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ANNEX C. CONTINENTAL

External Evaluation
African Nutrition Security Partnership (ANSP)
Country Annex: Continental

1 Introduction

1.1 Nutrition Situation

Table 1: Key statistics

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<tbody>
<tr>
<td>Total population</td>
<td>1,020,650</td>
<td>855,273</td>
<td>398,968</td>
<td>411,864</td>
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<td>Under-five mortality rate / infant mortality rate</td>
<td>111/71</td>
<td>109/76</td>
<td>84/63</td>
<td>132/88</td>
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<tr>
<td>Life expectancy at birth</td>
<td>57</td>
<td>54</td>
<td>55</td>
<td>53</td>
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<tr>
<td>GNI per capita</td>
<td>USD 1,483</td>
<td>USD 1,2192</td>
<td>USD 1,486</td>
<td>USD 905</td>
</tr>
<tr>
<td>% of population below international poverty line</td>
<td>42</td>
<td>49</td>
<td>45</td>
<td>52</td>
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<tr>
<td>% of children (2007-2011) early initiation of breastfeeding</td>
<td>46</td>
<td>48</td>
<td>51</td>
<td>41</td>
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<tr>
<td>% of children (2007-2011) who are exclusively breastfed (&lt;6 months)</td>
<td>34</td>
<td>37</td>
<td>52</td>
<td>25</td>
</tr>
<tr>
<td>% of children (2007-2011) introduced to solid, semi-solid or soft foods (6-8 months)</td>
<td>68</td>
<td>71</td>
<td>84</td>
<td>65</td>
</tr>
<tr>
<td>Antenatal care coverage at least once / at least four times (%)</td>
<td>78/49</td>
<td>78/47</td>
<td>89/51</td>
<td>71/45</td>
</tr>
<tr>
<td>Vitamin A supplementation (full) coverage rate</td>
<td>86</td>
<td>78</td>
<td>72</td>
<td>83</td>
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<tr>
<td>% of households consuming iodized salt (2007-2011)</td>
<td>55</td>
<td>49</td>
<td>50</td>
<td>52</td>
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<tr>
<td>% of infants with low birth weight (2007-2011)</td>
<td>13</td>
<td>12</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>% of under-fives suffering from underweight (WHO), (2007-2011)</td>
<td>19/6</td>
<td>21</td>
<td>18</td>
<td>23</td>
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<tr>
<td>% of under-fives (2007-2010) suffering from wasting (WHO)</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from stunting (WHO)</td>
<td>38</td>
<td>40</td>
<td>40</td>
<td>39</td>
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<tr>
<td>% of children under five suffering from anaemia 2007</td>
<td>59</td>
<td>63</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td>% of non pregnant women (aged 15-45) suffering from anaemia 2007</td>
<td>43</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>% of pregnant women (aged 15-45) suffering from anaemia 2007</td>
<td>48</td>
<td>49</td>
<td>50</td>
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</table>

Food and nutrition security in Africa, in particular in Sub Sahara Africa (SSA) has hardly improved over the last decade, despite many initiatives at global and regional level. The latter include initiatives by the African Union Commission (AUC) such as the revision of the African Regional Nutrition Strategy.

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3 6th Report on the world nutrition situation, UNSCN, Geneva; weighted calculation from tables 17-19, p 38-40

4 Draft factsheet 4: health and nutrition, African Union Commission, Department of Social Affairs, July 2013
Malnutrition in Africa is at present one of the leading causes of mortality among children under five. Data indicate that malnutrition including foetal growth restriction, stunting, wasting and micronutrient deficiencies (of vitamin A, zinc, iron and others) contribute to up to 45% of all child deaths in Africa. In SSA this amounts to more than 1.5 million deaths annually.

Nine percent of children under-five in SSA are wasted. In the Sahel region, an estimated 1.4 million children were suffering from severe acute malnutrition (SAM) in 2013. Countries of concern include Nigeria, Chad, Niger, Mali, Burkina Faso, Cameroon, Mauritania and Senegal. In DRC, about 1 million children under 5 suffered from SAM, while in Sudan and other countries in North Africa some 2 million children were affected by acute malnutrition (moderate or severe) in 2013. Acute malnutrition increases the risk of mortality due to infectious diseases. Children suffering from severe acute malnutrition are eight to ten times more likely to die from common illnesses including acute respiratory infections, diarrhoeal diseases and malaria than well-nourished children.

In SSA, 13 percent of babies are born with a low birth weight (less than 2.5 kg). More than a third of all children less than five years of age are stunted (an estimated 55 million children). Low birth weight and stunting are strongly associated with non communicable diseases such as diabetes and cardiovascular disease in adults. While in Asia the prevalence of stunting in children younger than five years decreased from 48% to 27% during the period 1990-2011, the prevalence in Africa decreased from 42% to 36% only. In Western Africa, stunting decreased marginally from 39% to 36%, while in Eastern and Southern Africa stunting declined from 51% to 42% and from 36% to 31% respectively. At present, 17 countries in Africa have stunting rates above 40% and 36 have rates above 30%. Figure 1 compares trends in stunting in Africa, Asia and globally over the last 25 years.

While in all developing countries together the total number of stunted children under five has declined from 248.4 million in 1990 to 159.7 million in 2011, the number in Africa has increased from 45.7 million to 56.3 million during this period in particular due to population growth in Eastern and Western Africa. In these regions the number of stunted children under five increased from 18 million to 22.8 million and from 12.8 to 18.9 million respectively.

Nearly half of all pregnant women and preschool children in SSA suffer from anaemia due to iron deficiency. Other micro-nutrient deficiencies, particularly of vitamin A, zinc and iodine, in children

5 Draft factsheet 4: health and nutrition, African Union Commission, Department of Social Affairs, July 2013
6 UNICEF Liaison Office to the AU and UN Economic Commission for Africa, press release on nutrition situation in Africa, Jan-August 2013
7 Low birth weight and/or stunting often result in catch-up growth, which in turn may lead to overweight.
9 See footnote 1.
under five years of age remain a major problem as well, and progress in combating these deficiencies is slow. Iron deficient anaemia (IDA) and vitamin A deficiency increase morbidity and mortality in young children, while iodine and zinc deficiency are associated with impairment of mental and intellectual functions in children and adults. Countries in Africa lose an estimated 2-3 percent of their Gross Domestic Product each year due to malnutrition including micro-nutrient deficiencies, and in doing so extend the cycle of poverty and impede economic growth. As elsewhere, the immediate causes of malnutrition in Africa are low dietary intake and diseases. Underlying causes include inadequate access to food and health services, an unhealthy environment (including unsafe water and inadequate sanitation) and poor child care practices.

Nearly half of the population of SSA (more than 400 million people) live below the poverty line of US $1.25 per person per day. Low purchasing power in combination with erratic weather/climate conditions negatively impact on households’ food security. Dietary intake, in terms of quantity and quality, is not improving in SSA relative to other regions of the world. While over the last twenty years in Asia the per capita availability of fruits and vegetables doubled from 300 to 600 grams (gross) per day, availability in SSA only increased by 10 grams per person per day. The consumption of fat and oil, vegetables, fruits and animal products in SSA is the lowest in the world. Dietary diversity, which is associated with child nutritional status and is also an indicator of micronutrient adequacy in the diet hardly improved in SSA during the last decade. Food insecurity in many countries in SSA has also deteriorated because of the high prevalence of HIV/AIDS, which not only heavily impacts on the burden of disease, but also has negative implications for the workforce and productivity. In addition, manmade disasters including conflicts and (civil) strife, natural disasters such as recurrent droughts, floods as well as pests and locust invasions have exacerbated food insecurity.

Lastly, although urbanisation and population growth are not unique to Africa, the pace and adverse effects on living conditions in SSA are bigger than in other parts of the world. During the period 1990-2012, the proportion of people living in urban areas in SSA increased from 28% to 38%. In absolute numbers, the urban population increased from 146.6 million people to 345.6 million, an increase of 236%. Of these more than 60% live in slums. SSA has the highest proportion of urban slum dwellers in the world, twice the average (33%) in developing countries. Chronic malnutrition among children in slums is high, sometimes higher than in poor rural areas.

1.2 Continental Policy Framework in Nutrition Security

The African Regional Nutrition Strategy (ARNS) 2005-2015 is the main continental strategy on nutrition. The strategy is being reviewed into a tool for analysis, planning and program delivery. The purpose of the revised ARNS is to sensitize Africa’s leaders about the essential role food and nutrition security plays in implementing strategies for socio-economic development. It re-emphasizes that nutrition is a basic input in poverty alleviation strategies and achieving the MDGs. The revised ARNS incorporates new information on the management of the disease burden, defines the strategic role of the African Union (AU) and Member States in nutrition and presents a framework for action to this end, including the ARNS contribution to the regional integration agenda though Regional Economic Communities (RECs). The plan of action sets out priority areas of action, objectives and strategies plus activities for achieving these objectives.

The New Partnership for Africa’s Development Planning and Coordinating Agency (NPCA 2001) is a programme of the AU, aimed at poverty eradication, promotion of sustainable growth and development and the empowerment of women through building genuine partnerships at country, regional and continental levels. NPCA is a blueprint for Africa’s development in the 21st century and aims to address challenges facing Africa including the attainment of the Millennium Development Goals (MDGs), the escalating poverty levels and underdevelopment of African countries and the continued marginalisation of Africa from the global economy\(^{14}\). NPCA’s Health Strategy (2007-2015) includes (a very limited number of) recommendations on nutrition interventions. NPCA’s Ten Year Strategy for the Reduction of Vitamin and Mineral Deficiencies (VMD) draft Plan of Action 2008-2011 provides a strategic framework to combat VMD. Priorities include food based strategies, supplementation, fortification and (clinical) management of VMD. Pilot countries where the plan is implemented include Algeria, Burkina Faso, Ethiopia, DRC, Senegal and Zambia. The VMD Strategy is complementary to NEPAD’s Agriculture and Food Security (FAFS) programme which focuses on helping African countries improve economic growth through agriculture-led development. The programme is guided by the CAADP framework\(^{15}\).

The Comprehensive Africa Agriculture Development Programme (CAADP), developed and endorsed in 2003 by the African leaders, identifies food-insecurity, hunger and malnutrition as major problems in Africa that required immediate action. The programme is built around four pillars. Pillar 3 focuses on increasing food supply, reducing hunger and improving responses to food emergency crises. Under this pillar, a Framework for African Food Security (2009) was formulated. One of the flagship CAADP pillar 3 programmes is the Home Grown School Feeding Initiative (2012).

The Pan-African Nutrition Initiative (PANI), drafted through a multi-stakeholder consultative process in 2005 and further refined to finality in 2008, applies a multi-sectoral nutrition lens to ongoing CAADP and NPCA initiatives with a view to identify opportunities to scale up programmes that have high potential to positively impact on nutrition. The PANI is a tool for analysis, planning and program delivery. Subsequently in 2011, NPCA and the Global Alliance for Improved Nutrition (GAIN) signed an agreement to develop a five year joint program which fully integrates nutrition security into the CAADP and helps to harmonize CAADP and nutrition interventions.

Africa’s Renewed Initiative for Stunting Elimination or the ARISE 2025 Initiative (2013) is an initiative led by the Department of Social Affairs of the AUC (DSA/ AUC), to bring together regional efforts on the reduction of child undernutrition in Africa. Its goal is to support member states in the elimination of child undernutrition in Africa by the year 2025, through regional and national advocacy for the elimination of child undernutrition and by establishing support mechanisms to help improve the efficiency and effectiveness on nutrition interventions\(^{16}\). An important source of inspiration of the ARISE initiative is the Cost of Hunger in Africa (COHA) Study.

The Cost of Hunger in Africa (COHA) Study is a project led by the DSA/AUC, and supported by the United Nations Economic Commission for Africa (UNECA), NEPAD Planning and Coordinating Agency, and the World Food Programme (WFP). The COHA is a multi-country study aimed at estimating the economic and social impact of child undernutrition in Africa. The study, launched in

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\(^{14}\) [http://www.nepad.org/history](http://www.nepad.org/history)

\(^{15}\) See: [http://www.nepad.org/foodsecurity](http://www.nepad.org/foodsecurity)

\(^{16}\) 5th Meeting of the ATFFND, Lesotho, July 2013. Available from:
2012, has been initiated in 4 countries (Egypt, Ethiopia, Swaziland and Uganda) and will be rolled out to another eight countries (Botswana, Burkina Faso, Cameroon, Ghana, Kenya, Malawi, Mauritania and Rwanda).

More than half of the 45 Scaling Up Nutrition (SUN) countries are from Africa. Among the 28 African countries which have joined the SUN are all four ANSP countries. NPCA’s Chief Executive Officer is a member of the SUN Lead Group. NPCA’s Senior Food & Nutrition Security Advisor is one of the SUN Country Network Resource persons.

1.3 Stakeholders in nutrition security

The Department of Social Affairs of the African Union Commission (DSA/ AUC) is responsible for initiating, planning, coordinating, harmonising and monitoring accelerated and sustained continental policies, programmes and projects that promote human development and social justice and the wellbeing of all Africans. The work of DSA/ AUC is based on the growing consensus that human development is important for economic and social progress. The department is responsible for health and nutrition, for social welfare including social protection, labour and employment as well as culture and sports. DSA/ AUC also hosts the African Committee of Experts on the Rights and Welfare of the Child. One of the core functions of the department, through the Division of Health, Nutrition and Population is focusing on nutrition security at household, community and national levels.

The objectives pursued by the Department of Rural Economy and Agriculture (DREA) of the African Union Commission (DREA/AUC) include (i) promoting agricultural and rural development; (ii) ensuring food security for Africans; (iii) achieving sustainable development and improved livelihoods for the population and; (iv) ensuring effective protection and development of the African environment including disaster risk reduction and adaptation to climate change. The Division of Agriculture and Food Security coordinates among others continent-wide initiatives on food and nutrition security and facilitates –in collaboration with NPCA (see below) the implementation of the CAADP agenda.

The New Partnership for Africa’s Development Planning and Coordinating Agency (NPCA) is tasked with the implementation of the NEPAD Programme and the African Union Development agenda. The core mandate of the NPCA is to facilitate and coordinate the implementation of regional and continental priority programmes and projects and to push for partnerships, resource mobilisation and research and knowledge management. Since 2011 NEPAD is fully integrated in the AUC structure.

The main coordinating body for nutrition in the AU is the African Task Force on Food and Nutrition Development (ATFFND) chaired by the DSA/ AUC. The ATFFND was established in 1987 by the OAU (the predecessor to the African Union) and UN agencies. ATFFND’s main objective was to advocate for and sensitize policy-makers in Africa on the role of food and nutrition security as a basic input in socio-economic development of the continent. After a period of inactivity, the ATFFND was reactivated in 2008 following the revision of the ARNS and acknowledgement that food and nutrition security are basic to health and need to be included in order to achieve MDG health targets. According to the TOR agreed on during the first meeting, the objective of the re-activated ATFFND is to assist African Union Member States in implementing the ARNS and achieving food and nutrition related MDGs for optimum health and development of all Africa’s Population throughout their life cycle. The specific objectives include the following: (i) to lobby and sensitise Africa’s policy-makers about the essential role of Food and Nutrition Security for socio-economic development at household, community and national levels; (ii) to support Member States to formulate their own national plans/strategies of nutrition; (iii) to work with RECs and other Regional Organizations to strengthen or establish social affairs desks with Food and Nutrition as a major component; (iv) to establish a network of sharing Food and Nutrition information on a regular basis; (v) to develop a progress report on the implementation of the ARNS Plan of Action by Member States and submit it to AU Summits on a regular basis; (vi) to support the establishment of a network of Africa’s NGOs and CSOs that work with communities on food and nutrition issues; (vii) to liaise with relevant Universities in Africa on the promotion of research aimed at

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17 Most of the information in this section has been provided by the UNICEF Continental office, collected from the various stakeholders in November 2013, on request of the MTE.
19 http://www.nepad.org/n pca
improving the status of Food and Nutrition Security on the continent and; (viii) to develop a Mechanism for Monitoring, Evaluation and Reporting on the Implementation of ARNS Plan of Action by Member States\textsuperscript{20}. An important task of the ATFFND is to review progress in the implementation of the ARNS. ATFFND also provides technical input into the COHA.

UNICEF and WFP both have liaison offices (LO) to the AU. The UNICEF LO was formally established in 2009. Staff consists of a head of the liaison office – the special representative to the AU/UNECA, a public affairs officer and administrative support staff. To support the implementation of EC/ ANSP activities UNICEF LO hired a consultant for six months (May – November 2012). Staff of the WFP LO also consists of a head of the liaison office, a public affairs officer and administrative support staff. In addition the WFP LO employs consultants for the COHA initiative. WHO and FAO have AU focal points within their Ethiopia country offices, while the country representatives and Regional Director for East Africa assume formal representation.

Table 2 summarizes which nutrition related activities supported by main stakeholders have thus far also been supported by ANSP at the continental level. The table also includes technical and administrative support provided by UN partners) at continental level\textsuperscript{21}.

Table 2: Nutrition related activities by stakeholder

<table>
<thead>
<tr>
<th>Activity</th>
<th>Stakeholder</th>
<th>Department of Social Affairs AUC (DSA/AUC)</th>
<th>Department of Rural Economy and Agriculture AUC (DREA/AUC)</th>
<th>NEPAD Planning and Coordinating Agency (NPCA)</th>
<th>FAO</th>
<th>UNICEF</th>
<th>WFP</th>
<th>WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa Day for Food and Nutrition Security (ADDNS)</td>
<td>Supported by all stakeholders</td>
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<td>African Task Force on Food and Nutrition Development</td>
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<td>The Africa Nutrition Champion</td>
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<td>Cost of Hunger in Africa (COHA) Study</td>
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<td>African Regional Nutrition Strategy\textsuperscript{22}</td>
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<td>Africa’s Renewed Initiative for Stunting Elimination (ARISE 2025 Initiative)</td>
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<td>Nutrition Regional Advocacy Strategy</td>
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<td>The Joint Ministerial Conference on Agriculture and Trade (JMCAT).</td>
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<tr>
<td>CAADP Nutrition Capacity Development workshops</td>
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<tr>
<td>The Africa Nutrition Forum\textsuperscript{23}</td>
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\textsuperscript{20} 1\textsuperscript{st} meeting of the ATFFND, Addis Ababa, 2009; available from: [http://reliefweb.int/sites/reliefweb.int/files/resources/C649112D4C596FA9492575B200231266-Full_Report.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/C649112D4C596FA9492575B200231266-Full_Report.pdf)

\textsuperscript{21} Based on a questionnaire designed and circulated by UNICEF LO.

\textsuperscript{22} ARISE was launched in April 2013. Various partners have expressed commitment to support in alignment with other nutrition initiatives.

\textsuperscript{23} This is the continuation of the Zambia-nutrition Forum; no information was readily available on this forum.
2 Findings

2.1 Overall Relevance and Appropriateness

Programme design

The overall objective of the ANSP is to contribute to the achievements of MDG 1, 4, 5 and 8 targets related to nutrition in West and East Africa ensuring that the rights of all children and women are protected from the adverse consequences of the volatile food prices. The specific objective is to improve the institutional environment at continental, regional and national levels contributing to a reduction in maternal and child undernutrition in Africa.

The continental part of the ANSP avails of a total budget of € 1,972,052 (excluding 7% administrative costs). The budget for the individual pillars is R1: € 1,136,436; R2: € 249,872; R3: € 335,872; R4: € 249,872. The programme is aimed at 4 results (taken from the work-plan for year 3), summarized in figure 3.

Figure 3: Design ANSP at continental level (according to work-plan for year 3)

The original design of the continental component of the ANSP is quite relevant. The approach consisting of strengthening harmonization around the ARNS and advocate for nutrition security is in principle well aligned with the SUN objectives, the ARNS plan of action and the aims of the ATFFND, in particular to lobby and sensitise Africa’s policy-makers and to support Member States to formulate their own national plans/strategies of nutrition in line with the ARNS. Also, building on the AUC and ATFFND as coordination mechanisms, according to the original project document\(^{24}\), is a relevant output, in particular give the second objective of the ANSP (strengthen the institutional environment contributing to a reduction in maternal and child undernutrition in Africa). Strengthening the ATFFND is also appropriate in view of UNICEF’s role regarding the revival of the ATFFND and its support to the ATFFND prior to the ANSP.

\(^{24}\) Support to Nutrition Strategy in West and East Africa programme, CRIS 2011 / 274-032)
Originally, the continental component also aimed to develop sustainable nutrition information systems and knowledge management with strong linkages with other information systems such as food security, early warning system and health management information systems. The original output at continental level as proposed in the project document was: support the collection and analysis of authoritative data available in Africa for dissemination and use for advocacy and awareness raising purposes. The last part (in italics) was incorporated in the 4-year global logframe, but disappeared in subsequent reports. After several changes the current output (as mentioned in the work-plan for year 3) is providing support to the inclusion of Africa Regional Nutrition Strategy (ARNS) indicators into the AfricalInfo database. A relevant result area has thus been transformed into a modest output with few linkages to the regional and/or country components.

**Coherence, completeness and complementarity to other initiatives**

The UNICEF LO to the AU/UNECA has encountered challenges in translating relevant result areas in a coherent set of outputs with matching activities as per the ANSP plans. This is among others related to the unique partnership planning mechanisms at continental level between UNICEF and DSA/AUC. A gap analysis in order to identify where and how ANSP at continental level could best add value by complementing other initiatives (including those by UNICEF at regional and/or country level) has not been undertaken. The programme shifted focus, as manifested among others by yearly changing outputs.

The four outputs under pillar 1, as outlined in the work-plan for year one, were different from the two outputs in the work-plan for year two. The two outputs in the work-plan for year 3 are again different. The four outputs in year 1 show a shift in focus from strengthening processes around the ATFFND in combination with advocacy to advocacy as stand-alone activity. The two outputs in year 2 confirm this change. The ten activities for the outputs under result 1 in the work-plan for year three focus on visibility, advocacy and awareness on nutrition security in general, rather than the need to provide adequate support for the implementation of nutrition action plans.

Awareness on the need to address malnutrition through nutrition specific interventions and multi-sectoral approaches among Africa’s leaders has increased significantly (as manifested among others by the number of SUN countries in Africa) since the inception and actual start of the ANSP evident Project documents do not elaborate to which extent UNICEF’s new output for year 3 (Policy dialogue, communication advocacy, continuous advocacy with the AUC to mainstream nutrition in development agenda) is complementary to or strengthening other initiatives or how advocacy is complementary (and thereby facilitating) outputs of the ANSP itself at continental, regional or country level.

The main activity in support of output 2 is to make technical inputs in the organisation, convening and conducting of the annual ATFFND. Work-plans (and logframe) don’t specify which of the ten specific objectives of the ATFFND (as mentioned in section 1.3) the ANSP intends to support, how results will be achieved and in which way support will strengthen the ATFFND’s mission and work.

According to the original project document, the continental component intends to work with the regional component to strengthen knowledge (....) on nutrition security in regional fora and institutions (ECOWAS, IGAD, ECSA-HC other relevant RECs) and at continental level with ATFFND and NPCA to promote integration between sectoral lines, strengthen coherence and coordination. Over time, this output has become less substantial (see above). Opportunities for coherence and complementarity between the continental component and the other components in particular activities regarding knowledge sharing/data analysis related to the AfricalInfo database initiative didn’t materialize as planned due to lack funding. This has resulted in loss of synergy, in particular between pillar 1 and pillar 3.

### 2.2 Monitoring framework

There are quite a few differences between the original 4 year work-plan as per the global logframe and the subsequent work-plans for year 1 and year 2. In particular activities for pillar 1 changed; for instance, support to the ATFFND to review ARNS in full cooperation with regional bodies (WAHO/ECSA-HC and other relevant RECs) and ensure effective embedding within NPCA/CAADP

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25 Changing outputs is not good practice. Activities can and should change depending on changing context and needs.
was reduced to: the ARNS is used as reference for advocacy and planning activities. There are other examples of other changes as well (please refer to section 2.3). Changes and the reasons for the changes are insufficiently elaborated in the narrative (interim) annual reports.

The work-plan for the continental part was revised in the second year to reflect new activities, which were partly mentioned in the interim reports. For instance, technical assistance to formulate a list of key nutrition indicators (the main activity output under pillar 3) was reformulated to ensure alignment with the COHA results (based on the advice of the AUC). Other changes (such as the delay / change in the provision of technical support for various activities) are not articulated in the interim reports. This includes moving activities from one pillar to another. There also is a disconnect between the work-plans and the logical framework. One of the challenges is that the logical framework doesn’t make a clear distinction between activities and outputs (with activities which in a logical manner contribute to specific outputs). The annual work-plans further contributes to confusion by mixing outputs and activities (and changing outputs). Another challenge is that not all activities and objectively verifiable indicators (OVI) have been refined/ updated in the work-plans. For instance, in the first year level there is no OVI for advocacy activities. Sometimes it is unclear what the causal relation is between the ANSP and the OVI. For instance, for output 2.1 (support to the ATFFND) the OVI is one meeting per year. This suggest that the ANSP is the organiser of the annual ATFFND or at least plays a critical role. Neither is true, ATFNND meetings take place with or without ANSP support.

Progress of the EC/ ANSP is outlined in the annual interim reports, but these are not always easy to follow due to the issues outlined above. However, the UNICEF LO provided the MTE with several informative reports that accompany the work-plans, reports on activities carried out by the nutrition consultant (see the sections below) and advocacy / communication work, which provided useful background information.

### 2.3 Pillar 1: Upstream policy development

#### 2.3.1 Relevance and Appropriateness

The work-plan for the first year outlines four outputs for pillar 1. Output 1.1 reads: Africa’s leaders committed to ensure adequate support to implement nutrition action plan for an effective and sustainable socio-development. In the original project document, the output for this result consisted of a set of three complementary (and coherent) activities consisting of the following:

Support to the ATFFND to:

- review the ARNS in full cooperation with regional bodies (WAHO/ECSA-HC and other relevant RECs) and ensure effective embedding within NPCA/CAADP;
- improve coordination on nutrition at continental level including revision of institutional arrangements and;
- develop an advocacy strategy and produce related materials.

The activities carried out in support of output 1.1 in year 1 and 2 were quite different. Supporting the ATFFND in relation to its mandate to assist African Union Member States in implementing the ARNS mainly consisted of the provision of technical and/or financial support to high level meetings, (preparing of or engaging in) advocacy statements made to the AUC and AU organs and networking to this end).

During the first year output 1.2 consisted of the provision of technical assistance for the Pan-African Forum on Children Panel of Discussion 2012 on Child Health and Nutrition in Africa. This is an activity and not an output (there is no logical relation between this activity and the ANSP objective and specific objective (improve the institutional development). In year one output 1.3 consisted of contributing to the Africa Food and Nutrition Security Day (ADFNSD) 2011 and 2012 and the Joint Ministerial Conference on Agriculture and Trade (JMCAT), which is also an activity. Unsurprisingly, the activities for outputs 1.2 and 1.3 were the same as the outputs themselves.

By contrast, the activities for output 1.4 were quite different from the output itself. The main activities during the first year consisted of (i) support towards the development of a harmonized tool for the
implementation of the ARNS and (ii) follow-up with the DSA / AUC on the submission of a note verbal to Member States for reporting on the ARNS. These activities were relevant and appropriate contributions to the use of ARNS as reference for advocacy and planning activities (output 1.4).

The work-plan for year 2 elaborates only 2 outputs under pillar 1. Outputs 1.2 and 1.3 (which the MTE considers activities) of the work-plan for year 1 were changed into advocacy activities in support of output 1.1 in the interim narrative report (but not the work-plan). Output 1.4 disappeared.

A new output for pillar 1 was introduced in year 2: policy dialogue, communication advocacy, continuous advocacy with the AU to mainstream nutrition in development agenda. In the work-plan for year 3, the OVI for output 1.1 is the number of advocacy activities conducted. For output 1.2, the OVI is the number of high-level events that increase awareness on nutrition organized and participated in. The OVIs thus demonstrate clearly that the focus of pillar 1 is on nutrition security awareness. The narrative reports on year 2 don’t make a distinction between activities for output 1.1 and output 1.2.

Table 2 summarizes outputs and activities under pillar 1 during the first two years, as elaborated in the work-plans. Activities are clustered if part of the same activity (for instance; identify Regional Economic Committees (REC) has been combined with: ensure early invitations to RECs).

Table 2: Outputs and Activities pillar 1 according to the work-plans (year 1 and year 2)

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<th>R</th>
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| 1.1| Africa’s leaders committed to ensure adequate support is provided to implement nutrition action plan for an effective and sustainable socio-economic development and a new output in year 2 only: Policy dialogue, communication advocacy, continuous advocacy with the AU to mainstream nutrition in development agenda | 1. Engage in advocacy within AU institutional mechanisms  
2. Recruit consultant (6 months) to support EC / ANSP activities  
3. Work on Africa Champion for Nutrition  
4. Update factsheet DSA/ AUC on health and nutrition  
5. Develop continental advocacy strategy  
6. Provide input in MNCH Annual Status Report | 1. Engage in advocacy within AU institutional mechanisms  
2. Recruit Programme Nutritionist  
3. Work on Africa Champion for Nutrition  
4. Update and facilitate translation of factsheet DSA/ AUC on health and nutrition  
5. Develop continental advocacy strategy  
6. Provide input in MNCH Annual Status Report |

**1.2** Provide technical assistance for the Pan-African Forum on Children Panel of Discussion 2012 on Child Health and Nutrition in Africa became an activity in interim report Y 2  
1. Engage in advocacy within AU institutional mechanisms  
2. Recruit consultant (6 months) to support EC / ANSP activities  
3. Work on Africa Champion for Nutrition  
4. Update factsheet DSA/ AUC on health and nutrition  
5. Develop continental advocacy strategy  
6. Provide input in MNCH Annual Status Report | 1. Participate in making input and make a presentation at the Pan-African Forum on significance of investing in child nutrition |

| 1.3 | Contribute to the agenda of the Africa Day for Food and Nutrition Security Day (ADFNS) 2011 and 2012 and Conference of Ministers of Agriculture and Trade (CAMAT) became an activity in interim report Y 2 | 1. Technical, financial and logistic support to  
a. 2011 ADFNS  
b. preparation for 2012 ADFSN  
c. JMCAT meeting | 1. Provide technical, financial and logistic support to  
a. 2012 ADFNS  
b. preparation for 2013 ADFNS |

| 1.4 | The African Nutrition Regional Strategy (ARNS) is used for advocacy and planning no longer an output under pillar 1 in interim report on Y 2 | 1. Provide technical and financial support to the AUC/DSA to develop a harmonized tool for the implementation of the ARNS | 1. Support to DSA/AUC to include harmonized ARNS tool in AfricanInfo database  
**New output under pillar 3 in interim report on Y 2** |

26 Activity was moved to pillar 2 in the interim report of second year. Because it was under pillar 1 in the work-plan, we have maintained it under pillar 1 here.

27 Activity was moved to result area 3 in the interim report
During the first two years of implementation, the ANSP supported advocacy for and the identification of a Champion for Nutrition from among Heads of States, provided relevant materials and statistics on child health and nutrition for the 2012 AU status report on Maternal, Neonatal and Child Health (MNCH), provided technical and logistical support for updating the factsheet on health and nutrition (issued by the DSA/ AUC), assisted the ADFNS technically/financially/logistically and contributed to the agenda, and provided support to the Pan-African Forum in Nutrition. In addition, the ANSP engaged in advocacy at a number of high level meetings, which were selected from the AU work calendar and joint programmes. These included the JMCAT meeting in 2012 and the launch of the ARISE 2025 initiative, the Multi-stakeholder Dialogue for High Level Ministerial Meeting for Africa and the African Common Position on Post-2015 Development Agenda in 2013.

The most significant activity in up-streaming policy at continental level during the first two years was the drafting of a Nutrition Advocacy Strategy for the African Union Commission (draft 2012). The strategy aims to foster sustainable engagement and involvement of African leaders and development partners to reduce malnutrition in the African Union (AU) member states. The strategy spells out the magnitude of the nutrition problem, possible interventions and roles and responsibilities of stakeholders. Expected results of the strategy include: (i) enhanced political engagement in nutrition security issues from high to low level leaders of Africa; (ii) streamlined reporting of AU Member States on the implementation of Africa Regional Nutrition Strategy (ARNS); (iii) strengthened collaboration of different experts from different sectors and development partners in food and nutrition security and: (iv) positioning nutrition security as a vehicle for accelerating the implementation of the MDG1, 2, 3, 4 and in the consultations for post 2015 Development Agenda.

The technical work for this activity was mainly carried out by the consultant during the period May - November 2012. A draft Nutrition Advocacy Strategy was shared with DSA/ AUC and finalized following recommendations from the Head of the Health, Nutrition and Population Division DSA/ AUC.

A complementary activity consisted of work related to output 1.1 which reads: the ARNS is used as reference for advocacy and planning activities. The main activity during the first year was to familiarize DSA/ AUC staff with the AfricanInfo database, sensitizing the DSA/ AUC to include (ARNS) nutrition indicators in the database, and secure approval for collaboration with DEA/ AUC. Follow-up activities during the second re-appear as output 3.1 in year two.

Advocacy activities under pillar 1 were relevant in terms of increasing nutrition security awareness, but not appropriate for improving the institutional environment for multi-sectoral approaches, because no strategy was devised to ensure dialogue between different sectors (health, agriculture and social protection), linking nutrition to food security, agriculture and poverty alleviation.

2.3.2 Effectiveness

UNICEF’s obvious key partner for ANSP activities is the Department of Social Affairs (DSA/ AUC). The project document strongly focused on strengthening the ATFFND, which DSA chairs, and the initial idea was that the ATFFND would act as the coordinator of the continental and regional components of the ANSP. The DSA/ AUC and UNICEF have worked together with regard to the ANSP, but the relationship has not been without challenges. The DSA/ AUC is of the opinion that the main added value of the ANSP is to support processes (were necessary complemented by capacity building, data analysis and information sharing. However, as the interim reports indicates, UNICEF has concentrated on advocacy (when and where the opportunity arises according to the UNICEF LO).

Another bone of contention has been the secondment of a program manager / nutrition specialist to the DSA. Due to disagreement on the place where this person should be based (Nairobi or Addis), which level (P5, P4 or even P3) is required and what tasks should be performed in combination with UNICEF internal bureaucratic procedures, this key-position of the ANSP continental component was still not filled two years after the start of the program. Mechanisms to mitigate the effects of this delay were apparently not in place, as the minutes from the tripartite meeting between EC, UNICEF and DSA/ AUC end of April 2013 show. At this meeting, the DSA suggested to appoint a focal point in the UNICEF LO to the AU, who would communicate directly with the DSA/ AUC on the partnership. The DSA also requested more engagement at a technical level, rather than just at the Commissioner level.

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28 Project Document page 5.
29 Lack of diplomacy from the side of UNICEF, unfamiliarity with AUC bureaucratic procedures are contributing factors.
Delays in the recruitment of a nutrition specialist have negatively impacted the effectiveness of ANSP activities. Under pillar 1, the appointment of an Africa Nutrition Champion is an example in case. UNICEF supported the drafting of the ToR and development of criteria for identifying candidates, but the actual appointment didn’t materialize during the years under review. In 2012, the annual ATFFND meeting was organized in Malawi which country was especially selected to align the champion’s process (for which the president of Malawi was the only candidate) with the AUC procedure. However, because UNICEF did not financially, logistically or otherwise support the ATFFND meeting, the follow-up action on the AUC Nutrition Champion delayed. The second time, in 2013, UNICEF did support and attend the ATFFND meeting in Lesotho where the King of Lesotho was nominated and endorsed by the participants. This was formally endorsed by the AU Summit in January 2014.

Other advocacy activities were more effective. One of these was support provided by the ANSP to the ADFNS in 2011 and 2012 and the ANSP contribution to the preparation of the AFNSD of 2013.

**Box 1: Mini Case study (related effectiveness of output 1.1)**

**Effective ANSP support to the Annual ADFNS**

As of 2009, the 30th of October has been declared the Africa Day for Food and Nutrition Security (ADFNS). The main aim of the ADFNS is to raise awareness on food security and nutrition and provide a platform where concerned stakeholders can discuss solutions and make recommendations on food security issues and ways to tackle malnutrition. In 2010 the UNICEF contribution to the 1st ADFNS meeting was minor.

However, since its start in 2011, the ANSP is one of the main contributors to the annual ADFNS, providing technical, financial and logistic support. UNICEF LO to the AU and UNECA is a member of various preparatory committees and provides active technical support in developing the agenda, contributing to/taking the lead in writing press releases, drafting key-note messages leading the internal consultations among the UN Heads of Agencies involved, liaising with ESARO and WCARO on technical inputs and so on. In 2011, at the 2nd ADFNS, specific ANSP input included the organization of the nutrition exhibition accompanying the ADFNS and UNICEF participation in the panel discussion. In 2012, the UNICEF LO to the AU and UNECA organized a Media Breakfast Briefing for journalists to highlight stunting as a silent emergency. UNICEF staff members participated in the panel discussion, making a presentation on the rationale, goals, objectives and impact of the first 1,000 Days of a child’s life. At the breakfast the EU Delegation to the AU, UNICEF and the NPCA provided briefs on the impact of stunting. The UNICEF LO to the AU and UNECA also produced publications such as the annual *ChildrenFirst* newsletter.

Under pillar 1 as well, UNICEF LO made a presentation on the significance of Investing in Child Nutrition at the Pan African Forum on Children in 2012, which contributed to the Forum’s call upon governments to invest in good nutrition during the first 1,000 days. Also advocacy related to the MNCH during the second year was effective. The UNICEF LO contributed to the policy brief on nutrition and reproductive, maternal, new-born and child health in preparation of the first AU International Conference on MNCH (August 201330). UNICEF was one of the more than 10 contributors; the ANSP did not feature among the six key opportunities mentioned in this publication for improving nutrition.

Advocacy at some other events was modest in terms of impact (increasing awareness), because UNICEF LO was only marginally involved. These included the launch of the ARISE 2025 initiative (co-organizers: DSA/AUC and WFP) and the Multi-stakeholder Dialogue for High Level Ministerial Meeting for Africa (co-organizers DREA/ AUC, FAO and NPCA) UNICEF did however sensitize Member States delegations to alert them on the stunting phenomenon in Africa and the need for Member States to take action. At the African Consultation on Post 2015 Development Agenda, the UNICEF LO to AU and UNECA led the Working Group on Human Development and guided the deliberations on this key priority to ensure attention is also paid to nutrition security in addition to food security.

The Nutrition Advocacy Strategy drafted during the first year of the ANSP has been building on existing initiatives such as the ARNS, the Ten Year UN Partnership Framework for the African Union

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Capacity Building, Pillar Three on Nutrition of the CAADP and Social Affairs Department Priorities for 2009 – 2013. According to the MTE, the draft does not sufficiently clarify how nutrition can be fast-tracked by using a multi-sectoral approach\textsuperscript{31}, provides few tools (for instance as outlined in the PANI) and even fewer examples. The draft Nutrition Advocacy Strategy was presented by the UNICEF consultant at the 4th ATFFND Meeting in December 2012. Comments were made by the participants for its finalization. However, because the consultant’s contract was not extended comments had not been addressed at the time of the MTE.

Work on harmonized indicators for monitoring ARNS progress was not effective. Activities undertaken in the first year (sensitization and preparation) were not followed-up as planned during the second year (please refer to section 2.4.2).

2.4 Pillar 2: Institutional development and capacity building

2.4.1 Relevance and Appropriateness

The only output under pillar 2 is support to the Africa Task Force on Food and Nutrition Development (ATFFND) as a major continental coordination mechanism in order to strengthen its mission and work.

During the first year, the ANSP provided technical input in the organization and the convening of the 4\textsuperscript{th} annual ATFFND meeting. The ANSP, according to the work-plan for the first year, notably ensured that early invitations were sent to eight Regional Coordination Committees (RECs) and that RECs needing financial support were identified and sponsored. During the second year of implementation, the ANSP assistance to the ATFFND consisted of administrative and financial support as well as technical input, for instance in the development of the draft programme and concept papers.

2.4.2 Effectiveness

The 4\textsuperscript{th} meeting of the ATFFND was not well attended. From the UNICEF liaison office to the AUC/UNECA only the consultant participated, UNICEF ESARO or WCARO did not participate nor any of the (invited?) RECs. The main recommendations from the meeting included the following: (i) prepare key-messages on nutrition based on evidence from the COHA effective enough to stimulate action; (ii), co-opt more partners in order to strengthen the ATFFND (and conduct a mapping exercise to identify more relevant partners) and; (iii) take advantage of upcoming opportunities to increase the profile of nutrition. The meeting didn’t lead to any recommendations on the selection of the Nutrition Champion (or the nomination of a candidate). According to the DSA/ AUC, chair of the ATFFND, this was at least partly due to UNICEF’s absence and lack of official and administrative support for the meeting\textsuperscript{32}. Later, the UNICEF LO offered to undertake the mapping exercise (presently ongoing).

By contrast, the 5\textsuperscript{th} annual meeting of the ATFFND was well attended by representatives from the AUC, governments, REC’s, UN agencies, NGOs and individual experts. The ANSP provided support through the preparation of the concept note and programme, as well as with logistics and administrative support. The meeting was very productive and formulated conclusions and recommendations on ten different topics. The meeting also allocated various tasks in relation to these ten topics. UNICEF/ANSP was tasked with mapping partners (draft a tool) in collaboration with NPCA and AUC, to continue work on the African Champion with CIFF (developing TORs for the Champion and Ambassadors), in close collaboration with NPCA lead the process of developing the concept of a nutrition score card/barometer and head the review of the ARNS. To this end the meeting made recommendations on the process (hire a consultant, involve RECs and so on) as well as the content (adapt to emerging issues and current context, quantify how much has been achieved and reduce the life-span of the strategy to 5 years). Work on the nutrition-score card is a potentially good example of institutional development which can contribute to up-streaming policy development.

\textsuperscript{31} The only sector mentioned is WASH.

\textsuperscript{32} Approved minutes of tripartite meeting DSA, UNICEF and EC.
Box 2: Mini Case Study (related to the effectiveness of output 2.1)

Nutrition Score Card to strengthen coordination

Nutrition is an example of a domain with many platforms for reviewing policies and strategies, dialogue between Members States is limited, synergies are not sufficiently capitalized on and resources are insufficient and at times under-utilized. This is in particular the case for nutrition with its multi-sectoral dimensions. The nutrition score card is a hand-on tool which addresses the above difficulties. It aims to provide updated information on achievements and early warning and is at the same time a tool for improving and integrating accountability systems. The card is expected to influence agendas of high level meetings of Ministers and/or Heads of State. Ownership among the AU member states is sought by using nationally available data and avoiding ranking.

Homework on the nutrition score card, to be carried out by the ANSP and NPCA, includes identification of the scope and value addition the introduction the card will bring as well as of current initiatives on which the score card can build (country profiles, nutrition dashboards and so on). Feed-back is expected well in advance of the next ATFFND annual meeting.

Another topic discussed was partnerships within the ATFFND, particularly the partnership between the ATFFND and the ANSP. The meeting concluded the following:

- Coordination among partners and within those partner organisations should be improved;
- The ATFFND stands as the steering committee for the nutrition partnerships in Africa in order to ensure harmony with AUC plans and continental policies;
- The partnerships should be built on the initiatives (e.g. SUN, REACH) that already exist, rather than starting all over;
- Governments should take the lead in these partnerships;
- The ATFFND needs to consider strategic engagement of the private sector;
- A mechanism should be established to ensure that even partners who are outside the ATFFND can be heard;
- ANSP has supported the CAADP technically and financially on meetings among countries to formulate CAADP plans;
- All regional Economic Communities (including COMESA) have been brought on board and continues to be involved;
- The Year 3 work plan of the initiative should take into consideration critical issues identified during the 5th Task Force meeting.

Despite the success of the last ATFFND and ANSP’s contribution (also in the follow-up) it is difficult to see what the added value of the ANSP is as compared to contributions by UNICEF before the ANSP came into existence. For instance, during the first ATFFND annual meeting in 2009, attendants concluded that there was an urgent need to harmonize and integrate the ARNS with other existing nutrition instruments and policy frameworks (e.g. NPCA, SUN). UNICEF was asked to produce a concept note to this aim. The ensuing “A Snapshot on the Nutrition Situation in Africa”33 aimed at alerting Africa’s leaders about the need to mainstream food and nutrition in national socio-economic planning, while the complementary discussion report “Food and nutrition security discussion paper”34, was the main input for the 2nd ATFFND meeting. During the meeting UNICEF’s input was considerable. The discussion paper was later also discussed at the April 2010 African Health Ministers’ Conference and the July 2010 AU Heads of State and Government Summit, which resulted in the decision to commemorate 30th of October each year as a day for food and nutrition security (ADFNS). The effectiveness and impact of UNICEF’s contribution on this 2nd ATFFND is until now unprecedented.

Another activity undertaken to strengthen nutrition capacity was updating of the factsheet on health and nutrition, one of the factsheets on activities of the DSA/ AUC. This activity –initially under pillar 1, was undertaken by the consultant in 2012, but DSA/ AUC approval was delayed due to various reasons including a new Commissioner for Social Affairs taking up position in 2012. The draft was undergoing final review at the time of the MTE.

2.5 Pillar 3: Nutrition data analysis and knowledge sharing

2.5.1 Relevance and Appropriateness

The envisaged output for pillar 3 during the first year of the ANSP consisted of the collection and analysis of authoritative data available in Africa for dissemination. Following the AU Heads of States and Governments request (March 2012) to mobilize resources for an Africa wide database (AfricaInfo) integrating both economic and social indicators, the ANSP committed technical and financial assistance to develop this data-base. To this aim, the ANSP in collaboration with DSA/ AUC –the responsible department, trained AUC focal points of the relevant AUC departments as a means to build capacity to support this data-base. Capacity building entailed defining indicators, inserting these into the system, managing harmonized information and ensuring efficient reporting. The focus was in particular on defining and ultimately including nutrition indicators. As outlined in section 2.4.1, work on familiarizing DSA/ AUC with the AfricaInfo database and sensitizing the DSA/ AUC to include (ARNS) nutrition indicators was carried out during the first half of 2012.

The main output for pillar 3 during the second year was supporting the DSA/ AUC in the development of a tool for harmonized data collection of ARNS information (consisting of nutrition indicators). This was one of the tasks of the consultant working for the ANSP in 2012. The activity would go hand in hand with training on the AfricaInfo database for the ANSP consultant and DSA staff. As such, the activity was relevant and appropriate.

The first two years of the ANSP coincided with the high level launch of the COHA (at the AU Conference of Ministers of Economy and Finance in March 2012) and dissemination of results for Ethiopia, Swaziland, Uganda and Egypt (June 2013). From all (public and personal) communication and observation, it is evident that the COHA is one of DSA/AUC’s flagships. The ARISE 2025 initiative, which heavily draws on information gathered in the COHA study, is a telling example in case.

UNICEF did not contribute to data collection in the first COHA pilot countries. According to the second interim report ANSP supported country level COHA launches, but information from others (including from the ANSP Uganda and WFP) contradict this. The MTE understands that UNICEF has expressed interest to participate in the COHA study scheduled to take place in Burkina Faso in 2014. According to the interim report, the ANSP highlighted linkages between the COHA and the ANSP during the partners briefing on the COHA in 2013 by the WFP Assistant Executive Director.

2.5.2 Effectiveness

During the second half of 2012, there were several challenges regarding the work on the tool for harmonized data collection. First, the training in the use of the AfricaInfo base, which was scheduled to take place during the 6 months consultancy of the ANSP consultant, was postponed because equipment was not available (related to funding constraints). In addition, in view of the revision of the ARNS and the related the Plan of Action, DSA/ AUC decided there was no need for the consultant to further work on defining indicators (for the harmonized tool). Later, when the first preliminary COHA study results became available, DSA/ AUC decided that in 2013 work on nutrition indicators should be guided by the results of the COHA study. Further activities related to the development of a tool for harmonized ARNS data collection were therefore not formulated. The output under this pillar was ultimately limited to support the establishment of the AfricaInfo database. This activity was completed (data were transferred from ESARO to the DEA, two expert workshops were organized, data base put in place in the said department and a focal point nominated in each of the 8 Departments of the AUC to work with the DEA). Support to capacity building for the development and maintenance of the AfricaInfo database consisted of capacity training, operationalization of AfricaInfo, training of AfricaInfo focal persons and ensuring collaboration through working with the African Development Bank and the UNECA.

Under Pillar 3, the ANSP also provided input for the annual MNCH report. Information provided in 2013 was better than in 2012. As a result, the 2013 MNCH report highlights the significance of nutrition for MCNCH and the need to mainstream nutrition in MNCH35. In the ensuing draft Plan of

Action towards Ending Preventable, Maternal, Newborn and Child Mortality\textsuperscript{36}, which was discussed at the MNCH experts meeting in December 2013, nutrition is one of the thematic areas for which strategic actions, results and indicators have been formulated\textsuperscript{37}.

In year 2, the visibility of ANSP was promoted mainly through the media breakfast organised at continental level and with UNICEF partners through the Children First Newsletter. The visibility of the ANSP in year 3 was mainly through the Heads of UN Liaison Offices to the AU and UNECA at the monthly meeting of the UN Liaison Team. In year 3, as outlined above, visibility of the ANSP was effectuated during the partners briefing on the COHA study in 2013 by the WFP Assistant Executive Director, where UNICEF LO, during the discussions made a set of recommendations to the DSA/AUC, WFP and UNECA on how to develop linkages between the COHA study and the ANSP. One of the key recommendations was to ensure the same countries involved (Ethiopia and Uganda) integrate COHA and ANSP in the joint programme of the UN Country Team. According to WFP, UNICEF thus far had not supported the COHA in either Uganda or Ethiopia however.

2.6 Efficiency

2.6.1 Operational Efficiency

The implementation of the ANSP is per detailed annual work plans and an overall 4 year work-plan. For each of the pillars, the annual work-plans contain expected outputs, planned activities, activity outputs, a timeline, lead and partners (but not detailing specifically who is doing what and where). The 4 year work-plan specifies base-line and end-line indicators. The first and second narrative interim reports provide information on the operational efficiency. The table below provide details of operational efficiency based on an analysis by the MTE on the completion of activities elaborated in the work-plan (and elaborated in sections 2.4, 2.5 and 2.6).

| Table 3: Level of accomplishments for key activities for the three pillars |
|---|---|---|---|---|---|
| Pillar 1 | Pillar 2 | Pillar 3 | All activities |
| outputs | activities | outputs | activities | outputs | activities | On-track | Delayed | Incomplete | total |
| 2011 - 2012 | 4 | 8 | 1 | 1 | 1 | 1 | 7 | 2 | 1 | 10 |
| 2012 - 2013 | 2 | 4 | 1 | 2 | 1 | 3 | 4 | 3 | 2 | 9 |

The MTE notes that UNICEF’s use of the word completed in its interim reports not necessarily means that the intended result has been achieved. For instance, activities regarding the harmonized tool are finished, but since no result has been achieved, the work is not completed. Likewise, there is a draft advocacy strategy, but this has not (yet) contributed to any output. The MTE team has marked these activities as incomplete. Activities which were supposed to be finalized during the first two years but are still on-going are classified as delayed. For instance the factsheet on health and nutrition was updated, but has not been printed and disseminated. At the time of the MTE there was no Africa Nutrition Champion yet (although someone was nominated) and the nutrition specialist had not yet taken up his assignment. According to the 2\textsuperscript{nd} interim report, “Unclear processes in transfer of funds from regional to continental offices also affected implementation of planned activities at continental level and resulted in low expenditure rates”. The MTE was however unable to establish to which activities reference was made and how exactly transfer of funds impacted on the implementation.\textsuperscript{38} Overall, progress was far less than reports suggest and operational efficiency was below standard.

2.6.2 Financial Efficiency

The total amount of funding available from the EC/ ANSP budget for the continental component is € 1,972,050 (excluding 7% administrative costs). In addition, for the first year, UNICEF made available from its own resources € 147,966. The budget for the first year was € 647,310. Expenditure in year 1 amounted to € 293,242. Only 29% of the EC/ ANSP funds allocated were actually used and 45% of

\textsuperscript{36} Draft Plan of Action towards Ending Preventable, Maternal, Newborn and Child Mortality; available from: http://www.carmma.org/download/file/fid/798Cached
\textsuperscript{37} UNICEF/ANSP is however not among the list of key partners whose support and critical contribution is acknowledged.
\textsuperscript{38} The ANSP is certainly not the only source of funding for the UNICEF AU-LO office.
the total budget for that year. The budget for year 2 was € 536,408, while expenditure was € 199,503, or 37% of the budget. Overall, during the first two years only 17% of the EC budget was spent. Under-

expenditure was mainly due to the delays in the hiring of the project coordinator. The projected expenditure for year 3 is € 401,966, leaving a balance of € 1,225,307 from the original ANSP allocation for year 4.

Table 4: Available funding and utilization of funds (Oct 2011 - Sept 2013)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC/ ANSP allocation (revised)</td>
<td>(a)</td>
<td>1,972,050</td>
<td>499,344</td>
<td>621,873</td>
</tr>
<tr>
<td>Funds from other sources</td>
<td>(b)</td>
<td>147,966</td>
<td>147,966</td>
<td>-</td>
</tr>
<tr>
<td>Total budget</td>
<td>(a + b)</td>
<td>2,120,016</td>
<td>647,310</td>
<td>621,873</td>
</tr>
<tr>
<td>Expenditure EC</td>
<td>(c)</td>
<td>145,275</td>
<td>199,502</td>
<td></td>
</tr>
<tr>
<td>Expenditure other</td>
<td>(d)</td>
<td>147,966</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total expenditure</td>
<td>(c + d)</td>
<td>293,241</td>
<td>199,502</td>
<td></td>
</tr>
<tr>
<td>% utilization of EC budget</td>
<td>(c + d)</td>
<td>59</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>% utilization of total budget</td>
<td>(c + d)</td>
<td>45</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>EC/ANSP balance for following year</td>
<td>(a - c + d)</td>
<td>1,826,775</td>
<td>1,627,274</td>
<td></td>
</tr>
</tbody>
</table>

More than half (58%) of the budget has been reserved for activities in support of results under pillar 1. For pillar 2 and pillar 3 the amounts allocated amount to 13% and 17% of the budget respectively. Surprisingly, although there are no activities under pillar 4, the budget also contains a budget-line for activities in support of this pillar. The amount allocated for pillar 4 is exactly the same as for pillar 2. Closer examination of the budget and expenditure reveals that ESARO allocated the costs of eight activities and divided these equally over the four pillars. These costs include staff costs (programme assistant and administrative assistant), costs of monitoring and evaluation, of international travel (country visit(s) and high level meetings in Brussels), start-up workshop and annual review meeting, dissemination workshops and country exchanges. Pillars 2 and 4 don’t have any other expenses than for these eight activities. Additional expenditure budgeted under pillar 1 includes the costs of the nutrition specialist (40%), additional international travel and training of trainers on nutrition advocacy. Under result 3 costs for documenting good practices has been budgeted as well as IT equipment and a system package for the nutrition specialist. Because these last two have not yet been utilized, expenditure during year two for pillars 2, 3 and 4 was identical (total costs of the 8 activities divided by 3). Expenditure per pillar over the first two years is summarized in the figure below.

Figure 4: Expenditure per pillar during the first two years

During the first year nearly €148,000 was spent on the continental component from UNICEFs own resources. This represents 30% of the total expenditure in year 1. During the second year all expenditure came from the EC/ ANSP budget.
2.7 Conclusions

Relevance

The continental part of the ANSP avails of a budget of more than 2 million euro for four years. Part of the added value of the continental component could have been to ensure a comprehensive approach and align strategies, at the various levels. The results for the four main result areas were succinct. What is missing, also in the logframe, is, firstly, that the results were ‘logically’ and consistently translated into outputs. Secondly, there is no vertical coherence between results (and matching outputs) at the different levels. Thirdly, outputs and results were changed or removed altogether during the course of the project. Fourthly, the terms outputs and activities were used indiscriminately, and thus no distinction was made between outputs and the activities needed to achieve them. The continental component of the ANSP has not capitalized on opportunities arising from ANSP work at regional and country level. ANSP specifically has not taken advantage of two types of opportunities: coherence and thereby added value of combining the four ANSP pillars in a meaningful way; and linking the different levels, which, at least conceptually, could run all the way from the household and community level, to the continental level.

Appropriateness

Given UNICEF’s comparative advantage of having in-house expertise and projects in nutrition, (mother and child) health, education and social protection, advocacy on opportunities and possibilities to link these sectors and/or mainstream nutrition in these sectors (drawing on examples from UNICEF country experience) would have been appropriate. The MTE found very few examples of advocacy for multi-sectoral linkages based on UNICEF’s own experience. In particular sharing knowledge on pillar 4 models of good practice would be an appropriate method for up-streaming policy, complementing the COHA study and the ARISE 2025 initiative, which heavily draws on information gathered by the COHA study. What ANSP does in pillar 4 is ‘offering a remedy’ for the problem signalled in the COHA study. While the COHA focuses on costs and results when we don’t pay attention to the prevention of hunger, the ANSP collects data on the costs and the results when we do pay attention to prevent chronic malnutrition.

Another opportunity for the continental component would be to single out multi-country thematic initiatives in which there has been horizontal learning and comparison between countries. The WANCDI (pillar 2, West Africa) is an example of an existing initiative. For pillar 3 the recently launched NutriInfo provides an opportunity.

Effectiveness

The strategy of the implementers of the ANSP is to select opportunities from the AUC work calendar and joint programmes, focussing on advocacy at commission level. The MTE found very few examples of strategic advocacy in selected fora where the ANSP could have had added value by combining advocacy at policy and technical level. Uneasy relations between ANSP’s main partner at the AUC, the Department of Social Affairs (DSA/AUC) and delays in the recruitment of a nutrition specialist have negatively impacted on the effectiveness of ANSP activities. Under pillar 1, the nomination of an Africa Nutrition Champion is an example in case. ANSP supported the drafting of the ToR and development of criteria for identifying candidates, but the actual nomination didn’t materialize in 2012. The nomination in 2013, during the 5th ATFFFND meeting was only effectuated in 2014.

39 According to UNICEF LO, (…) “The relationship between food security and nutrition security and the multi-sectoral dimension of nutrition security (at continental level) is only raised and highlighted by UNICEF. Quality of UNICEF advocacy did influence on the outcome of deliberations which today highlight these linkages and even the stunting issue. In 2013, WFP came on board to support UNICEF advocacy stunting through COHA study related work”. This, according to the MTE, exactly demonstrates the point: UNICEF’s advocacy at continental level is not strategic and focused, but merely repeating what the LANCET and SUN have been advocating since 2008. There are also examples (a power point presentation for example) which demonstrates this point.
The Nutrition Advocacy Strategy drafted during the first year of the ANSP was presented at the 4th ATFFND and comments were made by participants. However, because none of the UNICEF ESARO and WCARO regional advisors attended because of conflicting dates and the contract of the consultant was not extended, work on the strategy was in limbo since her departure in November 2012 and November 2013, the time of the MTE. Work on harmonized indicators for monitoring ARNS progress didn’t lead to any concrete results either. During the second year, the DSA/ AUC determined that work on nutrition indicators would be mainly guided by the COHA results and ANSP support for the development of a harmonized tool (indicators) for the implementation of the ARNS was no longer necessary. However, capacity building related to nutrition information sharing did occur according to plan either.

Activities aimed at supporting the ATFFND as the major coordination mechanism during the period 2011-2012 were not effective during the first year either. The 4th annual ATFFND was characterized by low attendance –UNICEF didn’t attend nor any of the REC’s. By contrast ANSP support during the second year was quite effective. Attendance at the 5th ATFFND meeting was excellent, and output covered an impressive ten topics. Homework assigned to the ANSP may be indicative of (restored) confidence in added value of the continental component.

Other positive examples are the ANSP contribution of logistical, administrative and technical support to the ADFNS in 2011 and 2012, which enabled the ANSP to influence the agenda and the ANSP contribution to the policy brief on nutrition and reproductive, maternal, newborn and child health in preparation of the first African Union International Conference on MNCH (August 2013). However, UNICEF was one of the more than 10 contributors; in the communication, the ANSP did not feature among the six key opportunities for improving nutrition.

**Efficiency**

Operational efficiency of the continental component during the first two years suffered from sub-optimal coordination within UNICEF because of the absence of a nutrition specialist. In addition timeliness suffered from the delays in the recruitment of the ANSP nutrition specialist at the continental level (the post was not filled two years into the programme) and the appointment of the Africa Nutrition Champion. In addition there were delays outside the control of the ANSP including finalization of the factsheet on health and nutrition (due to a change in DSA Commissioner) and capacity building for the management of the AfricaInfo database (due to funding constraints).

After two years only four out of nine activities were on track, while three were delayed and two were incomplete. The work-plan for the third year of the ANSP doesn’t include any activities in support of output 3 anymore.

Expenditure has been far less than planned and it is unclear how unused funds will/ can be spent in a relevant and coherent manner during the remaining years of ANSP implementation. According to UNICEF LO most of the funds will however be used to pay the salary of the nutrition specialist out-posted to the DSA/ AUC. The nutrition specialist will also assume the pending continental tasks and ensure increased spending of funds in relation to the said activities.

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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ADFNS</td>
<td>African Day for Food and Nutrition Security</td>
</tr>
<tr>
<td>ATFFND</td>
<td>African Task Force for Food and Nutrition Development</td>
</tr>
<tr>
<td>ALMA</td>
<td>African Leaders Malaria Alliance</td>
</tr>
<tr>
<td>AU(C)</td>
<td>African Union (Commission)</td>
</tr>
<tr>
<td>CIFF</td>
<td>Child Investment Fund Foundation</td>
</tr>
<tr>
<td>DREA</td>
<td>Department of Rural Economy and Agriculture</td>
</tr>
<tr>
<td>DSA</td>
<td>Department of Social Affairs</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture Organization</td>
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<tr>
<td>FTF</td>
<td>Feed the Future</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-Deficiency Virus</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
</tr>
<tr>
<td>M(N)CH</td>
<td>Maternal (Neonatal) and Child Health</td>
</tr>
<tr>
<td>MDG(s)</td>
<td>Millennium Development Goal(s)</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
</tr>
<tr>
<td>NEPAD</td>
<td>New Partnership for Africa’s Development</td>
</tr>
<tr>
<td>NPCA</td>
<td>NEPAD Planning and Coordinating Agency</td>
</tr>
<tr>
<td>OVI</td>
<td>Objectively Verifiable Indicator</td>
</tr>
<tr>
<td>REACH</td>
<td>Renewed Efforts Against Child Hunger</td>
</tr>
<tr>
<td>REC</td>
<td>Regional Economic Commission</td>
</tr>
<tr>
<td>SUN</td>
<td>Scaling Up Nutrition</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1 Introduction

1.1 Nutrition Situation

Table 1: Key statistics

<table>
<thead>
<tr>
<th>Key geographic, economic, and social characteristics</th>
<th>Africa</th>
<th>Sub-Saharan Africa</th>
<th>East and Southern Africa</th>
<th>West and Central Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (2010)</td>
<td>1,020,650</td>
<td>855,273</td>
<td>398,968</td>
<td>411,864</td>
</tr>
<tr>
<td>Under-five mortality rate / infant mortality rate (2011)</td>
<td>111/71</td>
<td>109/76</td>
<td>84/63</td>
<td>132/88</td>
</tr>
<tr>
<td>Life expectancy at birth (2010)</td>
<td>57</td>
<td>54</td>
<td>55</td>
<td>53</td>
</tr>
<tr>
<td>GNI per capita (2010)</td>
<td>USD 1,483</td>
<td>USD 1,192</td>
<td>USD 1,486</td>
<td>USD 905</td>
</tr>
<tr>
<td>% of population below international poverty line of US$ 1.25 per day (2007 - 2011)</td>
<td>42</td>
<td>49</td>
<td>45</td>
<td>52</td>
</tr>
<tr>
<td>% of children (2007-2011) early initiation of breastfeeding</td>
<td>46</td>
<td>48</td>
<td>51</td>
<td>41</td>
</tr>
<tr>
<td>% of children (2007-2011) who are exclusively breastfed (&lt;6 months)</td>
<td>34</td>
<td>37</td>
<td>52</td>
<td>25</td>
</tr>
<tr>
<td>% of children (2007-2011) introduced to solid, semi-solid or soft foods (6-8 months)</td>
<td>68</td>
<td>71</td>
<td>84</td>
<td>65</td>
</tr>
<tr>
<td>Antenatal care coverage at least once / at least four times (%) (2010)</td>
<td>78/49</td>
<td>78/47</td>
<td>89/51</td>
<td>71/45</td>
</tr>
<tr>
<td>Vitamin A supplementation full coverage rate (6-59 months) (%) (2011)</td>
<td>86</td>
<td>78</td>
<td>72</td>
<td>83</td>
</tr>
<tr>
<td>% of households consuming iodized salt (2007-2011)</td>
<td>55</td>
<td>49</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>% of infants with low birth weight (2007-2011)</td>
<td>13</td>
<td>12</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>% of under-fives suffering from underweight (WHO), (2007-2011)</td>
<td>19</td>
<td>21</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>% of under-fives (2007-2010) suffering from wasting (WHO)</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from stunting (WHO)</td>
<td>38</td>
<td>40</td>
<td>40</td>
<td>39</td>
</tr>
<tr>
<td>% of children under five with anaemia 2007</td>
<td>59</td>
<td>63</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td>% of non pregnant women (aged 15-45) with anaemia 2007</td>
<td>43</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>% of pregnant women (aged 15-45) with anaemia 2007</td>
<td>48</td>
<td>49</td>
<td>50</td>
<td>49</td>
</tr>
</tbody>
</table>

Malnutrition in Africa is at present one of the leading causes of mortality among children under five. Data indicate that malnutrition including foetal growth restriction, stunting, wasting and micronutrient deficiencies (of vitamin A, zinc, iron and others) contribute to up to 45% of all child deaths in Africa. In SSA this amounts to more than 1.5 million deaths annually.

