برنامج الأغذية العالمي

Programme Alimentaire Mondial

World Food Programme

Programa Mundial de Alimentos

Executive Board
Second Regular Session

Rome, 8–11 November 2010

PROJECTS FOR EXECUTIVE BOARD APPROVAL

Agenda item 9

For approval

Distribution: GENERAL
WFP/EB.2/2010/9-A/1
27 September 2010
ORIGINAL: ENGLISH

DEVELOPMENT PROJECTS – TAJIKISTAN 200173

Support for Tuberculosis Patients and their Families

Number of beneficiaries	136,000
Duration of project	36 months (1 January 2011–31 December 2013)
Food tonnage	12,483 mt
Cost (United States dollars)	
WFP food cost	4,225,209
Total cost to WFP	7,018,153

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.

Regional Director, ODC*:	Mr D. Belgasmi	tel.: 066513-3561
Liaison Officer, ODC:	Ms M. Jaring	tel.: 066513-2342

Should you have any questions regarding matters of dispatch of documentation for the Executive Board, please contact Ms I. Carpitella, Administrative Assistant, Conference Servicing Unit (tel.: 066513-2645).

* Regional Bureau Cairo (Middle East, Central Asia and Eastern Europe)

EXECUTIVE SUMMARY

Tuberculosis is endemic in Tajikistan, threatening the food security and livelihoods of patients and their families. It is widely recognized as a disease of poverty and is linked to labour migration, from which the remittance income to poor households constitutes half of gross domestic product. WFP support is an effective safety net for patients and families deprived of the income of their main breadwinner. Because WFP's assistance is conditional on adherence to treatment, food is an incentive for patients to complete their treatment and avoid the risk of developing drug-resistant strains of the disease.

WFP's main cooperating partners for tuberculosis assistance are the National Tuberculosis Control Centre, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Health Opportunities for People Everywhere Project. This development project builds on the achievements of a partnership alliance that has since 2007 increased cure rates, reduced death and default rates, slowed the rise of multi-drug-resistant tuberculosis and reduced food insecurity in the households affected.

This project will contribute to the goals of the National Tuberculosis Programme 2010–2015 and is in line with the draft National Health Strategy 2010–2020 and the Stop Tuberculosis Strategy of the World Health Organization. It is also aligned with the National Development Strategy 2007–2015 and the Poverty Reduction Strategy Paper 2010–2012. The project addresses Strategic Objectives 4 and 5[1] and contributes to Millennium Development Goals 1 and 6;[2] it also supports the fourth pillar of the United Nations Development Assistance Framework 2010–2015 for improved access to quality basic services for the vulnerable.

DRAFT DECISION*

The Board approves the proposed development project Tajikistan 200173 "Support for Tuberculosis Patients and their Families" (WFP/EB.2/2010/9-A/1) subject to availability of resources.

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

[2] Millennium Development Goal 1 – Eradicate extreme hunger and poverty; Millennium Development Goal 6 – Combat HIV/AIDS, malaria and other diseases

* 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. Tajikistan is a landlocked, low-income food-deficit country with a population of 7.3 million. Per capita gross domestic product (GDP) is US$1,753 – the lowest in Central Asia and Eastern Europe.[3] Only 7 percent of the land is arable. On independence in 1992 from the former Soviet Union, a five-year civil war caused widespread damage to infrastructure and the loss of an estimated 50,000 lives.

