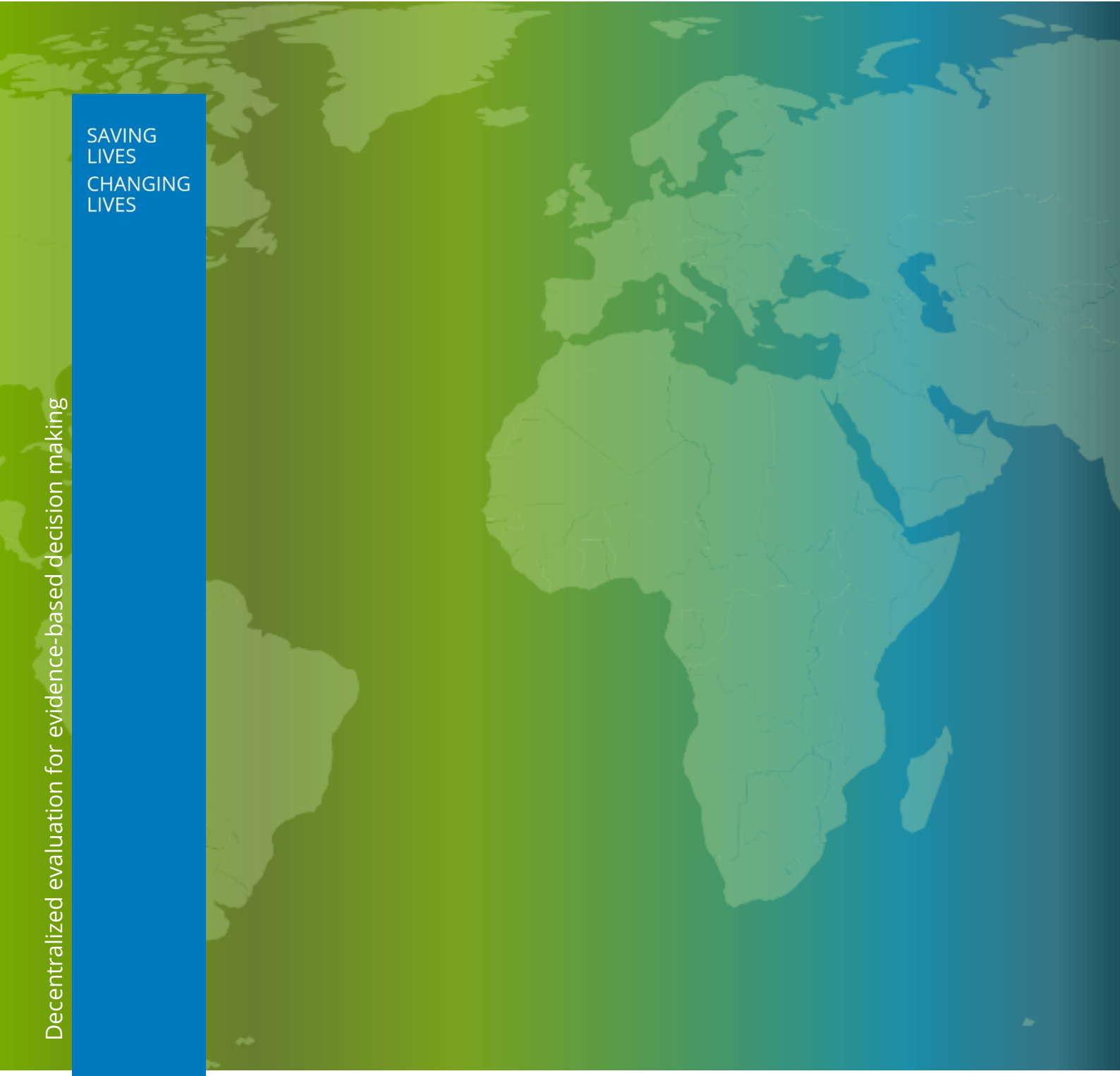

SAVING LIVES
CHANGING LIVES

Decentralized evaluation for evidence-based decision making

Decentralized Evaluation

Evaluation of the Intervention for the Treatment of Moderate Acute Malnutrition in Ngozi, Kirundo, Cankuzo and Rutana

2016–2019

Final Report, 22 May 2020
WFP Burundi
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WFP
World Food Programme

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Executive Summary

Subject of the Evaluation

E1. This evaluation, commissioned by the World Food Programme (WFP) country office in Burundi, took place from September 2019 to May 2020. The evaluation covered the Moderate Acute Malnutrition (MAM) treatment program implemented in the provinces of Ngozi, Kirundo, Cankuzo and Rutana during the period 2016 to 2019 to benefit children under five years of age and pregnant and lactating women (PLW). The evaluation was conducted in order to achieve the two objectives of *Accountability* and *Learning*.

E2. The intended users of this evaluation include WFP, UNICEF, WHO and other UN agencies, the donor Food for Peace (FFP), the Government of Burundi and national and international non-governmental organizations (NGOs) involved in the prevention and treatment of different forms of malnutrition in the country.

Background

E3. Burundi is a country in the East Africa Region, ranking 185 out of 189 on the 2019 Human Development Index. With an estimated population of 11.7 million in 2017, Burundi has the second-highest population density in sub-Saharan Africa, with more than 400 inhabitants per square kilometer. More than 65 percent of the population live below the national poverty line estimated at $1.90 per day.

E4. The prevalence of global acute malnutrition (GAM) ranges between 5 and 8 percent, with pockets of prevalence above 10 percent in some localities. In the provinces of Cankuzo, Kirundo, Ngozi and Rutana, the prevalence of MAM is 4.9, 5.2, 3.4 and 4.3 percent respectively. Globally, the country has the highest level of chronic malnutrition, with a current prevalence rate of 56 percent.

E5. Although the ratio of boys to girls at the primary level is equal to 1, the school dropout rate is higher for girls than boys, partly due to pregnancies that began during schooling. Approximately 16 percent of women of childbearing age have Chronic Energy Deficiency (CED), with adolescent girls aged 15–19 and women aged 40–49 slightly more likely to be affected. Despite progress in women's political participation in the country, gender inequalities remain significant. These gender disparities affect household food security in Burundi.

E6. The Government of Burundi's efforts to find long-term solutions to the problems of food and nutrition insecurity in the country are reflected in the availability of relevant policies, adherence to international initiatives such as the Scale Up Nutrition (SUN) movement, and the fight against poverty.

E7. As WFP's long-term vision in Burundi is to support the government's efforts to achieve the Sustainable Development Goals, the organization aims to reshape the food system in Burundi by promoting a multisectoral and systemic approach to food access and utilization. The UN family, international and national NGOs and government agencies are collaborating to implement a comprehensive package of nutrition interventions and to strengthen government capacity in nutrition.

Methodology

E8. The evaluation was designed to assess the MAM treatment program according to the following evaluation criteria: relevance, coherence, effectiveness, efficiency, impact, sustainability. Evaluation questions were developed under each of these criteria. It followed the United Nations Evaluation Group (UNEG) codes of conduct, ethics guide, guidelines, norms and standards, and specifically integrated human rights, gender and equity under each evaluation criterion and question, as well as data collection tools.

E9. In order to answer these questions, the evaluation team used a combination of qualitative and quantitative methods to triangulate the information obtained through (1) literature review and quantitative secondary data analysis and (2) qualitative primary data collection using three techniques: (a) semi- structured individual interviews with key informants; (b) focus group discussions (FGDs); and (c) direct observation of MAM processing operations.

E10. *Secondary quantitative data* collection was conducted in 20 randomly selected health centers (simple random sampling) in Ngozi and Rutana provinces, while *primary qualitative data* collection took place in the four provinces in eight health centers selected using a purposive sampling approach. Quantitative data collection was conducted in two of the four provinces, owing to the limited budget of the evaluation. However, the quantitative data collected from the 20 health centers in these two provinces was sufficient to make pertinent conclusions and recommendations for the evaluation. Data collection took place from 15 to 31 January 2020 in the four provinces.

E11. Limitations included the unavailability of data disaggregated by sex, age group and locality, as well as the absence of data on prevention and screening activities, but steps have been taken to mitigate these to the extent possible, including conducting analyses on aggregate data, and considering qualitative data only in the absence of quantitative data.

Key Results

E12. The key findings of the evaluation team are summarized below, structured according to the evaluation criteria, and indicating the type and reliability of evidence supporting each finding.

Evaluation Criterion 1 – Relevance

E13. The MAM treatment program meets the government's priorities and the expectations of recipients. It is implemented in accordance with national policies and protocols. However, with the significant reduction in the prevalence of acute malnutrition and the continued high prevalence of chronic malnutrition, it is important to combine the treatment of MAM with prevention interventions, in order to optimize the results in regard to stunting in the country. Other categories of beneficiaries such as the physically and mentally disabled, orphans and street children should be taken care of by the program (as part of social protection, for example), since they are also among the most vulnerable groups in society. The current implementation modalities of the program (which mean that beneficiaries spend most of the day at the health centers on the day of distribution) constitute a security risk for some PLW and mothers of children.

Evaluation Criterion 2 – Coherence

E14. There is a lack of close coordination among donors and different sectors in the planning and implementation of nutrition-sensitive interventions. The continuum of care from severe acute malnutrition (SAM) to MAM, and from centers for nutritional rehabilitation and learning (FARN)[1] to Supplementary Feeding Programmes (SFP) is taking place in all four provinces, as is the continuity between treatment and prevention activities in Kirundo and Ngozi provinces, thanks to collaboration between WFP, UNICEF and NGOs supporting community-based prevention activities.

Evaluation Criterion 3 – Effectiveness

E15. The geographical coverage of the program is 100 percent in the four provinces. Apart from in 2016, when admissions were low as a result of the slow start of the program, admission rates were as expected or even exceeded expectations, in particular in 2017. There was consistency between the increase in the number of children and PLW admitted to the program and the quantities of PlumpySup and Corn Soya Blend (CSB)++ distributed over time. There was also a seasonal annual variation in admissions, with peaks in admissions corresponding to peaks in childhood diseases and the lean season in Cankuzo, Ngozi and Rutana provinces. The median length of stay of children admitted to the program until recovery was six weeks. For all provinces, the performance indicator scores were above the standard requirements of Burundi's national protocol for the management of malnutrition (cure rate >70 percent, death rate <3 percent, default rate <15 percent), which endorses the program's effectiveness. Analysis of the data, however, revealed some data quality issues that need to be taken into account when interpreting the program effectiveness data. The availability of nutritional supplements presented a significant incentive for beneficiaries. However, unexpected negative consequences included close pregnancies (Kirundo province) and family sharing of food supplements, as well as illicit sales of these supplements. Irregular monitoring and supervision of program activities resulted in poor-

[1] Foyers d'apprentissage et de réhabilitation nutritionnelle

quality of service delivery, which affected the upkeep of the CMAM (community-based management of acute malnutrition) registration books and the individual record cards, and the reliability of the data transmitted.

Evaluation Criterion 4 – Efficiency

E16. The time lapse between the ordering and delivery of the food supplements was approximately six months. This long period delayed the start of treatment of beneficiaries admitted to the program. The "non-involvement" of government health workers in the estimation of nutritional supplement needs led to a lack of consideration of local factors, resulting in higher than expected admissions, as observed in 2017. The key causes of stock-outs include the insufficient storage capacity of health centers as well as the fact that the number of beneficiaries exceeded expectations, the illicit sale of food supplements and the admission of SAM cases into the MAM treatment program (admissions criteria were not always observed). Operational costs related to dietary supplements represented the largest item of expenditure (67.4 percent) of the MAM treatment program in Burundi during the period 2016 to 2019. Based on the calculations made by the evaluation team from the database provided by WFP, the average cost per beneficiary admitted was USD 24, and the cost per beneficiary cured was USD 26. Using the national supply chain or purchasing food supplements produced in neighboring countries would have made it possible to reduce the costs of the program and treat a larger number of beneficiaries.

Evaluation Criterion 5 – Impact

E17. The intertwining of the MAM treatment program and prevention interventions has reduced the prevalence of acute malnutrition in Kirundo province and kept it at a low rate. The inclusion of men as recipients of awareness-raising messages has increased their understanding of the importance of their role in family nutrition and of the support they need to provide to their pregnant and breastfeeding wives and children. Program planning was not conducted collaboratively, which was unconducive to government ownership of the program. Government capacity needs to be strengthened at the national, province and district levels for the design of, and budget-allocation and fundraising/mobilization for the MAM treatment program and other nutrition programs in general.

Evaluation Criterion 6 – Sustainability

E18. With the exception of the health information system, the integration of the MAM treatment program into Burundi's health system is generally incomplete. Major efforts still need to be made in terms of financial ownership of the program by government authorities; much effort also needs to go into the strengthening of the national supply chain of the Burundi medicine purchasing center (CAMEBU). Building the capacity of the multisectoral nutrition platform is important in order to sustain the achievements of the program, both at the institutional and the community levels. Thanks to the awareness-raising messages received, mothers of children under five years of age and the PLW have made positive changes to the eating habits in their households, despite the financial difficulties they experience in obtaining all the necessary foods for preparing balanced meals.

General Conclusions

E19. In response to the *first evaluation criterion*, the evaluation team concluded that the MAM treatment program remains relevant in the context of Burundi. Combining the MAM treatment program with preventive actions is crucial for a long-term effect on the target populations. The current arrangements for implementing the program (with beneficiaries having to spend most of the day at the health center on the day of distribution) constitute a security risk for certain PLW and mothers of children.

E20. In response to the *second evaluation criterion*, the evaluation team concluded that the program is coherent with other nutrition-specific interventions implemented in the four provinces through collaboration between WFP, UNICEF and NGOs addressing acute malnutrition. However, coordination with nutrition-sensitive sectors during the planning and implementation phase remains insufficient.

E21. In response to the *third evaluation criterion*, the evaluation team concluded that adequate geographical coverage of the program within the four provinces facilitated access to services. The good collaboration between WFP, UNICEF and NGOs supporting community-based prevention activities could facilitate access to the continuum of care from SAM to MAM, and from treatment of MAM to prevention interventions. Despite weaknesses related to admission errors and stock-outs of food supplements, the program's performance was good in all four provinces.

E22. In response to *the fourth evaluation criterion*, the evaluation team concluded that more careful planning of the ordering and delivery of the nutritional supplements could have improved the efficiency of the program, including its close integration with other nutrition-specific and nutrition-sensitive programs. Also, purchasing nutritional supplements produced in neighboring countries would have made it possible to lower the costs of the program and to support a larger number of beneficiaries.

E23. In response to the *fifth evaluation criterion*, the evaluation team concluded that the joint implementation of the MAM treatment program and prevention interventions produces better effects. The inclusion of gender components during program implementation, including raising the awareness of fathers of children under five years of age and husbands of PLW admitted to the program, has produced positive outcomes regarding the recognition of their importance in relation to family nutrition.

E24. In response to the *sixth evaluation criterion*, the evaluation team concluded that WFP has partially integrated the MAM treatment program into the health system in Burundi, with the exception of the health information system. The limited financial means of families is an obstacle in terms of access to the local market for the important foods that must be consumed to prevent malnutrition in the household.

Recommendations

E25. The findings and conclusions of this evaluation led the evaluation team to make the following recommendations:

Recommendation 1: *Strengthen the capacity of government authorities (*Ministry of Health and other key ministries) in planning, implementation and coordination.

Recommendation 2: *Conduct regular joint supervision* in order to strengthen the capacities of the health center officials and SFP managers for the proper application of the national protocol, and the improvement of the quality of services and the monthly data reporting.

Recommendation 3: *Systematically integrate gender and women's empowerment aspects into program monitoring activities and tools.*

Recommendation 4: *Review the process of service delivery in health centers* to reduce the workload of health center officials and SFP managers on distribution days and thus minimize the risk of violence against women.

Recommendation 5: *Study the possibility of applying a simplified protocol for the management of acute malnutrition* in the context of Burundi, in order to overcome difficulties in operationalizing the program, such as dilution and diversion (related to erroneous admissions and shortages of nutritional supplements), and weaknesses in the continuum of care between SAM and MAM.

Recommendation 6: *Develop and implement joint programs* to optimize long-term outcomes and prevent malnutrition.

1. Introduction

1. The program for the treatment of moderate acute malnutrition that is the subject of this evaluation was approved in early 2016 with funding from the United States Agency for International Development (USAID)/Food for Peace (FFP) for the provinces of Ngozi, Kirundo, Cankuzo and Rutana, for a period of four years (April 2016 to March 2019). The objective of this program was to improve the nutritional status of children under five years of age and pregnant and lactating women (PLW). As the funding had come to an end, the evaluation was conducted, in order to achieve the following two objectives:

a) ***Accountability*** – to report on all the results (planned and unplanned) that have been achieved by the program, to provide USAID/FFP with evidence of the relevance and effectiveness of moderate acute malnutrition (MAM) treatment for operational and strategic decision-making purposes;

b) ***Learning*** – to determine the reasons why some results have or have not been achieved, including aspects of gender equality, equity and women's empowerment, in order to extract lessons, good practices and recommendations for learning; consequently, to deliver evidence-based findings to inform operational and strategic decision-making. The findings will be actively disseminated, and the lessons incorporated into relevant lesson-sharing systems.

2. This is an activity evaluation commissioned by the World Food Programme (WFP) country office in Burundi, which took place from September 2019 to May 2020.

3. Stakeholders in the evaluation include WFP, the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the Food and Agriculture Organization of the United Nations (FAO), Scaling Up Nutrition (SUN), Burundi's Ministry of Health through the National Integrated Food and Nutrition Program (PRONIANUT), health provinces and districts and health workers engaged in health centers. Other stakeholders include Burundi's Ministry of Finance, non-governmental organizations (NGOs) such as World Vision, Concern Worldwide, Welthungerhilfe, Caritas Burundi and the Burundi Red Cross. At the community level, stakeholders include community leaders and the direct beneficiaries of the program. A detailed description of the role of each stakeholder, their involvement in the process of this evaluation and the potential use of the findings and recommendations can be found in Appendix 6.

4. The intended users of this evaluation include the WFP, UNICEF, the WHO (and other UN agencies as relevant), the donor (USAID/FFP), the Government of Burundi, and national and international NGOs involved in the prevention and treatment of different forms of malnutrition in the country.

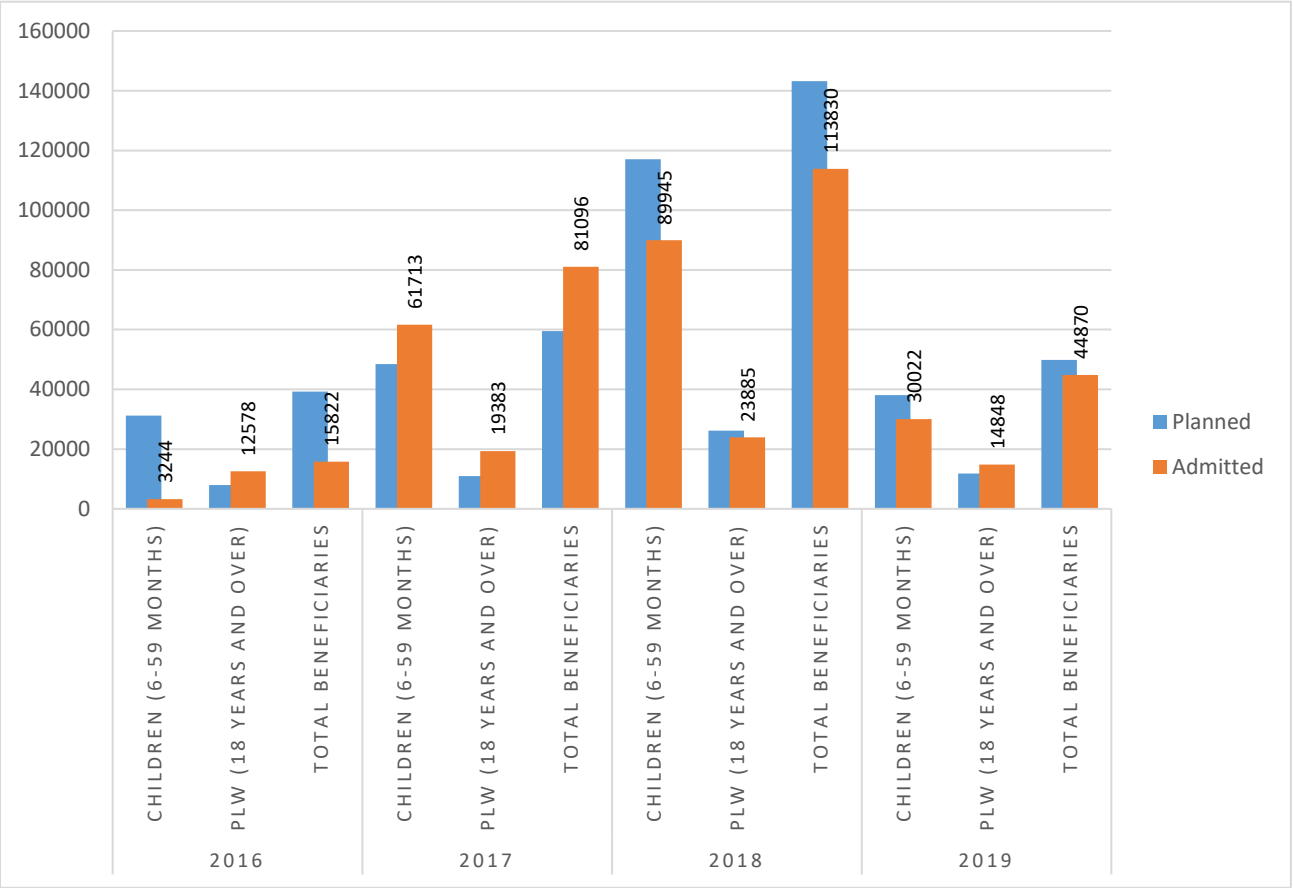
1.1 Evaluation Overview

5. The evaluation covered the MAM treatment program implemented in the four provinces mentioned above during the period 2016 to 2019 for children under five years of age and PLW, determined in accordance with the National Protocol for Integrated Management of Acute Malnutrition validated in October 2014 and revised in 2019 (PRONIANUT 2019). Other indirect beneficiaries include the parents (women and men) of children under five years of age and the spouses of the PLW admitted, as they are exposed to the awareness-raising messages delivered during the implementation of the program, as well as care providers in health structures and the community.

6. The evaluation took place in the four provinces where the MAM treatment program is being implemented, as well as in the capital city, Bujumbura (see map of intervention areas in Appendix 2).

7. Figure 1 shows trends in total admissions to the program versus planned admissions. It shows that in 2017, the program covered a higher number of beneficiaries than planned.

Figure 1. Expected versus actual beneficiaries, 2016–2019



8. Important partners in the implementation of the MAM treatment program include the WFP and the Ministry of Health, through its decentralized structures (health provinces, health districts, health centers and community health workers). Collaboration between the WFP and PRONIANUT ensures a widespread presence in the four provinces of intervention.

9. The total project budget provided by FFP for all WFP Burundi programs under an annual grant was USD47,923,099 for the four years of support (2016 to 2019). Table 1 below disaggregates the budget by year. Specifically, for the MAM treatment program in the four provinces, the amount of funding increased over the years, from USD737,430 in 2016 to USD3,627,044 in 2019, for a total of USD6,948,795 for the four years, representing 14.5 percent of the total FFP grant.

Table 1. Annual grant from the Food for Peace Fund (FFP), 2016–2019

	2016	2017	2018	2019	Total
Amount (USD)	8,000000	12,697,577	13,935,000	13,290,522	**47,923,099**
MAM treatment (USD)	737,430	747,447	1,836,874	3,627,044	**6,948,795**
% MAM treatment	9.2	5.9	13.2	27.3	**14.5**

10. No evaluation of the MAM treatment program, prior to this evaluation, has been conducted in the Burundi context.

1.2 Background

11. Burundi is a country in the East Africa Region, ranking 185 out of 189 on the Human Development Index (UNDP 2019). With an estimated population of 11.7 million in 2017, the country

has the second-highest population density in sub-Saharan Africa, with more than 400 inhabitants per square kilometer. More than 65 percent of the population lives below the national poverty line estimated at USD1.90 per day, while more than 90 percent of the population depend on agriculture as their main source of income (FAO et al 2018; WFP 2019a).

12. In Burundi the prevalence of global acute malnutrition (GAM) varies between 5 and 8 percent, with pockets of GAM prevalence above 10 percent in some localities. In the provinces of Cankuzo, Kirundo, Ngozi and Rutana, the prevalence of GAM is 4.9, 5.2, 3.4 and 4.3 percent respectively. Globally, the country has the highest level of chronic malnutrition, with a current prevalence rate of 56 percent. According to the Demographic and Health Survey, the prevalence of stunting is over 50 percent in almost all 18 provinces, with the exception of Bujumbura, Bururi and Rutana City Hall; some north-eastern provinces exceed 60 percent. The prevalence of anemia in children aged 6–59 months is over 60 percent, exceeding the WHO emergency threshold of 40 percent (EDS 2016/2017).

13. Factors that contribute directly to undernutrition in Burundi include a high prevalence of infectious diseases, a lack of dietary diversity and poor hygiene. Underlying factors include inadequate access to safe drinking water and to health and education services, and food insecurity. Added to this is the pressure on the country's limited resources caused by hosting in already food-insecure areas more than 50,000 refugees, mainly from the Democratic Republic of Congo, who depend on humanitarian assistance for basic food and nutrition. Fundamental factors include poverty, high population density and the continued influx of returnees and refugees, which contribute to competition for access to limited natural resources. Other external factors include drought, floods, landslides (due to environmental degradation) and high food prices at certain times of the year. The effects are more pronounced in the north of the country, particularly in Kirundo province, resulting in a longer lean season and regular displacement of people to neighboring Rwanda to carry out temporary work to meet their food and nutrition needs, and to return to Burundi when the climate becomes favorable again (UNICEF 2013).

14. In addition, Burundi has been faced with a humanitarian crisis in which economic recession, extreme food insecurity and a malaria epidemic have coincided, aggravated by the political instability the country experienced in 2015. The country is currently experiencing a certain lull, but the economic and social situation remains difficult for the majority of the population, particularly for internally displaced persons and refugees who are gradually returning to their places of origin (UNHCR 2019).

15. According to the results of the third Demographic and Health Survey, conducted in 2016–2017, men were generally better educated than women in Burundi. The proportion of individuals with no education were higher among women than among men (36 percent versus 24 percent). Similarly, a higher proportion of men than women had secondary or higher education (30 percent of men versus 25 percent of women) (EDS 2016/2017). Although the boy–girl ratio at the primary level is now equal to 1, the school dropout rate is higher for girls than boys, in part because of pregnancies which began during schooling (MSP 2013). Approximately 16 percent of women of childbearing age have chronic energy deficiency (CED), with adolescent girls aged 15–19 and women aged 40–49 slightly more likely to have CED than other women (USAID 2017a).

16. Progress in women's political participation has been recorded in recent years, with women holding 32 percent of seats in the National Assembly, 42 percent in the Senate, and 33.6 percent of posts at the province level and 16 percent at the commune level. Despite this, gender inequalities remain significant, with sexual and gender-based violence representing 13 percent of violence committed against women compared to 2 percent in the case of men in 2016, and the country ranks 108th on the gender inequality index (PNUD 2016). Gender roles are linked to a strong patriarchal culture in the country. Culturally, men head households, embody household authority, make important decisions and provide livelihoods for household members. Although women play a major role in the national economy and account for 55.2 percent of the labor force – particularly in the agricultural sector, which provides 90 percent of the country's food and exports – men control the distribution of resources at household level. Money earned by men sometimes does not reach other household members. They do not share it equally with women, nor do they prioritize pregnant women and children (PAM 2018a). The situation becomes more precarious for widows, single mothers, divorcees, returnees and female heads of households, as these groups are particularly vulnerable to

loss of assets and other forms of discrimination. Polygamy and cohabitation also result in the abandonment of previous or subsequent partners, and women who become widows are more likely to lose their land, because of expropriation by in-laws. With no control over resources, most Burundian women live in conditions of extreme poverty (Concern Worldwide 2019). These gender disparities affect household food security in the country.

17. The efforts made by the Government of Burundi to find long-term solutions to the problems of food and nutrition insecurity in the country are reflected in the availability of relevant policies such as the National Development Plan – Burundi Vision 2025 (UNDP 2011) and the Agricultural Investment Plan (2012–2017) (MINAGRIE 2011). The Government has also joined international initiatives such as the Scale Up Nutrition (SUN) movement and has made great efforts to address poverty-related challenges with the support of donors. For example, in 2017, Burundi received approximately USD 545 million of assistance for the fight against poverty from various bilateral and multilateral partners, such as the United States of America, the European Union, the Global Fund, the International Development Association, Germany, the Netherlands, the African Development Fund, and the Global Alliance for Vaccination. Approximately 21 percent of these funds were for humanitarian aid (OECD 2018).

18. WFP's long-term vision in Burundi is to support the government's efforts to achieve Sustainable Development Goal (SDG) 2: end hunger, achieve food security and improve nutrition by 2030. Therefore, WFP's objective is to reshape the food system in Burundi by promoting a multisectoral and systemic approach to food access and utilization. The country's overall strategy is aligned with national food and nutrition security policies and tools, as well as with the United Nations Development Assistance Framework (UNDAF) for 2018–2022.

19. The United Nations family (UNICEF, WFP, WHO, FAO and the International Fund for Agricultural Development – IFAD), international and national NGOs and government agencies are working together to implement a comprehensive package of nutrition interventions, including the treatment of severe acute malnutrition (SAM) and MAM, the prevention of undernutrition, food fortification, the Human Immunodeficiency Virus (HIV) program and the strengthening of government capacity in nutrition.

20. WFP and UNICEF are working together to combat malnutrition in the country. Based on the national protocol, UNICEF provides SAM treatment to children aged 6–59 months, while WFP provides SAM treatment to children in the same age group and PLW. WFP is also implementing a food fortification program to prevent micronutrient deficiencies in children aged 6–23 months. In partnership with local NGOs, UNICEF and WFP are also implementing preventive actions against chronic malnutrition.

1.3 Evaluation Methodology and Limitations

21. The evaluation adopted a "theory-driven evaluation" approach to analyze the complexity of the MAM treatment program from a systems perspective (Chen HT 2012; Rogers PJ 2008). The evaluation team analyzed the theory and objectives of the overall WFP project funded by FFP, including Strategic Objective 2 (Improving Nutrition), and specifically Strategic Outcome 3, which states that "children aged 6–59 months, adolescent girls, pregnant and lactating women and girls living in targeted provinces and communes improved their nutritional status during the year" (WFP 2019b). The underlying assumptions were explored through individual interviews with key informants during the inception mission to develop a simplified theory of change model that links investments (inputs) to the expected activities, outputs, outcomes and impact on the target population in the four provinces, as well as the different actors, mechanisms and contextual conditions that the program influenced (Vogel I 2012). This model is presented in Appendix 4. The theory of change guided the development of the evaluation matrix (Appendix 3) and the identification of different indicators to measure the changes or results that occurred in the medium and long term.

22. The evaluation was conducted according to the evaluation criteria laid out by the Organisation for Economic Co-operation and Development (OECD), including relevance, coherence, efficiency, effectiveness, impact and sustainability (OCDE/CAD 2019). Gender, equity and human rights elements have also been specifically integrated under each criterion and evaluation question (UNEG 2014). These six criteria were chosen in order to comprehensively and systematically assess the MAM treatment program in Burundi and to provide conclusions and recommendations that are realistic and reflect a good understanding of its planning and implementation. Indeed, although the USAID/FFP-funded MAM treatment measures were not based on an initial analysis of gender and protection, the evaluation team explored gender issues such as the participation of women and men in program implementation, men's participation in decision-making on household nutrition, the effects of the program on the food and nutrition of children under five (girls and boys) and PLW, women's decision-making power on household food and nutrition, and men's participation in household food and nutrition. The evaluation also verified whether fathers of children and husbands/spouses of PLW admitted to the program were indirectly considered through their exposure to awareness-raising activities. The evaluation integrated gender issues at all stages, to ensure that men, the most vulnerable households and female-headed households were adequately considered. Gender was also taken into account during the formulation of the evaluation's conclusions and recommendations.

Definition of the criteria used in this evaluation

Relevance: The extent to which the objectives and design of the intervention correspond to the needs, policies and priorities of the beneficiaries, the country, the international community and partners/institutions and remain relevant even if the context changes.

Coherence: The extent to which the intervention is coherent with other interventions within the country, sector or institution.

Effectiveness: The extent to which the objectives and results of the intervention have been, or are being, achieved.

Efficiency: The extent to which the intervention produces, or is likely to produce, results in a cost-effective and timely manner.

Impact: The extent to which the intervention has produced, or is expected to produce, significant and wide-ranging effects, positive or negative, intended or unintended.

Sustainability: The extent to which the net benefits of the intervention will continue or are likely to continue.

Source: OCDE/CAD 2019

23. The Terms of Reference listed the issues to be considered under each evaluation criterion (WFP 2019a). These questions were reviewed and supplemented by sub-questions developed by the evaluation team following the document review and individual interviews conducted with key stakeholders during the inception mission to Burundi from 22 to 24 October 2019. These adjustments made it possible to develop the evaluation matrix and data collection tools (see Appendix 3 and Appendix 8). This matrix presents the evaluation criteria, main questions and sub-questions, rationale, chain of reasoning, verification hypotheses, indicators, sources of information and data collection techniques. The main evaluation questions were accepted as proposed in the Terms of Reference (Appendix 1) with the exception of seven questions added by the evaluation team under the criteria of Relevance (Question 1.4), Coherence (Question 2.4), Effectiveness (Question 3.3), Efficiency (Questions 4.1 and 4.5), Impact (Question 5.3) and Sustainability (Question 6.3). The evaluation matrix guided the development of the data collection tools. It will also guide the data collection and analysis. The evaluation team refers to these to ensure that answers were provided to the questions developed under each evaluation criterion.

24. The evaluation team also used a participatory approach to ensure that the views and perspectives of all stakeholders were taken into account and that the findings were verified. Indeed, the evaluation findings, conclusions and recommendations were formulated with the aim of guiding decisions and actions to be taken by WFP and other users of the evaluation. These stakeholders were involved during the process as members of the evaluation committee and the evaluation reference group and, as such, participated in individual interviews during the collection of primary qualitative data and in the workshop on preliminary findings presented on 22 January 2020. In addition, the draft report underwent critical iterative processes between the evaluation team, WFP, the evaluation

committee and the evaluation reference group to have a collaborative discussion on the findings and to generate a common understanding of the conclusions and recommendations ("collaborative learning and adapting" approach) (USAID 2017b). The final report will be presented during a workshop to be organized by WFP in collaboration with key stakeholders in Burundi. This set of processes helped to strengthen the validity of the evaluation findings and conclusions.

25. In addition, the evaluation team adopted a "Realist Inquiry" approach during all stages of the process (Marchal et al 2012; Westhorp 2014).[2] In other words, the effectiveness and efficiency of the MAM treatment program were analyzed taking into account the socio-political, cultural and economic context in which the program activities were implemented in the four provinces and the country in general.

26. A mixed-methods approach to collecting quantitative and qualitative data was applied. The evaluation was both retrospective, to respond to accountability, and prospective, to respond to organizational learning. It followed the codes of conduct, ethics guide, guidelines, norms and standards of the United Nations Evaluation Group (UNEG). Information was obtained through (1) document and quantitative secondary data analysis and (2) qualitative primary data collection using three techniques: (a) semi- structured individual interviews with key informants; (b) focus group discussions (FGDs); and (c) direct observation of MAM processing operations. These different techniques are complementary in that the review of documents and secondary data assisted with the understanding of the programmatic context and the identification of indicators needed to assess the results, effects and impact of the program. The individual interviews enabled us to understand the experiences and perspectives of participants in relation to the various program activities and outcomes, while the FGDs helped to elicit the perceptions of service providers, opinion leaders, religious leaders, beneficiaries and community groups, in addition to assessing the "knowledge and skills" of parents of children under five years of age exposed to the program. Direct observations were useful in understanding the process and quality of MAM treatment activities in health facilities.

27. *Secondary quantitative data* collection was carried out in 20 health centers selected at random (simple random sampling) according to the LQAS (Lot Qualitative Assurance Sample) methodology in the provinces of Ngozi and Rutana.

28. The LQAS methodology was adopted by the sector in 1920 in order to verify the quality of lot batches before delivery. It has reinforced its reliability through the monitoring of large-scale production as well as by delivering rapid assessments of the coverage of health services in populations (Myatt et al 2012). Its use in this evaluation is in itself an innovation because it adapts a method recognized and used in other fields, the advantages of which (speed and low resources required for its implementation) are transferrable to the context of this evaluation.

29. The LQAS methodology recommends the selection of a random sample of 20 entities (health center, districts) from which to determine trends. These first elements of answers obtained quickly and at low cost facilitate decision-making and make it possible to evaluate the level of quality of an indicator. The LQAS does not allow representative percentages to be obtained, but from certain thresholds it is possible to determine whether an indicator has an unacceptable or acceptable level. A representative study with a confidence level of 95 percent and a margin of error of 2 percent would have required the collection of secondary data in 158 of the 168 health centers covered by the program, whereas the LQAS method requires just 20 health centers. The application of this methodology made it possible to evaluate the quality of the record-keeping in the health structures and their degree of concordance with the data in the databases shared by the partners (Appendix 9).

30. *Primary qualitative data* collection took place in the four provinces, in eight health centers selected using a purposive sampling approach (Palinkas et al 2015; Tongco 2007). The criteria for selecting the health centers were as follows: urban versus rural locality, easy accessibility or not, distance from the main referral health structure, good performance or not of the center in relation to national standards, provision of MAM and SAM services or MAM services without SAM (continuum

[2] Realist Inquiry is an evidence-based approach that goes beyond input–output oriented evaluation designs and seeks to uncover the mechanisms (underlying determinants and/or social behaviors) that influence (or not) the success of a policy, strategy or program.

of care). Appendix 7 presents the provinces, health districts, communes and health centers selected for the field visits for the collection of quantitative and qualitative data. Considering the number of activities carried out in each health center, this sample made it possible to reach saturation (Mason 2010) of data in the time allocated for field visits.

31. Data collection took place from 15 to 31 January 2020. The field collection process as well as the authorizations and connections made at the province, district and health center levels) was facilitated by WFP and PRONIANUT.

32. The team ensured that each stage of the evaluation was of high quality, based on evidence and causal links between project inputs, outputs and outcomes and informed by the Theory of Change Designed to Guide the Evaluation of MAM Treatment in the Provinces of Cankuzo, Kirundo, Ngozi, and Rutana in Burundi. The team equally ensured that international standards of evaluation procedure (OECD, UNEG and WFP's Decentralized Evaluation Quality Assurance System, DEQAS) were applied until the submission of the final deliverables.

