Executive Board
Second Regular Session

Rome, 8–11 November 2010

PROJECTS FOR EXECUTIVE BOARD APPROVAL

Agenda item 9

For approval

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DEVELOPMENT PROJECTS— LESOTHO 200169

Nutrition Support for Malnourished Children and other Vulnerable Groups

Number of beneficiaries	214,180
Duration of project	24 months (1 January 2011–31 December 2012)
WFP food tonnage	12,515 mt
Cost (United States dollars)	
WFP food cost	5,445,408
Total cost to WFP	9,796,239

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NOTE TO THE EXECUTIVE BOARD

This document is submitted to the Executive Board for approval

The Secretariat invites members of the Board who may have questions of a technical nature with regard to this document to contact the WFP staff focal points indicated below, preferably well in advance of the Board's meeting.

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EXECUTIVE SUMMARY

Lesotho has made considerable progress in addressing child mortality and increasing life expectancy, but challenges remain. Malnutrition is the cause of 22 percent of child mortality, while 56 percent of deaths of children under 5 are attributed to HIV-related illnesses. About 24 percent of Lesotho's population is living with HIV; malnutrition and HIV-related illnesses are physiologically linked.[1] This has led to changes in social structures, resulting in reduced capacity to provide adequate nutrition and care for infants and children.

Currently, 42 percent of all children under 5 are stunted and 40 to 60 percent are at risk of impaired cognitive growth owing to micronutrient deficiencies.[2] Stunting is partly a result of household food insecurity, which worsens during the lean season of January to March, when a third of households struggle to cover their food needs and provide children with an adequate diet. The situation is most severe in the mountainous region and in Berea district in the west.

This development project will reach more than 200,000 beneficiaries. It is WFP's first development project in Lesotho to focus exclusively on combating chronic malnutrition. The project is part of the first Joint United Nations Nutrition Programme, which will support outcomes 1, 2 and 3 of the United Nations Development Assistance Framework 2008–2012. It is aligned with ongoing government policies and programmes to address vulnerability, presented in the National Development Plan 2008–2012, and is rooted in lessons learned from joint United Nations missions conducted in March and April 2010.

The project aims to prevent and reduce malnutrition among vulnerable groups in the four districts most affected by chronic malnutrition through four activities: i) improving management of acute malnutrition; ii) improving child growth and development, with particular attention to reducing stunting and micronutrient deficiencies; iii) improving nutrition and health practices; and iv) enhancing capacity to inform and manage national nutrition improvement programmes.

The project meets WFP's Strategic Objectives 4 and 5,[3] and will help Lesotho meet Millennium Development Goals 1, 4, 5 and 6.[4]

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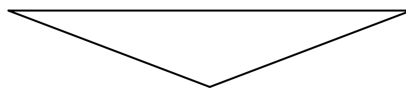
[1] Ministry of Health and Social Welfare Annual Joint Review 2009

[2] National Nutrition Survey 2007/08

[3] Strategic Objective 4 – Reduce chronic hunger and undernutrition; and Strategic Objective 5 – Strengthen the capacities of countries to reduce hunger, including through hand-over strategies and local purchase.

[4] Millennium Development Goals 1 – Eradicate extreme poverty and hunger; 4 – Reduce child mortality; 5 – Improve maternal health; and 6 – Combat HIV/AIDS, malaria and other diseases.

DRAFT DECISION*



The Board approves the proposed development project Lesotho 200169 “Nutrition Support for Malnourished Children and other Vulnerable Groups” (WFP/EB.2/2010/9-A/2) subject to availability of resources.

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

SITUATION ANALYSIS

1. Lesotho has a population of fewer than 2 million people.[5] The west, where the capital and urban areas are located, has plains and foothills, while the east is mountainous, with poor infrastructure and communications, and scarce – often eroded – arable land. In the east, access to markets is difficult, opportunities for income generation are few, and there is greater marginalization in terms of human, physical and political capital than in western Lesotho.

2. Although Lesotho produces less than half of its staple food needs, food availability is generally secure because of effective market links and a strong private sector. For many years, food imports were largely paid for through remittances from mineworkers based in South Africa, but remittances are now a fraction of what they were a decade ago. The Government also faces an economic crisis due to a significant reduction in Southern African Customs Union[6] revenue, exports and domestic incomes.

3. Gross domestic product per capita fell from US$3,200 at purchasing power parity in 2005 to US$1,400 in 2009. With a Gini coefficient of 0.63, Lesotho's national income is the second most unequally distributed in the world. Poverty and household food insecurity remain high, with nearly a quarter of all households classified as food-insecure. In 2009, following an exceptionally poor harvest, 23 percent of people were estimated to need external assistance to meet their basic livelihood needs.[7]

4. Lesotho is ranked 156th out of 182 countries in the United Nations Development Programme's (UNDP's) 2009 human development index. In 2008 life expectancy at birth was 45 years,[8] and maternal mortality increased to 972 per 100,000 live births in 2009. Rates of stunting are extremely high, averaging about 42 percent[9] nationally, and child anaemia is 49 percent. Underweight prevalence is 14 percent nationally, and 13 percent of all children are born with low weight.