2 6th Report on the world nutrition situation, UNSCN, Geneva; weighted calculation from tables 17-19, p 38-40
3 Draft factsheet 4: health and nutrition, African Union Commission, Department of Social Affairs, July 2013
There are no average regional (ESA) data on the prevalence of babies born with a low birth weight (less than 2.5 kg), but available country statistics indicate that the prevalence varies from 20% in Ethiopia to 7-8% (Kenya, Rwanda, Tanzania). Nearly 40% of all children less than five years of age in ESA are stunted (an estimated 25 million children). LBW and stunting are strongly associated with non-communicable diseases such as diabetes and cardiovascular disease in adults. While in Asia the prevalence of stunting in children younger than five years decreased from 48% to 27% during the period 1990-2011, the prevalence of stunting in Eastern Africa declined from 51% to 42% and in Southern Africa from 36% to 31%. Figure 1 compares trends in stunting in Africa, in Eastern Africa and in Southern Africa and developing countries in general over the last 21 years.

Figure 1: Trends in stunting (1990-2011)


While in all developing countries together the total number of stunted children under five has declined from 248.4 million in 1990 to 159.7 million in 2011, the number in Africa has increased from 45.7 million to 56.3 million during this period. In Eastern Africa, where population growth is faster than in Southern Africa, the total number of stunted children increased from 18.0 million in 1990 to 22.8 million in 2011. In Southern Africa, the number declined from 2.2 million to 1.8 million in the period 1990-2011. At present, from the 23 countries in ESA, 12 countries have stunting rates above 40%, 6 have rates above 30% and only 2 less than 30% (unknown prevalence: 3 countries).

Nine percent of children under-five in SSA are wasted. In five countries in Eastern Africa (Djibouti, Eritrea, Ethiopia, Somalia and South Sudan) more than 10% of the children under five are wasted. In 2011, an estimated 3.6 million (6.7%) of all children under five were suffering from wasting in Eastern Africa. In Southern Africa 0.3 million children suffered from moderate or severe wasting in 2011. Madagascar is the only country in this part of Africa with a level of wasting higher than 10%. Interestingly, while the average prevalence of wasting in Eastern Africa declined from 8.4% in 1990 to 6.7% in 2011, in Southern Africa wasting increased (from 4.7% in 1990 to 6.7% in 2011). Acute malnutrition increases the risk of mortality due to infectious diseases. Children suffering from severe acute malnutrition are eight to ten times more likely to die from common illnesses including acute respiratory infections, diarrhoeal diseases and malaria than well-nourished children.

At the same time, over-nutrition associated with changes in activity and consumption patterns, characterized by a shift away from diets based on staples and plant protein sources, and an increased intake of foods rich in total fat and saturated fatty acids, as well as processed, energy-dense, nutrient-poor foods and sweetened beverages, is rapidly increasing in Africa, in particular in Southern Africa. In Southern African the prevalence of overweight and obese children increased from 6.1% in 1990 to 16.3% in 2011 as compared to an increase from 4.2% to 7.3% in Africa as a whole. In Eastern Africa, the number of children suffering from overweigh increased only slightly, from 4% to 5% in 2011.

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4 Low birth weight and/or stunting often result in catch-up growth, which in turn may lead to overweight.
6 Eastern African countries (UN sub-region classification) include: Burundi, Comoros, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Rwanda, Seychelles, Somalia, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe.
7 Southern African countries under ESARO include Botswana, Lesotho, Namibia, Swaziland and South Africa. Also Angola—although it formally belongs to Middle Africa, is under the ESARO and included in the Southern African countries.
8 See footnote 1.
Nearly half of all pregnant women and more than 50% of preschool children in SSA suffer from anaemia due to iron deficiency. There are substantial differences between regions however. In Southern and Eastern-Africa nearly half of all pregnant women suffer from anaemia. The prevalence of anaemia among children under five in Eastern and Southern Africa is around 60%. Other micro-nutrient deficiencies, particularly of vitamin A, zinc and iodine, in children under five years of age remain a major problem as well, and progress in combating these deficiencies is slow. Iron deficient anaemia (IDA) and vitamin A deficiency increase morbidity and mortality in young children, while iodine and zinc deficiency are associated with impairment of mental and intellectual functions in children and adults. Countries in Africa lose an estimated to 2-3 percent of their Gross Domestic Product each year due to malnutrition including micro-nutrient deficiencies\(^9\).

Differences in malnutrition between Southern and Eastern Africa may partly be explained by persistent high levels of poverty in most Eastern African countries. Fourteen out of the 17 countries in Eastern Africa are low income countries and only one country (Mauritius) is an upper middle income country. In the Southern African region only one country is a low income country (Swaziland), while five are upper middle income countries. Stunting rates among upper middle income groups are on average a quarter (8.5%) of those among low income groups (38.2%). The same applies to wasting, with an estimated prevalence of 2.2% among the upper middle class income groups, as compared to 9.1% among children under five in low income households.

### 1.2 Regional (ESA) Policy Framework in Nutrition Security

Since the development of the ANSP, integration of nutrition in the development agenda has gained significant momentum. Many countries in Eastern and Southern Africa region now have political support for multi-sectoral coordinating mechanisms and frameworks for nutrition-sensitive development. Many countries also have joined global initiatives to advance nutrition. While there were 14 sub-Saharan African countries that had already joined the SUN Movement at the start of ANSP the number has in the course of the first two ANSP years doubled, to 28; at the time of writing this report, in January 2014, the number has further increased, to 31. At present, 15 out of the 23 ESA countries are a member of the Scaling Up Nutrition (SUN) movement. Thirteen countries of the 17 ESA countries in Eastern Africa (including Uganda and Ethiopia) and two countries in Southern Africa (Namibia and Swaziland) are SUN members. Eight ESA countries are among the early risers which joined in 2010 or 2011, including Uganda. The ESA countries are sharing their experience in costing and tracking nutrition interventions among others through workshops\(^10\).

Commitment to nutrition is also manifested by the relative high number of ESA countries where REACH has been established. Five out of the thirteen REACH countries are in Eastern Africa (Ethiopia, Mozambique, Rwanda, Tanzania and Uganda). Other significant global initiatives for the region include the US government’s “Feed the Future” (FTF) initiative, which has selected seven (out of a total of 19) countries in Eastern Africa as partners. This initiative, focusing on among others inclusive agricultural sector growth, gender integration, improved nutrition, private sector engagement and research and capacity building provides opportunities to boost multi-sectoral approaches to reduce malnutrition and provides good opportunities for linking up with the ANSP. Collaboration between the ANSP and FTF in Uganda is an example in case.

One of the most important African policies in nutrition relevant to the region is the African Regional Nutrition Strategy (ARNS) 2005-2015. The strategy was revised in 2004 and converted into a tool for analysis, planning and program delivery. Objectives of the revised ARNS relevant at regional level include increasing awareness among regional partners, stimulating action at regional level that leads to improved nutrition outcomes and defining mechanisms for collaboration and cooperation among various actors at national, regional and international levels. The ARNS is intended to contribute towards the integration agenda, including enhanced efforts for the development of an integrated regional infrastructure, for regional standards for food fortification and –more in general, coherent programmes that facilitate integration. A plan of action sets out priority areas of action, objectives and

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strategies plus activities for achieving these objectives. These include for instance integration of the ARNS onto the development agenda of the various Regional Economic Committees (RECs).

Another important programme is the New Partnership for Africa’s Development (NEPAD) (2001), a programme of the African Union (AU) aimed at poverty eradication, promotion of sustainable growth and development, and the empowerment of women through building genuine partnerships at country, regional and continental levels. NEPAD is a blueprint for Africa’s development in the 21st century and aims to address challenges facing Africa including the attainment of the Millennium Development Goals (MDGs), the escalating poverty levels and underdevelopment of African countries and the continued marginalisation of Africa from the global economy. NEPAD’s Health Strategy (2007-2015) includes a very limited number of recommendations on nutrition interventions. NEPAD’s Ten Year Strategy for the Reduction of Vitamin and Mineral Deficiencies (VMD) draft Plan of Action 2008-2011 provides a strategic framework to combat VMD. Priorities include food based strategies, supplementation, fortification and (clinical) management of VMD. Pilot countries where the plan is implemented in ESA include Ethiopia and Zambia. The VMD Strategy is complementary to NEPAD’s Framework for African Food Security (FAFS) 2008-2012 which focuses on helping African countries improve economic growth through agriculture-led development and is a companion document to the Comprehensive Africa Agriculture Development Programme (CAADP).

The Comprehensive Africa Agriculture Development Programme (CAADP), developed and endorsed in 2003 by the African leaders and managed by NEPAD, identifies food insecurity, hunger and malnutrition as major problems in Africa that require immediate action. The programme is built around four pillars. Pillar III focuses on increasing food supply, reducing hunger and improving responses to food emergency crises. While investment in increasing the production of staple foods will have an immediate, significant, impact on the poor, increasing the ability of the poor to access sufficient protein and micronutrients through varied, nutritious diets is necessary to ensure sustainable gains in the battle against poverty, hunger and malnutrition according to CAADP. One of the flagship CAADP pillar III programmes is the Home Grown School Feeding Initiative (2012).

The Pan-African Nutrition Initiative (PANI), drafted through a multi-stakeholder consultative process in 2005 and further refined to finality in 2008, applies a multi-sectoral nutrition lens to ongoing CAADP and NEPAD initiatives with a view to identify opportunities to scale up programmes that have high potential to positively impact on nutrition. The PANI is a tool for analysis, planning and programme delivery. Subsequently in 2011, NEPAD and the Global Alliance for Improved Nutrition (GAIN) signed an agreement to develop a five year joint program which fully integrates nutrition security into the Comprehensive Africa Agriculture Development Programme (CAADP) and which helps to harmonize CAADP and nutrition interventions.

1.3 Stakeholders in nutrition security

UNICEF’s main partners at the regional level are NEPAD (now fully integrated in the NPCA, see below) and the Intergovernmental Authority on Development (IGAD), an institutionalized collaboration of seven countries in the Horn of Africa. Other stakeholders include the East, Central and Southern Africa Health Community (ECSA-HC) with 10 member states, and several Regional Economic Communities (RECs) including the Common Market for Eastern and Southern Africa (COMESA) consisting of 19 countries, the East African Community (EAC) consisting of Burundi, Kenya, Rwanda, Tanzania, Uganda and the Southern African Development Community (SADC), with 15 member states. ECSA and IGAD are the most relevant regional bodies to take the lead on nutrition-specific priorities.

ECSA-HC’s Food and Security Programme seeks to contribute to improved nutritional status of the people of ECSA. Objectives include among others: (i) to collaborate with member states and other stakeholders to develop a food and nutrition security regional strategy in line with that of the AU; (ii) to strengthen partnerships between member states and private sector in accelerating food fortification

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11 http://www.nepad.or/history
12 See: http://www.nepad.org/foodsecurity
13 Although IGAD is an intergovernmental agency and technically not a Regional Economic Community (REC), IGAD is sometimes included when reference is made to RECs
and; (iii) to advocate for the integration of high impact evidence-based nutrition action in existing maternal, neonatal and child health programmes in Member States. The ECSA-HC has committed to increase nutrition expenditure from the health budget and scale up high impact nutrition interventions.

The focus of IGAD14 is on drought control and development. The IGAD objectives are among others to: (i) achieve regional food security (...) and; (ii) Initiate and promote programmes and projects to achieve regional food security (...). IGAD and UNICEF have a Memorandum of Agreement signed in April 2013 to formalize the partnership between the two agencies. A Programme Cooperation Agreement between UNICEF and IGAD was being finalized during the course of the evaluation to jointly develop the IGAD Regional Nutrition Policy and Strategy.

The landscape for REC's in support to the ARNS in Eastern and Southern Africa is complex with many regional nutrition priorities. COMESA does not have a nutrition policy or strategy. The SADC countries are in the process of finalizing the SADC Strategic Framework for Food Safety, Food Security and Nutrition. ECA finalized already in 2011 the ECA Food Security Action Plan (2011-2015).

| Table 2: country membership by partnership |
| ESARO countries | SUN | COMESA | ECSA-HC | ESA | IGAD | SADC |

The New Partnership for Africa’s Development Planning and Coordinating Agency (NPCA) is tasked with the implementation of the NEPAD Programme and the AU Development agenda. The core mandate of the NPCA is to facilitate and coordinate the implementation of regional and continental priority programmes and projects and to push for partnerships, resource mobilisation and research and knowledge management15. The NPCA coordinates among others CAADP’s Pillar III activities.

The main ESA regional coordinating body is the Food Security and Nutrition Working Group (FSNWG), based in Nairobi and chaired by FAO. Its nutrition sub-committee is chaired by UNICEF. The Regional Food Security and Nutrition Working Group (RFSNWG) for Eastern Africa based in Nairobi and the Regional Food and Nutrition Working Group for Southern Africa based in Johannesburg co-ordinate and provide the regional dimensions and coordinate technical support, advocacy and technical work on nutrition. Both regional nutrition working groups ensure dialogue between different sectors (health, agriculture and social protection). The Regional Nutrition Working Groups also support countries and coordinate with the AU through the African Task Force for Food and Nutrition Development (ATFFND).

The African Task Force on Food and Nutrition Development (ATFFND), initially established in 1987 was reactivated in 2008 following the revision of the ARNS. The objective of re-activated ATFFND is to assist AU Member States in implementing the ARNS and achieving food and nutrition related MDGs for optimum health and development of all Africa’s Population throughout their life cycle. The specific objectives in particular relevant for the region are to (i) work with RECs and other Regional Organizations to strengthen or establish social affairs desks with Food and Nutrition as a major component; (ii) establish a network of sharing Food and Nutrition information on a regular basis; and (iii) liaise with relevant Universities in Africa on the promotion of research aimed at improving the

14 Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan and Uganda.
15 http://www.nepad.org/npca
status of Food and Nutrition Security on the continent. An important task of the ATFFND is to review progress in the implementation of the ARNS.

A new platform for nutrition is the Eastern and Southern Africa Nutrition Forum which is made up of key stakeholders including the Department of Rural Economy and Agriculture of the AUC, NEPAD, government departments, RECs (SADC, EAC), intergovernmental platforms (IGAD), the ECSA-HC and UN agencies including UNICEF. The forum seeks to contribute to progress on stunting reduction in participating countries through knowledge sharing of best practices in specific thematic areas. It focuses on comparative advantages, challenges and solutions in addressing nutrition in the region. The first meeting was held in May 2013.

2 Findings

2.1 Overall Relevance and Appropriateness

Programme design
The overall objective of the ANSP is to contribute to the achievements of MDG 1, 4, 5 and 8 targets related to nutrition in West and East Africa ensuring that the rights of all children and women are protected from the adverse consequences of the volatile food prices. The specific objective is to improve the institutional environment at continental, regional and national levels contributing to a reduction in maternal and child undernutrition in Africa.

The ESARO component of the ANSP avails a total budget of € 4,476,534. The budget for the individual pillars is R1: € 1,418,006; R2: €1,284,750; R3: € 624,455; R4: €1,149,323. The programme is aimed at 4 results, summarized in figure 2 below.

![Figure 2: Design ANSP at ESARO level](image-url)

ANSP at ESARO level seeks to inform policy dialogue, strengthen knowledge and support policy development on nutrition security. It also seeks to promote integration between relevant sectors (e.g., health, agriculture, water, sanitation and hygiene), and ensure that policy and strategy documents are evidence-based and show better integration between sectoral lines leading to a stronger political commitment and increased funding for nutrition security\(^\text{17}\). The ANSP is thus well aligned with the SUN framework and roadmap and the ARNS objectives.

The ANSP ESARO also builds on regional initiatives. The institutionalized partnerships (through Memoranda of Understanding) with NEPAD and IGAD are examples of strengthening existing initiatives to mainstream nutrition (NEPAD through CAAPD pillar III programmes and IGAD in food security). Through its work with the IGAD and NEPAD, ANSP is well positioned to influence other RECs, including EAC, COMESA and other regional bodies such as the International Conference on the Great Lakes Region (ICGLR), Economic Community of Great Lakes Countries (CEPGL)\(^\text{18}\).

The ANSP aims to help set up and strengthen networks of institutions to build nutrition capacity in the region and create mechanisms for knowledge sharing and cross-country fertilization of experiences. The impact of ANSP is expected to go beyond targeted countries in East Africa, for example by including Kenya, Mozambique, Tanzania and other ESA countries in training activities, dissemination workshops and cross-sharing experiences, which is appropriate in terms of improving the institutional environment – new opportunities provided by the ANSP should be rolled out as wide as possible.

Collaboration with ECSA-HC and NEPAD/CAADP Pillar III provides a good opportunity of advocacy for and support to policies for high impact nutrition specific interventions in the health sector and nutrition sensitive programming in the agriculture/food security sector respectively. The design provides good opportunities to link ANSP pillar 4 experience at country-level with ESARO pillar 1 work.

**Coherence, completeness and complementarity to other initiatives**

ANSP is coherent and mutually reinforcing with the SUN movement. UNICEF coordinates with the SUN Secretariat activities that can support the SUN Initiative for instance during meetings. Please refer to section 2.3.1 for examples. In addition, the ANSP ESARO component is playing a significant role in bringing about continental consolidation through their focus on REC alignment which could ultimately lead to a coherent nutrition frame-work across RECs and across Africa. ANSP is also coherent with multi-sectoral initiatives, such as “Feed the Future”, which seek to strengthen resilient livelihoods and bring renewed attention to the complex relationships between agriculture, food security, and nutrition, and to measures that strengthen these relationships.

The ANSP-ESARO complements activities in the context of REACH, in particular in terms of facilitating processes, in particular coordination mechanisms such as the Regional Food Security and Nutrition Working Group (chaired by FAO) and its nutrition subgroup (chaired by UNICEF) and providing technical support such as for CAADP meeting.

As in WCA, the design of the ANSP ESARO component is such that the programme is fully integrated into the work and activities of the UNICEF-ESARO Nutrition section. As such the ANSP strengthens and reinforces its outreach in terms of coordination and support to countries in the region. According to the project document, “the regional component is the main component of the ANSP supported by the continental institutional base and fed by national scaling up actions”. The regional component is critical in terms of ensuring linkages and coherence and complementarity between the three levels. The MTE looked at the intended level of implementation of outputs (and complementary activities) of the ESARO to assess to what extent the design takes into account the regional “bridge” function.

Expected results at **regional level only** are the following:

- **Result area 1:**
  - R 1.1 Support the active participation of the RECs for the ARNS revision
- **Result area 2:**
  - R 2.1 Strengthen the regional networking of training and research institutions based on understanding of progress, constraints and lessons learned

\(^{17}\) Annex 1 Description of the action CRIS 2011 / 274-032

• Result area 3: no results

Expected results at regional and continental level are the following:
• Result area 1:
  ✓ R 1.2 In line with continental advocacy strategy and policies, deliver technical support to RECs to mainstream nutrition in agenda of high level seminars and meetings at regional level involving heads of states, line ministries and key decision makers.
• Result area 2: no results
• Result area 3:
  ✓ R 3.1 Support towards quality data collection methods, trend analyses and institutional dissemination to relevant stakeholders.

Expected results at regional level and country level are as follows:
• Result area 1 and 2: no results
• Result area 3:
  ✓ R 3.1 Support towards quality data collection methods, trend analyses and institutional dissemination to relevant stakeholders.
• Result area 4:
  ✓ R 4.1 Support toward formative research on infant and young child feeding and community-based nutrition interventions and assessment of opportunities for minimum package of cost-effective and safe interventions

The regional component seems well harmonized with the continental part in terms of pillar 1 activities, both in terms of advocacy and technical support. ANSP ESARO also strengthens the continental component of ANSP through its technical support of the AU. During the course of the MTE, UNICEF was interviewing a P4 nutritionist to work within the AUC. Furthermore, ESARO has organised high level meetings attended by AUC which are further elaborated upon in the continental report. Many activities in support of the continental component don’t feature in the work-plans. The focus on only a limited number of results does not fully reflect the challenges and successes endured by ANSP.

However, the link with the focus countries is limited (both at pillar 1 output and activity level). It is understood that ESARO UNICEF staff regularly supports advocacy at country level (all ESARO countries) but this is part of its regular work, largely demand driven and not a deliberate strategy to maximize ANSP opportunities arising from work in the two focus countries.

Result 2.1 seems to be a stand-alone output, unconnected to work done in the focus countries in terms of capacity development including the development of training modules (e.g. in Ethiopia) or in other countries in the region. There is virtually no complementarity to CAADP Pillar 3 activities (the designated pillar for nutrition and agriculture linkages) and the ANSP seems to lack a comprehensive approach in improving synergy with existing initiatives under pillar 2. The MTE found little evidence of concerted efforts either by the ANSP or in the context of REACH.

Linkages for result area R 3 between in particular ESARO and the Ethiopian ANSP are strong and gaining momentum. However, ESARO doesn’t support structured horizontal learning between the countries, with ANSP countries serving as “models”. The MTE judges the overall linkage between the regional component and the two focus countries as weak.

### 2.2 Monitoring framework

There are quite a few discrepancies between the results in original 4 year work-plan as per the global logframe and the subsequent work-plans for year 1 and year 2. Changes and the reasons for the changes are insufficiently elaborated in the narrative (interim) annual reports.

There is a significant disconnect between results, outputs and activities in both the logframe and the work-plans. One of the challenges is that the logical framework doesn’t make a clear distinction between activities and outputs (that is: indicating which activities are expected to contribute in a logical manner to a specific output). The annual interim narrative reports further contribute to confusion by calling activities outputs (and changing these annually). The work-plans year 1 and 2 merely consist of a list of activities per pillar without any (visible/ recorded) explanation on the connection between activities and outputs. Linkages between activities in year 1 and 2 are not provided either. As such, they are unfit to use as a framework for monitoring.
Another challenge is that some of the objectively verifiable indicators (OVI) have been ill defined, have not been updated or appear to lack a causal relation with the output. For instance, the target for the OVI for output 1.1 – which reads: the number of continental, regional or sub-regional nutrition strategies drafted, is one nutrition strategy paper. This target is not well defined (is this one per year or one for the duration of the ANSP; is this one for the whole continent or one for the ESA and WCA regions/ sub-regions each?) and if achieved, it is unclear what exactly the contribution of the complementary activity (support REC’s advocacy for nutrition) contributed. As reported for WCARO, a further observation is that the baseline often does not seem to reflect a comprehensive assessment of the start situation of early 2012 or of a link to the activities of the ANSP; baseline and target levels are not assessed at a realistic level and fail to demonstrate whether targets express any ambition in terms of accelerating progress. By and large, OVIs seem to be set very modest.

The work-plan for the regional part was revised in the second year to reflect new activities, which were only partly mentioned in the interim reports. For instance, the development of a nutrition investment toolkit featured in the work-plan for year one but had disappeared by year two. Strengthen strategic capacities national and sub-national level through the technical assistance platform was a new activity in the second year’s work-plan. Some changes (such as the delay / change in the provision of technical support for various activities) are not articulated. Although it is understood that activities change and modification are justified, the lack of a clear connection to specific outputs and a description on how the activity will contribute to this output is another reason why work-plans are unfit to use as monitoring framework. In the four-year workplan for year 3 outputs and activities are linked. Moreover, activities that were mentioned in the log-frame but disappeared / were renamed in progress reports re-materialized in this workplan. Because the workplans of the regional component for year 1 and year 2 consisted of activities only and did not link activities to specific outputs, the MTE uses the work-plan for year 3 as reference in the next sections.

Progress of the EC/ ANSP is outlined in the annual interim reports, but these are not always easy to follow due to the issues outlined above. However, thanks to UNICEF’s cooperation, the team has been able to unravel (part of) the differences between intended and actual outputs and activities.

### 2.3 Pillar 1: Upstream policy development

#### 2.3.1 Relevance and Appropriateness

The overall result for Pillar 1 (for all levels) is: Africa’s key policy-makers & leaders of civil society committed to review Plan of Action on Nutrition ensuring that adequate support is provided to implement nutrition action plan for an effective and sustainable socio-economic development. The regional component in the four year workplan has two related outputs. Outputs and activities as per this workplan are summarized in box 1. Because the activities during the first two years don’t precisely match the activities below, the MTE has categorized activities where they best belong.

<table>
<thead>
<tr>
<th>Output 1.1</th>
<th>Support the active participation of the RECs for the ARNS revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td>1.1.1 Support technically REC’s to advocate for nutrition</td>
</tr>
<tr>
<td></td>
<td>1.1.2 Development of toolkit for elaborating nutrition policy, strategy documents, operational and development plans; prepare and disseminate technical and advocacy materials, tools and policy briefs on Action through the technical assistance platform</td>
</tr>
<tr>
<td></td>
<td>1.1.3 Coordinate the implementation and planning of actions with the REACH framework; conduct evaluation of the coordination mechanisms at regional and country level.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output 1.2</th>
<th>In line with continental advocacy strategy and policies, deliver technical support to RECs to mainstream nutrition in agenda of high level seminars and meetings at regional level involving heads of states, line ministries and key decision makers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td>1.2.1 Support the ECSA-SADC-EAC-IGAD nutrition meetings</td>
</tr>
</tbody>
</table>
The ARNS is the key African strategy for nutrition. Supporting RECs to actively participate and contribute to the revision process provides opportunities for harmonized approaches and strengthened comprehensive nutrition programming. This in principle contributes to a coherent nutrition frame-work across RECs and ultimately across Africa.

In April 2013 UNICEF and IGAD signed a Memorandum of Agreement to formalize their partnership and to provide a situational analysis of the nutritional status in the Horn of Africa and the development of the IGAD Regional Nutrition Policy and Strategy. This policy will aim to (i) position nutrition in the development agenda; (ii) advocate for inter-sectoral collaboration at national level and: (iii) support capacity development to facilitate inter-sectoral action for nutrition, community participation and involvement as well as resource mobilization around nutrition programmes. It will take into account the specificity of the IGAD Member States’ contexts, particularly in terms of addressing equity issues among the mobile, cross-border populations, pastoralists and vulnerable communities.

IGAD’s mandate regarding cross-border populations makes it ideally placed to address food and nutrition security across countries –far more comprehensively than some other RECs which until recently had a tendency to focus on improving nutrition through harmonization of trade (e.g. food fortification, free trade of food crops). In addition, through Ethiopia, one of IGADs heavy weights (both due to its location, sharing borders with five out of its six fellow member states and its population size including very substantial numbers of pastoralists) IGAD has strong links with the AUC. ANSP’s partnership with IGAD is therefore highly appropriate, with potential for far reaching influence.

Under pillar 1, the ANSP ESARO provides ongoing technical support to ECSA-HC to develop a regional food security and nutrition policy. A stakeholder validation meeting was held during August 2013 in Nairobi. Support is timely and appropriate given that this is the first priority in ECSA’s Food Security Action Plan (2011-2015). The ANSP also provides support to SADC for the finalization of the Strategic Framework for Food Safety, Food Security and Nutrition. A stakeholder validation meeting was held in Johannesburg in 2012. COMESA doesn’t have a nutrition policy or strategy yet. ANSP continues to engage with them and involves them in multiple regional meetings, particularly those where other RECs are also participating in an effort to increase COMESA’s awareness on nutrition security.

ESARO is in the process of reviewing the African Regional Nutrition Strategy. The outcome of the review, i.e. a revised African Regional Nutrition Strategy will be another means by which to encourage RECs to adopt coherent regional strategies regarding nutrition. UNICEF partners with Children’s Investment Fund Foundation (CIFF) in funding workshops to bring together a regional technical team. UNICEF provided technical support. A complementary activity has been ANSP support to the SUN Secretariat to organize a workshop to discuss costing tools and methodologies to track financial investments in nutrition. The discussions and outputs from this workshop aim to accelerate progress for better costed national plans, ensure that best methodologies are available and facilitate that both nutrition-specific interventions as well as nutrition-sensitive development interventions are considered in national scale-up plans and to create clarity in how budgeting and implementation of costed plans can be made transparent and financially track-able.

ANSP ESARO also closely collaborates with NEPAD. Collaboration, institutionalized through a MOU has included the organization of meetings among RECs to discuss harmonization in nutrition action during the Eastern and Southern Africa Nutrition Forum (co-organized with NEPAD and ECSA-HC).

During the first two years of implementation ESARO has also supported high-level meetings in order to increase political awareness among African governments, to provide an opportunity for exchange among countries and global stakeholders and support the RECs to advocate for nutrition. As part of ANSP’s contribution to Pillar 1, the following high-level meetings were technically and financially supported:

19 Ethiopia is the current chair of IGAD and according to various sources relations with the AU(C) are excellent with extremely short lines.
20 The ECSA-HC website doesn’t acknowledge UNICEF as a partner however. Partners mentioned include among others USAID, World Bank, Family Health International (FHI) and the Commonwealth Secretariat (COMSEC). Information available from: http://www.ecsahc.org/links.php?id=154
22 ANSP Interim Report, UNICEF 2013
The International Conference Against Child Undernutrition held in Paris 2013, which spurred African countries to commit to scaling up nutrition by joining the SUN Movement.

The International Conference on Maternal Newborn and Child Health organized by the DSA/AUC was held in South Africa August 2013 where ESARO regional and continental components organized the Nutrition Security Session, Child Health, Newborn Health and Strategic Interventions.

A High-Level Regional Integration Seminar held in Botswana enabling RECs to engage in dialogue, network and sharing experiences on policies and strategies to reduce stunting. NEPAD, IGAD, ECSA-HC, SADC and the Common Market for Eastern and Southern Africa (COMESA) presented mandates, nutrition strategies and policies.

The Eastern and Southern Africa Nutrition Forum in June 2013 in Zambia co-organized by UNICEF, IGAD, NEPAD and ECSA-HC and attended by members of African Union Commission (AUC), NEPAD, SADC, EAC, IGAD, ECSA-HC, which highlighted the burden of stunting and global developments in stunting reduction.

In addition, the ANSP ESARO also provided substantial support to advocacy activities carried out at continental level, including technical support to and participation in high-level meetings such as the Africa Day for Food and Nutrition Security and the African Task Force for Food and Nutrition Development. Supporting these meetings was relevant, because they provide an opportunity to combine advocacy with increasing awareness of key stakeholders and partners of the need for nutrition policy formulation.

ANSP also provided technical and financial support to the RFSNWGs for Eastern and Southern Africa. These meetings bring together UN partners, donors and NGOs.

Under pillar 1, ESARO provides the organizational and administrative support to the ANSP annual review meetings and convenes in between meetings to review of progress (attendance largely through teleconferences). The program focal point is also based in ESARO. The ATFND is the designated platform to coordinate interventions of the ANSP at continental level. The EU management has been transferred from Brussels to the Delegation to the African Union based in Addis Ababa.

### 2.3.2 Effectiveness

UNICEF coordinates with the SUN Secretariat activities that can support the SUN Movement for instance during the meeting on Country Engagement and Way Forward on the SUN Movement (2012) and the Workshop on Costing and Tracking Investments in support of the SUN Movement (2013). UNICEF has also been participating in SUN Meetings and in Joint Missions (with FAO, WFP and/or WHO) to advocate for more countries to join the SUN Movement. ESARO reviewed the progress; identified challenges, opportunities; and highlighted areas for technical support needs such as the costing of national multi-sectoral plans and the mobilization of domestic resources during the 2012 Scaling Up Nutrition (SUN) Movement Government Focal Points’ Meeting in New York. ANSP collaboration with SUN is highly effective, because it builds on and strengthens existing initiatives and mechanisms, avoids parallel structure and rationalizes resources.

Some of the challenges in working with RECs include increasing awareness on nutrition for development and translation its multi-sectoral dimension into policy. The ANSP through its collaboration with NEPAD, which manages the CAADP and IGAD, with its intergovernmental mandate targeting a substantial part of Eastern Africa, demonstrates that improved synergies facilitate multi-sectoral policy development. As a result, RECs interest to support the revision of the ARNS and regional policies has increased considerably. ANSP support to NEPAD’s mapping of RECs has been delayed somewhat but is expected to gain momentum following its inclusion in the tasks agreed on at the 5th ATFND meeting.

Through ANSP continued efforts to help place nutrition on the agenda of high-level meetings, regional cohesiveness becomes ever stronger. The “Regional Discussion on Country Engagement and Way Forward in the SUN Movement” for example engaged 90 stakeholders from government partners, UN agencies, and regional organizations in dialogue, networking, and sharing of experiences to develop ways to reduce stunting within the context of resource constraints. The diversity of participants reinforces the notion that a broad-based partnership in terms of sectors and type of stakeholders is necessary for the reduction of stunting. Such meetings help promote political commitment to the SUN
Framework across Eastern and Southern Africa. Political buy-in is a key aspect of the SUN process to maintain full in-country support for nutrition. In addition this type of meetings can inspire other countries to join the SUN Movement, and improve collaboration among regional entities.

ESARO has also initiated/supported compilation of advocacy materials cum tools. These include the Africa Regional Situational Analysis on Child Nutrition consisting of background and literature review, regional policy survey and advocacy strategy paper. A complementary analytical paper on multi-sectoral nutrition policy survey is being finalized. In addition the ANSP commissioned an in-depth analysis of maternal nutrition interventions and programmes (please refer to section 2.5.2).

**Box 2: Effective up-stream policy (output 1.1)**

The combination of advocacy, facilitating attendance by RECs, UNICEF nutrition staff (of both ANSP focus and non-focus other countries) and other ANSP partners at coordination meetings and high level fora has accelerated RECs engagement in up-stream nutrition policies in Eastern Africa. By mid 2013, nearly all RECs, Including those (like COMESA) which initially let other priorities prevail, were on board in terms of supporting the revision of the ARNS and strengthening work on regional nutrition policies. Through its MoU with IGAD and NPEAD, UNICEF will ensure influence over complementary initiatives which the ANSP does not directly support. These include for instance a new initiative, the Programme on Food Security for Eastern Africa launched by the RECs and IGAD in August 2013, aimed at enhancing cooperation in the area of food and nutrition security. The programme aims to build on linkages between existing related interventions within the framework of the CAADP.

Eventually ESARO may play a significant role in bringing about continental consolidation through its focus on REC alignment. In addition, involvement of RECs contributes to a strengthened institutional environment at regional level as well as at the level of individual countries in line with the specific objective of the ANSP.

Under ANSP, the scope of the RFSNWG for Eastern Africa for nutrition has been broadened to include longer term nutrition security aspects (besides emergency nutrition). Within the RFSNWG for Southern Africa, UNICEF provides the nutrition lens to the discussion and is especially engaged in the joint nutrition survey, with specific interest in preserving the quality and reliability of the nutrition component of the surveys.

During the first two years of implementation two annual review meetings were organized in Bamako and Dakar respectively. The meetings were effective in discussing achievements, challenges and lessons learned during the first year, as well as next steps. The meetings were also an opportunity to share experiences reach a common understanding of the ANSP. The MTE observes however, that the meeting in Dakar was less effective in addressing some of issues raised in the EC’s response letter to the first interim report. Notable weaknesses in the design such as lack of coherence between the three levels, and problems around monitoring were hardly discussed. Monitoring and evaluation was mainly addressed in the context of country programs. Issues around the steering committee were not resolved and much of the attention was geared towards operational issues at the cost of more strategic aspects.

**2.4 Pillar 2: Institutional development and capacity building**

**2.4.1 Relevance and Appropriateness**

The overall output of the ANSP for pillar 2 is strengthened departments and units at all levels with qualified practitioners in nutrition and reinforced coordination mechanisms involving African networks. It is therefore appropriate and relevant that the regional component focuses on strengthening the regional network of training and research institutions. Table 3 summarizes the ANSP ESARO output and activities for pillar 2.

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Box 3: Result and activities for Pillar 2

<table>
<thead>
<tr>
<th>Output</th>
<th>2.1</th>
<th>Strengthen the regional network of training and research institutions based on understanding of progress, constraints and lessons learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2.1</td>
<td>Assess the nutrition learning needs and gaps in the region; develop a roadmap and support countries on curriculum revision for pre-service and in-service training</td>
<td></td>
</tr>
<tr>
<td>2.2.2</td>
<td>Capacity development packages to address nutrition sensitive development, leadership capacity and project management skills</td>
<td></td>
</tr>
<tr>
<td>2.2.3</td>
<td>Strengthen capacity for adaptive management of the community-based nutrition Programme*</td>
<td></td>
</tr>
</tbody>
</table>

* This activity was under pillar 4 in the workplans for the first and second year. Cornell University tasked with this activity had not yet started in the ESARO region at the time of the MTE. This activity is restricted to the focus countries.

Activities carried out during the first two years of the implementation of the ANSP included among others an assessment jointly initiated by UNICEF, the World Bank and Helen Keller International on the capacity of mid-level nutrition professionals in Kenya, Tanzania and Uganda. The assessment identified the following needs: (i) standard curricula for nutrition service providers; (ii) quality standards for performance-based appraisal; (iii) systems for the collection analysis and interpretation of nutrition indicators and: (iv) guidance for districts to plan, budget and manage nutrition activities at district level. In response, ANSP under pillar 2 seeks to strengthen the capacity of nutrition professionals in the region. The first step was to develop ToR and hire a consultant to map learning needs and gaps among policy makers, implementers and development workers in the region and identify training institutions to address these gaps. Next steps will include the developing of training modules and a package of advocacy and implementation modules.

Activities are relevant, clearly responding to a need. The MTE found ample evidence that there is a huge need for training of service providers (both pre-service as well as in-service) and for capacity building in nutrition among policy makers and programme implementers. During interviews representatives from government, NGO and UN partners expressed time and again the lack of nutrition capacity and the added value the ANSP could have in nutrition capacity building. The set of envisaged activities is also appropriate in the sense that training modules will be tailor-made for the various target groups.

2.4.2 Effectiveness

The ToR for the consultant mentioned above, finalized in 2012, included not only a mapping exercise (consisting of an assessment of needs and an audit of existing curricula), but also the drafting, validating and finalisation of a curriculum for pre- and in-service nutrition education. The consultant is expected to finish the work within 6 months, using interviews, surveys, and other tools not only for the mapping, but also to draft the curriculum. This is an effective way to speed up outputs, but the disadvantage is that the required expertise is not readily available.

The contract with the consultants was only signed in August 2013. The ANSP in Ethiopia and Uganda is also involved in mapping of nutrition capacity, setting up country-wide networks, supporting curriculum development and nutrition capacity building activities. These activities are complementary to ESARO activities. Results of the consultancy will facilitate the implementation of harmonized and appropriate standard nutrition curricula.

During the first year of implementation UNICEF started to explore institutions for partnerships. These included Wageningen Agricultural University for the development of the curricula for nutrition, food security and agricultural linkages and the African Nutrition Leadership Programme for a course on leadership and management of nutrition at decentralized levels. According to the annual report, during the second year the ANSP was entering a contract with an institution to develop a course module on nutrition and agriculture linkages along with a package of advocacy materials and technical briefs. However, at the time of the MTE a contract had not been signed yet and the MTE learned that the whole process was delayed because of financial issues. During the second year the ANSP also reviewed proposals from institutions to develop the nutrition leadership and management capacity in the region, but concrete results in terms of rolling-out a regular nutrition leadership and management seminar for target countries is expected to take place not before year 3.
A milestone in terms of capacity development was the CAADP Nutrition Capacity Development workshop for East and Central Africa held in Tanzania in February 2013\textsuperscript{24}, which 19 countries attended and a similar workshop for 14 southern African countries held in Botswana in September 2013. Participants represented the sectors of agriculture, health, education, finance, private sector, and civil society. There were also representatives from the AU, RECs, CAADP and Nutrition Development Partners, Donors, UN and NGOs. CAADP’s focus is in particular on integrating nutrition and agriculture. The workshop was technically, financially and in terms of content heavily supported by FAO and NEPAD. Also staff from ESARO was involved. ESARO supported the participation of the delegations from Ethiopia and Uganda for this workshop, as well as from the delegations from Namibia and Lesotho to the workshop in South-Africa for countries from Southern Africa. The ANSP didn’t contribute financially to this workshop. ANSP support to the synthesis of the nutrition situation in the respective countries (background briefs), elaborated in preparation for the workshop, was limited as was its contribution to group work for the country specific road-maps in comparison to the contribution of development partners in agriculture (FAO, CAADP, Ministries and so on). This calls into question what the added value of the ANSP is and will be in advancing the linkages between nutrition, food security and agriculture. There are also substantial needs for strengthening nutrition sensitive programming in the WASH, social protection and education sectors. These are all sectors for which UNICEF has in-house expertise and for which ample opportunities exist for doing by learning.

Strength capacity for adaptive management of the community-based nutrition intervention is part of the package of support activities which Cornell University will provide. The activity will start according to the workplan in April 2014, presumably in WCA focus countries first. Introduction of a tool to adjust programmes in year three of implementation of a four year programme has limited effect, as it only impacts the last year. In view of the delays it is questionable whether the programmes in Uganda and Ethiopia will benefit at all under the current ANSP.

2.5 Pillar 3: Nutrition data analysis and knowledge sharing

2.5.1 Relevance and Appropriateness

Under pillar 3 the ANSP aims to develop sustainable nutrition information systems and knowledge management with strong information systems such as food security, early warning systems and health management information systems. The output and activities of the ESARO component according to the four year work plan are summarized in table 4.

<table>
<thead>
<tr>
<th>Output</th>
<th>3.1 Support towards quality data collection methods, trend analysis, knowledge management and institutional dissemination to relevant stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td>3.2.1 Support real-time learning, sharing and documentation of project experiences through the technical assistance platform including support roll out of the “RapidSMS-based” system for programmes and survey data</td>
</tr>
<tr>
<td></td>
<td>3.2.2 Support the implementation of nutrition surveys and information systems; support country offices to document implementation processes</td>
</tr>
</tbody>
</table>

According to the project document, activities at ESARO level would consist of; (i) support to nutrition data collection from countries, (ii) strengthening linkages with national and regional food security data collection and analysis processes (including FEWSNET and COHA), improvement of nutrition context analysis in relation to disparities and; (iv) improvement of data collection methods and trend-analysis.

At global level, UNICEF has introduced MoRES (Monitoring for Results for Equity System) as a tool for monitoring progress, learning from achievements and challenges and adjust programs. The regional office in Nairobi organised a workshop for nutrition officers in 2012 on the use of MoRES, also as a means to harmonize monitoring frameworks for community-based nutrition programmes (in among other the ANSP focus countries). ANSP ESARO provides technical support to Ethiopia (but not Uganda) for developing a comprehensive nutrition monitoring framework. The workshop in

combination with ongoing technical support to Ethiopia is a good example of strengthening data collection methodologies and support real time learning.

A related activity planned for during the first year was the development of a “RapidSMS-based” system for stunting tracking. The envisaged advantages include standardized data collection and reporting and availability of real-time data. Two regional workshops were organized in Nairobi attended by staff from with UNICEF Headquarters in New York to explore the possibility of using SMS technology to monitor and report on nutrition indicators on real-time. In addition, ESARO participated in the Technology for Development workshop in Rwanda and consulted with participants on the “RapidSMS-based” system.

Under pillar 3 the ANSP is also developing the NutriInfo interactive website. This data-base aims to promote a standard comprehensive analysis of both prevalence and burden of malnutrition over time. WCARO has the lead. The development of an African wide web-based system for nutrition information is in principle an appropriate activity. However, this activity has provoked a lot of discussion. The AUC expected ANSP to build a web-based system for all available nutrition data, accessible for all countries in Africa, while the ANSP intended to focus on nutrition survey data and links to existing nutrition resource systems. A confusing factor was the parallel (but not directly related) ANSP activity at continental level in relation to the Africa wide database (AfricaInfo). This activity is in limbo due to lack of funding. Complementarity between the two data-bases has not been sought up-front.

The ANSP ESARO component under pillar 3 supports countries with evidence-based guidance on programming. To this end the ANSP has provided technical and administrative support to a review on literature on maternal nutrition interventions and programmes. Such a review is relevant in view of the intergenerational cycle of malnutrition and the fact that maternal nutrition is receiving less attention than it deserves in order to appropriately address malnutrition in particular stunting.

2.5.2 Effectiveness

ANSP support to Ethiopia has been effective and resulted in among others a nutrition information system which is capturing and tracking monthly growth data for timely feedback and action at health posts. Support is ongoing regarding linkages with existing nutrition information collection systems in Ethiopia – including from emergency nutrition and, eventually other sectors including the agricultural sector.

Despite some initial misunderstanding, the development of the NutritionInfo database has progressed, including integration and input of quality-assessed country data (national data such as DHS and MICS as well as sub-national surveys) from the past five years into the NutriInfo platform. However, it remains to be seen how effective this activity is. Effectiveness of a database depends on ownership of its users and there is a risk that past misunderstandings negatively impact. The plan for NutritionInfo is eventually to subsume it within AfricaInfo and advocacy for this will begin once NutritionInfo is ready for sharing. This is an initiative with a potentially positive impact on ownership (Note: this activity is under ANSP-WCARO and funded as such).

The review of literature on maternal nutrition interventions and programmes has resulted in recommendations on best approaches for a sustainable impact on maternal nutrition in the Eastern and Southern Africa. The report will be published shortly. This in-depth-analysis including hands-on recommendations is an effective way of analysing data and sharing knowledge. However, this activity is also a typical example of activities which are routinely carried out by UNICEF regional offices and the MTE misses a justification for funding under the ANSP.

ESARO has not supported the implementation of nutrition surveys in the region under the ANSP. Many countries in Eastern Africa have substantial experience with nutrition surveys, including surveys using the SMART methodology. Many countries including among others Uganda, Kenya and Ethiopia have guidelines for nutrition surveys and expertise to support less experienced partners. For ESARO this activity does not seem very relevant. Support country offices to document implementation processes is not provided to Ethiopia or Uganda.

25 Both data-bases are expected to hold nutrition data but the AfricaInfo will have much more information on economic and other sectoral indicators. NutriInfo is currently being run by UNICEF in WCARO while AfricaInfo in under the AUC.
There were some successes, but overall effectiveness of activities under this pillar is disappointing. There has been no follow-up (under the ANSP) in terms of strengthening country capacities in monitoring and evaluation using MoRES. The system is not (yet) used in either Ethiopia or Uganda for monitoring pillar 4 activities. The feasibility of a “RapidSMS-based” system for stunting tracking was found to be too ambitious. Challenges include country ownership of the technology, maintenance, and sustainability; government’s willingness to share real-time data; and the interoperability and scalability of the systems within different sectors or institutions. There has been very little support to (focus) countries regarding data collection and analysis, knowledge management and critical documentation. The MTE notes, that although this activity has not been effective in terms of contributing to pillar 3 outputs, ESARO’s approach is cost-effective because ESARO didn’t pursue this activity after consulting internal and external expertise.

2.6 Pillar 4: Scaling up Direct Nutrition Interventions

2.6.1 Relevance and Appropriateness

The ANSP output for pillar 4 is strengthened capacity for adaptive management of the community-based nutrition programme. The output and corresponding activity of the ESARO component are summarized in the table below.

Box 6: Result and activities for Pillar 4

<table>
<thead>
<tr>
<th>Output</th>
<th>4.1 Support toward formative research on infant and young child feeding and community-based nutrition interventions and assessment of opportunities for minimum package of cost-effective and safe interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td>4.1.1 Support to the development of a model for conducting formative research on nutrition interventions</td>
</tr>
</tbody>
</table>

The main role of the ANSP regional component is to further strengthen implementation of nutrition interventions at country level. This is to be achieved among other by strengthening leadership and strategic capacity among nutrition teams. Concrete activities according to the project document and the original logframe, would consist of two activities: (i) an assessment for minimum package of cost-effective and safe interventions and (ii) development of a model for conducting formative research on nutrition interventions. Activities in the annual plans for the first and second year as well as in the 4 year plan continue to change and miss clear linkages. Moreover, the 4 year plan mixes activities (inputs) with outputs. Also from reports and work-plans it is not clear from the way activities are formulated how activities will support the focus countries. The reality is however somewhat more coherent. The ANSP has signed a cooperation agreement with Cornell University to harness country experiences regarding the implementation of community-based nutrition interventions in the four ANSP focus countries. The main objectives of Cornell University support will be to 1) strengthen strategic capacities at national and sub-national levels, 2) strengthen the capacity for adaptive management of the community-based nutrition program and 3) support real-time learning, sharing and documentation of project experiences. This support is in principle relevant and appropriate.

UNICEF reports in its second interim report that ESARO provides direct country technical support and capacity building around specific priority areas such as stunting, which includes development of materials and tools. As part of this work, according to the 2nd interim report, ANSP financially and technically supported the development of the following technical documents for the (ESARO and WCARO) regions: (i) in-depth analysis of maternal nutrition interventions and programmes and (ii) Child Health and Nutrition Module as part of AUC’s publication of the 50 Years of Health and Development in Africa; Vision for the Next 50 Years. The MTE notes that this last activity was presented as an example of high level advocacy under pillar 1 in the first interim report and was as such better categorized, because it is not particular relevant for pillar 4. The first activity is not specifically relevant for pillar 4 either, according to the MTE. Moreover, the first interim report made a reference to this activity under output 3.1. Activities have been moved back to the pillars where they originated and their effectiveness assessed accordingly.
2.6.2 Effectiveness

Support by Cornell University to Ethiopia and Uganda had not yet started at the time of the MTE. Effectiveness during the implementation of the ANSP will be limited (although effective in the long term). Also, again as noted for the ANSP WCARO component, the expected result under this pillar aims at a coherent, coordinated and synergic implementation together with other sectors. Support by Cornell University in developing of multi-sectoral approaches applicable at national and sub-national levels is missing, which will hamper effectiveness.

ESARO has not supported formative research on IYCF in Uganda or Ethiopia. In Ethiopia research has yet to take place. In Uganda, where the ANSP hired a consultant, research was finished in 2012 and results were used to feed BCC. In Mali and Burkina Faso a consultant will carry out similar research, but seemingly independently of and not building on experience in Uganda. As also noted for WCARO, a strategy for building on experiences, mutual learning and sharing good practices to scale up interventions is missing. In sum, the MTE didn’t find any evidence of ESARO activities specifically in support of pillar 4.

2.7 Efficiency

2.7.1 Operational Efficiency

The implementation of the ANSP is per detailed annual work-plans and a 4 year work-plan. For each of the pillars, the annual work-plan contains planned activities. The work-plan for year 3 is the first plan which also contains outputs, implementing agency/ component and partners (but not detailing specifically who is doing what, when and where). The 4 year work-plan specifies base-line and end-line indicators. The first and second narrative interim reports provide information on what has been carried out. Work-plans (in particular for year two) and interim reports have been used to assess operational efficiency.

Because interim reports report progress against outputs rather than against activities the term “on track” used in the interim reports is quite meaningless. The MTE has attempted to assess whether planned activities were indeed carried out according to plan (at least in the planned year). Activities which were carried out according to plan were classified as on track (working towards or achieving the desired result) or incomplete (if the activity had been (partly) carried out but left unfinished because not feasible, lack of cooperation or other reasons). Examples of the ESARO component of incomplete activities include work on the RapidSMS based information system and support with nutrition surveys. Activities which were supposed to be finalized during the first two years but are still on-going are classified as delayed. Activities which were supposed to start but didn’t start at all are also classified as delayed. An example is strengthening of the capacity for adaptive management. The table below provides details of operational efficiency based on activities elaborated in the work-plan (in line with details in sections 2.4, 2.5, 2.6 and 2.7).

<table>
<thead>
<tr>
<th>PILLAR</th>
<th>PILLAR 1</th>
<th>PILLAR 2</th>
<th>PILLAR 3</th>
<th>PILLAR 4</th>
<th>ALL ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>On track</td>
<td>delayed</td>
<td>incomplete</td>
<td>total</td>
<td></td>
</tr>
<tr>
<td>2011 - 2012</td>
<td>6*</td>
<td>3</td>
<td>3</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>2012 - 2013</td>
<td>7</td>
<td>4</td>
<td>4 (5)**</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

* Support to high level meetings are taken as one (clustered) activity **Includes ESARO activities regarding the RapidSMS based information system; Support with implementation of nutrition surveys and information systems has been split into two separate activities.

Because of the disconnect between activities in the original work-plan for year 1 and actual implementation, it was impossible to judge progress comparing the work-plan and the interim report. The latter was therefore used as guidance, providing a somewhat flattered picture (start-up has been recorded as on track). For year two it was easier to track progress. Overall, progress for pillar 1 was excellent, for pillars 2 and 3 about half of the activities were on track, while there was no progress for pillar 4 at all.
2.7.2 Financial Efficiency

The total amount of funding available from the EC/ ANSP budget for the ESARO component is €4,476,534. The budget for the individual pillars is €1,418,006 for R1; €1,284,750 for R2; €624,455 for R3 and; €1,149,323 R4 (all excluding 7% administrative costs). For the first year, UNICEF contributed from other resources €125,313. The total budget for the first year was €1,314,378. Total expenditure in year 1 amounted to €669,153. Little over half (56%) of the EC/ ANSP funds allocated were actually used and 46% of the total budget for the first year. The budget for year 2 was €1,743,373, while expenditure was €1,609,536. During the 2nd year, 92% of the available funds were utilized and from the funds available from the EC/ANSP budget 89%. Overall, during the first two years of implementation 67% of the EC budget was spent. The projected expenditure for year 3 is €1,806,840 leaving for the last year a balance of €90,212 excluding funding from other resources (for year 3 as well as for year 4). Budget and expenditure are thus well in balance.

### Table 4: Available funding and utilization of funds (Oct 2011 - Sept 2013)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC/ ANSP allocation</td>
<td>(a)</td>
<td>4,476,534</td>
<td>1,189,065</td>
<td>1,162,190</td>
</tr>
<tr>
<td>Funds from other sources</td>
<td>(Y 1 and Y 2) (b)</td>
<td>706,497</td>
<td>125,313</td>
<td>581,184</td>
</tr>
<tr>
<td>Total budget</td>
<td>(a + b)</td>
<td>5,183,031</td>
<td>1,314,378</td>
<td>1,743,373</td>
</tr>
<tr>
<td>Expenditure EC</td>
<td>(c)</td>
<td>543,840</td>
<td>889,578</td>
<td></td>
</tr>
<tr>
<td>Expenditure other</td>
<td>(d)</td>
<td>125,313</td>
<td>537,731</td>
<td></td>
</tr>
<tr>
<td>Total expenditure</td>
<td>(c + d)</td>
<td>669,153</td>
<td>1,427,309</td>
<td></td>
</tr>
<tr>
<td>% utilization of EC budget</td>
<td>(c ) / (a)</td>
<td>46</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>% utilization of total budget (c + d ) / ( a + b)</td>
<td>51</td>
<td>82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EC/ANSP balance for following years</td>
<td>3,932,694</td>
<td>3,043,116</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*According to UNICEF detailed financial report 2012-2013 (Sept 30, 2013). Figure is incorrect according to MTE.

The rate of expenditure was 52% for pillar 1, 18% for pillar 2, 57% for pillar 3 and 67% for pillar four during the first two years. Expenditure for pillars 3 and in particular pillar 4 was disproportionate in comparison to achievements. Figure 2 shows the budget and expenditure during the first two years.

Figure 3: Budget and expenditure during the first two years per pillar

According to UNICEF, expenditure on pillar 4 entailed among others: an IYCF Workshop in Malawi (April 2012): 4 countries; an IYCF Workshop in Namibia (May 2012): 4 countries, Nutrition in HIV Workshop (November 2012): 5 countries; Code Training (February 2013): 2 countries; Micronutrient/CHD Workshop (March 2013): 7 countries and ProPAN Training (August 2013): 5 countries. This demonstrates that the budget for this pillar was not used to scale up direct nutrition interventions, but for activities ESARO is carrying out anyway – which as far as the MTE understood was not the
intention of the ANSP. In any case, these activities should feature under pillar 3 (capacity building) rather than pillar 4.

UNICEF kindly also provided additional information on expenditure broken down per budget-line for 2012 and 2013. The figures are for fiscal year 2012 and 2013 and therefore do not match the figures provided in table 5 and Figure 2. The break-down was calculated to see how the project expenditure was divided over the traditional (more commonly used) budget-lines.

Figure 3: Break-down per budget-line

Figure 2 illustrates that expenditure was fairly evenly distributed among the staff, contractual services and general operating cost, while expenditure on supplies and equipment and travel was less. This illustrates the extent of the technical assistance provided by ANSP.

At the time of the MTE, ESARO had not yet received funds for year 2. According to the EU, ESARO had applied for second year funding when it had utilised 68% of funds (instead of the required 70%). Thus the application was rejected. As a result, UNICEF in November 2013 was operating with a debt of almost 2 million owed to EU. However, after discussions with the EU on the calculations of the expenditure rates (ESARO was using slightly different formulas), a new financial report was submitted in October showing that the expenditure rate required (100% from year 1 and at least 70% from year 2). This was approved by the EU in December.

The ANSP in ESARO has been rather successful in leveraging additional resources. In addition to EC funds, funding was also received from the Japan Government, CIDA (Global Nutrition), CIDA (HIV and Nutrition), Bill and Melinda Gates, DFID, Government of Netherlands and UNICEF Regular Resources. For instance, in Year two, ESARO has been able to find substantial funding for a staff member under Pillar 2 and two major training events under Pillar 4 totalling more than €0.5M. Funds from the Government of the Netherlands include also funding for community nutrition for 4 years to Mozambique and Burundi (5 million each) as well as to Rwanda and Ethiopia (more than 10 million each).

2.8 Conclusions

Relevance

The overall objective and specific objective are relevant. Progress regarding the reduction of malnutrition, in particular stunting, in Eastern and Southern Africa remains slow, despite recent gains. The paradigm shift from addressing malnutrition through short term (emergency) nutrition interventions to multi-sectoral approaches necessitates improvement of the institutional environment, as the specific objective aims for.

ANSP-ESARO seeks to inform policy dialogue, strengthen knowledge and support policy development on nutrition security. It also seeks to promote integration between relevant sectors (e.g., health,
agriculture, water, sanitation and hygiene), and ensure that policy and strategy documents are evidence-based and show better integration between sectoral lines leading to a stronger political commitment and increased funding for nutrition security.\(^{26}\) The ANSP is thus well aligned with the SUN framework and roadmap and the ARNS objectives.

The ARNS is the key African strategy for nutrition and supporting RECs to actively participate and contribute to its revision provides opportunities for harmonized approaches and strengthened comprehensive nutrition programming. This in principle contributes to a coherent nutrition frame-work across RECs and ultimately across Africa.

The ANSP-ESARO complements activities in the context of REACH, in particular in terms of facilitating processes, including coordination mechanisms such as the Regional Food Security and Nutrition Working Group (chaired by FAO) and its nutrition subgroup (chaired by UNICEF) and providing technical support such as for CAADP meeting.

** Appropriateness**

The ANSP builds on regional initiatives—among others work by NEPAD and IGAD. The memorandum of understanding which ESARO/ANSP has signed with NEPAD and IGAD are appropriate to advance regional (and continental) multi-sectoral linkages (NEPAD through CAAPD pillar III programmes and IGAD in food security). Work with the IGAD and NEPAD also facilitates ANSP support to other RECs, because it demonstrates mutual synergies. Ongoing collaboration with and support to ECA-HC provides a good opportunity of advocacy for and support to policies for high impact nutrition specific interventions in the health sector.

The design of the ESARO is not coherent. Results in the logframe, have not been ‘logically’ and consistently translated into outputs. Secondly, vertical coherence between results (and matching outputs) at the different levels is insufficient. For instance, institutional and capacity development seems a stand-alone output unconnected to work done in the focus countries. Thirdly, outputs were changed or even omitted during the course of the project. Fourthly, the terms outputs and activities were used indiscriminately, and thus no distinction was made between outputs and the activities needed to achieve them.

The regional component is the main component supported by the continental institutional base and fed by national scaling up actions\(^1\), which will receive more than 4.5 million euro from the total ANSP budget. As such ESARO is critical in terms of ensuring linkages and coherence and complementarity between the three levels. The regional component seems well harmonized with the continental part in terms of pillar 1 activities, both in terms of advocacy and technical support. ANSP also strengthens the continental component of ANSP through its technical support of the AUC. Furthermore, ESARO have organised high level meetings attended by AUC which are further elaborated upon in the continental report. However, the link with the focus countries for pillar 1 seems negligible (both at output and activity level). Also the output and activities for pillar 2 – although highly relevant, seem unconnected to similar activities in the focus countries.

** Effectiveness**

For pillar 1 ANSP-ESARO coordinates with the SUN Secretariat for activities that can support the SUN Movement. During the first two years of implementation there were many examples. ANSP collaboration with SUN is highly effective, because it builds on and strengthens existing initiatives and mechanisms, avoids parallel structures and rationalizes resources.

The combination of advocacy, facilitating attendance by RECs, UNICEF nutrition staff of focus (and other countries) and other ANSP partners at coordination meetings and high level fora has accelerated RECs engagement in up-streaming nutrition policies in Eastern Africa. By mid 2013, nearly all RECs, were on board in terms of supporting the revision of the ARNS and strengthening work on regional nutrition policies. Through its MoU with IGAD and NEPAD, UNICEF also influences complementary initiatives which the ANSP doesn’t directly support such as the Programme on Food

\(^{26}\) Annex 1 Description of the action CRIS 2011 / 274-032
Security for Eastern Africa launched by the RECs and IGAD in August 2013, aimed at enhancing cooperation in the area of food and nutrition security.

ESARO has also been effective in advancing institutional development by combining a mapping of learning needs (consisting of an assessment of needs and an audit of existing curricula), but also the drafting, validating and finalisation of a curriculum for pre- and in-service nutrition education. The ANSP focus on capacity building in nutrition-agriculture linkages has not been very effective yet.

ANSP support to Ethiopia has been effective and resulted in among others a nutrition information system which is capturing and tracking monthly growth data for timely feedback and action at health posts. Support is ongoing regarding linkages with existing nutrition information collection systems in Ethiopia – including from emergency nutrition and, eventually other sectors including the agricultural sector. Overall, however, effectiveness of activities under pillar 3 has been disappointing, while activities under pillar 4 are yet to materialize.