33. A mixed-methods approach to the analysis of quantitative and qualitative data was applied, in addition to the triangulation of results for comparing the data obtained from various sources. Thus, for each analytical finding made, at least three data sources were used to confirm and verify the information collected. Investigators were trained on data collection methods and techniques. The collection tools were pre-tested and refined to ensure the fidelity and confidence of the data collected. The collection of quantitative data made it possible, on the one hand, to verify the quality of the record-keeping in the health facilities and, on the other hand, to compare the data in the health facilities with that contained in the databases.

34. Following pre-testing of the collection tools and during data analysis and reporting, the evaluation team made minor adjustments to the order of the evaluation questions:

a. Under the Relevance criterion, Question 1.3 became 1.1. Question 1.2 under the Relevance criterion was moved to the Efficiency criterion and merged with Question 4.1, as it dealt primarily with the timely achievement of program objectives, including logistics and adherence to delivery schedules for dietary supplements.

b. Question 2.2 under the Coherence criterion was moved up to the Relevance criterion and merged with Question 1.2, because together they addressed the suitability of the program for the needs of the beneficiaries and for the national protocol for the integrated treatment of acute malnutrition. Similarly, question of the Consistency criterion was moved up to the Relevance criterion and merged with Question 1.4 (now Question 1.3) because these two questions addressed the inclusion of gender issues in the program. Participants' responses to these two questions were redundant.

c. Question 6.3 of the Sustainability criterion has been deleted and merged with Question 5.3 of the Impact criterion for the same reasons as before.

35. An ethical visa was not required for the conduct of this evaluation. Nevertheless, the team ensured that ethical standards were respected at every stage of the process, including obtaining informed consent, ensuring confidentiality and anonymity of participants, respecting the culture and autonomy of participants, ensuring a fair selection system (including consideration of women and socially excluded groups),and coding direct identifiers (e.g. personal information such as name and address) during testing to ensure confidentiality. Members of the data collection team were briefed on the importance of confidentiality of the data reported and recorded. The conduct of the individual interviews and FGDs during the field visits had no adverse effects on participants, and the team did not encounter any ethical issues during the entire evaluation process.

36. Table 2 ci-dessous outlines the limitations of the evaluation and the actions taken by the team to mitigate them.

Table 2. Limitations of the evaluation with the measures taken to mitigate them

Limitations of the evaluation	Mitigation measures
Following a review of the databases provided to the evaluation team by WFP, it was noted that PLW admission data were not disaggregated by status (pregnant or lactating) and age. Disaggregation by age would have made it possible to estimate the proportion of adolescent girls among PLW, information that would have been relevant in formulating conclusions and recommendations specific to these sub-groups of beneficiaries.	The evaluation team explored the PRONIANUT and National Health Information Directorate databases to verify the existence of data on the age categories (15–17 years; >= 18 years) of the PLW. In the absence of these data, the team conducted aggregate analyses.
During the inception mission, interviews with the WFP country team in charge of WFP monitoring and evaluation informed us that WFP had initiated the collection of sex- and age-disaggregated data (6–23 months and 24–59 months) among children under five years of age admitted to the program only from January 2019 onwards.	The evaluation team explored the databases of PRONIANUT and the National Directorate of Health Information. In the absence of detailed disaggregated data, the team conducted aggregate analyses.
There was a lack of data on community-based prevention and screening activities (number of children screened, number of awareness sessions, number of cooking demonstration sessions for each health center, district or province).	We limited the scope of the analyses, as these activities could explain in more detail the observed variations in the number of admissions or the performance of the MAM treatment program. The analyses were limited to qualitative data.
The estimation of treatment coverage used indirect methods based on demographic data and the results of nutritional surveys. Since these two data sources have errors and a lack precision (e.g. the results of the nutritional survey will have 95 percent CI of +/- 1 to 2 percent), indirect estimates of coverage have very large confidence intervals. For example, in a population of 100,000 with a prevalence of GAM of 10 percent and a confidence interval of 2 percent, the total level of GAM could be 8,000 or 12,000. Therefore, if 6,000 children were in the program, the coverage could be 75 percent or 50 percent.	Although the interpretation of treatment coverage results used these indirect methods, the evaluation team made suggestions for methods that would /would have allowed program managers to better estimate program coverage in the future.
Financial data were not disaggregated by district and province and by type of beneficiary (child under five years old, pregnant woman, nursing woman).	The evaluation team disaggregated data by category of expenditure in the light of clarifications provided by the WFP team in charge of managing the program budget. However, it was not possible to disaggregate by province, district or type of beneficiary. The financial analysis was aggregated.

2. Results of the Evaluation

2.1 Evaluation Criterion 1 – Relevance

Question 1.1. To what extent is the intervention coherent with government needs and priorities and aligned with policies and protocols?

37. Children under five years of age and PLW are considered the most vulnerable populations affected by acute malnutrition. All national health and nutrition policies and strategies developed in Burundi emphasize these categories. Table 3 below presents a mapping of the different policies and plans in Burundi, as well as the links between these policies and maternal and child nutrition.

Table 3. Mapping of health policies/plans in Burundi and their links with nutrition

Policy/strategy	Year	Position of nutrition/aspects covered
National Social Protection Policy (2011)	2011	Ensure adequate *social protection* coverage for all.
National Gender Policy 2012–2025	2012	Contribute to the achievement of gender equity and equality through the establishment of a socio-cultural, legal, economic, political and institutional environment conducive to the *achievement of gender equality* in Burundi, as well as the effective integration of gender in development interventions in all sectors.
National Social Protection Strategy (2015)	2015	Increase access to basic social services in health, water and sanitation, and education; ensure *food and basic income security*; strengthen risk management (natural and social); contribute to a reduction in chronic malnutrition in young children.
National Health Policy 2016–2025	2016	Contribute to the reduction of the scale and severity of *priority diseases and health problems (including malnutrition);* improve the performance of the national health system and the community system; strengthen *intersectoral collaboration* for better health.
Burundi's Gender Action Plan	2017	Strengthen the engagement of women and men in affected populations; and support government capacities to *integrate a gender perspective and promote equal participation in food and nutrition security programs. Increase women's and girls' decision-making on food and nutrition security.*
Nutrition Strategic Plan 2019–2023	2019	Contribute to *reducing the prevalence of malnutrition in all its forms*; strengthen the *quality of outpatient and inpatient management of acute malnutrition*; scale up the management of malnutrition using the national PCIMA approach.

Multisectoral Strategic Plan for Food Security and Nutrition 2014–2017; 2019–2023	2014 2019	2014: Contribute to *improving the nutritional status of the Burundian population by reducing food insecurity and malnutrition. Reduce the prevalence of global acute malnutrition from 6 percent to 4 percent among children under 5 years of age.* 2019: Contribute to improving the *nutritional status of the Burundian population by significantly and equitably increasing the level of food security and nutrition. Improve access to nutritional services including the treatment of MAM.*
National Protocol for the Integrated Management of Acute Malnutrition 2014, 2019	2014, 2019	The treatment of MAM is part of this through the *Supplementary Feeding Programme (SFP).* The aim of SFP is to correct and prevent moderate acute malnutrition in target groups.

38. The MAM treatment program is therefore in line with all these policies and plans developed over several years in Burundi. Despite this, malnutrition remains a major public health problem in the country. According to the participants interviewed at the national level, the major current problem in Burundi is no longer acute malnutrition (which has been contained and whose prevalence has decreased significantly – to below 5 percent) but chronic malnutrition, whose prevalence is the highest in the world (54–56 percent), affecting one child in two in the country. Although the short-term mortality risks associated with chronic malnutrition are lower than those associated with acute malnutrition, the condition remains severe and is associated with lower life expectancy, lower levels of education and increased poverty. Therefore, while maintaining interventions to contain the acute form of malnutrition, it is important to increasingly combine specific approaches to nutrition (such as treatment of MAM) and nutrition-sensitive ones (preventive interventions), in order to optimize the results of the fight against malnutrition in the country in the long term.

39. To this end, WFP supported the development of the multisectoral nutrition strategy by recruiting a consultant who assisted the Government in the development of the plan. Another consultant, also recruited by WFP, is currently working on the development of the behavior change communication and community mobilization strategy. Other projects, such as the composition and delivery of a package of activities as a safety net for households, are being considered within the organization. The long-term objective of all these initiatives is to strengthen the capacity of households to cope with and withstand shocks, thereby helping to prevent malnutrition.[3]

40. The treatment of MAM is part of the package of activities of the country's health structures and is implemented in accordance with the national protocol for the integrated management of acute malnutrition under the coordination of the Ministry of Health, through PRONIANUT.

Question 1.2. To what extent did the treatment of MAM meet the needs of the most vulnerable people, in particular PLW, children and people with special needs?

41. As mentioned above, children under five years of age and PLW are among the most vulnerable categories of the population and are at high risk of morbidity and mortality due to malnutrition. Consequently, children suffering from MAM and acutely malnourished PLW receive nutritional supplements and awareness-raising messages to help them recover from their condition and to prevent relapse, in accordance with national and international protocols. The MAM treatment program is therefore appropriate to the needs of these beneficiaries.

[3] Nexus' approach currently advocated at the global level. WFP and UNICEF are reflecting on how to better address malnutrition, with a strong focus on prevention, supported by the Scale Up Nutrition (SUN) initiative. In the next 12 months, guidelines will be available for this purpose.

42. Parents of children under five years of age, PLW and Mentor Mothers[4] reported that the dietary supplements (PlumpySup and CSB++) used in the program were easy to store and use. Recipients had no difficulties with preparation and taste. In addition, no side effects were recorded as a result of consuming these products. The main difficulty mentioned was resale on the local market and sharing with the family (more details are provided in Section 2.3, Evaluation Criterion 3 – Effectiveness).

43. All the participants interviewed or who took part in the FGDs corroborated this opinion, but also expressed the view that other categories of beneficiaries such as the elderly, the physically and mentally disabled, orphans and street children should be taken care of by the WFP in the context of programs for social protection or school feeding because they are also part of the most vulnerable sections ofsociety.

Question 1.3. To what extent is the MAM treatment intervention coherent with national policies on gender, equity and women's empowerment, and how have these issues been taken into account in program design, implementation and monitoring?

44. The National Gender Policy 2012–2025 was developed in 2012 in the country. Although gender issues were not addressed during the design of the program, they were increasingly integrated during its implementation, particularly following the gender action plan developed in 2017 by the WFP, which followed up on the recommendations of a gender analysis study conducted in 2016.[5] Since 2018, WFP has been actively supported by the Swiss Government in its efforts to increasingly mainstream gender issues in its programs.

45. Women and men participate as Community Health Workers (CHWs), mid- upper arm circumference (MUAC) fathers, MUAC mothers and Mentor Mothers in the roll-out of the community screening activities. Children are screened, admitted to the program and cared for without gender discrimination. Awareness-raising messages in the health centers and households are aimed at PLW and their spouses, as well as mothers and fathers of children under five years old admitted to the program. Disaggregation of program data by age sub-group of children admitted (6–23 months; 24–59 months) was initiated in 2019.

46. The participants in the individual interviews and group discussions did not express any particular difficulty in accessing services, owing to the physical proximity of the health centers offering SFP services and free care. Some communities reserved the right to refuse admission to the program for cultural and/or religious reasons (more details provided in Section 2.3, Evaluation Criterion 3 – Effectiveness).

47. Two main risks to women's participation in the program were reported by interviewees and focus group participants:

- *Abuse of authority and influence peddling:* it has been reported that some CHWs and Mentor Mothers exploit the PLW they have referred to the health centers and who have been accepted by the program. Out of gratitude or a sense of obligation, these PLW give the CHWs and Mentor Mothers a quantity of the CSB++ they received in the health centers. The latter sell them on the local market in order to maintain their motivation.
- *Long days spent in the health center on distribution days and violence against women:* Beneficiaries spend almost the entire day at the health center on distribution days, owing to a lack of staff to carry out all the tasks related to this activity. It was reported that sometimes on their way back in the evening or almost at nightfall, some women were physically attacked by strangers and robbed of the CSB++ they had received at the health center. Once at home, they were also verbally and sometimes physically abused by their spouses, who did not appreciate their late return to the household.

[4] Mentor Mothers (chosen translation for the term 'Mamans Lumières' in French) are positive-deviant or role model women living in similar conditions as other members of their community, but without malnourished children.

[5] WFP. Baseline study report on gender mainstreaming in WFP's programme in Burundi in 2016.

Box 1 Key Results – Relevance

- The MAM treatment program responds to government priorities and is implemented in accordance with national policies and protocols. However, with the significant reduction in the prevalence of acute malnutrition and the continued high prevalence of chronic malnutrition, it is important to combine the treatment of MAM with prevention interventions, in order to optimize stunting outcomes in the country.
- The MAM treatment program is appropriate to the beneficiaries' expectations because it meets their needs in terms of food supplements and awareness-raising messages.
- Although gender considerations were not taken into account during program design, they were gradually integrated during implementation.
- The way the program is implemented (spending most of the day at the health center because there is only one distribution day in the week) is a safety risk for some PLW and mothers of children enrolled in the program.

2.2 Evaluation Criterion 2 – Coherence

Question 2.1. To what extent were FFP-funded MAM treatment interventions coherent with nutrition interventions funded by other donors?

48. The MAM treatment program in the four provinces evaluated was funded by FFP. In these provinces, other specific and nutrition-sensitive interventions were implemented in conjunction with MAM treatment and funded by other donors, particularly in the provinces of Kirundo and Ngozi.

49. At the central level, the various donors and technical partners have not pooled or coordinated their funding and/or intervention protocols. Normally, each sectoral meeting is held every month in Bujumbura, the nutrition sector meeting being co-chaired by UNICEF and WFP, in collaboration with PRONIANUT. However, there is not enough communication between the different sectors during the planning, financing and implementation of programs.

50. Similarly, at the peripheral level (districts and municipalities), there was no coordination between the programs to ensure complementarity in targeting the areas of intervention or the beneficiaries admitted to the selected areas. Such coordination should be ensured by the government authorities, in order to generate an optimal impact of the various interventions on children under five years of age, PLW and their families. However, the sectors are evolving in a compartmentalized manner because of the weak coordination mechanism.

Question 2.2. How did the referral mechanisms to other nutrition programs (health centers to the community and vice versa) work?

51. According to the national protocol for the integrated management of acute malnutrition, children and PLW identified in the household or community as malnourished are referred to the nearest health center for confirmation of diagnosis and appropriate treatment. This is what is done in the majority of cases (see more details in Section 2.3, Evaluation Criterion 3 – Effectiveness). Collaboration between WFP and UNICEF facilitates referrals and cross-referrals between the UNICEF-supported SAM treatment program and the WFP-supported SAM treatment program in the four provinces. Indeed, children admitted to outpatient therapeutic services are referred to SFP services when they are cured of their SAM. During their treatment, these children are followed up at home by the Mentor Mothers and CHWs, who take the opportunity to deliver awareness-raising messages in the households and the community.

52. In Kirundo province, the families of beneficiaries admitted to the MAM treatment program also benefit from the cash transfer, vegetable garden and small animal husbandry programs supported by the international NGO Concern Worldwide with WFP funding. Similar approaches to the fight against

malnutrition are also implemented by UNICEF, WFP and the FAO in the province of Ngozi, and financed by the Swiss Agency for Development and Cooperation. In the provinces of Rutana and Cankuzo, several children who are screened for MAM are also referred to centers for nutritional rehabilitation and learning (FARN)[6] supported by the international NGO World Vision. According to the health center directors interviewed, children admitted to FARN and who do not gain at least 200g after their 12-day stay in the program are transferred to SFP services in the health center. All these referral mechanisms between the health center and the community, recommended in the national protocol, ensure the continuum of care (between MAS and MAM in the health center) and prevention in the households and the community.

Box 2 Key Results – Coherence

- There is a lack of close coordination among donors and different sectors in the planning and implementation of nutrition-sensitive interventions.
- The continuum of care from SAM to MAM, and from FARN to SFP services takes place in all four provinces. Similarly, there is continuity between treatment and prevention activities in Kirundo and Ngozi provinces, thanks to collaboration between WFP, UNICEF and NGOs supporting community-based prevention activities.

2.3 Evaluation Criterion 3 – Effectiveness

Question 3.1. To what extent did the intervention work for pregnant and breastfeeding women, adolescents and children aged 6–59 months?

A. Geographic Coverage of MAM Treatment

53. Taking into account the budget available for the program, four provinces out of 18 (22 percent) were selected for the implementation of MAM treatment. The selection took into account WHO standards: MAM prevalence of 5-9 percent with aggravating factors such as disease, population displacement (border provinces), high population density and food insecurity. Once the four provinces were selected, a situation analysis of the health centers was conducted by the nutrition monitor and the provincial health office (PHO) to guide the selection of the health centers in which the treatment of MAM should be integrated, taking into account the areas of responsibility of all the health centers. Following this analysis, PRONIANUT, the PHO and the district health office (DHO) selected the health centers where the program was implemented, for a theoretical coverage of 100 percent.

54. During the analyses, the evaluation team found that the physical coverage rate (i.e. health centers delivering SFP service versus functional health centers in the zone) is 86 percent for the four provinces, with variations ranging from 77 percent (Ngozi) to 100 percent (Rutana). However, in reality, each province has 100 percent coverage. The differences are explained by the fact that the health centers not covered are those too close to one or more health centers that already offer SFP service in the same health area (area of responsibility). In the interest of equity, WFP, PRONIANUT, the PHO and the DHO have decided not to open SFP services in health centers that are very close to each other in the same health area. In such circumstances, a single health center was chosen, thus ensuring good accessibility of the service in all health areas with 100 percent coverage (Figure 8 in Appendix 9).[7]

[6] Foyers d'apprentissage et de réhabilitation nutritionnelle

[7] In the province of Cancuzo, a functional health center is in this situation (health center of Rujungu). In the province of Kirundo there are 11 health centers (Kabuyenge, Kibazi, Kigari, Mabuga, Nyakibanda, Nyamabuye, Rutare, Sasa, Sr Bene Tereziya Ntega, Vumbi). In the province of Ngozi, there are 13 health centers (Kabuyenge, Kibazi, Kigari, Mabuga, Nyakibanda, Nyamabuye, Rutare, Sasa, Sr Bene Tereziya Ntega, Vumbi). In Rutana province, all the functional health centers offer SFP services.

B. Treatment Coverage (Number of MAM Cases Admitted to the Program)

55. Treatment coverage is defined as the proportion of the eligible population that is actually admitted to the program. From 2016 to 2019, of the 234,841 children under five expected in the four provinces, 184,924, or 78 percent, were treated. The coverage rate varied greatly from year to year within the same province and between provinces. For example, the highest coverage rate in all provinces was observed in 2017, with higher than expected admissions of 175 percent, with variations ranging from 84 percent for Kirundo to 189 percent for Ngozi (Figure 9 in Appendix 9). These peaks in admissions in 2017 occurred because of returnees, internally displaced persons, the admission of beneficiaries living outside the areas of responsibility of health centers, community awareness and mass screening

56. As for the PLW, 51,311 were covered against the 45,942 expected from 2016 to 2019, i.e. a coverage of 111 percent. The coverage rate also varied greatly from one year to the next for the same province and between provinces (Figure 10 in Appendix 9). As for children under five years of age, the year 2017 recorded the highest coverage rate in all provinces, with rates ranging from 87 percent in Kirundo to 228 percent in Cankuzo.

57. Coverage rates above 100 percent or even 200 percent would be explained by the volatility and rapid change in the context, as well as by the errors in the numbers recorded for MAM prevalence. On the one hand, this is an element that is detrimental to the quality and efficiency of the program; on the other, it also demonstrates the program's capacity to absorb 10 to 80 percent more admissions. It would have been interesting during these periods to carry out coverage surveys such as SQUEAC,[8] SLEAC[9] or S3M[10] to ensure the real coverage rate and to check whether these high rates do not in fact hide many other cases that are not taken care of.

58. During the qualitative data collection, it became apparent that, for cultural reasons, the Batwa communities were not easily admitted to SFP services. They are indigenous people who prefer the traditional treatment provided by their traditional healers to the health care provided in government health facilities. Some religious communities, such as Seventh Day Adventists and "Zebia", were also hostile to the consumption of food supplements. These religions prohibit the consumption of certain foods, including food supplements distributed in the health centers, claiming that this conflicts with their principles and beliefs. Finally, some officials refused to admit their children to the program because they were ashamed to realize that despite their "advantageous" status in society they were harbouring a malnourished child.

C. Performance of the MAM Treatment Program

59. According to the national protocol for the integrated management of acute malnutrition, the performance of the MAM treatment program is evaluated on the following four main indicators: cure rate, death rate, default rate and rate of non-response to treatment. When these indicators reach expected standards, it indicates that the program is effective.

60. For all the provinces studied, the performance indicators are above the requirements of the standards of Burundi's national protocol for the management of malnutrition, such as cure rate >70 percent, death rate <3 percent, and default rate <15 percent. An improvement in these indicators can be noted for all provinces between 2016 and 2019. For example, the cure rate gradually increases from 88 percent in 2016 to 91 percent in 2017, then reaches 94 percent in 2018 and 96 percent in 2019 (Figure 2).

[8] SQUEAC is a coverage assessment method developed by Valid International, FHI 360/FANTA, UNICEF, Concern Worldwide, World Vision International, Action Against Hunger, Tufts University and Brixton Health. It is an efficient and accurate methodology to identify boosters and barriers to access to services and to estimate the coverage of nutrition programmes. It is termed semi-quantitative because it uses a mix of quantitative (numerical) data collected during regular programme supervision activities, small studies, small surveys and small area surveys, as well as qualitative data collected during informal focus groups and interviews with a range of informants.

[9] SLEAC is a large-area method designed to assess the coverage of a programme that offers the management of acute malnutrition across many service units. Its application provides a quick overview with a classification of coverage per unit (high, medium or low) and limited information on barriers to access.

[10] S3M is a wide area spatial surveying method ideally suited in this context.

61. These positive outcomes highlight the efficiency of the program. However, the evaluation team judged it necessary to take the analysis further by looking at the interactions between peaks of MAM case admissions and other pathologies, as well as the length of stay before recovery, in order to reinforce or qualify this conclusion.

D. Interactions Between Peaks of MAM Admissions and Other Pathologies

62. Treatment coverage is static, while the prevalence of malnutrition varies throughout the year because of external factors such as lean periods, childhood illness, or periods of field cultivation when parents are less available to provide care for children. The evaluation team found it necessary to verify whether there was a correlation between these known factors and the increase in MAM cases.[11]

63. The findings highlighted an annual seasonal variation in admissions, with peaks in admissions corresponding to peaks in childhood diseases (malaria, acute respiratory infection (ARI), diarrhea) and the lean season in the provinces of Cankuzo, Ngozi and Rutana, although this is somewhat less marked for these two provinces than for Cankuzo province (Figure 11, Figure 12 and Figure 13 in Appendix 9). This type of evolution can be interpreted as a sign of a quality program that is able to absorb natural and seasonal increases in malnutrition prevalence (Myatt et al 2012). Further investigation is needed to understand the recurrent peak admission observed annually during the period June–July for Cankuzo, July–August for Ngozi and January–February for Rutana. For Kirundo Province, the annual seasonal variation in admissions with peaks in admissions corresponding to the peak in childhood diseases and the lean season is not clear (Figure 14 in Appendix 9). This type of change can be interpreted as a sign of a program that is failing to absorb natural and seasonal increases in the prevalence of malnutrition and requires efforts to improve coverage or identify barriers to access. The other explanation would be that the joint implementation of interventions to prevent malnutrition, such as food distribution, cash transfers and vegetable gardens in the province of Kirundo, would have prevented the peaks from occurring (more details are provided in Question 5.1 of Section 2.5, Evaluation Criterion 5 – Impact). In the four provinces, the trend in PLW admissions follows that of MAM children, with peaks during the same periods (Figure 15 in Appendix 9).

E. Length of Stay in the Program

64. Although it is part of the performance criteria for malnutrition management programs, length of stay is rarely analyzed or reported in the monitoring and evaluation of MAM treatment programs.[12] Yet this indicator can provide important clues about the quality of care and the barriers it may encounter. A low average length of stay indicates a high default rate and low program retention capacity, which may be linked to a problem of acceptability (e.g. poor reception services or excessively long waiting time in the health center) or difficulties in accessing the service (e.g. distance too great to reach the health center or an impassable road).[13] By contrast, a long average length of stay may indicate a poor application of the care protocol in the health center (for example, criteria for exits not respected) or in the community (e.g. sharing of allocated food supplements). Analysis of the quantitative secondary data collected in the health centers visited showed that the average length of stay of children under five years of age admitted to the program was six weeks, which is considered "acceptable" by the national protocol for the management of acute malnutrition in Burundi (<8 weeks), and would therefore be in favor of the program's effectiveness.

65. However, further analysis of the distribution of length of stay shows that nearly 55 percent of children admitted to the program were reported to be cured at exactly six weeks, while all other lengths

[11] A good correlation between seasonal variations in admissions and these external factors can be interpreted as a sign of an effective programme (Myatt et al 2012).

[12] This failure goes beyond WFP Burundi or WFP in general and is observed throughout the nutrition sector, both in emergency and development contexts.

[13] In this evaluation, the interviews and FGDs took place in the health centers with people who have a certain ease of access to the health center. The assessment team could not conduct FGDs in the community because given the sensitive political context and the fact that visits to the community would have been considered as suspicious. Barrier analysis, which is normally done in the community with MAM babysitters who face problems accessing health centers could not be performed, and is a limitation of the evaluation.

of stay had frequencies of less than 10 percent (Figure 16 in Appendix 9). One would have expected to observe a distribution following the normal distribution, i.e., values that decrease regularly and symmetrically from the modal value (the highest value, here six weeks). The bell curve added to the histogram of residence times makes it possible to assess the difference between the expected and observed distribution. Extensive investigations need to be conducted to understand whether children are actually discharged from the program as cured or just kept in the program for six weeks regardless of changes in their nutritional status.

66. It was not possible to determine the length of stay of beneficiaries in the program before they dropped out, in view of the low number of default cases reported in the health center. The length of stay before dropping out is an interesting indicator of a program's retention capacity, also indirectly providing information on its quality and efficiency.

F. Quantities of PlumpySup and CSB++ Distributed

67. Analyses were carried out to assess the balance between the quantities of nutritional supplements distributed and the number of beneficiaries taken care of, in order to estimate adherence to the program. Figure 17 in Appendix 9 shows that there was consistency between the increase in the number of children admitted to the program and the quantities of PlumpySup distributed over time. Indeed, the quantities distributed increased with the growing number of beneficiary admissions. However, forecasts were often exceeded, particularly in 2017, owing to the significant peaks in admissions recorded during that year. Another reason was that health workers overestimated the number of beneficiaries in order to receive large quantities of food supplements (more details are provided below on the diversion of nutritional supplements, in Section H, Constraints).

68. A total of 1,183,575 kg of PlumpySup were distributed to 295,254 children, an average of 4kg per child. This is slightly higher than the expected average because, according to the national protocol for the integrated management of acute malnutrition, a child should receive 92g of PlumpySup per day, or 644g per week. As the average length of stay in the program is six weeks, a child should receive an average of 3.86kg of PlumpySup for the duration of treatment. Analysis by province (Table 4 below) shows that in the provinces of Ngozi and Cankuzo, the quantities distributed per child were lower (3.8kg – a shorter treatment duration of one week on average). Kirundo was just average at 3.9 kg. Rutana with 4.5 kg, had a higher average duration of treatment than the other provinces (more than seven weeks).[14] It should be noted that the 2016 data do not appear to be consistent with data from other years in terms of quantities distributed per beneficiary (ten times higher than Rutana and Ngozi); they are presented for information but were not taken into account in the calculations. This could be due to errors in the databases provided with an overestimation of the quantities distributed, an underestimation of beneficiaries, or a mix of categories of beneficiaries and types of nutritional supplements.

Table 4. Average quantities of PlumpySup (kg) distributed per child under five years of age, 2016–2019

	Cankuzo	Kirundo	Ngozi	Rutana	Total
2016	NA	NA	20,9	27	24,9
2017	2.8	1.9	2.5	3.1	2.7
2018	**5.5**	**5.8**	**6.2**	**6.2**	**5.8**
2019	3.2	2.9	4.3	2.1	3
Weighted average[a]	**3.8**	**3.9**	**3.8**	**4.5**	**4**

NA = Not applicable

[14] The assumption is that all children receive their rations as stipulated in the national protocol for the integrated management of acute malnutrition.

a The total is not a simple average but a weighted average. Some provinces received more nutritional supplements than others in absolute terms, which had an impact on the overall average.

69. As for the PLW, the quantities of CSB++ distributed also increased with the increase in the number of beneficiaries, with distribution peaks that exceeded forecasts in 2017 in the provinces of Ngozi and Cankuzo, owing to the large number of admissions during this period (Figure 18 in Appendix 9).

70. A total of 1,704 tons of CSB++ were distributed to 266,373 beneficiaries, i.e. an average of 6.4 kg per woman. According to the national protocol for the management of MAM, a pregnant or breastfeeding woman should receive 250g of CSB++ per day, i.e. 1,750g per week, for an average duration of three weeks of covered treatment, which is relatively low. Owing to the absence of data in the health centers and in the databases, the evaluation team could not estimate the quantities of CSB++ distributed to children under five years of age during periods of stock-outs of PlumpySup (see more details on stock-outs in the efficiency chapter). In the health centers, it was not possible to determine the actual length of time women stayed in the program in order to triangulate this information.

71. Unlike children under five years of age, the PLW are not monitored with individual record cards in which information from each visit is recorded in the health center. The analysis by province (Table 5 below) does not allow us to state that the provinces distributing the least CSB++ per woman would be the most effective in terms of results (Cankuzo and Rutana – because the duration of treatment is the shortest there – yet this duration is not specified).

Table 5. Average quantity of CSB++ distributed, by PLW, 2016–2019

	Cankuzo	Kirundo	Ngozi	Rutana	Total
2016	NA	NA	3.6	3.9	2.9
2017	6.9	7.2	7.5	6.3	6.8
2018	6.2	**9.3**	**9.7**	6.4	7.7
2019	6.6	**8.8**	**8**	7.6	7.7
Weighted average[a]	**6.6**	**8.4**	**7.2**	**6.1**	**6.4**

NA = Not applicable

a The total is not a simple average but a weighted average. Some provinces received more nutritional supplements than others in absolute terms, which had an impact on the overall average.

Question 3.2 Were there any unintended positive or negative outcomes?

72. According to the health workers interviewed and the managers, the main positive unintended outcomes were as follows:

> *"(...) apart from some of the religious adherents we mentioned, there are no constraints or taboos on access to services here. On the contrary, a malnourished person who is on the admission list considers himself lucky because he will benefit from food supplements, especially since most of the time these beneficiaries are destitute."*
> SFP Manager, Kirundo

- The admission of a significant number of beneficiaries to other services such as prenatal consultation, family planning, growth promotion monitoring, and the expanded program on immunization, owing to the attraction created by availability of CSB++ in the MAM treatment program. Culturally, pregnant women do not report their pregnancies in the community during the first trimester; but thanks to the program, they presented very early to the antenatal consultation service for screening, in the hope of benefiting from CSB++. In most cases, the women were also seen with their children, and health workers took the opportunity to screen them for malnutrition, vaccinate them, or catch up on the vaccines of those who had dropped out. Some women left neighboring provinces where there were no SFP services to come to the health centers that offered these services, always in the hope of benefiting from the nutritional supplements, thus contributing to the admission of

beneficiaries outside the areas of responsibility of the health centers (which explains some of the peaks in admissions observed).

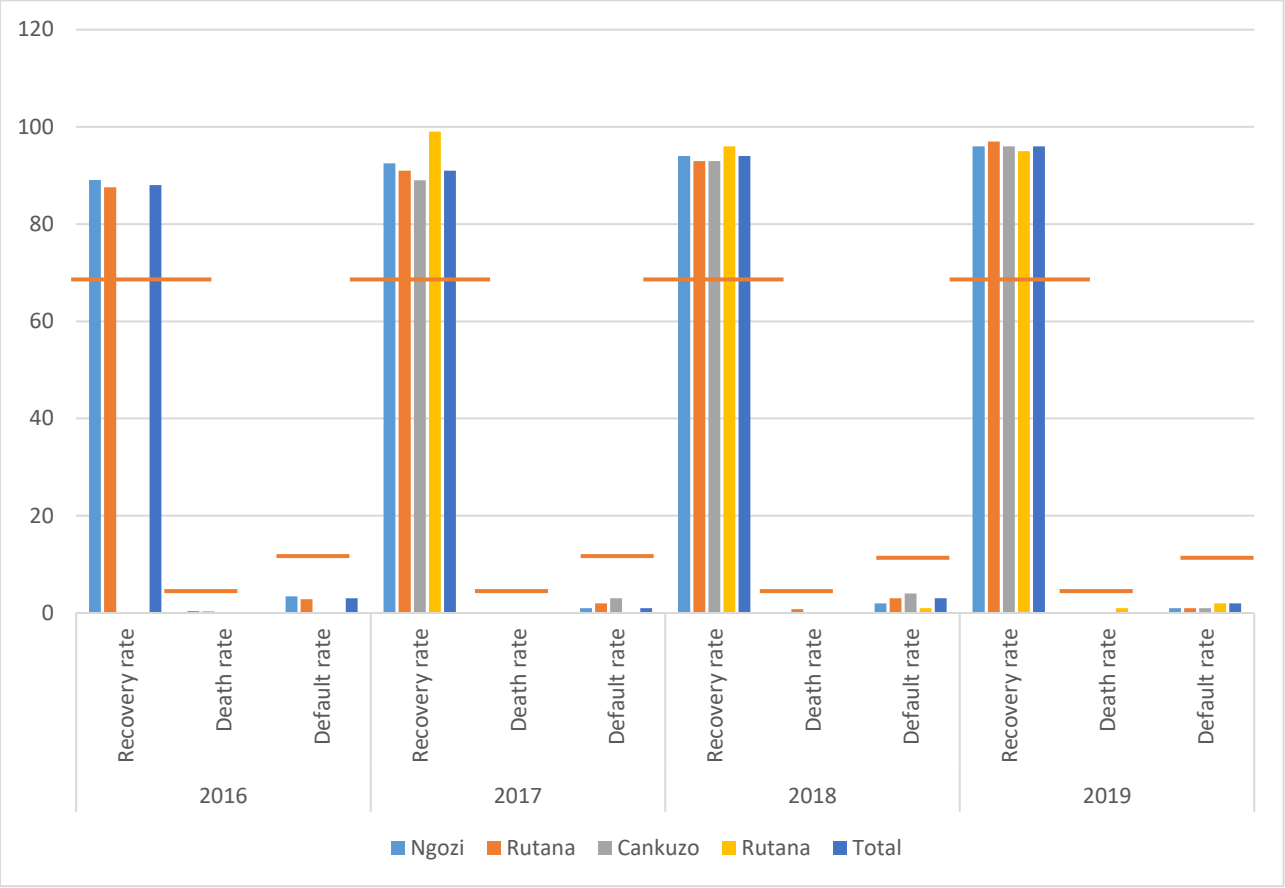
- In addition, *WFP's visibility increased with the implementation of the program,* both at the national level and at the province and health district levels. Thanks to the MAM treatment program, the WFP is now a key player in nutrition in the country.

73. As for ***unexpected negative results***, the following were identified:

- *Abandonment of contraceptive methods*. In Kirundo District, health workers and SFP managers have reported increasing cases of close pregnancies as women abandon contraceptive methods to become pregnant, in the hope of being admitted to the program and benefiting from CSB++. Many of these women even falsely declared themselves pregnant in order to benefit from CSB++, and it was following negative pregnancy test results that they were discharged from the program.
- *Sharing food supplements as a family*. According to the participants in the FGDs, it is normal that the porridge prepared from CSB++ is shared by all family members during breakfast.
- *Illegal sales of dietary supplements on the local market*. This would have led to cases of non-response to treatment due to insufficient consumption of nutritional supplements within the family. Nevertheless, active awareness-raising and intervention by law enforcement agencies (police) in markets and shops/stores has helped to slow down these illicit sales.
- *Increased workload of health-care staff*. Because only one day of the week is specifically dedicated to SFP activities (screening, care, distribution of nutritional supplements) in the health center, rather than having them spread over several days of the week,[15] health workers complained about the heavy workload and the fact that other health services are neglected in favor of distribution. The CHWs and members of the health committees (COSA) suggested supporting these workers during these days to alleviate this workload, with financial or in-kind incentives.
- *Lack of motivation of health staff, SFP managers, CHWs and Mentor Mothers*. According to the health workers interviewed, WFP does not provide food to the workers as an incentive. This negatively affects their motivation to carry out nutrition-related activities because they receive financial incentives for the implementation of the other services of the health center activity package within the framework of the performance-based financing program. Therefore, nutrition activities are not a priority for them. According to them, this lack of incentives is also the cause of some diversions and illicit sales of food supplements on the local market, which allow workers to make ends meet.

[15] PRONIANUT, the provincial health offices and the health district offices have decided on a single day of the week for SFP activities in the health centers to minimize the risk of the same beneficiaries being admitted to several health centers at the same time.

Figure 2. Performance indicators for the four provinces, 2016–2019



Question 3.3. To what extent have community mobilization and nutrition education activities led to increased awareness of and demand for nutrition services?

74. As part of the implementation of the program to treat acute malnutrition in Burundi, UNICEF and some NGOs are supporting the community component for the screening and referral of malnourished children and PLW. This support has benefited the WFP treatment program because, according to the health workers interviewed, the majority of beneficiaries admitted to the SFP services had been referred by the CHWs and the Mentor Mothers.

75. WFP distributed Infant and Youth Child Feeding Programme (IYCF) tools in the health center and IYCF guidelines are promoted in the health center and the community. In the province of Cankuzo specifically, WFP has trained MUAC mothers and fathers in active child screening and PLW in the community. Active screening campaigns carried out in December 2016 by PRONIANUT in six provinces of the country resulted in a significant admission of beneficiaries being observed in 2017 (PRONIANUT 2016). However, the irregularity of home screening, follow-up and outreach activities influenced the (lower) admission rate recorded in other years. As a result, regular community activities created demand for SFP services because people were more aware of and involved with the services.

> *"Before the intervention, malnutrition was not well known in our locality (...) the population used to rush to the traditional healers for treatment; but thanks to the awareness of the Mentor Mothers and the care in the health center, we have become aware of the consequences of malnutrition."* FGD with mothers of children <5 years old, Rutana

Question 3.4. What are the main factors that contributed to the achievement or non-achievement of performance indicators such as recovery, death and default in the targeted provinces?