5. High HIV prevalence has a profound impact on Lesotho's development potential. Although the prevalence rate has reduced to about 24 percent[10] from a peak of 31 percent in 2001, it is still the third highest in the world. Estimates of crude death rates in 2007 in the country's ten districts showed that they exceeded emergency thresholds in two and were at unacceptably high levels in an additional five; dependency ratios are increasing and stretching household resources.[11]

6. Chronic malnutrition, including iron-deficiency anaemia, has multiple causes such as poor feeding practices for the very young; disease and poor health; and household food insecurity, according to a 2004 Demographic and Health Survey.

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[5] The 2006 census counted 1,876,633 people.

[6] The Union shares revenues among its members, including Swaziland, Lesotho and Namibia, with the primary goal of promoting economic development through regional coordination of trade.

[7] Lesotho Vulnerability Assessment Committee/Disaster Management Authority. Lesotho Food Security and Vulnerability Monitoring Report 2009. Maseru.

[8] United Nations Development Programme. *Human Development Report 2009*. New York.

[9] The most recent figures are from the Lesotho Nutrition Survey, November to December 2007.

[10] Ministry of Health and Social Welfare. Lesotho 2010. Maseru.

[11] Owusu-Ampomah, Naysmith, S. and Rubincam, C. 2009. Reviewing Emergencies in HIV and AIDS-Affected Countries in Southern Africa: Shifting the Paradigm in Lesotho. National Aids Commission. Maseru.

7. Only 68 percent of children under 2 were fully immunized in 2009, down from 80 percent in 2008. Only 15 percent of mothers practise exclusive breastfeeding in the first 6 months, and the introduction of appropriate complementary foods is delayed for 30 percent of children. Protein intakes are inadequate: only 25 percent of children aged 23 months eat pulses and only a third eat animal-based protein.[12] HIV-related illnesses have resulted in the deaths of many parents, with children being cared for by grandparents who often lack the capacity to provide adequate nutrition and care.

8. Stunting in children is the irreversible result of growth failure, a long and slow cumulative process resulting from inadequate nutrition combined with recurrent or chronic illness. As well as weakening health and well-being, stunting limits intellectual potential and undermines overall economic development. The prevalence of stunting is 42 percent nationally, but varies significantly by district. Stunting rates are highest in Mokhotlong, Qacha's Nek and Thaba-Tseka districts in the mountainous region and Berea district in the foothills and lowlands, where they range from 46 to 55 percent. The prevalence of stunting doubles from 21 percent during infancy – 6 to 11 months – to about 50 percent in children aged 18 to 23 months. This trend is observed up to 5 years of age, leaving one in every two children in Lesotho at risk of growth impairment and mortality. Stunting is compounded by iron deficiency anaemia, which is highest in the same four districts, where it reaches 63 percent.[13]

9. Although moderate acute malnutrition is not generally at alarming levels, global acute malnutrition is currently at 2 to 3 percent,[9] and reports of high mortality among severely malnourished children have prompted the Ministry of Health and Social Welfare to establish a feeding programme for the treatment of severe and moderate acute malnutrition. However, health centres have no records of coverage or outcomes, so it is impossible to determine progress or results.

10. According to the Ministry of Health and Social Welfare, 22 percent of child deaths are attributed to malnutrition[1] and 56 percent of deaths in children under 5 are attributed to HIV-related diseases.[11] Moderate acute malnutrition is also frequently observed in adults with advanced AIDS disease,[14] compromising their recovery. Co-infection of HIV and tuberculosis (TB) is common, and about 80 percent of TB patients are also living with HIV; the incidence of TB is the second highest in the world, at 640 per 100,000 people.[1] Anti-retroviral therapy (ART) reaches 62,000 people, about 51 percent of those who need it.[15]

11. The Government is committed to fighting TB and HIV. In 2004, it adopted an integrated approach, with joint programming at all levels, and integrated service delivery at health facilities. There has been significant progress in rolling out ART and food support to people living with HIV (PLHIV), but efforts have been weakened by poor monitoring systems.

12. In Lesotho, responsibility for dealing with malnutrition is fragmented across many Government and partner structures, with the main actors being the Ministries of Health and Social Welfare and of Agriculture and Food Security, and the Food and Nutrition

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[12] All figures are from the most recent data available, Demographic and Health Survey 2004.

[13] According to the 2006 census, the total population of these four districts is 550,000.

[14] Data for Lesotho are not available, but information from other southern African countries suggests that adult malnutrition among patients starting ART ranges from 15 to 30 percent.

