in low-wage (often unskilled) occupations. Of the OVC nearly three quarters are age 10-18 and 38 percent have lost both parents, 50 percent of the remainder has lost their father, 43 percent live with at least one parent and 21 percent with grandparents. Three out of ten OVC live within a large family with six or more members.

[71] Partners and beneficiaries interviewed during the MTE confirmed high inability to generate income due to illness; loss of employment, home, marriage or family due to stigma; age (OVC); or demands of child care.

major challenge, with an attrition rate of 27 percent in the four years prior to 2008.[72,73] MTE informants cite this as a significant challenge to scaling up ART because often, PLHIV will not initiate or maintain ART if they are food insecure. Linking food support and school education is an effective way to redress the impact of HIV on OVC.[74] The Urban HIV/AIDS component is appropriate within the PRRO given that it: addresses a shock (HIV) and short term recovery; minimises the material and social damage caused by HIV; addresses household impact of HIV though food support for the entire household; assists beneficiaries with recovery of nutritional status; health and well-being; and links with sustainable livelihood support.

51. The next PRRO could test the use of cash/vouchers through a trial which, amongst other issues, considers: their use in urban as distinct from rural settings, as in other components; the experience of other components where *woredas* have switched from cash back to food; and the scope to link this with handing responsibility to national counterparts and which could include exploration of private sector involvement.

Internal coherence

52. *Relief and Productive Safety Nets Programme Components*. The PRRO objectives (both current and original) of the programme are strongly coherent with WFP's internal policies. As previously indicated, the new strategic objectives are consistent with the corporate framework. PSNP's transition to cash transfers and its focus on establishing a predictable safety net ensure that the PRRO is aligned with corporate policy on social protection. The use of Government systems to manage and deliver food transfers ensures the programme reflects the priorities outlined in Building National and Regional Capacity policy (2004) and the broader corporate alignment toward nationally owned processes.

53. *Targeted Supplementary Feeding Component*. Nutrition is a rising corporate priority for WFP, both in terms of saving lives during emergencies and for reduction of chronic hunger and under-nutrition. In September 2009 the executive policy council of WFP affirmed that nutrition is an area that requires accelerated focus and improvement across the organization in order to achieve the objectives set out in the new WFP Strategic Plan. The TSF is coherent with the corporate focus on proven targeted food-based nutrition interventions and enhancement of nutrition assessments, which forms the core of the WFP Nutrition Improvement Approach. The new strategy prioritises preventive interventions for pregnant and lactating mothers and young children up to 23 months old. However, because of the high GAM rates in Ethiopia, it can easily be justified to continue treating acute malnutrition among children up to 5 years of age.

54. *Urban HIV/AIDS component*. The urban HIV/AIDS component is a well-considered application of the WFP 2003 HIV policy: strengthen household and community capacity to respond to HIV impact on food security; improve human capital; support safety-net

[72] Federal HAPCO. Op. cit. P. 24.
[73] As of October 2009 226,801 people are starting ART and 167,271 are currently enrolled. *ART Update as at October 8. 2009*. Per Site. FHAPCO. http://www.etharc.org.
[74] Smart. T. *After my parents died: The effects of HIV on the mental health of children: A clinical review*. HIV and AIDS Treatment in Practice. Issue 149. November 2009. P.1.'AIDS affected children often lack adequate food and shelter, have more trouble staying in school and accessing medical care, and are at high risk of economic exploitation and sexual abuse'.

programmes; and use partners for dissemination of HIV prevention.[75] It remains coherent with the 2009 Executive Board update: nutritional support in HIV treatment and care programmes; nutritional support in tuberculosis programmes; social safety nets for people affected by HIV, including OVC and people experiencing hunger, poor nutrition and food insecurity; and support to national AIDS strategies.[76]

55. The 2003 policy commits WFP to HIV mainstreaming. This applies at two levels. Internal mainstreaming enables staff to understand HIV and develop programming competency. This is a necessary precursor to external mainstreaming which identifies how a programme can contribute to the response to HIV. The WFP HIV team has led mainstreaming across WFP by developing a Mainstreaming Strategy (covering all WFP Ethiopia programmes, not just the PRRO) and providing technical expertise on implementation.[77]

External coherence

56. *Relief and Productive Safety Nets Programme Components*. In 1993 Ethiopia adopted the National Policy on Disaster Prevention and Management (NPDPM). Its objectives are to save lives, integrate relief assistance with development efforts in order to mitigate the impacts of disasters, and enhance the coping capacities of the affected population through the creation of assets in the affected areas. The Relief and PSNP components are consistent with these objectives.

57. As part of the five-year Program for Accelerated and Sustained Development to End Poverty (PASDEP), the Government adopted a Federal Food Security Programme with a four pronged approach: a) stimulate agricultural production; b) address vulnerability through PSNP; c) improve management of Ethiopia's natural resource base; and d) strengthen disaster preparedness. WFP's contributions to PSNP - both the delivery of food aid and support to community-based watershed management - ensure the PRRO is coherent with key government policy priorities related to food security.

58. In the current UNDAF, WFP leads the Humanitarian Response, Recovery and Food Security thematic group and is a participant in several other groups. This role potentially provides a strong framework for ensuring the PRRO is coordinated and harmonised with other relevant humanitarian programmes within the UN system. The relief and PSNP components are coherent with humanitarian results matrix in the UNDAF. However, the logframe contains no PRRO indicators related to the UNDAF work plan. This is potentially a missed opportunity.

59. *Targeted Supplementary Feeding Component*. In 2008, the Government adopted The National Nutrition Programme (NNP).[78] This provides a broad framework for a range of nutrition-related interventions. The CBN component of the NNP is a development-oriented nutrition programme. CBN is being rolled out but will need some

[75]WFP Executive Board. *Programming in the era of AIDS: WFP's response to HIV/AIDS*. 2003.
[76] WFP. Executive Board. *Responding for results: WFP delivers on its HIV and AIDS programmes. Update on WFP's response to HIV and AIDS*. 2009.
[77] WFP Ethiopia HIV/AIDS Team. *HIV/AIDS Mainstreaming Programme 2007 and beyond.*
[78] Ethiopian Government (2008a), National Nutrition Strategy, FMoH, Addis Ababa, January 2008; and Ethiopian Government (2008b), Programme Implementation Manual of NNP – 1 July 2008 – June 2013, FMoH, Addis Ababa, April 2008.

time to achieve scale. This component primarily targets children under two and pregnant and lactating women. It is comprised of six core nutrition activities, including TSF.[79,80]

60. Originally the TSF was designed as a targeted nutrition support programme (a sort of nutrition safety net for moderately malnourished children under five and pregnant and lactating women) that operates as a medium-term programme in the absence of a general ration (the main 2002/03 emergency was over) and also where there are no facilities to treat Severe Acute Malnutrition (SAM). The TSF was planned as a programme that is linked up with the EOS Child Survival Initiative with wide geographical coverage. However, the context in which TSF operates has changed considerably. Specifically, in response to the new food security shocks since 2008, various food-based relief interventions have been expanded (e.g. including the Relief component of the PRRO and NGO-work in some *woredas*), which points to the need for TSF to ensure complementarity with other programmes and to avoid duplication. With the rollout of the Out-patient Therapeutic Programme (OTP), management of SAM cases primarily is being taken care of through the health posts network with support from UNICEF and NGOs (although referral between OTP and TSF still is a point of concern).

61. The TSF was developed before the NNP was adopted and is not yet fully aligned with the new more comprehensive approach. NNP emphasizes the need to address all underlying causes of malnutrition (household food insecurity, lack of appropriate maternal and child care, inadequate basic health services, unsafe water supply and lack of sanitation facilities). Although in principle it is a key strength of the TSF that the programme design is based on linking up relief distribution channels with the health sector, in practice the TSF primarily functions as a food distribution channel. The health and nutrition education component has limited impact on child feeding and knowledge and practices (ref. paragraph 218 for more details) and is community-based only (through the food distribution agents(FDA) at the Food Distribution Centres (FDCs), without links to the Health Extension Programme (HEP) through health posts at *kebele* level which is currently being rolled out nation-wide. The institutional linkages between the TSF and the PSNP are not yet strong. There is no link at all between the TSF and the water and sanitation sector. In the longer term, education is one of the most important resources that enable women to provide appropriate care for their children, including improved health seeking behaviour.

62. *Urban HIV/AIDS component*. This component is coherent with and supportive of national strategies. The Federal HIV/AIDS Prevention and Control Office (HAPCO) is responsible for overseeing the interim Strategic Plan II for Multi-Sectoral HIV and AIDS response in Ethiopia 2009-2011. It is aligned with PASDEP, the Health Sector Development Programme, the Education Sector Development Programme and the Millennium Development Goals. WFP is the main provider of nutrition for PLHIV. Jointly with the Ministry of Health and HAPCO, WFP has the lead responsibility for referral systems for food assistance and livelihood support for PLHIV and this is noted in the 'National Guidelines for HIV/AIDS and Nutrition in Ethiopia' and the accompanying

[79] (a) growth monitoring promotion; (b) pregnancy weight-gain behavioural change communication; (c) targeted food supplementation; (d) micronutrient supplementation; (e) parasite control; and (f) hygiene and sanitation.

'National Implementation Reference Manual on Nutrition and HIV/AIDS'.[81,82] WFP's partnership with HAPCO complements the Ministry of Health decentralization of health services to ensure universal access and linking community and health sectors. The component also contributes to one of the four priority strategies of the interim Strategic Plan II: strengthening institutional capacity and governance.

63. Harmonization and the coordination of donor activity on HIV and nutrition is the responsibility of HAPCO, consistent with the Three Ones principles advocated by United Nations Programme on HIV/AIDS (UNAIDS).[83] WFP supports this via the National Guidelines for HIV/AIDS and Nutrition. It also supports harmonization through the UNAIDS Unified Budget and Workplan. Additionally, WFP's support complements the USA President's Emergency Plan for AIDS Relief (PEPFAR's) Ethiopia programme.[84] WFP is responsible for dietary and nutritional support under the Division of Labour of the UNAIDS Unified Budget and Workplan and is the lead UN agency in addressing hunger in the scale-up to meet the universal access goals. WFP has a Memorandum of Understanding (MOU) with the World Health Organization (WHO) on joint advocacy on nutrition and HIV. It has a partnership with UNICEF on OVC that requires UNICEF to increase its response, and with UNAIDS on HIV in emergencies.

2.2. Outputs and implementation processes: elements of efficiency

64. In 2007, PRRO design estimated that approximately one million people would be vulnerable to rapid onset shocks. However, in 2008, over seven million people benefitted from general food distributions (see Table 5). In 2009, WFP once again had to scale up its operations to provide support to over six million beneficiaries.

65. The cost of operating the PRRO has been adjusted seven times since its inception.[85] As of November 2009 the resource requirements for the programme were estimated to be US$1295 million. The expansions have been justified on the basis of drought, locust outbreaks, floods, animal disease, insecurity, and food crisis.[86]

66. A total of 24 donors and two joint humanitarian funds (CERF and HRF) have financed the PRRO. The programme has been well-financed: US$832 million out of US$1295 million, or 64 percent when 55 percent of the period had elapsed. The figure published in December 2009 is US$1093 million or 84 percent when 66 percent of time elapsed. This makes this PPRO one of the best-financed programmes in WFP portfolio.

67. *Relief Component*. Repeated drought, floods and the lasting effects of the food price crisis have caused a significant increase in the number of beneficiaries in the relief and PSNP components since the inception of the programme. Due to a variety of reasons including rapid expansion of the programme, issues with donor commitments, and delays in the food management system, there has been a reduction in the number of

[81] The Guidelines and Manual are a component of the FMoH National Nutrition Strategy and the NNP.
[82] The Federal Democratic Republic of Ethiopia Ministry of Health. *National Nutrition and HIV/AIDS Implementation Reference Manual*. 2008
[83] Three Ones: one agreed AIDS action framework, one national coordinating committee, and one agreed country-level monitoring and evaluation system.
[84] Attachment-II, A-Programme Description. *Improving the lives of PLHIV on ART, Pregnant Mothers on PMTCT and their children and OVC through Supplementary food support and nutrition interventions*. (PEPFAR/WFP funding agreement.)
[85] In January 2010 an additional Budget Revision was submitted for approval.
[86] WFP Briefing Note. 2009.

rounds of transfers made and a restriction on the volume of rations given to each household under the relief component.

68. Delivering the volume of resources required to meet the demands of more than six million people would be an impressive undertaking in any circumstance. The achievement is even greater in Ethiopia given the limitations of institutional capacity, developing infrastructure, remote locations, challenging communications, and complex national and international pressures.

69. WFP has used its knowledge of food management to great effect in the Somali region. This region has been impacted by on-going drought and insecurity. WFP, in coordination, with the Government, established the 'hubs and spokes' system for food distribution. Under this programme WFP undertook the construction and rehabilitation of warehouses, established logistical offices in strategic locations throughout Somali region, used local fleets for transportation to final distribution points, and supported the formation of joint committees at the hub comprised of federal, regional and local Ethiopian Defence Force representatives and WFP staff. [87] In addition to these logistical inputs the programme had a number of programme components including training the Ethiopian Defence Force and engaging local officials in programme design.

70. *Productive Safety Nets Programme Component*. In 2009, the PSNP reached 7.54 million people and was operational in 290 *woredas*.[88] The component outputs vary according to geography, strength of local markets, food prices, and demand for cash over food transfers. Overall, the Ethiopian Government has set targets for transition from food to cash. Figure 1 summarises the progress being made towards those targets. As indicated by the chart progress towards the Government has been steady rather than rapid.

71. In 2007, an estimated three out of four PSNP beneficiaries (71.3 percent) reported that they had encountered delays in transfers (both cash and food). The situation was no better in 2008. Table 3 highlights that less than 50 percent of households received all the transfers (either cash or food) they were due in the first five months. Indeed, in the majority of regions, 24 to 50 percent of households received only fifty percent of the transfers they were due. [89] The extent of delays varies from year to year and across and within geographical regions.

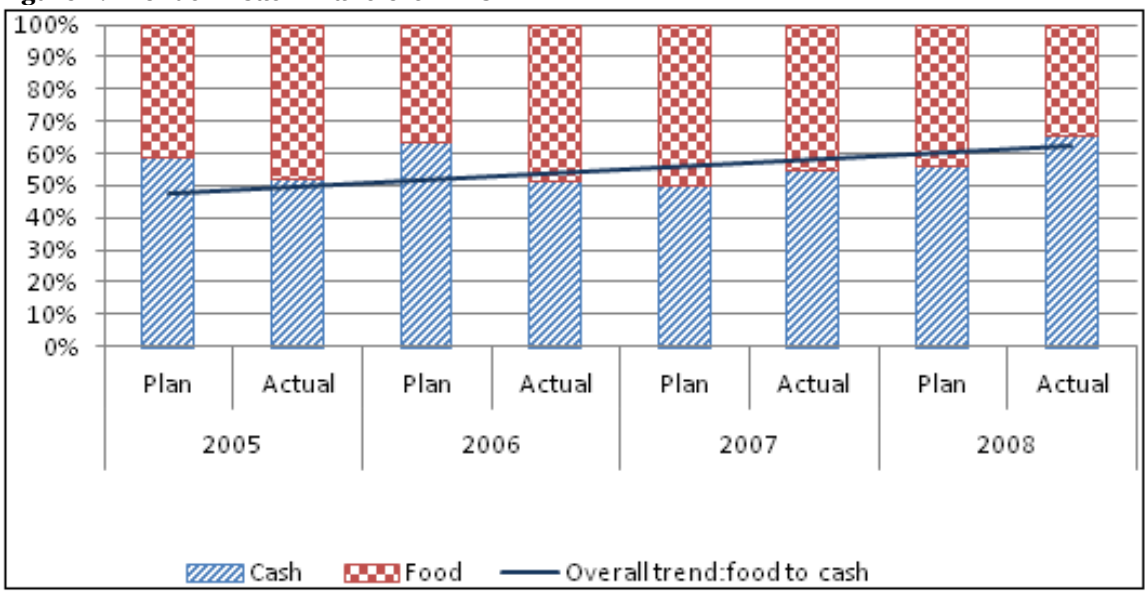
[87] WFP, Special Operations Report, 2009
[88] PSNP, *Aide Memoire,* 2009.
[89] IDS, PSNP, Assessment Report, 2009.

Table 2: Summary of Outputs 2008

Beneficiary Category	Planned			Actual			% Actual v Planned		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
The total number of beneficiaries includes all targeted persons who were provided with WFP food during the reporting period - either as a recipient/participant in one or more of the following groups, or from a household food ration distributed to one of these recipients/participants.									
Beneficiaries of General food distribution (GFD)	3,444,000	3,444,000	6,888,000	3,612,706	3,612,707	7,225,413	104.9 %	104.9 %	104.9 %
Children given food under supplementary feeding	219,257	206,729	425,986	316,452	298,369	614,821	144.3 %	144.3 %	144.3 %
Pregnant and lactating women participating in MCH/supplementary feeding	n.a.	200,464	200,464	n.a.	289,327	289,327	n.a.	144.3 %	144.3 %
Participants in Food For Work	225,616	156,784	382,400	378,234	262,840	641,074	167.6 %	167.6 %	167.6 %
Estimated number of beneficiaries impacted by HIV/AIDS	71,300	83,700	155,000	39,802	67,857	107,659	55.8 %	81.1 %	69.5 %

Output	Unit	Planned	Actual	% Actual v Planned
Quantity of food distributed through TSF programmes	mt	66,029	44,231	67.0 %
Quantity of food distributed through PSNP	mt	152,190	154,052	101.2 %
Quantity of food distributed through Relief programme	mt	473,066	357,389	75.5 %
Number of beneficiaries who received PSNP food	number	2,390,000	4,006,711	167.6 %
Number of beneficiaries who received Relief food	number	6,410,000	6,424,071	100.2 %
Number of partner staff trained on Food Aid Management and Beneficiary Targetting	number	275	240	87.3 %
Number of PLHIV beneficiaries on ART/HBC and PMTCT programme & their households who received food	number	79,572	69,207	87.0 %
Number of TSF beneficiaries who received proper nutrition education messages	number	653,219	607,494	93.0 %
Number of beneficiaries who received TSF food	number	737,000	1,063,703	144.3 %
Amount of area closure constructed by PSNP	ha	13,549	10,889	80.4 %
Number of seedlings produced by PSNP	number	242,943,550	381,797,000	157.2 %
Volume of area constructed for ponds (cubic meters) by PSNP		188,488	221,755	117.6 %
Quantity of area constructed for soil bund (sq. meters) by PSNP	sq. metres	10,278	9,150	89.0 %
Number of OVC receiving take home rations	number	56,413	38,452	68.2 %
Number of partner staff trained on Anthropometric Assessment, ART adherence follow up, HIV and Nutrition Counseling and so on	number	1,155	1,155	100.0 %
Quantity of food distributed through HIV/AIDS support programmes	mt	22,067	12,320	55.8 %

Figure 2: Trends in Cash Transfers in PSNP



Source: IFPRI, 2009

72. These delays undermine the programme's asset protection function.[90] In 2008, over 50 percent of respondent's limited/reduced their food consumption and 25 percent engaged in coping strategies such as borrowing cash, selling assets (such as livestock) or consuming food stocks.[91] IFPRI reports the following:

An ongoing operational concern is the difficulty in making regular payments to beneficiaries. This has complex consequences. Households receiving more than 900 birr but receiving transfers irregularly save a larger fraction of their transfers in the form of livestock than do households receiving the same amount but on a more regular basis. However, households with irregular transfers are more likely to report distress sales and report a much lower improvement in self-perceived welfare.[92]

Table 3: Percent of PSNP households receiving cash or food transfers

		9 January – 9 June 2008			
		Percent of households reporting due transfers received by percent of transfer			
Region	Number of households	0-50% of due transfers received	50-80% of due transfers received	80-100% of due transfers received	100% of due transfers received
Tigray	422	51	30	4	15
Amhara	289	25	35	20	21
Amhara – USAID	374	37	30	10	23
Oromiya	286	24	16	11	49

73. The cause of delays in food transfers is attributed to various issues including, rapid and dramatic increase in demand for food transfers, the challenges of mobilizing donor resources, difficulties contracting road transportation, consequences of the business Process Review (BPR), high staff turnover, and a range of minor logistical issues related to food management/distribution. All these issues are entirely valid reasons for delays in transfers. A number of issues are beyond the mandate and influence of WFP. However, there are clearly areas where WFP could be focusing its influence and resources to improve the timeliness of transfers.