G. Facilitating Factors

76. According to the participants in the individual interviews and FGDs, the main factors that have positively contributed to the achievement of the program's outcomes are as follows:

- *The training of health personnel*. The training of health workers on the screening and management of MAM in children under five years old and PLW was done in cascades. At least two providers were trained in each health center (health worker and SFP manager), as well as CHWs and Mentor Mothers. They have acquired a good understanding of the program and have promoted admissions and care.
- The *good geographical coverage of the program*, which has brought the health centers closer to the expected beneficiaries, thus facilitating access to services.
- *Free health care* for children under five years of age and PLW have also facilitated access to services in the health center.
- The *mass screening campaigns* conducted by CHWs and Mentor Mothers in December 2016 contributed to the spikes in admissions observed in the health centers in 2017.
- The *availability of nutritional supplements* (PlumpySup and CSB++) has increased the attendance rate at the health center.
- *WFP's financial support to the health districts* made it possible to carry out monitoring and supervision activities, although these were irregular.

H. Constraints

77. According to the program managers interviewed, one of the challenges in implementing the Memoranda of Understanding (MoUs) that link WFP and the State structures was the irregularity of planned monitoring and supervision activities, even though these were financially supported by WFP. It is always difficult to mobilize all the government actors concerned for joint visits because this depends on their availability (very busy schedules). The rate of implementation of WFP supervision activities in collaboration with PRONIANUT in 2019 was 20–30 percent of what had been planned, owing to difficulties in coordinating schedules (availability).

78. The other reason is that while many Ministry of Health officials have the technical capacity to judge the quality of the program, it is difficult for them to influence the operational and policy changes that should trickle down from their superiors.

79. These irregularities in monitoring and supervision certainly influenced the quality of the program. Since WFP reports and activity planning are based on data contained in the program database, the evaluation team analyzed the reliability of these data. The community-based management of acute malnutrition (CMAM) registration books in the health centers are the first place in which all MAM care information is recorded. It is from these registration books that monthly reports are prepared and entered into either the WFP database or the official DHIS2 database.[16] The evaluation team also analyzed the reliability of these data. During the field visits, the evaluation team compared the data in the health center registration books with those provided in the DHIS2 database, in order to assess their reliability.

80. Figure 3 below shows an overestimation of the data found in the WFP database versus the data found in the registration books. Indeed, about 6.4 percent more cases were reported for the whole of 2016, while 7.6 percent more cases were reported in 2017, about 7.7 percent in 2018 and 1.42 percent in 2019. Although these differences are not statistically significant (p value = 0.4 according to Table 20 in Appendix 9) and that these data can be considered acceptable overall, they demonstrate insufficient quality in record-keeping (registers and monthly reports) and problems in the reliability of data transmitted from the peripheral level to the central level.

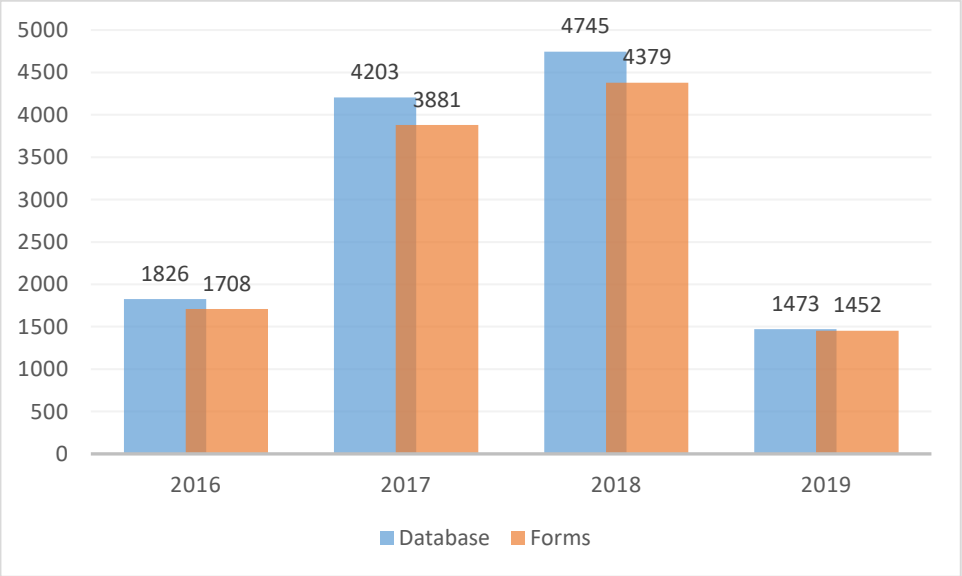
[16] DHIS is a software platform for reporting, analyzing and disseminating data from all health programs, developed by the Health Information Systems Programme. All health data from Burundi are entered online on this platform, which is the official reference

81. Depending on the chosen LQAS classification,[17] the quality of the databases can be classified as "acceptable". In fact, 10 of the 20 health centers had registration book data concordant with those in the databases and/or no significant difference. In the critical sites (of non-acceptable quality) the team noted an absence of important information such as admission or discharge dates in the registration books and the individual record cards. At sites with good record-keeping, there was a small discrepancy between the data extracted from the databases and those observed in the registration books and other paper records. Moreover, the small gap observed in 2019 (1.4 percent) was explained by an improvement in the reporting of data resulting from the deterrent effect of the police on the diversion of nutritional supplements, the sanctions imposed on offending health workers and the awareness-raising carried out among them.

82. The most important factor that would have affected the quality of the data would have been the frequency of monitoring, which in turn would have been related to the accessibility of the sites – roadside sites would have performed better because they were easily accessible, because of good road conditions (Figure 19 in Appendix 9). These sites would have received more frequent supervision from province and district officials, during which the anomalies identified were corrected. The other explanation would be the relative stability (low staff turnover) of the health workers operating in these health centers close to the roads.

83. According to the program officials interviewed, the overestimation observed at the DHIS2 level is explained by the fact that health center directors regularly revise upward the figures on the number of admissions at the end of the month before submitting them, so that they correspond to the large quantities of nutritional supplements distributed. This adjustment cannot be made on distribution days because workers are very busy providing services. Therefore, the actual numbers of admissions are reported in the registration books. However, the quantities of nutritional supplements distributed are higher than the number of beneficiaries admitted because some of these nutritional supplements are used for other purposes. Therefore, health workers harmonize the figures at the end of the month by increasing the number of beneficiaries admitted (which constitutes "cheating" according to the nutrition monitors and focal points interviewed).

Figure 3. Comparison of number of MAM admissions under five years of age from WFP database and registration books in 20 health centers



[17] The LQAS methodology gives the flexibility to set thresholds based on the context and needs of the program without imposing a threshold. The ultimate goal is to select realistic thresholds for program improvement.
Good quality: More than 14 out of 20 health centers have concordant data between registration books and database.
Acceptable quality: 13 out of 20 health centers have concordant data between registration books and database.
Quality not acceptable: 9 out of 20 health centers or fewer have concordant data between registration books and database.

Box 3 Key Results – Effectiveness

- Apart from the year 2016, when admissions were low as a result of the timid start of the program, admission rates were close to expectations or even exceeded expectations, in 2017 in particular.
- There was consistency between the increase in the number of children and PLW admitted to the program and the quantities of PlumpySup and CSB++ distributed over time.
- There was an annual seasonal variation in admissions, with peaks in admissions corresponding to peaks in childhood diseases (malaria, acute respiratory infection (ARI), diarrhea) and the lean season in the provinces of Cankuzo, Ngozi and Rutana.
- The median length of stay for children admitted to the program until recovery was six weeks.
- For all the provinces, the performance indicators are above the requirements of the standards of Burundi's national protocol for the management of malnutrition (cure rate >70 percent, death rate <3 percent, default rate <15 percent).
- Factors contributing to the achievement of results include the training of health workers, SFP managers and Mentor Mothers, the good geographical coverage of the program, free care, active community screening and awareness-raising on good health and nutrition practices.
- The availability of CSB++ in the health centers created interest in the program, resulting in significant admissions of beneficiaries coming from other services offered by the health centers. However, negative outcomes include close pregnancies (Kirundo province), family sharing of nutritional supplements, and illicit sales of these supplements.
- Irregular supervision and follow-up have negatively influenced the quality of the program, especially regarding the filling in of registration books and individual record cards, as well as monthly reporting.

2.4 Evaluation Criterion 4 – Efficiency

Question 4.1. Were the objectives of the program achieved within the time frame?

84. According to individual interviews with program managers and budget managers in the capital, funding for the MAM treatment program has been regularly disbursed by the donor as planned. Since the funding provided by FFP is a grant, the MAM treatment program was designed in accordance with the financial envelope made available to WFP by the donor. Consequently, the estimates of the number of expected beneficiaries and the related resources were made taking into account the total grant available. During implementation, the program was faced with admissions of a larger number of beneficiaries than expected, with unexpected negative effects on stocks (shortages). In order to bridge this gap, the WFP country office requested additional funds from the donor in 2018 for the purchase of nutritional supplements (PlumpySup and CSB++) needed to adequately cover the period 2018–2020.[18]

85. Despite the availability of funding and its disbursement over time, the main difficulty experienced by the program managers was the waiting period between the order of the food supplements and their actual arrival in the country. Indeed, CSB++ is provided "in kind" to the program. They are ordered from WFP headquarters in Washington, DC, in the United States. The procedures at headquarters consist of consolidating orders from several countries in order to ship large quantities of CSB++ by boat to the ports of Nairobi in Kenya and/or Dar Es Salaam in Tanzania.

[18] Activity 6 of the country's interim strategic plan 2018–2020

From these points, orders are dispatched to various countries, including Burundi, using road transportation or small boats that will dock in Bujumbura via Lake Tanganyika. This process of consolidation of several orders before shipment by headquarters is often the cause of the discrepancies between the admission of beneficiaries to the program and the actual arrival of the food supplements. In the case of Burundi, a period of six months usually elapses between the order of the CBS++ and its delivery in the country. In order to bridge these gaps while waiting for the arrival of CSB++, program managers are sometimes forced to instruct health workers to distribute other types of nutritional supplements to beneficiaries, such as super-cereals, in order to minimize the risk of default.

86. The analysis of secondary data from the health centers and interviews with health workers and SFP managers showed that all these centers experienced non-consecutive periods of nutritional supplement disruptions ranging from one to four months during the implementation period of the program (2016–2019). In order to bridge the gap, super-cereals were distributed to beneficiaries when available. Where PlumpySup was not available, CSB++ was distributed to children under five years of age admitted (as was the case in 2019). In the case of shortages of all types of food inputs, beneficiaries were obliged to wait for delivery of PlumpySup and CSB++ in order to continue their treatment.[19]

87. In addition to the gap between the order and delivery of nutritional supplements to the health centers, field monitors, nutrition focal points, logistics managers and health center directors cited the following reasons for the stock-outs of PlumpySup and CSB++ observed during the implementation of the program:

- ***At the health district level:*** The "non-involvement" of district pharmacy managers, health center directors and SFP managers in the estimation of nutritional supplement needs. In fact, they complained that this estimate was made unilaterally by the WFP, which used consumption data from previous months to estimate needs. According to these health workers, this approach did not take into account the regular fluctuations observed in the admission of beneficiaries during certain months of the year or for other reasons such as the return of refugees and internally displaced persons, and the admission into the program of beneficiaries living outside the areas of responsibility of the health centers. The district pharmacy managers interviewed were aware that deliveries of food supplements were made directly to the health centers by WFP, but had no information on the estimation of beneficiaries, or the ordering, storage and planning of delivery of nutritional supplements to these centers. All these activities were managed by WFP in parallel with the national supply chain system.
- ***At the level of health centers:*** The low storage capacity. The health centers do not have enough space to store large quantities of food supplements that can cover a period of two or three consecutive months. In addition, deliveries were irregular or late in remote or hard-to-reach health centers during the rainy seasons; as a result, these centers experienced more frequent stock-outs.
- ***At the community level:*** The "diversion" and illicit sale of PlumpySup and CSB++ on the local market, led to premature stock-outs in health facilities.

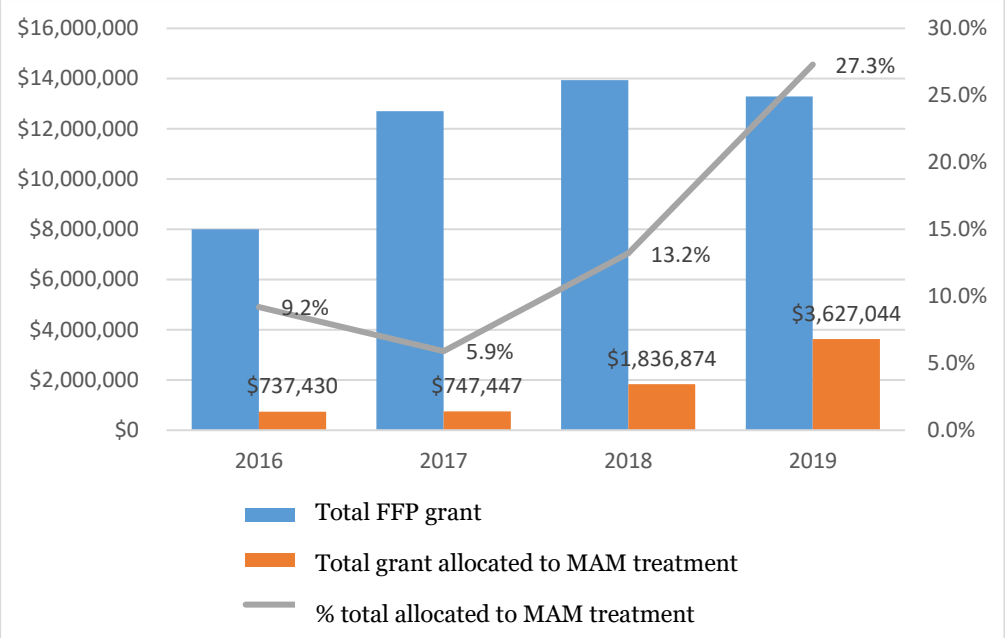
Question 4.2. Does the treatment of MAM have the most cost-effective return in terms of coverage and adherence?

88. The total project budget funded by FFP and received by the WFP Burundi country office as an annual grant has varied over time. It was USD 47,923,099 for the four years of support (2016–2019). The MAM treatment program has grown over time, as the budget specifically dedicated to it has increased over time from USD 737,430 in 2016 (representing 9.2 percent of the total budget) to USD 3,627,044 in 2019 (representing 27.3 percent of the total budget). The total expenditure allocated

[19] The distribution of super-cereals to treat MAM is in line with the national protocol for the management of acute malnutrition. However, within the specific framework of this project, the super-cereal is not financed by FFP. Funding from other sources was therefore used to treat beneficiaries admitted to the FFP-supported program, which constitutes a "dilution" and limits the analysis of the programme's cost-effectiveness.

to the treatment of MAM during the period 2016–2019 was USD 6,948,795. This amount has therefore tripled in the 4 years of program implementation, which is consistent with the growing number of admissions and the quantities of nutritional supplements distributed over time. Figure 4 below illustrates the trend in grant amounts allocated to the MAM program over the period 2016 to 2019 compared to the total FFP funding budget at the WFP country office

Figure 4. Trends in funding for the MAM treatment program, 2016–2019



89. Table 6 below shows that the different categories of activities were fully funded as planned. Some activities such as the purchase, transport, storage and distribution of CSB++ and PlumpySup in the HCs were spent beyond what was planned (more than 100 percent expenditure in 2017, 2018 and 2019), which confirms that additional funding was received by WFP in 2018 to meet the needs generated by the surplus of beneficiaries registered in 2017. Appendix 10 describes in detail the actual amounts spent each year, as opposed to the planned amounts[20].

Table 6. Difference between the actual versus planned disbursement rate during the implementation period of the 2016–2019 program (%)

	2016	2017	2018	2019
Purchase PlumpySup	100	0	96.9	96.7
Purchase CSB++	0	**104.3**	**115.3**	**100**
Transport of the PlumpySup to the Burundi	100	**0**	**105.8**	**105.3**
Transport of CSB++ to Burundi	0	**104.3**	**109.8**	**102.4**
Storage, transport and distribution of inputs in the country	100	100	**107.1**	**107.8**
Capacity development	100	44.6	99.3	101.6

[20] These results do not take into account indirect costs (government participation through infrastructure, health personnel and SFP support agents). Community participation (cost of screening, sensitization by mothers-to-be, opportunity cost of parents of children admitted to the programme) was also not taken into account. These elements, which require primary data collection, were not part of the terms of reference requirements. The financial analysis therefore focused on existing secondary data on programme expenditures

Project support	100	100	99.2	100
Others	100	100	100	100

90. In terms of expenditure by category for the MAM treatment program, Table 7 below shows that the purchase of dietary supplements accounted for 51.4 percent of total expenditure, 32.4 percent for PlumpySup and 19 percent for CSB++. Next came capacity development (17.2 percent), which includes the distribution of materials, equipment and supplies in the health center, as well as training of health workers and monitoring and supervision of program activities. Transport, storage and distribution of nutritional supplements have a cumulative percentage of 16 percent (5.2 percent + 6.1 percent + 4.7 percent).

91. In summary, operational costs related to nutritional supplements accounted for 67.4 percent (51.4 percent + 16 percent) of the total expenditure incurred, and therefore constituted the cornerstone of the MAM treatment program in Burundi during the period 2016– 2019.

Table 7. Expenditure by category for the MAM treatment program, 2016–2019 (USD)

	2016	**2017**	**2018**	**2019**	**Total**	**% expenditure**
Purchase PlumpySup	412,500	0	781,884	1,059,192	2,253,576	32.4
Purchase CSB++	0	355,831	101,665	862,125	1,319,621	19.0
Transport of the PlumpySup to Burundi	92,205	0	154,576	115,090	361,871	5.2
Transport of CSB++ to Burundi	0	147,514	23,869	252,014	423,397	6.1
Storage, transport and distribution of inputs in the country	21,558	36,865	75,922	193,091	327,436	4.7
Capacity building: materials/ equipment/ supplies, training, research, monitoring, supervision, etc.	125,882	16,882	433,251	616,760	1,192,775	17.2
Project support	37,042	139,795	156,150	156,150	489,137	7.0
Others	48,243	50,559	109,558	169,676	378,036	5.4
Total	**737,430**	**747,447**	**1,836,874**	**3,627,044**	**6,948,795**	**100.0**

92. With respect to the average cost per beneficiary (child under 5 years of age or PLW), the analyses determined that the average cost per beneficiary admitted/treated was USD24 per beneficiary admitted/treated and USD26 per beneficiary treated until recovery (Table 8 below). The highest costs were observed in 2019 (USD81 per beneficiary treated and USD83 per beneficiary cured);

this higher cost would be explained by the low number of beneficiaries admitted to the program in 2019 compared to the significant expenses incurred that same year, as the program expired in April 2019.

Table 8. Cost per beneficiary (children < 5 years or PLW) admitted/treated and per beneficiary cured (USD)

	2016	2017	2018	2019	Total
Actual program spending	737,430	747,447	1,836,874	3,627,044	6,948,794
Beneficiaries admitted for treatment (n.)	43,842	81,096	113,830	44,870	283,638
Beneficiaries treated until recovery (n.)	40,091	75,542	108,433	43,669	267,736
Cost per beneficiary treated	17	9	16	81	24
Cost per beneficiary cured	18	10	17	83	26

Question 4.3. How can the cost-effectiveness of MAM treatment be improved?

93. According to interviews with government officials, the efficiency of the program would be improved if the activities that account for the largest expenditure were integrated into the national health system. Indeed, the use of the national supply chain from the national level to the districts (through the central drug purchasing office for Burundi, CAMEBU) would have made it possible to make financial savings in terms of staff salaries, logistics, and monitoring and supervision costs, thus making it possible to treat a larger number of beneficiaries. However, the government authorities also recognized that CAMEBU does not currently have the technical (training), logistical (premises and vehicles) and financial capacity to take ownership of the management, storage and regular delivery of food supplements (PlumpySup and CSB++) in all the health centers that provide MAM treatment services in the four provinces. Similarly, at the province and health district levels, pharmacy managers do not have the necessary skills to manage such activities.

94. Other opportunities to improve efficiency would include:

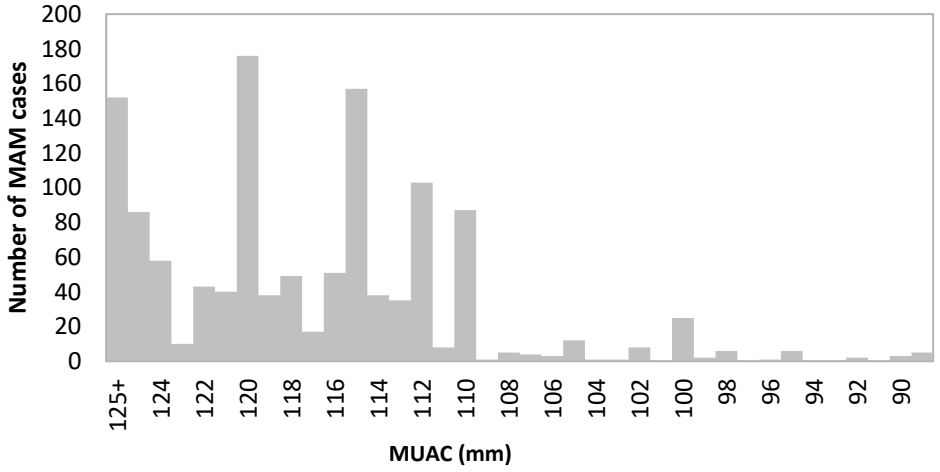
- The conduct of joint supervision, with a special emphasis on remote sites.
- The integration of the MAM treatment program with other nutrition-specific and nutrition-sensitive programs, which would promote the pooling of resources, faster recovery and relapse prevention.
- Training courses organized jointly with UNICEF and WHO to optimize resources and promote the continuum of care. It would also be more efficient to include training on the protocol for the integrated management of acute malnutrition in the curriculum of health schools, in order to ensure initial training and to anticipate the gaps created by the assignments of trained workers (high staff turnover).
- The purchase of nutritional supplements produced in neighboring countries such as Kenya, which has CSB++ production plants, or Rwanda, which produces super-cereals, would

reduce delivery delays and stock-outs, in addition to considerably reducing logistics costs.[21]

Question 4.4. What are the factors that determine the efficiency of the MAM treatment program?

95. One of the factors that determine the effectiveness of MAM treatment is the ability to detect and manage cases of MAM at the onset of the first signs of malnutrition. This will reduce treatment times and increase the chances of recovery. Analysis of MUAC at admission can give an indication of early treatment, with a median admission close to the admission criterion (125 mm) that can be translated as a sign of an efficient program. The analysis of the median MUAC at admission was carried out in the 20 health centers visited during the quantitative data collection. Figure 5 below shows that the median MUAC at admission is 120 mm on average, reflecting an acceptable level of early detection. However, the over-representation of the values 115 and 120 mm and the numerous rounded values (100 mm, 110 mm, etc.) reflect an insufficient accuracy in the taking of measurements, probably due to the delegation of these tasks to unqualified personnel on the days of distribution in the health centers, with a negative impact on the quality and efficiency of the program.

Figure 5. Mid-upper arm circumference (MUAC) on admission



96. In addition, further analysis points to other elements that are detrimental to the efficiency of the program:

- Approximately 21 percent of children are admitted to the MAM treatment program with a MUAC between 114 mm and 110 mm, instead of being admitted to the SAM treatment program instead. This results in a poor use of resources (nutritional supplements and health workers' time).
- The ambiguity of the national protocol[22] on this point could explain the misclassification of children with a MUAC between 110 and 114 mm. Approximately 7 percent of children admitted to the MAM program have a MUAC of less than 110 mm, which means that the protocol is not clearly respected, as these children should rather be cared for in the MAM treatment program. This finding was confirmed during individual interviews with nutrition focal points and health workers, who stated that in case of shortages in nutritional supplements (PlumpyNut) for the treatment of children with SAM, these children were systematically admitted to the SAM treatment program and received PlumpySup, because of

[21] Although purchasing nutritional supplements in Rwanda is not possible in the current context, owing to the political situation between the two countries, it is an option to explore when the political situation improves. Kenya is also an option to actively explore.
[22] The national management protocol allows children under 67 cm with a MUAC between 110 and 125 mm to be managed in the MAM program instead of the SAM program.

their high vulnerability and high risk of morbidity and mortality. One of the repercussions of these admissions was the premature stock-out of PlumpySup. It is therefore important to ensure that clear instructions are given to health care providers on the 114–110 mm category, and that better coordination between the MAM and SAM program is ensured, especially with regard to the management of nutritional supplements.

97. During individual interviews with program managers and FGDs with Mentor Mothers in Kirundo and Ngozi districts, it emerged that an important factor in improving program efficiency would be to ensure a close link between MAM treatment program activities and those of food security programs and cash transfer interventions implemented in the locality. According to these participants, families of children and PLW admitted to the MAM treatment program should also automatically be beneficiaries of these other programs, in order to accelerate recovery and prevent relapse.

Box 4 Key Results – Efficiency

- The time lapse between the order and delivery of the dietary supplements delayed the actual start of processing of beneficiaries admitted to the program.
- The use of super-cereals to compensate for shortages diluted the results of the analysis of the cost-effectiveness of the program to some extent.
- In addition to the fact that the number of beneficiaries exceeded expectations, stock shortages were caused by the difficulties of access to health centers and the insufficient storage capacity of these centers, as well as the illegal sale of food supplements and the admission of SAM cases into the MAM treatment program (admission criteria not always observed).
- Operational costs related to dietary supplements represented the largest expenditure item (67.4 percent) of the MAM treatment program in Burundi during the period 2016–2019.
- The average cost per beneficiary admitted was USD 24, and the cost per beneficiary cured was USD 26.
- Use of the national supply chain or the purchase of nutritional supplements produced in neighboring countries must be explored in order to determine the influence on the reduction of program costs and the management of a larger number of beneficiaries. Similarly, the systematic admission of families of MAM and PLW children into the joint food security and safety net programs could accelerate the recovery of beneficiaries and prevent relapses. These two points could be the subject of subsequent studies or testing in a future intervention for the treatment of MAM.[23]

2.5 Evaluation criterion 5 – Impact

98. The evaluation team analyzed the potential impact of the MAM treatment program in the four provinces through three questions asked in the Terms of Reference.

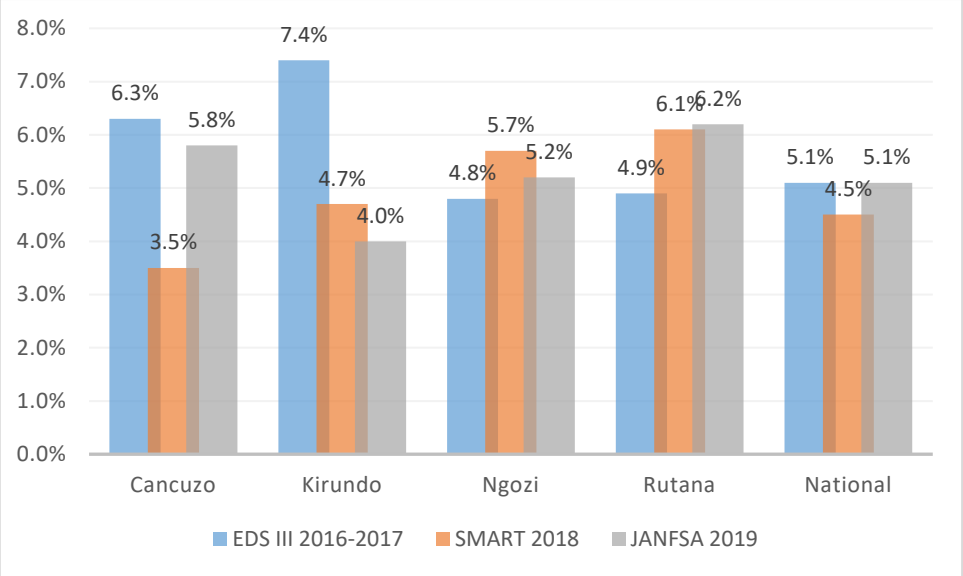
Question 5.1. To what extent has MAM treatment contributed to changing the nutritional status of targeted beneficiaries (6–59 months old children, lactating and pregnant women) in the targeted geographic areas?

99. The trends in the prevalence of acute malnutrition in the four provinces over the period 2016–2019 were analyzed. Figure 6 below shows that in Kirundo province, the prevalence of MAM among children under five years of age decreased gradually between 2016 and 2019, i.e. from 7.4 percent in 2016–2017 to 4 percent in 2019. The other provinces did not experience similar declines, with GAM prevalence instead increasing in 2019. These increases in 2019 would be explained by more frequent

[23] These suggestions are made on the basis of qualitative arguments, not quantitative analysis comparing the possible costs of each option. Kenya's production capacity was also not explored, as it was outside the scope of this evaluation.

stock-outs of PlumpySup for the treatment of MAM (and probably PlumpyNut for the treatment of SAM) in these provinces compared to Kirundo province. Annual reports mention frequent shortages in some of the health centers in Rutana in 2016 (PAM 2016), and in all provinces in 2017 and 2018 (PAM 2017; PAM 2018a). However, the particularity in Kirundo province is that during the periods of stock-outs in 2018, the NGO Concern Worldwide, in addition to SFP and with WFP funding, distributed "cover food" for the prevention of malnutrition under the auspices of the community resilience reinforcement project (WFP 2019a).

Figure 6. Change in prevalence of global acute malnutrition in the four study provinces and at the national level, 2016–2019



Sources: EDS III 2016-2017: Third Demographic and Health Survey in Burundi, 2016-2017. Key indicators.
ISTEEBU: National Survey on Nutritional Status and Mortality based on SMART methodology. Main report, February. 2018.
ISTEEBU: Enquête nationale sur la situation nutritionnelle et la sécurité alimentaire au Burundi, JANFSA January 2019.
DHS and JANFSA follow for their anthropometric part (prevalence of malnutrition) the recommendations issued by the SMART group. The data from these surveys are comparable.

100. Figure 7 below also shows a marked decline in MAM in Kirundo province between 2016 and 2019. In Ngozi and Rutana provinces, MAM prevalence declined slightly in 2019 after an increase between 2017 and 2018. At the national level, prevalence decreased slightly between 2017 and 2019.

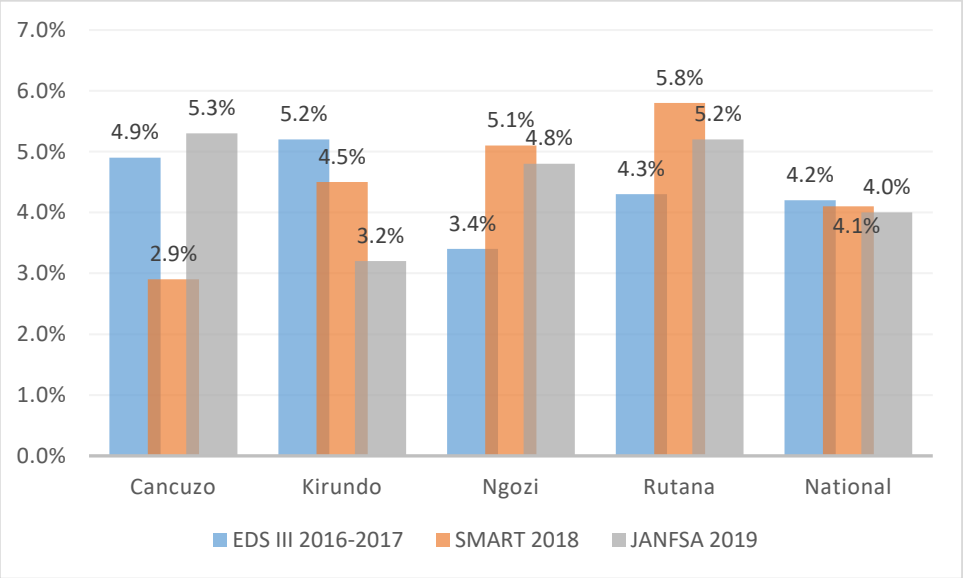
101. The differences observed between provinces could be explained by the fact that several interventions are implemented in conjunction with the MAM and SAM treatment program in the province of Kirundo. These other interventions include the prevention of stunting by targeting children under two years of age through care groups and using cash transfers linked to savings and credit associations. The interlinkage between the MAM treatment program and these prevention interventions would have made it possible to progressively reduce the prevalence of acute malnutrition and maintain it at a low rate.

102. In Kirundo province, this positive progress was most marked in Mukenke and Kirundo districts, where GAM prevalence by weight-for-height ratio in 2019 was far below 5 percent (2 percent and 3.3 percent respectively). Therefore, WFP and PRONIANUT agreed to discontinue support to the MAM treatment program in these two districts of the province. Based on this experience, WFP recruited a consultant to develop the Social and Behavior Change Communication (SBCC) Mobilization Strategy with the care group approach, to promote the prevention of stunting in children aged 6–23 months (first 1,000 days), and thereby prevent acute malnutrition.

103. The opinions expressed during the individual interviews and FGDs, regardless of participant category, was that the prevalence of MAM had decreased in children under five years of age, as had the prevalence of emaciation in PLW. The health center attendants mentioned that the birth weight

of children born to women admitted to the program and consuming CSB++ generally increased, with almost a majority of children whose mothers had been cared for being born with a normal weight (2.5 kg or more).

Figure 7. Changes in the prevalence of moderate acute malnutrition in the four study provinces and the state level, 2016–2019



104. Although the program has recorded significant cure rates that meet national standards, program managers, monitors, PHOs, nutrition focal points in the provinces and districts, as well as health center staff reported several beneficiaries who had been cured from the program and were readmitted about six months later. Therefore, the high cure rates would only reflect the short-term effects of the program. Relapse cases are not formally recorded in the health center reports as they are not part of the performance criteria set out in the national protocol. The evaluation team also did not have the time to verify these claims in the registration books and individual record cards in order to estimate relapse rates among children under five years of age who had recovered from the program. The follow-up of children who have recovered from the program should therefore extend beyond six to eight weeks of admission through including their families in programs to strengthen household and community resilience, in order to ensure healthy growth and prevent relapse.

Question 5.2. Does the intervention have the potential to positively influence gender relations, equity and women's empowerment?

105. In Burundi, family nutrition is culturally the responsibility of the women in the household. It is the woman who is in charge of cooking for the family, and taking care of sick children by taking them to hospital and continuing the follow-up until they are cured. Similarly, a PLW makes her own visits to the hospital. None of these tasks are assigned to the man. He just gives his agreement or not to the woman to attend the health center.

106. Although gender issues were not specifically considered in the design of the program, both men and women were taken into account during implementation. The Mentor Mothers were very actively involved in screening and community awareness-raising, resulting in the admission of a significant number of children under five years of age and PLW. The director of the health centers mentioned that more and more men were visiting the centers and were attending activities delivered

both in the centers and during home follow-up visits by the Mentor Mothers. Direct observations made in the health centers during the field visits confirm that both women and men were attending the awareness-raising activities.

107. The program also helped women to educate men at home on the importance of family nutrition, and to change the composition and preparation of family meals. During FGDs, fathers and mothers of children, as well as community leaders, mentioned that as a result of exposure to the awareness-raising messages, men understood better the importance of their role in family nutrition and the support they needed to provide to their pregnant or breastfeeding wives. As a result, they increasingly accompanied their pregnant wives to antenatal consultations, or accompanied their children to health centers to benefit from various services, and became more involved in decisions regarding good nutrition in the household (by regularly giving money for food purchases, supporting women in their work in the fields – especially rice fields[24] – and actively participating in vegetable garden activities). Although some were somewhat reluctant to change, the vast majority understood and adhered to the program's messages.

"Before, the men used to sell the family's possessions (...) for example all the milk from the cows in the household, all the avocados, all the eggs or all the fish products (fish) were sold and all the money used to drink alcohol; but after they became aware of it, some found that it was shameful to host a malnourished child or woman when they had the means to prevent malnutrition. Now they no longer misuse family assets. They give a share to the wife and children, or money to vary the household meals."
FGD with CHWs and Mentor Mothers, Kirundo

"Some of the men were selling the CSB++ given to their wives, to buy alcohol. But when they noticed that their wives were always referred to the health center, it caught their attention and they understood that they had serious malnutrition problems. As a result, they changed their behavior and family food became a priority." FGD with CHWs and Mentor Mothers, Rutana

Question 5.3. To what extent has the Government been persuaded to increase investment in nutrition?

108. The implementation of the MAM treatment program has seen the participation of the Government through PRONIANUT (training and supervision) and the health districts (monitoring and supervision in the field). Nutrition is considered a priority by the national authorities, who have provided the program with health structures and personnel funded by the state. Meanwhile, the Government has not yet invested financially in the purchase, storage and distribution of nutritional supplements, which comprise the most significant expenses for the program, and the prospects for this remain uncertain. One of the reasons for this is that ownership of the program was not sufficiently addressed during the planning phase, which was always under WFP's control, while its funding depended on the goodwill of donors, particularly FFP. Joint planning would probably have addressed the elements of ownership of each program component, and thus contributed to sustainability.

Box 5 Key Results – Impact

- The intertwining of the MAM treatment program and prevention interventions reduced the prevalence of acute malnutrition in Kirundo province and kept it at a low rate.
- The inclusion of men during the delivery of the awareness-raising messages helped men to better understand the importance of their role in family nutrition and the support they need to provide to their pregnant or breastfeeding wives and their children. This is in line with the gender-sensitive policies and strategies promoted by WFP (PAM 2015).
- Program planning was not done jointly, in order to initiate ownership of each component of the program by government authorities.

[24] Culturally it is only women who have to work in the rice fields.

2.6 Evaluation Criterion 6 – Sustainability

Question 6.1. To what extent have intervention implementation arrangements taken into account sustainability factors, such as capacity building of national and local government institutions, communities and other partners?

109. Although aspects of ownership were not formally described in the project document, WFP implemented a range of activities at different levels to ensure that acute malnutrition was addressed by government authorities and communities. The integration of MAM treatment is one of the important elements for ensuring the sustainability of care.

110. At present there is no commonly accepted international definition of integration or standards for integration in the health system. According to Rifat Atun et al (Atun et al 2009a; Atun et al 2009b), the assimilation of an intervention into a health system requires that its components are aligned with the key elements of the functioning of that system.

111. This section discusses the integration of MAM treatment into the national health system, using the model proposed by WHO, which defines six pillars of a health system: governance, financing, human resources, service delivery, equipment/inputs, and the health information system. For each pillar, the team analyzed the level of integration of MAM treatment implemented in the four provinces of Burundi in the light of existing data, in order to judge the degree of ownership of the program by the local authorities.

A. Governance

112. Full integration at this level is achieved when the mechanisms for accountability, drafting of policies, plans and reports, coordination and resource allocation are under the control of local authorities. Integration is partial when these responsibilities are shared between the health system and other organization(s).

