META-ANALYSIS OF UNICEF’S NUTRITION PROGRAMME EVALUATIONS (2009-2013)


March 2014

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The report was prepared by independent consultant David Ito with significant guidance and support by the Evaluation Office. Krishna Belbase, Senior Evaluation Officer, managed and led the process with active engagement from Nutrition Section, Programme Division.

The purpose of the report is to facilitate the exchange of knowledge among UNICEF personnel and its partners. The contents of the report do not necessarily reflect the policies or views of UNICEF.

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ACRONYMS

AIDS  Acquired Immunodeficiency Syndrome
ASEAN  Association of Southeast Asian Nations
AUC  African Union Commission
CDC  Centers for Disease Control and Prevention
CEE/CIS  Central and Eastern Europe/Commonwealth of Independent States (Regional Office)
CHW  Community Health Worker
CMAM  Community Management of Acute Malnutrition
CO  Country Office
C4D  Communication for Development
DFID  Department for International Development (of the UK)
DHS  Demographic and Health Survey
EAPRO  East Asia and Pacific Regional Office
ECOWAS  Economic of West African States
ESARO  Eastern and Southern Africa Regional Office
EU  European Union
GAIN  Global Alliance for Improved Nutrition
GEROS  Global Evaluation Reports Oversight System
GMP  Growth Monitoring and Promotion
HIV  Human Immunodeficiency Virus
HQ  Headquarters
IFA  Iron and Folic Acid
IFCR  International Federation of the Red Cross and Red Crescent Societies
IP  Implementing Partner
IYCF  Infant and Young Child Feeding
KAP  Knowledge, Attitudes and Practice (Survey)
IMAM  Integrated Management of Acute Malnutrition
MAM  Moderate Acute Malnutrition
MDG  Millennium Development Goal
MENA  Middle East and North Africa (Regional Office)
MICS  Multiple Indicator Cluster Survey
MMN  Multiple Micronutrients
MNP  Micronutrient Powder
M&E  Monitoring and Evaluation
NGO  Non-governmental Organisation
OECD/DAC  Organisation for Economic Co-operation and Development/Development Assistance Committee
OTP  Outpatient Therapeutic Programme
REACH  Renewed Efforts Against Child Hunger and Undernutrition
RO  Regional Office
ROSA  Regional Office for South Asia
RUSF  Ready to Use Supplementary Food
RUTF  Ready to Use Therapeutic Food
SAARC  South Asian Association for Regional Cooperation
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAM</td>
<td>Severe Acute Malnutrition</td>
</tr>
<tr>
<td>SC</td>
<td>Stabilisation Centre</td>
</tr>
<tr>
<td>SO</td>
<td>Specific Objective</td>
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<tr>
<td>SUN</td>
<td>Scaling Up Nutrition</td>
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<tr>
<td>TACRO</td>
<td>Regional Office for Latin America and the Caribbean</td>
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<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>WASH</td>
<td>Water Sanitation and Hygiene</td>
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<tr>
<td>WCARO</td>
<td>West and Central Africa Regional Office</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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EXECUTIVE SUMMARY

Adequate nutrition in a child’s early years is crucial to ensure his or her survival and development, both fundamental principles of the Convention of the Rights of the Child. For many decades, combatting maternal and child undernutrition has been an important part of UNICEF’s advocacy and programme work.

This meta-analysis is the first exercise to examine the adequacy and synthesized findings of a large number of UNICEF-supported evaluations in the area of nutrition. Apart from providing synthesized findings against evaluation key evaluation criteria and cross-cutting issues, it identifies what contributes to and what impedes successful nutrition programming to consolidate good practices and improve UNICEF’s performance.

This report is based on the findings of evaluations of UNICEF’s work in from 2009 – 2013 that addressed nutrition programmes or a nutrition programme component, that had a quality rating score of ‘satisfactory’ or higher and that were prepared in English, French or Spanish. It analyses 49 evaluations.

The analysis is in three parts. First, the report draws conclusions about the quality, coverage and adequacy of UNICEF’s evaluation of its nutrition programmes. Second, it analyses the findings of the evaluation reports with regards to relevance and appropriateness, effectiveness, efficiency, sustainability and additional issues such as multi-sectorality and coordination, national system and capacity development, monitoring and evaluation, equity and partnerships. In addition, it analyses the evaluation findings by programme component (infant and young child feeding, management of acute malnutrition, micronutrient-focused interventions, growth monitoring and promotion and nutrition in emergencies). It presents conclusions and makes recommendations to improve both the quality of evaluations of nutrition programmes and nutrition programmes themselves.

It was commissioned by UNICEF’s Evaluation Office and conducted in collaboration with UNICEF’s Nutrition Section with the support of an external consult. The report contains detailed findings, conclusions and recommendations. This summary focuses on key conclusions and recommendations.

Conclusions

Programme Relevance and Appropriateness
Nutrition programmes covered in the meta-analysis evaluations were found to be highly relevant in addressing local needs and were generally well aligned with national and donor policies and priorities. The appropriateness of nutrition programmes was challenged by poor programme design. Where Theory of Change (programme theory) was absent or poorly developed in programme design (nine out of 49 evaluations included in this meta-analysis), poor results frameworks and weaknesses in monitoring and evaluation challenged results based management, constrained the potential of programme monitoring systems to inform programme management, and resulted in inadequate package of nutrition interventions. The absence of causal analyses and/or baseline studies in the development of programme design (eight out of 49 evaluations in this meta-analysis) weakened the appropriateness of programme design.

Programme Effectiveness
UNICEF-supported nutrition programmes and interventions had mixed success in achieving programme objectives. Less than two-thirds of nutrition programme components evaluated in the meta-analysis had reached or were likely to reach all of their targets. Strong partnerships, adequate system and capacity development, integration into national systems and quick response in emergencies were found to contribute to the achievement of programme objectives. Where the achievement of objectives was challenged, a variety of constraining factors were identified including unrealistic timeframes, inadequate programme design, weak monitoring and evaluation systems, and insufficient qualified human resources. The funding of nutrition programmes was often found to be insufficient to achieve expected outcomes. Moreover, some nutrition programmes had limited effectiveness when UNICEF and/or other donors reduced or ceased their
financial support. In the case of CMAM, scale up to cover those in need was challenged by funding constraints for regular programming and reliance on emergency funds or external sources of assistance.

**Efficiency**
The evidence on the efficiency of nutrition programmes was weak and did not allow for substantive conclusions. Cost analysis was sparse across the evaluations used in the meta-analysis as financial inputs were rarely contrasted against programme outputs and outcomes. Some nutrition interventions such as micronutrient supplements, fortification and breastfeeding have proven to be high impact and cost-efficient but there is a need to evaluate their operational efficiency in various programme contexts which is a gap in evaluations. Evaluations need to examine more explicitly operational aspects including human resource allocations, institutional arrangements, timing and the use of low cost options in particular contexts which are potential constraints to realising programme outcomes and impact.

**Sustainability**
Some evaluations found that nutrition programmes’ financial, technical and institutional continuity was likely, while the majority of the evaluations found elements that hindered programme sustainability. The widespread reliance on external funding and procurement (e.g. RUTF) and the absence of national funding commitments was found to reduce the sustainability of some nutrition programmes. Other factors that weakened programme sustainability were the absence of strong national structures and systems, insufficiently trained staff, high turnover of staff, poor integration of nutrition programme components into national health systems, absence of multi-sectoral orientation of nutrition activities and insufficient national ownership of nutrition programmes.

**Multi-sectorality and Coordination**
The findings on multi-sectorality are mixed. Several evaluations identified use of well-functioning multi-sectoral approaches, however, a greater number of evaluations found that programmes or interventions were not able to overcome the challenges associated with multi-sectoral integration. When well integrated from programme design to implementation, a multi-sectoral approach was found to contribute to stronger programme results. Less than half of the evaluations that measured coordination (in development contexts) found it to be adequate. Factors that constrained coordination included a lack of clarity of national coordination procedures, limited government capacity to lead and unnecessary parallel coordination mechanisms which duplicated existing structures.

**National system and capacity development**
Significant work has been done in many countries in upstream policy work and in developing systems and capacity for nutrition programming but much still remains. Creating an enabling environment has been a priority of nutrition programmes which is evidenced by the large number of national nutrition policies and strategies developed, the extensive technical support provided in the creation of guidelines and technical structures at national level, and the training of government staff involved in nutrition programmes. Efforts to support upward policy work were found to support programme continuity and sustainability. However, much needs to be done to strengthen national systems to improve child and maternal nutrition outcomes.

**Equity**
UNICEF-supported nutrition programmes generally managed to target those most in need. However, findings on the integration of gender equality, HIV/AIDS and disabilities in nutrition programming were sparse. Challenges to programme coverage (reaching less reached) include weak mapping of vulnerability, limited coverage of health facilities, variable presence of implementing partners, variability of nutrition screening and limited geographic convergence among programme interventions.

**Partnerships**
Although all evaluation reports name the partners (implementing and/or collaborating) involved, only a small number of reports evaluate partnership initiatives. Partnership initiatives that led to joint nutrition programmes were deemed to be a comparative advantage in obtaining synergistic effects and gains in process, coverage and outcomes. In the identification of implementing partners, it was considered important
to select those that understood the local context and had substantive technical capacity. Strong partnerships, in which roles and coordination modalities were clearly established and respected, were found to contribute to programme success. However, in some instances too many implementing partners led to resources being spread too thinly and to difficulties in coordination which limited programme effectiveness and efficiency. In some programmes, disagreements between UNICEF and WFP were found over caseload estimates and operational approaches.

**Adequacy of nutrition evaluations**

The evidence base contains evaluations from most of the countries with highest burden of malnutrition\(^1\) although their scopes vary. Some of the countries with high burden of malnutrition did not conduct any evaluations during 2009-2013 (as per the evaluation database). Almost 25 per cent of UNICEF’s funds go to emergency programmes.\(^2\) However, nutrition emergency programmes have been the subject of only 18 per cent of all nutrition evaluations included in this meta-analysis and some had a limited scope.

The evidence base is weakened by gaps in the scope and quality of evaluations. Although the effectiveness of overall nutrition programmes is covered by a majority of programme evaluations, effectiveness of nutrition programme components is only partially evaluated (except for CMAM evaluation). Failure to contrast outputs and outcomes against objectives and the weak use of MICS and other survey data to measure impact are among the key issues.

**Recommendations**

1. Ensure that nutrition programme design is developed jointly with national and local stakeholders and based on better articulation of evidence, theories of change (programme theory) and programme theory that take account of national and local contexts. With the contribution of national and local stakeholders, UNICEF and other partners should incorporate needs assessments, feasibility studies, and causal analysis in the development of theory of change and well-articulated results framework for nutrition programmes. Good practices on multi-sectoral programming and coordination should be considered at programme design level.

2. Continue to develop national systems through upstream policy work, technical support and institutional capacity development. In both emergency and development settings, UNICEF should prioritize supporting the creation of an enabling environment for nutrition programmes. Numerous examples of good practices and lessons learned from country programmes can be used. UNICEF should continue to integrate nutrition programmes into national systems (health and other sectors) as this increases the potential for programme scale up and sustainability.

3. Continue to foster demand for nutrition services. UNICEF should prioritize outreach and community nutrition sensitization (availability of nutrition services, causal analysis of malnutrition, signs of malnutrition, etc.) so as to increase the demand for nutrition services. There are numerous examples of how nutrition programmes have contributed to an increase in the demand for nutrition services, which in turn increased nutrition programme effectiveness.

4. Strengthen nutrition programme M&E at country programme level through the provision of technical support, development of nationally-adapted M&E guidelines, and the allocation of necessary resources and funds to ensure adequate data collection, analysis, reporting and utilization. UNICEF should invest in improving nutrition M&E at country programme level to measure effectiveness and efficiency of nutrition programmes. In addition, when possible, UNICEF COs should use household survey (MICS) data for assessing impact including results that are attributable to UNICEF and other major contributors.

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\(^1\) The evidence base contains evaluations of ten of the 14 countries with the largest numbers of stunted children, and eight of the ten countries with the largest numbers of wasted children. Source: UNICEF Global Nutrition Database 2012.

\(^2\) This figure is based on UNICEF’s total expenditure for programmes in 2012 (taken from UNICEF’s 2012 Annual Report) and UNICEF total expenditure for ‘Other Resources Emergency Funding’ (taken from UNICEF’s 2012 Humanitarian Action and Post-Crisis Recovery Thematic Report).
5. **Integrate IYCF into other nutrition and health interventions.** UNICEF should provide further technical support and guidance on integration of IYCF into health system interventions. In addition, greater effort is needed for fundraising for IYCF and other less resources components so as to meet nutrition programme funding gaps.

6. **Strengthen equity aspects in programme design and implementation as well as in monitoring and evaluation.** Although the meta-analysis found nutrition programmes and interventions adequately targeted those most in need, more effort must be made to integrate gender equality and the needs of those with HIV/AIDS and disabilities in nutrition programming. More attention must also be paid to incorporating equity in monitoring and evaluation, especially evaluating the integration of disabilities in nutrition programming.

7. **Ensure that OECD/DAC criteria and programmatic and cross-cutting factors are evaluated in depth in future nutrition programme evaluations.** It is crucial that evaluations look at operational issues including use of low cost options, system building and scale up. In addition, guidance should be provided to external evaluators to ensure that OECD/DAC criteria and programmatic and cross-cutting factors are evaluated in an adequate and homogenous manner.

8. **Future nutrition programme evaluations should focus on the gaps of the existing evidence base and needs assessments.** There is a need for conducting more evaluations in regions/countries with high malnutrition burden and countries in emergency contexts.
1. INTRODUCTION

A child’s right to survival and development is a fundamental principle of the Convention of the Rights of the Child. Adequate nutrition in a child’s early years is crucial to ensure his or her survival and development. Nevertheless, undernutrition (insufficient food intake and repeated infectious diseases) in early childhood remains widely prevalent in developing countries, particularly in sub-Saharan Africa and South Asia.

For many decades, combatting maternal and child undernutrition has been an important part of UNICEF’s advocacy and programme work. UNICEF nutrition programming focuses on key proven practices, services and policy interventions for the prevention, management and treatment of undernutrition. Equity considerations in nutrition programming are particularly important, as stunting and other forms of undernutrition afflict the most vulnerable populations.

In countries where nutrition is identified as an area of UNICEF’s interventions, programme components typically include infant and young child feeding (IYCF), addressing micronutrient (vitamin A, iron, iodine) deficiencies, and community-based management of acute malnutrition (CMAM). Growth monitoring and promotion is less frequently implemented as a separate programme component and is occasionally integrated in IYCF. In recent years, nutrition programmes have tended to focus on the first 2-3 years of childhood as well as on maternal health and nutrition.

UNICEF is committed to the dissemination of lessons learned. As such, monitoring and evaluation are integral yet distinct parts of programme preparation, implementation and review. Certain nutrition programmes and programme components are evaluated and the reports are stored in UNICEF’s Evaluation Database (EDB). This report is a meta-analysis of these evaluations. It maps the evaluations and their findings systematically, draws conclusions about UNICEF’s nutrition programme performance and extracts lessons for the future. In addition, the synthesis will help strengthen UNICEF’s advocacy and programming to improve child nutrition.

In spite of certain limitations inherent to the meta-analysis, numerous findings and recommendations were extracted from nutrition programme evaluations and are synthesized in this report. Some of the gaps identified by the meta-analysis can provide guidance for future nutrition programme evaluations and for strengthening nutrition programming and policies. These findings and recommendations are mainly intended for UNICEF’s internal use although they may also be useful for UNICEF’s partners at the global, regional and country level. This meta-analysis report will form the basis of a report on Child Nutrition that will be presented to the UNICEF Executive Board in September 2014.

1.1 Organization of the report

This report is divided into five chapters. The first chapter presents a background of child undernutrition and the evolution of UNICEF nutrition strategies. It also explains the approach of the meta-analysis and presents the objectives, scope, and methodology used for the synthesis of findings. The first chapter concludes with the presentation of the constraints and limitations of the meta-analysis.

The second chapter analyses the evaluation evidence base. It describes the process for report identification and selection and the quality issues concerning the selected reports. This chapter also presents what the evidence base covers in terms of its content, the regions the evaluation reports are from, the geographic scope of the evaluation reports, and nutrition programme components. A review of the strengths and gaps of the evidence base is presented at the end of the chapter.

The third chapter presents the overall findings of the meta-analysis through a set of evaluation criteria that cover overall programme relevance and appropriateness, effectiveness, efficiency and quality issues, equity, multi-sectorality and coordination aspects, national system and capacity development, monitoring

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3 Undernutrition includes being underweight for one’s age, too short for one’s age (stunted), dangerously thin for one’s height (wasted) and deficient in vitamins and minerals (micronutrient malnutrition).
and evaluation, partnerships and programme sustainability. Overall conclusions and implications are presented at the end of the chapter.

The fourth chapter presents evaluation findings by nutrition programme component. These include infant and young child feeding, management of acute malnutrition, micronutrient-focused interventions, growth monitoring and promotion and nutrition in emergencies. Success factors, constraints and implications for each nutrition programme component are also included.

The last chapter presents overall conclusions and recommendations.

1.2 Background

Stunting, underweight, wasting, overweight and low birth weight currently affect millions of children worldwide. UNICEF’s 2013 report Improving Child Nutrition – The Achievable Imperative for Global Progress provides the following figures on child malnutrition:

- **Stunting** is a reflection of chronic undernutrition. It affects more than one quarter of children under 5 years of age, roughly 162 million children worldwide.
- **Underweight** is a composite form of undernutrition that includes elements of stunting and wasting. It affects approximately 16 per cent of children under 5 years of age, an estimated 101 million children worldwide.
- **Wasting** is a reflection of acute malnutrition. It affects more than five per cent of children under 5 years of age, an estimated 52 million children worldwide.
- **Overweight** occurs when weight for height is above two standard deviations from the median. It affects 7 per cent of children under 5 years of age, an estimated 43 million children worldwide.
- **Low birth weight** occurs when weight at birth is less than 2,500 grams. It affects more than 15 per cent of infants, an estimated 20 million infants worldwide.
- **Micronutrient deficiencies** - Between 4 and 5 billion people suffer from iron deficiency and an estimated 2 billion are anaemic. Women and young children are the most vulnerable.