**Efficiency**

Operational efficiency was satisfactorily, if somewhat erratic. Out of the 18 activities (identified by the MTE) carried out during the second year ten were on track, five were delayed, while three were incomplete/ had been carried out only partially with no further action foreseen. Progress for pillar 1 was excellent, while only about half of the activities for pillars 2 and 3 were on track. There were no activities in support of pillar 4. Support from Cornell University is yet to reach the focus countries in Eastern Africa. The MTE considers reporting on activities at regional level for pillar 4 in-transparent and incoherent. The two activities reported in support of pillar four in the second interim report featured under pillar 2 and 3 respectively in the first interim report.

At midterm, overall expenditure was 47% which is well balanced with the budget. This masks disparities between pillars however. Expenditure for pillars 3 (57%) and in particular pillar 4 (67%) was disproportionate in comparison to achievements. In terms of leveraging additional funds, the ANSP in ESARO has been rather successful. In addition to EC funds, funding was also received from the Japan Government, CIDA, Bill and Melinda Gates, DFID, Government of Netherlands and UNICEF Regular Resources.
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANSP</td>
<td>Africa's Nutrition Security Partnership</td>
</tr>
<tr>
<td>ARISE</td>
<td>Africa's Renewed Initiative for Stunting Elimination 2025 Initiative</td>
</tr>
<tr>
<td>ARNS</td>
<td>African Regional Nutrition Strategy</td>
</tr>
<tr>
<td>ATFFND</td>
<td>African Task Force on Food and Nutrition Development</td>
</tr>
<tr>
<td>AU</td>
<td>African Union</td>
</tr>
<tr>
<td>AUC</td>
<td>African Union Commission</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>COHA</td>
<td>Cost of Hunger in Africa Study</td>
</tr>
<tr>
<td>COMESA</td>
<td>Common Market for Eastern and Southern Africa</td>
</tr>
<tr>
<td>EAC</td>
<td>East African Community</td>
</tr>
<tr>
<td>ECSA-HC</td>
<td>East, Central and Southern African Health Community</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>ESA(RO)</td>
<td>Eastern and Southern Africa (Regional Office)</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
</tr>
<tr>
<td>FENCU</td>
<td>Federal Emergency Nutrition Cluster Unit</td>
</tr>
<tr>
<td>HEW</td>
<td>Health Extension Workers</td>
</tr>
<tr>
<td>GMP</td>
<td>Growth Monitoring and Promotion</td>
</tr>
<tr>
<td>IGAD</td>
<td>Intergovernmental Authority on Development</td>
</tr>
<tr>
<td>IRT</td>
<td>Integrated Refresher Training</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>MNP</td>
<td>Multiple Micronutrient Powders</td>
</tr>
<tr>
<td>NEPAD</td>
<td>New Partnership for Africa's Development</td>
</tr>
<tr>
<td>NPCA</td>
<td>New Partnership for Africa's Development Planning and Coordinating Agency</td>
</tr>
<tr>
<td>REACH</td>
<td>Renewed Efforts Against Child Hunger and Undernutrition</td>
</tr>
<tr>
<td>REC</td>
<td>Regional Economic Community</td>
</tr>
<tr>
<td>RFSNWG</td>
<td>Regional Food Security and Nutrition Working Group</td>
</tr>
<tr>
<td>SADC</td>
<td>South African Development Community</td>
</tr>
<tr>
<td>SMART</td>
<td>Standardized Monitoring and Assessment of Relief and Transitions</td>
</tr>
<tr>
<td>SUN</td>
<td>Scaling Up Nutrition Movement</td>
</tr>
<tr>
<td>UNECA</td>
<td>United Nations Economic Commission for Africa</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
</tr>
<tr>
<td>WCA(RO)</td>
<td>West and Central Africa (Regional Office)</td>
</tr>
<tr>
<td>WFP</td>
<td>United Nations World Food Programme</td>
</tr>
</tbody>
</table>
ANNEX E. REGIONAL WEST AND CENTRAL AFRICA

External Evaluation
African Nutrition Security Partnership (ANSP)
Country Annex: West and Central Africa

1 Introduction

1.1 Key Regional statistics West and Central Africa

UNICEF statistics show that West and Central Africa (WCA) – with exception of South Asia – have the highest malnutrition rates in the developing world in terms of underweight, wasting and stunting (UNICEF 2013). Over the past decades, the WCA Region has experienced insufficient progress in reducing food insecurity and child malnutrition in order to achieve the relevant MDG goals. Table 1 indicates that two out of five children under five are stunted, and one out of eight children is wasted.

Table 1: Key regional statistics West and Central Africa

<table>
<thead>
<tr>
<th>Key indicators on Nutrition Security</th>
<th>Sub-Saharan Africa</th>
<th>East and Southern Africa</th>
<th>West and Central Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (2011)</td>
<td>855,273</td>
<td>398,968</td>
<td>411,864</td>
</tr>
<tr>
<td>Life expectancy at birth (2011)</td>
<td>54</td>
<td>55</td>
<td>53</td>
</tr>
<tr>
<td>% of population below international poverty line of US$ 1.25 per day (2007-2011)</td>
<td>49</td>
<td>45</td>
<td>52</td>
</tr>
<tr>
<td>% of children (2007-2011) early initiation of breastfeeding</td>
<td>48</td>
<td>51</td>
<td>41</td>
</tr>
<tr>
<td>% of children (2007-2011) who are exclusively breastfed (&lt;6 months) (WHO threshold: &lt;50%)</td>
<td>37</td>
<td>52</td>
<td>25</td>
</tr>
<tr>
<td>% of children (2007-2011) introduced to solid, semi-solid or soft foods (6-8 months)</td>
<td>71</td>
<td>84</td>
<td>65</td>
</tr>
<tr>
<td>Antenatal care coverage at least once / at least four times)</td>
<td>78/47</td>
<td>89/51</td>
<td>71/45</td>
</tr>
<tr>
<td>Vitamin A supplementation coverage (6-59 months) 2011 (%)</td>
<td>78</td>
<td>72</td>
<td>83</td>
</tr>
<tr>
<td>% of households consuming iodized salt (2007-2011)</td>
<td>49</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>% of infants with low birth weight (2007-2011)</td>
<td>12</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from underweight (WHO), moderate &amp; severe</td>
<td>21</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from: wasting (WHO), moderate &amp; severe (WHO public health problem: &gt;10%)</td>
<td>9</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from: stunting (WHO), moderate &amp; severe (WHO: public health problem &gt;30% moderate, &gt;40% severe)</td>
<td>40</td>
<td>40</td>
<td>39</td>
</tr>
<tr>
<td>% of children under five suffering from anaemia 2007 2</td>
<td>63</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td>% of non pregnant women (aged 15-45) suffering from anaemia 2007 2</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>% of pregnant women (aged 15-45) suffering from anaemia 2007 2</td>
<td>49</td>
<td>50</td>
<td>49</td>
</tr>
</tbody>
</table>


As compared to the East and Southern Africa Region (ESAR), West and Central Africa has lower scores on almost all ten nutrition security related indicators. Only two out of ten (Vitamin A

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1 The West and Central African Region comprises of 24 countries (16 countries in West Africa and 8 countries in Central Africa)
2 6th Report on the world nutrition situation, UNSCN, Geneva; weighted calculation from tables 17-19, p 38-40
supplementation and iodized salt consumption) score better in WCA. Overall stunting levels are about the same in the two regions.\textsuperscript{3} Wasting and underweight figures are substantially higher in WCA. Very striking is the very low exclusive breastfeeding (EBF) rate in West Africa; this is to a great extent due to Nigeria with a 13% rate of EBF, but also Burkina is with 25% very low. In Central Africa, the largest country – DR Congo – has an average level of EBF (37%) whereas Chad and Gabon have very low levels below 10% (UNICEF 2013).

Within WCA, Nigeria and DR Congo represent the highest caseload of stunting. Worldwide Nigeria ranks second (after India) in the number of stunted children (over 11 million) with a stunting rate just above the WCA average, of 41%. DR Congo ranks number 8 worldwide with over 5 million of stunted children – 43% of the country’s under-fives. In West Africa Niger, Mali, Burkina Faso and Ghana have the highest number of stunted children, each one with a caseload of more than one million children. Niger has the highest percentage of stunted children and Ghana the lowest (51% and 28% respectively).

Rural to Urban ratios for WCA indicate that the underweight levels in rural areas are about two-thirds higher than in urban areas: 25% against 15% (ratio 1.7); the percentages of births attended by skilled health personnel differ even more between urban and rural areas, being 75% and 40% respectively (ratio 1.9) (source: UNICEF 2012).

Regarding anaemia levels, in 2007 about two out of three children under-five (U5) were reported to suffer from anaemia in Sub-Saharan Africa including West and Central Africa. Also here big differences are observed between countries: UNICEF reported for Burkina Faso and Mali – the two target countries for this region – a level of respectively 91.5% and 82.1% (UNICEF, Sept 2013). For women at reproductive age (15-45) the reported anaemia levels are that almost one out of two women are suffering from anaemia, and pregnant women to have a slightly higher level. These anaemia data indicate that it is a major problem in Sub-Saharan Africa. It is therefore remarkable that there have no ANSP goals been set for the reduction of anaemia in children and pregnant women.

With regard to ante natal care, data indicate that in West and Central Africa pregnant mothers are less attended by skilled health personnel during pregnancy as compared to Eastern and Southern Africa. With the exception of anaemia data from 2007, data on nutritional status of 15-45 year old and/or pregnant and lactating women are not directly at hand.

Compared to other developing regions, West and Central Africa has experienced the slowest progress in reducing child mortality over the past 20 years with a rate of 1.6% per year between 1990 and 2010 (as compared to 2.5% worldwide and 2.3% for ESAR). This is partly related to continuous high fertility rates. Food insecurity, poor access to health facilities as well as micronutrient deficiencies, particularly lack of vitamin A, iron and iodine, all affect the nutritional status of women and children thus contributing to some of the highest rates of child mortality in the world. Just to mention Mali and Burkina Faso, these countries rank no 2 and 3 on the world ranking of Under-five Mortality Rate in 2010 with respectively 178 and 176 deaths per 1000 live-births (UNICEF 2012).

1.2 Context: Regional Policy in Nutrition Security

The context in terms of regional initiatives and programmes aiming at Nutrition Security is changing rapidly as a result of global and regional initiatives. Besides, political commitment to control malnutrition has increased considerably at the regional and national levels. Most of the initiatives have occurred after the design of the ANSP programme in 2009 and also after the ANSP start of implementation, late 2011.

- In the first place, the SUN movement has gained momentum with 17 out of the 24 WCA countries now having subscribed to its charter (13 countries in West Africa; 4 countries in Central Africa) and with two more (Togo and Liberia) about to join (for more details on SUN Movement see ANSP Inception Report Annex A).
- Secondly, the Regional Economic Commission for West Africa (ECOWAS) Nutrition framework has been adopted in Sept 2011 calling more attention to MAM, IYCN, and Capacity Building.

\textsuperscript{3} Note: in the UNICEF SOWC 2012 report table 2, WCA was reported to have 40% and ESA 39% (data 2006-2010)
• The REACH initiative has gained momentum in the region with joint UN programmes taking shape in several countries including Chad, Congo, Ghana, Mali, Mauretania, and Niger.
• At the global level, the 2012 World Health Assembly has adopted an ambitious resolution calling for a 40% reduction of stunting, by 2025.
• In the West Africa region, the European Union together with other development partners has taken the initiative to start the Global Alliance for Resilience Initiative- AGIR in 2012. The aim of AGIR is to help build resilience to the recurrent food and nutrition crises that affect the countries of the Sahel region. AGIR started from the premise that a sustained effort is needed to help people in the Sahel to better cope with recurrent crises, instead of continuous emergency assistance as a response to these crises.
• The NEPAD focus on Agricultural Development (CAADP) has resulted in increased attention to, and support for, nutrition security. For instance, the CAADP Nutrition Workshop for West Africa which was held in Dakar in November 2011 has given impetus to the integration of nutrition in the formulation of national agricultural policies.

Moreover, in many countries in the region development partners are contributing technically and financially to nutrition security programmes, in particular for the screening and treatment of Global Acute Malnutrition (GAM). These programmes have gained momentum with the development of national protocols and the existence of efficient nutritional interventions to enhance the nutritional status of young children. The availability and distribution of newly introduced Ready-to-Use-Therapeutic Food (RUTF) over the past decade have contributed to the development of Community-based Management of Acute Malnutrition (CMAM).

Finally, many technical and financial partners are active in the field of nutrition and related sectors. An increasing number of these technical and financial partners including UN agencies, donor organisations and International NGOs have become members of the Regional Nutrition Working Group (RNWG, details below). Donor agencies such as EU-ECHO and USAID are changing their strategy towards developing responsive livelihood systems which can cope with adverse environments including climate change. They acknowledge that emergency interventions and treatment of malnutrition as such offer no long-term solution. Funding pledges continuously fall short of the demand for emergency response. Besides, in particular USAID is keen to fund programmes with a private sector component (eg. USAID Feed the Future).

2 Findings

2.1 Overall Relevance and Appropriateness

Design WCA regional programme

The design of the ANSP WCA regional programme – as has been reconstructed from the ANSP logframe and the presented documentation – raises the following observations with the MTE:

1. The ANSP programme is highly relevant for the West and Central African Region given the fact that the WCA region has a severe stunting levels (around 40%) which is an indication for action.

The ANSP-WCARO being the regional component of the EU-funded ANSP programme for West and Central Africa, was designed to contribute to the ANSP specific objective of “Improving the institutional environment – at WCA regional level – contributing to a reduction in maternal and child undernutrition in Africa”. As indicated above (in section 1.1 “key Regional Statistics WCA”) almost all nutrition security relevant indicators show the absolute need for enhancing institutional attention. There is no doubt a clear need to improve the policy environment and develop the technical and professional capacities. Good practices to improve the nutritional status of children, their mothers, and teenage girls – as future mothers – are dearly needed.

With regard to chronic malnutrition and acute malnutrition, within the WCA region, the nine Sahel countries are in particular affected because of erratic climatic conditions and high vulnerability in terms of food and nutrition security. Besides, exclusive breast feeding (EBF) practices are very low, the
lowest in the world as a result of the practice of the early introduction of liquids and semi-solids to infants which is deeply rooted in cultural beliefs.\textsuperscript{4} Infant and young child feeding practices

2. ANSP-WCARO programme component operates in a rapidly changing nutrition policy environment and context

As indicated in the introduction, the context in which ANSP is operating has rapidly changed since the ANSP programme was designed, in 2009/2010. In particular the publication of the Lancet Nutrition Series in 2008 as well as the Food Crisis of 2009 have renewed and strengthened the attention for Food and Nutrition Security. ANSP has been designed as a response to the Lancet Series and the Food Crisis. However, since the design of ANSP, there have been a wide range of new initiatives and programmes, in particular SUN and REACH, G8 New Alliance for Food Security & Nutrition to Fight Global Hunger, AGIR, ARISE, CAADP and more. Besides, the Lancet Series of 2013 has contributed new insights on the reduction of chronic malnutrition. Thus, unlike in earlier years, there now is a wide range of initiatives which each have their specific entry point and focus, but which at the same time have common agenda’s. Some are more comprehensive than others. To take the example of SUN and AGIR, one could say that the SUN indicators are all under AGIR’s second pillar.

The ANSP Inception Report recognizes that the SUN movement ‘represents an unprecedented collective global commitment to nutrition’. Since the start of SUN in 2010 already 16 out of the 24 countries of the WCA region have joined the movement. SUN members have agreed upon a clear Roadmap for developing a political and institutional set-up for increased attention to the reduction of chronic malnutrition and for the scaling-up of nutrition interventions. The SUN framework also allows for the expression of requirements for technical support and it is exactly this need to which UNICEF – either directly or in the context of REACH – is responding. ANSP funding to UNICEF (see below) makes this possible but the contribution by the WCARO programme is not yet fully aligned with the SUN framework and Roadmap. With 16 WCA countries being part of the SUN movement, the WCA region represents the largest regional concentration of SUN member states.

3. The ANSP-WCARO regional component is designed to contribute to the improvement of the institutional environment (see ANSP specific objective) in the WCA Region but in doing so does not single out the two ANSP target countries

The ANSP-WCARO regional component has limited means and staff to cover with the same commitment all 24 WCAR countries. Hence priorities are to be made in order to achieve its goal of reducing chronic malnutrition. In essence the focus of ANSP regional activities should be on Mali and Burkina Faso as these are the ANSP target countries, but this is not reflected in the design of the ANSP-WCARO programme. In particular it is relevant to contribute to, and to learn from, scaling-up interventions in Mali and BF and to roll out to the wider WCA Region, and vice-versa. This mutual learning approach is not clearly visible in the design.

4. The design of the ANSP-WCARO component does not clearly spell out a strategy for multi-stakeholder action to tackle the problem of undernutrition under the various pillars.

The ANSP inception report recognizes that the reduction of stunting requires investments in amongst others ‘broader multi-sectoral nutrition-sensitive approaches to development that act to counter the determinants of undernutrition’. The Inception Report continues by saying that ‘this is to be done by: (a) promoting agriculture and food security to improve the availability, access to and consumption of nutritious foods; (b) improving social protection; and (c) by ensuring access to health care’. During the Bamako February 2012 ANSP Inception workshop, it has been reported that ‘a strong emphasis was given to the critical importance of leveraging programmes and resources that are already in place as a way to improve multi-sectorality’.\textsuperscript{5}

However, it is not clearly reflected in the design of the WCARO component how the linkages to Agriculture and Food Security, WASH or Social Protection can be fully integrated in the Nutrition Security work of ANSP and how good practices of multi-stakeholder action can be identified, analysed and disseminated to the ANSP target countries. Experiences with multi-stakeholder approaches and good practices as in the case of nutrition security exist as, for instance, the work of ACF in some of the West African countries including Burkina Faso, is showing.\textsuperscript{6}

\textsuperscript{5} UNICEF ANSP Inception Report (version June 2012)
\textsuperscript{6} Source: ACF-WA and ACF-BF, personal communications; ACF 2013, reconcillier l'agriculture et la Nutrition and other ACF publications
Coherence, completeness and complementarity to other initiatives

In terms of coherence, completeness and complementarity the design of the ANSP-WCARO component raises the following issues:

5. The ANSP-WCARO programme component clearly builds upon existing activities and initiatives

Although ANSP has been formulated as a project with its own objectives and set of result areas, these largely coincide with the routine tasks of WCARO’s nutrition unit. As one staff member said: “These pillars are nothing new; this is what we do.” Even so the ANSP has enabled to go further and take up activities which go beyond the routine, and especially: to take up long term plans on reducing chronic malnutrition, which have been difficult to fund through other channels.

In the first place this becomes clear from the continuation of UNICEF assistance (both technical and financial) to ECOWAS on the organisation of the ECOWAS Nutrition Forum through its collaboration with the West African Health Organisation (WAHO). At the coordination level the ANSP has maintained and strengthened the support to the Regional Nutrition Working Group (RNWG) which has existed since as early as 2008. Further, the technical support to individual countries is an existing activity which is continued and to some extent expanded with the ANSP funding (see further below).

This might give the impression of “business as usual”, but this is certainly not the case. The WCARO programme is further expanding these activities in the context of preventing chronic malnutrition. For instance, in the region ANSP is part of and is contributing to the above-mentioned global and regional initiatives (SUN, REACH, ECOWAS-WAHO, CILSS, AGIR etc).

The problem with the rapidly changing context of so many initiatives is that the ANSP has not – at all stages – analysed its complementarity to these initiatives. In particular with the emergence of the SUN movement it is not always clear what role UNICEF should and could play within the context of ANSP funding. The same applies to some extent to the AGIR initiative where UNICEF-WCARO has played an active role during the formulation of the AGIR Roadmap, but it remains uncertain how UNICEF may contribute to AGIR’s further implementation. With REACH and WAHO the linkages are better established as UNICEF is hosting the REACH regional facilitator and a MOU has been signed with WAHO on joint collaboration. As one UNICEF staff member observed: “With all these initiatives it is difficult for stakeholders to see that the core principles stay the same while the language may differ from one initiative to another”.

6. In terms of budget ANSP is contributing to the integral implementation of work done by the WCARO Nutrition section, but at a modest level.

The design of the ANSP-WCARO component is such that the programme is fully integrated into the work and activities of the UNICEF-WCARO Nutrition section. As such the ANSP strengthens and reinforces its outreach in terms of coordination and support in the region.

It is difficult to distinguish the ANSP activities aiming at stunting reduction from the other WCARO Nutrition activities. The cumulative funds enable UNICEF to maintain a good number of staff with an appropriate range of competences, who are first and foremost intended to support countries in the region. Therefore, the ANSP funding should be considered more of an additional and catalytic funding to support its already existing activities and to expand to new activities such as the WA Capacity Building Initiative. As many activities are building on previous activities or are linked to earlier funding sources this also implies that it is not a simple task to define ANSP as an “evaluand”: what belongs to ANSP as a project and what to the ‘regular’ UNICEF WCARO remains somewhat arbitrary.

The ANSP regional component design has not clearly indicated nor made explicit that – contrary to the ANSP Burkina Faso summary sheet – the ANSP is complementing already existing activities. As a consequence, the ANSP at WCA regional level is less of project but more of a contribution to the already existing WCARO nutrition programme.

In terms of financial contribution to the UNICEF-WCARO Nutrition section budget, the ANSP contribution is relatively modest, being 17 % for the period 2012-13. During this period the WCARO nutrition section has used some $ 10,900,000, whereas ANSP spending over the same period was about $ 1,900,000. In case the exceptional expenditure of $ 3M on RUTF is taken out of the total
expenditure, the ANSP share increases to about a quarter of the WCARO nutrition section expenditure.\(^7\)

**7. The ANSP-WCARO component does not take into consideration a link to the Burkina and Mali components.**

A direct link to the Burkina Faso and Mali country programmes being the two target countries of the ANSP programme, has not been included in the WCARO component design. Though the ANSP programme is based on one overall logframe with specific activities for each of the components, a strategy how to support the two country programmes has not been included in the design of the WCA regional component. As an illustration may serve the main activities under pillar 1, 2 and 3 such as RNWG, ECOWAS Nutrition Forum, WANCIDI or SMART development which all have a wider regional scope; the activities which have a focus on the two countries are mainly studies the utility of which is yet to be proven (see further below under 2.4-2.6). Nor does the WCA component refer to cross-country learning on the basis of good practices to be shared in the region as developed in the two target countries. Rather, the UNICEF regional office routine of responding to country requests is followed. There also is no structured horizontal learning between the countries, with ANSP countries serving as “models”. This lack of interaction and focus on the two ANSP target countries in WCA is a missed opportunity as it would improve the coherence and thereby create a more distinct identity for the ANSP programme.

**Programme monitoring framework**

**8. The five expected outputs as formulated for ANSP-WCARO are a poor reflection of the wide range of approaches and activities UNICEF is currently undertaking in the region.**

The design of the WCARO component centres around 5 expected outputs under the four Pillars as they have been defined in the Workplan for Year 3 (Oct 2013–Sept 2014). Pillar 1 has two expected outputs whereas the other pillars only one.

The figure below is a graphic representation of the expected outputs of the ANSP-WCARO on the basis of the workplan for year 3. According to the ANSP coordinator, the Year 3 workplan intends to better integrate the logframe, the indicators and activities at all programme levels.

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\(^7\) Source: WCARO office, personal communication December 2013
As indicated above (see observation 5) the institutional embedding of the ANSP in the WCARO nutrition section allows for both continuity in activities, for complementarity and also enables a change of emphasis, in case the context of implementation changes. This process of changing direction towards more emphasis on nutrition security is, however, difficult to capture in a ‘project logframe’. At the same time it is also true that the logframe has been formulated in a way that allows to fit in activities that are not necessarily predefined – the case of food fortification being an example.

9. The logframe, annual work plans and budget are insufficiently coherent to represent a comprehensive framework for Monitoring and Evaluation

Whereas ANSP country programmes are based on the ANSP logic model including activities, outputs and outcomes, there is not such a thing for the regional level – including ANSP-WCARO – guiding its monitoring and evaluation. Monitoring is foremost based on the activities as formulated in the logframe and the overall ANSP progress indicators. However, it appears that the activities at regional level often do not match over the years and do not always link up with the overall ANSP expected results. WCARO workplans differ substantially from the first year of implementation, through to the second and third years; they are not coherent in their presentation. It is remarkable that the two ANSP Interim Reports are reporting against the workplan of activities and against the logframe indicators (as included in the EC/ UNICEF Agreement) as well (see for instance Yr 2 Interim report chapter 6). These 23 logframe indicators are often not linked at all to planned activities; for instance under Pillar 1 indicators 1.1, 1.4, 1.6, 1.7 and 1.8 are difficult to link to the logic model nor to planned activities.

Moreover, the logframe, annual work plans and budget are not always clearly aligned. For instance, activities presented in the logframe do not have a budget and activities presented in the budget cannot be found in the logframe. It is further observed that the baseline often does not reflect a comprehensive assessment of the start situation of early 2012 nor do they link to the activities of the ANSP (e.g. 1.7 on Adoption of BMS Code Legislation); or baseline and target levels are not assessed at a realistic level (e.g. 1.1 # of high level/ regional meetings); and it is not always clear whether the targets relate to the target countries only or to all countries at continental or regional level. In some instances, it is not quite clear to which pillar the activity intends to contribute, e.g. C4D is under Pillar 2 (CapDev) but is budgeted under Pillar 4, Cornell is budgeted under Pillar 2 and 4, Formative Research on IYCF is both presented under Pillar 3 and 4.

The ANSP Inception Report (final version) dates from June 2012. The final IR could have corrected the logframe and associated baseline in order to have a realistic M&E framework for progress assessment.

10. The ANSP programme has “safe” targets which are easily achievable, or which have, in some cases, already been achieved.

ANSP has generally expressed its targets in the form of numbers. An example for WCARO is “Number of continental, regional or sub-regional nutrition strategies drafted, updated or reviewed”, with a target of 1. Generally, the numbers bear no relationship to the number of countries that make up the region. The argument for the targets is not known, but targets are largely modest suggesting they have been set at the safe side of the spectrum.

More informative, and challenging, would be to have targets as a proportion, for example: By 2015 at least half of all countries. This would, in addition, emphasize the typical role of ANSP as a programme that seeks to use country level experience, to the benefit of the region, or even the continent.

2.2 Equity

Equity focus of programme design

11. From the regional perspective the possibility to address equity is far from evident as the activities focus on support to country programmes.

The overall ANSP design includes a focus on the first 1000 days of a child’s life from conception to 23 months. Improving the nutritional status of pregnant and lactating women as well as 0-23 month old children is the main target of the programme. In the WCA region the choice of the target countries is based on the high level and the absolute number of stunted children, though the countries with the highest number of stunted children – Nigeria and DR Congo – have been left out, presumably for
practical reasons. UNICEF-WCARO support to the other countries is more demand-based; recently often in relation to the country’s wish to join the SUN movement or the start-up of a REACH programme.

UNICEF targets mainly the rural areas, whereas urban populations – in particular in the outskirts of major towns and or the peri-urban areas – undernutrition levels including stunting levels are as high as in the rural areas. This manifestation is given less attention in the discourse on stunting.

There is no evidence that the ANSP-WCARO component is focusing on responsiveness to overcome barriers and bottlenecks to inequalities in access and coverage of key nutrition interventions.

2.3 Pillar 1: Policy Development

2.3.1 Relevance and appropriateness

The ANSP logframe formulates the Expected Result and activities at Regional level for Pillar 1 as follows:

<table>
<thead>
<tr>
<th>Pillar 1: Up-stream policy development and nutrition security awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expected Result 1:</strong> Africa’s key policy-makers &amp; leaders of civil society committed to review Plan of Action on Nutrition ensuring that adequate support is provided to implement nutrition action plan for an effective and sustainable socio-economic development</td>
</tr>
</tbody>
</table>

**WCARO Activities:**
- Support to the active participation of the Regional Economic Communities (RECs) for the ARNS revision;
- Development of toolkit for elaborating nutrition policy, strategy documents; operational and investment plans;
- Support to countries for the elaboration and revision of policy, strategy and action plans;
- In line with continental advocacy strategy and policies; technical support to RECs e.g. CILLS/ECOWAS, the West African Nutrition Champion, to mainstream nutrition in agenda of high level seminars/meetings at regional level involving head of states/ministers and key decision makers.

With regard to the relevance of the WCARO component to contribute to the achievement of ANSP expected result 1:

1. The focus on the Regional Economic Communities of West and Central Africa is most relevant for ECOWAS, the REC for West Africa and far less so for the Economic Community of Central African States (ECCAS). The latter is far less developed in streamlining and harmonizing policies and strategies in the field of nutrition. As such it is not relevant for the mainstreaming of Nutrition Security in Central Africa. On the other hand, the WA Economic Community is active in the field of nutrition security under its health branch WAHO which is actively promoting nutrition security through its Nutrition Forum.

2. The development of advocacy tools in order to analyze nutrition policies, strategies and planning could be a relevant approach to promote commitment amongst national (and regional) policy makers. However, the ANSP-WCARO component does not spell out at all what type of tools or instruments it intends to use and how these instruments may contribute to the achievement of the nutrition policy development and awareness goal.

3. Support to individual countries for mainstreaming nutrition security is an important element of the WCARO work in the Region. However – the region comprising 24 countries – the ANSP WCARO component should have spelled out what and how ANSP may contribute to its support of individual countries in the region, what approach it would take and what the priorities would be. Or alternatively, the ANSP activity – recognizing the important task already being undertaken by WCARO – should be read as: “Strengthening and expanding the support to countries...”

4. WCARO plays an important and catalytic role in mainstreaming nutrition on the agenda of many regional and national policy makers through its participation and professional contribution at high level
meetings. (Yet) this activity is predominantly a strengthening of already existing actions by the UNICEF regional office with more emphasis on reduction of chronic malnutrition complementary to the treatment of acute malnutrition. Hence, the baseline and target on logframe indicator 1.1 (‘# of high level/ regional meetings where nutrition is on the agenda’) are very poorly formulated and targeted (see section 2.2).

5. Given the great importance ANSP attaches to the multi-sectoral approach of mainstreaming nutrition security, it is remarkable that this very important and highly relevant element is not mentioned under pillar 1 as one of the main activities. In essence, the RNWG embodies organisations with a different background from various sectors but how to promote multi-sectoral approaches at the different levels is not prominent. The Inception Report emphasizes the importance of linking nutrition to food security, agriculture and poverty reduction (social protection) but this is not highlighted in the main activities and strategies at regional level.

2.3.2 Effectiveness

Regional Nutrition Working Group

The Regional Nutrition Working Group (RNWG) is the main mechanism for ANSP-WCARO regional work on pillar 1 in terms of policy advocacy for nutrition policy formulation and action (and for pillar 2; see section 2.5). The RNWG has been established in 2008 from the formal alliance of 5 organisations (MI, UNICEF, HKI, FAO, WFP). It was born from a common concern of these regional actors to have a long term perspective with regard to nutrition security in West Africa and Central Africa, as opposed to the prevailing emergency mode of nutrition-related interventions. The regional members of the RNWG have changed over the years, and so has the context, but, remarkably, the working group still exists and is steadily growing. There is apparent added value in having such a group, notably for initiatives that can only or best be done at regional level such as the promotion of standards and norms for food fortification or the development of nutrition curricula (see pillar 2).

The RNWG has a total of 19 not-for-profit members from UN, INGOs, donors and other technical partners mainly active in the West African Region (less in Central Africa). Though the RNWG has an informal status it operates as a well-established group, (to some extent) in the context of International Coordination of Humanitarian Assistance of UN and non-UN organisations. It has a clearly formulated vision and mission as well as a strategic plan 2013-2017, a detailed implementation strategy and a work plan for the period 2013-15.

Its main strategic orientations center around:
I. Regional coordination
II. Multi-sectoral partnership & synergies
III. Best practices promotion
IV. Promotion of technical support & capacity building
V. Informing and influencing policy formulation

Besides, 10 implementation strategies and 29 activities have been formulated. The implementation budget is around USD 1.5M and originates from contributing partners including UNICEF. The former president of Cabo Verde – Mr. Antonio Gomes Monteiro – has been nominated by the RNWG as their West African Nutrition Advocate to support advocacy for nutrition policy formulation since 2011 and is supported by some of the members for technical support. A small group (ACF, HKI, UNICEF, WHO) is in charge of the ANSP pillar 2 (capacity building) in collaboration with WAHO/ECOWAS (see further section 2.5).

12. The RNWG provides a relevant and important platform to promote, support and coordinate ANSP nutrition security activities in the region.

According to the RNWG facilitator based at UNICEF and confirmed by its members, the basis for the creation of the RNWG was the need to address the problem of malnutrition in view of the limited number of initiatives addressing its underlying causes, as most efforts are being focused on emergency programs. The RNWG significantly contributes to the advocacy activities for policy formulation towards tackling (chronic) malnutrition in the region through its exchange of initiatives and insights, through its coordination activities, its representation at high-level meetings and through its pooling of technical expertise and – in some instances – financial contributions. The members of the RNWG have joined forces and, hence, have created synergies around the formulation of a long-term vision of improvement of the nutritional status in West and Central Africa. It constitutes an alliance of
organizations not only originating from the UN system, but also including actors with a different background working in the field of nutrition. As such it is a not only a coordination group but also a partnership for action through its pooling of expertise (and financial contributions) from the individual members. An important activity is the provision of technical assistance in the context of REACH and SUN.

In general, the group is remarkably motivated to contribute to various activities: such as the WA regional CAADP Nutrition Workshop of Nov 2011, the 13th ECOWAS Nutrition Forum held in Burkina in 2012, or the formulation of the Resilience Practical Guide (“The Strengthening of Resilience into Nutrition Policies and Programmes”) in the context of the Regional Resilience Road Map (AGIR) in early 2013. Recent activities focus on the training of French-speaking African parliamentarians on nutrition security and the information provision to West African journalists.

Apparently, there is an added value in having a regional working group linking nutrition partners, notably for initiatives that can only or best be done at regional level. The RNWG creates synergy in the sense that it builds upon the strength of the individual members, e.g. UNICEF is to a large extent focusing on SAM and IYCNY promotion and provision of technical assistance, whereas MI is leading the promotion of micronutrients and food fortification in the region, or ACF and HKI being more active at the field level implementation of MAM and Food Security improvement. Whenever, a country makes a request soliciting specific expertise, the RNWG can reflect which organisation would be best positioned.

13. The ANSP financial contribution to the RNWG strengthens its functioning and operating

In West Africa, the RNWG is supported financially by the ANSP-WCARO component budget. The ANSP funding caters for the position of the RNWG facilitator as well as her capacity support activities. She is able to combine this with her REACH support activities thus creating an ideal match given the nature of these activities. ANSP is thus one of the funding sources (about 15% of committed funding) enabling to continue the RNWG functioning and operations and to make it more professional, with an operational workplan and funds for joint activities. Also the self-evaluation of the RNWG – done early 2013 – has been financed with ANSP funding.

However, none of the RNWG activities are directly focusing on ANSP target countries, Burkina Faso and Mali. Rather, the UNICEF regional office routine of responding to individual country requests is followed which implies that in principle all (24) countries in WCA are eligible for support. For instance, joint RNWG missions in 2013 have taken place in Cameroon and Chad, whereas REACH implementation plans have been supported for Mauritania, Niger, Ghana, Chad, and Congo. There is no structured horizontal learning between the countries, but the pool of regional experts themselves serve as learning conduits by taking lessons from one country to another.

Moreover, some concerns were expressed around the RNWG recent functioning and focus. Being at the cross-roads, differences exist between individual members in terms of financial resources made available to contribute to the RNWG work plan. Some of the planned activities under the RNWG were already budgeted for by individual members and would have been implemented any way. Other observations relate to the attendance and presentations at international workshops which is not always properly coordinated. The long discussions on the criteria defining who might become a member and who not have not energized all members. Lack of exchange on progress of some activities has also been mentioned as a current short-coming.

Through its overload of planned activities, the RNWG risks to become an ‘artefact’ with only a shared paper work plan. The main threat to its functioning and sustainability is the loss of coherence and complementarity by lack of coordination, sharing and learning. The use of the complementary expertise within organisations is sought but not in a systematic way. On the other hand, the RNWG has shown that it has been dynamic and able to renew itself on several occasions. Also at this stage it may be able to overcome some of the observed weaknesses.

Regional institutions: ECOWAS Nutrition Forum

The second important activity under pillar 1 is the support and collaboration with the Regional Economic Committee for West African States, ECOWAS. UNICEF WCARO has a long history of engaging with the health branch of ECOWAS, the West African Health Organisation (WAHO) based in
Bobo Dioulasso in Burkina Faso. ECOWAS has been active in the field of nutrition since the mid-nineties: e.g. the salt iodization directive of 1994, the resolution on food fortification in 2006 and acceleration of food fortification in 2008, and the resolution of nutrition of 2009 to enhance Vitamin A supplementation, to promote the Integrated Management of Acute Malnutrition and to endorse improved Infant and Young Child Nutrition practices. ECOWAS has been at the basis of improved Capacity Building for nutrition in the region. The ECOWAS Nutrition Forum is a bi-annual meeting where all relevant regional actors in the field of nutrition are gathering since the mid-nineties.

14. With the ANSP funding UNICEF is able to continue its technical and financial support to the ECOWAS bi-annual Nutrition Forum

Together with RNWG members, UNICEF WCARO provides technical and financial support to the mainstreaming of nutrition in the West African region through the ECOWAS Nutrition Forum which is held bi-annually. The Nutrition Forum is coordinated by WAHO since 2001. The main duty of the Forum is to assess regional and national progress on nutrition and contribute to the policy formulation at national level.

Since the mid-nineties, the ECOWAS Nutrition Forum has played a relevant role in the promotion of Nutrition Policy development for all fifteen member countries. In November 2012, the 13th Nutrition Forum was held in Burkina Faso with technical and logistic support by UNICEF. The funding contribution came however from another regional organization. UNICEF also contributed to the much smaller mid-term technical review meeting to assess progress on the implementation of the Nutrition Forum recommendations which was held in Monrovia in November 2013.

15. Effectiveness of the Nutrition Forum remains at the West African nutrition policy level

Though the direct effect of the Nutrition Forum is difficult to assess, the Forum is said to contribute to the strengthening of national nutrition programs, the capacity of its participants through exchange and sharing of good practices. It may also have contributed to the development of a common vision on nutrition in the West African region. However, (as yet) one cannot speak of the accomplishment of a West African Nutrition policy or strategy as has been formulated under the expected output 1.1 (see section 2.1 programme design and year 3 work plan).

There is no evidence that the ANSP contribution to the ECOWAS Nutrition Forum has had any outreach to the Central African Region, nor that is has contributed to the revision of the African Regional Nutrition Strategy as planned.

Nutrition Policy Support

16. UNICEF is playing an important role in strengthening the integration of nutrition in national policy development in several WCA countries, by providing tailor-made and hands-on assistance, at request

Upon request of the member countries UNICEF WCARO has provided Technical Assistance with regard to Nutrition to a wide number of countries. This has been in particular the case for countries newly joining the SUN movement – such as Sierra Leone, DR Congo, Guinea, Cameroon, Chad – and the countries where Country Implementation Plans were to be made in the context of REACH such as Mauritania, Niger, Ghana, Chad and Congo. The UNICEF International REACH facilitator has also provided support to the REACH programme in Mali which started early 2013. In several of these support missions UNICEF has been accompanied by experts of other UN agencies and international NGOs operating in the region in the context of the RNWG (see above). In the context of SUN, assistance at country level has been provided to the development of a SUN roadmap or support to the formulation of a Nutrition Policy action plan. Some of the initial advocacy was done in the course of international meetings such as the CAADP WA Nutrition WS of Nov 2011, the ECOWAS Nutrition Forum of 2012 or the International Conference on Child Undernutrition held in Paris in May 2013. The RNWG Nutrition Advocate contributed to the development of the 3Ns initiative in Niger and to the launch of REACH in Niger, Mali and Sierra Leone.

However, the progress on policy development and its implementation is not fully monitored; there is no systematic overview of the progress in the different countries apart from the SUN Movement road map monitoring. Even so, the fact that there is continuous demand from the side of countries for this type of support – in the form of (practical) assistance – is illustrative both for the perceived need and for WCARO’s competence and responsiveness.
**High level international meetings**

17. UNICEF is prominently present at a wide range of high level meetings in order to advocate for nutrition policy development; how this translates into action is less clear

UNICEF-WCARO has participated in or provided technical (and in some cases) financial assistance to a wide range of high level international meetings. Just to mention a few:

- CAADP West Africa meeting on integration of Nutrition, Nov 2011
- World Health Assembly 2012 (by RNWG Nutrition Advocate)
- African, Caribbean and Pacific (APC)-EU Joint Parliamentarian Assembly, May 2012
- Side meetings at the SUN Movement Focal Points meeting, Sept 2012
- ECOWAS 13th Nutrition Forum, Nov 2012
- Paris Conference Against Child Undernutrition, May 2013
- African, Caribbean and Pacific (APC)-EU Joint Parliamentarian Assembly, May 2012
- Conference on Maternal and Child Health in Africa, Aug 2013
- Monrovia ECOWAS Nutrition Forum technical review meeting, Nov 2013

The international RNWG Nutrition Advocate has been present at the World Health Assembly in Geneva in 2012 as well as at the parliamentary assembly meeting in Kampala in 2012.

The participation in international high profile meetings represents a substantial part in terms of time, preparation and finances of the WCARO nutrition team. In terms of monitoring only the number of high level meetings is recorded; the ultimate results in terms of follow-up to concrete action at national and/or regional level are less reported. From the documents available and consulted – e.g. the Paris conference May 2013 and Child Health in Africa Aug 2013 – it appears that emphasis is given to provide overviews of the actual situation with regard to child undernutrition and less on existing good practices which can be shared by other countries or actors. The focus on the 1000 days window of opportunity is not sufficiently coming out as the core of the matter. The dissemination of good practices remains at the background whereas the insights of to how to implement nutrition policies is crucial to reduce chronic malnutrition. In particular the question of how to develop effective multi-sectoral platforms – at all levels – remains unanswered. On the other hand, the UNICEF presentation at the Nov 2011 CAADP on financing nutrition interventions provides an example of the contrary.

### 2.4 Pillar 2: Capacity Development

#### 2.4.1 Relevance and appropriateness

The ANSP logframe formulates the Expected Result and activities at Regional level for Pillar 2 as follows:

<table>
<thead>
<tr>
<th>Pillar 2: Institutional development and capacity development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expected Result 2:</strong> Department and units strengthened at all levels with qualified practitioners in nutrition and coordination mechanisms involving African networking.</td>
</tr>
</tbody>
</table>

WCARO Activities:

- Support to ongoing initiative for Public Health Nutrition Research & Training. This initiative will build on the results of the Sustained Nutrition Research Agenda for the Year to Come (EU funded SUNRAY implemented by a consortium of research institutes from Europe and Africa);
- Complete a detailed inventory of existing public health & nutrition training programs;
- Develop prototype curricula for practical, competency-based, pre-service & in-service training in public health nutrition, borrowing from existing materials when available;
- Support countries in WCAR to adapt and roll out curricula developed at regional level.

With regard to the relevance of the WCARO component to contribute to the achievement of ANSP expected result 2:
1. The support to the initiative for Public Health Nutrition Research and Training has been high on the agenda for WAHO and regional partners for a long-time. In March 2009 a Workshop was held on Establishing a Regional Institute for Public Health Nutrition Research and Training in West Africa, which was held in Dakar. It was recognized that the capacity gap in nutrition was still a major challenge in West Africa in particular the limited capacity to implement highly needed large-scale nutrition interventions. Hence the response by UNICEF to the urgent need for nutrition capacity development in West Africa is highly appropriate and welcome.
2. The other formulated WCARO activities are a logical sequence of the support to the Capacity building initiative.
3. However, the link to the SUNRAY project is nowhere underpinned nor has been made clear what could be expected from its project results. The main foundation for WANCDI has been laid during the 2009 Dakar workshop and its successive reporting in Global Public Health in Nov 2010 (e.g. Pepping).
4. Other activities which have been implemented in the context of Capacity development have not been included in the WCARO activities (see below).

2.4.2 Effectiveness

**WANCDI project**

The first and foremost activity under pillar 2 Capacity Development is the West African Nutrition Capacity Development Initiative (WANCDI) which has started early 2013 with the recruitment of a UNICEF Technical Expert. The initiative is hosted by WAHO and based in Ouagadougou. It has been designed in such a way that it has a regional focus but provides country support to nutrition curriculum development.

18. The WANCDI initiative is highly relevant to respond to regional needs in nutrition capacity development – in particular in francophone and lusophone countries – as has emerged from the Nutrition Curricula mapping exercise.

The WANCDI initiative is based on a long-term vision for nutrition capacity building in the region with four main strategies including a ‘situational analysis’. This mapping of Nutrition Curricula has indicated that there are many gaps in Research and Training facilities for nutrition in the region. The anglophone countries – in particular Nigeria and Ghana – are well ahead of the francophone and lusophone countries with the latter having no nutrition training capacity at all. Nigeria by itself constitutes about half of the training capacity in the region in particular at BSc, MSc and PhD levels.

The initiative is building around a number of clear capacity building principles such as: establishing norms and standards for nutrition capacity building for the region (building on a model used earlier for the training of medical doctors), the inclusion of nutrition across curricula and not just a nutrition module ‘add-on’, South-South integration of expertise (e.g. Mauretania being supported by Senegalese technical expertise in the field of epidemiology).

19. ANSP funding to WANCDI has been essential to get it off the ground and has been used as a catalytic fund to start activities

Different actors close to the initiative have indicated – and this has been confirmed by the WANCDI coordinator – that ‘without ANSP there would have been no WANCDI’. For a long time, regional partners realized that a Nutrition capacity building programme was essential to improve technical and professional capacity in the region. RNWG members have actively contributed to prepare a proposal – or proposals (source: ACF) which were submitted to different donors. Finally funding appeared only to be possible under the ANSP. Though the ANSP contribution does not fully cover the intended activities it has been an essential step towards the start-up of the Initiative, in particular in making the first step of the implementation of the inventory and characterisation of Nutrition Curricula in the WA region.

Secondly, a number of individual technical support missions have been made under the WANCDI, including a technical review mission to Mali to assess the proposal for the establishment of a MSc on Nutrition. The mission concluded that the pre-conditions for the setting-up of such a MSc were not clear and that it would not be a stand-alone MSc but that it concerned an ‘option’ under the MSc of Public Health (see further Mali annex).
**Cornell project**

20. The Cornell support is formulated as a project within a project, that is: not only does it have its own objectives, it also has its predefined deliverables and outcomes.

The Cornell project to 'strengthen the capacity for adaptive management of the multisectoral community nutrition program' has been conceived at regional level under Pillar 2 Capacity Development. The project essentially offers a recipe in the form of three pre-defined cross-cutting strategies. But it is unclear how these will fit in and/or complement existing structures and efforts. The Cornell support aims at an ‘improved performance, sustainability and positioning for scaling up’ by delivering these three strategies at multiple levels, which in the absence of an institutional base clearly appears to be over-ambitious. Stakeholders interviewed at country level – in particular at the local level – about the merits of Cornell support responded that for them the need for such support was unclear.

The idea of addressing obstacles in an organic way and meanwhile promoting a multisectoral support is laudable. Cornell’s competence and experience are undisputed. But embedding this support and make it a distinct entity appears problematic, the more where there already is a wealth of activities, programmes and institutional entities. Countries are sensitive to support they did not ask for. The risk is that the Cornell contribution is perceived as a research project with its own agenda rather than a support that leads to results which merit research.

The project document (annex to the ANSP agreement) remains quite vague about what type of activities it intends to undertake; it claims to work for all four pillars (‘direct or indirect support for all four pillars’) but in its elaboration focuses on Pillar 1 and 4. It further claims to ‘address challenges’ but fails to describe how it will do so and what ‘innovative approaches to nutrition’ it will bring to do so.

The Cornell ‘capacity building of decision makers and nutrition communities’ project is proposed to be supported by a substantial UNICEF contribution ($965,035 for the four ANSP target countries; partially coming from ANSP funding). The MTE is of the opinion that such a large investment is not really underpinned nor justified given its set-up as ‘a project within a project’, its lack of appropriate embedding and its short-coming in clearly describing its operationalisation.

**Communication for Development (C4D)**

The WCARO office has made a concept note of how to implement C4D activities under the ANSP. The document clearly spells out the principles of C4D and it presents expected results and activities per Pillar as in the ANSP overall design. The emphasis is on behavioural change of mothers and caregivers as individuals but also of communities as a whole.

As the activities are taking place in the two target countries – Burkina Faso and Mali – the assessment of the effectiveness will be done at the country level (see country annexes BF and Mali).

**Other training activities**

Another set of training activities for a variety of target groups has been implemented as well. All of these trainings have a common denominator to the extent that they aim to provide information and knowledge to different groupings relevant for mainstreaming and (political) decision-making in the region. The training activities appear to be relevant and implemented with an appropriate approach. Ex-post assessments of relevance, approach and effectiveness have not been undertaken by UNICEF on a regular basis. The training activities concern professional media and journalists (in Niger and Burkina Faso in 2011 and in Senegal in 2012); training of 30 Nutrition focal points from 9 French-speaking West African countries including Burkina Faso and Mali (2012?); and training and establishment of a network of francophone parliamentarians (Nov 2013).

Two training sessions have been planned on leadership and capacity development facilitated by an external consultant. One session was held for French-speaking countries in Nov 2013 and the other one for English-speaking countries is still to take place.
2.5 Pillar 3: Information systems and knowledge

2.5.1 Relevance and appropriateness

The ANSP logframe formulates the Expected Result and activities at Regional level for this pillar as follows:

Pillar 3: Data analysis and Knowledge sharing

Expected Result 3:
Sustainable nutrition information systems and knowledge management developed with strong linkages with other information systems such as food security; early warning systems and health management information systems.

WCARO Activities:
- Implementation of the recommendations of the workshop organized by the regional nutrition working group in early 2011 which explored concrete ways to link food security and nutrition, for the benefit of Program managers in the field in West Africa.
- Development and roll out of a web-based data monitoring software programme for management of severe acute malnutrition and a dev-info regional nutrition database (both process and outcome indicators)
- Support to country nutrition surveys and nutrition information systems
- Formative research on community-based nutrition interventions
- Documentation of the implementation of programme activities (process, bottlenecks and lessons learnt)

With regard to the relevance of the WCARO component to contribute to the achievement of ANSP expected result 3:

1. It is not clear in what way ANSP-WCARO has developed a strategy to link food security to nutrition information systems. The main vehicle to further enhance nutrition surveys and information systems is the SMART tool, but this does not include food security data. Vulnerability Mapping is another tool which could link household food insecurity to nutritional status but this tool has not been included in the design of activities.
2. The development of a graphical web-based nutrition database presenting nutrition data and trends for the region is highly welcome but also needs a good understanding of its potential users at the regional and national levels, in particular policy-makers. A needs assessment of its users has not been included in the design.
3. Formative research in order to improve knowledge on specific issues related to the understanding of the principle causes of chronic undernutrition should be based on a thorough analysis of already available information before setting out for (often renewed) data and information gathering.

2.5.2 Effectiveness

SMART

21. Support has been provided to country nutrition surveys and information systems through the introduction and strengthening of SMART methodology which has proven to be a very successful tool

Under the pillar 3, UNICEF WCARO has provided technical support for the implementation of the SMART methodology for rapid collection and data analysis on a wide range of nutrition relevant indicators. The relative low-cost of the tool and its possibility for rapid data analysis, comparison and presentation makes it a very attractive tool to be used annually. Its incremental design to include new indicators when needed and the possibility to apply it at various level without excessive costs have contributed to its wide use (see further details in the Mali and Burkina Faso reports).
In 2012 18 SMART surveys, at national and/or regional level, have been executed in 14 countries in the sub-region. Sure signs of success are, firstly, that the methodology has in several countries been incorporated in DHS (in 2013 in Gambia and Liberia) and MICS surveys (in 2013 in Benin and Sao Tome) and, secondly, that training at the request of national staff continues (recent trainings took place in Cameroun, Liberia, Niger et Togo) while, thirdly, new requests for SMART technical assistance likewise keep coming in (12 such requests for 2013). A feature that is adding to SMART’s appeal is that the competence and complexity is being built up “one step at the time”: SMART has started by making headway with anthropometric indicators and is now taking the next hurdle, of also including IYCF behaviour indicators. In Burkina Faso this has been the case from 2012 onwards. The WCARO staff has been heavily involved as is clear from the role expected from them in 17 out of 20 SMART endeavours in 2013. The regional role is specialized and ranges from SMART planning to training, to integration of the methodology in other formats such as MICS and DHS instruments, to analysis and validation, and to evaluation of the inclusion of MNP and IYCF. The feedback to the use of SMART is overall very positive at all levels, in particular on its precision and rapidity as compared to DHS or MICS. Inherent in SMART is that the link between the National Health Information System and Early Warning System (EWS) have been strengthened through its higher frequency of application. All 15 ECOWAS countries are supposed to use SMART through the Harmonized Framework for Vulnerability Mapping. The target of application of SMART has already been surpassed in year 2.

However, the way the SMART survey results are currently being presented – at least in the case of Burkina Faso and Mali – calls for improvement. In the SMART reports it is very difficult to go to the core of the results. Policy briefs presenting the results of the survey findings in a concise and understandable way have not yet been found by the MTE team.

**Regional nutrition database**

22. The initiative to develop a website to make nutrition data for the Sub-Saharan African Region available by using already existing data sources, appears to be a relevant initiative. The Nutrition Info project is developing and maintaining a Regional Nutrition Dashboard – called Nutrition Info – with easy access to all available data on nutrition for the whole of Sub-Saharan Africa. As access to nutrition data are often not at hand or are limited in the region, this project will develop and maintain a database and site – called Nutrition Info – with easy access to all available data on standard nutrition indicators in the region:

- Data on children and women – stunting, global and severe acute malnutrition, underweight, MUAC, bilateral oedema, in children and Low BMI, Low Height, acute malnutrition and obesity in women along with population counts and data quality scores
- Visualization options – Table/graphs/ map showing current status of the selected indicator, population counts and data quality scores
- Time series options – Option to review data at specific time period or view the evolution of conditions over time

The web-based tool intends to present data on nutrition – amongst others chronic and acute malnutrition – for 48 countries on the basis of surveys done in the respective countries. As the tool includes data from surveys starting in the early eighties, it is possible to present and analyze trends over the past decades. The tool also intends to assess the data quality of the surveys used.

As such the web-based Nutri Info tool provides a very welcome and useful tool to manage nutrition survey data from sub-Saharan Africa. Work is still in progress as the website has not yet been finalized.

**Formative Research on community-based nutrition interventions**

Reported under pillar 4.

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8 source: ex WCARO staff, personal communication
Other activities

UNICEF has contracted a consultant to address the data quality of a number of nutrition data sets from DHS, MICS and CFSVA by using the ENA assessment tool. UNICEF itself has undertaken and reported on the analysis of the 2008 DHS as implemented in Nigeria.

However, no evidence has been provided on the following regional logframe activities:
- Follow-up of the RNWG early 2011 workshop which “aimed to give concrete ways to maximize nutritional benefits from food security interventions, by reviewing examples of successful programs and initiatives from throughout the region, while offering a chance to learn from the researches done by REACH, USAID’s IYCN project, ACF and FAO in the region” (activity 3.1)
- Support roll out of the RapidSMS based system for programmes and survey data (activity 3.3)
- Documentation of the implementation of programme activities (process, bottlenecks and lessons learnt) (activity 3.5)

2.6 Pillar 4: Scaling-Up Interventions

2.6.1 Relevance and appropriateness

With regard to Pillar 4 the ANSP logframe includes the following expected output and activities relevant for the WCARO component:

<table>
<thead>
<tr>
<th>Pillar 4: Scaling up interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expected Result 4:</strong></td>
</tr>
<tr>
<td>National comprehensive nutrition programmes implemented in coherent, coordinated and synergic manner with other sectors such as food security; health, WASH and social protection.</td>
</tr>
<tr>
<td><strong>WCARO Activities:</strong></td>
</tr>
<tr>
<td>- Assessment of opportunities for minimum package of cost-effective and safe interventions;</td>
</tr>
<tr>
<td>- Development of a model for conducting formative results for IYCF and community-based nutrition developed.</td>
</tr>
</tbody>
</table>

With regard to the relevance of the WCARO component to contribute to the achievement of ANSP expected result 4, the following:

1. The role of WCARO in the implementation of the scaling-up of national comprehensive nutrition programmes should be in the first place supportive to the national country programmes; however, the way the regional activities have been formulated does not clarify at all the supportive role;
2. No strategy has been developed on how national programmes can learn from each other good practices to scale-up interventions in an effective and efficient way; a clear framework how to analyse and document good practices to enhance joint learning is missing;
3. As the expected result under this pillar aims at a coherent, coordinated and synergic implementation together with other sectors, support to the development of multi-sectoral approaches applicable at national and sub-national levels has not been defined and is clearly lacking in the design of the WCARO component;
4. Given the fact that a substantial part of the WCARO budget is dedicated to this pillar 4, the logframe, nor the workplan or the budget provide a clear picture of what approach and activities are being undertaken to contribute to the ANSP expected result. The only defined activity is ‘formative research on IYCF’ which is expected to help improve IYCF programs in the region.

2.6.2 Effectiveness

23. The support role of UNICEF-WCARO to the Scaling-Up of interventions has remained rather limited.

According to the UNICEF WCARO nutrition team they have helped country teams to improve the package of interventions offered in the context of the prevention of acute malnutrition (e.g. develop the ‘WASH in Nutrition’ strategy). On another occasion the team has assisted to guide the revision and validation of the Malí national IYCF strategy. However, beyond providing technical support, WCARO...
has been less well positioned to work on scaling-up interventions, as pillar 4 applies more to country-level work (See further Mali and Burkina Faso reports). The role of WCARO should be complementary to the work done in the country programmes, by focusing on learning, documenting, analysing and evaluating lessons learned and good practices.

However, as already indicated earlier, Pillar 4 constitutes 21% of the total ANSP-WCARO budget which would justify well-defined and effective support to Scaling-Up interventions, at least through the documentation of good practices as they emerge in the two target countries or other countries in the region.

**Study on determinants of Child Feeding practices**

24. The study on Infant and Young Child Feeding practices is relevant in order to improve understanding but lacks a detailed review of already existing knowledge

The only other implemented activity so far is the implementation of the formative research on the determinants of Infant and Young Child Feeding practices in Benin and Mali. UNICEF has hired a consultant to undertake this formative research on complementary feeding. Field work has been finalized in Benin whereas due to the unrest in Mali, its implementation could only start in November 2013.

The work is expected to help to improve IYCF programs in the region and therefore appears to be relevant. A comprehensive research proposal has been approved by the Ethical committee in Mali. It will be implemented in the two ANSP target districts of Yorosso and Bankass. The methodology is mainly qualitative by nature making use of different methodologies. One informant in Mali indicated that substantial information on IYCF practices is already known. The MTE team being of the same opinion questions the absence of an extensive literature review and key informant interviews before undertaking the exercise.

2.7 Efficiency

2.7.1 Operational Efficiency

25. Programme implementation at regional level appears to be appropriate as the technical support by the WCARO team are often solicited by the individual countries

The provision of technical support by the WCARO team is in principle demand-led based upon requests by individual countries. Requests for support often come from the need to develop or adjust policies in the context of the SUN movement or the REACH initiative. The same applies for UNICEF support and/ or collaboration to regional institutions and initiatives (ECOWAS-WAHO, CILLS, AGIR, etc).

Also the activities coordinated under the umbrella of RNWG are making use of the complementarities of the different organisations represented including the expertise of UNICEF. Moreover, UNICEF is playing a prominent role in the RNWG as it hosts its facilitator who at the same time is the regional REACH facilitator. This combination provides a good outlook for appropriate and coordinated technical support on nutrition security mainstreaming in the region.

26. The ANSP WCARO component is insufficiently linked to the two ANSP WA target countries. Being part of the same ANSP programme, the link with the two target ANSP countries is rather weak. With ANSP providing technical and financial opportunities to promote and experiment with the scaling-up of nutrition security interventions in the two countries, a close follow-up in terms of exchange and learning is not yet present.

Moreover, the trainings and/ or studies (C4D, Cornell, Determinants of IYCF) which are implemented in Mali and Burkina Faso, appear to be carried out without appropriate needs assessments and ownership by the individual countries. In particular the Cornell support gives the impression of being a project in a project with little embedding in the actual structures.

27. ANSP WCARO does not fully make use of experiences at regional level with regard to multi-stakeholder action relevant for the scaling-up of nutrition security interventions
As indicated earlier, there are substantial experiences in the promotion of multi-stakeholder action for the sake of reduction of chronic malnutrition which includes relevant sectors for enhancing improved feeding and nutrition practices. International NGOs like ACF, GRET or HKI provide some examples\(^9\); other attempts have been made to document for instance the evidence of the role of agriculture for improved food and nutrition security (e.g. vegetable growing during the dry season in the Sahel region; production of enriched complementary foods; complementary feeding of animals for off-season milk production, etc) or the role of social protection (e.g conditional cash transfers).\(^{10}\)

### 2.7.2 Financial efficiency

28. The allocation of ANSP budget to the WCARO component is substantial, almost as large as the two ANSP WA country budgets together. More than half of the ANSP WCARO budget consists of staff costs.

The ANSP WCARO budget represents about 21.4% of total ANSP budget: € 4.2M. The two ANSP country budgets of Mali and Burkina Faso together have a projected budget of € 4.5M representing about 22.7% of the ANSP budget.

The ANSP WCARO budget includes a significant contribution for staff costs which represents about 53% of the € 4.2M budget. UNICEF has budgeted for 7 staff + 1 administrative support in the ANSP programme. However, it should be noted that their ‘own contribution’ to staff costs is 41% for the first two years of ANSP operation. There is the risk that the share of UNICEF own contribution might diminish during the remainder of the ANSP programme as other sources of funding from which UNICEF nutrition staff are being paid, might dry. The budget for Cornell activities are catered for by the WCARO ANSP budget. The same applies for the one year salary of a WCARO C4D Specialist.

The other budget expenditure categories are presented in the next figure:

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9 Re: ACF Reconciler …2013; ACF Aid for Nutrition 2013, GRET–BF (personal communication);
10 World Neighbours in Burkina Faso, CRESA in Niger, Oxfam in several countries
By Pillar the WCARO projected budget looks as follows: Result 1 33%; R2 25%; R3 21% and R4 21%. To some extent it is remarkable that Pillar 4 (Scaling-up interventions) is projected to be more than one-fifth of the total budget whereas the comparative advantage of the WCARO is with the other pillars (See 2.6.2). Again, this mainly relates to staff costs which represents 75% of the Pillar 4 budget. However, in reality the contribution from WCARO to the scaling-up has been less visible up to date. (source: Financial report year II)

29. ANSP-WCARO expenditure rate is slightly under the ANSP overall expenditure rate in the first two years
Overall expenditure rate is 37.3% of total budget after Year II (ending September 2013). The overall figure for the ANSP programme is 42%. During both years of implementation the WCARO expenditure has remained below the projected ones for that particular year: respectively 82% for year 1 and 70% for year two. When analysing the expenditure rate per pillar it clearly shows that the delay in expenditure mainly originates from the slow start of Pillar 2 (Capacity Development) activities: R1 49% R2 18% R3 40% R4 35%. The WANCDI activities only started early 2013.

2.7.3 Leverage of resources

30. WCARO nutrition activities benefit from other sources than ANSP
In terms of leverage from other sources WCARO has been able to secure other sources of funding which directly or indirectly contribute to the ANSP goals. Leverage is mainly from UNICEF’s other sources of funding. To some extent also other regional partners are contributing in the context of RNWG activities (MI, ACF, FAO, ECHO etc.) or WANCDI (e.g. HKI and MI), or MI for the ECOWAS Nutrition Forum.