113. In Burundi, the various national policies on mother and child health, in addition to the national protocol for the integrated management of acute malnutrition, have been developed by the government authorities with technical and financial support from partners. A single agreement has been signed in 2018 with follow-ups until 2019 between WFP, PRONIANUT and the health districts, with the program now being implemented under the coordination of PRONIANUT, particularly with regard to cascade training, monitoring and supervision. However, the allocation of resources dedicated to the storage and distribution of nutritional supplements was not managed by PRONIANUT or other government entities. In terms of governance, there is therefore partial integration for the treatment of MAM in Burundi.

B. Funding

114. Funding refers to the raising of funds to support the MAM treatment program and the means by which these funds are obtained. Integration is complete when the process of budgeting and fundraising for the program, and financing it, is entirely provided by local authorities.

115. In Burundi, although malnutrition is considered a priority by government authorities through adherence to the various multisectoral nutrition platforms and the development of policies, plans and protocols, no national budget line is currently directly allocated to nutrition, and specifically to the treatment of MAM. Funding for the program was entirely provided by the funds allocated by FFP. However, the Government participated indirectly by providing free care for children under five years of age and PLW, as well as the provision of health infrastructure, equipment and health personnel.

116. Both the FFP headquarters in Washington, DC, and the FFP country office are open to any approaches suggested by WFP which might arise from the results of this evaluation. As the prevalence of MAM is very low, future funding should be directed not only towards emergency response (as is currently the case), but also and above all towards the prevention of malnutrition. The integration of funding for the MAM treatment program is therefore partial in the country context.

C. Service Delivery

117. Services are fully integrated if they are delivered within the local health infrastructure and under the responsibility of government health workers. Integration is partial when this responsibility is shared between government health workers and staff specifically recruited for the MAM treatment program.

118. Since 2009, the treatment of acute malnutrition has been integrated into the package of activities of government health structures. Treatment services for MAM are therefore delivered within these structures, under the responsibility of the health center directors and SFP managers. With the exception of the management of nutritional supplements (see below), all treatment activities are delivered by government health workers, as well as monitoring and supervision, which are provided by the PHOs and nutrition focal points in the health districts.

119. In relation to the integration of SAM treatment with the other programs in the health package, the national protocol for the integrated management of acute malnutrition describes the mechanism of the continuum of care between SAM and MAM treatment. But there is not yet a formal link with the other programs with the scope of activities of the health centers such as family planning, antenatal consultation (ANC), Integrated Management of Childhood Illness, IYCF, etc., nor with nutrition-sensitive programs such as cash transfers, vegetable gardens, care groups and other interventions that aim to strengthen household resilience. Integration of service delivery is therefore partial in the country context.

D. Human Resources

120. Training of health-care providers on the national protocol was provided by PRONIANUT. WFP financed the refresher training of some PRONIANUT staff abroad, as well as the supervision of CHWs by social promotion technicians in the health districts. This training is a learning experience that may continue even after the end of the program's support.

121. One difficulty voiced by participants was the high turnover of trained staff, some of whom were posted to other locations, where the MAM treatment program was not available, while newly assigned officers to replace them were not trained. The national protocol for the integrated management of acute malnutrition is not part of the health school curriculum. Staff turnover has affected the quality of services, as described above. The health center directors, SFP managers, CHWs and Mentor Mothers have been also complained about the lack of reward for their involvement in the program.[25] Integration of human resources is therefore partial.

E. Infrastructure and Input Supply Chain

122. As already mentioned above, SFP services are deployed within state health structures, which is an important and positive element for sustainability. However, the delivery system for nutritional supplements (PlumpySup and CSB++) runs completely parallel to the national supply chain system represented by CAMEBU. The latter has no oversight of the ordering, storage and delivery of PlumpySup and CSB++. Since WFP has made commitments to the donor (FFP) to ensure the storage of nutritional supplements in good conditions (because these are the "cornerstone" of the program), it would have been difficult to transfer these skills to CAMEBU in a context of limited capacity. Indeed, CAMEBU does not have adequate space to store these food supplements, nor the skills and tools to manage them. The organization is already struggling to effectively manage pharmaceuticals under normal circumstances, and adding the management of dietary supplements would add to these difficulties. At the health center level, space is also limited for the storage of food supplements for a period of two to three months. Deliveries are made monthly, which adds to the logistical burden for WFP. The integration of infrastructure and the supply chain is therefore limited.

F. Health Information System

123. The monitoring system is fully integrated when the information technology infrastructure, data collection and analysis is provided by government institutions. In Burundi's MAM treatment program, data collection starts at the health district health centers, which then send the data to the

[25] CHWs and Mentor Mothers are not taken into account in the budgets of agreements and contracts between WFP and the Ministry of Health.

capital. As with other health data from the health structures, the monitoring data of the MAM treatment program are part of the DHIS2. This component is therefore fully integrated, although the quality of the data transmitted is not optimal.

Table 9. Overview of the level of integration of MAM treatment in each pillar of the health system

	Level of integration
Governance	Partial
Funding	Partial
Service Delivery	Partial
Human Resources	Partial
Infrastructure, supply chain	Partial
Health information system	Total

124. In summary, the general finding is that the program implementation agreements have partially taken into account the factors for integrating the treatment of MAM into five of the six pillars of the health system. As a result, the likelihood that the program's results will be sustained over time is low.

Question 6.2. To what extent will the benefits of the intervention continue for PLW and children 6–59 months after the end of the WFP intervention?

125. The awareness-raising messages conveyed by the Mentor Mothers were well received by the beneficiaries, who took initiatives to change their eating habits in the household by preparing balanced meals (consisting of the three main groups of nutritious foods) and to develop vegetable gardens.

> *"Yes, we have changed the way we prepare meals in our household; for example, how we add oil to the meal, and we now know the importance of the three nutritious food groups."* FGD with mothers of children, Rutana

> *"The women have changed their mentality regarding the proper preparation of family food. Before, they used to prepare food according to quantity, not quality. For example, they used to be able to cook only sweet potatoes every day, but now they vary the meals."* FGD with fathers of children, Ngozi

126. The major concern reported by mothers of children and PLW during the FGDs was the difficulty in applying the nutritional advice received at all times. With limited financial means, they cannot afford to buy all the important foods in the local market that they need to consume to prevent malnutrition in the household. This corroborates the results of the Fill the Nutrient Gap analysis, which showed that more than two-thirds of the Burundian population faces significant barriers to meeting their nutritional needs. As a result, nutritious food is unaffordable for 70 percent of the population (WFP 2019c).

127. Policies and protocols are available, health-care providers have been trained, capacity has been developed at both the health system and community levels, services are delivered through government health centers and the monitoring system is an integral part of DHIS2. These elements constitute assets that can be sustained when the support for the MAM treatment program ends. However, the implementation of all of these components depends on the availability of funding and good coordination with other nutrition-specific and nutrition-sensitive interventions. The recent development of a multisectoral approach to nutrition and the way it is budgeted is an opportunity to mobilize resources and sustain the achievements of the program.

Box 6 Key Results – Sustainability

- With the exception of the health information system, the integration of the MAM treatment program into the health system is generally limited. Major efforts still need to be made in terms of financial ownership of the program by government authorities, as well as to strengthen the national food supplement supply chain.
- As a result of the awareness-raising messages, PLW and mothers of children under five years of age have changed the eating habits in their households, despite the financial difficulties they face in obtaining all the important foods needed to prepare balanced meals.
- Capacity building of the multisectoral platform could be important for sustaining the achievements of the program at both the institutional and community levels.

3. Conclusions and Recommendations

128. Based on the results presented in the previous sections, a general review that meets the evaluation criteria is presented below. It is followed by six recommendations on how the Government of Burundi, WFP, FFP, and other key stakeholders can implement actions to build on the findings and the lessons learned.

3.1 General Review/Conclusions

3.1.1. Relevance

129. The MAM treatment program remains relevant in the context of Burundi because it responds to the Government's health, nutrition and development priorities, as well as to the needs of the beneficiaries. WFP therefore took these priorities into account during the design of the program. However, the current modalities for implementing the program (a single day of distribution, which means that most of the day is spent at the health center) constitute a security risk for some PLW and mothers of children.

3.1.2. Coherence

130. The MAM treatment program is coherent with other nutrition-specific interventions implemented in the four provinces through collaboration between WFP, UNICEF and PRONIANUT. However, coordination with other nutrition-sensitive sectors, such as food security, social protection, water and sanitation (to cite a few examples) during the planning and implementation phase remains inadequate.

3.1.3. Effectiveness

131. The geographical coverage of the program within the four provinces is excellent and facilitates access to services. Despite weaknesses related to admissions errors and stock-outs of dietary supplements, program performance was good in all four provinces. The application of awareness-raising messages on healthy eating at home and the use of super-cereals during certain periods of stock-out contributed to the effectiveness of the program. The availability of food supplements in the health centers made the program very attractive.

3.1.4. Efficiency

132. More careful planning of the ordering and delivery of nutritional supplements would have improved the efficiency of the program, including its thorough integration with other programs specific and sensitive to nutrition. The purchase, storage and distribution of dietary supplements represented the largest item of expenditure for the program. Insufficient storage capacity at the health centers meant that large quantities of food inputs, meant to cover a two- to three-month treatment period, could not be delivered. The strengthening and use of the national supply chain, joint training and supervision, the close integration of the MAM treatment program with other nutrition-specific and nutrition-sensitive programs, and the procurement of locally produced food supplements from neighboring countries would have lowered program costs and reached a larger number of beneficiaries.

3.1.5. Impact

133. The interlinkage between the WFP-supported MAM treatment program and NGO- supported prevention interventions has helped to reduce the prevalence of acute malnutrition in Kirundo province and maintain it at a low rate. The inclusion of gender elements during the implementation of the program, including awareness-raising among fathers of children under five years of age and husbands of admitted PLW, has enabled these fathers to better understand the importance of their role in family nutrition.

3.1.6. Sustainability

134. With the exception of the health information system, WFP has partially integrated the MAM treatment program into the health system in Burundi. Major efforts still need to be made in terms of financial ownership of the program by government authorities, as well as handing over the management of the food supplement supply chain to the Ministry of Health. The limited financial means of families limiting their access on the local market to important foods that need to be consumed to prevent malnutrition in the household.

3.2 Lessons Learned and Good Practices

Lessons learned

135. The time lapse between the order and the actual delivery of nutritional supplements, and the lack of consultation between WFP and health workers in estimating needs, led to a lack of consideration of local factors and resulted in a higher than expected number of admissions. Combined with the diversion of nutritional supplements, this led to stock-outs.

136. Program performance remained excellent despite problems related to diversion of food supplements due to supply shortages, the admission of SAM cases into the MAM program in error or when there were shortages of ready-to-use therapeutic foods for the treatment of SAM, the use of super-cereals when PlumpySup and CSB++ were in short supply, or the use of CBS++ for children under five years of age when there were shortages of PlumpySup, and the admission of children who had not gained at least 200 g after 12 days of FARN. This demonstrates the need to simplify the treatment of acute malnutrition (SAM and MAM) for better efficiency and effectiveness. The United Nations and its partners recognize the need to adapt the strategy for the management of acute malnutrition (WHO et al 2019), and key stakeholders have made recommendations to influence the 2020 Action Plan and call for, among other things, a commitment to simplify the current treatment approach so that all malnourished children – regardless of severity – are treated in a single program (ACF et al 2019). The operational constraints (diversions and dilutions) observed during this evaluation and described above corroborate the orientations currently suggested at the international level.

137. The implementation of MAM treatment in conjunction with other prevention interventions (social safety net through cash transfer, small-scale animal husbandry, etc.) enabled families to generate additional income and facilitated access to quality food in the province Kirundo; this has contributed to a significant reduction in the prevalence of acute malnutrition and keeping it below the emergency threshold in two districts. The optimal impact of the program would therefore result from the combined effects of treatment and prevention.

138. The irregularity of supervision had an adverse effect on the quality of the program, with errors in admissions, poor record-keeping, and dubious reliability of the data transmitted monthly. Insufficient consideration of gender and women's empowerment overshadowed the identification of gender-specific needs, and the needs of age sub-groups and socio-demographic conditions such as single-parent families, widows or divorced women, etc. These aspects should be improved in the next program cycle.

139. One of the repercussions of weak coordination between donors and different sectors is the siloed implementation of interventions funded by different donors at both national and district levels. This has hindered the possible complementarity of interventions and the pooling of resources for optimal impact on beneficiaries and their families. In addition, the lack of joint planning hampered the appropriate consideration of program ownership by the government authorities which is essential to ensure sustainability.

Good practices

140. The existence of several health, nutrition and gender policies and plans in the context of Burundi provide excellent opportunities to develop a program for the management of MAM that adequately meets the needs of national priorities, beneficiaries and implementing partners.

141. Although national coverage is low, the 100 percent geographical coverage in the four targeted provinces has facilitated access to services in all health areas, with a positive effect on the effectiveness of the program.

142. The inclusion of gender elements during the implementation of the program, particularly the awareness-raising among fathers of children under five years of age and husbands of admitted PLW, enabled these fathers to better understand the importance of their role in family nutrition and of the support they should provide to their wives during pre- and post-natal consultations.

3.3 Recommendations

143. Based on the findings and conclusions of this evaluation, the recommendations of the evaluation team are detailed below. The target group for each recommendation is clearly identified.

Recommendation	Justification, specific actions and timetable	Organization Responsible

1. Strengthen the capacity of government authorities in planning, monitoring and evaluation, implementation and coordination (Ministry of Health and other key ministries)	**a. Planning**
	• Systematize joint planning by actively involving
	  ○ PRONIANUT and the health districts in the project design (including the estimation of nutritional supplement needs, the identification of a multiplicity of international and national donors (including private sector actors), and the mobilization financial resources from these donors).
	  ○ UNICEF, in order to harmonize the criteria for selecting intervention districts, and streamline nutritional supplement orders to ensure a good continuum of care and to compensate for stock-outs.
	  ○ partners in charge of sectors such as social protection, agriculture, education, water and sanitation, etc., in order to reinforce the prevention aspects of the program: strengthening the resilience of families and communities.
	• Determine a strategy for government program ownership during joint planning. The strategy could be a step-by-step plan for integrating program components into each pillar of the health system.
	• Explore the possibility of purchasing nutritional supplements produced in neighboring countries such as Kenya, in order to reduce delivery delays, stock-outs and logistics costs, thus improving efficiency.
	
	Improve communication between WFP, PHOs, health districts, and health center staff, especially with regard to determining the quantities of nutritional supplements to order or deliver in the health centers, in order to prevent stock-outs and retain beneficiaries. Health center directors would like to requisition the quantities of nutritional supplements directly from the district for transmission to the national level, taking into account the number of "actual" and "expected" beneficiaries in the program. WFP and the Ministry of Health will triangulate the data and approaches used, streamlining them in order to estimate needs and taking into account the fluctuation of beneficiaries. This involvement of government authorities would make them more accountable in the future.
	
	This should be done this year, 2020, during the planning phase of the next program
		WFP needs to support this initiative, in collaboration with UNICEF and other United Nations agencies, and in collaboration with the relevant departments of the Ministry of Health and other ministries

Recommendation	Justification, specific actions and timetable	Organization Responsible
	cycle.	
	b. Implementation • Develop a plan to gradually strengthen CAMEBU's capacity to manage nutritional supplement stocks such as CSB++ and/or PlumpySup or alternatively identify other distribution channels that can effectively manage the storage and distribution of these nutritional supplements. • Analyze the storage capacities of health centers in the intervention districts and equip these infrastructures for storage of quantities that can cover two to three months of treatment. • Strengthen collaboration with UNICEF, in order to reinforce the continuum of care and optimize the rational management of nutritional inputs intended for the treatment of SAM and MAM. This should be done this year, 2020, during the planning phase of the next program cycle	
	c. Coordination • Strengthen the capacity of PRONIANUT to coordinate the MAM treatment program and other interventions specific and sensitive to nutrition, from the planning, resource mobilization and implementation phase, at the national, provincial and district levels. • Train more staff on the treatment of MAM, preferably train them from health training school stage, in order to alleviate the problem of staff turnover and ensure the continuity of services for the treatment of MAM, wherever they are assigned. Strong coordination would facilitate the pooling of resources and optimize the combined effects of interventions specific and sensitive to nutrition, particularly the strengthening of household resilience. This should be realized this year, 2020, during the planning phase of the next program cycle. For training in health schools, implementation must be considered in the long term, owing to the complexity of the process of integrating training into the curricula of	

Recommendation	Justification, specific actions and timetable	Organization Responsible
	these schools and training institutes.	
2. Conduct regular joint supervision	• Develop and implement, in addition to supervising, a range of activities to ensure the relevance, effectiveness and efficiency of the program in routine monitoring. These activities may include: o regular qualitative interviews with beneficiaries and various stakeholders o a regular verification of the concordance of data between health centers and those entered in the databases o SQUEAC/SLEAC-type surveys to ensure good coverage of the program and to identify potential bottlenecks o more in-depth analyses of the data to ensure its consistency and quality (e.g. analysis of seasonal variations in admissions, analyses of admissions by health center, etc.). • Improve the existing monitoring tools by incorporating the relevant indicators, and by disaggregating the data by type of beneficiary (child, pregnant woman, breastfeeding woman), age and gender. The data being tracked should also allow for the identification of the sex, age sub-group and socio-economic status for which effectiveness is best. More monitoring and joint supervision of the program should be undertaken by WFP, in collaboration with UNICEF, PRONIANUT, health districts, and donor(s) to improve the quality of services. The regular supervision of all implementation sites will strengthen the capacities of the health center and SFP managers for the adequate application of the national protocol, the improvement of the quality of care services and monthly data reporting. Follow-up data should identify gender, age sub-groups and socio-economic categories for which effectiveness is best. This should be done this year, 2020, during the planning phase of the next program cycle.	WFP should share the responsibility with UNICEF and PRONIANUT.

Recommendation	Justification, specific actions and timetable	Organization Responsible
3. Systematically integrate gender and women's empowerment aspects into program monitoring activities and tools	• Mainstream gender, equity and women's empowerment considerations in future planning and implementation cycles of the program, to better identify the age sub-groups with the greatest needs (e.g. 6–23 months in children, and adolescents aged 12–16 years old among pregnant and lactating women). This will also enable to take into consideration the more affected sex among children, along with the socio-economic characteristics of admitted beneficiaries. Issues such as awareness-raising among fathers and husbands of PLW would also be taken into consideration. • Integrate awareness-raising messages into SBCC strategies that specifically target indigenous populations such as the Batwa or followers of religions resistant to admission to the program. • Take into account the perspectives of other vulnerable populations such as the elderly, the physically and mentally disabled, orphans and street children, in relation to social protection programs. This should be done this year, 2020, during the planning phase of the next program cycle.	WFP should take the lead and actively support the Ministry of Health, Ministry of Social Affairs and Gender and the multisectoral nutrition platform in this initiative.
4. Review the process of offering services in health centers	Review this process, in order to reduce the workload of health center directors and SFP managers on distribution days and minimize the risk of violence against women. This would mean spreading the service over more than one day of the week or expanding the health center team on distribution days, in order to reduce the time spent by beneficiaries in the health center. CHWs and COSA members have expressed interest in supporting this. Pilot the initiative in one province for six months to a year and expand it to other provinces if the results are conclusive. Apply the chosen formula from the start of the implementation of the next project cycle in 2020–2021.	The Ministry of Health should consider this opportunity with the support of WFP and UNICEF.
5. Study the possibility of applying a simplified protocol for the care of acute malnutrition in the context of Burundi.	Such an initiative will make it possible to overcome the difficulties in making the program operational, such as dilution and diversion (related to erroneous admissions and shortages of nutritional supplements), weaknesses in the continuum of care between SAM and MAM, and the limited coverage nationwide. Each partner will be able to cover one or more provinces using the same processing log.	The Department of Health should lead this initiative, with the active support of key partners such as WFP, UNICEF and

Recommendation	Justification, specific actions and timetable	Organization Responsible
	Consider buying locally produced nutritional supplements from neighboring countries, to reduce delivery delays, stock shortages and logistics costs. This will have to be put into perspective for 2021, pending receipt of the international guidelines planned for 2020.	WHO.
6. Develop and implement joint programs	• Develop the strategy for the care of MAM so as to make systematic the admission of families of with MAM children and PLW into joint food security and safety net programs, in order to optimize the recovery of beneficiaries, break the vicious circle of malnutrition and prevent relapses in families. • Determine the package of specific and sensitive interventions/activities to be provided to beneficiaries admitted to the MAM treatment program, in addition to nutritional supplements and awareness-raising. • Increase national geographic coverage, as well as the targeting populations belonging to the ethnic, religious and social communities most reluctant to enter the program. The ramifications between the treatment of MAM and other programs should be made explicit in the project document, defining a package of curative and preventive services (safety net) to be provided to program beneficiaries, and identifying partners and different donors. A multiplicity of donors is essential for maximizing the chances of success, in line with the newly developed and budgeted for multisectoral strategy. The capacities of the SUN multisectoral platform should therefore be strengthened in this perspective, for better ownership by national authorities and communities. Pilot this joint planning mechanism at the national level and in one or two provinces during the preparation in 2020–2021 of the next program cycle. Expand it later in other provinces if the results of the pilot are conclusive.	The secretariat of the SUN multisectoral platform based within the 2nd vice-presidency of the Republic of Burundi is to take the lead. WFP, UNICEF, WHO, FAO, other UN agencies and donors of emergency and development programs should actively support the SUN secretariat.

APPENDICES

Appendix 1. Terms of Reference

Terms of Reference
FINAL EVALUATION of
Treatment of Moderate Acute Malnutrition intervention in Ngozi, Kirundo, Cankuzo and Rutana from 2016 to 2019
World Food Programme in Burundi, Republic of (BI)

List of acronyms

BI	Republic of Burundi
CO	Country Office
CFSVA	Comprehensive Food Security and Vulnerability Analysis
DEQAS	Decentralized Evaluation Quality Assurance System
EB	Executive Board
EC	Evaluation Committee
EFSA	Emergency Food Security Assessment
EM	Evaluation Manager
EQAS	Evaluation quality assurance system
ER	Evaluation Report
ERG	Evaluation Reference Group
FSMS	Food Security Monitoring System
GBV	Gender-based violence
GEEW	Gender equality and women's empowerment
HDI	Human development index
IDPs	Internally displaced persons
IOM	International Organization for Migration
IR	Inception Report
MAM	Moderate Acute Malnutrition
M&E	Monitoring and Evaluation
NGOs	Non-governmental Organization
OEV	Office of Evaluation
PLW/G	Pregnant and lactating women and girls
PLW	Pregnant and lactating women
UNCT	UN Country Team
UNDSS	UN Department of Safety & Security
UNEG	United Nations Evaluation Group
UNHCR	UN Refugee Agency
UN	United Nations
QS	Quality Support
RB	Regional Bureau
RBN	Regional Bureau in Nairobi
SUN	Scale Up Nutrition
TOC	Theory of Change
TOR	Term of References
FFP	Food For Peace
VAM	Vulnerability, Assessment, Mapping
WFP	World Food Programme

1. Introduction

1. These Terms of Reference (TOR) are for an evaluation of the treatment of Moderate Acute Malnutrition (MAM) for children 6-59 months, and pregnant and lactating women and girls (PLW/G), a sub-component of the Assistance to Vulnerable Food-Insecure Populations project, implemented in Ngozi, Kirundo, Cankuzo and Rutana from 2016 to 2019, and mainly funded by USAID/Food for Peace (FFP). This is an activity evaluation commissioned by World Food Programme (WFP) Burundi Country Office (CO) and will cover the period from 2016 to 2019.

2. These TOR were prepared by WFP Evaluation Manager based upon an initial document review and consultation with stakeholders and following a standard template. The purpose of the TOR is twofold. Firstly, it provides key information to the evaluation team and helps guide them throughout the evaluation process; and secondly, it provides key information to stakeholders about the proposed evaluation.

2. Reasons for the Evaluation

2.1. Rationale

3. USAID/FFP is an important donor to WFP in Burundi to address the humanitarian needs of the Burundian population and has funded MAM treatment interventions for the last three years in four provinces of the country. The evaluation will primarily be used by WFP Burundi to enhance project accountability towards the donor. A secondary objective is to produce strong evidence to feed into WFP evidence base for the improvement of future programs.

2.2. Objectives

4. Evaluations in WFP serve the dual and mutually reinforcing objectives of accountability and learning.
    - **Accountability** – The evaluation will assess and report on the performance and results of the MAM sub-component, to present high quality and credible evidence of actual impact to USAID/FFPIt will provide evidence-based findings to inform the relevance and effectiveness of the MAM treatment for operational and strategic decision-making.
    - **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. Findings will be actively disseminated and lessons will be incorporated into relevant lesson sharing systems. For these reasons, both accountability and learning have equal weight.

2.3. Stakeholders and Users

5. A number of stakeholders both inside and outside of WFP have interests in the results of the evaluation and some of these will be asked to play a role in the evaluation process. Table 1 below provides a preliminary stakeholder analysis, which should be deepened by the evaluation team as part of the Inception phase.

6. Accountability to affected populations is tied to WFP's commitments to include beneficiaries as key stakeholders in WFP's work. As such, WFP is committed to ensuring gender equality and women's empowerment (GEEW) in the evaluation process, with participation and consultation in the evaluation by women, men, boys, and girls from different groups.

Table 1: Preliminary Stakeholders' analysis

Stakeholders	Interest in the evaluation and likely uses of evaluation report to this stakeholder
INTERNAL STAKEHOLDERS	
World Food Programme Burundi	Responsible for the planning and implementation of WFP interventions at country level. It has a direct stake in the evaluation and an interest in learning from experience to inform decision-making. It is also called upon to account internally as well as to its beneficiaries and partners for performance and results of its programs.
Regional Bureau for East and Central Africa (RBN)	Responsible for both oversight of COs and technical guidance and support, the RB management has an interest in an independent/impartial account of the operational performance as well as in learning from the evaluation findings to apply this learning to other country offices. The Regional Evaluation Officers supports CO/RB management to ensure quality, credible and useful decentralized evaluations.
WFP Headquarters (HQ)	WFP HQ technical units are responsible for issuing and overseeing the rollout of normative guidance on corporate program themes, activities and modalities, as well as of overarching corporate policies and strategies. They also have an interest in the lessons that emerge from evaluations, as many may have relevance beyond the geographical area of focus. Relevant HQ units should be consulted from the planning phase to ensure that key policy, strategic and programmatic considerations are understood from the onset of the evaluation.
Office of Evaluation (OEV)	OEV has a stake in ensuring that decentralized evaluations deliver quality, credible and useful evaluations respecting provisions for impartiality as well as roles and accountabilities of various decentralized evaluation stakeholders as identified in the evaluation policy.
WFP Executive Board (EB)	The WFP governing body has an interest in being informed about the effectiveness of WFP programs. This evaluation will not be presented to the Board but its findings may feed into thematic and/or regional syntheses and corporate learning processes.
EXTERNAL STAKEHOLDERS	
Beneficiaries	As the ultimate recipients of food assistance, beneficiaries have a stake in WFP determining whether its assistance is appropriate and effective. As such, the level of participation with all beneficiaries and users, especially women, girls and disadvantaged groups will be engaged, their views and perspectives will be taken into consideration and will be determined and their respective perspectives will be sought.
United Nations Country team (UNCT's)	The UNCT's harmonized action should contribute to the realization of the government developmental objectives. It has therefore an interest in ensuring that WFP programs are effective in contributing to the UN concerted efforts. Various agencies are also direct partners of WFP at policy and activity level.
Implementing partner	*Programme National Intégré pour l'Alimentation et la Nutrition* (PRONIANUT) is the main WFP's partners for the implementation of the MAM treatment activities. The results of the evaluation might affect future implementation modalities, strategic orientations and partnerships. Information related to strategic operations and orientation, capacity development, handover and sustainability will be of particular interest.
Donors **USAID/FFP**	WFP operations are voluntarily funded by a number of donors. Donors have an interest in knowing whether their funds have been spent efficiently and if WFP's work has been effective and contributed to their own strategies and programs. Donors would be interested to assess what are strengths, gaps and lessons learned of MAM treatment.

7. The primary users of this evaluation will be:
   - The WFP Burundi Country Office and its partners in decision-making, notably related to program implementation and/or design, Country Strategy and partnerships.
   - Given the core functions of the Regional Bureau (RB), the RB is expected to use the evaluation findings to provide strategic guidance, program support, and oversight.
   - WFP HQ may use evaluations for wider organizational learning and accountability.
   - OEV may use the evaluation findings, as appropriate, to feed into evaluation syntheses as well as for annual reporting to the Executive Board.
   - The findings will also feed into annual corporate reporting and donor reporting.

8. The secondary users of this evaluation will be the Ministry of Health, through PRONIANUT and the non-governmental organizations (NGOs). The findings will be relevant for decision-making, notably related to program implementation and/or design, and partnerships.

3. Context and subject of the Evaluation

3.1 Context

9. Burundi is one of the poorest countries in the world, ranking 185 out of 189 on the human development index (HDI) with over 65 percent of the population living under the national poverty line of $1.90 per day. The country is the 9th most food insecure country in the world, sharing similar levels with Somalia, according to the 2018 World Food Security Report. Over 90 percent of the population are dependent on agriculture as their main source of income. With a population estimated at 11.7 million in 2017, Burundi has the second highest population density in Sub-Saharan Africa with more than 400 inhabitants per square kilometer. The high population density as well as the ongoing influx of returnees and refugees from DRC contributes to competition and disputes over scarce natural resources. It is worth noting that women play a major role in Burundi's national economy and represent 55.2 percent of the workforce. Women are particularly active in the agricultural sector, which provides 90 percent of food production and 90 percent of the country's export.

10. Globally, Burundi has the highest level of chronic malnutrition, with current prevalence level at 56 percent. According to the Demographic and Health Survey (DHS 2016/2017), stunting prevalence is above 50 percent in all 18 provinces except for Bujumbura Mairie, with some provinces in the north east over 60%. Global acute malnutrition (5-8 percent) has been rising over the past few years. Localized surveys have found prevalence levels far higher than 10 percent. The prevalence of anemia among children aged 6-59 months is above 60 percent, exceeding the WHO threshold of 40 percent.

11. Underlying drivers for undernutrition include poverty, poor access to clean water, and worsening access to basic services such as health and education. A high prevalence of infectious diseases, lack of diversity in diets and poor hygiene make the situation worse. Adding to the pressure on Burundi's limited resources, over 45,000 refugees, mainly from the Democratic Republic of the Congo, are hosted in already food-insecure areas and rely on assistance for basic food and nutrition.

12. The Government of Burundi's efforts to ensure long-term solutions to food and nutrition insecurity challenges in the country are translated into relevant country's policies including the National Development Plan, Burundi's Vision 2025, and the National Agricultural Investment Plan (2012-2017). The government also adhered to international initiatives, including the Scale Up Nutrition (SUN) movement. WFP's long-term vision in Burundi is to support the government's efforts to achieve Sustainable Development Goal (SDG) 2: end hunger, achieve food security and improve nutrition by 2030.

13. WFP's focus is to reshape the food system in Burundi by promoting a multi-sectorial and systems approach to food access and utilization. The overall country strategy is aligned with national food and nutrition security policies and tools, and the United Nations Development Assistance Framework (UNDAF) for 2018-2022.

14. The UN family (UNICEF, WFP, WHO, IFAD), INGOs, NGOs and governmental bodies have been working on a comprehensive package of nutrition interventions: Severe Acute Malnutrition (SAM) treatment, MAM treatment, prevention of undernutrition, fortification programs, HIV program (preventative actions, capacity strengthening, facilitate access to anti-retroviral treatment), and governmental capacity-building in nutrition.

15. WFP and UNICEF worked jointly to tackle malnutrition in the country. Through the national protocol, UNICEF delivers SAM treatment to targeted children and WFP delivers MAM treatment to targeted PLAW and their children between 6-59 months. In partnership with local NGOs, both agencies also implement prevention actions on chronic malnutrition. Moreover, WFP implement fortification program to prevent micronutrient deficiencies targeting children between 6-23 months.

16. WFP activities are aligned with national food security and nutrition strategies. WFP humanitarian, community recovery and development interventions are aligned with the communal development plans, nutrition activities are defined based on National Protocols, and the school meals program aligns with the government's reform of the education system. During implementation, WFP works with decentralized structures of the line ministries, which is a good mechanism to detect gaps in expertise and organize capacity strengthening training with a view to transferring skills to local institutions for a future program handover.

17. In Burundi, women represent around 55 percent of the total labor force. Despite some improvements in women's representation in decision-making positions, women still face many challenges. A research conducted by the ''Ministère de la Fonction Publique, du Travail et de l'Emploi" (PNRA) and supported by United Nations Development Program (UNDP) in 2017, showed that women only account for the 14.5 percent in the political sector, 29.1 percent in the economic sector, and 42.2 percent in the social sector, making an average of 39.7 percent women compared to 60.3 percent of men.

18. Gender disparities are reflected differently according to provinces and economic activities. Culturally, men are the head of the households. In regions where, contracted labor is the main source of income, women and children work on the house and farming, and the money earned by men sometimes does not reach other household members. Gender disparities continue to affect households' food security.[26]

19. " Food utilization and consumption refers to the socioeconomic aspects of household food and nutrition security, determined by knowledge and habits. Assuming that nutritious food is available and accessible, the household has to decide what food to purchase, how to prepare it, and how to consume and allocate it within the household. Women's health and nutrition affect newborns' birth weight and the mother's ability to breastfeed her infant for the first six months. Chronic energy deficiency (CED), as measured by body mass index (body mass divided by the square of the body height in kg/m2), is a measure of women's nutritional status. In Burundi, 16 percent of women of childbearing age have CED. Both adolescent girls 15 to 19 years and women 40 to 49 years are slightly more likely to have CED than other women. Household-level approaches to nutrition hide intra-household inequality in food consumption. Nutrition programs that provide food to the household as a whole, as opposed to specifically to pregnant and lactating women, result in an unequal distribution of food within a household. Men control the distribution of resources at the household level, and do not share the distribution equally with or prioritize pregnant and lactating women and children. " [27]

20. In addition, Gender-based violence (GBV) is widespread in Burundi. According to UNICEF (June 2018), nearly one in four Burundian women (23 percent) and 6 percent of men have experienced sexual violence, and children are particularly at risk. Only a small percentage of sex-related incidents are reported, so the actual number is likely much higher. Acknowledging the extent of the problem, the government established a law for the prevention, protection and punishment of GBV, which was adopted in December 2015. This law has now been in existence for three years yet, the texts of the law are generally not applied. This means those experiencing GBV are unaware there is a law that protects them. Thus, when they suffer it is not clear who to turn to or what to do. Rather, most of those who experience violence decide to remain silent or allow their families to settle the issue with the perpetrators.[28]

3.2 Subject of the evaluation

21. The decentralized evaluation will focus on MAM treatment for children 6-59 months, and pregnant and lactating women and girls (PLW/G), implemented as part of the Supplementary Feeding Programme, in accordance with the National Protocol for Integrated Community Management of

[26] World Food Programme in Burundi, Republic of (BI), 2018. Assistance to Refugees and Vulnerable Food-Insecure Populations, Standard Project Report 2018, p.15-16
[27] USAID, 2017. Burundi Gender Analysis, Final Report. URL: https://banyanglobal.com/wp-content/uploads/2017/07/USAID- Burundi-Gender-Analysis-Final-Report-2017.pdf
[28] World Food Programme in Burundi, Republic of (BI), 2018. Assistance to Refugees and Vulnerable Food-Insecure Populations, Standard Project Report 2018, p.15-16.

Acute Malnutrition validated on October 2017 with the participation of WFP-Burundi. With USAID/FFP funding, the activity was implemented in provinces of Ngozi, Kirundo, Cankuzo and Rutana provinces.

22. The scope of this evaluation will focus on the project implemented between July 1st, 2016 to March 31st, 2019. The rationale behind the scope of the evaluation is that relevant data started to be collected in 2016. WFP Burundi Country Office received an annual grant from FFP from 2016 to 2019. The total amount financed by Food for Peace is $47,923,099 USD. The table below disaggregates the grant amount per year. The details amount allocated only for the MAM treatment will be share during the inception phase with the evaluation team.

Table 2: Food for Peace fund per year.

Year/Total	2016	2017	2018	2019	Total
Amount	$8,000,000	$12,697,577	$13,935,000	$13,290,522	**$47,923,099**

23. The MAM treatment activity is contributing to Burundi Strategic Outcome 03: Children 6-59 months, adolescent girls, and pregnant and lactating women and girls (PLW/G) in the targeted provinces and communes have improved nutritional status throughout the year. This Strategic Outcome's aim is to improve the nutrition status by focusing on the treatment MAM, prevention of stunting, and prevention of micronutrient deficiencies, targeting children aged 6-59 months, adolescent girls and pregnant and lactating women (PLWs) and other nutritionally vulnerable populations.

24. The MAM treatment activity was implemented in partnership with the Ministry of Health and through its decentralized structures, health centers, health districts, community relay. The collaboration between WFP and PRONIANUT ensures an extensive field presence and offers the best prospects for sustainability. However, there are also some areas for future improvements: high staff turnover, insufficient level of capacity and ownership, short staff number, low level of information sharing and dissemination among staff.

25. The geographic area of the intervention includes the provinces of Ngozi, Kirundo, Cankuzo, and Rutana. The choice of these provinces was motivated by a prevalence of global acute malnutrition higher than or equal to 10 percent, or between 5 and 9 percent if aggravating factors are present such as: food insecurity, morbidity, displacement and population density.

26. Once children and PLW/G are screened for malnutrition, moderately malnourished children aged 6-59 months are given a daily ration of 100g of ready to use supplementary food (RUSF) while PLWs receive 250g of SuperCereal. The nutrition support provided is crucial for improving the nutrition status of the beneficiaries. For example, the recovery rate of the MAM treatment surpassed the set target, while the mortality rate approached zero in the targeted provinces. In addition, in 2018, the MAM treatment intervention covered a higher number of beneficiaries than initially planned (109 percent) due to returnees, movement of internally displaced persons and admissions of beneficiaries from other catchment areas.

27. Depending on the nutritional status of the targeted population and the region of intervention, beneficiaries may receive SAM treatment at first, and continue with the MAM treatment, once their status is enhancing. Most of them will then be targeted for SAM, implemented by UNICEF or MAM treatment, implemented by WFP. Although this evaluation will only focus on the MAM treatment, it is important to clarify that the SAM treatment, the MAM treatment, and prevention interventions are interrelated. A theory of change (TOC), in annex 6, has been developed with relevant stakeholders to prepare this evaluation. No specific logical framework is available for the MAM component.

28. Although no specific gender analysis has been made to develop the MAM treatment actions funded by USAID/FFP, the evaluation should mainstream gender perspectives and considerations through all stages of the evaluation and making sure that the most vulnerable women and women-headed households would be considered adequately. In addition of sex-disaggregated data, the information collected should include GEEW analysis and the evaluation findings should draw clear perspectives of the different targeted groups as well as pay attention to gender inequalities and specific gender

vulnerabilities and concerns. Gender issues and gender dimensions will need to be clearly stated.

