

# Decentralized Evaluation

An WFP's Nutrition Programs in the Karamoja region:  
Community Based Supplementary Feeding Programme  
(PRRO 200249) and Maternal Child Health Nutrition  
(CP 108070) in Uganda from 2013 to 2015

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Alison Gardner and Edgar Agaba

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## List of Acronyms

ACD	Assistant country director
ACF	Action Against Hunger
ADB	Africa Development Bank
AFC	Andrew Food Consults
AME	Analysis Monitoring and Evaluation
ANC	Antenatal Care
BR	Budget Revision
CAFH	Community Action for Health
CBSFP	Community Based Supplemental Feeding Program
CMAM	Community management of acute malnutrition
CG	Care Groups
CO	Country Office
CP	Country Program
CPs	Cooperating Partner(s)
CUAAM	Doctors with Africa
CWW	Concern Worldwide
DEQAS	Decentralized Evaluation Quality Assurance System
DD	Dietary diversity
DFID	Department for International Development (UK)
EM	Evaluation Matrix
ET	Evaluation Team
FAO	UN Food and Agriculture Organization
FGD	Focus group discussion
FMA	Food monitoring assistant
FSG	Family Support Groups
FSNA	Food Security and Nutrition Assessment
GAM	Global acute malnutrition
GDP	Gross Domestic Product
GHG	Growth, Health and Governance
GII	Gender Inequality Index
HF	Health Facilities
HQ	Headquarters
HIV/AIDS	HIV and AIDS
IMAM	Integrated management of acute malnutrition
ITC	Inpatient treatment centre
IYC	Infants and young children
IYCF	Infant and Young Child Feeding
LBW	Low birth weight
MAM	Moderate Acute Malnutrition
MC	Mercy Corps
MCHN	Maternal Child Health and Nutrition
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoLG	Ministry of Local Government
MT	Metric ton
MUAC	Mid-upper arm circumference
NEC	Nutrition Education Counselling

NGO	Non-government organization
OECD DAC	Organisation for Economic Co-operation Development Assistance Committee
OEV	Office of Evaluation
OTC/ ITC	Outpatient treatment centre/ Inpatient treatment centre
PDM	Post distribution monitoring
PLW	Pregnant/lactating women
PNC	Postnatal clinics
PR	Protective ration
PRRO	Protracted Relief and Recovery Operation
RB	Regional Bureau
ROU	Republic of Uganda
RWANU Karamoja	Resiliency through Wealth, Agriculture and Nutrition in Southern
SAM	Severe Acute Malnutrition
SC	Supercereal
SC+	Supercereal Plus
SF	Supplemental food
SFP	Supplemental Feeding Program
SLEAC	Simplified LQAS evaluation of access and coverage
SNR	Safety nets and resilience
SO	Strategic Objective
SOP	Standard Operating Procedure
SPR	Standard Project Report
SUN	Scaling Up Nutrition
TOR	Terms of Reference
UBOS	Uganda Bureau of Statistics
UNAP	Uganda Nutrition Action Plan
UNDAF	United Nations Development Assistance Framework
UNDP	UN Development Program
UNFPA	United Nations Population Fund
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
YCC	Young Child Clinics
VHT	Village health team
WB	World Bank
WFP	World Food Programme
WHZ	Weight-for-height Z score

## Executive Summary

1. This evaluation was commissioned by the Uganda CO to support the implementation of the nutrition programs in the new CP (2016-2020). The evaluation was designed to assess the WFP's Nutrition Programs in the Karamoja region in Uganda: Community Based Supplementary Feeding Program (PRRO 200249) and Maternal Child Health Nutrition (CP 108070) The objectives are two-fold: (1) accountability- to assess and report on the performance and results of the Community-based Supplementary Feeding Program (CBSFP) and the Maternal Child Health and Nutrition (MCHN) Program in the Karamoja region over the 2013-2015 period; and (2) learning- to determine the reasons why certain results occurred or not. The main users of the evaluation outcomes are the Country Office, Regional Bureau, WFP HQ and Office of Evaluation (OEV) as well as WFP's primary cooperating partners: the Ministry of Health (MoH) and UNICEF and the non-government organization (NGO) implementing partners: Community Actions for Health (CAFH) and Andrew Food Consults (AFC); and, lastly the donor, Department for International Development UK (DFID).
2. The two nutrition programs are evaluated against the following evaluation criteria: relevance, coherence, complementarity, effectiveness, efficiency<sup>1</sup>, and internal and external factors. The main evaluation questions, as indicated in the Terms of Reference (TOR), were: 1) How appropriate are the MCHN and CBSFP interventions; 2) what are the results of the CBSFP and MCHN activities, and 3) why and how have the CBSFP and MCHN activities produced the observed results? In order to respond to these questions, the ET carried out a number of research methods: document and secondary data reviews, 65 key informant interviews with stakeholders (Kampala and Karamoja), 16 focus group discussions with beneficiaries (193 women and 18 men), observation of service delivery (17 sites) and food storage sites and reviews of program registers and client cards. Possible limitations included short time (2 weeks) allocated to the mission, which was mitigated by a well-organized field schedule and long work days; the language and cultural constraints faced were addressed through use of Ugandan translators some of which were Karamajong. Lastly it was difficult to overcome the lack of reliability of some of the data<sup>2</sup> provided and a few of the key documents were not provided.

### Key Findings

Evaluation question 1: How appropriate are the MCHN and CBSFP interventions?

3. The MCHN and CBSFP programs and their activities were found to be relevant and the geographical targeting across the seven districts was found to be appropriate given the prevalent high levels of food insecurity and undernutrition (acute malnutrition rates of 12 percent and stunting at 45 percent when the program was designed). Some program accountability measures were found to be lacking, such as, a beneficiary feedback mechanism and no posted ration sizes at distributions and likely contributed to the systematic provision of small rations observed in over half

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<sup>1</sup> Program efficiency was not completely assessed due to a lack of availability of the necessary documents.

<sup>2</sup> The reliability of the CBSFP performance, some of the commodity output data and the nutrition education and counselling data was questioned by the evaluation team (ET).

the sites visited by the ET. Gender was not found to be well considered during the design of either program or since. An issue related to gender and beneficiary participation was found, in that, young boys experience significantly higher levels of MAM and participate in CBSFP at a much lower rate than girls<sup>3</sup>. This warrants further investigation. Transfer modalities, food rations and beneficiary selection criteria were found to be relevant for the most part because they allowed for the most vulnerable to be identified and reached through MCHN and CBSFP. For the MCHN program, piloting cash transfers as planned is needed and considering more cost-effective program approaches for beneficiaries not responding well to MAM treatment is also a critical need. The MCHN ration complies with WFP and international guidance but is no longer aligned with Uganda MCHN guidance (2007): a point that underlines the need to update the MCHN guidelines. Both programs were found to be coherent with Uganda nutrition policy, strategy and action plan and to follow the MCHN and IMAM guidelines with the one exception mentioned. As well, the program aligns with WFP corporate strategy and nutrition policy while alignment with the gender policy is less complete as noted. Complementarity with other programs, such as SAM treatment programs (CBSFP) and MoH ANC/PNC clinics (MCHN), was found to be high from the design perspective but weaker when accounting for shortfalls in implementation. Referrals and linkage with agricultural programs were not considered in the design of either program, however, gardening projects have been integrated in the CBSFP with mixed success. More effort is required to link nutrition program beneficiaries and households with PLW and children under age two with WFP's and others complementary programs to address undernutrition. WFP has supported national coordination structures and currently supports district nutrition coordination in Karamoja districts, but the effectiveness is mixed and more effort is required to strengthen district nutrition coordination.

Evaluation question 2: what are the results of the CBSFP and MCHN Activities?

4. For the MCHN program on average between 2013 and 2015, the actual number of beneficiaries achieved program targets while only 12 percent of the planned food distribution occurred. For the CBSFP on average 80 percent of the planned numbers of beneficiaries participated in the program between 2013 and 2015. At the same time, program sites increased from 150 to 170 with no significant increase in beneficiary numbers. Further, the numbers of child beneficiaries decreased in 2014 and 2015 while the MAM levels increased indicating a lack of congruence between beneficiary need and participation. On average 64 percent of the target set for food distribution was achieved; less than expected given the higher percent of the beneficiary target achieved. This may be partially explained by beneficiaries not attending both monthly clinic visits and/or might indicate issues with food loss<sup>4</sup> and reporting. The ET and two other CBSFP reviews identified problems with the accuracy of the performance indicators reported. Nutrition education and counselling (NEC) data was reported for some of the three evaluation years<sup>5</sup>. The ET also found the nutrition counselling for CBSFP beneficiaries to be inadequate and the timing of MCHN nutrition sessions to limit participation. On the other hand, the ET was impressed with the enthusiasm expressed by MCHN/CBSFP beneficiaries during the

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<sup>3</sup> Nutrition indicators by sex were reported in the first FSNA Karamoja, Gender Supplement (July 2016) and additional data was provided on MAM levels and the level of significance between girls and boys MAM rates. The difference in MAM rates for boys (7.5 percent) and girls (10 percent) was found to be significant.

<sup>4</sup> For further details please see Annex 17 of the Evaluation Report

<sup>5</sup>For the MCHN program NEC data was reported for 2015 and for the CBSFP it was reported for 2014 and 2015.



nutrition education sessions observed and by their ability to repeat messages and identify changes made.

5. The MCHN program reached an estimated 47 percent of PLW and 41 percent of children, however, inadequate funding significantly limited food distributions and made it difficult to achieve any improvement in stunting and LBW or children's diets. A CBSFP indicator, recovery rate, showed a steady decline over the evaluation period which the ET attributes to slow improvement in data quality rather than a decline and feels more efforts are required to continue to improve data quality<sup>6</sup>. Regarding CBSFP coverage, in 2015 it was 49 percent and thus close to the SPHERE standard, however, the overall level masked low coverage in two districts. The CBSFP may be helping to maintain low mortality levels in Karamoja but doesn't seem to have had any impact on SAM prevalence which fluctuates similarly to MAM prevalence.

Evaluation question 3 why and how have the CBSFP and MCHN activities produce the observed results?

6. A number of internal factors hindered program results. Issues related to food procurement, management and storage, such as, MoH food storage facilities out of compliance with WFP guidance and foods in storage near 'best use' dates. Problems related to food distributions were also observed in that food handlers did not practice proper hygiene and systematized provision of smaller rations was observed in over half of the sites visited.
7. MCHN reporting was found to be time consuming and to duplicate other MoH reporting and staff in some sites did not completely understand the data required. The MCHN log frame indicators reported on are too few and focus on child beneficiaries; however, the data needed to track additional indicators is collected. A number of problems related to the tracking of CBSFP performance indicators were identified and the ET questions its usefulness in guiding programs; this underlines the need to strengthen efforts to improve it. Further, additional indicators need to be reported, such as, beneficiary relapse rates and mortality and SAM levels as outcome indicators would also help to assess program impact; this data is available in FSNA reports. The recent use of FSNA data to target food resources is commendable as it helps to put WFP's resources where they can potentially have more impact. Another issue identified was the counting of beneficiaries; a critical problem that the introduction of SCOPE (as planned) with its unique beneficiary identification number will hopefully resolve. Monitoring of the more technical aspects of both programs and the monitoring of food storage and distributions was found to be inadequate.
8. Issues related to management and staffing were also found to hamper the effectiveness of both programs. WFP does not have sufficient nutrition program or monitoring staff and available staff lack expertise in monitoring of nutrition programs. And within WFP's reporting and supervisory structures a technical nutrition linkage is not included which limits the influence of technical experts on program monitoring and other field level functions. Capacity, work load and turnover of MoH staff were also found to limit program effectiveness and CPs staff also appeared to vary in capacity. The commitment and capacity of VHT was also identified as a problem related to screening and referrals of CBSFP beneficiaries and follow-up with malnourished patients.

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<sup>6</sup> This concurs with other recent CBSFP reviews findings.

9. The program partners were well selected, however, more support from WFP was called for to support their activities, such as, reporting. For the MCHN program overreliance of MoH staff addressed a lesson learned from past programs, i.e. funding MoH positions is not sustainable; however, it also hampered reporting and other activities over the evaluation period. A lack of a gender analysis during the program planning phase and the absence of a gender advisor contributed to the low achievement of gender results.
10. Regarding external factors, the significant underfunding of the MCHN program significantly constrained food distributions and in turn potential impact. Other factors, such as a drought in 2015 and the difficulty to produce food crops affects food security and over dependence on food assistance. Entrenched gender roles constrain opportunities for women to receive proper care and rest during pregnancy and to care for their children. Widespread alcoholism is another factor.

### Overall Conclusions

11. The MCHN and CBSFP programs were found to be appropriate and activities relevant. They were also found to be coherent with Uganda nutrition policy and guidelines and WFP's strategic plan and normative guidance. The only exception was the MCHN rations pointing to the need to update the MCHN guidelines. It was only in the area of gender that the programs were out of alignment with WFP policy. In terms of complementarity, both programs considered this in design, however, in implementation some activities need to be strengthened to ensure this. Activities to complement the CBSFP and MCHN programs, such as, food security/livelihoods or WASH, were not adequately considered during program design, although some exist and WFP nutrition program beneficiaries participate in them, a referral system has not been developed. WFP participated in coordination activities at the national level and has worked to strengthen coordination at the district level, however, results are inconsistent across districts and for these structures to function sufficiently to support nutrition programs more effort is needed.
12. The effectiveness of the MCHN was compromised by underfunding; despite this, it reached its planned number of beneficiaries and contributed to increasing the number of ANC visits in targeted health centres. Over the evaluation period, program coverage increased for women, but remained the same for children. The MCHN program was not found to be effective in improving outcomes such as LBW or the quality of children's diets<sup>7</sup>. The CBSFP reached 80 percent of its planned beneficiaries and increased community mobilization and MUAC screening. Reporting on MAM treatment indicators has been problematic, however, the quality is improving and efforts to further this need to be strengthened and continued. CBSFP program coverage, measured in 2015, was moderately effective overall with two district reporting low coverage. Inadequate referrals<sup>8</sup> between WFP nutrition programs and with other nutrition programs limited program effectiveness, synergy and joint impact. Over the evaluation period a large number of MAM cases were recuperated and it is likely that the CBSFP reduced the number of SAM cases and may have helped to maintain the low mortality levels in the region. The program nutrition education and counselling sessions need strengthening and appear to have been somewhat effective in communicating messages and supporting behaviour change.

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<sup>7</sup> LBW data was extracted from the ProMIS data based and analysed for the three evaluation years; results showed fluctuation or a non-declining trend. Similarly FSNA on the quality of young children's diets was compared for the two evaluation years available 2014 and 2015; results showed some improvement (0.7 to 14 percent) but it was likely non-significant.

<sup>8</sup> From the CBSFP client card review and program sites visited by the ET very low referral between MAM and SAM program was reported or with the MCHN and visa versa. This finding was further substantiated through interview with UNICEF staff.

Gender results were less than expected as efforts to reach fathers and husbands of beneficiaries were minimal.

13. MCHN data collection and forms need to be streamlined with MoH reports and additional outcome indicators (e.g. ANC/PNC attendance) should be added to the log frame. Similarly, additions to the CBSFP log frame are needed. Use of FSNA to target food assistance should continue. MoH and CPs food storage and accountability needs to be improved to meet WFP standards and the systematic distribution of smaller rations observed needs to be investigated and addressed immediately. The number of WFP, CPs and MoH staff was insufficient and technical capacity of most staff involved was inadequate. In addition, WFP's supervisory structure lacks a linkage with nutrition technical supervision. Mapping of WFP and others nutrition and complementary program intervention sites was also identified as a need to support nutrition program beneficiaries' access to other programs that could improve food security/livelihoods, WASH, etc.

#### Lesson Learned

14. The MCHN funding short fall and its dependence on internal funding contributed to low program output. Early on, the program should have been redesigned to cover fewer districts and beneficiaries so that it could have achieved more.

#### Recommendations

- ▶ Start in 2016 and go through 2017

R1. The MoH and CO with RB support should develop a SFP model that provides services at health facilities and selected CBSFP outposts and MoH outreach clinics in Karamoja and integrate with OTC/ITC and MCHN services.

R2. The CO with RB support should update the MCHN program through piloting cash transfers for PLW as planned, encourage and support the MoH in the revision of the MCHN guidelines and pilot MCHN services in Outreach clinics.

R3. The CO Nutrition unit and WFP Karamoja Area Office should increase their nutrition staff and build the capacity of staff in nutrition monitoring through hiring a Karamoja regional nutritionist and increasing the nutrition staff in the CO nutrition unit.

R4. The CO Nutrition and AME units should improve the quality of MCHN and CBSFP reporting and add to the programs indicators tracked to increase the data available to guide programs and show impact.

R5. The CO Nutrition unit with RB support should improve the quality of the nutrition education and counselling provided in MCHN and CBSFP to enhance program effectiveness.

R6. The CO Nutrition unit with support from the CO gender advisor should develop and integrate a more gender focused approach in MCHN/CBSFP nutrition programs with the objective of reaching more boys (CBSFP) and men (both).

- ▶ Start immediately and continue through 2017

R7. The CO logistics unit and Karamoja sub offices logisticians and warehouse storekeepers should collaborate to support and improve MoH and CPs food storage, management and beneficiary distribution.

- ▶ Already started in 2016 and continue through 2018

R8. The CO should advocate for a multi-sectoral nutrition approach and given its food security mandate, it should strengthen the overlap and referral of MCHN/CBSFP beneficiaries and food security/livelihoods programs and: (1) continue the process of making their public works program more nutrition sensitive, and extend these efforts to WFP's other programs; and (2) with nutrition coordination partners, use mapping data to develop a referral system so that MCHN, SFP and OTC/ITC beneficiaries access programs that improve their sanitation and hygiene, literacy and access other nutrition programs as needed.

## 1. Introduction

1. KonTerra Group was contracted to conduct the evaluation of WFP's Nutrition Programs in the Karamoja region in Uganda: Community Based Supplementary Feeding Programme (PRRO 200249) and Maternal Child Health Nutrition (CP 108070). This evaluation is commissioned by the programme/nutrition unit WFP-Uganda Country Office and covers the period from January 2013 to December 2015. The main objectives of the evaluation are:
  - Accountability – The evaluation will assess and report on the performance and results of the Community-based Supplemental Feeding Program (CBSFP) and the Maternal Child Health and Nutrition (MCHN) nutrition programmes in the Karamoja region over the 2013 – 2015 period.
  - Learning – The evaluation will determine the reasons why certain results occurred or not to draw lessons, derive good practices and pointers for learning. It will provide evidence-based findings to inform operational and strategic decision-making.
2. The evaluation was commissioned to support the new Country Programme (2016-2020) in integrating the MCHN component with the government health system and to further its efforts at renewing coordination, targeting complementary interventions and to increase the focus on nutrition-sensitive activities in the livelihood and safety net projects operating in the region. The evaluation is expected to provide evidence of what worked in the past for the MCHN and CBSFP components, draw lessons learned and provide programmatic recommendations for operational planning relevant to the CP MCHN component under the new resilience framework. The main users of the evaluation's results are the WFP Country Office, WFP Regional Bureau, WFP HQ and OEV as well as WFP's primary cooperating partners; and, lastly the donor, Department for International Development UK (DFID). The current evaluation coincides with the end of DFID's funding streams and the beginning of the new CP.
3. Scope: The evaluation covers the duration of the CBSFP activity under the PRRO (2013-2015) and the MCHN activity under the CP (2009-2015) in seven districts of Karamoja region. The evaluation focuses on the latter 3 years of MCHN programme implementation for which WFP had a relatively stable programme implementation period. Over this time period, the MCHN programme was funded through WFP internal funds primarily and the UN Joint Programme on Population, an interagency collaboration supported by DFID. The evaluation assesses the design and performance of both activities, including the project outcomes, partnership strategies, linkages to complementary projects or activities, and modalities of implementation. The ET conducted 65 key informant interviews with stakeholders (Kampala and Karamoja), sixteen focus group discussions with beneficiaries (193 women and 18 men), observation of service delivery (17 sites) and food storage sites and reviews of program registers and client cards.

### 1.1 Overview of the Evaluation Subject

4. Under PRRO 200249, WFP Uganda has been implementing Community Based Supplementary Feeding Programme (CBSFP) in seven districts<sup>9</sup> of Karamoja region. The purpose of the programme is to provide treatment for moderate acute malnutrition (MAM) among children 6-59 months, Pregnant and Lactating Women (PLW) and other malnourished individuals. Field level implementation is done through WFP's CPs: AFC and CAFH, both of which are Non-Government

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<sup>9</sup> The seven districts in Karamoja region include: Abim, Amudat, Kaabong, Kotido, Napak, Nakapiripirit and Moroto.

Organizations (NGO). CBSFP is implemented in collaboration with UNICEF and the Ministry of Health (MoH)<sup>10</sup>. Under its CP 10870, WFP Uganda has been implementing maternal and child health nutrition (MCHN) in Karamoja region in collaboration with the MoH. The purpose of the programme is to address chronic undernutrition by providing essential nutrients, promoting IYCF and improving health seeking behaviour antenatal care and post- natal care at health facilities in the region. The CP 108070 MCHN and PRRO 200429 SFP activities continue from the previous CP 104260 and PRRO 101213.

