Fighting Hunger Worldwide

WFP World Food Programme wfp.org

# Standard Project Report 2015

## World Food Programme in Swaziland, Kingdom of (SZ)

### Food by Prescription

**Reporting period: 1 January - 31 December 2015**

| Project Information | |
|---|---|
| Project Number | 200353 |
| Project Category | Development Project |
| Overall Planned Beneficiaries | 174,651 |
| Planned Beneficiaries in 2015 | 39,341 |
| Total Beneficiaries in 2015 | 28,278 |

| Key Project Dates | |
|---|---|
| Project Approval Date | February 17, 2012 |
| Planned Start Date | January 01, 2012 |
| Actual Start Date | January 01, 2012 |
| Project End Date | June 30, 2016 |
| Financial Closure Date | N/A |

| Approved budget in USD | |
|---|---|
| Food and Related Costs | 5,846,785 |
| Capacity Dev.t and Augmentation | 263,932 |
| Direct Support Costs | 2,561,611 |
| Cash-Based Transfers and Related Costs | N/A |
| Indirect Support Costs | 607,064 |
| **Total** | **9,279,392** |

| Commodities | Metric Tonnes |
|---|---|
| Planned Commodities in 2015 | 2,098 |
| Actual Commodities 2015 | 848 |
| Total Approved Commodities | 9,312 |

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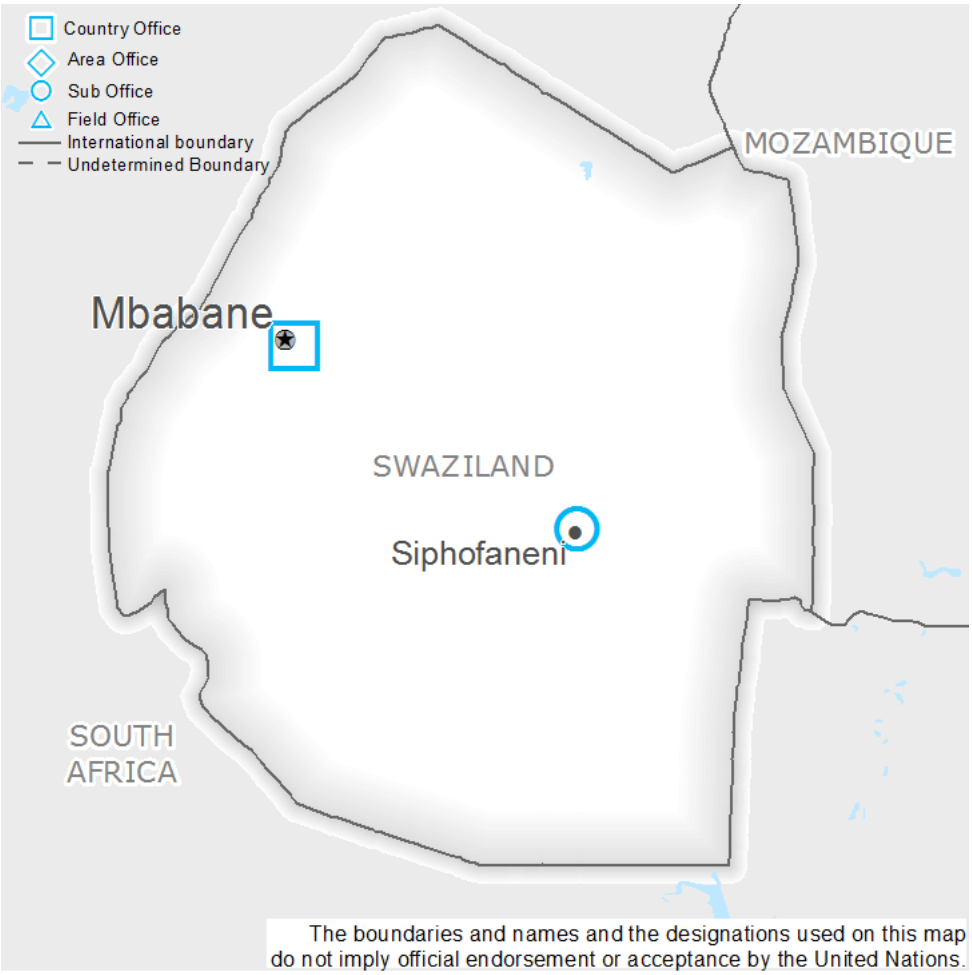
# COUNTRY OVERVIEW




## Country Background

The Kingdom of Swaziland has a population of 1.1 million people and ranks 150 out of 188 in the 2015 Human Development Index. While Swaziland is a lower middle income country, 63 percent of Swazis live below the national poverty line (less than USD 1.25 per day). Swaziland faces significant development challenges including high income inequality, high unemployment and the impact of HIV and AIDS.

Swaziland has a very high HIV prevalence: 26 percent of the population between the ages of 15-49 and 41 percent of pregnant women receiving antenatal care live with HIV. Life expectancy is 49 years and 45 percent of children are orphaned or vulnerable. The country has made significant progress to achieve Millennium Development Goal (MDG) 6 to combat HIV/AIDS, malaria and other diseases by 2015.

Swaziland is ranked 115 out of 187 countries in the Gender Inequality Index. Factors contributing to increased vulnerability among women and girls include weak legislation; poor access to income generating opportunities and social services; and gender-based violence. Swaziland is on track to reach MDG 2, to achieve universal primary education, and MDG 3, to promote gender equality.

Chronic malnutrition is a concern in Swaziland: Stunting affected 25.5 percent of children under five years in 2014, a decline from 31 percent in 2010. Factors associated with stunting in Swaziland include poor infant feeding practices, low birth weight, poor levels of postnatal care, HIV/AIDS, poor access to sanitation, and maternal education. Among children under 5 years, 2 percent were wasted and 6 percent were underweight in 2014. The Cost of Hunger in Swaziland report found that 3 percent of Gross Domestic Product (GDP) is lost annually to child malnutrition. Swaziland is partially on track to achieve MDG 1, but targets to reduce poverty and achieve decent work for all are

unlikely to be fully met.

Swaziland is vulnerable to drought in the south-eastern part of the country. The 2015 spike in food insecurity disrupted five consecutive years of declining rates of food insecurity. An estimated 23.5 percent of Swazis are moderately to severely food insecure as of the early lean season in 2015, and food insecurity is expected to worsen as lean season progresses. Chronic food production deficits and rising food prices have serious implications for food access, particularly among the 77 percent of Swazis who rely on subsistence farming for their livelihoods.