[15] National AIDS Commission 2009 Annual Report on the National Response to HIV and AIDS

Coordination Office (FNCO) under the Prime Minister's Office. Nutrition surveillance is extremely poor, in terms of both data collection and data analysis. No adequate interventions are available for treating chronic malnutrition, including micronutrient deficiencies.

PAST COOPERATION AND LESSONS LEARNED

13. Since 2002, WFP programmes in Lesotho have included large-scale relief and recovery interventions responding to the triple threat of food insecurity, weak governance and HIV prevalence. The most recent protracted relief and recovery operation (PRRO 105990) applies a social protection approach, particularly to addressing the needs of HIV-affected households and communities.

14. Development-oriented primary education support has been in place in Lesotho since 1966. WFP has renewed its partnership with the Government to promote greater national financial and managerial ownership. A 2009 decentralized evaluation of the school feeding programme established that WFP had worked constructively with the Government at both the central and district levels. Exit and hand-over strategies were seen as positive developments.

15. The Government prioritizes social protection. It runs a universal old-age pension scheme and implements a national Integrated Early Childhood Care and Development Programme that includes pre-primary care. The Ministry of Education and Training is responsible for funding and implementing nationwide school feeding programmes for primary schools. It is exploring the feasibility of introducing nutrition support interventions at the early childhood care and development (ECCD) centres under its oversight. The Government has expressed a commitment to continuing support to the nutrition sector.

PROJECT STRATEGY

16. This development project (DEV) aims to reach 200,000 beneficiaries. It is WFP's first DEV in Lesotho to focus exclusively on combating chronic malnutrition. It contributes to the first Joint United Nations Nutrition Programme (JUNNP) through outcomes 1, 2 and 3 of the United Nations Development Assistance Framework (UNDAF) 2008–2012. The project is based on the recommendations of United Nations missions from March to May 2010 and a review of key documents.[16] It is aligned with government policies and programmes to address vulnerability, presented in the National Development Plan 2008–2012.

17. The current UNDAF ends in December 2012 and all United Nations agencies will realign their respective projects with the new UNDAF to start in January 2013. This project will therefore end in December 2012. A second phase starting in 2013 may be proposed, subject to funding availability and the findings of an evaluation.

18. The overall objective of the DEV is to prevent and reduce malnutrition among vulnerable groups in four districts.

[16] National Nutrition Survey 2007, Child Health Survey 2010, DHS 2004, National Nutrition Policy 2009, National HIV and AIDS Strategic Plan 2006–2011.

19. The intended outcomes are to:

i) improve the nutritional well-being of the targeted population;

ii) increase the survival of adults and children with HIV after 6 and 12 months of ART;

iii) improve the success of TB treatment for targeted cases; and

iv) make progress towards nationally owned hunger solutions.

20. The project will contribute to the achievement of MDGs 1, 4, 5 and 6, and is in line with the Government's Policy on Infant and Young Child Feeding. The Government has also endorsed the Global Strategy for Infant and Young Child Feeding of the World Health Assembly's Resolution 55.25 of May 2002, which aims to optimize infant and young child feeding.

21. The National HIV and AIDS Strategic Plan (2006–2011) highlights the importance of nutrition in delaying the progression of HIV to AIDS, and the integration of nutritional support as part of a comprehensive treatment package, including micronutrients, for improving the quality of life of PLHIV by reducing mortality and morbidity.

22. The project will address malnutrition, including micronutrient deficiencies, in districts with high levels of stunting among children under 5, and the nutritional vulnerabilities of groups including pregnant and lactating women. It will target three districts in the mountains – Mokhotlong, Qacha's Nek and Thaba-Tseka – where stunting prevalence averages 50 percent, and Berea district in the lowlands.

23. The project will adopt a comprehensive food-based approach, including curative and preventive interventions to address the nutritional challenges facing children and adults, while mobilizing households and communities around healthy nutrition practices. Given the profound impact of HIV and TB on maternal, child and adult nutritional well-being, the activities are linked to general disease awareness, testing and positive living education, where possible.

24. The project's four activities are:

i) improving the management of acute malnutrition;

ii) improving child growth and development, with particular attention to reducing stunting and micronutrient deficiencies;

iii) improving nutrition and health practices; and

iv) enhancing capacity to inform and manage national nutrition improvement programmes.

Activity I: Improving the Management of Acute Malnutrition

25. WFP will partner the Ministry of Health and Social Welfare and the United Nations Children's Fund (UNICEF) to implement nutrition rehabilitation for malnourished children under 5, pregnant and lactating women, and PLHIV and TB who are initiating ART and/or directly observed treatment, short-course for TB (TB-DOTS). WFP will provide supplementary food rations through clinics and health centres, to meet the nutritional needs of moderately acute malnourished target groups; UNICEF will support the treatment of severely malnourished children.