29. No specific information from past evaluations can be used for this current evaluation.

30. The total number of planned and actual beneficiaries for 2016, 2017, 2018, 2019 are presented under Table 3. Additional disaggregated data will be made available to the evaluation team at the inception stage.

Table 3. Actual total beneficiaries from 2016 to 2019

Type of beneficiaries	*Planned*				*Actual*			
	2016	2017	2018	2019	2016	2017	2018	2019
Children (6-23 months)	35,868	9108	26,832	18,447	21,525	42,344	45,947	13,817
Children (24-59 months)	18,232	4630	53,168	36,553	10,941	21,523	43,998	13,275
PLW (18 plus)	18,159	11,096	17,100	7,500	12,566	19,789	32,462	13,288
Total beneficiaries	72,259	24, 834	62,500	45,032	45,032	83,656	40,380	24, 834

31. The decentralized evaluation will focus on the implementation period between 2016 and 2019.

32. The other documents specifically related to the USAID/FFP MAM component are listed under section 4.3.

33. Please refer to annex 1 to visualize the country map. Additional programming details will be made available at the inception stage of the evaluation.

4. Evaluation Approach

4.1. Scope

34. The evaluation will cover the activities related to MAM treatment for pregnant and lactating women and children aged 6-59 months, in provinces of Ngozi, Kirundo, Cankuzo and Rutana provinces. WFP nutrition programming aims to both prevent acute malnutrition where required, as well as ensure adequate capacity for treatment of MAM. WFP's programming to treat MAM relies on the provision of specialized nutrition products where appropriate, in addition to the provision of routine medical care and promotion of optimal health and nutrition practices through nutrition assessment, education, and counselling. The TOC (Annex 6) provides a complete visual perspective of the main actions and assumptions for the MAM treatment financed by FFP in Burundi.

35. The target groups for this evaluation are pregnant and lactating women and girls, and children aged 6- 59 months receiving MAM treatment.

36. Funded by USAID/FFP and implemented by WFP Burundi, the decentralized evaluation will focus on the implementation period between 2016 and 2019.

37. The evaluation team may face some of the following challenges while undertaking the evaluation process:

    a. Programming followed the annual grant cycle and annual projects mainly focused on outputs;
    b. The annual projects proposal were activity-based rather results-based (no baseline or logframe are available); However, to some extent, the evaluation team will have access to specific data that will allow them to rebuild a baseline on the acute malnutrition status for the targeted provinces.
    c. The annual project proposals were not informed by a previous gender analysis;
    d. While WFP has maintained an accurate quantitative database of MAM treatment cases, only limited qualitative data is available.

38. To address these limitations:

a. A TOC has been recently developed with relevant stakeholder to structure this evaluation;
b. The evaluation team will have access to quantitative data through the WFP database to be able to be aware of the situation at the beginning of the interventions; The evaluation team will be expected to review the TOC in the inception report.
c. The evaluation will integrate specific gender-sensitive data and will draw specific attention to gender perspectives;
d. Qualitative and participatory data collection methods will be used to collect qualitative information.

39. All data will need to be at least disaggregated by age, sex, and region.

4.2. Evaluation Criteria and Questions

40. The evaluation will focus on the six DAC evaluation criteria: relevance, coherence, effectiveness, efficiency, impact, and sustainability.[29] The evaluation will address the key questions outlined in Table 2, which will be further developed by the evaluation team during the inception phase. Collectively, the questions aimed at highlighting the performance of MAM treatment, and lessons learned could inform future strategic and operational decisions.

41. Allied to the evaluation criteria, the evaluation will address the key questions outlined below, which will be further developed/revised by the evaluation team during the inception phase. The evaluation team is expected to further develop the main evaluation questions in an evaluation matrix annexed to the inception report. The matrix will include: main evaluation question, sub-questions, data sources, and data collection methods.

42. The evaluation should analyze how GEEW objectives and GEEW mainstreaming principles were included in the intervention design, and whether the object has been guided by WFP and system-wide objectives on GEEW. The GEEW dimensions should be integrated into all evaluation criteria as appropriate.

Table 2: Criteria and evaluation questions

Criteria	Evaluation Questions
Relevance	• To what extent the MAM treatment was in line with the needs of the most vulnerable, most particularly with pregnant and lactating women and girls, and children? • Did distribution schedules, logistics, access, and MAM treatment interventions were aligned with realities and needs of the targeted beneficiaries, as well as • disabled persons?
	• To what extent is the intervention aligned with the needs and priorities of the government?
Effectiveness	• What were the major factors influencing how MAM treatment contributed to meet the performance indicator on recovery, death and dropout in the targeted provinces? • To what extent did the intervention deliver results for pregnant and lactating women, girls and children 6-59 months? • Were there unintended positive/negative results?

[29] DAC Evaluation criteria: https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

Criteria	Evaluation Questions
Coherence	• To what extent the MAM treatment interventions funded by FFP were coherent with other donors interventions in nutrition program? • To what extent the program was aligned with government policies and nutrition protocols? • How did the referral mechanisms to other nutrition programs (health facility • to community and vice-versa) worked?
Efficiency	• What is the cost-effectiveness analysis of MAM treatment in the targeted regions compare to similar programs in the country or within the sub- region? • Did MAM treatment has the most cost-efficient performance for coverage and adherence? • How can the cost-efficiency of MAM treatment be improved? With specific attention to: o Cost per ration distributed; o Cost per beneficiary reached; o Cost per beneficiary effectively adhering to an established protocol; • What factors drive the cost-efficiency of MAM treatment?
Impact	• To what extent has the MAM treatment contributed to changing the nutrition status of the targeted beneficiaries (lactating and pregnant women and girls, children 6-59 months)? • To what extent has the MAM treatment contributed to meet the performance indicator on recovery, death and dropout in the targeted provinces? • To what extent has the government being influenced to increase investments in nutrition?
Sustainability	• To what extend did the intervention implementation arrangements include considerations for sustainability, such as capacity-building of national and local government institutions, communities and other partners? • To what extent will the benefits of the intervention continue for pregnant and lactating women and girls and children 6–59 months after the end of WFP's • intervention?

4.3. Data Availability

43. The main sources of information available to the evaluation team, including qualitative and quantitative data, are listed below.

Primary data:

a. Annual FFP Proposal;
b. FFP Concept Notes;
c. FFP Biannual Reports;
d. FFP Annual Results Reporting;
e. WFP Burundi Nutrition Database;
f. WFP Post Distribution Reports;
g. WFP Burundi Country Annual Report;
h. Burundi Interim Country Strategic Plan 2018-2020;

Secondary data:

a. Burundi National guideline on Integrated Management of Acute Malnutrition (IMAM);
b. Implementing partner's reports;
c. USAID Gender Analysis 2017, Burundi;
d. USAID Food Assistance Factsheet;

e. Additional documents may be made available to the evaluation team at the inception stage of the evaluation.

44. Concerning the quality of data and information, the evaluation team should:

a. Assess data availability and reliability as part of the inception phase expanding on the information provided in section 4.3. This assessment will inform the data collection.

b. Systematically check accuracy, consistency, and validity of collected data and information and acknowledge any limitations/caveats in drawing conclusions using the data.

4.4. Methodology

45. The evaluation team will conduct a comprehensive realistic evaluation approach. . The adoption of participatory and innovative approaches is highly encouraged.

46. To answer the evaluation questions, a mixed-methods approach is proposed:

- **Desk Review and Context Analysis:** A careful analysis of existing data and information from secondary sources including policy documents, program documents, monitoring reports, annual project reports;
- **Quantitative primary data collection:** from a representative number of pregnant and lactating women, health workers, and other significant actors, through a carefully designed survey, bearing in mind that gender dimensions vary from one region to the other and there are key elements to be assessed;
- **Qualitative primary data collection:** through interviews, focus group discussions, key informative interviews, storytelling and most significant change approach, as well as other participatory methods, if relevant. This should cover pregnant and lactating women, health workers, and other significant actors.
- **Costs Analysis:** to answer the questions related to efficiency will require cost-effectiveness analysis and cost-efficiency analysis on MAM treatment intervention.

47. The full methodology will be confirmed and refined by the evaluation team during the inception phase, but it should:

- Employ the relevant evaluation criteria listed above;
- Use mixed methods (quantitative, qualitative, participatory, etc.) to ensure triangulation of information through a variety of means;
- Demonstrate impartiality and lack of biases by relying on a cross-section of information sources (stakeholder groups, including beneficiaries, etc.). The selection of field visit sites will also need to demonstrate impartiality. The evaluation team should ensure that the methodology and evaluation implementation are ethical and conform to the UNEG Ethical Guidelines for Evaluation;
- Apply an evaluation matrix geared towards addressing the key evaluation questions taking into account the data availability challenges, the budget and timing constraints;
- Ensure through the use of mixed methods that women, men, girls, and boys from different
- stakeholder's groups participate and that their different voices are heard and used;
- Mainstreams gender equality and women's empowerment in the way the evaluation is designed,
- collected and analyzed (as above) and the ways findings are reported, and conclusions and recommendations are made. The methodology should emphasis learning perspectives, such as good practices, strengths, gaps, lessons learned and recommendations for MAM treatment intervention in the four provinces.

48. The methodology should be GEEW-sensitive, indicating what data collection methods are employed to seek information on GEEW issues and to ensure the inclusion of women. Particular attention should be made to marginalized groups and people with disabilities. The methodology should ensure that data collected is disaggregated by sex and age; an explanation should be provided if this is not

possible. Triangulation of data should ensure that diverse perspectives and voices of both males and females are heard and taken into account.

49. Looking for explicit consideration of gender in the data after fieldwork is too late; the evaluation team must have a clear and detailed plan for collecting data from women and men in gender-sensitive ways before fieldwork begins.

50. The evaluation findings, conclusions and recommendations must reflect gender analysis, and the report should provide lessons/ challenges/ recommendations for conducting gender-responsive evaluation in the future.

51. To ensure independence and impartiality, an Evaluation Committee, and an Evaluation Reference Group will be appointed and involved through all the evaluation phases.

52. The Evaluation firm will be asked to set out how ethics can be ensured at all stages of the evaluation and that they seek appropriate ethical clearances (institutional and local) for the design ahead of going to the field.

53. The Evaluation team will need to expand on the methodology presented in the TOR, and develop an Evaluation Matrix as part of this.

4.5. Quality Assurance and Quality Assessment

54. WFP's Decentralized Evaluation Quality Assurance System (DEQAS) defines the quality standards expected from this evaluation and sets out processes with in-built 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 (EQAS) and is based on the UNEG norms and standards and good practice of the international evaluation community and aims to ensure that the evaluation process and products conform to best practice.

55. DEQAS will be systematically applied to this evaluation. The WFP Evaluation Manager will be responsible for ensuring that the evaluation progresses as per the DEQAS Process Guide and for conducting rigorous quality control of the evaluation products ahead of their finalization.

56. WFP has developed a set of Quality Assurance Checklists for its decentralized evaluations. This includes Checklists for feedback on quality for each of the evaluation products. The relevant Checklist will be applied at each stage, to ensure the quality of the evaluation process and outputs.

57. In addition, to enhance the quality and credibility of this evaluation, an outsourced quality support (QS) service directly managed by WFP's Office of Evaluation in Headquarter provides a review of the draft inception and evaluation report (in addition to the same provided on draft TOR), and provide:
    a. Systematic feedback from an evaluation perspective, on the quality of the draft inception and evaluation report;
    b. Recommendations on how to improve the quality of the final inception/evaluation report.

58. The evaluation manager will review the feedback and recommendations from QS and share with the team leader, who is expected to use them to finalize the inception/ evaluation report. To ensure transparency and credibility of the process in line with the United Nations Evaluation Group (UNEG) norms and standards[30], a rationale should be provided for any recommendations that the team does not take into account when finalizing the report.

59. This quality assurance process as outlined above does not interfere with the views and independence of the evaluation team, but ensures the report provides the necessary evidence in a clear and convincing way and draws its conclusions on that basis.

60. The evaluation team will be required to ensure the quality of data (validity, consistency and accuracy)

[1] UNEG Norm #7 states "*that transparency is an essential element that establishes trust and builds confidence, enhances stakeholder ownership and increases public accountability*"

throughout the analytical and reporting phases. The evaluation team should be assured of the accessibility of all relevant documentation within the provisions of the directive on disclosure of information. This is available in WFP's Directive CP2010/001 on Information Disclosure.

61. All final evaluation reports will be subjected to a post hoc quality assessment by an independent entity through a process that is managed by OEV. The overall rating category of the reports will be made public alongside the evaluation reports.

5. Phases and Deliverables

62. The evaluation will proceed through the following phases. Annexes 2 and 5 provide a more detailed timeline.

- **Phase 1 – Preparation phase (12 June – 12 August)**
  - Preparation will be done by WFP Country Office including preparation for the TOR selection of the evaluation team, and contracting of the evaluation company. This is done in collaboration with WFP's regional and headquarter evaluation offices. The TOR is used for competitive tendering for an evaluation team through the WFP Burundi procurement function.
- **Phase 2 – Inception (27 August – 21 October)**
  - Based on an initial mission by the evaluation team leader, possibly including other members of the team, an inception report will be produced. The inception report, following WFP DEQAS guidance, will detail how the team intends to conduct the evaluation with an emphasis on methodological and planning aspects including the theory of change and evaluation matrix. (deliverables: inception report).
- **Phase 3 – Fieldwork (5 November – 5 December)**
  - Data collection is expected to take 3-4 weeks, with some primary data collection in the four intervention provinces and secondary data analysis forming the majority of the work. (deliverables: fieldwork debriefing).
- **Phase 4 – Analyses and reporting (6 December – 12 February)**
  - Based on the data collection and analysis, the desk review, and additional consultations with stakeholders as needed, a draft and final evaluation report will be produced. The draft report is to be circulated by the evaluation manager for comments and thereafter comments considered by the evaluation team in the final evaluation report. (deliverables: draft and final evaluation reports).
- **Phase 5 – Dissemination and follow-up (17 February – 17 March)**
  - WFP Burundi will disseminate the final evaluation report to key internal and external stakeholders. In addition, the recommendations from the evaluation team will be considered in future programming decisions (deliverables: Case study, Data storytelling, Storytelling products, Video, PowerPoint presentation).

63. The expected deliverables from the evaluation exercise are the following:

a. **Inception report,** using WFP recommended template. The evaluators will confirm the final evaluation questions, the approach and the methods that will be used to answer the evaluation questions. This means setting out a full study design including what data is being collected and for what purpose, how sampling is done, how the data is being analyzed and triangulated. The inception report should outline the roles and responsibilities of the evaluation team in alignment with the deliverables. The inception report must also include how the data has been quality- assured, and how the evaluators will manage and safeguard ethics during the life of evaluation. The inception report will include the list of outcome indicators that will be monitored during the evaluation process. Annexed to the inception report, the evaluation team should include a detailed work plan, including timeline and activities, and a communications and learning plan;

b. **Evaluation report**, including a first draft, using WFP recommended template. It must set out a detailed methodology section, study design, and any limitations or where the study design

was compromised. Should detail how data was collected, validated and analyzed, and how conclusions were drawn. How different types of methods were brought together in the analysis. Annexes to the final report include but are not limited to a copy of the final TOR, bibliography, detailed sampling methodology, maps, a list of all meetings and participants, final survey instruments, transcripts from key informant interviews, focus group discussions, table of all standard and custom indicator with baseline, and endline values;

i. **Clean data sets**, including quantitative data sets in Excel, statistical software code, and transcripts and/or notes from focus group discussions and key informant interviews, a satisfying ethic protocol to ensure anonymous data.

c. Dissemination

i. **Case study** of MAM treatment, including main findings, good practices, most significant changes, lessons learned, limitations, conclusions, and recommendations;
ii. **Storytelling products** for each of the targeted beneficiaries of MAM treatment, representing the four regions of interventions;
iii. **Data storytelling** (2 pages) of the main findings of the evaluation;
iv. **Dissemination video** on the main findings of the evaluation;
v. **PowerPoint presentation** of main findings and conclusions for debriefing and dissemination purpose, dissemination videos on the main findings od the evaluation.
vi. Two-page summary of the evaluation report

6. Organization of the Evaluation & Ethics

6.1. Evaluation Conduct

64. The evaluation team will conduct the evaluation under the direction of its team leader and in close communication with the WFP evaluation manager. The team will be hired following the agreement with WFP on its composition.

65. The evaluation team will not have been involved in the design or implementation of the subject of evaluation or have any other conflicts of interest. Further, they will act impartially and respect the code of conduct of the evaluation profession.

6.2. Team composition and competencies

66. The evaluation team is expected to include 3-4 members, including the team leader. To the extent possible, the evaluation will be conducted by a gender-balanced, geographically and culturally diverse team with appropriate skills to assess gender dimensions of the subject as specified in the scope, approach and methodology sections of the ToR. At least one team member should have WFP experience.

67. The team will be multi-disciplinary and include members who together include an appropriate balance of expertise and practical knowledge in the following areas:

- One team member with sound expertise in nutrition, public health and/or nutrition anthropology with previous experience of work with WFP;
- One team member with strong expertise in economic development and health economists;
- One team member with strong expertise in gender equality;
- One team member with strong competencies in communication, visual information dissemination, graphic design, and videos ;
- Prior experience evaluating multi-stakeholder programs, e.g. UN and donor programs, is required;
- Prior experience in humanitarian interventions;
- Experience in the evaluation of large scale nutrition delivery programs, preferably with integrated management of acute malnutrition, supplementary feeding, maternal and child health nutrition programs, etc.

- Sound experiences in data collection and analysis (quantitative and qualitative) skills and experience from similar exercises;
- Experience with USAID/FFP is an advantage;
- Familiarity with Burundi context is a significant advantage;
- All team members should have strong analytical and communication skills, evaluation experience. A majority of team members should be fluent in English and French (oral and written).

68. **The Team leader will:**

    a. The Team Leader assumes responsibility for the entire evaluation processes and is the main contact with the evaluation manager.

    b. Have advanced University degree in International Affairs, Economics, Nutrition/Health, Agriculture, Environmental Science, Social Sciences or another field relevant to international development assistance.

    c. More than 15 years of progressively responsible professional experience in evaluation, including at least 5 previous assignments as Team Leader.

    d. Have technical expertise in one of the technical areas listed above as well as expertise in designing methodology and data collection tools and demonstrated experience in leading similar evaluations.

    e. She/he will also have leadership, analytical and communication skills, including a track record of excellent English and French writing and presentation skills.

69. Her/his primary responsibilities will be: i) defining the evaluation approach and methodology; ii) guiding and managing the team; iii) leading the evaluation mission and representing the evaluation team; iv) drafting and revising, as required, the inception report, the end of fieldwork (i.e. exit) debriefing presentation and evaluation report in line with DEQAS.

70. **The Senior Evaluator (co-team leader) will:**
    a. Take a leading role in the design, data collection, data synthesis and analysis, and report writing.
    b. Advanced University degree in International Affairs, Economics, Nutrition/Health, Agriculture, Environmental Science, Social Sciences or another field relevant to international development assistance, or First University Degree with two additional years of relevant work experience from the minimum experience requirement stated below.
    c. More than 10 years of progressively responsible professional experience in evaluation.

71. Her/his primary responsibilities will be: Co-lead on evaluation and approach, co-author of all deliverables (especially the integration of quantitative/survey results), support expert for nutrition development economics and gender analysis.

72. The other team members will bring together a complementary combination of the technical expertise required and have a track record of written work on similar assignments.

73. **Team members will:** i) contribute to the methodology in their area of expertise based on a document review; ii) conduct fieldwork; iii) participate in team meetings and meetings with stakeholders; iv) contribute to the drafting and revision of the evaluation products in their technical area(s).

6.3. Security Considerations

74. **Security clearance** where required is to be obtained from WFF Burundi Country Office.

- As an 'independent supplier' of evaluation services to WFP, the evaluation company is responsible for ensuring the security of all persons contracted, including adequate arrangements for evacuation for medical or situational reasons. The consultants contracted by the evaluation company do not fall under the UN Department of Safety & Security (UNDSS) system for UN personnel.

75. However, to avoid any security incidents, the Evaluation Manager is requested to ensure that:

- The WFP CO registers the team members with the Security Officer on arrival in country and arranges a security briefing for them to gain an understanding of the security situation on the ground.
- The team members observe applicable UN security rules and regulations – e.g. curfews etc.

6.4. Ethics

76. WFP's decentralized evaluations must conform to WFP and UNEG ethical standards and norms. The contractors undertaking the evaluations are responsible for safeguarding and ensuring ethics at all stages of the evaluation cycle (preparation and design, data collection, data analysis, reporting and dissemination). This should include, but is not limited to, ensuring informed consent, protecting privacy, confidentiality and anonymity of participants, ensuring cultural sensitivity, respecting the autonomy of participants, ensuring fair recruitment of participants (including women and socially excluded groups) and ensuring that the evaluation results in no harm to participants or their communities.

77. Contractors are responsible for managing any potential ethical risks and issues and must put in place in consultation with the Evaluation Manager, processes and systems to identify, report and resolve any ethical issues that might arise during the implementation of the evaluation. Ethical approvals and reviews by relevant national and institutional review boards must be sought where required.

7. Roles and Responsibilities of Stakeholders

78. The WFP Burundi Country Office:

The WFP Burundi Country Office Management (Director or Deputy Director) will take responsibility to:

- Assign an Evaluation Manager for the evaluation: Ms. Gabrielle Tremblay;
- Compose the internal evaluation committee and the evaluation reference group (see below);
- Approve the final TOR, inception and evaluation reports;
- Ensure the independence and impartiality of the evaluation at all stages, including establishment of an Evaluation Committee and of a Reference Group;
- Participate in discussions with the evaluation team on the evaluation design and the evaluation subject, its performance and results with the Evaluation Manager and the evaluation team;
- Organize and participate in two separate debriefings, one internal and one with external stakeholders;
- Oversee dissemination and follow-up processes, including the preparation of a Management Response to the evaluation recommendations.

a- **The Evaluation Manager**:

- Manages the evaluation process through all phases including drafting this TOR;
- Ensures quality assurance mechanisms are operational;
- Consolidates and shares comments on draft TOR, inception and evaluation reports with the evaluation team;
- Ensures expected use of quality assurance mechanisms (checklists, quality support
- Ensures that the team has access to all documentation and information necessary to the evaluation; facilitates the team's contacts with local stakeholders; sets up meetings, field visits; provides logistic support during the fieldwork; and arranges for interpretation, if required;

- Organizes security briefings for the evaluation team and provides any materials as required.

b- **An internal Evaluation Committee** has been formed as part of ensuring the independence and impartiality of the evaluation. The evaluation committee will approve the products from all the processes.

79. **An Evaluation Reference Group** has been formed, as appropriate, with representation from internal and external stakeholders for the evaluation. The ERG members will review and comment on the draft evaluation products and act as key informants in order to further safeguard against bias and influence.

80. **The Regional Bureau**: the RB will take responsibility to:

- Advise the Evaluation Manager and provide support to the evaluation process where appropriate;
- Participate in discussions with the evaluation team on the evaluation design and on the evaluation subject as required;
- Provide comments on the draft TOR, Inception and Evaluation reports;
- Support the Management Response to the evaluation and track the implementation of the recommendations;
- While the Regional Evaluation Officer will perform most of the above responsibilities, other RB relevant technical staff may participate in the evaluation reference group and/or comment on evaluation products as appropriate.

81. **Relevant WFP Headquarters divisions** will take responsibility to:

- Discuss WFP strategies, policies or systems in their area of responsibility and subject of evaluation.
- Comment on the evaluation TOR, inception and evaluation reports, as required.

82. The Office of Evaluation (OEV). OEV, through the Regional Evaluation Officer, will advise the Evaluation Manager and provide support to the evaluation process when required. It is responsible for providing access to the outsourced quality support service reviewing draft ToR, inception and evaluation reports from an evaluation perspective. It also ensures a help desk function upon request.

8. Communication and budget

8.1. Communication

83. To ensure a smooth and efficient process and enhance the learning from this evaluation, the evaluation team should place emphasis on transparent and open communication with key stakeholders. These will be achieved by ensuring a clear agreement on channels and frequency of communication with and between key stakeholders. These will be achieved by ensuring a clear agreement on channels and frequency of communication with and between key stakeholders during the inception period.

84. Dissemination products should include gender-sensitive data.

85. As part of the international standards for evaluation, WFP requires that all evaluations are made publicly available. Following the approval of the final evaluation report, the report will be made public.

86. All deliverables have to be written in French, and the Evaluation firm is responsible to provide an English translation for the inception report and evaluation report.

87. The following dissemination products should produce by the evaluation team:
    a. **Case study;**
    b. **Storytelling products;**

c. **Data storytelling;**
d. **Dissemination video;**
e. **PowerPoint presentation.**
f. **Two-page summary**

88. It is strongly recommended that the evaluation team include the case study, the storytelling products, as well as the data storytelling into the final report.

89. WFP Burundi will also use dissemination products for awareness-raising and programme communication.

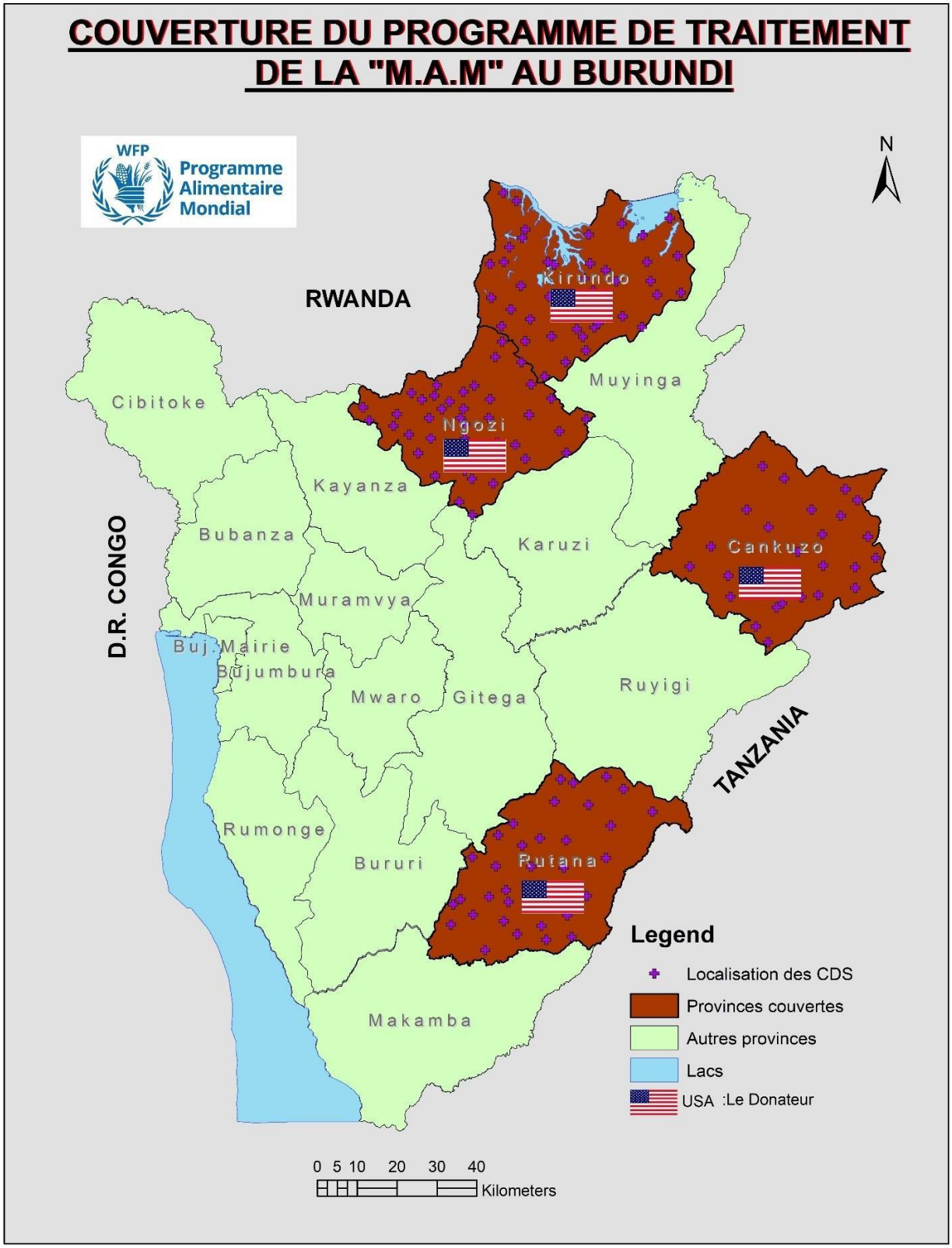
8.2. Budget

90. For the purpose of this evaluation, WFP will procure an evaluation firm through Long-term Agreements (sometimes called 'service level agreement'). Bidding firms will have to submit their proposals using the template for the provision of decentralized evaluation services (document attached), by August 5th 2019.

91. The total budget for the evaluation is $160,000 USD, released in tranches against the high quality and timely delivery of specific key deliverables. The proposals will be assessed according to technical and financial criteria. Firms are encouraged to submit realistic, but competitive financial proposals. The budget is inclusive of all travel, subsistence and other expenses; including any workshops or communication products, and translation costs that need to be delivered.

92. Please send any queries and submit proposals to Gabrielle Tremblay, Evaluation Manager, at gabrielle.tremblay@wfp.org, copying Roberto Borlini, Regional Evaluation Officer, roberto.borlini@wfp.org.

Annex 1 Map


COUVERTURE DU PROGRAMME DE TRAITEMENT DE LA "M.A.M" AU BURUNDI
WFP
Programme Alimentaire Mondial
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RWANDA
D.R. CONGO
TANZANIA
Kirundo
Muyinga
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Buj. Mairie Bujumbura
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Gitega
Ruyigi
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Bururi
Rutana
Makamba
Legend
Localisation des CDS
Provinces couvertes
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Annex 2 Evaluation Schedule

	Phases, Deliverables and Timeline	Key Dates
Phase 1 – Preparation		**Up to 9 weeks**
	Desk review, draft of TOR and quality assurance (QA) using ToR QC	(3 weeks)
	Sharing of draft ToR with outsourced quality support service (DE QS)	(3 days)
	Review draft ToR based on DE QS feedback	(3 days)
	Circulation of TOR for review and comments to ERG, RB and other stakeholders (list key stakeholders)	(2 weeks)
	Review draft ToR based on comments received	(1 week)
	Submits the final TOR to the internal evaluation committee for approval	
	Sharing final TOR with key stakeholders	
	Selection and recruitment of evaluation team	(3 weeks)
Phase 2 – Inception		**Up to 7 weeks**
	Briefing core team	(1 day)
	Desk review of key documents by evaluation team	3 days
	Inception mission in the country (if applicable)	(1 week)
	Draft inception report	(1 week)
	Sharing of draft IR with outsourced quality support service (DE QS) and quality assurance of draft IR by EM using the QC	(1 week)
	Revise draft IR based on feedback received by DE QS and EM	(1 week)
	Submission of revised IR based on DE QS and EM QA	
	Circulate draft IR for review and comments to ERG, RB and other stakeholders (list key stakeholders)	(2 weeks)
	Consolidate comments	
	Revise draft IR based on stakeholder comments received	(1 week)
	Submission of final revised IR	
	Submits the final IR to the internal evaluation committee for approval	
	Sharing of final inception report with key stakeholders for information	
Phase 3 – Data collection		**Up to 3 weeks**
	Briefing evaluation team at CO	(1 day)
	Data collection	(3 weeks)
	In-country Debriefing (s)	(1 day)

	Phases, Deliverables and Timeline	Key Dates
Phase 4 – Analyze data and report		**Up to 11 weeks**
	Draft evaluation report	(3 weeks)
	Sharing of draft ER with outsourced quality support service (DE QS) and quality assurance of draft ER by EM using the QC	(1 week)
	Revise draft ER based on feedback received by DE QS and EM QA	(1 week)
	Submission of revised ER based on DE QS and EM QA	
	Circulate draft ER for review and comments to ERG, RB and other stakeholders (list key stakeholders)	(2 weeks)
	Consolidate comments	
	Revise draft ER based on stakeholder comments received	(2 weeks)
	Submission of final revised ER	
	Submits the final ER to the internal evaluation committee for approval	
	Sharing of final evaluation report with key stakeholders for information	
Phase 5 – Dissemination and follow-up		**Up to 4 weeks**
	Case study	
	Data storytelling	
	Storytelling products	
	Dissemination video	
	PowerPoint presentation	
	Prepare management response	(4 weeks)
	Share final evaluation report and management response with OEV for publication	

Annex 3 Membership of the Evaluation Committee

Purpose: The overall purpose of the evaluation committee is to ensure a credible, transparent, and quality evaluation process in accordance with WFP Evaluation Policy 2016-2021. It will achieve this by supporting the Evaluation Manager (EM) through the process, reviewing evaluation deliverables (TOR, inception report and evaluation reports) and submitting them for approval to the Chair of the Committee.

The composition of the evaluation committee:

- WFP Country Director or delegated to the Deputy Country Director (Chair)
- WFP EM (Secretary)
- WFP Nutrition Team Leader
- WFP Head of Programme or Deputy Head of Programme
- RBN Regional Evaluation Officer
- WFP M&E officer

Responsibilities of the Evaluation Committee: the EC is responsible for approving the TOR, inception report, baseline and endline report of the evaluation.

Input by Phase and Estimated time per EC member (excluding the Evaluation manager) – (1/2 day)

Phase 1: Planning

- Nominates an EM.
- Decides the evaluation budget.
- Decides the contracting method, well in advance to enable the evaluation manager to plan for the next phase of the evaluation.

Phase 2: Preparation (½ to 1 day)

- Reviews the TOR on the basis of:
  - The external Quality Support advisory service feedback
  - ERG comments
  - The EM responses documented in the comments matrix
- Approves the final TOR.

Phase 3: Inception (2 days)

- Briefs the evaluation team including an overview of the subject of the evaluation.
- Informs the design of the evaluation during the inception phase as key stakeholders of the evaluation.
- Supports the identification of appropriate field visit sites on the basis of selection criteria identified by the evaluation team noting that the EC should not influence which sites are selected.
- Reviews the draft IR on the basis of the external Quality Support advisory service feedback

Phase 4: Data Collection and Analysis (2 days)

- Are key informants during the data collection
- Act as sources of contextual information and facilitating data access as per the needs of the evaluation.
- Attend the validation/debriefing meeting, and support the team in clarifying/validating any emerging issues and identifying how to fill any data/information gaps that the team may be having at this stage.
- Facilitate access to stakeholders and information as appropriate
- Attend debriefing meeting with Evaluation Team.

Phase 5: Report (2 days)

- Review the draft ER on the basis of :
  - The external Quality Support advisory service feedback
  - ERG comments
  - The Evaluation team responses documented in the comments matrix
- Approve the final ER.

Phase 6: Disseminate and Follow-up Phase (1 day)

- Facilitate preparation of the management response to the evaluation recommendations
- Approve the Management Response
- Disseminate evaluation results
- Make the report publicly available
- Is finally responsible to ensure periodic follow up and updating of the status of the implementation of the recommendations.

Procedures of Engagement

- The Chair of the Committee will appoint members of the evaluation committee
- The EM will notify the members of the time, location and agenda of meetings at least one week before the meeting, and share any background materials for preparation.
- Approval can be made via email on the basis of submission to the EC chair after endorsement by all EC members
- EC meetings will be held face-to face and/or via electronic conference call/Skype and/or email depending on the need, the agenda and the context

Annex 4 Membership of the Evaluation Reference Group

Purpose: The overall purpose of the ERG is to support a credible, transparent, impartial and quality evaluation process in accordance with WFP Evaluation Policy 2016-2021. ERG members review and comment on evaluation TOR and deliverables. The ERG members act as experts in an advisory capacity, without management responsibilities. Responsibility for approval of evaluation products rests with the Country Director/Deputy Country Director as Chair of the Evaluation Committee.

Composition of ERG:

a. WFP Country Director or delegated to the Deputy Country Director (Chair)
b. WFP Evaluation Manager
c. WFP Nutrition Team Leader
d. WFP Head of Programme and Deputy Head of Programme
e. RBN Regional Evaluation Officer
f. WFP M&E officer
g. WFP Gender officer
h. WFP Nutrition officer
i. Representatives of other key stakeholders

Tasks: the ERG will review the evaluation products and provide comments to the evaluation team.

Time commitment-:

ERG members responsibilities by Evaluation Phase	**Estimated time required**
Phase 2: Preparation • Review TOR and provide feedback ensuring that the TOR will lead to a useful evaluation output and provide any additional key background information to inform the finalization of the TOR. • Identify source documents useful to the evaluation team. • Attend ERG meeting/conference call etc.	**1 day**
• Phase 3: Inception • Meet with evaluation team (together and/or individual members). The ERG is a source of information for the evaluation, providing guidance on how the evaluation team can design a realistic/practical, relevant and useful evaluation. • Assist in identifying and contacting key stakeholders to be interviewed, identifying and accessing key documentation and data sources, and identifying appropriate field sites. This is important in their role of safeguarding against bias. • Review and comment on the draft Inception Report (see inception report • Template, Quality Checklist, and Comments Matrix).	**1 day**
Phase 4: Data collection and analysis • Act as key informant during the data collection stage. • Assist the evaluation team by providing sources of information and facilitating data access. • Attend the validation /debriefing meeting conducted by the evaluation team at • the end of the fieldwork**.**	**1.5 days**

ERG members responsibilities by Evaluation Phase	Estimated time required

Phase 5: Report
• Review and comment on the draft evaluation report (see evaluation report Template, Quality Checklist, and Comments Matrix), specifically focusing on accuracy and on quality and comprehensiveness of evidence base against which the findings are presented, and conclusions and recommendations are made.
  ○ Particular attention should be given to ensuring that the recommendations are relevant, targeted, realistic and actionable.
  ○ The ERG must respect the decision of the independent evaluators regarding the extent of incorporation of feedback provided to them by the ERG and other stakeholders, as long as there is sufficient transparency in how they have addressed the feedback, including clear rationale for any feedback that has not been accepted.
	2+ days

Phase 6: Disseminate and Follow-up • Disseminate final report internally and on websites of ERG members as relevant; • Share as relevant evaluation findings within respective units, organizations, networks and at key events; • Provide input to management response and its implementation (as appropriate).	