74. Indeed, over the past two years WFP has undertaken a number of initiatives aimed at developing a more strategic focus for its capacity-building efforts. Despite these efforts, the MTE could find only limited analysis of the key bottleneck to improving the efficiency of the food management system.

75. In 2007, WFP initiated a capacity-building Strategy. This is a very brief document. However, it does contain a number of key recommendations including:

- The need to obtain more clarity on where the Government would like to focus capacity-building efforts. This is a core issue in establishing ownership of the strategy process;

- Integrate capacity-building discussions in the existing task force or working groups. Possibly identify a capacity-building focal point;

[90] Cash, Food, Payment and Risk in PSNP, Judith Sanford, 2009.
[91] IDS, PSNP, Assessment Report, 2009.
[92] IFPRI, An Impact Evaluation of Ethiopia's Productive Safety Nets Program, 2009.

- Identify capacity-building needs and a plan for capacity-building.

76. In 2008, WFP undertook a review of the food pipeline programme. A draft of this report again contained critical recommendations:

- Disaster Preparedness and Prevention Agency (DPPA) and WFP should work together and develop a new, simple but robust tracking system that caters to all parties' requirements. This system should address all the gaps observed and draw from the advantages of Commodity Movement Processing and Analysis System so that the complete DPPA supply chain is covered;

- Commodity Movement Processing and Analysis System in its current status is not pertinent to DPPA. It is too heavy and technically demanding to maintain or change because it was designed to cater to WFP and the UN system.

77. In 2009, WFP took a more significant step toward addressing capacity-building by developing the establishment of FMI Concept Note. The initiative recognises the need for a major overhaul of the food management system. Its objective is to re-build food management structures of federal and regional bodies. The first stage in the Food Management Improvement has been to improve food distribution reporting systems. This aims to enable more accurate and rapid assessment of food distribution.

78. The initiatives highlighted above are important steps towards building a more strategic approach to building the capacity of food management system. However, it has taken WFP over three years to establish FMI. Evidence of the need to improve the predictability of food aid has been available since the inception of PSNP in 2005. In addition, MTE finds FMI is not yet fully implemented. As a result there is no strategic analysis of the bottlenecks in the food management system, there are no benchmarks against to measure progress of current capacity activities and there are no clear indications of what role WFP can play in improving the food management system.

79. In comparison, since 2005 PSNP has undertaken a comprehensive analysis of the cash transfer systems including, fiduciary risk assessments, audits, and numerous systems reviews. Performance targets have been established for the delivery of transfers. Two independent impact evaluations have been undertaken and large panel survey has been established. These initiatives demonstrate the possibility of what can be achieved in Ethiopia. In addition, PSNP has created a strategic framework that ensures greater accountability and transparency and establishes a strong evidence base for decision makers, as well as mechanisms for identifying the priorities for capacity-building initiatives in order to improve the efficiency of the programme.

80. The MTE finds the FMI is an important, but much delayed, initiative. The evaluation found that the delay in the implementation of FMI has caused stakeholders to become sceptical over WFP commitment to building capacity. Stakeholders also question whether FMI, in isolation, can generate the resources and institutional leverage necessary to effect significant changes within food management system.

81. In contrast, the approach taken by WFP in Somali region has had significant and positive effects on programme coverage. The establishment of Special Operations such as 10721.1 led to WFP taking over the logistical management and coordination of food transfers. As a result, food delivered against food allocated was at 30 percent, whereas

overall food delivered against allocation in the period October 2008 to September 2009 was 94 percent.[93]

82. *Targeted Supplementary Feeding Component*. The first phase (PRRO 10362.0) of TSF was marked by sharp increases in geographical and beneficiary coverage. However, as Table 7 shows, the trend has been reversed since the inception of the current PRRO, as a result of reduced funding levels and increased food costs. Analysis of the last TSF distribution round reveals that only 179 (39 percent) of all rural *woredas* in Ethiopia were covered. Regional coverage varied substantially, ranging from 68 percent of the *woredas* in Tigray to only 20-23 percent in Amhara and Oromiya regions and zero coverage in Afar and Gambella (in both cases due to constraints on the part of the regional health bureau EOS screening was delayed). There obviously is a need for higher geographical (and thus beneficiary) coverage in the most acutely food-insecure *woredas*. Comparison of the TSF geographical coverage pattern with the results of the Standard Nutrition surveys reveals that there is relative overconcentration of resources in Tigray and SNNPR while the highest needs for treatment of MAM exist in Somali and Afar[94] region and some areas of SNNPR. Also, there is still relative under-coverage in Amhara and Oromiya regions.

Table 4: TSF achieved coverage 20005-2009

	PRRO 10362.0			PRRO 10665.0[95]	
Coverage	**2005**	**2006**	**2007**	**2008**	**2009[96]**
Regions[97]	7	10	10	7	5
Woredas	165	260	342	166	202
No. pregnant/lactating women (million)	0.173	0.228	0.369	0.289	0.356
No. under fives (million)	0.301	0.484	0.783	0.615	0.756
Total no. beneficiaries (million)	0.474	0.712	1.152	0.904	1.112

Source MTE team

83. The TSF is one of the smaller components in PRRO. In 2008, annual TSF expenditures amounted to US$38.9 million for coverage of around 900,000 beneficiaries with 3 to 4 rounds of food per year, leading to an overall approximate cost of US$43 per beneficiary per year. Ideally, TSF coverage would be needs based and not resources-based. However, the evaluation finds that WFP Ethiopia, Government and other stakeholders face a major challenge in securing contributions required to ensure acceptable coverage, in terms of both number of *woredas* and total number of beneficiaries.[98] Key donors have reduced their financial contributions to the TSF (it is

[93] WFP, Special Operations Report, 2009.
[94] Note: Only one standard nutrition survey was undertaken in Afar region, different results might be found in new surveys in Afar region.
[95] Source: WFP (2009), SPR 2008 Ethiopia; Project 10665.0, Addis Ababa, 2009.
[96] Figures refer to Round One only which was undertaken in 167 *woredas* in the period May/August and ad-hoc screening results in 35 additional *woredas* in Amhara, SNNPR and Oromiya. Due to operational problems, no screening/distribution took place in this round in Afar and Gambella regions. Round two screening is scheduled for November/December and was not yet undertaken when the mission visited Ethiopia. The total anticipated number of beneficiaries for 2009 is 1.238 million.
[97] In 2006 and 2007 all regions in Ethiopia were covered; in the current PRRO, seven regions are covered: Somali region, Oromiya, Amhara, Tigray, SNNPR, Gambella and Afar.
[98] Ultimately, within the boundaries of the funding and resources that are available, coverage will have to be needs based. It is relevant to note that nationwide around 0.78 million under fives are estimated to be in need of treatment for moderate acute malnutrition. At first sight, this target figure seems to be closely matched by the total coverage achieved in 2007. However, it needs to be noted here that there has been

possible to earmark to specific components within the PRRO due to loss of confidence in the effectiveness of the TSF programme.

84. The TSF Activity Implementation Manual states that in order to ensure timely relief response, the lag time between the screening and transmission of the results to the *woreda's* TSF focal person should be a maximum of three days.[99] Food distribution should take place within 21 days after the transmission of the screening results. However, as a result of institutional capacity issues (e.g. inadequate (Disaster Preparedness and Prevention Bureau[DPPB]) food transport tendering processes and poor communication between DPPA/B and Ministry of Health/Regional Health Bureau [RHB]), these targets are regularly not achieved. In the first half of 2009, serious delays occurred in Amhara, Oromiya and Somali regions and food distributions were cancelled or over two months late.[100]

85. The problem of delays, highlighted in the previous PRRO evaluation report, persists.[101] The TSF mid-year review meeting in June 2009 recommended several proposals for timeliness of food movement.[102]

86. A specific issue is that the relief/TSF hybrid model used in the Somali region faces various operational challenges at the community level that are caused by a combination of socio-cultural factors and the prevailing security situation.[103] While the search for alternative distribution mechanisms for the Somali region was justified in 2008, humanitarian access has improved in a number of areas within the region over 2009 resulting in a certain level of duplication between the regular relief food assistance including the blanket CSB distributions to 35 percent of the population on the one hand and the relief/TSF hybrid programme on the other.[104]

87. *Urban HIV/AIDS component*. Data on output for the HIV/AIDS component is only available for 2007-2008. Direct comparison with data from 2007 is not always possible due to changes in eligibility criteria. The Results Report for 2009 was being compiled during the MTE and will include reporting on recently added sites.

88. The HIV/AIDS component did not reach its target for the output on the timely provision of food in sufficient quantities due to: removal of support to Home Based Care

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considerable level of false inclusions (see under the results section) and that only a certain proportion of all rural *woredas* in Ethiopia were covered by the TSF. This means that there were many malnourished children in Ethiopia who were not reached by the TSF.

[99] WFP Ethiopia (2007), TSF in support of the Enhanced Outreach Strategy (EOS) for Child Survival Interventions; Activity Implementation Manual, Addis Ababa, September 2007.

[100] According to WFP staff this delay was caused by lack of experienced staff within DPPB due to the on-going BPR process within the regional government.

[101] In the previous PRRO evaluation, the problem of delayed food deliveries for the TSF was mainly attributed to inadequate DPPB food transport tendering processes and poor communication between DPPA/B and Ministry of Health/RHB. WFP food deliveries to the logistics hub were found to be on time.

[102] WFP Ethiopia (2009), Minutes of the TSF programme mid-term review meeting – Mekelle, June 11-12, 2009.

[103] An internal (undated) WFP memo lists the following challenges for the hybrid programme implementation in Somali region: failure to follow the targeting criterion, mismanagement of the food commodity, interference of local leaders and *woreda* administration, under rationing, absence of nutritional message delivery, low involvement of the FDA from the community (or even complete absence), low monitoring from regional and area coordinators.

[104] Note: In contrast, the regular TSF programme is seem as being complementary to the general relief food assistance including the 35 percent CSB as the TSF provides specialised rations to treat moderate malnutrition.

Volunteers (HBCVs); the introduction of BMI of 18.5 and below as a new enrolment criterion for eligibility; and low enrolment rates in PMTCT. Component sites visited by the MTE were confident that all eligible PLHIV on ART were enrolled in the programme. At 12,320 mt the overall tonnage of food distributed was 55.8 percent of the target and one in five beneficiaries reported not receiving food on time. In addition to the above causes, this was due to: an initial three-month delay until the Government signed the MOU; HAPCO's confusion over distribution reporting delayed food entry into the country; and the increased cost of food commodities caused decreased purchase of food, leading to shortage in some months.

89. Data on timely provision of food to OVC is included in overall statistics and not broken into recipient category as all local beneficiaries receive food from the same source during the same time period. The tonnage distributed to OVC was 7,392 mt. The component's Monitoring and Evaluation (M&E) matrix should include indicators on timeliness to ensure consistency with the PRRO.

90. For HIV capacity-building, counterpart staff outputs and the PRRO logframe requires reporting of percentage of target trained. This needs definition of both numerator (number trained) and denominator (number of counterpart staff, which is difficult to determine). The logframe should therefore be changed to report number trained, rather than percentage trained. Comparing 2007 to 2008, fewer discussion sessions with beneficiaries (531 : 323) and training of partner personnel (4,914 : 1,394) were conducted as most training occurred in the first year and many HBCVs ceased working. The project still managed to reach its target of training beneficiaries. Information on training topics gathered in monitoring reports contributes to comprehensive accounting for the capacity-building provided.

Coordination and partnership

91. *Relief and Productive Safety Net Programme Components*. The PRRO relies upon effective partnerships and coordination in Ethiopia. PSNP and relief components utilise Government systems for both logistics and procurement. The exception is the Somali region, where WFP manages food distribution via the hubs and spokes system. WFP and the Government have an MOU that governs the partnership. Overall, the evaluation concludes that the WFP relationship with the Government focuses on operational pragmatism, i.e. ensuring operational and policy space exists to deliver food transfers.

92. WFP Ethiopia country office senior management uses its role as a leading humanitarian agency to great effect. WFP has made significant strategic contributions to agreements with the Government regarding defining scale of humanitarian appeals and on improving the access to and delivery of humanitarian assistance in the Somali region.

93. Operationally WFP is a key player in enabling the food management system to function. There is broad recognition that the Government has significant gaps in capacity. WFP's partnership provides it a unique role to provide support to the Government in identifying needs and building its capacity. At present, WFP plays a critical role in the FMTF, which coordinates food distribution activities of all stakeholders. The FMTF is also mandated to address coordination and capacity issues of the food management system.

94. Throughout the country, WFP staff work closely with the government to support and monitor food transfers. WFP staff train government staff in issues ranging from warehouse management to community watershed management. The presence of WFP staff in the most food-insecure areas enables improved communication on the status of transfers.

95. There are positive lessons to be learned from WFP's establishment of joint committees at the hubs in Somali region. These committees have facilitated improved communication and coordination in the region. As a result there has been a significant increase in the percentage of food aid delivered against allocation.

96. The harmonisation agenda features in aspects of the PRRO and there have been number of important lessons learned. In the PSNP, WFP has signed the MOU outlining the principles under which the programme will operate. WFP staff members participate, although not always consistently[105], in the coordination processes that support PSNP. In these processes WFP staff members are seen as effective advocates for local procurement, quality of public works, a full food ration and the roll-out of the PSNP in pastoral regions.

97. Stakeholder interviews identified areas where coordination and harmonisation could be further strengthened. Examples cited agreeing to and maintaining a stronger conceptual approach to the inclusion of PSNP beneficiaries in emergency appeals, and developing a stronger strategic and inclusive approach to the development of the FMI.

98. *Targeted Supplementary Feeding Component*. The TSF component has a quadripartite agreement, signed in June 2005, between the Federal Ministry of Health (FMoH), DPPA, UNICEF and WFP.[106] The MOU expired in April 2008 but is still used as the overall operating framework for the programme. The main contractual framework consists of a set of annually renewed Field Level Agreements (FLA) that are signed by WFP and the DPPBs and provide operating budgets for the different government levels involved.

99. In May 2008, a MOU was signed regarding the implementation of the TSF by WFP and DPPA (now DRMFSS) up to the end of 2010. The new agreement specifies that the TSF will reach an estimated 665,667 beneficiaries per year, with allocation plans to be agreed upon by DPPA's regional bureaus and WFP. The Emergency Nutrition Coordination Unit (ENCU) is the responsible body for compilation and verification of screening data, and for the coordination of TSF and other emergency supplementary food responses. See Annex 5 for further details on the legal framework behind EOS/TSF.

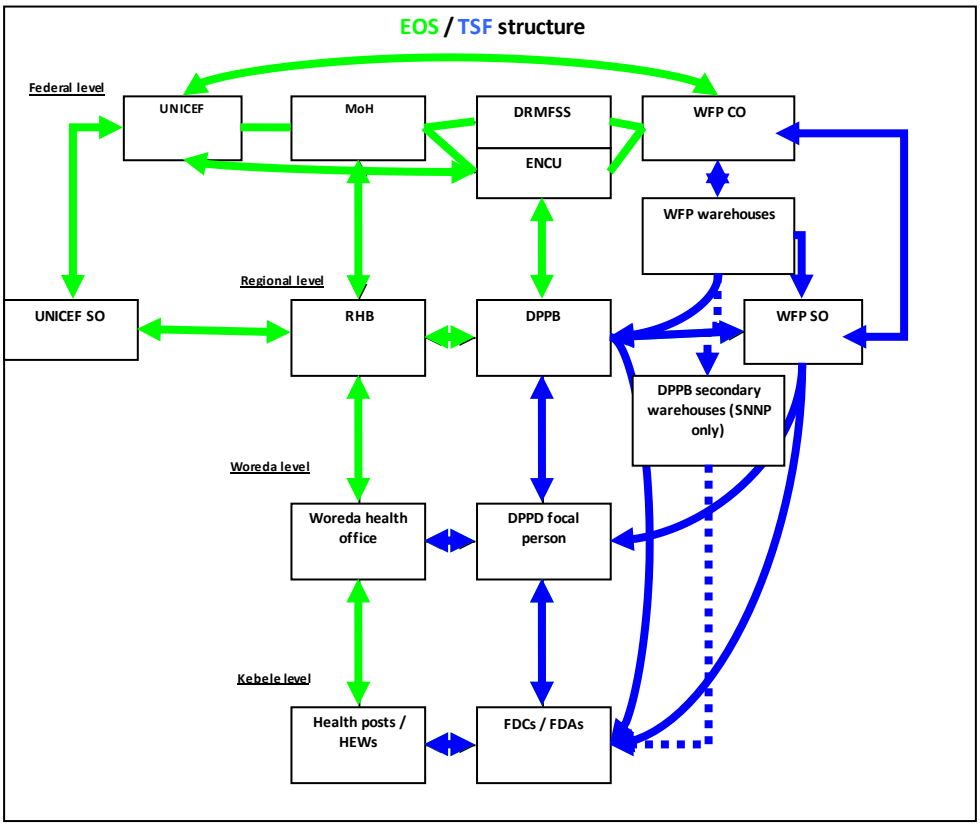
100. The flow chart below gives an overview of the role of the four parties at the different geographical levels (federal, regional, *woreda* and *kebele* level). It shows how the programme intends to link up the health sector and relief distribution channels. Particular operational weaknesses of the EOS/TSF to be addressed through redesign and capacity-building programmes are more involvement and linking up with health post personnel/HEWs at the *kebele* level, better overall coordination of the different

[105] Stakeholder interviews

[106] The ENCU, (present at federal and regional level) is not a separate signatory to the TSF MOU but from the start onwards has been charged with the responsibility to verify EOS screening data. Originally this was done before the food order would be placed, but to avoid delays the system was later on changed into retrospective confirmation of screening results.

programmes at *woreda* level, and better communication between the *woreda* and regional levels in order to eliminate/reduce delays in food delivery[107]. The BPR process within the Government could serve to bring the TSF closer to the health sector, food security support (PSNP) and emergency relief programmes, but this opportunity has not yet been exploited.

Figure 3: Organizational linkages



101. *Urban HIV/AIDS Component*. Consistent with the PRRO and WFP's HIV policy, the HIV/AIDS component engages with partners and builds capacity. At local levels all partners and stakeholders constitute a coordinating committee, chaired by HAPCO, which oversees and monitors all aspects of implementation. Under the MOU with HAPCO it is responsible for overall coordination of the HIV component at national, regional and town levels and reports to WFP (but WFP can assist with this reporting). Federal HAPCO recently came under the auspices of the Ministry of Health, causing concern about loss of authority and staff reductions. Some regional HAPCOS remain attached to the president's office. To ensure consistency and capacity, partly due to BPR, the project placed a coordinator position in the Addis Ababa HAPCO office.

102. Other Direct Operational Costs (ODOC) is used to provide material support to facilitate food distribution and services to beneficiaries. A baseline of administrative and financial support minimum standards are established against which to build capacity. In

[107] E.g., in the first half of 2009 serious delays occurred for the TSF in Amhara, Oromiya and Somali region and food distributions were cancelled or over two months late. According to WFP staff this delay was caused by lack of experienced staff within DPPB due to the on-going BPR process within the regional government.

addition, ODOC builds partners' technical and organizational capacity for nutritional education and counselling, support to beneficiaries, management and training of HBCVs, and monitoring and reporting. Health service partners are included in capacity-building. Capacity-building is based upon needs assessments in which national partners (HAPCO, donors, and UN agencies) participate. Capacity-building activities carried out by these partners have been monitored during project implementation. The quality of partnerships varies according to partners' commitment, but due to project design, both the partners themselves and WFP are able to monitor and respond to weaknesses and challenges. Partners told the MTE that WFP capacity-building assists them with broader organizational capacity development. For example, the monitoring and reporting skills development enables better accountability to their other donors, and having the partnership with WFP increases their ability to form other donor partnerships.

103. In addition, MOUs were established with NGOs supporting PLHIV thus enhancing their well-being and social and community engagement. The newly established Food by Prescription programme at Save the Children US provides partnership opportunity although there had been no communication with WFP at the time of the MTE. Food by Prescription could support severely malnourished PLHWA and WFP could pilot providing their households with rations. WFP would continue supporting moderately malnourished food insecure PLHWA and their households. Given scale of need and potential for site expansion this is unlikely to require alteration of programme objectives. Linking with partners providing Home Based Care (HBC) compensates for WFP's inability to support HBCVs with food. Across Ethiopia, *edirs*[108], have transformed to respond to HIV by contributing to prevention, care and support, and community mobilization. Whilst *edirs* are not implementing partners, many are linked to NGOs, and participate in every level of project implementation, and serve on the local project coordinating committees. Their unique capacity to monitor every household is a major resource, particularly in locating and supporting OVC. Overall, the partnerships established are building local capacity to manage and implement the component and have the potential to move towards sustainable independent operation.