Constrained economic growth is expected to hinder implementation of social policies benefiting vulnerable Swazis in years of increased need. GDP growth stood at an estimated 2.5 percent in 2014, significantly below the targeted 5 percent annual average growth rate. From 2015, a decline in Southern Africa Customs Union (SACU) revenue, and forecasted suboptimal performance in the agriculture sector are expected to constrain government finances.

# Summary Of WFP Assistance

WFP assistance aims to improve food and nutrition security and the livelihoods of the most vulnerable households impacted by poverty and HIV/AIDS. From 2016, WFP will introduce a new Country Strategy with the objective to gradually handover food and nutrition initiatives to the Government of Swaziland. To achieve this, WFP will transition from a partner supporting direct implementation to a strengthened advocacy and advisory role.

In 2015, WFP implemented three Development Projects (DEVs) targeting the most vulnerable Swazis: orphans and vulnerable children (OVC) and malnourished people living with HIV and tuberculosis (TB). The projects together reached 102,598 beneficiaries. In addition, WFP enhanced the government's capacity to manage food and nutrition security interventions, including food security monitoring and emergency preparedness and response.

DEV 200422 provided support to OVC aged two to eight years attending community-run child care centres called neighbourhood care points (NCPs). DEV 200508 augmented DEV 200422 by providing food assistance to caregivers of OVC at NCPs, who prepared meals and provided complementary services for OVC.

WFP, under DEV 200353 and in partnership with the Ministry of Health, assisted people living with HIV and TB to improve treatment adherence and health outcomes by providing nutrition assessments with care and support services.

WFP's main achievements in 2015 demonstrated readiness to support full transition of food and nutrition security interventions to the government. WFP provided food assistance to young OVC while partnering with UN agencies to provide technical assistance toward strengthening the national social protection system to absorb OVC as a vulnerable population and to advocate for nutrition-sensitivity in safety nets.

As the multilateral convener of the Scaling Up Nutrition (SUN) Movement, WFP acted as a leading partner in developing the capacity of government to address childhood undernutrition. The prevention of stunting became a key priority in the national development agenda in part thanks to WFP advocacy. WFP supported the development of the National Nutrition Policy and national Stunting Action Plan that will lay out concrete actions to strengthen the multi-sectoral approach for mother and child nutrition.

These activities contributed to progress toward Millennium Development Goals 1, 2, 3 and 6. WFP activities supported the priorities of the Government of Swaziland, through the Poverty Reduction Strategy and Action Programme, and aligned with the United Nations Development Assistance Framework (UNDAF) for 2011-2015.

| Beneficiaries | Male | Female | Total |
|---|---|---|---|
| Children (under 5 years) | 28,000 | 29,345 | 57,345 |
| Children (5-18 years) | 12,969 | 14,072 | 27,041 |
| Adults (18 years plus) | 8,547 | 9,665 | 18,212 |
| **Total number of beneficiaries in 2015** | **49,516** | **53,082** | **102,598** |

| Distribution (mt) | | | | | | |
|---|---|---|---|---|---|---|
| **Project Type** | **Cereals** | **Oil** | **Pulses** | **Mix** | **Other** | **Total** |
| Development Project | 1,771 | 85 | 301 | 774 | 0 | 2,931 |

| Distribution (mt) | | | | | | |
|---|---|---|---|---|---|---|
| **Project Type** | **Cereals** | **Oil** | **Pulses** | **Mix** | **Other** | **Total** |
| **Total Food Distributed in 2015** | **1,771** | **85** | **301** | **774** | **0** | **2,931** |

# OPERATIONAL SPR

## Operational Objectives and Relevance

Swaziland has a very high HIV prevalence, with 26.5 percent adults aged 15-49 and 38 percent women of child-bearing age infected with HIV. The tuberculosis (TB) and HIV co-infection rate among new TB cases is above 80 percent. According to the Swaziland National Nutrition Council (SNNC), acutely malnourished HIV and TB clients are particularly vulnerable to poor adherence to treatment, which is associated with poor outcomes such as drug resistance and increased mortality in the first three months of treatment.

Under the leadership of the Ministry of Health (MoH) and overall coordination of the Swaziland National Nutrition Council, the objective of this development project is to improve treatment outcomes of malnourished clients on antiretroviral therapy (ART) and TB treatment. The expected outcomes of the development programme are related to reduced undernutrition by improving nutritional recovery of these clients and improved adherence to ART and TB treatment.

These goals align with WFP Strategic Objective 4, to reduce undernutrition and break the intergenerational cycle of hunger. The project supports the implementation of the government's National Comprehensive Package of HIV Care and Treatment and align to the national Strategic Framework for HIV and AIDS (eNSF) 2014-2018. It contributes to the UNDAF (2011 – 2015) and the Joint United Nations Programme of Support for HIV and AIDS (JUNPS) as well as the achievement of Millennium Development Goal 6 and the goals of the Zero Hunger Challenge.

To accelerate Swaziland's progress in addressing child undernutrition, WFP Swaziland has committed to build political and technical capacity in the Government of Swaziland to prevent stunting in a high HIV prevalence context. Under this project, WFP assists the SNNC to undertake formative research into priority interventions for stunting prevention in Swaziland, and to develop a comprehensive Stunting Action Plan to contribute to the goal to reduce stunting prevalence in the National Health Sector Strategic Plan (2014-2018).

## Results

### *Beneficiaries, Targeting and Distribution*

In 2015 WFP provided malnourished clients on ART, TB treatment, and pregnant and lactating women, including those accessing services for the prevention of mother-to-child transmission (PMTCT) of HIV, with a monthly ration of nutrient-fortified Super Cereal. The supplementary feeding aimed to support patients to recover from moderate acute malnutrition (MAM), leading to improved treatment outcomes and access to treatment. The programme also supported the families of clients with a monthly ration of cereals, pulses and vegetable oil. This household ration supported them to cope with the costs of care, and prevented sharing of the client's ration, thus increasing the likelihood of the client's nutritional recovery. The household rations had the added benefit of mitigating the impact of HIV and AIDS on affected households. This is recognized by the extended National Strategic Framework of 2014-19 and the Joint UN Programme of Support on HIV and AIDS.

WFP, together with the Ministry of Health, implemented the Food by Prescription (FBP) programme in 12 main health facilities across the country. In 2014, an assessment of the decentralization of nutrition services showed that the 12 main health facilities extend services to approximately 80 percent of the smaller health facilities, or 'satellite' clinics, in their catchment areas.