26. Nutrition rehabilitation activities will be linked to health services such as integrated management of childhood illnesses, including paediatric ART, and the provision of ART and TB-DOTS for adults along with micronutrient supplementation. The provision of supplementary feeding will form part of the minimum package. Given heavy burdens on

health staff, food will be handled by cooperating partners and distributed monthly at health centres.

27. Linkages will be strengthened with community and home-based outreach programmes, to improve early detection of weight loss and moderate acute malnutrition, its causes and possible remedies, and to encourage home-based recovery support. The capacities of clinic-based staff and village health workers (VHWs) will be enhanced through provision of training, tools and materials, in partnership with the Ministry of Health and Social Welfare, UNICEF and the World Health Organization (WHO).

28. Over the two-year project, 4,200 women and children will receive take-home rations of corn-soya blend (CSB), sugar and oil until they have adequately recovered – usually after three months. Entry and exit criteria are based on the Lesotho National Guidelines for the Integrated Management of Acute Malnutrition, using mid-upper-arm circumference and weight-for-height. For an average of four to six months, 3,200 malnourished adult ART and TB-DOTS patients per month will receive CSB, following basic food-by-prescription principles based on body mass index (BMI) criteria.

Activity II: Improving Child Growth and Development, with Particular Attention to Reducing Stunting and Micronutrient Deficiencies

29. To ensure that children’s growth is not compromised during the January to March lean season, WFP will provide a food supplement to 58,500 children aged 6 to 23 months; 45,000 pregnant and lactating women will also receive a supplement during the season, to support foetal and infant growth. Rations of CSB, oil and sugar will be delivered monthly to distribution sites in community councils, where cooperating partners will organize beneficiary lists and manage the distributions. Diet quality will be monitored throughout the year to ensure that macro- and micronutrient intake remains sufficient.

30. This activity also targets children aged 2 to 5 years who are enrolled in ECCD centres managed by community volunteers under the auspices of the Ministry of Education and Training. Micronutrient-rich meals prepared with fortified maize meal, pulses, oil, CSB and sugar will be provided to 30,600 children twice daily for 180 days a year, covering 80 percent of micronutrient needs. UNICEF supports the Ministry of Education and Training by providing water and sanitation facilities and educational material to schoolchildren including those in ECCD centres. WFP’s food assistance will consist of dry food products and so linkages will be explored with the community gardens to be developed under activity III as a way of introducing fresh produce into the children’s daily meals, thus contributing to improved dietary balance and increasing the children’s familiarity with a variety of fruits and vegetables.

31. The gathering of children and pregnant and lactating women at central locations offers opportunities for health and nutrition education and for surveillance of critical nutritional challenges, such as impaired growth and micronutrient deficiency disorders, in these target groups. Beneficiaries will also be given access to health services such as vaccination, and to distributions of vitamin A capsules, deworming tablets, and iron and foliate supplements.

Activity III: Improving Nutrition and Health Practices

32. The activity aims to improve communities’ feeding and caring practices, identify and address special nutritional needs, and support nutritional recovery when needed.

33. Nutrition education in the four districts will use the "positive deviance" approach.[17] All caregivers in the community – mothers, fathers, teachers, etc. – will be targeted, and education will focus on infant and young child feeding practices, and appropriate food for pregnant and lactating women and people with special nutrition needs, such as PLHIV and TB patients.

34. This activity will be conducted by trained VHWs, who will mobilize and empower households and communities to obtain and engage in the necessary nutrition knowledge and practices for ensuring healthy lives. The VHWs will be provided with a modest food basket of maize meal to compensate for the time and effort devoted to community work. Their increased engagement in communities is expected to help improve the early identification and referral of acute malnutrition cases.

35. As adult chronic illness has a profound influence on household care and livelihood capacity, and overburdened households have a reverse impact on the recovery of PLHIV and TB initiating treatment, household food assistance – maize, pulses and oil for five people, including the patient – will be provided for the duration of recovery, to complement the nutrition rehabilitation supplements offered under activity I. This package covers half the basic daily household requirement and will help to improve household food consumption and facilitate treatment and nutritional recovery for the chronically ill person.

36. WFP will work with the Ministry of Agriculture and Food Security and the Ministry of Forestry and Land Reclamation and with the Food and Agriculture Organization of the United Nations (FAO) to establish community gardens. These gardens will encourage good nutritional practices and dietary diversity by providing the means to apply the nutrition knowledge obtained during education sessions. The gardens will be constructed and maintained by community members from households caring for individuals supported through activities I and II, and other vulnerable households identified by community councils. Inclusion in garden work will be determined by household socio-economic conditions, access to land, level of interest in participating and food security screening.

37. Those directly engaged in the garden work will be compensated with a household food basket covering half the basic daily food requirements – maize, pulses and vegetable oil – of five people; those in need of improved dietary diversity will also benefit from the gardens' produce. The gardens will function as demonstration sites for appropriate agricultural and horticultural practices that households can replicate using their own land and productive assets. Food assistance will be provided for three to six months.