In 2006, UNICEF developed a joint health and nutrition strategy (2006-15) to help to create enabling institutional frameworks and evidence-based analysis for policy and decision-making in order to leverage large scale acceleration of effective coverage of proven interventions. National governments continue to be UNICEF’s primary partners at the country level as well as the other UN agencies including WFP, WHO, and FAO. In addition to UN agencies, UNICEF has expanded its partnership with the Global Alliance for Improved Nutrition (GAIN), the Micronutrient Initiative, and the World Bank. Since 2006, UNICEF has hosted and led the Global Nutrition Cluster, which brings various partners together to improve nutrition response during emergencies. New initiatives have also been established in the past few years to scale up nutrition efforts. UNICEF is a key partner in the Scaling Up Nutrition (SUN) movement and is also a member of the Renewed Efforts Against Child Hunger (REACH) initiative. Partnerships with regional bodies focusing on food and nutrition security are becoming increasingly important particularly with the Economic of West African States (ECOWAS), the Association of South East Asian Nations (ASEAN), the South Asian Association for Regional Cooperation (SAARC) and the African Union Commission (AUC). Recent years have also seen an increase in partnerships with the private sector (such as DSM, Unilever, etc.) to find innovative ways to address malnutrition.

Evaluations in UNICEF contribute to accountability, lessons learning and improved results through scale up implementation. Evaluations examine both design and implementation aspects including cross-cutting strategies and partnerships. Recent Evaluation Policies (2008 and 2013) have recommended that each programme component is evaluated once during the programme cycle and there is particular emphasis on the use of evaluation findings through proper dissemination and management response. The meta-analysis provides an opportunity to look at the evaluation quality and adequacy of content and an opportunity to synthesize findings and lessons. This meta-analysis constitutes part of a series of such work that the Evaluation Office has been organizing in collaboration with counterpart divisions and sections.
1.3 Objectives and scope of the meta-analysis

The meta-analysis aims to contribute to the knowledge and evidence base of UNICEF-supported nutrition programmes by synthesizing evaluation findings, extracting success factors and constraints, and making evidence-based recommendations.

The specific objectives (SO) of the meta-analysis are to:

SO 1 - Provide an overview of UNICEF’s evaluations related to child nutrition programmes including their focus, coverage, and quality and draw conclusions regarding their adequacy and relevance.

SO 2 - Present synthesized evaluation findings on key outcomes and the effectiveness of UNICEF strategies and interventions based on a systematic analysis of what works and what does not work (and why) in planning, management and implementation of UNICEF nutrition strategies.

SO 3 - Propose ways to strengthen coverage, quality and use of evaluation and suggest key actions for strengthening UNICEF’s advocacy and programme response to improve child nutrition in both development and emergency contexts.

The findings from SO1 will inform SO3 as they will identify the weaknesses in coverage and quality of UNICEF’s nutrition evidence base. SO2 will inform SO3 as it will synthesize the actions that are required for strengthening UNICEF’s advocacy and programme response to improve child nutrition in both development and emergency contexts.

The scope of the meta-analysis includes the following evaluation criteria, and programmatic and cross-cutting factors:

- Relevance and appropriateness – alignment of programme design with local needs and with national and donor priorities and policies, appropriateness of programme design (theory of change)
- Effectiveness – extent to which programme objectives are reached (outputs vs. targets)
- Efficiency – analysis of inputs vs. outputs
- Equity and reaching less reached – including gender equality, reaching the hard-to-reach, persons with disabilities, persons with HIV/AIDS
- Multi-sectorality and coordination aspects
- National system and capacity development – including upstream policy work, provision of technical support, development of systems guidelines, and protocols and training of staff and volunteers
- Monitoring and evaluation
- Partnerships
- Sustainability – including ownership by national structures, integration of nutrition programmes into the national health system and other sectors, scaling up

1.4 Methodology

This section presents the methodology used in the meta-analysis.

Consolidation of the evidence base

Based on discussions between the Evaluation Office and the consultant, and in consultation with the Nutrition Section, the following criteria were used to select valid evaluation reports and consolidate the evidence base. The criteria are further explained in Chapter 2.

- time period - evaluation reports produced between 2009 and 2013
- evaluations that cover nutrition programme components significantly
- exclusion of evaluation reports that have an “unsatisfactory” quality rating
- language of evaluations
Overview of the evidence base

The “mapping” exercise reviews the content of the evidence base and describes the evaluation base in terms of:

- geographic scope
- nutrition programme components
- region of evaluation
- evaluation scope

It seeks to understand the characteristics and identify potential limitations of the evidence base.

Synthesis of findings and qualitative analysis

Each report in the evidence base was reviewed and findings underwent the following processes:

- **extraction** of qualitative data according to selected evaluation criteria and programmatic and cross-cutting factors from reports to a database in Microsoft Excel
- **coding** of qualitative data according to document number, region, country/countries, geographic coverage, nutrition programme component, evaluation scope
- **collation** of qualitative data by evaluation criterion, programmatic and cross-cutting factor
- **qualitative analysis** of collated qualitative data

1.5 Constraints and limitations

As with any meta-analysis, there are methodological challenges that limit the findings.

*Comparison of results of interventions* - Comparison of interventions among countries was difficult due to varying contexts, a range of levels of development and time spans for implementation.

*Variability of evaluation content and methods* - The evaluative content was not homogenous and evaluation methods were not standardized across the evaluation base.

*Timing of evaluations* - The meta-analysis is based on evaluations that were conducted between 2009 and 2013 during which time UNICEF’s strategies, partnerships and programming have evolved considerably. For this reason, the findings may be somewhat dated.

*Resources for the meta-analysis* – The work was carried out in a short-time frame (three months) with the support of a consultant who worked under the guidance of the Evaluation Office. Ideally, it would have been better to combine subject expertise with evaluation expertise in such work.

Despite these limitations, the meta-analysis was able to provide a substantive evaluative assessment of the performance of UNICEF’s nutrition programmes and draw lessons and recommendations for the future.
2. OVERVIEW OF THE EVALUATION EVIDENCE BASE

This chapter describes how evaluations included in the meta-analysis were identified. It describes the evaluation evidence base in terms of its characteristics, content coverage, strengths and limitations.

2.1 Consolidation of the evidence base
Sixty-two potential evaluation reports were identified by the Evaluation Office from the Evaluation Database. The reports were reviewed and those that did not meet the selection criteria (described below) were excluded.

Evaluation selection criteria
Time period – The meta-analysis looked at reports produced between 2009 and 2013. By covering evaluations from the last five years, the most recent findings were obtained. Moreover, significant progress in evaluation quality is thought to have been made in this time period.

Coverage of nutrition programme components – The meta-analysis included reports that evaluated nutrition programme as a whole and which significantly addressed key nutrition programme components namely infant and young child feeding (IYCF), community-based management of acute malnutrition (CMAM), micronutrient-focused interventions, growth monitoring and promotion, and nutrition in emergencies. There have been several inter-agency evaluations that have examined at UNICEF’s role as a cluster coordinator. These evaluations were excluded from the meta-analysis as they did not focus on UNICEF’s entire nutrition response, rather on UNICEF’s leadership as cluster coordinator.

Evaluation Report Quality - In order to extract solid findings, reports scored “unsatisfactory” through the Global Evaluation Report Oversight System (GEROS) scoring system were excluded. Evaluation reports with a pending GEROS score were scored over the course of the meta-analysis.

Language of the evaluation reports – The meta-analysis included reports in English, French and Spanish.

Nine reports were initially removed as they did not comply with the evaluation selection criteria (three due to unsatisfactory quality, two due to language restrictions, and four due to a lack of content on nutrition programme evaluation). A deeper review over the course of the meta-analysis led to the removal of four additional reports that did not have enough content on nutrition programme evaluation. As such, 49 evaluation reports comprise the evidence base for the meta-analysis. The following calculation illustrates the result of the selection process.

<table>
<thead>
<tr>
<th>Initial potential number of evaluation reports to include in the evidence base</th>
<th>62</th>
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<tbody>
<tr>
<td>First screening and removal of reports that did not meet the selection criteria</td>
<td>-9</td>
</tr>
<tr>
<td>Second screening and removal of reports that did not meet the selection criteria</td>
<td>-4</td>
</tr>
<tr>
<td>Final number of evaluation reports included in the meta-analysis</td>
<td>49</td>
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The reports that were included in the meta-analysis are listed in Annex 1.
2.2 Coverage of evidence base
This section describes the content of the evaluation reports in terms of nutrition programme component, regional coverage, geographic scope and evaluation scope (evaluation criteria, programmatic and crosscutting factors).

Nutrition programme component coverage

*Note on nutrition in emergencies:* For the purpose of this meta-analysis, nutrition in emergencies is reported as a nutrition programme component although it is understood that the typical nutrition programme components (IYCF, micronutrients....) are often common in the context of emergencies. Second, in this meta-analysis a programme is considered to be “Nutrition in Emergencies” only if the evaluation report states it so, not if it was conducted in a country that is typically considered an “emergency” country.

The review of evaluation reports shows significant coverage of nutrition programme components (see table 1). Over half of the evaluation reports cover micronutrient-focused interventions, CMAM, IYCF and growth monitoring and promotion. Nutrition in Emergencies, however, is only covered in 18 per cent of the evaluation reports. This is an interesting finding to note as almost 25 per cent of UNICEF funds go to humanitarian programmes.4

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<th>N</th>
<th>%</th>
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<td>Micronutrient-focused interventions</td>
<td>36</td>
<td>73%</td>
</tr>
<tr>
<td>Community-based management of acute malnutrition</td>
<td>32</td>
<td>65%</td>
</tr>
<tr>
<td>Nutrition in Emergencies</td>
<td>9</td>
<td>18%</td>
</tr>
<tr>
<td>Infant and Young Child Feeding (IYCF)</td>
<td>36</td>
<td>73%</td>
</tr>
<tr>
<td>Growth monitoring and promotion (GMP)</td>
<td>29</td>
<td>59%</td>
</tr>
<tr>
<td>Nutrition programme as a whole</td>
<td>25</td>
<td>51%</td>
</tr>
</tbody>
</table>

Regional Distribution
The evidence base contains evaluation reports from all UNICEF regions (see table 2). Evaluations in the EAP, ESA and WCA regions are most represented while those conducted in SA, CEE/CIS, LAC, and MENA, regions are the least represented. However, it should be noted that not all regions have the similar number of countries. SA, for example, contains only seven countries. The table on the next page shows the number of reports from various regions.

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4 This figure is based on UNICEF’s total expenditure for programmes in 2012 (taken from UNICEF’s 2012 Annual Report) and UNICEF total expenditure for ‘Other Resources Emergency Funding’ (taken from UNICEF’s 2012 Humanitarian Action and Post-Crisis Recovery Thematic Report).
5 For the purpose of this meta-analysis, “micronutrient-focused interventions” include those that aim to treat and/or prevent micronutrient deficiencies. However, findings on the use of micronutrients for medical treatment, such as the use of zinc for the treatment of diarrhoea, are not included in this meta-analysis.
Table 2 – Distribution of evaluations by region

<table>
<thead>
<tr>
<th>Region</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAP</td>
<td>11</td>
</tr>
<tr>
<td>ESA</td>
<td>11</td>
</tr>
<tr>
<td>WCA</td>
<td>8</td>
</tr>
<tr>
<td>SA</td>
<td>5</td>
</tr>
<tr>
<td>CEE/CIS</td>
<td>4</td>
</tr>
<tr>
<td>LAC</td>
<td>3</td>
</tr>
<tr>
<td>MENA</td>
<td>2</td>
</tr>
<tr>
<td>Regional</td>
<td>3</td>
</tr>
<tr>
<td>(more than one region)</td>
<td>2</td>
</tr>
</tbody>
</table>

The vast majority of evaluations were commissioned by UNICEF Country Offices. These reports evaluate nutrition programmes or interventions implemented at the national or sub-national level. UNICEF Evaluation Office (headquarters) commissioned two thematic evaluations that covered more than one region.

**Evaluation scope**

The evaluation reports were reviewed based on their coverage of evaluation criteria and programmatic and cross-cutting factors. The overview reveals that the most covered criteria and factors are partnerships (100 per cent of evaluation reports), monitoring and evaluation (79 per cent of evaluation reports), overall programme effectiveness (79 per cent of evaluation reports) and programme sustainability (74 per cent of evaluation reports).

The least covered criteria and factors are the effectiveness of Growth and Monitoring Promotion (GMP) interventions (0 per cent of evaluation reports), disabilities in nutrition programming (7 per cent of evaluation reports), gender equality in nutrition programming (17 per cent of evaluation reports), and inclusion of HIV/AIDS in nutrition programming (19 per cent of evaluation reports).

A comparison between evaluations of “nutrition programmes” and evaluations of “nutrition interventions integrated in health programmes” was made. It found evaluations of nutrition interventions that are integrated in health programmes have a more limited evaluation scope.

A table illustrating the coverage by evaluation criteria and programmatic and cross-cutting factors can be found in Annex 2.

**Quality**

The evaluation reports were reviewed in terms of their quality based on the GEROS quality scoring method. The following figure describes the evidence base according to the four quality scores given by GEROS (outstanding, highly satisfactory, mostly satisfactory, and unsatisfactory). In order to provide a full distribution of reports by quality scores, reports deemed unsatisfactory have also been included in figure 1. However, reports deemed unsatisfactory were excluded from all other sections of the meta-analysis.

Figure 1 – Distribution of evidence base by quality score prior to removal of “unsatisfactory” evaluation reports (N=52)

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6 The consultant used the GEROS scoring method to score the 19 reports that did not have a GEROS score prior to the meta-analysis.
The distribution by evaluation quality scores reveals that approximately half of the reports are rated highly satisfactory, while about a third are rated mostly satisfactory. Tabulation of the evidence base by quality score does not appear to indicate differences in evaluation quality among regions, geographic coverage or nutrition programme components.
2.3 Strengths and weaknesses in the evidence base

In view of the recommended policy that each country programme component should be evaluated at least once in the programme cycle, it is evident that nutrition is an under-evaluated area and there is significant room for more systematic planning and resource allocation to nutrition programme evaluations.

One key strength of the evidence base is that it includes evaluations from nine of the 14 countries with the highest burden of child stunting in the world. In addition, seven of the ten countries with the highest incidence of wasting are also represented in the evidence base.

The majority of evaluations have a national scope. This is not surprising as most UNICEF-supported nutrition programmes and interventions are implemented at the national level. In terms of scope of nutrition evaluations, a comparison between evaluations of “nutrition programmes” and evaluations of “nutrition interventions integrated in health programmes” was made. Results show that evaluations of nutrition interventions that are integrated in health programmes have a more limited evaluation scope. Although this may be understandable as health programme evaluations mainly focus on health issues, it represents a limitation to the adequate evaluation of nutrition interventions in health programmes.

Although all nutrition programme components are represented in the evaluation base, the evaluation scope of each programme component was found to be variable. A larger set of evaluation criteria/questions (OECD/DAC criteria, programmatic factors, cross-cutting strategies) were used to evaluate CMAM than other programme components. There is no evaluation of GMP as evaluations fail to do more than describe GMP activities. One gap is the lack of impact evaluations due to which analysis of impact could not be done.

Eighteen per cent of the evaluations in the meta-analysis concern nutrition programmes in emergencies. It was found to be generally evaluated in sufficient depth as the evaluations addressed OECD/DAC criteria, programmatic factors and cross-cutting factors. However, in view of significant budget allocations to nutrition and widespread need in emergencies, this is an under-evaluated area.
3. OVERALL NUTRITION PROGRAMME FINDINGS

This section synthesizes the findings of the evaluation reports included in the meta-analysis that covered nutrition programme as a whole. The findings are based on key evaluation criteria and cross-cutting issues at the programme level. Findings on specific nutrition programme components are presented in Chapter 4.

3.1 Relevance and appropriateness

As per OECD/DAC definition, relevance in evaluation refers to the extent to which programmes are suited to the needs, priorities and policies of the target group, recipient and donor. Of the 49 reports included in this meta-analysis, 26 reports evaluated the extent to which nutrition programmes were in line with local needs. The nutrition programmes they evaluated were generally found to be very much in line with local needs. Nutrition programmes were found to focus on the needs of the most vulnerable sub-groups of the population which generally include children under 5 years old and pregnant and lactating women.

Eighteen reports evaluated the extent to which nutrition programmes were aligned with national and donor priorities and policies. The evaluated programmes were generally found to be well aligned. This included national nutrition policies, health and nutrition strategies, Millennium Development Goals, United Nations Development Assistance Framework, and REACH strategies.

Although programmes were generally found to be well designed, the following weaknesses were identified:

- Nine evaluations identified weak or missing programme frameworks (results frameworks, logical frameworks, theory of change) in the programme design. This made it difficult to make connections between outputs, outcomes and impact and to measure indicators. In addition, these issues limited the ability to provide useful data to programme management through monitoring and evaluation.

- Nine evaluations identified issues in the selection of nutrition interventions. The most cited problem was the absence of a complementary package of nutrition interventions. Other examples include the absence of growth monitoring and promotion, the weak capacity and system building of national nutrition stakeholders, and the lack of nutrition-sensitive interventions in other sectors.

- Eight evaluations found that causal analyses and/or baseline studies were not conducted prior to the programme design. This weakened the effectiveness and appropriateness of nutrition interventions and limited programme management, monitoring and evaluation.