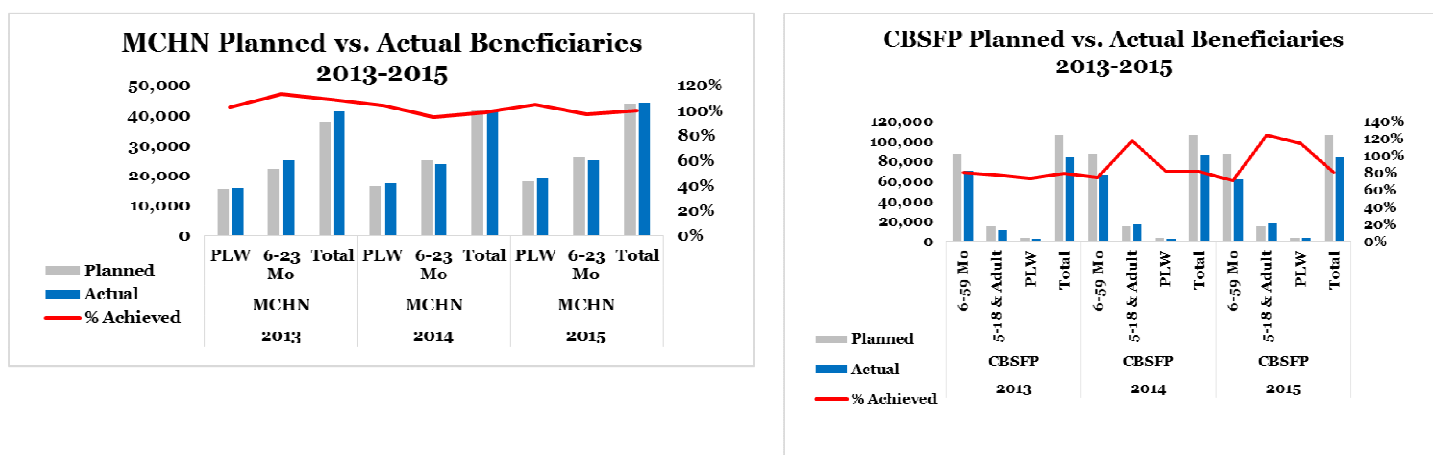
Table 1 Key Facts: CP 108070 and PRRO 200429, Timing, Objectives and Activities<sup>11</sup>

Key Facts	CP 108070	PRRO 200429
Approval Date	12 November, 2009	14 November, 2012
Duration	31 December, 2015	31 December, 2015
Budget Revisions (BR)	BR3, BR7	BR3, BR5
Objectives/Activities	SO2 & 4: Most chronically vulnerable communities have strengthened their resiliency to shocks and chronic child hunger has been cut / Prevention of Stunting	SO1: Nutrition: Treatment of Moderate Acute Malnutrition

Source: CP and PRRO SPRs (2013-2015)

5. This report will discuss the extent to which the Programmes reached the population in need. Figure 1 shows the trends in the actual number of beneficiaries for both programmes, Chapter 2 will provide an analysis on the reasons why MCHN programme managed to reach beneficiaries planned while CBSFP capacity to reach planned beneficiaries was less effective.

Figure 1. MCHN and CBSFP Total beneficiaries by year and achievement rates



Source: Promis data base and CP/PRRO Annual Workplans

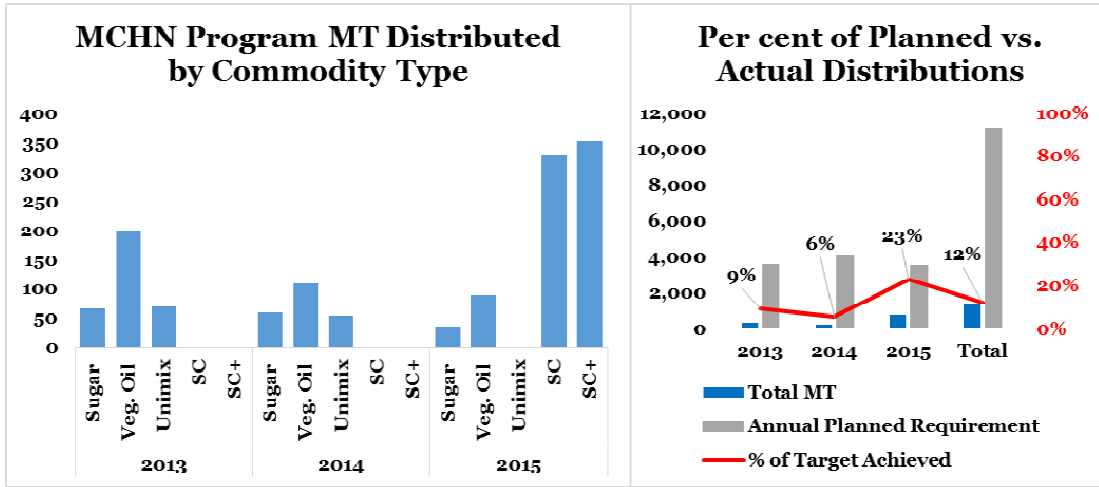
6. The following figures 2 and 3 show the planned versus the actual commodities distributed by the two programs. For the CBSFP and MCHN young child beneficiaries receive different rations from the older beneficiaries.

<sup>10</sup> List of Partners of CBSFP and MCHN programmes: Ministry of Health, Local government in the seven Karamoja region districts (Kaabong, Kotido, Abim, Napack, Moroto, Nakapiripirit, Amudat), UNICEF, Community Actions for Health (CAFH) and Andrew Food Consult (AFC), Donor- DFID.

<sup>11</sup> Only nutrition objectives and activities have been included.

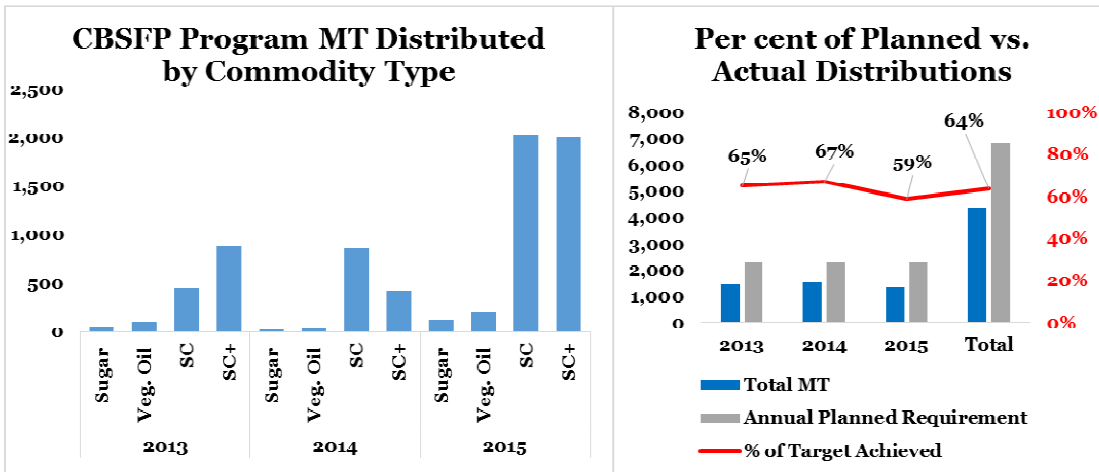
<sup>12</sup> Only relevant budget revisions (BR) (that affected nutrition components) are shown.

Figure 2: MCHN Program MT Distributed by commodity type and percent of planned vs actual distributions



Source: ProMIS data base

Figure 3: CBSFP Program MT Distributed by commodity type and percent of planned vs actual distributions



Source: ProMIS Data Base

- Since 2013, the CBSFP has been funded solely by DFID through its resilience programme and the MCHN program was primarily funded internally by WFP and also by DFID through its joint programme on population. Figure 4 illustrates the evolution of the funding levels over the period covered by the evaluation, showing that CBSFP programme was fully funded whereas MCHN was funded an average of 52 percent of the needs per year.
- Modification to the initial MCHN and CBSFP Designs: The Budget Revisions (BR) to the CP 108070 and PRRO 200429 with changes relevant to the MCHN or CBSFP activities are briefly described below.

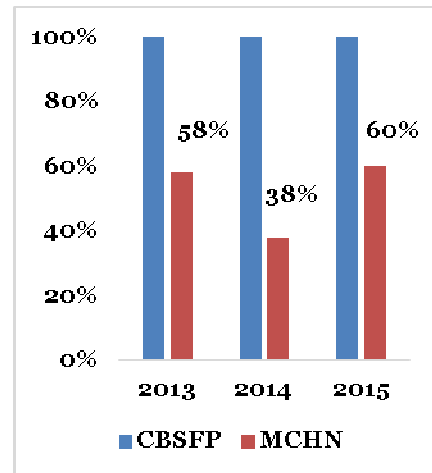


Figure 4: Funding Levels for CBSFP and MCHN

9. PRRO 200429: BR 3 (11/2013)- discontinued WFP support to therapeutic feeding programme patients in Karamoja in line with WFP's 2012 nutrition policy and in agreement with the United Nations Children's Fund (UNICEF); and revised the ration for the treatment of moderate acute malnutrition (MAM) among beneficiaries over age five. A ration of Supercereal (SC), vegetable oil and sugar were substituted for Supercereal Plus (SC+) in compliance with WFP guidelines.
10. PRRO 200429: BR 5 (end 2014 or early 2015)- The number of therapeutic feeding in-patients reduced to below 100 per month and it was no longer cost efficient for WFP to continue providing food rations to their caregivers so this ration was discontinued.
11. CP 108070: BR 3 (early 2013): Increased the number of MCHN beneficiaries in line with recent increased attendance from 25,000 to 38,000 per year for 2013 and 2014.
12. BR 7 (10/2014)- Extended the program by 13 months in order to align with the Government National Development Plan (2015-2019), the UNDAF (2016-2020) and WFP's country strategy (2015-2019); and to enable country office to utilize the results of the Uganda country portfolio evaluation in designing the next country program (2016-2020). Increased the number of planned MCHN beneficiaries by 5 percent in line with actual attendance.

## 1.2 Context

13. The Republic of Uganda is a landlocked country in east Africa with plentiful natural resources, large fresh-water resources, a high agricultural potential, minerals and an estimated 3 billion barrels of soon-to-be-tapped oil reserves. While the country is endowed with immense natural resources and has experienced rapid development, poverty is still high at 19.7 percent in 2012/2013<sup>13</sup>. While there has been reduction in poverty rates (a decrease from 56 percent in 1992), the country continues to grapple with undernutrition and food insecurity. At the same time, by 2013 Uganda had achieved two Millennium Development Goal targets and was on track to meet another eight. This is compounded by the country's high population growth rate of 3 percent annually, one of the highest in the world. According to the 2014 national population census, Uganda has a population 34.8 million.<sup>14</sup> The proportion of the population that is food insecure increased from 19 percent in 1992 to 21 percent in 2007 and almost 30 percent of households were considered food insecure in 2010.<sup>15</sup>
14. The rates of undernutrition are still high in children under 5 years at 33 percent for stunting, 5 percent for wasting and 14 percent underweight.<sup>16</sup> The Cost of Hunger Report states that nationally 2.3 million children are stunted and almost one million are underweight. It further highlights that this costs the nation US\$ 899 million in lost revenue in 2009, estimated at 5.6 percent of Gross Domestic Product (GDP). Micronutrient deficiencies are also high. The rate for anemia among young children was 49 percent and among women of reproductive age, it was 23 percent.<sup>17</sup> Regarding Vitamin A, 33 percent of children 6 to 59 months were found to be deficient and a similar level of deficiency (35 percent) was found among women.<sup>18</sup> Conversely, iodine deficiency is no longer a problem attributed to the government policy on salt iodization. The precise causes of undernutrition and food insecurity vary geographically and across livelihoods. In fact, at national level, food is available

<sup>13</sup> Uganda Poverty Status Report, 2014

<sup>14</sup> UBOS, 2016, The National Population and Housing Census 2014 – Main Report, Kampala.

<sup>15</sup> USAID Uganda, (2010). Feed the Future Strategic Review.

<sup>16</sup> Uganda Demographic Health Survey 2011, August.

<sup>17</sup> Ibid, 10.

<sup>18</sup> Ibid, 10.



however access and food utilization are inadequate. Other causes are related to dietary diversity, cultural and social traditions and poverty levels. Undernutrition disproportionately affects rural areas, where rates of stunting are over 36 percent compared to 19 percent in urban areas.<sup>19</sup>

15. Regarding gender, while the National Gender Policy was approved in 2007, challenges exist in its implementation including gender equality and women's rights. The recent Human Development Report, reported that the Gender Inequality Index (GII) value for Uganda was 0.538, ranking it 122 out of 155 countries in the 2014 index<sup>20</sup> with 35 percent of parliamentary seat held by women, and 22.9 percent of adult women had reached a secondary level of education compared to 33.5 percent of their male counterparts.
16. Government policies and priorities in relation to food security and nutrition: Uganda joined the Scaling Up Nutrition (SUN) movement in 2011. Operationalizing Uganda's commitment, led to development of the Uganda Nutrition Action Plan (UNAP), which elaborates strategies and interventions to address malnutrition (and stunting in particular) in Uganda multisectorally, especially targeting women and young children. Until recently UN REACH under WFP coordinated UN Agencies nutrition programming and supports the implementation of the UNAP. In 2013, the government renewed its commitment to reproductive MCH and reducing maternal and infant mortality rates by 2017 through accelerating higher coverage of essential MNCH services in high-burden areas including Karamoja<sup>21</sup>.

#### Karamoja context

17. Karamoja is often referred to as the most neglected part of the country. It's a semi-arid area of northern Uganda comprised of 7 districts. It has a population of 1.37 million people<sup>22</sup> who are primarily pastoralists and agro-pastoralists. Karamoja has suffered from recurrent food insecurity and stagnating high levels of malnutrition influenced by a number of factors, such as, increasingly frequent and severe natural disaster, especially droughts, and the combination of frequent natural disasters, cattle rustling violence, severe environmental degradation, poor infrastructure, high poverty rates and weak agriculture that have eroded people's capacity to cope and left them structurally vulnerable to hunger. As a result, relatively small shocks have led to high levels of acute malnutrition. The people of Karamoja also experience high disease incidence, have poor sanitation and hygiene facilities and practices, and feed their infants and young children poorly. Over 80 percent of the population in Karamoja lives below the poverty line and the region suffers from low levels of education and literacy rates at 12 percent compared to national level of 71 percent.<sup>23</sup>
18. The region's infant mortality rate of 87/1,000 live births exceeds the national level of 54/1,000.<sup>24</sup> The under 5 mortality rate and maternal mortality ratio also exceed national levels. In addition to the highest level of stunting (45 percent), Karamoja also has the highest level of wasting (7 percent) and underweight (32

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<sup>19</sup> UBOS, ROU, (2012), Uganda Demographic Health Survey 2011, August.

<sup>20</sup> Human Development Report 2015, UNDP

<sup>21</sup> MoH, (3013), Reproductive Maternal, Newborn and Child Health Sharpened Plan for Uganda.

<sup>22</sup> UBOS projection 2014.

<sup>23</sup> Uganda National Household Survey, 2013.

<sup>24</sup> UBOS, ROU, (2012), Uganda Demographic Health Survey 2011, August

percent).<sup>25</sup> Anemia levels are also significantly higher in Karamoja with 50 percent of young children affected and 43 percent among women.<sup>26</sup>

19. Dietary diversity, an indicator associated with diet adequacy, is very low in Karamoja region. Among young children (6 to 23 months) only 5.8 percent<sup>27</sup> meet the criteria for a minimum acceptable diet due to food security and poor feeding practices. Female headed households, are poorer and more food insecure as most women have unequal rights and limited access to productive and financial resources that affect food access at household level. In Karamoja, female headed household are more prevalent at 44 percent compared to the 31 percent found nationally.<sup>28</sup>
20. Key nutrition programs in Karamoja: Nutrition interventions addressing the immediate causes of undernutrition are predominantly health sector based. Specifically, ongoing nutrition programs include: management of severe acute malnutrition implemented through inpatient centres and outpatient clinics (homebased treatment) with support from UNICEF/DFID; and management of moderate acute malnutrition (MAM) through community based programs supported by WFP. Additional nutrition interventions include maternal nutrition, micronutrient supplementation, the promotion of improved infant and young child feeding practices, hygiene promotion and diarrhoea management are supported by USAID implementing partners.

### 1.3 Evaluation Methodology and Limitations

21. According to the TOR, the evaluation focused on three of the DAC evaluation criteria they selected: relevance, effectiveness and efficiency. In addition coherence and complementarity were explicitly included to address aspects of the ToR sub-question. The evaluation addressed the standard three key questions included in WFP Operations Evaluations which were found to be adapted to this evaluation: Question 1: How appropriate were the CBSFP and MCHN activities? (Relates to Relevance, Coherence and Complementarity); question 2: What are the results of the CBSFP and MCHN activities?<sup>29</sup> (Relates to Effectiveness and Efficiency): question 3: Why and how have the CBSFP and MCHN activities produced the observed results, including the gender results? (Relates to internal and external factors). The three key evaluation questions were further elaborated and described with sub-questions (including those in the ToR), with corresponding measures/ indicators<sup>30</sup>sources of information, data collection method, etc. in an evaluation matrix (EM) which can be found in Annex 2.
22. The evaluation team was gender and culturally balanced with a female Team Leader and a male team member, two female and two male translators. The evaluation unfolded in three phases: Inception Phase (July 11<sup>th</sup>- August 2<sup>nd</sup>), Evaluation Mission (August 10<sup>th</sup>- 24<sup>th</sup>) and Report writing (August 25<sup>th</sup>-November 10<sup>th</sup>). WFP's Decentralized Evaluation Quality Assurance System (DEQAS) based on UNEG standards and good practice of the international evaluation community has been systematically applied to this evaluation. WFP Uganda's Assessment, Monitoring and Evaluation (AME) unit was responsible for ensuring that the evaluation follows the

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<sup>25</sup> Uganda Demographic Health Survey 2011, August.

<sup>26</sup> Ibid, 19.

<sup>27</sup> WFP, UNICEF (2015), Food Security and Nutrition Assessment, Karamoja Region, Uganda, June and in the most DHS (2011), only 2.2 of young children met the minimum criteria for an adequate diet.

<sup>28</sup> Uganda Poverty Status Report, 2014.

<sup>29</sup> Question 3 was not requested in the TOR, however, the ET felt it was important to include so the findings of the evaluation could be explained and understood.

<sup>30</sup> The assessment of the outputs and outcomes of the nutrition programmes has been assessed against WFP corporate indicators and nutrition normative guidance and international nutrition program guidance standards, such as SPHERE.

DEQAS Step by Step Process Guide. The relevant checklists of DEQAS have been applied at each stage, to ensure the quality of the evaluation process and outputs. In addition, to enhance the quality and credibility of this evaluation an external reviewer directly managed by WFP's OEV and a KonTerra evaluation manager provided feedback on the main deliverables of the evaluation. The evaluators are committed and abide to the UNEG Code of Conduct for UN Evaluations (2008)

23. Site mapping and selection: The ET used a combination of purposive and random sampling methods to select the MCHN and CBSFP program sites to visit during fieldwork. First, given the limited time of five days to conduct field visits, five districts were selected out a total of seven. District selection was done purposively after comparing districts' characteristics, such as prevalent livelihood zones, population density, level of malnutrition, percent of female-headed households, health and food security indicators to determine which districts were more similar so a combination of districts representing the range of factors could be identified (see Annex 6 for a table of district indicators reviewed). Based on this approach the following districts were identified: Amudat, Moroto, Nakapiripirit, Kaabong and Kotido; these represented well the two CPs operational areas and allowed the ET to visit all four of WFP's sub-offices in Karamoja. (See Annex 20 for a copy of the actual field mission schedule.) The program intervention sites to be visited were selected purposively and randomly the evening before or early in the morning of the day of the district to be visited based on the lists of MCHN and CBSFP sites, location and beneficiaries (see Annex 7) from January to June 2016 of this year and sub-office lists of MCHN and CBSFP clinics coinciding with the ET visit. Factors, such as, CBSFP hotspots were considered, a balance of outposts closer and at greater distance were selected and consideration of including the different beneficiary groups and the inclusion of men and boys. For MCHN a combination of hospitals and health centres II and III and a privately managed facility was also visited for comparison with the MoH run health facilities. In addition, the travel times and distances between program sites in the selected districts were considered along with the timing of clinics and other program activities and accommodating ET interviews with WFP, CPs and other stakeholders.
24. Data collection tools: A range of information gathering techniques, with an appropriate mix of qualitative methods (key informant interviews, focus group discussions (FGD)) was used to gather and analyze data as identified in the evaluation matrix (see Annex 5). Gender was mainstreamed throughout our data collection methods starting from specific questions on gender incorporated into the evaluation matrix and gender sensitive data collection tools following from this. The methods promoted participation of different groups of stakeholders including women, men, boys and girls and sought to avoid biases including gender bias. Regarding CBSFP, women and girls, and other beneficiary groups including adult men were interviewed and for MCHN beneficiaries, consultation with husbands took place to garner their perspectives on the program. For the CBSFP, men and boy beneficiaries were included in interviews and FGD as well as women and girls. Groups of females were interviewed separately from males, wherever possible, by a female ET member and translator, which allowed the women and girls to provide feedback freely. Also, the evaluation took into consideration issues that could affect the participation of men and women such as time, place and accessibility as to allow maximum participation. Before starting an interview, team members clarified their commitments to relevant codes of conduct for these interviews, notably its voluntary nature, non-attribution and confidentiality requirements. The ET triangulated information obtained from of women, girls, men and boys through other sources of information, namely through

observation and perceptions from the health workers and WFP staff. Special attention was paid to understand the cultural beliefs and behaviors that affect health and nutrition habits and the extent to which these affected the perceptions of the women and girls. During the data analysis the ET paid special attention to ensuring that the perceptions from women, girls, men and boy were appropriately and accurately represented, in particular in relation with their needs and participation in the programme.

25. Triangulation: To substantiate findings of the evaluation, as part of their analysis, the ET used methodological triangulation which involved using more than one option to gather data, such as interviews, observations, and documents. Reported data and information was triangulated to the extent possible to substantiate findings and make conclusions.
26. ET's extraction of disaggregated data: Because WFP's yearly SPR reports did not include disaggregated nutrition program data<sup>31</sup>, it was necessary for the ET to extract the data from WFP's ProMIS data base for nutrition program outputs (beneficiary numbers and quantities of the different foods distributed) and also for MCHN outcome data not analysed and reported in the SPRs. The extraction of data included disaggregation by age and sex so that all participant groups could be reported.
27. Quality Assurance: DEQAS defines the quality standards expected from this evaluation and sets out processes with steps for Quality Assurance, Templates for evaluation products and Checklists for their review. DEQAS is closely aligned to the WFP's evaluation quality assurance system and is based on UNEG standards and good practice of the international evaluation community; it was systematically applied to this evaluation.