38. The community gardens activity will build on lessons learned from the establishment of fruit-tree nurseries, orchards and vegetable gardens by groups of PLHIV and their families under PRRO 10599.

Activity IV: Enhancing Capacity to Inform and Manage National Nutrition Improvement Programmes

39. Activities I, II and III will contribute to WFP Strategic Objective 5 by supporting capacity development in health service delivery and providing models for replication in other districts. Through activity IV the project will also implement two activities aimed at

[17] This is an asset-based, problem-solving and community-driven approach that enables the community to discover successful behaviours and strategies and develop a plan of action for promoting their adoption by all concerned.

enhancing nationally owned hunger solutions: strengthening of nutrition information systems, and support to food fortification.

40. The national nutrition surveillance system will be strengthened in partnership with the Ministry of Health and Social Welfare, FNCO and UNICEF, with the aim of improving the management of nutrition data. Support will include surveillance through collection, analysis and interpretation of malnutrition rates and other nutrition indicators, which is currently the responsibility of FNCO, and collection of data and management of information from nutrition interventions, currently the responsibility of the Ministry of Health and Social Welfare.

41. Medical treatment programmes have information systems for recording and monitoring patients' well-being, which contribute to good case management and the appraisal of overall programme performance. The integration of nutrition information in these systems will be explored, to enhance the management of both the disease and the nutrition condition of patients and to inform programme design and implementation.

42. National food fortification will contribute to improving micronutrient intake across Lesotho. The focus is on developing policies and standards tailored to local situations, consumption patterns, price considerations, industrial and retail capacities, and control and oversight mechanisms. WFP will support studies and facilitate expert consultations among the parties involved in food fortification, in collaboration with WHO, the United Nations Industrial Development Organization and UNICEF.

43. The implementation strategy aims to maximize the sustainability of all interventions through connection among activities and with other interventions. The positioning of WFP's DEV within a wider JUNNP will increase its effectiveness through complementary technical support from other United Nations agencies, particularly UNICEF and WHO.

44. WFP and other United Nations agencies will work with the Ministry of Health and Social Welfare to improve the technical and managerial capacity for feeding programmes, including staff capacities, and for integrated nutrition support to the delivery of HIV and TB treatment.

45. The Ministry of Education and Training is committed to gradually taking over the provision of meals to children attending ECCD centres. The Ministry of Finance and Development Planning is committed to taking over blanket supplementation for children under 2 years of age, as part of Lesotho's social safety nets. Nutrition education and support for community and home gardening are designed to change household behaviour in ways that are sustained after project activities cease. The inclusion of food and nutrition support for PLHIV and TB in a comprehensive treatment package will be pursued in funding proposals to the Global Fund.

TABLE 1: BENEFICIARIES, BY ACTIVITY			
	Beneficiaries		
Activity	**Men/boys**	**Women/girls**	**Total**
Activity I: Improving the management of acute malnutrition			
Supplementary feeding: children < 5	1 360	1 440	2 800
Supplementary feeding: pregnant and lactating women	-	1 400	1 400
Supplementary feeding; ART/TB-DOTS patients	6 220	6 580	12 800
Activity II: Improving child growth and development, with particular attention to reducing stunting and micronutrient deficiencies			
Blanket food supplements: children < 2	28 430	30 070	58 500
Blanket food supplements: pregnant and lactating women	-	45 000	45 000
Early childhood nutrition: children 2–5	14 870	15 730	30 600
Activity III: Improving nutrition and health practices			
Village health workers	-	2 800	2 800
Community gardens	4 410	4 670	9 080
ART/TB-DOTS family support	31 100	32 900	64 000
TOTAL	**80 170**	**134 010**	**214 180**[18]

Note: Activity IV does not have direct beneficiaries.

[18] ART/TB-DOTS patients who are beneficiaries under the supplementary feeding will also receive the ART/TB-DOTS family ration, but have been counted only once for the total project.

TABLE 2: FOOD RATION, BY ACTIVITY *(g/person/day)*							
	Activity I		Activity II		Activity III		
Food	**Supplementary feeding: children <5 and pregnant and lactating women**	**Supplementary feeding: ART/TB-DOTS patients**	**Blanket feeding: children <2 and pregnant and lactating women**	**Early childhood nutrition: children 2–5**	**VHWs**	**ART/TB-DOTS household support**	**Community gardens**
Maize meal	-	-	-	120	400	200	200
Pulses	-	-	-	25	-	60	60
Oil	20	-	20	15	-	20	20
CSB	200	250	200	60	-	-	-
Sugar	15	-	15	10	-	-	-
TOTAL	**235**	**250**	**235**	**230**	**400**	**280**	**280**
Total kcal/day	***1 037***	***1 000***	***893***	***936***	***1 464***	***1 110***	***1 110***
% kcal from protein	13.9	18.0	13.9	11.1	9.3	10.5	10.5
% kcal from fat	27.8	13.5	27.8	20.1	4.2	19.6	19.6