Nutrition assessments, education and counselling were included in routine clinical consultations at the health facilities for all clients on ART and TB treatment, and pregnant and lactating women. Clients were targeted for food assistance based on their nutritional status, which doctors or nurses measured using body mass index (BMI) of less than 18.5, mid-upper arm circumference (MUAC) of less than 23cm, or 5 percent weight loss in a month. Based on referrals from a clinician, malnourished clients then received food from WFP dispensaries at the health facilities.

Adult clients received an individual ration of 10 kg Super Cereal and a household ration of 36 kg cereals, 5 kg pulses, and 2.5 kg vegetable oil on a monthly basis. Clients and their families were discharged from the programme when the client reached healthy nutrition status and was able to maintain it for two consecutive months. The expected nutritional recovery time for adults is six months, based on national programme guidelines.

In 2015, WFP reached 28,278 beneficiaries, or 72 percent of the planned target, including malnourished clients and their family members. The overall number of people reached is consistent with previous years. Due to extremely limited resources for the project, WFP distributed 40 percent of the planned food. To mitigate the impact of the funding shortfalls on clients' nutritional recovery, WFP reduced and then stopped distributing the household ration, but continued the individual client ration of SuperCereal to maintain supplementary feeding.

Data on new client enrolment in the programme indicate that in October to December 2015, the average number of new patients decreased by about 30 percent compared to previous months of the year. This decline in new enrolments coincided with the halt of the household ration, and a time of increased food insecurity related to the effects of the El Nino phenomenon (drought) and increases in food prices. Combined, these factors could mean clients' access to care becomes compromised.

WFP is in the process of conducting a malnutrition prevalence survey to assess the number of eligible clients in light of changes to the eligibility guidelines for antiretroviral therapy (ART) rolled-out by the Ministry of Health in 2015. Should the results, expected in 2016, indicate changes in the population of malnourished patients, WFP and government will adjust the project plans accordingly. Programme coverage may be lower than expected because clinic staff have not had resources to expand FBP services in pace with the expansion of HIV care and treatment services in satellite clinics. WFP capacity development efforts, to be discussed in later sections of this report, aim to further integrate FBP services into HIV and TB treatment expansions. Bringing services closer to vulnerable people through decentralization important because it can address barriers to accessing treatment such as transport costs, which are becoming increasingly challenging for families who are struggling to cope with the economic hardship brought by the drought.

In addition to adult TB and HIV clients, the programme also provided nutritious rations children and adolescents aged 6 months to 18 years. Many of these children are HIV positive or exposed to HIV. After children finished treatment through the government-run Integrated Management of Acute Malnutrition (IMAM) programme in health facilities and recovered fully, they were discharged and referred to the FBP programme to receive a monthly ration of 10 kg of Super Cereal for 3 months. In 2015, WFP provided rations to a total of 324 children, or 126 percent of those planned. WFP reached more children discharged from the IMAM programme this year because the government was able to expand the programme, which now is available in 40 health facilities. The expansion made the service accessible to more children compared to previous years. In addition, WFP trainings of clinicians on nutrition assessment and referral procedures in early 2015 are likely to have contributed to the increase in the number of children enrolling.

**Table 1: Overview of Project Beneficiary Information**

| Beneficiary Category | Planned | | | Actual | | | % Actual v. Planned | | |
|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| **Total Beneficiaries** | **18,490** | **20,851** | **39,341** | **13,272** | **15,006** | **28,278** | **71.8%** | **72.0%** | **71.9%** |
| **By Age-group:** | | | | | | | | | |
| Children (under 5 years) | 2,203 | 2,518 | 4,721 | 1,662 | 1,886 | 3,548 | 75.4% | 74.9% | 75.2% |
| Children (5-18 years) | 7,042 | 7,908 | 14,950 | 5,019 | 5,666 | 10,685 | 71.3% | 71.6% | 71.5% |
| Adults (18 years plus) | 9,245 | 10,425 | 19,670 | 6,591 | 7,454 | 14,045 | 71.3% | 71.5% | 71.4% |
| **By Residence status:** | | | | | | | | | |
| Residents | 18,490 | 20,851 | 39,341 | 13,291 | 14,987 | 28,278 | 71.9% | 71.9% | 71.9% |

**Table 2: Beneficiaries by Activity and Modality**

| Activity | Planned | | | Actual | | | % Actual v. Planned | | |
|---|---|---|---|---|---|---|---|---|---|
| | Food | CBT | Total | Food | CBT | Total | Food | CBT | Total |
| Nutrition: Treatment of Moderate Acute Malnutrition | 257 | - | 257 | 324 | - | 324 | 126.1% | - | 126.1% |
| HIV/TB: Care&Treatment | 39,084 | - | 39,084 | 27,954 | - | 27,954 | 71.5% | - | 71.5% |

| Table 3: Participants and Beneficiaries by Activity (excluding nutrition) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Beneficiary Category** | **Planned** | | | **Actual** | | | **% Actual v. Planned** | | |
| | **Male** | **Female** | **Total** | **Male** | **Female** | **Total** | **Male** | **Female** | **Total** |
| **HIV/TB: Care&Treatment** | | | | | | | | | |
| ART Clients receiving food assistance | 964 | 2,048 | 3,012 | 1,266 | 1,428 | 2,694 | 131.3% | 69.7% | 89.4% |
| TB Clients receiving food assistance | 753 | 1,844 | 2,597 | 695 | 783 | 1,478 | 92.3% | 42.5% | 56.9% |
| PMTCT Clients receiving food assistance | - | 906 | 906 | - | 487 | 487 | - | 53.8% | 53.8% |
| **Total participants** | **1,717** | **4,798** | **6,515** | **1,961** | **2,698** | **4,659** | **114.2%** | **56.2%** | **71.5%** |
| **Total beneficiaries** | **18,369** | **20,715** | **39,084** | **13,139** | **14,815** | **27,954** | **71.5%** | **71.5%** | **71.5%** |

The total number of beneficiaries includes all targeted persons who were provided with WFP food/cash/vouchers during the reporting period - either as a recipient/participant or from a household food ration distributed to one of these recipients/participants.

| Table 4: Nutrition Beneficiaries | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Beneficiary Category** | **Planned** | | | **Actual** | | | **% Actual v. Planned** | | |
| | **Male** | **Female** | **Total** | **Male** | **Female** | **Total** | **Male** | **Female** | **Total** |
| **Nutrition: Treatment of Moderate Acute Malnutrition** | | | | | | | | | |
| Children (under 5 years) | 97 | 109 | 206 | 122 | 138 | 260 | 125.8% | 126.6% | 126.2% |
| Children (5-18 years) | 24 | 27 | 51 | 30 | 34 | 64 | 125.0% | 125.9% | 125.5% |
| **Total beneficiaries** | **121** | **136** | **257** | **152** | **172** | **324** | **125.6%** | **126.5%** | **126.1%** |

| Commodity | Planned Distribution (mt) | Actual Distribution (mt) | % Actual v. Planned |
|---|---|---|---|
| Corn Soya Blend | 406 | 167 | 41.1% |
| Maize | 1,407 | 583 | 41.4% |
| Peas | 197 | 63 | 31.8% |
| Vegetable Oil | 88 | 36 | 40.9% |
| **Total** | **2,098** | **848** | **40.4%** |

## *Story Worth Telling*

Once a month Jabulile Dlamini* travels 30 kilometres from her homestead to Mkhuzweni Clinic in Swaziland's Hhohho region to receive antiretroviral therapy. She was diagnosed with HIV in 2013, when she was only 29 years old.

Together with her husband Moses*, she takes care of their four little children. Moses works as a brick layer. Jabulile herself used to sell vegetables at the market before she got sick. Once her body started deteriorating, she had to give up work, which led her family into serious financial difficulties, as Moses' wages are not enough to cater for the needs of the entire family.

Four months ago, Jabulile was admitted to the clinic's Food by Prescription programme. Ever since she started eating the nutritious food from the monthly take-home rations, she has continuously gained weight and feels much healthier. She now feels strong enough to continue with her life and recently started going back to the market place to sell vegetables to help support her family.

Because of a continuing drought in the region, the family has not been able to grow vegetables for their own consumption. Jabulile says the household ration is of critical importance for her family, especially during years with a bad harvest like this one. With it, Jabulile does not feel that she needs to share the SuperCereal with her husband and kids, so she has been able to recover quickly and return to earning a living.

*Names changed

## Progress Towards Gender Equality

Gender was mainstreamed into the implementation of the FBP programme. The key gender indicators for this project include sex-disaggregated monitoring of food distributions to beneficiaries, outcomes, and indicators that measure decision-making about food rations by men and women in their households. The latter shows that women are making decisions about the use of rations in 66 percent of households, while men and women make decisions about food use together in about 17 percent of households and in the remaining 17 percent of households, men are the decision-makers. More women, and fewer men, are making decisions about ration use compared to 2014. The data is consistent with trends seen in patterns about men and women decision-makers in WFP Development Project 200508, in which 93.5 percent of women make decisions about household rations and less than 1 percent of those decisions are made by men.

One explanation for these results is a perception in Swazi culture that women are traditionally the decision-makers about food issues in their homes. Another explanation for the achievements is when the targets for decision-making were set, no baseline information about gendered household decision-making was available, and so the targets were made based on equal decision-making between men, women, and men and women together. Now that 2 years of data reflect that women are predominantly making decisions about food use, the targets may need to be adjusted to be more realistic.

FBP assistants counsel clients and report on their progress monthly. The nutrition counselling covers how to use good nutrition as part of HIV and TB care, and proper use of the food provided through the programme. Gender equality on use of the household ration is part of WFP training for FBP assistants and is reinforced by WFP monitors at monthly site visits.

There is gender balance among the FBP assistants (12 men and 12 women), which ensures that clients can choose between male and female assistants. This is especially important when assistants counsel pregnant women.

In order to adhere to do no harm principles, and to respect patient confidentiality guidelines set by the Ministry, WFP did not directly interview clients because this would have required accessing personal information from medical records. Information about household decision-making related to food, patient safety and awareness of programme rules was reported by FBP assistants.

| Cross-cutting Indicators | Project End Target | Base Value | Previous Follow-up | Latest Follow-up |
|---|---|---|---|---|
| **Proportion of households where females and males together make decisions over the use of cash, voucher or food** | | | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Base value**: 2014.12 , **Latest Follow-up**: 2015.06* | =40.00 | 13.00 | | 16.90 |
| **Proportion of households where females make decisions over the use of cash, voucher or food** | | | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Base value**: 2014.12 , **Latest Follow-up**: 2015.06* | =30.00 | 57.00 | | 66.00 |
| **Proportion of households where males make decisions over the use of cash, voucher or food** | | | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Base value**: 2014.12 , **Latest Follow-up**: 2015.06* | =30.00 | 30.00 | | 17.10 |

# Protection and Accountability to Affected Populations

Clients did not report any safety incidents at the government health facilities or in transit to or from the facilities. This meets WFP's target to achieve 100 percent safety for men and women clients, and was consistent with the standard of safety achieved in previous years.

Health facilities also have secure storage areas for FBP commodities to safeguard against one of the main safety risks to the programme, theft.

In 2015, 93 percent of clients were well-informed that they were eligible for food assistance based on nutrition assessment measures, and understood they would be discharged when they returned to a healthy weight and maintained it for two months consecutively. Clients were reported to understand where to lodge complaints: 90 percent correctly identified that they could direct complaints to clinicians or to the FBP assistants. Clients were less clear regarding the amount of food they were entitled to. Only 43 percent correctly described the client ration of Super Cereal and the household ration.

Although clients received information about the rations they are entitled to at their enrolment in the programme and, during nutrition education and counselling assessments conducted monthly by FBP assistants, it is possible that shortfalls and a lack of a household ration during some months may mean clients did not fully understand the ration sizes to expect. FBP assistants also counsel clients on good nutrition practices and the use of the food rations, so that they are aware of how to get the maximum nutritional benefit from the nutrition support they receive.

To address improve client knowledgeability about ration entitlements, WFP will re-train FBP assistants in the counselling of clients on programme rules, and will give a renewed emphasis to this component of client counselling during monthly site visits by WFP monitors to FBP assistants.

In 2014 it was not possible to disaggregate data by sex but in 2015 the data collection was amended to examine differences in protection and knowledge of eligibility between men and women.

| Cross-cutting Indicators | Project End Target | Base Value | Previous Follow-up | Latest Follow-up |
|---|---|---|---|---|
| **Proportion of assisted people (men) informed about the programme (who is included, what people will receive, where people can complain)** | | | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Base value**: 2015.06* | =90.00 | 75.60 | | |
| **Proportion of assisted people (men) who do not experience safety problems travelling to, from and/or at WFP programme site** | | | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Base value**: 2014.12 , **Latest Follow-up**: 2015.06* | =100.00 | 100.00 | | 100.00 |
| **Proportion of assisted people (women) informed about the programme (who is included, what people will receive, where people can complain)** | | | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Base value**: 2015.06* | =90.00 | 75.10 | | |
| **Proportion of assisted people (women) who do not experience safety problems travelling to, from and/or at WFP programme sites** | | | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Base value**: 2014.12 , **Latest Follow-up**: 2015.06* | =100.00 | 100.00 | | 100.00 |
| **Proportion of assisted people informed about the programme (who is included, what people will receive, where people can complain)** | | | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Base value**: 2014.12 , **Latest Follow-up**: 2015.06* | =90.00 | 98.00 | | 75.35 |
| **Proportion of assisted people who do not experience safety problems travelling to, from and/or at WFP programme site** | | | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Base value**: 2014.12 , **Latest Follow-up**: 2015.06* | =100.00 | 100.00 | | 100.00 |

## Outputs

In 2015, WFP continued to implement the programme at all 12 targeted health facility sites while strengthening government capacity to achieve full national ownership of the programme over time. By providing trainings in programme guidelines, management, coordination and monitoring, WFP built the capacity of the Ministry of Health to further integrate nutrition services into Swaziland's HIV and TB response. WFP was able to reach 28,278 beneficiaries, which is consistent with the number of beneficiaries reached in previous years.

Of the four planned technical assistance activities for 2015, all were completed. First, WFP continued covering the costs of 22 of 24 FBP assistants to support operations of the programme in health facilities. Second, WFP food monitors conducted site visits monthly to train and support FBP assistants to efficiently provide services to clients and manage the programme. Trainings covered quality monitoring and tracking of patient progress, food management and distribution.

Third, WFP trained 62 clinicians in 2 health facilities in collaboration with SNNC, which completed trainings of doctors and nurses begun in 2014. The refresher trainings reinforced nutrition assessment techniques and referral procedures in line with the national FBP guidelines.

This training aimed to ensure eligible malnourished ART and TB clients and PLW were identified and enrolled in the programme. FBP guidelines were also included in the review of national guidelines on antiretroviral therapy (ART), and in a review of the national guidelines for integrated management of acute malnutrition (IMAM) for children.

Fourth, WFP implemented a malnutrition prevalence survey, prompted by changes to national ART guidelines, to understand how changes in eligibility to start treatment might drive changes to the number of people eligible for nutrition services. The new national ART guidelines were brought in line with international WHO guidelines, and allowed patients to initiate ART earlier than before (with a CD4 count of 500, rather than 350). The guidelines also aim to increase TB detection. Together, this means more people will be on treatment and therefore, more will need to be assessed for nutritional status. Depending on how many people are malnourished, more may become eligible for nutrition support. Results of the malnutrition prevalence survey will provide better estimates in the number of eligible patients, thus informing forecasting and planning for the programme in 2016. The results will also support preparations for the handover of the programme to the government.

Decentralization of care and treatment services is a strategy to strengthen access to care for patients, and is prioritized in the national HIV strategy. About 80 percent of all public health facilities in Swaziland are able to provide ART now. Based on the results of a 2014 assessment on the extent and quality of existing nutrition outreach to satellite clinics, about 80 percent of satellite clinics were found to offer Food by Prescription services, or refer patients to a facility that could, although services were implemented with varying consistency and quality in satellite clinics. FBP assistants have varying capacity and resources to conduct routine oversight of nutrition services at satellite clinics. WFP worked to promote decentralization of nutrition services in line with the ART decentralization by advocating for consistent referrals and training staff at satellite facilities in program implementation. The results of the 2015 malnutrition prevalence survey will assist WFP and SNNC to better understand the level and locations of need for decentralized nutrition services, should a growing number of malnourished patients be found in satellite health facilities, in order to strategically target further technical support.

| Output | Unit | Planned | Actual | % Actual vs. Planned |
|---|---|---|---|---|
| **SO4: HIV/TB: Care&Treatment;** | | | | |
| Number of government staff trained by WFP in nutrition programme design, implementation and other nutrition related areas (technical/strategic/managerial) | individual | 24 | 24 | 100.0 |
| Number of health centres/sites assisted | centre/site | 12 | 12 | 100.0 |
| Number of technical assistance activities provided | activity | 4 | 4 | 100.0 |

## Outcomes

The project's expected outcomes were to improve nutritional recovery of malnourished ART and TB patients, and therefore contribute to improved ART adherence and success of TB treatment. In 2015, WFP and the Ministry of Health achieved improved results over the previous year across all outcomes, despite extremely limited funding for NACS services and rising vulnerability to food insecurity in the face of a country-wide drought.

Steady improvements have been made over results from 2014 among ART and TB treatment patients. Although nutritional recovery rates have not met the target, efforts to improve data quality and nutrition services delivery at health facilities continued to drive better nutritional recovery rates. As a result of the El Nino phenomenon, over a quarter of all Swazis are facing moderate to severe food insecurity. This food insecurity could have held back improvements to nutritional recovery rates among malnourished HIV and TB clients, who are one of the most vulnerable groups to the effects of the drought, including rising food prices and crop losses.

ART adherence, measured by tracking patients who are alive and known to be on treatment 36 months after they have started, improved over the previous year. TB treatment success also improved. Achieving better treatment outcomes relies on a number of factors, including delivery of care and treatment services through the national ART and TB programmes. In 2014, as in previous years, about 15 percent of patients in the national ART programme were lost-to-follow-up which is when patients stop coming to health facilities for treatment and the health system is unable to track them. Reasons for this can be related to poor access to care or other social issues such as stigma. The government has identified research into the causes for loss-to-follow-up as a key priority to improve ART retention. WFP will follow this issue closely, and advocate for nutrition services as a strategy to reduce loss-to-follow-up of patients.

A 2013 review of the project identified 3 key strategies to improve nutritional recovery rates: improving consistency of nutrition services, which were occasionally disrupted due to funding challenges; improving data quality to accurately track outcomes; and decentralizing nutrition services to increase accessibility of nutrition services in line with ART and TB treatment. WFP made progress where feasible in implementing each of these strategies in 2014 and 2015 and will continue to pursue these strategies in 2016 to work toward a smooth handover of the project to the government.