104. The support WFP provides to partners to operate IGAs to prevent graduating beneficiaries from returning to chronic and acute food insecurity is a central feature of component design. However, the MTE finds that partners are unable to satisfy demand and lack the expertise to conduct a successful range of sustainable livelihood programmes.[109]

Implementation mechanisms

Targeting

105. *Relief Component*. Relief targeting uses National Food Aid Targeting Guidelines issued by the then DPPA in November 2000. The Government and WFP are currently reviewing the guidelines with a view to identifying gaps and limitations that hinder the timeliness of relief and the proper utilization of resources. [110] Since the introduction of the guidelines, a range of innovations has been introduced in the humanitarian sector. These include the Household Economy Approach, which generates planning figures for the geographic targeting of relief. A process has been introduced to prioritise *woredas*

[108] Traditional funeral associations
[109] Ethiopian Network of PLHIV. *Study on IGA and PLHIV*.
[110] WFP, ToR, Targeting of Relief. 2010

most in need of relief (see Annex 5). In addition, in line with the new mandate for risk management, a *woreda* risk-profiling component, building on existing information systems, has just been launched to profile *woredas* according to risk and likely impacts of defined shocks.

106. *Productive Safety Nets Programme Component*. PSNP uses a combination of administrative and community-based targeting to select beneficiaries. The overall criterion for selection to the programme is households that have faced continuous food shortages (usually a three or more month period when the household is unable to produce sufficient food for consumption) in the last three years and who have received food assistance. The programme also includes households impacted by a severe loss of assets.[111]

107. Programme beneficiaries are separated into two categories:

- Public Works (at least 80 percent of participants): intended for able-bodied men and women, lactating women for a period of 10 months after giving birth, and female-headed households, and

- Direct Support (up to 20 percent of participants): designed for individuals unable to participate in public works who do not have sufficient and reliable support from children or remittances. Such individuals include some disabled or elderly persons, pregnant women and orphaned teenagers.

108. Reviews of PSNP conclude that targeting of the programme is improving. An IFPRI study finds:

> *The proportion of households identifying poverty-related characteristics as a reason why households are selected for Public Works has risen over time. In 2008, "people who are seen to be poor" is listed as a criterion by 62 percent of respondents in Tigray, 75.9 percent in Amhara, 67.3 percent in Oromiya, and 72.4 percent in SNNPR. Increasingly, respondents are also able to list more specific criteria, such as small landholdings or lack of livestock.*

109. Improvements have also been made in the communication surrounding the programme. Specifically, ensuring Government staff have access to programme implementation manuals and guidelines and public announcements of targeting lists have ensured that there is greater transparency about the targeting process.

110. The PRRO strategic objectives differentiate between households that suffer acute versus chronic vulnerability. In Ethiopia, the lines between these two groups are, in reality, frequently blurred. Chronically food insecure households targeted under PSNP can still be vulnerable to acute climate or economic shocks. The MTE finds that lack of conceptual clarity causes confusion and misunderstanding between stakeholders who support the Relief and PSNP components of the programme.

111. *Targeted Supplementary Feeding Component*. Overall, geographical targeting for TSF is coherent with the Government classification of specific communities regarded as a humanitarian priority. However, there is a need to increase geographical coverage – and

[111] World Bank, PSNP, Project Appraisal Document, 2009

thus, beneficiary coverage – in the most acutely food-insecure *woredas*. For instance, 70 percent of the October 2009 Priority 1 *woredas* were covered by the eleventh TSF round with distribution of food in the period June – August 2009[112,113] (see Annex 5).

112. The evaluation finds that the geographical coverage of the TSF does not fully keep abreast of the changes in communities classified as a humanitarian priority. In the June/August '09 TSF distribution round, coverage of the most food-insecure *woredas* was better in regular TSF *woredas* (71 percent of the *woredas* in this category were given a high priority rating in the October '09 classification) when compared to *'ad hoc'* TSF *woredas* (49 percent had a high priority rating in October '09). This is a surprising finding as the '*ad hoc'* category was established in order to respond to newly emerged needs in *woredas* not, currently, covered by the regular TSF after the downscaling of the programme early 2008. This finding might mean that almost half of the '*ad hoc' woredas* identified in the April humanitarian classification system were affected by a temporary food security shock and recovered within a few months'. On the other hand, about two thirds of the regular *woredas* apparently are chronically food insecure (always given a high humanitarian priority), which justifies continued assistance.

113. For the three regions visited by the evaluation team, it was assessed whether the average number of TSF beneficiaries per *woreda* is in line with peak malnutrition (as indicated by the findings of the standard nutrition surveys at *woreda* level undertaken in each of the regions). The comparison is a rough proxy for individual targeting efficiency. The comparison of the expected total number of wasted children (GAM) at peak malnutrition with actual TSF coverage figures shows that a substantial level of false inclusions (coverage of children who are not malnourished) is likely in Amhara and SNNP region while there generally still seems to be under-coverage in Somali region (for further details see Annex 5).[114]These findings underscore the need to improve EOS screening procedures as is currently being done in response to the 2008 TSF Outcome Evaluation study that highlighted the same issue of false inclusions.[115] In 2009, WFP initiated a pilot study of the 'gatekeeper concept' which might also help to reduce targeting errors.[116]

114. The FLA for the TSF programme are customised contracts at regional level that are normally updated every six months. They contain budgets for internal transport storage

[112] A similar analysis of TSF coverage (11th round) compared with the July '08 hotspot classification shows that 60 percent of Priority 1 *woredas* were covered and 11 percent of Priority 2 *woredas*.
[113] At beneficiary level it was also found that two-thirds of the recipients of the 11th TSF round live in October '09 Priority 1 *woredas*.
[114] Peak malnutrition levels were based on the Standard Nutrition Survey findings plus a certain margin for really bad years. It needs to be noted here that these surveys are using Weight-for-Height as indicator while the TSF uses MUAC as entry criteria which tends to result in slightly higher malnutrition prevalence. For SNNP, a GAM level of 20 percent was taken, 15 percent for Amhara and 25 percent for Somali region. In this analysis, inclusion of severely malnourished children is not regarded to be a false inclusion. See Annex 5 for further details.
[115] In relation to the false inclusions problem, a recent ENCU guidance note on EOS screening data quality is stressing the need to avail of credible screening results for effective TSF targeting with limited inclusion and exclusion errors.
[116] In this approach, the EOS screening is a referral to a second screening done by health workers who are paid a daily stipend to undertake this specific task. The gatekeeper concept was first piloted in SNNP as this region was known to suffer from high numbers of false inclusions. According to the WFP country office, the new approach works well, primarily because of good commitment to the initiative from the side of high-level regional administration officials. The pilot is currently being expanded to Afar region, another region well-known for its high level of false inclusions.

and handling (ITSH) and ODOC.[117] Over the past two years, considerable fluctuation has been found in TSF ITSH and ODOC rates per region (see Annex 5).[118] However, the rates generally were found to be lower than the average rates according to each budget revision for the PRRO, indicating that the TSF with food deliveries at sub-*kebele* level logistically is not an expensive programme *per se*.

115. *Urban HIV/AIDS Component*. Food insecurity, not HIV status alone, is the entry point for the component. Beneficiary selection criteria consider: food insecurity/poverty level, HIV status, service utilisation, BMI of 18.5 and below, and age for OVC. Targeting is inclusive; sex workers are readily included. PEPFAR policy stipulates the 18.5 BMI criterion, provides for individuals (not households), and does not allow food support to HBCVs. HBCVs, many of whom are PLHIV, provide nutritional counselling at food distribution centres, conduct home visits, and support OVC. The removal of food support as an incentive has caused a significant decline in their numbers during this PRRO. Wrap-around funds from other donors provides food support for PLHIV households.

116. Towns are selected according to population size, HIV prevalence, target population size, levels of food insecurity, potential to build upon and link with existing health and community services, and WFP's capacity to implement at minimal operational cost. To ensure access equity the Coordinating committees select beneficiaries from those nominated by implementing partners. WFP conducts random checks to monitor adherence to targeting criteria. In one site the MTE was informed that beneficiaries found selling food are removed. Overall, the beneficiary and site selection criteria and processes, within the resources available, mean that the component is able to focus upon the beneficiaries most in need of food support and to locate in places where it can maximise the effectiveness of the infrastructure and systems of the local response to HIV. However there are some issues that affect the component's operations.

117. Clinicians and component personnel have clinical and ethical concerns about the 18.5 BMI criterion for inclusion and graduation because some clients with a BMI above 18.5 have malnutrition; rapid body fat changes can occur early in ART treatment and disguise malnutrition; and anecdotal knowledge that other countries use a higher BMI or use clinical evidence of malnutrition as additional criteria. The component is commissioning a study to investigate this. Moreover, this criterion prevents assistance to PLHIV before they become malnourished, thereby compromising their health.

118. Food assistance is used to attract pregnant women with HIV to PMTCT programmes. The component is not reaching its target due to factors beyond its influence. Pregnant Ethiopian women often do not access health services. Those who do are reluctant to test for HIV due to stigma. The MTE saw PMTCT programmes where women are closely monitored to encourage compliance.

119. Many chronic and acutely food-insecure PLHIV and OVC remain unable to access the programme. Funding limitations restrict the component's reach. All partners told the

[117] Under ITSH, costs include loading at the WFP warehouse and unloading at the FDP, transport costs (both by truck and by pack animals), logistics service administration costs (only for Amhara where contracting is done through ORDA), and food distribution costs (payments against daily rates for the FDAs). Under ODOC, costs are included for DPPB (salary costs for the TSF manager and three to four staff plus administrative and vehicle running costs), for the zonal logistics offices (salaries for two to four staff members plus administrative and vehicle running costs) and for the *woredas* (payments against daily rates for *woreda* TSF focal points/food distribution assistants).

[118] Presumably, this reflects volatile transport market conditions. But also it reflects achievement of variable levels of success in the bargaining process between WFP Ethiopia and the different DPPBs.

MTE of their inability to support these PLHIV and children due to eligibility restrictions or quota limits. Only children in the most severe circumstances are assisted. While the ration is only provided to the child, in reality it is often shared within the household. This might be rectified, as recent PEPFAR draft policy states that it does not support household food insecurity 'with the exception of food assistance to OVC *and caretakers*' (emphasis added).[119]

120. The component appropriately establishes a commitment to OVC to the age of 18. Substantial project funds are committed to supporting this thus restricting the ability to assist other children. The length of commitment exceeds programme lifespan and funding cycles, which further adds to viability concerns. (It might be possible to alleviate some of this through exploring household livelihood support initiatives.) This limitation will have increasingly pronounced consequences as: since 2004 the number of OVC (due to AIDS) in rural areas was expected to exceed that in urban areas; their total number would increase until 2010, as well as the massive problem of an estimated 5.4 million OVC in the country.[120]

121. UNICEF also provides OVC interventions and WFP has been trying to secure closer collaboration without success. Both organizations can operate at town level on joint targeting of OVC. Given the complexity, urgency and scale of the problem it is appropriate for the UNDAF to take responsibility for OVC.

122. Overall the MTE finds the HIV/AIDS component: targets those most in need of food support; strengthens beneficiary referral, promotes service utilisation and graduation; strengthens partnership and networking amongst services; enhances the component's sustainability; and strategically develops the local integrated response to HIV. The MTE was informed that, in Ethiopia, this design is distinctive. Given the limited capacity of the organized response to the epidemic to date, WFP is making a vital contribution to the national response.

123. An internal audit found that WFP is responsible for not releasing ITSH and ODOC finances on time to partners. This has not been rectified and impacts across WFP, but particularly on the HIV/AIDS component with its many partners.

Monitoring and evaluation

124. The PRRO makes a number of commitments regarding the monitoring of the programme. In the past two years WFP has started to produce regular PDM reports. The specific objectives of these reports are to understand: (i) the demographic and socio-economic characteristics of beneficiaries including their food/income sources, food gaps and coping mechanisms; (ii) targeting efficiency; (iii) food/cash ration size and distribution process; (iv) utilization of food/cash assistance including their consumption patterns; (v) impacts of the food/cash assistance on beneficiaries' livelihoods. However, the evaluation team finds PDM to be weak in three critical areas. Firstly, management of the PDM does not reflect the principles of harmonization. In addition, WFP Ethiopia has implemented an action-based monitoring (ABM) approach which not only aims at collecting data but also provides on-the spot guidance and assistance to WFP monitors and partners on how to address problems encountered during the field visits. A software

[119]Technical Considerations. Provided by PEPFAR Technical Working Groups for the FY 2010 COP. President's Emergency Plan for AIDS Relief.
[120] *AIDS in Ethiopia 6th edition*. 2006.

tool has been developed to capture ABM information for management use. The ABM tool is periodically reviewed to ensure production of management information reports on time. The MTE finds that these systems for monitoring and evaluation are necessary but are insufficient.

125. In comparison PSNP has established a comprehensive framework for monitoring and evaluation. This is summarised in Table 8. This framework combines internal reviews and monitoring with independent audits, reviews and evaluations. This ensures significantly higher degrees of accountability and transparency. The comprehensive nature of the framework enables all PSNP stakeholders to identify and prioritise, at a strategic level, areas of capacity-building or bottlenecks in the flow of cash transfers.

Table 3: Framework of Monitoring and Evaluating PSNP

Types of reports	Information provided	Frequency	Examples of indicators
Monitoring Reports	Regular collection of information at output and activity level, including regular financial reports (IFRs).	Monthly from woreda to Regional level; Quarterly to Federal level	- Number of public works completed - Volume of transfers delivered
Information Centre Reports	Information collection from a sample of *woredas* largely focused on timeliness of transfers, but also includes price data. A key set of indicators on the HABP may also be collected.	Every two weeks	- Date and amount of transfers to *woredas* and beneficiaries - Maize prices
Rapid Response Mechanism Report	Regular assessments of implementation at *kebele*, *woreda* and regional levels to address critical implementation problems as they occur. This includes transfers to beneficiaries, public works, capacity issues and others.	Every two months from Federal level (regularly from Regional and below)	- Number of households targeted - Beneficiary satisfaction with PSNP
Annual Assessments	- *Purchasing power study* to inform the setting of an appropriate wage rate for the PSNP - *PW Review* (planning) to assess the adequacy of PSNP public works plans - *PW Review* (technical) to review the quality and sustainability of PSNP PW - *Risk Financing (RF) Review* to determine the effectiveness of the RF response, if triggered - *Appeals Review* to assess the functioning of the appeals system - *Independent Procurement Assessment* to review procurement processes at *woreda* level.	- Annual - Annual - Annual - As needed - Annual - Annual	- Average prices in PSNP markets over time - Number of public works meeting technical standards - Number of Appeals Committees established - Volume of goods procured
Audits	- The *Financial Audit* includes an audit of accounts; systems audit; and review of transactions to beneficiaries to ensure that funds were used for purposes intended. - The *Commodity Audit* review to ensure in-kind resources are used for the purpose intended.	- Quarterly rolling, annual - Annual	- Percent of households receiving full payment - Quality of food stock records
Evaluations	- *Social Assessment* to confirm the effectiveness of targeting and assess relevant social issues - *Public Works Impact Assessment* to determine if the objective of the PSNP PW were met - *Biannual Impact Evaluation*, a regionally representative household survey, to assess outcomes and impacts of all component of FSP - *Risk Financing impact assessment* to determine if the objectives of RF were met.	- Once - Every two years - Every two years - As needed	-Qualitative review of targeting - Benefit-cost assessment of public works - Change in household food gap

Source: World Bank, 2009

126. The MTE recognises that implementing this range of initiatives maybe beyond the financial and institutional capacity of WFP. However, the evaluation finds that WFP current approach to monitoring and evaluating the components of the PRRO is

insufficient given the scale and importance of the programme, the donor expectations surrounding transparency and accountability, and the increase demand for evidence that will assist the prioritization of capacity-building efforts.

127. *Relief Component*. The MTE found a limited monitoring and evaluation system for this component. A system for reporting food distribution has been established. However, in July 2009 a joint effort of WFP, donor and the Government reviewed food distribution reporting systems for relief food aid. The report found significant variations were found in reporting standards across regions. The review also assessed the quality of reporting to be higher in PSNP compared to relief.[121] This finding is remarkable given that food distribution has been in operation for two decades while PSNP was established five years ago.

128. Overall, the MTE finds significant weaknesses in the PRRO's approach to evaluating the relief component. It is recognised that there are inherent challenges in monitoring and evaluating humanitarian efforts. However, the frequency of humanitarian crisis, the high probability that events will consistently impact specific geographical areas, and the levels of resources invested in humanitarian response suggest that resources could be applied to establishing a robust M&E framework.

129. *Productive Safety Nets Programme Component*. Indeed, PSNP has established a comprehensive framework for monitoring and evaluation. This framework has weaknesses, specifically, in the monitoring. However, the evaluation mechanisms in PSNP are very high quality. The programme has established an impact evaluation that collects quantitative data from three thousand households on a regular basis. In addition, a panel survey of nine households provides qualitative and quantitative data. The reports from surveys are in the public domain.

130. *Targeted Supplementary Feeding Component*. There is no monitoring of weight gain as an outcome indicator. The ABM system focuses on the implementation process through FDA reports and FDC monitoring checklists. While there is a PDM system with beneficiary interviews, monitoring is not frequent, not all regions are covered, and it is unclear whether or how the information gathered is used for fine-tuning the TSF programme. In order to improve the credibility of the TSF programme, it is suggested that WFP considers analyzing the results in some selected sentinel sites of consecutive nutrition screening rounds as a population-level monitoring system. Obviously, this would only work if mid-upper arm circumference (MUAC) data are of sufficient quality, which currently is not the case. In such an approach the effects of seasonality and annual variations could be adjusted via trends analysis. World Bank is supporting the establishment of a national nutritional surveillance system in Ethiopia which will take some time but might in future provide population-level data (disaggregated at *woreda* level) on GAM prevalence for children under five and acute malnutrition among women.[122] Such information potentially could be highly useful for indirect monitoring of the effectiveness of TSF and other interventions to improve nutrition status.

131. *Urban HIV/AIDs Component*. In its Performance Monitoring Plan the component has created an excellent results-based system that monitors an extensive range of indicators including ART uptake and adherence, nutritional status and QOL (compiled

[121] Joint Federal DRMFSS-Donors-WFP Field Mission Report on Food Distribution Reporting, 2009.
[122] Saldanha L (2009), Strengthening Nutrition Information/Surveillance for Early Warning within the Framework of the National Nutrition Programme, World Bank, August 2009

from clinic records); questionnaires, beneficiary weight measurements; school attendance sheet review; and monthly and quarterly partner reports.[123,124] It provides detailed analysis of operations and beneficiary impacts, and identifies best practices and challenges. Donors are impressed with reporting, which augurs well for retaining donors and attracting new ones. The component M&E framework is linked with the WFP global and country results-based processes.

132. Operational monitoring occurs at all levels. The HIV team provides M&E support to sub-offices (SOs) and implementing partners. Both the HIV team and SO focal points regularly visit component partners. HBCVs and *edir* members visit and monitor beneficiaries in their homes. Coordinating committees monitor and review partners' quarterly reports. Because these committees use participatory processes, partners, as well as WFP, respond to problems. For example, one town is changing its core partner from an NGO to HAPCO. This comprehensive monitoring system provides incisive information about progress and difficulties. Consequently, the MTE found it could add little to the knowledge already possessed by the component.

2.3. Results

Effectiveness

133. *Relief Component*. The strategic objective for this component is "saving lives and protecting livelihoods". A sample of WFP's PDM reports indicate that households are likely to utilise between 80-90 percent of food aid transfers for household consumption. This would suggest that transfers are sufficient to meet household demand and address at saving lives element of the strategic objective and the consumption smoothing requirements at the output level. However, there is little evidence of how the relief component is impacting livelihoods and achieving the timeliness requirements at outcome level.

134. *Productive Safety Nets Component*. The component contributes to two strategic objectives: a) prevention of acute hunger and investment in disaster preparedness and mitigation measure; and b) Reduction of chronic hunger and under-nutrition. There is evidence to suggest that the vast majority of PSNP beneficiaries use food transfers for the intended purpose, thereby contributing to the reduction in the chronic hunger objective. Table 8 highlights how poorer households (classified as direct support) are more likely to consume all of the food provided.[125] The table also highlights that there is some, albeit limited selling of food and/or redistribution.