## Limitations

28. The ET's encountered some limitations to conduct this evaluation: (1) The time allocated to field visits was short—only five days to visit program sites for two programs over a large geographical area with poor travel conditions<sup>32</sup>. (2) The language and cultural constraints was partially mitigated by the national consultant on the team, and the use of interpreters. (3) The reliability of some of the data<sup>33</sup>, was questioned by the ET, and as such, was a constraint to assessing CBSFP performance and using some of the commodity output data. (4) The late timeliness in accessing some documents delayed to some extent the analysis and report writing. Also the lack of access to some documents (programme budgets<sup>34</sup>, resource mobilization plans and donor reports) limited the analysis of efficiency of the programmes. (5) Due to time and resource limitations, gathering primary quantitative data was not planned or carried out, however, information and feedback gathered from the FGDs and interviews with beneficiaries will be analyzed for patterns, trends and outliers. As well, secondary quantitative data has been

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<sup>31</sup> For example, SFP data from the refugee camps is reported together with WFP's Karamoja program as required by corporate SPR reporting. Also SC and SC+ are reported as one commodity in the SPRs as required by corporate SPR reporting. Extracting data from the ProMIS data base provided more information for analysis and more opportunities to triangulate findings.

<sup>32</sup> Given the schedule of field visits and the CBSFP clinic/distribution schedule in Kaabong and Kotido districts, it wasn't possible for the ET to observe any CAFH supported CBSFP clinics.

<sup>33</sup> The reliability of the CBSFP performance, some of the commodity output data and the nutrition education and counselling data was questioned by the evaluation team (ET).

<sup>34</sup> The ET learned that budgets were confidential and thus could not be shared with the ET.

reviewed from reports, such as, the FSNA and DHS and are data from them is included where relevant.

29. Notwithstanding the above-mentioned potential constraints, the ET believes that CP 108070 MCHN activities and PRRO 200429 CBSP can be reliably evaluated as it has clear statements of intended results, defined and appropriate indicators, targets for achievement and some gender disaggregated data.

## 2. Evaluation Findings

### 2.1 How appropriate are the MCHN and CBSFP interventions?

#### 2.1.1 Geographical targeting and relevance of activities

30. The MCHN and CBSFP Programs are relevant given that Karamoja has the worst infant, young child and maternal mortality indicators in Uganda as elaborated in the context section. Health facility/hospital deliveries in Karamoja are the lowest in Uganda and postnatal care visits for women and newborns are also low. Karamoja experiences the highest levels of food insecurity and the worst nutrition problems among women and children in Uganda. Thus targeting the seven districts in the region was appropriate. See the following table for a comparison of nutrition data available when the two programs were designed.

Table 2: Uganda and Karamoja MCH Nutrition Indicators

Program	Indicator	Karamoja Region		Uganda
MCHN	Stunting (children 6-59 months)	45%		33%
MCHN	Underweight (adult women)	33%		11%
CBSFP	Wasting (children 6-59 months)	7.1%	11.7% (FSNA, 2012)	4.7%

Source: DHS, 2011 and FSNA 2012

31. The bi-annual FSNA surveys confirm the high food insecurity and undernutrition levels in the Karamoja region and its seven districts. They also document the trend in these indicators over time, as well as, the variation between districts. (See Annex 9 for a table of acute malnutrition and food consumption scores by district.)
32. The MCHN activities, nutrition and health education coupled with the distribution of food rations for pregnant/lactating women and infants/young children six to 23 months, were also found to be appropriate, particularly since they were effectively used as incentives to increase attendance at ANC/PNC and Young Child Clinics (YCC). MCHN program data demonstrates that more women attend ANC and PNC visits when food is distributed (see para 97 for further information). Further, the use of balanced protein/energy fortified food supplements among underweight pregnant women and young children in food insecure households has been identified as an effective intervention to increase birthweights and growth and weight of infants and young children.<sup>35</sup>
33. Regarding the CBSFP activities, screening and treatment of moderate acute malnutrition (MAM) in areas where global acute malnutrition (GAM) is above the threshold of ten percent is called for in international guidance (UNHCR/WFP 2009) and is identified as one of the ten high-impact nutrition specific interventions

<sup>35</sup> Bhutta et al (2013), Maternal and Child Nutrition 2: Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?, Lancet Nutrition Series, Lancet.

recommended in the Lancet Nutrition Series (2013). Thus in the Karamoja region, such programs when designed were appropriate and continue to be.

34. MCHN and CBSFP beneficiaries (mothers and caretakers) during FGD reported high satisfaction with program activities including the food ration and especially nutrition, health and hygiene education sessions. During the education sessions observed, most beneficiaries were engaged—responding at the appropriate times—and reported enjoying learning about better hygiene practices and how to feed and take care of themselves and their children.
35. At the MCHN and CBSFP food distributions observed by the evaluation team (ET), posters depicting the ration foods and bi-weekly/monthly quantities were not found making it difficult for beneficiaries to know if they are receiving the appropriate quantities of foods<sup>36</sup>. Further, during FGD, beneficiaries were asked if they knew how to make complaints about the program, they responded that they did not, thus no clear way for beneficiaries to provide feedback and for WFP and CPs to adapt program activities to beneficiary needs was identified by the ET. One of the CPs noted that they have a compliant desk at food distributions; unfortunately due to scheduling it wasn't possible for the ET to observe any of their food distributions to confirm this.
36. Regarding gender, in so far as the program targeted women, the malnourished and food insecure and nutritionally vulnerable, including boys and adult/elderly men, it was integrated in design. However, in the design and since, insufficient efforts were made to include men in program sensitization activities and nutrition/health sessions. Between 2013 and 2015, gender modifications in programming did not appear to occur. However, one will start later this year, i.e. dialogs with men as part of the MCHN activities.

#### 2.1.2 Relevance of transfer modalities, food rations, and beneficiary selection criteria

37. Regarding the SFP, the food ration for children 6 to 59 month ration, 200 grams of SC+/day as specified in WFP/international and Uganda MoH guidance, was found to be effective and well accepted by beneficiaries. In 2014, a PRRO 200429 BR 3, added a pre-mix ration of SC, vegetable oil and sugar, for PLW and beneficiaries over age five; this aligns with WFP, international and Uganda MoH guidance. (See Annex 10 for details about the two rations and their nutritional composition).
38. WFP Cooperating Partner (CPs) staff reported young children with moderate acute malnutrition (MAM), for the most part, responded well to treatment. On the other hand, it was reported that malnourished pregnant women did not respond well to treatment. This may be explained by their high energy needs, insufficient overlap between the MCHN program and CBSFP and inter-family sharing of the pre-mix ration. CPs staff also reported that elderly beneficiaries did not respond well to treatment due to high levels of vulnerability and if they did, they often relapsed indicating a need for ongoing assistance to improve their food security.

Table 3: MCHN Rations for Pregnant/Lactating Women

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<sup>36</sup> In one PDM report reviewed from Nakapiripirit and Amudat (May 2016), information regarding beneficiaries remembering seeing posters with food entitlements at CBSFP sites was included; 92 percent of beneficiaries acknowledged seeing posters and eight percent did not.

	WFP Uganda MCHN Ration (2009-to date)			PLW & Infant /Child 6-23 months Uganda MCHN Guidelines (2007)	PLW & Infant/Child 6-23 months WFP MCHN Toolkit (2011)	WFP Programming for Nutrition Specific Interventions (2012)	
	PLW (2009-to date)	6-23 months (2009-2014)	6-23 month (2015-to date)			Children 6-23 months	PLW
Fortified Blended Food (SC)	229 gm.	229 gm.	200 gm.	229 gm.	200-250 gm.	100-200 gm.	100-200 gm
Vegetable Oil	25 gm.	25 gm.	0	29 gm.	20-25 gm.	0	amount not specified
Sugar	15 gm.	15 gm.	0	29 gm.	15-20 gm.	0	amount not specified

Source: SPRs, MCHN Guidelines (2007), MCHN Toolkit (2011) and WFP Programming for Nutrition Specific Interventions (2012)

39. The MCHN program ration for 2013 and 2014 for PLW and children six to 23 months consisted of the same pre-mix ration provided to malnourished beneficiaries. Starting in 2015 as outlined in CP BR7, children six to 23 months received 200 grams of SC+ while the PLW continued to receive the same pre-mix ration. This change aligned the MCHN child ration with WFP guidance<sup>37</sup> which is more current than Uganda MCHN guidelines (2007) and in the opinion of the ET it is justified due to research<sup>38</sup> that documents the need for animal products to support young child growth and the inclusion of milk powder in SC+. WFP guidance on the MCHN ration for PLW provides a range for the included food items and is not entirely consistent with the Uganda MCHN guidelines. The WFP ration falls about mid-range in the SC quantity and includes less oil and sugar, most likely a cost saving measure, and thus provides a similar level of nutrients but less calories--around seven percent. (See table 3) These findings point to the need to update the WFP MCHN guidelines.
40. For the MCHN program, food rations as the transfer modality was appropriate when the program was designed. In the last few years, a number of studies comparing cash to food rations, including one from Karamoja<sup>39</sup> have found cash to be less expensive to implement compared to food rations and more effective in diversifying diets, an indicator of improved dietary quality. A recent UNICEF Karamoja nutrition review (2015) recommends substituting cash for MCHN food and WFP's current CP includes piloting cash for PLW MCHN beneficiaries early in 2017; the ET concurs.
41. The beneficiary criteria for the CBSFP program are aligned with international guidance and/or the Guidelines for Integrated Management of Acute Malnutrition (IMAM) in Uganda (2010). For example, the international guidance, WFP/UNHCR Guidelines for Selective Feeding, do not include all the beneficiary groups, such as, children between age six and 18 and malnourished adults without chronic diseases, included in Uganda's IMAM guidance and the CBSFP. Given the high level of acute malnutrition in Karamoja among other age groups, such as adults (33 percent, DHS 2011), this problem should be addressed. However, other approaches with lower costs per beneficiary may be more effective in reaching more of the older malnourished children and adults.
42. The MCHN beneficiary criteria follow the selection criteria are "blanket", covering all pregnant women and lactating women up to six months postpartum and

<sup>37</sup> WFP Programming for Nutrition Specific Interventions, 2012

<sup>38</sup> Dror DK, Allen LH. The importance of milk and other animal-source foods for children in low-income countries. Food Nutr Bull. 2011;32:227-43.

<sup>39</sup> Gilligan et al (2013), Impact Evaluation of Cash and Food Transfers at Early Childhood Development Centers in Karamoja, Uganda; Final Impact Report, WFP, UNICEF, IFPRI.

infants/young children between six and 23 months as described in the Guidelines for Planning and Implementation of MCHN Programme in Uganda (2007) and international guidance on MCHN programs doesn't exist.

### 2.1.3 Precision of the criteria to select beneficiaries

43. The priority groups targeted by both programs were included in Uganda health and nutrition strategies and MCHN/IMAM guidelines. Notably, PLW and children between birth and age two are the highest priority group for prevention activities and PLW and children between six and 59 months for curative ones.
44. Given the clearly defined CBSFP admission criteria theoretically the selection process is transparent and it appeared as such to the ET. Similarly, the MCHN program has clear admission criteria that appeared to be followed by the ET and confirmation of eligibility for pregnant women is easily confirmed. For infants and young children this may be more difficult. The ET found anecdotal information regarding Village Health Team (VHT) members' referral of ineligible children and their admission to the program<sup>40</sup> in some areas undermining the CBSFP eligibility criteria; and for the MCHN programme, stories of children being borrowed by women so they could access the program were related to the ET.
45. It would have been extremely relevant to target men (husbands, fathers, community leaders) for sensitization on gender issues, and in particular, as they relate to improving health and nutritional status of their families. In addition, since men are critical to supporting their families in adopting improved nutrition and health practices, they as well need well designed nutrition/health education sessions.
46. In Uganda, like many sub-Saharan countries and also in Karamoja region, young boys are significantly more at risk to be stunted than girls<sup>41</sup>. And diverging from national findings, in Karamoja young boys suffer more from MAM than girls and at a significantly higher level (10 versus 7.5 percent, respectively).<sup>42</sup> Interestingly, this does extend to severe acute malnutrition (SAM) when the levels between the girl and boy children are similar. (See Annex 21 for anthropometric data disaggregated by sex.)
47. When the number of young boy CBSFP beneficiaries were compared to girls in 2015, a much higher percent of girls participate in the program, 55 percent compared to 45 percent for boys. (See Annex 21 for more information.) The reasons for higher undernutrition among young boys are usually attributed to the higher level of physical activity among boys and girls role in food preparation and caring for younger children providing access to food between meals. Further investigation may be warranted to understand why boys are significantly more acutely malnourished in Karamoja and how to prevent it. And as well, to provide sensitization and adapt activities to ensure young boys higher participation in CBSFP.

### 2.1.4 Coherence with Government of Uganda Policy

48. Both the MCHN and the CBSFP are consistent with and align with the Government of Uganda development, health and nutrition policies currently and at the time of the programs' design. Uganda's Nutrition Policy and Action Plan (2011-2016) call for

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<sup>40</sup> This was also a finding of the Review of the CBSFP and noted in the draft report August 2016.

<sup>41</sup> Wamani et al, (2007), Boys are more stunted than girls in Sub-saharan Africa: a meta-analysis of 16 Demographic Health Surveys, BMC Pediatrics, 7:17.

<sup>42</sup> Stunting, wasting and global acute malnutrition rates are reported in the first FSNA Karamoja, Gender Supplement (July 2016); additional data was requested by the ET and the significance of the difference in MAM levels for boys and girls was tested and is presented in Annex 21.



increased access to nutrition services for women and children, such as, MCHN and programs to address moderate acute malnutrition. The MCHN programs follows the MoH's MCHN guidelines for the most part except for a variation in rations as noted. The MoH Health Sector Plan identifies maternal, infant and young child nutrition as priority areas and also calls for the treatment of MAM making WFP's nutrition program in Karamoja in line with it.

49. Similarly, the CBSFP program is aligned with the MoH IMAM guidelines (2010). Recently WFP supported the update to the IMAM Guidelines (2016) and the CBSFP programs are currently in the process of integrating the changes, such as, receiving SAM children after completing treatment versus previously receiving them at CBSFP when they reached MAM admission criteria to ensure programming consistency.

#### 2.1.5 Coherence with WFP Corporate Strategy, Nutrition and Gender Policies

50. The MCHN program aligns with WFP's Strategic Objective four (WFP Strategic Plan 2008-2013;2014-2017) to reduce chronic hunger and undernutrition indicators and its intended outcome is to help bring undernutrition indicators, such as, stunting below critical levels and to break the intergenerational cycle of chronic hunger. Thus Strategic Objective four was appropriately selected during program design and continues to be relevant since Karamoja region still reports the worst levels of stunting in children and underweight in women in Uganda.
51. Regarding the CBSFP, it aligns with WFP Strategic Objective one (WFP Strategic Plan 2008-2013; 2014-2017) to save lives and protect livelihoods with the intended outcome of reducing acute malnutrition among young children, PLW and malnourished adults. Given the context in Karamoja at the onset of the evaluation period the selection of strategic objective one was appropriate and currently as Karamoja moves more in the direction from rehabilitation into development, integrating the CBSFP under strategic objective four in the new CP was the correct choice.
52. The MCHN and CBSFP program also aligns with WFP's nutrition policy and normative guidance and WFP's Country Strategy for Uganda (2009-2014) which encompass the treatment of MAM and the prevention of stunting.
53. Regarding the nutrition programs' congruence at design with the WFP's gender policy (2009), neither the PRRO nor the CP undertook a gender analysis during their design or inception phase. The CP document mentions breaking gender barriers through improved MCHN programs, however, how this will be done is not specified and activities, such as, engaging men and boys in awareness raising on shared household chores and child care responsibilities and nutrition and health education as specified in the gender policy did not occur during the evaluation period (2013-2015), although community dialogues with men are currently planned as a pilot in 2016. The PRRO does not describe or specify gender as part of the CBSFP.

#### 2.1.6 Complementarity between MCHN and CBSFP and with Other Programs including Agriculture Programs

54. Inherent in its design, the MCHN Program complements the MoH's Maternal and Child Health (MCH) services. It provides a food supplement (a balanced energy/protein blended food fortified with micronutrients) for PLW and young children after

attending medical screening, immunizations and nutrition and health education. It has been shown to improve coverage and attendance at ANC, PNC and Young Child Clinics (YCC).

55. Regarding the CBSFP, it treats moderate acute malnutrition (MAM), and is one of the two programs to treat acute malnutrition; as such, it complements the MoH UNICEF supported out-patient (OTC) and in-patient (ITC) treatment programs to address severe acute malnutrition (SAM). A well-managed MAM treatment program with good coverage, is cost-effective since it catches moderately malnourished children before their condition deteriorates into SAM. Children with acute malnutrition (severe and moderate) experience higher rates of morbidity and mortality, thus treating acute malnutrition complements and supports health these objectives.
56. To increase the complementarity between MAM and SAM treatment a stronger and more formalized referral system between the two programs needs to be developed. To improve program coverage and to support early case finding, referrals from ANC, PNC, Young Child Clinics and in some places from VHT need strengthening.
57. Complementarity and synergy between programs could be strengthened through developing a formal referral system from MCHN (ANC, PNC and YCC clinics) to the CBSFP so that malnourished PLW and infants/young children identified during clinic screening quickly receive treatment. Currently MoH Outreach Clinics do not include MCHN services limiting coverage to health facilities (primarily hospitals and health facility (HF) IIIs and some HF II). Thus an opportunity exists to expand MCHN coverage through offering this service through MoH Outreach Clinics as requested by health staff.
58. Similarly, although the CBSFP includes over 150 program sites in the seven districts, its' services are not provided at MoH health facilities or at outreach clinics. Health facilities are in various stages of entering CBSFP patient data along with OTC/ITC patients in MoH integrated nutrition registers. Taking this to the next step and integrating CBSFP with MoH services (including SAM treatment) is needed and could potentially be accomplished through including CBSFP and SAM treatment services in MoH Outreach Clinics and MAM treatment in health facilities without compromising program coverage.
59. During the nutrition program design, linkages, referrals and/or complementary food security and agriculture activities were not planned or envisioned. However, over the three year implementation period because of high and static level of acute malnutrition, perceived high level of relapsed MAM cases<sup>43</sup> and increased availability of evidence linking acute malnutrition with food insecurity in Karamoja, coupled with an increased emphasis on the importance of nutrition sensitive interventions to address undernutrition, this need was identified. To address this, small pilot projects with each CPs began in 2015 consisting mainly of the distribution of staple crop and vegetable seeds to mothers of malnourished children who had prepared land. In some cases, Mothers' Groups were used as the modality to transfer information and seeds. Reports from CPs are positive, however, the small pilot projects have not been reviewed so their effectiveness is not known. Some beneficiaries pointed out that many of the gardens failed because of lack of timely rainfall and inadequate plans for

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<sup>43</sup> Reliable data on the number of new CBSFP admissions that are relapse cases is not available, however, various stakeholders mentioned a high percent of relapse MAM cases as a problem.

watering; this finding was substantiated in the recent Review of WFP CBSFP Karamoja, (draft August 2016).

60. To support the complementarity of WFP nutrition programs, more formal linkages and referrals between programs, such as, nutrition program beneficiaries with food security/livelihoods and WASH programs is needed to support the prevention of undernutrition as well as recovery from MAM. To carry this out, WFP could work toward targeting its public works, agriculture and school feeding programs to families with PLW and young children. To support this, the CO could develop an integrated map with all WFP Karamoja program intervention sites. In addition, mapping of other nutrition intervention sites, including SAM treatment (health facilities), USAID MCH program and health facility outreach clinics is needed to promote synergy between programs.
61. Although outside the evaluation period, recently WFP, FAO and UNICEF have begun collaborating on developing a nutrition sensitive Public Works Program. This would go beyond integrating nutrition messages and include targeting the “1000 days” households (PLW and children between birth and two years old) with program modification and activities to help to address their health and nutrition problems.

#### 2.1.7 Support of Government of Uganda Nutrition Structures in supporting the coordination of WFP and Partner nutrition programs

62. Over the evaluation period, WFP through REACH has supported Uganda nutrition coordination structures at the national level. In Karamoja region, WFP at the district level through its nutrition focal points, participate in the district nutrition coordination meetings chaired by the MoH District Nutrition Focal Points, and have supported the development of district nutrition plans. The ET found variation between districts in functioning of coordination structures in terms of the regularity of meetings and the development of district nutrition plans. In tandem, UNICEF with its Karamoja regional nutritionist and financial support for MoH District Nutrition Focal Points, also supports nutrition coordination structures. However, more support is needed since not all districts have functioning district nutrition coordination structures and the absence of a WFP nutritionist at the Karamoja regional level, may be partially responsible for this.
63. From discussions with WFP, CP and district nutrition focal points, it appears that in districts with active coordination structures, decisions have been taken to reduce duplication and improve coordination between nutrition programs. The example given was assigning USAID’s RWANU and GHG MCHN programs to work outside of a five or ten kilometre radius of health facilities and for WFP’s MCHN program to be integrated with MCH services at health facilities. However, confusion exists about the size of the MoH MCHN program area and several stakeholders interviewed acknowledged that this division didn’t protect against double participation of beneficiaries.
64. The scope for nutrition program coordination at the district level is larger than currently understood. In one district visited by the ET, MCHN clinics were scheduled on the same day as CBSFP outposts in the same health facility catchment area, making it impossible for malnourished PLW and young children to participate in both programs as intended. When queried, the CPs and MoH health facility staff initially seemed unaware of the problem.