2. Tajikistan faces challenges arising from its geography, history, institutional weakness and the global economic crisis. Economic growth between 2000 and 2008 averaged 8 percent per year, but it fell to 3.4 percent in 2009 as a result of severe weather and energy shortages during the preceding winter and the international food and financial crises.[4] Tajikistan ranks 127th of 182 countries in the 2009 human development index.[3]

3. Tajikistan remains the poorest country of the Commonwealth of Independent States (CIS) and is among the most fragile of the former Soviet republics. Social indicators have improved in recent years, but they remain low as a result of poor public services, persistent energy shortages and low per-capita incomes. Tajikistan is the only country in Central Asia unlikely to achieve most of its Millennium Development Goals (MDGs).[5]

4. Remittances from the 1.5 million labour migrants, mostly in Russia, are one of the most important sectors in the economy: they accounted for 50 percent of GDP in 2008 and served as a safety net for many families. In 2008, the average annual remittance per person was US$251, compared with US$114 for central and eastern Europe and the CIS.[6] With the recent economic slowdown, remittance earnings in 2009 were US$1.7 billion, a fall of 33 percent from the record US$2.7 billion in 2008.[7]

5. The poverty rate has declined steadily over the last decade, but it is still high. The last World Bank poverty survey in 2007 indicated that 41 percent of the population were living below the poverty line of US$41 per month and 17 percent were below the extreme poverty line of US$26 per month. This is, however, a significant improvement from the 64 percent living below the poverty line in 2003 and the 83 percent who were doing so in 1999.[6]

6. Public healthcare in Tajikistan has deteriorated since 1990, when it was relatively well funded at 6 percent of GDP, but it has remained below 2 percent since 1995; it accounted for 1.9 percent of GDP in 2009. By the end of 2004 annual per capita spending on healthcare was less than US$2 – 6.5 percent of the national budget; in 2010 it stands at 6 percent. The country has the lowest number of medical professionals per capita, who are also the lowest paid in the CIS.[8]

[3] UNDP. 2009. *Human Development Report, Statistical Update 2008/2009*. Available at: http://hdrstats.undp.org

[4] The Economist Intelligence Unit. 2010. *Tajikistan Country Report*. London.

[5] UNDP. 2009. *Accelerating MDG Attainment*. New York. Only MDGs 1 and 2 are likely to be achieved by 2015.

[6] World Bank. 2007. *Tajikistan Living Standards Survey*. Washington DC.

[7] International Monetary Fund and National Bank of Tajikistan monthly monitoring of remittances.

[8] WHO/UNDP. 2009. *Review of Tuberculosis Control in Tajikistan*. Geneva.

7. Tuberculosis (TB) incidence in Tajikistan is 231/1,000, the highest in the World Health Organization (WHO) European region;[9] it causes severe economic loss, as in other parts of Central Asia. The TB-related burden of illness and death is especially high in food-insecure rural areas of Tajikistan. TB patients are usually male migrants from poor food-insecure families who migrate to Russia or Kazakhstan to work; they usually live in substandard conditions and are often the sole household breadwinners. Those who are given a positive diagnosis of TB leave their jobs and return home or are deported by the host country. This results in a triple impact on the households: i) loss of the main income source; ii) increased health expenses; and iii) the risk of spreading the disease to family members.

8. Multi-drug-resistant TB (MDR-TB) and extensively drug-resistant TB constitute a major challenge for TB control. When patients interrupt their drug treatment because they lose motivation or return to a host country to work, they develop the drug-resistant strain of TB and the cure becomes much more difficult. The mortality rate for MDR-TB is 80 percent, compared with 5 percent for regular TB when treated. Treatment lasts at least 18 months rather than six months, and the medical cost is dramatically higher: a full course of treatment for a regular TB patient costs between US$10 and US$15, whereas MDR-TB treatment costs US$4,000.[10]

9. Of the 27 countries with the highest MDR-TB rates 14 are former Soviet Republics, of which Tajikistan ranks fifth with a 23 percent MDR-TB rate among all TB cases. In its first survey of Tajikistan, WHO found an MDR-TB rate of 17.4 percent among new TB cases and 67.2 percent among previously treated TB patients in Dushanbe city and Rudaki district. The latter rate is a third higher than the 41 percent in 2006, and is the highest rate ever reported among previously treated TB patients in any sub-national area in the world.[11]

Poverty, Food and Nutrition Security

10. Approximately 74 percent of the population live in rural areas and 26 percent in towns; 75 percent of the poor and 72 percent of the extremely poor live in rural areas and are vulnerable to climate and price shocks.[6] Despite a record cereal harvest in 2009 as a result of good rainfall and agricultural reforms, Tajikistan depends on food imports to meet 40 percent[12] of its needs. WFP market monitoring shows that food prices are higher than they were in 2007 before the food price crisis; the prices of bread and cooking oil doubled in 2008 and remain high. Tajikistan depends on international aid to sustain its food supply.