[123] WFP Ethiopia. *Urban HIV/AIDS Project Implementation Manual*. Annex 3. M&E Matrix. Performance Monitoring Plan.
[124] The quality of the project's M&E system is reinforced by the WFP *'The M&E Guide for Food Assisted Programming'* 2009. Which generally recommends programmes not use QOL indicators unless able to access 'exceptionally strong M&E capacity'. The Guide specifically profiles WFP Ethiopia's HIV/AIDS QOL M&E system as an example of best practice. Under PRRO Outcome 3.3 the Urban HIV/AIDS project is responsible for 'Improved nutritional status and *QOL* of food-insecure PLHIV on HBC, ART Therapy and PMTCT'.
[125] IDS, PSNP Assessment Report, 2008

Table 4: Use of PSNP food transfers (last 12 months)

Use of Food	Public Works%		Direct Support%		All Current PSNP %	
We ate all the food	332	(70.6)	99	(86.1)	431	(73.7)
Sold some food, ate the rest	68	(14.5)	6	(5.2)	74	(12.6)
Gave away some food, ate the rest	20	(4.3)	6	(5.2)	26	(4.4)
Sold the food to buy other food	21	(4.5	0	(0.0)	21	(3.6)
Gave some food as payment, ate the rest	13	(2.8)	0	(0.0)	13	(2.2)
Sold all the food for cash	10	(2.1)	3	(2.6)	13	(2.2)
Gave all the food to livestock for feed	1	(0.2)	0	(0.0)	1	(0.2)
Gave all the food to others as a payment	0	(0.0)	1	(0.9)	1	(0.2)
Other	5	(1.1)	0	(0.0)	5	(0.9)
Total	**538**	**(78.3)**	**149**	**(21.7)**	**687**	**(100)**

Source: IDS, 2008

135. Progress in supporting households to develop risk mitigation strategies is less positive. PSNP transfers are meant to discourage households from using negative coping strategies such as selling assets. The evaluation has highlighted that timeliness and predictability of transfers are the critical factors in reducing negative coping strategies. Studies show that households that receive unpredictable and lower than the intended level of transfers are much more likely to make distress sales of assets.[126]

136. *Targeted Supplementary Feeding Component*. The previous PRRO evaluation concluded that the programme resulted in nutritional and health benefits but that these were not measured.[127] Due to the absence of regular TSF monitoring data on effectiveness after the initial scaling up of the TSF, it was recommended to undertake annual performance studies.[128] The studies undertaken in 2007 and 2008 concluded that the TSF was not very effective in terms of reducing the prevalence of low MUAC among children under five years of age (recovery rates of only 49 percent - 62 percent), and that the programme was marked by high inclusion errors (both severely malnourished children who should attend a therapeutic feeding programme and real false inclusions of non-malnourished children who in principle are non-eligible but apparently were still selected[129]), significant delays between screening and actual food distribution, and problems with compliance (it was found that in many households the targeted children ate less than half of the TSF food- however, a note here is that the rations in the TSF actually are double those of regular supplementary feeding programmes to allow for sharing within the family). The 2008 Outcome study found that the TSF intervention is effectively reducing malnutrition based on Weight-for-Height but there were no

[126] IFPRI, PSNP, Impact Evaluation, 2009

[127] WFP OE (2007), Summary Evaluation Report Ethiopia PRRO 10362.0, Rome, October 2007

[128] The new MOU for the TSF that was signed in April 2008 stipulates these surveys are the joint responsibility of DRMFSS and WFP.

[129] e.g., in the 2008 Outcome Study it was found through re-measurement of a sample of selected children a few days after the EOS screening that only 36 percent of the children enrolled in the TSF were acutely malnourished based on Weight-for-Height (< -2 Standing Deviation {SD}-score) while 64 percent of the children enrolled did not have GAM. One-third of the children with GAM were actually affected by SAM). Among the children enrolled in the TSF, only 54 percent was found to have acute malnutrition based on MUAC <12 cm. Mean Weight-for-Height Z-score was -1.72 with 1.1 SD (regular bell shape, indicating normal distribution). This means that for non-malnourished children the chance of being selected for the TSF was highest if their Weight-for-Height was around -1.72 SD-score, but that there were also some children included with much better nutritional status.

statistically significant changes in MUAC between the TSF and control groups.[130] Key results of the outcome studies are summarised in Annex 5.

137. The Knowledge, Attitudes and Practices study, undertaken recently to assess the effectiveness of the TSF in relation to the second objective for the programme on nutrition education, highlighted that the TSF has a limited impact on child feeding and knowledge and practices as traditional beliefs (e.g. that colostrum is dirty) are not easily changed and the frequency of the nutrition education sessions for the mothers is low,[131] Also, it was found that temporary or permanent separation of the child from the mother is a constraint for practicing optimal breastfeeding. The study recommended to make it conditional that mothers (and not fathers) collect the TSF rations, that additional nutrition education sessions be organized during the intervals between food distribution rounds, and that closer linkages should be fostered between the TSF and health facilities, e.g. by using the health post as an alternative for FDCs and via better integration of the TSF nutrition education with the activities of HEWs.

138. *Urban HIV/AIDS Component*. The component's 2008 Annual Results Survey monitored all outcome indicators and demonstrated significant beneficial outcomes and achievement of targets for PLHIV on ART and OVC, but not for PMTCT (reaching 48.5 percent of target).

Table 5: Indicator Performance for Urban HIV/AIDS Component

Outcome indicators	Baseline (June 2006) %	Actual (November 2008) %	% of target
PLHIV gaining weight by at least 10% 6 months after starting ART	24.6	47.4	n/a
% of beneficiaries on ART taking 95% of medication in last month	76.7	96.4	101.3
PLHIV with improving/stabilising health condition	85.6	95.1	99.9
PLHIV with improved functional status	73.2	92.4	108
School enrolment of OVC	80.1	98.8	104
School attendance of OVC	90.9	98.4	n/a

139. The impact of the component's contribution to ART programming is shown by a three-fold increase in the number of clients enrolled in ART in component townships.[132,133] All government agencies, partners and beneficiaries interviewed during

[130] Average improvement of 0.56 Z-score in the TSF group against improvement of 0.25 Z-score in the control group, both over a 6-month follow-up period. For MUAC, both groups gained 0.45 cm over the 6-month follow-up period.

[131] Some key findings are that only 52 percent of the caregivers had correct knowledge about the preparation of the TSF food, that only 62 percent of the caregivers know that the TSF food should assist to recover from malnutrition, that there is no difference between TSF beneficiary caregivers and non-beneficiary caregivers in terms of knowledge on optimal breastfeeding practices and feeding of children with diarrhea although a significant difference was found in knowledge about complementary feeding. See: Belachew T (2009), Assessment of knowledge, attitude and practice of mothers/care givers of index under five children in EOS/TSF targeted areas of Ethiopia, Faculty of Public Health, Jimma University, 2009.

[132] WFP Ethiopia Urban HIV/AIDS Project. *Results Report for 2007 and 2008*.

[133] It is accepted by WFP and donors that it is difficult to attribute changes in outcomes solely to food assistance, and thus *contribution* rather than *attribution* is the most reasonable relationship between food supplementation and outcomes. WFP. *The M&E Guide for Food-Assisted HIV Programming*. Draft. 2009e.

the MTE endorsed the component and consistently stated that food support brings bed-ridden, isolated, PLHIV back to life, and that the provision of both food and ART is critical.

140. The HIV component's use of a social and safety net approach is the most suitable way to address nutrition and QOL of PLHIV and OVC. Its design is innovative and highly relevant to national HIV circumstances by reaching beyond just targeting food support to also strengthening beneficiary referral, service utilisation and graduation, partnerships, and networking in ways that enhance the component's sustainability. It strategically develops the local integrated response to HIV by integrating HIV care and support, prevention, and stigma reduction. The capacity development provided to partners not only facilitates food delivery but also contributes to their operational and organizational capacity. Given the limited capacity of the Ethiopian national response to the epidemic to date, WFP is making a vital contribution.[134] It facilitates a continuum of care returning PLHIV to well-being, provides them with social capital, and returns them to community life. This was typified by the woman who told the MTE of being rejected by husband and family upon her diagnosis with HIV, of being provided with WFP food and PMTCT services during pregnancy, of her child being born HIV uninfected, of finding a new 'family' on joining a PLHIV association, and of now telling her story when working as a community HIV educator.

141. Stigma has a profound influence on the component; it is a key factor causing the food insecurity experienced by beneficiaries and preventing them from accessing services. For example, commonly, in Addis Ababa female PLHIV avoid identification by providing false addresses, registering at an ART facility far from their home, and requesting referral to a food distribution centre in another sub-city.

142. Sustained HIV mainstreaming requires country office commitment. Focal points with authority should be placed in the programme unit and other relevant units. The HIV Mainstreaming Strategy and Matrix can be updated.

Impact

143. *Relief Component*. The MTE could find no comprehensive and statistically valid evaluations of the impact arising from the Relief Component. The PDM report does explore the impact of food transfers on diet but the report does not disaggregate this data by programme component.

144. *Productive Safety Nets Component*. Overall, the evaluations of PSNP indicate the programme is having a positive impact. This is a major achievement given the food price crisis and several significant droughts. However, assessments of the extent of the programme's impact do vary. The IFPRI impact evaluation concludes:

Food and Nutrition Technical Assistance (FANTA) Project and WFP. *Food Assistance Programming in the Context of HIV*. Washington, D.C: FANTA Project, Academy for Educational Development, 2007.

[134] SPM II. P. 7 'There were numerous challenges in the implementation of SPM I…they include :insufficient institutional capacity, including poor resource absorption capacity; shortage of qualified human resources and rapid turnover of staff; weak leadership at regions and local government levels; inadequate involvement of key stakeholders; ineffective mainstreaming and multi-sectoral approach; high level of stigma and discrimination; insufficient and ineffective engagement of civil society; insufficient community involvement;…'

> When households receive reasonable high levels of transfers, when these transfers are predictable, and when they also receive access to Other Food Security Programme services designed to improve farm productivity, food security improves, asset growth is faster, and yields rise. The improvement in food security is less than expected but arguably asset growth is higher than expected. The programme does act as a safety net provided transfers are reliable. By contrast, unpredictable levels of transfer have less positive impacts and the uncertainty of their receipt forces households to be more likely to make asset distress sales. Increasing transfers to beneficiaries, making them more predictable, and continuing to strengthen the links to productive components of the OFSP will further improve the impact of the Food Security Programme.[135]

145. The IDS Assessment of PSNP provides a more positive assessment of impact:

> Overall the four regional studies found that the PSNP is stabilising livelihoods and improving the food security of beneficiary households. Feedback from beneficiaries about the programme and its impact on their lives and livelihoods has been broadly positive – especially by protecting households from distress sales of assets. The PSNP continues to contribute in other key ways, for example, beneficiaries report that the programme is having an impact on education and children staying in school.[136]

146. Evaluations of the community based resource suggest positive trends related to WFP's contributions to community watershed management.[137] However, institutional capacity issues were noted as a major constraint to ensuring effective public works structures.

147. *Targeted Supplementary Feeding Component*. Within the TSF there is no measurement of population level impact (the annual TSF outcome studies focus on effectiveness in terms of recovery rates and nutrition impact on beneficiaries, see above). Impact assessment for a supplementary feeding programme could focus on wider improvements in nutrition conditions in Ethiopia including reduction of chronic hunger and under-nutrition (which is strategic objective 3 in the revised PRRO logframe). In this approach, possible TSF impacts to be monitored would include the stabilization /reduction of moderate acute malnutrition prevalence (strategic objective one in the original PRRO logframe) which Governments much beyond the effectiveness of the targeted feeding programme expressed in terms of proportion/absolute numbers of MAM children that have been rehabilitated (strategic objective three in the original PRRO logframe).

148. WFP regularly participates in high-level nutrition coordination meetings where implementation of the new NNP is one of the issues being discussed. Overall, the roll-out of the NNP has been rather slow and it is not easy to pinpoint where exactly WFP has had definite influence, e.g. so far there seems to have been rather limited involvement in the process of establishment of a national nutritional surveillance system and no clear plans have been developed as to how to integrate TSF within the CBN and for

[135] IFRI, An Impact Evaluation of Ethiopia's PSNP, 2009.
[136] IDS, PSNP, Assessment Report, 2008.
[137] M.A. Consulting Group, Impact Assessment of the PSNP Public Works Programme, 2009.

harmonization of the nutrition education within the TSF with the HEP that is currently being rolled out in Ethiopia.

149. Also, there is a need for WFP Ethiopia to define a specific strategy on how the TSF can impact on nutrition conditions during crises through playing a role within the wider framework of relief interventions (including GFD and the OTP), especially as the relief operations have been scaled up enormously in response to the new food security shocks that have struck Ethiopia since 2008.

150. *Urban HIV/AIDS component*. Implicit in its responsibility for the food and nutrition needs of those affected by HIV under the UNAIDS Division of Labour is that WFP will conduct advocacy. This is especially important if those affected are unable to advocate for themselves, as is the case in Ethiopia, and where additionally, HIV is highly stigmatised and where formal and informal leaders are reluctant to acknowledge food insecurity and seek assistance. [138]

151. The component has been highly successful in advocating for nutrition and HIV at national and global levels. It participated in creating the 'National Guidelines for HIV/AIDS and Nutrition in Ethiopia', and the accompanying 'National Implementation Reference Manual on Nutrition and HIV/AIDS.' WFP effectively advocated for nutrition's inclusion in the Ethiopian proposal for the Global Fund to Fight AIDS, TB and Malaria and assisted with the proposal development. Most strikingly, the component's advocacy had a global impact. WFP Ethiopia raised issues from the component at PEPFAR international forums, advocated for food to be included in PEPFAR policy, and influenced the inclusion of supplementary food in its revised indicators compendium.[139].

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

Sustainability/Connectedness

153. *Relief and Productive Safety Nets Programme Components*. The hand-over strategy outlined in the PRRO is based on two elements. The first is centred on the phasing out of food assistance. There have been positive trends in this direction. Examples include the emergence of cash transfers in PSNP, the introduction of new mechanisms such as drought risk financing, and the general policy drive toward improved disaster management. In addition, the Government continues to make investments in markets, infrastructure and commercial agriculture. Politically, Ethiopia

[138] UNAIDS. *Second Independent Evaluation 2002-2008. Country Visit to Ethiopia. Summary Report*. P.10. Whilst civil society and PLHIV are represented on national policy making bodies, informants 'were unable to provide examples of specific policy or programming outcomes resulting from civil society representation and participation, and noted that civil society influence remains limited.'
[139] PEPFAR is the world's largest bilateral contributor to HIV/AIDS.

has made clear its wish to reduce dependency on food aid. However in practice, as the past three years have demonstrated, food aid has remained the preferred response to major economic and climatic shocks. Phasing out this preference will take time.

154. The second element of the strategy is to ensure that the Government has the capacity to provide an appropriate response. The challenges of building capacity in Ethiopia are significant. WFP has an important role to play in ensuring that the Government delivers extensive/substantial resources to millions of poor, often very remote, households. However, this role could be more clearly defined, and benchmarks and indicators that demonstrate increased capacity could be utilised more frequently. This would bring greater clarity and accountability to WFP and its capacity-building efforts.

155. *Targeted Supplementary Feeding Component*. The previous PRRO evaluation concluded that there is no clear hand-over strategy for TSF but that the EOS/TSF programme expects to be phased out as the National Nutrition Programme, along with its CBN and HEP components, is rolled out. At the end of 2009, the HEP was found to be in an advanced stage of roll-out nationwide. The roll-out of the CBN component of the NNP is not so advanced. Most of the planned activities have yet to materialise in practice, including a concrete plan for how to sustainably incorporate TSF as one of the core elements of the CBN.

156. For the EOS/TSF, under the current PRRO the main emphasis for capacity development has been on short training sessions, primarily focused on how to improve the quality of MUAC screening (for the HEWs, organized by UNICEF), as well as on overall TSF implementation issues (for the FDAs, organized by WFP). This reflects a focus on capacity-building at the individual level for field-level Government staff. There seems to have been limited follow-up with refresher courses for higher-level key actors in the EOS/TSF programme after the initial rounds of training of Government staff at federal, regional, zonal and *woreda* level in 2005/06. No structured ongoing institutional capacity development has taken place. Partly because of the BPR process within the Government, there is an urgent need for more technical support and training of regional Government counterpart staff and institutions on the TSF programme. For instance, in order to improve timeliness of food deliveries, the DPPBs need to improve tendering and contracting for transport, as well as commodity tracking. [140]

157. *Urban HIV/AIDS component*. The component's long-term strategy is to transfer responsibility for PLHIV and OVC food support to national counterparts. This will require the Government to recognise and commit to HIV as a food insecurity issue. Component sites currently vary in commitment, capacity and partnership strength. In some towns all levels of partners, including regional HAPCOs, are committed and implementation is successful. These can be encouraged to move toward greater ownership, with WFP continuing to provide technical assistance and capacity-building. This can be emphasized in the next PRRO. Also, WFP could consider shifting the MOU from HAPCO to the Ministry of Health, considering national-level changes and WFP's increased emphasis on health systems. However, this would then require clarification about which government department is responsible for OVC to ensure WFP (and other UN agencies) can establish appropriate programming arrangements.

[140] e.g., in order to improve transport tendering and contracting, it is currently being considered to temporarily second WFP logistics staff to the DPPBs.

158. Sustainability of component impact upon PLHIV beneficiaries depends upon partners' capacity to provide an effective range of sustainable livelihood programmes. To maintain compliance with ART, health and well-being components, beneficiaries need food security. Without it they risk chronic and acute food insecurity, the potential to cease adherence to ART, and consequent threats to health and well-being.

159. Finally, the partnership model can be replicated across the response to HIV regardless of WFP involvement. It has demonstrated its value and impact, particularly as a combined partnership approach has greater impact than the cumulative impact of individual organizations.

2.4. Cross-cutting issues

Gender

160. The PRRO focuses on gender at the output level. Specifically, WFP has made a positive commitment to increase the role of women in the management of Community Food Security Task Force (CFSTF) and ensuring women have access to food transfers. Internal, WFP monitoring reports positive progress towards meetings these outputs.[141] However, evidence suggests increasing representation of women in the management of CFSTF may not address the more fundamental issue of ensuring the programme hears and responds to the needs and concerns of women. The 2009 IFPRI reports that women are both less likely to be aware of and make contact with CFSTF.[142]

Table 6: Household contact with the Community Food Security Task Force (CFSTF), by region and gender of the household head, 2008

	Tigray		Amhara		Oromiya		SNNPR	
PSNP beneficiary status	Male-headed HH	Female-headed HH	Male-headed HH	Female-headed HH	Male-headed HH	Female headed HH	Male headed HH	Female headed HH
	(percent)							
	Aware that the CFSTF exists							
Received Public Works	93	92	89	86	86	96	92	88
Received Direct Support	88	79	80	73	71	61	76	75
Received Public Works and Direct Support	100	95	100	-	-	-	-	-
	Aware that the CFSTF exists and had contact with the CFSTF							
Received Public Works	77	69	87	69	79	85	84	83
Received Direct Support	67	45	71	58	67	53	76	63
Received Public Works and Direct Support	83	58	79	-	-	-	-	-

Source: IFPRI, 2009. Note: Cells are left blank if there were fewer than 10 responses. HH = household.

161. In the HIV/AIDS component, the MOU with HAPCO commits to involving women across all operational aspects. Most of the PLHIV beneficiaries are women (70 percent in 2008). Of the total beneficiaries (including household members) 60.3 percent are female and 5.6 percent are on the PMTCT programme. This is consistent with higher HIV

[141] WFP, Summary report
[142] IRPI, PSNP Descriptive Report, 2008.

prevalence amongst females[143], entry criteria giving females priority, and more prevalence of food insecurity amongst females. The component operational manual specifies ways in which partner's strategies account for gender. A recent Country Office Gender Audit review found the gender perspective and analysis of key HIV documents to be adequate.[144]

Protection

162. Protection is a highly relevant issue for the PRRO in Ethiopia. The insecurity in Somali region highlighted the need for a stronger focus on protection. However, lower levels of insecurity are reported in other regions of PRRO operations. The IDS panel survey and WFP's PDM report both track protection issues.

163. WFP has nominated a staff member to be "point person for protection" and has initiated a process of incorporating protection into its staff training programme. The training focuses on ensuring staff safety and the incorporation of protection measures to reduce risks to beneficiaries.

164. Multiple priorities are restricting the resources and staff time devoted to developing and implementing protection protocols. However, given the importance of the issue in the lives of beneficiaries and staff, the MTE suggests that WFP should consider a stronger commitment to mainstreaming a security strategy.