The first strategy, improving consistency of nutrition services, was difficult to achieve in 2015 because of funding shortfalls, with fewer resources available over the previous year. Lack of funding compromised the consistent availability of the household ration for clients' families, which was reduced and then halted at the end of the year. Temporary stops to the household ration could have negatively affected the number of new patients enrolling in Food by Prescription services, as well as the nutritional recovery rates of enrolled patients. Even though the client supplementary feeding ration was maintained, clients are likely to share the supplementary food with family members, which delays their recovery. Without the household ration, there is less incentive for patients to access treatment services because food assistance can off-set the costs of accessing care, such as transport or lost wages related to time spent going to the clinic. To ensure consistent delivery of nutrition support, WFP will continue to work with the Ministry of Health and partners to secure sustainable funding for the project in 2016, and resource mobilization will be considered a key component during development of the handover strategy.

Occasionally delayed food distributions also contributed to inconsistent service delivery thus WFP continued efforts to improve communication and performance of logistics and contracted transporters to ensure timely delivery of food.

The second strategy, improving data quality, was achieved through trainings on how to better track patient progress. After reviewing programme data from 2013 and 2014, SNNC and WFP identified a need to re-train Food by Prescription assistants on routine data collection and analysis. Building on trainings conducted in 2014, WFP and SNNC staff conducted monthly visits to healthcare facilities to reinforce data quality trainings. Following this training it was noted that nutritional recovery rates in TB and ART patients increased considerably. Refresher trainings should be conducted in 2016 to ensure improved data quality is maintained.

The third strategy, decentralization of nutrition services to satellite clinics, requires ongoing collaboration with the Ministry of Health because nutrition services are implemented with varying degrees of quality and consistency. Decentralization is key to the continued improvement of nutritional recovery and lowered default rates because clients are often enrolled in Food by Prescription in one of the 12 main health facilities, and are then referred to satellite clinics for follow-up. If satellite clinics do not offer nutrition services, they must consistently assess and refer Food by Prescription clients to facilities that can provide nutrition support. Another reason for decentralizing nutrition services is to reduce travel time and costs for patients accessing nutrition services, as satellite clinics are often closer to patients' homes than the 12 main Food by Prescription health facilities. The Food by Prescription programme will need to adapt how it delivers its services to ensure coverage of nutrition services can keep pace with rapidly expanding HIV and TB services in satellite clinics. Progress to inform decentralization strategies has been made through the conduct of a malnutrition prevalence survey, which examined the rates of malnutrition among patients in both the 12 main facilities and patients in satellite clinics. The results of the survey, expected in

2016, will inform where malnutrition among HIV and TB patients is highest, allowing WFP and the MOH to prioritize these areas to strengthen decentralization where services are most needed in 2016.

In addition, WFP will explore complementarity with ongoing partner initiatives to improve access to treatment and adherence.

| Outcome | Project End Target | Base Value | Previous Follow-up | Latest Follow-up |
|---|---|---|---|---|
| **SO4 Reduce undernutrition and break the intergenerational cycle of hunger** | | | | |
| **Reduced undernutrition, including micronutrient deficiencies among children aged 6-59 months, pregnant and lactating women, and school-aged children** | | | | |
| **ART Nutritional Recovery Rate (%)** | | | | |
| *ALL TARGETED HOSPITALS AND HEALTH CENTERS IN SWAZILAND , **Project End Target**: 2016.06 Collected monthly from health facility records , **Base value**: 2011.12 WFP programme monitoring From health center records , **Previous Follow-up**: 2014.12 WFP programme monitoring Health facilities records , **Latest Follow-up**: 2015.12 WFP programme monitoring Health facilities records* | >75.00 | 10.00 | 27.00 | 45.00 |
| **TB Treatment Nutritional Recovery Rate (%)** | | | | |
| *ALL TARGETED HOSPITALS AND HEALTH CENTERS IN SWAZILAND , **Project End Target**: 2016.06 From health centers records , **Base value**: 2011.12 WFP programme monitoring from health centers records , **Previous Follow-up**: 2014.12 WFP programme monitoring Health facilities records , **Latest Follow-up**: 2015.12 WFP programme monitoring Health facilities records* | >75.00 | 25.00 | 21.00 | 33.00 |
| **Project-specific** | | | | |
| **TB Treatment Success Rate (%)** | | | | |
| *ALL TARGETED HOSPITALS AND HEALTH CENTERS IN SWAZILAND , **Project End Target**: 2016.06 Ministry of Health Annual report , **Base value**: 2011.12 Secondary data Ministry of Health Annual report , **Previous Follow-up**: 2014.10 Secondary data Ministry of Health, TB Annual Report , **Latest Follow-up**: 2015.04 Secondary data Ministry of Health, TB Annual Report* | =85.00 | 69.00 | 76.00 | 79.00 |
| **ART Adherence Rate (%)** | | | | |
| *ALL TARGETED HOSPITALS AND HEALTH CENTERS IN SWAZILAND , **Project End Target**: 2016.06 Ministry of Health Annual report , **Base value**: 2011.12 Secondary data Ministry of Health Annual report , **Previous Follow-up**: 2013.09 Secondary data Ministry of Health, ART Annual Report , **Latest Follow-up**: 2015.04 Secondary data Ministry of Health, ART Annual Report* | =80.00 | 69.00 | 73.00 | 78.00 |

## Sustainability, Capacity Development and Handover

Through the programme, WFP is committed to supporting the capacity development of the MoH on nutrition assessment counselling and support services. The project's extension by one year, to June 2016, has allowed WFP to provide technical assistance to the MoH and the SNNC with a view to prepare for full national ownership of the programme. A handover strategy and timeline is currently under discussion and will be developed with the MoH and SNNC to facilitate a smooth transition.

WFP supported development of the National Health Sector Strategic Plan and its costed implementation plan, which include the FBP programme, as a key contributor to ensuring clients' access to HIV and TB care and treatment. The costing of nutrition assessment, counselling and support services led to the SNNC requesting for funding of the

project through the Ministry of Health's budget allocation for the first time FY 2016-17, beginning in March. Final allocations are still being discussed to determine feasibility of the request in light of current negative economic forecasts and potential need to re-prioritize the budget to strengthen the response to the drought, related to the El Nino phenomenon. In 2015, WFP provided financial support for the operational costs related to 22 out of the 24 Food by Prescription assistants, and continued to advocate that the Ministry take on these costs to insure sustainability of these staff who are essential to the programme's operations. This achievement shows the commitment of the Ministry of Health to work to increase their financial commitments and work toward full national ownership of the programme.