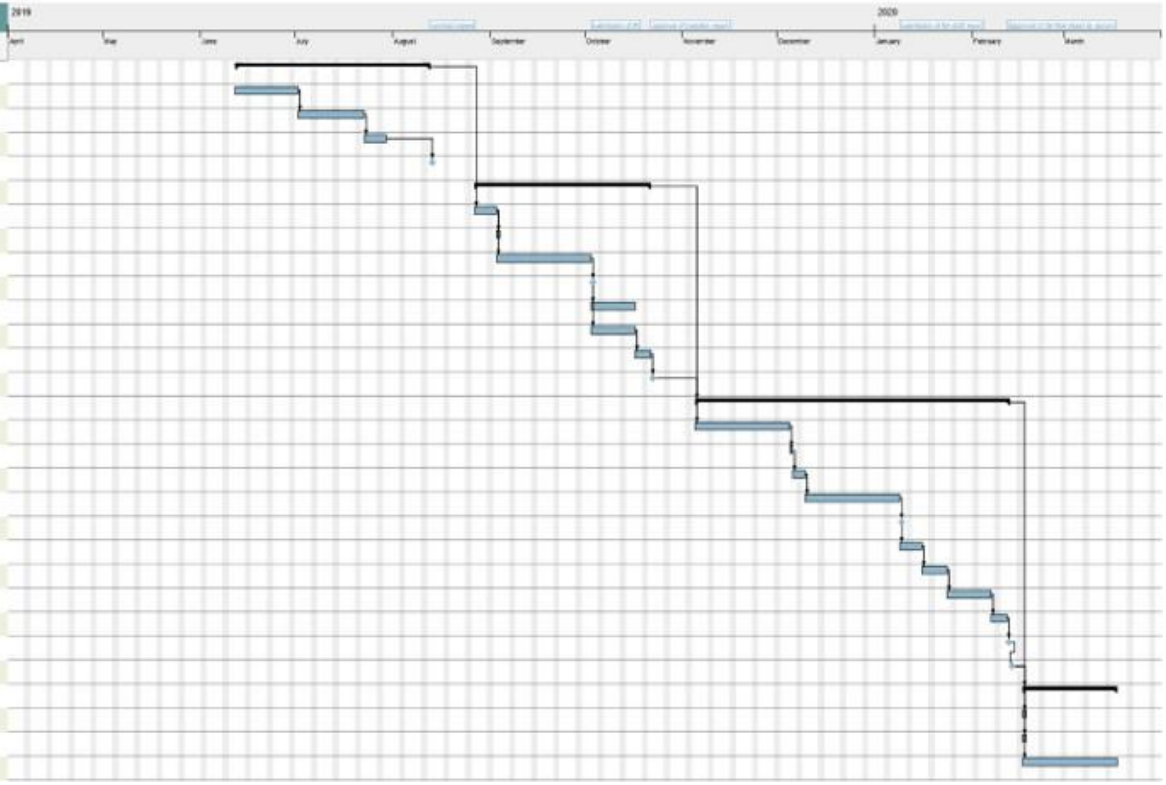
Procedures of Engagement :

- The EM will notify the ERG members the time, location and agenda of meeting at least one week before the meeting, and share any background materials for preparation
- ERG meetings will be held via electronic conference call/Skype.
- The ERG will meet at least once per quarter;
- ERG members, representing their organizations will also be interviewed by the evaluation team during the inception and data collection phases. This will be indicated in the evaluation schedule, and ideally confirmed prior to the commencement of the data collection phase
- For each of the key evaluation products (Terms of Reference, Inception Report, Evaluation Reports), the ERG members will provide feedback electronically to the EM. For the Inception Report and Evaluation Report, the EM will consolidate all feedback for forwarding to the Evaluation Team and will ensure that these have been appropriately responded to by incorporating them in the reports or providing rationale where feedback is not incorporated.

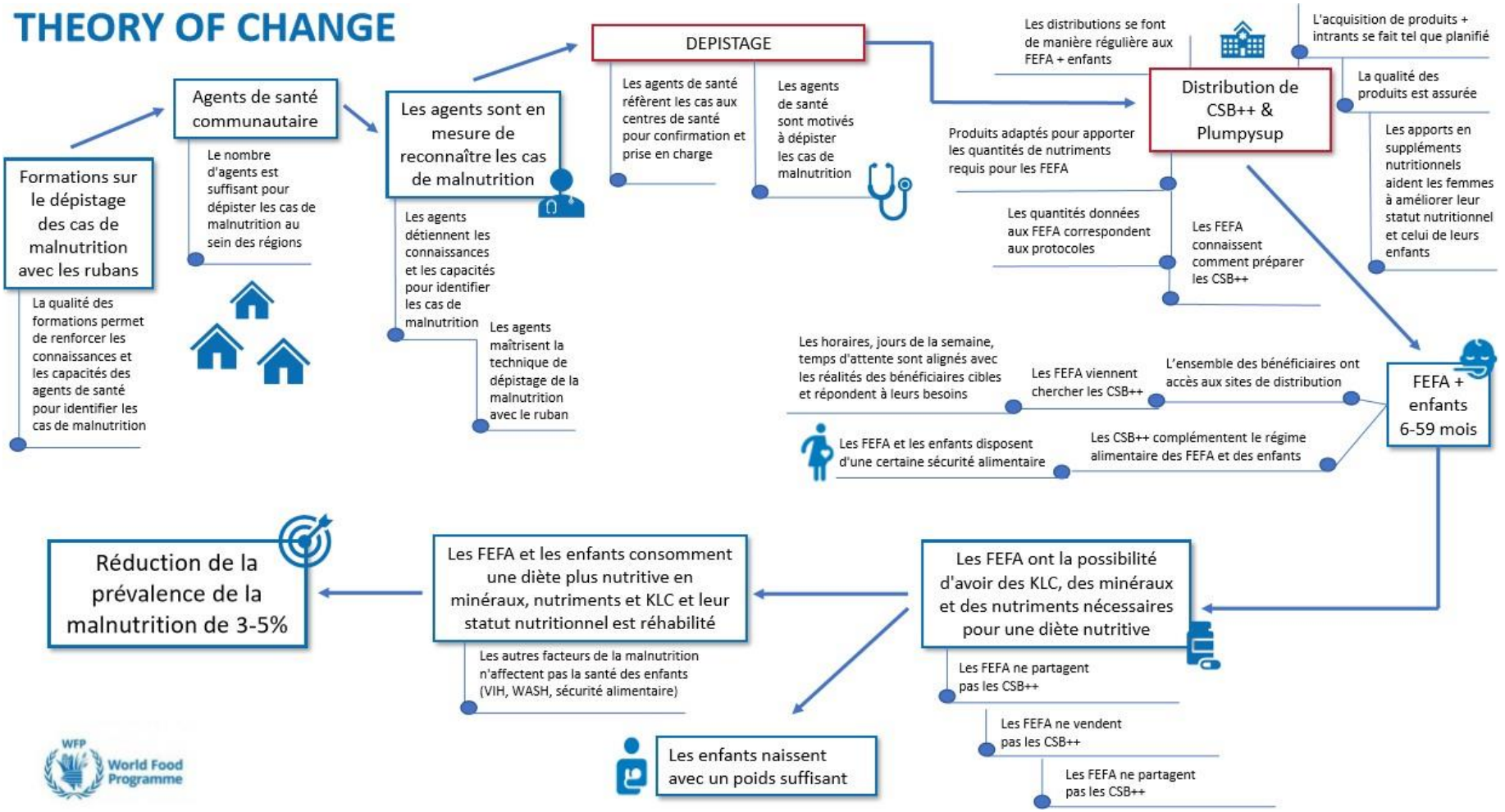
Annex 5 Gantt Chart Project

Gantt Chart

Name	Begin date	End date
preparation phase	12/06/19	12/08/19
TOR finalized quality assured and approved	12/06/19	01/07/19
LTA firms prepare bids	02/07/19	22/07/19
review of bids	23/07/19	29/07/19
contract signed	13/08/19	13/08/19
inception phase	27/08/19	21/10/19
inception mission in Burundi	27/08/19	02/09/19
inception debriefing	03/09/19	03/09/19
elaboration of inception report	03/09/19	02/10/19
submission of IR	03/10/19	03/10/19
internal and external quality assurance (D...	03/10/19	16/10/19
circulation of IR for review by WFP	03/10/19	16/10/19
incorporation of feedback in IR	17/10/19	21/10/19
approval of inception report	22/10/19	22/10/19
field phase	05/11/19	12/02/20
field data collection	05/11/19	04/12/19
in-country debriefing	05/12/19	05/12/19
data cleaning	06/12/19	09/12/19
elaboration of draft report	10/12/19	08/01/20
submission of the draft report	09/01/20	09/01/20
internal quality control on draft report	09/01/20	15/01/20
external quality control (DE QS)	16/01/20	23/01/20
circulation of the draft report for commen...	24/01/20	06/02/20
revision of draft report	07/02/20	11/02/20
submission of the final report	12/02/20	12/02/20
approval of the final report by donors	13/02/20	13/02/20
dissemination of findings	17/02/20	17/03/20
publication of the report on WFP website	17/02/20	17/02/20
report shared with donors	17/02/20	17/02/20
elaboration of management response	17/02/20	17/03/20

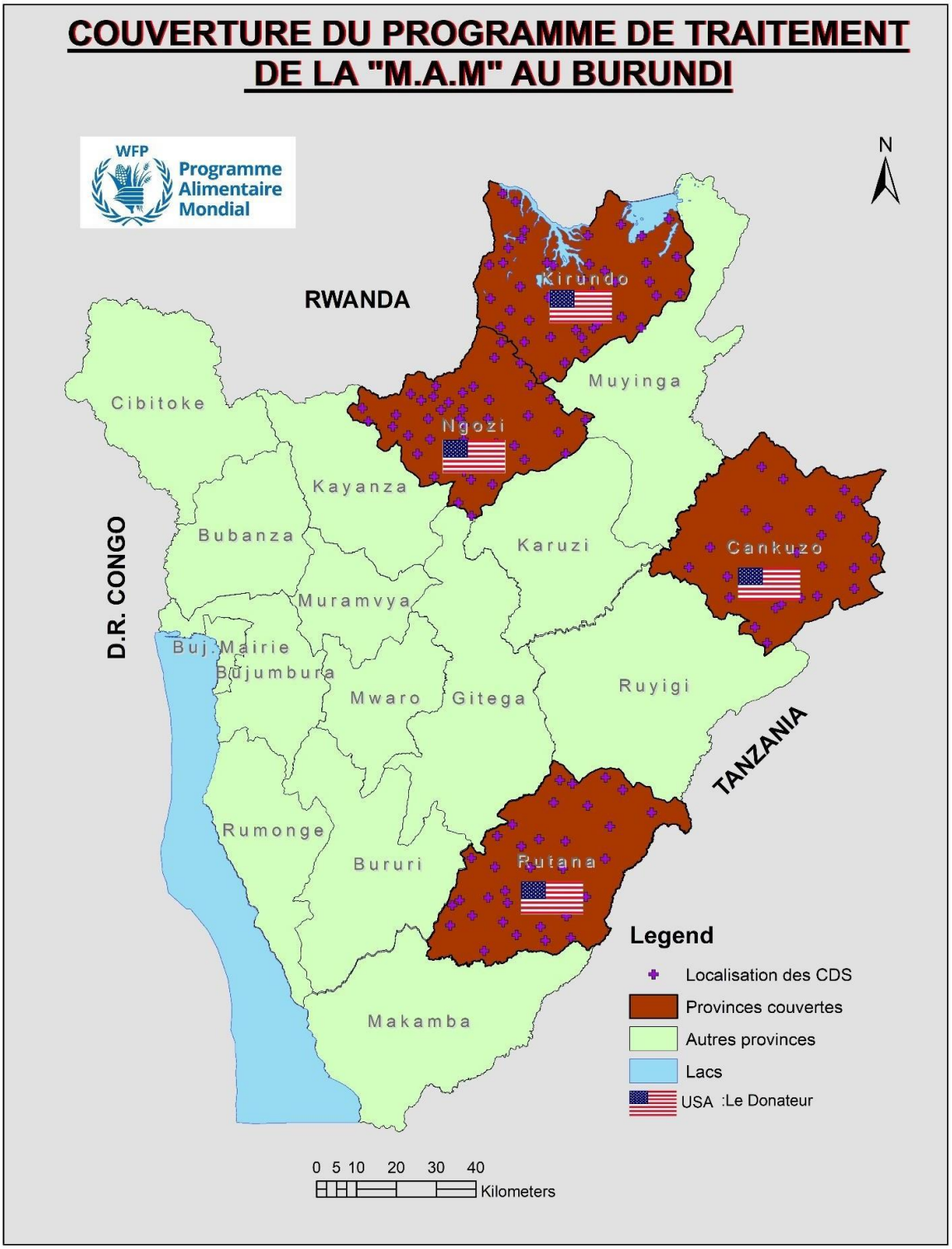


Annex 6 MAM Treatment, Theory of Change



Appendix 2. Map

Map 1. Areas of intervention (four provinces) of MAM treatment financed by FFP in Burundi



Appendix 3. Evaluation Matrix

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
1 Relevance					
1.1	To what extent is the MAM treatment in line with the needs of the most vulnerable, most particularly pregnant and lactating women and girls, and children?	▪ How is MAM treatment appropriate for PLW, pregnant and lactating girls and adolescents? ▪ How does this treatment address the needs of children under five years of age? ▪ What are the problems associated with the use and consumption of PlumpySup (storage, preparation time, taste, side effects)? ▪ Is PlumpySup shared with the family? Resale? Other constraints? ▪ What are the problems related to the use and consumption of CSB++ (storage, preparation time, taste, side effects)? ▪ Is CSB++ shared in family? Resale? Other constraints?	▪ Needs/barriers to access of the target population to nutrients (PLW, pregnant girls, adolescents, children under 5 years) ▪ Root causes of malnutrition in PLW, pregnant girls, teenagers, children under 5 years of age ▪ Links between program activities and the needs of the target population ▪ Problems related to the use and consumption of dietary supplements	▪ WFP Project Proposal ▪ Program Progress Reports ▪ National health and nutrition policies targeting women, men, adolescents and children ▪ Key informants: (WFP: WFP Country Director and Deputy Director, Nutrition Program Manager, Team Leader/ Officer - Nutrition, PRONIANUT Director, PRONIANUT Focal Point for Treatment Program, nutrition/health focal point at the governorate and district level, health center managers, health workers; mothers/ mentor mothers, community health workers, community outreach workers; mothers and fathers of children under five, PLW)	▪ Literature review ▪ Individual interviews ▪ Group discussions ▪ Compare the needs identified in the documents with those expressed by key informants Quality of evidence: good. Enough documentation; still needs to be completed through interviews and focus group discussions
1.2	Did the distribution schedules, logistics, access, and MAM treatment interventions align with the realities and needs of the targeted beneficiaries, as well as disabled persons?	▪ What is the origin of the PlumpySup ordered and distributed to children < 5 years old? ▪ What is the origin of the CSB++ ordered and distributed to the PLW? ▪ What are the prospects for local production of these products, or	▪ Source of dietary supplements used in the MAM treatment program ▪ Prospects for local production of dietary supplements ▪ Level of harmonization of schedules, logistics and	▪ Project proposal from the WFP (Interim Country Strategic Plan) ▪ Program Progress Reports ▪ Program Logical Framework Indicators ▪ Key informants (WFP logistics officers from the national level to the	▪ Literature review ▪ Individual interviews ▪ Group discussions ▪ Compare the opinions of the different stakeholders with the issues identified in the documents.

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
		other types of dietary supplements? ▪ Did the distribution schedules meet the needs of PLW, children under five and other vulnerable populations? ▪ Were distributions on schedule? ▪ Logistical means used (means of transport, loading, unloading, ...) were they appropriate to the geographical access conditions and the climate of the intervention areas?	access with the realities and needs of the beneficiaries	districts; supervisors of PRONIANUT inputs, health center managers, health workers; mothers and fathers of children under five years old, PLW)	Quality of evidence: average; not enough documentation of distribution schedules. In-depth interviews and group discussions will help to bridge this gap.
1.3	To what extent is the intervention aligned with the needs and priorities of the government?	Was the design of the WFP program consistent with government priorities?	▪ Extent to which objectives, activities, including those related to gender, women's empowerment and equity (targeting of intervention areas and beneficiaries) are in line with national priorities ▪ Program data (inputs, outputs, performance indicators) disaggregated by gender and by area of operation	▪ National health and nutrition policies targeting women, men, adolescents and children ▪ Project proposal from WFP ▪ Key informants (USAID/FFP; WFP: Country Director and Deputy Director, Head of nutrition program, Team Leader/ Nutrition Officer, Director PRONIANUT, Focal Point PRONIANUT for the treatment program, Nutrition/Health Focal Point in the governorate and district, health center managers, health workers.	▪ Literature review ▪ Individual interviews ▪ Compare the information summarized in the literature with that expressed by key informants Quality of evidence: good.
1.4	How can issues of gender, equity and equality be addressed? Have women's empowerment issues been taken into account in the design,	▪ Have community consultations been held to examine gender perspectives on malnutrition, e.g. discussing the roles of women and men in household nutrition decision-making,	▪ Key messages used in community and advocacy activities to promote gender equality and the prevention of sexual and gender-based violence, and to remove	▪ National health and nutrition policies targeting women, men, adolescents and children ▪ Project proposal from WFP	▪ Literature review ▪ Individual interviews ▪ Group discussions Quality of evidence: average; no preliminary gender

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
	implementation and monitoring of the program? (Question inserted by the evaluation team)	gender-specific taboos and cultural practices to ensure that the program is gender sensitive? ▪ What is WFP's engagement and feedback mechanism to gather community views and provide feedback on decision-making? ▪ To what extent were individuals, in all their diversity, consulted to judge relevance prior to the implementation of the program? ▪ How were these individuals able to communicate about relevance throughout the program? Questions of protection ▪ Did participating in/receiving the treatment result in difficult situations between the couple/ in the household/community? ▪ Has consumption of the full ration been compromised? Were any risks identified?	cultural and/or social barriers that may negatively impact on nutritional status ▪ Mechanisms for WFP engagement and feedback to the community ▪ Risks related to admission and participation in the program	▪ Key informants (WFP: Country Director WFP and Deputy Director, Head of nutrition program, Team Leader/agent - Nutrition, Director PRONIANUT, PRONIANUT Focal Point for the treatment program, Nutrition/Health Focal Point at the governorate and district level, health center managers, health workers; mothers/ mentor mothers, community health workers, community outreach workers; mothers and fathers of children under five years of age, PLW)	analysis prior to the implementation of the intervention. Data disaggregated by sex and age in children under five years of age, but not disaggregated by age in PLW.
2 Coherence					
2.1	To what extent were the MAM treatment interventions funded by FFP coherent with other donor interventions in nutrition?	▪ Is the MAM treatment program coherent with nutrition programs funded by other donors? If so, which ones? ▪ How does coordination between the MAM treatment program and other nutrition-specific and nutrition-sensitive interventions work?	▪ Link between the MAM treatment program and nutrition interventions funded by other donors ▪ Intricacies between the MAM treatment program and other interventions for the treatment and prevention of malnutrition (criteria for targeting beneficiaries, referrals and counter-referrals)	▪ Project proposal from WFP ▪ Key informants (USAID/FFP; WFP: Country Director WFP and Deputy Director, Head of nutrition program, Team Leader/ Nutrition Officer, Director PRONIANUT, PRONIANUT focal point for the treatment program, nutrition/health focal point in the governorate and the district,	▪ Literature review ▪ Individual interviews ▪ Identify other nutrition programs and their donors ▪ Establish links between these programs and the MAM treatment program. Quality of evidence: average; no documents on the comprehensive presentation of programs funded by other donors. This information

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
				health center managers, health workers). ▪ Multi-sectoral platform	will be obtained during individual interviews.
2.2	To what extent was the program aligned with government policies and nutrition protocols?	▪ Is the MAM treatment intervention coherent with the community-based management protocol for acute malnutrition? ▪ Is the MAM treatment intervention coherent with other nutritional protocols?	▪ Interaction between the MAM treatment program and other nutritional interventions	▪ National health and nutrition policies ▪ Project proposal from the WFP ▪ National Malnutrition Protocols Key informants (WFP: Country Director WFP and Deputy Director, Head of nutrition program, Team Leader/agent - Nutrition, Director PRONIANUT, ▪ PRONIANUT Focal Point for the treatment program, Nutrition/Health Focal Point in the governorate and district)	▪ Literature review ▪ Individual interviews ▪ Identify other dietary programs/protocols ▪ Establish links between these protocols and the MAM treatment program Quality of evidence: good.
2.3	How did referral mechanisms to other nutrition programs (health facility to community and vice versa) work?	▪ Has the MAM program been implemented in coordination with partners in order to avoid gaps or overlaps? ▪ What referral mechanism has been put in place to coordinate program activities with other partners?	▪ Functioning of the referral mechanism and counter-referral with other nutrition programs	▪ Program Progress Reports ▪ Key informants (health center managers, health workers, etc.); mothers/ mentor mothers, community health workers, community outreach workers; mothers and fathers of children under five, PLW)	▪ Literature review ▪ Individual interviews ▪ Compare the information from the review with that expressed by key informants Quality of evidence: program reports do not sufficiently mention referral mechanisms. This information will be obtained during individual interviews and group discussions.
2.4	To what extent is the intervention for the treatment of MAM aligned with national	▪ What elements of the project determine the active participation and commitment of	▪ Participation of women in the different activities	▪ National health and nutrition policies targeting	▪ Literature review ▪ Individual interviews ▪ Group discussions

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
	policies on gender equality and women's empowerment? (Question inserted by the evaluation team)	women in the treatment of MAM? ▪ Have certain measures, e.g. in awareness-raising work or complementary measures, been taken to address inequalities due to age and/or gender? ▪ Can we see results in regards to equality? ▪ Have principles of equality been incorporated into the nutrition messages?	(screening, management, follow-up, prevention)	women, men, teenagers, children ▪ Key informants (WFP: Head of Nutrition Programme, Chief Nutrition Officer, PRONIANUT Focal Point MAM program, health center managers, health workers; mothers and fathers of children under five, community health workers, mothers and fathers of children under five, PLW)	Quality of Evidence: average; insufficient policy documents about gender. This information will be obtained during individual interviews and group discussions.
3 Effectiveness					
3.1	To what extent did the intervention deliver results for pregnant and lactating women, girls and children 6-59 months of age?	▪ What was the geographic coverage of the program? ▪ What was the coverage of beneficiaries (pregnant women, lactating mothers, adolescents, children under five years of age)? ▪ What factors have limited the achievement of acceptable coverage? ▪ Were these limiting factors different for different types of beneficiaries? ▪ What were the main constraints to accessing services? ▪ Were access constraints to the sites different for lactating women, pregnant women, adolescents and what were they?	▪ Proportion of health centers offering MAM treatment services ▪ Proportion of the eligible population (PLW, adolescents, and children) participating in the program (coverage) ▪ Proportion of the target population participating in an adequate number of distributions (membership)	▪ Program Progress Reports ▪ Quantitative databases of the program ▪ Key informants (health center managers, health workers, etc.); mothers/ mentor mothers, community health workers, community outreach workers; mothers and fathers of children under five, PLW	▪ Literature review ▪ Individual interviews ▪ Group discussions ▪ Quantitative data analysis: comparison of outputs to targets Quality of evidence: good.
3.2	Were there any unintended positive or negative results?	▪ What were the unexpected positive outcomes for each type of beneficiary?	▪ Unexpected results ▪ Number of admissions to health and nutrition services	▪ Program Progress Reports ▪ Quantitative databases of the program	▪ Literature review ▪ Individual interviews ▪ Group discussions

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
		▪ What were the unexpected negative outcomes for each type of beneficiary? ▪ To what extent has the availability of dietary supplements in health facilities had a positive or negative influence on participation in and use of other health and nutrition services such as immunization, antenatal and postnatal care, general counselling or health promotion?	before and after the start treatment of the MAM	▪ Key informants (service providers, beneficiaries - health center managers, health workers; (e.g., mothers and mentor mothers, Community Health Workers, community outreach workers; mothers and fathers of children)	▪ Quantitative data analysis: identification of unintended trends Quality of evidence: average; program reports do not mention this information. They will be obtained during the individual interviews and group discussions.
3.3	To what extent have community mobilization and nutrition education activities led to awareness and demand for nutrition services? (Question inserted by the evaluation team)	▪ What is the effect of community mobilization on stimulating buy-in and participation in the program? ▪ How did men, women, girls and boys participate in treatment follow-up? What consultations have been initiated? ▪ What is the effect of dissemination messages on women versus men, and neighbors/neighbors not benefiting from the program? ▪ What is the effect of dissemination on parents and children?	▪ Number of engagement sessions conducted ▪ Number of people (women, men, boys, girls) exposed to WFP-supported nutrition messages ▪ Number of targeted informal caregivers (male and female) receiving three key messages and of advice supported by WFP ▪ Number of people reached through interpersonal communication approaches for change in behavior, disaggregated by sex and age ▪ Degree of awareness created by mobilization activities ▪ Proportion of children aged 6- 23 months who receive a minimum acceptable diet ▪ Minimal dietary diversity – women	▪ Program Progress Reports ▪ Quantitative program databases ▪ Key informants (service providers, beneficiaries - health center managers, health workers; (e.g., mothers and mentor mothers, Community Health Workers, community outreach workers; mothers and fathers of children)	▪ Literature review ▪ Individual interviews ▪ Group discussions ▪ Quantitative data analysis: identification of trends Quality of evidence: average; program reports do not mention this information. They will be obtained during the individual interviews and group discussions.

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
3.4	What were the major factors influencing how MAM treatment contributed to meeting the performance indicators on recovery, death and default in the targeted provinces?	▪ To what extent have the performance indicators been met? ▪ What were the enablers and constraints to reaching PLW and children?	▪ Rates of cure, death, default, non-response to treatment ▪ Enabling environment (legal, institutional, socio-economic, cultural) ▪ Supply factors (access to services) ▪ Demand factors (beneficiaries joining)	▪ Program Progress Reports ▪ Quantitative program databases ▪ Key informants (service providers, beneficiaries - health center managers, health workers; (e.g., mothers and mentor mothers, Community Health Workers, community outreach workers; mothers and fathers of children)	▪ Literature review ▪ Individual interviews ▪ Group discussions ▪ Quantitative data analysis: comparison of the results obtained with the standards Quality of evidence: good.
4 Efficiency					
4.1	Were the program objectives achieved within the time frame of the program? (Question inserted by the evaluation team)	▪ Were the funding and program activities carried out as planned? ▪ Have there been any changes in the schedule? ▪ Did the ordering and distribution of the food supplements take place on a regular basis in order to prevent stock-outs?	▪ Activities carried out versus planned	▪ Program Progress Reports ▪ Quantitative databases of the program ▪ Key informants (WFP budget and finance management team, WFP logistics team)	▪ Literature review ▪ Individual interviews Quality of evidence: good.
4.2	Does MAM treatment have the most cost-efficient performance for coverage and adherence?	▪ How cost-effective is the current implementation of the program?	▪ Total costs and costs by category (personnel/ material/ transport/ etc.) ▪ Rate of disbursement / actual and planned (variance) ▪ Overhead costs of project implementation ▪ Cost per type of distributed ration (CSB++ versus PlumpySup) ▪ Cost per type of beneficiary admitted (for each of the targets: pregnant women, lactating women, children < five years)	▪ Program financial reports ▪ Program financial databases ▪ Procedures manual ▪ Key informants (WFP budget and finance management team, WFP logistics team, health workers)	▪ Literature review ▪ Individual interviews ▪ Analysis of direct costs; comparison of costs between provinces Quality of evidence: average; expenditure data are not disaggregated by province.

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
			▪ Cost per type of beneficiary who effectively adheres to an established protocol (from admission to recovery) ▪ Disease-Related Nutrition Expenditures: de-worming, prevention and early treatment of diarrheal diseases, malaria prevention and control		
4.3	How can the cost- efficiency of MAM treatment be improved?	▪ Could the same results be achieved with fewer resources?	▪ Alternatives to the treatment of MAM ▪ Local production of dietary supplements ▪ Integration of dietary supplements into the national supply chain system	▪ Program Financial Reports ▪ Key informants (WFP budget and finance management team, WFP logistics team, health workers)	▪ Literature review ▪ Individual interviews Quality of evidence: average; program reports do not mention this information. They will be obtained during individual interviews.
4.4	What factors drive the cost-efficiency of MAM treatment?	▪ What are the intrinsic and extrinsic elements that determine program efficiency? ▪ How could these elements be used to improve the efficiency of MAM treatment?	▪ Coordination with other nutrition programs ▪ Staff capacity (mixed skills) ▪ Capacity building of the implementing organization	▪ Program Financial Reports ▪ Program financial databases ▪ Key informants (WFP budget and finance management team, WFP logistics team, health workers)	▪ Literature review ▪ Individual interviews ▪ Cost analysis; cost comparison across borders Quality of evidence: average; program reports do not mention this information. They will be obtained during individual interviews.

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
4.5	Did the monitoring and supervision of the program proceed as planned? (Question inserted by the evaluation team)	▪ Was monitoring and supervision of the program regular? ▪ What is the level of participation of beneficiaries and non-beneficiaries in follow-up activities?	▪ Regularity of monitoring and supervision activities ▪ Quality of monitoring and supervision activities ▪ Participation of beneficiaries and non-beneficiaries	▪ Program Reports ▪ Key informants (health center managers, mentor mothers and Community Health Workers, etc.)	▪ Literature review ▪ Individual interviews ▪ Group Discussions Quality of evidence: good.
5 Impact					
5.1	To what extent has MAM treatment contributed to changing the nutritional status of the targeted beneficiaries (lactating and pregnant women and girls, children 6-59 months of age)?	▪ What is the impact of the intervention on the nutritional status of the target populations (lactating women and children) pregnant, children from 6 to 59 months)? ▪ What is the potential of MAM treatment to influence the reduction of stunting or the prevention of malnutrition (long-term impact) in lactating and pregnant women and children aged 6-59 months?	▪ Prevalence of MAM, SAM, GAM in children under five years of age ▪ Prevalence of wasting in women of childbearing age, pregnant and lactating women ▪ Reduction of close pregnancies among women ▪ Reduction of early teenage pregnancies ▪ Children born with adequate birth weight	▪ Program progress reports ▪ Nutrition survey reports ▪ Demographic Health Survey Report (EDS) ▪ Key informants (service providers, beneficiaries - health center managers, health workers; (e.g., mothers and mentor mothers, Community Health Workers, community outreach workers; mothers and fathers of children)	▪ Literature review ▪ Individual interviews ▪ Group discussions Quality of evidence: average; intervention is too short term to produce a strong impact. The potential impact will be estimated.
5.2	To what extent has the government been influenced to increase investments in nutrition?	▪ To what extent has the program influenced government involvement in initiatives addressing MAM and the nutrition sector in general?	▪ Ownership of the program by the national authorities	▪ Program Progress Reports ▪ Key informants (USAID/FFP; WFP Country Director and Deputy Director, Nutrition Program Officer, Team Leader/Nutrition Officer, Director, WFP Country Director and Deputy Director, Nutrition Program Officer, Team Leader/Nutrition Officer, Director, WFP Country Director) PRONIANUT, health center managers)	▪ Literature review ▪ Individual interviews Quality of evidence: average; program reports do not mention this information. They will be obtained during individual interviews.

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
5.3	Does the intervention have the potential to positively influence gender relations, equity and women's empowerment? (Question inserted by the evaluation team)	▪ How do men support women's nutrition during the prenatal and postnatal periods? ▪ How are men involved in decisions about food after receiving nutritional advice and messages? ▪ How do men support women who participate in community activities outside the household?	▪ Knowledge and retention of nutrition messages by men, women and adolescents ▪ Empowering women to make changes after entry into the program ▪ Measures taken by women to change their feeding practices in the household and the results of their actions ▪ Men's participation in decisions concerning food in the household	▪ Program Progress Reports ▪ Key informants (service providers, beneficiaries- health center managers, health workers; mothers/ mentor mothers, Community Health Workers, community facilitators, mothers and fathers of children)	▪ Literature review ▪ Individual interviews ▪ Group discussions Quality of evidence: average; program reports do not mention this information. They will be obtained during individual interviews.
6 Sustainability					
6.1	To what extent did the intervention implementation arrangements include considerations for sustainability, such as capacity building of national and local government institutions, communities and other partners?	▪ To what extent has the management of MAM treatment been integrated and contributed to health system strengthening?	▪ Governance ▪ Human Resources: health workers, community outreach workers and mentor mothers trained ▪ Government funding: cost of MAM treatment integrated into national budgets, plans and policies ▪ Infrastructures, equipment ▪ Service Delivery ▪ Information system	▪ Program Progress Reports ▪ Project proposal from the WFP ▪ Key informants (USAID/FFP; WFP Country Director and Deputy Director, Nutrition Program Officer, Team Leader/agent - Nutrition, Director PRONIANUT, health center managers)	▪ Literature Review ▪ Individual interviews Quality of evidence: average; program reports do not mention this information. They will be obtained during individual interviews.
6.2	To what extent will the benefits of the intervention continue for pregnant and lactating women and girls and children 6-59 months after the end of the WFP intervention?	▪ What is the government's policy on the sustainability of nutrition interventions? ▪ What exit and sustainability strategies does WFP have in place?	▪ Government sustainability policies and measures in MOUs regarding ownership program's progress ▪ Local production of dietary supplements for the treatment of MAM ▪ Purchase of local production of agricultural ingredients	▪ National Policies and Strategies ▪ Project proposal from WFP ▪ Key informants (USAID/FFP; WFP Country Director and Deputy Director, Nutrition Program Officer, Team Leader/agent - Nutrition, Director	▪ Literature review ▪ Individual interviews Quality of evidence: average; program reports do not mention this information. They will be obtained during individual interviews.

	Evaluation criteria/ questions	Sub-questions	Indicators	Sources of information	Data collection methods/ data analysis
			for the prevention of malnutrition	PRONIANUT, health center managers)	
6.3	To what extent has the program influenced the participation of women in decision-making structures and institutions? (Question inserted by the evaluation team)	▪ What is the program's contribution to women's empowerment?	▪ Women's participation in decision-making spheres on household food and nutrition (from national to community level)	▪ Program Progress Reports ▪ Key informants (service providers, beneficiaries - health center managers, health workers; (e.g., mothers and mentor mothers, Community Health Workers, community outreach workers; mothers and fathers of children)	▪ Literature review ▪ Individual interviews ▪ Group discussions Quality of evidence: average; program reports do not mention this information. They will be obtained during the individual interviews.