2.8 Impact

In the context of the ANSP WCARO component it is difficult to address the issue of Impact at this stage. In the first place, WCARO is operating in 24 countries in the region, each one with its own dynamics and different contributing factors and programmes. WCARO has more of a supportive role to various initiatives and actions. Secondly, WCARO impact should be based on the achievements of stunting reduction on the long run.
2.9 **Sustainability**

31. ANSP funds clearly complement other UNICEF-WCARO funding in order to maintain its supportive and promotional role for nutrition security in the region.

Though the ANSP contribution is relatively modest, the cumulative funds enable UNICEF to maintain a good number of staff with an appropriate range of competences such that the regional office can play the role that it is expected from. The ANSP contribution to UNICEF WCARO can be better described as core-funding to continue its advocacy work in the field of nutrition security and provide support to the 24 countries in the region. This type of financial support clearly enhances sustainability of the UNICEF WCARO nutrition activities as it builds upon their existing activities and staff competencies.

Although ANSP is formulated as a project with its own objectives and set of pillars (result areas), these largely coincide with the routine tasks of WCARO’s nutrition unit. Being so, the ANSP has enabled UNICEF WCARO to go further and take up activities which go beyond the routine, and especially to take up long term plans, which have been difficult to fund through other channels. Good examples are activities under the RNWG described under pillar 1 and the WANCIDI programme under pillar 2. In terms of sustainability both are special cases as they represent a long term vision.

3 **Conclusions**

*General conclusions*

1. For UNICEF WCARO the RNWG clearly is the main mechanism for regional work on ANSP’s pillar 1 and 2 and to a very limited extent on pillar 4. (Pillar 3 work is by nature in UNICEF’s realm and is not placed in the RNWG workplan.) ANSP is for UNICEF the funding mechanism that makes it possible to continue the RNWG work. The ANSP funding contributes to making the RNWG more professional (workplan, facilitator) and provides finances for joint activities. The RNWG has an independent identity which does not come from ANSP or ANSP pillars. In terms of inputs and efforts UNICEF has been (one of) the most prominent member.

2. ANSP in terms of a model programme is meant to remain at the forefront of new developments with respect to nutrition security. This implies that it should continuously ask, ‘what next?’ when milestones have been reached. Given the highly dynamic context in which ANSP is operating in the WCA region, with new initiatives having emerged over the past few years (SUN, REACH, AGIR, etc.) and nutrition policies now being in place in many of the regional countries, UNICEF has not yet clearly positioned itself; but it has all means to do so!!

3. In general the question “Why” has been taken care of. Many countries in the region have become convinced that they should do something to reduce chronic malnutrition in their respective countries. UNICEF has played an important role to develop that conviction. But “How” to implement these policies on the ground, together with other stakeholders, is the current challenge; with the questions “At what cost?”, “With which (predictable) results?” and “How to maintain this?” looming. This is where ANSP’s added value should lie.

4. The current nutrition discourse is vested on the positive attitude of the international donor community and technical partners at present. This is reflected in the wide number of initiatives (as mentioned SUN; REACH; AGIR; ARISE, etc.) that have recently emerged. There is always a risk that this attention may subside once donor attention is attracted to another development priority. In the context of ANSP, UNICEF has not always been sufficiently alert that its ANSP activities remain at the forefront of nutrition security mainstreaming and to avoid the notion of ‘business as usual’. In its annual planning UNICEF has not subsequently reflected upon and strategized in this rapidly changing context. For instance the question “Has stunting prevention come out as an integrative element for UNICEF nutrition activities?” has not sufficiently been answered by UNICEF.

5. Despite the fact that the current discourse of nutrition creates an overload of documents, meetings and conferences on the topic, some concepts do have the power to both engage and apply at different levels and to bring actors together. Resilience is such a concept; this could be further exploited in the context of UNICEF ANSP activities as has been shown by the RNWG Resilience Guide.
6. Most interesting of ANSP is the integration of the four pillars linking different elements of “Nutrition Institutional Strengthening”. This link is a strength of the programme which should be maintained and strengthened as much as possible during the implementation phase; however, the link to the Pillar 4 activities in particular those in the two ANSP target countries remains relatively weak.

4 Lessons Learned and Good Practices

Potential lessons learned could be:
Pillar 1: Compile lessons learned across WA countries and align write-up with lessons required by SUN
Pillar 2: The WANCDI programme to support Capacity development at a regional level.
Pillar 3: Smart use of SMART – see pillar 3
Pillar 4: Concept of resilience lends itself to innovative approach.

But these lessons learned are still to be developed and well-documented.
1 Introduction

1.1 Key national statistics

Table 1: Key national statistics

<table>
<thead>
<tr>
<th>Key geographic, economic, and social characteristics</th>
<th>Burkina Faso</th>
<th>West and Central</th>
<th>Sub-Saharan Africa (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (2011) x 1000</td>
<td>16,968</td>
<td>411,864</td>
<td>855,273</td>
</tr>
<tr>
<td>Under-five mortality rate/infant mortality rate, both 2011</td>
<td>146/82</td>
<td>143/88</td>
<td>121/76</td>
</tr>
<tr>
<td>Life expectancy at birth (2011)</td>
<td>55</td>
<td>53</td>
<td>54</td>
</tr>
<tr>
<td>GNI per capita (PPP)</td>
<td>USD 1310</td>
<td>USD 1604</td>
<td>USD 2145</td>
</tr>
<tr>
<td>% of population below international poverty line of US$ 1.25 per day (2006-2011)</td>
<td>45</td>
<td>52</td>
<td>49</td>
</tr>
<tr>
<td>% of children (2007-2011) early initiation of breastfeeding</td>
<td>20</td>
<td>39</td>
<td>45</td>
</tr>
<tr>
<td>% of children (2007-2011) who are exclusively breastfed (&lt;6 months) (threshold: &lt;50%)</td>
<td>25</td>
<td>24</td>
<td>33</td>
</tr>
<tr>
<td>% of children (2007-2011) introduced to solid, semi-solid or soft foods (6-8 months)</td>
<td>61</td>
<td>63</td>
<td>69</td>
</tr>
<tr>
<td>Antenatal care coverage at least once</td>
<td>34</td>
<td>45</td>
<td>47</td>
</tr>
<tr>
<td>Vitamin A supplementation coverage rate (6-59 months) 2011, full coverage (%)</td>
<td>87</td>
<td>90</td>
<td>86</td>
</tr>
<tr>
<td>% of households consuming iodized salt (2007-2011)</td>
<td>34</td>
<td>65</td>
<td>53</td>
</tr>
<tr>
<td>% of infants with low birth weight (2007-2011)</td>
<td>16</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from underweight (WHO), moderate &amp; severe</td>
<td>26</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from: wasting (WHO), moderate &amp; severe (WHO public health problem: &gt;10%)</td>
<td>11</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from: stunting (WHO), moderate &amp; severe (WHO: public health problem &gt;30% moderate, &gt;40% severe)</td>
<td>35</td>
<td>40</td>
<td>39</td>
</tr>
</tbody>
</table>

1.2 National Policy Framework in Nutrition Security

Burkina Faso has detailed specific nutrition policies and strategies. The national level Nutrition Directorate was created within the Ministry of Health as early as 2002. In the same year the first National Strategy for Food Security was published. The National Nutrition Policy (PNN) followed in 2007. In the same year the Conseil national de concertation en nutrition (CNCN) was established to be followed, in 2010, by publication of the Plan Stratégique Nutrition (PSN) 2010-2015. These national plans and policies address improvement of the envisaged nutrition interventions and especially their integration in the health systems. Nutrition has also been integrated, to some extent, in the Stratégie de croissance accélérée et de développement durable (SCADD 2011-2015) and likewise in the Plan National de Développement Sanitaire (PNDS 2011-2020).

In 2012 another important policy document was completed and adopted: the 2011-2015 Programme National du Secteur Rural (PNSR). Towards the end of 2013 the Politique Nationale de Sécurité Alimentaire et Nutritionelle (PNSAN) came out. While the PNSR is a long term rural development plan, in which nutrition has to some extent been woven in, the PNSAN rather has a food security lens with a focus on food deficiencies at times of crisis. PNSR and PNSAN are not by nature complementary, which is a criticism voiced by several respondents, and also in a recent ACF study.2 (ACF has in addition screened the PNSR for integration of nutrition, and found substantial gaps. To name but one of the gaps identified: the potential role for agriculture to address micronutrient deficiencies.) PNSR and PNSAN are steered by different councils, both based in the Ministry of Agriculture.

1.3 Technical and financial partners in Nutrition Security

SUN membership and partnership arrangements

Burkina Faso joined the SUN Movement in 2011 and is making progress in setting up the policies and programming required to scale up nutrition. The CNCN (see above) is the convening body. It is located within the Ministry of Health. The Director of Nutrition, also based in the Ministry of Health, is the SUN Country Focal Point. She is assisted by vice presidents of the Ministry of Agriculture and Food Security, the Ministry of Hydraulics and Sanitation, the Ministry of Social Action and National Solidarity and the Ministry of Economics and Finances. The Donor Convener is a UNICEF representative. Donors providing assistance for national plans include UNICEF, WHO, WFP, FAO, EU, ECHO, OFDA, USAID, World Bank and several NGOs. The development partners have their own separate platform called the Group of Technical and Financial Partners for Nutrition Security (PTF). This platform is divided into four sub-groups: Acute Malnutrition Management, Infant and Young Child Feeding, Food Security, and Advocacy and Political Dialogue.3

<table>
<thead>
<tr>
<th>Pillars</th>
<th>Measures foreseen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition-specific</td>
<td>Elaboration of Plan to Scale Up IYCF</td>
</tr>
<tr>
<td></td>
<td>Elaboration of Plan to Scale Up Management of Moderate Acute Malnutrition (MAM)</td>
</tr>
<tr>
<td></td>
<td>Elaboration of Plan to address micronutrient deficiencies</td>
</tr>
<tr>
<td>Nutrition-sensitive</td>
<td>Elaboration of the national Food and Nutrition Security Policy</td>
</tr>
<tr>
<td></td>
<td>Elaboration of Strategy for school canteens</td>
</tr>
<tr>
<td></td>
<td>Elaboration of BCC Plan for food and nutrition security</td>
</tr>
<tr>
<td>Capacity building</td>
<td>Integration of nutrition in the Human Resource Development Plan of the Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Revision of curricula to include nutrition (Health; Agriculture)</td>
</tr>
<tr>
<td></td>
<td>Training of health agents and community health workers on IMAM and IYCF at the national level (2 health agents per health facility, at least 2 CHWs per village) as part of the IYCF and SAM management scaling-up plans</td>
</tr>
<tr>
<td>Governance &amp; Coordination</td>
<td>Reinforcement of intersectoral cooperation regarding nutrition, at central (CNCN), regional and provincial level</td>
</tr>
<tr>
<td></td>
<td>Adoption and use of common results framework for multisectoral interventions</td>
</tr>
<tr>
<td></td>
<td>Establishment of biannual monitoring of inclusion of nutrition (mainstreaming) in all sectors</td>
</tr>
<tr>
<td>Mobilisation of funds **</td>
<td>Estimate the funds required for scaling up all nutrition interventions</td>
</tr>
<tr>
<td></td>
<td>Increased mobilisation of internal and external funding for nutrition</td>
</tr>
<tr>
<td></td>
<td>Monitor the financial allocations for nutrition, of Government and Partners, in the health and agriculture budgets</td>
</tr>
</tbody>
</table>

* Source: [http://scalingupnutrition.org/sun-countries/burkina-faso](http://scalingupnutrition.org/sun-countries/burkina-faso)

** The IYCF scaling up plan is currently being costed, by ANSP/UNICEF. To the MTE’s knowledge this is not done as yet for the other nutrition interventions. The activities in the last row of the table – mobilisation of funds – are yet to be addressed.


3 Source: [http://scalingupnutrition.org/sun-countries/burkina-faso](http://scalingupnutrition.org/sun-countries/burkina-faso)
The table above summarises the SUN Road Map. As will be discussed later UNICEF/ANSP has systematically contributed to 9 of the 15 measures listed, in partnership with the Nutrition Directorate.

Special (and positive) features in the Burkina Faso setting

A country-wide network of pre-selected NGOs and CBOs provides a foundation for health-related prevention endeavours

In the context of the Programme d’Appui au Développement Sanitaire (PADS), the Ministry of Health has contracted a network of Community Based Organisations (CBO/OBCE) to deliver the health and nutrition services at community level. The aim is to achieve equitable access to prevention services all over the country. The country’s 63 health districts are to this effect divided in 21 lots, with an NGO ‘renforcement de capacité’ (Rencap) in charge of the selected CBOs in each lot. The Rencap NGOs are themselves also contracted and as such form a network of (19) pre-selected partners of the Ministry. The network has been in existence since 2008/2009. Thus in Burkina there is a strong institutional foundation of NGOs and CBOs which are both vertically and horizontally linked and which have already worked on matters of prevention in the regions and districts they are based in. The local population knows them for their previous work; likewise any new work – such as the IYCF intervention package – can be grafted on previous work. In the course of 2012 a National Policy for community health has been developed with ANSP/UNICEF technical assistance. The IYCF package by nature falls within the implementation of this policy.

Strong linkages between the Ministry’s Nutrition Directorate and UNICEF’s nutrition unit ensure close cooperation; nutrition firmly situated in the health sector

The ties between the Ministry’s Nutrition Directorate and UNICEF’s nutrition unit are historical: “We are family” as staff members expressed it and this is no exaggeration given that UNICEF’s most senior nutrition officer is the predecessor of the current director while another member of the UNICEF équipe and the Director are former classmates. This proximity shows in close working ties and continuous interaction. However, it is also true that the institutional setting of nutrition in the Ministry of Health, together with the close links with UNICEF, have automatically led to nutrition being health-led. At the time of the MTE visit the Ministry of Agriculture had just re-named one of its existing units to be the main entry point for nutrition. Thus far, however, this Ministry has not had the right institutional setting, nor the expertise, to effectively address nutrition (personal communication, senior staff, Ministry of Agriculture).

A clear division of work within UNICEF’s nutrition unit has created space for one staff member to focus exclusively on ANSP’s pillar 4: the IYCF programme

ANSP Pillar 4, the IYCF programme, has been planned and strategised in minute detail. This has been possible as one staff member has since his arrival in 2012 devoted all his time to it. Work on the other 3 pillars is integrated in the duties of the other team members.

2 Findings

2.1 Overall Relevance and Appropriateness

2.1.1 Country programme design

The 2011-2015 programme aims at 7 results under 4 result areas (“pillars”), summarised in the figure below. The programme in Burkina Faso avails of a total budget of € 2,401,800 excluding administrative costs. The budget for the individual pillars is R1: € 528,246; R2: €234,554; R3: €580,000; R4: €1,059,000.

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4 http://www.pads-burkina.org/index.php?option=com_contact&view=contact&id=1&Itemid=6

5 The name is: Direction de l’Alimentation et de la Promotion de la Qualité Nutritionnelle (DAQPN)
Most of the above fit seamlessly with the priorities listed in Table 2 – the SUN Road Map. The notion of policies that become “effective” (R1 in the table) is of course somewhat debatable – the discussion on gaps in the PNSR refers. As discussed with the country team the main challenge is to do all of the above in an integrated manner, where different levels of interventions interact and thereby give added value to the already existing interventions.

Unlike in other ANSP countries (notably Uganda) the sub-country levels are not spelled out. This is not all that necessary in Burkina given that there is a practical division of labour within the nutrition unit (see above) and partners know this. Also, although the R4 results are defined for only 2 (out of 13) regions, these results in fact are the results of the test phase of a nation-wide plan. ANSP pillar 4 effectively funds the first, or test phase, taking place in these 2 regions. This is exceptional when we compare R4 in Burkina with the other 3 ANSP countries. In Burkina the phrase “scaling up” has been interpreted in the literal sense, by design.

### 2.1.2 Coherence, completeness and complementarity to other initiatives

**Close links with the Ministry of Health and the NGOs Rencap**

ANSP/UNICEF has found a national embedding in the first place with the Nutrition Directorate in the Ministry of Health. This coherence not only applies for work in the ANSP context, but also for work on, for example, activities related to CMAM. The UNICEF Nutrition section has been able to establish close linkages with a wide range of Government partners and their technical and financial partners, most of whom take part in the above-mentioned PTF. The earlier described contractual mode with the Rencap NGOs provides a generally recognised link with the health system (section 1.3 refers). The ANSP aim is to engage in contracts with 5 NGOs Rencap during the test phase of pillar 4. At the time of the MTE visit the 3rd such contract was being negotiated. From the discussions and also in the field visits, it was clear to the MTE that the interactions with these NGOs have been positive and intense, with firm and yet gentle guidance by the UNICEF staff member. The aim clearly is “unity in diversity”:
to secure a uniform model for the IYCF programme, even though the NGOs all have their specific strengths and weaknesses.

A counter-balance to the prevailing emphasis on crisis-related acute forms of malnutrition is highly relevant
Humanitarian needs are notoriously under-funded – Table 3 refers.

<table>
<thead>
<tr>
<th>Appeal sector</th>
<th>2013</th>
<th>Funds received</th>
<th>Funding gap (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>12,000,000</td>
<td>4,758,657**</td>
<td>7,241,343 (60)</td>
</tr>
<tr>
<td>Other</td>
<td>10,226,485</td>
<td>3,469,080</td>
<td>6,757,405 (66)</td>
</tr>
<tr>
<td>Total</td>
<td>22,226,485</td>
<td>8,227,746</td>
<td>14,019,429 (63)</td>
</tr>
</tbody>
</table>

**Includes $ value of RUTF purchased

Given the more pressing and immediate needs the risk is that structural needs are not attended and that positive trends—a decline in chronic malnutrition—are not heralded as an achievement. For example, currently the nutrition data that are routinely generated are largely focused on acute malnutrition prevalence. The same goes for the purpose, and use, of the annual SMART surveys. Although these are also meant to allow reporting on declining, and thus positive, trends, the wording is in terms of severe and moderate acute malnutrition. It is understandable that in countries which are used to handle crises, data use is primarily for early warning, and to identify areas requiring priority action. As it is, there has been no plan nor programme specifically devoted to the first 1000 days window of prevention, until the current programme which is set to start in 2013, through ANSP funding. This programme has the potential to counter-balance the prevailing emphasis on crisis-related acute forms of malnutrition, and will specifically address the 1000 days window, which has hitherto been neglected.

2.1.3 Programme design and M & E arrangement

Programme monitoring frameworks

The logical model in its current form appears not to be in use
ANSP/UNICEF has made efforts to capture the programme logic for each country in the form of logical models. The foundation of these models is the by now well-known diagram shown below. A similar diagram is used in ANSP’s sister programme MYCNSIA, in Asia.

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The model is specified by showing the interventions for each of the cells and the underlying assumptions for this to work as intended. The interventions (not shown here) are colour coded and in that sense give an indication of the level they need to address. For example, pillar 4 interventions are shaded purple. Taking the example of Burkina Faso, the ensemble of diagrams takes 6 slides; they also take considerable space in the country reports.

The MTE acknowledges that drafting the intervention logic in the above way may have been helpful in the design phase, also to put the ANSP programme in its context and be aware of assumptions and so-called killer assumptions. However, the MTE has not seen the logical model in use, nor is it likely that the model in its current form is still needed. The reasons are fivefold:

Firstly, the model depicts ANSP as if it is a typical stand-alone project while in reality ANSP is usually building on precursor projects or on parallel projects, or simply is part of existing routines. Secondly, and the same comment was made in the MYCNSIA programme: the cell for household food insecurity gets less attention in the full set of slides than do the other cells. The model, in other words, is in practice biased towards nutrition-specific interventions. Thirdly, the model is typical for a set of interventions describing what needs to be done to address nutrition insecurity. As described elsewhere in this report this is by now by and large known. The current debate is rather on how the interventions should be put in place, as a coherent, multi-sectoral package that is tailored to the local context. Fourthly, it stands to reason that the nutritional status of communities will improve if the entire model is implemented, as a package. This is the main argument in the Lancet series (2008; 2013) and is also well documented in research. ANSP’s more specific added value is that it brings the perspective of preventing chronic malnutrition and thus focuses on the window of the first thousand days. Lastly, the model is limited to the country level and does not make the link between country and regional level, let alone with the continental level. As is discussed elsewhere in this report these links are important and are part of the ANSP identity.

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2.1.4 Partnership with EU in practice

There has been little interaction with the EU Delegation other than occasional exchanges during the regular PTF platform meetings. Yet the former Head of Delegation reputedly took a keen interest in the programme. As the ANSP programme is reported on at higher levels there is apparently no oversight role from the part of the national level EU Delegation. The MTE did not get to meet the staff member of the EU Delegation, but did meet with DG ECHO. The DG ECHO staff expressed a keen interest in, and support for, the direction taken by ANSP/UNICEF: to go all out for prevention of chronic malnutrition, in a systematic way. However, more regular reporting, even during the planning phase, would have been welcome.

2.2 Equity Focus

*Equity focus of the strategies implemented for the reduction of stunting and anaemia: geographic, gender, age, income and ethnic origin, etcetera*

Food insecurity is wide-spread, pointing to the need for country-wide programming. The map below signifies a well known problem of targeting nutrition insecurity that arises from food insecurity: often pockets are spread all over the country even though some regions are clearly worse off.

![Vulnerability in terms of food insecurity](image)

There is ample evidence that, although “lack of knowledge” plays a role, poverty is a main cause for poor diets. The earlier quoted multi-country ACF study has put the issue of access to balanced diets in an equity perspective: the poorest strata simply lack the money for a properly balanced diet. Figure 4 refers.

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9 Source: ANSP/UNICEF staff at the Country Office
10 ACF-International (2013) Étude De Cas Réconcilier l’Agriculture et la Nutrition; Étude de cas sur les politiques agricoles et la nutrition au Burkina Faso. [www.actioncontrelafaim.org/en/content/seeds-of-good-nutrition](http://www.actioncontrelafaim.org/en/content/seeds-of-good-nutrition) (English) and [www.actioncontrelafaim.org/fr/content/graines-bonne-nutrition](http://www.actioncontrelafaim.org/fr/content/graines-bonne-nutrition) (French)
The links between food (in)security and (mal)nutrition are context specific
As noted in the ACF case study, certain regions of relative food security show high malnutrition rates. This phenomenon is commonly known as the paradox of having both high productivity, and yet poverty and malnutrition. In Burkina Faso the paradox applies to the Cascade region in the West, just like it does for the neighbouring Sikasso region in Mali (note: in the Mali ANSP programme this region has been selected as one of the 2 pillar 4 regions). Reasons cited are amongst other the heavy workload of women, inadequate nutrition practices, and above all: low income due to unfair pricing of the crops produced.

The “best” sequence to achieve full coverage is to some extent arbitrary

Figure 5: Prioritisation of Burkina Faso’s 13 regions for introduction of IYCF
The sequence as proposed for introduction of the IYCF programme – see figure above – is apparently based on multiple arguments, including poverty and malnutrition prevalence. Given the data, however, there is ample reason to argue that IYCF is meaningful throughout the country, and that, given the plan to go full-scale, the actual sequence is not all that important. Not unimportant is also the fact that the pilot phase results should be convincing and help to attract funding for rolling out.

**Narrowing the nutrition security gap between the wealth strata is not a self-evident part of ANSP’s pillar 4 IYCF plan; yet this ought to be a possibility for Burkina’s IYCF programme**

Chronic malnutrition in Burkina has been increasing from 30% in 1993 to 39% in 2003 and has since been decreasing, to 32.9% in 2012.\(^{11}\) However, the decrease started earlier (in 1998) for the wealthiest quintile as compared to the other four quintiles.\(^{12}\) Although the rapidity of the decline appears the same for the five quintiles, the earlier start of the decline in the wealthiest quintile has resulted in a larger gap between the rich (prevalence 18%) and the poorest quintile (prevalence 42%), in 2010.\(^{13}\) The above suggests that the success of the IYCF programme that is about to take off should not only be measured in the regular anthropometric indicators that are part of the SMART surveys and of “Enquêtes de couverture de base”, but should also contain an assessment of the programme’s uptake among the poorest quintiles. Ideally, the programme should ascertain if it has succeeded in narrowing the gap between poor and better-off households. It is conceivable that future evaluations undertake to do this. It is also conceivable that the mothers’ groups (Groupes d’Apprentissage et de Suivi des Pratiques d’ANJE (IYCF), or GASPA) at village level commit to ensuring that every expectant mother enters the routine of the GASPA groups, and stays in it, until the baby reaches the age of two years.

**IYCF indicators are generally poor but some stand out as critical: questions regarding the minimal diet targets\(^{14}\)**

Although in Burkina multiple nutrition indicators show poor results, this is especially so for the indicator of diet diversity and for the composite indicator of minimal diet. The 2012 SMART survey indicated that on average only 1.44 food groups were consumed by children 6-23 months old (0.95 in the North to 1.097 in the Centre). For children aged 6-8 months old this was as low as 0.67. In 8 of the 13 zones the proportion of 6-23 months old who had eaten all four food groups ranged between 0 and 3%. This has translated in an extremely low proportion of children receiving a minimal diet, with on average only 3.5% of all 6-23months old children satisfying this criterion. It is noteworthy that the ambitions of ANSP in this regard appear modest, namely: “The percentage of children aged 6 to 23 months in the North and Central Plateau regions receiving complementary food containing at least 4 or more food groups has increased respectively from 2.2% in 2010 to 6% in 2015 (North) and from 2.8% in 2010 to 6% in 2015 (Central Plateau).” The above begs the question, firstly, if the transition to ‘a proper minimal diet’ should be measured by its composite components (with OVI’s set for the three components). A second question is how realistic it is to expect impact indicators to significantly improve at project completion if by that time the basic requirements of a minimal diet are fulfilled for only 6% of the target population of children. And reversely, if by 2015 the impact indicators would have improved whilst the minimal diet indicators were still at only 6% one would conclude that a less-than-minimal diet, although not optimal, still had made a difference.

**Responsiveness to barriers and bottlenecks to inequalities in access and coverage of key nutrition interventions**

Unlike programmes addressing moderate acute malnutrition (MAM) the IYCF programme will address the entire country and will thereby avoid inherent inequity problems

The current coverage for MAM is 7 out of 13 regions.\(^{15}\) As will be discussed later in this report the IYCF programme is set to address this inequity, not by better or more equitable care for malnourished children, but by community level ‘systems’ which prevent malnutrition from happening and which will, hopefully, thereby also include early identification of, and care for, children with acute malnutrition. The

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12. ACF (2013), Etude de Cas, Réconcilier l’agriculture et la nutrition; Etude de cas sur les politiques agricoles et la nutrition au Burkina Faso
13. UNICEF, presentation by Biram Ndiaye, April 2013
14. The Country Office reports in response to the first draft of the MTE report that “Meanwhile great progresses are registered in the Plateau Central which indicate that the initial targets were set too low, for some indicators. The 2013 SMART survey have also shown good progresses in 2013 on the key IYCF indicators. Notably, exclusive breastfeeding has increased from 25% (DHS 2010) to 47% while the minimum adequate diet has increased from 3% (DHS, 2010) to 7% in 2013.
IYCF programme will be country-wide. Its design starts from coverage norms that are feasible, in the sense that individual health workers and CBO staff have manageable targets which he or she can be expected to achieve. This implies a certain proximity to the catchment area population, including all wealth strata. There thus is a possibility for this programme to be by nature equitable. For the Nord Region and for Plateau Central the coverage aimed for at the time of completion of ANSP is 85%. The ultimate coverage aimed for is 90%, for all regions.\footnote{IBFAN/APAIB/Action chant des femmes (ACF) (2013) Documentation des bonnes pratiques (Promotion des pratiques optimales d’ANJE à travers un partenariat avec des organisations communautaires de base au niveau de la région du Plateau Central). (Draft 1 avant évaluation finale)}

There is a dilemma of having good solutions for nutrition sensitive interventions, which, however, cannot be rolled out as a recipe, over an entire country. This is the case for increasing access to, and use of, complementary foods.\footnote{Plan de passage à l’échelle des interventions d’Alimentation du nourrisson et du jeune enfant (Draft2 pour Budgétisation après atelier national de revue) } Regarding access to complementary foods there are several approaches, which complement each other. A recent development are the locally produced fortified flour varieties (Misola, Yonhama), of good quality, with support of specialised NGOs. There now are some 30 production units spread over the country. However, the products are still insufficiently known and marketed. The experience of GRET shows that with proper sensibilisation 30% of the mothers in two eastern provinces now regularly buy these fortified flours. Obstacles to do so are both cultural (lack of habit; perception that there is no need) and economic. Innovations to sell ready-made baby porridge in kiosks in poor neighbourhoods are under test. Most partner NGOs promote improved recipes based on locally available cereals – millet, sorghum, maize – and there also is a large variety of existing recipes, published by the Nutrition Directorate. These serve to work with what is feasible, but do not necessarily promote all nutritional requirements, notably for micronutrients. Some NGOs therefore specifically promote for households to grow micronutrient-rich foods themselves.

CONCLUSION: The sequence of introduction of the programme has taken poverty and stunting prevalence into account, to some extent. These criteria are less important than in other countries given that in Burkina Faso the IYCF intervention package is planned for total coverage, in the entire country. The coverage by field level staff (Health; CBOs) is deliberately chosen to be manageable in the sense that a limited number of mothers is to be monitored by individual Health/CBO staff. This proximity should also ensure that no one is overlooked, which should not be too difficult as pregnancy is by nature a condition that becomes self-evident. A further conclusion is that all regions have their specific issues affecting the population, an extreme being the conditions in Boucle du Mouhoun and Cascade. The programme will need to prove itself in terms of access to, and use of, both nutrition-specific interventions and nutrition-sensitive interventions. If it manages to do the latter and document that all strata (wealth quintiles) access and profit equally from the programme, it has the potential of a model programme.

Certain common practices affect IYCF and its chances to succeed
The IYCF programme has wisely chosen to limit itself and not take up all kinds of issues which go beyond its domain. Even so, it operates in a context of existing practices that have an effect on the programme’s likelihood to succeed: excision (also known as female genital mutilation) and child labour of children as young as three years in gold panning. Both practices affect children, albeit in a different way and at a different age. (Gold panning also has an indirect influence: all volunteers have the option to earn a guaranteed income of well over CFA 2500 per day; this reputedly affects the readiness to get involved in ANSP.) The fact that the IYCF programme uses locally established NGOs and CBOs which all have a history of preceding and parallel projects offers a partial solution. To give an example,

- AMMIE, in the North, is a Rencap NGO with a rights-based orientation.\footnote{AMMIE: Appui Moral, Materiel et Intellectuel à l’Enfant} It has, for example a project on prevention of Female Genital Mutilation in the same project areas where IYCF will be executed. AMMIE will do what is required for IYCF, and will no doubt weave in its rights-based perspective.
- In fact, all NGOs have their own identity and with it, their way of working, their strengths and weaknesses. The IYCF model as it is now being developed and implemented is setting standards, but at the same time will allow a certain leeway, in order to accommodate each NGO’s special qualities. (Source: UNICEF staff, personal communication)
• It is conceivable that in the course of time, and given that the IYCF test-phase includes 5 Rencap NGOs, each with their network of CBOs, there will be horizontal learning between the different approaches, with quantitative (impact and behaviour) data to support the lessons. The main track (the standard) which all have to follow is “Suivre la maman, following the three A’s: Appréciation, Analyse, Action”. This track is by nature equitable, as the entire population is targeted.

2.3 Pillar 1: Policy Development

2.3.1 Relevance and appropriateness

Table 4: Pillar 1 Expected Results

<table>
<thead>
<tr>
<th>Area</th>
<th>Expected Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>Africa’s key policy-makers &amp; leaders of civil society committed to review Plan of Action on Nutrition ensuring that adequate support is provided to implement nutrition action plan for an effective and sustainable socio-economic development.</td>
</tr>
<tr>
<td>Regional</td>
<td>Support the active participation of the RECs for the ARNS revision.</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Inclusion of nutrition within rural sector policies becomes effective by 2015.</td>
</tr>
<tr>
<td>Yr 3 Workplan</td>
<td>Yr 3 Workplan:</td>
</tr>
<tr>
<td></td>
<td>- Africa’s leaders committed to ensure adequate support provided to implement nutrition action plan for an effective and sustainable socio-economic development.</td>
</tr>
<tr>
<td></td>
<td>- Policy dialogue, communication advocacy, continuous advocacy work with the AU to mainstream nutrition in development agenda.</td>
</tr>
<tr>
<td></td>
<td>In line with continental advocacy strategy and policies, deliver technical support to RECs to mainstream nutrition in agenda of high level seminars and meetings at regional level involving heads of states, line ministers and key decision makers.</td>
</tr>
<tr>
<td></td>
<td>One activity that was originally planned, and has been executed, has been omitted in the yr 3 workplan: Support the development and implementation of the Scaling Up Nutrition Roadmap.</td>
</tr>
<tr>
<td></td>
<td>As noted before, the activities, although relevant, cannot by themselves be expected to achieve the desired result of “nutrition being effectively included (mainstreamed) into rural sector policies.” The indicators are not helpful here as they simply substitute the phrase “effective” for “integrated”. This, as said before, is an interpretation issue. It is noteworthy that for other issues the yr 3 work plan has become more precise than the original logframe and has omitted hard-to-verify items such as “raising awareness”.</td>
</tr>
</tbody>
</table>

2.3.2 Effectiveness

The evidence is that all planned-for activities have been implemented. As mentioned earlier both the 2011-2015 Programme National du Secteur Rural (PNSR, in 2012) and the Politique Nationale de Sécurité Alimentaire et Nutritionnelle (PNSAN, in 2013) have been completed. In addition a 3-day Nutrition Workshop attended by over 200 Parliamentarians was organised July 2013 by ANSP with the support of the President of the National Assembly. The National Assembly members agreed on six resolutions at the conclusion of the meeting which included commitments to: 1) enforce laws for the protection of children’s nutrition, 2) advocate to increase the budget to fight malnutrition, 3) invest in nutrition in their respective decentralised locality, 4) support government in the implementation of free health care for children under 5 years of age including for malnutrition, 5) develop capacity and recruit a critical number of nutritionists, and 6) ensure that nutrition is systematically identified as a planning objective by multiple sectors such as water and sanitation, food security, social protection, education and gender. The training is due to be replicated at regional level.
It is noteworthy that more activities than were listed above have effectively been implemented, not least because of the close partnership with the Ministry’s Nutrition Unit. An example is the SUN Road Map – table 2 refers.

### 2.4 Pillar 2: Capacity Development

#### 2.4.1 Relevance and appropriateness

<table>
<thead>
<tr>
<th>Table 5: Pillar 2 Expected Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continental</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Regional</strong></td>
</tr>
<tr>
<td><strong>Burkina Faso</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

In the Yr 3 workplan the activities to achieve the above have been refined and specified as compared to the original logframe. They are for both CAP/Matourkou and NPHS:

- Conduct an assessment of the inclusion of nutrition topics in the modules currently taught in the NPHS / CAP Matourkou
- Organise a workshop to define the key topics to be integrated in the training curricula
- Organise a workshop to review existing NPHS / Matourkou training curricula in order to include key nutrition topics
- Organise a workshop to validate the revised curricula
- Organise a training workshop on the key nutrition topics integrated into the curricula for NPSH / Matourkou teachers who will be responsible for the teaching of nutrition modules
- Monitoring / evaluation of the implementation of the integration of nutrition in the training curricula of the NSPH / Matourkou

For **multisectoral coordination of nutrition and food security**:

- Support the organisation of the National Consultative Council for Nutrition (NCNC) annual meeting
- Support the organisation of the national workshop to review the format and functional mechanisms of the National Consultative Council for Nutrition (NCNC) and regional committees of the Nutrition Council
- Support the organisation of annual meetings of the regional committees of the Nutrition Council

The original activity listed in the logframe: Development of the capacity of community resource persons on implementation of nutrition activities, was made more specific and shifted to pillar 4.

**Vertical coherence between national and regional level capacity building**

The capacity building outputs and activities in Burkina Faso are entirely consistent with the regional WANCDI initiative – the WCA Annex refers. In WANCDI the aims are: to 1) identify research and training institutions that can be further supported to move forward the nutrition agenda in the region; 2) develop prototypes of curricula in public health nutrition at the bachelor, masters, doctoral and allied medical levels; 3) enable closer ties between research, training and programmes; and, 4) technically assist in the field of public health nutrition. This last aim can be through WAHO in creating an enabling environment, assisting countries to join the SUN Movement, and in leadership development for national nutrition focal points. The UNICEF staff member who steers WANCDI is based in Ouagadougou which has facilitated interaction with the Country Office.

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The identical formulation for Matourkou Agricultural Training Centre and the National School of Public Health (NPHS) indicates a model approach for curricular reform

The steps taken by both CAP Matourkou and the NPHS colleges – from a first assessment, to a final evaluation – are virtually identical. Special is that the choice was made to not simply draft a nutrition module but to really integrate nutrition in all the different subject courses taught. For NPHS this has amounted to 10 courses, ranging from “agents itinérants de santé” (health assistants), to midwives, to (selected) academic level courses.

2.4.2 Effectiveness

The early evidence is that the approach – the process – to include nutrition in all relevant curricula has been successful. The effectiveness is yet to be established.

Pointers to the likelihood of success are:
- The process has been systematic and clear, to an extent that NPHS could easily emulate the Matourkou sequence of steps
- Great ownership and facilitation by CAP/ Matourkou, also for the NPHS.
- Used the expertise of a large number of organisations (DN, FAO, DAPQN, ENSP-Bobo, etc)
- Validation by experts of 14 national organisations which in one way or another are implicated in higher education and/or agriculture, health and nutrition
- The process has served as an example for WANCDI and FAO (FAO both at regional level – Accra and global level – Rome)
- ANSP/UNICEF – both the UNICEF Burkina Faso Country Office and the Ouagadougou based WCARO staff – provided extensive technical support and financial resources.

The MTE tried both in CAP Matourkou and in NPHS to get to see the actual changes in the curricula, in order to compare “before and after”. This request could not be fulfilled.

CONCLUSION: The fact that “agriculture” has taken the lead and that “health” has followed is exceptional. Yet apparently the sequence is not all that important. As explained by staff of the Nutrition Directorate: “We just started where we knew people were interested.” The early evidence is that the approach to include nutrition in all relevant curricula has been successful. The effectiveness is yet to be established – in NPHS the first batch of students is yet to graduate. It is unclear, at least to the MTE, what the exact changes in the curricula have been.

Multisectoral coordination of nutrition -and food security has largely been supported in the form of meetings; unreported, however, is significant added value of multi-pillar linkages at decentralised levels – Box 1 (section 2.7.1) refers

ANSP/UNICEF has technically and financially supported meetings at national and regional levels, including the Regional Committees of the Nutrition Councils. As stated in the interim progress reports “These meetings are opportunities to discuss linkages between nutrition and other sectors, especially nutrition and agriculture. Next steps include implementation and monitoring of recommendations from the annual meetings.” In addition, and on a practical note, the meetings in the Northern region, which is the first of two test phase regions for piller 4, have also served to discuss the pillar 4 IYCF programme. Master trainers required for pillar 4 were, for example, identified through these contacts.

CONCLUSION: A preliminary conclusion is that the hands-on experience of being trained as a master trainer, and subsequently acting as a trainer of trainers (the well-known cascade model) has been invaluable for attendants of the regional meetings. It is to be expected that, as more and more regions are getting enrolled in the IYCF scaling up, there will be veritable ownership also at the level of regional senior staff, across the country. This would be a naturally created linkage between pillars 1, 2 and 4, at the decentralised levels. This effect, although not as such foreseen, nor mentioned, in the work plans and reports, could in itself become a model of good practice. Box 1 (section 2.7.1) refers.
2.5 Pillar 3: Information systems and knowledge

2.5.1 Relevance and appropriateness

Table 6: Pillar 3 Expected Results

<table>
<thead>
<tr>
<th>Continental</th>
<th>Sustainable nutrition information systems and knowledge management developed with strong linkages with other information systems such as food security, early warning systems and health management information systems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional</td>
<td>Support towards quality data collection methods, trend analysis, knowledge management and institutional dissemination to relevant stakeholders</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>• The link between the National Health Information System and the Early Warning System (EWS) is strengthened</td>
</tr>
<tr>
<td></td>
<td>• The process of implementation of multisectoral community interventions aimed at reducing chronic malnutrition among children is documented</td>
</tr>
</tbody>
</table>

In the Yr 3 workplan the activities to achieve the above have been refined and specified as compared to the original logframe. They are:

1. Assist in the production of quarterly reports on the detection and treatment of severe acute malnutrition for dissemination during meetings of the Early Alert System
2. Monitor the evolution of food and nutrition vulnerability of the Ouagadougou and Bobo-Dioulasso urban populations (VAMU surveys)
3. Monitor the evolution of the prevalence of acute malnutrition among children aged 0 to 59 months (SMART surveys)
4. Assess the coverage of nutrition activities related to infant and young child feeding (IYCF) and the management of severe acute malnutrition (1 consultancy x 3 years)
5. Carry out a research to document the process of implementation of multisectoral community interventions conducted in the North and Central Plateau regions in order to reduce chronic malnutrition among children.

In the context of the remainder of the programme the first activity appears an activity that has slipped into the ANSP programme. The second activity has been taken over by another initiative. The 3rd activity – the SMART surveys – do more than is listed here and are as such in all respects relevant. The last 3 activities appear the most appropriate in the ANSP context.

2.5.2 Effectiveness

Most but not all activities have been implemented – see above.

The 3rd activity – SMART – has been prominent in the progress reports. It should be added that Burkina Faso is one among a host of countries where SMART surveys have been supported and executed. The incremental design – IYCF/behaviour indicators have been included since 2012 – is likewise no exception (the main report refers). Like in other countries there has been positive feedback at all levels on both precision and rapidity of SMART. The regional (WCARO) role of validation / quality assurance remains necessary. However, the 2013 survey results are yet to be shared with WCARO (personal communication, WCARO). A special feature in Burkina is that over the years a competent pool of ‘SMART enquêteurs’ has been formed, who are well distributed over the country, and who can be called upon for new adaptations and applications.

The 4th activity (: Assess the coverage of nutrition activities related to IYCF) can potentially benefit from the regular SMART surveys; a rare opportunity in Burkina Faso to use pillar 3 (SMART) to the benefit of pillar 4.

Given that SMART surveys are done annually there is a possibility to use the SMART regional and provincial level data as counterfactuals for IYCF district data, over time, and so measure a difference between the 2 trends. This technique, the so-called Difference in Difference can save costs and simply be good practice to properly establish impact. A condition would be that the IYCF data collection follows the SMART format and indicators. (The MTE noted that in the first such Enquête de couverture de base study the all-important minimal diet indicator was missing.)

2.6 Pillar 4: Scaling-Up

2.6.1 Relevance and appropriateness

The pillar 4 programme has an exclusive focus on prevention: IYCF

The choice in Burkina for its pillar 4 programme to focus exclusively on prevention is clear in the logframes and workplans.

Table 7: Pillar 4 Expected Results

<table>
<thead>
<tr>
<th>Continental</th>
<th>National comprehensive nutrition programmes implemented in coherent, coordinated and synergic manner with other sectors such as food security, health, WASH and social protection.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional</td>
<td>Support toward formative research on infant and young child feeding and community-based nutrition interventions and assessment of opportunities for minimum package of cost-effective and safe interventions</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>The coverage of infant and young child feeding (IYCF) interventions in the North and Central Plateau regions is increased in order to reduce chronic malnutrition</td>
</tr>
</tbody>
</table>

In the Yr 3 workplan the activities to achieve the above have been refined and specified as compared to the original logframe. They are:

- To provide technical support to the IBFAN/APAIB/ACF Consortium (Central Plateau region) to develop a new technical proposal based on the IYCF promotional model as spelled out in the scaling up plan
- To provide supportive supervision and monitoring to local NGO (AMMIE and SEMUS) for the implementation of IYCF interventions based on life cycle approach
- Conduct support field visit to improve the quality of nutrition service delivery as part of the implementation of the existing Project cooperation agreements (PCAs) related to IYCF.
- To provide technical support to the MOH for developing, validating and printing an IYCF training kit.
- Conduct IYCF training sessions for health workers as part of the implementation of the IYCF scaling up plan

All these, and more, are relevant to achieve the expected result.

Whereas the expected result (Table 7 refers) is limited to certain regions, the ambitions over time, after the ANSP period, are in fact to cover the entire country

The evidence in programme design and in the process chosen to give the programme an institutional basis in the health system demonstrate that the programme is set to become institutionalised as part of the Ministry’s routines. This is a typical example of use of ANSP funding as a catalyst and “seed-money” for a country-wide programme. In the view of the MTE team it also is a good example of using ANSP funding in the way it was originally meant.

A mother-focused life cycle approach has been selected

In the design the choice has been for a life-cycle approach, to follow the mother (“Suivre la maman”). It is noteworthy that the focus on the life cycle of individual women (mothers in the course of their reproductive life) outweighs the multi-sectoral focus depicted in this pillar’s continental level expected result (Table 7 refers). The multi-sectoral focus has, as it were, become subservient to the personal appeal of the life cycle and the IYCF behaviour changes. (The programme could thus have been named MIYCF where the M stands for mother.)
The approach has been detailed in a set of 7 power point presentations accompanied by training manuals, using the cascade approach. The pyramid is captured as follows:

IYCF is set for an ambitious arrangement of total coverage that is both feasible and features 3 consecutive categories of mothers and their babies

Remarkably, the entire ‘system’ is set up from a calculation of what would be feasible at the bottom of the pyramid: the Groupes d’Apprentissage et de Suivi des Pratiques d’ANJE (IYCF), or GASPA. GASPAs will each exist of some 15 women. Monthly meetings of each GASPA are foreseen. The calculation resulted in a norm: each Agent de Santé à Base Communautaire (ASBC; second layer) can be expected to successfully guide some 5 GASPAs. The GASPAs are distinguished in 3 categories, of, firstly, pregnant women; secondly, mothers and their 0-6 months old infants; and thirdly, mothers and their 6-23 months old children. ASBCs will thus each cover some 50 children aged 0 - 23 months and an average 31 pregnant women. The progression from one GASPA into the next has yet to be solved. The initial findings are that women are keen to join the group of pregnant women, but prefer to remain in that initial group.

The above-mentioned modules and manuals follow the categorisation in the 3 strata: pregnant mothers; mothers with infants; mothers with young children.

A situational analysis, at community level, has the double purpose of generating both a locally relevant inventory and ownership of its outcome.

The IYCF programme has been formulated on the basis of extensive orientation and study on the current situation. The obstacles that inhibit optimal IYCF practices are considerable. Taboos and harmful practices are most often cited, in addition to, or in combination with, poverty. They include:

- Strong and negative influence of influential persons such as husband, grandmother, village heads, traditional healers
- Traditional practices which inhibit exclusive breastfeeding
- The perception that children, including infants, must drink water
- The perception that breast milk does not suffice during the first 6 months and that complementary feeding is necessary
- Use of poor nutritional value porridge
- Food taboos regarding eggs, liver, milk
- Poor access to complementary food suitting the needs of 6-23 months old children
- Insufficient knowledge how to properly prepare complementary meals
- Poor involvement of the husbands/fathers
- Unstructured set-up and implementation of sensibilisation programmes

In the health system noteworthy gaps are:

- Absence of IYCF indicators in the routine HMIS
- Lack of a national strategy to address complementary feeding of 6-23 months old children; no promotion for fortified flour nor for Micro Nutrient Powders for use at home.

Furthermore IYCF is not integrated in the emergency plans that deal with crises nor are the main actors trained to do so. In addition there are of course structural problems such as the precarious food security; the annual period of the hunger gap (la soudure); and problematic access to drinking water.
Aanaemia reduction targets are missing in ANSP; the case of MNP\\textsuperscript{21}.

Burkina Faso has with 91.5% anaemia among pre-school children the highest anaemia prevalence of the 4 ANSP countries. The diagram below refers.

### 2010 - Nutrition indicators (3)

![Nutrition Indicators Diagram](image)

Source: UNICEF, N.Zagre, September 2013

Anaemia does not feature in SMART surveys. In children it is not routinely monitored. One reason for that is practical: it involves taking blood samples. There thus is a risk that anaemia remains a hidden phenomenon even though the consequences are severe and even though it is closely associated with malnutrition. The MTE notes that SUN has included anaemia targets (50% reduction of anaemia in women of reproductive age), in conformity with the global targets set by the 2012 World Health Assembly.\\textsuperscript{22} Anaemia prevalence among women was 54% in 2003 and has slightly decreased, to 49% (DHS 2003, 2010). In the group of pregnant women, anemia dropped 10 points, but is with 58% still very high (DHS 2010).

A general observation is that specific attention for anaemia appears to be minimal, or remains implicit, or has faced difficulties. The IYCF programme which is about to take off does not currently have a provision for Micro Nutrient Powders (MNP). The proposal to do so has been written, but funding has yet to be found.\\textsuperscript{23} The experts in the Burkina Country Office judge that, in the absence of MNPs and given the very high (92%) prevalence of anaemia among pre-school children, the IYCF prevention programme is unlikely to fully achieve its potential. MNPs have been an issue in all four ANSP countries. Part of the issue is their cost, and with it, the long term burden that countries ought to commit to once MNPs have become part of the prevention package. To illustrate this: in the proposal for “adoption de la fortification à domicile au Burkina Faso” procurement of MNPs takes up 80% of the budget.\\textsuperscript{24}

CONCLUSION: The prevalence of anaemia among pre-school children is at 92% very high. Whereas in MYCNSIA, ANSP’s sister programme in Asia, anaemia reduction targets are included as a measure of project impact, this is not the case in ANSP, even though anaemia is a formidable issue. The issue of high and moreover recurrent cost of MNPs is a concern. Long term adoption of MNPs is unlikely even though experts argue that without MNPs the IYCF prevention programme is unlikely to fully achieve its potential.

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\\textsuperscript{23} Ministère de la Santé, Direction de la Nutrition, Processus d’introduction et d’adoption de la fortification à domicile au Burkina Faso, Oct 2013

\\textsuperscript{24} Ibid.
Nutrition sensitive interventions not only are desirable; to achieve the envisaged targets they are essential

The thesis of a MSc student attached to UNICEF’s nutrition section, presented calculations which indicate that the envisaged reduction of chronic malnutrition will only be achievable if the intervention package includes not only nutrition-specific, but also nutrition-sensitive interventions (assuming that fertility will remain at current high levels). The MTE notes that this is likely to apply also in other countries. If confirmed, it would typically be an example of results that are worth sharing, which should be encouraged by the regional offices.

Currently, nutrition-sensitive interventions in the IYCF context are still insignificant – table 9 refers

Most efforts to link prevention of chronic malnutrition to the agricultural (and livestock) sector are taking place outside ANSP. For instance ACF is implementing a multi-sectoral Food Security and Nutrition programme in the Eastern Region aiming at improved resilience. ACF is integrating Nutrition activities with Food Security by collaborating with both the Health sector and Agriculture. In Nutrition they work on IYCF, EBF, BCC, WASH, MAM and health monitoring. In Agriculture they support farming communities to improve production and marketing. Also GRET is active in producing and marketing of complementary feeding (fortified flour) through local SMEs in both urban and rural areas.

CONCLUSION: There is no reason why experience of organisations such as ACF and GRET cannot be incorporated once the foundation of working with the GASPA (the mothers’ groups) is laid. The most important aspects of the IYCF programme are that it, firstly, is entirely community-based, and secondly, focuses on prevention, while, thirdly, it is standardised with a view to achieve a best practice model. If MNPs were to be introduced on a short term basis (see above) the finding that they are no longer required would be an excellent impact indicator!

2.6.2 Effectiveness

The planned for IYCF activities are on schedule. As reported by the CO:

- A full draft of the IYCF Scale Up Plan was developed and includes an IYCF situational analysis, recommended priority actions and strategic options. The Plan was reviewed in a national workshop in April 2013. A second national workshop in the first quarter of year 3 is expected to validate the Plan for immediate implementation. The IYCF Scale Up Plan is informed by the experiences in both the Plateau-Central and Nord Regions.

- IYCF community interventions were started in the Central Plateau region through the IBFAN/APAIB/ACF consortium; technical and financial support was given during the first year of the ANSP and continued during this reporting period. The coverage of the IYCF community interventions has increased from 0 to 71% during this time period. The quarterly activity report for the first quarter of 2013 reported reaching 33,278 pregnant women and mothers of children under two years of age with IYCF services. An endline survey in the Plateau-Central Region has started in August 2013. (Note MTE: the endline will serve as a baseline for the full-scale IYCF programme which is due to start.)

- In the Nord Region, IYCF community interventions based on the life-cycle approach were started in May 2013 through a partnership between ANSP and two local NGOs, AMMIE and SEMUS. [...] A baseline survey of current practices is ongoing (completion is expected in the first quarter of year 3) and training of community-based organisations and community health workers started in June 2013. The implementation is expected to increase coverage of IYCF and other services from 0 to 60% in 2014.

MNP provision remains a funding issue

Anaemia is not monitored among pregnant and lactating women, but the country has a long experience of routinely giving iron and folic acid supplementation and this practice is encouraged through the IYCF platform. As for MNPs, the funding issue is the key constraint.

25 Aïssata TRAORE, Comment accelerer la reduction de la malnutrition chronique chez les enfants de moins de 5 ans au Burkina Faso avec une approche pro-equité. Master 2 Sciences, Technologies, Santé, Septembre 2013, Université Montpellier.
Pillar 4 effectiveness is at this stage difficult to assess; provisional positive judgements can be derived from generic principles

The MTE reported during the debriefing:

- Effectiveness at this stage is difficult to assess
- Coherence between the pillars is strong
- Opportunity to be complementary to all that is playing out yet to be seized – Health still the main entry point
- Collaboration / complementarity with WASH and Education not visible. Potential is there?
- Current situation offers great opportunities

At this point in time it is indeed too early to decide on the IYCF programme’s effectiveness. Yet it is possible to make informed predictions. For this we use the criteria of the SUN Common Results Framework (CRF). As mentioned in the SUN website “a CRF serves as the basis for developing, aligning and securing approval for nutrition-relevant plans which cover different sectors. An agreed CRF enables multiple stakeholders – including different government ministries and external stakeholders – to work towards common goals (or set of results) for the improvement of nutrition and to agree how responsibility for implementation and achievement of results will be shared by different sectors. The overall cost of the CRF will incorporate costs of multiple sectors and will reflect the overall financial requirements to successfully scale up nutrition.” Table 8 refers.

Table 8: SUN’s CRF criteria applied to ANSP’s IYCF in Burkina Faso, as a measure of expected effectiveness

<table>
<thead>
<tr>
<th>CRFs ideally have the following features</th>
<th>Applied to Burkina Faso IYCF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected result for improvement of nutritional status</td>
<td>Yes, from beginning, to 2015 (end of ANSP), to 2025 (full coverage)</td>
</tr>
<tr>
<td>Defined populations in which these improvements will be seen</td>
<td>Yes</td>
</tr>
<tr>
<td>Interventions necessary to achieve the results and clear indications on the current coverage level and on the goal coverage</td>
<td>Yes</td>
</tr>
<tr>
<td>Identified responsibilities of line ministries and sectors within government for implementing the interventions</td>
<td>To some extent</td>
</tr>
<tr>
<td>The roles and responsibilities of non-government partners</td>
<td>Yes</td>
</tr>
<tr>
<td>A shared framework for performance monitoring and evaluation</td>
<td>Yes: will have the SMART survey anthropometric indicators plus IYCF indicators</td>
</tr>
<tr>
<td>A matrix of costs which identifies the contribution of government (including human resources) and of other implementers</td>
<td>Costing is under way; the MTE does not know if it also includes the sources of funding.</td>
</tr>
</tbody>
</table>

* Source: [http://scalingupnutrition.org/about/common-results-frameworks](http://scalingupnutrition.org/about/common-results-frameworks)

The Burkina IYCF programme is set to satisfy all the above criteria, and more. As also noted in the SUN website: In practice, different forms of CRFs are being adopted by governments which are specific to that context. Special for the programme is that it will be possible to compare its implementation and results in different in-country contexts, including the existence of preceding and/or parallel projects which will inevitably affect design and execution, as well as costs. A strict M&E plan has been designed which includes impact level indicators. The results of annual SMART surveys will be used as ‘controls’. It will thus be possible to determine factors of success (or failure) given actual results in different contexts. And thus: to identify the interventions that have in actual fact proven to be necessary – as in the CRF above. (Note: This is different from modelled interventions and their effects, as in LiST. 27). The MTE notes that this is an example of having different ANSP pillars combined for the sake of ANSP’s goal: to offer evidence-based models of good practice.

Effectiveness regarding successful inclusion of nutrition sensitive interventions must likewise be judged in future; generic principles for the process of inclusion can already be assessed.

The current arrangements for pillar 4 are predominantly driven by and within the health sector. For example, the Rencap NGOs all have a health focus, which is understandable given their embedding in

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26 [http://scalingupnutrition.org/about/common-results-frameworks](http://scalingupnutrition.org/about/common-results-frameworks). Also see [http://ije.oxfordjournals.org/content/39/suppl_1.toc](http://ije.oxfordjournals.org/content/39/suppl_1.toc)

27 The Lives Saved Tool (LiST) uses estimates of the effects of interventions on cause-specific child mortality as a basis for generating projections of child lives that could be saved by increasing coverage of effective interventions. Estimates of intervention effects are an essential element of LiST, and need to reflect the best available scientific evidence.
PADS.28 Yet there are linkages foreseen with the agriculture sector, and at national level linkages with specialised NGOs such as GRET have already been established. Thus, although the current priority is to first get the community level IYCF planning and programming off the ground, the nutrition sensitive interventions are part of a next phase. (The MTE witnessed 2 sessions, led by 2 different Rencap NGOs.)

As discussed in an earlier section, mainstreaming nutrition is by nature complex, and this is especially so for agriculture. Recently a lot of work has been done, and has been published, precisely on this topic. What is more; gold standards, although still generic in nature, are gradually agreed upon.2930 Table 9 refers for a screening exercise of Burkina Faso’s IYCF programme.

**Table 9: CAADP/FAO criteria applied to ANSP’s IYCF, as a measure of expected effectiveness** *31

<table>
<thead>
<tr>
<th>What does mainstreaming nutrition in agriculture mean practically?</th>
<th>Applied to Burkina Faso IYCF pillar 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incorporate explicit nutrition objectives and indicators into the design of programmes and investments, and track and mitigate potential harms</td>
<td>Yes, apart from potential harms. A conceivable harm which merits to be tracked is lack of access and/or exclusion of vulnerable households</td>
</tr>
<tr>
<td>2. Assess the context at the local level to address the types and causes of malnutrition</td>
<td>Yes, this is included in the “autodiagnostics communautaires”</td>
</tr>
<tr>
<td>3. Target the vulnerable and improve equity</td>
<td>This is unclear, thus far. But given that the aim is near-total coverage (≥ 85%) there is scope to include this if the programme makes it an issue. This may require special, non-stigmatizing visual tools.</td>
</tr>
<tr>
<td>4. Collaborate and coordinate with other sectors and programmes</td>
<td>Yet to be implemented. One idea is to include agriculture extension staff and/or have them as co-trainers. Another idea is to use Matourkou graduates and so give follow up to pillar 2 programme activities. It is also possible that the NGOs and CBOs with relevant experience take the lead and show by example. Most likely there will be locally appropriate solutions which differ from one place to another.</td>
</tr>
<tr>
<td>5. Maintain or improve the natural resource base (water, soil, air, climate, biodiversity)</td>
<td>No, in so far as documented at this point in time. It is conceivable that here visual material focusing on resilience would be appropriate (the main MTE report refers)</td>
</tr>
<tr>
<td>6. Empower women</td>
<td>Yes: this is the foundation of the approach. The involvement of rights-based Rencap NGOs will help to lead the way how to do this in a respectful way – by including husbands and grandmothers; local leaders, religious leaders.</td>
</tr>
<tr>
<td>7. Facilitate production diversification, and increase production of nutrient-dense crops and small-scale livestock</td>
<td>Yes: this is the principle but it is yet to be implemented, considering local conditions, habits, and food preferences. There are NGOs in the country with a wealth of specific experience. UNICEF has closely cooperated with GRET.</td>
</tr>
<tr>
<td>8. Improve processing, storage and preservation</td>
<td>As above</td>
</tr>
<tr>
<td>9. Expand markets and market access for vulnerable groups, particularly for nutritious foods</td>
<td>As above</td>
</tr>
<tr>
<td>10. Incorporate nutrition promotion and education around food and sustainable food systems</td>
<td>As above</td>
</tr>
</tbody>
</table>

* Source: CAADP Agriculture Nutrition Capacity Development Initiative East and Central Africa Workshop, Guiding Principles for integrating Nutrition and Agriculture. March 2013, Dar es Salaam

28 http://www.pads-burkina.org/  
29 Charlotte Dufour: Mainstreaming nutrition in agriculture investment plans- Lessons learnt, challenges and opportunities. FAO Nutrition Division, October 2013  
30 The list is very similar to CAADP Agriculture Nutrition Capacity Development Initiative East and Central Africa Workshop, Guiding Principles for integrating Nutrition and Agriculture . 25th February – 1st March 2013, Dar-Es-Salaam, Tanzania  
31 The format may also help as a checklist for the programme itself
CONCLUSION: In Burkina Faso’s IYCF there is attention for the issue of nutrition-sensitive interventions, but the current priority is to first get organised for the nutrition-specific interventions of the IYCF package. Gold standards for mainstreaming nutrition into agriculture have by now been generated in the literature, albeit in a generic form. The above table appears a good starting point, as a checklist, for pillar 4 intervention packages. Of course, like the CRF above, it will need refinement. Given the country-wide NGO Rencap arrangement it should also be possible to use the list for comparison between the 5 (and eventually 19) NGO/CBOs networks in Burkina Faso.

2.7 Efficiency

2.7.1 Operational efficiency

- ANSP-Burkina Faso builds upon previous project experience (such as PADS NGOs)
- Also for lessons learned, available knowledge and studies done (implicitly)
- Logic model, logical framework, work plan and budget appear not always logically associated.
- Adjustment of activities and budget priorities appear to be “rigid”

As reported in sections 2.4.2 and 2.5.2 the ANSP Burkina programme has ample opportunity for what may be called, indeed, operational efficiency. The opportunities are partly used, but are not all that explicit, as they appear, simply, “common sense”. In the ANSP context they may best be described as connections both between the various pillars and between the sub-national levels of the ANSP programme. Box 1 below refers.

CONCLUSION: The MTE saw little evidence on paper, or in the original design, of a deliberate strategy to use ANSP as a catalyst for long term, strategic interventions necessitating additional funds. And yet, this is in practice how ANSP funds are used in Burkina Faso’s IYCF (pillar 4): as “strategic seed money”, driven by particularly motivated teams, or even individuals.

Box 1: Multi-pillar connections for ownership of nutritional issues

The current events in Burkina Faso show the possibility to connect the pillars and levels (and above all: people) in an organic way:

- **pillar 1**: Sub-national meetings of the Regional Committees of the Nutrition Councils, are used, among other things, to raise interest among participants
- **pillars 2 & 4**: From the above, selected persons are trained as IYCF master trainer, and subsequently act as a trainer of trainers (the well-known cascade model), in their own region.
- **Across the sectors**: In the above, there is every possibility to include persons of different sectors, including agriculture, and, at a later stage, the graduates who have been taught the newly improved nutrition curricula (also pillar 2).
- **Across the country**: As more and more regions are getting enrolled in the IYCF scaling up, there will be veritable ownership also at the level of regional senior staff – attendants of the above meetings, amongst others – and this across the country.

All of the above in combination, demonstrate the potential for “organic” linkages between pillars 1, 2 and 4, at the decentralised levels; essentially it would be people being connected, and motivated. This effect, although not as such foreseen, nor mentioned, in the work plans and reports, could in itself become a model of good practice.