WFP and the Ministry initiated a malnutrition prevalence survey among adult HIV and TB patients, as well as PLW, and will finalize the results in early 2016. The survey objective is to quantify the number of malnourished HIV and TB patients and pregnant and lactating women in health facilities, which will allow the Ministry and WFP to understand 1) whether nutrition assessments are being conducted routinely, 2) how many people accessing are eligible for assistance through Food by Prescription, compared to the number of people enrolled. This information will help WFP and the Ministry to understand if further nutrition assessment and referral trainings are needed, and will ensure the program planning is evidence-based, to support government in forecasting and budgeting to absorb the programme.

WFP provided capacity development through on-the-job training of the FBP assistants in programme management and implementation, admission criteria, food distribution, and nutrition education and counselling to clients. The trainings were conducted through monthly visits by WFP field monitors, resulting in continued improvements in outcome monitoring, building on in-depth trainings in previous years. The monthly support to FBP assistants is expected to contribute to enhanced follow-up of patients and improved health outcomes, as well as efficient management of the programme. These trainings are expected to continue in 2016 to maintain improvements in data quality and outcome results.

While nutrition indicators have been fully integrated into FBP data collection tools, and the patient data in the HIV, TB and Public Health Units at health facilities, the MoH has not yet been able to take over the analysis of the data and reporting for the programme. A goal of the project is to fully integrate FBP data into the key indicators reported through the Ministry of Health's Health Monitoring Information System. This would allow the Ministry to access quicker updated results and better use information to inform programme oversight and decision-making to better respond to patients' needs. WFP will continue to advise on inclusion of key nutrition-related indicators in MOH HIV and TB monitoring and strategic information use in 2016.

Continuing trainings begun in 2014, WFP and SNNC trained clinical staff in 2 of the 12 health facilities on nutrition assessment, education and counselling, as well as guidelines for referring eligible patients to receive nutrition support. This effort aimed to improve implementation of nutrition assessments and referrals in health facilities, including the satellite clinics, making sure malnourished patients are identified and referred for food assistance and that the services are decentralized to rural areas.

WFP joined the HIV Treatment Care and Support Technical Working Group, chaired by the Swaziland National AIDS Programme and comprised of stakeholders from across the health sector including government, NGOs and development partners such as donors and other UN agencies. WFP will continue to explore complementarity with other partners working to strengthen patient adherence and treatment success. WFP worked with members, including WHO, UNICEF and the SNNC, to ensure the national FBP guidelines were integrated into a review and update of the Integrated Management of Acute Malnutrition guidelines, to be rolled out in 2016.

# Inputs

## *Resource Inputs*

Programme resources in 2015 were mostly cash contributions, with overall funding reaching less than one-fifth of the project's funding needs.

The Ministry of Health provided valuable human resources, as well as clinical infrastructure as the project is implemented in government. The Government of Swaziland continued to support food assistance interventions by facilitating the importation of commodities.

| Donor | 2015 Resourced (mt) | | 2015 Shipped/Purchased (mt) |
|---|---|---|---|
| | In-Kind | Cash | |
| Luxembourg | 0 | 292 | 0 |
| **Total** | **0** | **292** | **0** |

See Annex: Resource Inputs from Donors for breakdown by commodity and contribution reference number

## Food Purchases and In-Kind Receipts

No new food purchases completed in 2015. Food distributed in 2015 came from stocks carried over from 2014.

## Food Transport, Delivery and Handling

Good road networks in Swaziland facilitated efficient transport of food to the health facilities. This and the availability of secure storage areas in the health facilities facilitated smooth delivery of food to beneficiaries.

Due to limited availability of resources, WFP was forced to curtail and later halt distribution of household ration commodities, but the delivery of Super Cereal was prioritized and maintained. Overall, timely dispatch of food to the health facilities was achieved in 2015 thanks to improved reporting on food stocks in facilities and continued communications with transporters.

## Post-Delivery Losses

Appropriate food handling practices by WFP, the FBP assistants and the contracted transporters ensured that food reached the beneficiaries with minimal losses in 2015. WFP provided continuous support to the FBP assistants on food management, through monthly monitoring visits and training on food handling and storage procedures.

# Management

## Partnerships

The Ministry of Health is the main government counterpart for the programme in Swaziland. The MoH provides crucial inputs to support project implementation and oversight, such as human resources and infrastructure in the ART, TB, and Public Health units and national level management through the SNNC. Within the MoH, the SNNC is the key partner for the implementation of the programme; SNNC staff provide policy leadership, technical backstopping, and coaching to clinical staff and FBP assistants in health facilities. SNNC also employs the 24 FBP assistants and are responsible for their oversight.

The partnership with the Ministry is framed by the Development Project Action Plan agreement (DPAP) for the programme signed by WFP and the Ministry, which outlines the main implementation arrangements and the respective roles and responsibilities, cementing government ownership and commitment to the project.

WFP also actively participates in the HIV Treatment Care and Support Technical Working Group with a number of government, NGO and development partners. This contributes to integrating nutrition assessment, counselling and support into HIV services throughout the health sector, improving service delivery.

WFP works with the National Emergency Response Council on HIV and AIDS (NERCHA) which coordinates national interventions on HIV, TB and Malaria. Through this partnership, WFP has successfully advocated for the inclusion of nutrition assessment counselling and support in the eNSF (2014 - 2018) and subsequent HIV response operational plan, and the TB National Strategic Plan. WFP has also worked with NERCHA and the Ministry of Health to cost HIV-nutrition interventions, supporting government planning and decision-making related to these programmes. The inclusion of nutrition assessment, counseling and support services in these frameworks signifies that the country and HIV and TB stakeholders see the programme as a priority initiative with high impact to improve HIV and TB client health outcomes.

WFP implements the programme in partnership with United Nations agencies as part of the Joint United Nations Programme of Support (JUNPS) for HIV and AIDS, which includes FAO, ILO, UNAIDS, UNDP, UNESCO, UNFPA, UNICEF, UNODC and WHO as members. The FBP programme contributes to the HIV Treatment, Care and Support pillar of the JUNPS. WFP also collaborated with WHO and UNICEF on the review of the national IMAM guidelines, to update them in line with international guidance and ensure complementarity with the FBP programme.