Appendix 4. Theory of Change Designed to Guide the Evaluation of MAM Treatment in the Provinces of Cankuzo, Kirundo, Ngozi, and Rutana in Burundi

Appendix 5. Documents Gathered

Type of document	Comments / titles & dates of documents received	Received Y/N (N/A)	Link to the Evaluation Matrix
Project-related documents (if applicable)			
Mission Commission Report		N	
Project Document (including the Logical Framework in Appendix)	Contributed to the development of the theory of change and the Evaluation Matrix.	Y	
Standard Project Reports	WFP 2018. *Assistance to Refugees and Vulnerable Food-Insecure Populations, Standard Project Report 2018,* Burundi: WFP, 2018, pp 15–16. Provides an overview of the program's progress	Y	
Budget Revisions		N	
Note for the record (NFR) of the Program Review Committee meeting (for the original intervention and budget revisions if any).		N	
Approved Excel budget (for original intervention and budget revisions if any)	The approved budget is broken down by category of expenditure and by year. Useful for financial analysis. The limitation is the lack of disaggregation by province.	Y	
Intervention/Project Plan (details of numbers and food requirements of beneficiaries by region/activity/month and partners)	This document will be analyzed in more depth during the data collection and analysis phase itself.	Y	
Other			
Country office strategy papers (if applicable)			
National Strategy Document (if any)	*PAM 2017. Burundi country gender action plan 2017-2020*. Burundi: WFP, April 2017. Provides an overview of Burundi's gender strategy. Will inform the gender analysis of the evaluation, although developed after the MAM treatment program was started.	Y	
Other	*Burundi: Annual Country Report – Country Strategic Plan 2018 – 2020, ACR Reading Guidance*. Burundi: WFP, 2018.	Y	

Type of document	Comments / titles & dates of documents received	Received Y/N (N/A)	Link to the Evaluation Matrix
Evaluation reports (if applicable)			
Comprehensive Reviews on Food Security and Vulnerability	*The State of Food Security and Nutrition in the World 2018. Building resilience to climate change for food security and nutrition*. FAO, IFAD, WHO, WFP and UNICEF, Rome: FAO, 2018. Will help describe and understand the food and nutrition context of Burundi.	N	
Reviews on Plant and Food Security (FAO/WFP)		N	
Reviews on Emergency Food Security		N	
Food Safety Oversight System Bulletins		N	
Market Reviews and Bulletins		N	
Joint Review Missions (UNHCR/WFP)		N	
Inter-agency journals		N	
Need for quick review		N	
Feasibility study liquid and coupons		N	
Other			
Supervision and reporting (if applicable)			
Monitoring and Evaluation (M&E) Plan	This document will be further analyzed during the actual data collection and analysis phase.	Y	
Country Status Report (SITREP)		N	
Briefing for the Country Manager		N	
Food Distribution and Post-Distribution Supervision Reports	These reports would have provided clues about the quality and efficiency of the distributions and the reliability of the distribution data.	N	
Monthly Supervision Reports	Monthly process monitoring report - April 2018: this document summarizes the number of supervisions as well as the observations and recommendations resulting from these supervisions. There is only one report of this type, and the availability of all the reports would have shown the robustness of the M&E system and would have been a strong argument for the quality of the data found in the reports and databases.	Y	
Beneficiary Audit Reports	These reports would have provided an indication of the quality and reliability of beneficiary data.	N	

Type of document	Comments / titles & dates of documents received	Received Y/N (N/A)	Link to the Evaluation Matrix
Specific Donor Reports			
Performance monitoring reports (if applicable)			
Actual and projected beneficiaries by activity and area/lease by year	Annual reports, bi-annual reports but only present data by location, the beneficiary database can provide this information. The provision of beneficiary audit reports would have allowed for triangulation of information and would have provided an additional argument on the quality of the data provided.	Y	
Male vs. female beneficiaries by activity and zone/rental per year	Annual reports, bi-annual reports but only present data by location, the beneficiary database can provide this information. The provision of beneficiary audit reports would have allowed for triangulation of information and would have provided an additional argument on the quality of the data provided.	Y	
Beneficiaries by age group	Annual reports, bi-annual reports but only present data by location, the beneficiary database can provide this information. The provision of beneficiary audit reports would have allowed for triangulation of information and would have provided an additional argument on the quality of the data provided.	Y	
Tonnages distributed by activity and year Actual and Forecast	Annual reports, bi-annual reports but only present data by location, the beneficiary database can provide this information. The provision of Food Distribution and Post-Distribution Supervision reports would have allowed triangulation of information and would have been an additional argument on the quality of the data provided.	Y	
Commodity type by activity			
Actual and planned cash requirements/coupons (US$) by activity and year			
Operational documents (if applicable)			
Organizational chart for the main office and sub-offices			
Activity guidelines			
Mission Reports	Mission Report for the preparation of the evaluation	Y	
Overall vision for the period covered by the evaluation			
Review of logistics capabilities			

Type of document	Comments / titles & dates of documents received	Received Y/N (N/A)	Link to the Evaluation Matrix
Partners (if applicable)			
Annual reports of cooperative partners	USAID 2017. *Burundi Gender Analysis, Final Report,* USAID, 2017. Will be analyzed	Y	
List of partners (Government, NGOs, UN agencies) by location/activity/role/tonnage operated	Agreement documents between partners These documents will be further analyzed during the actual data collection and analysis phase.	Y	
Field level agreements (FLAs), Memorandum of Understanding (MOUs)	Documents of agreements between WFP and the health districts. These documents will be analyzed in greater depth during the actual data collection and analysis phase.	Y	
Team/ coordination meetings (if applicable)			
Logistics/Food security/Food documentation gathering		N	
NFRs of coordination meetings		N	
Other			
Evaluations/ reviews			
Evaluations/ Reviews of past or ongoing operations	There have been no evaluations or reviews of operations prior to this evaluation.		
Resource mobilization (if applicable)			
Resource mobilization strategy		N	
NFRs of donor meetings		N	
Other documents collected by the team (including external documents) (if applicable)			
National Surveys	EDS 2016/2017. *Third Demographic and Health Survey in Burundi (EDSB-III). Key Indicators 2016-2017.* Institute of Statistics and Economic Studies of Burundi (ISTEEBU), May 2017. Helps describe and understand the socio-demographic and health context of the MAM treatment intervention.	Y	
Annual Report			
National Strategy	Government of Burundi 2019. *Multi-sectoral Strategic Plan for Food Security and Nutrition (PSMSAN II)*. Government of Burundi, 2019. Helps to understand the programmatic context of the MAM treatment program	Y	

Type of document	Comments / titles & dates of documents received	Received Y/N (N/A)	Link to the Evaluation Matrix
	Helps to link MAM treatment with other nutrition-specific and nutritionally sensitive interventions.		
National Strategy	MINAGRIA. *National Agricultural Investment Plan (PNIA),* Bujumbura: MINAGRIE, June 2011 Helps to link with other nutrition-specific and nutrition-sensitive interventions	Y	
National Strategy	PRONOUNCE 2019. *Plan Stratégique de Nutrition (2019-2023)*, Ministry of Public Health and the Fight against AIDS (PRONIANUT), February 2019. Helps to link with other nutrition-specific and nutrition-sensitive interventions.	Y	
National Strategy	*National Protocol for the Integrated Management of Acute Malnutrition (PCIMA),* Ministry of Public Health and the Fight against AIDS (PRONIANUT), April 2019. Describes the treatment strategy for MAM	Y	

Appendix 6. Key Stakeholder Interviews

Name	Organization	Position
National Level (Bujumbura)		
Patrizia Papinutti	WFP	Deputy Country Director
Michael Ohiarlaithe	WFP	
Séverine Giroud	WFP	Head of Unit, Nutrition
Pochon Martine	WFP	Gender and Protection
Nkeshimana Gaston	WFP	Policy Officer Programme - Nut
Ntamagiro Anatole	WFP	Budget and Programming
Nshime Shadia	WFP	Finance Officer
Mahwane Jean	WFP	VAM Officer
Jean Baptiste Niyongabo	WFP	Programme Associate, M&E
Hyppolite Niyongabo/Liena Narame	WFP	Logistics Officer
Dr. Tumwibaze Alice	PRONIANUT	Inputs Committee, M&E
Elisabeth N. Zanou	UNICEF	Nutrition Manager
Dr Busogoro	WHO	
Isidore Sindabarira	FAO	Nutrition Focal Point
Leif Davenport	FFP Bujumbura	FFP Officer
Mpoziriniga Daring	FFP Bujumbura	Food Security Specialist
Mike Manske	FFP Washington	Nutrition Advisor
Gates Russell and Mrs. Biton	Concern Worldwide	CountryDirector
Mbengue Martha	World Vision	Country Director
Dr Sibomana Célestin	Second Vice-Chairperson	Focal Point SUN/PMSAN
Ngozi Province		
Mpoyi Willy	WFP Ngozi	Field Office Manager
Barihuta Leonidas	WFP Ngozi	Field Nutritionist
Hakizimana Siméon	WFP Ngozi	Field Monitor SFP
Karombo Charles	WFP Ngozi	Logistician
Kayobera Augustin	Ngozi Health District	Nutrition Focal Point
Diane Niyonzima	Ngozi Health District	Pharmacy Manager
Stéphanie Congere	Provincial Health Office	Nutrition Focal Point
Félicité Irakiza	Health Center (HC) Ngozi	HC Deputy Manager
Hawa Kwizera	HC Ngozi	SFP Manager
Uwizeyimana Astérie	HC Ngozi	SFP support staff
Dévote Ndacayisaba	HC Burasira	HC manager
Justine Bangirimana	HC Burasira	SFP Manager
Pontian Minani	HC Burasira	NSS Support Officer
Kirundo Province		
Emmanuel Nkeraguhiga	Health District	Nutrition Focal Point
Odette Nibitanga	Health District	Pharmacy Manager
Fidèle Ntuyenabo	Provincial Health Office	Nutrition Focal Point
Beatrice Ngezahimana	HC Kirundo	HC Manager
Françoise Nyandwi	HC Kirundo	SFP Manager
Beatrice Niyonzima	HC Kirundo	SFP support staff
Eric Harerimana	HC Sigu	HC Manager
Cankuzo Province		
Hermenegilde Ndengutse	Health District	Nutrition Focal Point
Bonaventure Kiranyagara	Health District	Pharmacy Manager
Renilde Ndabaganitse	HC Cankuzo	HC manager
Frédéric Bandushubwenge	HC Cankuzo	SFP Manager
Dieudonné Ndikumana	HC Cankuzo	NSS Support Officer
Bernard Nkuriyingoma	HC Cendajuru	HC and SFP manager
Brigitte Ngendabanyiwa	HC Cendajuru	SFP support staff
Rutana Province		
Emmanuel Niyonkuru	Health District	nutrition focal point

Etienne Bucumi	Health District	Pharmacy Manager
Mariane Manirakiza	Provincial Health Office	Nutrition Focal Point
Appolinaire Nsabimana	HC Rutana	HC Manager
Denis Nintunze	HC Gatakazi	HC director
Moise Maombi	HC Gatakazi	SFP Manager
Longin Harushimana	HC Gatakazi	NSS Support Officer
WFP Gitega		
Gloriose Nyandimbane	WFP Gitega	SFP field Mitor
Tharcissus Niyonkuru	WFP Gitega	Field Office Manager

	Location	Number of participants
COSA and fathers of children under 5 years of age (beneficiaries and non-beneficiaries)	HC Ngozi	2 women, 7 men
Mentor Mothers and CHWs	HC Ngozi	6 women, 2 men
PLW (beneficiaries and non-beneficiaries)	HC Ngozi	12 women
COSA and fathers of children under 5 years of age (beneficiaries and non-beneficiaries)	Burasira Health Centre, Ngozi	1 woman, 8 men
Mentor Mothers and CHWs	Burasira Health Centre, Ngozi	5 women, 3 men
PLW (beneficiaries and non-beneficiaries)	Burasira Health Centre, Ngozi	12 women
COSA and fathers of children under 5 years of age (beneficiaries and non-beneficiaries)	HC Kirundo	2 women, 7 men
Mentor Mothers and CHWs	HC Kirundo	5 women, 3 men
Pregnant Women and Nursing Women (beneficiaries and non-beneficiaries)	HC Kirundo	12 women
COSA and fathers of children under 5 years of age (beneficiaries and non-beneficiaries)	HC Sigu	6 men, 1 woman
Mentor Mothers and CHWs	HC Sigu	4 women, 2 men
PLW (beneficiaries and non-beneficiaries)	HC Sigu	12 women
COSA and fathers of children under 5 years of age (beneficiaries and non-beneficiaries)	HC Cankuzo	2 women, 7 men
Mentor mothers and CHWs	HC Cankuzo	6 women, 2 men
PLW (beneficiaries and non-beneficiaries)	HC Cankuzo	12 women
COSA and fathers of children under 5 years of age (beneficiaries and non-beneficiaries)	HC Cendajuru	2 women, 7 men
Mentor mothers and CHWs	HC Cendajuru	6 women, 2 men
PLW (beneficiaries and non-beneficiaries)	HC Cendajuru	12 women
COSA and fathers of children under 5 years of age (beneficiaries and non-beneficiaries)	HC Rutana	2 women, 7 men
Mentor mothers and CHWs	HC Rutana	6 women, 2 men
PLW (beneficiaries and non-beneficiaries)	HC Rutana	12 women
COSA and fathers of children under 5 years of age (beneficiaries and non-beneficiaries)	HC Gatakazi	2 women, 7 men
Mentor Mothers and CHWs	HC Gatakazi	6 women, 2 men
PLW (beneficiaries and non-beneficiaries)	HC Gatakazi	12 women

	Individual interviews	Group discussions		Direct observations
		Number of sessions	Number of participants	
National	20	-	-	-
Provincial	9	-	-	-
Health District	8	12	116	4
Health Centre	19	12	112	4
Total	**54**	**24**	**226**	**8**

Appendix 7. Health Centers Selected for Data Collection

Table 10. Health centers selected for secondary quantitative data collection in the provinces of Ngozi and Rutana

Province	Health district	Commune	Health center
Ngozi	Buye	Mwumba	1. Cahi 2. Gatobo 3. Buziragaham
		Nyamuren	4. Gitare
		Gashikanwa	5. Gashikanwa
	Kiremba	Kiremba	6. Nyamugari
		Marangara	7. Giheta
		Bisiga	8. Bisiga
	Ngozi	Ruhororo	9. Taba1 10. Mubanga1
Rutana	Gihofi	Bukemba	11. Kabanga
		Giharo	12. Butezi
		Gitanga	13. Gitanga 14. Kinzanza
	Rutana	Mpingakoye	15. Kiguhu 16. Mpinga 17. Ngara
		Rutana	18. Kivoga 19. Gasakuza
		Musongati	20. Musongati

Table 11. Health centers selected for qualitative primary data collection (purposive sampling)

Province	Health district	Commune	Health center
Ngozi	Ngozi	Ngozi	1. Ngozi Health Center
		Ruhororo	2. Burasira Health Center
Kirundo	Kirundo	Kirundo	3. Kirundo Health Center
	Busoni	Busoni	4. Sigu Health Center
Cankuzo	Cankuzo	Cankuzo	5. Cankuzo Health Center
		Cendajuru	6. Cendajuru Health Center
Rutana	Rutana	Rutana	7. Rutana Health Center
		Musongati	8. Gatakazi Health Center

Appendix 8. Data Collection Tools

Tools for collecting quantitative data in health structures

Table 12. Performance indicator collection sheet

In-Patient Therapeutic Program (ITP), Out-Patient Therapeutic Program (OTP), Supplementary Feeding Program (SFP)[31]

	Months	Number of cured	Number of defaulters	Number of deaths	Number of transfers/ other	% cured [32]	% defaulters	% death	% transfers/ other
1									
2									
3									
4									
5									
6									
7									
…									
…									
30									
31									
32									
33									
34									
35									
36[33]									

[31] ITP and OTP data will only be collected if facilities exist in the visiting health centres.
[32] Researchers will only record the number of recoveries, defaults, deaths, transfers/other, the data will then be entered into an Excel file which will automatically calculate the percentages and plot the trend curves.
[33] Data will be collected for the period from April 2016 to April 2019.

Table 13. Admission data collection sheet: ITP, OTP, SFP[34]

	Month	Numbers of admissions	Moving average 3 months[35]	Moving median 3 months
1				
2				
3				
4				
5				
6				
7				
8				
…				
…				
…				
…				
29				
30				
31				
32				
33				
34				
35				
36[36]				

[34] ITP and OTP data will only be collected if facilities exist in the visiting health centres.
[35] Researchers will only record the number of admissions and the data will then be entered into an Excel file that will automatically calculate averages and medians and plot trend lines.
[36] Data will be collected for the period April 2016 to April 2019.

Table 14. Data collection sheet: Mid-upper arm circumference (MUAC) at admission in OTP and SFP[37]

MUAC	Admissions
125	
124	
122	
121	
120	
119	
118	
117	
116	
115	
114	
113	
112	
111	
110	
109	
108	
107	
106	
105	
104	
103	
102	
101	
100	
99	
98	
97	
96	
95	
94	
93	
92	
91	
90	
89	
88	
87	

[37] ITP data will be collected only if facilities exist in the visiting health centres.

Table 15. Data collection from MUAC at discharge (non-compliance rates) in OTP and SFP[38]

MUAC	Admissions
>125	
125	
124	
122	
121	
120	
119	
118	
117	
116	
115	
114	
113	
112	
111	
110	
109	
108	
107	
106	
105	
104	
103	
102	
101	
100	
99	
98	
97	
96	
95	
94	
93	
92	
91	
90	
89	
88	
87	

[38] ITP data will be collected only if facilities exist in the visiting health centres.

Table 16. Data collection sheet: OTP and SFP time to discharge[39]

Week	Number
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	

Table 17. Data collection sheet: OTP and SFP reference type[40]

Reference	Number
Community outreach worker	
Spontaneous (mother alone)	
Mentor Mother	
Community leader	
NGO personnel	
Health personnel (passive screening)	
Other	

[39] ITP data will be collected only if facilities exist in the visiting health centres.
[40] ITP data will be collected only if facilities exist in the visiting health centres.

Table 18. Data collection sheet: ITP, OTP, SFP defaulter over time[41]

	Month	Number of admissions	Moving average 3 months[42]	Moving median
1				
2				
3				
4				
5				
6				
7				
8				
…				
29				
30				
31				
32				
33				
34				
35				
36[43]				

Table 19. Data collection sheet: Time to default before OTP and SFP[44]

Week	Number
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	

[41] ITP and OTP data will be collected only if facilities exist in the visiting health centres.
[42] Researchers will only record the number of default cases and the data will then be entered into an Excel file that will automatically calculate averages and medians and plot trend lines.
[43] Data will be collected for the period April 2016 to April 2019.
[44] ITP data will be collected only if facilities exist in the visiting health centres.

Qualitative primary data collection tools

Interview guide with government officials (PRONIANUT, SUN secretariat, nutrition/health focal points at the provincial and district levels), technical partners (WFP, UNICEF, FAO), donors

Introduction, confidentiality and access to information

This interview is being conducted as part of the evaluation of the WFP-funded program for the treatment of moderate acute malnutrition in the provinces of Ngozi, Kirundo, Cankuzo and Rutana. The purpose of this evaluation is to examine the process, outputs, outcomes and possibly the impact of the intervention in these provinces, in order to make appropriate recommendations for its improvement. An essential part of the evaluation process is to conduct interviews with key informants such as yourself to obtain your views on the implementation of the program. We would like to thank you for giving your consent to participate in this evaluation. Be assured that your answers will be strictly confidential. Although you may be quoted in the evaluation report, the source of the citation will not be identified by your name, title or institutional affiliation.

The evaluation team

Participant information

Date:	**Name of organization:**		
Participant	**Name:**	**Title/Function:**	**Contact details:**

Questions	Responses/Quotes from respondent(s)
Relevance	
Meeting the needs and priorities of the government and the needs of the most vulnerable populations	
In your opinion, to what extent is the design of the MAM treatment program aligned to the government's national priorities and strategies?	
To what extent is this program relevant to WFP's national and international priorities and strategies (***question for WFP teams only***)?	

Questions	Responses/Quotes from respondent(s)
Tell us to what extent the intervention to treat MAM is relevant to the Community-Based Management of Acute Malnutrition (CMAM) and other nutritional protocols?	
How have gender, equity and women's empowerment issues been taken into account in the design, implementation and monitoring of the program in relation to the: Targeting of intervention areas? Targeting of beneficiaries, including the most vulnerable?	
How is this MAM treatment program appropriate for: PLW, including teenage girls? Children under the age of five?	
In your opinion, are there categories of beneficiaries that have not been taken into account? If so, which ones?	
Coherence	
Coherence between FFP funding for MAM and nutrition interventions funded by other donors	
How does the coordination between the FFP-funded MAM treatment program and other donor-funded nutrition-specific and nutrition-sensitive interventions work in terms of: Selection of intervention areas? Targeting of beneficiaries? Referencing and counter-referencing?	
Effectiveness	
Program Outputs and Contributing Factors	
What are your views on the results of the program in relation to: Capacity development carried out by WFP? The screening and management of PLW? Screening and management of children < 5 years old?	

Questions	Responses/Quotes from respondent(s)
Coordination of activities with other programs?	
What were the unexpected positive or negative results?	
What is your opinion of the means of engagement between WFP and the community for gathering their views and providing feedback on decision-making processes (engagement and feedback)?	
What are the main factors that contributed to the achievement of these results? For PLW For children < 5 years old	
What do you think should be improved?	
Efficiency	
Achievement of program objectives within the duration of the program	
Were funding and activities delivered as planned?	
Has there been any change in the schedule? If so, why?	
Program cost and efficiency improvement options	
In your opinion, could results be achieved with fewer resources? If so, explain. If not, why not?	
Impact	
Changes in the nutritional status of beneficiaries in the four provinces	

Questions	Responses/Quotes from respondent(s)
In your opinion, what is the impact of the intervention on: The prevalence of MAM? The prevalence of wasting in women of childbearing age, and pregnant and lactating women? The reduction of close pregnancies in women? Reducing teenage pregnancy? The birth weight of children?	
What is the potential impact on: Stunting Prevention of malnutrition in the long term?	
Impact on government authorities	
To what extent has the program influenced the government's involvement in addressing MAM and investing in the nutrition sector in general?	
Impact on gender relations, equity and women's empowerment	
How has the program helped to empower women in the raising of awareness among men, women, the elderly and youth about the importance of family nutrition?	
Sustainability	
To what extent has the management of MAM treatment contributed to strengthening the health system in regards to: Governance (policy and strategy development)? Human resources: training of health workers, community outreach workers, mentor mothers? Equipment within health structures? Integration of MAM treatment funding in national budgets? Integration of the ordering, storage and distribution of nutritional supplements into the national supply chain system?	

Questions	Responses/Quotes from respondent(s)
Integration of program monitoring data into the national health information system?	
What is the government's approach to sustainability for nutrition interventions addressing the treatment and prevention of MAM? In Memoranda of Understanding regarding program ownership? For the local production of nutritional supplements for the MAM treatment? Local production and distribution of agricultural ingredients for the prevention of malnutrition?	

Interview Guide for Nutritional Supply Chain Managers (PRONIANUT and WFP)

Participant information

Date:	**Name of organization:**		
Participant	**Name:**	**Title/Function:**	**Contact details:**

Questions	Responses/Quotes from Respondents
Relevance	
Distribution schedules, logistics, coverage, access	
What is the origin of the PlumpySup ordered and distributed to children < 5 years old?	
What is the origin of the CSB++ ordered and distributed to the PLW?	
Were the logistics implemented (means of transport, loading, unloading, etc.) appropriate for the geographical access conditions and climate of the intervention areas?	
What are the main constraints related to the coverage of all health centers?	
What are the main constraints related to access to the health centers covered?	
Efficiency	
Achievement of program objectives within the duration of the program	
Is the ordering and distribution of food supplements done regularly to prevent stock-outs? If not, why?	
Were distribution schedules regularly adhered to? If not, why not?	

Questions	Responses/Quotes from Respondents
Has funding been allocated as planned?	
Has there been any change in the schedule? If so, why?	
Program cost and efficiency improvement options	
In your opinion, could the same results be achieved with fewer resources? If so, how?	
Sustainability	
To what extent has the management of MAM treatment contributed to health system strengthening in terms of integrating the ordering, storage and distribution of nutritional supplements into the national supply chain system?	

Guide for focus group discussions with the four categories of participants defined in the evaluation methodology:

1) **Health center managers and health workers**
2) **Community health workers/community outreach workers and mentor mothers**
3) **Mothers of children < 5 years and PLW (beneficiaries and non-beneficiaries)**
4) **Community leaders and fathers of children < 5 years old (beneficiaries and non-beneficiaries)**

Introduction, confidentiality and access to information

This discussion is being conducted as part of the evaluation of the WFP-funded program for the treatment of moderate acute malnutrition in the provinces of Ngozi, Kirundo, Cankuzo and Rutana. The purpose of this evaluation is to examine the process, outputs, outcomes and possibly the impact of the intervention in these provinces, in order to make appropriate recommendations for its improvement. An essential part of the evaluation process is to conduct focus group discussions with service providers, program beneficiaries and non-beneficiaries. We would like to thank you for giving your consent to participate in this discussion. Rest assured that your answers will be kept strictly confidential. Although you may be cited in the evaluation report, the source of the citation will not be identified by your name, title or position.

The evaluation team[45]

Information on the activity and participants

Date: **Name of the town:** **Name of the health facility:** **Category of participants:** 1) Health center managers and health workers 2) Community health workers/community outreach workers and mentor mothers 3) Mothers of children < 5 years and PLW (beneficiaries and non-beneficiaries) 4) Community leaders and fathers of children < 5 years old (beneficiaries and non-beneficiaries)			
Number of male participants	**Number of female participants**	**Total number of participants**	

[45] Not all questions will be asked to all categories. They will be adapted to each category of participant. These group discussion guides will be further adapted to the different categories of participants during the in-depth literature and quantitative data analysis phase prior to field visits. In addition, they will be pre-tested and refined accordingly, prior to actual data collection.

Questions	Responses/Quotes from Respondent(s)
Relevance	
Meeting the needs and priorities of the government and the needs of the most vulnerable	
Are there categories of beneficiaries that have not been reached? If so, which ones?	
Were community consultations held to expose gender perspectives on malnutrition before the intervention was initiated or during the intervention to: • Discuss the role of women and men in decision-making on household nutrition? • Discuss the taboos and cultural practices related to the nutrition of PLW and children < 5 years old?	
Tell us about the key messages used during the program's outreach activities to promote gender equality and the prevention of sexual and gender-based violence?	
Meeting the needs of beneficiaries	
In your opinion, what are the obstacles related to the use and consumption of PlumpySup in connection with: • Storage? • Preparation time? • Taste? • Side effects? • Sharing within the family? • Sale?	
Tell us about obstacles related to the use and consumption of CSB++ • Storage? • Preparation time? • Taste? • Side effects?	

Questions	Responses/Quotes from Respondent(s)
• Sharing within the family? • Sale?	
Coherence	
Coherence between the treatment of MAM and other nutrition-specific and nutrition-sensitive interventions	
What other types of interventions in the locality are targeting the same beneficiaries as MAM treatment?	
Describe the mechanism through which a recipient of MAM treatment is admitted to these other interventions and vice versa.	
Effectiveness	
Program Outputs and Contributing Factors	
What are your views on the results of the program in relation to: • Health center coverage? • Access to services by PLW? • Access to services by children < 5 years old? • The channels for referencing and cross-referencing between programs?	
What are the main constraints and taboos related to access to services? • For PLW (including teenage girls)? • For children < 5 years old?	
What are the main factors that contributed to the achievement of results? • For PLW • For children < 5 years old	
Did you notice any difference in attendance at the health center compared to the availability or lack of availability of dietary supplements? Explain.	

Questions	Responses/Quotes from Respondent(s)
Results of community mobilization and nutrition education activities	
In your opinion, how has raising community awareness stimulated buy-in and participation in the program?	
What was the level of participation among the target populations (women, men, boys, girls)? Explain	
What about the means of engagement between WFP and the community (you) to gather your views to inform decision-making?	
What would you say about the feedback you received from WFP as a result of these exchanges?	
What are the top three things you would have changed in this program if you could?	
Efficiency	
Distribution calendars	
Was the distribution of food supplements carried out regularly without stock-outs? If not, what were the reasons?	
Have stock shortages negatively affected attendance at health facilities? If so, explain.	
Impact	
Changes in the nutritional status of beneficiaries in the four provinces	
Have you observed a change in your community as a result of the implementation of the MAM treatment intervention? • The nutritional status of women of childbearing age, pregnant and lactating?	

Questions	Responses/Quotes from Respondent(s)
• Close pregnancies in women? • Early teenage pregnancy? • The birth weight of children? • Prevention of malnutrition in the long term?	
Impact on gender relations, equity and women's empowerment	
How has the program helped to empower women in the raising of awareness among men, women, the elderly and youth about the importance of family nutrition?	
Explain how men participate in decisions on household nutrition after receiving nutrition advice and sensitization?	
Sustainability	
What has changed in the way you handle or prepare meals in your household?	
What are the results of these actions?	
What difficulties did you face when you wanted to change your eating practices in the household?	

Checklist for direct observation in health structures

The team will use this checklist to observe the environment within the health facilities, the adequacy of its tools for social behavior change, the quality of the assessment and classification of the nutritional status of children under five years of age, the availability and use of the protocol for the management of acute malnutrition (focusing on the treatment of MAM), the availability of adequately trained staff, food supplements and adequate infrastructure, stock management and record-keeping.

Checklist adapted from Nutrition Assessment, Counselling and Support (NACS)

Equipment and materials		**Yes**	**No**
1.	The site has at least one functional scale for measuring the weight of children in kg to the nearest 100g.		
2.	The site has at least one adult weighing scale/ scale for adults		
3.	The site has at least one height gauge that measures the height of children to the nearest cm.		
4.	The site has at least one measuring rod that measures adults.		
5.	The site has tape measures for measuring the brachial perimeter of children and adults.		
6.	The site has copies of algorithms/guidelines for the management of acute malnutrition in children and PLW.		
7.	The site has at least one set of nutritional advice cards to be used in advising carers (mothers and fathers) of children on the prevention and treatment of moderate acute malnutrition.		
8.	The site has at least one set of nutritional advice cards to be used in advising PLW.		
9.	The site has data entry forms and a system for compiling data that includes data on the treatment of MAM in children under five years of age, and PLW.		
10.	The site has a graph with body mass index thresholds.		
11.	The site has a graph with the weight/height (W/H) thresholds in z-score of the WHO child growth standards, year 2006.		
12.	The site has utensils (e.g. bowls, tablespoons, saucepans, kitchen) for cooking demonstrations (preparation and use of CSB++).		
Nutritional assessment and classification		**Yes**	**No**
13.	At least two health care providers are trained in the management of acute malnutrition in children under 5 years of age, and PLW.		
14.	For all children arriving at the site for the first time, weight is measured to the nearest 100g, height is measured in cm, P/T index is calculated and brachial perimeter is measured to the nearest mm.		
15.	The weight/height index and/or brachial perimeter are recorded on the registration cards of children under five years of age.		
16.	For all PLW arriving at the site for the first time, weight is measured in kg, height is measured in cm, body mass index is calculated and brachial perimeter is measured.		
Nutritional treatment alans		**Yes**	**No**
17.	Each MAM child receives PlumpySup on the basis of a treatment plan developed for his or her nutritional and health status.		
18.	Each acutely malnourished pregnant or lactating woman receives CSB++ based on the guidelines developed in the national MAM management protocol.		

19.	Each accompanying person receives an explanation on the criteria for entry and exit of the child, the purpose of PlumpySup[46] and how to consume it.		
20.	Each PLW receives an explanation of the child's entry and exit criteria, the purpose of CSB++ and how to prepare and consume it.		
21.	Entry and exit criteria for dietary supplements are posted in a place easily visible to health workers, caregivers of children under five and PLW.		
22.	Every MAM child receives enough packets of PlumpySup to last until the next visit to the health center, according to national guidelines.		
23.	Every admitted PLW receives sufficient CSB++ to last until the next visit to the health center, according to national guidelines.		
Infrastructure and amenities		**Yes**	**No**
24.	The site has enough PlumpySup to handle MAM cases for at least 3 months.		
25.	The site has enough CSB++ to handle malnourished PLW cases for at least 3 months.		
26.	The site has sufficient space to store PlumpySup, CSB++ and related products.		
27.	The space available for storage of PlumpySup, CSB++ and related products is clean and sufficiently ventilated.		
Inventory management and record-keeping		**Yes**	**No**
28.	The head of the health center submits a regular monthly report on the number of children under five years of age, pregnant women and lactating women receiving food supplements according to the agreed schedule.		
29.	The manager of the health center regularly submits an estimate of PlumpySup and CSB++ supply needs according to the agreed schedule.		
30.	The site store in charge of the nutritional supplements correctly keeps stock records for PlumpySup and CSB++.		
31.	The health worker completes the counseling record for each client consulted.		
32.	The data officer compiles the nutritional data according to the agreed (monthly) schedule.		
33.	"First to expire, first out" procedures and inventory management are used for PlumpySup, CSB++ and other commodities.		
34.	Dietary supplements are ordered at least 3 months in advance to avoid stock-outs.		

[46] Plumpy'Sup™ is a ready-to-use supplementary food paste (RUSF) also defined as Lipid-based Nutrient Supplement Large Quantity (LNS LQ). It was designed for the treatment of moderate acute malnutrition from the age of 6 months, within the framework of nutritional supplementation programs. Plumpy'Sup™ is also suitable for children leaving therapeutic feeding programs to prevent relapse into severe acute malnutrition (Nutriset 2018).

Appendix 9. Additional Results on Effectiveness

Figure 8. Geographic coverage of SFP by province

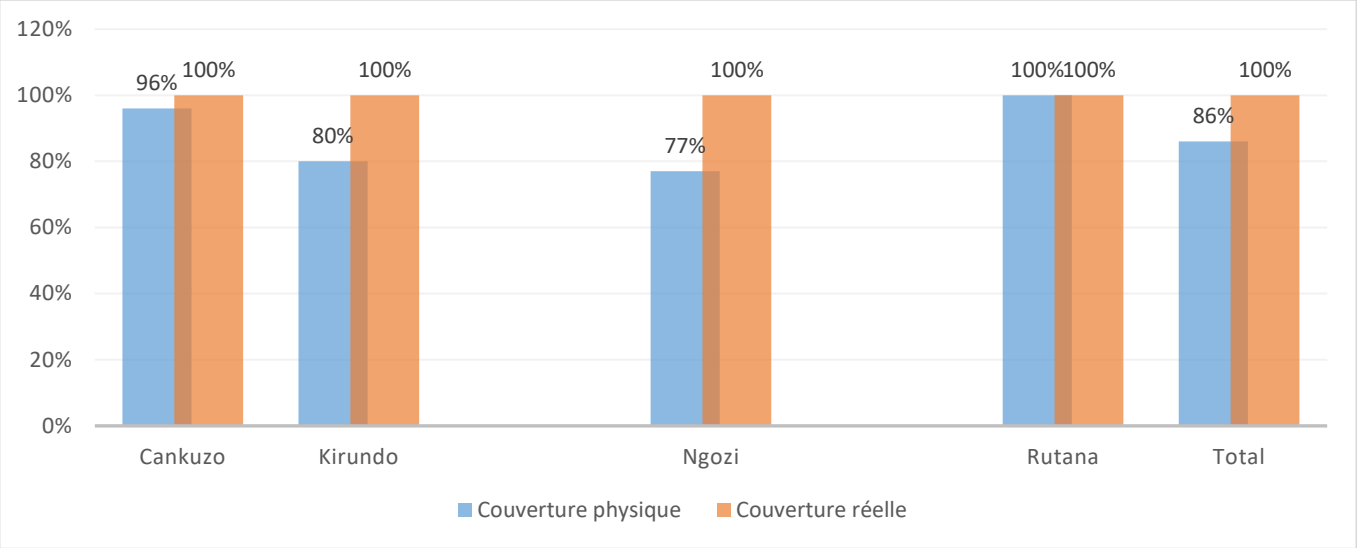


Figure 9. Treatment coverage by province and by year for children under five

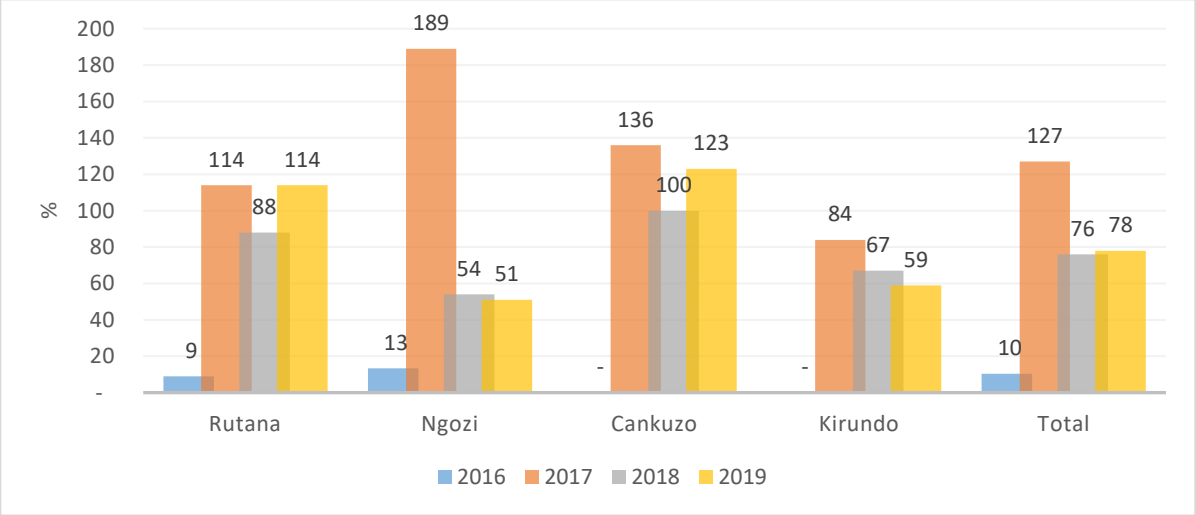


Figure 10. Treatment coverage by province and year for PLW

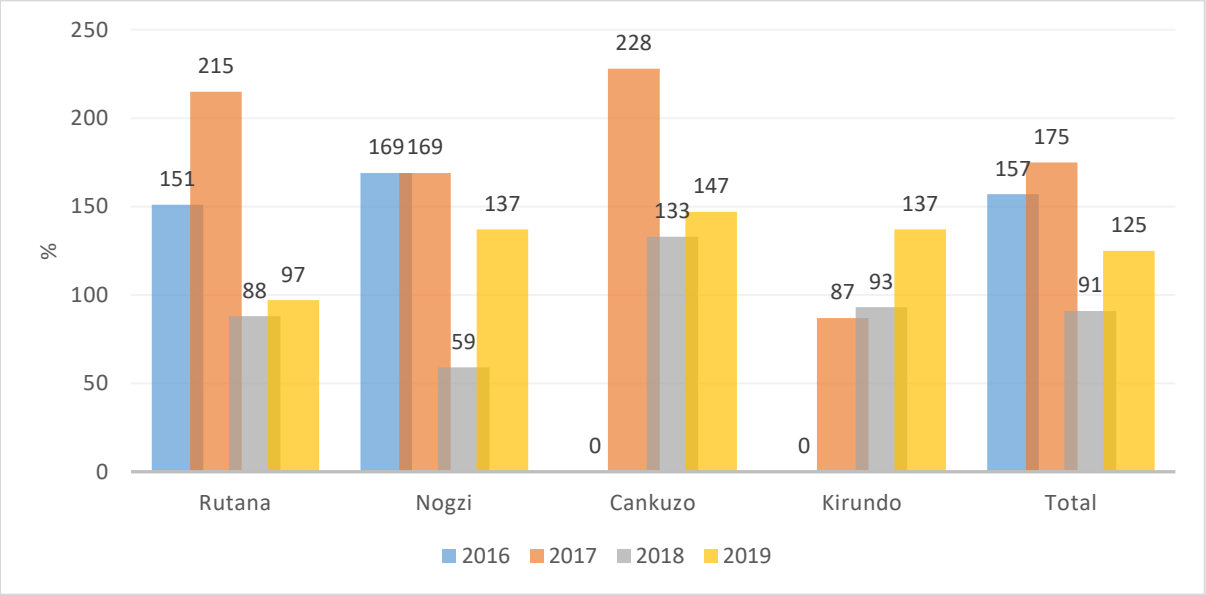
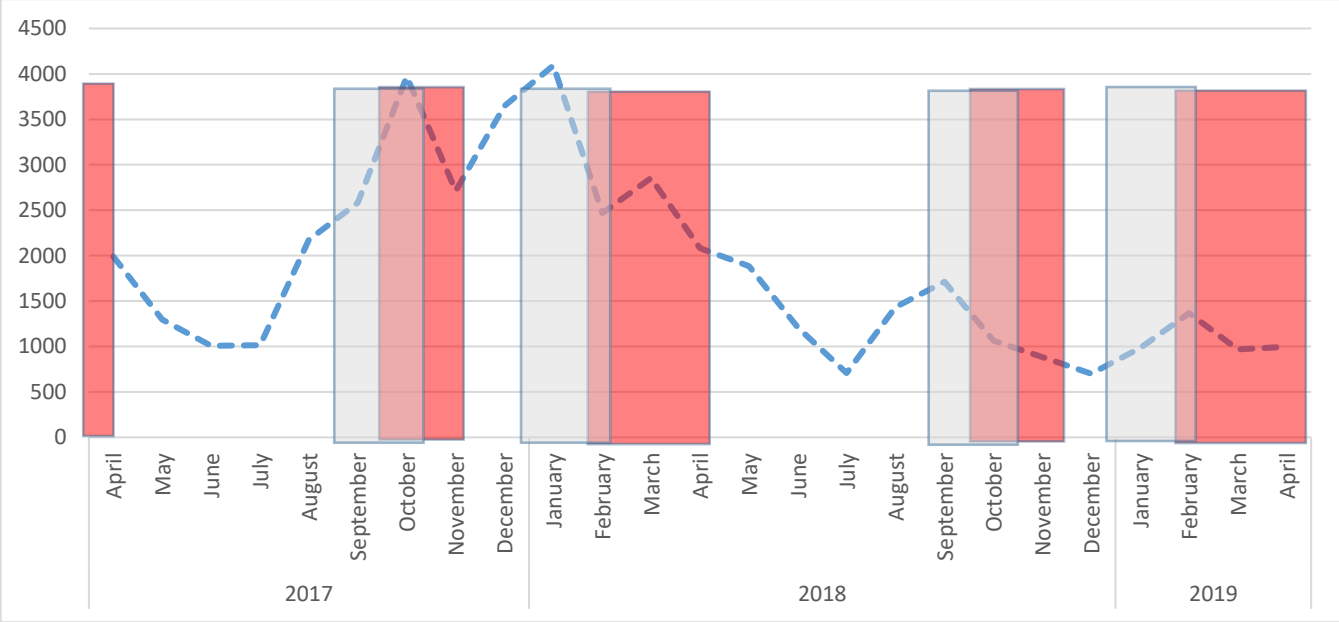


Figure 11. Evolution of the number of MAM cases for children under five in the province of Cankuzo, 2017–2019

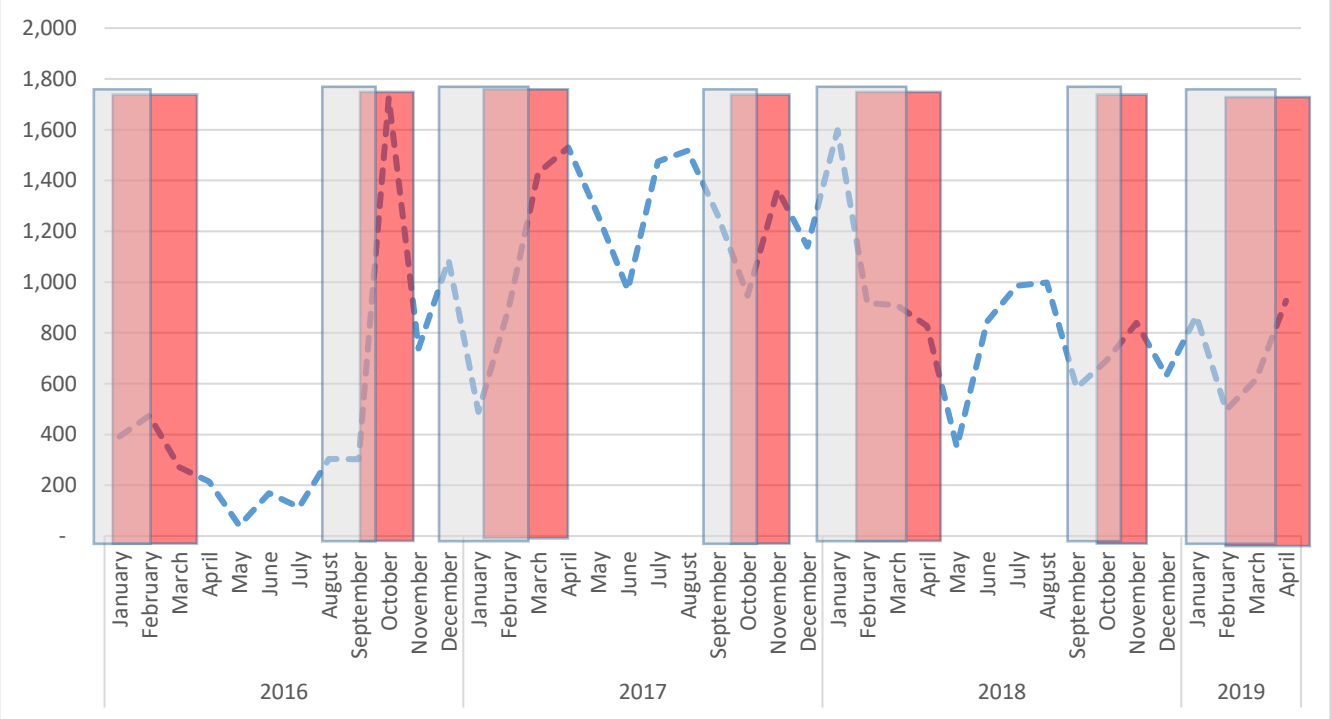


Period of childhood illness (ARI, malaria, diarrhea)[47]

Lean period[48]

[47] The Famine Early Warning System Network (FEWS NET), Livelihoods zoning « plus » Activity in Burundi.
[48] Ibid.