11. Two-thirds of the rural population depend on markets for their food needs. Food-insecure populations spend 70 percent of their incomes on food; the poorest families routinely incur debt to buy food, and their diet is poor in vegetables, proteins and micronutrients.[13]

12. A 2008 joint food security and nutrition assessment by WFP, the Food and Agriculture Organization of the United Nations (FAO), the United Nations Children's Fund (UNICEF)

[9] WHO. 2007 *Tajikistan TB profile*. Geneva Available at: http://apps.who.int/globalatlas/predefinedReports/TB/PDF_Files/tjk.pdf

The WHO Regional Office for Europe covers western and eastern Europe, the CIS, the Balkans, the Caucasus, Israel and Turkey.

[10] WHO/UNDP. 2009. *Review of Tuberculosis Control in Tajikistan*. Copenhagen.

[11] All statistics from WHO. 2009. *Global Tuberculosis Control: a Short Update to the 2009 Report*. Geneva.

[12] FAO crop and food security assessment, October 2009, p. 26. Available at: http://documents.wfp.org/stellent/groups/public/documents/ena/wfp220375.pdf

[13] Tajikistan Food Security Monitoring System. WFP internal document.

and the Government showed that 1.7 million people in rural areas were food-insecure,[14] of whom 540,000 were severely food-insecure; 1.16 million people were moderately food-insecure, accounting for 23 percent of rural households. In towns, 500,000 people were identified as food-insecure, of whom 15 percent were severely food-insecure and 22 percent moderately food-insecure.

13. The food security monitoring system results of April 2010 show that food insecurity affects 1 million people in rural Tajikistan – 35 percent of the rural population.[15] A comparison of food security monitoring data with information from WFP's post-distribution monitoring of the TB project shows that food-insecure and TB-affected households share the same characteristics: low income, few assets such as livestock or land, and high vulnerability to shocks. Khatlon and Sughd regions, which have the highest population densities and numbers of TB patients, are also the poorest and most food-insecure areas of the country.

14. The incidence of TB in some districts of Khatlon region is two to three times higher than the national average; mortality rates are two to five times higher. In 2008, 25 percent of new TB cases registered were from this region.[16] TB patients are among the lowest income-earners in the country: they do not own assets such as livestock or land and live mainly in disaster-prone and food-insecure areas.[17]

15. The nutritional status of children under 5 has not improved since the last nationwide survey in 2005. Global acute malnutrition is estimated at 5 percent to 7 percent; chronic malnutrition is between 27 percent and 39 percent.[18] The main causes of malnutrition are lack of money to buy food, poor dietary diversity, inadequate feeding practices and lack of clean water and hygiene. Tajikistan has one of the highest infant mortality rates in the CIS at 46/1,000 live births,[6] twice the CIS average.

Government Policies and Programmes

16. The National TB Programme (2003–2010), which was based on directly observed treatment with short-course chemotherapy (DOTS) and supported by the Government and international partners, has been succeeded by the National TB Control Programme 2010–2015, which provides a framework for implementation of TB activities on the basis of the WHO Stop TB Strategy. The programme was jointly developed by the United Nations Development Programme (UNDP), WHO and the Ministry of Health, with financial support from the Global Fund.