WFP co-leads the Scaling Up Nutrition Movement in Swaziland with the Swaziland National Nutrition Council. Through the SUN Movement, WFP advocated for aggressive stunting reduction targets to be set in national policies such as the Prime Minister's Swaziland Development Index and the National Health Sector Strategic Plan II (2014-18), and the new UN Development Assistance Framework (UNDAF) 2016-2020, setting a common agenda for addressing child undernutrition. This year, WFP continued to support the country to achieve stunting reduction goals by building the evidence base on key drivers of stunting in Swaziland, and developing a prioritized Stunting Action Plan with representatives of the Ministries of Health, Agriculture, Education, Economic Planning and Development, Industry Commerce and Trade and civil society. WFP also partnered with UN agencies and the SNNC to revise the National Food and Nutrition Policy, and to revise national guidelines for the Integrated Management of Acute Malnutrition. These activities continue to strengthen the policy framework and guidance to insure children receive quality nutrition services.

| Partnership | NGO | | Red Cross and Red Crescent Movement | UN/IO |
|---|---|---|---|---|
| | National | International | | |
| Total | | | | 9 |

| Cross-cutting Indicators | Project End Target | Latest Follow-up |
|---|---|---|
| **Number of partner organizations that provide complementary inputs and services** | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Latest Follow-up**: 2015.12* | =1.00 | 1.00 |
| **Proportion of project activities implemented with the engagement of complementary partners** | | |
| *SWAZILAND, HIV/TB: Care&Treatment , **Project End Target**: 2016.06 , **Latest Follow-up**: 2015.12* | =100.00 | 100.00 |

## Lessons Learned

In 2015, WFP faced extremely limited funding to implement the project yet still made progress toward improving nutritional recovery and treatment outcomes for HIV and TB patients and paving the way for future transition of the programme to full national ownership and implementation.

The project was extended for an additional year, through June 2016, to allow WFP and the Ministry to implement strategies to improve nutritional recovery rates, including improving consistency of nutrition services, improving data quality to accurately track patient outcomes; and decentralizing nutrition services. Progress in these initiatives has resulted in improved nutritional recovery rates for both TB and ART patients, and is further discussed in the Outcomes section of this report. In 2016, WFP will continue to pursue these strategies to ensure further improvements to reach nutritional recovery rate targets. Resource mobilization and sustainable financing of nutrition support will be a main concern of the planned development of the handover strategy. Trainings on data quality and on programme guidelines will be continued in 2016 to ensure accurate targeting and referral of the clients by clinicians, and to reinforce with FBP assistants the importance of patient knowledgeability about ration entitlements and gender equality in the programme.

The continuation of the project into 2015 also introduced an adjustment to the planned number of beneficiaries, bringing the forecast more in line with the number of people reached at the facilities. However, a need to update the evidence about prevalence of malnutrition among HIV and TB patients was identified. Thus WFP also began a malnutrition prevalence survey in 2015 to inform planning and forecasting for the project, as well as strategies to strengthen decentralization of services to satellite clinics.

In 2015 WFP developed a new Country Strategy (2016-2020). During this process, WFP consulted partners in government, donors, civil society and UN agencies to get their views on the role of nutrition in the HIV and TB response, and how WFP can more effectively support the Government. Stakeholders confirmed that need for the project continues, and agreed that WFP is uniquely positioned to enhance capacity of the Government to take over the project.

The need for continued nutrition services in HIV and TB are and treatment is demonstrated by the consistent demand for the programme and its prioritization in national policies guiding the HIV response, including the national HIV strategy and the national health strategy. The roll-out of new ART guidelines in 2015 has increased the number of people eligible for treatment substantially. Good adherence will be a top priority to ensure patients can consistently access treatment and achieve viral load suppression. Interest in nutrition services to support patients' access to treatment has grown particularly in late 2015 as the ongoing drought drove up food prices and people's vulnerability to food insecurity.

Stakeholder consultations noted WFP's history of enhancing government capacity to implement the project, including support to mainstream nutrition approaches to HIV and TB care and treatment in policy frameworks, to plan for these services adequately, and to strengthen monitoring and evaluation of results (described in the Sustainability, Capacity Development and Handover section of this report).

Stakeholders agreed that WFP should work toward full handover of the project to the MOH. External funds to the project are extremely limited, and the MOH has acknowledged that for the project to continue beyond 2016, the MOH must gradually absorb financial and operational responsibilities. The Ministry began to absorb human resources costs, and has committed to increase contributions over time. In order to improve sustainability of the project, the development of a handover strategy with clear timelines and budget responsibilities must be accelerated.

To strengthen the evidence needed to inform the priorities in the handover strategy, WFP will commission an external Operational Evaluation of the project in 2016. The evaluation will assess the project performance and make recommendations on further technical assistance needs to improve project outcomes and efficiency. Stakeholder consultations have already identified key areas for assistance leading up to the handover, including review of programme design, financing strategy, supply chain management, oversight mechanisms, decentralization of services and referral strengthening, and further integration of monitoring and evaluation into health management information systems.

WFP provided technical assistance for child nutrition initiatives in 2015, and continued leadership on the Scaling Up Nutrition Movement. WFP has provided substantial assistance to reach stunting reduction targets set in the national development agenda. Through implementing the Swaziland Stunting Prevention Initiative WFP has learned the continued need to advocate for high-level engagement to ensure nutrition coordination mechanisms, policy frameworks and action plans are functioning optimally. The development of a national Stunting Action Plan prioritized multi-sectoral approaches to child nutrition, including nutrition education and behaviour change communication, improved infant and young child feeding, nutrition advocacy, and nutrition surveillance, among others. Stakeholders confirmed that under the new Country Strategy, WFP should continue assistance to implement the newly developed Stunting Action Plan, strengthen nutrition coordination mechanisms and advocacy, and support innovative approaches to improve the scale or introduce new initiatives to ensure Swaziland is on track to meet its commitments to reduce stunting so children can grow up to lead healthy, productive lives.

# Operational Statistics

## *Annex: Participants by Activity and Modality*

| Activity | Planned | | | Actual | | | % Actual v. Planned | | |
|---|---|---|---|---|---|---|---|---|---|
| | Food | CBT | Total | Food | CBT | Total | Food | CBT | Total |
| Nutrition: Treatment of Moderate Acute Malnutrition | 257 | - | 257 | 324 | - | 324 | 126.1% | - | 126.1% |
| HIV/TB: Care&Treatment | 6,515 | - | 6,515 | 4,659 | - | 4,659 | 71.5% | - | 71.5% |

# Annex: Resource Inputs from Donors

| Donor | Cont. Ref. No. | Commodity | Resourced in 2015 (mt) | | Shipped/Purchased in 2015 (mt) |
|---|---|---|---|---|---|
| | | | In-Kind | Cash | |
| Luxembourg | LUX-C-00125-12 | Corn Soya Blend | 0 | 58 | 0 |
| Luxembourg | LUX-C-00125-12 | Maize | 0 | 234 | 0 |
| | | **Total** | **0** | **292** | **0** |