2.7.2 Financial efficiency

The ANSP Burkina budget is subdivided in 30% staffing costs, 50% contracts and surveys, and 20% for a range of other activities including workshops/ conferences, training, equipment, etc. The budget item contracts and surveys include two main surveys – VAMU and SMART – and the subcontracting of PADS NGOs for the implementation of Scaling Up interventions under Pillar 4. Moreover, a good number of activities / organisations are being supported from the ANSP funding – in total 10% of the total budget. Travel is not separately budgeted for.

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CAADP Agriculture Nutrition Capacity Development Initiative East and Central Africa Workshop, Guiding Principles for integrating Nutrition and Agriculture. 25th February – 1st March 2013, Dar-Es-Salaam, Tanzania
Budget utilisation is 37% of planned budget after two years of implementation. Utilisation differs substantially from one Pillar to another: Pillar 1 is the lowest with 24% of planned budget whereas Pillar 2 is the highest with 55%. The other two Pillars are at 40% resp 37% expenditure rate. Overall the major deviations were the non-implementation of VAMU (0%) and the much larger expenditure for the inclusion of nutrition indicators in EWS (362%). But the latter was all paid from non-EU funding (see below). The budget for Cornell and C4D activities in Burkina are catered for by the WCARO ANSP budget. Unlike in Mali timely payment by UNICEF to subcontractors has not been a problem.

2.7.3 Leverage of (new) resources

External, country level

Tracking resources allocated for nutrition is an identified challenge in Burkina Faso

The SUN website for Burkina acknowledges that “Tracking resources allocated for nutrition is an identified challenge in Burkina Faso. Currently, specific funding for nutrition is classified as a ‘sub-account’ within the mother and child health account within the national budget and only national account funding and expenditures can be tracked. The Government of Burkina Faso is planning to establish a national budget line for nutrition. The SUN Government Focal Point has committed to mobilising both domestic and external resources for nutrition as one of his top three priorities in the 12-month period up to September 2013.”

Predominance of external funding of nutrition at country level

A recent study in Burkina Faso assessed the sources of funding for nutrition. The results show that in the period 2006-2011 the budget for the Nutrition Directorate has been as low as 0.1% to 0.7% of the Ministry of Health budget.

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33 http://scalingupnutrition.org/sun-countries/burkina-faso/progress-and-impact/mobilizing-resources
Table 10: Significant external funding of Nutrition Action Plans 2006-2011 in Burkina Faso

<table>
<thead>
<tr>
<th></th>
<th>2006 %</th>
<th>2007 %</th>
<th>2008 %</th>
<th>2009 %</th>
<th>2010 %</th>
<th>2011 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF</td>
<td>73.1</td>
<td>42.9</td>
<td>69.6</td>
<td>52.8</td>
<td>76.6</td>
<td>20.2</td>
</tr>
<tr>
<td>OMS</td>
<td>12.1</td>
<td>8.0</td>
<td>1.9</td>
<td>0.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HKI</td>
<td>10.0</td>
<td>19.2</td>
<td>0.5</td>
<td>13.0</td>
<td>4.9</td>
<td>6.4</td>
</tr>
<tr>
<td>PADS</td>
<td>3.6</td>
<td>3.2</td>
<td>39.5</td>
<td></td>
<td>4.9</td>
<td>6.4</td>
</tr>
<tr>
<td>PADS/nutrition</td>
<td></td>
<td></td>
<td>0.03</td>
<td>54.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAM</td>
<td></td>
<td></td>
<td></td>
<td>0.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td></td>
<td></td>
<td></td>
<td>9.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GoB/MoH</td>
<td>26.9</td>
<td>3.8</td>
<td>1.7</td>
<td>3.8</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>27.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Directoraten Nutrition</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>


The predominance of external funding sources, notably UNICEF, is also clear in Table 10 above. Like in MYCNSIA countries such as Nepal, there are thus several problems. Firstly, the nutrition budget resorts under the Ministry of Health budget, of which it is a very small proportion. Increasing these proportions by a few percentage points will not solve the issue. Secondly, the high level political support as expressed, among other things, in SUN membership is not translated in national budgets. This has an inherent risk of nutrition becoming a donor-driven issue. Thirdly, the vast majority of funds goes to emergency nutrition programmes targeting children who are acutely malnourished; this inadvertently suggests that “nutrition is receiving its fair share”. The MTE notes that increases in national nutrition budgets are not part of SUN monitoring.

**Internal, ANSP level**

Leveraged funding has covered about 27% of total expenditure in Y1 and Yr 2. The main sources of external non-EC funding have been general UNICEF resources, which provided funding for staff under Pillar 1; the inclusion of nutrition indicators in EWS; and the Scaling Up activities under Pillar 4. More than 90% of the non-EU funds were resourced in Yr 1 representing 53% of ANSP expenditure in that period. In Yr 2 the non-EC contribution declined to a mere 2%.

### 2.8 Impact

**2.8.1 First indications of impact (foreseen and unforeseen)**

Potential for “mainstreaming” nutrition into Education is there and could be a next step

The close collaboration between the 2 ministries in pillar 2: capacity building, is a potential prelude to having more ministries following suit. Already there is interest from a third Ministry (Education). Although this is not part of ANSP, there is potential to mainstream nutrition into Education, as a next step, following pillar 2 activities in agriculture and health. Please refer to Table 2: Elaboration of Strategy for school canteens. Given that there are activities already – such as, indeed, the school canteens – it would be necessary to have pillar 4 type on-the-ground activities go together with pillar 2 type activities. The latter could then follow the CAP Matourkou and NPHS model of curriculum adaptations, in this case both for the teachers and for students. If this were to happen and if this then could be argued to have become a model for consecutive pillar 2 interventions, from one sector to another, it would be quite an achievement. However, at this stage it is fair to say, as emphasised by respondents in CAP Matourkou, that:

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There is as yet little collaboration between the 3 sectors in the above sense, of curriculum adaptation.

Teachers have very limited knowledge about nutrition.

Education does indeed provide interesting opportunities for collaboration: cantines scolaires, school gardens, nutrition in curriculum, CED for adolescents, Centres d’Alphabétisation for adults (mainly women).

**2.8.2 Feasibility of achieving programme impact targets for reduction of anaemia and stunting**

Impact targets have differed across the countries and have not been aligned with SUN\(^{36}\)

The envisaged impact of ANSP has been described in different ways. The global logframe states for its OVI:

- (overall) MDG targets for MDGs 1, 4, 5 and 8 related to nutrition show progress in selected countries and regions
- (specific)
  - Improvement of nutrition governance at continental, regional and national level (composite indicator\(^{37}\)): (1) adoption of nutrition strategy, (2) implementation/existence of nutrition M&E system, (3) existence of multisectoral coordination mechanism\(^{38}\)
  - Countries have implemented mechanisms to scale up nutrition high impact interventions for children and women

However, ANSP’s 2012 Inception Report noted that “The four focus countries discussed relevant impact and outcome indicators. It was agreed that stunting among young children and anaemia among children and pregnant women at the community level among food insecure groups targeted by the programme will be the main impact variables. Various outcome indicators such as infant and young child feeding practices and coverage of various nutrition and health services (micronutrient supplementation, nutrition communication and education, and others) were also universally relevant”. At country level this has led to the following targets in Burkina Faso’s logframe:

<table>
<thead>
<tr>
<th>Country</th>
<th>Target re: stunting reduction</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>Stunting prevalence amongst children under five in the North and Central Plateau regions has decreased from 39% in 2010 to 29% in 2015, ie: by 10% points</td>
<td>In 2012 the prevalence was 34%(^{39}) resp. 35%(^{40}). At that time the pillar 4 IYCF activities were yet to start. Note: the 2015 envisaged reduction is only the beginning of a longer term process, with more ambitious indicators for 2025.</td>
</tr>
</tbody>
</table>

The envisaged impact measures will not capture the impact of the programme as a whole (the 4 pillars together), nor will the proposed OVI be entirely attributable to ANSP. (A similar observation was made for the MYCNSIA programme in Asia.)

CONCLUSION: The current measures of ANSP impact have their limitations: they are not attributable and they do not reflect the potential impact of the programme as a whole, that is: the *combination* of the 4 pillars. Yet it was precisely this combined effect which was stressed both in the original project document and in the IR. The fourth pillar, if properly executed, does have the potential of impact level improvement in the anthropometric indicators – but this will need more time to materialise than is available in the ANSP project. This problem has in Burkina Faso been neatly addressed, by making reduction by 2015 part of a longer trajectory, up to 2025. This is in line with the SUN (and WHO) time scale.

**Anaemia reduction targets have not been defined nor have they been pursued**

Contrary to what was stated in the Inception Report there are no anaemia reduction targets in ANSP.

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\(^{36}\) SUN target is 40% reduction of the global number of children under five who are stunted, by 2025. This apparently refers to the future population, implying that in absolute terms the reduction will be more, depending on population growth.

\(^{37}\) Composite indicator: specific indicators adapted from the WHO Landscape Analysis.

\(^{38}\) Baselines and targets of the specific objective indicators to be defined during the inception phase.

\(^{39}\) Burkina Faso Annex to First Interim Report, September 2012

\(^{40}\) This information was extracted from UNICEF (2012), *State of the World’s Children 2012*
IYCF targets, fertility and demographic transition: should they be regarded and assessed in combination?

The arguments in favour of prevention programmes such as IYCF have been increasingly forceful. Off late they have become economical in nature: each dollar spent on prevention will bring a gain of 18 dollars.\(^{41}\) Although important, also for advocacy, bringing out this argument is not a core strength of UNICEF.

There is, however, another angle to this discussion, as was brought out in a recent study.\(^{42}\) In Burkina Faso the targets of programme impact in terms of reduction of chronic malnutrition are set as a proportion of the under-five population, decreasing from 39% in 2010, to 29% by 2015. A reduction of 40% by 2025, as proposed by WHO (and SUN) translates in an actual reduction of 56%, in terms of number of cases avoided. This is because the population of under-fives will in the period 2010 till 2025 have increased from just over 3 million, to well over 4 million, due to the country's high fertility, of 5.9.\(^{43,44}\) The same argument applies to the ANSP target, of 29%. In simple terms: the higher the fertility, the more difficult to achieve reduction targets.\(^{45}\)

The above-mentioned study has calculated that nutrition-specific interventions alone will not achieve the target, and that additional, nutrition sensitive interventions are needed. The study has not looked into the effects of reduction of fertility, which reduction is not unlikely once parents have gained confidence in the survival of the children they already have. In fact, this confidence was brought out by parents in communities visited by the MTE and also is a well-known phenomenon in the public health literature: the demographic transition.\(^{46,47}\)

CONCLUSION: The IYCF programme in Burkina has a long term horizon. The reality that reduction of chronic malnutrition prevalence is more feasible if fertility is also reduced has thus far remained implicit in the IYCF design. In the IYCF Enquêtes de couverture de base, fertility indicators are routinely included. The long duration of the IYCF programme, and the phased design, have the potential to document an acceleration of the so-called demographic transition, as an overall impact indicator of a successful prevention package. If this would be the case it would be an additional argument in favour of prevention programmes.

2.8.3 Broader potential & unintended effects at the various levels of implementation

For this discussion we refer to the main report.

2.9 Sustainability

2.9.1 Capacities and ownership for sustained results

The pillar 3 interventions of mainstreaming nutrition in the curricula of all courses where this is pertinent are in principle sustainable; this needs to be verified

\(^{41}\) See, for example: [http://www.ifpri.org/blog/healthy-growth-breeds-healthy-growth](http://www.ifpri.org/blog/healthy-growth-breeds-healthy-growth)

\(^{42}\) Aïssata TRAORE, Comment accelerer la reduction de la malnutrition chronique chez les enfants de moins de 5 ans au Burkina Faso avec une approche pro-equité. Master 2 Sciences, Technologies, Santé, Septembre 2013, Université Montpellier.


\(^{45}\) As stated in section 1.1.2: Extrapolation of the currently achieved rate of reduction in global stunting, of an average 1.8% per year, means that by 2025 stunting will be alleviated for 40 million children. To reach the set WHA target the rate of reduction should more than double, to 3.9% per year.

\(^{46}\) “The process by which a country moves from high birth and high death rates to low birth and low death rates with population growth in the interim”. The classic description of the demographic transition is based on observations from the West. It describes a falling death rate followed sometime later by a decline in the birth rate. The transition in the developed countries took around 100 years and is classically attributed to improvement in socio-economic conditions which changed child survival rate and fertility preferences. (However), Since 1960, the demographic transition in SOME developing countries has occurred much more rapidly than in developed countries. For example in Bangladesh this transition occurred in a span of 10 years. Furthermore, In Bangladesh, birth rates have fallen without the simultaneous socio-economic improvement.

The inclusion and address of nutrition at the level of curricula will in principle be systematic. There are some conditions for this to be so. The teachers/lecturers must themselves be trained, and must have a natural affinity with the topics. Nutrition should be taken seriously and thus figure in exams. Preferably the students are given opportunity to do nutrition specific/sensitive practicals “in the field” and write their dissertations on themes that are taken up in real life work environments. In other words, the fact that curricula are mainstreamed does not necessarily mean that the persons taking these courses will also have incorporated the knowledge in ways that will make them act accordingly.

2.9.2 Comprehensive and inter-sectoral stunting reduction strategies

IYCF has potential to bring a routine of preventing malnutrition, by aiming for “beaux enfants”

In its current form monitoring of the nutritional status of under-fives has the nature of screening for acute malnutrition. The concept is derived from emergency practice as is also clear in the ANSP Burkina workplan (result area 3.1): “Assist in the production of quarterly reports on the detection and treatment of severe acute malnutrition for dissemination during meetings of the Early Warning System”. In countries such as Burkina Faso, with a history of drought and failed Harvests, it is common for government and aid organisations to be geared to crisis. In practical terms this means that the focus is on detection of disease and acute malnutrition rather than on control for health. This partly explains the lack of focus on growth monitoring promotion (GMP), as a tool to maintain health and take pride in healthy babies. Rather, the focus is on quarterly screening routines that are initiated by Government, assisted by development partners. Organisations such as DG ECHO even have targets for the numbers of acutely malnourished children they should reach.

- Yet the gist of the IYCF projects that are about to take off in the North is that of “beaux enfants” (Komneeba) and this is also the parlance in village meetings attended by the MTE. Pregnant women in the GASPA groups were promised their newborns would weigh at least 3kg (!) if they adhered to the messages given, and this promise was greeted with glee. In Central Plateau bouncing babies and healthy twins were shown off and presented as evidence of harmony and good nutritional practice, both within the village and in households, after just two years of nutrition promotion.

There is need to generate convincing data, also for potential funders

It is well known that the relative risk for SAM children to die is 8-10 times the risk of healthy children, and that the cost of treating SAM and MAM children is high. The argument in favour of prevention of MAM and SAM is convincing, on paper: it will be both cost-saving and it will reduce under-5 mortality. Yet, as mentioned by several respondents, it is hard to get donors to engage in prevention programmes. Reasons given were that “Donors tend to think they are funding nutrition when they put their money in programmes for malnourished children, while in reality these programmes do little or nothing for children above the cut-off points”. It is conceivable that a more rousing prevention angle (“Beaux bébés” / Prevention is better than cure / More healthy babies / Lower population growth / Multisectoral approaches therefore a must ...) could be used to advantage.

CONCLUSION: It will be imperative for the IYCF programme to generate convincing data that prevention pays off, also in monetary terms. The IYCF has the enormous advantage that it can do so based on real-life data – this in contrast with the Lives Saved tool (LiST) which works with estimates of intervention effects. To this author’s knowledge there are as yet no publications reporting on the actual effectiveness of a standardised, population level prevention programme implemented in different settings, over time. The IYCF programme in Burkina offers this possibility. It is currently being costed.

Use of a growth chart will have the added advantage that trends become visible and can be recognised and interpreted by (groups of) parents.

48 Also see http://www.ifpri.org/blog/healthy-growth-breeds-healthy-growth
50 The Lives Saved Tool (LiST) uses estimates of the effects of interventions on cause-specific child mortality as a basis for generating projections of child lives that could be saved by increasing coverage of effective interventions. Estimates of intervention effects are an essential element of LiST, and need to reflect the best available scientific evidence.
Currently there is no growth chart in use. It is planned for as an integral part of the GASPA’s package of service in addition to the use of MUAC. In the IYCF setting use of the growth chart will hopefully make parents natural promoters of good practice, for other parents to follow suit.

3 Conclusions

Conclusions have been included in the text of this report.

4 Lessons Learned and Good Practices

Selected (potential) good practices

- The IYCF programme
- The CAP Matourkou/NSPH programme
- Multi-pillar connections for ownership of nutritional issues – Box 1 refers
ANNEX G. COUNTRY ETHIOPIA

External Evaluation
African Nutrition Security Partnership (ANSP)
Country Annex: Ethiopia

1 Introduction

1.1 Nutrition Situation

Table 1: Key statistics

<table>
<thead>
<tr>
<th>Key geographic, economic, and social characteristics</th>
<th>Ethiopia</th>
<th>East and Southern</th>
<th>Sub-Saharan Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population in thousands (2011)</td>
<td>84,734</td>
<td>398,968</td>
<td>855,273</td>
</tr>
<tr>
<td>Under-five mortality rate (infant mortality rate), both 2011</td>
<td>77/52</td>
<td>84/63</td>
<td>109/76</td>
</tr>
<tr>
<td>Life expectancy at birth (2011)</td>
<td>59</td>
<td>55</td>
<td>54</td>
</tr>
<tr>
<td>GNI per capita (PPP)</td>
<td>USD 1,110</td>
<td>USD 1,486</td>
<td>USD 1,2192</td>
</tr>
<tr>
<td>% of population below international poverty line of US$ 1.25 per day (2006-2011)</td>
<td>39</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>% of children (2007-2011) early initiation of breastfeeding</td>
<td>52</td>
<td>51</td>
<td>48</td>
</tr>
<tr>
<td>% of children (2007-2011) who are exclusively breastfed (&lt;6 months)</td>
<td>52</td>
<td>52</td>
<td>37</td>
</tr>
<tr>
<td>% of children (2007-2011) introduced to solid, semi-solid or soft foods (6-8 months)</td>
<td>55</td>
<td>84</td>
<td>71</td>
</tr>
<tr>
<td>Antenatal care coverage at least once (at least four times)</td>
<td>19</td>
<td>89 / 51</td>
<td>78 / 47</td>
</tr>
<tr>
<td>Vitamin A supplementation coverage rate (6-59 months) 2011, full coverage (%)</td>
<td>71</td>
<td>72</td>
<td>78</td>
</tr>
<tr>
<td>% of households consuming iodized salt (2007-2011)</td>
<td>15</td>
<td>50</td>
<td>49</td>
</tr>
<tr>
<td>% of infants with low birth weight (2007-2011)</td>
<td>20</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from underweight</td>
<td>29</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from wasting (public health problem: &gt;10%)</td>
<td>10</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from stunting, (&lt; public health problem &gt;30%)</td>
<td>44</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>% of pre-school children suffering from anaemia2</td>
<td>54</td>
<td>64</td>
<td>63</td>
</tr>
<tr>
<td>% of pregnant pregnant 15-45 suffering from anaemia2</td>
<td>31</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>% of women 15-45 suffering from anaemia2</td>
<td>17</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Ethiopia has made significant strides in scaling up community-based nutrition programmes since the National Nutrition Plan (NNP) was launched in 2008. Stunting prevalence decreased from 58 to 44 percent in the period 2005 to 2011. The proportion of children underweight dropped by 20 percent from 2000 to 2005 and by 12 percent from 2005 to 2011. Both stunting and underweight prevalence indices fell by an average of 1.34 percentage points per year. Male children are slightly more likely to be stunted than female children (46 percent and 43 percent, respectively). With the exception of first order births, there is an inverse relationship between the length of the preceding birth interval and the

2 Ethiopia Demographic Health Survey (DHS) Final 2011
propportion of children who are stunted. The longer the interval, the less likely it is that the child will be
stunted. The prevalence of wasting in Ethiopia has remained constant over the last 11 years\(^2\). Interestingly, stunting and wasting prevalences among children belonging to the highest wealth quintile are only slightly lower than in children belonging to the lowest quintile, suggesting that wealth alone doesn’t significantly reduce malnutrition. By contrast, children whose mother have benefitted from secondary education or more are less than half as likely to be wasted or stunted than children whose mother had no education. It is important to note, that the prevalence of stunting among children in the highest and second highest wealth quintile group is still a high 20\%. Geographical disparities between regions are substantial with the highest levels of stunting in Afar, Amhara and Tigray Regions (more than 50\% in 2011) and high (20\% or more) levels of wasting in Afar and Somali Regions. Rural children are nearly twice as likely to suffer from wasting and 1.5 times as likely to be stunted.

The main causes of the persistent high level of stunting in Ethiopia are intra-uterine growth retardation, manifested as low birth weight (LBW), neo-natal growth faltering and poor child feeding practices. According to Ethiopia Demographic Health Survey 2011, 11 percent of children born during the five years before the survey weighed less than 2.5 kilograms. Based on mothers subjective perceptions 21 percent of all live births were perceived to be very small\(^2\). An important contributing factor to high prevalence of LBW is early marriage and associated early pregnancy and giving birth. Twelve percent of adolescent girls (aged 15-19 year) in Ethiopia are already mothers or pregnant with their first child. LBW is strongly associated with non-communicable diseases such as diabetes and cardiovascular disease in adults\(^3\), adding to the (future) burden if disease associated with malnutrition.

Poor child feeding practices in Ethiopia include lack of exclusive breastfeeding of infants aged 0-5 months, sub-optimal complementary feeding practices and poor hygiene. According to the Ethiopia Demographic Health surveys (EDHS) exclusive breastfeeding rates increased marginally from 49\% to 52\% in the period 2006 – 2011. In 2011, only half of the children aged 6 – 8 months received complementary food and a mere 4\% of all children under two benefitted from recommended infant and young child feeding practices IYCF. An estimated 50,000 infants deaths per year are attributable to poor breastfeeding habits, that is 18\% of all infant mortality\(^6\). Mothers in the highest wealth quintile were more likely to apply good IYCF then those among the poorest (11\% compared to only 1\%). The same applies to mothers who completed secondary education or higher, but even among this group the number of women applying recommended IYCF was only 30\% (as compared to 2\% among women with no education).

Maternal malnutrition is a significant problem in Ethiopia with 27\% of all women being either too thin or undernourished. Data\(^3\) indicate that women belonging to the lowest wealth quintile are twice as likely to be thin as those in the highest wealth quintile. An estimated 17\% of of women of reproductive age suffer from iron deficiency anemia (IDA) and 31\% of all pregnant women. Anemia is also unevely divided over the various regions, with women in Somali, Afar and Dire Dawa regions three to four times as often affected as women in Addis Ababa, Tigray and the SNNP\(^6\).

Iron, iodine and vitamin A deficiencies among children under five are a significant health problem in Ethiopia. Nearly half (44\%) of all children under five suffered from anemia in 2011 (down from 54\% in 2005)\(^2\). In 2005\(^1\), 45\% of children under five suffered from iodine deficiency disorders (IDD) half of whom severely. In five regions IDD is a severe or moderate public health problem. Micronutrient deficiencies in combination with malnutrition are estimated to contribute directly (as main cause) to 28\% and indirectly (as aggravating factor) to more than half of all under five mortality in Ethiopia.

The recent Cost of Hunger in Africa (COHA) Study on Ethiopia\(^8\) estimates that two thirds of all adults (67\%) of the working age population were stunted at childhood. Another finding is that 16\% of all class repititions in primary school are associated with the higher incidence of repitition by stunted children

\(^3\) National Nutrition Programme, June 2012-June 2015

\(^4\) Low birth weight and/or stunting often result in catch-up growth, which in turn may lead to overweight.


\(^6\) This maybe due to the fact that highland households frequently eat teff, relatively iron rich.

\(^7\) Iodine Deficiency Disorders National Survey in Ethiopia, December 2005.

\(^8\) Cost of Hunger in Ethiopia, Implications on National Development and Prosperity, Summary Report, WFP, UN-ECA and UAC, June 2013.
(4% higher than non stunted children). The COHA also estimates that a reduction in stunting by the year 2025 to 10% could yield an annual average savings in ETB 9.2 billion (US$ 784 million).

### 1.2 National Policy Framework in Nutrition Security

The Growth and Transformation Plan (GTP), 2010/2011-2014/2015, is Ethiopia’s main strategic framework for development. The GTP has the following major objectives: (i) Maintain at least an average real GDP growth rate of 11% and attain MDGs; (ii) Expand and ensure the quality of education and health services and achieve MDGs in the social sectors; (iii) Establish suitable conditions for sustainable nation building through the creation of a stable democratic and developmental state; and (iv) Ensure the sustainability of growth by realizing all the above objectives within a stable macroeconomic frame-work. One of the pillars of the GTP is enhancing expansion and quality of social development including better food security and nutrition. The GTP does not provide any additional information how to achieve this. However, the signatories of the National Plan on Nutrition (NNP) commit to work together to prioritize the elimination of malnutrition from Ethiopia as one of the most viable strategies for achieving the Growth and Transformation Plan and MDGs.

The revised NNP was revised in 2010 to incorporate new initiatives or approaches. The revised NNP seeks to strategically address nutrition problems by embracing the multi-sectoral and multi-dimensional nature of nutrition. It incorporates the lifecycle approach which maps out key actions needed to improve the nutritional status of strategic target groups (women and children). It also seeks to strengthen initiatives such as the Accelerated Stunting Reduction Initiative, National Food Fortification Programme and multi-sectoral linkages among key NNP implementing sectors. The new NNP ensures the involvement of various sectors and full utilization of existing structures such as the Health Extension Programme, agriculture extension program and schools, women and youth associations, other social sectors, CSOs and private sectors. The strategy targets all members of households, boys and girls and men and women. The revised NNP June 2013 – June 2015 identifies five Strategic Objectives: (i) Improve the nutritional status of women aged between 15-49 years and adolescents 10-19 years; (ii) Improve the nutritional status of infants, young children and children under 5 years with emphasis on the first two years of life; (iii) Improve nutrition service delivery for communicable and life-style related/non communicable diseases affecting all age groups (iv) Strengthen implementation of nutrition-sensitive interventions across sectors and; (v) Improve multi-sectoral coordination and capacity to ensure NNP implementation. The NNP addresses topics under including policy framework, regulatory frame-work, multi-sectoral coordination and capacity building, nutrition communication and gender dimensions. The revised NNP is headed by the Government of Federal Democratic Republic Ethiopia and signed by nine State Ministries (Health, Education, Industry, Water and Energy, Trade, Agriculture, Labour and Social Affairs, Finance and Economic Development and Women, Children and Youth affairs). The revised accountability and results matrix illustrates how each sector can contribute to better nutritional outcomes. This is major change from the previous NNP, which was led by MoH.

The Community Based Nutrition Program (CBN) is one of the key components of the Ethiopian NNP. The program was initiated in 2008 in 39 woredas. The CBN has been rolled out in tranches (four until now) and is currently implemented in 328 woredas with support from UNICEF, the World Bank, JICA, DfID and other development partners. The main objective of the CBN is to improve the nutritional status of children aged below two years of age by strengthening communities’ capacity to assess malnutrition problems, analyze its causes, and take actions by making better use of family, community and outside resources. The potential impact of CBN program is illustrated by the positive trends in nutritional status documented in the findings of the mid-term evaluation conducted in 2011 in the four big regions (Tigray, Amhara, Oromia and Southern Nations, Nationalities and Peoples (SNNP) regions (please refer to section 2.5.2 for details). Emergency nutrition is addressed by the Emergency Nutrition Guideline (2004), which defines basic concepts and criteria related to emergency nutritional interventions and establishes locally appropriate, internationally acceptable standards for general food rations and selective feeding programs as well as overall interventions.

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A recent nutrition programme is the School Health and Nutrition Program (2012), which aims to improve access to better health and nutrition services for school-age children and teachers. The program includes a school feeding and a school gardening component. Ethiopia also avails of several laws and regulations regarding food fortification and infant feeding (salt iodization, fortified flour, fortified infant formula and an food supplement directive). The BMS Code of Marketing and Food Fortification is being advanced to provide the legal framework for these directives. There are also many other strategies/policies/guidelines that are relevant for nutrition. Several of these –many recently revised, provide excellent frameworks for nutrition-sensitive programming. These include among others the Water Sanitation and Hygiene Strategy 2011-2016 (2011), with its complementary WASH implementation guideline, the National Social Protection Policy (draft, 2012) and the National policy and strategy on disaster risk management (2009) which aims to reduce risks and the impacts of disasters through the establishment of a comprehensive and integrated disaster risk management system within the context of sustainable development.

Other relevant policies are the Health Sector Development Plan (HSDP), Health Extension Programme (HEP), the Food Security Strategy 2010-2014 (2007) and the National Social Protection Policy (NSPP), launched in 2012. The NSPP is a milestone attempt to reduce poverty. The objectives of NSPP include among others (i) protection of the poor from the adverse effects of shocks and destitution; (ii) increase in the scope of social insurance, access to equitable and quality health, education and social welfare services; (iii) guarantee a minimum level of employment for the long term unemployed and under-employed and: (iv) enhance the social status and progressively realize the social and economic rights of the excluded and marginalized. The Food Security Program expects to make a substantial contribution to food security for chronic and transitory food insecure households in rural Ethiopia. The programme aims to put chronic food insecure households on a trajectory of asset stabilisation first, then asset accumulation. Relevant nutrition specific and nutrition sensitive strategies/policies/guidelines as well as regulations are summarized in the table below (adapted from table 2 in the National Nutrition Plan and the Nutrition Country Paper, Ethiopia, CAADP).

### Table 2: Nutrition relevant strategies/policies/guidelines/regulation

<table>
<thead>
<tr>
<th>Nutrition specific</th>
<th>Body</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Nutrition Strategy</td>
<td>Federal Ministry of Health</td>
<td>2008</td>
</tr>
<tr>
<td>National Nutrition Program (Revised) 2013-2015</td>
<td>Federal Ministry of Health</td>
<td>2013</td>
</tr>
<tr>
<td>National Strategy for IYCF</td>
<td>Federal Ministry of Health</td>
<td>2013</td>
</tr>
<tr>
<td>Management of SAM</td>
<td>Federal Ministry of Health</td>
<td>2007</td>
</tr>
<tr>
<td>Management of MAM</td>
<td>Federal Ministry of Health</td>
<td>2011</td>
</tr>
<tr>
<td>Micronutrient Guideline</td>
<td>Federal Ministry of Health</td>
<td>2006</td>
</tr>
<tr>
<td>Nutritional support for PLWHA</td>
<td>Federal Ministry of Health</td>
<td>2011</td>
</tr>
<tr>
<td>Agriculture and Food Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agriculture Growth Program</td>
<td>Federal Ministry of Agriculture</td>
<td>2010</td>
</tr>
<tr>
<td>Food Security Strategy</td>
<td>Federal Ministry of Agriculture</td>
<td>2007</td>
</tr>
<tr>
<td>Poverty Reduction and Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Growth and Transformation Plan</td>
<td>Federal Government</td>
<td>2010</td>
</tr>
<tr>
<td>Plan for Accelerated and Sustained Development to End Poverty (PASDEP)</td>
<td>Federal Government</td>
<td>2007</td>
</tr>
<tr>
<td>Public Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Sector Development Plan</td>
<td>Federal Ministry of Health</td>
<td>2010</td>
</tr>
<tr>
<td>Health Extension Program</td>
<td>Federal Ministry of Health</td>
<td>2005</td>
</tr>
<tr>
<td>Reproductive Health Strategy</td>
<td>Federal Ministry of Health</td>
<td>2011</td>
</tr>
<tr>
<td>National Strategy for Child Survival</td>
<td>Federal Ministry of Health</td>
<td>2005</td>
</tr>
<tr>
<td>Education</td>
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<td></td>
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<tr>
<td>School Health Nutrition Strategy</td>
<td>Federal Ministry of Education</td>
<td>2012</td>
</tr>
<tr>
<td>Social Protection</td>
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<tr>
<td>National Social Protection Policy</td>
<td>Ministry of Labour and Social Affairs</td>
<td>2012</td>
</tr>
<tr>
<td>Nutrition Relevant Laws and Regulations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Protection Law (90 days)</td>
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<td></td>
</tr>
<tr>
<td>Implementation Code of the Marketing of BMS: final decision level</td>
<td></td>
<td>2012</td>
</tr>
<tr>
<td>Food Supplement and Infant Formula Registration Guideline</td>
<td></td>
<td>2011</td>
</tr>
</tbody>
</table>
1.3 Technical and financial stakeholders in nutrition security

The National Nutrition Coordination Body (NNCB) and National Nutrition Technical Committee (NNTC) were established in 2008/2009 at the Federal level to ensure effective coordination and linkages at the national level. The NNCB is the highest governing body responsible for leadership, policy decision and coordination of the NNP. Under the revised NNP, the chair at Federal level remains the MOH (for the time being). The NNCB comprises of the eight involved Ministers, donors, development partners, civil society organizations, academia and the private sector. The revised NNP articulates the human resource capacity building activities needed for an effective multi-sectoral coordination and implementation. The NNTC consisting of directors and technical officers from the eight ministries and one representative from UNICEF provides guidance on the implementation of the NNP and decisions taken by the NNCB. At Regional level, similar coordination mechanisms have been set up, chaired by the MOH, MOA or the MOE. In most regions the Regional Director of Agriculture is the chair.

The Nutrition Development Partners Group (NDPG), chaired by UNICEF consists of representatives of UN agencies and donors. The NDPG provides a platform for sharing and disseminating information, including updates on NNTC progress and issues, work on new policies or revisions as well as strategies and action plans by the members. The NDPG also facilitates/coordinates advocacy initiatives, joint field missions, workshops and technical support.

Ethiopia is both a SUN and REACH country. Ethiopia, whilst not having sent an official letter of commitment, joined the SUN in 2011 and is as such one of the SUN early risers. The SUN focal point identified three key priorities for 2013: (i) Support the implementation of the revised National Nutrition Programme; (ii) Scale-up newly designed nutrition-sensitive interventions, across different government ministries while strengthening existing nutrition-specific actions; and (iii) Improve and harmonise the current nutrition information system and ensure linkages with other sectors’ plans and programmes.

REACH started activities in Ethiopia in 2011. The REACH Coordinator is also advisor to the Minister of Health. REACH supports various initiatives to strengthen multi-sectoral approaches. This has entailed bringing together partners to identify linkages between agriculture and nutrition programming resulting in useful recommendations to mainstream nutrition into the agriculture plan. REACH also finalized the nutrition stakeholder and activity mapping. UN agencies, coordinated by UNICEF and REACH, have been instrumental in revitalising and strengthening the National Nutrition Coordination Body and providing technical inputs for the revision of the National Nutrition Programme.

UNICEF and DFID are the SUN donor conveners for Ethiopia. Main donors for food and nutrition security include the EU, the World Bank, USAID, Irish Aid, Canada (CIDA), Japan (JICA), the Netherlands and the Bill and Melinda Gates Foundation.

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11 Most of the information in this section is derived from the Ethiopia SUN country Summary, September 2012.
12 This may change if the NNP is transferred to the OPM.
2 FINDINGS

2.1 Overall Relevance and Appropriateness

Country Programme design

The overall objective of the ANSP is to contribute to the achievements of MDG 1, 4, 5 and 8 targets related to nutrition in West and East Africa ensuring that the rights of all children and women are protected from the adverse consequences of the volatile food prices. The specific objective is to improve the institutional environment at continental, regional and national levels contributing to a reduction in maternal and child undernutrition in Africa.

The ANSP budget for Ethiopia is of € 3.068,280 excluding administrative costs. The budget for the individual pillars is R1: € 257,000; R2: € 624,000; R3: € 384,480; R4: € 3,068,280. The programme is aimed at six results, summarized in the figure below.

To better understand the structure of the EC/ ANSP Ethiopia, the MTE categorized the components outlined in the four-year work plan by the intended level of implementation (at national and regional level only, at national/regional and woreda/kebele level, or at woreda/kebele level only).

Expected results at national/regional level are the following:

- Result area 1
  - R 1.1 Revised multi-sectoral National Nutrition Plan endorsed and nutrition security and stunting a national priority

- Result area 2
  - R 2.2 Medical and Agricultural universities convening update seminars on nutrition security and stunting reduction
Result area 3:
  ✓ R 3.3 Consolidated health, nutrition and food security data base developed and piloted in the project woredas (in line with the Regional initiative)

Result area 4: none

Expected results at national/regional level and woreda/kebel level are as follows:

Result area 1:
  ✓ R 1.2 Disseminate the revised multi-sectoral National Nutrition Plan in coordination with the REACH facilitators by June 2012

Result area 2:
  ✓ R 2.1 Health extension worker supervisors able to conduct regular and quality supportive supervision to build the capacity of health and agriculture extension workers to implement stunting reduction activities at kebele (sub district) level

Result area 3: none

Result area 4: none

Expected results only at district level or below are as follows:

Result area 1: none
Result area 2: none
Result area 3: none
Result area 4:
  ✓ R 4.1: Implement integrated Community Based Nutrition program for reduction of stunting and reduction Anaemia prevalence among pregnant and lactating women

The ANSP is well aligned with UNICEF Ethiopia’s country programme (2012-2015), in particular its Survival and Health Programme Component. This component will address the major causes of disease and malnutrition among children and regional disparities thereof. It will support the GTP objectives to reach the MDGs and improve the quality of health and nutrition services and the HSDP goal to reduce morbidity, mortality and disability and improve the health and nutrition status through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health and nutrition through a decentralised and democratised health system. The survival and health component also supports (among others) the UNDAF outcome of ensuring that by 2015, the Ethiopian population, in particular women, children and vulnerable groups will have improved access to and use of quality health, nutrition and WASH services. In addition, it will contribute among others to effective inter-sectoral coordination mechanisms for the implementation of national and regional plans for improved health and survival of women and children. The ANSP focus on stunting is in particular relevant in view of the revised NNP.

The ANSP builds on achievements on the one hand, supporting ongoing work in up-stream policy (in particular the revision of the NNP), strengthening institutional capacity of partners in multi-sectoral emergency needs assessments, early warning and nutrition assessments, data collection, analysis and report writing and scaling up direct nutrition interventions. On the other hand the ANSP seeks to fill gaps in knowledge and skills. These include: (i) support to HEWs; (ii) behavioural change communication for IYCF and; (iii) refresher training (IRT) for all CBN implementing woredas.

The ANSP supports 20 woredas located in Amhara, Ormoiya and SNNP regions that are part of the 2nd tranche of the roll out of the CBN. The selected woredas will benefit from increased support and supervision to improve existing CBN practices and strengthen multi-sectoral linkages. Whilst support to the CBN as such is appropriate, the choice (beyond UNICEF’s control) in terms of e.g. decreasing inequity may be not the most appropriate (please refer to section 2.3). ANSP activities are either an expansion of an existing activity or a new activity that would not materialize without EC funding. The summary sheet does not clearly outline which activities fall in the latter category and why. Interim reports do not shed light on this issue either. In particular the MTE had difficulties to see the added value of the ANSP. ANSP seemed to be a source of funding of the country programme, not a programme with a distinct own identity.

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13 Ethiopia Country Program 2012-2015, UNICEF. Approved September 2011
14 Ethiopia Ethiopia country summary sheet
15 The CBN programme is being rolled out in tranches: tranche 1, (39 woredas, in 2008 - 2009), tranche 2 (54 woredas, in 2009 - 2010), tranche 3 (77 woredas, from 2010 - 2012), and tranche 4, an additional 100+ woredas in 2012 - 13.
The ANSP aims in particular to strengthen GoE capacity to implement the NNP and to increase support to CBN in 20 woredas. Both require capacity building in multi-sectoral approaches and strengthening multi-sectoral linkages, which ensures internal coherence. As demonstrated earlier in this section, several results are expected at federal, regional and woreda level. The activities to this end are both synergistic and coherent. For instance, dissemination of the NNP and support to multi-sectoral coordination mechanisms at federal and regional level will lead to more collaboration between different sectors and pooling of resources for capacity building also at lower levels (because the cascade approach is the preferential mode of working). Strengthened collaboration at woreda level, in turn, may help upstream policy. For example, guidelines for models for community based production of supplementary feeding or effective BCC. Another example is the development of an integrated nutrition information system (federal level) in combination with capacity building (regional level) and piloting of the system (woreda level).

The focus on stunting reduction through increased multi-sectoral collaboration is coherent with the general policy environment (SUN, REACH) and NNP strategic objectives (SO). The ANSP directly supports SO1, SO2 as well as SO4 and SO5. Activities consist of an interesting mix of nutrition-specific and nutrition-sensitive intervention. Through collaboration with new partners in mainstreaming nutrition (such as the MOE, the MOA and the Bureau of Women, Youth and Child Affairs) the SNSP supports new nutrition-sensitive activities which complement existing nutrition specific activities in the health sector, and at times improve their coverage (out-of school youths). In doing so, the ANSP fills some important gaps as elaborated in Ethiopia’s country summary sheet –although activities have been adjusted in some cases to reflect new realities.

The geographical concentration of pillar 4 interventions is in 20 woredas, which were selected by the government of Ethiopia (GoE) because of their high levels of stunting and food insecurity (selection criteria for the CBN program). The ANSP strengthens and complements routine CBN activities among others by (supporting) capacity building of health staff (IRT), ensuring supplies (for deworming and reduction of anaemia) and strengthening growth monitoring and promotion including BCC for improved infant and young child feeding practices (IYCF). The combination with UNICEF’s WASH, for the water supply component in 8 woredas, and for sanitation and hygiene in all 20 woredas, is coherent and complementary.

The ANSP in Ethiopia is a multi-stakeholder partnership (institutionalized through various Memoranda of Understanding/agreements) of UNICEF, various universities (Addis Ababa University, University of Bahir Dar) and NGOs which support GoE departments at federal and regional level as well as government structures (health facilities and schools) at woreda levels. The ANSP aims in particular to strengthen GoE capacity to ensure the scale up of nutrition through a multi-sectoral approach at national, district and sub-county level and deliver on the UNAP commitments related to the strengthening of the policy, legal and international frameworks and the capacity to effectively plan, implement monitor and evaluate nutrition programming (R 1.1 and R 2.1). In addition several results (R 2.2, R 2.3 and R 4.2) relate to communication and advocacy, in line with the UNAP objective to create awareness of and maintain national interest in and commitment to improving and supporting nutrition programs. In doing so, the ANSP fills some important gaps as identified in the gap analysis undertaken as part of the UNAP development.

Monitoring frameworks

The monitoring framework for Ethiopia is based of UNICEF’s conceptual model for nutrition (UNICEF 1990 and Lancet 2008). Starting form this framework, the logical model was built on outcomes and outputs planned for Ethiopia. The model is concise and straightforward, clearly indicating the relation between activities and outcomes and outputs. Indicators include WASH indicators such as handwashing coverage and knowledge on hygiene. An indicator table, linked to the logic model shows the operational definition of indicators, the responsible agency, methods and data sources to be used and the frequency and time-line for monitoring.

The gap analysis consisted of comparing recent performance in Uganda in addressing young child and maternal nutrition with potential and desired performance. Please refer to page 11 of the UNAP.
The four year workplan is based on (a simplified version of) this indicator table. There are no major discrepancies between the (revised) four year workplan and the subsequent workplans for year 1 and year 2 (apart from some delays, please refer to section 2.7.1). Objectively verifiable indicators (OVIs) are well defined but not quantified for pillar 4 (for example: increase by 10 percentage points from the base-line). Base-line data are yet to be incorporated. Also, in the translation from the indicator table into the workplan, OVIs on outputs have been partly lost.

Unfortunately, interim reports don’t report on progress of the implementation of activities but only of results (in unmeasurable terms as “on track” or “delayed”). It is unclear whether the indicator table is (still) used for monitoring purposes.

### 2.2 Equity Focus

In terms of where to operate, UNICEF followed advice and direction from GoE. The CBN programme focuses on densely populated food insecure agrarian regions in Amhara, Oromia, SNNPR and Tigray, which have the highest rates of stunting in Ethiopia. Woredas targeted by the ANSP were already part of the CBN and could thus quickly absorb additional support. By comparison targeting the harder to reach communities such as those found in the developing regions could have been more challenging, but these would be less able demonstrate impact from a strengthened CBN programme.

Levels of stunting in the four CBN regions at the start of the programme were worse than in other regions of Ethiopia (as per the selection criteria). However, the evaluation of the effectiveness of the CBN shows that stunting levels declined substantially\(^\text{17}\) from 51% to 41% in less than three years. The level of stunting in the ANSP target woredas is 37%, somewhat lower than the national average as estimated in the revised NNP (40%). In any case, the level of stunting is a public health concern warranting extra support.

The focus on rural areas is justified as the data in the table below demonstrate. Rural children are more often stunted and rural women are more likely to suffer from anaemia. Disparities in terms of education, wealth quintile, sanitation facilities and water-source between urban and rural are substantial. Data are from the latest Ethiopian Demographic and Health Survey.

<table>
<thead>
<tr>
<th></th>
<th>Stunting (U5)</th>
<th>Wasting (U5)</th>
<th>Anaemia (U5)</th>
<th>Lowest wealth quintile</th>
<th>No education (women)</th>
<th>Secondary + education (women)</th>
<th>Unimproved sanitation facility (households)</th>
<th>Unimproved water source (households)</th>
</tr>
</thead>
<tbody>
<tr>
<td>rural</td>
<td>46.2</td>
<td>10.2</td>
<td>45.4</td>
<td>23.9</td>
<td>58.1</td>
<td>0.6</td>
<td>90.6</td>
<td>58.0</td>
</tr>
<tr>
<td>urban</td>
<td>31.5</td>
<td>5.7</td>
<td>35.2</td>
<td>2.3</td>
<td>28.3</td>
<td>11.9</td>
<td>53.7</td>
<td>5.2</td>
</tr>
</tbody>
</table>

As in other countries, the ANSP in Ethiopia has a naturally in-built gender dimension because of its orientation towards (pregnant and lactating) women. The programme is also clearly directed at the most vulnerable children (children under five with particular emphasis on children under two). In Ethiopia, boys under five are more likely to be stunted than girls both at national level and in the 20 ANSP woredas. Countrywide, 46% of the boys and 42% of the girls under five are stunted. Wasting prevalence among boys is significantly higher at 11.1% than among girls (8.2%) under five. Global data indicate that gendered differences are less pronounced among children aged 6-18 months; differences in levels of stunting and wasting between boys and girls tend to sharply increase after 18 months. Because the ANSP targets all children under 5, with emphasis on children under 24 months of age, the project provides potential opportunities to address gender-based differences in levels of undernutrition.

DFID, USAID and ECHO advised that research will be required to extend and adapt the CBN to the developing / pastoral regions of Ethiopia as populations are geographically dispersed, some are mobile, and distances between clients and health extension workers could be vast. With GoE’s

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\(^{17}\) Assessing the impact on child nutrition of the Ethiopia Community-based Nutrition Program Report, J White and J Mason, Report to UNICEF, September 2012
request to cover 100% of woredas, UNICEF can now prioritise vulnerability, i.e. areas that have suffered from limited investment in terms of institutional development and infrastructures.

### 2.3 Pillar 1: Upstream policy development

#### 2.3.1 Relevance and Appropriateness

The overall result for Pillar 1 (for all levels) is: Africa's key policy-makers & leaders of civil society committed to review Plan of Action on Nutrition ensuring that adequate support is provided to implement nutrition action plan for an effective and sustainable socio-economic development. The workplan for Ethiopia has two related outputs. Outputs and activities as per this workplan are summarized in box 1.

#### Box 1: Results and activities for Pillar 1

<table>
<thead>
<tr>
<th>Output</th>
<th>1.1 Revised multi-sectoral National Nutrition Plan endorsed and nutrition security and stunting a national priority</th>
</tr>
</thead>
</table>
| Activities | 1.1.1 Update the national nutrition plan to accelerate stunting reduction and C4D  
1.1.2 Convene inter-sectoral coordination meetings using the REACH, nutrition development partners and national nutrition technical working  
1.1.3 Conduct federal workshop to review & plan for linkages of NNP with multi-sectoral programmes (MOA, WASH and MOE and others) and evaluation of the coordination mechanisms at regional and country level. |
| Output | 1.2 Disseminate the revised multi-sectoral National Nutrition Plan in coordination with the REACH facilitators by June 2012 |
| Activities | 1.2.1 Conduct regional and woreda level NNP familiarization meetings to support districts (woredas) coordination bodies (Ethiopia) to implement the revised NNP  
1.2.2 Conduct familiarization meetings on multi-sectorality of nutrition security and stunting reduction to four medical and agricultural universities.  
1.2.3 Advocacy tool for targeting media developed and utilized in order to make multi-sectoral nutrition security and stunting reduction priority issue for T.V/radio programs and press  
1.2.4 Provide orientation to media on stunting reduction and multi-sectorality of nutrition security and disseminate NNP |

Under Pillar 1 the EC/ ANSP aims to support the revision and implementation of the revised NNP. During the first year of the implementation of the ANSP, UNICEF helped revitalize the multi-sectoral National Nutrition Coordination Body (NNCB) and co-convened a core group for the revision of the National Nutrition Plan. UNICEF pushed for a multi-sector approach in the revised NNP. Specifically, it requested to include nutrition sensitive interventions in education as well as early stimulation. Later UNICEF’s advocated for early endorsement (before December 2012) through the Nutrition Development Partners forum (NDPM) and through the REACH mechanism.

Policy formation processes and meetings supported during the lead to its official endorsement include:
- two multi-sectoral meetings at national level to finalize ToR of the NNCB; and to review and comment on the draft revised multi-sectoral NNP. UNICEF/ANSP provided financial and technical support.
- two Federal Ministry of Health meetings with the National Nutrition Technical Working Group; consultation workshops between the Ministries of Agriculture and Health in collaboration with the REACH partnership to explore agriculture and nutrition linkages;
- two consultative workshops attended by over 60 GoE participants from Health, Agriculture, Education, Water, Social Protection, Gender, Trade and Industry ministries, as well as representatives from academia, private sector, UN Agencies and NGOs.

UNICEF/ANSP also provided technical support via REACH to explore nutrition and agriculture linkages (both globally and Ethiopia-specific), as well as food and nutrition insecurity in different agro-ecological zones for different target groups. In addition, communication specialists from WCARO
reviewed the nutrition communication component of the NNP and provided suggestions for further improvement. The ANSP also provided technical assistance for the NNP baseline survey and the gender assessment.

Box 2: Mini Case study (related to appropriateness of output 1.1)

Strengthening nutrition through mainstreaming gender

According to Ethiopian law, all sectoral ministries address women’s affairs in the preparation of policies, laws and development programmes and projects. The NNP highlights the gender dimensions of nutrition ranging from unequal gender based intra-household resource distribution and harmful practices to gender based violence and early marriage and seeks to address gender inequity where possible. Interventions for improving the nutritional status for adolescents include promotion of girls education and the delay of early marriage till age 18 and first pregnancy after marriage. Support the involvement of women’s development groups in nutrition sensitive agriculture and livelihood programmes is one of the initiatives the NNP embraces as a means to improve the nutritional status of women. Organizing women’s groups, supporting the preparation of complementary food and improving access of women to self-help groups to grants and credits are other ones. Another output of the NNP is strengthened capacity of women based structures and associations at all levels for NNP implementation.

The implementation of the NNP at community level will depend nearly in its entirety on women. The government’s strategy to scale up new health extension in a short time is founded on the establishment of a health development army (HDA18), community level groups of 30 households represented model women who are responsible for training network members, leading group discussions and monitoring the implementation of agreed plans for households. To effectively use the HDA for the promotion of optimal adolescent, maternal and child feeding practices, the NNP seeks to strengthen the capacity to implement gender responsive nutrition programmes. This will be done through training of health workers, making available IEC materials, strengthening monitoring and mentoring support by Health Extension Workers (HEW), for which the ANSP, under pillar 2, provides critical support.

The endorsement of Ethiopia’s NNP in June 2013 is a success story for the ANSP and UNICEF. During the launch of the NNP, UNICEF made a presentation on the multi-sectoral nature of nutrition, the symbiotic relationship of nutrition and early stimulation, and nutrition for development.

ANSP funding furthermore helped establish multi-sectoral nutrition coordination committees at the regional level as a direct follow-up to the NNP launch. In addition the ANSP financially supported the printing, translation in local languages and disseminations of the NNP. Dissemination events in July to September 2013 included regional and woreda level multi-sectoral meetings, distribution of an advocacy video filmed in one of the ANSP focus regions (SNPPR), and media trainings. For further dissemination activities at regional and woreda level more advocacy tools were developed. These were all relevant activities.

ANSP’s technical and financial inputs and assistance to key sectors were appropriate and finely tuned to successfully revise the NNP such that it is more pertinent and relevant to Ethiopia’s nutritional needs and development. Ethiopia has established nutrition budget lines within sectoral ministries and is making progress in developing tracking systems for both domestic and external spending on nutrition that is linked to the national nutrition plan. Ethiopia has committed to allocate additional domestic financing of USD $15 million per year to nutrition up till 2020 and build on the existing multi-sectoral coordination system to accelerate the scaling up of proven nutrition interventions.

During the launch, Ethiopia’s Deputy Prime Minister and First Lady urged GoE and partners to invest in nutrition as a key development agenda for Ethiopia. GoE will facilitate the scale-up of increased agricultural productivity; promotion of girls’ education; immunization; integrated management of neonatal and childhood illnesses (IMNCI); water, sanitation and hygiene (WASH); family planning, prevention of mother-to-child transmission of HIV (PMTCT), skilled delivery and delaying of pregnancy.

A complementary activity under pillar 1 is awareness raising among the media, in particular on the multi-sectoral approaches to reduce malnutrition and stunting. Capacitating the media is in principle an appropriate method to increase awareness, raise issues on the agenda and/ or keep the momentum.

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18 Health Development Army volunteers operate at a ratio of 1 HDA to 5 households, where one woman functions as the leader (model) of the network and five women operate as network members. A model is selected based on the status of her implementation of the 16 components of the health extension programme and responsible for training network members.
2.3.2 Effectiveness

ANSP support to the revision of the NNP significantly advanced the multi-sectoral dimension of nutrition. The NNCB, reactivated with UNICEF support, brought together representatives from the Ministries Agriculture and Rural Development, Water Resource, Education, Finance and Economic Development, Women Affairs, DPPA and UNICEF (as partner representative) under the chairmanship of the State Minister of Health. The multi-sectoral composition of the NNCB contributed to strengthened linkages between nutrition and other sectors and clarification of the major roles, responsibilities and contributions of each sector for the NNP. The NNCB also gave guidance to the core group tasked to draft the revised NNP, which finalized the main document for the NNP including the logical framework and monitoring matrix. The revised NNP has been signed by the Government of Ethiopia, represented by nine Ministers, who commit to work through enhanced strategic partnerships, at federal level and below. GoE has a reputation for ensuring ministerial adherence to policies. In this sense, the targeting of Ethiopia as a country for ANSP funding was an effective choice.

ANSP’s technical and financial support for the NNP has been effective in influencing GoE multi sector strategies across the nine ministries. MoH reported that bureaucratic bottlenecks in communication between the ministries have now been removed allowing more effective programming. Multi-sector information flows between the nine ministries involved in developing multi-sector approaches are now more efficient, effective and timely as they communicate directly with their counterparts in different ministries. Prior to the revision process, inter-ministerial technical information requests, at Addis level, required more formal procedures; technical advisors in one ministry would not have written directly to technical advisors in another ministry. The process of the NNP revision, during which the ministries worked together at a technical level has removed these institutional blockages.

ANSP support has also contributed to putting stunting on the agenda. Reducing stunting from 44% to 30% by 2015 is one of the three core performance indicators of the NNP18. In addition, the revision has been effective in aligning the NNP with the prevailing policy environment; it compliments SUN and REACH, and is coherent with contemporary emergency programming, in particular multi-sector resilience building. Endorsement of NNP was planned for December 2012, but GoE delayed this process by six months. As a consequence, the timeframe for some planned ANSP activities has shifted back slightly, including regional and woreda level dissemination workshops. These will be organized by regional and woreda sector bureaus with support from partners working at regional and woreda levels including UNICEF. For instance in Bahir Dar in Amhara region, the ANSP provided materials and statistics and supported the compilation of a slide presentation for the upcoming workshop scheduled for early November (shortly after the MTE visit to the Regional Bureau). The (Federal) Deputy Ministry of Agriculture was expected to attend the event.

Overall, ANSP funding helped identify and address key gaps in the development of the NNP. The ANSP focus on technical and financial support during the design phase of the NNP, including support to the gender assessment and review of the nutrition education component was an effective approach. In addition, support to meetings and workshops provided effective learning processes for participants, because discussions and group work contributed to common understanding and agreements.

During 2013, a start was also made with supportive advocacy. UNICEF opted for the use of PROFILES20 as an advocacy tool for nutrition awareness. A lost opportunity seems UNICEF’s lack of participation in the COHA study in Ethiopia. Combining information on costs (Profiles and the COHA) with benefits is one of the most effective ways to generate interest and understanding.

Under the ANSP an advocacy plan was developed consisting of three key components: (i) achieving political/social commitment for change, goals and targeting media; (ii) social mobilization for wider participation, collective action, and ownership, including community mobilization and; (iii) behaviour change communication for changes in knowledge, attitudes, and practices of specific audiences. An advocacy video was produced. The filming was done in one of the ANSP pillar 4 woredas in SNNPR. The video combines advocacy for nutrition and visibility for the EU/ANSP in one.

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18 The other two core indicators are: wasting down from 9.7% to 3% and maternal thinness from 27% to 19%.
20 The COHA also uses Profiles. Essentially, PROFILES is a tool to calculate the costs of malnutrition, with a track record in effectiveness.
In 2013, UNICEF’s media relation section developed Terms of Reference (TOR) to conduct training for journalists and editors. Some 70 journalist (in majority consisting of women) participated in the training which started in September and will be follow-up regularly every four months. In addition, as of September 2013, dissemination of bi-monthly media messages on nutrition started.

### 2.4 Pillar 2: Institutional development and capacity building

#### 2.4.1 Relevance and Appropriateness

The overall output of the ANSP for pillar 2 is strengthened departments and units at all levels with qualified practitioners in nutrition and reinforced coordination mechanisms involving African networks. Box 3 summarizes the ANSP Ethiopia outputs sand activities for pillar 2.

**Box 3: Result and activities for Pillar 2**

| Output 2.1 | Health extension worker supervisors able to conduct regular and quality supportive supervision to build the capacity of health and agriculture extension workers to implement stunting reduction activities at kebele (sub district) level |
| Activities 2.1.1 | Train 500 HEWs supervisors in 20 EC supported districts on CBN, data utilization and supervisory skill |
| Output 2.2 | Medical and Agricultural universities convening update seminars on nutrition security and stunting reduction. |
| Activities 2.2.1 | Contract with medical and agricultural universities to assess the current curriculum for nutrition |
| Activities 2.2.2 | Conduct sensitization workshops for medical and agricultural colleges on new development of nutrition (Ethiopia) |

Output 1 under Pillar 2 aims to capacitate Health Extension Worker (HEW) supervisors to conduct regular and quality supportive supervision to build the capacity of HRW and Agriculture Extension Workers (AEW) to implement stunting reduction activities at kebele level. To this end, during the first two years of implementation, the ANSP provided Regional and Zonal level Master Training/ Trainer of Trainers to health professionals who cascade training down to woreda health professionals, who in turn cascade training to HEWs. During the course of ANSP, the Enhanced Outreach Strategy for Child Survival transitioned to the Health Extension Programme in which every HEW supervises the model women/leaders of the Health Development Army (HDA) volunteers. The HDA has replaced a system relying on community health volunteers. Health staff advised that regular HDA capacity building is necessary as they are unskilled volunteers. Annual refresher training is required for both HDA and HEWs.

The ANSP supported the development of the in-service Integrated Refresher Training (IRT) modules for HEW Community Maternal, Newborn and Child Health (CMNCH) and the national and regional training of trainers. In addition ANSP provided financial and technical support to the development of materials for IRT participants including IRT modules and counselling books (family health cards).

In addition, materials for capacity building of supervisory skills are being developed by a taskforce under the FMOH with support from UNICEF, WHO, Save the Children, the World Bank and Alive and Thrive. The ANSP signed an agreement with L10K to monitor field activities including the work of the supervisors (please refer to section 2.6 for details).

At national level, the ANSP provided technical support to the review and evaluation of the national curricula for dietetics and community nutrition.

#### 2.4.2 Effectiveness

The IRT was rolled out to all four regions where the CBN is implemented, first targeting master trainers at national and regional level and later HEWs. In 2012, 192 national and 1,911 regional trainers profited from IRT masters training (Training of Trainers or TOT). Subsequently, the IRT was rolled out to more than 560 woredas (including the 20 ANSP woredas) in the four regions targeted by the CBN more than 31,000 HEWs received IRT. 30,000 IRT modules and 1,000,000 family health cards have...
been issued in conjunction with CMNCH activities. In the 20 woredas targeted by the ANSP more than 500 HEWs were trained. Supervisors received additional training on CBN and data utilization to supervisors, to enable supervisors to provide supportive supervision to health extension workers. The training was done at regional and zonal level. Targeted training and use of GoE systems avoids the creation of unsustainable parallel systems and is thus an effective and sustainable measure to capacitate community level health institutions.

The IRT manual was translated in local languages, duplicated for the TOT and distributed to all Regions with financial support from the ANSP. The manual aims to equip HEWs with the knowledge, attitude and communication skills required to train and support community volunteers (now: Health Development Army). The manual pays ample attention to the importance of good nutrition and its multi-sectoral dimensions (making it an effective tool in the training of HEWs despite the fact that the manual was published in 2011).

Family Health Cards (FHC) track the growth of the child by monthly weighing and effectively signals to the caregiver the progress of the child, regardless of whether the caregiver is illiterate or innumerate. The tool is a simple and effective measure enabling caregivers to discuss and compare charts with other caregivers. Health staff reported that numbers of children being admitted into therapeutic feeding programmes has fallen due to earlier identification and referral to supplementary feeding programmes by HEWs.

Zonal and woreda health professionals advised that the cascade process down to the community level is hindered by delays in funds received from UNICEF. UNICEF advised that the system is dependent upon all Zonal offices submitting timely invoices, and that no payments are forwarded unless all invoices from all Zones are received.

As of MTR, training had focused on UNICEF’s traditional partners only – health, education and WASH. The NNP advises that a nutrition unit will be established in MOA for mainstreaming nutrition in agriculture and livestock sectors (including fishery, dairy and poultry), as well as supporting nutrition linkages in PSNP, and an MOU is being established by UNICEF and FAO to support MoA to conduct Orientation of Agricultural Development Agents (ADAs) on nutrition. This is due to start in year three. Training of Farmer Training Centres (FTCs) will promote and transfer replicable and sustainable models of gardening for diversified food production. This will include nutrition sensitive interventions, linkages between HEWs and ADAs for improved household nutrition practices, mainstreaming nutrition interventions into the agriculture policy and community based complementary food production.

Save the Children has developed nutrition sensitive training modules and provided nutrition-sensitive Agriculture and Dietary Diversification training to 1,987 development agents and agriculture extension workers. Furthermore, they trained 837 school teachers in homestead gardening and dietary diversification\(^{21}\). Closer coordination and collaboration to ensure complementarity and avoid re-inventing the wheel would contribute to greater effectiveness of the ANSP capacity building.

The review and evaluation of the national curricula for dietetics and community nutrition was carried out by means of round table discussions and national-level workshops attended by more than 60 participants from 8 local universities and several development partners. Planned follow up, the


![Figure 2: number of health workers profited from IRT in ANSP woredas](image-url)
dissemination of NNP to four medical and agricultural universities\textsuperscript{22} via sensitization workshops, has been delayed due to delays in GoE signing the NNP. The activity has been contracted out to Addis Ababa University. Workshops will provide training to university management, lecturers and students enrolled in health, agriculture and nutrition fields on multi-sectoral responses for nutrition security and the accelerated stunting reduction strategy. Thereafter, it is assumed the universities will adapt their curriculum to incorporate emerging nutrition concepts.