Figure 12. Evolution of the number of MAM cases for children under five in the province of Ngozi, 2016–2019

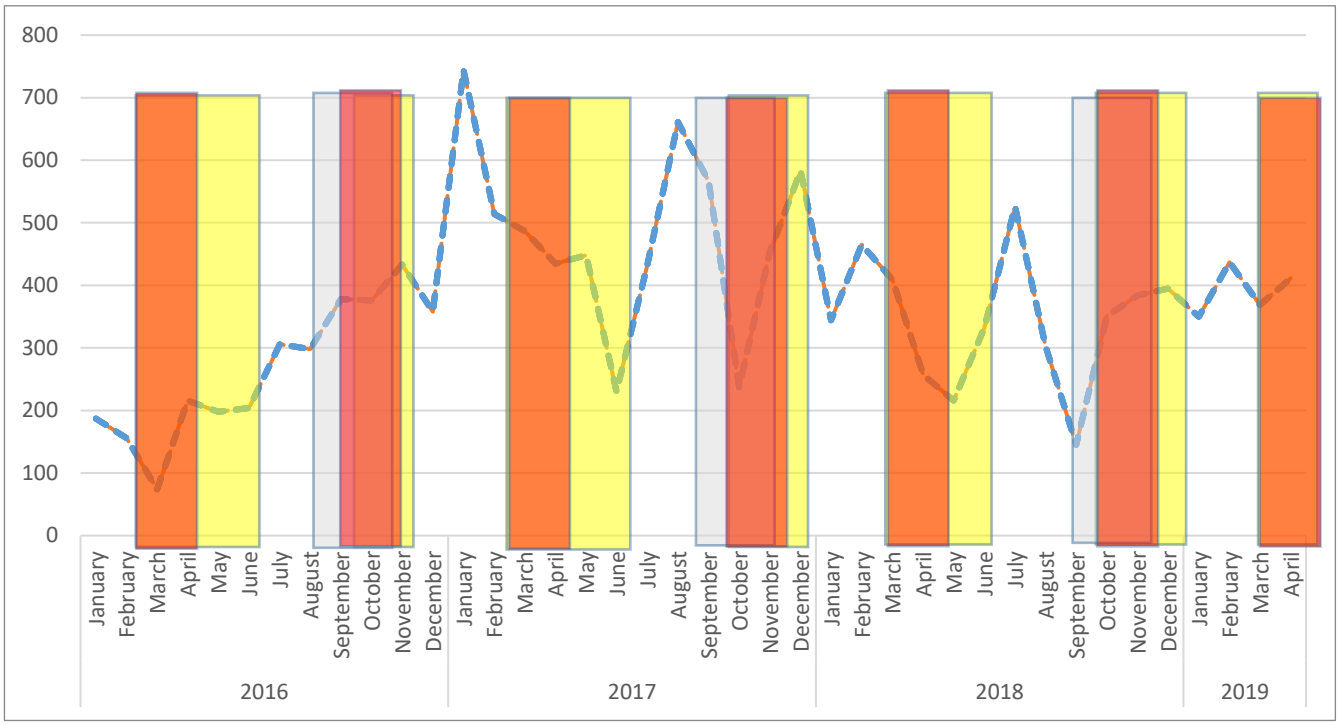


Period of childhood illness (ARI, malaria, diarrhea)[49]

Lean period[50]

[49] Ibid.
[50] Ibid.

Figure 13. Evolution of the number of MAM cases for children under five in the province of Rutana, 2016–2019



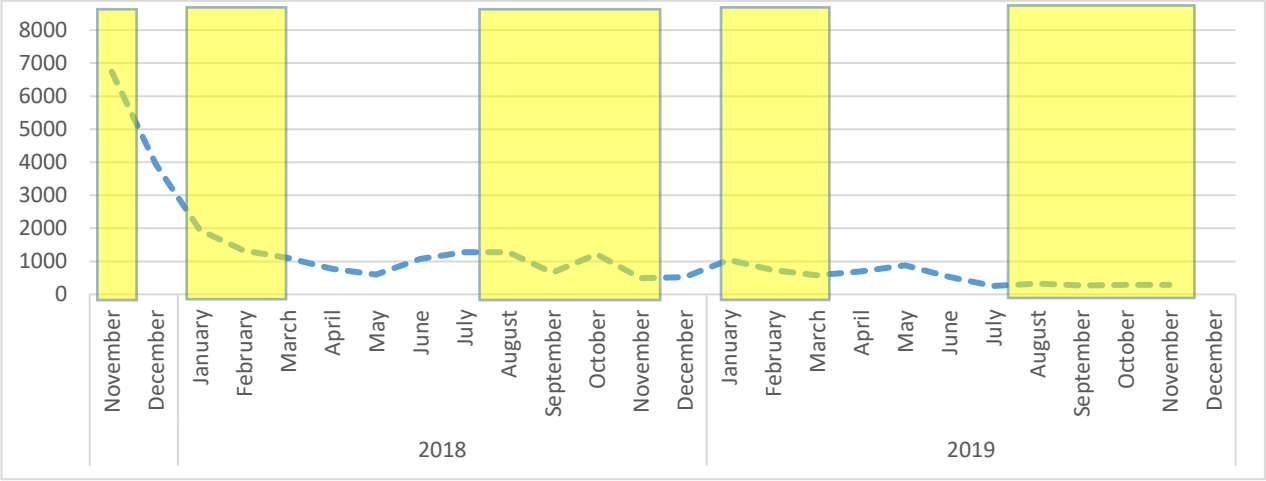
Period of childhood illness (diarrhea)[51]

Period of childhood illness (malaria)[52]

Lean period[53]

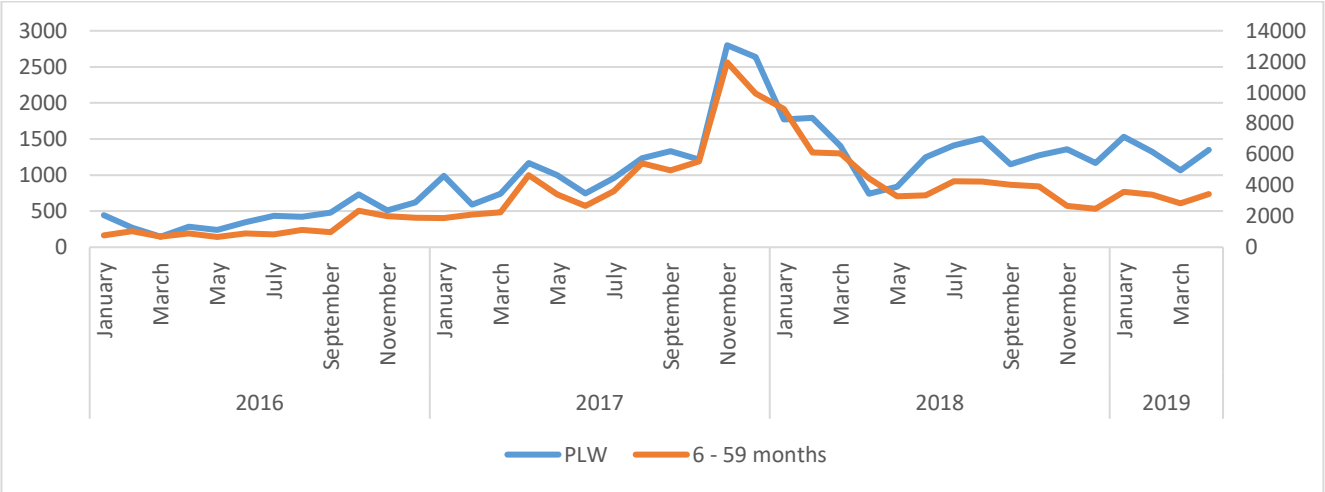
[51] Ibid.
[52] Ibid.
[53] Ibid.

Figure 14. Evolution of the number of MAM cases for children under five in the province of Kirundo, 2017–2019



Period of childhood illness (ARI, malaria, diarrhea) and lean period[54]

Figure 15. Total annual admission rates for PLW and children under fivc



[54] Ibid.

Figure 16. Length of stay before recovery (number of weekly visits)

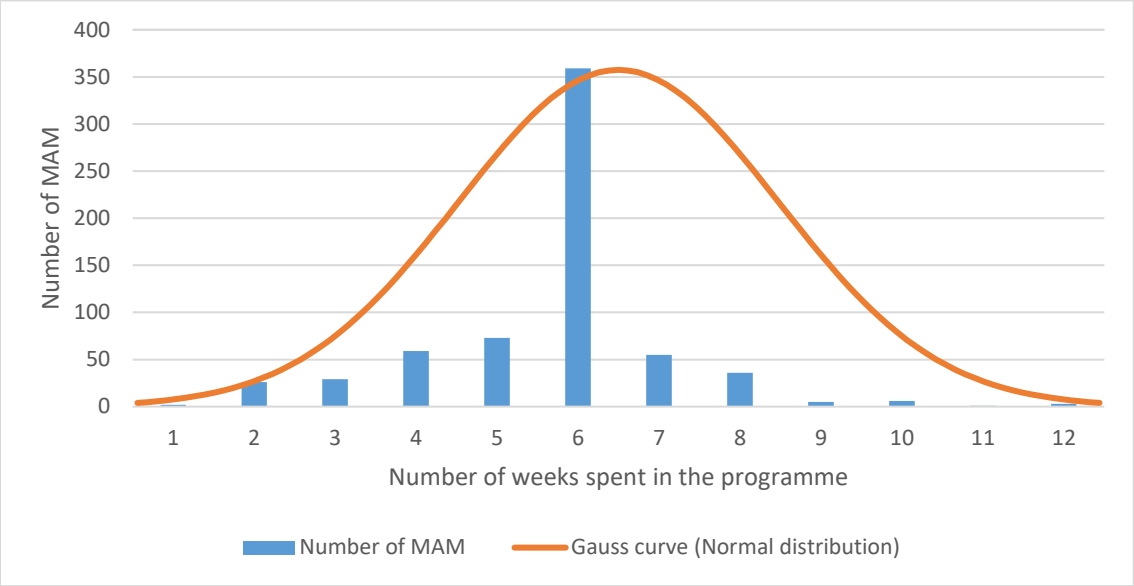


Figure 17. Quantity of PlumpySup distributed, by province and by year

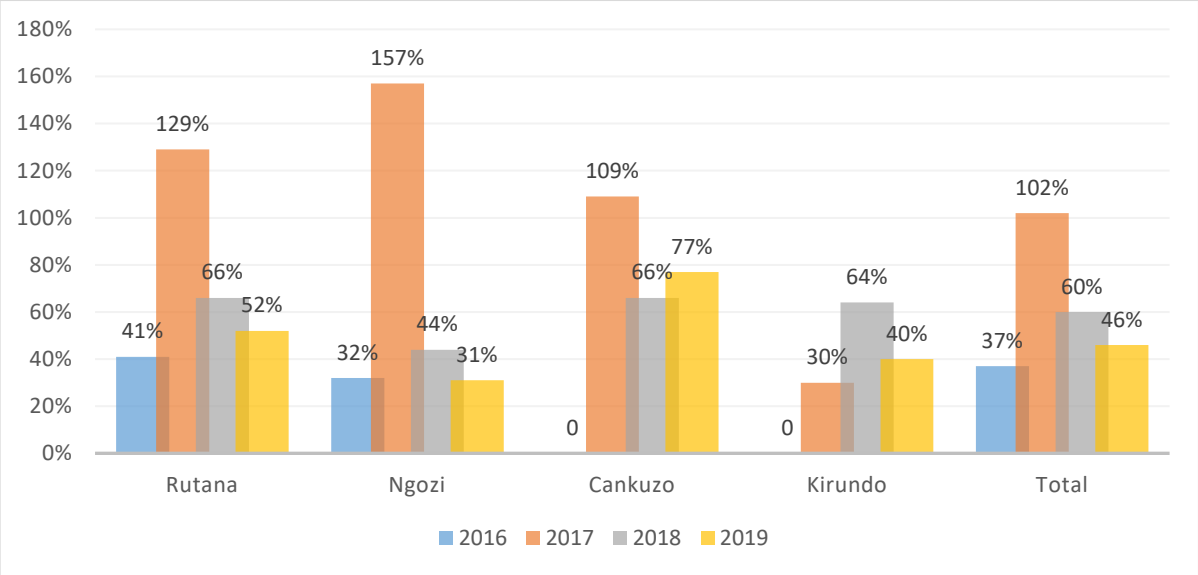


Figure 18. Quantity of CSB++ distributed versus planned, by province and by year

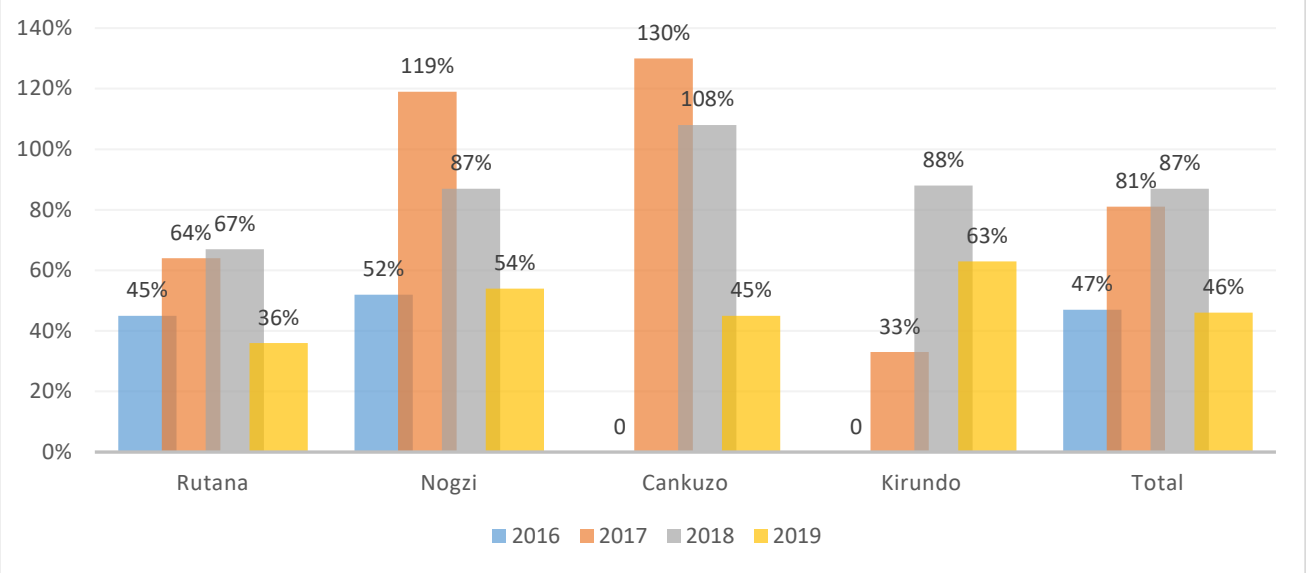


Table 20. Chi2 test to compare data from databases and registration books

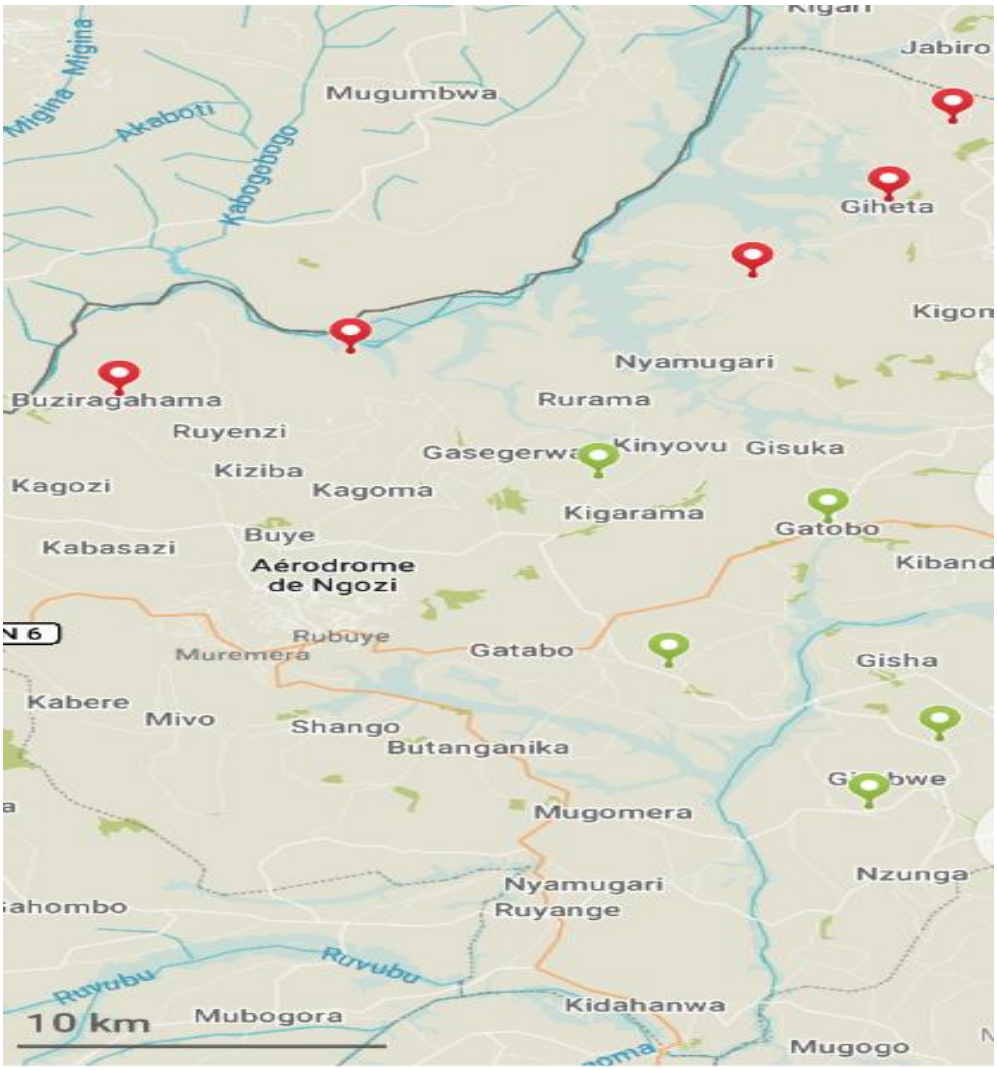
Province	Health center	Year	Database	Register	P value	Significant difference
Ngozi	Bisiga	2016	0	0	0.00014	Yes
		2017	0	128		
		2018	219	264		
		2019	102	61		
		Total	**321**	**453**		
Rutana	Butezi	2016	0	0	6.79E-25	Yes
		2017	292	72		
		2018	486	463		
		2019	203	233		
		Total	**981**	**768**		
Ngozi	Buziragahama	2016	83	25	7.54E-06	Yes
		2017	330	249		
		2018	308	293		
		2019	112	107		
		Total	**833**	**674**		
Ngozi	Cahi	2016	89	80	5.51E-14	Yes
		2017	640	334		

Province	Health center	Year	Database	Register	P value	Significant difference
		2018	131	121		
		2019	19	59		
		Total	**879**	**594**		
Rutana	Gasakuza	2016	77	81	0.70422	No
		2017	148	130		
		2018	158	138		
		2019	37	39		
		Total	**420**	**388**		
Ngozi	Gashikanwa	2016	92	78	0.17097	No
		2017	319	360		
		2018	283	300		
		2019	154	135		
		Total	**848**	**873**		
Ngozi	Gatobo	2016			0.94623	No
		2017	71	74		
		2018	244	250		
		2019	96	104		
		Total	**411**	**428**		
Ngozi	Giheta	2016	110	78	0.03655	Yes
		2017	262	162		
		2018	172	127		
		2019	28	6		
		Total	**572**	**373**		
Rutana	Gitanga	2016	122	123	0.35205	Yes
		2017	128	118		
		2018	167	199		
		2019	75	91		
		Total	**492**	**531**		
Ngozi	Gitare	2016	94		0.63178	No
		2017	151	169		
		2018	96	91		

Province	Health center	Year	Database	Register	P value	Significant difference
		2019	12	11		
		Total	**353**	**271**		
Rutana	Kabanga	2016	447	575	3.32E-50	Yes
		2017	361	763		
		2018	990	700		
		2019	164	80		
		Total	**1 962**	**2 118**		
Rutana	Kiguhu	2016	73	56	0.00989	No
		2017	121	125		
		2018	226	159		
		2019	85	102		
		Total	**505**	**442**		
Rutana	Kivoga	2016	191	326	1.18E-17	Yes
		2017	223	147		
		2018	238	129		
		2019	92	96		
		Total	**744**	**698**		
Rutana	Mpinga	2016	91	5	0.22524	No
		2017	116	164		
		2018	109	119		
		2019	14	12		
		Total	**330**	**300**		
Ngozi	Mubanga	2016			0.80838	No
		2017	121	108		
		2018	238	232		
		2019	57	58		
		Total	**416**	**398**		
Rutana	Musongati	2016	87	74	0.51043	No
		2017	109	100		
		2018	175	134		
		2019	63	65		

Province	Health center	Year	Database	Register	P value	Significant difference
		Total	**434**	**373**		
Rutana	Ngara	2016	178	175	0.9113	No
		2017	216	211		
		2018	217	221		
		2019	109	119		
		Total	**720**	**726**		
Ngozi	Taba1	2016	59	59	0.232698	No
		2017	296	289		
		2018	228	284		
		2019	55	62		
		Total	**638**	**694**		
Ngozi	Nyamugari	2016	110	54	1.88E-11	Yes
		2017	447	308		
		2018	218	293		
		2019	33	51		
		Total	**808**	**706**		
Rutana	Kizanza	2016	171	ND	<0.005	Yes
		2017	376	ND		
		2018	132	ND		
		2019	81	ND		
		Total	**760**	**0**		
	Total	2016	1 826	1 708	0.439611	No
		2017	4 203	3 881		
		2018	4 745	4 379		
		2019	1 473	1 452		
		Total	**12 247**	**11 420**		

Figure 19. Map showing the ten centers of the province of Ngozi selected for primary data collection



(In red the centers with discrepancies between the registration books and database and in green the centers with concurring data)

Appendix 10. Additional Results on Efficiency

Table 21. Total actual expenditure versus planned expenditure in 2016 (USD)

	Planned expenditure (project plan)	Total actual expenditure	% Total spent
PlumpySup	412,500	412,500,	100
CSB++	0	0	0
Transportation of PlumpySup to Burundi	92,205	92,205,	100
Transportation of CSB++ to Burundi	0	0	0
Storage, transport and distribution of goods in the country	21,558	21,558	100
Materials/ equipment/ supplies Technical support (training, research follow-up supervision etc.)	125,882	125,882,	100
Project support	37,042	37,042	100
Other	48,243	48,243	100
Total	**737,430**	**737,430**	**100**

Table 22. Total actual expenditure versus planned expenditure in 2017 (USD)

	Planned expenditure (project plan)	Total actual expenditure	% Total spent
PlumpySup	0	0	0
CSB++	341,000,	355,831,	104.3
Transportation of PlumpySup to Burundi	0	0	0
Transportation of CSB++ to Burundi	141,366,	147,514	104.3
Storage, transport and distribution of goods in the country	36,865	36,865	100
Materials/ equipment/ supplies Technical support (training, research, follow-up, supervision, etc.)	37,861	16,882	44.5
Project support	139,795	139,795	100
Other	50,559	50,559	100
Total	**747,447**	**747,447**	**100**

Table 23. Total actual expenditure versus planned expenditure in 2018 (USD)

	Planned expenditure (project plan)	Total actual expenditure	% Total spent
PlumpySup	806,584	781,884	96.9
CSB++	88,137	101,665	115.3
Transportation of PlumpySup to Burundi	146,057	154,576	105.8
Transportation of CSB++ to Burundi	21,739	23,869,	109.8
Storage, transport and distribution of goods in the country	70,887	75,922	107.1
Materials/ equipment/ supplies Technical support (training, research, follow-up, supervision, etc.)	436,454	433,251	99.2
Project support	157,458	156,150	99.1
Other	109,558	109,558	100
Total	**1,836,873**	**1,836,874**	**100**

Table 24. Total actual expenditure versus planned expenditure in 2019 (USD)

	Planned expenditure (project plan)	Total actual expenditure	% Total spent
PlumpySup	1,095,153	1,059,192	96.7
CSB++	861,874	862,125	100
Transportation of PlumpySup to Burundi	109,260	115,090	105.3
Transportation of CSB++ to Burundi	246,170	252,014	102.3
Storage, transport and distribution of goods in the country	179,056	193,091	107.8
Materials/ equipment/ supplies Technical support (training, research, follow-up, supervision, etc.)	606,760	616,760	101.6
Project support	359,096	359,096	100
Other	169,676	169,676	100
Total	**3,627,044**	**3,627,044**	**100**

Appendix 11. Bibliography

Short reference	Full reference
ACF et al 2019	*Joint Statement 2019. Make the Global Action Plan on Wasting about Action.* ACF, ALIMA, AMREF, CIFF, Concern, ECF, et al. 2019.
Atun et al 2009a	*Integration of targeted health interventions into health systems: a conceptual framework for analysis.* Rifat Atun, Thyra de Jongh, Federica Secci, Kelechi Ohiri and Olusoji Adeyi. September 2009.
Atun et al 2009b	*A systematic review of the evidence on integration of targeted health interventions into health systems.* Rifat Atun, Thyra de Jongh, Federica Secci, Kelechi Ohiri and Olusoji Adeyi. September 2009.
Chen HT 2012	*Theory-driven evaluation: Conceptual framework, application and advancement.* In: R. Strobl et al. (Ed.), editor. Evaluation von Programmen und Projekten für eine demokratische Kultur. 2012. p. 17–8.
Concern Worldwide 2019	*Analyse des barrières et opportunités pour l'égalité des genres en provinces Bubanza et Kirundo*. Rapport définitif, janvier 2019.
EDS 2016/2017	*Troisième Enquête Démographique et de Santé au Burundi (EDSB-III). Indicateurs Clés 2016-2017.* Institut de Statistiques et d'Études Économiques du Burundi (ISTEEBU), mai 2017.
FAO et al 2018	*L'État de la sécurité alimentaire et de la nutrition dans le monde 2018. Renforcer la résilience face aux changements climatiques pour la sécurité alimentaire et la nutrition.* FAO, FIDA, OMS, PAM et UNICEF, Rome : FAO, 2018. http://www.fao.org/3/i9553fr/i9553fr.pdf
ISTEEBU 2018	*Enquête Nationale sur la Situation Nutritionnelle et la Mortalité basée sur la méthodologie SMART. Rapport principal,* ISTEEBU, février 2018.
ISTEEBU 2019	*Enquête nationale sur la situation nutritionnelle et la sécurité alimentaire au Burundi, JANFSA,* ISTEEBU, janvier 2019.
Marchal et al 2012	*Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research.* Bruno Marchal, Sara van Belle, Josefien van Olmen, Tom Hoerée and Guy Kegels, Evaluation (22 April 2012) 18:2, pp 192-212. https://doi.org/10.1177%2F1356389012442444
Mason 2010	*Sample Size and Saturation in PhD Studies Using Qualitative Interviews.* Mark Mason, Forum: Qualitative Social Research (2010) 11:3. http://dx.doi.org/10.17169/fqs-11.3.1428
MINAGRIE 2011	*Plan National d'Investissement Agricole (PNIA),* Bujumbura : MINAGRIE, Juin 2011. http://www.fao.org/3/a-az475f.pdf
MSP 2013	*Étude sur les grossesses en milieu scolaire.* Ministère de la Santé Publique avec l'appui de l'UNFPA, Novembre 2013.

Short reference	Full reference
Myatt et al 2012	*Reference technique sur l'évaluation semi-quantitative de l'accessibilité et de la couverture (SQUEAC) / l'évaluation LQAS simplifié de l'accessibilité et de la couverture (SLEAC).* Myatt, Mark et al. Washington, DC : FHI 360/FANTA. 2012.
Nutriset 2018	*Malnutrition aigüe modérée (traitement) – plumpysup,* Nutriset, 2018. https://www.nutriset.fr/products/fr/plumpy-sup
OCDE/CAD 2019	*Des meilleurs critères pour des meilleurs évaluations. Définitions adaptées et principes d'utilisation. Réseau du CAD de l'OCDE sur l'évaluation du développement (EvalNet).* Available from: www.oecd.org/dac/evaluation
OECD 2018	*Development Finance Data – Aid at a glance charts*, OECD, December 2018. https://public.tableau.com/views/OECDDACAidatagla ncebyrecipient_new/Recipients?:embed=y&:display_co unt=yes&:showTabs=y&:toolbar=no?&:showVizHome= no
Palinkas et al 2015	*Purposeful sampling for qualitative data collection and analysis in mixed method implementation research.* Lawrence A Palinkas, Sarah M Horwitz, Carla A Green, Jennifer P Wisdom, Naihua Duan and Kimberly Hoagwood, Adm Policy Ment Health (2015) 42:5, pp 533-544. https://dx.doi.org/10.1007%2Fs10488-013-0528-y
PAM 2015	*Politique en matière de problématique hommes- femmes. 2015-2020.* PAM, Juillet 2015.
PAM 2016	*Rapport annuel programmes nutrition 2016. Traitement de la malnutrition aiguë modérée,* janvier 2017, p 5.
PAM 2017	*Rapport annuel programmes nutrition 2017. Traitement de la malnutrition aiguë modérée,* janvier 2018, p 7.
PAM 2018a	*Aide aux réfugiés et aux populations vulnérables en situation d'insécurité alimentaire, Rapport de projet standard 2018*, Burundi : PAM, 2018, pp 15-16.
PAM 2018b	*Rapport annuel programmes nutrition 2018. Traitement de la malnutrition aiguë modérée,* janvier 2019, p 7.
PAM 2019	*Rapport semestriel janvier-juin 2019. Programme de prise en charge de la malnutrition aiguë modérée au Burundi*, juillet 2019, p 10.
PNUD 2016	*Rapport sur le développement humain 2016. Programme des Nations Unies pour le Développement,* disponible : http://hdr.undp.org/sites/default/files/HDR2016_FR_Overview_Web.pdf
PRONIANUT 2016	*Rapport de dépistages de masse de la malnutrition aiguë dans six provinces prioritaires.* Décembre 2016.
PRONIANUT 2019	*Protocole national de prise en charge intégrée de la malnutrition aiguë (PCIMA),* Ministère de la santé publique et de la lutte contre le SIDA (PRONIANUT), avril 2019.
Rogers PJ 2008	*Using programme theory to evaluate complicated and complex aspects of interventions.* Evaluation. 2008;14(1):29–48.

Short reference	Full reference
Tongco 2007	*Purposive Sampling as a Tool for Informant Selection*. Ma. Dolores C. Tongco, Ethnobotany Research and Applications (2007) 5, pp 147–158.
UNDP 2011	*Vision Burundi 2025*, UNDP, June 2011. https://www.bi.undp.org/content/dam/burundi/docs/ publications/UNDP-bi-vision-burundi- 2025_complete_EN.pdf
UNDP 2019	*Rapport sur le développement humain*, UNDP, 2019. http://hdr.undp.org/sites/default/files/hdr_2019_overview_-_french.pdf
UNDP 2019	*Indices et indicateurs de développement humain*, UNDP, 2019. http://hdr.undp.org/sites/default/files/2018_human_ development_statistical_update_fr.pdf
UNEG 2014	*Integrating human rights and gender equality in evaluation*. 2014. p 168.
UNHCR 2019	*Situation du Burundi*. https://www.unhcr.org/fr/situation-au-burundi.html
UNICEF 2013	*Analyse de la malnutrition des enfants*. 2013.
USAID 2017a	*Burundi Gender Analysis, Rapport final,* USAID, 2017. https://banyanglobal.com/wp-content/uploads/2017/07/USAID-Burundi-Gender- Analysis-Final-Report-2017.pdf
USAID 2017b	*Collaborating, Learning, and Adapting (CLA) – An analysis of what CLA looks like in development programming*, USAID, 2017. https://www.globalcommunities.org/publications/2017 -USAID-CLA.pdf
Vogel I 2012	*Review of the use of ' Theory of Change ' in international development*. UK Dep Int Dev. 2012;(April).
Westhorp 2014	*Realist impact evaluation: an introduction*. Gill Westhorp, London: Overseas Development Institute, September 2014. http://www.odi.org/sites/odi.org.uk/files/odi- assets/publications-opinion-files/9138.pdf
WFP 2019a	*Terms of Reference: Final evaluation of Treatment of Moderate Acute Malnutrition intervention in Ngozi, Kirundo, Cankuzo and Rutana from 2016 to 2019.* Burundi: WFP, 2019.
WFP 2019b	*Project Log Frame (version 3.0)*, WFP, 2019.
WFP 2019c	*Restitution des résultats et recommandations dans le cadre de l'analyse Fill the Nutrient Gap*. Bujumbura, 6 juin 2019. https://fscluster.org/sites/default/files/documents/burundi_fng_dissemination_presentation_burundi_final.pdf
WHO et al 2019	*Simplified approaches for the treatment of child wasting. An executive briefing from a technical consultation between the World Health Organization, the Office of the United Nations High Commissioner for Refugees, the United Nations Children's Fund and the World Food Programme*, Geneva 26–27 March 2019

LIST OF ACRONYMS

ANC	Antenatal Care
BMI	Body Mass Index
CAMEBU	Centrale d'achat des médicaments du Burundi
CED	chronic energy deficiency
CHW	community health worker
CMAM	Community-Based Management of Acute Malnutrition
CSB++	Corn Soya Blend "plus-plus"
COSA	Health Committees
DEQAS	Decentralized Evaluation Quality Assurance System
DHO	District Health Office
DHS	Demographic and Health Survey
FAO	Food and Agriculture Organization of the United Nations
FARN	Foyers d'apprentissage et de réhabilitation nutritionnelle/ Centers for nutritional rehabilitation and learning
FFP	Food for Peace
FGD	focus group discussion
FLA	Field level agreement
GAM	global acute malnutrition
GEEW	gender equity and the empowerment of women
HC	health center
HDI	Human Development Index
HIV	human immunodeficiency virus
IFAD	International Fund for Agricultural Development
IMCI	Integrated Management of Childhood Illness
ITP	In-Patient Therapeutic Programme
IYCF	Infant and Youth Child Feeding
LNS LQ	Lipid Nutrient Supplement Paste Large Quantity
LQAS	Lot Qualitative Assurance Sample
MAM	moderate acute malnutrition
M&E	monitoring and evaluation

MINAGRIE	Ministère de l'Agriculture et de l'Élevage/ Ministry of Agriculture and Livestock
MoU	Memorandum of Understanding
MUAC	mid-upper arm circumference
NACS	Nutrition Assessment, Counselling and Support
NFR	Note for the record
NGO	non-governmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Co-operation and Development
OEV	Office of Evaluation
OTP	Out-Patient Therapeutic Programme
PCIMA	Prise en charge intégrée de la malnutrition aiguë/ Integrated treatment of acute malnutrition
PHO	Provincial Health Office
PLW	pregnant and lactating women
PMSAN	Plateforme Multisectorielle d'Alimentation et de Nutrition/ Multi-sectoral Food and Nutrition Platform
PRONIANUT	Programme National Intégré d'Alimentation et de Nutrition/ National Integrated Food and Nutrition Program
QC	Quality control
QS	Quality support
RUSF	ready-to-use supplementary food
SAM	severe acute malnutrition
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goal
SFP	Supplementary Feeding Programme
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
SUN	Scaling Up Nutrition
TOR	Terms of Reference
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund

USAID	Agence des États-Unis pour le Développement International/United States Agency for International Développent
WFP	World Food Programme
WHO	World Health Organization

Oxford, May 2020, numéro de rapport

WFP Burundi Country Office
[Site web]

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