- Six evaluations found that a poor understanding of the causes of malnutrition and of the magnitude of the needs of the target population led to design issues such as insufficient time for implementation, unrealistic caseloads, insufficient attention to challenges in coverage, insufficient capacity to reach the agreed caseload, and inadequate programme scale to have an effect.

3.2 Programme effectiveness

According to the OECD DAC criteria for evaluating development assistance, effectiveness measures the extent to which an activity attains its objectives. Of the 49 reports included in the meta-analysis, 39 evaluated effectiveness. Of the 39 reports, 24 found that all programme targets had been reached or were likely to be reached. Eight evaluations found that some targets had been reached or were likely to be reached and seven evaluations found that targets were not met or unlikely to be met.
Table 4 – Nutrition programme effectiveness as per targets met

<table>
<thead>
<tr>
<th>Evaluation Description</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluations that found that all targets were reached/likely to be reached</td>
<td>24</td>
<td>61.5%</td>
</tr>
<tr>
<td>Evaluations that found that some targets were reached/likely to be reached</td>
<td>8</td>
<td>20.5%</td>
</tr>
<tr>
<td>Evaluations that found that targets were unlikely to be reached</td>
<td>7</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

The success factors that contributed to effectiveness and the factors that hindered effectiveness as cited in the evaluation reports are presented below.

**Key success factors**

*Quick response in emergencies* - In most emergencies, UNICEF had been successful at responding quickly through pre-positioning of therapeutic foods and rapid action plans.

*Strong partnerships* - In development contexts, UNICEF generally managed to create strong partnerships which helped it achieve programme goals and objectives.

*Other factors* - In addition, strong information systems and adequate funding were key success factors.

**Key weaknesses and constraints**

*Unintended outcomes* – Several evaluations identified that beneficiaries sold intervention inputs (food rations, supplementary and therapeutic foods) or failed to give MNPs to children due to strange flavour. Community mobilization and acceptance was found to be weaker in programmes where communities had not been part of the programme design (top-down approach).

*Inadequate timeframes for programme implementation* – A number of evaluations found the failure to meet targets was a result of inadequate timeframes. Reports found that the absence of baseline studies and inadequate programme design were behind unrealistic timeframes.

*Insufficient data on programme progress* – Some reports were unable to analyse programme effectiveness due to the absence of monitoring systems, coverage figures, information on compliance or the effects on micronutrient supplementation on the status of recipients.

*Absence of partners* – In insecure settings, UNICEF had difficulty in finding sufficient partners (national and international) to implement nutrition programmes.

*Weak integrated approach* – Especially when rolling out pilot studies, some evaluations found that interventions should have targeted the same populations so as to ensure a “portfolio approach” and increase the overall effectiveness of the programme.

*Insufficient funding* - The funding for nutrition programmes was often found to be insufficient to achieve expected outcomes. Moreover, numerous nutrition programmes experienced a decrease in effectiveness when UNICEF and/or other donors reduced or ceased their financial support. In the case of CMAM, scale up to cover those in need was challenged by funding constraints for regular programming and reliance on emergency funds or external sources of assistance.

**3.3 Efficiency and quality issues**

This section summarizes findings on efficiency, including the allocation and use of resources and procedure coordination and human resources issues. Of the 49 reports included in the meta-analysis, 14 do not offer substantive findings on efficiency. The findings from the remaining 35 reports are summarized below.

*Timeliness of procedures* – Fourteen reports identified problems related to timeliness including late release of funds from donors, the complexity of donor funding modalities and problems with supply and management of goods. However, 11 reports concluded that the implementation rate was appropriate according to the results frameworks’ process indicators. Five reports identified a prompt and timely
inception of nutrition programmes while three reports found that programme inception and resource mobilization was slow.

Cost analysis – Eight reports examined cost efficiency of nutrition programmes. Of these, five reports identified that the cost of nutrition inputs and delivery was high, namely the cost of imported ready to use therapeutic food (RUTF), the high cost of partnerships with international NGOs as opposed to local NGOs, and the added cost of covering faraway and remote communities. Twelve reports stated that it was not possible to measure the cost efficiency of nutrition programmes given the absence of sufficient data to conduct such analysis. This was often related to the lack of centralized reporting systems, limited financial data available from implementing partners, and the lack of disaggregated expenditure by specific activity. Only one evaluation in the evidence base (Bangladesh) reached a conclusion on the cost-effectiveness of nutrition interventions. It found that the most cost-effective nutrition activities in the country were MNP distribution, anaemia counselling and school-based nutrition education. This finding, however, may not be applicable to other contexts and programmes.

Human resource mobilization – The real-time assessment of UNICEF’s response to the Sahel food and nutrition crisis that covered Nigeria, Niger, Mauritania and Chad concluded that human resources had, to a large extent, been mobilized effectively, although delays and administrative constraints had limited the coverage of beneficiaries in a timely manner. However, the evaluation of the food and nutrition security programme in Timor-Leste identified problems in the recruitment of national and international staff. The main reasons cited were the difficulty to find staff with the right skills to fill technical positions and the slow speed of UN recruitment procedures.

The key issues cited by evaluators with regards to programme efficiency are presented below as success factors and constraints.

Key success factors

Adequate training of service delivery staff – Programmes that managed to build and sustain the technical capacity of service delivery staff were more likely to reach their targets.

Strong government commitment increased cost-efficiency – The global evaluation of community management of acute malnutrition that included case studies from five countries (Chad, Ethiopia, Kenya, Nepal and Pakistan) concluded that when government commitment is strong, direct support to the government by UNICEF is the most cost-efficient delivery modality because of strong government ownership which is also conducive to programme scale up.

Key weaknesses and constraints

Insufficient incentives for service delivery staff – Evaluators found that nutrition interventions rely significantly on the work of volunteers and community health workers. However, they are not always remunerated for their work which limits their motivation, the quality of their work, and the continuity of their involvement.

Insufficient human resources - Some evaluations found that nutrition programmes suffer from insufficient staff to manage, supervise and monitor nutrition interventions.

High turnover of human resources - High turn-over of staff in partners, local stakeholders and UNICEF (staff in surge capacity) was found to undermine the human capacity development and sustainability aspects of nutrition interventions in multiple evaluations. This limitation was particularly reported in the evaluations of nutrition in emergencies.

Insufficient supervisory capacity of UNICEF partners – Fourteen reports found that UNICEF’s implementing partners were not sufficiently supervising their work. In some cases supervision was non-existent. The main reasons cited in the reports are the lack of clarity of supervisory responsibilities among partners and the

7 Evaluations were unclear with regards to the thresholds used to determine that the costs were too high.
insufficient logistical and human resources required to supervise activities regularly. Moreover, programme effectiveness was found to be reduced in countries where national and local institutions did not have sufficient capacity or were not sufficiently involved in the supervision of nutrition programmes.

3.4 Equity
Reaching those most in need

Overall, evaluations found that nutrition programmes adequately targeted those most in need. The factors associated with success in reaching targeted populations were the use of integrated planning frameworks and community assessments, strong partnerships, strong outreach activities, and the acceptance of programme activities (goods and services).

The factors that limited reaching the most in need were found to be:

- Weakness in nutrition outreach resulted in poorly structured interaction between facility-based workers and community health workers and led to weak case identification.
- Insufficient data from programmes, outdated census on population statistics, lack of agreement on calculations, weak estimates of incidence, low funding of coverage surveys, and failure to disaggregate programme data by type of vulnerability.
- When UNICEF nutrition programmes are integrated into national systems and additional human resources are not included in the programme, the workload of existing primary health care staff, community health workers and volunteers increased. Numerous evaluations found that the quality of nutrition services and staff motivation was negatively affected by increased workloads and budgetary limitations to cover incentives.
- Site selection for nutrition interventions was not always done according to nutrition-relevant selection criteria.

Reaching the hard-to-reach

Although the identification and targeting of those in need was found to be adequate by most evaluations, reaching the hard-to-reach was found to be a recurring challenge. Remoteness and lack of transportation for outreach workers were the two most common limitations. In some contexts, insecurity was a factor that impeded safe and frequent access to those in need. Other constraints mentioned in the reports were:

- Weak motivation of outreach workers to reach hard-to-reach areas due to absence/insufficient economic incentives (especially the case for volunteer community health workers).
- Limited capacity of the national system - uneven distribution of health facilities and variable presence of NGOs in remote areas, and difficult access (transportation) to certain areas.
- Limited geographic convergence between programme interventions in remote areas.
- Insufficient focus on nomadic and pastoralist populations.

Gender equality – Of the 49 reports included in the meta-analysis, only eight contain substantive findings on gender equality in nutrition programming. Of these eight reports, three found that nutrition programmes had not integrated gender equality in a significant way. Five evaluations found gender equality had been addressed in one or more of the following ways: integration through alignment with the MDG objective on gender equality and women’s empowerment, integration of gender equality into policy documents, disaggregation and analysis by gender of monitoring and reporting data, the presence of capacity building, training, advocacy and rights-based efforts towards mainstreaming gender equality, the identification of gender assistance issues such as the seclusion of women and the adaptation of nutrition interventions to gender issues through male sensitization and home-based screening.
**Integration of HIV/AIDS in nutrition programming** - Of the 49 reports included in the meta-analysis, only eight evaluated the integration of HIV/AIDS in nutrition programming. These reports found that HIV/AIDS had been included using a variety of modalities, including targeting of HIV/AIDS cases for CMAM identification of stigmatization of HIV/AIDS cases in IMAM sites, programme design efforts to reach HIV/AIDS, inclusion of HIV/AIDS in national nutrition strategies, linking CMAM to HIV/AIDS programmes training health workers on infant feeding and HIV, and communication and C4D efforts to sensitize populations on HIV/nutrition.

**Integration of disabilities in nutrition programming** – Only three reports of the 49 included in the meta-analysis evaluated the inclusion of people with disabilities in nutrition programming. All three reports concluded that nutrition programmes did not integrate the needs of people with disabilities.

### 3.5 Multi-sectoralism and coordination

#### 3.5.1 Multi-sectoralism

Of the 49 reports included in the meta-analysis, 18 provided substantive findings on multi-sectorality and the findings provided a mixed picture. There are multiple examples of well-functioning multi-sectoral approaches in UNICEF nutrition programmes in both emergency and development settings. Eight reports found that multi-sectoral approaches had been well integrated in programme design and implementation through a variety of modalities:

- The nutrition sector was integrated with one or more sectors including health, child protection/psychosocial, WASH, C4D, HIV/AIDS, agriculture, livelihoods and education towards joint reduction of undernutrition and child mortality.
- Successful integration of a multi-sectoral approach of nutrition programming into policy, strategic plans and protocols which thus supported upstream policy development
- Nutrition programmes used innovative multi-sectoral approaches such as the “5+1 axes” strategy and the “convergence approach”. The “5+1 axes” strategy integrates all the sectors as well as humanitarian responses (on nutrition and refugees) into a single programmatic approach. Integrated missions address the response in five geographical areas and provide initial testing for the programme and its possible adaptation. The “convergence approach” selects priority areas based on malnutrition and food insecurity mapping. Inputs from different sectors that address the underlying determinants of malnutrition are concentrated in these priority areas. This approach was found to provide synergistic benefits.

These eight reports agreed that the multi-sectoral approach had contributed to increased programme result and that challenges in multi-sectoral integration had been successfully overcome. Other nutrition programmes, as highlighted in 10 reports, were not able to overcome challenges in multi-sectoral integration. These evaluations reported that the programmes encountered the following difficulties:

- A poor understanding of the needs of the population was reflected in a weak (or absence of a) results framework/theory of change which led to unclear results. This limited the options for monitoring and evaluation of cross-sector results of the programme.
- A multi-sectoral approach was not at the forefront of the design of the logical model, multi-sectoral coordination was inadequate or insufficient, there was weak support from the other relevant sectors in spite of the programme design, or continued reliance on sectoral approaches to programme design and intervention planning
- Lack of uniform commitment towards the “complementary package” within some UNICEF country offices due to insufficient internal coordination (“silo effect”)
- Insufficient fund mobilization: the “pass-through” funding mechanism (i.e. separate budget lines and targets) of some nutrition programmes limited the convergence of activities. Donors were often not the same for nutrition and other sectors.
• “Siloed” support from the Regional Office (RO) to the Country Office (e.g. Regional Office Nutrition to Country Office Nutrition), thus limiting the potential for an integrated approach. This was seen in the tools proposed by the RO which did not allow for an integrated response plan.
• Limited capacities (systems and structures) of governments and implementing partners and weak understanding of the benefits of an integrated approach by the government
• The high number of partners in multi-sectoral/joint programmes limited the frequency of coordination meetings.

3.5.2 Coordination
UNICEF plays an important coordination role within the Nutrition Cluster System, however, because the focus of this meta-analysis is on UNICEF-supported nutrition programmes and interventions, UNICEF’s role in the Nutrition Cluster System which is often evaluated as part of inter-agency evaluations is not included in this report.

Of the 49 nutrition evaluation reports included in the meta-analysis, 26 provide substantive findings on coordination. Nine out of the 26 reports found adequate coordination. Some of the key elements associated with adequate coordination reported by the evaluations were:

• Combining multiple UN agencies in the administration of a programme was found to avoid duplication of efforts and the strategic application of each agency’s comparative advantage. Moreover, it allowed for speaking with one voice on policy and programme issues. This was found to be an important asset in supporting governments on difficult policy decisions.
• Inclusion of a large number and variety of stakeholders (government structures, international organizations, NGOs, academia, local representatives, and private sector) in programme design and implementation led to a high achievement of objectives.
• High frequency of meetings allowed the immediate and longer term programmatic needs to be dealt with and quick corrective measures to be implemented.
• According to the 2013 Global Evaluation of CMAM programmes, nutrition coordination and advocacy helped nutrition to rise on the policy agenda and resulted in the development of strategies and policies that include CMAM in some countries.

According to 17 of the 26 reports, a variety of issues limited effective coordination. These evaluation reports identified the following weaknesses and constraints in coordination:

• Lack of clarity of national coordination procedures to both national and international actors, confounding the initial relief response
• Limited governmental capacity to carry out nutrition coordination leading to uncoordinated planning and funding
• Weak or late inclusion of stakeholders in nutrition coordination affecting the frequency of services and social mobilization
• Lack or poor coordination between UNICEF and WFP resulting in duplication of interventions or disrupting the IMAM continuum. The estimation of MAM caseload numbers was a matter of disagreement in some countries.
• Inadequate or insufficient coordination resulting in unequal concentration of resources such as the absence of partners in priority regions
• Unnecessary parallel coordination mechanisms duplicating existing national coordination structures
• The focus of some coordination mechanisms on the exchange of work plans and reports limited the harmonization of nutrition activities and procedures.
3.6 National system and capacity development
This section synthesizes findings on upstream policy work, national system development and human resource capacity building.

Upstream policy work
Of the 49 reports included in the meta-analysis, 22 evaluated and provided substantive findings on upward policy development. Fifteen of the 22 reports found that nutrition programmes had done substantive upward nutrition policy work which led to the development and improvement of national nutrition policies and strategies. Such efforts led to the following results:

- Development of post-emergency recovery strategies
- Inclusion of nutrition security into regional policy workshops (ASEAN and SAARC)
- Passage of laws on food fortification
- Advocacy to integrate the Nutrition Programme Office within the Ministry of Health

Ten of the 22 reports found that further upward policy work is needed to create an enabling environment for nutrition programmes to achieve maximum results. Some of the upward policy development work that needs to be done in certain countries, as suggested by the reports, should focus on integrated strategic planning, development of national nutrition policies, strategies for planning, implementation, and evaluation and raising nutrition to the top of the national political agenda.

Technical assistance
Of the 49 reports included in the meta-analysis, 20 evaluated and provided substantive findings on technical assistance. Fifteen of the 20 reports found that nutrition programmes provided significant technical assistance in a variety of ways, as described below.

- Support the development of a Master Course in Nutrition for training of high level cadres
- Support the production of guidelines for nutrition and inter-sectoral programming
- Support the production of national protocols for the treatment of malnutrition
- Support the creation of technical committees
- Support the integration of management of malnutrition into the basic health services
- Support the integration of the nutrition “complementary package”
- Support the creation and strengthening of nutrition early-warning, and surveillance and monitoring systems
- Certification of maternities on breastfeeding management, which reinforces the baby-friendly approach
- Development of software supporting the decision-making process of nutrition service delivery staff

Five of the 20 reports have found that technical assistance was insufficient. The following needs were reported.

- Although guidance for malnutrition treatment is generally adequate at the global and national level, further work is needed in creating guidelines for planning and monitoring, integration into other child health and nutrition programmes, equity and gender, community assessment and mobilization, MAM management, micronutrient supplementation, and cultural adaptation of nutrition programmes.
- Further guidance on how to integrate IYCF and CMAM is needed.
- Further emphasis is needed on supporting government systems by shifting from an “implementing” to a “support” approach, which includes the creation of system-level indicators.
Training and human resource capacity development

Of the 49 reports included in the meta-analysis, 24 evaluated and provided substantive findings on training and human resource capacity development. Twenty-one of the 24 reports found positive results from training and human resource capacity building efforts in nutrition programmes. The evaluation reports identified the variety of ways these efforts were conducted:

- Technical training to programme partners (government, implementing partners, community health workers and volunteers and other national stakeholders involved) at all levels (headquarters, regional, district, sub-district, and local levels), including training on programme management, administration, coordination, targeting and monitoring. In some countries, training was done “pre-service” as well as “in the job”. The latter form of training was considered to be more efficient than the “trainer-of-trainer approach”. “Cascade training” at central and district levels was also thought to have successfully prepared staff to carry out their roles and increase adherence to nutrition protocols.
- Supporting Ministries of Health in recruiting and deploying qualified personnel in priority areas not supported by NGOs. In some countries, this initiative aimed to integrate UNICEF-supported temporary health recruits into the public service hence contributing to the sustainability of capacity building efforts.
- A proper balance between the capacity building of individuals, organizations and the enabling environment was thought to enhance the likeliness that results would be sustained beyond the life of the programme.