As part of the ENGINE project (please refer to section 2.6.2) Save the Children also builds capacity of academic institutions, integrating nutrition into 12 health and agriculture colleges. Core competency training courses for nutrition, health and agriculture professionals including 58 different course/modules have been designed. UNICEF and Save the Children have met several times to ensure there is no duplication of efforts as far as the universities are concerned. ANSP support and collaboration in this process is strengthening the multi-sectoral dissemination.

### 2.5 Pillar 3: Nutrition data analysis and knowledge sharing

#### 2.5.1 Relevance and Appropriateness

Under pillar 3 the ANSP aims to develop sustainable nutrition information systems and knowledge management with strong information systems such as food security, early warning systems and health management information systems. The output and activities of the ESARO component according to the four year work plan are summarized in box 5.

<table>
<thead>
<tr>
<th>Output</th>
<th>3.1</th>
<th>Consolidated health, nutrition and food security data base developed and piloted in the project woredas (in line with the Regional initiative).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.1</td>
<td>Consultancy on information system for baseline and endline assessment and finalization of the M&amp;E frame work</td>
<td></td>
</tr>
<tr>
<td>3.2.2</td>
<td>Training for regional/district level on nutrition information system</td>
<td></td>
</tr>
<tr>
<td>3.2.3</td>
<td>Procure IT equipment Ethiopia</td>
<td></td>
</tr>
<tr>
<td>3.2.4</td>
<td>Pilot nutrition information system implemented in 3 districts (woredas) one woreda from each of the 3 target regions</td>
<td></td>
</tr>
</tbody>
</table>

Baseline data for the ANSP were extracted from a survey carried out in tranche 2 and tranche 3 CBN areas and analysed with support from Tulane University (who seconded a consultant). The analysis was also used to finalize the monitoring and evaluation framework, capturing key indicators to be used for monitoring and re-assessment in the planned end-line survey.

A key activity under pillar 3 is support to the improvement of data flow within MoH. The CBN component of the NNP captures monthly growth monitoring data that allows for the tracking of underweight children since December 2012. In addition, data on weight gain of pregnant women (and subsequent birth weight data) are collected each month by the woreda health offices. Data are regularly transmitted from the woreda health offices to the Regional Health Bureaus for more thorough analysis of the nutrition situation to facilitate immediate feedback, analysis and action.

Prior to NNP, the focus was on emergency nutrition data. MOH did not have a nutrition unit at federal level and the Emergency Nutrition Coordination Unit (ENCU), which sits in the Ministry of Agriculture Disaster Risk Management and Food Security Sector, only collects early warning information and emergency food and nutrition security data, including severe acute malnutrition admission and treatment data, in drought prone areas. Under the Enhanced Outreach Strategy (EOS) data on acute malnutrition (MUAC screening) are collected every six months during health weeks in all drought prone woredas. The latter are often of poor quality and unreliable timing. At regional level the ANSP therefore supports capacity building of health staff in the collection of nutrition data.

The lack of a dedicated nutrition unit meant till now there has been little attention to and capacity for integrating CBN data in the Health Management Information System (HMIS) within the Federal MoH, and the integration of nutrition data from different sources (EOS, ENCU). Since the establishment of

\textsuperscript{22} Makelle, Wolita Sodo, Bahirdar and Haromaya
the new nutrition unit in MoH however, there is increasing capacity for data collection and data quality control. To capacitate the new nutrition unit, ANSP is working with MoH through a steering committee comprised of multiple partners to help build capacity and establish a centralized nutrition database. This will allow MoH to extrapolate from multiple data sources (e.g. CBN, CMAM) as well as by different levels of disaggregation (e.g. region/ woreda, livelihoods, hotspot priority woredas, and donor). Simple queries can be run off it for federal MOH and stakeholders such as CBN participation rates per woreda, and if available through recent nutrition survey, stunting rates per woreda.

2.5.2 Effectiveness

Base-line

Two years into the CBN program, UNICEF and the World Bank supported an evaluation study aimed at assessing the effectiveness for tranches 2 and 3 (please refer to section 2.1 for more details) of the CBN. To this end, four evaluation sample surveys were carried out in 2009 and 2010. A quasi experimental design was used to assess impact on the population. No direct comparison groups were included (in line with GoE policy). Data collection was by cluster (enumeration area) consisting of 15-18 households. Data collected included nutrition indicators as well as food security data (hot spot classification, seasonality, drought and household hunger scale), housing characteristics, care of childhood illness, maternal health seeking behaviour, CBN program coverage and service delivery.

For tranche 2, to which the 20 ANSP woredas belong, the original base-line was carried out in 2009 and a follow-up survey to assess impact was carried out in 2011. Data from the latter were used as base-line prior to the ANSP. Unfortunately, data extracted represent only a fraction of the wealth of data collected in the evaluation study. Important nutrition indicators (including underweight and wasting), for which the NNP and / or the CBN set targets have apparently not been extracted (were not reported) without any further explanation. Contextual information on food security, CBN service delivery and program participation is completely missing as are important data on WASH indicators.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>NNP Base-line 2008/2013</th>
<th>NNP Target 2013/2015</th>
<th>CBN Tranche 2 Baseline</th>
<th>CBN Tranche 2 Mid-line</th>
<th>ANSP woredas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting among children (6-23 months)</td>
<td>46/45</td>
<td>40/30</td>
<td>51</td>
<td>41</td>
<td>37</td>
</tr>
<tr>
<td>Underweight among children (6-23 months)</td>
<td>38</td>
<td>30</td>
<td>32</td>
<td>29</td>
<td>n.a</td>
</tr>
<tr>
<td>Wasting children (6-23 months)</td>
<td>11/10</td>
<td>5/3</td>
<td>9</td>
<td>15</td>
<td>n.a</td>
</tr>
<tr>
<td>Exclusive breast feeding (children 0-5 months)</td>
<td>32/52</td>
<td>60/70</td>
<td>67</td>
<td>89</td>
<td>82</td>
</tr>
<tr>
<td>Introduction of solid, semi-solid or soft foods (children 6-8 months)</td>
<td>25</td>
<td>50</td>
<td>67</td>
<td>48</td>
<td>51</td>
</tr>
<tr>
<td>Minimum diet diversity (children 6-23 months)</td>
<td></td>
<td></td>
<td>27</td>
<td>50</td>
<td>46</td>
</tr>
<tr>
<td>Minimum acceptable diet (children 6-23 months)</td>
<td></td>
<td></td>
<td>4</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Children with diarrhoea fed same or more</td>
<td>25</td>
<td>50</td>
<td>59</td>
<td>69</td>
<td>n.a</td>
</tr>
<tr>
<td>Diarrhoea (children 6-59 months)</td>
<td></td>
<td></td>
<td>30</td>
<td>21</td>
<td>n.a</td>
</tr>
<tr>
<td>Improved toilet facility (% of households)</td>
<td></td>
<td></td>
<td>7</td>
<td>23</td>
<td>n.a</td>
</tr>
<tr>
<td>Improved drinking water sources (% of households)</td>
<td></td>
<td></td>
<td>40</td>
<td>34</td>
<td>n.a</td>
</tr>
<tr>
<td>Safe stool disposal (% of households)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
</tr>
<tr>
<td>Coverage of IFA/MMN during last pregnancy (%)</td>
<td></td>
<td></td>
<td>29</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>% of mothers attending 4 or more ANC</td>
<td></td>
<td></td>
<td>32</td>
<td>36</td>
<td>36</td>
</tr>
</tbody>
</table>

The discussion chapter in the base-line report (EU woreda extract from the main report) does not provide any explanation. The MTE was advised that the reason for this incomplete and incomprehensive analysis was that UNICEF did not consider a more thorough analysis necessary.
Table 3 above summarizes the data from the main survey report and the EU woreda extract. The table also compares these data with available NNP base-line values and targets. Some of the NNP 2008 indicators have been adjusted in the revised NNP (NNP 2013) to reflect changes (improvements) which occurred in the period 2008-2012. Mid-line data from the CBN evaluation and base-line data for ANSP woredas indicate that many of the NNP targets had already been achieved in 2012 (highlighted in blue), before the ANSP started.

The combination of NNP targets already having been achieved and incomplete base-line data makes it impossible to attribute any effect to the ANSP. Additional mid-line and end-line surveys are planned for mid-2013 and mid 2015, but without a complete set of base-line data and a comprehensive analysis of available contextual information these surveys will not be able to measure the effectiveness of the CBN let alone any added value of the ANSP. A possible solution is to attempt not to use separate base-line data for the 20 ANSP supported woredas but make use of the World Bank evaluation data and other complementary data.

**Nutrition Information System**

The same consultant who analysed base-line data also provides technical support for the analysis of the nutrition information captured monthly from all woredas, and improvements to the database. The new system allows dashboards to be readily available, which facilitate multiple triangulations from different data sources. Dashboard can be filtered geographically, or via hot spots, or zones. This was not possible before. Below is a hypothetical example of a dashboard which illustrating triangulation of data multiple data sources

![Figure 3: dashboard of nutritional data from multiple sources](image)

Support to MOH for improved data collection and integration of data is progressing well. At regional level, ANSP conducted training to 30 trainers in nutrition data collection for the HIS. This was cascaded to 380 health staff as well as staff who collect early warning data under the Ministry of Agriculture Disaster Risk Management and Food Security Sector at woreda level. Trainers are also charged with the follow-up through supervision and mentoring of HEWs. Monitoring visits focused among others on improving the quality of data collection, particularly in standardizing denominators for calculating Community-based Nutrition Growth Monitoring and Promotion participation rates.

Zonal health staff advised that reports from woredas had improved since they had received training in data-base and data management. Prior to database training, quantitative data was sometimes reportedly confused and contradictory. Zonal health staff advised that figures are now more accurate which has led to improved and more efficient stock management.

Although the process of working with the federal MOH and the new nutrition unit has only recently started, capacity building has been an ongoing priori. The training includes developing skills for
nutrition data analysis and report writing using the new nutrition information system, both by the Federal Emergency Nutrition Cluster Unit (FENCU) as well as through a component of the CBN health supervisor training.

It is anticipated that the process initiated by ANSP is likely to create demand from GoE for further use of nutrition information for program monitoring and performance, potentially using the dashboard type mechanism. UNICEF has presented this type of mechanism to the FMOH and steering committee to show the potential uses. This type of comprehensive nutrition information database will allow for strengthening the use of the information for planning and development, particularly at woreda level, as well as for early warning.

2.6 Pillar 4: Scaling up nutrition

2.6.1 Relevance and Appropriateness

The ANSP output for pillar 4 is strengthened capacity for adaptive management of the community-based nutrition programme. The output and corresponding activity are summarized in the box below.

<table>
<thead>
<tr>
<th>Output 4.1</th>
<th>Implement integrated Community Based Nutrition program for reduction of stunting and reduction anaemia prevalence among pregnant and lactating women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td></td>
</tr>
<tr>
<td>4.1.1</td>
<td>Conduct Micro-planning/ review meetings/supportive supervision</td>
</tr>
<tr>
<td>4.1.2</td>
<td>Conduct Sensitization/orientation workshops on CBN at district/sub-district levels</td>
</tr>
<tr>
<td>4.1.3</td>
<td>Support refresher training for 5000 HW/HEW in 20 districts</td>
</tr>
<tr>
<td>4.1.4</td>
<td>Support Ministry of Education on the finalization of school health and nutrition strategy</td>
</tr>
<tr>
<td>4.1.5</td>
<td>Provide orientation for school community on multi-sectorality of nutrition security and stunting reduction participation</td>
</tr>
<tr>
<td>4.1.6</td>
<td>Development and implementation of C4D strategy for behavior, social change and community participation</td>
</tr>
<tr>
<td>4.1.7</td>
<td>Orientation of Agricultural development agents on nutrition</td>
</tr>
<tr>
<td>4.1.8</td>
<td>Conduct monthly growth monitoring and promotion session at village level for children under the age of followed by individual counseling and community dialog to analyze the cause of malnutrition and to take necessary action to prevent malnutrition</td>
</tr>
</tbody>
</table>

ANSP pillar 4 focuses on an array of multi-sector activities including support to the CBN (activities 1-3 and activities 6 and 8) and to the MOE School Health and Nutrition Strategy orientation for school communities on the multi-sectoral dimensions of nutrition security and stunting reduction (activity 4 and 5). In year three, Pillar 4 will also provide orientation to Agricultural Development Agents on nutrition (activity 7). UNICEF is closely collaborating with the GoE and others for pillar 4 activities.

UNICEF collaborated with the GoE in conducting sensitization workshops from which trainings were cascaded down to 34,000 HEWs. Using the cascade training structure is appropriate to GoE institutional structures. UNICEF has signed an agreement with the Last 10 Kilometers (L10K) to support HEWs on an ongoing base. Support includes integrated refresher training (IRT), strengthening of supervision and referral systems as well as data collection and use. L10K also develops capacities of schools in engaging in nutrition promotion and school-based micronutrient supplementation. This is highly relevant, given that a national School Health and Nutrition Strategy survey (MoE, 2008) indicated that 23% of surveyed children were stunted and a similar percentage of them were also underweight\textsuperscript{23}. L10K will also build nutrition capacity of agriculture development agents (ADA’s) starting in year 3.

UNICEF also signed a partnership agreement with the German Foundation for World Population (Deutsche Stiftung Weltbevölkerung or DSW) to support the Bureau of Women, Child and Youth Affairs with activities targeting adolescents. Including adolescents is highly relevant in view of the revised NNP (and LANCET June 2013 recommendations). For the community based production of

complementary food (CF), UNICEF closely collaborates with Addis Ababa University and Bahir Dar University, appropriately securing expertise and capacity (including at regional level).

The combination of capacity building at regional and woreda level and supporting interventions at community level makes a strong tandem. Also, in view of the new emphasize of the revised NNP on multi-sectoral approaches, support to new partners such as the Bureau of Women, Child and Youth Affairs, the MoE and the MoA is appropriate. Last but not least, in many of the 20 ANSP woredas, UNICEF’s WASH department programme is active in installing new/ improving existing water points and building capacity in water supply maintenance and sanitation and hygiene promotion. As outlined in section 1.3, WASH and nutrition have common (nutrition) impact indicators. This strengthens the multi-sectoral dimension.

2.6.2 Effectiveness

Capacity building

As mentioned in section 2.4.1 the ANSP supported sensitization meetings and workshops for Zonal Health Office focal persons on the transition from the EOS to the Health Extension Programme, which was cascaded to HEWs. This was followed by regional and woreda level micro-planning to prepare the 24-month Annual Work Plan. Review meetings and supportive supervision were then carried out by woreda Health Centre and Primary Health Care Unit staff.

Woreda health staff, supported by L10K, also trained HEWs to conduct monthly growth monitoring and promotion sessions for children under the age of two, followed by counselling and community dialogue to discuss causes of malnutrition and ways to prevent it. Data from the 20 ANSP show that attendance gradually increased from less than 30% to more than 70% during the first two years of implementation.

Figure 4: Participation in CBN in ANSP woredas

Source: Jessica White, Analysis of nutrition data collected in EU woredas

The IRT emphasizes the need for HEWs to promote the Lifecycle Approach which emphasizes the first 1,000 days of life. Growth monitoring as of yet consists of weighing children only (height is not measured). Children whose weight gain is unsatisfactorily are screened for acute malnutrition (MUAC). Care-takers of moderately acutely malnourished children receive counselling. Where available, children will enter into targeted supplementary feeding programmes which provide a three month ration\(^2\). Severely acutely malnourished children are referred to health facilities. With more than 70% of the children attending, GMP is clearly effective in early detection of underweight, allowing screening and other appropriate follow-up. In addition, data collected by HEWs are representative enough for nutrition security decision making.

\(^2\)Bi-annual or quarterly MUAC screening is also carried out as part of the EOS. This allows for the identification of acutely malnourished children who are not captured during monthly community monitoring (because they don’t attend or because CBN is not yet implemented)
HEWs have 16 health related modules to work through with their communities. HEWs are also tasked with training the Health Development Army (HDA). Whilst HEWs are assisted by HDA, HDA’s are volunteers with limited skills. This is a significant bottleneck. Systematic regular top up training is required for HDAs to remain effective.

**IYCF and anaemia reduction**

ANSP also supported activities aimed at reducing micro-nutrient deficiencies. This has included the provision of deworming and iron-folate (IFA) to pregnant women. More recently, ANSP through DWS also supports reduction of anaemia of adolescent girls. DSW’s (Foundation for World Population) general focus is on youth sexual and reproductive health needs/ rights and adolescent and youth empowerment. Under the ANSP, DSWs objective is to improve nutritional status of women aged 15-49 years and adolescents 10-19 years. DSW’s goal is to break the intergenerational cycle of malnutrition focusing on improving nutritional status of 75% of adolescents to reduce low birth weight and stunting by 2015 through behavioural change. Target groups include unmarried adolescents –future parents, married adolescents, as well as families of adolescents at community level. Collaboration with the ANSP is through the Adolescent Nutrition Support Programme which works via youth clubs – youth to youth (Y2Y) as entry point for NNP to inform on nutrition, early marriage and stunting. Inclusion of young women for anaemia reduction has increased the effectiveness of this activity, in particular because also out of school girls are reached.

Initially, the ANSP had planned for the distribution of Micronutrient Powders (MNP) to children under two (as per result 2.2 of the NNP). However, despite intense advocacy efforts by UNICEF and others, GoE has not yet approved the importation of MNPs, because of sustainability concerns. UNICEF has proposed to relocate funds (€ 400,000), in support of scaling up of community based production of complementary food (CF). UNICEF and Addis Ababa University, as well as UNICEF/FAO and Bahir Dar University have been piloting community based production of complementary foods from local cereals during the first years of ANSP implementation. The piloting has provided a lot of lessons learned.

Sustainability issues encountered in the development of the CF component have highlighted the need for agriculture and health extension services to promote crop selection based on nutritional content in addition to yields, and for home and school garden and fruit gardens. It has also highlighted the need for agriculture and health extension services to promote nutrition messages and diversify production of vegetable and fruits with micronutrient rich varieties as well as promote household animal production for animal protein including poultry and fish products. The project concluded there is a need to strengthen collaboration between health and agriculture sectors to provide integrated support to communities and share experiences and best practices to improve “Child and Maternal Nutrition”.

Activities proposed for scaling up the CF component take into account these lessons learned. Activities include among others organizing women groups, support the preparation of complementary food, providing a revolving fund to support procurement of start-up capital and promotion of consumption of diversified foods. In close collaboration with FAO, UNICEF provides support to Agricultural Extension Programmes among others by strengthening capacity of farmer training centres to implement nutrition-sensitive interventions including homestead gardening and school gardening. Agricultural development agents attached to these centres have been trained in nutrition. Nutrition education to targeted women re-enforces promotion of good nutrition provided by HEWs and increases effectiveness. The scale up of local complementary food production to ANSP woredas is expected to create economic opportunities for women through development groups and cooperatives.
School-based health programmes in the past were fragmented and uncoordinated due to being implemented by different stakeholders. This led to inefficient and ineffective programme delivery as well as poor results. The SHNS recognizes and embraces the multi-dimensional nature of health and nutrition issues, and harnesses a multi-sectoral approach among the Ministries of Education; Health; Agriculture; Water Resources; Women, Children and Youth Affairs; Labour and Social Affairs; the...
private sector; civil society organizations; and the community. The SHNS is complemented by training modules for HEWS to train mothers (parenting education (and fathers), and to encourage early stimulation of babies/children). UNICEF also pushed for mothers and adolescent girls to learn about early childhood developments in schools. SHN WASH message are equally strong with lessons incorporating WASH modules 25.

ASNP also funded technical assistance for capacity building for school promotion of nutrition security and stunting reduction. UNICEF, FAO and WFP worked together to formulate national strategy promoting regionally tailored nutrition advice based on environment school gardens. This appears an effective use of each agency’s comparative strengths.

In terms of equity and outreach, programme coverage also targets children out of school. UNICEF has produced brightly coloured attractive books which promote health and nutrition messages through humorous stories about animals. Primary school children are given a set of books in a specially made bag and asked to read to one child once a week who does not attend school. This will ensure key messages have a broader outreach beyond the school community, i.e. to those who are unable to attend school. It also encourages early learning for younger children. Other initiatives focus on teachers, parent-teacher associations, faculty members and educators to promote key nutrition security actions through school clubs (youth, out of school adolescent girls and boys, environment, mini-media and others). This chapter of ANSP appears thoroughly appropriate, effective and sustainable.

In year three, Pillar 4 will provide orientation of Agricultural Development Agents (ADA) on nutrition. NNP seeks to mainstream nutrition in the agriculture sector, with linkages with livestock (fishery, dairy, poultry, etc.), horticulture. It will also support nutrition linkages in various agricultural programmes and safety nets such as the PSNP. The newly established nutrition section of MoA would benefit from close linkages with UNICEF. UNICEF is preparing a MoU with FAO to support Ministry of Agriculture to conduct Orientation of Agricultural Development Agents on nutrition. Orientation is due to start in year three. L10K will provide nutrition capacity building for ADA’s. Ultimately this training will strengthen linkages between HEWs and ADAs for improved household nutrition practices.

NNP seeks to mainstream nutrition interventions into the agriculture policy and investment framework plan and support local complementary food production and create economic opportunities for women through development groups and cooperatives through the CBN programme in food insecure areas and through the USAID supported ENGINE programme in surplus areas. The main implementing agency for the latter is Save the Children. Collaboration between the various programmes does exist, but stronger linkages and collaboration between L10K and Save the Children’s ENGINE nutrition sensitive agricultural tools (referred to under Pillar 2-capacity building) could enhance cohesiveness of USAID and EU funded programmes and increase overall effectiveness.

2.7 Efficiency

2.7.1 Operational Efficiency

The implementation of the ANSP is per detailed annual work plans and an overall 4 year workplan. For each of the pillars, the annual workplans contain expected outputs, planned activities, activity outputs, a timeline, lead agency and partners (but not detailing specifically who is doing what, when and where). The 4 year workplan specifies base-line and end-line indicators (or: endline indicators in o to base-line data). The first and second interim reports provide information on operational efficiency. During the first year, the main delay was the finalization of the revised NNP. As a result, all activities under pillar 1 were delayed. In year 2, the NNP was finalized, but activities related to its dissemination and capacity building for implementation were (naturally) delayed. Most of these are being

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25Modules include instructions for schools ("Schools shall be equipped with improved water, environmental sanitation and hygiene facilities"), teachers ("Children shall be taught good personal hygiene such as washing hands before eating and after visiting the toilet") and ownership and sustainability (Ensure mechanisms are put in place for ownership and sustainability of SHN programmes (such as school feeding programmes and other promotive nutrition interventions, cooking demonstrations and school gardens). Available from:
implemented in year 3. Some other delays in year 2 such as capacity building of ADAs under pillar 4 are also a consequence of the delayed finalisation of the NNP. On another note, due to GoE concerns about sustainability (as referred to in section 2.6.2), UNICEF planned procurement and distribution of MNP could not take place. All other activities were on time. The MTE rates the overall operational efficiency as good.

2.7.2 Financial Efficiency

The total amount available from the EC/ANSP budget in Ethiopia is € 3,068,280 (excluding 7% administrative costs). In addition, for the first two years UNICEF made available from other resources € 639,230 (expenditure from other funding sources). The budget (total projected costs) for the first year was € 1,431,672. Expenditure in year 1 amounted to € 833,178 or 58% of the total budget (but 41% of the EC/ANSP allocation). The budget for year 2 was € 983,084, while actual expenditure was € 525,838 (e.g. € 311,367 from the ANSP budget plus € 214,472 from other funding sources). During the first two years only 41% of the EC budget was spent according to UNICEF’s detailed financial reports. The projected costs for year 3 are € 438,402 leaving a substantial amount of nearly 2 million euro (€ 1,910,091) for the last year. This is slightly more than the residual funds calculated by UNICEF (€ 1,709, 264).

| Table 4: Available funding and utilization of funds (Oct 2011 - Sept 2013) |
|-------------------------------------------------|------|------|------|
| EC/ ANSP allocation                            | Total | Year 1 | Year 2 |
| (a)                                            | 3,068,280 | 1,006,914 | 768,612 |
| Funds from other sources (Y 1 and Y 2) (b)     | 639,230 | 424,758 | 214,472 |
| Total projected costs (a + b)                  | 3,707,510 | 1,431,672 | 983,084 | 438,402 |
| Expenditure EC (c)                             | 408,420 | 311,367 |
| Expenditure other (d)                          | 424,758 | 214,472 |
| Total expenditure (c + d)                      | 833,178 | 525,838 |
| % utilization of EC budget (c )/ (a)           | 41 | 41 |
| % utilization of total budget (c + d )/( a + b)| 83 | 68 |
| Balance EC for next year (a_{total} - c_{t-1})| 2,659,860 | 2,348,493 |

The low budget utilization of year 2 is related to procurement of multiple micronutrient supplements, for which UNICEF had budgeted USD 400,000. This was not used during the years under review as the government policy did not allow procurement of the supplements. As indicated in the table above, 53% of all expenditure during the first two years came from the ANSP budget and 47% from other sources. This is significantly more than the overall ANSP distribution (85.7% from the ANSP budget and 14.3% from other sources including UNICEF’s own resources).

Whether the ANSP has been able to leverage funds for the roll out of the program into other woredas in Ethiopia is impossible to say: ANSP is one of the many funding sources for UNICEF’s support to the CBN (or in general, the child survival and health programme component of UNICEF’s country programme), and the EC is neither the largest or the first donor providing funding to UNICEF’s support in the nutrition sector.

Ethiopia’s budget is the biggest of all four ANSP focus countries, amounting to one third (34%) of the total allocation for the four countries (and 16% of the total amount available for the ANSP). Table 3 demonstrates that expenditure (from all funding sources) in Ethiopia for pillar 3 was relatively high (68% of the budget), expenditure for pillars 1 and 2 was somewhat behind (with 37% and 31% respectively) and expenditure on pillar 4 was on track (44%). This well matches operational efficiency, demonstrating some delays for pillar 1 and 2 activities due to the late endorsement of the NNP.
Expenditure broken down per budget-line for 2012 and 2013 was provided by UNICEF as well. The figures are for fiscal year 2012 and 2013 and therefore don’t match the figures provided in table 5 and Figure 2. The break-down was calculated to see how the project expenditure was divided over the traditional (more commonly used) budget-lines. Figure 2 illustrates that expenditure was very much biased towards grants to counterparts, indicating that much of the activities are being outsourced.

Figure 5: break-down per budget-line

2.8 Impact

Given that ANSP is not a direct implementation project for a particular process, but rather one that has many different aspects, which ultimately focus on capacity building through UNICEFs country programme, in many different constituencies, it is difficult to demonstrate impact. ANSP is flexible in that it is able to address strategic gaps. ANSP’s unique added value appears to be its ability to address capacity building gaps.
Dissemination of the multi-sector NNP and support for monitoring its implementation is underway. UNICEF, also with ANSP funds, has helped accelerate a policy paradigm shift from the NNP focus on nutrition in emergencies to one of nutrition in development. The revised and launched NNP with its focus on stunting reduction and multi-sectorality is a significant result which will have far reaching impact through the many ministries that have endorsed its objectives.

There is clear ownership of the process by GoE. ANSP has strategically and discreetly influenced key elements of GoE policy formation. However, while there is clear ownership of a multi-sectoral approach in the health sector, it is too early to see if ownership of other Ministries is parallel to that of MoH, although all share the overall objective of reducing malnutrition through the GTP. It is noted that whilst Ethiopia has a costed multi-sectoral nutrition plan, there is limited funding for it. As of the MTR, only 67% of the NNP was funded, leaving a gap of 182 million US$. The extent to which the nine ministries can operationalize NNP activities is therefore uncertain.

Capacity building under pillar 2 regarding an integrated database for nutrition and related relevant data is facilitating demand from within MoH for CBN data. GMP data can be used at regional and lower levels to compare weak and strong woredas. Dashboards will enable woredas to conduct multiple triangulations from different data sources and thus compare progress, identify problems and respond accordingly. In addition, although UNICEF has provided some IT equipment to Regional Health Bureaus, it has yet to provide IT equipment at the woreda level and –through L10K, strengthen capacity for data collection and analysis. As with the training itself, the capacity to examine and compare trends will positively impact on MoH’s nutrition security monitoring capacity.

Support under pillar 4 consisting of support to government’s structures and systems would have taken place regardless of ANSP. The MTE heard several times that other than complementary food studies and higher level policy changes, “ANSP has introduced nothing new on the ground for health compared to neighbouring non ASNP woredas in the region.” However, there are indications that the ANSP addresses low CBN attendance, an issue of concern identified in the assessment/evaluation of the effectiveness. The evaluation revealed that only 30% of eligible children attended community GMP sessions at community level. As elaborated in section 2.6.2, data from the 20 ANSP show that attendance gradually increased from less than 30% to more than 70% during the first two years of implementation. At the same time underweight decreased from nearly 30% to less than 10%, demonstrated clear impact.

![Figure 6: Trends in underweight in ANSP woredas](image)

While Pillar 4 appears to have value addition in the health sector, it is also noted that Ethiopia’s pillar 4 towers above all other pillar 4 in terms of funding available. This raises some questions regarding value for money for Ethiopia’s Pillar 4. A shift in focus from the health sector towards multi-sector linkages on the ground would possible increase impact. ANSP support to the education component, i.e. the School Health and Nutrition Strategy) is a great success story, perhaps not least because it entails a true mix of Pillar 1, 2 and 4 activities.
2.9 Sustainability

Sustainability of the ANSP in terms of objectives is assured, because they are firmly engrained in government policies notably the NNP. As noted earlier, GoE has a reputation for ensuring adherence to policies. The targeting of Ethiopia as a recipient for ANSP funding thus appears a strategic choice to ensure maximum impact in terms of testing and supporting a multi-sectoral approach to nutrition.

ANSP focus on strengthening existing GoE health infrastructure rather than the creation of parallel systems ensures sustainability and institutional harmonization and ownership. Capacity building of Heath Staff (at Zonal and woreda level) who in turn cascade training down to HEW level ensures clear ownership within the health sector. Support provided by L10K with ANSP funding contributes to strengthening of skills for supervision and programme implementation. The review and adaptation of curricula of local universities with a view to incorporate new nutrition concepts will ensure that (future) health staff avails of the necessary nutrition capacity to provide training of trainers and supervise designated nutrition focal points. The complementary food component is an important step in making nutritious complementary foods available to mothers at low cost in a sustainable manner. The scale up of local complementary food production to ANSP woredas through a multi-sectoral approach including home-based gardening and food processing is expected to create economic opportunities for women through development groups and cooperatives. And, if succeeding in this regard, the CF component is self-sustainable.

Capacity building of teachers in nutrition and support to the development of the school curriculum via the National School Health and Nutrition Strategy at national level will ensure sustained ownership and impact from within the Ministry of Education. It is too soon to see if ownership within MoA matches that of MoH and MoE. At the time of the MTR, there was some institutional uncertainty as to what the multi sector approach means on the ground for the agricultural department. Given that the NNP is but a few months old at the time of MTR, this is not surprising.

3 Conclusions

Relevance and appropriateness

The ANSP is coherent with the policy environment (SUN, REACH) and well aligned with the strategies to address nutrition outlined in the NNP, in particular to reduce stunting and strengthen GoE capacity to scale up nutrition through a multi-sectoral approach at national, regional woreda and kebel level. The ANSP in Ethiopia is a multi-stakeholder partnership (institutionalized through various partnership agreements), in which government – including (local) authorities, institutions (among others Addis Abeba University and Bahir Dar University) and NGOs (L10K, DWS) work closely together and contribute financial and human resources towards the partnership. Cohesion in the programme is assured through linkages between the activities at federal, regional, zonal and woreda level. Policy development at federal level clearly guides lower levels, and there is also some evidence that work done at woreda/kebele level helps upstream policy development (e.g. extension of the CBN programme throughout the country). Support to the development of the nutrition information system shows how pillars benefit from cross-fertilisation: capacity development (pillar 3), guided by pillar 1 (NNP) at policy level and fed by data collection work on the ground (pillar 4).

Equity Focus

The ANSP is clearly directed at the nutritionally most vulnerable: children under five (with particular emphasis on children under two) and pregnant and lactating women. The programme has a naturally in-built gender dimension, as in all ANSP focus countries. The 20 ANSP woredas benefitting from increased support and supervision to improve existing CBN practices and strengthen multi-sectoral linkages have not been selected because they were worse off in terms of stunting, poverty or education, but per GoE’s plan for the implementation of the CBN programme. GOE’s recent decision to roll out the CBN throughout Ethiopia, also to hard to reach communities in developing regions provides new opportunities to include equity considerations in selecting CBN woredas.
Effectiveness

ANSP support to the revision of the NNP significantly advanced the multi-sectoral dimension of nutrition. The NNCB was reactivated and ANSP’s technical and financial support for the NNP revision process during which all eight involved ministries worked together at a technical level has facilitated communication and removed institutional blockages between ministries. The integration of nutrition data into one system cum capacity building of MOH staff for improved data collection and integration of data progressed well. Zonal health staff advised that reports from woredas had improved since they had received training in database and data management. However, analysis of baseline data was incomplete and not very comprehensive. This will further contribute to the problem of attributing impact of the ANSP

The ANSP involves a series of stakeholders in the implementation of the NNP. A particular strength is UNICEF’s partnership with governmental structures outside the health sector, including the Bureau of Women, Child and Youth Affairs, MOE and MOA. Support to MOE at federal level (the finalization of the School Health and Nutrition Strategy) and nutrition capacity building of teachers is a great success story, perhaps not least because it effectively combines pillar 1, 2 and 4 activities. UNICEF’s partnerships with DWS to support activities targeting adolescents (through the Bureau of Women, Child and Youth Affairs), is an effective way to include out-of-school (in particular female) youth. For the community based production of complementary food (CF), UNICEF closely collaborates with Addis Ababa University and Bahir Dar University, effectively securing expertise and capacity (including at regional level).

Generally, the combination of capacity building at regional and woreda level and supporting interventions at community level makes a strong tandem. In some (so far eight) of the 20 ANSP woredas, UNICEF’s WASH department programme is active in installing new/improving existing water points and building capacity in WASH. This strengthens the multi-sectoral dimension and effectiveness in reducing stunting.

Efficiency

The rate of progress in Ethiopia has been quite satisfactorily despite the delay of the finalization of the NNP and related activities, delays outside UNICEF’s control. Ethiopia’s budget is the biggest of all four ANSP focus countries, amounting to one third (34%) of the total allocation for the four countries (and 16% of the total amount available for the ANSP). The budget for pillar 4 is in particular high, raising some questions regarding value for money under this pillar. A greater focus on multi-sector linkages on the ground could imply greater cost effectiveness, because this is where the added value of the ANSP is highest.

Whether the ANSP has been able to leverage funds for the roll out of the program into other woredas in Ethiopia is difficult to say: ANSP is one of the many funding sources for UNICEF’s support to the CBN (or in general, the child survival and health programme component of UNICEF’s country programme), and the EC is neither the largest or the first donor providing funding to UNICEF’s support in the nutrition sector.

Impact

UNICEF, also with ANSP funds, has helped accelerate a policy paradigm shift from the NNP focus on nutrition in emergencies to one of nutrition in development. The revised and launched NNP with its focus on stunting reduction and multi-sectorality is a significant result which will have far reaching impact in terms of involvement of the many ministries that have endorsed its objectives.

Capacity building under pillar 2 regarding an integrated database for nutrition and related relevant data is facilitating demand from within MoH for CBN data. Strengthened capacity for data collection and analysis will positively impact on MOH’s nutrition security monitoring capacity.

Support under pillar 4 consisting of support to government’s structures and systems would have taken place regardless of ANSP. The MTE heard several times that other than complementary food studies and higher level policy changes, “ANSP has introduced nothing new on the ground for health compared to neighbouring non ASNP woredas in the region.” However, there are strong indications
that the ANSP positively impacts on underweight in ANSP supported woredas underweight decreased from nearly 30% to less than 10% in just over two years.

**Sustainability**

Sustainability of the ANSP in terms of objectives is assured, because it is firmly engrained in government policies notably the NNP. In addition, the ANSP (or: UNICEF’s country component in particular the Survival and Health Programme Component) is designed in such a way that many results are likely to be sustained well after the life span of the project. The ANSP builds on and advances ownership of multisectoral approaches for nutrition at all levels as intended (and formulated) in the NNP. Under pillar 1, the ANSP supports the GoE to roll out the NNP including new coordination structures fostering multi-sectorality. Support to the finalization of the National School Health and Nutrition Strategy at federal level and capacity building at woreda level has contributed to sustained ownership and impact from within the Ministry of Education. Collaboration with the Bureau of Women, Child and Youth Affairs and the MOA provides additional opportunities to increase ownership of the NNP.

In the health sector, ANSP focus on strengthening existing GoE health infrastructure ensures sustainability and institutional harmonization and ownership. The review and adaptation of curricula of local universities with a view to incorporate new nutrition concepts will ensure that (future) health staff avails of the necessary nutrition capacity to provide training of trainers and supervise designated nutrition focal points.
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
</tr>
<tr>
<td>CBN</td>
<td>Community Based Nutrition</td>
</tr>
<tr>
<td>CMAM</td>
<td>Community Based Management of Acute Malnutrition</td>
</tr>
<tr>
<td>CMNCH</td>
<td>Community Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society Organization</td>
</tr>
<tr>
<td>DHA</td>
<td>Development Health Army</td>
</tr>
<tr>
<td>DRMFSS</td>
<td>Disaster Relief Management and Food Security Secretariat</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EDHS</td>
<td>Ethiopian Demographic and Health Survey</td>
</tr>
<tr>
<td>ENUC</td>
<td>Emergency Nutrition Coordination Unit</td>
</tr>
<tr>
<td>EOS</td>
<td>Enhanced Outreach Strategy for child survival</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>EWS</td>
<td>Early Warning System</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organization</td>
</tr>
<tr>
<td>FMoH</td>
<td>Federal Ministry of Health</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GMP</td>
<td>Growth Monitoring and Promotion</td>
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<tr>
<td>GoE</td>
<td>Government of Ethiopia</td>
</tr>
<tr>
<td>HEW</td>
<td>Health Extension Worker</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HSBDP</td>
<td>Health Sector Development Programme</td>
</tr>
<tr>
<td>IDA</td>
<td>Iron Deficiency Anaemia</td>
</tr>
<tr>
<td>IDD</td>
<td>Iodine Deficiency Disorder</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IMAM</td>
<td>Integrated Management of Acute Malnutrition</td>
</tr>
<tr>
<td>IRT</td>
<td>Integrated Refresher Training</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>L10K</td>
<td>Last 10 Kilometres</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>NDPM</td>
<td>Nutrition development partners meeting</td>
</tr>
<tr>
<td>MICS</td>
<td>Multi indicator Cluster Survey</td>
</tr>
<tr>
<td>MOA</td>
<td>Ministry of Agriculture,</td>
</tr>
<tr>
<td>MOE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
</tr>
<tr>
<td>NNBC</td>
<td>National Nutrition Coordination Body</td>
</tr>
<tr>
<td>NIS</td>
<td>Nutrition Information System</td>
</tr>
<tr>
<td>NNP</td>
<td>National Nutrition Program</td>
</tr>
<tr>
<td>NNS</td>
<td>National Nutrition Strategy</td>
</tr>
<tr>
<td>OTP</td>
<td>Outpatient Therapeutic Programme</td>
</tr>
<tr>
<td>PLW</td>
<td>Pregnant and Lactating Women</td>
</tr>
<tr>
<td>PSNP</td>
<td>Productive Safety Nets Programme</td>
</tr>
<tr>
<td>RHB</td>
<td>Regional Health Bureau</td>
</tr>
<tr>
<td>SAM</td>
<td>Severe Acute Malnutrition</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WASH</td>
<td>Water and Sanitation</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Program</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1 Introduction

1.1 Key national statistics

Nutritional status

Recent UNICEF statistics indicate that in recent years Mali is making progress on the most relevant nutrition indicators underweight, wasting and stunting. This is a trend which has been visible since the beginning of the century as stunting levels declined from more than 40% (ca. 42%) to under 30% in 2012/13; underweight levels also fell from around 30% to less than 20%. Wasting levels also declined but less significantly as it fell from just over 10% to just under 10%.1 However, the reduction is not big enough to reach the MDG 1 target of halving hunger. The most recent figures (SMART 2012 and 2013) are only based on data collected in the Southern part of Mali excluding the three conflict-ridden regions of Tombouctou, Gao and Kidal, representing less than 10% of the total national population. Figures indicate that Acute Malnutrition in the North is higher than in the South whereas chronic malnutrition is lower in the North.

Within the regional context of West and Central Africa, the eleven nutrition relevant indicators presented below in table 1 indicate that Mali does not differ substantially from most of the regional indicators. The main deviations are found for ‘introduction to (semi-)solid and soft foods’ (lower for Mali), and supplementation of Vitamin A and iodized salt (higher for Mali).

<table>
<thead>
<tr>
<th>Key geographic, economic, and social characteristics</th>
<th>Mali UNICEF 2007-11</th>
<th>West and Central Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (2011)</td>
<td>15,480</td>
<td>411,864</td>
</tr>
<tr>
<td>Under-five mortality rate (infant mortality rate), both 2011</td>
<td>176/98</td>
<td>132/88</td>
</tr>
<tr>
<td>Life expectancy at birth (2011)</td>
<td>51</td>
<td>53</td>
</tr>
<tr>
<td>GNI per capita (PPP)</td>
<td>USD 1050</td>
<td></td>
</tr>
<tr>
<td>% of population below international poverty line of US$ 1.25 per day (2006-2011)</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>% of children (2007-2011) early initiation of breastfeeding</td>
<td>46</td>
<td>41</td>
</tr>
<tr>
<td>% of children (2007-2011) who are exclusively breastfed (&lt;6 months) (WHO threshold: &lt;50%)</td>
<td>38</td>
<td>25</td>
</tr>
<tr>
<td>% of children (2007-2011) introduced to solid, semi-solid or soft foods (6-8 months)</td>
<td>25</td>
<td>65</td>
</tr>
<tr>
<td>Antenatal care coverage at least once (at least four times)</td>
<td>70/35</td>
<td>71/45</td>
</tr>
<tr>
<td>Vitamin A supplementation coverage rate (6-59 months), full coverage (%)</td>
<td>96</td>
<td>83</td>
</tr>
<tr>
<td>% of households consuming iodized salt (2007-2011)</td>
<td>79</td>
<td>52</td>
</tr>
<tr>
<td>% of infants with low birth weight (2007-2011)</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from underweight (WHO), moderate &amp; severe (severe)</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from: wasting (WHO), moderate &amp; severe (WHO public health problem: &gt;10%)</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from: stunting (WHO), moderate &amp; severe (WHO: public health problem &gt;30% moderate, &gt;40% severe)</td>
<td>38</td>
<td>39</td>
</tr>
</tbody>
</table>

Source: Adapted from UNICEF.org/ Mali_statistics; State of World’s Children 2012; Global Nutrition report 2013; SMART 2012 and 2013

The two SMART studies 2012 and 2013 also give indications for the two ASNP target regions Sikasso and Mopti. In both years the two regions are below the average for South Mali (representing 90% of the total population) in terms of wasting and underweight; only in 2012 severe wasting in Mopti was higher than average. Stunting levels in Sikasso are higher than the average for Mali in both years. The figure for Sikasso is even the highest in the country with Koulikoro and Segou being the other regions with stunting levels higher than 30% and are therefore ‘seriously at risk’ according to WHO standards. This is the so-called “Sikasso paradox” as the region has the best conditions in the country for agricultural production in terms of natural and economic resources. Stunting levels are highest for the age groups 24-35 months and 12-23 months (respectively 35.7% and 31.7%), whereas wasting levels are highest for 6-11 resp 12-23 months (15.0% and 13.3%; SMART 2012). This clearly indicates that both chronic and acute malnutrition problems are concentrated in specific regions as well as for specific age groups.

### Table 2: Results of SMART surveys 2012 and 2013 for Mali-Sud and the two target regions

<table>
<thead>
<tr>
<th>Region</th>
<th>SMART 2012 (n= 9039 enfants)</th>
<th>SMART 2013 (n= 6354 enfants)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wasted</td>
<td>Severely wasted</td>
</tr>
<tr>
<td>Mali-Sud +Bamako</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td></td>
<td>8.6%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Sikasso</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Mopti</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.6%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

The estimated number (caseload) of under 5 (U5) children in Mali at risk to suffer from acute malnutrition in 2013 is estimated at 660,000 (210,000 SAM and 450,000 MAM; source Nutrition Cluster Juin 2013). For 2013, the Nutrition Cluster estimated target for treatment is almost 400,000 U5 children (270,000 MAM and 125,000 SAM) which represent about 60% of the estimated caseload. In Sept 2013, 55 per cent of the annual target caseload has been treated.

The caseload of chronic malnutrition in 2014 is estimated at about 1 million U5 children. Sikasso region represents the highest expected number of affected children, whereas Mopti is number five.

### Table 3: Expected caseload of stunted children in 2014

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>Chronic Malnutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% No of Children affected</td>
<td></td>
</tr>
<tr>
<td>Kayes</td>
<td>2.375.000</td>
<td>21.8 117.571</td>
</tr>
<tr>
<td>Koulikoro</td>
<td>2.885.000</td>
<td>31.2 197.126</td>
</tr>
<tr>
<td>Sikasso</td>
<td>3.149.000</td>
<td>32.8 237.384</td>
</tr>
<tr>
<td>Ségou</td>
<td>2.786.000</td>
<td>33.4 205.714</td>
</tr>
<tr>
<td>Mopti</td>
<td>2.426.000</td>
<td>21.7 114.313</td>
</tr>
<tr>
<td>Tombouctou</td>
<td>804.000</td>
<td>27.8 48.755</td>
</tr>
<tr>
<td>Gao</td>
<td>646.000</td>
<td>16.3 23.226</td>
</tr>
<tr>
<td>Kidal</td>
<td>81.000</td>
<td>13.6 2.208</td>
</tr>
<tr>
<td>Bamako</td>
<td>2.157.000</td>
<td>13.0 48.593</td>
</tr>
<tr>
<td>Mali</td>
<td>17.309.000</td>
<td>27.5 995.000</td>
</tr>
</tbody>
</table>

Source: UNICEF expected caseload stunted children 2014 (Based on SMART 2011 and 2013)

With regard to the utilization of specific high impact interventions the following table describes the situation on the basis of the most recent figures available. The table clearly indicates that the levels of Vitamin A supplementation and Deworming have reached almost general coverage in 2013. The utilization of iodized salt is lagging behind. This is reported to be caused by the lack of a legal basis for mandatory fortification of salt creating loopholes for imports of non-iodized salts. Fortification of salt is

2 UNICEF Mali Situational Report Sept 2013
3 UNICEF Internal Retreat ppt June 2013
voluntary. The table further shows that the levels of anemia with Under five children and pregnant and lactating women are still very high (resp 72%, 55% and 60%). The reduction of anemia levels by 2.5% per year is one of the expected results of the ANSP in Mali.

### Table 4: High impact interventions and anemia levels

<table>
<thead>
<tr>
<th>Indicator</th>
<th>%</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplementation of vitamine A</td>
<td>98</td>
<td>2013</td>
<td>DNS (SIAN 2013)*</td>
</tr>
<tr>
<td>Deworming</td>
<td>98</td>
<td>2013</td>
<td>DNS (SIAN 2013)*</td>
</tr>
<tr>
<td>Anaemia</td>
<td>72</td>
<td>2010</td>
<td>MICS</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>55</td>
<td>2010</td>
<td>MICS</td>
</tr>
<tr>
<td>Lactating women</td>
<td>60</td>
<td>2010</td>
<td>MICS</td>
</tr>
<tr>
<td>Iodized salt</td>
<td>64.4</td>
<td>2010</td>
<td>MICS</td>
</tr>
</tbody>
</table>

Source: UNICEF Nutrition internal retreat June 2013; * DNS/SIAN 2013 gives figures for Mali Sud only

Since 2003, during the six-monthly National Nutrition Week (SIAN) blanket supplementation of Vitamin A (6-59 month children and post-partum women) and deworming of U5 children has been taking place. Since 2008, also screening for Acute Malnutrition is being done by using MUAC. The National Nutrition Week appears to be a very successful approach to reach out to U5 children and their mothers with more than 80% of children being screened.

### 1.2 National Policy Framework in Nutrition Security

#### Policy framework

The national policy framework in Mali to promote Nutrition Security has changed considerably in 2013 with the adoption of the National Nutrition Policy (NNP). The Policy was adopted by the government of Mali in January 2013. Moreover, a plan of action was about to be finalized at the end of 2013 at the time the MTE was visiting Mali.

The adopted Nutrition Policy builds on the progress, lessons learned and insights achieved over the past few years. The Policy provides a clear overview of the institutional and nutritional context and analyses the causes and consequences of malnutrition, in particular the linkages with the achievement of MDGs. It sets out 14 strategies to achieve its general and specific objectives (to be realized in 2021). The interesting element of the Policy is its multi-sectoral orientation by including solid coordination mechanisms of the most relevant national institutions, implementing partners (technical partners, NGOs, civil society, private sector) and decentralized government levels.

The National Nutrition Policy builds on and includes earlier policies such as:

- Under the Ministry of Health:
  - Nutrition Feeding for Young Children, 2006
  - National Guidelines for Vitamin A Supplements, 2006
  - National Strategic Plan for Food and Nutrition, 2006
  - Ministerial Decree Governing the Code of Marketing of Breast Milk Substitutes, regulating the Marketing, Information and Control of the Quality of Breast Milk Substitutes, 2006
  - Protocol for the treatment of GAM is in place

- Under the Ministry of Agriculture:
  - National Program for Investments in the Agriculture Sector (PNISA) 2011-2015 and related National Priority Investment Plan (PNIP). The PNISA has been developed as part of the Comprehensive African Agriculture Development Program (CAADP) initiative at continental level.

source: Nyirandutiye DH, et al.; 2011
It appears that previous policies on Food and Nutrition – such as the National Strategic Plan 2006 – have not worked because of a lack of funding and clear priority-setting. Stakeholders also agree that the IYCF policy of 2006 is outdated and needs revision.

Since the beginning of 2013, a monitoring system has been in place for the registration of treatment of U5 children for Acute Malnutrition in one of the three UREN types of establishment (URENAM (MAM-cases), URENAS (SAM cases), URENI (SAM cases with complications) on the basis of the GAM protocol.

**Nutrition governance and coordination**

The 2013 National Nutrition Policy also includes the design of the coordination mechanisms for Nutrition Governance. This includes in the first place a National Nutrition Council (CNN), which will meet annually and will be attended by ministries involved in nutrition, the Food Security Commission, local authorities, and representatives from civil society and the private sector. It will be chaired by the Minister of Health. The Council will be accompanied by an Intersectoral Technical Committee on Nutrition (CTIN), supported by a Technical Secretariat under the Ministry of Health.

At decentralized levels – region, cercle and commune – the directors of health are the main coordinators of nutrition related programmes and activities. As head of the their respective health departments they liaise with the Regional/Local/Communal Development Committees (COCSADs) for the implementation, coordination and monitoring of the National Nutrition Policy.

Mali has joined the SUN Movement in March 2011. The Nutrition Advisor in the Ministry of Health serves as the SUN Government Focal Point. He was involved in the coordination of the small multi-sectoral group which worked together to develop the National Nutrition Policy and supported the process which led to its technical validation.

The Government has established a Restricted Technical Secretariat (‘Comité Restreint’) composed of different Ministries relevant for Nutrition Security (Ministry of Health, Agriculture, Social Development, Education) and the SUN facilitator as well as the two REACH facilitators. This is the core multi-sectoral committee to coordinate nutrition related policy-making in Mali.

A number of interviewed stakeholders have indicated that it is clear that the capacity of the government to implement the existing policies, in particular at decentralized levels, is insufficient. The concept of nutrition and its multidimensional character is poorly understood by the different ministries relevant for nutrition, eg. Ministry of Agriculture or Education.

It has been observed on several occasions that more and more already established projects seek to add a nutritional component and intend to go beyond the former approach of only screening and treatment. In order to create consistency and avoid overlap between projects, there appears to be a need for (standardised) monitoring and evaluation of these projects within government which is currently lacking (personal communication, staff Ministry of Health).

### 1.3 Technical and financial partners in Nutrition Security

Technical and Financial partners active in the field of Nutrition (both emergency and development-oriented) are represented in the Mali Nutrition Cluster in the context of the IASC Global Nutrition Cluster (GNC), of which UNICEF is the Lead Agency. The Nutrition Cluster brings together about 70 different organisations (UN, national and international NGOs, donors, Government of Mali etc.). About 30 NGOs are implementing Nutrition programmes (Screening and treatment of GAM and/or SAM, blanket feeding, IYCF, etc). Most of them (22 out of 31) have become involved in IYCF-type of activities. About 85% of the 1860 Health Centres are receiving support from these technical and financial partners. There are four Nutrition sub-Clusters established at regional level, including Mopti where UNICEF is co-lead together with the Regional Director Health under the MoH.

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Mali is one of the twelve countries in which a REACH Secretariat has been established to provide joint and coherent support by the four relevant UN organisations to the government of Mali. REACH advocates for a multi-sectoral and multi-stakeholder approach to fight malnutrition, in order to improve the impact of nutritional interventions. Since late 2012 (but officially launched in Jan 2013), its secretariat has been established within WFP and is composed of a national and international facilitator. The Mali REACH team includes the nutrition focal points from UNICEF, FAO, WHO, WFP, the Government and the REACH Facilitators. UNICEF actively contributes to the coordination of nutrition related activities through REACH. REACH has been involved in providing technical support to the formulation of the National Nutrition Policy as well as its Plan of Action, costing of activities and its communication plan. REACH is working jointly with the Mali SUN Government Focal Point to achieve the formulated nutrition priorities; amongst other by the strengthening of institutional capacity for improved national nutrition governance and the development of a National Multisectoral Nutrition Information System.

The World Food Programme (WFP) in Mali is an important partner when it comes to nutrition-specific activities in including treatment of moderate acute malnutrition, prevention of acute and chronic malnutrition and addressing micronutrient deficiencies through local food fortification, local production of nutritious foods and the distribution of MNPs. The World Health Organisation (WHO) is focusing on the policy making with regard to health including nutrition.

The ANSP Mali project has a national embedding through a technical committee of 14 members which includes the most relevant government Ministries, REACH and SUN facilitators, as well as other organisations such as ANSSA of the National University and ASDAP, an NGO active in health and partner of UNICEF. This wide representation reflects the expectations created by the project’s ambitious objectives as they were communicated. A smaller Task Force has been established to coordinate project implementation.

2 Findings

2.1 Overall Relevance and Appropriateness

*Mali country programme design*

The ANSP Mali country programme is based on the overall ANSP programme design. The Mali logframe as developed at the start of the programme presents about 20 activities divided over the four result areas to be realized in the course of the four years of implementation (4-6 activities per result area). The Mali Workplan for year 3 (Oct 2013- Sept 2014) integrates most of the activities originally identified but puts them in a more logical order of expected outputs and related activities. The following figure provides an overview of the expected outputs as presented in the Mali workplan for year 3.

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6 source: WFP: PAM au Mali ppt, July 2013
Coherence, completeness and complementarity to other initiatives

The design of the ANSP Mali country programme raises the following observations with the MTE:

1. The ANSP programme in Mali is very relevant to respond to the need to reduce chronic malnutrition in the country.

   Given the country context with the high levels of chronic malnutrition (in particular in three provinces which are seriously at risk) and the high caseload of chronic malnutrition (about 1 million U5 children), the ANSP programme is highly relevant for Mali. Despite the fact that Mali is a ‘rather average’ country in terms of relevant nutrition indicators as compared to the other countries in the West and Central African region, the U5 mortality rate is higher than the average for the region, even one of the highest in the world (rank 3). It is estimated that about one-third of the mortality is caused by or related to undernutrition. This is related to the low figures for exclusive breastfeeding and the poor practice of appropriate Infant and Young Child Feeding (IYCF). The programme design has set clear quantified expected results under Pillar 4 to be reached during its implementation period (Chronic Malnutrition reduced by 4%; Anemia reduced by 10%; and 60% of mothers applying optimal IYCF practices in the selected project target areas).

2. ANSP-Mali builds upon previous activities in the country and is based on a wide network of development and emergency partners

   The strength of the ANSP design is its foundation on UNICEF’s existing nutrition activities when it comes to management of Acute Malnutrition, IYCF and its contribution to the development of national policies. As lead of the Nutrition Cluster UNICEF interacts, coordinates and collaborates with a wide range of technical and financial partners including many national and international NGOs implementing nutrition emergency and development programmes. For instance, UNICEF is contributing with financial (and often technical) support to about 30% of all Health Centres in the country through thirteen international and national NGOs, such as Alima, Acted, Catholic Relief, ASDAP, Terres des Homme, Médecins du Monde, etc. Furthermore UNICEF is well –established as

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7 source: Nutrition Cluster 2013
partner in the REACH initiative which is an important partner for the Government of Mali. This country experience and network makes it possible for UNICEF to pursue and scale-up nutrition-specific and/or relevant activities in the country. Within the context of ANSP, ASDAP is the main implementing partner. UNICEF and ASDAP have been working together on Nutrition issues (in particular MAM) since 2008 when a first agreement was signed. At this moment, UNICEF is supporting ASDAP in 8 districts in 4 regions including the two target districts Bankass (Mopti region) and Yorosso (Sikasso region).

Vesting, however, the ANSP programme on previous activities and existing networks creates the risk that the new programme remains too much focussed on these activities and lacks the dynamic reorientation of reducing chronic malnutrition and anaemia. For instance the presentations of the UNICEF Nutrition 2013 retreat is mainly focusing on the Management of Acute Malnutrition and less so on the multisectoral prevention of Chronic Malnutrition including nutrition-sensitive activities. (We will explore this further under 2.7 Pillar 4 Scaling-Up).

3. The design of the Mali programme reflects the situation at the time of its formulation (2010-11). The Mali programme component operates in a rapidly changing nutrition policy environment and context. The ANSP design does not reflect this highly dynamic situation, nor has it been responsive to it.

In 2012, the political and social situation of Mali changed dramatically as a result of the insurrection in Northern Mali and the consequent Coup d’Etat in March 2012. Amidst an emerging food and nutrition crisis as a result of poor harvests late 2011 – the conflict brought about the halt of many emergency and development activities including health and nutrition activities. The consequent 2012-13 political turmoil resulted in many changes at Ministerial level and new priorities. However, the many changes also brought a new dynamic with regard to nutrition policy making and governance: the National Nutrition Policy was adopted in January 2013 and a Nutrition Plan of Action is about to be finalized. Together with other initiatives to implement the new Nutrition Policy, the environment in which the ANSP has been designed has changed dramatically. Coordination mechanisms have been formulated and set-up within government and (see 1.2 policy context)

Moreover, Mali joining the SUN movement in March 2011 and the initiation of the REACH coordination in late 2012 has substantially complemented to the changes of the policy environment for nutrition governance. To these substantial changes can be added the international nutrition-relevant initiatives around AGIR and CAADP, which are also incorporated in Mali.

This highly dynamic policy environment for nutrition governance which emerged after the ANSP formulation but before the ANSP inception workshop held in Bamako in March 2012, is not reflected in the formulation of concrete activities. Most of the activities as formulated in the Mali logframe and summary sheet (both dated 2012) have for instance not incorporated the SUN indicators of progress, nor the REACH initiative.

4. The design of the ANSP lacks a clear situational and causal analysis of chronic malnutrition in Mali.

The design of the ANSP Mali programme is not based on a clear situational analysis and description of chronic malnutrition in Mali as a whole nor in the country’s different regions. It also lacks a clear underpinning for the choice of the two regions Mopti and Sikasso, though the latter has the highest level of chronic malnutrition in the country. ANSP Mali claims that UNICEF activities are built on the basis of high-impact interventions but does not make explicit which interventions it is prioritizing and in which way these might be effective and efficiently implemented. Of course, UNICEF – and its nutrition partners – are aware of the situation of chronic malnutrition in the country. But this knowledge has not been made explicit to describe the political, socio-economic and institutional situation surrounding nutrition governance on which its implementation strategy must be based.

One of the issues is that the figures of undernutrition levels including stunting and wasting has differed considerably over the past 10 years from the 2006 DHS to 2010 MICS and the SMART survey results 2011-2013. The reason of this sharp decline is not understood; whether this is a real improvement or one only in figures is not known but has substantial implications for the ANSP strategy, for instance ‘what is the basis of this improvement?’
5. The multi-sectoral dimension of ANSP has been put high on the agenda during the Bamako February 2012 inception WS; this is reflected in the design of the ANSP Mali programme

There is wide recognition by the Malian Government and its Technical and Financial partners that the goal of reducing chronic nutrition is to be achieved through multi-sectoral coordination and cooperation. The UNICEF inception report of June 2012 (based on the Inception WS held in Bamako in March 2012) reflects this emphasis on ‘a multi-sectoral approach linking nutrition to food security, agriculture, and poverty alleviation’. This is unmistakably reflected in the design of the ANSP activities under the four Pillars (eg. Expected outputs 1.3, 2.1, 2.3, 3.1 and 4.1).

**Programme monitoring framework**

6. The ANSP Mali logical model, logframe, annual work plans and budget are not always consistent and coherent to present a comprehensive framework for Monitoring and Evaluation

The ANSP Mali country programme is based on the ANSP logic model including activities, outputs and outcomes, which should guide its monitoring and evaluation. As is the case with the other ANSP programme components – including WCARO – monitoring of progress is foremost based on the activities as formulated in the logframe and the overall ANSP progress indicators. However, the presentation of the Mali activities has changed over the years which makes it difficult to assess progress and achievement of key indicators. Moreover, the logframe does not stipulate the partners which are also influencing the achievement of certain expected outputs, as is the case for instance with the development of the National Nutrition Policy, its plan of action and the costing of the Plan. UNICEF is one of the contributing co-facilitators in this process amongst others. The same applies to more or less extent to the other ANSP pillars and related expected outputs and outcomes.

The two ANSP Interim Reports reporting against the workplan of activities do not make clear what the contribution of the Mali programme has been towards achievement of the formulated indicators of progress.

As is the case with the WCARO programme component, the Mali logframe and annual work plans are not always clearly consistent with the annual budget: activities presented in the logframe do not have a budget and activities presented in the budget cannot be found in the logframe.

2.2 Equity Focus

Mali has an average level of chronic malnutrition of about 28% (SMART 2011-2013) which has decreased from 38% in 2006 (source: DNS 2006). Within the WCA region, the former figure indicates a better than average figure as compared to other countries in the region as a result of a rapid decline. However, there are great differences within Mali with three regions being above the intervention threshold of 30%, Sikasso being one of these regions. The selection of pillar 4 regions is based on the high prevalence of stunting: Sikasso and Mopti are 1 and 5 in Mali. The case of Sikasso being number one in terms of stunting prevalence is very particular as the conditions for crop production are best in this region with a good rainfall pattern, relative fertile soils and a well-established institutional (eg agricultural extension) environment. This is called the “Sikasso Paradox”. Causes of chronic malnutrition are several: the level of selling of crops including cotton and maize which income is managed by men, the consequent high workload of women in cotton and maize production, as well as the high levels of indebtedness by farm households due to low prices. Also inadequate nutrition practices are being cited.

It is not clear why the Mopti region has been selected. The region has the fifth highest stunting levels in the country, after Sikasso and four more regions. The Mopti Region has 8 districts (‘cercles’) of which three in the Delta Interieur du Niger (the floodplain) and five in the dryland area. Three of the eight districts have been directly affected by the 2012 crisis: Douentza was occupied; Tenenkou and Youvarou were under attack by rebels.