## 2.2 What are the results of the CBSFP and MCHN activities?

### 2.2.1 How much progress have been achieved by WFP nutrition programs towards delivery of planned outputs?

65. On average over the three evaluation period years, the actual number of beneficiaries reached achieved program targets set. For 2014 and 2015, based on the overachievement in numbers of beneficiaries reached in 2013, the targets were increased and very nearly achieved for 2014 with a slight overachievement in 2015 (see Table 4). Overall, more children are reported as beneficiaries because they participate in the program longer than PLW, i.e. for 18 months instead of one year or less. The number of PLW increased between 2013 and 2015 as shown in Table 4.
66. The actual number of beneficiaries is calculated based on data from each participating health facility; the highest month of beneficiary participation for PLW and young children is selected and these two numbers are used to generate annual beneficiary site numbers for PLW and young children. This data is compiled from the 53 sites to generate total annual beneficiary numbers. These figures are useful for estimating monthly food needs, but underestimate the total number of beneficiaries reached annually and don't account for the length of beneficiary participation.

Table 4: MCHN Planned versus Actual Beneficiaries 2013-2015

Year	Type of Beneficiary	# of Planned Beneficiaries	Actual # of Beneficiaries	% Target Achieved
2013	6-23 months	22,311	25,304	113
	PLW	15,505	15,967	103
	<b>total</b>	<b>37,816</b>	<b>40,839</b>	<b>108%</b>
2014	6-23 months	25,263	23,947	95
	PLW	16,737	17,425	104
	<b>total</b>	<b>42</b>	<b>41,255</b>	<b>98%</b>
2015	6-23 months	26,019	25,216	97%
	PLW	18,081	18,992	105%
	<b>total</b>	<b>44,1</b>	<b>43,442</b>	<b>101%</b>

Source: ProMIS Data base for actual beneficiaries, CP/PRRO Annual Workplan and SPRs 2013-2015 for planned beneficiaries

67. Table 5 provides the metric tons (MT) of the various commodities distributed over the three evaluation years compared to the annual commodity requirements as presented in the MCHN Annual Workplan (2013-2015). The following table illustrates the large short fall in food distributed compared to the annual requirements. Only 12 percent of the food required as specified in the annual workplans over the evaluation period was distributed (1,363 MT compared to the planned 11,169 MT). This was due to inadequate funding levels and, as a result, there were periods of time when no food or half rations were distributed. (See Figure 5 for more information on the pipeline breaks.) During 2015, the quantities of food distributed increased significantly over the previous years; still, however, less than a quarter of the food distribution target was met.
68. The ET identified changes in food distributed in the MCHN program near the end of 2014 when Unimix, an enriched maize and bean flour, was replaced with WFP's newer blended food products, Supercereal (SC) and Supercereal plus (SC+). Table 5 shows that the quantity of sugar distributed to beneficiaries over the 3 year period was reduced by 53 percent between 2013 and 2015; at the same time vegetable oil was reduced by 45 percent. The reduction in sugar and vegetable oil was coupled with

reductions in the fortified blended food; and at times there wasn't any sugar or oil available.

Table 5: MCHN Program MT of Foods Distributed Compared to Planned Requirement (2013-2015)

Year	Sugar	Veg. Oil	Unimix	SC	SC+	Total MT	Annual Planned Requirement	% of Target Achieved
2013	66	199	70	0	0	335	3,600	9.3%
2014	60	110	54	0	0	224	4,066	5.5%
2015	35	89	0	329	351	804	3,503	23%
<b>Total</b>	<b>161 MT</b>	<b>398 MT</b>	<b>124 MT</b>	<b>329 MT</b>	<b>351 MT</b>	<b>1,363 MT</b>	<b>11,169 MT</b>	<b>12.2%</b>

Source: ProMIS Data base, CP/PRRO Annual Workplan 2013-2015 and ET Calculations

69. In Table 6 the quantities of foods required based on the actual number of beneficiaries reported and their planned rations are presented. The total planned quantity of foods required (2013-2015), 11,169 MT was found to be lower, but similar to the total MT of food required based on the rations for the actual number of beneficiaries (i.e. 11,708 MT) (see Table 6).

Table 6: Quantities of Foods Required (MT) for Rations<sup>44</sup> based on the Actual Numbers of Beneficiaries (2013-2015)

Beneficiaries	2013			2014			2015				Yearly Total	
	Veg. oil	Sugar	Unimix	Veg. oil	Sugar	Unimix	Veg. oil	Sugar	SC	SC+		
Children- 6 to 23 months	228	137	2,086	216	130	1,974	0				1,874	6,645
PLW	144	87	1,317	157	94	1,437	163	98	1,566	0		5,063
<b>Total</b>	<b>372 MT</b>	<b>224</b>	<b>3,403</b>	<b>373</b>	<b>224</b>	<b>3,411</b>	<b>163</b>	<b>98</b>	<b>1,566</b>	<b>1,874</b>		<b>11,708 MT</b>

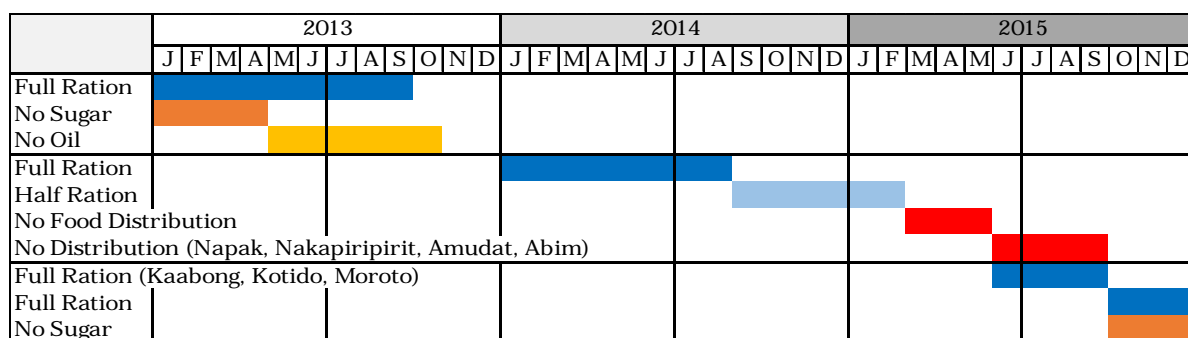
Source: ET calculations

70. Figure 5 provides information on the reductions and suspensions of the food ration over the evaluation period. Between 2013 and 2015, the quantities of food reported as distributed were not sufficient to cover the quantity of foods required based on the ration(s) and the actual number of beneficiaries even after taking into account the months when food distributions were suspended and half rations were provided. This obviously limited the potential impact of the program on MCHN outcomes.

71. Interestingly the quantities of food distributed by year are not entirely congruent with the figure. In 2014, only 6 percent of the target food distribution was achieved and it appears from the figure that more food was distributed compared to 2015 when 23 percent of the planned food was distributed. Further the number of beneficiaries declined which supports the lower food distribution figures in that year and as discussed in para 97 health staff reported the lack of food decreased participation in ANC/PNC and Young Child clinics.

Figure 5: MCHN Ration Reductions and Suspension of Food Distributions

<sup>44</sup>Daily ration for children 6 to 23 months (2013-2014) and PLW (2013-2015) was 25 gram oil, 15 gram sugar and 229 grams Supercereal. In 2015, the children's daily ration changed to 200 grams of Supercereal Plus.



Source: CP SPR 2013 and WFP correspondence 2014/2015

72. From 2013 to 2015, each year on average 80 percent of the planned number of beneficiaries participated in the program with very little variation. (See Table 7.) WFP's approach of using cooperating partners (CPs), Community Action for Health (CAFH) and Andrew Food Consults (AFC) was critical in meeting the 80 percent achievement of beneficiaries over the evaluation period.
73. Interestingly the number of program sites increased from 150 to 170 over the three years, however, this did not seem to increase the total number of beneficiaries but may have increased the numbers of beneficiaries reached in more distant locations through newer sites implying that the number of beneficiaries in other sites may be declining.

Table 7: CBSFP Planned versus Actual Beneficiaries 2013-2015

Year	Type of Beneficiary	# Planned Beneficiaries	Actual # Beneficiaries		% Target Achieved
2013	6-59 months	87,98	70,483		80.1
	5-18 years	14,84	5,85	11,576	78.0
	Adults		5,726		
	PLW	3,18	2,364		74.3
	<b>total</b>	<b>106</b>	<b>84,423</b>		<b>79.6</b>
2014	6-59 months	87,98	66,184		75.2
	5-18 years	14,84	7,741	17,446	117.6
	Adults		9,705		
	PLW	3,18	2,616		82.3
	<b>total</b>	<b>106</b>	<b>86,246</b>		<b>81.4</b>
2015	6-59 months	87,98	62,651		71.2
	5-18 years	14,84	10,471	18,455	124.4
	Adults		7,984		
	PLW	3,18	3,649		114.7
	<b>total</b>	<b>106</b>	<b>84,755</b>		<b>80.3</b>

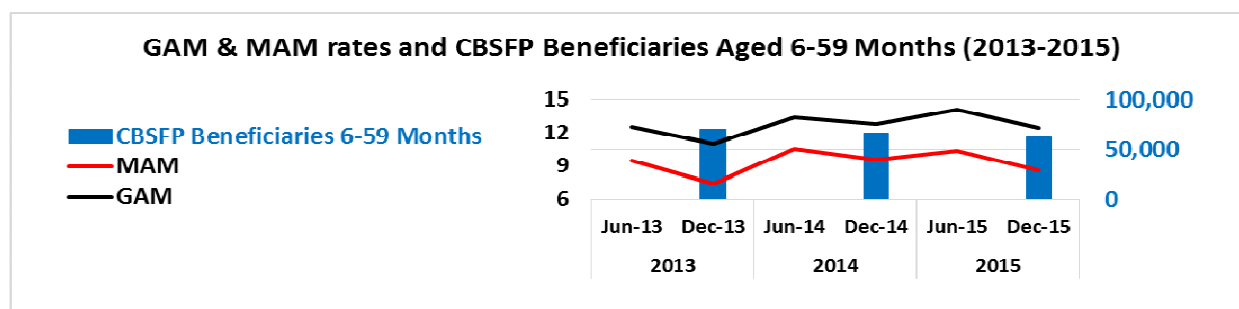
Source: ProMIS Data Base and CP/PRRO Annual Workplan 2013-2015

74. The yearly actual beneficiary numbers are based on the total number of beneficiaries enrolled at the beginning of a calendar year with monthly admissions and discharges being added/subtracted from the beneficiary number at the beginning of the year. The steady decline of nine percent in the number of children between six and 59 months between 2013 and 2015 is worrying since they are the primary age group targeted

because of their high nutrient needs, growth rate and increased risk of mortality. In the program's best year, 2013, only 80 percent of the program target for young children was achieved and by 2015 it had reduced to 71 percent.

75. In 2014 and 2015 when moderate acute malnutrition (MAM) levels were higher than in 2013, the number of young children beneficiaries steadily declined indicating little of the expected correlation between beneficiary caseload and levels of MAM over the evaluation period.

Figure 6: GAM and MAM Rates and CBSFP Children Beneficiaries (6-59 months)



Source: ProMIS Data base and FSNA reports (2013 -2015)

76. Between 2013 and 2015, 64 percent of the planned quantities of sugar, vegetable oil and SC were distributed. When considering the individual commodities, SC has the lowest distribution achievement of 40 percent with sugar and oil reaching 51 percent of their set targets. (See Table 8.) A target for SC+, the most critical commodity for a MAM treatment program, was not set so it's not possible to assess its achievement. However, given that the overall distributed quantities of SC and SC+ are similar and that the number of young children who receive SC+ represent on average 78 percent of the caseload, it appears that significantly less SC+ than needed was distributed.

77. One explanation why more foods were not reported as distributed is that some beneficiaries living a distance from food distribution sites attend only one of the two monthly distributions<sup>45</sup>. It might also indicate over counting of CBSFP beneficiaries or issues with food loss and/or reporting of this data (see para 136 to 139 for more information on potential food loss). The higher tonnage of SC distributed compared to SC+ in 2015 is questioned by the ET, given that it is distributed to young children who make up over two-thirds of the beneficiaries.

Table 8: CBSFP MT of Foods Distributed Compared to Number of Beneficiaries and Targets<sup>46</sup>

Year	# of 6-59 mos. children	# of PLW, older children & adults		Sugar	Veg. Oil	SC	SC+	Total MT	Annual Planned Requirement	% Target Achieved
2013	70,483	13,94		50 MT	97 MT	447 MT	885 MT	1,479 MT	2,279 MT	65%
2014	66,184	20,062		48	68	713	699	1,528	2,279	67%
2015	62,651	22,104		24	43	859	419	1,345	2,279	59%
Total Food				122	208	2,019	2,003	4,352	6,837	
% of Target Achieved	75.5%	PLW	Children/ adults	51%	51%	40%	no target set			64%
		90.4%	106.6%							

<sup>45</sup> This was substantiated by CPs staff, CPs monthly and PDM reports.

<sup>46</sup> The target achieved represents the average of three commodities, sugar, vegetable oil and SC since no target was set for SC+, the commodity with highest tonnage.

78. It was difficult to compare the quantities of food required to the number of CBSFP beneficiaries partially because the rations<sup>47</sup> reported to the ET were not entirely consistent with the food reported as distributed in 2013. (See Table 9.) Another factor was the change in ration for beneficiaries over age five during 2014. For 2015, when the quantities of food required based on beneficiary numbers and rations (2,217 MT) was compared to the quantities of food distributed (2,279 MT), 61 percent of the food requirement based on beneficiary numbers was distributed, similar to the percent achievement of the food distribution target (59 percent) in 2015.

Table 9: Quantities of Foods Required to Provide Rations<sup>48</sup> based on Number of Beneficiaries<sup>49</sup>

	2013	2014			2015			
	SC+s	Supercereal Plus (SC+)			Veg. oil	Sugar	SC	SC+
Children (6 to 59 months)	1692 MT	1,588 MT			0			1,504 MT
PLW, children 5-18, adults	335 MT	Veg. oil	Sugar	SC+	66 MT	40 MT	607 MT	0
		Date of ration change not available; cannot be determined						
Total Food Required	2,027 MT	Cannot be determined			66 MT	40 MT	607 MT	1,504 MT

Source: ET calculations

79. Over the evaluation period both programs increased program sites. (See Table 10.) For the MCHN program nine sites were added between 2013 and 2015 for a total of 53 participating health facilities. At the same time beneficiary numbers increased from 40,839 to 43,443 or by six percent and the number of sites increased by 21 percent indicating that either the additional sites did not attract many new beneficiaries or that participation in the original 42 health facilities may be decreasing or a combination of the two factors.

80. Likewise additional CBSFP sites, actually 20 were added over the evaluation period. (See Table 10.) At the same time, there was little change in beneficiary numbers; an increase of 1,800 in 2014 followed by a decrease in 2015 and ending with participation similar to 2013. It's not clear to the ET why beneficiary numbers did not increase with a 13 percent increase in sites, although the same factors mentioned in relation to MCHN program sites may be at play here as well.

Table 10: Number of MCHN Program Implementing Health Facilities and CBSFP Sites

Year	# of MCHN Program Implementing Health Facilities		CBSFP Sites	
	Planned	Actual	Planned	Actual
2013	41	42	97	150
2014	41	43	97	165
2015	97	53	97	170

Source: Planned data SPR CP/PRRO 2013-2015 and actual data from WFP Kampala Nutrition Unit

81. The MCHN nutrition messaging and counselling data is based on MoH monthly reports and is only available for 2015. (See Table 11.) The ET understands that

<sup>47</sup> The ration for children six to 59 months was 200 g. SC+ over the evaluation period. The ration for older children/adults was 200 g. SC+ for 2013 and part of 2014 and for the rest of 2014 and 2015, the ration changed and consisted of 25 g. oil, 15 g. sugar and 229 g. SC.

<sup>48</sup> Ibid, 38.

<sup>49</sup> The quantities of food required based on the numbers of reported beneficiaries was calculated based on the total number of beneficiaries divided by three (beneficiaries participate for a maximum of three months). This number was multiplied by the quantity of ration foods needed for 12 months.



nutrition education sessions took place in the previous years but facilities did not track and report the beneficiaries participating. The planned percent is high at 100 since all beneficiaries should receive nutrition education as part of their ANC or YCC visits prior to receiving food. Special activities to reach out and engage men are not included, however, men are required to accompany women at their first ANC visit and thus receive nutrition counselling and education during this visit along with their wives. The lower participation of men (75 and 76 percent) could reflect the fact that men are not required to accompany their wives to each ANC visit and thus do not and attend fewer nutrition education and counselling sessions. Very few men bring their children to YCC and, in turn, few would attend nutrition education sessions there.

Table 11: MCHN<sup>50</sup> Nutrition Messaging and Counselling Data

Indicator	2015	
	Planned (%)	Actual (%)
Proportion of men exposed to nutrition messages supported by WFP	100	75
Proportion of men receiving nutrition counselling supported by WFP	100	76
Proportion of targeted caregivers (male and female) receiving 3 key messages delivered by WFP	100	98
Proportion of women exposed to nutrition messaging supported by WFP	100	86
Proportion of women receiving nutrition counselling supported by WFP	100	89

Source: SPR CP 2015

82. During MCHN site visits the ET observed, in most locations<sup>51</sup>, nutrition education was provided to groups but only to the women who come early and before any screening takes place not allowing the women who arrived later to participate in the group nutrition education sessions. This aligns with the MCHN Guidelines (2007), which suggest health and nutrition education takes place shortly after clients arrive in the waiting areas; regardless many women miss the opportunity to hear nutrition information.

83. Table 12 includes information on the percent of CBSFP beneficiaries' men and women who attended group nutrition education sessions which take place at food distributions.

Table 12: CBSFP<sup>52</sup> Nutrition Messaging and Counselling Data

Indicator	2014		2015	
	Planned (%)	Actual (%)	Planned (%)	Actual (%)
Proportion of men exposed to nutrition messages supported by WFP	100	88	100	75
Proportion of men receiving nutrition counselling supported by WFP	100	92	100	76
Proportion of targeted caregivers (male and female) receiving 3 key messages delivered by WFP	100	90	100	100
Proportion of women exposed to nutrition messaging supported by WFP	100	85	100	86
Proportion of women receiving nutrition counselling supported by WFP	100	90	100	89

Source: PRRO SPR 2014 and 2015

84. It also includes information on the percent that received individual one-on-one nutrition counselling. The CBSFP nutrition messaging and counselling data is based on WFP CPs, AFC and CAFH monthly reports. The CBSFP clinics are structured so that beneficiaries attend a nutrition education session prior to receiving food assistance as the ET observed during site visits. As a result, most beneficiaries or their caretakers receive nutrition education bi-monthly during program participation so it

<sup>50</sup>Data on nutrition messaging for 2014 and 2013 is not included in the CP SPRs and other sources of this data were not available to the ET.

<sup>51</sup> In one of the eight MCHN health facilities visited the group nutrition education session took place just before food distribution, however, this may have done for the benefit of the ET.

<sup>52</sup>Data on nutrition messaging for 2013 is not included in the PRRO SPR and other sources of this data were not available to the ET.

is surprising that a higher percentage of beneficiaries are not exposed to nutrition messages.

85. Although the ET observed nutrition education sessions at each CBSFP site, they may not always occur and/or there may be a problem with data collection or with the data itself. There are very few adult men beneficiaries participating in the program<sup>53</sup>, however, they as well, receive their food rations after attending a nutrition education session thus it's not clear why a lower percentage of men are reached since virtually all beneficiaries remain until they receive their food rations.
86. The nutrition counselling observed by the ET, occurred during the measurement component of screening and readmission and thus was of very short duration and involved the nurse posing two or three questions to the mother/caregiver about recent illness, or child's appetite. The counselling was targeted to children not gaining sufficient weight and did not occur with each mother/caretaker and thus in the ET's opinion, the counselling was inadequate in coverage and for beneficiaries covered, it was too short which likely affected its effectiveness. Because of the high volume of patients at some sites, it is understandable that individual counselling is not always possible, however, given its importance particularly for beneficiaries who may have missed a visit or who are not responding this is a critical part of program services and should not be downplayed. Particularly since research has shown the importance of nutrition counselling in supporting treatment and preventing recidivism.
87. The ET understands that longer nutrition counselling sessions take place with each beneficiary/caregiver during the first admission visit, however, it wasn't possible to observe this.<sup>54</sup> The ET questions how the coverage of nutrition counselling can be higher or similar to the exposure to nutrition messages.
88. The ET noticed a large number of older siblings bringing their younger siblings to CBSFP sites, if this regularly occurs mothers or caregivers are not attending nutrition counselling or education sessions minimizing their impact.
89. The ET observed five MCHN and four CBSFP group nutrition education sessions and in addition questions about nutrition and health education were included in FGD with MCHN and CBSFP beneficiaries. Overall the ET was impressed by the interest and enthusiasm of beneficiaries when participating in sessions and, as well, by their ability to remember and repeat nutrition messages heard and reported changes made as a result. On the other hand, the ET identified some weaknesses in the nutrition education sessions, such as, lack of quality, large posters developed for low literate populations to illustrate the messages being communicated.<sup>55</sup> The groups of women beneficiaries were too large to allow for sufficient interaction and engagement, except for one site where the beneficiaries attended shorter sessions in smaller groups.
90. It also appeared by observing sessions and from the messages remembered that the sessions did not cover many of the topics well enough. The nutrition topics, such as, how to eat more protein and micronutrient-rich foods (MCHN) and appropriate infant and young child feeding (IYCF) (both programs) did not appear to be well

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<sup>53</sup> Disaggregated data by sex for adults was not available to the ET. However, the ET only observed two adult men at CBSFP sites during field work.

<sup>54</sup> New CBSFP admissions are for the most part screened at the first clinic of the month and during the ET field work the sites visited held their second monthly clinics.