Eight of the 24 reports identified the following challenges and limitations with regards to training and human resource capacity building:

- Training was not focused on the actual epidemiological burden.
- After an emergency, some country programmes were too focused on relief implementation and made little effort to strengthen local emergency planning and management capacities. The opportunity to train nutrition service delivery staff was not seized. This could be attributed to the lack of support from some donors to include human capacity building in relief programmes.
- Benchmarks for human resource capacity building were not included in results frameworks.
- High turnover of staff affected the sustainability of capacity building effort and achievements.
- Training of nutrition service providers and managers was deemed insufficient to carry out their duties.
- Gaps in community health worker capacity to conduct nutrition counselling and home-visits was overlooked which affected service quality and effectiveness. The main constraints of Community Health Workers (CHWs) were the overburdening by numerous programmes, problems in access and transport, and inadequate incentives.
- It was unclear if capacity building was an isolated endeavour or if it fit in a larger upstream plan.
- No concrete steps were taken to integrate of nutrition in capacity development in other sectors.

3.7 Monitoring and Evaluation

Of the 49 evaluations included in the meta-analysis, 33 examined the monitoring and evaluation of nutrition programmes. These covered a variety of elements including the quality and accuracy of data on performance and results, the adequacy of data reporting and analysis, the appropriateness of indicators set in results frameworks/logframes, the utilization of data to improve and update programme design and result indicators, and the quality and use of nutrition information and surveillance systems.

The findings on M&E systems are mixed. It is clear that weak monitoring systems and weak data greatly affected both programming monitoring as well as evaluations. The evaluation reports highlighted the following successful examples as well as weaknesses of monitoring and evaluation in nutrition programmes and interventions.
Key successes

*Development of innovative and nationally adapted information systems* – In Indonesia, a DevInfo database with MDG related data was used in order to identify priority areas and strategies for development planning. UNICEF capitalized on DevInfo to provide training for a human-rights based approach to situation analysis of women and children. Also in Indonesia, a web-based nutrition information system was piloted that reported and collected of anthropometric data, indicators on breastfeeding and on distribution of MNP. As a response to the Indian Ocean Tsunami, the Tsunami Recovery Impact Assessment and Monitoring System was developed by the International Federation of Red Cross and Red Crescent Societies (IFRC) with the support of UNICEF and others, which used a common analytical framework to assist governments, aid agencies and affected populations to assess and monitor the rate and direction of tsunami recovery. In the Maldives, UNICEF led the development of a national Online Nutrition and Child Health Surveillance System which aimed to strengthen primary health care and preventive care actions. The evaluation of the Indian Ocean Tsunami concluded that evidence-based data collection systems were extremely useful for planning, implementing, monitoring and evaluation.

*Coordination of M&E* – In Niger, monthly partner coordination meetings helped to correct problems in the information chain of M&E. Moreover, data quality was verified at every level of the information chain.

*Introduction of mobile applications* – Compared with existing paper based methods, mobile applications were found to be a positive contribution toward monthly reporting from individual facilities to the district and national level in Tanzania.

*Surge capacity and technical support* – In Pakistan, UNICEF was found to provide surge capacity and technical support to start the Nutrition Information System effectively.

*Studies in support to scale-up* – IYCF/MNP coverage surveys and CMAM evaluation in Nepal and the IFA coverage study in Bangladesh are examples of good studies used to support nutrition programme scale. They were found to provide useful inputs for decision-making on how these interventions can be mainstreamed at larger scale.

*Technical support to national system’s M&E* – The mid-term evaluation of EU/UNICEF partnerships found that valuable support was being provided to national systems to include nutrition indicators in government’s monitoring frameworks.

*M&E as a programme objective* – The food security and nutrition programme in China included the development of national databases on nutrition status of women and children as one of its objectives. The evaluation found the programme successfully achieved this objective. It was also found that monitoring reports provided evidence and effective support to programme management.

Weaknesses and constraints

*Poor planning of monitoring and evaluation* – In Kosovo monitoring and evaluation of the nutrition programme was not planned in the results framework and programme plans. In Rwanda, it was not well defined and not based on appropriate indicators. In Chad and Ethiopia, nutrition information systems did not include CMAM performance indicators. In Nicaragua, Dominican Republic and Ghana, availability of data on programme progress was very limited.

*Insufficient and poor quality data* - Numerous evaluations found problems in collecting adequate quality data due to inadequate capacity at the frontline level. They reported there was insufficient training and inadequate or an absence of guidelines for data collection. The 2013 Global Evaluation of CMAM found there was a lack of reliable data on MAM performance indicators that made it difficult to ascertain effectiveness of the MAM intervention, whether implemented through counselling, provision of supplementary foods, or both. The report also found that there was not enough data on relapse to provide
evidence on linkages between interventions to address SAM and MAM. In Pakistan, data was not consistently collected and analysed as stipulated in the national guidelines for screening. In the mid-term evaluation of EU/UNICEF partnerships, information on achievements in terms of results at the level of outputs and outcomes as per the logframe was not available. Consequently, proper evaluation of the programme performance in terms of achieved vs. intended results was not possible. Moreover, the reporting system consisted of a set of “self-scored” indicators on progress achieved which made the M&E system less transparent and also less informative.

Weak analysis and utilisation of programme data – Inefficiencies in data analysis and reporting were found by a number of evaluations. In CMAM interventions, analysis of nutrition data beyond percentages of Sphere performance indicators was not always done. In Burkina Faso, Niger, and Chad the quality of nutrition programme data was not verified so the positive results on programme effectiveness must be taken with caution. Moreover, in Burkina Faso data was collected monthly but only analysed and reported on every three months which could potentially delay corrective actions significantly. In Timor-Leste data was not used to extract lessons learned and identify programmatic constraints. In Bangladesh, the programme’s failure to utilize the findings and tools of the Food Security and Nutrition Surveillance Project was identified as a missed opportunity.

Parallel M&E systems – In Chad and Ethiopia, UNICEF created a parallel nutrition M&E system to that of the government. This created confusion in the information transfer chain and led to information gaps in both systems. The 2013 Global Evaluation of CMAM found that information systems for CMAM developed in parallel to national systems were not sustainable.

Lack of staff to collect and analyse data – In Chad and Ethiopia, the evaluation found that were not enough qualified staff to conduct data collection and analysis.

Lack of coherence in data collection within CMAM – In Pakistan, collection and use of anthropometric data was not found to be synchronized across the components of CMAM. SCs used WFH data while OTPs and SFPs used MUAC data. The evaluation in Cameroon had difficulty evaluating programme effectiveness given the variety of data collection methods used in the field.

Inadequate indicators in the results framework – In Timor-Leste, monitoring of the nutrition programme was found to be relatively weak because the programme results framework lacked enough indicators of progress along the results chains. This meant that although the framework might provide an overall impression of programme progress, the data and information provided was not sufficiently detailed to inform programme management. In Cambodia, programme monitoring was focused on activities and outputs while outcome level changes were disregarded. The lack of sufficient outcome level monitoring meant that the realization of objectives was not adequately assessed in order to inform programme management.

Weak use of Multiple Indicator Cluster Surveys (MICS) – Only 15 of the 49 evaluation reports mentioned the use of MICS surveys for the programme evaluation. Of the 15 reports, five use MICS to evaluate programme effectiveness. The other ten reports only use MICS data to describe the nutrition context of the area of intervention or to describe the programmes M&E/surveillance components. In some cases, the absence of anthropometry in MICS surveys was deemed as a missed opportunity to collect valuable data on the population’s nutrition status. Overall, it is clear that the potential of MICS surveys is not sufficiently seized in planning and conducting nutrition evaluations.

3.8 Partnerships
Although all evaluation reports name the partners involved, only half evaluated the work and relation between implementing partners and only a small number of reports evaluate partnership initiatives.
In addition to UNICEF’s work with implementing partners (mainly local governments and NGOs), UNICEF was also part of partnership initiatives with foreign governments and supra-national organizations as described in the figure below.

Table 5 – Types of UNICEF partnerships as found in the evidence base

<table>
<thead>
<tr>
<th>Implementing Partners</th>
<th>Local governments and ministries, local NGOs, international NGOs, academic institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign governments</td>
<td>Government of Netherlands, Government of Australia</td>
</tr>
<tr>
<td>Supra-national organizations (non-UN)</td>
<td>European Union/ECHO</td>
</tr>
<tr>
<td>United Nations Organizations (UN)</td>
<td>WFP, FAO, WHO, UNODC, UNIDO, ILO, UNESCO, UNDP, UNFPA, MDG Achievement Fund</td>
</tr>
</tbody>
</table>

Partnership initiatives with foreign governments and supra-national organizations were based on the development of common objectives for one or more country programmes. In the EU/UNICEF partnership in Asia for example, logic models were developed to reduce undernutrition in the countries included in the partnership. These models looked into causal factors and provided a listing of activities (mainly in the health sector) that were deemed useful to address these causal factors. Partnerships with other UN agencies were generally based on agency-specific roles and technical competence. Such partnerships took different forms, from technical advice to actual programme component implementation.

**Key success factors**

*Partnership initiatives* - A comparative advantage of conducting joint nutrition programmes was reported in numerous countries such as Kosovo, Kenya and China. The individual strengths, mandates and experience of multiple partners were found to have a synergistic effect and promoted significant gains in process, coverage and outcomes. The evaluations also found that one of the key advantages of a multi-country approach is the exchange of information and lessons learned between country programmes.

*Understanding the local context* - The advantage of understanding local customs prior to the identification of partners was evidenced in Indonesia where local NGOs were prioritized in the programme partnership. Local NGOs were more trusted and accepted by the community, and were willing to integrate within the camps to access community structures and local knowledge.

*Partner capacity* - In Niger, strong partnerships with organizations with strong local experience and substantive technical capacity was found to be critical to the success of the response to the food and nutrition crisis. The strengthening of partnerships through the development of partnership frameworks, as was done in Kenya to support the delivery of essential nutrition services, was found to be a valuable tool to guide the implementation of nutrition interventions as it clearly laid out roles and coordination modalities. The evaluation found that the effective scale-up and integration of IMAM into the national health services was facilitated by the strong partnership in the programme.

*The engagement of academia* – Academics’ engagement in nutrition programmes was found to be of high value. The mid-term evaluation of EU/UNICEF partnerships highlighted the support given by the University of Washington in the development of technical guidelines on baseline studies and evaluations. This work was found to support the strengthening of national/local nutrition information systems.

**Weaknesses and constraints**

*Issues with respect to implementing partners* - In heavily-funded emergencies such as the Indian Ocean Tsunami, an exponential growth in the number of NGOs was found to lead to larger partnerships in UNICEF-
supported nutrition interventions. However, the capacities of local NGOs were found to be variable with regards to reporting and accountability. Moreover, with the corresponding decrease in funding after the emergency, the presence and capacity of numerous local NGOs decreased which resulted in a loss of services.

The high number of partners in the nutrition intervention in Peru was found to obstruct the achievement of homogenous results across regions and populations given the difficulty to coordinate a large number of organizations over a large geographic space. A similar situation was found in Afghanistan where the thin spread of limited resources combined with a very high number of partners was found to greatly limit the potential for programme effectiveness.

In Timor-Lesté relationships with NGOs were driven by contractual aspects of programme implementation (e.g. short contract duration). This was found to potentially limit the development of civil society’s capacity.

**Partnerships with other UN agencies** – In spite of a general climate of agreement between UNICEF and WFP at regional and global level, disagreement in caseload estimates and differences in operational approaches between these agencies were found in several contests, such as the response to the food and nutrition crisis in the Sahel.

### 3.9 Programme sustainability

Of the 49 reports included in the meta-analysis, 37 evaluated sustainability of UNICEF nutrition programmes. Although some evaluations found that nutrition programmes’ financial, technical and institutional continuity was likely, the majority of the evaluations (28 of 37) found elements that hindered programme sustainability.

**Key success factors and lessons**

**Institutional and system sustainability** – Significant progress has been made in upward policy work, including guidelines, policies, regulations and strategic planning. It was found that where an “enabling environment” (i.e. upward policy development) had been established, efforts towards the development of capacity were more sustainable.

A strong nutrition authority and nationally owned overarching strategy for nutrition was found by the Global Evaluation of CMAM to be important to support programme potential for long-term impact. Numerous evaluation reports identified that decentralization in governance of services for young children appeared to have augmented programme ownership at provincial and local level increasing the potential for sustainability. This was possible through capacity building and support of partners to local structures. In addition, increased government participation in planning and management of nutrition programme components was found to reflect governmental willingness to gain ownership of nutrition programmes and was conducive to programme sustainability. Where strong partnerships existed, the integration of nutrition programmes into national structures and systems was facilitated.

**Financial sustainability** – Nutrition programmes were found to be more sustainable where nutrition activities were co-financed by local structures. This reflected local ownership and leadership, both necessary elements for programme continuity. The Global Evaluation of CMAM report found that overall there was a heavy dependency on UNICEF to support the bulk of capital costs on start-up but that there were some countries where these diminished over time as governments tended to absorb more of recurrent costs.

**Programme design and implementation** – The way in which nutrition programmes were designed was found to affect programme sustainability in various ways. The implementation of nutrition programmes through existing national structures and systems was found to increase programme sustainability. Moreover, when partners supported rather than substituted national structures, nutrition programme components were more likely to be integrated into national structures. The inclusion of exit and handover strategies and
sustainability plans in programme design was also found to be conducive to programme ownership and continuity. In addition, programme implementation and scale up was enhanced when it was sustainably integrated with other interventions and in the context of strong inter-sectoral approaches to address malnutrition.

**Key weaknesses and constraints**

The following findings should be interpreted with the understanding that not all contexts, such as chronic conflict or newly created governments, are conducive to the development of sustainable programmes and national systems within the time framework of a UNICEF-supported nutrition programme.

**Funding and leverage** – Overall, evaluations found that there was a dependence of nutrition programmes on external financing and partnerships for implementation and continuity. This finding is not surprising as UNICEF works in developing countries and in emergencies where leveraging national funds is difficult. The reliance on stop-start, short term, mainly external emergency funding made nutrition programmes less likely to achieve preventive and sustainable outcomes. In addition, some donors considered some nutrition interventions, such as CMAM, to be emergency projects that are not eligible for development funds which reduce their potential for continuity. Some evaluations also found that high-cost interventions, such as the Mobile Decision Support Software Applications in Tanzania, were financially possible due to the contribution of external funds but unlikely to be up-scaled if such funds were removed.

**Capacity and systems** – Several reports concluded that sustainability was not possible without strong national structures and systems to implement nutrition programmes. In addition, the scale up of nutrition programmes was found to be heavily hampered where human resources were insufficiently trained and where there was frequent turnover of programme staff.

**Programme integration** – Numerous evaluations observed an absence of integration of nutrition programme components into national health systems. In many of these cases, planning for such integration was not well conceived. Moreover, sustainability was reduced where multi-sectoral orientation of nutrition activities was absent. Overall, it was found that global guidance on the subject is weak.

**National ownership** - A weak understanding of the programme approach by national stakeholders, such as for community-based interventions, reflected in insufficient continuous sensitization and lack of political will at the community level, was found to reduce nutrition programme continuity. Moreover, where national priorities have a predominant focus on food insecurity, governmental perception of malnutrition as a priority can be overshadowed. Some evaluations also found that in emergency settings, there was a risk that direct intervention by UNICEF and its IPs was seen by some governments as “quick fixes” that did not require further governmental commitment.

**Partnerships** - In some contexts, such as hard-to-reach and conflict-affected areas, UNICEF has at times found it difficult to find sufficient partners to bring nutrition programmes to scale which reduces the likelihood that programmes will meet targets and become sustainable. Evaluations also found that some nutrition programme partnerships were affected by the isolation of agency-specific roles and the lack of integration of planning and agreement on common indicators which reduced the potential of programme sustainability.
4. FINDINGS BY NUTRITION PROGRAMME COMPONENT

This chapter provides findings specific to key programme components of nutrition programmes. Of the 49 evaluations, 32 had an explicit focus on Infant and Young Child Feeding, 32 on the Management of Acute Malnutrition, 36 on Micronutrient-focused Interventions, 15 on Growth Monitoring and Promotion, and nine examined Nutrition in Emergencies. Thirty-one of the 49 evaluations focused on three or more nutrition programme components. For each programme component, the findings on effectiveness were synthesized. The factors that contributed to or impeded success were identified and implications for future programming are outlined. The findings are intended to strengthen specific programme components.

4.1 Infant and Young Child Feeding (IYCF)

4.1.1 Key findings

The meta-analysis found that IYCF interventions were rarely implemented on their own. Instead they were integrated in the programme design of nutrition and/or health programmes (mainly IMCI and MNCH). Within health programmes, IYCF activities were found to be included in the basic health care and ante-natal packages offered to pregnant and lactating mothers and caretakers. IYCF activities were provided through a variety of service points including primary health care centres, hospitals, women’s groups, and community health services. Within nutrition programmes, IYCF was found to be integrated into other nutrition interventions such as the management of SAM and MAM including their outreach activities, and food distributions. In a number of evaluations, IYCF was conducted through a multi-sectoral approach between the food security, nutrition and health sectors.

IYCF interventions were generally not evaluated independently but as part of overall health and nutrition programmes. Consequently, programmatic and cross-cutting factors specific to IYCF interventions were not evaluated in depth.

Of the 32 evaluations that evaluate health and nutrition programmes that include IYCF interventions only 16 examined the effectiveness of IYCF interventions. Please see Annex 1 for a list of evaluation reports that cover IYCF.