Mainstreaming HIV

165. It is appropriate for WFP to mainstream HIV consistent with WFP policy. Although data are not currently available to confirm this, rural areas are likely to receive less HIV prevention education than urban areas. The available research is inconsistent about levels of HIV-related knowledge, attitude and risk. One set of studies found that 43 percent of respondents did not know all three HIV prevention methods.[145] Increased HIV prevalence has been detected in small towns where urban and rural people interact, causing concern for future spread of HIV into rural areas.[146] WFP has extensive reach to beneficiaries and workers, particularly in rural areas, and since the national response to HIV is undeveloped, it is appropriate for WFP to contribute. WFP also has an obligation to provide its workers with HIV prevention education. Given the urban HIV prevalence of 7.7 percent, it can be assumed that a similar percentage of its urban workforce is infected with HIV.

166. Findings regarding WFP's HIV mainstreaming achievements are mixed. MERET, Children in Local Development, Food-for-Education and TSF have been working on mainstreaming the longest; nevertheless their success is mostly attributed to their programme staff assuming responsibility for implementation. The HIV team facilitated an inter-agency process to develop a 'Package of Rapid Interventions to address HIV/AIDS in Emergency Situations,' but the WFP Relief section has not mainstreamed HIV within its programme, which is needed if WFP is to encourage wider sectoral engagement. The evidence base and recommendations from the PSNP HIV and AIDS Mainstreaming paper will enable WFP to build upon existing HIV mainstreaming

[143] FHAPCO. Single Point Estimate 2007.
[144] WFP Ethiopia. *Draft Gender Audit WFP Country Office Ethiopia*. 2009.
[145] FHAPCO. Op. cit. P. 13.
[146] FHAPCO. Op. cit. P. 12

activities, including strategies supporting HIV affected households (and in MERET) and productive roles for PLHIV in operational and implementation activities.[147] After some successes, initiatives with the transport sector (as specified in the PRRO) have ceased due to implementation difficulties, confusion with government agencies about partnership, and failure of WFP Logistics section to assume responsibility for implementation.[148] In addition, WFP supports capacity development and mainstreaming of Government partners across various sectors through training and technical and material support.

3. Conclusions and recommendations

3.1. Overall Assessment

Relevance and appropriateness

167. The MTE concludes that the four components of the programme have been both relevant and appropriate responses to circumstances of the targeted populations. However, the PRRO MTE finds the PRRO's approach to ensuring the food management system has the capacity to deliver transfers in a timely manner has been severely delayed. This delay has led to reputational risks for WFP in Ethiopia. Specifically, the delays have prevented strategic analysis of the opportunities and constraints facing the food management system. In addition, the current FMI programme lacks the type of strategic profile and coherence (both internal and external) required to create substantive change in the food management system. Overall, the MTE finds WFP approach to capacity-building will not, therefore, meet the commitments outlined in the PRRO design.

168. The programme components are broadly coherent with key internal and external policy processes. The partnership model developed in the HIV/AIDS component should be considered for replication across the response to HIV/AIDS in Ethiopia regardless of WFP involvement. However, the TSF programme pays insufficient attention to linkages between relief programmes and sectors related to the underlying causes of malnutrition (household food insecurity, inadequate maternal and child care, unsafe water supply and inadequate sanitation facilities).

Efficiency

169. The PRRO provides resources to a vast population often under the most challenging circumstances. The evaluation concludes that the PRRO appears to have efficiently targeted activities under the Relief, PSNP, and HIV/AIDS components. Targeting in TSF could be improved, both geographical targeting and individual targeting (reduced inclusion of children who do not meet the specified selection criterion, MUAC <12 cm).

170. The implementation of the PRRO requires WFP to build and maintain strong partnerships. The HIV/AIDS component provides important lessons for other PRRO components showing how to enhance participating agencies efficiency through

[147] *Study for Mainstreaming HIV and AIDS into PSNP Operations in Ethiopia*. A joint Government of Ethiopia-Donor Study. 2009

[148] Integrated Service for AIDS Prevention and Support Organisation (ISAPSO). *Project Evaluation Report on Capacity-Building of Road Transport Companies for HIV/AIDS Mainstreaming*. 2008.

programme design that maximises partner's engagement and capacity-building. Similarly, within PRRO WFP staff been active participation in a range of coordination mechanisms. Continued and consistent support to these mechanisms will allow WFP to make significant strategic contributions to programmes such as PSNP.

Effectiveness

171. The programme has effectively responded to a significant increase in demand for food aid transfers. Resources have been mobilized and distributed to millions of poor households. This is a significant achievement. However, there is considerable evidence to suggest that the effectiveness of food transfers is reduced if there are delays or uncertainty in the delivery process. The evaluation concludes that WFP should improve its approach to ensuring the timely delivery of transfers.

172. There have been significant institutional changes in the environment within which the PRRO operates. The largest change has been the establishment of PSNP programme. This initiative is leading the reform of the humanitarian sector in Ethiopia. PSNP has introduced a new range of institutional standards for transparency, accountability, and programme performance. The introduction of impact evaluations, multi-partner and regular audits, joint donor missions, and thematic reviews are all examples of best practice. The MTE concludes that WFP, as the leading humanitarian agency, and the PRRO, as the largest and most strategic humanitarian initiative in Ethiopia, needs to set new standards in monitoring and evaluation. Specific attention needs to be given to regular impact evaluations of relief and TSF components.

Impact

173. The impact and systems for assessing impact vary across the PRRO components. As already highlighted there are no comprehensive evaluations of the relief component. In contrast, there are numerous reviews and evaluations which conclude that the PSNP is having a positive impact on Food Security. However, reports vary in their analysis of the scale of the impact. The nutrition education component within the TSF was found to have a limited positive impact on child feeding knowledge and practices. The Urban HIV/AIDS component contributes to the response to HIV at many levels: government, NGO, community, and mobilization of PLHIV in peer support groups. It has been effective in advocacy on food and nutrition nationally and globally. Its advocacy role is crucial in the Ethiopian setting, and not just on food and nutrition, but also on issues such as stigma and sustainable livelihoods. The stigma associated with HIV in Ethiopia is an important factor contributing to food insecurity of PLHIV and can hinder their access to component services. It is appropriate for the component to maintain and expand its advocacy role.

Sustainability

174. The hand-over strategy outlined in the PRRO is based on two elements. The first is centred on the phasing out of food assistance. The second element of the strategy is to ensure that the Government has the capacity to provide an appropriate response. The introduction of PSNP with its focus on cash transfers and resources to make multi-annual investments in capacity demonstrates a positive trend. However, the MTE concludes that overall the PRRO needs to develop a more appropriate capacity-building strategy and that progress towards sustainability will be incremental.

175. The HIV/AIDS component's long-term strategy is to transfer responsibility for PLHIV and OVC food support to national counterparts. This will require the Government to recognise and commit to HIV as a food insecurity issue.

3.2. Key issues for the future

176. Key lessons can be learned from the delays in WFP's development of a strategic approach to capacity-building. While there were aspirations to develop a more focused approach towards capacity-building, numerous emergencies occurred over the timeframe of the PRRO, and staff time and resources were focused on the management of these emergences. This may have been appropriate in the context; however the lack of focus on longer-term capacity has delayed improvements in the efficiency of the food management system.

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

178. Over the next five to ten years WFP (and donors) should be prepared to provide large-scale targeted nutrition support in Ethiopia, as part of the Government nutrition policy framework and in line with existing needs. In particular, it should focus on achieving: a) more synergies and reduced duplication of efforts with the PSNP and emergency relief food assistance; b) improved linkages with water, sanitation and hygiene programmes; c) greater focus within the EOS/TSF on effective nutrition education on optimal maternal and child care; and d) greater coherence and coordination with other supplementary/therapeutic feeding programmes by NGOs and/or Ministry of Health. WFP Ethiopia needs to make changes in the TSF design to improve the operational efficiency and effectiveness of the programme. Current efforts to pilot various changes in the programme can improve individual beneficiary targeting and compliance. Additional changes are needed in the design of the TSF programme in order to reduce the lag time, to ensure more flexibility and to ensure more linking up with the health and nutrition education through the health posts. Overall, there is need for more focus on institutional capacity development at the different administrative levels involved in the TSF implementation, through NGO involvement in a capacity-building function.

179. The HIV/AIDS component has difficulty providing graduating beneficiaries with access to sustainable livelihoods. This is an important issue requiring strategic attention, including exploring scope to address the challenge on a national level.

180. Future WFP HIV programming might be affected by the need to create broader urban food safety nets given increasing evidence of poor urban households experiencing serious food shortages and other stresses and increasing rural-urban migration.[149] Initiatives to incorporate HIV into broader urban interventions require careful consideration because WFP will need to manage potential tension between urban programming and maintaining commitment to the HIV epidemic. Fundamental to this is recognising that support to health system HIV medical management, in itself, does not mitigate the social and personal experience of those affected by HIV. After more than

[149] World Bank. *Country Assistance Strategy for the Federal Democratic Republic of Ethiopia*. 2008. (P. 11)

two decades of HIV response in Ethiopia the powerful stigma of HIV has not lessened. PLHIV and OVC will remain stigmatised and thus vulnerable to chronic and acute economic and food insecurity into the long term, and many PLHIV will be diagnosed only when ill. Consequently, WFP will need to maintain specialised HIV food programming.

3.3. Recommendations

181. Based on the findings and conclusions presented in this report the MTE recommends the following:

Rec. 1. **WFP should immediately devote resources to the establishment of a Capacity-Building Strategy and Task Force. This strategy should include in-depth problem analysis, clear concise action plan, and indicators to highlight improvements in performance. The Task Force should comprise Government, relevant donors and WFP.**

The strategy must outline a framework for how the entire food management system will be independently analysed. This analysis should lead to a clear assessment of bottlenecks and identify the areas in which WFP can viably contribute.

Additional requirements within WFP for the strategy are as follows:

- A dedicated team that reports directly to WFP Ethiopia senior management;
- The strategy should incorporate clear principles of harmonisation. Specifically, it should identify ways in which WFP will work with the Government, donors and ongoing initiatives related to capacity-building;
- The goal and activities to be undertaken in this strategic initiative should be outlined in a clear logframe. This tool will be used to manage and monitor progress;
- Indicators in the current PRRO logframe should be adjusted and linked to this strategy.

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

WFP should work with donor agencies to ensure greater degrees of accountability and transparency in the food management system.

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

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

Examples of strategies include:

- Systematic involvement of Heath Education Workers in the implementation and monitoring of the TSF, including more emphasis on childcare/nutrition education and the piloting of a Positive Deviance model within the TSF;

- Stronger convergence with water, sanitation and hygiene interventions as safe household water supply is a key factor affecting nutritional status of children in Ethiopia;

- Develop tailored packages for the TSF programme that aim at maximizing synergies with other programmes in the *woredas* (PSNP, relief, CBN roll-out). There is a need to achieve higher coverage of *woredas* classified as being food insecure (in line with regular updates of the Government classification of humanitarian priority areas). Also, it is suggested to develop a specific emergency modality for the programme (e.g. to be referred to as TSF+) which would operate alongside the Relief component of PRRO. TSF+ would only operate in *woredas* classified as a high priority in an emergency. It would be implemented by Government agencies and supported by NGOs involved in nutrition programming. The evaluation recommends that WFP work closely with the Government in considering establishment of a technical assistance facility (a consortium of NGOs) that has the capacity to support the health posts, the *woreda* health offices and/or the regional DPPB. This new approach will require contingency funding to be made available to WFP;

- WFP should take efforts to strengthen the design, delivery and complementarity of the TSF programme: a) to reduce TSF targeting errors, in collaboration with UNICEF and Government; b) piloting of different food transport arrangements for TSF; c) for Somali Region, to temporarily suspend the TSF and targeted CSB distributions for pregnant and lactating women and children under five years old within the GFD, and implement blanket CSB distribution through TSF distribution sites to all pregnant and lactating women and children under five years (scaling up the TSF/hybrid model); and d) if the current pilot study demonstrates that Supplementary Plumpy is effective and cost-efficient, to formally integrate the use of new ready-to-use supplementary foods (like Supplementary Plumpy) for children under five years old, especially for the new TSF+ where there would be more technical support to programme managers and implementers involved at *woreda* and *kebele* level.

Rec. 5. **Given the success of the Urban HIV/AIDS component, it should continue and, if funding allows, expand to new towns.**

Rec. 6. **The critical importance of WFP's role and contribution to advocacy and the institutional and programming response to HIV in Ethiopia should**

be acknowledged and the HIV team should be supported with the technical capacity to continue this work.

Rec. 7. **WFP Ethiopia should increase its commitment to HIV mainstreaming to ensure programming interventions are implemented.**

4. Annexes

Annex 1: Terms of reference

Evaluation of Ethiopia Protracted Relief and Recovery Operation (PRRO) 10665.0

"Responding to Humanitarian Crises and Enhancing Resilience to Food Insecurity"

Duration of PRRO: Three years (01/01/2008 – 31/12/2010)

Total Cost to WFP: US$1,295,291,546

I. Background

I.A. Context of the Evaluation

About 80 percent of Ethiopia's population lives in the rural areas, mostly in the central highlands, and are dependent on rain-fed agriculture. Since the 1990s, the rainfall patterns have become erratic, and any sub-optimal rainfall (drought, excessive rain, poor distribution) can leave millions of people unable to meet their food needs due to poor yields; a severe drought can shrink production by as much as 90 percent. In addition to the rainfall factor, crop production in the highlands takes place where an estimated 50 percent of the land is degraded. Putting the two elements together means that even in the best of years more than 8 million rural people cannot meet their basic food needs (referred to as the chronically food-insecure). Should the rainfall pattern be unfavourable, a further 7 million people are at risk of acute food insecurity. Between 1996 and 2006, an average of 6.9 million people per year required food assistance, peaking at 13 million as result of the 2002 drought. It is in response to these needs that WFP has been providing food assistance to support vulnerable populations in Ethiopia, the latest being under the auspices of this PRRO that is the subject of this evaluation.

In 2008, drought ravaged large parts of the country for many months, with a devastating effect on crops and livestock resulting in more than 12 million people requiring food assistance. With soaring global food and fuel prices, WFP struggled to find commodities in the global market to provide this assistance - while acute malnutrition rates rose and child mortality increased in the worst affected southern and eastern regions of the country. The unfolding conflict in the Somali region added a further layer of complexity by hampering the provision of assistance in the Somali lowlands.

In addition to the above factors, Ethiopia faces many development problems as can be seen from the following statistics:

- In 2008 Ethiopia was ranked 169th out of 179 countries in the Human Development Index;[150]
- 31 million people, out of a total of 77.5 million, live below the poverty line[151]

[150] http://hdr.undp.org/en/statistics/
[151] http://docustore.wfp.org/stellent/groups/public/documents/eb/wfp102979.pdf

- Each year between 6 and 13 million people in Ethiopia face the risk of acute food insecurity;[152]

- GDP per capita is US$97;[153]

- Ethiopia has one of the most nutritionally deprived populations in the world: the prevalence of wasting is 10.5 percent, which is above the threshold defining a nutrition alert; Ethiopia also has the highest rates in Africa for stunting (44 percent) and for wasting (38 percent);[154]

- The HIV/AIDS prevalence rate amongst adults is high and increasing, from 3.2 percent in 1993 to 4.4 in 2003; the rate fell to 2.1 percent in 2007 but the 2009 estimate shows an increase to 2.4 percent;

- The net enrolment rate for 2003/04 was 67 percent and only 3.8 percent of the population attains higher education.[155]

The national economy is dominated by subsistence agriculture characterised by small-scale farming and livestock husbandry. The sector employs 85 percent of the country's labour force, contributes 45 percent of the GDP and accounts for 60 percent of all exports. Agricultural productivity is low due to low use of improved agricultural inputs, erratic rainfall, low soil fertility and environmental degradation.

Food insecurity is pervasive with domestic production failing to meet demand even in the best of years, and food production needs to increase by 500,000 metric tons per year simply to meet the consumption needs of a population that is growing by 2.75 percent per year. The country is heavily dependent on food imports, a large majority of which is aid, with emergency food assistance accounting for 10 percent of average grain production.[156]

The Ethiopian Government has attempted to address the various constraints that are faced by the country and to decrease dependence on humanitarian aid by implementing agricultural growth programmes and broader food security and poverty reduction strategies. While these efforts have indeed increased agricultural production, there are worries that short term production gains due to expanded cultivation come at the expense of the natural environment. In recognition of these perceived weaknesses, the Government has launched the PASDEP. The priorities of the Plan, spanning 2006 – 2011, are further improvements in agricultural productivity, natural resources management, food security, and livelihood diversification, and aims at ending chronic food insecurity and recurrent food crises.

In addition, the Government launched its food-security programme (FSP) in 2005. One of the three pillars of the FSP, the PSNP, is a major component of the government strategy to reduce vulnerability to famine. Since its launch, the PSNP has expanded, in terms of coverage, from 5 to 7.2 million people, with further expansion to the Somali region being envisaged. It provides a multi-annual predictable transfer – a mix of food

[152] http://docustore.wfp.org/stellent/groups/public/documents/eb/wfp102979.pdf
[153] Ibid.
[154] Ibid.
[155] http://www.mofaed.org/macro/PASDEP%20Final%20English.pdf.
[156] http://docustore.wfp.org/stellent/groups/public/documents/eb/wfp102979.pdf.

and cash – in exchange for labour in environmental rehabilitation and drought mitigation.

The UN country team, including WFP through this PRRO (as well as Country Programme 10430.0), supports government programmes, incorporating humanitarian strategies (UNDAF II 2007 – 2011). The UNICEF/WFP joint EOS, Child Survival with TSF supports the government child-survival programme.

PRRO 10665.0, the subject of this evaluation, has the following main objectives:

- Stabilise and/or reduce acute malnutrition among people affected by acute food insecurity resulting from natural disasters or conflict;
- Increase the ability of PSNP beneficiaries to manage shocks and invest in activities that enhance their resilience;
- Rehabilitate children under 5 with moderate acute malnutrition and pregnant and lactating women identified during the EOS screening in food-insecure districts;
- Enhance the basic nutrition knowledge of mothers and other women in communities targeted by EOS/TSF;
- Improve the nutritional status and QOL of food-insecure people living with HIV/AIDS through HBC, anti-retroviral therapy (ART) and PMTCT;
- Increase school enrolment and attendance of orphans and vulnerable children (OVC) in HIV/AIDS affected urban communities;
- Increase the capacity of government, particularly at local levels, and communities to identify food needs, develop strategies and carry out hunger and disaster risk reduction programmes.

There are four components under this PRRO:

Safety Net: WFP, through this PRRO, supports the PSNP which aims to protect chronically food-insecure people from acute food insecurity so that they can progress towards more resilient livelihoods. The PSNP provides about US$200 million per year in transfers, about half in food, donated through WFP or NGOs or purchased by the government; PSNP is funded by donors. The mix of cash and food transfers is based more on season rather than location. The PRRO aims to forge greater linkages to complementary investments such as credit and training, and to broader initiatives such as the sustainable land management agenda. WFP aims to continue to build local capacities and use learning from MERET to support the graduation from assistance. It promotes consideration of gender, nutrition and HIV/AIDS, working with partners to expand the use of HIV/AIDS community conversations. Government capacity is to be enhanced in disaster risk management and community-based environmental transformation. WFP aims to support linkages to the government's relief programme should a large-scale emergency occur. Food is to support consumption smoothing during lean seasons and in areas where financial and market capacity is weak. **It must be**

emphasized that this evaluation is not intended to evaluate the PSNP itself but to evaluate WFP's contributions to it.

PSNP aims to reach 7.2 million people (in 262 districts) that used to be chronic recipients of relief food aid. In each district, communities select food-insecure households that have regularly received relief assistance and households that have recently become vulnerable owing to severe loss of assets, including through illness or injury. Households typically receive assistance for six months a year for at least three years, with most of the food being distributed during the lean season of June – August.

Relief: The government's relief programme assists people facing periodic acute food insecurity caused by natural disasters or conflict. WFP supports efforts to use livelihood analysis, especially the household economy approach, to assess food and non-food needs, focusing on regional and local capacities for early warning and emergency needs assessment. Through the logistics and information and communications technology clusters and the Food Aid Task Force, WFP supports the government's capacity for fast, efficient and large-scale response to unpredictable multiple hazards. WFP leads the United Nations efforts to support DRMFSS in developing a package of rapid HIV/AIDS interventions for humanitarian emergency response. In the event of widespread disaster, WFP is prepared to use contingency plans and funding mechanisms to respond to needs.