17. Some of the challenges to be addressed by the National TB Control Programme 2010–2015 are TB-HIV co-infection control, MDR-TB management and TB control in prisons. The objectives are: i) to ensure access for all TB patients to effective diagnosis, treatment and recovery; and ii) to prevent the spread of TB infection and disease.

18. Because migrant workers are particularly susceptible to TB, the programme emphasizes the development and implementation of measures to improve access to TB services in

[14] WFP, FAO, UNICEF, Government of Tajikistan. 2008. *A Joint Emergency Food Security, Livelihoods, Agriculture and Nutrition Assessment, April –May 2008*. Rome.

[15] WFP, FAO, UNICEF, Government of Tajikistan. 2010. *A Joint Emergency Food Security, Livelihoods, Agriculture and Nutrition Assessment, April 2010*. Rome.

[16] WHO. 2009. *National Programme for Population Protection against Tuberculosis*. Dushanbe.

[17] WFP post-distribution monitoring of TB activities, 2008–2010.

[18] WFP, FAO, UNICEF, Government of Tajikistan. 2008. *A Joint Emergency Food Security, Livelihoods, Agriculture and Nutrition Assessment, April–May 2008*. Rome; WFP/WHO. 2009. Tajikistan Food Security and Nutrition Monitoring System. Rome. UNICEF. 2009. *The State of the World's Children*. New York.

Tajikistan and host countries, with reference to measures to improve the socio-economic conditions of patients and reduce the burden of the disease among vulnerable population groups.

PAST COOPERATION AND LESSONS LEARNED

19. WFP began working in Tajikistan in 1993 after the outbreak of civil conflict in response to the needs of people displaced by violence, since when it has provided food assistance for 5 million beneficiaries. WFP began to support TB patients and their families in 2003, opening two TB centres serving 1,000 beneficiaries; by 2007 there were 11 centres serving 8,300 beneficiaries.

20. Recognizing WFP's experience in supporting TB activities and its wide rural distribution network, the Ministry of Health National Coordination Committee on Prevention and Combating HIV/AIDS, Tuberculosis and Malaria asked the Global Fund to provide financial support to WFP. Since 2007, the Global Fund has allocated US$1.2 million to WFP through UNDP, enabling it to expand food assistance for TB patients to all 64 districts in the country. In 2010, WFP was providing food assistance to an average of 20,000 patients and family members each month under protracted relief and recovery operation 106030.

21. A number of reports attest the value of incentives to ensure that TB patients adhere to treatment. The provision of food is particularly important because TB is linked to poverty and malnutrition: a malnourished person with a weak immune system is predisposed to developing TB and other infectious diseases, and TB leads to malnutrition.[19] Incentives to increase adherence to DOTS has increased markedly since the days of the Soviet republics with their high MDR-TB rates and impersonal, regimented healthcare.

22. Data collected through the National Tuberculosis Centre (NTC) in 2007, which was disseminated in 2009, show that treatment success for TB patients receiving WFP food assistance was 89 percent compared with 77.6 percent for those not receiving it; 14.5 percent of patients without food support failed to complete treatment, whereas among those receiving a food incentive the failure rate was only 2.8 percent.

23. WFP's main cooperating partner since 2003, the Health Opportunities for People Everywhere Project (Project HOPE), conducted a case study in March 2005 in two districts, which found that "… a food supplement incentive programme can substantially increase TB treatment completion and cure rates among poor and vulnerable TB patients."[20] The cure rate in the two districts was reported to be 25 percent higher for patients who received food rations; the treatment completion rate was 40 percent higher.

24. In an evaluation of the early partnership between WFP and Project HOPE, WHO found that "… the results were highly positive, raising the question of whether in the future to supply all impoverished TB patients and their families with food assistance."[20] In its 2009 evaluation, WHO observed: "Temporary food assistance is an important factor in adherence, family support and positive outcomes, and should be a part of TB care."[21]

[19] Cegielski, J.P. and McMurray, D.N. 2004. The relationship between malnutrition and tuberculosis: evidence from studies in humans and experimental animals. *The Int. Jour. of Tuberculosis and Lung Disease* 8(3): 286–298.