Moreover, most of the evaluations that evaluated the effectiveness of IYCF interventions reported results achieved in terms of outputs (example: total number of mothers reached in IYCF counselling). This was partly because IYCF indicators in the results frameworks were defined as outputs rather than outcomes. This may be because child mortality and undernutrition are determined by multiple causal factors and that the direct impact of IYCF interventions on the reduction of undernutrition is difficult to measure. The evaluations could have broadened their scope and used outcome data from various household surveys such as DHS and MICS. Outputs on their own have limited value and only become meaningful if they are linked to intervention and programme objectives, in this case the reduction of undernutrition and/or child mortality. Consequently, it is hard to draw conclusions from the outputs reported by the evaluations.

IYCF activities

Thirty-two of the 49 evaluations in the meta-analysis covered nutrition and health programmes that included one or more types of IYCF activities. As explained above, these activities are part of health or nutrition programmes. The table on the next page lists the typology of IYCF activities that were supported through UNICEF programmes.
Table 6 – IYCF activities by country

<table>
<thead>
<tr>
<th>IYCF activities</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>IYCF through food distribution programme</td>
<td>Burkina</td>
</tr>
<tr>
<td>IYCF Communication for Development</td>
<td>Burkina, Tanzania, Philippines, Cambodia, China</td>
</tr>
<tr>
<td>IYCF in CMAM</td>
<td>Niger, Chad, Nepal, Pakistan</td>
</tr>
<tr>
<td>IYCF integrated in health services</td>
<td>Philippines, Ethiopia, Pakistan, Uzbekistan, Timor-Lesté, Cambodia, Kenya, Djibouti, Indonesia, Nepal, Bangladesh, Laos, Afghanistan, Kosovo, Moldova, Ethiopia</td>
</tr>
<tr>
<td>Establishment of human milk bank</td>
<td>Philippines</td>
</tr>
<tr>
<td>IYCF in the workplace</td>
<td>Philippines</td>
</tr>
<tr>
<td>Promotion and monitoring of the International Code of Marketing of Breast-milk Substitutes</td>
<td>Serbia, Philippines, Djibouti, Indonesia, Lao PDR, China</td>
</tr>
<tr>
<td>Baby-friendly hospital support</td>
<td>Togo, Cambodia, China, Kosovo</td>
</tr>
<tr>
<td>IYCF upstream policy development</td>
<td>China, Kosovo, Niger, Philippines</td>
</tr>
</tbody>
</table>

IYCF Communication for Development (C4D) – This activity aims to change the behaviour of mothers towards breastfeeding and educate them (as well as their families and communities) on the risk of the improper use of breast-milk substitutes and inadequate complementary feeding. The evaluations identified three types of approaches: interpersonal, community and media. As highlighted by the Evaluation of the Indian Ocean Tsunami, IYCF C4D needs to be accompanied by the corresponding legislative environment to achieve the expected behavioural change at large scale.

IYCF integration in health services – Work towards the inclusion of IYCF in health services was observed in numerous countries. This work focuses on those services that provide pre- and post-natal care to ensure that service providers are appropriately trained and mothers are adequately supported.

Promotion and monitoring of the International Code of Marketing of Breast-milk Substitutes – UNICEF generally serves as a first point of reference to governments on the Code. Depending on the context, this activity included one or more of the following interventions: training of national experts, drafting a national Code and the corresponding national policies and laws, advocacy to protect the Code, and financial support to investigate violations of the Code. Evaluations did not report on the adequacy or results of the work on promoting and monitoring the Code which is an area for future evaluations.

Effectiveness

As reported above, a key concern is that not much attention has been given to proper evaluation of effectiveness of IYCF interventions. Of the 32 evaluations that cover one or more IYCF interventions (integrated in a health or nutrition programme), only 16 evaluated the effectiveness of IYCF interventions.
Of the 16 evaluations that evaluated the effectiveness of IYCF interventions, 10 found that all intervention targets had been reached or were likely to be reached. Five evaluations found that some of the intervention targets had been reached or were likely to be reached and one evaluation found that intervention targets were unlikely to be reached.

**Key success factors**

*Locally adapted HR strategies* – Much of the counselling on IYCF was conducted by health staff, community workers and volunteers and every programme needed to adapt its counselling strategy to the local context and resources. In the Philippines, the use of Volunteer Peer Counsellors was deemed effective to promote IYCF practices as they are able to reach far and beyond the coverage areas of health structures. However, given the voluntary nature of their work, the evaluation found that volunteers were not able to exercise authority over their activities which affected their motivation and ownership. In Uzbekistan, Patronage Nurses were in charge of sensitizing older generations of women on optimal child feeding and caretaking practices so that they would not pass on inadequate messages to their pregnant or lactating daughters-in-law.

*Use of guidance* - Based on the available UNICEF guidance on IYCF, all five countries in the EU/UNICEF partnership were found to focus on a relevant and complete set of activities to roll-out IYCF interventions. These included production of national guidelines, effective and culturally appropriate counselling cards, and capacity development on counselling techniques. In the Indian Ocean Tsunami emergency programme, guidelines for controlled use of donated infant formula supported by UNICEF were in place in all three
countries (Indonesia, Sri Lanka, Maldives) after the tsunami and were seen as important in preventing breastfeeding from declining.

Communication and sensitization – Sensitization at community level, mainly conducted through CHWs and volunteers, was reported by numerous evaluations as an effective strategy to prevent malnutrition. As observed in Ethiopia, areas in which intense nutrition sensitization and education (outreach) was conducted were found to significantly reduce the prevalence of stunting. In addition to outreach work, other approaches to nutrition communication and sensitization were also found to be effective. For example, in Cambodia, access to media and communication increased over time as more of the population gained access to television, radio and mobile phones. The Behaviour Change Communication campaigns, which focused on these media outlets, improved knowledge of breastfeeding and complementary feeding practices.

Key weaknesses and constraints

Timeliness – The mid-term evaluation of EU/UNICEF partnerships found that IYCF interventions had generally suffered delays because IYCF toolkits needed adaptation to the country settings. In some countries, government budgets for IYCF roll-out were not readily available upon programme start up. In Uzbekistan, IMCI activities (which include IYCF) at the primary health care level were delayed and faced problems due to the absence of the respective MoH decree upon programme start up.

Programme design - In the Philippines and Cambodia, evaluations found that programmes with an IYCF component were too short to change behaviours effectively. In addition, insufficient political commitment to IYCF was found at the initiation of the programme.

Monitoring and evaluation – Several challenges in IYCF monitoring and evaluation were reported. In the Philippines, the evaluation found that weak monitoring and evaluation of activities did not allow for analysis of the adequacy and effectiveness of IYCF activities. In Cambodia, processes for monitoring community-based IYCF interventions were found to lack quality standards and tools to support continuous improvement. Moreover, programme-quality indicators to support programme planning and management were found to be inadequate. Developing clear, evidence-based guidelines for quality and aligning monitoring tools to support these standards were found to be essential and necessary steps. Capacity building in the areas of monitoring and supporting programme improvement at all levels was deemed necessary. In Moldova, monitoring and evaluation indicators set in the results framework were found to lack sufficient guidance to evaluate adequately the counselling of mothers on breastfeeding.

Additional findings

Capacity building – Evaluations contained valuable examples of how capacity building has contributed to an increase in the effectiveness of IYCF interventions. In Uzbekistan, the cascade training method used in the project helped train a critical mass of health staff in a limited time period. The training of health staff was thought to have led to the provision of adequate consultation to pregnant and lactating mothers about the benefits of breastfeeding. In Cambodia, capacities have been built at multiple levels which were reported likely to contribute to programme performance and sustainability. Programme support to policy and guidelines were found to enhance the enabling environment for food security and nutrition interventions. Working through national systems was found to result in enhanced capacities at multiple levels, in particular at the sub-national level.

Upstream policy development – The EU/UNICEF partnership mid-term evaluation found ample evidence of upstream policy development on IYCF in most countries covered by the partnership. However, the evaluation also found a significant gap between policies and plans and the actual implementation of IYCF activities. There were examples of IYCF activities that were hampered by the absence of proper policies or by policies that are limited in scope. In the Philippines, an IYCF intervention focused on the establishment of lactation stations in companies. However, the regulations agreed to by participating ministries only required companies with over 200 employees to establish these stations. Moreover, labour regulations impeded IYCF staff from accessing these companies to evaluate them.
In Kosovo, a protocol was developed for systematic follow-up visits and for training in Infant and Young Child Feeding Counselling. This protocol was in line with national nutrition policies. In Indonesia, the evaluation found that continuous advocacy and campaigning with different stakeholders on the importance of breastfeeding were likely to have helped to increase the rate of exclusive breastfeeding. In numerous countries, UNICEF and its partners advocated for the promotion and protection of the International Code of Marketing of Breast-milk Substitutes.

**Integration in national structures** - Close linkages of IYCF interventions with ongoing government programmes were achieved when interventions were implemented through existing national structures. For example in Nepal, IYCF interventions were delivered through the country’s public health care system. Given the encouraging results found in IYCF pilot-test areas and the well-functioning partnership with the national structures, a full nation-wide scale-up of IYCF was deemed possible. In Uzbekistan, the mother-child health training package was integrated into the pre-service training curriculum as well as in the national certification system which contributes to the sustainability of the intervention.

**Government ownership & programme sustainability** – Leveraging of resources that foster government ownership was considered by several evaluations to contribute to programme sustainability. In the Philippines, IYCF interventions complemented existing national programmes with significant leverage of resources by national and local governments. In Cambodia, decentralization has fostered scale-up of Early Childhood Development (ECD) services and increased potential for sustainability as local communities take ownership of ECD programming. In Indonesia, UNICEF managed to leverage resources for scaling up of IYCF through linkages with the social protection programme.

**Integrated/multi-sectoral approach** – The mid-term evaluation of the EU/UNICEF partnership found that although the programme design made use of a multi-sector approach in which health, food security and nutrition are interrelated in order to enhance nutritional conditions of children and women, outputs were not achieved at the local level two years into the programme. In Cambodia, the provision of food security and nutrition programmes which include IYCF interventions was found to be largely uncoordinated across sectors (health, education, labour, agriculture).

The integration of IYCF interventions with other programme components led to positive results. In Uzbekistan, the evaluation confirmed the effectiveness of packaging projects in one programme as it proved to be cost effective, accountable and more results based. In the EU/UNICEF partnership mid-term evaluation, the scaling up of nutrition interventions through the introduction of IYCF on large social protection programmes in Indonesia and Philippines was found to be a promising strategy. The integration of nutrition in conditional cash transfers (Indonesia and Philippines) and the integration of MNP in the IYCF programme (Nepal) provided good opportunities for learning across countries.

**4.1.2 Implications**

The evaluation of IYCF interventions show mixed results on effectiveness as only 10 out of 16 evaluations indicated that all targets had been met or were on the way to being met within the programme timeline. Similarly, the findings on programmatic and cross-cutting IYCF factors suggest that IYCF interventions have significant room for improvement. Based on the findings and recommendations of the evaluations, the following key actions are suggested.

- Promote relevant programmatic linkages of IYCF with other programme components (IYCF in CMAM, IYCF in social protection, MNP in IYCF, etc.). The corresponding policies, strategies, and guidance are needed for such linkages both at UNICEF and at country level.
- Provide guidance and support to country offices on the development of IYCF process and target indicators that enable proper evaluation of the effectiveness of IYCF interventions.
- Promote feasibility studies of IYCF interventions prior to programme design so as to identify implementation challenges (e.g. access to women, cultural and gender issues, geographical access).
and incorporate them into intervention planning. When the context does not allow for feasibility studies, such as in emergencies, they may have to be conducted after the programme start up.

- Ensure that future evaluations examine IYCF component independently (or as a part of programme evaluation but with in-depth focus on IYCF interventions) and produce findings specific to IYCF.
- Address the inadequate economic incentives which cause motivational issues of frontline IYCF workers (mainly CHWs). This issue needs to be addressed and factored into programme designs and budgets so as to reach the desired objectives.
- The need to integrate IYCF into CMAM was recommended by numerous evaluations. CMAM was considered to be a very valuable entry point for IYCF activities as it supports malnourished children’s environments by improving the behaviours and practices of caretakers. For IYCF to be fully integrated in CMAM, the necessary policies, strategies and guidelines need to be established a priori.

4.2 Management of Acute Malnutrition

4.2.1 Key findings
Of the 49 evaluations included in the meta-analysis, 31 evaluations covered management of acute malnutrition. Annex 1 lists the evaluation reports that cover management of acute malnutrition.

CMAM activities
Although CMAM is the most common type of intervention used by UNICEF to address acute malnutrition, there are other modalities used as well. The following table describes intervention modalities by country found in these 31 evaluations.

<table>
<thead>
<tr>
<th>Type of intervention</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based Management of Acute Malnutrition/Integrated Management of Acute Malnutrition</td>
<td>Burkina Faso, Niger, Chad, Nigeria, Mauritania, Kenya, Tanzania, Ethiopia, Pakistan, Nepal, Timor-Leste, Djibouti, Yemen, Indonesia, Laos, Philippines, Bangladesh, Afghanistan, Cambodia, DRC</td>
</tr>
<tr>
<td>Integrated Nutrition Action against Malnutrition</td>
<td>Ghana</td>
</tr>
<tr>
<td>Community Based Nutrition Programme</td>
<td>Rwanda</td>
</tr>
</tbody>
</table>

Note: The Integrated Nutrition Action against Malnutrition focuses on acute malnutrition of children under-three years of age. The Community Based Nutrition Programme is a flexible programme modality that includes at least one of the following nutrition components: management of acute malnutrition, breastfeeding promotion, micronutrient deficiencies.

Effectiveness
Of the 31 evaluations that covered management of acute malnutrition (SAM and MAM), 25 evaluated effectiveness. The remaining six evaluations contributed to the understanding of processes but do not compare results against targets. In other words, they did not evaluate the effectiveness of the intervention.
Of the 25 evaluations that evaluate the effectiveness of management of acute malnutrition interventions, 19 evaluations found that interventions had reached their targets or were likely to reach their targets. Five evaluations found that some targets were met or likely to be met and one evaluation found that none of the targets or performance standards were likely to be reached.

Most evaluations used Sphere Minimum Standards as indicators for the effectiveness of SAM interventions (>75 per cent recovered, length of stay <60 days, deaths <10 per cent, defaulters <15 per cent). Only a few evaluations reported the percentage of non-responders and the percentage of medical referrals, which are valuable indicators to further the understanding of SAM performance even if they are not included in the Sphere Minimum Standards.

**Key success factors**

*Outreach and community sensitization* – The community approach of CMAM is significantly built on outreach activities that focus on screening, referrals and case-follow up, sensitization, nutrition education, and prevention of malnutrition. The 2013 Global Evaluation of CMAM found that strong case identification was the most important mechanism for increasing access and promoting equity. Moreover, it found that demand for CMAM services increased in many countries because of efficient use of community resources, and identification and referral of children.

The mid-term evaluation of EU/UNICEF partnerships found that implementation of CMAM had been an effective way to identify SAM cases. As outreach and community sensitization is mainly carried out by
CHWs in most countries, developing a community strategy that defined a package of activities to be performed by CHWs and using different opportunities to screen and follow-up with children was found to be good practice. Where CHWs had the necessary capacity, supervision and motivation to conduct outreach activities, demand for CMAM was effectively increased and programme targets were more likely to be met.

Community sensitization improved the understanding of the CMAM approach by the community and paved the way for behavioural changes and improved nutrition care practices. Sensitization of community leaders and influential people was found to lead to an equitable strategy for accessing children by the 2013 Global Evaluation of CMAM. Different approaches towards sensitization existed across evaluations. In Nepal, local leaders were included in discussions on the management of CMAM through meetings with medical staff and administrators in the district health offices. In Kenya, outreach, community mobilization and sensitization through mass communication, radio and seminars were found to improve the demand for CMAM.

Low opportunity-cost for caretakers – The majority of evaluations agreed that the community approach to CMAM caused minimal social disruption when compared to the facility-based in-patient approach. Given the increased coverage and proximity to the population, CMAM was found to facilitate caregivers’ access to services, reduce transportation costs and reduce opportunity costs.

**Key weaknesses and constraints**

*Programme design* – The positive impact of conducting preliminary evaluations and feasibility studies prior to CMAM implementation was highlighted by several evaluations. In Chad, the programme design successfully incorporated the findings of preliminary nutrition surveys, the analysis of the causes of malnutrition, and the analysis of the capacity of the national health system. However, feasibility assessments were not carried out in Pakistan prior to CMAM commencement. Consequently, the programme design overlooked male resistance and difficulties reaching women which significantly limited the roll out of CMAM. Moreover, the lack of initial rapid nutrition assessments in Pakistan handicapped the development of adequate targets and intervention planning. Challenges towards CMAM implementation, such as the work burden of CHWs, seasonal migration of the target population and the use of alternative healthcare were overlooked in programme design due to the absence of preliminary feasibility studies in Nepal. It is worth noting that in some contexts, such as in emergencies, it is not always possible to conduct preliminary evaluations and feasibility studies prior to the programme commencement.

Some evaluations also found that CMAM interventions did not update programme design after significant contextual changes. In Nepal for example, the results framework was not updated throughout the programme although the implementation mode changed. In Pakistan, the evolution from an emergency intervention to an integrated long-term programme did not result in the review of strategies and planning to address acute malnutrition.

A large number of evaluations identified the failure to integrate IYCF into CMAM as a missed opportunity.

*Human resources* – CMAM services are provided by a combination of facility-based staff and CHWs. The 2013 Global CMAM Evaluation and seven other evaluations found that the motivation of CHWs involved in CMAM activities was significantly hampered by high workload and insufficient economic incentives. This problem was associated to poor service quality and CMAM performance especially in outreach activities such as screening, referrals, case home follow-up and community sensitization and education. High workload was a result of CHW involvement in multiple programmes. Low motivation was a result of heavy workloads as well as insufficient or lack of economic incentives, especially for volunteer CHWs. Other challenges found by CHWs were related to the lack of transportation to reach remote populations and insufficient training and guidance.