The Government's relief programme targets disaster-prone areas through the DRMFSS early-warning system and multi-agency seasonal assessments, for which the household economy approach is being rolled-out as the standard method. Based on estimated needs, multi-agency rapid assessment teams in disaster-affected districts determine the type, scale and duration of emergency assistance. At the local level, community representatives select beneficiary households by following national targeting guidelines, which recognise the special vulnerability of children, pregnant women, the elderly and the disabled.

Targeted Supplementary Feeding: The EOS/TSF programme is unique in its large-scale, holistic approach to malnutrition and child survival. It remains an important bridge for the implementation of the HEP, and is part of the sector-wide approach to nutrition. EOS/TSF is both curative and preventive, addressing basic health, food, and maternal and child care issues. Linkages to other humanitarian programmes, especially therapeutic feeding centres, and to wider health, social and food security programmes, such as PSNP, have been forged. WFP advocates for and supports partners in incorporating HIV/AIDS considerations, particularly through expanding community conversations. Women food distribution agents play a greater role in community nutrition services. The anticipation is as community health and nutrition programmes strengthen, EOS/TSF needs should decline.

TSF beneficiaries are identified through six-monthly EOS nutrition screening by regional health bureaux and UNICEF.As of 2009, some 22 of the districts under TSF are implementing the CBN approach: under this approach, EOS screening is done by Health Extension Workers in an event termed as Community Health Days (CHD). Between 80 and 100 percent of children under five are screened. All children between 6 and 59 months with MUAC of less than 12 cm, and all pregnant and lactating women with MUAC less than 21 cm are referred to the TSF programme. The 12 cm cut-off point for children was decided with stakeholders in the Ethiopian nutrition community to ensure that children with high mortality risk benefit from TSF. During the PRRO, needs are

expected to reduce by 10 percent a year as HSEP and other food security programmes expand.

Urban HIV/AIDS: The joint United Nations programme on AIDS aims to increase its support to the strategic framework for the national response. WFP is integrated with this programme and linked to other HIV/AIDS services. Pending resource availability, WFP covers more towns and increases the coverage in existing towns. With food assistance, food-insecure urban households maintain HIV/AIDS treatment programmes and education for orphans. Food-for-treatment programmes have a built-in hand-over strategy: once nutritional status is stabilised and treatment has taken hold, the person moves to partner programmes supporting income-generating activities.

Towns are selected based on their HIV/AIDS prevalence rates. Targeting criteria for food assistance is agreed between federal and regional HIV/AIDS prevention and control offices (HAPCOs) and their cooperating partners. Through involvement of NGOs, community associations, representatives of *kebele* (administrative unit of communities) and *edirs* (traditional burial associations), communities select people based on assessment of household food security status. Patients on ART therapy and PMTCT are referred from health facilities; communities identify HBC clients and households supporting orphans and vulnerable children. Support to such children is contingent on 80 percent school attendance; the take-home ration is provided through town distribution centres. Given increasing levels of food insecurity and HIV/AIDS in towns, WFP support is expected to reach 50 percent more people than at present.

The expected outcomes of the PRRO are:

- Stabilised and/or reduced acute malnutrition among people affected by unpredictable acute food insecurity as a result of natural disasters or conflict;

- Increased ability of PSNP beneficiaries to manage shocks and invest in activities that enhance their resilience;

- Rehabilitated moderate/acutely malnourished children under 5 and pregnant and lactating women identified during EOS screening in food-insecure districts;

- Enhanced basic knowledge on nutrition-related issues for mothers and other women in communities targeted by EOS/TSF;

- Improved nutritional status and QOL of food-insecure people living with HIV/AIDS on HBC, ART therapy and PMTCT;

- Increased school enrolment and attendance of OVC in HIV/AIDS-affected urban communities;

- Increase the capacity of government, particularly at local levels, and communities to identify food needs, develop strategies and carry out hunger and disaster risk reduction programmes.

The major expected outputs of the PRRO include:

- Timely provision of food in sufficient quantity for targeted beneficiaries in conflict- and disaster-affected areas;
- Timely provision of food in sufficient quantities for PSNP beneficiaries;
- Beneficiaries supported in the creation and maintenance of assets;
- Timely provision of nutritious food in sufficient quantity for targeted malnourished young children and women;
- Basic nutrition awareness provided in an efficient manner at the community level;
- Timely provision of food in sufficient quantities for HIV/AIDS beneficiaries;
- Timely provisions of take-home rations provided to OVC;
- Provision of capacity-building assistance to entities involved in hunger and risk reduction programmes.

I.B. Stakeholders

The key stakeholders in PRRO 10665.0, their interest and role in the evaluation, are:

Stakeholder map

Key stakeholder groups	Role in CP 10430.0	Interest in the evaluation	Implications for the evaluation
Operations Department (OM)	Responsible for WFP operations' implementation globally	Improving future programme implementation in the country	Ensure clearly articulated conclusions and recommendations that will guide WFP's future interventions in Ethiopia and, possibly, lessons learnt may be applicable to WFP's interventions in other countries
Regional Bureau (OMJ)	Programme Support to Ethiopia	Improving future programme implementation in the country, findings to possibly lead to fine tuning of the interventions for the remaining PRRO period	Ensure clearly articulated conclusions and recommendations that will guide the PRRO's future implementation in Ethiopia and, possibly, lessons learnt may be applicable to WFP's interventions in other countries in the Region

Key stakeholder groups	Role in CP 10430.0	Interest in the evaluation	Implications for the evaluation
Country Office	Directly responsible for overseeing the implementation of the PRRO and for reporting on progress	Improving future programme implementation in the country, evaluation findings to feed PRRO implementation during its remaining period, and in similar future interventions	Ensure clearly articulated conclusions and recommendations that will guide WFP's interventions in Ethiopia. The CO is a key informant for the evaluation and will provide qualitative and quantitative data to the evaluation team
Host government (Food Security Coordination Bureau, Disaster Prevention and Preparedness Agency, Ministry of Health, HAPCOs, Ministry of Agriculture and Rural Development, Ministry of Education, and Ministry of Finance and Economic Planning	Is the recipient and benefactor of WFP support, is responsible for the implementation of the PRRO. Ultimately, WFP hands-over to it the programme and its funding	Review of accomplishments and bottlenecks, improving future programme implementation in the country, examining the synergies with other donor support, assess its capacity to take over programmes and funding	Ensure clearly articulated conclusions and recommendations that will inform the government on the effectiveness of the PRRO and guide future interventions in Ethiopia. The government is a key informant for the evaluation and will provide qualitative and quantitive data to the evaluation team, and will elaborate on the PRRO's intervention *vis a vis* its overall policies
UN agencies (FAO, UNDP, OCHA, UNAIDS UNICEF, WHO, UNFPA)	Partners in joint programming and provision of complimentary support	Review of accomplishments and bottlenecks, refinement of joint programming and synergies of interventions, ensure continued consistency of PRRO with overall CT goals	UN partner agencies are key informants to the evaluation, they will provide qualitative and quantitative data to the team, will provide information on relevance of the PRRO to the UNDAF II and the overall goals of the CT
NGOs (Save the Children UK) and community based organizations	Provide complimentary inputs for the various interventions of the PRRO	Review of accomplishments and bottlenecks, refinement of joint programming and synergies of interventions.	NGOs and community based organizations are partners in the various components of the PRRO, they will provide qualitative information and quantitative data to the team

Key stakeholder groups	Role in CP 10430.0	Interest in the evaluation	Implications for the evaluation
Communities	Direct beneficiaries of WFP support, form committees for activity identification and design, assist in beneficiary targeting	No direct interest other than in the implications of the findings for them.	Key informants to the team, site visits and group/individual interviews to be conducted, will highlight their constraints and the extent to which PRRO is addressing them. Particular attention to be given to the level of their participation in the operations' activities, and the extent of women participation
Donors	Financers of the PRRO and other UN interventions, have geo-political interests in the country/region	Evaluation findings might influence future funding decisions	Key informants to the team at the country level on issues of appropriateness and value added of WFP activities
WFP Board	This PRRO is part of the approved portfolio of WFP's field operations for which the EB is accountable	Ensure that the dual purpose of accountability and learning are achieved	Ensure clearly articulated conclusions and recommendations that will enable the EB to ensure that future interventions in Ethiopia take this evaluation into consideration

II. Reason for the Evaluation

II. A. Rationale

This evaluation is timed to precede the preparation and design of the successor PRRO that may follow this one at its termination date of December 2010. As such, the findings of the evaluation will feed into the design of the new PRRO taking into consideration the lessons learnt from the current PRRO. Furthermore, it is envisaged that WFP will engage in the preparation of the Ethiopia Country Strategy Document (CSD), in which case, this evaluation and that of Country Programme (currently ongoing) will feed into the CSD.
The expected users of this evaluation will be, primarily, the WFP Country Office in Ethiopia, the Ethiopian Government, and the partners that are involved in its implementation. The findings of this evaluation will be presented to WFP's Executive Board in June 2010**.**

II. B Objective of the Evaluation

One of the objectives of the evaluation of PRRO 10665.0 is accountability to the stakeholders in terms of tallying and reporting on the work that has been carried out and the results achieved, using the planned objectives and targets as the benchmark against which to assess performance. The accountability to the donors, in terms of reporting on the results of their investments, is also an important element. In this regard, Annex VI provides the details on the contributions that have been made to the PRRO.

The other objective of the evaluation is to draw lessons from the experience gained from the implementation of this PRRO. Given that WFP has been providing support to the large food insecure populations in Ethiopia for decades, particular emphasis should be

put on identifying those practices, under the safety net component, that are indeed increasing the resilience of these populations to food insecurity.

III. Scope of the Evaluation

III. A. Scope

The evaluation will cover all components of the PRRO, from its start in January 2008 to date. As mentioned, the activities of this PRRO are continuations of similar activities supported by WFP under previous interventions and, as such, this evaluation will also take into consideration evaluations of these past interventions.

The various components of the PRRO are implemented in a large number of chronically food-insecure districts in the various regions (262 districts included under the safety net component alone). Given that the geographic scope is too large to cover in its entirety, the evaluation team, in consultation with the WFP CO, will select a sample of districts and component sites to visit during the field trip, ensuring, to the extent possible, that site visits are as representative as possible. The evaluation team will present, in the pre-mission report, the sampling criteria that the team will use.

III.B. Evaluability Assessment

The logical framework matrix, attached to the component document as it was approved in October 2007, shows a results hierarchy at the outcome and output levels and performance indicators are provided

The annual Standard Project Reports (SPR) for this programme are also available and they do provide narrative and data on the project achievements. Outputs for each of the activities are provided, juxtaposing actual achievements to those planned. However, at the outcome level, there are no baselines for all of the indicators; the SPR for 2008, prepared early in 2009, provides values for all the outcome indicators and, as such, the evaluation team will need to devise methods to compare outcome achievements using, perhaps, secondary data.

In addition, a mid-term evaluation of the PRRO that preceded this one was conducted and the findings of that evaluation will be a useful resource to the evaluation team.

The CO in Ethiopia operates an ABM system and this provides up to date information on PRRO implementation. It allows rapid corrective measures to be undertaken and high standards to be maintained while generating greater community involvement and sense of ownership over assets created. ABM data is stored in a database able to produce district-level profiles for tracking performance across all WFP-supported activities. This data also prove invaluable to the evaluation. In addition, the CO conducts annual or biennial surveys to measure outcome level indicators; again, while useful, the absence of baseline data will need to be addressed by the team.

IV. Key issues/key evaluation questions

The evaluation will proceed with a systematic analysis of the following issues, which are further developed in the evaluation report template:

- **Operation design: relevance and appropriateness**. Here the evaluation will analyse the objectives of the operation, its internal and external coherence, its design as well as the appropriateness of the activities according to needs;

- **Outputs and implementation processes: elements of efficiency**. It includes an analysis of the level of outputs, the channels of delivery, the implementation mechanisms, the external and internal institutional arrangements, the cost and funding of the operation as well as its cost-efficiency.
- **Results.** Here the evaluation will assess, to the extent possible, the effectiveness, impact and sustainability of the operation;

- **Cross-cutting issues**. The main cross-cutting issues to be taken into consideration are gender, partnership, capacity development, advocacy, protection, environmental impact/coping with climate change.

Within the above framework, the evaluation will look more specifically in the following issues:

- The safety net component is designed to build on the experience gained through the MERET-PLUS component of WFP's Country Programme (CP 10430.0). This evaluation should review the linkages between this PRRO and the CP and the extent to which there are mutually reinforcing implementation mechanisms. The recent mid-term evaluation of the CP should provide insightful information to the PRRO evaluation;

- The safety net component is supported through either cash (non WFP) or food transfers. The evaluation should compare and contrast the use of both instruments;

- Since the catastrophic famines of the 1970s and 1980s, the food insecurity problems of Ethiopia are well known and well understood. This evaluation should examine closely, and clearly document, evidence that shows that WFP's activities under the safety net component are indeed increasing the livelihood resilience of those at risk of food insecurity;

- The targeting of support under the relief and the supplementary feeding components should be examined to ensure that errors of inclusion/exclusion are minimised;

- With a view to incorporating "protection" issues in a successive PRRO, that may follow this one, this evaluation should look into how protection issues may have affected the operational and food insecurity environments. Specifically, the evaluation should review whether WFP's programming modalities mitigated protection risks to beneficiaries;

- The effectiveness and efficiency of specialised foods, as opposed to 'traditional' food commodities, should be examined;

- Capacity Development: The PRRO envisages various activities that will strengthen the capacity of the Government counterparts to take over the planning

and management of food-based programmes. The extent to which this has been achieved should be evaluated.

In terms of outputs and implementation processes, the evaluation will determine the level of outputs actually achieved *vis a vis* those planned. The evaluation will review the degree to which the channels used for implementation have been able to deliver the expected outputs and whether they had sufficient staff, training, technical know-how and the expected supplementary funding. The evaluation will also examine how partners have been able to monitor the implementation and to report on achievements.

In terms of results, the evaluation will review and analyse data to determine the degree to which the stated objectives of the programme have been achieved i.e. establish the effectiveness of the programme and its outcomes. The evaluation will also aim to determine how outcomes are leading (or are likely to lead) to intended and any unintended (positive or negative) impacts.

The evaluation will also consider various cross-cutting issues including gender and gender relations and the extent to which these have been captured in the design and implementation of the activities undertaken in the targeted areas.

V. Evaluation Design

V.A. Methodology

In order to compare planned and actual achievements, the evaluation team will use, and corroborate, information provided by the WFP CO; in the absence of sufficient data, the team will need to determine alternative means to verify achievements. This will include regular monitoring data as well as aggregated and analysed information relating to the implementation of the PRRO, including regular reports from implementing partners, field visit reports, assessment reports, the mid-term evaluation of 2007, contextual and background information on the food security situation in Ethiopia and information regarding the operating environment there.

The team will also use, and corroborate, information and data provided by the Government pertaining to the PRRO and any other information that is relevant to the purposes of this evaluation. All information and data, from whichever source, will be checked for accuracy by the evaluation team.

In addition, the team will visit and interview, and collect data and information from, the Government, UN agencies and NGOs that are partnering with WFP in the implementation of this PRRO.

Furthermore, the team will go on field visits to interview, and collect data and information, from the relevant officials of local government as well as the personnel who are directly overseeing the activities that are being undertaken by the PRRO. The team will also assess the quality of the outputs that have been achieved, and reported on, and the level and effectiveness of support being provided by the various partners. It will also conduct focused-group discussions and individual interviews with the beneficiaries of the PRRO to assess the views of men and women, boys and girls, on the appropriateness and effectiveness of the activities that are being undertaken.

The methodology for the selection of project sites to be visited will be done by the evaluation team. Selection criteria might include:

- Availability of some sites where several types of activities are being undertaken in close proximity;
- Selection of sites such that a comparison can be made between assisted communities and non-assisted ones;
- Selection of sites to ensure that all partners are amply represented;
- Logistical feasibility.

V.B. EQAS

WFP has developed an Evaluation Quality Assurance System (EQAS) based on the UNEG norms and standards and good practice of the international evaluation community (ALNAP and Development Assistance Committee). It sets out process maps with in-built steps for quality assurance and templates for evaluation products. It also includes checklists for feedback on quality for each of the evaluation products including the TOR. All these tools are available with OEDE. EQAS will be systematically applied during the course of this evaluation and relevant documents provided to the evaluation team.

V.C. Phases and Deliverable

	Description	Team Leader (days)	Team member (days)	Oct				Nov				Dec				Jan				Feb			
		63	52	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Evaluation phase																							
1	**Pre-mission report**																						
	Briefing	4	4																				
	Prepare draft Pre-mission report	7	6																				
2	**Evaluation Mission**																						
	Prepare field mission																						
	Field mission	24	24																				
	Field mission debriefing																						
3	**Evaluation Report/Summary Report**																						
	Prepare eval/summary reports	21	14																				
	first revision of eval/summary reports	3	2																				
	Respond to stakeholder comments	1	1																				
	second revision of eval/summary reports	3	1																				

VI. Organization of the evaluation

VI. A. Expertise of the evaluation mission

The mission will be composed of the following internationally recruited experts:

Team Leader (TL). The TL will have proven expertise in the evaluation profession and will have solid experience in leading evaluation missions and will have proven expertise in the evaluation of the food-based interventions, with specific expertise in the transition from relief to recovery. The consultant will specifically review and evaluate the relief and safety net components. In addition, the consultant will review the partnerships forged under the PRRO, the strategic linkages with other programmes (of the UN and the government and, in particular, with WFP's CP 10430.0) and capacity development aspects of the PRRO. In addition, the TL will present the evaluation findings at the required debriefing sessions, will facilitate team discussions and will draw together the written inputs from the other team members in order to produce the required reports (Evaluation and Summary). The Team Leader is responsible for adhering to the attached time-line, and for carrying out the tasks and outputs as identified in it. The TL will devote a total of 59 working days, over a period of four months, to this evaluation. See further details in the attached job description.

Member, Nutritionist (NT). The NT will have proven experience in the evaluation of nutrition interventions. The NT will specifically review the implementation of the nutrition components of the PRRO and ascertain the relevance, effectiveness, efficiency and sustainability of these components. The NT will compile the findings, conclusions and recommendations in a report form and will assist the TL to integrate his/her report into the draft and final Evaluation Report and will participate in the drafting and finalization of the Evaluation Summary Report. See further details in the attached Job Description. The consultant will adhere to the attached time-line and will devote a total of 51 working days, over a period of four months, to this evaluation.

Member, HIV/AIDS Specialist (HS). The HS will have proven experience in the evaluation of HIV/AIDS interventions, preferably with experience/knowledge on the nutritional aspects of the pandemic. The consultant will specifically review the implementation of the HIV/AIDS component of the PRRO and ascertain the degree to which the stated operation plan has been achieved. The consultant will compile the findings, conclusions and recommendations in a report form and will assist the TL to integrate his/her report into the draft and final Evaluation Report and will participate in the drafting and finalization of the Evaluation Summary Report. See further details in the attached Job Description. The HS will adhere to the above time-line and will devote a total of 5 days, over a period of four months, to this evaluation.

All team members will adhere to Code of Conduct as outlined in the attached Job Descriptions. Team members will be expected to sign a statement confirming their awareness of the Code and their ability to conform to it as part of the contractual agreement with WFP. Furthermore, team members confirm that there is no conflict of interest between their respective roles in the evaluation and the WFP activities in Ethiopia.

VI. B. WFP stakeholders' roles and responsibilities

The Ethiopian Government: The concerned Government officials will brief the evaluation on the overall socio-economic situation of the country and provide the

evaluation with the necessary information and data that will further the objectives of this evaluation as stated above.

WFP CO Ethiopia: The CO will prepare all the necessary information that will enable the evaluation mission to be as efficient and effective as possible. The CO will schedule and prepare a programme for the evaluation mission during its mission to Ethiopia, including setting up of the necessary appointments with key informants. The CO will also make the necessary logistical arrangements (including travel permits if necessary) for the field trips to the activity sites.

WFP RB: The RB will assist the CO, if necessary, in the preparation and carrying-out of this evaluation.

OE: Ms Marian Read, WFP Senior Evaluation Officer, is the OE Evaluation Manager (EM) for this evaluation. The EM will finalise the TORs of the evaluation, in consultation with the CO and RB, including the job descriptions of the team members. The EM will recruit the members and ensure that all the contractual procedures are carried out to enable the members carry out their tasks. The EM will also ensure that travel arrangements for the teams are in place. On completion of the evaluation, the EM will review and comment on the evaluation report, and will manage its circulation to the concerned stakeholders and will compile the comments received.