<sup>55</sup> The new nutrition education materials recently developed for the CBSFP is based on formative research carried out by the MoH (and shared with the ET). They are an improvement, however, they are not designed for audiences with low literacy and are not comprehensive. New IYCF nutritional materials developed by UNICEF and the MoH will be available soon for WFP's and others' use.

covered and the nutrition topics that could be recalled were too few<sup>56</sup>. (See Annex 18 for a list of the nutrition/health topics recalled.) Recent CBSFP PDM reports indicate some additional nutrition education topics covered (breastfeeding and nutrition for pregnancy) and confirm that sessions on hygiene are best remembered.

91. The reported uptake of health, hygiene and nutrition practices by beneficiaries based on education sessions was notable. Changes related to hygiene, eating a more balanced diet and feeding children more frequently were reported most frequently (see Annex 18 for a complete list).
92. From ET observation of MCHN health workers' nutrition counselling skills, they appear to need improvement as sessions were short and not interactive as called for by MHCN guidelines. Observation of CBSFP staff counselling was limited and clients were triaged based on lack of response to treatment, however, time was too short to adequately counsel during MUAC screening. Other nutrition education approaches<sup>57</sup> and materials are being developed and used in Karamoja and could potentially be used to expand WFP's resources. All of these nutrition education programs await evaluation (UNICEF in process and Mercy Corps (MC) and Concern Worldwide (CWW) next year).
93. The ET concludes that the lack of quality in the group nutrition education and individual counselling sessions and, as well, the lower than expected numbers of mothers attending CBSFP clinics likely reduced the uptake of improved nutrition and health practices for both programs and may have limited MCHN program results. Regarding CBSFP the lack of more systematized and quality counselling for returning patients likely contributed to lower recovery rates and longer stays on the program.

2.2.2 How much progress has been made by the WFP nutrition programs towards achievement of intended outcomes?

94. Data is not available on the number of food distributions MCHN beneficiaries are entitled to receive and the numbers actually received. This information is critical to determine the potential of the MCHN program to achieve its outcomes. With the introduction of the SCOPE database it will be possible to track individual beneficiaries and quantify their level of participation; and, as well, to disaggregate and analyse data based on this.
95. The CP log frame includes two MCHN program indicators focused on young children participants. One indicator focuses on their level of participation or program coverage and the other on the adequacy of their diets. As presented in Table 13, program coverage of children is low at 50 percent and children with minimum adequate diets is extremely low at 14 percent. It appears as if MCHN program coverage has improved between 2014 and 2015 from 36 to 50% and the slight increase in the number of child beneficiaries over this time period supports an increase in program coverage.

Table 13: Log Frame MCHN Program Coverage and Diet Indicators for Children (6 to 23 months)

Indicator	Project End Target	Base Value	December 2014	December 2015
Proportion of eligible children (6-23 months) who participate in the program	> 70%	NA	35.6%	50%
Proportion of children (6-23 months) who consume a minimum acceptable diet	>70	NA	0.7%	14%

<sup>56</sup> The MCHN sessions observed focused on HIV/AIDS, family planning, some basic nutrition information and the benefits of the MCHN program. Whereas, the CBSFP sessions covered the importance of the child health card and the information on it, how to prepare the foods provided and who should eat it (observed two times) and information on how to access nutritious foods to feed young children through gardening.

<sup>57</sup> UNICEF, MC and CWW are all engaged in nutrition education programming in Karamoja and have carried out formative research to develop program approaches, curriculum and messages.

Source: Karamoja FSNA Reports (2014 and 2015)

96. However, as noted in Table 14 it is only a two percent increase rather than the 14 percent increase found in the FSNA (July 2015) an indication of the small sample size of young children. The program target of 70 percent coverage was not met over the evaluation period and actually child coverage stagnated as health facilities were added and PLW increased. The reason for this is not clear to the ET.

Table 14: Number of MCHN Beneficiaries Compared to Karamoja Population and Estimated Program Coverage<sup>58</sup>

	Number of MCHN Program Beneficiaries			Karamoja region populations based on Uganda Census (2014)	Estimated Program Coverage		
	2013	2014	2015		2013	2014	2015
PLW	15,967	17,425	18,992	40,129	39.8%	43.4%	47.3%
Children- 6 to 23 months	25,304	23,947	25,216	60,80	41.6%	39.3%	41.5%

Source: ProMIS Data base and ET calculation

97. ANC enrolment data from sites with MCHN programs indicates an increase in participation over the evaluation period. (See Table 15.) Interestingly in 2014 ANC participation declined; during this year the MCHN program had the lowest funding and significantly less food was reported distributed. Health workers interviewed by the ET confirmed that pipeline breaks lead to reductions in MCHN activities and, in turn, ANC, PNC and YCC attendance. They also reported that MCHN activities helped them to increase their numbers of ANC and PNC clients and achieve their ANC targets.

Table 15: Karamoja Trend in MoH ANC Program Enrolment and PNC Visits Data from MCHN Participating Health Facilities<sup>59</sup> (2011-2015)

	2011	2012	Evaluation Period			% increase/decrease between 2013 and 2015
			2013	2014	2015	
# of ANC clients enrolled	7,016	8,420	8,585	6,913	9,456	12.3%
# of PNC visits	4,757	4,874	5,501	4,174	5,020	-8.7%

Source: ProMIS Data base and ET calculation

98. There is large variation in the enrolment by district over the evaluation period; five districts showed increases and in two districts enrolment declined. (See Annex 11 for a table of ANC enrolment by district.) For PNC visits there is an overall decrease between 2013 and 2015 with lowest attendance in 2014; this calls into question the program's role in attracting clients for PNC and/or the reliability of the data. (See Annex 11 for a table of PNC visits by district.) Data is also collected on place of birth (health facility or home); however, for the evaluation period, only 2015 data was available<sup>60</sup> and thus it wasn't possible to see if a trend existed.

99. According to FSNA data, the proportion of children with minimum adequate diets, a combined indicator of meal frequency, diet diversity and breastfeeding/milk products, appears to have improved but is still extremely low and with the smaller sample of children between 6 to 23 months the confidence limits would be wide partially explaining the difference in the data between 2014 and 2015. A similar indicator made up of the same three IYCF practices indicates very low levels of compliance with 2.2 percent having nutritionally adequate diets in Karamoja (DHS, 2011). A recent review of nutrition programs Karamoja concurs and concludes that

<sup>58</sup> Karamoja region population based on Uganda Census is based on 66 percent of the estimated child beneficiary population between six and 59 months since child participate in the program for twelve months and PLW participate on average for one year.

<sup>59</sup> The data counts each ANC participant once; this may be why the numbers of lower than the MCHN program beneficiaries.

<sup>60</sup> It was only for six months of the year and the accuracy of the data for three of the six months reported appeared inaccurate.

over the ten year MCHN program implementation period there was no improvement in young children's diets.<sup>61</sup> For the DHS (2011) IYCF indicator, low diet diversity (3.5 percent) is the lowest of the three nutrition/diet indicators.<sup>62</sup> The CO's planned Cost of Diet Study which estimates the cost to feed young children nutritionally adequate diets based on locally available foods will provide information to help address the poor dietary intake of IYC.

100. The FSNA (1/2016) reports cereals and tubers (six times a week) and vegetables (five times a week) as the most commonly consumed foods followed by pulses and oil (three times a week). Diets are particularly low in animal source protein rich foods, particularly meat<sup>63</sup> and fruit consumption is rare. Household dietary diversity (DD) is low with 46 percent of households consuming less than 4.5 different food groups daily (FSNA, 6/2016). The MCHN ration, although more protein-rich than most cereals, doesn't help to address women's dietary food gap, because it is cereal based and this partially extends to the children's ration which is also cereal-based but in addition, includes powdered milk. Both SC and SC+ are fortified with micronutrients and have been shown to help address anemia which is prevalent in the region.
101. The four CBSFP indicators included in the PRRO log frame are the SFP outcome indicators required in WFP's monitoring documents.<sup>64</sup> The four indicators (recovery, deaths, non-response and defaulters) mirror the SPHERE guidelines and Uganda IMAM guidelines (2010, 2016), however, non-response has a lower acceptable threshold of ten versus WFP's/SPHERE's 15 percent. (See Figure 7 for SFP indicators performance and Annex 12 for data by indicator.) In addition, the CO in 2015, started tracking CBSFP program coverage a WFP corporate and SPHERE indicator.
102. When viewing figure 7, it appears that between 2013 and 2015, recovery rates in all age groups declined slightly and, and as expected the defaulting and non-response rates increased. The death rates of participants is consistently low as expected. Non-response rates are high among PLW (24 percent in 2015) and the elderly (30 percent in 2015), two groups that face recuperation difficulties due to social conditions (the elderly) and high nutrient and calorie needs (PLW). For reasons explained below, the ET feels this reflects slow and consistent improvement in data quality rather than an actual decline in cure rates and increases in defaulting and non-response rates. Based on the ET observation, register and client discharge card reviews and recent reports<sup>65</sup>, the ET questions the accuracy of three of the SFP outcome indicators: recovery, defaulting and non-response. (See Figure 7 for trends and Annex 12 for data on CBSFP indicators by beneficiary groups and year.)

Figure 7: CBSFP Outcome Indicators by Lifecycle and Age Groups (2012-2015)

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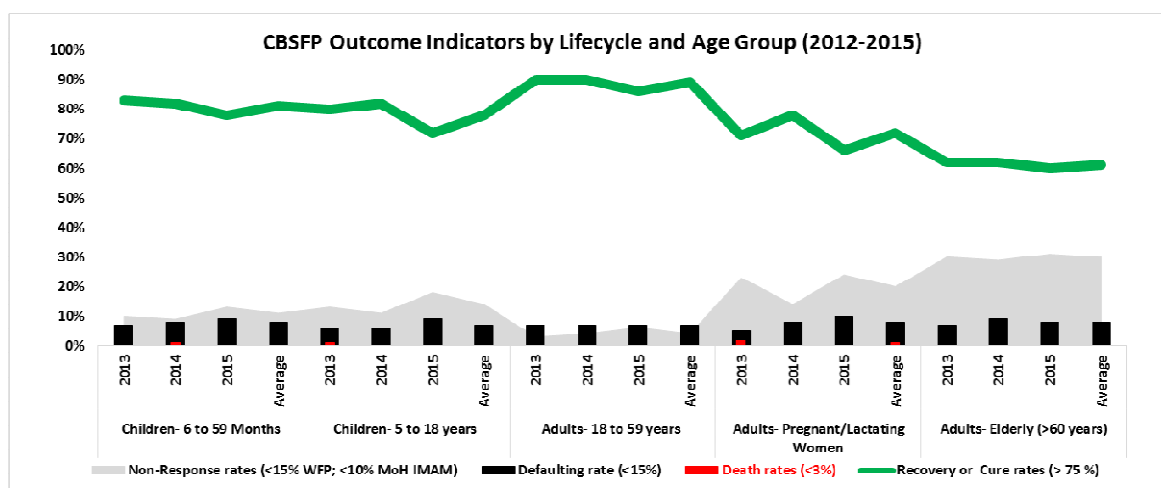
<sup>61</sup> Hailey and Muwaga, (2015), Karamoja Nutrition Programme review report, UNICEF Uganda.

<sup>62</sup> The other two are minimum meal frequency at 30 percent and consumption of breastmilk/milk products at 97 percent.

<sup>63</sup> Amudat district is the exception regarding consumption of animal-rich foods. Milk is more available and more widely consumed.

<sup>64</sup> Including: WFP Nutrition: Measuring Nutrition Indicators in the Strategic Results Framework (2014-2017) Briefing Package and Minimum Monitoring Requirements (2014).

<sup>65</sup> Coverage assessment of SFP to treat MAM in Karamoja April- June, 2016, draft; CBSFP Program Data Review 2015, June 2016; and the Review of WFP CBSFP Karamoja Region draft August, 2016



Source: ProMIS Data base

103. The CBSFP 2015 Data Review Report (June 2016) offers a comprehensive review of the program’s outcome data. The report noted a number of problems related to collecting the raw data to generate program outcomes identified through register reviews, such as, defaulters retained on the program rather than being discharged, incomplete data on attendance, relapse, returning defaulters and discharge status, clients retained on the program past the three month limit and clients wrongly discharged as cured before attaining the target weight.<sup>66</sup> Some of these same data issues were also identified in the Review of WFP CBSFP Karamoja (draft report August 2016), the recent program coverage reports (2015, 2016) and the ET register review (see para 106 and 107 and Annex 13).
104. The CBSFP Data Review report also noted that sites lacked written guidance on program attendance/discharge criteria and there was a lack of consistency on the application of discharge criteria across districts. This was also a finding of the ET and, as well, the ET observed some variation in the age groups of beneficiaries across districts. The expertise and capacity of focal persons and data clerks also varied across the districts. In some cases, the ET observed that focal persons could not differentiate between the various categories of exits; this was also a finding of the CBSFP data review.
105. The lack of consistent and accurate identification and recording of type of client discharge, i.e. cured, defaulter or non-response, critical to outcome indicators was also observed in the ET register reviews for 2014 and 2015 (see Annex 13). For the most part, clients were discharged as cured after three months; few defaulter or non-responders were identified and the register data was often not consistent with the recorded outcome of “cured”. The ET noticed that this problem was being addressed in the sites in Moroto the ET visited. In the ET review of discharged client cards during site visits, most of the cards reviewed included accurate discharge data in terms of timing and type of discharge (see Annex 13). Interestingly, in the observed sites where discharges were more accurately categorized, recovery rates were lower and defaulter and non-response rates were higher.
106. The CBSFP Data Review compared raw admission data from two districts to ProMIS (WFP data based and the CP narrative reports) and revealed inconsistencies with beneficiary numbers. A similar review of relapse data from six districts also

<sup>66</sup>Until the recent introduction of MoH Integrated Nutrition Program Registers, it wasn’t possible to ascertain if children discharged by MUAC were appropriately discharged because a space for MUAC discharge measurement was not included, however, this has been corrected in the new registers.

indicated variation between raw data and ProMIS reports. Relapses, not a WFP or MoH IMAM outcome indicator, but an important measure of program effectiveness was generally not captured on the client cards as observed by the ET (see Annex 13). It appears from the CBSFP data review, similar to the ET findings, that returning relapsed and defaulting clients, are significantly underreported. Efforts are underway across the districts visited by the ET, to address this.<sup>67</sup>

Table 16: CBSFP Coverage: District Population (children-6 to 59 months) compared to Estimated and Actual Caseloads for 2015<sup>68 69 70</sup>

District	Population 6-59 months	MAM prevalence		Estimated Yearly Caseload	Actual CBSFP Reported Caseload 2015	SLEAC Coverage Survey Results 2015	
		Dec. 2014 (FSNA)	June 2015 (FSNA)			MAM Point Coverage	Coverage Classification
Abim	19,627	4.7%	6.9%	2,013	1,706	N/A	High
Amudat	20,116	8.4%	8.0%	2,445	3,410	0.57 [0.48-0.66]	High
Kaabong	30,469	14.1%	12.4%	7,348	9,201	0.70 [0.61-0.79]	High
Kotido	32,204	8.5%	10.9%	3,411	7,055	0.42 [0.33-0.52]	Moderate
Moroto	18,817	15.8%	12.3%	1,306	7,452	0.19 [0.12-0.26]	Low
Nakapiripirit	30,544	6.1%	10.8%	1,812	13,338	0.27 [0.21-0.34]	Low/ Moderate
Napak	26,139	9.3%	10.8%	5,327	8,099	0.78 [0.72-0.85]	High
Karamoja Region	207,57	9.6%	10.4%	26,444	50,261	0.49 [0.47-0.52]	Moderate

Source: SLEAC Coverage Survey Report (2015), Review of WFP CBSFP Karamoja (draft report, 8/2016), FSNA reports and ET Calculation

107. In 2015, WFP and UNICEF jointly commissioned their first Simplified LQAS Evaluation of Access and Coverage (SLEAC) Survey to measure coverage of their MAM and SAM treatment programs. (See MAM program coverage results in Table 16). Overall Karamoja CBSFP coverage was found to be 49 percent and rated as moderate. The districts' coverage rates ranged from a low of 19 percent (Moroto) to a high of 78 percent (Napak). The SPHERE standard for MAM program coverage in rural areas is 50 percent or above and thus overall the CBSFP nearly achieves this<sup>71</sup>,

<sup>67</sup> At new admission screenings, the names of discharged clients are read and returning clients identified as defaulters and relapsed (on the client cards). The ET noticed in some sites visited that returning clients were identified more often on client cards. However, another issue remains. Non-response clients returning after discharge are not possible to capture because a space to note this information is missing from the client card.

<sup>68</sup> Figures in 'Population 6-59' column are based on the WHO Neonatal and Child Health Profile Uganda (2013) where the population of children less than 59 months is estimated at 19 percent. Because zero to six months children are not included an estimated of 18 percent was used. The population figures are taken from the Uganda Census 2014.

<sup>69</sup> Estimated Yearly Caseload column: The MAM/SAM caseload formula for estimating caseload over a given time period was used as presented and defined in: CMAM Forum, How do we estimate case load for SAM and/or MAM in children 6 – 59 months in a given time period?, Mark Myatt. Estimated Caseload = N (population 6-59 months) X P (Average December/June MAM prevalence used) X K (corrective factor or incidence usually 2.6 is used) X C (estimated program coverage- SLEAC result was used and for Abim the average of the other "high" districts was used- .65)

<sup>70</sup> Actual CBSFP Reported Caseload 2015 figures are as presented in the Review of the WFP Uganda CBSFP Draft Report, August 31, 2016 and based on cumulative new enrolments over the course of 2015.

<sup>71</sup> Of note, the recent SLEAC survey (April-June 2016) found a lower MAM program coverage rate of 44 percent when applying the MUAC screening criteria only (the same methodology used in 2015 survey). Data available by district was not available but could be provided by ACF is requested by WFP. Data provided by Ben Allen, ACF Global Emergency Coverage Advisor.

however, the district average masks two districts (Moroto and Nakapiripirit) with unacceptably low coverage rates.

108. Table 16 provides 2015 CBSFP caseload data (actual and estimated) and compares this to the survey coverage results. The data helps to illustrate the problem of high and in some cases very high yearly reported caseloads in six of the seven districts compared to the expected or estimated caseloads (based on SLEAC coverage estimates). The reported high caseloads particularly where there is moderate or low program coverage support the anecdotal observation related by WFP staff and others that the same beneficiaries cycle through the program repeatedly.<sup>72</sup> And without unique beneficiary identification numbers during the evaluation period, it is not possible to assess if beneficiaries do participate in the program repeatedly.

109. Admitting children not eligible for the program is another explanation heard by the ET and triangulated by WFP staff and the recent CBSFP assessment.<sup>73</sup> Notably where coverage is lowest there are the highest discrepancies between estimated and reported caseloads, potentially indicating higher numbers of repeat or ineligible beneficiaries in a year. The ET observed four sites where MUAC screening was in process; in all of these sites children's MUACs were measured once and not repeated as called for in the IMAM protocols.<sup>74</sup> Some of the sites visited by the ET served high number of beneficiaries, such as, 350 or 400. Lines and waiting times were long and CP staff taking measurements, although most showed proper technique, others were observed incorrectly measuring children's upper arm length and inaccurately identifying the mid-point likely contributing to inaccurate measurement<sup>75</sup>. It wasn't possible for the ET to check staff measurements to confirm their accuracy. In two clinics, the ET was able to review the cards of newly admitted beneficiaries and of the cards reviewed nearly all were appropriately admitted. Based on ET observation of screening, findings from the recent CBSFP assessment and high reported caseloads, it is likely that at least in some districts children are admitted to the program that are not eligible.

### 2.2.3 To what extent have the outputs led to the realization of outcomes and these contributed to the realization of Strategic Objectives?

#### 2.2.3 A - MCHN Program: WFP SO4 reduce undernutrition levels and break the intergenerational cycle of chronic hunger

110. The low performance of the MCHN program in the provision of food rations has affected achievement of outcomes. Further few MCHN program outcomes are included in WFP's corporate indicators and thus little available data exists to show achievement or lack thereof. However, WFP does collect data on an MCHN outcome indicator, LBW. It is collected in monthly MCHN reports and entered into the ProMIS database and was analysed by the ET. (See Table 17.)

Table 17: LBW Rates in Karamoja Health Facilities Participating in MCHN Program (2013-2015)

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<sup>72</sup> The ET heard from CPs staff that mothers restrict the food intake of their young children so that they are eligible for the program and respond poorly when participating so they can be readmitted for relapse after discharged. This was also a finding of the recent CBSFP review.

<sup>73</sup> ET heard from WFP and CP staff that VHT refer children to CBSFP as a favour to families and, in some sites, they are often admitted whether they qualify or not.

<sup>74</sup> Not taking MUAC measurements twice was also a finding in the recent WFP CBSFP review.

<sup>75</sup> Mothers/caregivers with their children stood during measurements as did the CP staff; chairs for the mother and child to sit during MUAC was not available, nor was there a table to facilitate recording measurements.



Year	2013	2014	2015
LBW rate	6.9%	9.0%	8.6%

Source: Promis data base and ET calculation

111. If the MCHN program contributed to a reduction in LBW a declining trend would be expected, however, between 2013 and 2015 this was not found. Given the periods of ration reductions and suspension and overall low achievement in food distribution, it is not surprising that the MCHN program does not appear to contribute to reducing LBW.
112. Karamoja region DHS data (2006, 2011) and FSNA data for several undernutrition indicators is provided in Annex 14, however, more recent data is needed to assess impact of the MCHN program. Further, because estimated program coverage was low at around 40 percent and food distribution was limited, it is very unlikely that the program would have contributed to any potential declining trends in undernutrition, such as, LBW, stunting or acute malnutrition in the targeted population.

#### 2.2.3 B - CBSFP: WFP SO1 is to save lives and reduce acute malnutrition to below emergency levels

113. Children with moderate and SAM are at higher risk of morbidity and mortality, and thus programs to treat these conditions can contribute to reductions in mortality and morbidity. Well managed MAM treatment program, catch children before they deteriorate and become severely acutely malnourished, thus contributing to reductions in SAM prevalence. To prevent acute malnutrition, treatment programs need to be complemented by programs which address the causes of acute malnutrition, such as, for Karamoja, food insecurity and poor diet diversity, poor access to safe water and sanitation, poor hygiene practices, gender inequality and poor IYCF and care practices.

Table 18: FSNA Trend in Indicators Impacted by MAM Treatment Programs (2012-2016)<sup>76</sup>

Indicator	dec-12	jun-13	dec-13	jun-14	dec-14	jun-15	dec-15	jun-16
Mortality (crude mortality; #)		0.60	---	0.53	--	XX	--	
GAM (children 6-59 months)	12.5% [11.7%-14.0%]	12.5%	11.0%	13.4%	12.8%	14.1%	12.4%	11.0%
SAM (children 6-59 months)	3.2% [2.7%-3.9%]		2.5%	2.8%	3.2%	3.7%	3.8%	2.3%
MAM (children 6-59 months)	8.6%		7.5%	10.6%	9.6%	10.4%	8.6%	8.7%

Source: FSNA reports

114. Table 18 shows trends in indicators potentially impacted by SFP. Crude mortality data over the evaluation period is close to the threshold for normal or slightly above; treating children with acute malnutrition, including MAM likely has supported the maintenance of these low levels. The trend in the prevalence of SAM does vary somewhat, but not significantly and no declining trend was found over the evaluation period indicating little or no impact of the CBSFP on SAM prevalence. The prevalence of MAM also varies over the evaluation period; most variation is seen between the lean and harvest seasons and the levels remain within the confidence limits.

#### 2.2.4 What is the efficiency of the MCHN and CBSFP delivery models vis-à-vis results of the respective programs?

<sup>76</sup> For month 6/2015, the ET does not have the data. It has been related that the mortality level are WNL and thus aren't included in the FSNA reports

115. Information to assess some measures of efficiency were not available. For example resource forecast and budgets do not exist for sub-units/nutrition programs and further, they are confidential. Without budgets it was difficult to assess if resources were used optimally or to evaluate the costs versus service provided by CPs or to assess costs per beneficiary. Since the evaluation was of nutrition programs requiring specialized food products that meet WFP nutrition standards and are procured internationally a comparison to local products would not have been meaningful. However, several findings related to the efficiency of MCHN and CBSFP were revealed to the ET and are presented in this section.
116. As discussed in para 40, the provision of food versus cash in the MCHN program and in particular for women is likely to be less efficient in terms of cost and may have less effect on improving diet diversity based on a recent study in Karamoja commission by WFP.<sup>77</sup> Under the new CP early in 2017, cash transfers will be piloted for women MCHN beneficiaries. Closely monitoring and carrying out an evaluation of the pilot and including an indicator of diet diversity would be important and coupling cash transfers with support to improve iron/folate supplement distribution is also important to compensate for the loss of micronutrients when cash replaces SC distribution.
117. Transitioning to cash transfers for children is also likely to increase diet diversity among children. However, replacing SC+ is more complicated given its milk powder and micronutrient content and a recent finding<sup>78</sup> related to a spill-over effect of the food provided to children aged three to five on reducing stunting among younger siblings.
118. In a number of areas the efficiency of some of the CBSFP beneficiary groups can be questioned. With respect to the adults in Karamoja, one-third of men and women are underweight<sup>79</sup> and thus meet the eligibility criteria for the CBSFP with most not participating. When conditions, such as, underweight are so prevalent, further research may be warranted to determine the risk associated with the condition in the Karamojong and to assess if other program approaches would be more efficient through reaching higher number of those at risk at a lower cost per beneficiary.
119. Along the same lines, program outcome data, CPs staff and the recent CBSFP review identified elderly (30 percent on average<sup>80</sup>) and PLW (20 percent on average) beneficiaries as having high rates of non-response and as mentioned non-response rates presumably are under reported. This warrants further study to understand if a more intensive approach is needed for PLW given the importance of improving their nutrition status and if as several CPs staff suggested many of the elderly beneficiaries are extremely vulnerable and need ongoing assistance, such as, a cash transfer which would be a more efficient program approach.
120. A number of factors related to CBSFP caseloads also point to program inefficiencies. For example, the high yearly caseloads compared to estimated caseloads points to large numbers of ineligible beneficiaries participating in the program. Other factors indicating inefficiency are low program coverage, particularly in some districts, the reported cycling of the same beneficiaries through the program

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<sup>77</sup> Gilligan et al, (2013), Impact of cash and food transfer at Early Childhood Development Centres in Karamoja, Uganda, Final Impact Report. WFP/UNICEF/IFPRI. The evidence continues to build on the greater effectiveness of cash transfers to improve diet diversity and in turn diet quality in comparison to food rations.

<sup>78</sup> Ibid 67.

<sup>79</sup> Underweight is measured as a body mass index (BMI) < 18.5 with 32.8 percent of women underweight and 33.1 percent of men as reported in the DHS (2011).

<sup>80</sup> See Annex 12 CBSFP Outcome Indicators by Lifecycle and Age Groups (2012-2015).

repeatedly and the retention of beneficiaries beyond the three month limit. There are a number of factors already discussed related to this, such as, poor VHT screening and referral and suboptimal screening and admission at CBSFP sites coupled with low capacity/inadequately trained CP focal point and data staff, who do not admit and discharge beneficiaries properly and/or record this information well. The ET also met health facility focal points who did not completely understand the various types of program discharge and are responsible for transferring data from CP registers to the health facility nutrition program registers.

#### 2.2.5 How did the MCHN and CBSF programs contribute to gender results?

121. The children (6 to 23 months) MCHN beneficiary data disaggregated by sex over the evaluation period shows that more girl children (27,171) benefited from the program compared to boys (26,034) over the evaluation period. (See Annex 22 for complete information by year.) The sex ratio of boys to girls it is 0.96 or estimated at one indicating fairly equal participation between boy and girl children.
122. A number of MHCN activities contributing to increased gender equality were observed. During health facility visits, the ET observed that husbands of pregnant women attending ANC clinics had to attend the first ANC visits and participate in HIV/AIDS counselling and testing as a couple. Women participating in FGD described the HIV counselling and testing with their husbands as an important program benefit and service to them and their families.<sup>81</sup> In a male FGD, men shared that they are beginning to recognize the importance of nutrition in pregnancy and assisting their wives during pregnancy because of what they are learning at ANC visits with their wives. They also revealed that they are starting to recognize the importance of ANC. These findings demonstrate a positive change in men understanding of the care necessary for their wives when pregnant.
123. In one site visited, the ET observed that health workers refused to serve male partners of pregnant women if they were not properly dressed (i.e. wearing trousers) as a way to fight social cultural norms. This should be addressed as it likely discourages men from attending ANC visits with their wives and seeking health care.
124. In Kaabong and Kotido, the ET observed male VHT members leading community mobilization and promoting the engagement of men in the MCHN program. Many VHT members are men, if they were better trained in how men can contribute to the improved health and nutrition status of their wives and children, another channel for disseminating this information and promoting gender equality would be created. Although young boys are more at risk to be acutely malnourished, a significantly higher number of girls (six to 59 months) participate in the CBSFP program compared to boys. (See Annex 22 for the CBSFP data disaggregated by sex between 2013 and 2015).<sup>82</sup> The ratio of boy participants compared to girls is 0.83 confirming significantly lower participation of boys. This issue and how it is compounded by the higher levels of undernutrition among boys is discussed in paras 46 and 47.
125. Men can be difficult to access, because they are often away from their homes managing livestock and among the Karamojong, it has been solely the women's responsibility to provide for the household and to ensure adequate health, child care and nutrition. Thus, it is not surprising that there has been a lack of involvement of

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<sup>81</sup> At this first visit husbands are also provided information about the importance of ANC, hospital births, nutrition for pregnancy and the importance of rest and reduced work load during pregnancy.

<sup>82</sup> Disaggregated data for the other beneficiary groups, such as, older children, adults and the elderly was not available to the ET.

men in CBSFP including low program participation. Further WFP/CPs haven't focused on engaging men/fathers and sensitizing them about acute malnutrition and how it is prevented and treated and how to support their children who may be malnourished. Sensitizing men on this issues might help promote their involvement in child feeding and care and limit the inter-familial sharing of foods for malnourished children.

126. CPs have started drama groups to develop and perform shows that spread nutrition and health messages. A similar number of men are required to participate as women. The CPs provide the nutrition/health messages and vet the drama before it is performed. The ET was not able to observe a performance however CP reports and staff document the success of dramas in involving men in disseminating nutrition and health messages and modelling more gender balanced roles.
127. Some of the Mothers' Care Groups initiated to support mothers with children slow to recuperate include male members, however, this was mentioned in only one district and results of these approach were not available.
128. Between 2013 and 2015, WFP Uganda, similar to most CO, did not employ a gender advisor; instead they relied on a staff focal point with other responsibilities and limited gender expertise. During this time, gender was not well integrated and thus opportunities to enhance impact were missed. Recently a gender advisor (six month contract<sup>83</sup>) has come onboard in response to the corporate requirement to develop a CO gender action plan. The importance of this in relation to WFP Uganda's nutrition programming should not be underestimated given that the relationship of gender dynamics with nutrition and food security is widely documented.

#### 2.2.6 Has the VHT structure and community mobilization enhanced program effectiveness?

129. Interviews with Health workers (involved in MCHN clinics) indicate that no MCHN community sensitization or mobilization activities have been carried out or are planned. The program as implemented reaches women at health centres during antenatal and postnatal care and reaches infants and young children at their births or immunization visits. The MHCN program focus is health facility based, however, it lacks the community-based approach described in the CP 108070 document, including jointly mobilized and trained VHT to provide outreach, education, referrals and community-based growth monitoring. Such an approach was needed to achieve the 80 percent or higher program coverage described in the CP document.
130. The CBSFP relies on the VHT members for community sensitization and mobilization and for the monthly initial screenings of children and, in some areas, adults are screened. Children with MUAC measurements between 11.5 and 12.5 cm without bilateral oedema are referred to the CBSFP for rescreening and admission. Children with MUACs less than 11.5 cm or oedema are referred to health facilities for rescreening and admission to Outpatient/Inpatient treatment (OTC/ITC) for SAM. CBSFP supported by WFP, its CPs and integrated with health facilities<sup>84</sup> and OTC/ITC supported by UNICEF and its partner CUAAM and implemented in health facilities are designed intended to be one integrated program with joint initial screenings in communities and cross referrals.

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<sup>83</sup> The gender advisor's contract may be extended.

<sup>84</sup> The CBSFP uses MoH nutrition program registers, provides data for MoH monthly reports and in most locations stores its food in health facility storage facilities.

131. VHT MUAC screening for children occur during the first two weeks of each month and because this didn't coincide with the ET field visits none were observed. In one area, the ET was able to review MoH VHT Integrated CBSFP Screening Registers. Out of the twelve registers reviewed: two had no recorded MUACs indications, seven had the letter 'Y' representing MUAC measurements between 11.5 and 12.5 cm for all the children listed, and the remaining three registers had recorded a combination of yellow and green MUACs. The registers had been reviewed by a CP staff and for the three registers that provided a combination of MUAC results the confirmed MUAC were fairly accurate, however, not all cases were checked. However, for the four other registers this was not the case and a fair number of children's MUAC were not confirmed revealing an issue with referrals.<sup>85</sup> These VHT register findings, although from only one district and a relatively small number of registers were triangulated through discussion with the WFP intern reviewing the CBSFP who also found problems in completion and accuracy of MUAC data presented in the VHT screening registers.
132. Other problems indicating variation in capacity and commitment of VHT members were also identified. At two CBSFP sites, the ET met VHT members who were intoxicated.<sup>86</sup> CPs staff reported issues with VHT screening and referral performance; this was triangulated by CAFH reports and the CBSFP Data Review Report. In addition, the recent CBSFP review report notes issues with VHT screening performance in five of the seven districts and issues of VHT high workload and their challenges with literacy and comprehension were found in all districts. On the other hand, the ET met a number of VHT members who appeared to have a good understanding of their CBSFP screening and referral responsibilities and appeared to take this role seriously.
133. Another issue is the number of NGO supported community health activities that VHT are involved in. They are many and the various community activities do not appear to be coordinated, calling into question whether as volunteers it's possible for them to fulfil all these responsibilities well.
134. The ET compared district level VHT screening and referral data with enrolment, caseload and estimated SLEAC coverage for February 2015.<sup>87</sup> The month were selected because SLEAC estimated program coverage was available for districts. (See Annex 15 for a copy of the table and additional analysis of the screening information.) The comparisons indicate little relationship with the percent of the child population screened by district, referred and enrolled in CBSFP with district MUAC prevalence, estimated district program coverage and caseload. This lack of correlation indicates potential problems with screening and referral or with rescreening at enrolment or both.
135. Clearly VHT community sensitization and mobilization has increased MUAC screenings and referrals and supported reaching more potential beneficiaries and, in turn, increased CBSFP participation. However, the ET questions the capacity,

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<sup>85</sup> The issue of VHT referrals was also identified by a recent screening and referral activity implemented by CONCERN. Their Mothers' Group Lead Mothers have been trained in conducting MUAC measurements and have been provided yellow and red screening tickets with numbers to provide to mothers with child identified to be at risk. Mothers are provided two tickets to provide to the VHT member, one for them to keep and other for the mother to provide to the health facility if she is referred by the VHT. A review pointed out that few of the children (and tickets) make it to health facility or CBSFP sites and the identified bottleneck is the VHT.

<sup>86</sup> This was also a finding of the recent review of WFP CBSFP.

<sup>87</sup> The screening, referral data and actual caseload data was compiled from tables in an Annex in the draft report of the Review of the WFP CBSFP dated August 31, 2016. The data was extracted from CP monthly reports.

commitment and time available to the VHT members to carry out MUAC screening well enough to identify children with MAM and refer them to the CBSFP.

2.3 Why and how have the CBSFP and MCHN activities produced the observed results, including the gender results?

### 2.3.1 Which internal factors contributed to the level of results obtained?

#### 2.3.1.1 Food procurement, storage and management

136. There are a number of aspects of food procurement, storage and management that affect the quality of the food stored, such as, respecting the best use/expiration dates of foods, timely delivery to health facilities, proper transportation, storage and management of food. This is particularly important for nutrition programs since most of the specialized food products are more perishable and have shorter shelf lives.
137. During field work, the ET visited a number of the MCHN and CBSFP food storage rooms. All of the storage rooms visited did not follow at least some food storage guidelines. The challenges observed included poor or no ventilation, the absence of pallets with bags of food/boxes of food stored on the floor, food stacked against walls and in some cases up to the ceiling, and pests and rodents damage. (See Annex 16.) Another common challenge observed was the lack of proper documentation of the food distributed in the available registers and/or on wall charts in some sites visited. It was not clear to the ET how reports were generated from sites where proper documentation was not found.
138. Health workers interviewed, particularly in relation to the MCHN food storage, expressed concerns regarding the quality of the food storage and management. This was triangulated by FGDs with beneficiaries, who in a small number of cases had complaints that SC received appeared rancid and was not edible. This was triangulated by CPs staff who mentioned problems in the past and also in June and July of this year with weevil infested SC. The ET is not able to estimate the extent of damaged SC. Some concerns related to quality of food were raised, particularly for SC+ since boxes of it were observed at some sites that were close to their best use date.<sup>88</sup> (See Annex 16.)
139. Poor food storage practices and food damage, was more frequently observed at MCHN storage facilities. WFP has mitigated some of the effects of the inadequate food storage through its scheduled twice monthly food deliveries to health facilities and schools. However, the ET observed some sites that reported less frequent deliveries and food on hand for two to three months.
140. Two of the WFP district warehouses were observed: one in Moroto and the other in Kotido. Overall the warehouses were clean, the food well organized and stored on pallets with up to date stock cards<sup>89</sup>. Bags of SC to be distributed in September 2016 had a best use date of September providing a narrow window for distribution to facilities and beneficiaries and helping to substantiate WFP's distribution of foods close to their expiration to CPs. On the other hand, all the foods stored in the Moroto warehouse had best use dates before or after April 2017 and warehouse staff reported current stock would be distributed in September and October of this year.

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<sup>88</sup>The ET learned from WFP storekeepers that two months past the "best use" date printed on food, the food expires. In one location some of the SC+ was past its best use date by nearly two months and in others it appeared that some of the food would not be able to be distributed until after its best use date.

<sup>89</sup> Another exception was observed in the Kotido warehouse, in that, some leaky oil containers had stained oil boxes.

141. The ET visited WFP's warehouse in Tororo where it observed clean and orderly storage of the MCHN and CBSFP foods on pallets along with up to date stock cards.<sup>90</sup> The storekeeper reported that foods are stored a maximum of six months and the best use or expiration dates for the four commodities had dates from April through October of 2017.<sup>91</sup> Based on the information provided, the ET concludes that the foods presently stored will be delivered to sub-office storage facilities and, in turn, to health facilities in time so that they can be distributed before their best use dates.
142. The ET concludes that it is not possible to establish the extent of food storage and management issues between 2012 and 2015. However, current evidence from a number of food storage facilities and triangulated by CPs staff, indicates widespread food storage issues that in some cases coupled with foods close to expiration likely contributed to loss of commodities.

### 2.3.1.2 Food Distribution

143. During the ET field visits, a number of challenges related to actual food distribution were observed. As mentioned (para 35), a procedure for beneficiaries to make complaints and posters with information on the size and measurements of food rations, provided during distributions were not observed at any of the food distribution sites visited. On the other hand, during FGD CBSFP beneficiaries related knowing the size of their or their children's rations and that they in fact had been receiving full rations.
144. The provision of smaller food rations than designed is more likely to be systematized and to occur more often when picture signage with ration food sizes and measurements are not available. This compounded by a lack of compliant procedure observed by the ET at all sites visited may have contributed to the provision of smaller rations than designed in five of the six MCHN food distributions<sup>92</sup> and in one of the five CBSFP food distributions observed. (See Annex 17 for more specific information by site).
145. It was also noticed that proper hygiene, washing hands and using gloves to pre-mix the CBSFP ration for beneficiaries over 5 and gloves when measuring the SC provided to women MCHN beneficiaries was not followed. Staff were observed in both program at all sites using their hands, and in many cases, handwashing was not possible. Cans were used to estimate the SC (MCHN women) and pre-mix ration for CBSFP beneficiaries over age five, and it appeared that dry food was not always measured consistently or accurately with the can heaping at different levels. (See Annex 17.) For MCHN distributions, oil and sugar appeared to be provided more often in smaller quantities and the pre-mix provided to CBSFP in some cases was less than designed. Improper hygiene risks spreading disease to vulnerable beneficiaries and the systematic distribution of smaller rations limits program impact.

### 2.3.1.3 Protective Ration

146. Protective rations (PR) for the households with CBSFP beneficiaries, a new approach began this year during the worst part of the lean season (March through

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<sup>90</sup> Two food storage violations in the Tororo warehouse were observed. SC+ boxes were stacked higher than guidance recommends which contributes to breakage of boxing and repackaging. This was also found with the boxes of oil.

<sup>91</sup> It wasn't possible for the ET to triangulate this with past food dispatch records.

<sup>92</sup> In MCHN sites, 2 sites provided the correct child ration and 4 did not and for the PLW ration, 2 provided the correct amount of SC, 2 sites provided less and for the other 2 it wasn't possible to assess. At one site less oil was provided and in two sites it appeared that less sugar was provided. Regarding CBSFP the correct child ration was provided in all five sites observed and in four of the five sites observed adults were provided the correct ration and in site they were provided less of the pre-mix ration.

May). FSNA data was used to identify 30 sub counties with higher levels of acute malnutrition and in these areas a PR of sorghum, pulses and vegetable oil designed for six family members was provided.<sup>93</sup> CPs staff reported that the protective ration increased screening and enrolment, was positively perceived by beneficiaries and improved recovery rates through reducing non-response and defaulting. PDM reports from this time period help to substantiate this as they show a higher ration rate by the intended beneficiary.<sup>94</sup> On the other hand, it was reported that the availability of the PR may have increased beneficiary numbers with ineligible beneficiaries.<sup>95</sup> The recent CBSFP review, compared recovery and non-response rates over the PR period to the same time period in 2015 and found a positive impact of the PR on non-response and cure rates in most districts, however, the data was not disaggregated by participating sub counties and other factors, such as, improved household food security in 2016 may have influenced improvements found. Pending results from more complete analysis, the ET concludes that continuing the PR during the lean season as implemented can support improved CBSFP outcomes. Further, piloting cash transfers because of their greater efficiency and impact on diet diversity should be considered. And closer monitoring of this activity may be needed to ensure impact and to guard against ineligible beneficiaries gaining access.

2.3.1.4 Does the data collected through MCHN/CBSFP activities provide the information needed to track the performance indicators?

147. The tracking of the MCHN monitoring and performance indicators is done by health facility staff. The program data is entered in a number of health facility registers (ANC, PNC, YCC) that are used by health staff to compile the MCHN monthly reports. Health staff responsible for the MCHN program complained about how much extra work the MCHN monthly report is and that most of the required information duplicates MoH HMIS reporting. The ET also noticed sites where the MCHN focal points did not completely understand the MCHN report and did not have the proper training and ongoing mentoring/supervision on MCHN data collection and reporting.

148. The ET concludes that the high reporting requirement and lack of MCHN staff training and mentoring affects the quality of the data and rethinking MCHN data collection is warranted given that it duplicates MoH reporting and places too high a burden on overstretched staff.

149. Within the CP log frame, the two WFP MCHN corporate indicators are included. They focus on children (coverage and minimum adequate diet) and although the data was available in the FSNA reports, they weren't reported in the SPRs. In addition, the ProMIS data base collects program performance indicators, such as, ANC/PNC participation and health facility deliveries and also an outcome indicator, the numbers of LBW infants, though these are not WFP corporate indicators. Not all of this data is routinely analysed and reported. Further, the FSNA could collect data on MCHN coverage for PLW. Thus the M&E system could do more to provide additional performance and outcome data to guide programmatic decisions.

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<sup>93</sup> WFP used FSNA data to target its food resources. In mid-2015, during a MCHN funding shortfall, WFP started targeting food distribution using FSNA data to identify districts with higher levels of acute malnutrition. This enabled its food resources to go where it potentially could have had more impact.

<sup>94</sup> In the Napak/Amudat report (May 2016) reported consumption by the intended beneficiary increased from 37 to 67 percent and similarly, in Moroto/Nakapiripirit report (May 2016), it was reported as an increase from 15 to 54 percent.

<sup>95</sup> Review of WFP CBSFP Report, draft August 31, 2016.



150. The data collection for the CBSFP program is done by the CPs staff: nurses, data clerks and program focal points. For the most part, the necessary data to monitor and assess the program is collected. The problem lies, in the quality of the data; this starts in the data collection process with the rescreening and admission/readmission of beneficiaries, and follows along to the transfer of measurements and other data to registers and monthly reports. In paras 102 to 105, the deficiencies found in the data collection and reporting process are identified and triangulated. As a result the ET questions the quality of the performance data (recovery, defaulting and non-response rates) and its usefulness in guiding program decisions. The efforts underway to capture information formerly not well collected and to improve the overall quality of data collection and reporting, particularly focused in Moroto district are helping to address data quality issues identified by the ET and other recent CBSFP reviews.
151. One important program performance indicator, the percent of patients who relapse, not a SPHERE standard, although tracked, is not reported. In the Karamoja context, where WFP and CPs staff believe there is a high level of relapsed and returning beneficiaries, reporting on this indicator is important to better understand the caseload and program coverage issues identified. The need to better understand patient relapse will also benefit from WFP's SCOPE data base currently underway, which will have the capacity to computerize program beneficiaries across programs and identify them uniquely. The SCOPE data base will also help to quantify the 'length of stay' (LoS) for CBSFP beneficiaries and the length of program participation for MCHN beneficiaries.
152. Another performance indicator included in the IMAM guidelines but not a WFP corporate indicator, LoS on the program is currently collected but not reported. Ongoing reporting of this indicator would support staff understanding of the importance of how to assign the types of discharge properly (discussed in paras 104 to 106); in addition, to providing information on program performance.
153. The WFP corporate indicators and PRRO log frame do not include SFP outcome indicators that monitor program impact. The potential impact of SAM/MAM treatment programs on mortality is discussed along with the effects of well-run MAM program can have on SAM prevalence is discussed (paras 114 to 117). And, although it is difficult for a MAM treatment program to lower GAM/MAM rates, tracking MAM as is done through FSNA, is critical in the Karamoja context and has proved useful in guiding program decisions. The ET concludes that more outcome indicators are needed to track the impact of the CBSFP and recommends adding crude mortality and SAM indicators (both currently collected in the FSNA) to the current CP log frame.

#### 2.3.1.5 Analysis, Monitoring and Evaluation Unit

154. In March of 2014, WFP's AME Unit broaden its concentration from internal M&E to include more involvement in WFP/UNICEF FSNAs. Prior to this, the assessments were entirely outsourced from data collection to analysis and report writing. Since 2014 the AME unit has produced its own data analysis and reports, but continues to outsource data collection. This has enabled the CO to do additional data analysis and produce new reports, such as the one of gender (July 2016) which includes the presentation of disaggregated nutrition data (para 35 and Annex 21) and provides useful CBSFP information.
155. In the past year FSNA data has been effectively used to support targeting of nutrition program resources (see paras 146.) Using FSNA data to guide programming decisions and target resources supports greater impact of WFP programs and should

be continued and FSNA data should be further exploited to track log frame indicators as discussed (paras 149 and 153).

156. The AME extracts data from ProMIS data base to measure program outputs and outcomes, and it heavily relies on FSNAs to collect program impact data. For the MCHN program the FSNA works well for assessing program coverage and the ProMIS data base provides data from MCHN program sites that can be used to assess outcomes and outputs. As mentioned, the ET extracted MCHN output and outcome data from the ProMIS data base and analysed it for this report. This could be done regularly (bi-annually) so that the nutrition unit and other staff understand more about the MCHN program's performance.
157. Another issue was the difficulty in determining the actual number of MCHN/CBSFP beneficiaries as no computerized unique beneficiary numbering system exists for either program. This leads to discrepancies in beneficiary numbers and potentially makes attribution of the program results difficult. Importantly, no methods to reduce double counting or to assure data quality were found by the ET. The introduction of the data management system SCOPE with its unique beneficiary ID numbers will help to address double counting of beneficiaries.
158. On the data collection front, there are still challenges related to linkages, quality and use of data with partners for both programs. To address this, AME and nutrition unit staff could design strategies with MoH and CPs to streamline reporting, provide on-job training for CPs and health workers and carry out exchange visits of best performing sites to share effective data collection and reporting approaches.

#### 2.3.1.6 Program Monitoring

159. The ET found that technical program monitoring and monitoring of food distributions for both programs need strengthening. WFP Karamoja sub-office food monitors assistants (FMA) participate in the food deliveries and monitoring of food distributions and in joint quarterly district nutrition program monitoring of MCHN and CBSFP program activities. And, FMA also carry out field program monitoring on their own, sometimes unannounced to observe usual program activities.<sup>96</sup> It wasn't possible for the ET to review FMA field monitoring reports to assess the quality of their food distribution and nutrition program site monitoring or to determine the number/percent of program sites covered yearly. Some of the deficiencies observed at program sites (e.g. children measured only once, smaller rations distributed, improper measurement procedures followed) suggest that the coverage of monitoring is inadequate and/or its comprehensiveness needs strengthening. In some districts WFP sub-offices have nutrition focal points, such as, in Moroto (short-term contract) and Kotido, but in most locations WFP lacks monitoring staff with nutrition expertise, which likely limits the more technical aspects of program monitoring, such as, measurement technique, quality of client cards/register reviews and nutrition education and counselling.
160. Post food distribution monitoring also occurs quarterly using a questionnaire developed by WFP staff and administered to a sample of CBSFP beneficiaries. It provides information on beneficiaries' perceptions of the ration: its quality, how it is used by the household and who consumes it, etc. The monitoring is carried out by CPs in the districts where they implement CBSFP. From review of PDM reports, it would

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<sup>96</sup> One WFP staff noted that there wasn't much difference in program activities observed during surprise visits versus the planned ones. However, he had found food arriving late during unannounced visits.

be helpful if all information reported by the two CPs was the same and some of the data presented needs to be better interpreted and explained.

### 2.3.1.7 Management and Staffing

161. A number of management and staffing issues were identified that affected program effectiveness and efficiency. WFP does not have sufficient nutrition program or monitoring staff and most of the monitoring staff work across WFP's programs and do not have adequate expertise in nutrition. In terms of the supervision and reporting structure, FMA report to sub-office managers without technical supervision from the program unit and nutrition staff in Kampala.
162. There are three nutrition staff in Kampala, an international nutritionist and two national nutritionists who support the two Karamoja nutrition programs, the refugee nutrition programs and the unit's other nutrition work<sup>97</sup>. The workload of the nutrition staff makes it difficult for them to devote sufficient time to setting the standards and ensuring the quality Karamoja nutrition programs including monitoring, as well as, CPs and MoH staff mentoring and training.
163. The management of the nutrition programs lies within the management structure for field activities. Sub-office managers report to the Area Office manager and this position reports to the Deputy Country Director (DCD) who also supervises the head of the program unit. This structure provides a gap in nutrition technical supervision and relies too heavily on the DCD to ensure the technical quality of nutrition programs. Integrating technical nutrition supervision within the supervisory structure at the various levels of field staff could help to address this.
164. The ET also observed some other management issues. One of them is related to the role of in-charge staff persons at health facilities. Their responsibilities include accountability for the MCHN food; however, the WFP FMA supervise the food handler staff without involvement of the in-charge. Health staff identified this as one of the factors contributing to poor management of the food stores and lack of accountability.
165. Another challenge affecting both nutrition programs, is the competency and capacity of health staff. Some of this is related to high staff turn-over<sup>98</sup> and lack of training and a supervisory mentoring structure to promote quality data collection, record keeping and food storage and management. For example, many of MoH food handlers reported to the ET that they had not been trained in hygiene procedures, food storage or record keeping. Similarly, some of the health workers involved in the nutrition/health education MCHN component related that they had not been trained in the provision of nutrition education or in the MCHN program guidelines.
166. All the CPs staff interviewed by the ET reported that they had received training in the CBSFP program and in particular in their roles and responsibilities. However, the ET noted a wide variation in CPs staff. In the northern districts where the CO relied on health facility and school staff, issues including competing job responsibilities, and in some cases, a lack of understanding of critical program indicators and how to report them were observed. And in the southern districts where the CP employed more staff directly there appeared to be variation in the capacity of nutrition staff between districts and in their ability to understand screening procedures and program indicators and, in turn to mentor other staff. In areas with weaker nutrition

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<sup>97</sup> Some of the WFP Kampala nutrition unit other work involves the micronutrient powder (MNP) pilot project and engagement in nutrition coordination structures.

<sup>98</sup> MoH high staff turn-over in Karamoja is out of WFP's sphere of influence.

staff, it may be more difficult to improve screening, admission and the quality of reporting.

### 2.3.1.8 Screening, Referrals and Follow-up with CBSFP Non-responders and Defaulters

167. A new issue regarding screening recently came up when the SLEAC coverage report was released in July. This survey added WH (weight-for-height) Z scores<sup>99</sup> to the MUAC measurements used previously since both are included as eligibility criteria in the IMAM guidelines, and found a larger than expected percent of children eligible through WHZ scores that would not be detected by MUAC screening.<sup>100</sup> Some programs have since started to include weight and height measurements for children not eligible by MUAC measurements<sup>101</sup>, however, the impact of this may be limited. Two recent journal articles<sup>102</sup> and an ACF MAM coverage expert point out that unless the MUAC screening threshold is raised a significant number of eligible children will continue to be missed. How acute malnutrition is diagnosed and what this means programmatically is a new area and still one of controversy meaning that MAM screening guidance has not been updated to reflect this and may not be in the near future.

168. As mentioned in the results section, although VHT referrals provided an overwhelming high percent of program beneficiaries, accurate and consistent referrals from VHT to CBSFP was identified as a problem. In addition, the cross referral system from the MoH programs, such as, ANC, PNC, YCC did not appear to exist<sup>103</sup>; and there was little or no referral from the MCHN program to the CBSFP. There was some referral observed between the CBSFP and OTC/ITC, but not to the extent expected given the interrelationship of the programs and the previous IMAM guidelines (2010) that called for all OTC patients to be referred to the CBSFP program once they improved reached the eligibility criteria for the program. According to ET interviews and observation, health facility staff received some forms for CBSFP patients being referred to OTC/ITC, but there was no mechanism to cross check and ensure they were actually enrolled. (See Annex 13 which compiles referral/discharge information from CBSFP client cards.)

169. CP staff reported lack of VHT follow-up with beneficiaries defaulting and/or non-responding. In some areas, Care Groups/Family Support Groups (FSG/CG) have been formed to support families with malnourished children defaulting from treatment. The use of parents who have successfully recuperated their malnourished children in FSG/CG was reported to the ET as an effective strategy to trace defaulters.<sup>104</sup> And, although the use of FSG/CG has not been evaluated, Abim district has shown particular success in lowering their defaulter rates using FSG members to go door to door and mobilize beneficiary families to attend distributions (noted in the CBSFP review draft report).

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<sup>99</sup> WHZ score is an abbreviation for weight-for-height Z score. The Z-score system expresses anthropometric values as several standard deviations (SDs) below or above the reference mean or median value and 2 SDs below the average weight-for-height reference mean is considered an admission criteria to MAM treatment programs and requires a current weight and height measurement and the WHO reference charts.

<sup>100</sup> According to the SLEAC (draft June 2016), MUAC screening identified 60 percent of children (6 to 59 months) and WHZ screening identified 64 percent of children eligible for MAM with an overlap of 24 percent of cases identified between the two screening methods.

<sup>101</sup> As reported by WFP staff and observed by the ET in CBSFP sites visited.

<sup>102</sup> Roberfroid et al, (2015), Inconsistent diagnosis of acute malnutrition by weight-for-height and MUAC: contributors in 16 cross sectional surveys from South Sudan, the Philippines, Chad, and Bangladesh, *Nutrition Journal* 14:86; and Lailou et al, (2014), Optimal Screening of Children with Acute Malnutrition Requires a Change in Current WHO Guidelines as MUAC and WHZ Identify Different Patient Groups, *PLOS one*, vol. 9, issue 7.

<sup>103</sup> Based on CBSFP client card review (see Annex 13) and ET interviews with CP and health staff.

<sup>104</sup> This ET finding was also a finding included in the recent CBSFP review.

170. On the other hand, the use of FSC/CG to follow-up with non-responders has had limited impact as reported to the ET and triangulated in the CBSFP review. It appears familial sharing and other behaviors that contribute to non-response are entrenched; and other strategies may need to be found address this problem.<sup>105</sup>

2.3.1.9 Were the lessons learned from previous nutrition programs appropriately used?

171. As mentioned in para 130, the CP document suggests piloting and scale up of a community-based approach for MCHN activities in order to reach more beneficiaries in line with past MCHN program evaluations and the MCN Thematic Review (2005)<sup>106</sup>. This was not carried out and given the funding constraints it was likely not an option. The MCN Thematic Review, also called for sufficient M&E expertise to support future program planning and to demonstrate results. This was not applied over this evaluation period as discussed in para 160.

172. One of the lessons from the past CP, was that the provision of financial assistance to health staff was not sustainable. Applying this lesson contributed to the overburden of health staff and, in turn, the quality of the program and reporting (para 147). The shortage of MoH staffing in Karamoja is a widely accepted problem that affects the implementation of a number of donor-supported health programs and thus needs to be addressed jointly by the MoH, donors, UN agencies and health partners.

173. One of the recommendations from the previous PRRO evaluation (101213 in 2012) was to continue CBSFP in community sites even though its costs are higher than facility based programs. Its higher beneficiary coverage was seen as an important benefit. The community approach has been supported by DFID and as a result this implementation modality continues and expanded as more sites were added over the evaluation period.

2.3.1.10 Is the choice of partners consistent with the requirements to achieve results?

174. Because the MCHN program was planned and designed with MoH staff to be implemented through its health facilities, they for the most part, comply with the MoH MHCN guidelines. As mentioned it is the areas of staff, an overall shortage and high turn-over where there are shortcomings. As noted, new MoH staff need training and seasoned staff need mentoring and supervision in their MCHN responsibilities. Thus WFP could have been more proactive in developing and implementing initial training sessions, an ongoing MCHN supervisory/mentoring mechanism even though the MoH staff shortage could have made this difficult to accomplish and a less burdensome monitoring and reporting system.

175. The choice of the CPs, AFC and CAFH, is consistent with the technical demands of program implementation. From review of their strategies, yearly program reports and partner performance evaluations and from ET interviews, both CPs have shown their ongoing commitment to the program and in addressing deficiencies. However, as noted a number of problems with the program were identified, particularly with the challenging aspects, such as, quality of implementing activities (e.g. screening, nutrition education) and with the quality of data and reporting. In recent months WFP has started to support CPs in addressing the issue of data quality and reporting,

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<sup>105</sup> Ibid, 103.

<sup>106</sup> The MCN Thematic review called for a more funds and resources for community-based approaches including more nutrition and health education and consideration of engaging CBO/NGOs in addition to government as partners in order to make the programs more effective.

more of this support was needed earlier and will be needed going forward for CPs to succeed in improving the quality of their implementation and reporting.

176. The ET concludes that in the case of the MoH, its performance may have affected the expected MCHN program outputs. Regarding the CPs, their responsibility as it relates to the VHT and screening and referral of identified children was found to be lacking by the program coverage survey (2015). However, the difficulties identified of working with the VHT elaborated elsewhere in the report (paras 132 to 135) and the fact that they are not employed by the CPs, make it hard to hold CPs accountable for this.

2.3.1.11 Did the nutrition technical support from the RB/Rome respond to the CO needs?

177. WFP staff report good support from the RB. However, it was not possible for the ET to triangulate this information nor assess properly the adequacy of RB nutrition support due to the lack of access to reports of RB nutrition missions.

2.3.1.12 What internal factors helped/hindered the achievement of gender results?

178. As mentioned (para 55) there was no gender analysis undertaken in the CP/PRRO design phase under evaluation or in the preparation for the follow-on CP started this year<sup>107</sup>. The lack of gender training for CPs and MoH staff was also a factor that likely limited achievement of gender results.

2.3.2 What are the main opportunities and threats in the external operating environment that influenced results?

2.3.2.1 What were the effects of underfunding on Implementation of the MCHN Program?

179. As highlighted previously (para 68), the MCHN program, funded almost from WFP internal funds, was drastically under resourced. On average 2.6 million \$US or approximately half of the 5 million \$US planned budget was received over the three year evaluation period with 2.3, 1.9 and 3.0 million \$US received from 2013 through 2015.<sup>108</sup> Further, it was difficult for the CO to plan and act strategically based on lower funding level given the late timing of WFP's Strategic Resource Allocation Committee decisions. The CO decision to reduce<sup>109</sup> or suspend rations for over the half of the three year period under evaluation instead of redesigning with a lower number of beneficiaries is questioned by the ET. If the program had been redesigned with fewer districts targeted and selected based on the levels of nutrition indicators the program was trying to improve<sup>110</sup>, it may have been possible to show impact.

2.3.2.2 Was the MoH and Ministry of Local Government (MoLG) able to fulfil its financial commitment?

180. The government's commitment is in-kind and met through the provision of staff and/or parts of staff positions. In theory the government has met its obligation as staff are assigned to the various MCHN program responsibilities in health facilities, however, due to inadequate funding, recruitment and supervision of health workers remains low. Further, the hardship experienced by health staff assigned to Karamoja contributes to high turnover and, in turn, a combination of high staff vacancies and less experienced staff. The MoLG also faces funding constraints; as a result they are not providing adequate MCHN supervision.

<sup>107</sup> The ET understands that the CP was given a gender marker score of 2A.

<sup>108</sup> Only 300,000 \$US per year was committed through another funding stream.

<sup>109</sup> Including the times that half rations and rations with one or more foods missing were provided.

<sup>110</sup> The indicators referred to include: ANC/PNC participation, health facility births, underweight in women, LBW and child stunting.

### 2.3.2.3 How has the quality of national policies contributed to MCHN/CBSFP programs?

181. The Ugandan government with donor support has developed the policies, strategies (UNAP) and guidelines (MCHN program, IMAM, IYCF) that provide the framework for addressing the country's nutrition issues and provide the foundation, rationale and guidance for WFP's nutrition programs in Karamoja. At the end of the evaluation period, the IMAM guidelines updated in 2010 were again revised. On the other hand, as mentioned the MCHN guidelines are in need of revision; it has been over nine years since their last updating and over this time period the nutrition context has evolved, lessons have been learned and WFP's specialized food products have changed dramatically as research and international standards on supplemental foods have evolved. This has led to some inconsistency between WFP and MCHN guidance.

### 2.3.2.4 Did political or natural events, such as drought, affect MCHN/CBSFP results?

182. Karamoja is subject to recurrent cyclic droughts and climate change has severely affected rainfall patterns making it more difficult to produce crops. The drought and severe lean season, in 2015, was seen as the main driver of the acute malnutrition rates, the highest in seven years. As higher numbers of eligible malnourished beneficiaries seek treatment, it is more difficult for programs to provide quality service to higher caseloads and tougher for the malnourished to recover given the increased pressure on rations and lower food security. As discussed, the PR can help to address these issues.

183. A method to support managing the higher MAM caseloads during the lean season is the Concern Surge Community Management of Acute Malnutrition<sup>111</sup> Approach. CWW with the support of UNICEF/CUAAM and the MoH is piloting this in Moroto district with the OTC/ITC program. The Surge approach including one staff person per district, in addition to staff training and monthly analysis of SAM caseload data, develops simple district staff plans enabling health facilities in 'hot spots' with higher caseloads to borrow staff from facilities in less affected areas a few days each month coinciding with OTC/ITC clinics during the lean season. Piloting this approach in MAM 'hot spots' is needed to support CBSFP outposts in hotspot areas.

184. Strengthening programs, such as, public works and agriculture programs (climate smart and nutrition sensitive) and kitchen gardens/small livestock to address food insecurity and prevent undernutrition is a critical need identified by ET and by others.

### 2.3.2.5 Were there any issues related to beneficiaries that have affected program results?

185. Several issues identified among beneficiaries affected nutrition program results. One factor is the Karamojong's over dependence on food aid developed over the last 50 years. In response communities have modified their social and economic behaviours, including caregivers/beneficiaries who deliberately do not comply with nutrition programs to remain eligible as described in paras 44 and 109.<sup>112</sup>

186. Another critical factor is the high level of alcoholism among the adult population. This as a detrimental effect on household food security and the nutritional adequacy

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<sup>111</sup> The terms CMAM and IMAM are used interchangeably by international nutritionists.

<sup>112</sup> ET interviews and Draft Review WFP CBSFP report (draft August 2016).

of diets and the feeding and care of children<sup>113</sup>. Over consumption of alcohol is widely reported in Karamoja and considered a factor in poor nutrition program compliance and VHT performance.<sup>114</sup>

187. The heavy physical work load of Karamojong women who by necessity support their families also contributes to poor pregnancy outcomes, such as, LBW and, poor IYCF and care, which in turn, contributes to lower nutrition indicators and the need for nutrition program support. Lastly, the low educational level of women means that the nutrition and health behavior change is a longer process with meaningful improvements occurring more slowly.

2.3.2.6 What external factors helped or hinder the achievement of gender-related results?

188. Overall the entrenched gender inequality and the lack of shared household, child care and financial responsibilities between parents hindered the achievement of gender results. In particular, the high adult female work load and the semi-nomadic agro-pastoralist culture where men contribute little to household expenses makes it more difficult for nutrition improvements among women and children to be realized. This is compounded by the high percent of men practicing polygamy. In Karamoja 51 percent of marriages are polygamous—more than twice the national average (DHS, 2011).

### 3. Conclusions and Recommendations

#### 3.1 Overall Assessment/Conclusion

189. The ET concludes that while both programmes are relevant and necessary to address undernutrition in Karamoja, the CBSFP's contribution to treating MAM among children, PLW and other malnourished individuals although significant has been limited due to implementation and reporting problems and low coverage in some areas. The MCHN programme due to low funding over the evaluation period has contributed to increased ANC attendance, but shown little measurable impact.

190. Appropriateness and Relevance of the MCHN Program and CBSFP: The MCHN Program was found to be relevant, in particular because Karamoja has the worst maternal and child health indicators in Uganda and a low rate of hospital delivery. The fact that food insecurity and acute malnutrition are also the highest in Uganda makes the CBSFP relevant as well. The nutrition program activities were revealed to be appropriate, especially the nutrition/health education and counselling. The other program activities, such as, identification and treatment of MAM and the use of fortified blended food to act as an incentive to encourage ANC, PNC and YCC attendance were also determined to be appropriate. Beneficiary satisfaction with both programs as reported in FGD and PDM (CBSFP) was high; including the food ration and the nutrition/health education. Neither program provides sufficient information to beneficiaries regarding the size of food rations or a mechanism for beneficiary feedback.

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<sup>113</sup> Home brewing of alcohol is one of the most common sources of income generation reported by women (FSNA, ET FGD). Sorghum that in the past might be used for household consumption is more likely to be diverted into alcohol with the dregs from the bottom of the storage containers reportedly fed to children. (Dancause, Alcol and Gray, (2010), Beer is the cattle of women: Sorghum beer commercialization and dietary intake of agro-pastoral families in Karamoja, Uganda, Soc Science Med, vol. 70, Issue 8, pg 1123-1130.)

<sup>114</sup> ET interviews and Draft Review WFP CBSFP report (draft August 2016).



191. The CBSFP food rations comply with international, WFP and Uganda IMAM guidance and were found to be effective for treating children. Some variation was found between Uganda IMAM SFP and international SFP guidance regarding beneficiary groups. The IMAM guidelines include more beneficiary groups, increasing beneficiary caseloads and burdening sites with additional beneficiaries with lower risk that could potentially be reached through more cost-effective programs. The MCHN rations are aligned with WFP guidance and current evidence but diverge from the MoH MCHN guidelines (2007) that need updating.
192. Coherence: The WFP's Karamoja nutrition programs align with the Uganda nutrition policy, strategy and action plan and support and align with the nutrition/health priorities in the MoH Health Sector Plan. The CO in 2015 supported the update of the IMAM guidelines. The nutrition programs are well aligned with WFP's Strategic plans (2008-2013; 2014-2017). They also align with WFP's nutrition policy and normative guidance.
193. Complementarity: Regarding complementarity, the MCHN program complements the MoH's MCH services and for CBSFP, it is one of two programs to treat acute malnutrition, and as such complements the MoH's SAM treatment programs supported by UNICEF. Referrals between MoH clinics and between SAM and MAM treatment need strengthening to exploit the program synergy. More integration of the CBSFP with the health system is needed and could be accomplished through including CBSFP and OTC SAM treatment in MoH Outreach Clinics. Integrating the MCHN program in Outreach Clinics, particularly in areas with high food insecurity would improve program coverage and potentially impact.
194. Even though no complementary activities were part of either program design, the CBSFP has incorporated gardening activities with mixed results. And efforts are currently underway to integrate nutrition sensitive activities in WFP's public works program. An important effort, particularly if households with PLW and children under two are targeted and if the selected activities support improved nutrition and food security. In addition to Public Works activities, ensuring access to nutrition programs and extending the targeting of WFP's other programs to households with PLW and children under age two is needed to provide greater food security and help to prevent undernutrition. Activities such as developing a Karamoja map (and using it to train staff) including all WFP program sites and other nutrition programs would help support referrals and synergy between programs.
195. Coordination: WFP through REACH supported nutrition coordination at the national level and in Karamoja, WFP's nutrition focal points participate in MoH district nutrition coordination meetings and activities. MoH engagement varies between districts and WFP and UNICEF has supported this: in places where MoH staff are more active it has been involved in addressing nutrition coordination problems. Increased efforts by WFP and UNICEF are needed to support districts with gaps. Districts are in various stages of developing district nutrition plans and WFP has participated in this.
196. Effectiveness and Impact: Despite receiving half of the requested budget between 2013 and 2015, the MCHN program increased its planned number of beneficiaries and achieved them for children and nearly achieved them for PLW. Over the course of the evaluation period, ANC visits increased and health facilities met their targets. During 2014, the year when the lowest quantities of MCHN food were distributed, data show a decrease in ANC and PNC participation that staff

attributed to the smaller quantity of food distributed. In addition, health facility staff consistently report that the MCHN program increased health facility births, YCC attendance and immunization rates. Regarding program outcomes, coverage for PLW increased over the evaluation period and remained about the same for children; less than half of the estimated PLW and 40 percent children participate. The reductions and suspensions in rations affected over half of the evaluation period and thus it's not surprising that the outcome indicators showed little if any improvement. Beneficiaries report the rations increase the number of meals they consume; and the group nutrition and health education sessions were appreciated and beneficiaries could report messages heard and changes made in their hygiene and nutrition practices.

197. The CBSFP received 80 percent of its planned beneficiary numbers over the evaluation period, with little variation between years. The primary age group, children six to 59 months, had the lowest caseload achievement. The quantities of food distributed (on average 64 percent) compared to beneficiary numbers were less than expected indicating lower beneficiary participation in distributions and/or reporting problems. CBSFP support to VHT has increased community mobilization and sensitization around malnutrition and contributed to higher enrolment. However, the contribution of VHT training to carry out MUAC screening and identify cases of acute malnutrition is not completely clear and appeared to vary widely.
198. Accurate reporting of three of the MAM treatment outcome indicators, defaulting, recovery and non-response, has been problematic, however, the quality appears to have improved over the evaluation period and further efforts along these lines are underway. It is likely that program outcome indicator targets for defaulting, non-response and recovery is not as high/low as reported and some may not be achieved. Problems of reporting of outcome indicators were linked with inadequate staff understanding of program criteria and how to apply them. Data on program coverage was available for 2015 and at 49 percent, it nearly achieved the SPHERE standard of 50 percent. However, this masked two districts with unacceptably low coverage rates. Low coverage coupled with higher than expected beneficiary caseloads indicates problems with screening, admissions and discharges of beneficiaries and underlines the need to improve coverage. Most of the CBSFP referrals reported are from VHT. A lack of referrals between the two nutrition programs and from health facility clinics to CBSFP was found. Extending the referral system to other nutrition programs carrying out screening is also needed.
199. The program has recuperated large numbers of malnourished beneficiaries, reduces the number of SAM cases treated in OTC/ITC and may be helping to maintain the low mortality levels in the region. The program's nutrition education sessions have been beneficial; beneficiaries revealed that they understand why their children are malnourished, how to prepare the food rations and some report having improved their hygiene and nutrition practices.
200. Efficiency: Information to assess some measures of efficiency were not available and one measure was not relevant. Several other factors related to the efficiency of MCHN and CBSFP activities were found. The provision of food versus cash in the MCHN program and in particular for women is likely to be less efficient in terms of cost and may have less effect on improving diet diversity, thus plans to pilot cash for PLW is needed along with supporting health facilities in increasing iron/folate distribution for pregnant women. The efficiency of some of the CBSFP beneficiary groups, such as, adults who participate at a low rate particularly compared to the

percent eligible indicating that research may be warranted and other program approaches might be more cost-effective. Elderly beneficiaries have high non-response rates indicating their need for potentially more intensive and ongoing assistance. PLW also have high non-response rates given the importance of improving their nutritional status developing a more intensive approach is needed. A number of factors related to CBSFP also indicate inefficiency, such as, low program coverage in two districts and caseloads significantly higher than expected.

201. Gender- Appropriateness, Effectiveness and Key Findings: Regarding congruence with WFP's gender policy shortfalls were found. A gender analysis was not conducted during the program design and activities to address gender were not well featured in either program. It would have been relevant to target men for sensitization on gender issues as they relate to improving health and nutritional status of their families. The absence of a gender advisor during the evaluation period likely limited the achievement of gender results in both programs.
202. Husbands and fathers of beneficiaries need to be more exposed to nutrition/health information so they can support their families in making the necessary changes. To this end, both programs need to do more to integrate a gender approach including engaging husbands/father in dialogs to understand their barriers to supporting their families in improving nutrition and health behaviours. The community dramas based on nutrition and health messages and involve men in the development and performance is an excellent dissemination approach and also a good way to involve as well as to reach men.
203. Factors Affecting Nutrition Program Results: Health workers claim that heavy workloads affect their moral and this could be affecting the reporting and quality of the data collected. Streamlining the monthly reporting form to reduce duplication of data collection is needed along with training and supervision/mentoring. Program monitoring was found to be deficient. Developing a more comprehensive MCHN training, mentoring and supervision component is needed and resolving the issue regarding local government monitoring should be made a priority by WFP and the MoH. The FSNA, ProMIS data base and MoH HMIS system collect the data needed to monitor the program and take decisions regarding program intervention areas, however, more emphasis is needed on quality assurance and regular analysis of some of the data.
204. CPs staffing varied, with AFC relying on more on its own staff and some health facility staff, and CAFH relying more on health facility staff and teachers; and even among AFC the capacity of their hired staff varied. In program areas with less qualified staff (CPs, MoH/schools) it will be more difficult to improve the quality of CBSFP activities. Reviewing the CBSFP client flow with the objective of minimizing client waiting time and improving the quality of data is needed, especially at sites with high caseloads. Piloting the CMAM "surge" approach currently in place in Moroto district for OTC/ITC should also be considered during the lean season for CBSFP in "hot spots" areas.
205. In five of the six MCHN and one of the five CBSFP food distributions the ET observed, smaller rations than designed were distributed (see Annex 17 for details). The required accountability mechanisms: a system for beneficiaries to register complaints or signage with rations were not found at the sites visited. The provision of smaller rations and inadequate accountability mechanisms observed point to a higher risk of food theft and warrants further

investigation by WFP. Food handlers for both programs do not follow proper hygiene practices. Both programs were found to have poor storage capacity that did not comply with WFP food storage guidelines. In some storage rooms foods close to (or past) their best use dates were found.

206. The ET found at all levels of WFP, CPs and MoH that the number of staff was insufficient and the nutrition technical expertise of most staff involved with the two programs was inadequate. Nutrition program monitoring was also found to be deficient. Within WFP's supervisory structure, technical nutrition supervision is not provided for FMA and nutrition focal points. This is exacerbated by a lack of nutrition staff in the Kampala nutrition unit.

207. WFP's staffing, budgeting, management and program accountability have not kept pace with the CO's shift from food to food assistance and to the implementation of more technical nutrition programming, and those need to be reviewed and revised to reflect this shift.

### 3.2 Lessons Learned

208. The severe MCHN funding shortfall provides an opportunity to draw a lesson learned. The CO reliance on WFP internal funding for a large part of a program's budget exposes WFP and its partners to significant risks, such as, low program results. After the budget shortfall was first realized, program redesign to reduce districts and health facilities would have better supported reaching program outputs and, in turn, potentially achieving outcomes.

### 3.3 Recommendations

R1. The MoH and CO with support from the RB should develop a SFP more fully integrated with the Uganda health system to enhance its effectiveness through providing services at MoH health facilities and selected outreach clinics and CBSFP outposts in Karamoja. To accomplish this, WFP should map the current CBSFP outposts, health facilities and MoH outreach clinics, acute malnutrition rates (district and sub-district) and district MAM/SAM program coverage so that the areas in most need can be identified and services expanded to reach them. This approach should be integrated with OTC/ITC and MCHN services and include:

- An agreement with the MoH, DHO and Local Governments with an incentivized contribution from GoU increasing over time to cover costs initially supported by donors and including a Karamoja region MoH phase-over plan.
- Stronger collaboration with UNICEF to improve IMAM outcomes, including strengthening VHT<sup>115</sup> capacity to screen and follow malnourished children, a common referral system with a built-in feedback mechanism, and the development of a common audit/review of the integrated nutrition program register.
- Use of pooled donor funds to cover the costs of transportation for Outreach Clinics and support partners to strengthen and integrate IMAM (SAM/MAM treatment).
- A narrowing of the beneficiary groups to young children and PLW<sup>116</sup> coupled with designing new or linking with other interventions for acutely malnourished adults and the elderly that are more cost-effective. At the same time, selecting another

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<sup>115</sup>Supporting a review of the VHT structure with the objective of determining how best to deliver the quality health and nutrition services at the community level is recommended. And for now CPs with WFP support should identify areas with VHT are working well and those where they are not and with the district health teams work to resolve the bottlenecks.

<sup>116</sup> This will better align with international SFP guidance.

specialized food product, such as, a ready-to-use SF, to treat PLW and strengthening follow-up and referral of malnourished PLW to MCHN programs.

- Piloting the “Surge” approach in integrated IMAM/SFP clinics in hotspots during the lean season to decrease waiting times and improve quality of service.
- Pending the results of an analysis in process, the PR should continue, however, with the piloting and evaluation of cash transfers.
- In collaboration with UNICEF, hire a consultant (MUAC/IMAM) to determine how to address the problem of current screening criteria missing children with MUACs above the threshold who are eligible because of their low WHZ scores.
  - ▶ Timeframe: Start in 2016 and continue through 2017
  - ▶ Responsibility: CO Nutrition/Program Unit and RB

R2. The CO with leadership from the MoH and support from the RB should update the MCHN Program to enhance effectiveness and impact through the following:

- As planned, pilot a cash transfer for PLW in the MCHN program. As this expands and MCHN provision of SC is reduced, ensure through collaboration with UNICEF and the MoH that the barriers to improved coverage of iron/folate supplements during pregnancy are addressed.
- Under the leadership of the MoH support the updating of the MCHN guidelines; and as part of this process, develop targeting criteria for implementation and thresholds related to ANC/PNC/YCC participation and facility delivery, and stunting and LBW rates that trigger phase-over to the MoH.
- The CO should collaborate with UNICEF<sup>117</sup> to ensure that if areas are selected for micronutrient powder (MNP) distribution in Karamoja they do not overlap with MCHN sites where children are provided SC+ to avoid double fortification.
- With the MoH, pilot the integration of the MCHN program with Outreach Clinics to expand coverage and reach underserved areas. Consider adding a community-based MCHN approach and jointly piloting this with UNICEF.
  - ▶ Timeframe: Start in 2016 and continue through 2017
  - ▶ Responsibility: CO Nutrition/Program Unit and RB

R3. The CO nutrition unit and the WFP Karamoja Area office should increase their nutrition staff and also build capacity of other staff in nutrition monitoring to improve MCHN and CBSFP effectiveness and impact through the following:

- At the Karamoja region level, a nutritionist with a strong background in program monitoring and quality is needed to train and supervise the nutrition focal points in each district, the MoH regional nutritionist and CPs so that data quality is improved and maintained.
- The WFP Karamoja nutritionist should report to the head of the Area office with technical supervision from the CO Nutrition Unit; and in turn the Karamoja nutritionist should provide technical supervision and mentoring to the nutrition focal points and FMA and support the regional/district nutrition coordination structures and the MoH regional nutritionist.

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<sup>117</sup> It is the ET's understanding that UNICEF has received funds to conduct a MNP feasibility study in Karamoja and in other areas of Uganda, WFP, UNICEF, MoH and the USAID SPRING project have collaborated on carrying out the feasibility research and introducing MNPs.

- The CO nutrition unit needs to strengthen its capacity and numbers in order to devote more staff time to Karamoja nutrition program monitoring and WFP/MoH/CP staff training and mentoring to improve the quality of data and functioning of the MCHN and CBSF programs.
  - ▶ Timeframe: Start in 2016 as soon as possible and continue through 2017
  - ▶ Responsibility: CO Nutrition/Program Unit and Karamoja Area Office

R4. With the support of the MoH, the CO Nutrition and AME Units should improve the quality of MCHN and CBSFP reporting and increase the program indicators tracked in order to enhance the data available to guide programming. This should be accomplished through the following:

- Streamline the MCHN monthly reporting form so that it is less duplicative of other MoH/HMIS reports.
- For both programs design and implement plans for improving the quality of data collected. CBSFP is further along in this regard, however, an actual plan along with training and support materials is needed for both programs.
- Add a relapse indicator (already included in ProMIS) and crude mortality and SAM prevalence data (collected in the FSNA) to the CBSFP log frame<sup>118</sup>. For the MCHN log frame, coverage data for PLW should be added<sup>119</sup> and the ANC/PNC and place of delivery data collected needs to be analysed and reported bi-annually and added to the log frame<sup>120</sup>.
  - ▶ Timeframe: Start in 2016 and continue through 2017
  - ▶ Responsibility: CO Nutrition and AME Units

R5. In collaboration with the MoH, the CO logistics Unit and Karamoja Sub offices logisticians/warehouse store keepers should work together to improve Food Storage and Management.<sup>121</sup>

- The systematic delivery of reduced rations observed should be immediately investigated. A number of measures related to accountability should be implemented: signage with pictures of foods and ration sizes, food measurement tools and gloves, a beneficiary complaint mechanism and more frequent/rigorous monitoring of food distributions, including unannounced observation and regular review of registers.
- Moving toward cash transfers and fewer commodities will decrease space needed to store food, however, an assessment is needed to determine how food accountability, management and storage can be improved.
  - ▶ Timeframe: Start immediately and continue through 2017
  - ▶ Responsibility: CO Logistics Unit and Sub-office logisticians

R6. The importance of improving of improving nutrition education and counselling (NEC) cannot be emphasized enough. The CO Nutrition Unit and MoH staff with support from the

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<sup>118</sup>Consider adding a 'length of stay' indicator once the data quality is improved.

<sup>119</sup> This could easily be done through adding a question to the FSNA.

<sup>120</sup> Adding LBW and stunting indicators to the log frame should occur after the program is securely funded and food distributions occur regularly, however, continuing to report and share this data (as it is already collected) with the MoH is recommended.

<sup>121</sup> If CBSFP recommendations related to beneficiaries group and changing the specialized food product for PLW are implemented along with changing the MCHN modality for PLW to cash, the nutrition program food commodities will be limited to SC+ and RUSF (or similar product), simplifying program logistics as well as food storage and management.

RB should improve the quality of NEC in MCHN/CBSFP to enhance program impact through:

- Collaboration with UNICEF and other nutrition partners, review the available nutrition curricula and materials (groups and individual counselling) and select, adapt and/or develop a nutrition and health nutrition education (group) and counselling (individual) curricula for MCHN and one for CBSFP.<sup>122</sup> Visual aids and counselling tools to use during sessions should also be sought.
- Train CP and MoH staff on the curricula; and presentation and counselling skills.
- Strategize with CPs, MoH, community leaders, VHT and others involved in Karamoja nutrition programming to design approaches, building on the success of others<sup>123</sup> to reach the husbands and fathers of MCHN and CBSFP beneficiaries.
  - ▶ Timeframe: Start in 2016 and continue through 2017
  - ▶ Responsibility: CO Nutrition Unit and RB

R7. The CO Nutrition Unit with support from the CO Gender Advisor and RB should develop and integrate more of a gender focus in the nutrition programs with the objective of reaching more boys and men to enhance program effectiveness through:

- More sensitization of men on gender issues, and in particular, promoting sharing of household chores and child feeding and communication of men's role in caring for their wives and children and ensuring their good health, including nutrition.
- Given the higher level of undernutrition among young boys, an assessment to determine why their participation in CBSFP is lower than girls is warranted. Following this, the recommendations of the assessment should be implemented.
  - ▶ Timeframe: Start in 2017 and continue through 2018
  - ▶ Responsibility: CO Nutrition Unit, Gender Advisor and RB

R8. Considering the high levels of stunting and acute malnutrition, in addition to the MCHN program other preventive nutrition programs are called for. The CO should advocate for an integrated multi-sectoral nutrition approach<sup>124</sup> and given its food security mandate and the fact that food insecurity is one of the main drivers of acute malnutrition in Karamoja, it should strengthen the overlap and referral of MCHN/CBSFP beneficiaries and food security/livelihoods programs through:

- As currently underway with UNICEF, make WFP's public works programs nutrition "sensitive" and extend this beyond delivering nutrition messages to beneficiaries. Include an assessment of households with PLW and children under 2 to understand their needs and to adapt the "work activities" offered to attract beneficiaries in ways that enhance child care and nutrition.<sup>125</sup> Once this has been done, extend these same efforts to WFP's other Karamoja programs and ensure participation of WFP nutrition program beneficiaries in WFP's complementary programs.

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<sup>122</sup> It is envisioned that there would be significant overlap between the two, however, the CBSFP curricula would focus more on practical skills, approaches and recipes to address acute malnutrition and prevent it and the MCHN one would focus more on nutrition for pregnancy, lactation and IYCF.

<sup>123</sup> Such as, MC who recently started a media campaign to reach fathers and has some initial positive results and CWW's project involving men that has shown promising results. CPs use of dramas groups could also be reviewed and the results of male involvement Mother's/Family Support Groups could be tracked.

<sup>124</sup>This is also a conclusion of the UNICEF Karamoja nutrition review (2015).

<sup>125</sup> Examples, such as, making simple household tools to support improved hygiene (e.g. dish drying racks, tippy taps for hand washing), and make attending screening and health visits and nutrition education sessions part of the required work, etc.

- Through coordination structures and other mechanisms engage with partners to strengthen the complementarity of WFP programs with others programs.
- With nutrition coordination partners/structures, use WFP program data and that from other organizations (and/or link with other mapping activities) to develop effective systems of referral between MCHN, SFP and OTC/ITC and other programs, such as, sanitation and hygiene and literacy and other nutrition programs.
  - ▶ Timeframe: Already started in 2016 and continue through 2018
  - ▶ Responsibility: CO Nutrition and SNR Units and UNICEF