*Supervision* – The mid-term evaluation of EU/UNICEF partnerships revealed that the supervision of staff conducting CMAM activities was problematic in some countries. The evaluations in Chad and Ghana also reached this conclusion, especially where staff shortages and high staff turnover were found. Inefficient
supervision often led to poor CMAM performance, gaps in the CMAM continuum and disruptions in the supply chain. In Kenya, inadequate supervision of supply-chain management was found to be one of the greatest challenges to the CMAM intervention.

**Monitoring and evaluation** – The 2013 Global Evaluation of CMAM found that none of the countries included in the evaluation had conducted KAP surveys before, during and/or after the intervention. This was found to limit the analysis of the effectiveness of the intervention on nutrition knowledge, aptitude and practices of the targeted communities. In addition, the failure to conduct anthropometric surveys before and after numerous CMAM interventions limited the analysis of the change produced by the intervention on outcome indicators.

**Management of severe acute malnutrition (SAM)** – The evaluations have identified a number of challenges specific to SAM.

- **Problems with service frequency** – SAM beneficiaries were seen on the same day which led to crowding and operational constraints. (Sahel)
- **Poor condition of SAM facilities** – The poor conditions of the facilities were sometimes unsuitable for delivering care even to the minimum standards. (Sahel)
- **Failure to follow protocol** – Weak adherence to protocols, including admission criteria, referrals, and discharge. (Ethiopia, Cameroon, Pakistan, Yemen) In some cases, inappropriate admissions accounted for more than 50 per cent of admissions. (Yemen)
- **Sharing of RUTF** – Sharing of RUTF among non-SAM children increased noncompliance, relapses and longer stays under treatment. (Ethiopia, Kenya)
- **Long distance to out-patient therapeutic programme (OTP)** – In spite of the increased proximity to target populations of the CMAM approach, some OTPs were still found to be far by caregivers which led to high defaulter rate. (Nepal, Cameroon) This was a particular challenge for nomadic populations. (Cameroon)
- **Dependence on RUTF for SAM treatment** – The entire SAM intervention was halted when the government banned the use of imported RUTF. (Bangladesh)

**Management of moderate acute malnutrition (MAM)** – Although UNICEF does not directly work on MAM, MAM is part of the CMAM continuum and weaknesses in MAM interventions can have a significant impact on UNICEF-supported SAM interventions (e.g. failure to treat children with MAM can increase the caseload of children with SAM). A variety of challenges specific to MAM were found by several evaluations. In Niger, the main challenges were the variability of number of IPs per region, the cross-border mobility of the target population, and the variability in the quality of screening. In Ethiopia, the challenges to MAM included low targeted-supplementary feeding coverage, inconsistent distributions, false enrolment, weak follow-up, and insufficient linkages to counselling. Finally, the evaluation in Nepal highlighted an issue that also affects MAM interventions in other countries which is the absence of standardized indicators to evaluate MAM performance.

**CMAM continuum** – The linkages between CMAM components are essential for the optimal management of acute malnutrition. The 2013 Global Evaluation of CMAM and six other evaluations found inefficiencies in CMAM continuum mainly in the referral and transfer process between CMAM. Examples from specific countries are provided below:

- CHWs did not note when children are close to SAM cut-offs and do not refer them to more intensive counselling and monitoring. (Global)
- There were gaps in the linkages between screening and referral processes because CHWs did not record the number of referrals and data indicating percentage of children referred to CMAM services was not available. (Global)
- Lack of follow-up system to track stabilized children (inpatient treatment) and to ensure they return to the outpatient treatment. (Kenya)
- There were more mobile nutrition centres than integrated health centres. (Sahel)
There were poor linkages between OTP and SC both for referral to the SCs and discharge back to OTPs. (Pakistan)
Transfer and counter-transfer of children was weak (inpatient-outpatient/SAM-MAM). (Chad)
Referrals from OTP were not noted in TFC registers and discharges of stabilized children were often not relayed to OTP staff. (Ethiopia)

Other factors that contributed to gaps in the CMAM continuum were the poor coordination between WFP and UNICEF on strategy development, planning and implementation of the CMAM continuum (Chad, Sahel, Pakistan), private health care providers were not included in the CMAM continuum (Global), and there was poor coordination of partners working in the same area (Chad).

**Outreach and community sensitization** – The 2013 Global Evaluation of CMAM found that less intense focus was given to the community outreach component which posed a challenge for improving case identification and coverage. Outreach activities with regards to the recognition of the signs of wasting and understanding of factors contributing to malnutrition were found to be of poor quality. Moreover, the evaluation found that outreach was often challenged by a lack of concern for poorer members of society, language/dialect differences, and weak acceptance of male responsibility in childcare. Case follow-up through home visits was found to be the weakest CMAM activity because of overburdening of CHWs workload, insufficient CHW motivation, and insufficient supervision, monitoring and evaluation.

The 2013 Global Evaluation of CMAM also found that CHWs conducting outreach activities found hard-to-reach areas even harder to reach in cold weather. Case-finding in areas with lower population density and challenging access was not effective in Nepal. In addition, female CHWs were found to face acceptance issues in some contexts. In Pakistan, the community outreach strategy did not fully consider traditional gender roles as they affect access to women and children. In Nepal, the evaluation found that men need a greater sensitization regarding nutrition policies and their roles in supporting child feeding and care.

The CMAM evaluation in Cambodia found the need to work more on the demand side of CMAM because undernutrition was often not recognized by caretakers as a problem that needs treatment. As mass media activities to support the efforts of CHWs tend to significantly increase CMAM performance, more funds are needed to launch awareness campaigns and more linkage with C4D activities are needed according to the 2013 Global Evaluation of CMAM.

**Additional findings**

The following are the additional findings on some of the evaluation criteria and cross-cutting issues examined by the CMAM evaluations.

**Integration into national health systems** – The integration of CMAM into national health systems is necessary for CMAM to become sustainable in a given country. In addition, it increases government ownership and increases coverage and malnutrition prevention potential. The 2013 Global Evaluation of CMAM found that CMAM interventions were being regularized within the National Health Systems although this was often done in an ad-hoc manner and needs to be further standardized. Where integration was well planned and based on capacity assessments, efficiency increased and scale-up was facilitated. For example, in Ethiopia, seizing the coverage of national health structures for screening and active case-finding by CHWs and volunteers was found to facilitate the scaling up of CMAM activities.

As observed by the evaluation of CMAM in Pakistan, where CMAM is not integrated with the national health system, it is not a mainstreamed solution to acute malnutrition. Poor integration was found to result in weaker demand for CMAM by the communities and limited potential to reach those in need. Moreover, duplication of resource allocation, overlap of activities and overburdening of staff was attributed to poor CMAM integration by several evaluations including the 2013 Global Evaluation of CMAM.

**Capacity building** – Capacity building is a core activity to roll out and scale up CMAM activities. However, it can be a challenge when frontline staff such as CHWs and volunteers already have a significant workload and need to cover hard-to-reach areas. The response to the Sahel food and nutrition crisis anticipated this...
challenge and provided the necessary resources by including training, increased human resources, and ongoing integration of new health staff into public service. Continuous capacity building through training and on the job support was found to improve CMAM services in Ethiopia. An innovative approach towards capacity building was developed in Ethiopia where CHWs were trained and given more responsibility (capacity and right to administer treatment) to ensure an available cadre to provide services at CMAM sites. This contributed to increased coverage and to reaching the previously unreached SAM children.

**Technical support and guidance** – CMAM guidelines have been created and efforts to harmonize them with other national protocols were in process in most of the countries covered by the 2013 Global Evaluation of CMAM. Moreover, technical assistance was found to strengthen the management capacity of national systems and to contribute to strategies that help to train and motivate staff and retain trained staff. As found in Nepal, the evolution from the substitution approach of international NGOs to direct technical support to district health offices was found to be successful in maintaining and improving the quality of CMAM services.

Multiple evaluations have identified weaknesses in CMAM guidance. These included: insufficient global guidance on outreach (2013 Global Evaluation of CMAM, Pakistan), weak national guidance on CMAM implementation (Chad), weak global and national guidance on the integration of CMAM into national health systems (Chad, Kenya, Pakistan), lack of national agreement on guidelines for screening, relapse, readmissions, referrals and home visits (Kenya, Pakistan), absence of global guidance on nutrition counselling in Sphere Standards (Nepal), weak global guidance in the results-based management of CMAM (Pakistan), weak or absence of national guidance on equity and gender and MAM management (Pakistan), weak national guidance on management of SAM for people with HIV/AIDS (Cameroon).

**Sustainability** – The use of imported RUTF represents a challenge for CMAM sustainability in contexts where local RUTF production is deemed feasible and least costly. In Bangladesh, the use of imported RUTF was banned by the government leading to the disruption of the SAM component in CMAM while a locally produced substitute was developed. A local substitute, in the form of food supplements, was developed which helped to reduce the prevalence of SAM although recovery took somewhat longer than with RUTF. In Kenya, dependence on RUTF mainly procured with emergency funds was found to limit capacity building efforts for long-term investment in local production. In DRC, Government leverage of the CMAM programme was found to be low which resulted in CMAM stock-outs as soon as the UNICEF-supported programme came to an end.

**Scaling up** – The 2013 Global Evaluation of CMAM found that expanding the critical mass of human resources in outreach activities was a requirement for CMAM scale up. Moreover, it found that insufficient number of well-trained health workers was a major constraint for scaling up. Opportunities were missed to engage in joint planning and M&E for integrated scale up of child development programmes, which was an important lesson for scaling up CMAM. The 2013 Evaluation of the Sahel Food and Nutrition Crisis found that CMAM scale up was not coordinated or oriented proportionally to the needs of regions with regards to SAM. In fact, scale up was found to be done according to the availability of NGOs in a given area. The evaluation also found that no clear criteria were being used to justify which health centres were upgraded to nutrition centre status.

**Partnerships** – The evaluation of the CMAM programme in Pakistan provided valuable lessons learned with regards to CMAM short-term partnerships. Effectiveness was found to be hampered by short term agreements of three to six months between UNICEF and IPs. The short-term project approach was found to limit monitoring and capacity building opportunities. Moreover, the evaluation found that short-term agreements reflected lack of commitment to long term funding and planning which was likely to affect the performance of staff adversely.

**Multi-sectoral approach** – The 2013 Global Evaluation of CMAM found that CMAM was well integrated with WASH interventions. WASH inputs, particularly in provision of water taps and acceptable latrines, was found to improve the quality of CMAM services. In Niger, psychosocial activities was found to be well integrated with CMAM to respond to the Sahel food and nutrition crisis.
4.2.2 Implications
The evidence from the available evaluations of CMAM reflects a generally high level of effectiveness, as determined by Sphere performance standards. However, there is room for improvement in the management of CMAM interventions. Based on the evaluation findings and recommendations, the following actions are suggested (some of these may already be underway following the recommendations of the Global CMAM Evaluation).

- Strengthen guidance to country offices on outreach, CMAM integration into national health systems, nutrition counselling, management of SAM for people with HIV/AIDS and focus on gender in CMAM interventions.
- Integrate CMAM into national health systems from programme inception and duly include in programme design and planning. Strengthen health systems to support the management of SAM.
- When feasible, conduct feasibility assessments and baseline studies for appropriate CMAM intervention design to enable baseline-endline comparison and adequate programme evaluation. When the context does not allow for it, such as in emergencies, feasibility studies may have to be conducted after the programme start up. When baseline studies are not possible, real-time evaluations have been proven useful to update programme design, objectives and implementation.
- Capitalise on the numerous examples of good practice in strengthening the community component of CMAM and in increasing demand for CMAM services through community sensitization and mass media campaigns. Increased demand has led to increased coverage of those in need as well as those in hard-to-reach areas. Ensure the necessary resources are available to increase demand of CMAM services.
- Ensure adequate human capacity development through pre-service training and mainstreaming of training in national curricula. Where appropriate, address motivational issues of frontline CMAM workers (mainly CHWs) due to inadequate economic incentives. This issue needs to be addressed and factored into programme designs and budgets so as to reach the desired objectives.
- Where appropriate, address the high number of SAM non-respondents found in some countries and include reporting on non-respondents in regular CMAM M&E.
- Advocate for long-term funding of CMAM, as it is often considered by donors to be a short-term emergency intervention. Advocate for further leverage of governments’ financial contribution to CMAM thus increasing government commitment and ownership.
- Ensure adequate coordination between CMAM partners, including governments, IPs, UNICEF and WFP. At programme design level, ensure joint CMAM strategies and objectives are developed at country level. At programme implementation phase, ensure UN agencies and IPs collaborate to find synergies among activities so as to strengthen the CMAM continuum, avoid duplication, maximize impact and ensure an efficient use of resources.
- Continue to promote upstream policy work on CMAM to ensure an adequate policy environment.
- Where appropriate, explore possibilities for sustained local production and procurement of goods (e.g. RUTF, micronutrients, etc.) to reduce the dependence of more expensive imports.
4.3 Micronutrient-focused interventions

4.3.1 Key findings
Micronutrient-focused interventions were found to be incorporated into nutrition and health programme designs and not delivered as stand-alone interventions. Of the 49 evaluations included in the meta-analysis, 36 evaluations covered nutrition programmes that contain one or more micronutrient-focused intervention. Annex 1 lists the evaluation reports that cover micronutrient-focused interventions. Key interventions consist of micronutrient supplementation, large-scale food fortification and home fortification. The following table lists these by country.

Table 8 – Types of micronutrient-focused interventions by country

<table>
<thead>
<tr>
<th>Activity type</th>
<th>Activity</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micronutrient supplementation</td>
<td>Planning for future supplementation intervention</td>
<td>Burkina Faso</td>
</tr>
<tr>
<td></td>
<td>Vitamin A supplementation</td>
<td>Chad, Niger, Nigeria, Mauritania, Chad, Tanzania, Kenya, Nepal, Madagascar, Timor-Leste, Djibouti, Cambodia, Ethiopia, Bangladesh</td>
</tr>
<tr>
<td></td>
<td>Iron/ folic acid/iron folate supplementation</td>
<td>Nepal, Pakistan, Bangladesh, Laos, Philippines, Indonesia, Moldova, Ethiopia</td>
</tr>
<tr>
<td></td>
<td>Vitamin D</td>
<td>Moldova</td>
</tr>
<tr>
<td>Large-scale food fortification</td>
<td>Fortified cereals/blended food</td>
<td>Kenya, Timor-Leste</td>
</tr>
<tr>
<td></td>
<td>Salt iodisation</td>
<td>Nepal, Timor-Leste, Kosovo</td>
</tr>
<tr>
<td></td>
<td>Fortified oil</td>
<td>Pakistan</td>
</tr>
<tr>
<td></td>
<td>Fortification of staple foods</td>
<td>Nepal, Bangladesh, Laos, Philippines, Indonesia</td>
</tr>
<tr>
<td>Home fortification</td>
<td>Multi-micronutrient powder/sprinkle supplementation</td>
<td>Philippines, Kenya, Nepal, Pakistan, Timor-Leste, Cambodia, Indonesia, Bangladesh, Laos, Afghanistan</td>
</tr>
</tbody>
</table>

Iron, folic acid, iron folate, and vitamin A supplementation were found to be integrated into both nutrition and health programmes. Multiple micronutrient supplementation and food fortification were integrated into nutrition programmes. As expected, linkages with the health sector were found for all micronutrient-focused interventions.

In addition to the micronutrient-focused interventions described above, evaluations found that significant work had been done in most countries on advocacy and upstream policy development, including support for planning and guidelines formulation and advocacy for national policies for addressing micronutrient deficiencies.

Effectiveness
One of the key findings is that not much attention has been given to the proper evaluation of effectiveness of micronutrient-focused interventions. Of the 36 evaluations that covered a micronutrient-focused intervention, 16 mentioned the type and frequency of the activity conducted but failed to contrast outputs/outcomes against targets or adequately analyse the processes involved. The remaining 20 evaluations did evaluate the effectiveness of micronutrient-focused interventions.

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* More recently known as “home fortification”.
Of the 20 evaluations that examined effectiveness of micronutrient-focused interventions, variable results on effectiveness were observed. Twelve of the evaluations found that intervention targets had been reached or were well on their way to being reached. Four evaluations found that some of the intervention targets had been reached or were on their way to being reached and four evaluations found that intervention targets were not reached or were unlikely to be reached.

Key success factors

Supply chain – An adequate supply chain was maintained in the vitamin A campaign in Madagascar as well as in the distribution of MNP in Cambodia contributing to the effectiveness and coverage of the interventions. Given the provincial scope of the intervention in Madagascar, further enhancement of the supply chain management capacities was deemed necessary.

Efficiency – From the different nutrition programme components implemented in Bangladesh, MNP distribution, anaemia counselling and school-based nutrition education were identified as potentially highly cost-effective activities.

Communication and social mobilization – In order to reach the target population, effective sensitization strategies in Madagascar included the implication of local media for social mobilization, the training of animators and journalists and the adaptation of communication actions in the local dialect. In addition, active participation of mothers and the community was achieved. In the Dominican Republic, a high participation of private sector in the iodised salt sensitization campaign was reached thus increasing...
national ownership. Moreover, it was found that beneficiaries of the sensitization campaign had a tendency to disseminate the new knowledge to others, thus contributing to a multiplying effect of the campaign’s messages. In Cambodia, iron and folic acid (IFA) distribution to pregnant and lactating mothers was enhanced with a nationwide mass media campaign on anaemia prevention and treatment which led to an increased demand for IFA supplementation at primary health care level.