Cooperating Partners: The UN agency and NGO partners will avail themselves to meet with the evaluation team and to provide them with data and information that will further the objectives of this evaluation.

VI. C. Communication

Most of the material to be used by the evaluation mission will in the English language. Meetings in Ethiopia, with the various stakeholders, will be conducted in English. The Evaluation Report and the Summary Report will be drafted and finalised in English. WFP will be responsible for translating these documents, as necessary. During the field trip, should discussions with stakeholders take place in a local language, the CO will ensure that the mission is accompanied by a translator who is proficient in the local language, and who will translate for the team members.

The various milestones for communication between the evaluation team and WFP are built into the attached time-line. The evaluation team will be responsible for adhering to these milestones unless otherwise agreed to by WFP.

VI. D. Budget

The total budget for this evaluation is US$127,000.

Operation	**PRRO 10665.0**
Title	Protracted Relief and Recovery Operation Ethiopia
Initial budget	US$ 561,324,284
Initial tonnage (mt)	959,327
Initial number of beneficiaries	3.8 million (yearly maximum)
Initial duration	3 years
Budget revision 9/06/2008	Revised non food costs US$491,687
Budget revision 10/06/2008	Budget increase cost US$250,522,296 for additional commodities.
Budget Revision 18/06/2008	Revised non food costs US$14,936,208
Budget revision 5/09/2008	Budget increase cost US$303,856,040 for an additional 378,642 mt of food. Increased budget to respond to increased number of people suffering from acute food insecurity from 853,000 to 4.6 million by June 2008
Budget revision 09/12/2008	Revised non food costs US$24,428,373
Budget revision 8/06/2009	Budget increase cost US$139,110,195 for an additional 253,343 mt of food. Response to a prolonged emergency following 2008 drought and impact of high food and fuel prices: 4.9 million targeted for 2009.
Budget as at 30 Aug 2009	US$ 1,295,291,546 for 1,591,312 mt of food.
Level of funding according to implementation as at August 2009	The project is implementation time is at 55 percent and level of funding at 61 percent.

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Annex 3: List of persons met and places visited

Federal Government	State Minister for Agriculture, Ministry of Finance, Ministry of Agriculture, DMRFSS, Ministry of Health,
Regional and *Woreda* Government Offices in Amhara, Somali Region, and SNNPR	Regional Bureaus of DMRFSS and Regional Health Bureaus, and HAPCO
WFP Staff	Senior Management, Logistics, HIV team, TSF, PNSP, Protection Officer, Policy Team, Monitoring and Evaluation, Programme staff in Somali Region and SNNPR.
UN Agencies	Resident Representative, OCHA, UNICEF, and UNAIDS
Donors	USAID, DFID, Irish Aid, SIDA, World Bank, ECHO, CIDA, Norwegian Embassy,
NGOs	Save the Children, CRS, CARE, MSF,
Research Agencies	IFPRI

Annex 4: Methodology and evaluation matrix

Evaluation matrix

Evaluation Criteria	Issues	PSNP	Relief	TSF	Urban HIV/AIDS
Strategic Issues					
Relevance (addressing existing needs)	Relevance of the intervention in the specific Ethiopian context	Given the range of crisis impact Ethiopia over the past three years- how relevant is the PRRO?	Given the range of crisis impact Ethiopia over the past three years- how relevant is the PRRO?	Is the TSF relevant and appropriate for addressing child nutrition and survival needs given the recent context changes: (a) drought; (b) conflict in Somali region; (c) food/fuel/financial crisis? (*focus on nutritional rehabilitation of children under five and P&Ls, enhancement of basic nutrition knowledge)*	How relevant and appropriate is WFP support to PLHIV through the Urban HIV/AIDS Programme?
Relevance (external coherence)	External coherence with strategies of other stakeholders.	Have operations under the PRRO influenced key policy debates on the PSNP?	Have operations under the PRRO influenced key policy debates on emergency relief interventions?	Has the PRRO EOS/TSF influenced key policy debates on sector-wide approaches to nutrition (both preventive and curative)? Is the PRRO contribution to the TSF programme in line with the national nutrition strategy?	Has the PRRO influenced key policy debates on food security and nutrition and HIV/AIDS?
Relevance (internal coherence with WFP policy framework)	Mainstreaming of HIV/AIDS	Has HIV/AIDS been effectively mainstreamed into the PSNP programme?		Has HIV/AIDS effectively been mainstreamed into the TSF programme?	Has HIV/AIDS been effectively mainstreamed across the PRRO?

Evaluation Criteria	Issues	PSNP	Relief	TSF	Urban HIV/AIDS
Operational Issues					
Efficiency	Needs assessment and targeting	Assess WFP contributions to ensuring gender is effectively addressed in the management and distribution of food transfers.	What WFP contributions have been made towards to ensuring relief programmes address the issues of inclusion and exclusion?	Is the geographical targeting for the PRRO support to EOS/TSF in line with the spatial pattern of malnutrition prevalence in Ethiopia (how have the targeted food insecure districts been selected)? What have been PRRO contributions to TSF in order to address the issues of inclusion and exclusion? How successful has WFP been in the partnerships and implementation arrangements (including the effect of the BPR)?	How effective has WFP been in forming partnerships and providing capacity-building to identify food needs, develop strategies and carry out hunger risk reduction programmes?
Effectiveness	Outputs achieving outcomes	What contributions has WFP made to ensure PSNP delivers timely, appropriate and predictable transfer in order to enable more resilient livelihood strategies?	How effective has WFP been so far in order to stabilise and/or reduce acute malnutrition through relief food distribution?	Does the TSF achieve planned outcomes (stabilise and/or reduce acute malnutrition through the TSF programme)? Do existing M&E systems suffice to provide evidence of this?	Does the Urban HIV/AIDS programme achieve planned outcomes?
Impact	Effect of PRRO on institutions	How and to what extent have activities under the PRRO increased capacity of key partners?		What is the contribution of the TSF programme towards capacity development for key actors in the HSEP implementation?	How is WFP's and their partner's contributions to PLHIV and OVC assisting them in the longer term? What are the wider consequences of WFP's contribution to food support for PLHIV and OVC?

Evaluation methodology

Evaluation Criteria	Samples	Method/Data sources
Broad Strategic Themes		
Relevance (addressing existing needs)	Relevance of the intervention in the specific Ethiopian context	Focus group discussions Donor programme documents Government policies Donor position papers
Relevance (external coherence)	External coherence with strategies of other stakeholders and advocacy	Review donor coordination Meeting minutes Documents from reviews and evaluations
Relevance (internal coherence with WFP policy framework)	Mainstreaming of HIV/AIDS	Review of programme documents Focus group discussions
Operational Themes		
Efficiency	Needs assessment and targeting	Literature review Focus group discussions Stakeholder meetings
Effectiveness	Outputs achieving outcomes	WFP reports and monitoring Donor reports Focus groups
Impact	Effect of PRRO on institutions	Evaluations Focus group discussion

Annex 5: Other technical annexes

Overview Standard Nutrition Survey Results 2008-2009

	2008		2009	
	< 10%	**>= 10%**	**< 10%**	**>= 10%**
Afar		1 survey, GAM **22.5** (SAM 4.5)		
Amhara	3 surveys, GAM between **5.1** and **7.2** (SAM ranging from 0.4 to 1.1)	5 surveys, GAM between **12.1** and **15.7** (SAM ranging from 0.5 to 1.7)	3 surveys, GAM between **5.1** and **8.1** (SAM ranging from 0.2 to 0.6)	3 surveys, GAM between 10.8 and 12.7 (SAM ranging from 0.7 to 1.2)
Beneshangul -Gumuz				1 survey, GAM 13.2 (SAM 1.9)
Dire Dawa				
Gambela				
Oromiya	4 surveys, GAM between **6.9** and **9.0** (SAM ranging from 0.3 to 1.4)	4 surveys, GAM between **10.0** and **12.8** (SAM ranging from 0.0 to 2.2)	1 survey, GAM **7.2** (SAM 1.5)	3 surveys, GAM between 10.8 and 12.8 (SAM ranging from 1.0 to 1.6)
SNNP	23 surveys, GAM between **3.0** and **9.1** (SAM ranging from 0.0 to 1.7)	13 surveys, GAM between **10.0** and **23.4** (SAM ranging from 0.5 to 3.5)	12 surveys, GAM between **2.7** and **9.6** (SAM ranging from 0.1 to 0.9)	6 surveys, GAM between 10.5 and 16.4 (SAM ranging from 0.6 to 2.1)
	2008		**2009**	
	< 10%	**>= 10%**	**< 10%**	**>= 10%**
Somali		1 survey, GAM **23.4** (SAM 2.2)		7 surveys, GAM between **14.5** and **21.9** (SAM ranging from 0.8 to 3.3)
Tigray			4 surveys, GAM between **2.8** and **6.3** (SAM ranging from 0.1 to 0.6	

Outline of the Targeted Supplementary Food Programme

1. The TSF is an innovative, large-scale supplementary feeding programme for treatment of MAM that was established in 2004. The programme replaced the provision of supplementary food rations to 35 percent of the needy population[157] alongside the general food distribution under the 2002/03 EMOP. The TSF design is based on linking up nutritional screening through bi-annual EOS[158] health outreached campaigns at (sub) *kebele* level with targeted community-based food distribution (‘*at the door step*’). The EOS campaigns are supported by UNICEF and deliver an integrated package of child and maternal health interventions (Vitamin A supplements, measles vaccination, insecticide treated bed nets, de-worming, MUAC screening) as a key component of the Government Child Survival Interventions (CSI) strategy. The TSF is supported by WFP and provides supplementary food for malnourished children under five (6 – 59 months) and malnourished pregnant and lactating women as identified in the screening campaigns.[159] The TSF programme primarily has a curative nature but also has a (small) education component on child feeding practices which is more preventive in nature. The programme does not include treatment of SAM. With the roll-out of the OTP, management of SAM cases primarily is being taken care of through the health posts network (support from UNICEF and NGOs).

2. During the previous PRRO, the TSF has been enormously successful in scaling up its geographical coverage to 325 vulnerable chronically food-insecure *woredas* (*woredas* with recurrent lack of access to food in more than two months per year) across the ten regions in Ethiopia.[160] By end 2007, the TSF reached nearly 80 percent of the drought-prone *woredas* and achieved coverage increased from 0.47 million beneficiaries in 2005 to 1.1 million by 2007.

3. Due to diminishing donor interest (donors did not feel there was sufficient evidence of impact on TSF effectiveness), early 2008 at the start to the current PRRO the programme had to be downscaled to a total of 167 *woredas*. The prioritization of *woredas* on the one hand was based on aiming at covering those with highest malnutrition rates, but on the other hand also aimed at maximizing convergence with WFP emergency food aid and the food assistance to PSNP participants and with the Ministry of Health CBN programme scale-up in Oromiya and SNNPR[161][162]. At the same time, a Ministry of Health-supported system ‘*ad hoc*’ screening was added in order to enhance the emergency response capacity of TSF in areas that are not covered (anymore) by the regular programme but for which acute nutritional crises are being reported or that have become priority 1/2 on the regularly revised hotspot

[157] Targeting criteria for these supplementary rations were pregnant and lactating women, children under five years, the elderly and disabled. However, this system had an in-built weakness as the targeting of this 35 percent food aid was left to the community leaders and they often did not apply objective indicators for identification of the really needy people (for both general food distributions and the 35 percent supplementary ration).

[158] Enhanced Outreach Strategy

[159] Cut-off points for malnutrition are 12.0 cm for children under five and 21.0 cm for pregnant and lactating women.

[160] The TSF component has quickly expanded after pilots in 2 *woredas* in SNNPR that started in April 2004.

[161] In February ’08 criteria were developed to prioritise the worst affected *woredas*: (a) more than 10 percent of children found to have MUAC < 12.0 cm, (b) hot spot status in 2006/07; (c) *woredas* identified during Dec. ’07 Meher assessment; (d) *woredas* being relief recipients in 2007; (e) PSNP *woredas* in 2007; and (f) status as CBN *woreda* in Oromiya and SNNPR regions. Source: Ethiopian Government/UNICEF/WFP (2008), Minutes of TSF Contingency Measures meeting, Addis Ababa, 25 February 2008.

[162] In Gambella region, there have been accountability/reporting problems in the collaboration with DPPB and the last screening that was undertaken was in mid-2008.

classification matrix. The evaluation noted that there is no set of strict/specific criteria for inclusion in the *'ad hoc'* category. The '*ad hoc*' response is dependent on availability of sufficient food resources within the TSF pipeline and execution of an ad-hoc screening campaign in the selected *woredas* (undertaken by RHB/*woreda* health office with verification of the results by ENCU). The food support to identified beneficiaries consists of a one-off distribution of a 3-month ration of 25 kg CSB and 3 l. of oil[163]. In 2009, so far 35 *woredas* in Amhara, Oromiya and SNNPR have been covered under the '*ad hoc*' category, while currently preparations are underway to include 3 *woredas* in Somali region.

Table 7: Composition of the TSF food ration

Commodity	Current monthly ration scale per adult (kg)	Average ration energy per person per day (kCal)	Daily ration protein content (g) %	Daily ration fat content (g) %
CSB	8.333	1093	38.25	16.39
Vegetable oil	0.914	245	0.00	27.21
Total	**9.247**	**1338**	**38.25**	**43.60**
Energy %			**11.4**	**29.3**
Recomm. PW/LM		350 – 550[164]	10-12	17 or more
Recomm. Under fives		1000[165]	10-12	17 or more

4. The set/up of the TSF programme is very different from regular Supplementary Feeding Programmes. The implementation of EOS/TSF is based on Ministry of Health screening teams providing ration cards to the selected beneficiaries for TSF and referring them to the FDCs at *kebele* level[166]. These centres are run by FDAs, women from the community who get a small financial incentive for their work and are being supervised by the *woredas* /zone DPP TSF focal person. Current payment level is around 300 birr per FDA per distribution round. After the screening by the health campaign teams, TSF beneficiaries will twice get 3-month food rations without any further taking of measurements or monitoring of weight gain/nutritional status. The TSF is based on automatic discharge after six months, unless they are screened in again. The food ration is the same for the children and women: 25 kg of CSB and three litres of vegetable oil. This ration provides 1338 kcal p.p.p.d. and is designed to allow for some sharing in the household (WFP Handbook recommends 1000 kcal for take-home rations in regular Supplementary Feeding Programmes).

[163] Because of problems around the supply and availability of CSB due to increasing global food prices and limited local production capacity, WFP Ethiopia is currently testing an alternative Ready-to-use food (Supplementary Plumpy) that is suitable to treat moderate malnutrition and can replace the traditional CSB/oil rations. If the recovery rate, recovery time, change in Weight-for-Height Z-scores, level of food sharing in the household and analysis of cost-effectiveness all are favourable, the possibility for local production and scale-up in Ethiopia will be investigated.

[164] This recommendation reflects the additional energy requirement during the last trimester of the pregnancy (350 kcal/day) and for the first six months of breastfeeding (550 kcal/day). Additional energy requirements for recovery from malnutrition are not included in the recommendation. (WFP, Food and Nutrition Handbook).

[165] Allows for some sharing, the target child needs to get 500 kCal from the supplementation per day.

[166] In total, there currently are 1231 FDCs that are operated by 2462 FDAs.

TSF Geographical Coverage Against October 2009 Hotspot Classification

Table 8: Achieved TSF geographical coverage in June/August 2009
(11 round distribution against October 2009 hotspot classification

Region	No. of priority 1 *woredas*	No. of *woredas* covered in TSF 11th round	TSF coverage (%)	Priority 1 *woredas* No. of TSF beneficiaries 11th round	No. of priority 2 *woredas*	No. of *woredas* covered in TSF 11th round	TSF coverage (%)	Priority 2 *woredas* No. of TSF beneficiaries 11th round
Afar	6	0	***0***	0	19	0	***0***	0
Amhara	32	25	***78.1***	64,871	26	2	***7.7***	4,744
Benesh. Gumuz	2	0	***0***	0	3	0	***0***	0
Dire Dawa	1	0	***0***	0	0	0	***0***	0
Gambella	3	0	***0***	0	6	0	***0***	0
Harar	0	0	***0***	0	0	0	***0***	0
Oromiya	47	31	***66.0***	84,426	60	8	***13.3***	31,010
SNNPR	35	26	***74.3***	96,057	46	21	***45.7***	85,815
Somali	28	21	***75.0***	79,808	11	9	***81.8***	26,236
Tigray	16	16	***100.0***	80,795	17	9	***52.9***	38,922
Total	**170**	**119**	***70.0***	**405,957**	**188**	**49**	***26.1***	**186,727**

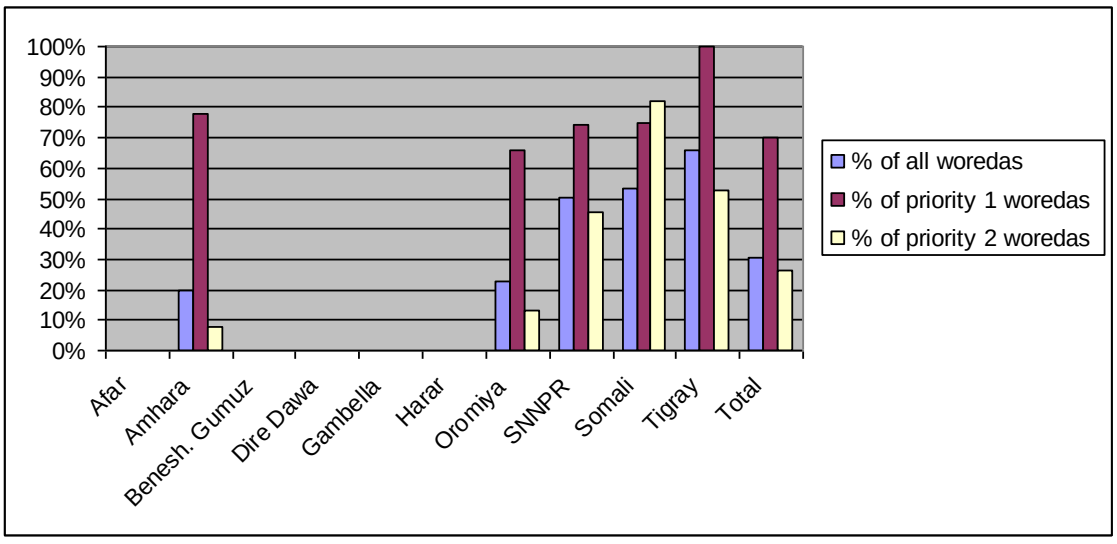
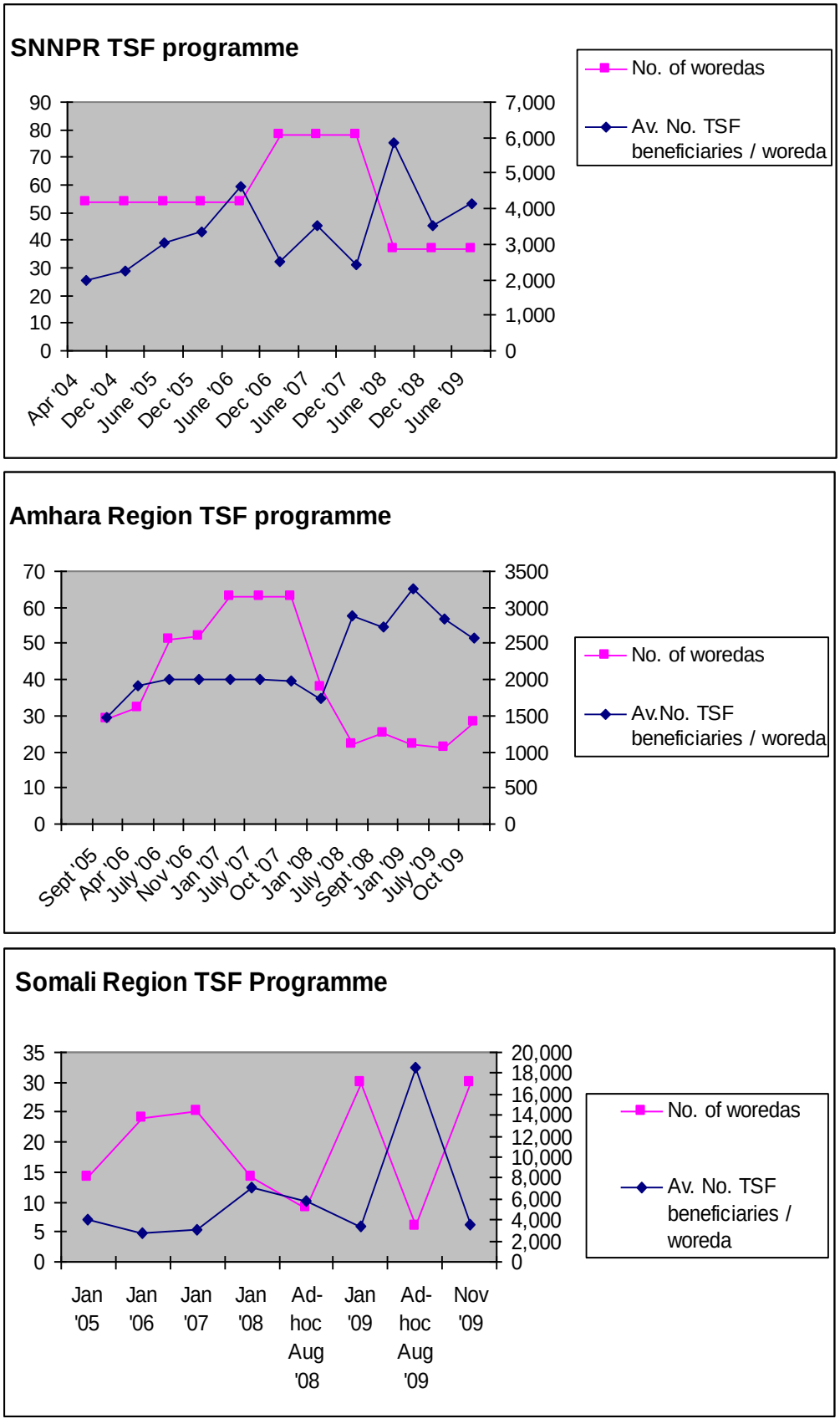


Figure 4: TSF geographical coverage by hotspot classification

Analysis of TSF Coverage in SNNP, Amhara, and Somali regions



1. If we assume that peak malnutrition levels centre around a GAM rate of 20 percent in SNNP region (which is on the high side but might be true in bad years, especially when malnutrition is assessed through MUAC measurements), it can be calculated that the total maximum TSF coverage of under fives would be around 3.7 percent of the population[167], i.e. about 3700 beneficiaries per *woreda* with 100,000 inhabitants (but 100 percent coverage normally is not attained) while peak coverage in June '08 amounted to around 6000 beneficiaries per *woreda* and 4000 beneficiaries per *woreda* were covered in the last round (June – August '09).