[20] Project HOPE. 2005. *Using Incentives to Improve Tuberculosis Treatment Results: Lessons from Tajikistan*. Washington DC, CORE Group. Available at: http://www.coregroup.org/storage/documents/Workingpapers/Proj_Hope_Tajikistan_TB_case_study.pdf

[21] WHO/UNDP Review of Tuberculosis Control in the Republic of Tajikistan, 2009.

PROJECT STRATEGY

25. WFP's support under development project (DEV) 200173 will be provided for all TB patients registered in the DOTS programme in all 64 districts of the country: 136,000 recipients will receive food support during the three years, an average of 25,000 per month; 40 percent of the beneficiaries are expected to be in Khatlon region, which has the highest population density and some of the worst food security indicators and TB rates. DEV 200173 aims to stem the alarming growth of MDR-TB: its intended outcomes are: i) achievement of higher completion and success rates for TB treatment; and ii) provision of an effective safety net for patients' families during treatment.

26. The outputs of the project include: i) a six-month food ration for 45,200 TB patients; and ii) a six month food ration for 90,600 family members.[22]

TABLE 1: NUMBER OF BENEFICIARIES

Beneficiaries	Men	Women	Total
TB patients	29 000	16 200	**45 200**
Family members	39 000	51 600	**90 600**
TOTAL	**68 000**	**67 800**	**135 800**

27. The TB programme will be implemented in coordination with NTC, the Global Fund and Project HOPE. Under its agreement with the Global Fund, WFP provides food for six months for all TB patients registered for DOTS. For the first two months, when they are in-patients in a health institution, they receive hot meals. On release to complete treatment from home, they receive a take-home ration for an additional four months until the end of treatment; the families of TB patients will receive WFP support as a safety net for the same period to compensate for the loss of income. If a patient drops out of treatment, however, family assistance is stopped: this condition increases the patient's motivation to complete treatment.

28. Experience from WFP's TB food support to date shows that the current food basket of fortified wheat flour, enriched vegetable oil, pulses and salt is accepted by the beneficiaries.

TABLE 2: FOOD RATIONS (*g/person/day*)

Number of feeding days/year	Wheat flour	Pulses	Veg. oil	Salt	Total	kcal/day	% kcal from protein	% kcal from fat
180	400	40	15	5	460	1 669	13.1	11.6

29. Total food requirements amount to 12,483 mt, as shown in Table 3.

[22] WFP will support on average two family members for each TB patient.

TABLE 3: TOTAL FOOD REQUIREMENTS (*mt*)					
Beneficiaries	**Wheat Flour**	**Pulses**	**Veg. Oil**	**Salt**	**Total**
TB patients	3 700	362	136	45	**4 243**
Family members	7 150	724	273	93	**8 240**
TOTAL	**10 850**	**1 086**	**409**	**138**	**12 483**

30. The partners contributing to the national TB control programme and the health sector include the Global Fund, WHO, UNDP, the United States Agency for International Development, Project HOPE, Caritas, the International Federation of Red Cross and Red Crescent Societies and *Kreditanstalt für Wiederaufbau* (German Credit Institution for Reconstruction). They provide financial, policy and technical assistance and contribute drugs and medical supplies; they are also involved in advocacy, reconstruction of health infrastructure, social mobilization and research.

31. WFP's Gender Policy[23] will be integrated into the implementation, management and evaluation of the TB programme through a focus on the role of women heads of household receiving family rations. The fact that 36 percent of the TB patients are women puts severe strain on households, particularly when they are in-patients. WFP plans to partner with UNDP on an income-generation project to help women who have recovered from TB to access a micro-finance project to start small businesses.