**Key weaknesses and constraints**

*Timeliness* – Many of the delays in the programme in Timor-Leste were found to be related to high staff turn-over and recruitment. Most organizations found difficulty in recruiting technically qualified national and international staff. Moreover, UN recruitment procedures were found to be time consuming and there appeared to be no Human Resources format to recruit a joint programme coordinator within the UN system. In Lao PDR a specific programme output addressed capacity development to avoid delays in the supply chain of MNPs (sprinkles) and Zinc. However, the evaluation found that the supply chain of a multitude of supplies, including Vitamin A capsules, micronutrient powders, iron and folic acid supplements was often disrupted. The distribution to the health centres was delayed by almost six months due to unclear accountability for supply distribution and financing of transportation. In the Dominican Republic, delays in the delivery of campaign materials to implementing partners were found to be related to limitations in programme management.

*Procurement and stock management* – Difficulties with procurement and stock management were found in Ethiopia and Kosovo. In Ethiopia, the evaluation found stock outs of vitamin A, IFA and essential micronutrients in the majority of the health posts visited. In Kosovo, IFA supplementation was halted all together after finding difficulties in IFA procurement which, according to the evaluators, contributed to the intervention not reaching its target to reduce micronutrient deficiencies in pregnant women.

*Monitoring and evaluation* – In three evaluations, covering seven countries in total, the monitoring and evaluation of micronutrient-focused interventions was found to be inadequate. The following constraining factors were identified:

- Programme results frameworks lacked enough indications of progress along the results chains meaning that the data and information provided by monitoring and evaluation were not sufficiently detailed to inform programme management.
- Partners did not sufficiently take the opportunity to analyse regularly monitoring data, enhancing learning and informing programme management decision-making based on progress made so far.
- The monitoring of the campaign was not realized because the national counterpart that had agreed to make it possible did not deliver due to logistical issues.
- Monitoring and evaluation of MNP and IFA supplementation was a matter of concern due to reliability of data and variable frequency.
- There was difficulty assessing the effectiveness of micronutrient supplementation delivery models because monitoring systems for MNP / MMN / IFA distribution were mainly concentrated on collection of distribution data and did not provide coverage figures, information on compliance or the demonstrated effects of the supplements on the health status of the recipients.

**Additional findings**

*Multi-sectoral approach* – In Cambodia (iron deficiency intervention) and in Timor-Leste (salt iodisation and vitamin A supplementation interventions), programme designs incorporated a multi-sector approach in which health, food security and nutrition were integrated in order to enhance nutritional conditions of children and women. However, the evaluation found that in spite of a coordinated selection of geographical areas across the various programme components, the coverage of each of the programme components differed significantly which resulted in limited synergy at the local level. Consequently, the evaluations found that the costs of joint programming had not yet been followed by the benefits in terms of synergy between the components at the local level.
The evaluation of the vitamin A supplementation campaign in Madagascar found that the multi-sectoral collaboration of technical and financial partners and the effective multi-sectoral and local financial participation had highly contributed to the good coverage of supplementation of vitamin A in children under 5 and on pregnant and post-partum women.

Integration of national structures – In Madagascar (vitamin A supplementation) and in Timor-Lesté (salt iodisation, vitamin A supplementation), micronutrient-focused interventions were integrated in national structures (political, administrative, traditional and religious leaders) at the central and community level in planning and implementation, supervision. Such integration led to increased capacity building and national ownership. For management purposes, the programme in Madagascar used an existing working group which enhanced efficiency of governance and management arrangements of the programme and reduced transaction costs.

Capacity building - In Timor-Lesté (salt iodisation and vitamin A interventions), the systemic focus of the programme, building capacities at organizational levels, enhanced the likeliness that results would be sustained beyond the life time of the programme. In Cambodia (anaemia reduction intervention), capacities were built at multiple levels. Programme support of initiatives on policy and guidelines enhanced the enabling environment for food security and nutrition interventions. Working through national systems has resulted in enhanced capacities at multiple levels in partner agencies, in particular at the sub-national level. Such systemic capacities were likely to enhance sustainability. In the Republic of Moldova, communication and sensitization interventions to increase knowledge, attitudes and practice on anaemia and vitamin A deficiency were highly effective as found by the programme’s endline survey. The high coverage and effectiveness of training to health staff to sensitize caretakers and pregnant and lactating mothers was thought to have contributed to the good result.

In Madagascar challenges in capacity building were encountered. The training of health staff and community health workers was not accomplished as per the programme’s result framework. In addition, the training was thought to be too short to have sufficient effect on the target population. In Timor-Lesté, the evaluation found that relationships with NGOs were often driven by annual plans rather than by longer-term partnership arrangements and concerns, which at times jeopardizes opportunities to build civil society capacities. In Bangladesh and Cambodia, MNP stock outs were frequent due to inadequate capacity for supply management in national structures. This was a particular challenge in Cambodia as supply inefficiencies had not been taken into account when scaling up the MNP intervention nationwide.

Enabling environment - The mid-term evaluation of EU/UNICEF partnerships on nutrition security found that overall the attention to support the development of preventive policies related to micronutrient powders was relatively limited. In Indonesia (micronutrient and IFA supplementation to pregnant women), the lack of national policy and unclear guidelines on micronutrient supplementation to pregnant women was found to create confusion among frontline health staff and led to varying amounts of micronutrients and IFA given to pregnant women. In Laos, only a partial approach was undertaken towards the use of MNP supplementation since the national strategy only envisaged the use of MNP for emergencies and not for regular micronutrient deficiency prevention.

4.3.2 Implications

The evaluation of micronutrient-focused interventions shows variable results on effectiveness and cross-cutting issues. Based on synthesized findings, the following actions are suggested.

- Promote multi-sectoral synergies at national and local level through improved programme design, collaboration with various partners and effective coordination arrangements. Special attention should be given to the timing and sequencing of multi-sectoral activities for a given target population so as to attain potential synergies.
- Strengthen guidance on the integration of micronutrient-focused interventions into national health systems and promote its use. In addition, develop guidance on micronutrient control strategies
jointly with food security and agriculture sectors and provide guidance on how to translate these strategies into action at country level.

- Capitalize on good practice from other countries on implicating local structures and communities to achieve local acceptance and increase coverage.
- Where appropriate, address gaps in micronutrient supply chain management and provide the necessary capacity development and resources to ensure adequate and timely service delivery.
- Where appropriate, address gaps in monitoring and evaluation systems to strengthen results based management of micronutrient-focused interventions.
- Identify and address gaps in upstream policy development that hamper the implementation and scale up of micronutrient-focused interventions.
- Capitalize on good practice on communication and sensitization campaigns, such as those used in Madagascar, to increase the acceptability of micronutrient-focused interventions.
- Ensure that future evaluations of micronutrient-focused interventions identify good practices and lessons learned through systematic evaluation of both programmatic and cross-cutting factors.

4.4 Growth monitoring and promotion

4.4.1 Key findings

Of the 49 evaluations included in the meta-analysis, only fifteen evaluations covered nutrition programmes that contained one or more type of GMP activities. This suggests that GMP is not integrated as a significant component in UNICEF nutrition programmes. The table below illustrates the types of GMP activities by country found in these fifteen evaluations.

GMP activities

<table>
<thead>
<tr>
<th>GMP activities</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to planning of &quot;nutrition minimum package&quot; to contain GMP</td>
<td>Burkina Faso, Niger, Chad</td>
</tr>
<tr>
<td>GMP included in routine national health care services</td>
<td>Tanzania, Ethiopia, Ghana, Indonesia, Bangladesh, Philippines, Moldova, Rwanda, Afghanistan, Lao PDR, Nepal</td>
</tr>
</tbody>
</table>

Where GMP was included in the nutrition programme, evaluations found that it was integrated in the routine national health care services. In other countries such as Burkina Faso, Niger and Chad, efforts to include GMP in the "nutrition minimum package" were ongoing. The nutrition programme in Afghanistan took an innovative approach towards GMP by a trainer-of-trainer approach which has the potential of increasing the coverage of GMP training in a cost-effective way.

Extracting findings on effectiveness and its contributing factors is not possible for GMP interventions as none of the evaluations provide information on outputs-vs-targets or evaluate programmatic or cross-cutting factors specific to GMP interventions.

4.4.2 Implications

From the available evidence in these 15 evaluations, it is possible to conclude that GMP has neither been a priority focus of nutrition programmes nor evaluations in recent years, although a number of countries with strong nutrition programme such as Ethiopia, Bangladesh, Nepal, Tanzania, Ghana have included GMP in their health care system. It is likely that results frameworks in many countries do not include indicators to measure progress and effectiveness of GMP activities or because GMP is seen as part of other nutrition interventions (e.g. CMAM) and as such, it is not evaluated explicitly. In light of the absence of concrete evaluation findings specific to GMP interventions, the following actions are suggested.
• Assess the adequacy of guidance on GMP in light of new developments in nutrition programming including lessons from successful countries and as appropriate, develop further guidance / promote use of selected GMP interventions and indicators in results frameworks.

• Ensure that future evaluations of nutrition programmes include an explicit focus on the evaluation of GMP.

• The 2007 UNICEF consultation on GMP suggested the following process, monitoring and outcome indicators which should be considered in future guidance, results frameworks, and evaluations.

Table 10 – List of GMP indicators suggested in the 2007 UNICEF consultation

<table>
<thead>
<tr>
<th>Process/performance indicators</th>
<th>Outcome indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• coverage (100 per cent within community)</td>
<td>• Proportion of children faltering</td>
</tr>
<tr>
<td>• participation (80 per cent at least 80 per cent of the time)</td>
<td>• Proportion of faltering children who recuperated by the next visit and by the third visit</td>
</tr>
<tr>
<td>• frequency of supportive supervision visits (monthly for the first 6 months, then quarterly thereafter)</td>
<td>• Knowledge and practices of mothers</td>
</tr>
<tr>
<td>• quality of counselling/mentorship (tbd)</td>
<td></td>
</tr>
<tr>
<td>• performance indicator for workers (tbd)</td>
<td></td>
</tr>
<tr>
<td>• No. of feedback/community discussion sessions held</td>
<td></td>
</tr>
</tbody>
</table>

4.5 Nutrition in Emergencies

4.5.1 Key findings

Of the 49 evaluations included in the meta-analysis, 9 evaluations covered emergency nutrition programmes. The following table illustrates the types of nutrition programme components covered by these evaluations.

Table 11 – Types emergency nutrition interventions by country

<table>
<thead>
<tr>
<th>Type of nutrition programme intervention</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMAM</td>
<td>Burkina Faso, Niger, Chad, Nigeria, Mauritania Laos, Pakistan, Chad, Kenya, Nepal, Ethiopia</td>
</tr>
<tr>
<td>Micronutrient-focused intervention</td>
<td>Burkina Faso, Niger, Chad, Nigeria, Mauritania, Laos</td>
</tr>
</tbody>
</table>

9 There have been several inter-agency evaluations that have examined at UNICEF’s role as a cluster coordinator. These evaluations were excluded in the meta-analysis as they did not focus on UNICEF’s entire nutrition response, rather on UNICEF’s leadership as cluster coordinator.
Maldives, Burkina Faso, Niger, Chad, Mauritania, Sri Lanka

Online nutrition surveillance system development
Maldives

Blanket feeding of RUSF for children 6-24 months old
Burkina Faso, Niger, Chad, Nigeria, Mauritania

Effectiveness
All nine evaluations evaluated the effectiveness of the emergency nutrition programmes. The effectiveness of CMAM interventions was measured against Sphere standards. The other nutrition interventions were measured against programme targets. The findings are generally positive but suggest significant room for improvement. Of the nine evaluations, five were found to have reached or were likely to reach all targets, three evaluations found to have reached or were likely to reach some targets, and one evaluation found that targets were unlikely to be reached.

Figure 8 – Level of effectiveness of emergency nutrition interventions

![Figure 8](image_url)

Key success factors
Nutrition surveillance system development – An innovative approach towards nutrition surveillance was developed in Maldives. An Online Nutrition and Child Health Surveillance System was developed and integrated into the national health system which was found to strengthen primary health care and preventive care actions.

Demand for CMAM – In the Sahel evaluation, increased community awareness about the existence of services for malnourished children was found to help to identify and refer children in a timely manner for treatment. Active case finding was effective in increasing admissions.

Local procurement of RUTF – In Burkina Faso, developing local procurement for RUTF was found to be a success from which other countries can learn.

Key weaknesses and constraints
Basing recovery response on needs assessment - The rapid needs assessment carried out in the immediate aftermath of the Indian Ocean Tsunami was found to have guided actions for the entire recovery period. The evaluation found that a more profound assessment should have been undertaken six to eight months later to develop a more substantive strategy for the move from emergency actions to recovery and development.

Lack of NGO partners – In the Sahel and in Aceh/Indonesia (Indian Ocean Tsunami), emergency nutrition programmes found difficulty in finding sufficient NGO partners to cover the needs of the affected population and deliver against UNICEF core commitments (SAM, IYCF, Micronutrients).
National capacity – The real-time evaluation of the food and nutrition crisis in the Sahel found that while inputs are widely available, capacity at national, district, and end-user (health post) levels limited the effectiveness of the effort.

CMAM protocols – In the Sahel evaluation, several problems were found with regards to adherence to nutrition protocols, including the lack of discharge criteria, poor quality of anthropometric measurements, double registration (fraud by mothers), lack of uniformity of admission and discharge criteria within the same country, poor reporting in terms of completeness, frequency and analysis. In Laos, appropriate registration and monitoring of SAM cases as well as supervision of health centre staff appeared to be problematic.

Non-responders - In the Sahel evaluation, further analysis of national and/or regional data performed by the evaluation team revealed a high number of non-responders (recovery criteria not met after the prescribed nutrition management period) due mainly to low adherence to treatment with repeated absences, and to the almost total lack of community monitoring through home visits.

Local involvement – In the Indian Ocean Tsunami evaluation, despite rhetoric by international organizations and health leaders, participatory involvement of displaced people in their own care and in helping to address their social and mental health needs was not found to be instituted as part of the response plan.

Outreach - CHWs were found to devote less attention to home visit follow-ups because they had too many programs to implement and they were not regularly monitored and supervised which affected their motivation.

Guidelines - The lack of detailed information in the guidelines on the frequency and procedures for screening, active case findings, referrals, follow up through home visits, and absence of tools and nutrition information systems made the assessment of the overall effectiveness of community outreach component difficult. There is also a clear lack of guidelines for IYCF in emergencies.

Reporting - Parallel systems for information management were not found to be sustainable in the Sahel. Simplification of reporting tools and integration with national systems was deemed necessary. Heavy reporting burdens for health workers through numerous formats for various interventions were found which were thought to result in job stress. Merging reporting formats can help keep reporting burdens at reasonable levels and facilitate integration of interventions and cross analysis. Lack of harmonization in reporting systems poses challenges for evaluating effectiveness.

Additional findings

Integration into the national health system - In Sri Lanka, the government’s designation of UNICEF as the key partner in rebuilding the primary health care system (including IYCF counselling services) in affected areas strongly assisted continuity in the absorption of UNICEF initiatives into the national health system. Immunization and primary health care programmes, for example, were found to be fully integrated into the governmental system. Good immunization and nutritional outcomes in the south reflect the relevance of UNICEF health activities. Here, the programme concentrated on redeveloping facilities, strengthening preventive health programmes, and assessing needs. In the Sahel, positive results from the MAM intervention were thought to be partially attributable to the integration of MAM within the primary health care services However, the alignment of the nutrition programme to national policies as well as the integration of the nutrition programme into the national health system was found to be weak and a major handicap to the start-up and implementation of nutrition interventions.

Capacity development - In the Sahel evaluation, health workers were found to be able to perform well if they were well trained and effectively supervised, and if the health centres were well equipped and regularly supplied. In all three countries affected by the Indian Ocean Tsunami, the evaluation found that progress could have been even better if more attention had been devoted to training focused on the actual epidemiologic burden. Moreover, training health managers who supervise primary care personnel and engaging in health policy actions at higher levels would have strengthened the relief-to-recovery transition. In addition, the opportunity to develop new approaches and to train new staff in IDP camps was not seized.
Integrated approach for CMAM - Combining community mobilization and sensitization for CMAM with those of other health and nutrition interventions in the Sahel was found to contribute to its effectiveness, along with using various community health opportunities to screen children.

Multi-sectoral approach - Although part of the programme design in the Sahel, linkages of nutrition interventions with child psychosocial stimulation and WASH activities were found to be very limited. The evaluation attributes this to the sparse internal engagement and coordination within UNICEF, the weak interest from implementing partners, and inadequate funding. Within nutrition programmes, IYCF was found to be poorly integrated into CMAM.

Support from the regional office – The real-time assessment of UNICEF’s response to the Sahel Crisis that covered Nigeria, Niger, Mauritania and Chad found that the support of the regional office to the country offices was judged useful and appreciated. However, regional office requests to the country offices overwhelmed emergency specialists in country offices due to the lack of an adequate framework for dealing with horizontal issues.

4.5.2 Implications
The findings presented above were found in nutrition emergency programmes but many of the findings are common to programmes in non-emergency settings. More countries focus on CMAM alone as opposed to CMAM together with IYCF, micronutrient and information. Thus this already highlights that UNICEF’s emergency response may not address all core commitments. The recommendations presented below focus only on emergency-specific nutrition programme related to maternal and child nutrition.

Further institutionalize multi-sector coordination for nutrition in emergencies within UNICEF and advocate for it with governments, donors and implementing partners. Ensure that nutrition sector coordination is well-established in high risk countries.

- Learn from other emergencies where local RUTF was developed in a timely and efficient manner, such as Burkina Faso during the Sahel food and nutrition crisis.
- If programme feasibility studies are not possible prior to the emergency operation, it is recommended that they are conducted as soon as possible after programme start up. Real-time independent assessments, as the one conducted in the Sahel, allowed for the updating of programme design and implementation in emergencies.
- Ensure that capacity building and training is adapted to the epidemiological burden specific to the emergency.
- Ensure that a full package of critical services is being delivered to affected populations at times of emergency (by filling the gaps in services identified by evaluations)
5. OVERALL CONCLUSION AND RECOMMENDATIONS

Based on synthesized findings from the evaluations, this chapter presents conclusions and makes recommendations for strengthening UNICEF’s evaluation evidence base on nutrition and for improving nutrition programming.