2. If the same calculation is applied to Amhara region where a peak GAM level of 15 percent is more realistic, this would give a maximum coverage of 2745 TSF beneficiaries per *woreda* whereas the peak coverage figure for January '09 was 3253 on average.

3. For Somali region, the total maximum TSF coverage would be 4.6 percent of the population if we assume a peak GAM level of 25 percent. For the regular TSF rounds, coverage centred around 3,000 to 3,500 (equalling 71 percent coverage of the estimated total of malnourished children 6 – 59 months of age and malnourished pregnant and lactating women for an average *woreda* of 100,000 people). The exception is the distribution in January '08 which was undertaken in 14 *woredas* and reached 7,035 beneficiaries per *woreda* on average, which clearly is much higher than the number that would be expected. As is shown in the graph, peak coverage in Somali region amounted to over 18,500 for a blanket TSF distribution which was implemented in six *woredas* in August 2009. This is very close to the expected total of 18,400 for all under fives and pregnant and lactating women that would be present per 100,000 people.

4. It thus seems that the achieved TSF coverage level in SNNPR is unrealistically high (indicating that there must be a substantial number of false inclusions of children who are not malnourished (SAM would be better treated through therapeutic care but is not seen as a false inclusion), in Amhara region the average coverage is also somewhat higher but in Somali region in nearly all rounds somewhat lower than the estimated total acutely malnourished beneficiaries (GAM). This finding underlines the need to improve EOS screening data quality[168]. From WFP side, in 2009 a pilot was started on the 'gatekeeper concept'[169] that also might help to reduce targeting errors.

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[167] It can be calculated that in total about 18.3 percent of the population would fall in the age group of 6 – 59 months or be a pregnant or lactating woman. This is based on the assumption that about 14.5 percent of the population falls in the 6 – 59 months category and that 20.2 percent of the population are women of childbearing age (15 – 49 years) of whom 19 percent are pregnant or lactating up to 6 months after birth (9.45 percent is the average proportion of women of childbearing age in rural areas in Ethiopia who are pregnant – calculated based on the following equation: 8.4 percent = 0.85*4/5X + 0.15*1/5X); the figure is multiplied by 2 to also include lactating women up to 6 months after birth). All figures are taken/adapted from the 2005 DHS survey.

[168] In relation to the false inclusions problem, a recent ENCU guidance note on EOS screening data quality is stressing the need to avail of credible screening results for effective TSF targeting with limited inclusion and exclusion errors.

[169] In this approach, the EOS screening is a referral to a second screening done by WFP-employed nurses. The gatekeeper concept was first piloted in SNNPR as this region was known to suffer from high numbers of false inclusions. According to the WFP country office, the new approach works well, primarily because of good commitment to the initiative from the side of high-level regional administration officials. The pilot is currently being expanded to Afar region, another region well-known for its high level of false inclusions.

Legal Framework for EOS/TSF

5. The MOU for the EOS/TSF between FMoH, DPPA (now DRMFSS), UNICEF and WFP was signed in June 2005. The project was meant to run for three years from April 2004 onwards and to cover 325 vulnerable *woredas* in 10 regions targeting 6.7 million under-fives, with three-monthly supplementary food rations (consisting of CSB and vegetable oil but ration size not specified) for 8 percent of them (no specification of cut-off points to be used for targeting). No planned coverage figures were stated for pregnant and lactating women. The multi-causality of malnutrition was acknowledged and nutrition education was to take place every 3 months. Overall responsibility for coordination and management of the EOS/TSF programme was stated to lie with the Government (both at federal and regional level). Through focusing on the same geographic locations (to the extent possible), it was aimed to achieve synergistic effects of complementary resources and activities. The document specifies the responsibilities for each of the four agencies (a.o., FMoH to transmit EOS screening data from *woredas* health office to *woredas* DPP within 3 days; DPPA to collaborate with WFP to ensure that distribution of food takes place within three weeks after transmission of the data from the *kebele*; UNICEF to support FMoH; WFP to follow the leadership of FMoH and DPPA with regard to time table, area selection, administrative arrangements, and formation of locally selected food distribution centres, to provide ITSH budgets to the regional DPPBs for implementation, monitoring and evaluation activities, and to make available technical support and nutrition training materials).

Analysis of TSF FLA 2008 and 2009 and Comparison with Average Rates Applied by WFP Donors Ethiopia for this PRRO

Table 9: LTSH and ODOC rates (US$/mt) in the 2008 and 2009 FLAs for the TSF programme

	FLA 2008 (Jan – Dec)		FLA 2008 (revised; Jun - Dec)		FLA 2009 (Mar – Dec)		FLA 2009 (revised; Jul - Dec)	
	LTSH	**ODOC**	**LTSH**	**ODOC**	**LTSH**	**ODOC**	**LTSH**	**ODOC**
Afar	80.09	6.60			73.17	5.80	66.98	13.88
Amhara	79.68	7.50	90.20	9.50	88.56	6.86	103.47	15.33
Beneshangul Gumuz	128.25	49.46			-	.	-	-
Gambella	228.96	25.50			190.43	47.57	96.09	80.96
Harari	46.31	7.89			-	-	-	-
Oromiya	98.17	8.65			100.71	25.18	88.11	44.06
SNNPR	129.37	3.54	69.08	3.42	68.63	4.09	58.96	8.04
Somali	98.73	3.86			134.94	8.39	96.83	11.64
Tigray	102.29	11.84	60.45	25.57	76.21	5.16	68.09	10.32
Average rates as per the various PRRO budget revisions	**113.50 123.46**	**9.49-12.01**	**123.46–156.62**	**10.29-12.01**	**156.62–159.74**	**10.29-8.65**	**159.74**	**8.65**

6. The main contractual framework for the TSF was the set of annual FLAs which are signed between WFP and the regional DPPBs. The FLAs provide the operating budget with costs breakdown at the regional logistics coordination office, zonal logistics offices and at *woreda* level. For implementation of the current PRRO, a MOU was signed between WFP and DPPA in May 2008 for the continuation of the TSF programme which is pursuant to the signing of the Basic Agreement signed in September 2005. The estimated TSF beneficiaries are 665,667 per year, located in food insecure districts (9 WFP delivery points) with a total projected cost of US$ 123,202,988. DPPA is to be responsible for alignment of the programme with the

NNP, and is responsible for needs assessments, nutrition surveillance, baseline surveys (through ENCU), and targeting in coordination with other emergency supplementary food responses. The DPPBs are to implement a Results Based Management framework through regular monitoring and reporting of their programme, with capacity-building from WFP as required/requested. Annual performance surveys are the joint responsibility of WFP and DPPA.

Key Findings of the 2007 and 2008 TSF Outcome Studies

2007 TFS Performance Study

7. The first performance study to measure effectiveness of the programme was undertaken in 2007 by WFP Ethiopia in consultation with the WFP Regional Bureau nutritionist[170]. The study showed that over 80 percent of the children enrolled in TSF also received the service package of the EOS component. Defaulter and death rates were found to be very low (both 2 percent , which is below Sphere standards). Intra-household ration sharing was encountered in 56 percent of the cases (selling of the TSF ration was found to be very rare though) and only one-third of the mothers reported to add oil to the CSB porridge. The TSF recovery rate after the two distribution rounds[171] (6 months after MUAC screening) was found to be 61 percent, which is below the national standard of >75 percent[172]. The re-admission rate was 27 percent, indicating the there is a need to improve effectiveness. The study concluded that all in all the integrated approach of a food-based intervention together with basic health care delivery was successful. Some changes were recommended in the logistical arrangements in order to reduce the delays between the screening and actual food distribution, support to UNICEF/ENCU efforts to improve the screening data quality, systemization of the involvement of HEWs in the implementation and monitoring of the TSF including for the nutrition education component, and to consider application of the Positive Deviance model which already is in use in Ethiopia.

2008 TFS Outcome Evaluation Study

8. The second performance study was undertaken in 2008 in 8 selected *woredas* (one intervention and control woreda per region in Tigray, Afar, Amhara and Somali region) by an external team based on a more rigorous approach including control groups[173]. The major outcomes measured were changes after 1, 2, 3 and 6 months from the date of enrolment in Weight-for-Height Z-score, weight and MUAC. A range of other variables were measured to estimate the role of confounding and effect modification. Efficacy was measured by follow-up of children for whom the TSF food was not shared with other household members or only other children below five years in the household. The study found a high rate of false inclusions (46 percent of children enrolled were actually not malnourished) and overall poor compliance due

[170] WFP Ethiopia (2007), TSF Performance Study Report, Addis Ababa, December 2007. The basic design of the study was to compare follow-up MUAC measurements taken in May – June 2007 with the entry MUAC measurements in November/December 2006 and to collect information on recovery, readmission, defaulter and death rates. This methodology does not take into account the seasonality aspect, as the initial screening was done in the main harvest period while the follow-up screening was undertaken in the lean period.

[171] Even in Amhara region where only one distribution round took place, more than 60 percent of the children showed improved nutritional status, which might indicate that next to the TSF programme also other factors have been at play leading to improvements in the nutritional status despite the supposedly negative seasonality effect.

[172] However, it needs to be realized here that actually 21 percent of the children were SAM cases who normally would need more intensive nutrition support in order to recover.

[173] Skau J, T Belachew, T Girma & BA Woodruff (2009), Outcome evaluation study of the Targeted Supplementary Food (TSF) programme in Ethiopia, Copenhagen/Jimma/Addis Ababa, June 2009.

to sharing with others in the household. The study found that the TSF intervention is effective with regard to reduction of malnutrition based on Weight-for-Height Z-score (average improvement of 0.56 Weight-for-Height Z-score in the TSF group against improvement of 0.25 in the control group), but that there were no statistically significant changes in MUAC between the TSF and control groups (both gained 0.45 cm over the 6-month follow-up period). Recovery rates based on MUAC measurement were a low 49 percent only. Two factors showed an effect on effect of the TSF on nutrition status change: (a) nutritional status at baseline (the children who at the start of the intervention were more malnourished showing greater recovery), and (b) type of water supply (greater recovery when household avails of safe water supply). The main recommendations of the 2008 Outcome study are to improve targeting of the programme, to minimise intra-household sharing and to link the TSF programme more closely to health centres to improve the referral of severely malnourished children.

Revised Logical Framework for PRRO 10665.0 for the period October, 2009 – December, 2010, which realigned the project's log-frame with the new Corporate Results Framework.

LOGICAL FRAMEWORK SUMMARY		
Outcomes and outputs	**Performance indicators**	**Risks, assumptions**
SO. 1 Save live and protect livelihood in emergencies **Outcome 1.1** Reduced or stabilised acute malnutrition in children under-five in targeted emergency affected populations. **Outcome 1.2** Improved food consumption over assistance period for targeted emergency affected households. **Outcome 1.3** Reduced or stabilised moderate/acutely malnourished children under 5 and pregnant and lactating women identified during EOS screening in food-insecure districts.	**Prevalence of MUAC.** Household food consumption score 1.3.1 Recovery rate (%) of children. 1.3.2 Prevalence of low MUAC for under 5 children and pregnant and lactating women	Complementary activities, especially water, sanitation and health, are implemented by other stakeholders/partners. Insecurity may hamper humanitarian assistance in some areas. Government continues to support WFP programmes.
Output 1.1 Timely provision of food in sufficient quantity for targeted beneficiaries in conflict-and disaster-affected areas.	Actual beneficiaries receiving WFP food assistance as % of planned beneficiaries, by gender and age group. Actual tonnage of food distributed as a % of planned distributions, by food type.	Sufficient and timely resources secured by bilateral agencies, NGOs and government for remaining 50% of national caseload.
Output 1.2 Increased participation of women in the management of food distribution.	Proportion of women in leadership positions in food management committees.	Women are encouraged and willing to participate in the management of food.
Output 1.3 Timely provision of nutritious food in sufficient quantity for targeted young children	Actual number of children receiving WFP food assistance as % of planned. Actual tonnage of food distributed to children.	
Output 1.4 Timely provision of nutritious food in sufficient quantity for targeted women.	Actual number of women receiving WFP food assistance as % of planned. Actual tonnage of food distributed to targeted women.	
S**O. 2** Prevent acute hunger and invest in disaster preparedness and mitigation measures		Cooperating partners have complementary funding. Sufficient provision of non-food items and funds to cover capital costs. Secure environment.
Outcome 2.1 Increased ability of PSNP beneficiaries to manage shocks and invest in activities that enhance their resilience	% of households reporting reductions in food deficit of at least two months. Proportion of beneficiaries with access to and/or benefiting from created assets	
Outcome 2.2 Adequate food consumption over assistance period for target households at risk of falling into acute hunger	Household food consumption score	

LOGICAL FRAMEWORK SUMMARY		
Outcomes and outputs	**Performance indicators**	**Risks, assumptions**
Output 2.1 Timely provision of food in sufficient quantities for PSNP beneficiaries.	Actual beneficiaries receiving WFP food assistance as % of planned beneficiaries, by gender and age group. Actual tonnage of food distributed as % of planned distributions, by type.	Funding available for capacity-building.
Output 2.2 Developed**,** build or restore livelihood assets by targeted communities and individuals.	Numbers and types of community assets created in WFP-assisted *woredas* vs. planned. Number of development agents trained in food for assets through WFP support vs. planned. Numbers and types of training sessions held.	Cooperating partners have the capacity and are willing to support asset creation. Targeted beneficiaries are willing to participate in asset creation.
SO 4 Reduce chronic hunger and under-nutrition. **Outcome 4.1** Enhanced basic knowledge on nutrition-related issues for mothers and other women in communities targeted by EOS/TSF. **Outcome 4.2** Improved nutritional status and QOL of food-insecure people living with HIV/AIDS on HBC, ART therapy and PMTCT. **Outcome 4. 3** Increased school enrolment and attendance of OVC in HIV/AIDS-affected urban communities.	% of beneficiaries with improved caring and/or feeding practices through the EOS/TSF. Weight gain among beneficiaries; target at least 10% gain in 6 months. % of beneficiary patients on ART taking 95% of medication in last three months. Absolute enrolment of OVC from households receiving take-home rations. Attendance rate: % of OVC from households receiving take-home rations attending classes.	Adequate provision of services and non-food items by NGO and United Nations partners and government to address other causes of malnutrition and morbidity. Schools function without interruption.

LOGICAL FRAMEWORK SUMMARY	
Outcomes and outputs	**Performance indicators**
Output 4.1 Basic nutrition awareness provided in an efficient manner at the community level.	% of beneficiaries receiving proper nutrition education messages
Output 4.2 Timely provision of food in sufficient quantities for HIV/AIDS beneficiaries.	Numbers of beneficiaries targeted in HIV/AIDS-supported programmes receiving food. Actual tonnage of food distributed through HIV/AIDS-supported programmes.
Output 4.3 Timely provisions of take-home rations provided to OVC.	Numbers of OVC receiving take-home rations. Quantity of food distributed as take-home rations to OVC.
SO. 5 Strengthen the capacities of countries to reduce hunger, including through hand over strategies and local purchase. **Outcome 5.1** Increase the capacity of government, particularly at local levels, and communities to identify food needs, develop strategies and carry out hunger and disaster risk reduction programme. **Outcome 5.2** Increased marketing opportunities at national level with cost effective WFP local purchases.	*Food need assessment methodology in place* Number of farmer associations, cooperatives and unions participated in selling cereals to P4P Food purchased locally as percentage of food distributed in country.
Output 5.1 Provision of capacity-building assistance to entities involved in hunger and risk reduction programme **Output 5.2** Local purchase from smallholder farmers will be effected	Counterpart staff trained under WFP's technical assistance activities, as % of planned. Numbers and types of technical cooperation capacity-building activities provided. Number of participating peasant association/ cooperatives/ unions in P4P

Acronyms

ABM	action-based monitoring
AIDS	acquired immune deficiency syndrome
ART	Anti-retroviral therapy
BMI	Body Mass Index
BPR	Business Process Review
CBN	Community-Based Nutrition
DHS	Demographic Health Survey
DPPA	Disaster Preparedness and Prevention Agency (now DRMFSS)
DPPB	Disaster Preparedness and Prevention Bureau (now DRMFSS)
DRMFSS	Disaster Risk Management and Food Security Sector (ex DPP/A/B)
ENCU	Emergency Nutrition Coordination Unit
EOS	Enhanced Outreach Strategy
FDA	Food Distribution Agent (TSF)
FDC	Food Distribution Centre
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FLA	Field Level Agreement
FMOH	Federal Ministry of Health
FMTF	Food Management Task Force
GAM	Global Acute Malnutrition
GDP	gross domestic product
GFD	General Food Distribution
HAPCO	Federal HIV/AIDS Prevention and Control Office
HBC	Home Based Care
HBCV	Home Based Care Volunteer
HEP	Health Extension Programme
HIV	human immunodeficiency virus
IDS	Institute of Development Studies
IFPRI	International Food Policy Research Institute
IGA	Income Generating Activity
ITSH	internal transport storage and handling
M&E	monitoring and evaluation
MAM	moderate to acute malnutrition
MERET	managing environmental resources to enable transitions
MOU	Memorandum of Understanding
MUAC	mid-upper arm circumference
mt	metric tons
MTE	Mid-Term Evaluation
NGO	Non-governmental organisation
NNP	National Nutrition Programme
ODOC	Other Direct Operational Costs
OTP	Out-patient Therapeutic Programme
OVC	orphans and vulnerable children
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PEPFAR	President's Emergency Plan For AIDS Relief (USA)
PLHIV	People Living with HIV
PDM	post-distribution monitoring
PMTCT	prevention of mother to child transmission
PRRO	protracted relief and recovery operation
PSNP	productive safety net programme
QOL	quality of life
RHB	Regional Health Bureau
SAM	Severe Acute Malnutrition
SD	Standing deviation

SNNPR	Southern Nations, Nationalities and Peoples Region
SPM	Strategic Plan for Multi-Sectoral HIV and AIDS Response in Ethiopia
SPR	Standard Project Report
SO	Sub Office
TSF	Targeted Supplementary Feeding
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
WFP	WFP
WHO	World Health Organization

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