32. In collaboration with Project HOPE, WFP will explore the feasibility of a cash/voucher pilot project and will undertake a market analysis in towns and rural areas. Following a 2008 study of the comparative advantages of cash transfers,[24] WFP is consulting the Global Fund, the Government, donors, banks and non-governmental organizations that have carried out cash transfers in Tajikistan. If cash transfers and voucher programmes are found to be appropriate, WFP will consider introducing a cash/voucher pilot supporting TB patients and their families through a budget revision to DEV 200173.

33. WFP and its partners will develop advocacy to raise awareness of the need to reduce the incidence of TB in Tajikistan and of the role of food and cash support in TB treatment. As the prime advocate for food or cash support, WFP will raise awareness among its partners, particularly the Ministry of Health, of the need to sustain the delivery of food and cash or vouchers to TB patients and their families, complementing its support for gradual assumption by the Government of responsibility for TB treatment. Local authorities are under a presidential order to increase their part in TB treatment and prepare for hand-over. This document will be a basis for consultations between WFP, the Government and partners with regard to a future hand-over. In view of the vulnerability of TB patients and their families, it will be necessary to continue with incentives under a future social-protection programme to ensure the success of the TB control programme.

MANAGEMENT, MONITORING AND EVALUATION

34. WFP will procure food locally, particularly iodized salt, which is readily available. Most of the other items in the food basket will be imported from the region, mainly from the Russian Federation and Kazakhstan. Food arrives in Tajikistan by rail through Uzbekistan

[23] WFP/EB.1/2009/5-A/Rev.1.

[24] WFP. 2008. *Assessment of the Feasibility of Cash/Voucher Options*. Available at: http://home.wfp.org/stellent/groups/public/documents/ena/wfp196791.pdf

at Dushanbe, Kurgan-Tyube in the south and Khujand in the north. WFP maintains sufficient warehouse capacity in these locations and maintains a 100 mt warehouse in the eastern town of Khorog in Gorno-Badakshan autonomous *oblast* (province), the most remote and inaccessible operational area.

35. WFP is responsible for the delivery of food from its regional warehouses to hospitals and TB centres; NTC and Project HOPE are responsible for storing, handling and distributing food in their areas. Distributions take place every two months, three times in each treatment period. NTC covers the costs of medical staff and provision of complementary food for cooked meals for patients in hospital for the whole country. WFP will undertake regular monitoring and reporting and engage with NTC in training food monitors.

36. The NTC registers TB patients and administers their DOTS along with, in most cases, the first two months of in-patient care. All patients who register receive treatment free. NTC will manage the lists of patients who register for DOTS and will monitor food distributions to in-patients, out-patients and family members.

37. Project HOPE, WFP's cooperating partner in 11 districts, will manage the lists of TB patients who register for DOTS in these districts. Project HOPE trains and oversees medical staff in TB clinics in medication and healthcare follow-up. Project HOPE and NTC will monitor treatment adherence and outcomes in their districts. WFP and NTC will monitor food distributions.

38. The Global Fund – the main donor for NTC, Project HOPE and WFP – is expected to provide WFP with the required funding for all TB patients through UNDP; this accounts for a third of total requirements. To secure resources to support family members, WFP will engage donors who have previously funded its work in Tajikistan and donors from emerging economies that have a strategic interest in Central Asia.

39. In 2013, WFP will undertake a self-evaluation of its TB activities in Tajikistan. Should a cash/voucher component have been introduced by then, the evaluation will include a review of the comparative advantages of cash and vouchers over food transfers.