5.1 Conclusions
Conclusions are based on the findings of the meta-analysis of nutrition programme evaluations detailed in the body of the report, regarding programme relevance and appropriateness, programme effectiveness, efficiency, sustainability and cross-cutting issues, including national system and capacity development, multi-sectorality and equity as well as adequacy of nutrition evaluations.

Programme Relevance and Appropriateness

Nutrition programmes covered in the meta-analysis evaluations were found to be highly relevant in addressing local needs and were generally very well aligned with national and donor policies and priorities. The appropriateness of nutrition programmes was challenged by poor programme design. Nutrition programmes were found to focus on the nutritional needs of the vulnerable sub-groups of the population which generally include children under 5 years old and pregnant and lactating women. Adequate alignment with national nutrition policies, health and nutrition strategies, MDGs and UNDAF strategies was found across nutrition programmes. Where theory of change was absent or poorly developed in programme design (nine out of 49 evaluations included in this meta-analysis), poor results frameworks and weaknesses in monitoring and evaluation challenged results based management, constrained the potential of programme monitoring systems to inform programme management, and resulted in inadequate package of nutrition interventions. The absence of causal analyses and/or baseline studies in the development of programme design (eight out of 49 evaluations in this meta-analysis) weakened the appropriateness of programme design.

Programme Effectiveness

UNICEF-supported nutrition programmes and interventions have had mixed success in achieving programme objectives. Less than two-thirds of nutrition programme components evaluated in the meta-analysis had reached or were likely to reach all of their targets. Of all nutrition programme components, the achievement of all targets was highest in CMAM interventions, followed by IYCF and micronutrient-focused interventions. However, the number of non-responders in SAM was found to be a matter of concern and IYCF was not integrated into CMAM in practice. The least effective component was Nutrition in Emergencies for which only half of the interventions were found to have reached or were likely to reach all their targets. Strong partnerships, adequate system and capacity development, integration into national systems and quick response in emergencies were found to contribute strongly to the achievement of programme results. Where the achievement of objectives was challenged, a variety of constraining factors were identified including unrealistic timeframes, inadequate programme design, weak monitoring and evaluation systems, and insufficient qualified human resources. The funding for nutrition programmes was often found to be insufficient to achieve expected outcomes. Moreover, numerous nutrition programmes experienced a decrease in effectiveness when UNICEF and/or other donors reduced or ceased their financial support. In the case of CMAM, scale up to cover those in need was challenged by funding constraints for regular programming and reliance on emergency funds or external sources of assistance.
Figure 9 – Comparison of effectiveness across nutrition programme components

The meta-analysis found that CMAM interventions have the highest proportion of “all targets reached/likely to be reached”, followed by IYCF, micronutrient-focused interventions, and nutrition in emergencies.

Weaknesses in the quality of programme data and monitoring and evaluation suggested that results on programme effectiveness may not be too precise. One of the most common findings was the weakness of monitoring and evaluation systems in nutrition programmes. Although there are a few evaluations in the meta-analysis that found adequate and operational M&E systems, the majority of evaluations found significant challenges to M&E which limit M&E’s potential to improve design and address programmatic challenges. The main challenges for M&E were weak data collection, followed by poor data analysis and utilization, and the inclusion of inappropriate indicators in results frameworks.

**Efficiency**

The evidence on the efficiency of nutrition programmes was weak and did not allow for substantive clear conclusions. Cost analysis was sparse across the meta-analysis as financial inputs were rarely contrasted against programme outputs and outcomes in evaluations. Only one evaluation (Bangladesh) provided findings on the cost efficiency of nutrition interventions. A possible reason for this weakness is that evaluators take the findings of the Lancet Series on high-impact/cost-efficient nutrition interventions for granted without trying to contrast the Lancet findings against the reality/context of the programme or intervention being evaluated. Evaluations need to examine more explicitly operational aspects including human resource allocations, institutional arrangements, timing and the use of low cost options in particular contexts. Most available findings on programme efficiency were related to the implementation rate and budget expenditure. Although implementation rates were generally found to be acceptable, a significant number of evaluations found challenges related to the timeliness of nutrition activities. Over half of the evaluations in the meta-analysis identified challenges in ensuring a critical mass of qualified and motivated human resources which was linked to the failure to reach programme objectives.

**Sustainability**

Although some evaluations found that nutrition programmes’ financial, technical and institutional continuity was likely, the majority of evaluations found elements that hindered programme sustainability. Factors that contributed to sustainability included upward policy work such as guidelines, policies, regulations and strategies, implementing nutrition programmes through existing nutrition structures, strong government ownership, including sustainability aspects in programme design, and co-financing programmes which increase local ownership. However, the widespread reliance on external
funding and procurement (e.g. RUTF) and the absence of national funding commitments was found to reduce the sustainability of numerous nutrition programmes. Other factors that weakened programme sustainability were the absence of strong national structures and systems, insufficiently trained staff, high turnover of staff, absence of integration of nutrition programme components into national health systems, absence of multi-sectoral orientation of nutrition activities and insufficient national ownership of nutrition programmes. As nutrition programmes are taken to scale, there is a need for UNICEF to be more systematic in considering financial and institutional sustainability in advocacy and programme planning and management.

**Multi-sectorality and Coordination**

The findings on multi-sectorality are mixed. Several evaluations identified well-functioning multi-sectoral approaches in UNICEF, however, a greater number of evaluations found that programmes or interventions were not able to overcome the challenges associated with multi-sectoral integration. When well integrated from programme design to implementation, a multi-sectoral approach was found to contribute to greater programme results. Factors that contributed to a strong multi-sector approach included: integrating the approach into policy, strategic plans and protocols, integrating the nutrition sector with one more sectors (such as a child protection, WASH, C4D etc.), and employing innovative multi-sectoral approaches such as the “5+1” strategy and the “convergence approach”. Evaluations that reported weaker multi-sectoral approaches identified the following challenges: insufficient internal coordination and fund mobilization, ‘siloeed’ support from the regional offices, limited capacities of partners, and the lack of multi-sectoral approach in the design of the programme logic model. **Less than half of the evaluations that measured coordination found it to be adequate.** Factors that constrained coordination included a lack of clarity of national coordination procedures, limited government capacity to lead and unnecessary parallel coordination mechanisms which duplicated existing structures.

**National system and capacity development**

*Significant progress has been made in upstream policy work and in developing systems and capacity for nutrition programming but more work is still needed.* Creating an enabling environment has been a priority of nutrition programmes which is evidenced by the large number of national nutrition policies and strategies developed, the extensive technical support provided in the creation of guidelines and technical structures at national level, and the training of government staff involved in nutrition programmes. Efforts to support upward policy work were found to support programme continuity and sustainability. However, the meta-analysis found that nutrition was not high on the national agenda in some countries. Moreover, evaluations found that numerous nutrition policies were not translated into action and that further technical support was needed for the creation and integration of guidelines into national systems. With regards to human capacity building, high turnover of staff (mainly frontline staff) was found to reduce the sustainability of human resource capacity building.

**Equity**

*UNICEF-supported nutrition programmes generally managed to target those most in need. However, findings on the integration of gender equality, HIV/AIDS and disabilities in nutrition programming were sparse.* The factors associated with high programme coverage were the use of integrated planning frameworks and community assessments, strong partnerships, strong outreach activities, and community acceptance of programme activities. Findings also suggested that better geographic coverage is obtained when programmes are fully integrated into the national health system, when decentralization and scale-up are combined, and when programme design is based on the findings of needs assessments. Challenges to programme coverage (reaching less reached) included weak mapping of vulnerability, limited coverage of health facilities, variable presence of implementing partners, variability of nutrition screening and limited geographic convergence among programme interventions.

**Partnerships**

Partnership initiatives that led to joint nutrition programmes were deemed to be a comparative advantage in obtaining synergistic effects and gains in process, coverage and outcomes. In the identification of
implementing partners, it was considered important to select those that understood the local context and had substantive technical capacity. Strong partnerships, in which roles and coordination modalities were clearly established and respected, were found to contribute to programme success. However, in some instances too many implementing partners led to resources being spread too thinly and to difficulties in coordination which limited programme effectiveness and efficiency. In some programmes, disagreements between UNICEF and WFP were found over caseload estimates and operational approaches.

**Adequacy of nutrition evaluations**

The evidence base contains evaluations from most of the countries with highest burden of malnutrition although their scopes vary. Some of the countries with high burden of malnutrition did not conduct any evaluations during 2009-2013 (as per the evaluation database). There is also relatively weak coverage of nutrition programmes in emergencies. Almost 25 per cent of UNICEF’s funds go to emergency programmes. However, nutrition emergency programmes have been the subject of only 18 per cent of all nutrition evaluations included in this meta-analysis (9 of 49) and some had a limited scope. There is a need to conduct comprehensive evaluations of nutrition programmes as a whole in regions and countries where under nutrition rates are high and where there is an increased inflow of investment including emergencies.

The evidence base is weakened by gaps in the scope and quality of evaluations. Although the effectiveness of overall nutrition programmes is covered by a majority of programme evaluations, effectiveness of nutrition programme components and interventions is only partially evaluated (50 per cent of IYCF interventions, 80 per cent of CMAM interventions, 61 per cent of micronutrient-focused interventions, none for Growth Monitoring and Promotion). Failure to contrast outputs and outcomes against objectives and the weak use of MICS and other survey data to measure impact are two main issues. The lack of analysis of efficiency including an analysis of low cost options and operational efficiencies is among the weakest aspects covered in the evaluations. In addition, the evaluation scope varies across the evidence base pointing to the need for additional lessons and good practices on programmatic and cross-cutting issues such as national system development and capacity building (which is linked closely to sustainability), upstream policy work, multi-sectorality and equity.

5.2 Recommendations

Based on the findings and conclusions from the meta-analysis of nutrition evaluations, the following recommendations are provided. These include measures to strengthen future evaluative evidence base as well as measures to strengthen programme planning, design and response.

1. **Ensure that nutrition programme design is developed jointly with national and local stakeholders and based on better articulation of evidence and theories of change (programme theory) that take account of national and local contexts.** With the contribution of national and local stakeholders, UNICEF and other partners should incorporate needs assessments, feasibility studies, and causal analysis in the development of theory of change and well-articulated results framework for nutrition programmes. Where a multi-sectoral approach is relevant, the inclusion of partners from other sectors in the development of results frameworks is necessary to ensure programmatic synergies in reaching target populations and geographical convergence. Good practices on multi-sectoral programming and coordination should be considered at programme design level. This also requires capacity strengthening of UNICEF nutrition staff in results based programme planning and management and on use of multi-sectoral approaches to addressing nutrition outcomes.

2. **Continue to develop national systems through upstream policy work, technical support and institutional capacity development.** In both emergency and development settings, UNICEF should

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10. The evidence base contains evaluations of ten of the 14 countries with the largest numbers of stunted children, and eight of the ten countries with the largest numbers of wasted children. Source: UNICEF Global Nutrition Database 2012.

11. This figure is based on UNICEF’s total expenditure for programmes in 2012 (taken from UNICEF’s 2012 Annual Report) and UNICEF total expenditure for ‘Other Resources Emergency Funding’ (taken from UNICEF’s 2012 Humanitarian Action and Post-Crisis Recovery Thematic Report).
prioritize supporting the creation of an enabling environment for nutrition programmes. Numerous examples of good practices and lessons learned from country programmes can be used. UNICEF should continue to integrate nutrition programmes into national systems (health and other sectors) as this increases the potential for programme scale up and sustainability. At the national level, through various partnership initiatives, UNICEF should promote and support the assessment of human resource and institutional capacity gaps upon which national strategies and action plans to address capacity gaps to address malnutrition in children and women should be based.

3. Continue to foster demand for nutrition services. UNICEF should prioritize outreach and community nutrition sensitization (availability of nutrition services, causal analysis of malnutrition, signs of malnutrition, etc.) so as to increase the demand for nutrition services. There are numerous examples of how nutrition programmes have contributed to an increase in the demand for nutrition services, which in turn increased nutrition programme effectiveness. Nutrition outreach activities, in both nutrition and health programmes, should be allocated necessary resources and funds. Attention should be paid to the continuum of nutrition services, including outreach and nutrition sensitization, between facility-based staff and community health workers. Moreover, outreach activities should be monitored and supervised and relevant and adequate indicators should be included in results frameworks.

4. Strengthen nutrition programme M&E at country programme level through the provision of technical support, development of nationally-adapted M&E guidelines, and the allocation of necessary resources and funds to ensure adequate data collection, analysis, reporting and utilization. UNICEF should invest in improving nutrition M&E at country programme level to truly understand the effectiveness of nutrition programmes. This is important for UNICEF to strongly show its comparative strength in nutrition and also for showing greater accountability for results to donors, national governments and other stakeholders. UNICEF HQ and ROs should provide guidance to COs on how to maximize the utilization of M&E data, analysis and reporting. In addition, when possible, UNICEF COs should use household survey data (MICS, DHS) for assessing impact including results that are attributable to UNICEF and other major contributors.

5. Integrate IYCF into other nutrition and health interventions. UNICEF should provide further technical support and guidance on integration of IYCF into health system interventions. Although steps have been taken towards the integration of IYCF into CMAM and other interventions, this practice was not evident in the 2009-2013 nutrition programmes included in the meta-analysis. In addition, greater effort is needed to improve fundraising for IYCF and other less resources components so as to meet nutrition programme funding gaps.

6. Strengthen equity aspects in programme design and implementation as well as in monitoring and evaluation. Although the meta-analysis found nutrition programmes and interventions adequately targeted those most in need, more effort must be made to integrate gender equality and the needs of those with HIV/AIDS and disabilities in nutrition programming. More attention must also be paid to incorporating equity in monitoring and evaluation, especially evaluating the integration of disabilities in nutrition programming. Programme budgets need to include sufficient incentives and means of transportation for outreach workers and volunteers to reach the hard-to-reach so as to ensure an adequate geographic coverage of nutrition programmes.

7. Ensure that OECD/DAC criteria and programmatic and cross-cutting factors are evaluated in depth in future nutrition programme evaluations. The terms of reference for evaluations of nutrition programmes, nutrition programme components, and nutrition interventions in health programmes should be more systematic in addressing OECD/DAC criteria and programmatic and cross-cutting factors. It is crucial that evaluations look at operational issues including use of low cost options, system building and scale up. In addition, guidance should be provided to external evaluators to ensure that OECD/DAC criteria and programmatic and cross-cutting factors are evaluated in an adequate and homogenous manner. As found by numerous evaluations in the meta-analysis, the success of evaluations largely depends on the
availability of M&E data at country level. Therefore, verification of data availability should be done prior to the commencement of the evaluation so as to adjust evaluation objectives accordingly.

8. **Future nutrition programme evaluations should focus on the gaps of the existing evidence base and needs assessments. There is a need for conducting more evaluations in regions/countries with high malnutrition burden and countries in emergency contexts.** Priority should be given to areas where knowledge gaps have been identified (effectiveness of IYCF and micronutrient-focused interventions, system development and capacity building, upstream policy work, multi-sectorality, and equity). It is important to evaluate more frequently nutrition programmes as a whole, especially in regions/countries where undernutrition is widely prevalent and nutrition programme investments are growing. These evaluations should have an impact focus and use MICS and other survey data that include nutrition outcome and impact indicators. A greater coverage of evaluation of nutrition in emergencies is recommended to reflect UNICEF’s programmatic priorities. The evaluation of the 2012-2013 Food and Nutrition Crisis in the Sahel (which included a real-time independent assessment upon programme start-up, the evaluation of country programmes, and a regional evaluation) can be used as a reference for future evaluations of nutrition in emergencies.
WORKS CITED


UNICEF. Humanitarian action and post crisis recovery. 2012.


## Annex 1 - Mapping of Nutrition Interventions in Evaluation Base

<table>
<thead>
<tr>
<th>Evaluation report title</th>
<th>Year of publication</th>
<th>Countries</th>
<th>Region</th>
<th>Geographic scope</th>
<th>Nutrition components</th>
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<td>Assessing the impact on child nutrition of the Ethiopia Community-based Nutrition Program</td>
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<td>Scaling up and improving the integrated management of acute malnutrition treatment in non-conflict areas on the Democratic Republic of Congo (May 2011-April 2013)</td>
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### ANNEX 2 - COVERAGE OF EVALUATION CRITERIA / ISSUES IN THE EVALUATION BASE

<table>
<thead>
<tr>
<th>Evaluation criteria</th>
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<tr>
<td>Partnerships / Implementing partners</td>
<td>49</td>
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<tr>
<td>Monitoring and evaluation</td>
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<td>Effectiveness – overall nutrition programme</td>
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<td>Programme sustainability</td>
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<td>Equity – covering most in need</td>
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<tr>
<td>Efficiency and quality</td>
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<td>Appropriateness of programme design</td>
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<tr>
<td>Coordination</td>
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<td>Relevance - alignment with local needs</td>
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<td>Effectiveness – Management of acute malnutrition</td>
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<td>Training / Technical Support</td>
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<td>Upstream policy work</td>
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<td>Effectiveness – Micronutrient-focused interventions</td>
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<td>System development</td>
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<tr>
<td>Multi-sectorality</td>
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<td>Relevance – alignment with national and donor priorities and policies</td>
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<td>Equity – gender equality</td>
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<td>24%</td>
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<tr>
<td>Effectiveness – Nutrition in Emergencies</td>
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<td>Equity – inclusion of persons with HIV/AIDS</td>
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<td>Effectiveness – Growth monitoring and promotion</td>
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