TABLE 3: TOTAL FOOD REQUIREMENTS, BY ACTIVITY *(mt)*								
	Activity I		Activity II		Activity III			TOTAL
Food *(g/person/ day)*	**Supplemen-tary feeding: children < 5 and pregnant and lactating women**	**Supplemen-tary feeding: ART/TB-DOTS patients**	**Blanket feeding: children < 2 and pregnant and lactating women**	**Early childhood nutrition: children 2–5**	**VHWs**	**ART/TB-DOTS household support**	**Commu-nity gardens**	**Total *(mt)***
Maize meal	-	-	-	734	806	2 304	2 304	6 148
Pulses	-	-	-	153	-	692	692	1 537
Oil	30	-	248	92	-	230	230	830
CSB	302	576	2 484	367	-	-	-	3 729
Sugar	23	-	186	62	-	-	-	271
TOTAL	**355**	**576**	**2 918**	**1 408**	**806**	**3 226**	**3 226**	**12 515**

Note: Activity IV does not involve food distribution.

MANAGEMENT, MONITORING AND EVALUATION

46. The project will be managed by WFP in collaboration with the JUNNP and under the United Nations Delivering as One approach. The JUNNP is guided by the United Nations Steering Committee, chaired jointly by the Minister of Finance and Development Planning and the Resident Coordinator, with members consisting of heads of United Nations agencies and government ministries.

47. WFP will recruit an international specialist in monitoring and evaluation to design and manage information systems that ensure adequate project monitoring and to improve the information available for policy, strategy and programme decision-making; the specialist will transfer methods and knowledge to government counterparts. Efforts will be made to establish information collection and consolidation mechanisms with existing systems and government staff capacities, roles and responsibilities.

48. Food will be delivered to the Government’s Food Management Unit (FMU) in Maseru, which will transport them to the district FMUs, with WFP providing a subsidy. District FMUs will deliver food to distribution points, according to WFP’s requests. Cooperating partners will manage and supervise food distributions and support other nutrition improvement activities, such as community gardens. WFP currently has four cooperating partners: World Vision International, the Lesotho Red Cross Society, Catholic Relief Services and Patriot Vision in Action.

49. Post-distribution monitoring will be undertaken by field monitors working from field offices in the three mountain districts. Berea district will be covered from the Maseru field office.

50. Outcome information will be derived from routine health and nutrition information systems, regular monitoring activities and thematic surveys focusing on behaviour change.

51. Baseline data will be collected in the second half of 2010. A process review will take place at the end of the first year, to inform management decision-making for the second year and provide basic impact information for the development of a possible second phase of the project. Reviews will consider the JUNNP as a whole, looking explicitly at the integration of the various organizations and components. A multi-agency team will undertake the review, with support from an external team leader.

52. To implement the project, WFP will build on existing logistics capacity and partnership with the FMU. Technical expertise for developing and implementing nutrition activities will be available in WFP’s country office and regional bureau and will also be drawn from partnership with other United Nations agencies and non-governmental organizations (NGOs) in Lesotho.

ANNEX I-A

PROJECT COST BREAKDOWN			
Food[1]	**Quantity (*mt*)**	**Value (*US$*)**	**Value (*US$*)**
Cereals	6 149	1 619 901	
Pulses	1 535	793 802	
Oil and fats	831	914 364	
Mixed and blended food	3 730	1 930 254	
Others	270	187 086	
Total food	**12 515**	**5 445 408**	5 445 408
External transport			434 810
Landside transport, storage and handling			1 597 698
Other direct operational costs			475 648
Direct support costs[2] (see Annex I-B)			1 201 800
Total WFP direct costs			**9 155 364**
Indirect support costs (7.0 percent)[3]			640 875
TOTAL WFP COSTS			**9 796 239**

[1] This is a notional food basket for budgeting and approval. The contents may vary.

[2] Indicative figure for information purposes. The direct support cost allotment is reviewed annually.

[3] The indirect support cost rate may be amended by the Board during the project.

ANNEX I-B

DIRECT SUPPORT REQUIREMENTS (*US$*)	
Staff costs	
International professional staff	349 680
Local staff - national officers	196 000
Local staff - general service	344 000
Staff duty travel	33 920
Subtotal	**923 600**
Recurring expenses	
Rental of facility	40 000
Utilities general	2 600
Office supplies and other consumables	15 000
Communications and IT services	17 000
Vehicle running cost and maintenance	105 000
United Nations organization services	17 000
Subtotal	**196 600**
Equipment and capital costs	
Vehicle leasing	81 600
Subtotal	**81 600**
TOTAL DIRECT SUPPORT COSTS	**1 201 800**