ANNEX I

PROJECT COST BREAKDOWN			
Food[1]	**Quantity** ***(mt)***	**Value** ***(US$)***	**Value** ***(US$)***
Cereals	10 850	3 202 766	
Pulses	1 086	449 043	
Oil and fats	409	560 718	
Salt	138	12 682	
Total food	**12 483**	**4 225 209**	4 225 209
External transport			167 353
Landside transport, storage and handling			1 560 875
Other direct operational costs			80 870
Direct support costs			524 715
Total WFP direct costs			**6 559 021**
Indirect support costs (7.0 percent) [2]			459 131
TOTAL WFP COSTS			**7 018 153**

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

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

ANNEX II: LOGICAL FRAMEWORK

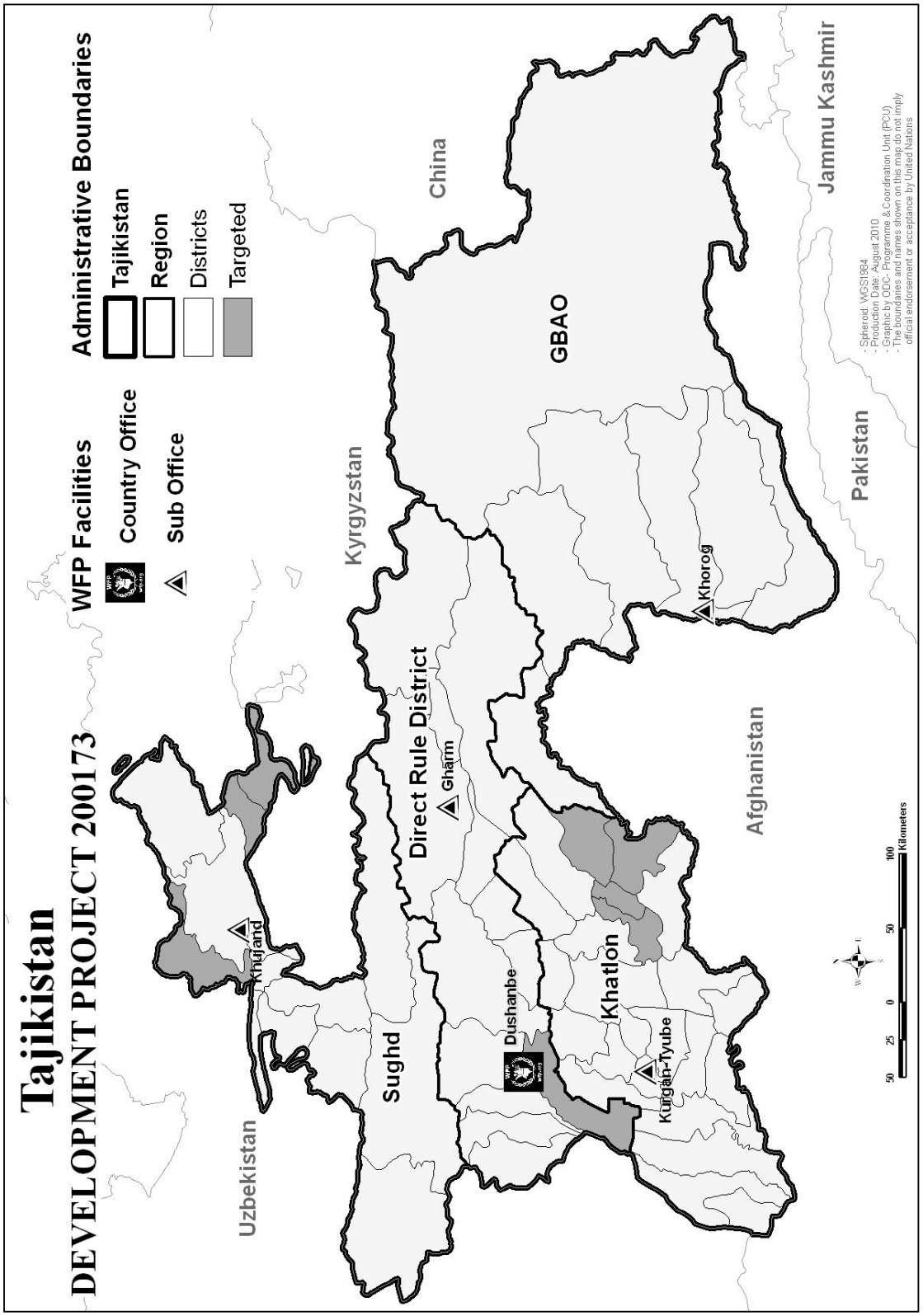
Results	Performance indicators	Risks, assumptions
UNDAF Outcome: Pillar 4, Outcome 3: There is greater access for the most vulnerable to quality healthcare services, and improved health behaviours to improve and reduce communicable diseases	Outcome indicator: ➢ Proportion of TB cases detected and cured Baseline: 40.5% Target: 86.0% Output indicator: ➢ Number of TB patients who received incentives	Assumptions: Continued cooperation and input from Ministry of Health and the Committee on Emergency Situations at the national level Continuous financial support for health sector from the Government Risks: No unexpected crises exacerbating already poor and fragile health indicators No major deterioration of socio-economic indicators as a result of external financial shocks
Strategic Objective 4: Reduce chronic hunger and undernutrition		
Outcome 4.1 Adequate food consumption over assistance period for targeted households	➢ Household food consumption score	Project funding requirements met Security conditions in place and adequate to reach the targeted beneficiaries
Outcome 4.2 Improved success of TB treatment for targeted cases	➢ TB treatment success rate ➢ % of TB patients registered under DOTS in a given year who have successfully completed treatment	Continued support for the health sector
Outcome 4.3 Reduced default rate among TB DOTS patients	➢ TB treatment default rate	