The selection criteria for the specific districts is not clear as the current UNICEF staff were not present when the selection was made. Mainly practical reasons have been mentioned such as: Bankass is
one of the six (now eight) districts (in three regions Mopti, Segou and Sikasso) where ASDAP is working with UNICEF funding. It is also relatively well endowed and reachable, increasing opportunities of success. Yorosso has been selected as it reflects the ‘Sikasso paradox’ (people produce but do not properly feed themselves, or, more popularly: “paradox of plenty – hunger in a bountiful world” as has been elaborated in neighbouring regions in Burkina Faso, where the same applies. Both districts (Bankass and Yorosso) show high levels of anaemia: 80% for children <5 and 52% for Pregnant Women).

The ANSP has a strong focus on reaching out to:
- women and children 0-23 months
- poor rural households

However, no distinction has been made for different livelihood systems, eg, agricultural, pastoral or fish-based. Neither is there a distinction for wealth quintiles and accessibility.

Responsiveness to barriers and bottlenecks are not explicitly integrated in the design and implementation of the ANSP-Mali activities.

2.3 Pillar 1: Policy Development

2.3.1 Relevance and appropriateness

<table>
<thead>
<tr>
<th>Pillar 1: Up-stream policy development and nutrition security awareness</th>
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<tbody>
<tr>
<td><strong>Expected Result 1:</strong></td>
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<tr>
<td>Africa’s key policy-makers &amp; leaders of civil society committed to review Plan of Action on Nutrition ensuring that adequate support is provided to implement nutrition action plan for an effective and sustainable socio-economic development</td>
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<tr>
<td><strong>Mali main activities:</strong></td>
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<tr>
<td>1.1 Elaboration of a costed national nutrition multi sectoral action plan.</td>
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<td>1.2 Development and dissemination of nutrition advocacy tools.</td>
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<td>1.3 Support the National Multi-sectoral development of nutrition committee and the Technical Committee</td>
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<tr>
<td><strong>Expected outputs</strong></td>
</tr>
<tr>
<td>• National nutrition policy developed and disseminated</td>
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<tr>
<td>• A five year multisectoral nutrition action plan available and roll out.</td>
</tr>
<tr>
<td>• Advocacy tools and strategic documents elaborated and disseminated.</td>
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Activities originally proposed, as presented in the logframe
- Elaboration of a costed national nutrition multi sectoral action plan.
- Development and dissemination of nutrition advocacy tools.
- Advocacy for nutrition at the community level, regional assembly and local councils.
- Support to the National Multi-sectoral development of nutrition committee and the Technical Committee.
- Support the post of Nutrition Adviser/ focal point in the Office of the Minister at Ministry of Health.
- Advocacy for increased budget allocation for nutrition in the health, agriculture and social protection sectors.
- Increase awareness on linkages between nutrition and food security.

Source: ANSP Mali Country Summary sheet; ANSP Workplan 2013

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8 As noted in the ACF case study “The maps of food insecurity and malnutrition only partly overlap: certain regions of relative food security show high malnutrition rates. This phenomenon is commonly known as the paradox: of having both high productivity, rich soils, and yet malnutrition. In Burkina Faso the paradox applies to the Boucle du Mouhoun region in the West, while in Mali it applies to the neighbouring Sikasso region. Reasons cited are amongst other the heavy workload of women, inadequate nutrition practices, and low income due to unfair pricing of the crops produced.

9 SMART surveys 2012.
With regard to the design of this pillar, the MTE has the following observations:

1. Support to the formulation of the National Nutrition Policy, the related plan of action for its implementation including a costing plan, communication plan is very relevant as this represents a major step towards improving nutrition governance and the implementation of nutrition-specific and relevant actions. However, UNICEF is one of the partners contributing and supporting the Nutrition Policy formulation process; in particular in the context of REACH there are other relevant partners as well such as WFP, FAO and WHO. This is not reflected in the way the expected outputs and activities have been formulated. For instance, in the workplan for year 3 no other partners are mentioned than the Ministry of Health and Cornell University (though it is not clear at all what the role of the latter would be).

2. In the design of the Pillar there has barely been any attention paid to the support to the implementation strategy of the National Nutrition Policy at decentralized levels, in particular regional and district levels. The multi-dimensional character of nutrition security is mentioned but the ‘how to’ has not been incorporated in the strategic priorities.

3. Nowhere in the design, logframe or annual workplans has been indicated the purpose, strategy and type of activities with regard to the ‘development and dissemination of nutrition advocacy tools’.

4. The support to the Nutrition committee, national focal point, and technical committee is very relevant for the strengthening of the Nutrition Governance in Mali and is in line with the REACH partnership and the SUN movement.

5. It is surprising that there is no mention of the UNICEF support to the revision of the 2006 IYCF policy and tool development. Also there is no mention of another priority of the Nutrition Division which is the formulation of a directive for the use of Micro-Nutrient Powders. The DN has indicated that they urgently need capacity support for its development and implementation in the country (source: MoH/DN personal communication).

2.3.2 Effectiveness

7. In Mali nutrition policies are now in place; but new priorities and gaps are emerging

Since the start of ANSP early 2012, result 1.1 has been achieved: the National Nutrition Policy has been developed to minimize the adverse effects of malnutrition on health and economic development, has been formulated and disseminated, the Multi-sectoral Nutrition Action Plan (2013-2017) on the basis of the NNP has been formulated (Final draft Sept 2013; still to be formally approved), a costing plan is underway, and the remaining elements (such as a communication plan) are being developed. The NNP was given high priority following the National Forum on Nutrition held in 2010 and despite of the political crisis of 2012-13. These achievements represent a major step forward in improving the nutrition policy environment in Mali on which future programmes and actions will be vested. As indicated before, in the context of REACH, UNICEF has significantly contributed to the development of the NNP and its Plan of Action 2013-17. However, the costing of the Plan of Action implying the valuation and standardisation of the costs for implementing the strategies to scale up nutrition based on agreed unit costs of effective interventions, is coordinated by the World Bank.

One element which is poorly developed in the policy and action plan is the Coordination at decentralized levels and collaboration between different sectors (NNP §4.2.2). This is a key element to the further success of the policy and needs to be better elaborated. Furthermore, as indicated, the formulation of a micro-nutrients supplementation directive is one of the MoH priorities which deserve more explicit attention.

8. Coordination and governance of the Nutrition sector appears to be strengthened and effective

Also ‘expected result 1.3’ has been achieved since the start of ANSP in Mali. It is obvious that the Nutrition Governance in Mali has been greatly strengthened over the past few years (see also above 1.2 Nutrition Governance and coordination): Mali has joined the SUN movement, a SUN focal point is in place and Mali is actively participating and contributing to the movement; REACH coordination in which UNICEF is actively participating, is in place with a national and international facilitator and four UN focal points; together the REACH coordination team has played – and is playing – an important role in developing the technical dimension of the NNP and action plan, in particular by supporting the process of bringing together all relevant stakeholders and making a comprehensive multi-sectoral nutrition situation analysis.
9. **UNICEF is actively contributing to the IYCF strategy review but this is not mentioned under the ANSP activities**

UNICEF has actively contributed to and support to the revision of the IYCF strategy and tool development (modules, training material, C4D, illustration material, monitoring, etc). This is an important element in the National Nutrition Policy and Action Plan to reduce chronic malnutrition and one of the priorities for the Nutrition Division of the Ministry of Health and it is one of the priorities for Scaling-Up under Pillar 4 (See below). The revised strategy was expected to be finalized in August 2013 but this was delayed till December, whereas the training of trainers on IYCF will take place in January 2014 (source: UNICEF ppt 2 Nutrition Retreat, June 2013; MoH/DN personal communication).

Given the fact that this is a core element of the strategy to Scale Up nutrition interventions, it is remarkable that this is mentioned neither in the logframe, nor in the work plans.

10. **An advocacy strategy has not come off the ground nor the situational analysis of capacities and gaps**

An advocacy strategy has not been developed by UNICEF in Mali. Moreover, advocacy tools such as a nutrition handbook, a cartoon and a comic book are claimed to be developed by UNICEF, but have not yet been made available to the MTE team. Also there is no sign that ‘a situational analysis of capacities and gaps’ in nutrition – as is presented in the ANSP Mali Logic model 10 has been done. Admittedly, however, all activities related to capacity building (pillar 2) have been suspended – section 2.4 refers.

### 2.4 Pillar 2: Capacity Development

#### 2.4.1 Relevance and appropriateness

<table>
<thead>
<tr>
<th>Pillar 2: Institutional development and capacity development</th>
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<tr>
<td><strong>Expected Result 2:</strong></td>
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<td><strong>Mali main activities:</strong></td>
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<td><strong>Expected outputs:</strong></td>
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<td><strong>Activities originally proposed, as presented in the logframe:</strong></td>
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*Source: ANSP Mali Country Summary sheet 2012; ANSP Workplan 2013*

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10 source: Interim Report Yr 1 Sept 2012
Two observations are made with regard to the design of Pillar 2:

1. In the Mali Logframe and workplan a good number of expected outputs and main activities have been formulated. In the workplan for year 3 the detailed activities are sufficiently spelled out and provide a coherent framework for enhanced capacity building by strengthening educational institutions in the country.

2. The pillar 2 targets the support to improve capacities at different levels (high schools, specialized professional institutions and university level) and for diverse categories of target groups from different professional background: community health workers, health volunteers, health nurses, medical doctors and agronomists. This is a very ambitious programme which does not clearly provide a clear focus and priority-setting in particular with regard to the specific target groups of which the capacities are to be improved in order to contribute to the ANSP country objectives. Moreover, the initiative to establish a Master Course on Nutrition could be supported from the region-wide WANCID initiative.

2.4.2 Effectiveness

11. None of the above mentioned activities under Pillar 2 Capacity development have materialised. All actions are deferred to year 3 (2014). UNICEF Mali has implemented only a number of preparatory activities with regard to the three activities identified. Preliminary talks have been held with the Nurse Teaching School and the University of Bamako. A proposal has been received for the set-up of a Nutrition Master, which has been commented by UNICEF-Mali and the WANCID coordinator based in Burkina Faso (source: Etat d’avancement ANSP Nov 2013).

12. The MTE signals substantial doubts on some of the above strategic choices made

The priority given to provide support the development of a Nutrition Master within the Faculty of Medicine is considered by many involved a “dead end”. The MTE agrees with this position. So far – after more than one year of discussions – it appears that no MSc in Nutrition will be established but that it concerns a specialisation under the MSc of Public Health. Furthermore, the budget solicited is relatively high (USD 258,000) as compared to other ANSP budget items and there is no clear justification of the costs involved. After several requests by UNICEF, the Faculty has not been able to come up with an outline of the programme of instructions and the expected nutrition modules. 11 The report of the backstopping mission by the WANCID coordinator to Mali indicates that the priorities should be –amongst others – with the gradual introduction of nutrition training courses at different levels but foremost at professional level (‘licence professionelle’), and with the development of nutrition modules for the training courses of health, agriculture and other rural development professionals. This mainly concurs with the expected outcome 2.1. Another priority suggested is the organisation of summer courses on nutrition, but the target group for these courses is not indicated. A general recommendation was made that the revision of nutrition curricula should be aligned with the standards as developed by the West African Health Organisation or the capacity enhancement of community resource persons. Also it was observed that certain budget lines wer not well substantiated. 12

The MTE team fully concurs with these observations and is of the opinion that the emphasis under Pillar 2 should go to Capacity Development activities which can contribute more significantly to the ANSP Mali objectives instead of spending large amounts on an activity with relative little potential impact, such as the revision of nutrition material for professional training of nurses and agronomists.

11 UNICEF Mali – personal communication Nov 2013
12 Roger Sodjinou Rapport de Mission au Mali, July 2013
## 2.5 Pillar 3: Information systems and knowledge

### 2.5.1 Relevance and appropriateness

<table>
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<tr>
<th>Pillar 3: Data analysis and Knowledge sharing</th>
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<td><strong>Expected Result 3:</strong></td>
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</table>
| **Mali main activities:** | 3.1 Support integration of nutrition indicators into the health information system and the food security early warning system  
3.2 Conduct national nutrition SMART survey  
3.3 Documentation of the implementation of nutrition interventions at scale |
| **Expected outputs:** | • Nutrition information available on regular and timely manner.  
• Nutrition indicators integrated into the national health information system and the early warning system. |

Activities originally proposed, as presented in the logframe:
- Implementation of national nutrition surveys using SMART methodology.
- Implementation of food and nutrition vulnerability of urban population (VAMU) in 2 urban areas Bamako and Yorosso (Sikasso Region).
- Production of bi annual bulletins on nutrition and food security Early Warning System.
- Support the integration of nutrition indicators in the national health system.
- Documentation of the implementation of nutrition interventions at scale (process, bottlenecks and lessons learnt).

*Source: ANSP Mali Country Summary sheet 2012; ANSP Workplan 2013*

With regard to the relevance and appropriateness of the Pillar 3, the MTE has the following observations:

1. The support to the integration of nutrition indicators (3.1) and the implementation of SMART (3.2) are highly relevant given the limited capacity and financial means of the Mali Government to do so. Moreover, they provide the opportunity to harmonize the monitoring and analysis of relevant nutrition indicators and improve coordination and action.
2. The main activities however do not address the quality of data collection and information management.
3. The documentation of implementation of nutrition interventions (3.3) should be addressed under Pillar 4 as it mainly addresses the issue of bringing to scale. Documentation is highly relevant for deriving lessons learned and the formulation of good practices on the basis of the practical experience of scaling-up interventions.
4. The Pillar 3 does not address the issue of providing appropriate and relevant information with regard to the context and data (both at national level but also of the target areas) relevant for the achievement of the specific programme objectives of reducing chronic malnutrition and anemia and improving nutrition governance. A clear baseline against which changes can be evaluated is absent.

Several of the activities listed above belong in the domain of early warning and emergency response. Although valuable in themselves these show the somewhat hybrid nature of ANSP where ANSP funding is used to continue emergency-related activities.

### 2.5.2 Effectiveness

13. The integration of nutrition indicators has been successfully implemented for the monitoring of Acute Malnutrition

The ANSP Year 1 Annual Report – Mali Annex indicates that “UNICEF has also developed, in collaboration with Nutrition Cluster partners, a simplified tool and a revised protocol for the integrated
management of acute malnutrition in May 2012. Since then, UNICEF has supported the training of about 3,400 health workers on this tool and monitoring system.” A guide has been developed by UNICEF and disseminated.

This Nutrition monitoring system (‘Surveillance Nutritionelle’) has started to operate since the beginning of 2013 under the responsibility of the Ministry of Health/ DNS. The monitoring system is based on the revised protocol for the Management of Acute Malnutrition which was adopted in 2012. The ‘Surveillance Nutritionelle’ presents the information of admissions at the different levels (Moderate, Severe and with Complications) as well as the U5 mortality on a weekly basis and per region. At the end of 2013, about 250,000 children (MAM, and SAM) were admitted into the system which represents about 38% of the expected caseload. Out of 594 reported death, about half were reported from Sikasso. No indication has been found why this is the case.

The different partners under the Nutrition Cluster have decided to adopt this MAM monitoring tool and are reporting on a weekly basis. The analysis of findings is done regularly by the Ministry of Health/DN, disseminated (for instance on www.humanitarianresponse.info) and discussed by the members of the Nutrition Cluster. As such it has become a relevant part of the national Health Management Information System providing regular, up-to-date and relevant information for decision-making.

14. The introduction of the SMART methodology for the implementation of national nutrition surveys has been a great success

In close collaboration with WFP and WHO, UNICEF has supported the National Statistics Institute (INSTAT), – as well as the MoH/DN and the National Public Health Research Institute – to introduce and implement the SMART methodology for the collection of relevant nutritional information (and of child mortality). This is done in order to strengthen the collection of information on child development in a systematic way to be able to monitor progress and to evaluate the impact of interventions. The standardisation and harmonisation of the collection of nutritional information relevant for all stakeholders in the country is a great advancement as compared to the past. UNICEF has significantly contributed to the introduction of the SMART approach to data collection and analysis and the training of implementors at the different levels. Capacity to implement the SMART methodology has greatly improved. The INSTAT is the prime government organisation responsible for its implementation. It does so in close collaboration with the Ministry of Health-DN/DNS.

Various stakeholders have indicated that the standardized, rapid and simple way of data collection and reporting is of great significance; in particular the rapidity of implementation, analysis and reporting provides a major advantage over the previous approaches used (DHS and MICS). It must however be mentioned that the introduction of the SMART already started long before the start of the ANSP programme. The ANSP funding however made it possible to continue the (technical and financial) support to the SMART implementation in Mali in 2012 and 2013 (though only in the South of the country). It was decided to implement the survey in the month of June at the start of the lean period. Unfortunately in 2012, the implementation took place about a 2-3 months later than in 2011. This was due to the insistence of some stakeholders to do the SMART survey also at district level; this has proven to be disruptive for the overall survey as the commitment to do consecutive surveys in the same season could not be kept.

15. (Most) other planned activities under this pillar have not been implemented

Planned activities as presented in the Mali logframe have not been implemented. These are:

- Documentation of the implementation of nutrition interventions at scale (process, bottlenecks and lessons learnt).
- Implementation of food and nutrition vulnerability of urban population (VAMU) in 2 urban areas Bamako and Yorosso (Sikasso Region).

As indicated under the design it may indeed be questionable whether these activities are (still) relevant and appropriate. UNICEF has however not reported why these activities are left out.

- Production of bi annual bulletins on nutrition and food security Early Warning System and integration of nutrition indicators in EWS.

UNICEF claims to have contributed to the inclusion of the outcome of the SMART survey in the Early Warning Bulletin (Second Interim Report). It is not clear to which Bulletin UNICEF is referring, but
FEWSNET is the best known. It is however the main policy of FEWSNET to ‘include nutrition (and mortality) indicators in early warning analysis’ \(^{13}\)

16. **The analysis of nutrition indicators points at a downward trend but figures are not always consistent; the important indicator of anaemia (for U5 and women) has not been recorded since 2010.**

As earlier indicated the trend of relevant nutrition indicators over a period of twelve years (2001-2013) is clearly downward in particular of the underweight and stunting indicators. The methodology applied over this period has changed substantially from DHS and MICS towards SMART. Besides for the years 2012 and 2013 it was only possible to implement the national survey in six regions (and Bamako) as a result of the conflict in the North. It appears that since the introduction of the MICS in 2010 the downward trend has considerably weakened and that the main nutrition indicators are more or less at a constant level. It is not clear whether this break in the trend is due to external factors or that the change of data collection has had some effect. So it a question whether the data range is consistent over the years.

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<tbody>
<tr>
<td>% Underweight U5: moderate &amp; severe</td>
<td>33,2</td>
<td>26,7</td>
<td>18,9</td>
<td>19,7</td>
<td>20</td>
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<tr>
<td>% Wasting U5: moderate &amp; severe</td>
<td>10,6</td>
<td>15,2</td>
<td>8,9</td>
<td>10,4</td>
<td>10,0</td>
<td>8,9</td>
<td>8,6</td>
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<tr>
<td>% Wasting U5: severe</td>
<td>1,6</td>
<td>5,9</td>
<td>1,9</td>
<td>2,2</td>
<td>2,1</td>
<td>2,3</td>
<td>1,9</td>
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<tr>
<td>% Stunting U5: moderate &amp; severe</td>
<td>38,2</td>
<td>37,7</td>
<td>27,8</td>
<td>27,0</td>
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<tr>
<td>% Anemia U5</td>
<td>82,8</td>
<td>81,2</td>
<td>71,9</td>
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<td>% Anemia Women</td>
<td>73,4</td>
<td>67,6</td>
<td>55,0</td>
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17. **The SMART methodology is to some extent more oriented towards emergency situations and less so to address a broad range of chronic malnutrition indicators**

The SMART Methodology is a survey method developed to focus to a large extent on a rapid assessment of emergency situations. Hence it intends to assess the nutritional status of U5 children and the mortality rate in order to evaluate the magnitude of a crisis situation rather than indicators assessing chronic malnutrition. This is also reflected in the implementation of SMART in Mali. For instance, the SMART methodology does not assess anemia, which makes it difficult to evaluate the trends and progress on one of the important indicators relevant for the ANSP achievement. SMART does instead assess the nutritional health status of women of childbearing age (15-49) through upper-arm measurement and body mass index as an indicator of chronic energy deficiency. Other important indicators relevant for chronic malnutrition such as early initiation and length of Exclusive Breast Feeding or the application of appropriate IYCF practices are not addressed under SMART in Mali. Also in the SMART of Oct 2012 for the two target districts Yorosso and Bankass these additional indicators were not incorporated. UNICEF backstopper for data management however indicated that the introduction of SMART has been incremental to the extent that gradually new indicators will be added. For instance, in the near future IYCF practices might be included in the SMART methodology.

\(^{13}\) source: FEWSNET website
2.6 Pillar 4: Scaling-Up

The ANSP Mali logframe for Pillar 4 includes the following expected results and outputs:

### Pillar 4: Scaling up interventions

**Expected Result 4:**
National comprehensive nutrition programmes implemented in coherent, coordinated and synergetic manner with other sectors such as food security; health, WASH and social protection.

**UNICEF Mali:**
4.1 Support to scaling up community-based nutrition interventions in two districts Yorosso (Sikasso region) and Bankass (Mopti region).
4.2 Integrated multi-media behaviour change communication strategy
4.3 Agree on a standard monitoring system to be put in place

**Expected outputs**
- Rate of chronic malnutrition is reduced by 4%
- Prevalence of anemia is reduced by 10% (2.5% per year)
- At least 60% of mothers with children from 0-24 months year old have adopted and applied optimal infant and young child feeding in 2 districts of Yorosso and Bankass.

**Activities originally proposed, as presented in the logframe:**
- Technical assistance to scaling up nutrition interventions at different levels (national, sub-national and community) including communication for development.
- Support to scaling up community-based nutrition interventions in two districts Yorosso (Sikasso region) and Bankass (Mopti region).
- Conduct a detailed assessment on the community based nutrition activities in place in the two areas.
- Conduct a baseline survey.
- Design a multi-sectoral community nutrition model to implement in the targeted areas.
- Training in communication skills as well as counselling and support of health workers and community volunteers.

*Source: ANSP Mali Country Summary sheet; ANSP Workplan 2013*

2.6.1 Relevance and appropriateness

With regard to the relevance of the design of Pillar 4 Scaling Up nutrition interventions, the MTE has the following observations:

1. The proposed activities as formulated in the Mali logframe – and later reformulated in the Workplan Yr 3 (Sept 2013) – activities are not always in line with the Mali ANSP logic model. The Mali ANSP Logic model points at:
   - Consumption of animal products or iron-fortified foods; coverage of social protection schemes;
   - Improved hygiene among others. through handwashing and sanitation;
   - IYCF and maternal nutrition counseling;
   - EBF and continued BF; complementary feeding at 6 month; minimal acceptable diet, etc.
   - Supplementation: MNPs, Vitamin A
   - Government delivery system in place and micronutrient supplements are available

The planned activities as presented in the Mali logframe and under Workplan Yr 3 (of Sept 2013) only emphasize assistance and support to Scaling Up interventions and the design of a "multi-sectoral community nutrition model". But there is no reference to, nor prioritisation of the above mentioned logic model activities.

2. Moreover, there is no systematic assessment nor strategizing how to integrate these activities into the comprehensive multi-sectoral nutrition model which can be implemented at district level given the available capacity; the main focus is on IYCF and nutrition counseling.

3. The expected outputs as formulated in the Mali logframe are more at outcome level than outputs.

4. The expected outputs for Pillar 4 are formulated in terms of quantitative results. This is a pleasant exception as compared to the other Pillars; however, assuming that the targets are for the two districts.
only, it is not clear what the baseline is and for what year. It is also not clear what the current trend is in reduction of stunting and anemia.

5. There is no attention in the design of Pillar 4 to nutrition-sensitive activities which should be an important element of any programme aiming at the reduction of chronic malnutrition.

6. The main output 4.3 as formulated in Workplan Yr 3 (“Standard Monitoring System”) is redundant under Pillar 4. A standard monitoring system has already been developed with the introduction of SMART and the “Surveillance Nutritionelle” (See Pillar 3).

7. The study to better understand the basic determinants of feeding practices in Bankass and Yorosso is a qualitative survey being implemented in the districts. However, it is not clear whether existing knowledge has been explored and used to answer the main research questions. For instance, the Red Cross has undertaken a KAP study on Essential Family Practices with regard to nutrition. Also, several national consultants such as RESADE in Bamako have extensive knowledge on this issues (see further WCARO report)

2.6.2 Effectiveness

Understanding the nutritional and institutional context

18. The baseline which has been made is only partial and does not provide a detailed assessment of nutrition activities at the regional and district levels where ANSP intends to operate for Pillar 4

Similar to the lack of a comprehensive analysis and baseline at national level, a situational analysis of capacities, gaps and institutions active in the field of nutrition has not systematically been made before the Scaling Up interventions at district level were prioritized. In Oct 2012 a SMART survey has been done in Bankass and Yorosso which will serve as a quantitative baseline for relevant nutrition indicators. This is an important but isolated description of the nutritional context. Other activities to describe the nutritional and institutional context have been ad-hoc and dispersed, and certainly not systematic. Important contributing partners as ASDAP in Bankass (and later in Yorosso) and Cornell University have started their activities before the local situation was well understood. Only after the start of their activities they have started to analyse the context and to identify other implementing partners and programmes. Eg. ASDAP has mapped the different interventions well into 2013 and Cornell has identified relevant actors representing various sectors only in June 2013. This lack of a comprehensive situational analysis has contributed to the failure of the start-up of activities in Yorosso district. If a better assessment had been made of the implementing organisations and their nutrition-related programmes, ANSP implementing strategies and priorities for Sikasso would have been different.

Strategic choices to develop a minimum package for prevention of chronic malnutrition

19. There is not yet a contour visible of the design of a comprehensive package for the prevention of chronic malnutrition in the two target districts

One of the most important expected results of ANSP in Mali – as in the other target countries – is the development of ‘an integrated and comprehensive package including nutrition relevant and nutrition sensitive interventions which can be implemented at the district level’. This is an important goal not only expressed by the MoH/DN but also at regional and district levels to reduce chronic malnutrition. There is a need to have “a model, a minimum prevention package that can be shown to be effective, at reasonable cost, and with potential for replication elsewhere.” However, the development of the nutrition package has not really been strategized. A few nutrition-relevant activities have been promoted (or continued); the main prevention activities so far implemented are:

- Management of Acute Malnutrition (which already started before ANSP)
- IYCF support groups, and
- Communication skills C4D

But main nutrition relevant interventions such as MNP distribution have not yet been strategized. The MNP strategy is expected to be based on Save the Children experience in Yorosso but the MoH/DN is not really in favour of their approach.

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14 GoM, INSTAT: Enquete Smart Anthropometrique et de Mortalite Retrospective dans les Districts Sanitaires de Yorosso (Sikasso) et Bankass (Mopti) au Mali, Oct 2012
Nutrition sensitive interventions have not yet been identified to be promoted amongst other stakeholders, whereas the NNP strategies clearly provides guidance (eg. Promotion of School Feeding, Homestead production or Social Protection measures). The costing of the interventions and the monitoring of relevant indicators is not consequently implemented. For instance IYCF indicators are not integrated in the MAM monitoring system (Surveillance Nationale). At the level of training UNICEF has taken the initiative together with the MoH/ DN to form a pool of IYCF trainers. This training targets in the first place regional health staff and staff of NGOs working in the field of MAM.

Moreover, UNICEF has not tried to identify good practices already existing in Mali on which Scaling-Up interventions could be based. For instance, the approach known as FARN (Foyer d’Apprentissage et de Réhabilitation Nutritionnelle) is one of the approaches from which could be learned.

There is also the issue how to reach out to the target groups of mothers (pregnant and lactating) and stunted children under two years of age. With regard to MAM targeting there is a large gap between ‘expected cases of GAM’ and the actual caseload (in Bankass only 36% of expected cases for 2013 were reached by Oct 2013). This shows that it will also be problematic to reduce the number of stunted children if no specific strategies are developed to reach out to all of them.

**Embedding of Scaling Up interventions at District level**

20. The embedding of Scaling Up interventions with ASDAP in Bankass is a clear choice but not without its risks.

**Bankass**

The embedding of ANSP in Mopti Region – in particular in Bankass District – is foremost with the health sector. The MTE has observed that there is a good solid basis for the ANSP approach as the main stakeholders in health are working well together: including the DRS, Medicin Chef CSREF, FELASCOM, DSES, ASDAP; and other stakeholders as well. Both at regional level (DRS) as at district level there is a very keen interest to collaborate with UNICEF on the issue of nutrition security in order to reduce and prevent chronic malnutrition. The basic structure on which most of the health stakeholders are working is the protocol which is in place for the treatment of Global Acute Malnutrition (MAM and SAM).

UNICEF has entered an agreement with ASDAP for the implementation of Scaling-Up activities in Bankass. ASDAP is well established to do so as it has been in the district for a long time. There are two other NGO programmes active in the field of Nutrition: SAFEM and NEMA. SAFEM focuses on Nutrition, Agriculture and Gender and is supported by a Belgian NGO with EU funding. NEMA is a short duration programme implemented by HKI, CRS and Save the Children for only 10 months. NEMA originally worked in Douentza but had to leave the district as a result of the Mali internal crisis in Jan 2013.

ASDAP has been working with UNICEF funding in the district since 2008 (as in 6 other districts) and has a very good collaboration with DRS Mopti, DS Bankass and DSESBankass. There is a recognition of the role of ASDAP in providing public health services in particular in the fields of Reproductive Health, HIV-AIDS, Nutrition (identification and treatment of GAM) for more than a decade. The activities under ANSP have started early 2013 with training activities of 50 Health Agents, 562 community health workers and 360 members of IYCF community support groups (24 groups of 15 persons each). The latter two activities covered 11 health zones which represents 50% of the total number in the district (22 health zones). All have been trained in the principles of IYCF and communication techniques.

However, there are two major risks involved in vesting the ANSP activities with an organisation which has been active in the health sector for so long. First of all, nutrition security is an activity which goes beyond the “classical” health services at district and community level. ASDAP has a very strong health profile because of its previous activities and what is reflected in its close collaboration and integration with DS Bankass and DSES Bankass. At the start of the ANSP related activities there has been no reflection on the close relationship with Health and its consequences how to develop from there a multi-stakeholder partnership at district level.

15 Source: DS Bankass personal communication; but the calculation of the denominator creates huge problems.
Moreover, the second risk relates to the relatively limited experience of ASDAP staff with Nutrition Security implementation; even the introduction of CMAM is of a rather recent date in 2012 and IYCF is completely new to all ASDAP staff. Some staff has been recruited recently with the start of ANSP funding and have relatively little experience.

In terms of effectiveness it is yet difficult to assess the results achieved so far as IYCF activities have started only a short while ago. The training of IYCF community support groups was only 1 day. The content of the training includes Essential Family Practices and Essential Nutrition Actions which is too comprehensive to teach in only 1 day as was recognized by both ASDAP staff and participants interviewed (1 IYCF group).

Some testimonies during the IYCF support group interview (present 11 Women and 1 Man) indicated that there is a clear interest and understanding of the matter. This is shown by the following observations based on the exchange with the IYCF group:

- Need for Exclusive Breast Feeding is well understood and practised;
- Complementary feeding practices understood but difficult to practice; e.g. the suggestion to give soup prepared of meat or fish are difficult to apply due to lack of meat or fish;
- Iodized salt is being tested by Community Health Workers (“Relais”);
- Pregnant women and young children need to be supplemented with iron in order to avoid fatigue;
- Hygiene: washing hands, latrines, cleaning of public space

21. The choice of Yorosso for the implementation of Scaling Up interventions in the Region of Sikasso has been a complete failure

The choice of the second target district in Mali, Yorosso district in Sikasso Region, has been a complete failure as Save the Children has already been active in the field of health and nutrition for more than five years. UNICEF has made serious efforts to involve Save the Children to include prevention of chronic malnutrition and anaemia in their programme activities but unfortunately Save the Children did not come up with a proposal. As a response UNICEF has decided to invite ASDAP to establish a team in Yorosso which was formalized by amending the existing Partner Agreement with ASDAP in Sept 2013. During the MTE visit at the end of 2013 members of the ASDAP team were in the process of getting settled.

However, the MTE seriously questions the situation where UNICEF starts up a new project in Yorosso which is complementing a strong and well established programme by Save the Children. The MTE judges that it will be very difficult to make headway and produce impact according to the expected results of reducing chronic malnutrition.

So far, no concrete activities have been undertaken in Yorosso district under ANSP (up to November 2013).

22. Engagement for multi-stakeholder implementation of nutrition policies at decentralized levels is so far poorly developed

At national level there have been good advancement in multi-sectoral involvement of 4 ministries in nutrition security: Health, Agriculture, Education and Social Development (DSES) have been contributing to the formulation of the National Nutrition Policy and its Plan of Action. Each of these ministries has a nutrition focal point. The National Nutrition Council which includes actors at different levels including the relevant ministries is a major forward in mainstreaming nutrition at the national policy-making level. Also the alignment with SUN objectives clearly indicates the political will to respond to the multi-dimensional character of the reduction of chronic malnutrition.

However at the decentralized levels in Mali (region and district) the engagement for multi-sectoral planning and implementation of nutrition relevant activities is less visible and not yet developed. In Mopti Region there is not a multi-sectoral approach as yet. There is a sub-cluster for Nutrition, which meets every two weeks, and which is co-led by the Regional Director of Health together with UNICEF, but the sub-cluster is mainly emergency oriented focusing on the identification and treatment of acute
malnourished children. The MTE has observed that other sectoral regional departments are not aware of the ANSP project in Bankass (and Mopti) despite its official launching in Mopti in Dec 2012. In Sikasso Region there is a Regional Committee to Fight against Malnutrition.  

At decentral level in Bankass District, most of the interviewed sectoral representatives acknowledge that a multisectoral approach is very necessary: relevant sectors need to be involved according to their competences; furthermore they indicate that there is a need for more concrete knowledge on nutrition and their role in preventing chronic malnutrition and that there is a need for Nutrition focal points at the different departments. Agriculture agents and teachers (Education) do not have any (detailed) knowledge about nutrition.

However, in practice the Multisectoral approach is getting off the ground very slowly. Only in November 2013 a first Round Table was held upon invitation of the District Governor ('prefet') and facilitated by the District Council. This very recent initiative of a “Round table for Food and Nutrition Security” was considered a first step towards more comprehension of the multi-dimensional character of nutrition. But the minutes of the meeting show that there is still a lot of misunderstanding of what is multi-stakeholder collaboration for nutrition security. As such real collaboration between sectors still has to come off the ground; no strategic choices have been made as yet. At this stage there is little collaboration with Education at ‘Academie’ and ‘CAP’ levels despite the fact that education provides interesting opportunities for collaboration as is being acknowledged by the sub-regional director: School feeding, school gardens, nutrition in curriculum (e.g. in curricula of Special schools for adolescents, and Alphabetisation Centres for adults (mainly women) to discuss nutrition essentials). Also in the Agricultural sector it is observed that agricultural staff at regional and district level have no/ little knowledge about Nutrition nor about the role they could play.

Within UNICEF there is no collaboration between the Nutrition section and the WASH and Education sections; UNICEF WASH and Education are not active in the Bankass.

**Supportive training/ studies**

23. The support activities planned under Pillar 4 have – with one exception – only been implemented partially, quite recently or are still to start; harmonization is an issue

The various supportive activities under the ANSP in Mali to Scale Up interventions in the two target districts have been implemented at a different speed and with various results:

- The SMART survey on nutrition indicators and mortality has been implemented in October 2012. This important baseline survey has been implemented on time.
- C4D training has been implemented in Bankass but the DSES was not convinced what was new about the approach C4D; e.g. interpersonal counselling is known and already applied in the District.
- Cornell University support has led to one – mainly introductory – visit in June to Bankass and Yorosso Districts. The expected monthly support from Burkina has yet to materialize.
- KAP survey implemented by RESADE: data collection has taken place during which 900 HHs were interviewed in 30 villages; the survey is still to be analyzed but has the potential to provide interesting information.
- The study on feeding practices’ determinants: is still to start in Bankass and Yorosso; the training of enumerators has taken place in November 2013.

It appears that almost two years after the start of the ANSP programme there are still a good number of activities taking place which are meant to increase the understanding of the nutrition situation in the two target districts; all these preparatory and formative activities should have been finalized by the end of 2012 in order to be included in the strategizing of Scaling Up interventions in the districts.

Besides, in Bankass activities as C4D and the Cornell support are not well harmonized with the existing situation in the district. On the basis of observations made by district staff the activities were initiated without a good understanding on the objectives and an appropriate needs assessment.

16 Source: HKI personal communication
17 Source: Secteur Agricole, CAP-Bankass
18 Source: UNICEF-Mopti WASH and Education sections (personal communication)
2.7 Efficiency

24. Programme preparation and implementation has been poorly managed by UNICEF in Mali
In this respect a number of observations are made by the MTE:

- ANSP-Mali is not built on previous lessons learned, available knowledge and studies done; for instance the ‘determinants of IYCN practices’ has not started by a review of available and relevant literature nor by interviewing key informants with good knowledge of the subject; the Cornell University activity is not based on already existing nutrition security structures nor development bodies at different levels; no assessment has been made of already existing initiatives with regard to the integration of Food Security and Nutrition with which a great number of International NGOs in Mali have experience (ACF, HKI, Save the Children, CRS, etc).
- Loss of institutional memory within UNICEF; it has been difficult to trace the background of certain strategic decisions made, for instance the choice of the regions and districts for implementation. Moreover, the sourcing of relevant documents also appeared difficult; for instance relevant documents were only retrieved after conclusion of the field work in Mali on www.humanitarianresponse.info/mali
- No appropriate baseline including a contextual analysis has been made as a preparation of the implementation of interventions in Bankass and Yorosso; at least an inventory of relevant information and stakeholders should have been made and documented.
- The identification of Yorosso as a target district has been unsatisfactory; despite the fact that also the intended partners (Save the Children) share some blame for the delay, it should not have been possible that almost two years after the start of ANSP in Mali no activity has taken place;
- Logic model, logical framework, work plan and budget have appeared to be dissociated at the beginning but still are half-way the ANSP implementation.

25. Coordination of implementation of field activities appears not always to be appropriately done
Despite the fact that UNICEF is the Nutrition Cluster co-lead, and the regular meetings between stakeholders, there appears to be a lack of coordination and prioritisation with regard to the implementation of field activities. Yorosso is a clear case where other implementing NGOs as Save the Children and CRS were already established to work on nutrition. But also in the case of Bankass there is an overlap in support to the field of Nutrition to the Health District. So far, this has been relatively small (2 smaller projects are operational in Bankass: SAFEM (Oct 2011 - Dec 2014) and NEMA (by HKI/Save and CRS; ending in Dec 2013). But CARE has announced to the other Nutrition Cluster members that it will start a new project in 8 Health Districts in Mopti Region including Bankass in 2014. The project will encompass three components: Food Security, Nutrition and WASH and will last five years.

26. Budget utilization after two years has been relatively slow
The ANSP Mali budget represents 11% of the total ANSP budget with a total budget of € 2,062,900. It is subdivided in 38% staffing costs and 49% for contracts and surveys, with the remainder being mainly training activities (9%). The ANSP Mali budget is less detailed as compared to other country budgets. The budget item contracts include two main items, the SMART survey and the subcontracting of the national NGO ASDAP for the implementation of Scaling Up interventions under Pillar 4. These two activities make up 45% (resp 22% and 23%) of the total ANSP budget in Mali (see figure below). The budget for Cornell University, the determinants of Malnutrition study, determinants of feeding practices study and C4D training which are implemented in Mali are coming from and are managed by UNICEF WCARO. The sub-contract for RESADE (KAP baseline survey) has been integrated in the ASDAP contract (see below).

The expenditure rate in Mali has been relatively slow with 28% of planned budget being used after two years. This is mainly due to the non-implementation of Pillar 2 activities (see 2.4) and the delay in the implementation of Scaling Up activities in Bankass and Yorosso. On the other hand about two-third of the budget for Pillar 1 has been used, well above the expected expenditure rate half-way programme implementation.
Funds additional to EC funding for the ANSP programme mainly originate from other sources of external funding to UNICEF. In the first two years 22% of total expenditure was sourced from other funds available to UNICEF. Two budget items benefited: the SMART survey (in Yr 2) and one of the nutrition specialists (in Yr 1 and 2). Interestingly, the external funding was higher in Yr 2 than in Yr 1 which indicates that the leverage of ANSP funding may be sustained over the years of implementation.

27. Financial management of ANSP funded activities and in particular the subcontracted activities has been very poor resulting in unacceptable delays of payments and activities

The conditions and procedures for sub-contracting as currently used by UNICEF (e.g. length of contracts, sub-sub contracting, financial procedures and payments) are not conducive for partners to implement activities and may jeopardize the progress of the programme. The MTE has observed:

- Unacceptable delays of payment to (sub-) contracted partners causing severe liquidity problems and delays (According to UNICEF Mali this was related to software issues (Vision being complex). The issue has been taken up by management but took in total three months to be solved (only in Dec 2013)
- The KAP study is sub-contracted to RESADE through ASDAP which in itself is a sub-contractor of UNICEF. The delay of payments to ASDAP has had severe consequences to RESADE to the extent that its management was not able to make any more payments.
- ASDAP has received a contract of 12 months renewed for another 9 months (resp. for the periods Oct 2012-Sept 2013 and Oct 2013- June 2014). The contract is renewable but it is unacceptably short as compared to the ASNP project duration and long-term goals. This will cause limitations to ASDAP in terms of staff management and activity planning which may jeopardize the sustainability of its implementation.

2.8 Impact

28. At this stage it is not possible to make any judgement with regard to the impact at outcome level.

In the first place, at local level in the two target districts activities have barely started: not at all in Yorosso and only recently in Bankass. As the baseline information (SMART and KAP studies) has only been done in 2013 the quantitative measurement of impact on relevant nutrition outcomes will go beyond the projected ANSP duration.
The effectiveness of ANSP activities are at this stage difficult to assess, but a few elements will play an important role in becoming a success:

- The coherence between the pillars which currently has been lost will need to be restored
- Opportunity to be complementary to other stakeholders is there but yet to be seized
- The relevant sectors for nutrition security need to take up their role and willingness to coordinate

Yet the current situation offers great opportunities with the nutrition policy and governance set-up in place and the increased interest amongst government and their technical and financial partners for nutrition security.

### 2.9 Sustainability

29. Capacities and ownership for the implementation of multi-sectoral programmes to reduce chronic malnutrition have been greatly improved at national level, but are still poor at decentralized levels

The sustainability of ANSP actions are vested in the capacities and ownership of the different stakeholders including the Mali Government. The formulation and implementation of the National Nutrition Policy, the accompanying Multisectoral Action Plan and the improved coordination and governance for Nutrition has greatly enhanced ownership. Also the introduction of the SMART methodology to assess nutrition indicators and the close monitoring of acute malnutrition cases is contributing to the improved capacity to assess the impact of stunting reduction interventions. However, the capacity to implement and to monitor progress at decentralized levels is still quite weak. The ‘how to’ multi-sector action planning and implementation is poorly understood and barely coming off the ground. This needs much greater attention from the ANSP in Mali.

### 3 Conclusions and Lessons Learned

#### Conclusions

The five main conclusions with regard to the ANSP Mali programme are:

1. The design of ANSP in Mali (logframe, expected outputs and activities) does not reflect anymore the current context in Mali which has changed considerably since the ANSP programme has been formulated and even after the Inception workshop has taken place. A coherent National Nutrition Policy has been put in place including a plan of action, and the Nutrition Governance and coordination has been greatly strengthened. New national and international coordination platforms such as REACH and SUN have become very relevant (see findings 3, 7 and 8). This calls for a major review and updating of the ANSP Mali programme in particular for Pillar 1 and 3.

2. Nutrition capacity development (Pillar 2) has not come off the ground and has no clear strategy and prioritisation. Capacities with regard to nutrition policy making and implementation are still quite limited at national level despite the great interest of the Government of Mali to reduce chronic malnutrition. This is in particular the case for how to develop and implement multi-sectoral approaches and programmes at decentralized levels. Nutrition awareness at regional, district and community level is almost absent within other ministries than the Ministry of Health as stakeholders consider nutrition to be a health issue to be covered by the health institutions including the UREN system (see findings 5, 19 and 21).

3. The achievements of ANSP under Pillar 3 are very visible and have contributed to the introduction and incremental build-up of a harmonized data collection system for nutrition indicators through the use of the SMART methodology which has been adopted by most relevant stakeholders. Also the set-up of the harmonized monitoring system for the collection of treatment of acute malnutrition data means a great step forward. Both systems imply a good foundation for further analysis and action for the prevention and treatment of acute and chronic malnutrition in Mali. It is important to assure the quality and completeness of data collection routines (see findings 13 and 14).
4. The implementation of Pillar 4 Scaling Up activities has only recently started in Bankass (since early 2013) and is yet to start in Yorosso. So far, the development of a model for Scaling Up nutrition interventions appears to be problematic in terms of selection of target districts (in particular Yorosso in Sikasso Region), the scope and focus of the Scaling Up activities (e.g. no inclusion of micro-nutrient supplementation or bio-fortification interventions as yet), and the initial embedding of interventions in the health sector (lack of comprehensive multi-sectoral planning and implementation at district or community level).

Moreover, not all the supportive activities such as C4D, Cornell, determinants study have been harmonized and aligned with the context at decentralized level or based on already existing knowledge and competences (see finding 23).

5. ANSP has more the characteristic of institutional programmatic funding based on a contribution to the overall UNICEF Mali Nutrition section programme than that of a project aiming at the reduction of chronic malnutrition. In terms of implementation and use of inputs (both human and financial) ANSP Mali builds upon previous activities (e.g. NNP action plan formulation, SMART, MAM, IYCF review, MN supplementation) with a gradual change of focus and scope towards the reduction and prevention of chronic malnutrition. But ANSP in Mali is certainly not a stand alone project with clear quantified targets. The formulation of ANSP as a project disguises the way how the activities have been designed and implemented. A project assumes an ‘add-on, in the case of ANSP to the reduction of stunting and anemia. But in the case of ANSP Mali there is more of continuity and building upon previous activities which makes it difficult to assess ANSP as a project with a clear logic model, logframe and expected outputs (see finding 2).

Lessons learned

The main lessons learned are:
1. A comprehensive programme as ANSP needs a consistent set of expected outputs, outcomes and related activities based on an in-depth situational analysis, and a solid and consistent logframe including quantified targets (which is only the case for Pillar 4).
2. Activities and expected outputs need to be regularly (annually) reviewed for their relevance and completeness.
3. Progress monitoring needs to be based firstly on the monitoring of the implementation of planned activities and expected outputs and secondly on the data collection of relevant nutrition indicators (outcomes)
4. UNICEF staff should be better aware of the importance of institutional memory and assure a solid documentation of its strategic choices
ANNEX I. COUNTRY UGANDA

External Evaluation
African Nutrition Security Partnership (ANSP)
Country Annex: Uganda

1 Introduction

1.1 Nutrition Situation

Table 1: Key statistics

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<tr>
<td>Total population (2011)</td>
<td>34,509</td>
<td>855,273</td>
</tr>
<tr>
<td>Under-five mortality rate (infant mortality rate), both 2011</td>
<td>90/58</td>
<td>121/76</td>
</tr>
<tr>
<td>Life expectancy at birth (2011)</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>GNI per capita (PPP)</td>
<td>USD 1,320</td>
<td>USD 2,145</td>
</tr>
<tr>
<td>% of population below international poverty line of US$ 1.25 per day (2006-2011)</td>
<td>38</td>
<td>49</td>
</tr>
<tr>
<td>% of children (2007-2011) early initiation of breastfeeding</td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>% of children (2007-2011) who are exclusively breastfed (&lt;6 months) (WHO threshold: &lt;50%)</td>
<td>62</td>
<td>33</td>
</tr>
<tr>
<td>% of children (2007-2011) introduced to solid, semi-solid or soft foods (6-8 months)</td>
<td>75</td>
<td>69</td>
</tr>
<tr>
<td>Antenatal care coverage at least once (at least four times)</td>
<td>48</td>
<td>47</td>
</tr>
<tr>
<td>Vitamin A supplementation coverage rate (6-59 months) 2011, full coverage (%)</td>
<td>60</td>
<td>86</td>
</tr>
<tr>
<td>% of households consuming iodized salt (2007-2011)</td>
<td>96</td>
<td>53</td>
</tr>
<tr>
<td>% of infants with low birth weight (2007-2011)</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from underweight (WHO), moderate &amp; severe (severe)</td>
<td>14/3</td>
<td>20</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from: wasting (WHO), moderate &amp; severe (WHO public health problem: &gt;10%)</td>
<td>5/1.5</td>
<td>9</td>
</tr>
<tr>
<td>% of under-fives (2007-2011) suffering from: stunting (WHO), moderate &amp; severe (WHO: public health problem &gt;30% moderate, &gt;40% severe)</td>
<td>33/14</td>
<td>39</td>
</tr>
</tbody>
</table>

While poverty levels in Uganda have declined from 39% in 2002 to 23% in 2010 and food production is sufficient to meet population needs, progress in the reduction of malnutrition has been slow\textsuperscript{171}. During the period 2006-2011, stunting decreased from 38% to 33%, underweight from 16% to 14% and wasting from 6% to 5\%\textsuperscript{172}. The causes of young child malnutrition in Uganda range from “policy issues to immediate household conditions to underlying cultural and community factors”, as comprehensively summarized in the Uganda Nutrition Action Plan 2011-2016 (UNAP).

\textsuperscript{172} Uganda Demographic Health Survey, 2006 and 2011.
The UNAP highlights inadequate dietary intake due to suboptimal maternal and infant feeding practices and a high disease burden as the immediate causes of child malnutrition. The broad underlying factors according to the UNAP are:

1) Household food insecurity, mainly related to poor access to a diversified diet due to seasonality in food production, variable food prices and seasonal earning patterns contribute to the poor quality of the diet, in particular in terms of micro-nutrients.

2) Inadequate maternal and child care including care constraints because of the heavy workload of women, engaged in farm and household chores as well as income generating activities, in combination with a high fertility rate (total fertility rate in rural areas is 6.8 and in urban areas 3.8).

3) Poor access to health care (i.e. effective health facilities and services, including nutrition services and education) and to a healthy environment (consisting of access to a safe water supply, toilets/latrines and other sanitation services).

The main causes of the persistent high level of stunting in Uganda are intra-uterine growth retardation (IUGR), manifested as low birth weight (LBW), neo-natal growth faltering and poor child feeding practices. LBW prevalence in Uganda is 14%\textsuperscript{174}. An estimated 16,000 babies weighing less than 2,500 gram at birth died in 2009\textsuperscript{2}. LBW is also strongly associated with non communicable diseases such as diabetes and cardiovascular disease in adults\textsuperscript{175}. Poor child feeding practices in Uganda include lack of exclusive breastfeeding of infants aged 0-5 months, sub-optimal complementary feeding practices and poor hygiene. According to the Uganda Demographic Health surveys (UDHS) exclusive breastfeeding rates increased only marginally from 60% to 63% in the period 2006-2011. In 2011, only 6% of all children under two benefitted from recommended infant and young child feeding practices (IYCF), as compared to 23% in 2006. Mothers in the highest wealth quintile were more likely to apply good IYCF as were mothers who completed secondary education or higher, but also among these groups the number of women applying recommended IYCF remain low with 11% and 8% respectively.

UDHS data also indicate that undernutrition (wasting and stunting) is highest among children living in rural areas with low or no educational attainment and/or belonging to the lower wealth quintiles. By the same token, figures indicate that women belonging to the lowest wealth quintile are twice as likely to be thin as those in the highest wealth quintile. Similarly, children aged 6-59 months in the lowest wealth quintile and/or whose mothers have no education are twice as likely to be stunted as children in the highest quintile and/or whose mothers have completed secondary school or higher. It is important to note however, that the prevalence of stunting among children in the highest wealth quintile group is still a high 21%. Geographical disparities between regions are substantial with the highest levels of both stunting and wasting in Karamoja. Malnutrition contributes to an estimated 60% of all child deaths in Uganda.

Micronutrient deficiencies are a serious problem in Uganda as well. UDHS data indicate that 49% of all children under five and 23% of women of reproductive age suffer from iron deficiency anemia (IDA). In addition, about one in five children under five and nearly 20% of all women of reproductive age (15-49 years) are affected by vitamin A deficiency. Zinc deficiency ranges from 20% to 70% in children and 20% to 30% in adults. In 2010, the burden of stunting, LBW, IDA and iodine disorders was estimated to cost Uganda at least US$ 310 million worth of productivity\textsuperscript{176}. The recent Cost of Hunger in Africa (COHA) Study on Uganda estimates that Uganda loses up to $899 million due to malnutrition every year. The study also revealed that over 975,000 children under the age of five are suffering from anaemia, acute diarrhoeal diseases, acute respiratory infection (ARI) or fever due to poor nutrition\textsuperscript{177}.

\textsuperscript{172} Uganda Demographic Health Survey, 2011
\textsuperscript{174} Uganda Demographic Health Survey, 2011
\textsuperscript{175} Low birth weight and/or stunting often result in catch-up growth, which in turn may lead to overweight.
\textsuperscript{176} Malnutrition: Uganda is paying too high a price, GoU, USAID, WFP. FANTA 2 and, FHI360, December 2010
\textsuperscript{177} Cost of Hunger in Uganda, Implications on National Development and Prosperity, Summary Report , WFP, UN-ECA and UAC, June 2013.
Despite progress, achieving the MDG 1 target of 10% underweight by 2015 is a challenge in view of the current levels of stunting\(^{178}\) and wasting and the rate of progress.

### 1.2 National Policy Framework in Nutrition Security

The Constitution of the Republic of Uganda (1995) requires the state to encourage and promote good nutrition, mandating the Ministries of Health (MOH) and of Agriculture, Animal Industry and Fisheries (MAAIF) to develop relevant policies to ensure the provision of quality food and nutrition services. The Uganda Food and Nutrition Policy (UFNP) was approved in 2003, a National Food and Nutrition Strategy Investment Plan was drafted in 2004 and a Food and Nutrition Bill was approved in 2008. The Uganda Food and Nutrition Council (FNC) was created to implement the UNFP. In 2010 that Uganda placed nutrition high on the political agenda, when the Minister of Foreign Affairs at the UN General Assemblee committed to tackle malnutrition. The 2010-2015 National Development Plan (DNP) has incorporated nutrition as cross-cutting theme that requires multi-sectoral action in at least four sectors: health, agriculture, education and gender, labour and social development. The Uganda Nutrition Action Plan 2011-2016 (UNAP) was launched by the President himself and signed by eight ministers from the following Ministries: MOH, MAAIF, Ministry of Education and Sports (MOESS), Ministry of Local Government (MOLG), Ministry of Gender, Labour and Social Development (MGLSD), Ministry of Trade and Cooperatives (MTC), 2\(^{nd}\) Deputy Prime Minister and Minister of Public Service and the Minister of State, Finance, Planning and Economic Development. Representatives of nearly all these Minisitries were also involved in the drafting of the UNAP. In addition, representatives of a number of institutions (Makerere School of Public Health, Regional centre for Quality of Health Care, Uganda National Academy of Sciences) and international organisations (IFPRI, UNICEF, WHO, WFP) participated as well as some experts.

The UNAP has five objectives and 12 key outcome indicators, including stunting, underweight, micronutrient deficiencies, LBW, exclusive breastfeeding, diet diversity score and average daily energy intake. The five objectives with matching strategies and interventions strongly reflect the multisectoral approach. For example strategy 1.2 is to address gender and socio-cultural issues that affect maternal, infant and young child nutrition, among other through advocacy and seeking solutions for reducing the workload for all women; another example is strategy 2.2 which consists of the aim to enhance post-harvest handling, storage, and utilisation of nutritious foods at the household and farm level. In August 2012, an implementation matrix for the UNAP was developed which outlines specific interventions by sector against the five objectives. The interventions are aligned with national priorities and are within the mandates for each sector. A mapping exercise is presently being conducted to provide information on the actual implementation and alignment of programs and interventions within the UNAP framework. For some sectors sector plans have been finalized. Some of these plans have been costed, while costing of plans for other sectors is ongoing (see section 2.3).


Uganda is both a SUN and REACH country. Uganda signalled its commitment to the SUN in March 2011, and is as such one of the SUN early risers. Uganda has adopted the SUN strategy on focused interventions covering the 1,000 days directed to women of reproductive age, newborns and children under two years of age. The SUN focal point identified for 2013 three key priorities: (i) the mobilisation of resources for the implementation of the UNAP; (ii) support / establishment of national and district

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\(^{178}\) The outcome indicators for stunting specified in the Uganda Nutrition Action Plan 2011-2016 are based on UDHS 2006 figures and in view of new data not realistic. The target of 33% stunting by 2015 had already been reached in 2011.

\(^{179}\) Compiled from: Nutrition Country Profile, policies in Uganda at [https://extranet.who.int/nutrition/gina/en/policies/1565](https://extranet.who.int/nutrition/gina/en/policies/1565)
level coordination structures and; (iii) establishment of mechanisms to monitor and evaluate the implementation of the UNAP. USAID is the donor convener; additional donors include DFID, Irish Aid, the World Bank and UN agencies including UNICEF.

REACH which started activities in Uganda in 2011, is the designated UN body for SUN facilitation. REACH aims to (i) operationalize the functioning of the Food and Nutrition Council; (ii) improve communication across sectors through the Multi-sectoral Nutrition Working Group; (iii) harmonize planning and budgeting within sectors through sectoral Nutrition Coordination Committees; and (iv) foster coordination at the district level through newly established District-level Multi-sectoral Nutrition Coordination Committees.

1.3 Technical and financial stakeholders in nutrition security

The UNAP coordination unit/secretariat in the Department of Policy Implementation and Coordination of the Office of the Prime Minister (OPM) is responsible for facilitating the actual coordination of the UNAP. The secretariat is also the SUN convening body. The SUN focal point is the permanent secretary and Accounting Officer in the OPM. The UNAP coordination unit/secretariat receives technical support from REACH, UNICEF, USAID and Irish Aid.

Policy coordination of the UNAP and nutrition programming at large is mainly done by the Food and Nutrition Council (FNC), which comprises the Permanent Secretaries of the 8 implementing Ministries. The FNC meets quarterly to review progress on the performance of key nutrition indicators, to analyse budget performance, to analyse constraints and to provide strategic direction.

The Uganda Nutrition Coordination Forum is responsible for the (bi-annual) review of the implementation of the UNAP. Another task of this Forum is to provide advice and advocacy for nutrition. Members include representatives from the OPM and the line ministries involved in the development of the UNAP as well as REACH facilitators including UNICEF, donors (including USAID, Irish Aid), as well as NGOs, civil society and the private sector, represented through the Private Sector Foundation Uganda (PSFU). The Forum is chaired by the SUN focal point. The nutrition multi-sectoral technical coordination committee, also known as TWG or technical working group, comprises (representatives of) the eight implementing line ministries, the national planning authority, development partners, CSOs, academia and the private sector, and is responsible for the technical coordination of nutrition. This committee is chaired by the SUN focal point and coordinated by the head of the (UNAP) coordination unit in the OPM. Development partners also have other platforms including the Health Development Partners Group, and the Development Partners Sectoral Committees. A Development Partners’ Nutrition Committee is directing the project, which has been awarded some US$ 300,000 through the SUN Multi-Partner Trust Fund, will also support capacity-building by CSOs in monitoring and evaluation of nutrition investments and reporting on SUN activities at the national and grassroots levels. In addition, seven universities, one agricultural college, one paramedical school and one nurse’s training school are part of the academic sector involved in capacity building for nutrition.

In 2013 the Uganda Civil Society Coalition on Scaling Up Nutrition (UCCO-SUN) was established. The aim of UCCO-SUN is to advocate for increased policy development and resource allocation for improved nutrition outcomes. The project, which has been awarded some US$ 300,000 through the SUN Multi-Partner Trust Fund, will also support capacity-building by CSOs in monitoring and evaluation of nutrition investments and reporting on SUN activities at the national and grassroots levels. In addition, seven universities, one agricultural college, one paramedical school and one nurse’s training school are part of the academic sector involved in capacity building for nutrition.

The main donors for the nutrition sector in Uganda are the EC, DFID and USAID/FTF. USAID/FTF focusing on inclusive agricultural sector growth, gender integration, improved nutrition, private sector engagement and research and capacity building and supports the scaling up of the Essential Nutrition Actions through key district-based programs to improve nutrition in facility and community settings in the areas of highest chronic undernutrition (North and Southwest Uganda). FTF is the donor of the 180 Most of the information in this section is derived from the UNAP and the Uganda SUN country Summary, September 2012. 181 PSFU is an umbrella organization for members of the private sector engaging in nutrition related activities who are members of the PSFU. Representatives are mostly involved in food fortification and are doing a gap assessment for capacity to enroll new industries to receive support for fortification. 182 http://scalingupnutrition.org/wp-content/uploads/2012/10/FINAL-UGANDA-SUMMARY.pdf
main ANSP partner at District level (Community Connectors). UNICEF received from DFID for the period 2011-2012 more than £ 1,500,000 for feeding programmes in combination with WASH activities in Karamoja. DFID will also provide funds for the roll out of the ANSP in Karamoja (please refer to section 2.7.2).

2 FINDINGS

2.1 Overall Relevance and Appropriateness

Country Programme design

The programme in Uganda avails of a total budget of € 1,459,372 excluding administrative costs. The budget for the individual pillars is € 203,334 for R1; € 515,314 for R2; € 205,468 for R3 and € 535,256 for R4. The programme is aimed at 10 results, summarized in the figure below.

To better understand the structure of the EC/ ANSP Uganda, the MTE categorized the components outlined in the four-year work plan by the intended level of implementation (at national level, at district/subcounty level or below and at both levels).

Expected results at national level are the following:

- Result area 1:( all results)

<table>
<thead>
<tr>
<th>R4: Scale up of SUN essential interventions</th>
<th>R1: Upstream policy development and nutrition security awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Creating local capacity for scale-up of SUN nutrition interventions in pilot districts</td>
<td></td>
</tr>
<tr>
<td>2. In collaboration with USAID/FTF partner and district authorities ensure support for BCC activities to promote nutrition</td>
<td></td>
</tr>
<tr>
<td>1. Finalized sector-specific operational plans and community nutrition implementation guide inclusive of plans for nutrition / health, education, gender &amp; labour, water and sanitation and inclusive of progressive targets for budgetting in the nutrition sector</td>
<td></td>
</tr>
<tr>
<td>1.2 Execute periodic reviews on progress made on UNAP implementation</td>
<td></td>
</tr>
<tr>
<td>1.3 Revision and updating Food and Nutrition Policy Framework</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R3: Nutrition data analysis and knowledge sharing</th>
<th>R2: Institutional development and capacity building</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Formative research on current nutrition practices, obstacles and enablers to adequate nutrition in communities to inform the design of community-based nutrition model</td>
<td></td>
</tr>
<tr>
<td>2. Conduct food and nutrition security assessment (Baseline and annual) in pilot districts to support implementation of community-based nutrition model and support to Uganda national nutrition Repository center.</td>
<td></td>
</tr>
<tr>
<td>3. Support to Uganda Repository center</td>
<td></td>
</tr>
<tr>
<td>1. Strengthened capacity at national and district level (pilot districts) for planning, monitoring and implementation of community and facility based nutrition interventions in partnership with national / regional health service quality assurance institution</td>
<td></td>
</tr>
<tr>
<td>2.2 Advocacy pursued with agricultural sector for the inclusion of nutrition-oriented training modules into curriculum of agriculture sector specialists</td>
<td></td>
</tr>
<tr>
<td>2.3 Media capacitated for reporting and awareness creating on nutrition</td>
<td></td>
</tr>
</tbody>
</table>
✓ R 1.1 Finalized sector-specific operational plans and community nutrition implementation guide inclusive of plans for nutrition / health, education, gender & labour, water and sanitation and inclusive of progressive targets for budgetting in the nutrition sector
✓ R 1.2 Execute periodic reviews on progress made on UNAP implementation
✓ R 1.3 Revision and updating Food and Nutrition Policy Framework

• Result area 2:
  ✓ R 2.2 Advocacy pursued with agricultural sector for the inclusion of nutrition-oriented training modules into curriculum of agriculture sector specialists

• Result area 3:
  ✓ R 3.3 Support to Uganda Repository center

• Result area 4: none

Expected results at national level and district or below are as follows:

• Result area 1: none
• Result area 2:
  ✓ R 2.1: Strengthened capacity at national and district level (pilot districts) for planning, monitoring and implementation of community and facility based nutrition interventions in partnership with national / regional health service quality assurance institution
  ✓ R 2.3: Media capacitated for reporting and awareness creating on nutrition

• Result area 3: none
• Result area 4: none

Expected results only at district level or below are as follows:

• Result area 1: none
• Result area 2: none
• Result area 3:
  ✓ R 3.1: Formative research on current nutrition practices, obstacles and enablers to adequate nutrition in communities to inform the design of community-based nutrition model
  ✓ R 3.2: Conduct food and nutrition security assessment (Baseline and annual) in pilot districts to support implementation of community based nutrition model

• Result area 4:
  ✓ R 4.1: Creating local capacity for scale-up of SUN nutrition interventions in pilot districts
  ✓ R 4.2: In collaboration with USAID/FTF partner and district authorities ensure support for BCC activities to promote nutrition

The programme is implemented in 5 districts, located in the South West (3) and the North (2). Please refer to the next paragraph for details on the selection of the pilot districts.

**Coherence, completeness and complementarity to other initiatives**

The aim of the ANSP is to assist Uganda in modelling community-based models for nutrition and scaling up coverage of essential nutrition interventions. As such, the ANSP is well aligned with the strategies to address nutrition outlined in the UNAP (as well as the policy environment in general as exemplified among others by Uganda's commitment to the SUN movement). The ANSP aims in particular to strengthen GoU capacity to ensure the scale up of nutrition through a multi-sectoral approach at national, district and sub-county level and deliver on the UNAP commitments related to the strengthening of the policy, legal and international frameworks and the capacity to effectively plan, implement monitor and evaluate nutrition programming (R 1.1 and R 2.1). In addition several results (R 2.2, R 2.3 and R 4.2) relate to communication and advocacy, in line with the UNAP objective to create awareness of and maintain national interest in and commitment to improving and supporting nutrition programs. In doing so, the ANSP fills some important gaps as identified in the gap analysis undertaken as part of the UNAP development\(^{183}\).

In line with the overall ANSP in all four countries, the programme in Uganda consists of a combination of activities at national, district and subcounty level. The geographical concentration of pillar 4 interventions is in 5 pilot districts. These districts –also called early riser or SUN districts, have been selected using two criteria: high levels of malnutrition and the presence of USAID/Community Connector Project (CC) Project. CC core activities are aimed at improving nutrition through community

\(^{183}\) The gap analysis consisted of comparing recent performance in Uganda in addressing young child and maternal nutrition with potential and desired performance. Please refer to page 11 of the UNAP.
based activities targeting rural households and connecting these activities to subcounty/district level activities. The ANSP complements these activities among others by building capacity of health staff in Integrated Management of Acute Malnutrition (IMAM), promotion of appropriate infant and young child feeding practices (IYCF) and growth monitoring and promotion (GMP). Outreach at community level is carried out by health facility staff and Village Health Teams trained by CC and ANSP staff. This strategy—consistent with the recommendation provided in the Mid-Term Review Report on the UNICEF Country programme—to strengthen the ability to respond at community level through strategic partnerships, results in synergies that maximize the contribution of the programme to reduction of malnutrition.

Cohesion in the programme is assured through linkages between the activities at district and subcounty level on the one hand and the national level at the other hand. Work done at district/subcounty-level feeds into policy development and vice versa. For instance, formative research on current nutrition practices, obstacles, and enablers to adequate nutrition has been used to inform the design of the community based nutrition model, but also the IYCF communication strategy at national level, and the communication BCC strategy at district/subcounty level. As outlined in the previous section, several results are expected at both country and district/subcountry level. The activities to this end are both synergistic and coherent. For instance, capacity building in multi-sectoral planning at country-level results in (costed) sector-specific operational plans, while capacity building at district/subcounty level results in multi-sectoral plans including budgets to be incorporated in national plans.

The ANSP in Uganda is a multi-stakeholder partnership (institutionalized through various Memoranda of Understanding), in which government—including (local) authorities, institutions (among others Makerere School of Public Health) and health facilities, UNICEF and the USAID/Community Connector Project work closely together and contribute financial and human resources towards the partnership.

2.2 Monitoring framework

The workplan for Uganda was revised during the first year after consultation with partners in order to reflect new realities including, among others the transfer of the coordination of the UNAP from the National Plan Authority to the Office of the Prime Minister and the fact that the ANSP had to find a new partner for the implementation of the base-line survey (and follow-up surveys). UNICEF also reviewed and adopted the ANSP indicator table for use in the five pilot districts, linking the indicator table to the logical model. In the draft indicator table (attached to the first interim report) all communication activities were reflected under Result area 1 (in line with the logical frame-work) and all capacity building activities under result area 2. However, the workplans for year 2 and 3 and the second interim report follow the original workplan (as per the revision in the first year) in which communication activities are part of pillar 2 and capacity building activities are spread over pillar 2, 3 and 4.

There are no major discrepancies between the original 4 year workplan and the subsequent workplans for year 1 and year 2 (apart from some delays, please refer to section 2.7.1) in terms of activities. However, there is a disconnect between the workplans and the logical framework. Firstly, the logical framework doesn’t make a clear distinction between activities and outputs. In addition, activities nor objectively verifiable indicators have been refined/updated. For instance, the activities under pillar 4 as outlined in the logical framework don’t include training of health providers or village health teams, establishing of IMAM partnerships with USAID/FT and others as summarized in the workplans. The ANSP in Uganda has not updated the logical framework because it doesn’t play any role in monitoring and reporting (which is guided by the annual work-plans).

Progress of the EC/ANSP is measured through annual surveys, activity reports, and annual project implementation reports. Overall achievement in terms of outcomes and impact towards the overall objective of contributing to reduced malnutrition will be measured by an end-line survey. Please refer to section 2.5 for more details. The main objectively verifiable indicators (OVIs) for the impact of the ANSP are reduced stunting, reduced anaemia and increased exclusive breastfeeding. Activities under R 4 are not well linked to these OVIs (for instance: no linkage between BCC and exclusive

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breastfeeding), targets are not realistic in view of base-line findings (please refer to section 2.8), have not been updated or were not set in the first place (anaemia).

2.3 Equity Focus

The EU/ANSP in Uganda is implemented in the following 5 pilot districts: Kabale, Kanungu and Ibanda in the South-Western Region, Nebbi in the West Nile Region (North-West) and Pader in the Northern Region. As mentioned in the previous section, one of the criteria used for the selection of these district, was a high level of poor nutrition. UDHS 2011 and base-line data indicate that the selected areas were well chosen in view of addressing needs of (some of) the worst off population groups. Firstly, the focus on rural areas is justified given the disparities in nutritional status, education and WASH indicators rural and urban areas. The table below provides data (derived from the UDHS 2011).

Table 2: Rural and urban populations (%) by nutrition indicators, education level and WASH indicators

<table>
<thead>
<tr>
<th></th>
<th>Rural (U5)</th>
<th>Wasting (U5)</th>
<th>Anaemia (U5)</th>
<th>No education (women)</th>
<th>Secondary + education (women)</th>
<th>Unimproved sanitation facility</th>
<th>Unimproved water source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>35.6</td>
<td>4.2</td>
<td>50.9</td>
<td>15.2</td>
<td>2.5</td>
<td>73.4</td>
<td>33.6</td>
</tr>
<tr>
<td>Urban</td>
<td>18.6</td>
<td>4.8</td>
<td>38.0</td>
<td>3.5</td>
<td>16.1</td>
<td>27.5</td>
<td>8.9</td>
</tr>
</tbody>
</table>

Secondly, the 5 pilot districts have poor nutrition indicators indeed, as a comparison between data from the UDHS 2011 and from the base-line survey carried out in these five districts shows. In terms of stunting, the selected districts (except Pader) all have a prevalence above the national average, while Kabale and Kanungu have levels which are also above the regional average. The prevalence of anaemia in all selected districts is well above the national average as well as above the regional averages. The levels of wasting (not one of the outcome indicators for the ANSP) in the selected districts are however by and large lower than national and regional levels, with the exception of Pader. Also the prevalence of maternal thinness in the five selcted districts is lower than regional and national averages.

Table 3: Stunting, anemia and wasting prevalence in ANSP pilot districts and by region

<table>
<thead>
<tr>
<th></th>
<th>National</th>
<th>South-West</th>
<th>Ibanda</th>
<th>Kabale</th>
<th>Kanungu</th>
<th>West-Nile</th>
<th>Nebbi</th>
<th>North</th>
<th>Pader</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting (U5)</td>
<td>33.4</td>
<td>41.7</td>
<td>34.9</td>
<td>42.0</td>
<td>43.0</td>
<td>37.8</td>
<td>33.6</td>
<td>24.7</td>
<td>21.8</td>
</tr>
<tr>
<td>Wasting (U5)</td>
<td>4.7</td>
<td>4.9</td>
<td>1.7</td>
<td>3.6</td>
<td>3.1</td>
<td>6.2</td>
<td>4.5</td>
<td>3.4</td>
<td>5.3</td>
</tr>
<tr>
<td>Anaemia (U5)</td>
<td>49.3</td>
<td>24.6</td>
<td>62.1</td>
<td>n.a.</td>
<td>n.a</td>
<td>64.4</td>
<td>91.9</td>
<td>34.0</td>
<td>70.2</td>
</tr>
<tr>
<td>Thinness (BMI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women 15-49 Y</td>
<td>17.9</td>
<td>18.6</td>
<td>5.1</td>
<td>2.1</td>
<td>2.8</td>
<td>34.0</td>
<td>10.5</td>
<td>20.6</td>
<td>10.9</td>
</tr>
<tr>
<td>Anaemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Women 15-49 Y</td>
<td>49.3</td>
<td>24.6</td>
<td>62.1</td>
<td>n.a.</td>
<td>n.a</td>
<td>64.4</td>
<td>91.9</td>
<td>34.0</td>
<td>70.2</td>
</tr>
</tbody>
</table>

As in other countries, the ANSP in Uganda has a naturally in-built gender dimension because of its orientation towards (pregnant and lactating) women. The programme is also clearly directed at the most vulnerable children (children under five with particular emphasis on children under two). Among children under five, boys are significantly more likely to be stunted than girls both at national level and in the 5 ANSP districts. In the latter the level of stunting among boys was 38.9% and among girls 30.7%. Wasting prevalence among boys was also higher, but the difference between boys and girls was not significant. Gendered differences were less pronounced among children aged 6-18 months;

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186 Wasting levels differ per season. If surveys are carried out at different times of the year, results are difficult to compare. Nevertheless, the differences in maternal thinness between the region and the targeted districts are too big to be explained by seasonal influence.
differences in levels of stunting between boys and girls tend to sharply increase after 18 months. Because the ANSP targets all children under 5, with emphasis on children under 24 months of age, the project provides potential opportunities to address gender-based differences in levels of undernutrition.\footnote{Formative research carried out under pillar 3 on IYFC and other practices impacting on nutrition didn’t explore the reasons for this gendered difference. Other research carried out in SSA suggests that maybe higher morbidity in boys is an underlying cause.}

The programme comprises a (substantial) BCC component, which includes broadcasting of tailor-made programmes and messages in the local language and the training of local drama/dance/singing groups in communicating IYCF messages, again in the local language, aimed at also reaching the least educated people who only speak the local language.

### 2.4 Pillar 1: Upstream policy development

#### 2.4.1 Relevance and Appropriateness

Under Pillar 1 the EC/ ANSP aims to support the implementation of the UNAP through guiding the planning process at national level as well as at district and subcounty level. During the first two years ToR were made for a team of consultants to facilitate sector specific plans, teams of consultants were recruited and sector implementation plans, including costing, were developed for the health / nutrition, the education and the WASH sector. Sector review meetings (5 days workshop) were held to identify key priority interventions for each sector. The plans were validated by stakeholders from various line Ministries, development partners (UN agencies, USAID), UNAP secretariat/ OPM) and a final report submitted. The plan for the gender, labour and social development sector, also supported by the ANSP, is underway. The development of costed plans for the other four sectors (Agriculture, Local Government, Finance and Trade & Industry) is supported by WFP/ REACH partners. All plans will be endorsed by the OPM.

The ANSP has also provided technical and financial assistance (through consultants) in the development of a Community Nutrition Implementation Guide. The aim of the guide is to help form a common understanding among partners in various sectors on what community nutrition programming is and how sectors can / should contribute to the implementation of community based nutrition activities. The guide has been endorsed for application at field-level programming by all sectors. Please refer to section 2.5 for details.

Under pillar 1 (R 1.2), the ANSP also provides technical and financial support for reviewing progress on the UNAP implementation. This includes support to the UNAP secretariat for overall coordination through the Uganda Nutrition Coordination Forum. During the first meeting in 2013 (combined with the costing validation workshop) priority interventions per sector for the next three years were identified and sectors tasked with refining their workplans accordingly. The ANSP also provides technical and financial support to the nutrition multi-sectoral technical coordination committee. Meetings are held monthly. Activities were relevant in upstreaming policy and appropriate, because they complemented each other and were carried out at the right moment.

Another output under this pillar is the revision and updating of the Food and Nutrition Policy Framework, in particular the Food and Nutrition Bill (in draft since 2009) and Food and Nutrition Strategy (in draft since 2005). The process is delayed due to hand-over issues. The Food Nutrition Council (which will include key line ministers and permanent secretaries). The planned approach under the ANSP will consist of providing technical support (consultants) and holding stakeholder meetings/workshops.

#### 2.4.2 Effectiveness

The UNAP has been effective in addressing gaps such as low prioritisation of nutrition by government, lack of coordination structure to link sectors on nutrition programming and poor appreciation of centrality of nutrition to development (to name a few of the gaps identified). The ANSP, by providing technical and financial support to stakeholders from various sectors and to the UNAP secretariat (OPM), has facilitated the involvement of key stakeholders in the implementation of the UNAP and the...
The development of multi-sectoral plans. A total of 52 people were involved including representatives from the seven line ministries and from the OPM/UNAP secretariat, development partners (FAO, UNICEF, WHO, WFP and USAID) and the REACH secretariat. The ANSP contribution is substantial, because of its scope (covering 4 sectors) and timelines (the process started soon after the overall supervision and coordination of the UNAP had been transferred to the OPM).

Sector plans complement each other and in doing so strengthen overall effectiveness of nutrition interventions. For instance, the sector plan drafted by the Ministry of Gender, Labour and Social Development focuses on an enabling environment. This entails the development of guidelines for maternal protection including among others maternity leave and enabling breast-feeding at the workplace. Both are known to positively impact on exclusive breast-feeding rates, in particular in combination with BCC messages. The Ministry will train labour inspectors and community development officers etc. to strengthen adherence to the guidelines.

In the sector plan for the education sector integration of nutrition in the curriculum is combined with the promotion of school gardening (both at primary and secondary schools), support to the improvement of processing and storage of food at school level, the use of fortified foods at boarding schools and support to establishing hand-washing facilities.

An unusual partner is the Ministry of Local Government (MoLG). MoLG has the mandate to issue locally applicable bylaws and ordinances. In several of the five ANSP pilot districts local government has announced new (or the revival of (parts of) old) ordinances in support of nutrition. These ordinances, sometimes proposed by the newly established nutrition coordination committees (please refer to section 2.4) not only define general principles, but also roles and responsibilities of community leaders, community members and village health teams and specify penalties. The latter is a very effective way of ensuring compliance. For instance, in Kabale, the MTE was informed that various male heads of households had been imprisoned after failing to build a pit-latrine (after a three months notice); here after a warning usually sufficed.

**Box 1: Mini Case study (related to effectiveness of output 1.1)**

**Strengthening nutrition through local government ordinances in Ibanda District.**

The objective of ordinance on food and nutrition 2013 issued in Ibanda District is to increase food production, distribution, storage, and consumption within the District. Under the ordinance, households have the duty (among others) to organize food production, storage, and protect annual production in the family; all adults have to promote public awareness on food security and nutrition with the help of the District Production Officer. The Village Health Teams and Health Workers shall (i) teach members of the community about the importance of a balanced diet and; (ii) encourage and sensitize members of the community to grow a variety of foods for home consumption. Village Health Team members shall not demand money from members of the community in exchange of services offered. Community leaders have to appoint one day of every month to carry out general cleaning and maintenance of village and access roads.

Any person (...) who fails or omits to perform his duty under the ordinance commits an offence and is liable on conviction to: Caution or Community Service not exceeding 6 month in case of a first offender; Imprisonment not exceeding 06 months on second conviction; both fine not exceeding 50 currency points and imprisonment not exceeding 6 months for a subsequent conviction.

Membership of and attendance at the technical coordination committee and the Uganda Nutrition Coordination Forum show strong involvement in and ownership of the UNAP including its implementation by the line ministries. The importance of ownership maybe illustrated by the case the Ministry of Water and Environment (MoWE). Because this Ministry was not among the Ministries involved in the development of the UNAP and no signatory, it felt no ownership and was unwilling to actively contribute to the development of the sectorplan for WASH.

For pillar 1 results, UNICEF has effectively combined funds from the ANSP with its in-house expertise in nutrition to ensure technical support where and when needed. Examples include the drafting of the TOR’s for nutrition consultants, recruiting nutrition expertise, supervision of the same and monitoring outputs. In addition, ANSP support to the organisation of validation and/or review workshops has been effective in fostering ownership and adjusting plans and priorities where appropriate.
ANSP activities in support of the revision of the Food and Nutrition Policy Framework have mainly consisted of advocacy with Parliament. Advocacy has included the production of Briefs, two Advocacy Sessions and drafting Resolution on Nutrition. The messages focussed on the nutritional challenges and what government and members of parliament (MP) could do to improve nutrition for children. MPs could: (i) review and enact the Food and Nutrition Bill; (ii) Require and monitor that critical sectors such as agriculture, education, water and sanitation and gender and labour plan and budget for nutrition; and: (iii) use nutrition messages for Ugandan families for education and awareness in their own constituencies. However, advocacy did not lead to prioritization of the review of the Food and Nutrition Bill, which has to be finalized before the Food and nutrition Policy can be handed over officially from the MAAIF to the OPM. As a result ANSP attempts to get the UNAP TWG to agree on TOR for the consultant to be recruited to support the revision (to be funded under the ANSP) were unsuccessful and preliminary work could not start.

2.5 Pillar 2: Institutional development and capacity building

2.5.1 Relevance and Appropriateness

The first result (R 2.1) under pillar 2 is strengthened capacity at national and district level (pilot districts) for planning, monitoring and implementation of community and facility based nutrition interventions in partnership with national / regional health service quality assurance institutions. To this aim, various activities have been undertaken by the ANSP. Firstly, the existing UNAP training package for local governments, developed by the OPM, has been revised with ANSP support. The package includes tools for planning, budgetting, implementation and monitoring of nutrition interventions. Part of this package was used to orient district and subcounty local government leaders towards UNAP and multi-sectoral nutrition program implementation in the five pilot districts. Also, in all five pilot districts nutrition coordination committees (DNCC) were established, whose members were also oriented on the UNAP. DNCC members typically include representatives from departments of Planning and Finance, Health, Community development, Education, Agriculture and Water. The DNCC chairperson is the Chief administrative officer (CAO). Membership of civil society organizations, the private sector and inclusion of political, academia and religious leadership is encouraged. DNCC members in turn were involved in the orientation of subcounty nutrition coordination (SNCC) committees.

The second activity under R 2.1 consists of the development of a comic book focussing on the importance of nutrition. The book is targeting primary school children and through them parents and the community. Topics covered include the improtance of eating a variety of foods in the right amount, a clean environment and seeking treatment when ill. The book advocates for multisectoral approaches including home-gardening and improving sanitation and hygiene practices. Various stakeholder meetings have been held to discuss and fine-tune the book. This activity has been undertaken on request of and in partnership with the MOES, following inclusion of nutrition in school health guidelines.

A third activity under R 2.1 is the development of a training package and tools for pre-service and in-service health care providers. For this activity, the ANSP is partnering with the Health Tutors College Mulago affiliated to Makerere University and under the MOES. The overall aim of the Health Tutors’ Curricula is to develop and equip health professionals with knowledge and skills for managing, teaching education and health related disciplines as well as conducting reserach. The college focus is on capacity building of mid-level professionals. ANSP supported activities during the first two years have included:

- Training of trainers (TOT) to incorporate nutrition training (for previous 1st and 2nd year tutor students).
- Development, pre-testing, validation and evaluation of a tool to incorporate nutrition in primary health care (PHC) and clinical placement activities.
- TOT of Kampala City Council Authority employees and Mulago Hospital preceptors to include nutrition in day to day PHC activities.
The ANSP has also provided materials to be used in the course and for participants to use at their work place. Materials provided include MUAC tapes, IYCF materials (counselling cards for health workers) and so on. The TOT courses do not specifically target health professionals from the five pilot districts (although there were participants from all pilot districts except Nebbi).

Next steps include the development of a training module and training guide for tutors of nursing and para-medical schools, conduct TOT on the developed module and train practicing tutors in Northern Uganda on the module.

The second output under pillar 2 comprises of advocacy pursued with agricultural sector for the inclusion of nutrition-oriented training modules into the curriculum of agriculture sector specialists. Stakeholders agreed that one training module on nutrition would be developed and used for all community level service providers including agricultural extension workers, community development officers, Village Health Team (VHT) members and so on. The VHT nutrition module developed by UNICEF is being revised to this end. This module (VHT Participants Manual A5 Draft 4, first drafted in 2011) does include already many linkages to (the work of) agricultural extension workers.

The third and last output/ result for pillar 2 comprises of capacity building of the media for reporting on and awareness creation on nutrition. The fist activity comprised of the finalization of a nutrition communication strategy and plan. The aims of the plan are to: (i) Create strong visibility, to increase the political stake in the issue of nutrition security and strengthen dialogue with key counterparts; (ii) inform and inspire nutrition security in the international community – linking national and international communication platforms and; (iii) demonstrate accountability for EU funding, showcasing how the funds are used. The plan is implemented under the guidance of UNICEF staff in Kampala. Activities during the first two years of the ANSP have included the following:

- Development of a media training package (which includes information on the UNICEF-EU partnership on reducing stunting in the Scale Up Nutrition countries in sub-Saharan Africa, the magnitude and impact of stunting in Africa and Uganda and ways media can promote awareness efforts on reducing anaemia and stunting in Uganda)
- Training of journalists
- Designing scripts and radio spots
- Development of 10 sessions for radio talk-shows in close collaboration with USAID, FHI360 and Community Connector Project
- Documentation of the project through video documentary and photography –following households/ project activities over time
- Contracts with five local radio stations
- Identification of local drama/dance/singing groups for nutrition awareness activities

Media coverage on nutrition, livelihoods and food security issues in Uganda is followed up on regularly and quarterly updates on nutrition issues to journalists are being provided.

### Box 2: Mini Case study (related to appropriateness of output 2.3)

**Local drama groups for nutrition**

Local drama/dance groups feature prominently in Uganda’s social life. No wedding, functioning or official event without a drama performance. There is ample evidence that drama can be an effective instrument in the spread of information. In Uganda, drama has been used extensively in campaigns to raise awareness on HIV/AIDS. Benefits and challenges are well documented. Challenges include the post-show implementation and funding. A major benefit is that shows are in the hands of the people and well accessible also for people who are illiterate. In addition drama is cost-effective (once start-up funding has been secured, the groups can maintain themselves).

The ANSP has identified in all pilot districts local drama groups. In total some 25 key groups at district-level and an additional 150 groups at parish level, consisting on average of 10 - 20 people, have been trained in writing songs/ dialogues on nutrition. The groups are mobilized whenever community based activities are organized to sensitize communities on nutrition activities and/ or create stronger awareness of nutrition and food security.

The initial log-frame included under pillar 1 the development of an advocacy strategy plus implementation plan as well as implementation of activities referred to in the advocacy strategy. The financial and technical support of this activity was taken up by USAID however, and a draft Uganda Nutrition Advocacy Strategy was finalized in December 2012. The ANSP contribution consists of making available a national consultant to draft the Social and Behaviour Change Communication Strategy (SBCC) and Plan 2013, which is to be finalized soon. A third component consists of the...
social mobilization sub strategy, which is being finalized by USAID/SPRING. Once the SBCC and social mobilization sub strategies are ready, the 3 pieces will be combined into a national nutrition communication strategy that will be costed by UNICEF.

2.5.2 Effectiveness

In all 5 district DNCC consisting of 8 to 10 members have been trained in planning and implementing nutrition services in 2013 (up to October. In addition, in each district 5 SNCC have been trained during the first phase. The second phase of training of SNCC members in remaining subdistricts is ongoing. The use of the cascade mode according to stakeholders has been very effective for both trainers and trainees, as it strengthens mutual understanding and commitment towards the common goal of multi-sectoral efforts to reduce malnutrition. By the end of October, some districts (like Kabale) had submitted to the Ministry of Finance or drafted (like Ibanda) the first ever multi-sectoral plans (plus budget) for nutrition. In Kabale district, several subcounties had also made multi-sectoral plans and submitted these to the district authorities. Nutrition coordination committees were said to be working well. The MTE was told however, that in particular among non-health professionals knowledge on nutrition was not (yet) sufficient for effective supervision (of village health teams, SNCC’s). The same was observed about new (district) nutrition focal points if these were non health professionals.

More than 100 students from 17 institutions (mostly nursing colleges/ midwivery schools) participated in the TOTs organized by Health Tutors College Mulago. After the first course (in 2012), tutors incorporated their new knowledge in the courses provided by their respective institutions. Because community work is part and parcel of most in-service training, tutors also had an opportunity to translate general information into context-specific information. This in turn was shared in the 2nd TOT year. In this way, tools and knowledge are permanently validated. Interestingly, several nurses who participated in the TOT also support school health programmes, thus ensuring that nutrition is integrated in school health, in line with the new School Health and Nutrition Policy.

As outlined above, stakeholders agreed to use one nutrition module for all community service providers. An advantage of using the same training module is that it unites service providers from different sectors under one umbrella. It also makes both training and supervision easier. All community level service providers will be periodically supervised (quarterly technical support supervision is planned for), in principle by DNNC members. A disadvantage some stakeholders expressed is that not all opportunities to link-up with sector specific responsibilities and activities can be included in one module. Elsewhere this has been solved by adding separate sector-specific modules as annexes.

The community component of the ANSP, the “Integrated nutrition programme”, was officially launched in February 2013 in the 5 pilot districts. In the South West, the prime minister launched the programme. The ANSP made good use of this high level event in terms of publicity by issuing a joint press release, facilitating radio talk-shows, a briefing for print, television and radio journalists and an exhibition of among others BCC materials developed for the project (banners, flyers, posters). The event attracted 3 Government Ministers and local government leaders (chief administrative officers, LC 5 members, RDC’s) from 13 districts in south western Uganda.

Communication materials developed under the project consistently carry the logo’s of the main partners: the GoU, SUN, EU, USAID and UNICEF, illustrating that activities are undertaken in partnership. An added advantage of this way of working is that EC visibility is increased in line with requirements. Training of journalist has been carried out in the South-West (25 journalists) and the North (9 journalists). Following the training in February 2013, nutrition in relation to the ANSP has been mentioned more than 25 times (up to September 2013) in radio messages, on television or in the newspaper.

An interesting feature of advocacy activities and training in awareness is the increasing attention for the role of men/fathers in improving nutrition. The importance of men in sharing the burden of women in child care, health seeking behaviour, home gardening and so on is a recurrent theme in all BCC activities ranging from the performances of the drama-groups and radio-messages to education materials (comic book) and work in support of policies/strategies (Social and Behaviour Change Communication Strategy (SBCC) and Plan 2013). This mainstreaming of “male gender”, if further strengthened could well be a major contributing factor in increasing effectiveness and impact.
2.6 Pillar 3: Nutrition data analysis and knowledge sharing

2.6.1 Relevance and Appropriateness

There are three activities under pillar 3. R 3.1 and R 3.2 consist of data gathering and analysis in support of pillar 4 activities in the five pilot districts. R 3.1 consisted of formative research to explore the triggers and enablers of improved nutrition and Infant and Young Child Feeding (IYCF) practices. The study aimed to (i) gain an appreciation of existing knowledge, attitudes and practices (KAP) and beliefs community members have about nutritional practices; (ii) learn about the challenges mothers face that affect adequate nutrition practices and (iii) determine what would encourage mothers to start employing adequate practices, to learn how mothers can improve feeding practices, and to ascertain the support mothers need to change their behaviour. The results of the research, carried out late 2012, were intended to inform the design of community-based nutrition programme interventions.

The first part of the research consisted of a literature review on maternal and child nutrition in Uganda and knowledge gaps. Given the identified gaps, the research then explored the socio-cultural and ecological factors affecting nutrition practices in target districts. Data was collected from purposively selected pregnant women, husbands of pregnant women and women who had recently delivered, mothers or female in-laws of the pregnant women and women with children under five particularly those living in the same household by means of focus group discussions. More than 40 focus group discussions were conducted, including discussions with different groups of key-informants ranging from village health teams (VHT) (2 VHT per district) to health facility staff (25 staff in charge, 25 nurses) and community development officers. The data was analysed using content analysis and organized in relation to the study themes and sub themes.

For R 3.2 and R 3.3. of the ANSP, UNICEF is partnering with the Uganda Nutrition Research Resource Centre at Makerere School of Public Health and MoH. The Uganda Nutrition Research Resource Centre has four broad aims: (i) Electronic and physical documentation of nutrition research data and information collected in Uganda; (ii) management and analysis of nutrition research data; (iii) Capacity building for partner agencies on nutrition data collection and handling; and (iv) Advocacy and Communication for nutrition. The centre has also been tasked with the base-line survey in the five pilot districts (R3.2), conducted in November 2012.

The broad objective of the base-line survey (R 3.2) was to obtain data on indicators on health, nutrition, food security, gender and socioeconomic status with a view to monitor and/or improve programming and policy interventions in the five pilot districts. The survey methodology followed the SMART protocol, in line with Uganda’s recommendations for nutrition surveys188. For the study a total of 1,284 households in the five pilot districts were selected, using a two stage random cluster sampling design. Data was collected on about all variables known to potentially influence nutrition outcomes, including: age; sex; weight; height; bilateral pedal oedema, morbidity for common diseases and conditions, infant feeding practices of children under five; ownership of household assets, livestock and land; income sources and expenditures; food consumption diversity; hunger and food security; education status; of mother and household head; water and sanitation; immunization/ supplementation and deworming; ownership and control of key household items/assets between husbands and wives; and time allocation to household chores between husband and wives. Data collected consisted of quantitative data only. Annual follow-up assessments will be carried out in all 5 pilot-districts to measure progress. Table 3 summarizes the main findings of the base-line survey.

188 Guidelines on Nutrition Survey Methodology in Uganda, MOH/WHO/ UNICEF/WFP
Table 4: Key findings ANSP base-line study in the five districts

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Base-line survey 2012</th>
<th>Country-baseline (UDHS 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting among children 6-59 months</td>
<td>35.0</td>
<td>33.4</td>
</tr>
<tr>
<td>Underweight among children 6-59 months</td>
<td>11.6</td>
<td>13.8</td>
</tr>
<tr>
<td>Wasting children 0-35 months (% severe)</td>
<td>3.5 (1.1)</td>
<td>4.7 (0)</td>
</tr>
<tr>
<td>Anaemia children 6-35 months &lt; 110 g/l (&lt;70 g/l)</td>
<td>75.8 (9.7)</td>
<td>49.3 (1.5)</td>
</tr>
<tr>
<td>Exclusive breast feeding (children 0-5 months)</td>
<td>72.0</td>
<td>63.0</td>
</tr>
<tr>
<td>Introduction of solid, semi-solid or soft foods</td>
<td>80.1</td>
<td>67.0</td>
</tr>
<tr>
<td>Median duration of breastfeeding (months)</td>
<td>22.0</td>
<td>19.0</td>
</tr>
<tr>
<td>Wasting of women 15-49 years (MUAC) / (BMI)</td>
<td>2.2 / 5.1</td>
<td>11.7 / 17.9</td>
</tr>
<tr>
<td>Anaemia women 15-49 years (&lt;110 g/l) (&lt;90 g/l)</td>
<td>50.0 (9.7)</td>
<td>23.0 (0.6)</td>
</tr>
<tr>
<td>Mothers’ educational status: non</td>
<td>12.2</td>
<td>12.9</td>
</tr>
<tr>
<td>Mothers’ educational status: above ordinary/secondary</td>
<td>3.4</td>
<td>5.2</td>
</tr>
<tr>
<td>Diarrhoea (children 6-59 months)</td>
<td>29.7</td>
<td>23.4</td>
</tr>
<tr>
<td>Fever (children 6-59 months)</td>
<td>41.0</td>
<td>40.4</td>
</tr>
<tr>
<td>Acute Respiratory Infections (children 6-59 months)</td>
<td>63.1</td>
<td>14.8</td>
</tr>
<tr>
<td>unsafe water (% of households)</td>
<td>34.2</td>
<td>29.7</td>
</tr>
<tr>
<td>no sanitation facility (% of households)</td>
<td>12.5</td>
<td>9.7</td>
</tr>
</tbody>
</table>

Under result 3.3 the ANSP supports the data collection function of the Uganda Nutrition Research Resource Centre, known as the Uganda National Research Repository (UNRR). The UNRR was established in 2011 with technical support from UNICEF and financial support from ECHO. The repository is both a physical and electronic data repository which provides access to data-sets and other raw materials from different sources on priority health topics including the Millennium Development Goals, risk factors, epidemic-prone diseases, health systems, environmental health, violence and injuries, equity among others see (see http://nutrition.musph.ac.ug/ and www.unr.ug). UNRR provides on-line access to UNICEF and WHO’s annual summary of health-related data, to useful links and relevant press releases etc.

2.6.2 Effectiveness

The formative research on nutrition pratices was a one time off exercise, primarily used to inform the BCC component of the ANSP. The chosen methodology, reviewing literature to first identify gaps in order to inform the survey is the standard approach to this type of research. Results, which were available in January 2013, have been used mainly to inform the BCC process: the development of messages (filling knowledge gaps), choice for channels of communication (for instance, which radio stations) and the design (such as the importance of including husbands). Although the aim was to identify both triggers/enablers of and factors hindering/limiting good practices, recommendations focus on mitigating the latter, much less on how enablers can be further strengthened or used as examples (for instance: what makes the majority of the women (72%)! practice exclusive breastfeeding? What are the characteristics of women who practice good IYCF? Positive deviants?). More emphasis on enablers has been found to increase the effectiveness of BCC, in particular those which targetgroups are able to practice themselves, and provide useful information for Trials of Improved Practices (which the researchers recommend to pilot).

The base-line study is well aligned with the UDHS in terms of data collected, but findings can’t always be compared because they are reported in a different format (for instance: minimal meal frequency is reported as average number of meals consumed instead of the number of children eating the recommended number of meals per age group), different cut-off levels are used (diet diversity) or information is not reported at all (prevalence of severe stunting and underweight). Comparing base-line findings with matching UDHS data as far as possible suggest that the overall malnutrition
prevalence (stunting and wasting) in the five pilot districts is comparable to the national average; anaemia and underlying morbidity and WASH factors are worse than national, whereas IYCF practices are better. However, in several of the five pilot districts, nutrition levels are worse than the overall averages (please also refer to section 2.2).

Several partners at district level told the MTE team that results of the base-line survey were considered an “eye-opener”, justifying greater focus on nutrition. The ANSP failed to fully capitalize on this positive reaction. Findings were hardly shared outside the pilot districts (and are not readily available from the internet). In addition, the official release of the survey was several months after publication.

Because the survey will be repeated each year (in principle in the same month) progress of the program can be measured on an annual basis. Additionally, because many underlying factors are also measured, findings can be (and are intended to be) used to adjust interventions (ranging from BCC messages to community based activities carried out by partners) or to intensify advocacy for complementary action. Many opportunities for using this tool effectively are under-utilized however. These include more in-depth analysis of quantitative data (multivariate analysis to identify the groups most at risk); combining quantitative data with qualitative data collection (multi sector key informant interviews, FGD with livelihood groups) to identify nutrition bottlenecks) for the analysis of livelihoods (strengths & bottlenecks), for triangulation purposes and to feed into (district) training and more complete and comprehensive reporting (and use of standard cut-off levels).

2.7 Pillar 4: Scaling up nutrition

2.7.1 Relevance and Appropriateness

The first output under pillar 4 (R 4.1) is creating local capacity for scaling-up (SUN) nutrition interventions in the 5 pilot districts. Activities under this result complement output R 4.2, which consists of ensuring support for BCC activities to promote nutrition in collaboration with the USAID Community Connector and district authorities. The combined activities provide a scalable model for nutrition interventions to reduce stunting, which, if effective will be rolled out.

The first activity under R 4.1 comprises the creation of local capacity for community based/ integrated management of acute malnutrition (IMAM). Several activities to this aim have been carried out. Early 2013, UNICEF commissioned an assessment to obtain information on nutrition related capacity at health facility level. Another aim of the assessment was to identify health workers for training. The assessment was carried out by district health teams and staff from Mwanamugimu nutrition unit at Mulago Hospital with financial and technical support from UNICEF/ANSP. The Mwanamugimu nutrition unit also trained national nutrition trainers and supervisors. Another activity under this pillar has been training of district health team members and health workers in IMAM. A package especially developed for mentorship and supervision was used to train the district health teams in supervision, monitoring (and making action plans to this end), data collection etc. Supplies for IMAM were provided under the ANSP as well. These included materials (MUAC tapes, weighing scales, measuring boards, registration materials and so on) and therapeutic food supplies (RUTF, F100, F75 and resomol).

Another activity under R 4.1 consisted of capacity building in IYCF, notably growth monitoring and promotion (GMP) and micronutrient suplementation (IFA and micronutrient powder) as well as BCC. Capacity building of health workers in IYCF was combined with capacity building in IMAM.

Result 4.2 also consists of a set of complementary activities. Firstly, a BCC booklet and materials were developed and printed (based on among others the results of the formative research undertaken under pillar 3). Second, local drama / informal groups were identified and trained in BCC messaging. Third, as outlined in section 2.5.2, the media were catapulted for creating awareness on nutrition. Lastly, village health team members were trained in community nutrition. These community based activities complement health workers efforts in educating caretakers/ mothers on IYCF. To further strengthen BCC, UNICEF will also sign a contract with Community Development Foundation Uganda (CDFU), an NGO with good BCC expertise.
For all the activities under pillar 4 UNICEF closely collaborates with the USAID funded community connector (MOU signed in October 2013). This collaboration is highly relevant, because the activities of the community connector project (CC) are hand in glove with the ANSP activities.

### Box 3: Mini Case study (related to the relevance of output 4.2)

**Partnership with CC**

The goal of the CC is to reduce poverty through improvement of nutrition outcomes and the livelihoods of the most vulnerable households in targeted districts. CC use the family life model to frame activities. Activities at community level are aimed at improving (i) livelihoods (establishing of and support to community groups for poultry, home-gardening, tree-nurseries); (ii) nutrition related behavior through BCC and (iii): household hygiene practices (installation of drying racks, tippy taps (hygienic water “taps” made out of a plastic bottle and wood), pit-latrines and bath shelters, stimulation / facilitation of use of water harvesting, energy saving stoves). CC’s approach consists of organizing sensitization meetings for and by local leaders, nutrition and livelihood campaigns, community dialogue meetings aimed at community members. The programme is implemented by professional staff in close collaboration with volunteers. In each sub-county the work is coordinated by (paid) community connector officers (CCO) who rely on a network of community knowledge workers (mostly female) for work at community level (not paid, but receiving incentives). These in turn supervise community nutrition promoters (nearly all female) who serve as models for the community. The latter are unpaid, but CC supports income generating activities carried out by these promoters (providing seedlings at low costs that the promoters can sell with a little profit). CC also closely works with institutions: with schools to support school gardening, with health facilities for WASH.

#### 2.7.2 Effectiveness

As part of the health facilities’ assessment commissioned by UNICEF mentioned in the previous section, a total of 146 health facilities were visited in the five pilot districts. All facilities were found to have linkages to community workers/volunteers, usually to VHTs. 64% of all VHTs were involved in outreach services, and clients were often (40%) referred to community workers/volunteers. Many VHTs (64%) had been trained in the basic VHT package but very few (5%) had been trained in the additional nutrition module yet. Weighing scales, height boards, MUAC tapes, as well as child health cards were found to be generally available but clinical methods to assess malnutrition, such as checking for oedema and pallor, were generally more popular than anthropometry and malnutrition was rarely classified. Nutrition education was conducted at a few health facilities only, sessions were not documented and the number of health workers trained was very low or zero. A few facilities in each of the districts (but not any in Ibanda and Nebbi Districts) possessed copies of the Infant and Young Child Feeding Policy Guidelines and used them. The assessment team identified 30 health facilities which provided outpatient and inpatient IMAM, the latter at hospital at district level and at health centre IV level (officially there is one health centre IV per subcounty, but only those with a medical officer qualify for IMAM in-patient care). A strong point, increasing its effectiveness, of the assessment was that it identified which resources (human as well as material) were available (and/or could be mobilized from local resources). This enabled DHTs and UNICEF to make per district tailor-made plans for strengthening IMAM in terms of capacity building/supervision and the provision of supplies.  

For capacity building in IMAM and IYCF a cascade approach was used. First, 15 national trainers and supervisors were trained by the Mwanamugimu nutrition unit at Mulago Hospital. Next some 210 health workers were trained. Lastly, 60 district health team (DHT) members were trained in supervision and monitoring skills. Some of the trainers and supervisors (e.g. district nutritionists) are part of the DHT, whereas others are based at health centers (mainly at HC IV). In each district, the DHT also appointed from its midst a nutrition supervision team, typically consisting of a medical officer, the district nutritionist and a nurse. The ASNP thus builds on and strengthens an activity which already existed (supervision through out-reach by the DHT), but did not include supervision of nutrition service delivery. An additional advantage is that supervision includes all service delivery not only nutrition services.

During a second phase training an additional 300 health workers were trained. In addition, 600 members of village health teams were trained in community nutrition, including GMP and MUAC.

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189 During the third year of the ANSP (2014), a pilot will be carried out on home fortification with micro-nutrient powder (MNP, consisting of 15 ingredients) in eight districts in Uganda including the five ANSP districts. UNICEF/WFP are the lead UN agencies. The supplies will not be funded under the ANSP, but all other activities including capacity building and BCC will be integrated in existing ANSP activities.
screening. The VHT’s play a significant role in mobilizing community members for out-reach activities carried out by health teams. They also assist health workers with registration, nutrition education etc.

Supervision teams conducted quarterly supervisory visits (visiting approximately 30 health facilities in each district with a special focus on nutrition). Field visits revealed several challenges regarding GMP and IMAM. Registration was sometimes (still) poor (and/or faulty), children were not yet screened in all facilities (and/or not at every entry-point) and in some districts supplies (RUTF) were not always delivered in time and/or in sufficient quantities. The consensus appeared to be that more supervision would solve most of these problems (including supply issues). Despite these challenges, overall progress during the first year (2013) was considerable in terms of coverage and timely detection of acute malnutrition.

Data illustrate that investments in CMAM (training, setting up structures and the provision of supplies) have been effective in reducing SAM. This is largely due to strengthened community screening (MUAC) which identifies children at risk of SAM at an early stage. Care-takers of children suffering from moderate acute malnutrition (MAM) without complications are counselled by health staff and VHT on IYCF and health seeking behaviour. A weaker point in CMAM is that there have been gaps in the supply of RUTF (in among others Nebbi). In addition, RUTF is expensive and provision of RUTF through the routine health system is too costly to be sustained without donor support. USAID is currently funding WFP/UNICEF in support of testing the feasibility of the local production of RUTF.

As mentioned in section 2.4.2, the ANSP in partnership with CC also trained 34 journalists to improve their knowledge in nutrition and raise their interest in incorporating nutrition messaging in the media. Following contracts with local radio stations, six radio talk shows were facilitated and 35 radio spots on infant feeding and maternal health were aired in the local language. In addition, two BCC working group meetings were conducted to orient the stakeholders on the “bottom up approach” in message development with a focus on refining messages from the community for translation into the BCC booklet, propose media changes, review/define doable actions at community level and propose new BCC materials.

2.8 Efficiency

2.8.1 Operational Efficiency

The implementation of the ANSP is per detailed annual work plans and an overall 4 year workplan. For each of the pillars, the annual workplans contain expected outputs, planned activities, activity outputs, a timeline, lead agency and partners (but not detailing specifically who is doing what, when and where). The 4 year workplan specifies base-line and end-line indicators.

The first and second interim reports provide information on the operational efficiency. During the first year, the periodic review on progress made under the UNAP was delayed, mainly due to the fact that coordination of the UNAP moved from the National Planning Authority to the OPM. In year 2, this activity was on track, but result 1.3, the revision and updating of the Food and Nutrition Policy Framework was delayed again due to the need to transfer responsibilities (from the MAAIF to the OPM). Because the result areas and the reporting format for year 1 and year 2 are different, it is not self-obvious whether all activities under pillar 2 were on time. Result 2.2 consisting of advocacy targeting the agricultural sector to include nutrition oriented training into the curriculum of agricultural staff—including agricultural extension workers, did take place, but training itself was delayed. Stakeholders agreed that one training module for all community level service providers was preferred, and the existing module should therefore be adjusted accordingly (which is taking time). Consequently, during the first two years, agricultural extension workers were not included in the training. Results under pillar 3 were carried out according to plan, but the base-line survey was delayed from May to to November 2012 because a new partner had to be found, and results were not fully available and shared until the first half of 2013. Activities for results area 4 were on time. Details of operational efficiency as compiled by the MTE from the Y 1 and Y 2 interim reports are summarized in the table below.
Table 5: Level of accomplishments for activities per pillar

<table>
<thead>
<tr>
<th></th>
<th>Pillar 1</th>
<th>Pillar 2</th>
<th>Pillar 3</th>
<th>Pillar 4</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of activities</td>
<td># of activities</td>
<td># of activities</td>
<td># of activities</td>
<td># of activities</td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>No</td>
<td>-</td>
<td>-</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>2011 - 2012</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>2012 - 2013</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1 (?)</td>
<td>9</td>
</tr>
</tbody>
</table>

Financial resources were available in time (although there were delays in the disbursement of funds from the EC due to unfamiliarity with EC procedures at UNICEF ESARO). The MTE observed, that the project is largely managed by a national nutrition specialist rather than an international P4 nutrition manager as planned (not funded under the ANSP). This post has been vacant for over a year now. An important factor contributing to operational efficiency in particular for pillar 4 outputs is UNICEF’s collaboration with the CC.

Box 4: Mini Case study (related to efficiency of outputs 4.1. and 4.2)

Rationalizing resources through collaboration

The collaboration between the CC, ANSP and the GoU not only positively impacts on the overall effectiveness of the ANSP (the added value of the sum of activities of the three partners being far greater than the impact/added value of the activities separately), but also on the cost-effectiveness (efficiency). There are many examples of how the partnership enables stakeholders to rationalize resources. Examples include the following: (i) CC staff supports, supervises and monitors the work of various community groups of volunteers such as community knowledge workers, growth promoters and drama groups and provides technical support to sub-county coordination committees (complementing governmental services); (ii) UNICEF capacity building improves supervisory and monitoring skills of governmental staff not only in nutrition but in other sectors as well (planning and budgeting, reporting) and; (iii) GoU health staff supervises and monitors IMAM activities and reports on progress (on behalf of all partners).

In the three districts in South Western Uganda –new districts for UNICEF, where a sub-office has not yet been established, CC are UNICEF’s eyes and ears. CC collect data and reports, liaise with authorities at all levels, monitor progress of ANSP supported activities (activities supported by the ANSP only as well as activities supported by more partners including CC) and update UNICEF Kampala regularly.

2.8.2 Financial Efficiency

The total amount available from the EC/ANSP budget in Uganda is € 1,459,372. In addition, for the first two years UNICEF made available from its own resources € 115,925. The budget for the first year was € 313,075. Expenditure in year 1 amounted to € 218,832 or 62% of the ANSP budget for the first year. The budget for year 2 was € 345,548, while actual expenditure was € 722,970 (from the ANSP budget) plus € 90,215, a total of € 813,185 or more than twice the original budget. During the first two years 63% of the EC budget was spent, leaving some € 543,279 for the remaining two years. The projected costs for year 3 are € 658,100, leaving a shortage for year 3 and no funds at all from the original ANSP allocation for year 4. UNICEF therefore has to secure funds from other sources.

Table 6: Available funding and utilization of funds (Oct 2011 - Sept 2013)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC/ ANSP allocation (a)</td>
<td>1,459,371</td>
<td>313,075</td>
<td>345,548</td>
<td>543,279</td>
</tr>
<tr>
<td>Funds from other sources (b)</td>
<td>115,925</td>
<td>25,710</td>
<td>90,215</td>
<td>114,821</td>
</tr>
<tr>
<td>Total budget (a + b)</td>
<td>338,785</td>
<td>425,763</td>
<td>658,100</td>
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</tr>
<tr>
<td>Expenditure EC (c)</td>
<td>193,122</td>
<td>722,970</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditure other (d)</td>
<td>25,710</td>
<td>90,215</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total expenditure (c + d)</td>
<td>218,832</td>
<td>813,185</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% utilization of EC budget (c) / (a)</td>
<td>62</td>
<td>209</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% utilization of total budget (c + d) / (a + b)</td>
<td>65</td>
<td>191</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance EC for next years</td>
<td>1,266,249</td>
<td>543,279</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Uganda’s budget is smaller than the budget for the other three ANSP countries, amounting to less than 20% of the total allocation for the four countries (and 7% of the total amount available for the ANSP). Table 3 demonstrates that Uganda has been spending relatively more than the other three countries...
during the first two years of the ANSP, with a particular high expenditure for pillars 3 (83% of available funds) and pillar 4 (63% of available funds).

As summarized table 5, the ANSP budget for Uganda during the first two years consisted for 74.8% of funds from the ANSP programme while 15.2% of funds came from UNICEF’s own resources. This is not significantly different from the overall ANSP distribution (85.7% from the ANSP budget and 14.3% from other sources including UNICEF’s own resources), as the figure below demonstrates.

**Figure 1: Available ANSP funding and utilization of funds (Oct 2011 - Sept 2013)**

Expenditure broken down per budget-line for 2012 and 2013 was provided by UNICEF as well. The figures are for fiscal year 2012 and 2013 and therefore don’t match the figures provided in table 5 and Figure 2. The break-down was calculated to see how the project expenditure was divided over the traditional (more commonly used) budget-lines. Figure 2 illustrates that expenditure was fairly evenly distributed among the different budget-lines.

**Figure 2: break-down per budget-line**

The ANSP has also been able to leverage funds for the roll out of the program into other districts. DFID has committed 10 Mio US$ for the extension of the programme in the the Karamoja region, the poorest region of Uganda with the highest levels of child and maternal undernutrition. In addition CIDA has made available 3 Mio US$ for complementary micro-nutrient activities. Funding under the ANSP
has thus been successfully used as “seed money”, to convince other donors that it’s possible – through a concerted effort at national, district and sub-county level – to deliver results worthwhile to be replicated.

Another aim of the ANSP is to prompt the GoU for funding for nutrition (and eventually completely incorporate nutrition in the national budget). As of the last quarter of 2013, two out of five districts had submitted a budget for nutrition (please also refer to section 2.4.2) to be incorporated in next year GoU budget. In addition, the GoU contributes substantially in kind through staff and supplies.

### 2.9 Impact

The ANSP has enabled UNICEF to play an increasingly important role in upstreaming policy development in nutrition. UNICEF’s role has evolved from being one of the (many) stakeholders at the time the UNAP was drafted, to being a key partner in the further development of the UNAP and its actual implementation. By facilitating the development of multi-sectoral plans at central level and in (pilot) districts/subcounties, the ANSP may well have substantial long term impact on reducing malnutrition in Uganda through policy development (and the implementation thereof). The MTE heard time and again that the ANSP could further add value to the process by increasing its support towards the development of guidelines and of multi-sectoral plans in sectors which have not yet done so and by rolling out nutrition interventions in new districts and increasing capacity building (including support to refresher courses) and curriculum development, both of which would consolidate impact.

Evidence suggests that behaviour is influenced by many different factors, including interpersonal factors (family, peers, social networks), community (school, work place, and institutions), and governmental (local, state, and national policies). Under the ANSP, BCC at community level is complemented by BCC through the media, at schools (through the school health programme in which nutrition is gaining momentum), and at governmental level (ranging from the creation of local platforms for nutrition such as district coordination committees to the issuance of ordinances for improving food and nutrition security). In addition, CC livelihood activities at community level facilitate households transition to improved (child) feeding habits. The combination is likely to positively impact on behavioural change.

The outcome indicators for R 4.1 include decreased # of children stunted, underweight and wasted and an increase in the # of children exclusively breastfed. The objectively verifiable indicators (OVI) in the original workplan were: stunting reduced by 5% points (from 46% to 41%) and exclusive breastfeeding up from 35% to 65%. Base-line data indicate that in 2012 the prevalence of stunting was 35% (well below the the planned reduction to 41%) and exclusive breastfeeding was 72% (well above the foreseen increase to 65%) in the five pilot districts. Unfortunately, the (originally, tentatively) set goals were not re-evaluated to take into consideration base-line figures (no adjustment was found in the workplan for year 3). The Cost of Hunger in Africa study on Uganda recommendation for stunting is to set aggressive targets in Uganda and establish a goal of 10% reduction.

The recently published framework for actions to achieve optimum child nutrition (Lancet 2013) outlines three groups of immediate underlying factors influencing child nutrition: (i) breastfeeding, nutrient rich food and eating routine; (ii) feeding and care-giving practices and parental stimulation and (iii) access to use of health services and safe and hygienic environment. The ANSP in Uganda addresses a substantial number of these because of its smart partnerships (for example: the ANSP support to health facilities (direct for nutrition, indirect because increased supervision of the District Health Teams can also be expected to positively impact on the overall performance of the health sector) in combination with CC’s community based activities aimed at improving a safe and hygienic environment. An opportunity not fully utilized is the linkage between UNICEF’s water /WASH program and the ANSP. This programme is only implemented in Nebbi and Pader (traditional UNICEF Districts) and linkages are not very strong.

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190 Black R. E et. al. Maternal and child undernutrition and overweight in low-income and middle-income countries, Lancet vol. 382, August 2013, p 428
Nevertheless, given its broad scope, it is highly likely that ANSP is well equipped to contribute to a substantial reduction of stunting (5% in four year seems too modest!). However, it will be impossible to attribute this to specific activities undertaken by the ANSP.

2.10 Sustainability

The ANSP is designed in such a way that many results are likely to be sustained well after the life span of the project. Firstly, the ANSP is a true multi-stakeholder partnership in which UNICEF, government, and the USAID/Community Connector Project work closely together, all contributing financial and human resources towards the partnership. The ANSP builds on and furthers ownership of multisectoral approaches for nutrition at all levels as intended (and formulated) in the UNAP. The work done under pillar 1 pillar is potentially sustainable because (i) nutrition is being tackled through a multi-sectoral approach which addresses important immediate causes of malnutrition (notable IYCF and poor WASH); (ii) because multi-sectoral plans (national, district and sub-county plans) are to be incorporated in Uganda’s national budget. The total costs for all nutrition programming is an estimated 0.7% of the budget. The common opinion among stakeholders appears to be that advocacy is needed to secure financial resources from the GoU to support nutrition at central level and from donors – at least for the time being, for the roll-out of multi-sectoral approaches at District/subcounty level.

Capacity building under pillar 2 for multi-sectoral planning, characterized by a cascade approach supported by the development / further refinement of tools improves the potential sustainability, in particular if rolled out to include more districts.

The routine health management information system collects very few data on nutrition. The data which are collected (malnutrition as disease, growth monitoring) are not filled in at all or erroneously (malnutrition as disease is usually overlooked). The UNAP monitoring and evaluation framework does not entail any linkage to the routine HIMS. The base-line surveys and annual follow up surveys, effective as they maybe in monitoring progress, are not sustainable beyond the life-time of the ANSP in the present set-up. There is no policy to employ (and train) supervisors and enumerators for these surveys from among the rank and file of community workers (including CDOs, agricultural extension workers, members of VHT), which is a lost opportunity to increase sustainable expertise in monitoring and evaluation.

Support to the Uganda National Nutrition Repository under pillar 3 has a positive impact on availability of (in- and out-country) information on nutrition and analysis thereof. There are many models possible to ensure financial sustainability at the long term, including increased involvement of staff and students of Makerere University, involvement of the private sector (e.g. to facilitate marketing of fortified foods). Plans remain to be developed.

Many activities under pillar 4 have also in-built mechanisms for potential sustainability. These include the implementation of multi-sectoral plans (under the budget of the GoU), capacity building of health staff and VHT in nutrition (providing districts continue to provide funds for supervision) and the work of community nutrition promoters (income generating activities in combination with BCC).

3 Conclusions

Relevance

The ANSP is well aligned with the strategies to address nutrition outlined in the Uganda Nutrition Action Plan 2011-2016 (UNAP), in particular to strengthen GoU capacity to scale up nutrition through a multi-sectoral approach at national, district and sub-county level and deliver on the UNAP commitments related to strengthening of policy, legal and international frameworks and the capacity to effectively plan, implement monitor and evaluate nutrition programming. Several ANSP results relate to communication and advocacy, also in line with the UNAP objective to create awareness of and commitment for improving and supporting nutrition programs. The ANSP fills some important gaps as identified in the gap analysis undertaken as part of the UNAP development.
The ANSP in Uganda is a multi-stakeholder partnership (institutionalized through various Memoranda of Understanding), in which government – including (local) authorities, institutions (among others Makerere School of Public Health) and health facilities, UNICEF and the USAID/ Community Connector Project work closely together and contribute financial and human resources. Cohesion in the programme is assured through linkages between the activities at district, subcounty and community level on the one hand and the national level at the other hand. Work done at district/subcounty/community level feeds into policy development and vice versa.

Equity Focus

The ANSP is clearly directed at the nutritionally most vulnerable: children under five (with particular emphasis on children under two) and pregnant and lactating women. As such, the programme has a naturally in-built gender dimension, like all ANSP country programmes. An interesting feature of advocacy and BCC activities is increased attention for the role of men/fathers in improving nutrition. This mainstreaming of “male gender”, if further strengthened, could be a major contributing factor in increasing the overall effectiveness and impact of the ANSP in Uganda.

The selection of the five pilot districts is appropriate in view of their poor nutrition indicators. Also the focus on rural areas is justified given the disparities in nutritional status, education and WASH indicators between rural and urban areas. The ANSP also addresses inequity in its BCC activities by targeting the least educated through radio-broadcasting tailor-made programmes and messages and performances of local drama groups in the local language.

Effectiveness

The ANSP has facilitated the involvement of key stakeholders in the implementation of the UNAP and the development of multi-sectoral plans. These plans complement each other and will therefore strengthen overall effectiveness of nutrition interventions. UNICEF has effectively combined its in-house expertise in nutrition with ANSP funding to ensure technical and financial support where and when needed. A particular strength in Uganda is the involvement of the Ministries of Gender, Labour and Social Development focusing on an enabling environment (like maternity leave) and Local Government, mandated to issue locally applicable bylaws and ordinances (like the Ibanda ordinance aimed at increasing food production and consumption). Results for capacity building under pillar 2 and pillar 4 are substantial in terms of the scope of activities and numbers of people trained. Use of the cascade approach has facilitated coverage, enabled training of relatively large numbers of different stakeholders in a short time and contributed to ownership.

Collaboration between the GoU, the ANSP and the CC is positively impacting on the overall effectiveness of the ANSP: the added value of the sum of activities of the three partners is far greater than the impact/added value of the activities separately, in particular for pillar 4 activities. In the three districts in South Western Uganda – new districts for UNICEF, where a sub-office has not yet been established, CC are UNICEF’s eyes and ears.

Efficiency

The rate of progress in Uganda has been quite satisfactorily despite some delays, mostly outside UNICEF’s control. Partnerships have positively impacted on the cost-effectiveness. There are many examples of how collaboration has enabled stakeholders to rationalize resources.

ANSP budget for Uganda is smaller than the budget for the other three ANSP countries, amounting to less than 20% of the total allocation for the four countries (and 7% of the total amount available for the ANSP). Uganda has been spending relatively more than the other countries during the first two years of the ANSP, with a particular high expenditure for pillar 3 (83% of available funds) and pillar 4 (63% of available funds). Due to the high expenditure, the budget for year 3 shows a deficit, while there are no ANSP funds left for year 4. About 15% of the funding came from UNICEF’s own resources.

Impact

The ANSP in Uganda is able to address a substantial number of immediate underlying factors influencing child nutrition because of its smart partnerships. For example, ANSP support to health facilities (capacity building and providing supplies for CMAM and IYCF) will have a direct impact on
nutrition, but also an indirect effect because increased supervision of the DHTs will positively impact on the overall performance of the health sector. The partnership with CC for community based activities aimed at improving a safe and hygienic environment and diet diversity through home gardening will further increase impact. However, there seem to be unused opportunities for linking the ANSP to UNICEF’s water/ WASH and education activities in Nebbi and Pader districts (traditional UNICEF Districts).

Given its broad scope, it is highly likely that ANSP is well equipped to contribute to a substantial reduction of stunting. The set goal of 5% in 4 years is too modest, and 10% as recommended by the COHA seems feasible. However, it will be impossible to attribute this to the ANSP.

**Sustainability**

The ANSP is designed in such a way that many results are likely to be sustained well after the life span of the project. The ANSP builds on and advances ownership of multisectoral approaches for nutrition at all levels as intended (and formulated) in the UNAP. Under pillar 1, the ANSP supports government instution to make multisectoral plans at national, district and sub-county level, to be incorporated in Uganda’s national budget. The latter two also increase sustainability of activities under pillar 4, once district and sub-county budgets for nutrition are resourced. Emphasis on capacity building in multi-sectoral planning and in nutrition specific interventions (CMAM, IYCF including BCC and GMP) further adds to sustainability. There are some concerns on the sustainability of the latter in terms of full incorporation in the health system, in particular of supplies (RUTF).
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immuno-Deficiency Syndrome</td>
</tr>
<tr>
<td>CC</td>
<td>Community Connectors</td>
</tr>
<tr>
<td>CMAM</td>
<td>Community Based Management of Acute Malnutrition</td>
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<tr>
<td>DHT</td>
<td>District Health Team</td>
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<tr>
<td>DNCC</td>
<td>District Nutrition Coordination Committees</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture Organization</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GoU</td>
<td>Government of Uganda</td>
</tr>
<tr>
<td>HC</td>
<td>Health Centre</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-Deficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>IMAM</td>
<td>Integrated Management of Acute Malnutrition</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
</tr>
<tr>
<td>LC 5</td>
<td>(Local) Council of the District</td>
</tr>
<tr>
<td>MAAIF</td>
<td>Ministry of Agriculture, Animal Industry and Fisheries</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDG(s)</td>
<td>Millennium Development Goal(s)</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, New born and Child Health</td>
</tr>
<tr>
<td>MoES</td>
<td>Ministry of Education and Sports</td>
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<tr>
<td>MoFPED</td>
<td>Ministry of Finance, Planning and Economic Development</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MP</td>
<td>Member of Parliament</td>
</tr>
<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
</tr>
<tr>
<td>NDP</td>
<td>National Development Plan</td>
</tr>
<tr>
<td>NPA</td>
<td>National Planning Authority</td>
</tr>
<tr>
<td>OPM</td>
<td>Office of the Prime Minister</td>
</tr>
<tr>
<td>OVI</td>
<td>Objectively Verifiable Indicator</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>RDC</td>
<td>Resident District Coordinator</td>
</tr>
<tr>
<td>REACH</td>
<td>Renewed Efforts Against Child Hunger</td>
</tr>
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