ANNEX II: LOGICAL FRAMEWORK

Results	Performance indicators	Risks, assumptions	Resources required
UNDAF OUTCOME(s) Individuals, civil society organizations, national/local public and private institutions have the capacity to achieve/deliver and sustain universal access to HIV prevention, treatment, care and support, and to mitigate HIV's impact District institutions able to provide quality and sustained health, education and social welfare services National institutions able to implement sustainable pro-poor economic development, environmental management and household food security policies and strategies, with special focus on vulnerable groups including women, young men and women and the disabled	**UNDAF outcome indicators** National and district institutions have capacity to reduce and address micronutrient deficiencies and chronic malnutrition among children < 2 Increased national and district capacity to reduce child mortality due to acute malnutrition Increased capacity of national and district institutions to safeguard the health, nutrition and well-being of food-insecure PLHIV and TB and patients on ART and TB treatment Increased capacity of national institutions to strengthen surveillance systems for effective management of nutrition data		
Strategic Objective 4: Reduce chronic hunger and undernutrition			
DEV objective: To prevent and reduce malnutrition among vulnerable groups in the four districts most affected by chronic malnutrition			
Outcome 1.1 Improved nutritional well-being of targeted population	➢ Prevalence of stunting among targeted children under 2: height-for-age as % ➢ Prevalence of iron deficiency anaemia in children 2–5 in ECCD centres ➢ Supplementary feeding performance indicators: recovery rate, defaulter rate, death rate, non-response rate – by target group ➢ % of adult ART and TB-DOTS patients with BMI <18.5 at initiation of food support attaining BMI >18.5 on termination of food support, by target group	Intra-household food sharing of food supplements is limited Health centres are accessible Adequate medical support is available in the form of drugs and trained health personnel for ART, TB-DOTS and other critical illnesses interfering with nutritional well-being	Baseline and end-line nutrition survey, including micronutrient deficiencies Survey of knowledge, attitudes and practices, including dietary patterns of selected target groups

ANNEX II: LOGICAL FRAMEWORK

Results	Performance indicators	Risks, assumptions	Resources required
Outcome 1.2 Increased survival of adults and children with HIV after 6 and 12 months of ART **Outcome 1.3** Improved success of TB treatment for targeted cases	➢ Infant and young child feeding practices: - exclusive breastfeeding - introduction of complementary foods ➢ Household food consumption scores for: - households participating in nutrition education - households caring for ART and TB-DOTS patients receiving food assistance ➢ Proportion of children 6–23 months receiving foods from 4 or more food groups ➢ % of adults and children with HIV known to be on treatment 6 and 12 months after initiation of ART ➢ % of TB cases registered under DOTS programme in a given year who have successfully completed treatment	No critical emergency situation that could influence basic food availability for targeted individuals and households	Programme monitoring, including use of existing health information systems that are to be strengthened as part of this project Programme performance will be compared with international standards and national figures
Output 1.1 Food and/or non-food items distributed in sufficient quantities and quality to targeted beneficiaries	➢ Numbers of supplementary feeding beneficiaries receiving individual supplements: children < 5, pregnant and lactating women, ART/TB-DOTS patients ➢ Numbers of children and women receiving seasonal blanket supplements ➢ Number of children receiving meals through ECCD centres ➢ Number of VHWs receiving food assistance ➢ Number of beneficiaries receiving food assistance through participation in community gardens ➢ Number of beneficiaries receiving food assistance through ART/TB-DOTS support activities Targets: as per beneficiary table, all by category and as % of planned figures ➢ Tonnage of food distributed as % of planned, by food type and by category		Post-distribution monitoring

ANNEX II: LOGICAL FRAMEWORK

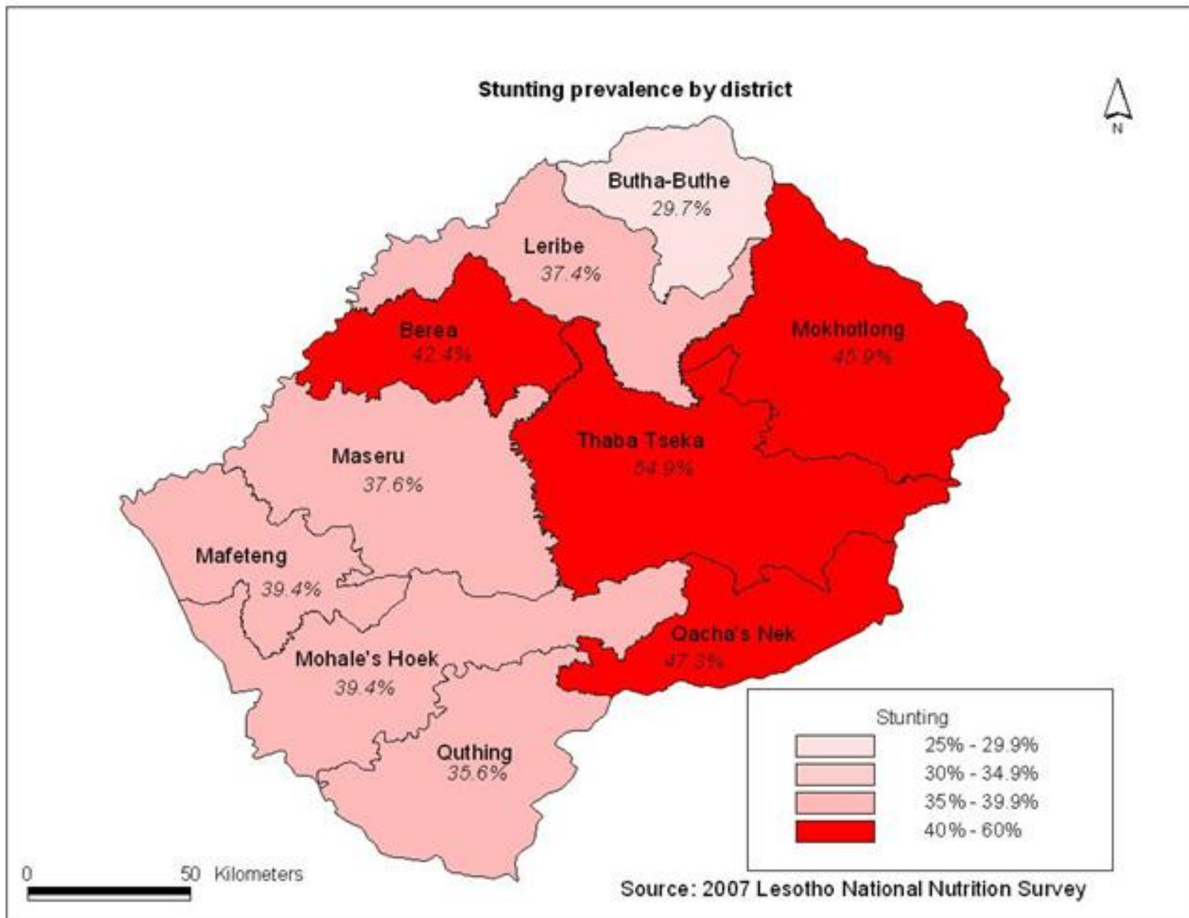
Results	Performance indicators	Risks, assumptions	Resources required
Output 1.2 VHWs trained and supported with tools and materials ***Output 1.3*** Nutrition education activities undertaken ***Output 1.4*** Number of community gardens established	➢ Number of VHWs supported with capacity development Target: 2 800 ➢ Numbers of women, men, girls and boys receiving nutrition education, by category and as % of planned figures Target: To be determined following baseline data collection ➢ Number of community gardens established Target: 5 000 beneficiaries per year		
Strategic Objective 5: Strengthen the capacities of countries to reduce hunger, including through hand-over strategies and local purchase			
DEV objective: To prevent and reduce malnutrition among vulnerable groups in the four districts in Lesotho mostly affected by chronic malnutrition			
Outcome 2.1 Progress made towards nationally owned hunger solutions ***Output 2.1*** Food consumption data available for national decision-making ***Output 2.2*** Private sector and Government technical consultation facilitated ***Output 2.3*** Information management technical assistance provided and guidance papers prepared	➢ National Fortification Policy submitted for Government approval ➢ Nutrition surveillance implementation plan developed and in place on trial basis at selected sites ➢ Clinic-based information routinely utilized at all levels ➢ Number of district consumption surveys conducted Target: 3 ➢ Number of consultation meetings organized with support from technical experts Target: 2 ➢ Number of technical review missions and consultations organized Target: 2	Government structures are ready and committed to initiating and strengthening fortification and surveillance activities	Mid- and end-of-project stock-take with main national counterparts

ANNEX II: LOGICAL FRAMEWORK

Results	Performance indicators	Risks, assumptions	Resources required
Output 2.4 Information management training, tools and materials made available at selected trial sites	➢ Number of sites with adequate capacity to implement surveillance and/or improved information management Target: 20		

ANNEX IV

Map of Lesotho with Project Areas (shaded)



Note: The project targets the four districts showing highest stunting rates.

The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the World Food Programme (WFP) concerning the legal status of any country, territory, city or area or of its frontiers or boundaries.

ACRONYMS USED IN THE DOCUMENT

ART	anti-retroviral therapy
BMI	body mass index
CSB	corn-soya blend
DHS	Demographic and Health Survey
ECCD	early childhood care and development
FMU	Food Management Unit
FNCO	Food and Nutrition Coordination Office
JUNNP	Joint United Nations Nutrition Programme
LVAC	Lesotho Vulnerability Assessment Committee
MDG	Millennium Development Goal
NGO	non-governmental organization
PLHIV and TB	people living with HIV and/or TB
PRRO	protracted relief and recovery operation
TB	tuberculosis
TB-DOTS	directly observed treatment, short-course for TB
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
VHW	village health worker
WHO	World Health Organization