ANNEX II: LOGICAL FRAMEWORK

Results	Performance indicators	Risks, assumptions
Output 4.1 Food and non-food items distributed in sufficient quantity and quality to targeted women, men, girls and boys under secure conditions	➢ Number of women, men, girls and boys receiving food, including fortified, complementary and special nutritional products, and non-food items, by type and as % of planned Target: 100% of planned and actual distribution. ➢ Tonnage of food distributed, by type, as % of planned, by quantity, quality and timeliness Target: 100 percent of planned	Project funding requirements are met Access to beneficiaries is possible Technical partners are available Natural disasters and extreme weather Government continues to give health sector high priority in budget
Strategic Objective 5: Strengthen the capacities of countries to reduce hunger, including through hand-over strategies and local purchase		
Outcome 5.1 Progress made towards nationally owned hunger solutions	➢ Annual meeting with the Government and main partners on developing a hand-over strategy Target: One annual consultation	Adequate resources (funding and staff) to carry out activity Interest and participation of stakeholders
Output 5.1 Agreed hand-over strategies in place	➢ Number of government staff trained in implementation of safety net for TB programmes Target: Five government staff trained per year	Ministry officials and partners remain in position Project funding requirements are met Government budget for TB programme implementation and monitoring is available Technical partners are available Government continues to give social sector high priority in budget
Output 5.2 Strengthen the capacities of countries to design, manage and implement tools, policies and programmes to predict and reduce hunger	➢ Increased number of government staff trained in TB food monitoring	

ANNEX II: LOGICAL FRAMEWORK		
Results	**Performance indicators**	**Risks, assumptions**
Output 5.3 Food purchased locally	➢ Increased and cost-effective WFP local purchases. Target: One market assessment by the end of 2011 ➢ Food purchased locally, as % of total food purchased Target: 5%	Limited resources for local procurement Market conditions do not allow local purchases

ANNEX III



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

CIS	Commonwealth of Independent States
DEV	development project
DOTS	directly observed treatment, short-course
FAO	Food and Agriculture Organization of the United Nations
GDP	gross domestic product
MDG	Millennium Development Goal
MDR-TB	multi-drug-resistant tuberculosis
NTC	National Tuberculosis Centre
Project HOPE	Health Opportunities for People Everywhere Project
TB	tuberculosis
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization