Evaluation of DFATD-funded Project Accelerating Nutrition Improvements in Sub-Saharan Africa

Evaluation Report

Department of Nutrition for Health and Development

WORLD HEALTH ORGANIZATION

December 18, 2015

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KvK 59473029
TVA N^{o} NL8535.09.244.B01

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List of Acronyms

ANI:	Accelerating Nutrition Improvements in Sub-Saharan Africa
AFRO:	WHO Regional Office for Africa
BCC:	Behavior Change and Communication Program
CDFU:	Communication for Development Foundation Uganda
CIP:	Country Implementation Plan
CLM:	Cellule de Lutte Contre la Malnutrition
CMN:	Coverage Monitoring Network
CO:	WHO Country Office
CRF:	Common Results Framework
DAC:	OECD Development Assistance Committee
DFATD:	Canadian Department of Foreign Affairs, Trade and Development
DAN:	Division Alimentation Nutrition
DHIS2:	Health Management Information System developed by HISP
eLENA:	e-Library of Evidence for Nutrition Actions
EU:	European Union
FANTA:	Food and Nutrition Technical Assistance Project
FAO:	Food and Agriculture of the United Nations
GAIN:	Global Alliance for Improved Nutrition
GAVI:	Global Alliance for Vaccines and Immunization
GINA:	Global database on the Implementation of Nutrition Action
GMP:	Community Growth Monitoring and Promotion
HKI:	Helen Keller International
HQ:	WHO Headquarters
HIMS:	Health Information Management System
IBFAN:	International Baby Food Action Network
ICYN:	Infant, Child and Youth Nutrition
IFNSS:	Integrated multisectoral Food and Nutrition Security Policy
ILO:	International Labor Organization
IMAM:	Integrated Management of Acute Malnutrition
IST:	WHO Inter-Country Support Team
ITC:	Inpatient Therapeutic Care
KAP:	Knowledge, Attitude and Practices
MDGs:	Millennium Development Goals

MI:	Micronutrient Initiative
MoH:	Ministry of Health
MUAC:	Mid-upper arm circumference
NFNC:	National Food and Nutrition Council
NGO:	Non-governmental organization
NHD	Department of Nutrition for Health and Development
ODA:	Official Development Assistance
OECD:	Organization for Economic Co-operation and Development
PAD:	Project Appraisal Document
PD:	OECD's 2005 Paris Declaration on Aid Effectiveness,
PMF:	Project's Performance Monitoring Framework
PSG:	Project Steering Group
REACH:	Renewed Efforts Against Child Hunger
RO:	WHO Regional Office
SAM:	Severe Acute Malnutrition
SBCC:	Social and Behavior Change Communication
SCoNS:	Subcommittee on Nutrition Surveillance
SFG:	Service for Generations
SMART:	Standardized Monitoring and Assessment of Relief and Transactions
SPRING:	Strengthening Partnerships, Results, and Innovations in the Nutrition Globally Project
SUN:	Scaling Up Nutrition
TOT:	Training of Trainers
UNAP:	Uganda Nutrition Action Plan
UNICEF:	United Nations Children's Fund
USAID:	United States Agency for International Development
VHT:	Village Health Team
WCRF:	World Cancer Research Fund
WCO:	WHO Country Office
WHO:	World Health Organisation
WFP:	World Food Program

Acknowledgments

The Evaluation Team would like to thank the many participants in this evaluation for their contributions, in particular Dr. Francesco Branca and his team at the Secretariat of the World Health Organization (WHO) in Geneva, the staff from the WHO Country Offices (WCO) in Uganda, Zimbabwe and Senegal, the Inter-Country Support Team (IST) in Zimbabwe and Burkina Faso, the Regional Offices (RO) in Zimbabwe and the Republic of Congo. We would also like to thank the representatives from REACH, SUN, the UN organizations met (UNICEF, FAO, WFP), the donor DFATD, and from other donors met in the field.

We would like to express our special gratitude to the WHO country teams and the Ministries of Health in Senegal, Uganda and Zimbabwe for their assistance in coordinating the meetings and visits during the case study field missions, deepening the Team's understanding of ANI's implementing environment. Additionally, we appreciate the generosity of the Health actors in the field including doctors and nurses, health center representatives and focal points, and community health volunteers. These actors are entrenched in the local villages and know intimately the importance of nutrition monitoring and early intervention. Our knowledge of the ANI Project in real terms and awareness of its genuine contribution to nutritional health was deepened by these consultations and shared accounts.

Executive Summary

The purpose of this Evaluation was to assess the relevance and performance of the Accelerating Nutrition Improvements in Sub-Saharan Africa Project (ANI). It fulfills the dual objectives of accounting for the Canadian Department of Foreign Affairs, Trade and Development's investment as well as providing a learning opportunity for WHO on project impact.

The Project supports eleven (11) countries in sub-Saharan Africa in their efforts to improve nutrition status of Women and Children. The Project is implemented by the WHO Department of Nutrition for Health and Development at the Geneva headquarters jointly with the WHO Regional Office for Africa and respective WHO Country Offices, with the objectives to

i) Strengthen nutrition surveillance systems in all eleven countries in collaboration with national governments;
ii) Conduct nutrition surveys in Rwanda, Sierra Leone, Zambia and Zimbabwe to collect baseline data for scaling-up nutrition interventions;
iii) Support the scaling-up of evidence-informed nutrition actions in Ethiopia, United Republic of Tanzania and Uganda.

This Evaluation has been conducted in three phases. During the first phase an Inception report was prepared, which defined the evaluability of the ANI project and developed the evaluation framework including the questionnaires. The second phase consisted of fieldwork. Three sample country were visited by the Evaluation team, where interviews and focus groups were conducted with WHO, Ministry of Health and the other main stakeholders (e.g., REACH, SUN representatives, UN agencies, NGOs, DFATD), completed by visits to intervention sites. The last third phase was devoted to analysis and reporting.

Key conclusions

ANI is a successful project, because it helps countries and their health development partners investing in building sustainable national information systems that are able to make real-time health data available. In certain of the ANI countries it is the only project dedicated to strengthen the country's nutrition surveillance system.

The Project has made a major contribution to revitalize the national health information system, although the project's duration has been too short to measure sustainable impact. ANI has provided an opportunity and has fostered partnerships to improve programming for nutrition surveillance. It has also contributed to national ownership of the Nutrition agenda and has reinforced country capacities in this field. The Project is highly appreciated by all stakeholders; created a strong "buy-in" by the Ministries of Health (appropriation); and its activity package, in particular the integration of Scale-up and Surveillance, generated interest from other donors. Indeed, the integration of practical activities and data-gathering appeared to mutually reinforce each component.

However, the ANI supported nutrition surveillance systems are not fully effective yet to inform national action plans and country-wide nutrition management. The project has produced good outputs, such as tools, guidelines and training modules, which are available to the countries, but the project period hasn't been long enough to transform the Project results into sustainable information systems in the partner countries.

The Project's approach — country-led, participatory, and working with multiple partners — led to real ownership of the Project by the Government counterpart, but also to delays due to

the long and cumbersome process. The donor imposed a few important parameters of the project, such as the project duration, selection of certain countries, and elements of the approach (e.g. working with NGOs), but the Country implementation plans were really driven by the country. The Project hasn't been able to keep its initial planning, and with remaining funds amounting $3.6 million as of September 2015, i.e. 20% of the total Project budget, it will not succeed to complete all activities before December 2015. A no-cost extension is necessary to build on the results realized so far.

A long-term perspective is needed to build capacity and strengthen Nutrition surveillance and delivery systems and therefore WHO should develop an end-of-project strategy during the remaining project period, in order to sustain the Project results.

ANI benefited from a strong commitment of staff involved, but the project's management modalities appeared to be sub-optimal: understaffing; sub-optimal contractual modalities for the project staff; insufficient financial control; delays caused by the procurement process; and lack of standard internal reporting procedure. The project has suffered, particularly at the start, from an unclear accountability framework (roles and responsibilities) due to the absence of a standard operational framework for Project management within WHO. ANI hasn't been sufficiently mainstreamed into the WHO-organization (particularly at the country level), despite all the efforts made by the Award Manager and the regional officers. In this respect, the Steering Committee hasn't been functioning as it should have.

Key recommendations

(1) The Evaluation team recommends a no-cost extension of the Project of one year (till December 2016).
(2) The Department of Nutrition for Health and Development of WHO should prepare an end-of-project strategy and incorporate the key project activities in the WCO workplans.
(3) NHD should forcefully continue including gender considerations into nutrition programming.
(4) Instead of having specific operational rules and guidelines for each, externally financed, project, WHO should develop a standard operational framework for Project Management, providing guidance to project teams on roles and responsibilities with regard to project preparation; financing agreement; contract management; procurement and financial management; technical and financial reporting; monitoring and supervision; auditing, and project closing.
(5) The Evaluation team recommends that WHO uses its own auditing rules to organize the mandatory end-of-project audit.

1 Introduction

1.1 Evaluation mandate, scope and objectives

The Accelerating Nutrition Improvements in Sub-Saharan Africa (ANI) is an $18 million project awarded to the Department of Nutrition for Health and Development (NHD) of the World Health Organisation (WHO) by the Canadian Department of Foreign Affairs, Trade and Development (DFATD) through two Grant Arrangements between the Government of Canada and the WHO. The project runs from 2012 to 2015 (with a no-cost extension from June 2015 to December 2015).

The criteria for this evaluation were those set out in the WHO Terms of Reference, which were also recommended by the UN Evaluation Group and the OECD Development Assistance Committee (DAC) for program evaluations, i.e. Relevance and Performance (Effectiveness, Efficiency, and Sustainability), as well as the cross-cutting themes Equity in Access and Gender equality.

The evaluation fulfills the dual objectives of accounting for DFATD's, investment as well as providing WHO a learning opportunity on project impact – in all its offices, and also, at the Government level in those 11 countries involved in the ANI project: Burkina Faso, Ethiopia, Mali, Mozambique, Rwanda, Senegal, Sierra Leone, United Republic of Tanzania, Uganda, Zambia and Zimbabwe. The exercise includes WHO's implementing partners to learn lessons about the role of non-governmental organisations (NGOs) engaged in project implementation in partnership with WHO and national governments.

The rationale of this evaluation, is to:

- Describe the project's results in reference to outcomes and explore enabling factors or barriers to achievement;
- Evaluate WHO's project management process, the project's interaction with governments and partners, and develop recommendations for WHO management at the country, regional and headquarters levels for process improvement, including fund allocation, human resources management, and decision-making and communication; and,
- Examine how the project addressed transversal issues of gender, equity and human rights factors.

Of the 11 countries in which the ANI project is active, three were selected in consultation with the project team for the evaluation: Uganda, Senegal and Zimbabwe. Each one of these countries represent the various country-based project components: (i). Strengthen nutrition surveillance systems in collaboration with national governments and establish links with the national health information systems (Uganda, Zimbabwe and Senegal); (ii) Conduct nutrition surveys to collect baseline data for scaling-up nutrition interventions (Zimbabwe); and (iii) Support the scaling-up of evidence-informed nutrition actions (Uganda).

The Evaluation Team for the mandate consisted of:

- *Madeleine Guay,* M&E expert and Evaluation Team Leader (ETL), served as the Team's interlocutor and was responsible for all aspects of work planning, coordination of the evaluation process, liaising with the Project Authority, analysis and reporting on evaluation criteria, preparing draft and final reports. She visited staff in Ottawa, Geneva and completed field missions in Uganda and Zimbabwe.
- *Marie-Claude Rioux*, Social development expert, was responsible for assessing, analysis and reporting on the effectiveness and equity issues and for assessing ANI

project in Senegal. She completed field visits in the three case-study countries Senegal, Uganda and Zimbabwe.
- *Marie-Jeanne Offosse*, Nutrition and Public health expert, took part in the country visits in Uganda and Zimbabwe, where she collected data on sustainability and relevance of the Project.
- *Allyson Quijano*, Legal expert, assisted the Evaluation team in all phases, particularly during the reporting phase. She took part in the field mission in Senegal and edited the report.
- *Franke Toornstra*, ACT-for-Performance's Chief Executive and Project Management expert, contributed to the Inception report and was responsible for assessing the managerial process. He assured the quality assurance and quality control (QA/QC) throughout the entire evaluation.

1.2 ANI project outcomes and objectives

The ANI project supports 11 high-burden countries in sub-Saharan Africa listed above in their efforts to improve the nutrition status of Women and Children, with the following objectives:

i. Strengthening nutrition surveillance systems in all 11 countries in collaboration with national governments and establish links with the national health information systems.
ii. Conducting nutrition surveys in Rwanda, Sierra Leone, Zambia and Zimbabwe to collect baseline data for scaling-up nutrition interventions.
iii. Supporting the scaling-up of evidence-informed nutrition actions in Ethiopia, United Republic of Tanzania and Uganda.

The WHO Director of Nutrition in WHO's Headquarters in Geneva has managed the grant in collaboration with the WHO Director of the Health Promotion Department in the Regional Office for Africa. A Project Steering Group was established to provide global strategic direction and other guidance for overall project monitoring. Within WHO, the ANI project has involved over 25 people in various capacities at the WHO Country Office (WCO), Inter-Country Support Team (IST), Regional Office (RO) and Headquarters (HQ) levels.

In the implementation of the ANI project, WHO is closely working with partner agencies, including UN agencies (i.e. FAO, UNICEF, WFP), Renewed Efforts Against Child Hunger (REACH), the Scaling Up Nutrition movement (SUN), several bilateral donors and Agencies, such as USAID and the United States Centers for Disease Control. WHO estimates that the nutrition surveillance strengthening activities will ultimately reach the following outcomes:

i. Provide indirect benefit to 66 million women of reproductive age and 46 million children under five years of age; and;
ii. Enable up to 25% of districts to have functioning surveillance collection that will feed into national surveillance systems in the eleven countries.

Similarly, WHO estimates that by supporting the scale-up of direct evidence-based nutrition interventions, the Project will:

i. provide direct benefits to a minimum of 150,000 children under five and 200,000 women of reproductive age over the duration of the Project (three years);and
ii. Over the longer term, through the training of healthcare workers and the implementation of programs at national levels, such as breastfeeding promotion, the

Project will benefit approximately 15 million children under five and 20 million women in the countries targeted by this Project.

1.3 Development context

The eleven (11) ANI countries are all confronted with multi-faceted nutrition challenges, including food availability, the nutrition status of women and children and human resources and governance.

- Inadequate knowledge from households (i.e., poor feeding practices), poor water and sanitation as well as limited access to health facilities contributes to malnutrition in ANI countries, in addition to low food production.
- Stunting in all countries, except Senegal, is above the WHO cut-off level for public health significance (20%).
- Childhood obesity is emerging as a public health problem, with six out of the 11 ANI countries already having more childhood obesity than wasting.
- While 2,500 grams is internationally agreed upon cut-off point on low birth weight, it is noted that low birth weight in all ANI countries except Rwanda and the United Republic of Tanzania is above 10%.
- Based on the latest national estimates, six countries (Ethiopia, Mali, Mozambique, Senegal, Sierra Leone and Zambia) are currently above the cut-off levels of public health significance for underweight, stunting and wasting.

Cut-off values for public health significance

Indicator	Prevalence cut-off values for public health significance
UNDERWEIGHT	< 10%: Low prevalence; 10-19%: Medium prevalence; 20-29%: High prevalence; = 30%: Very high prevalence
STUNTING	< 20%: Low prevalence; 20-29%: Medium prevalence; 30-39%: High prevalence; = 40%: Very high prevalence
WASTING	< 5%: Acceptable; 5-9%: Poor; 10-14%: Serious; = 15%: Critical

Reference: WHO, 1995.

- Capacity for planning, implementation and monitoring of nutrition intervention is limited; thus, the relatively high level of advocacy efforts has not yet translated into the tangible result of increased budgetary allocations across all levels.
- Nutrition surveillance is weak, and primarily conducted in areas that are traditionally prone to hunger although malnutrition is occurring in almost all parts of the country.

In the ANI countries selected under the present evaluation, WHO address numerous challenges with a specific response, such as follow:

1.3.1 Uganda

With a population of 33 million, the Republic of Uganda produces sufficient food to meet the needs of the country's growing population. Nevertheless, the country experiences food insecurity in some areas, inadequate household nutrition knowledge, and is confronted with chronic illness and disease, and poor water and sanitation conditions.

Nutrition indicators[1] for under-five children are: stunting 33%; underweight 14%; wasting 5%; anaemia among children of 6-59 months 50%. Notwithstanding efforts to improve nutrition intervention, routine monitoring remains challenging.

[1] Uganda 2011 DHS https://dhsprogram.com/pubs/pdf/FR264/FR264.pdf

ANI project covers six (6) districts out of 112 and includes two components: (i) nutrition surveillance and (ii) scaling-up of evidence-informed nutrition action. The project objectives are to:

i. Scale up action to reduce stunting rates among under-five children through improved complementary feeding practices in target districts by 2015; and
ii. Strengthen nutrition surveillance in target districts and at the national level to improve monitoring of the national nutrition situation.

Project beneficiaries are estimated at 2.5 million inhabitants with 517,000 under-five children. In collaboration with Uganda's Ministry of Health, the ANI project is implemented by: the WHO country office, FHI (funded by USAID/Fanta), Service for Generations (SFG), HMIS, and a Ugandan based NGO, Communication for Development Foundation Uganda (CDFU).

1.3.2 Zimbabwe

With a population of 15.8 million, Zimbabwe remains fragile and subject to natural and economic shocks with 2.2 million people food-insecure in 2014[2]. Inadequate nutrition knowledge from households, HIV and AIDS prevalence rates (at 14.7%, it is the fifth highest in the world) are key factors contributing to malnutrition. Nutrition indicators[3] in Zimbabwe for under-five children are as follow: stunting 27,6%; underweight 11,2%; wasting 3,3%; anaemia among children of 6-59 months 24%. These rates are lower than the average in comparison to Sub-Saharan African countries. Great efforts are being made to establish an enabling environment for nutrition intervention, however routine surveillance remains challenging.

In Zimbabwe, ANI has two components: (i) nutrition surveillance and (ii) nutrition surveys. The project objectives are to:

i. Ensure nutrition surveillance is effectively integrated into the NHIS and implementation is managed well;
ii. Ensure the timely availability of nutrition information at all levels;
iii. Identify effective programs to address the causes of undernutrition, create a plan of action, and apply an evidence based approach for long-term strategic planning; and
iv. Identify a food vehicle for food fortification through a nutrition food consumption dietary pattern survey in Zimbabwe; and
v. Support micronutrient surveys.

1.3.3 Senegal

Senegal is located in West Africa with a population of 14.7 million.[4] The production of major staple food crops covers barely 30% of consumption needs. The decline in agro-pastoral production indicates a likely continued deterioration of the food and nutrition security situation[5] in addition to low food production, inadequate household knowledge, poor water and sanitation, and low access to health. Nutrition indicators[6] for under-five children are: stunting 19%; underweight 13%; wasting 6%; anaemia among children of 6-59 months 60%. Appreciable efforts are made to build an enabling environment for nutrition intervention, however routine surveillance remains challenging.

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[2] The Zimbabwe Vulnerability Assessment Committee (ZVAC), 2014 rural livelihoods assessment report.
[3] Multiple indicators cluster survey (MICS) 2014 retrieved on the WEB: http://www.childinfo.org/files/Zimbabwe_2014_KFR.pdf
[4] Projection based on RGPH 2013 population (13 million)
[5] Food security and Humanitarian implication in West Africa. FAO, June 2015
[6] Enquête Démographique et de Sante 2014, retrieved on the Web : http://www.dhsprogram.com/pubs/pdf/FR305/FR305.pdf

ANI's essential function in Senegal is a nutrition surveillance project. The project objectives are to:

i. Improve existing nutrition surveillance; and
ii. Strengthen collaboration between the various sectors involved in nutrition interventions.

The project supports the following interventions: advocacy; development of the reference document, guidelines, tools and implementation plans; establishment of sentinel surveillance; strengthening of routine information system; and monitoring and evaluation. Interventions are implemented by CLM in partnership with other organizations, such as UNICEF, WFP, FAO, USAID, World Bank, HKI, MI and Intrahealth. The DSRSE/DAN (Division Alimentation-Nutrition) of Senegal's Ministry of Health is also WHO's main implementing partner and responsible for SMART and AGVSAN surveys at the national level.

1.4 Stakeholders

The stakeholders of this Evaluation are:

- **Donor:** DFATD, who has requested this evaluation, in order to quantify the impact of funding on the nutritional well-being of the target population;
- **WHO** country offices, regional offices and HQ, who will learn from the Evaluation on the effectiveness and efficiency of project implementation. Specifically, evaluation of a large project such as ANI would contribute to the credibility of the organization, as it addresses the accountability aspects.
- **Governments** in the 11 countries involved in the project, who can use the Evaluation to sustain the Project's results.
- **WHO implementing partners,** to learn lessons about role of civil society organizations in implementing projects in partnership with WHO and governments;
- **Partners:** other UN organizations that formed REACH (the FAO, the WFP and UNICEF).

2 Evaluation approach and methodology

2.1 Overview

The Evaluation Team applied a realist evaluation framework to inform the development and guide the conduct of all stages of work. Realist evaluation is a theory-driven approach that focus on the mechanisms and contextual factors leading to the success (or not) of an intervention. Realist evaluation employs mixed methods of data collection techniques with the goal of collecting the most relevant, useful data with which to address the evaluation questions.

The evaluation team began with an evaluability assessment as a pre-evaluation activity. It involved an assessment of both performance measurement tools and systems in place in support of an evaluation. After approval of the inception report, the Team conducted documentary research and began field missions in Uganda, followed by visits to Zimbabwe, Senegal and Geneva.

Evaluators conducted analysis of all reference documents, interview notes, and group discussion transcripts using closed and open coding techniques based on the evaluation framework questions and indicators. Content from all lines of evidence is transferred to an evaluation question/indicator basis to allow for triangulation analysis. Data collection was conducted at headquarters, regional, country and provincial levels, allowing for post-field visit comparison, as well as analysis of project implementation mechanisms at all levels.[7]

2.2 Data collection and analysis

2.2.1 Evaluation tools

An Evaluation Framework (See Appendix A) was developed to structure the data collection process. This Framework served as the main tool for designing the data collection instruments and reporting on findings. Other tools include: include: interview questionnaires, customized according to the country and a focus group guide. All data are documented in a template to facilitate data analysis and report writing. The Team will use the Microsoft Office suite of tools for this purpose. The sampling framework, data collection and analysis techniques described below were designed to generate the evidence based on the issues and questions set out in the Framework.

2.2.2 Sampling framework

Uganda, Zimbabwe and Senegal were selected by the WHO to assess the relevance and performance of the ANI project. The selection process for establishing these countries as the evaluation sample considered: country budget; country language; logistic and security issues, if any; authorities' availability to facilitate meetings; and most importantly, the representativeness of these countries for the Project objectives. Visited regions in the three countries were then selected by WHO with the ministry of Health to assess the various components of the ANI project in the field at a provincial, district and community level. The critical criteria selection was the distance in order to be able to travel from the capital.

[7] ILO (March 2014). Integrating gender equality in monitoring and evaluation of projects, accessed at: http://www.ilo.org/wcmsp5/groups/public/@ed_mas/@eval/documents/publication/wcms_165986.pdf

Key stakeholder groups were interviewed to sample a variety of perspectives and experiences across project responsibilities, and even within the same country across different implementation sites. Meetings were arranged with the following stakeholders:

- Representatives of WHO headquarters, regional, sub-regional and country offices in charge of planning, implementation, monitoring and reporting on intervention(s);
- Direct beneficiaries, including the national and sub-national governments and health districts supported by the ANI project;
- Key implementing partners, such as NGOs, health center representatives and/or consultants involved in the implementation of the ANI project; and
- Partners such as REACH and SUN representatives, UN organisations such as UNICEF, WFP, FAO working closely with WHO on development and implementation of ANI and other child survival activities.

2.2.3 Data collection

The following methods were used to complement the Team's technical knowledge: desk review, case studies, interviews, focus group and SWOT analysis. The methodology involves soliciting input from stakeholders to evaluate the assessment criteria. Data collection instruments were customized according to the country context. Each stakeholder group was posed questions to assess the different criteria. Team members were assigned specific criteria to assess and focused on these throughout the evaluation and especially during the field mission. Members coordinated on strategy and shared information throughout the process to facilitate an understanding of issues unique to each country. Following each country visit, debriefing sessions were held with stakeholders and data were shared with WHO and within the Team to inform other primary data collection activities.

Desk review: A background document review was necessary to understand the context of the ANI project within the WHO and NHD and with respect to international commitments in nutrition. The review included: the concept note; approval documents, administrative agreements; and, program planning/management documents, such as the PMF, CIPs, the Standard Operating Procedure for ANI, the PSG meeting minutes, financial reports and other project management documents (see list of documents in Appendix D).

Case studies: Secondary data collection also included a review of the activities, outputs, and results reported in the project's annual progress reports and in the PMF baseline report with respect to the case studies in Senegal, Uganda and Zimbabwe (Appendix C).

Face-to-face and telephone interviews were conducted with various stakeholders. Following approval of the work plan, field missions took place from September 14 through October 3, 2015. Face-to-face interviews were carried out with DFATD staff after the country visits.

Focus group and individual discussions with health and nutrition workers involved administrating questionnaires when visiting the Ministry of Health and health districts during field missions. The WHO country office facilitated the Team's request to arrange for interviews. A guide for focus group guide questionnaires was applied to solicit the opinions of the health workers who participated in the training sessions. The questions were structured to solicit evidence on the progress made in training. This line of inquiry contributes to the assessment of the expected achievement of outcomes, i.e., enhancing capacity of governments to target and deliver nutrition interventions while identifying any unintended outcomes (positive or negative).

A SWOT assessment was conducted to evaluate the efficiency and effectiveness of the managerial process. The SWOT analysis functions to explain underlying factors of program

strengths and weaknesses and identify risks and opportunities, and will result in recommendations for improvementt.

2.2.4 Analysis and reporting

Data analysis and triangulation of all documentary evidence and primary data collected on each of the evaluation questions/criteria were used to prepare this report following the review of key information from field visits and other project documentation. The conclusions for each of the evaluation criteria were based on the relevant findings, while the recommendations were based on the conclusions; these linkages were made explicit in the narrative of this report.

2.3 Constraints and limitations

Limiting factors and risks for the evaluation were identified during the inception phase. One factor involves staff turnover and specifically access to WHO and DFATD staff who were involved during the critical phases of preparation and project but were no longer working on the project. Indeed, donor teams involved during the conception phase of the project were no longer available once implementation began. Another factor was access to all implementing partners and key stakeholders given the short length of field missions. Some key questions concerning the regional and global activities work plan and the scale up component budgeting that were sent by email at the end of the data collection phase, have not been responded by the headquarters. Finally, it was sometimes difficult to collect all administrative WHO documents and financial information – data essential to assess the efficiency criteria. In the field, for example, key project information was not available – often because the short window of the ANI project did not allow for full publication of results.

3 Evaluation findings

The sections below detail the findings of the evaluation according to the themes listed in the Terms of Reference and the Inception report. In line with the terminology used in the TOR, the "Accelerating Nutrition Improvements in Sub-Saharan Africa" project will hereby be referred to as "ANI" formed by the "Surveillance" and the "Scale up" project.

3.1 Relevance of the intervention

3.1.1 Design of the project

Finding #1: ***WHO used participatory approaches to design the project, which fostered a real ownership of the project by the partner countries. Yet, WHO encountered difficulties with the project implementation due, in part, to inadequate planning, principally caused by an over-ambitious timeline required by the donor, making project execution more complex.***

WHO's design process for the ANI project employed participatory and coordinated approaches that took into account the needs of the beneficiaries, especially direct beneficiaries: the national and sub-national governments, districts, health facilities, that are supported by the ANI project. The ANI planning process included the Ministry of Health and other key stakeholders, especially the UN organisations. A process that appeared to be time-consuming but produced highly positive outcomes such as a strong ownership of the ANI project by the partner countries.

In March 2013, the Country Implementation Plans (CIP), the main planning documents, were approved in Uganda, Zimbabwe, and Senegal, one year after the two Grants between the Government of Canada and WHO were signed, in March 2012. Thus the participatory validation process created delays based on the project implementation schedule, but at the same time assured ownership by the Ministries of Health, a key condition to strengthen surveillance systems in a sustainable way.

Alignment with country-led strategies, existing nutrition systems and the SUN agenda, and coordination with the United Nations Renewed Efforts Against Child Hunger (REACH) was an important requirement for the design of the project. Therefore, ANI activities were planned according to this sustainable and complementary approach with SUN movement and REACH where it operates in 6 of the 11 ANI countries (Ethiopia, Mali, Mozambique, Rwanda, Tanzania and Uganda –Senegal just have been posted) to assist governments of countries with a high burden of child and maternal undernutrition to accelerate the scale-up of food and nutrition actions. That provided an adequate response to the repeated shortcomings as reported by the UN with respect to the lack of a coordinated global approach between countries and development partners on what information countries should collect to measure health progress[8]. According to the Department of Health statistics and Information Systems, donor programmes collect data for specific diseases and systems are fragmented and duplicative. A situation we observed in ANI countries, especially in Uganda where relatively large amount of funds are spent in the health sector. In general, countries and development partners do not invest in building information systems that are able to make real-time health data available to all who need it.

[8] According to the Department of Health statistics and Information Systems, currently there are at least 600 health indicators that countries could be required to report upon through various global agreements, resolutions and programmes under United Nations agencies, partners and donors retrieved in http://www.who.int/mediacentre/commentaries/improving-health-data/en/

The CIPs presented project goals and objectives in the country with a budgeted implementation plan and a monitoring and evaluation framework. Each ANI country was asked to select its own list of indicators that would be included in the surveillance package and collected by the surveillance system depending of the potential actions and interventions in the country. Some country's specific queries were also included, like in Uganda where the Ministry of Health specifically asked to engage with local organizations to implement various activities; and in Zimbabwe where the CIP added a nutrition food consumption dietary pattern survey on the Government's request, in spite of being considered by the donors beyond the scope of the project. In Senegal, supports to national nutrition surveys and to the sentinel system were added on behalf of the Ministry of Health in addition to its support of the existing nutrition surveillance system.

Box #1: The CIP planning process in Uganda

In Uganda, the WHO Country Office, representatives of the Prime Minister's Office which is responsible for coordinating national multi-sectoral nutrition interventions, representatives of the Ministry of Health, and of other stakeholders including experts from universities, worked together to draft the CIP, taking into consideration on-going work of the government in strengthening nutrition activities The CIP was reviewed collectively with the Scale up country teams of Ethiopia and Tanzania at a Review meeting held in Entebbe in October 2012 and again at the Review meeting held in Addis Ababa in November 2012. REACH facilitator also participated in these two review meetings as part of the Uganda country team to discuss and review draft CIP.

Source: WHO, *WHO Process followed to*

ANI's design was also based on a sound understanding of the local institutional and governance context, as a result of WHO's convening role and long-term engagement with countries to detect and raise visibility for neglected or critical health systems issues. In preparation of the ANI project concept note, WHO organised in December 2011, a workshop to review countries' current nutrition surveillance systems/activities (highlighting gaps and potential for strengthening) and to prepare a draft proposal for each country based on a generic framework for follow-up work in individual countries. Several actors active in nutrition surveillance were involved such as UNICEF, USAID, FAO, WFP, among others[9].

Program duration too short

Despite the scrupulous project preparation process, ANI's contractual duration appeared to be a significant factor in the project execution, being too short for a system strengthening project such as ANI. The ANI Country Implementation Plans didn't adequately acknowledge this very short timeline.

The initial funding period granted by DFATD was a little bit more than three years (March 2012-June 2015), which was extended with six months to Dec 2015. Even with the extension, all informants considered even the project period as too short to attain the project outcomes. According to WHO, stakeholders echoed this viewpoint in several countries indicating that a longer period of time was required to effectively attain some impacts, particularly with respect to improved nutrition program monitoring and delivering effective nutrition interventions. The length of the planning process and the CIP approval increased the complexity of the project, and reduced the effective implementation time to less than two years, going against the general acceptance that capacity building and health system strengthening need long-term perspectives[10].

[9] Each year, WHO organized a list of workshops and meetings that help guiding the project, for instance, in 2012 in Addis Ababa, or in July 2013 in Zanzibar or in Entebbe in 2015. They are reported in the Annual reports.

[10] WHO, *Everybody's Business – WHO's Response to the Health systems challenges*, p.30.

According to WHO, these serious concerns regarding the project duration were shared from the beginning with DFATD by the Award Manager, the Director of the Nutrition for Health and Development Department (NHD) and his staff, but Canada had complied with the broader agenda of the Muskoka Initiatives in Maternal, Newborn and Child Health that was launched under the G-8 and the leadership of the Canadian Prime Minister in 2010, who committed to ANI under the US$7.3 billion Muskoka framework with a definite timeframe of 5 five years, thus ending in 2015.

Addition of Scale up project to the initial Surveillance project

The engagement with the Muskoka initiatives led DFATD to add the second, Scale-up component to the initial ANI-surveillance project with an additional funding in the amount of US $10.2 million. Stakeholders highly appreciated this integration between Surveillance and Scale up. However, NHD isn't particularly experienced with Scale-up field interventions, especially not with such a large amount for a single department. NHD usually manages and implement smaller standardisation projects, such as the development of guidelines, health protocols and health policy etc. The addition of the Scale up grant made it very challenging for NHD that had to develop its own implementation rules (i.e. a standard operating procedure for the ANI project) to organize its accountability vis-à-vis the donor for the management of major funds that were going to be implemented by WHO country offices under guidance from the Regional Director who reports directly to the Regional Committee. The absence of a direct hierarchical relation between the Headquarters at the one hand and the Regional Office and the Country offices at the other hand, makes it important for WHO to organize project management accountability, and develop a Standard Operational Framework for Project Management, in particular concerning projects where all layers of the organization are involved (see also Chapter 3.3.2 on Results Based Management and 3.5.2 on the Managerial Process).

The resources provided for each component

The amounts planned and allocated to the Surveillance and Scale up components appeared to be insufficient in certain cases. In Zimbabwe, the project was only implemented in 4 of the 10 selected districts because of a budget shortage. Training in Uganda on Social and Behaviour Change Communication reached fewer beneficiaries for the same reason according to the NGO implementers.

According to the Ministries of Health of evaluated countries and other stakeholders, ANI should be scaled up in order to attain the ambitious impacts described in the Logic model. To realize its full impact, the project should be able to work in more than the 6 Ugandan districts supported of its 120 total and in more than the 4 pilot districts of Zimbabwe's 59. Only Senegal plan to support surveillance system in all its districts, nevertheless with too few activities to strengthen the surveillance system in a durable way (see Chapter 3.2 on Sustainability).

Selection of countries/regions

The selection of the ANI countries was agreed upon by DFATD and WHO and according to eligibility criteria, i.e., SUN classification (3 SUN high burden countries for Scale up), and Sub Saharan African countries with weak surveillance systems. Other selection criteria were (i) the level of malnutrition related diseases (stunting, underweight and anemia in pregnant women); (ii) the number of beneficiaries not reached by effective interventions to combat maternal and child malnutrition; (iii) lack of technical and financial support by donors; (iv)

governance index[11]; and (v) request for WHO support. According to the WHO, 14 Sub-Saharan African countries have requested support to strengthen nutrition surveillance and 22 others to expand the delivery of direct nutrition interventions. Among them, a total of 11 countries were approved according to the selection process described above.

However, according to the WHO Concept notes, Zambia and Senegal had not asked for support from WHO on nutrition programmes in 2011-12. Furthermore, Burkina Faso, Ethiopia, Mozambique and Rwanda had not specifically requested support in nutrition surveillance although they had asked for support on nutrition programmes[12]. Two countries, Mali and Ethiopia, were specifically added upon DFATD's requests. Mali and Ethiopia are two long-term countries of focus for the Canadian Government's international development efforts.

TABLE 1: STUNTING IN CHILDREN UNDER AGE 5 IN ANI SUB-SAHARAN AFRICA COUNTRIES

	Stunting (%)	Developing World Rank (#) on 40 Sub-Saharan Africa countries
Ethiopia	40,4 (2014)	1
Rwanda	37,9 (2014)	10
Tanzania	34,7 (2014)	11
Zambia	40,0 (2014)	12
Uganda	34,2 (2012)	16
Mozambique	43,1 (2011)	17
Sierra Leone	37,9 (2013)	18
Zimbabwe	27,6 (2014)	21
Mali	38,5 (2006)	23
Burkina Faso	32,9 (2012)	25
Senegal	19,4 (2014)	32
Sub-Saharan Africa Average	32%	40 Sub-Saharan Africa countries

Source: Joint Child Malnutrition Estimates (UNICEF/WHO/World Bank)

Note that all ANI countries showed a high rate of Under-five stunting, i.e. the percentage of children 0-59 months who are more than two standards deviations below the median height-for-age of the WHO Child Growth Standards[13].

Four countries (Senegal, Burkina Faso, Mali and Zimbabwe) showed an Under-five stunting rate below the average in the region (35%), as showed in the Table 1 here-before.

3.1.2 Validity and logic of the project

Finding #2: ***The ANI project responds to the specific country needs that are poorly addressed by the government and donors and, above all, in a very promising way with the association of the two complementary objectives of Surveillance and Scale up activities. ANI's interventions were consistent with the objectives of each component***

[11] WHO classify countries according to a nutrition governance score (strong, medium or weak) depending of a set of elements considered as crucial or successful development and implementation of national nutrition policies and strategies, WHO, Concept note Scaling up nutrition interventions and strengthening surveillance and accountability frameworks: the WHO contribution, a programme for 2012-2015, Draft, December 2011 (p.5)

[12] According to WHO's concept note: Table 1 country selection criteria (p.7)

[13] Stunting is defined as the percentage of children 0–59 months who are two standard deviations below (moderate and severe) median height-for-age of the WHO Child Growth Standards

***and stakeholders to strengthen the surveillance system and scale up interventions and are viewed as an attractive package by the stakeholders*.**

Information Systems and Statistics for Nutrition in Sub-Saharan Africa countries are usually weak and underfunded. Governments and their partners, i.e. the United Nations agencies, donors, global health partnerships, are requesting more and better health data. This means robust and reliable health information systems are able to generate quality data to monitor health programmes, including nutrition, and report on results.

As presented in SUN reports[14], nutrition systems exist in some form in Sub-Saharan African countries, but there is no standardized approach for information systems. All countries developed their own unique approaches: in many countries, nutrition data come from a series of separate systems managed by different stakeholders for specific purposes and only few have strengthened their capacity to use information from diverse sectors to inform decision-making.

The Table 2 here-after shows three levels of development of the Information Systems for Nutrition in the 34 countries in Africa according to SUN. Of the three ANI countries that were visited during the field mission, Uganda and Senegal are classified under the second group that are developing a CRF that would enable them to collate, analyse and report data across key sectors. Zimbabwe is among the most advanced group of nine countries that are already collecting and analyzing data from diverse sources and have established CRFs. Nevertheless, all three countries need a lot of additional resources to strengthen their existing nutrition surveillance systems, which are largely underfunded.

In Uganda, a lot of donors intervene in the nutrition sector, but inadequate coordination, and donor conditions and, earmarking, result in challenges and harm program effectiveness. The country planned to commit US$ 12 million per year to Nutrition programs for 5 years (UNAP; 2011/12-2015/16), approximately 2.5 % of the total annual ODA for Health of US$ 500 million. Uganda reported 2,275,000 stunted children in 2013. According to the SUN report, there is no transparent mechanism to track nutrition expenditures.

TABLE 2: LEVEL OF DEVELOPMENT OF NUTRITION INFORMATION SYSTEMS IN THE 34 SUB-SAHARAN AFRICAN SUN COUNTRIES, ANI COUNTRIES

Level	Information systems for Nutrition Development	SUN countries	ANI countries
0	No information currently available	Guinea Bissau, Liberia, South Soudan, Togo	
1	Countries access information from surveys and routine data sources to perform situation analyses and monitor implementation of selected programmes. There is no developed common results framework (CRF) to consistently collate, analyze and present information across key sectors.	Benin, Burkina Faso, Cameroun, Congo Republic, Congo DR, Ivory Coast, Comoros, Ghana, Guinea, Mali, Niger, Nigeria, Swaziland	Burkina Faso, Mali
2	Countries with CRF established or under development to collate, analyze and present information across key sectors. They are strengthening systems to monitor implementation at decentralized level	Burundi, Chad, Kenya, Mauritania, Senegal, Tanzania, Uganda, Zambia,	**Senegal,** Tanzania, **Uganda**, Zambia
3	Countries use CRF to collate information from main sources across relevant sectors. They are able to collect data at decentralized level but require support to revitalize, refine and strengthen systems for optimal analysis, presentation and use of available information	Gambia, Ethiopia, Namibia, Malawi, Madagascar, Mozambique, Rwanda, Sierra Leone, Zimbabwe	Ethiopia, Mozambique, Rwanda, Sierra Leone, **Zimbabwe**

[14] SUN, Information Systems in Nutrition, April 2014.

Source: SUN, Information Systems for Nutrition, April 2014

The Uganda Nutrition Action Plan (UNAP) serves as the multi-sectoral common results framework for nutrition, but the UNAP M&E framework is still undergoing development. A mid-term review of the UNAP is expected and monitoring tools are being finalized while reporting of progress needs to be strengthened. Specifically, the UNAP reports an absence of a national nutrition database and information system, a lack of standardised data collection tools, a low demand for nutrition information, weak coordination, and a lack of a national nutrition research agenda.

In Zimbabwe, ANI was the only dedicated project on Nutrition Surveillance system strengthening during our field visit in September 2015. In general, the country experiences a situation of inadequate funding for all critical public programs, a zero growth of the government budget and a quasi-total dependency on external aid. Zimbabwe reported 553,000 stunted children in 2013. The country planned to commit US$ 18 million per year for 2013-2015, which is 15% of the total annual ODA for Health of US$125 million. The Implementation Matrix of the Food and Nutrition Security policy functions as the common results framework to monitor commitments across sectors with clear objectives and actions, but a joint M&E framework has not been developed and therefore, parallel reporting mechanisms remain between sectors. The surveillance system that routinely collects nutrition data from a district-based representative sample, shows some challenges. For instance, data transmission guidelines and standard operations are out of date in view of the new child health card. Health workers' capacity must also to be updated to adequately capture, analyse and transmit the nutrition surveillance data and related data collection activities. Overall, the nutrition data collection tools are non-uniform in the various regions.

According to the Country SUN reports, Senegal was committed to increase nutrition funding from year to year, to reaching US$ 5 million per year, about 3.5 % of the total ODA for Health that amounts up to US$ 140 million 2010[15]. Senegal reported 626,000 stunted children in 2013. It is important to note that ANI provided WHO the opportunity to start working on nutrition in Senegal. Senegal is still waiting for a multi-sectoral Nutrition Strategy that will be finalized once the orientation document for nutrition development has been validated. Consequently, the common results framework, which in theory is based on the Nutrition Strategy, has not yet been elaborated.

Coherence of the ANI activities

The interventions of the ANI project formed a coherent package to reach the objectives of the surveillance system strengthening (in Senegal, Zimbabwe and Uganda) and Scale up components (in Uganda), and are in line with the country nutrition priority areas (see in Table 3 below).

However, activities were not always implemented as planned in the CIP, i.e. in Senegal where some activities were not foreseen in the approved CIP. Some staff of Districts and local health facilities interviewed in the field in the visited countries didn't consider all project interventions as key.

The planning of the interventions were viewed by some participants at the local level as a *top down* participatory approach, inclusive of the Ministry of Health and key nutrition

[15] Official Development Assistance (ODA) for Health to Zimbabwe, Uganda and Senegal, retrieved from http://www.who.int/gho/governance_aid_effectiveness/countries/zwe.pdf, http://www.who.int/gho/governance_aid_effectiveness/countries/uga.pdf http://www.senegalbusinessservices.com/healthy-care-sector/official-development-assistance-oda-for-health-to-senegal

stakeholders (such as other UN-agencies and international NGOs). A *bottom up* participatory approach, i.e. with broader consultations with local government and CSOs, would ensure that funding more adequately meets the local needs for stronger and better nutrition surveillance.

ANI activities include situation analysis, development of the list of indicators in nutrition and of adequate surveillance tools, capacity building for key staff on routine surveillance and activities related to scaling up, development of recipe and Social and Behavior Change Communication, support of periodic nutrition and health surveys, and of micronutrient or food consumption nutrition, among others, to provide a baseline etc. Other activities such as the funding of the Subcommittee on Nutrition Surveillance (SCoNS) in Zimbabwe appeared to be a strong element to promote government ownership of the surveillance system funded by ANI and the coordination among many stakeholders. In Uganda, the association between surveillance activities and scale up activities were considered highly relevant and viewed as a strong element of sustainability (See Chapter 3.4 on Effectiveness). According to the WHO and Uganda's Ministry of Health, some donors from the nutrition donor group, such as the World Bank and the EU, showed interest in the continuation of the ANI package.

TABLE 3: ADEQUACY OF DESIGN AND PLANNING INTERVENTIONS, FUNDING AND IMPLEMENTATION MECHANISMS ON ANI PROJECT IN UGANDA, ZIMBABWE AND SENEGAL

Dimension	Uganda	Zimbabwe	Senegal
Alignment with priority	In line with UNAP priority areas	In line with country nutrition priority areas	In line with country nutrition priority areas
Adequacy of interventions designing and planning	Inclusive of Ministry of Health and Nutrition stakeholder; Some participants viewed the process more as a top down participatory approach. -Integration of global nutrition targets indicators into country Health Information system; -Capacity strengthening of key staff -Enabling monthly outreaches and growth screening at community level; -Development of district-customized recipes	Inclusive of Ministry of Health and key Nutrition stakeholders; Some participants viewed the process more as a top down participatory approach. ANI supports Ministry of Health strategy for the improvement of nutrition surveillance[16] -Support to development of adequate tool for Nutrition surveillance *is relevant*: i) Integration of nutrition of global nutrition targets indicators into country Health Information system; ii) Refining of existing HMIS indicators[17]; iii) Provision of inputs to the upcoming Mother and Child register. -Capacity strengthening of key staff on routine surveillance *is relevant*: i) Training on the estimation and relevance Nutrition indicators; ii) development of guidelines -Support the completion of Nutrition surveys *is relevant*. The food consumption survey as well as the Micronutrient survey provides the country inputs for evidence-based decisions that cannot be efficiently gathered using routine reporting system.	Inclusive of Ministry of Health and Nutrition stakeholder; The participants viewed the process more as a bottom-up participatory approach. -Support to development of adequate tool for Nutrition surveillance *is relevant*: but interventions do not always fit with the planned CIP for Senegal.
Adequacy of funding	Insufficient funding	Underestimation of funds for the Research component and mentorship (*at least $ 80,000 / annual / District)*[18].	Insufficient funding
Adequacy of mechanisms	Successful decentralization of implementation leadership at District level and involvement of Civil Society; Long procurement process	Funds disbursement process is not conducive for timely activity implement by field teams; Involvement of civil society	Funds disbursement process is not conducive for timely activity; Successful involvement of Civil Society

[16] The improvement of Nutrition surveillance has always been in the Nutrition Department annual workplan since 2010.
[17] Refining entailed: categorization by age group; gender sensitive data segregation.
[18] Estimation based on data from the District of Mutare. Total amount allocated to Mentorship is estimated to 60,000 for the 10 Districts supported by the ANI project.

3.2 Sustainability

Finding #3: ***The ANI project delivered sustainable outputs, such as tools and modules and produced some institutional changes, but the potential to produce sustainable outcomes at the systems level, as expected by the project's logic model, has not been fully realized, mainly due to time and resource constraints.***

Provision of strategically planned and well-coordinated technical support is one of the ''seven behaviours'' for international partners to adopt, in order to accelerate sustainable progress towards MDGs in the Health sector (See the adjacent Box 2)[19].

The design and planning of ANI includes specific measures to produce sustainable results, but lack of time and, some shortage of resources undermine the potential that the outputs and institutional changes, such as a sustainable nutrition surveillance systems, will last.

The project's intended purpose to strengthen the existing institutional systems of nutrition surveillance in ANI countries – the Health Information Management System (HIMS) – and to reinforce routine efforts, is a very strong element of sustainability. The development of tools, such as nutrition surveillance guidelines in Senegal and Zimbabwe, nutrition registers or tally sheets in Zimbabwe and Uganda, training modules in surveillance (See ANI results in Table 5 of Chapter 3.4 on Effectiveness) owned by the country, also guarantee continuity. Capacity building of key staff is highly relevant to create impacts and lasting benefits. The engagement of other donors, such as UNICEF, creates the potential for the continuation of funding and technical support.

Box #2 the seven behaviors

1. Agreement on priorities that are reflected in a single national health strategy; through a process of inclusive development and joint assessment.
2. Resource inputs recorded on budget and in line with national priorities
3. Financial management systems harmonized and aligned; capacity building and country systems strengthened and used.
4. Procurement/supply systems harmonized and aligned, parallel systems phased out. National ownership can include benefiting from global procurement.
5. Joint monitoring of process and results is based on one information and accountability platform.
6. Opportunities for systematic learning between countries developed and supported by agencies (south-south/triangular cooperation).
7. Provision of strategically planned and well-coordinated technical support

Source: www.internationalhealthpartnership.net

Fostered by ANI, the WHO Regional Office (AFRO) provided the opportunity to the WHO country offices to streamline Nutrition interventions and incorporate them into their biannual budgets. Yet, there is no real mainstreaming strategy developed in ANI countries to support the continuation of the ANI activities. The WHO and the Ministry of Health haven't yet launched formal discussions with other donors and the Ministry of Finance to secure continuous funding for the Surveillance and Scale up activities of ANI.

In spite of its potential, the reality that the ANI project fell behind schedule and hasn't implemented all the activities across all districts, challenges the sustainability of the project's results. Another weakness is the high turn-over in general within the organisations and/or shortage of staff in the government at central and local levels.

[19] Seven Behaviours, How development partners can change for the better retrieved from: http://www.internationalhealthpartnership.net/en/about-ihp/seven-behaviours/

Partners such as UNICEF committed to complement ANI and support HIMS training in other districts in Zimbabwe and Uganda. In Uganda, UNICEF, WHO, USAID, Global Alliance for Improved Nutrition (GAIN) and other nutrition stakeholders also commit to provide Health facilities with HMIS tools.

Specifically, each country evaluated during the field mission presents elements of sustainability:

In Uganda:

- Enabling the strengthening of the institutional system – the HIMS – to promote the routine surveillance, instead of continuing periodic surveys;
- Training planned by the Ministry of Health in the whole country on the revised HIMS;
- Capacity building includes aspects of planning and budgeting, and advocacy for the Districts;

In Zimbabwe:

- Successful collaboration with the Health Information Department of Ministry of Health, leading to the incorporation of additional nutrition criteria into HIMS data elements and DHIS2;
- Plan exists to train the health officers in the whole country on the revised Nutrition Surveillance system.
- UN partners highly interested and involved, especially UNICEF.

In Senegal:

- Revitalization and strengthening of the national system to establish nutritional surveillance, incorporating new indicators;
- Capacity building of key staff of the main national structures;
- Participatory approach that includes the national and sub-national governments that are supported by the ANI project;
- Training plan for the entire country (however not budgeted).

Room for improvement:

The sustainability of the ANI project could be improved in each of the visited countries with the following measures (Table 4):

TABLE 4: MEASURES TO IMPROVE PROJECT SUSTAINABILITY

Country / Dimension	Room for improvement	Opportunity
Uganda		
Enabling routine surveillance at national level as well as in some specific Districts	Orientation/training of more individual at facility level (all nurses and Clinical officers on the) on the use and the relevance of nutrition column in the registers (06)	Commitment to support HMIS training countrywide (UNICEF) Resource Center put in place a good structure that allows data quality control up to District level.
Strengthening Health workers Capacity	Budget allocation for the provision of bicycle to VHTs for effective coverage of all villages within a District.	
Zimbabwe		
adequate tool for Nutrition surveillance	Ensure effective use of the Child Growth Monitoring tally sheet by Health Facilities.	
Capacity building on reporting on nutrition indicators and surveillance	Train more nurses at Health center level; Extend training to Nurse-aid; Provide training to Village Health Workers on Growth Monitoring, especially height measurement; Training/retraining of District Manager;	Existence of districts nutrition mentorship program, that provides orientation on nutrition reporting during its visit to Health Facilities.

	Support (financially) districts nutrition mentorship program	
Strengthening data quality control/ assurance	Support (financially) monthly mentorship visit at health facility data quality control/review at lower level (facility level); Provision of sufficient anthropometric equipment to health facilities and villages health workers; specially height measurement equipment; Improvise height board in using plastic height measurement tape that is less expensive and more hygienic.	Online access to data (with DHIS2) allow real time identification of unreliable data by Province and Headquarter; RBF requirements encourage internal data quality control by Health facility teams; RBF quarterly data quality review is an opportunity to ensure quality to data reported on Vitamin A and Growth Monitoring. UN agencies provide as much as their budget allows anthropometric equipment to Health facility to support effectiveness of Growth Monitoring; Existence in Zimbabwe of local manufactures that can provide plastic height tape.
Senegal		
Adequate tool for Nutrition surveillance Strengthening data quality control/ assurance Enabling routine surveillance at national level Nutrition surveillance sentinel sites	Ensure integration of new nutrition information columns in registers and make them available. Provide efficient supervision at district level. Strengthen coordination and information sharing between health facilities and districts Proceed to data analysis at national level and give feedback to the field (region and districts) on a rolling basis Complete properly the first phase of the implementation of sentinel sites (5 sites)	Could represent an opportunity for concrete rapprochement between Ministry of Health and ''Cellule de lutte contre la Malnutrition'' Online access to data (with HMIS) allow real time access to data Partners and people are committed, if delay are too long there will be a risk for general disengagement and disinterest

3.3 Aid effectiveness: Ownership, harmonization, alignment and Results-Based Management

The principles of aid effectiveness described below are drawn from the OECD's 2005 Paris Declaration on Aid Effectiveness, henceforth referred to as the Paris Declaration (PD).

3.3.1 Aid effectiveness (ownership, alignment and harmonization)

Finding #4: ***WHO is truly committed to respect partner country leadership and to help strengthen their capacity to exercise it. ANI supports partner countries' institutions, using institutional procedures whenever possible, and harmonizes with partners, especially with respect to the REACH and SUN movement(s) as planned in the CIP with varying results depending on the country's situation.***

WHO is a signatory of the principles agreed to by countries and development partners at the high-level forum on Aid Effectiveness in Paris that aims for greater ownership by government, alignment with national priorities, and harmonization between development partners. The WHO agreed to work with the OECD Development Assistance Committee and others to increase development partner accountability in health, focusing on ways in which applying the Paris Principles support health systems development.

As discussed in Chapter 3.1 on Relevance, ANI's design includes specifications to ensure that the Surveillance and Scale up activities ''align with country-led strategies and the SUN movement and complement the REACH workplans in country''[20].

The CIPs did support national nutrition strategies and existing surveillance systems. ANI was planned and implemented in a way that permits partner countries to exercise real leadership over their development nutrition strategy and coordinate nutrition interventions, as required by the ownership principle. WHO used country systems whenever possible (with the Ministry of Health and/or the districts via Direct Financial Cooperation) and ANI built capacities of the health workers in the districts in nutrition, but also in planning and budgeting as in Uganda (public financial management).

In the three countries evaluated, ANI established relationships with the SUN movement and with REACH in Uganda, the only country where this network operates. REACH and the SUN mechanisms are located at the highest executive and political level, i.e. at the Prime Minister's Offices in Uganda and Senegal and at the President's Office in Zimbabwe, which clearly signals the country's commitment regarding its battle against malnutrition, and points to a multisectoral approach. However, it also introduced a competency tension between the SUN focal point structure and the Ministry of Health because among other thing roles and responsibilities aren't well defined.

The National Food and Nutrition Council (NFNC) acts as a focal point for the SUN movement in Zimbabwe and coordinates the Food and Nutrition Security Policy that commits to six results including an Integrated multisectoral Food and Nutrition Security Information System (IFNSS). The NFCN acts as a Chairpersons of the Sub Committee on Nutrition Surveillance, established by ANI and composed of the National Nutrition Department and Health Information Unit, UN Development partners, NGOs, academics etc. According to the NFNC, the effectiveness of the platform is limited by the NFNC's budget constraints and understaffing with only one SUN coordinator. There are very few players in Nutrition Surveillance in Zimbabwe and coordination between the partners is thus easier than in Uganda and Senegal. Still, NFNC believes that the role and responsibilities of government and partners must better be clarified to engage in a real multisectoral approach. Fostered by ANI, WHO works with the Ministries of Health and Agriculture and the NFNC, and coordinates with UNICEF, FAO and WFP.

In Uganda, roles and responsibilities should also be better defined among government and partners, according to REACH. Coordination is difficult in an environment with scarce resources committed to the Sun movement (they also operate with one permanent staff). A lot of donors contribute to surveillance system strengthening, for instance the UNICEF, the FAO, the WFP, the Strengthening Partnerships, Results, and Innovations in the Nutrition Globally project (SPRING21), or the USAID funded Food and Nutrition Technical Assistance Project (FANTA). Various support is provided to collect, analyze and improve the quality of the data, the production of which is often driven by the donor's results framework, and not by the country's own performance framework. REACH supports the development of nutrition district plans in Uganda, budget capacity building, and a mapping exercise in partnership with WHO and the International Baby Food Action Network (IBFAN), an ANI implementing partner, as planned in the CIP. But after three years, the mapping exercise led by REACH,

[20] Grant Arrangement between the government of Canada and the WHO, ANI: Scale up of Nutrition Interventions, p.7

[21] SPRING's is dedicated to strengthening global and country efforts to scale up high-impact nutrition practices and policies) and bring together experts from JSI Research & Training Institute, Inc., Helen Keller International, The International Food Policy Research Institute, Save the Children, and The Manoff Group.

has yet to be shared with stakeholders. In general, information about the stakeholders' activities is not gathered by the government and the meetings in nutrition with the government and the donors are rare. REACH is pushing to do an end-term review of the Uganda Nutrition Action plan to promote good governance and funds accountability. Harmonization among the UN organizations, especially between UNICEF and WHO should be strengthened particularly for surveillance activities with UNICEF and scale up interventions going on in the country.

In Senegal, the SUN coordinator is the ''Cellule de Lutte contre la Malnutrition'' (CLM) located in the Prime Minister's Office, which does not work very closely with the Ministry of Health. Since 1995, the Cellule has been implementing nutrition activities in Senegal and works with NGOs to collect nutrition data. It is important to note that the Ministry of Health has no budget line for nutrition apart from nutrition expenses in the running costs budget. Much is expected from the on-going review of the Nutrition Policy, or the "Lettre de politique'', whose origin dates back to 2001. The review should be particularly helpful to redefine roles and responsibilities in the perspective of the adopted multisectoral approach, notably the role of the Ministry of Health, and the coordination between all stakeholders. Canada has made the publication of this document a conditionality of its $US 50 million budget support to Senegal.

3.3.2 Results-based management

Finding #5: ***WHO carefully planned the ANI project by results, but could improve its use of RBM tools for resource management, especially financial management and for reporting*****.**

The WHO introduced results-based management in 2006 with a revised Accountability Framework designed to support the approach in WHO's the highly decentralized environment. The organization is one of the fifteen specialized agencies within the UN System — like the FAO, UNICEF, WFP, and UNDP — which operates autonomously. WHO's Secretariat in Geneva[22] reports directly to the World Health Assembly, the supreme decision-making body of WHO that generally meets in Geneva in May of each year, and is attended by delegations from all 194 Member States.

Since 2006, institutional reforms are still being implemented to fully harmonize the roles and responsibilities of the six Regional offices and Headquarters. The organisation has not yet succeeded in implementing a new and all-encompassing accountability framework[23]. The main objective of the reform is to install a matrix organization and make Headquarters Directors fully accountable for their respective areas of expertise.

In this context, the NHD Director, Award Manager, to whom DFATD awarded $US 18 million in ANI grants, found himself in unchartered waters and had to find a way to structure his accountability framework for the project. The draft Standard Operating Procedure for ANI implementation was a solid attempt to define respective roles and responsibilities of the organization's parties involved, and to set out procedures for coordination between Headquarters, the Regional offices and the Country Offices (CO), but wasn't optimal to manage the project efficiently, as reported in Chapter 3.5.2 on Managerial Process. For

[22] The ''Secretariat'' employs 7000 health and other experts and support staff on fixed-term appointments, working at headquarters, in the six regional offices, and in countries.

[23] WHO, Roles, responsibilities and matrix management, retrieved from http://www.who.int/about/who_reform/matrix-management/en/

instance, the ANI financial reports were prepared according to WHO's usual expenditure nomenclature for its operational budgets, and not by ANI results as planned in the CIP. Further, this explains why the Zimbabwe CO could not present the 2013, 2014, and 2015 annual disbursement statements (of the CIP) to the evaluation mission and had to prepare them on the specific request of the mission. Same thing in Senegal where it's Country Office was only able to provide a consolidated report according to the CIP including expenditures, through November 11, 2014. Uganda however could present the evaluation team a detailed CIP work plan (Gantt chart), associated budget, and disbursements, by year. ANI apparently has not harmonized standard reporting procedures for financial or technical reports.

In line with WHO policy, ANI developed several planning tools, including the Logic model, effectively a very detailed Performance Monitoring Framework (PMF) for which a baseline was established during the second year of the project's execution. The WHO Country Offices developed their CIPs with their own specific monitoring and evaluation frameworks, operational plans, monthly progress reports, annual reports – remarkably lacking any reference to the PFM.

The planning process respects the RBM principles; specifically, the objectives were clearly formulated in the Logic Model and the CIP and resources were well aligned to achieve them. However, the dual monitoring framework, PMF and the CIP, were neither harmonized nor aligned. The COs used the CIP monitoring framework they developed themselves (and specific to each CO) and report mainly on ANI activities (inputs) rather than outputs or outcomes.

The PMF is a parallel RBM framework with little use despite the money and time WHO spent producing it. Due to the complexity of the indicators, the PMF baseline study took a while to develop, not to mention the attribution/contribution issues which were raised. Moreover, because of the project timeline, the endline study planned at the project's end to assess the results and the impacts according to the PMF, is rather useless and will not be implemented, unless DFATD grants a no-cost extension to justify it.

3.4 Effectiveness of the project (performance)

3.4.1 Achievement of the expected outcomes of the ANI project

Finding #6: ***ANI project reached significant output and outcomes in strengthening nutrition surveillance systems, enhancing the capacity of primary care and district staff, and supporting scale-up interventions. Indeed, pilot activities were initiated that have national impact. The project is still in active implementation phase, and it will be a challenge to complete all activities smoothly before the end of December in the case study countries. Indeed, the project neither implemented all ANI planned activities nor did it cover the expected national coverage due to time and budget constraints.***

ANI project initiated nutrition surveillance system strengthening in 11 Sub-Saharan Africa countries with associated scale up nutrition interventions in Uganda, Ethiopia and Tanzania, as presented in Table 5 below.

As discussed, Ministries of Health were all very engaged in ANI project, a strong factor that contributed to the results in the three countries visited. They all collected higher quality data describing nutrition status in intervention sites, provided surveillance and nutrition training to nutritionist, nurses, community health officers, government analysts, district nutrition committees. Data are integrated in existing health systems, but implementing countries have not yet reached the stage of monitoring nutritional status changes and using the information to feed into national or sub-national level programs' planning and implementation strategy.

Nevertheless, ANI's expected national coverage was generally not met. Two of the three countries covered fewer districts than the target in the CIPs, and even far below the 25% target as described in the ANI Logic model. It is unlikely that the number of beneficiaries presented in the Annual reports would be reached.

More specifically:

- In Uganda, the targeted coverage was 6 of 111 districts to reach a total of 632,199 women beneficiaries aged 15-49 and 562,590 children under 5. According to the field mission, all 6 districts were covered, but fewer trainings were held due to an underestimation of the effort and delays in the sequence of the activities.
- In Zimbabwe, the targeted coverage was 10 of 59 districts to reach a total of 332,145 women beneficiaries aged 15-49. Only 4 districts were covered. Of the 2 planned surveys activities, only 1 was completed (in September 2015).
- In Senegal, the targeted coverage wasn't specified. All districts were covered (76 in the country) to reach a total of 5,403,485 women beneficiaries aged 15-49 and 2,701,743 children under the age of 5.

Measuring the impact of ANI in project countries would require assessing sustainable changes observed throughout implementation in an environment favorable to the continuous improvement of health conditions, especially for women and children under 5 years. Based on various findings, which emerged from a very brief analysis of project, observations are focused primarily on short and medium term results. It is still too early to measure long-term impact.

The following table 5 summarizes project achievements to date in case study countries.

TABLE 5: SUMMARY OF PROJECT ACHIEVEMENTS

	Senegal	Uganda	Zimbabwe
Strengthening surveillance system			
Output - Baseline data established			
	- All visited countries contributed to the baseline data through desk review and perception survey. Baseline data were intended to inform the ANI PMF monitoring as well as to help the government to monitor changes in nutrition status.		
Output - Nutrition surveillance system strengthened (25% of district system harmonized & feeding into national system; Government's health analysts trained to collect and analyze data)			
	National coverage - All 76 districts out (no targets) represents 100% of 76 districts in Senegal - Sentinel sites: 5 districts out of 5 districts (ongoing)	- 6 districts out of 6 planned; represents 8% of 80 districts in Uganda	- 4 districts out of 10 planned; represents 7% of 59 districts in Zimbabwe.
	National policy - Advocacy to accelerate the implementation of the nutrition policy review to strengthen nutritional surveillance.	- Not Applicable (N/A)	- N/A
	Nutrition indicators : All visited countries have incorporated additional nutrition elements into their national register and report systems (HMIS, DHIS2, SNIS)		
	Availability of adequate tools - IDSR guidelines revised and validated - Context analysis of nutrition surveillance in Senegal - Nutrition surveillance guidelines - Registers do not yet collect all information (weight/age and height/age remain to be integrated)	- Nutrition indicators in registers, tally sheet, HMIS report); - Nutrition addendum developed and customized	- Nutrition routine surveillance guidelines - "Nutrition Register" to be integrated into the upcoming Mother and Child Register. - Child Growth Monitoring tally sheet
	Training - Routine surveillance: national orientation workshop for the 14 Heads doctors and nutrition focal points of the 14 medical regions, Focal points have then trained district teams (5 key people by team) - Training of 7 hospitals' CREN (Centre de recuperation nutritionnelle) and 36 districts operation CREN in management of acute severe malnutrition. - Sentinel sites: Orientation and training of regional and district medical managers concerned by sentinel surveillance - Training and launching of 5 sentinel surveillance sites (1st round) (with CVCA complementary funds)	- Training of nutritionists, nutrition assistants, nurses on growths standards and roll out - Training of government analysts on the UNAP SUPA tool and the WHO ANI Landscape analysis tool. - Districts' Nutrition Committee trained on planning and budgeting	- Training provided to Provincial Nutritionist; District Nutritionists; District Health Information officers; community health nurses. - Orientation provided to health facilities' nurses.
Outcome - Increased ability of governments to monitor changes in nutrition status and to target interventions to those most needed.			
	- All visited countries have collected data on nutrition indicators including WHA targets in regards to maternal, infant and young child nutrition. However, no systematic analysis and decision-making have resulted from this data yet.		
Outcome - Enhanced capacity of governments to plan and implement nutrition strategies in order to target interventions and to modify strategies, where need.			
	- Ministry of Health has access to electronic data from the routine surveillance system across the country.	- Ministry of Health does not yet have access to data from the routine surveillance system form the field.	- Ministry of Health has access to electronic data from the routine surveillance system from intervention sites. Not

	- Ministry of Health has also launched nutrition sentinel surveillance on 5 sites (ongoing). - No systematic data analysis yet at the national level.	- Adequate tools are available but not yet implemented; training planned for October.	across the country yet and no systematic data analysis yet at the national level.
	All visited countries need to improve data quality control and to establish periodic field supervision and nutrition review.		
Scale up activities			
Output – Direct evidence-based nutrition interventions integrated in national strategy, and scaled up			
	- N/A	- District assessment (includes perception survey) - Knowledge and practices survey (KAP) - Food Based Dietary Survey	- N/A
Output – Number of health workers trained on the delivery of nutrition intervention			
	- N/A	- Reviewed and updated IMAM Guidelines; - Developed training package for Inpatient Therapeutic Care; including 7 modules for facilitators and TOT; - Trained facilitators and TOT for ITC; - Updated GMP training modules; - Districts' health team capacity strengthened in planning; GMP and mentorship; - Health workers and VHT capacity strengthened in GMP	- N/A
Outcome – Increased access to direct evidence based nutrition interventions for women and children			
	- N/A	- Mother's knowledge on malnutrition determinants and prevention and capacities in optimal complementary feeding (food demonstration and counseling); - Availability of District-customized recipes on complementary feeding. - Leaders and husbands sensitized on nutrition of pregnant and lactating women as well as ANC.	- N/A
Outcome – Increased quality of services provided by health workers to deliver prevention and treatment nutrition interventions to women and children			
	- N/A	- Increase health workers confidence in ICYN; and SAM management.	- N/A
Survey			
Output – Data and estimates provided to national and global processes			
	- Support to the national SMART survey in 2014.	- N/A	- Food consumption survey (ongoing) - Supported micronutrient survey
Outcome – Increased access to information on national and global progress in nutrition (SUN, GINA, eLENA)			
	- SMART survey provides useful complementary information and data to Ministry of Health. - Info and data are shared with SUN although the coordination isn't always efficient.	- N/A	- Micronutrient survey provides the country inputs for evidence-based decisions that cannot be efficiently gathered using routine reporting system. - Info and data are shared with SUN.

3.4.2 Strengthening nutrition surveillance

Finding #7: *ANI project initiated activities, including relevant capacity building, the provision of equipment and material, and monitoring and supervision, critical to strengthening of existing national health information system(s) in specified districts, etc. At this stage, however, the project has generally not met its goal of harmonizing at least 25% of district systems and enabling districts to populate the national system. Longer term involvement is needed to build National nutrition surveillance systems that are capable of informing action plans and managing nutrition issues on a countrywide basis.*

As noted, ANI has worked toward developing, streamlining and reinforcing existing national health system through system reinforcement and training of health workers. According to ANI's 2015 Annual reports, it strengthened the nutrition surveillance capacity of more than 1600 health workers. In Senegal, the Project supported the implementation of a complementary sentinel surveillance system.

Most field observations indicate ANI's successful collaboration with Ministries of Health in case study countries, but activities were not all implemented as planned, sometimes because of lack of time and/or lack of budget. Generally, the CIPs have been very ambitious with respect to the timeline, resources allocated and also capacity of government counterparts.

Nevertheless, ANI was the starting point for large-scale initiatives coordinating partnerships and providing an opportunity to improve programming for nutrition surveillance. Nutrition surveillance system strengthening has also contributed to national efforts to build strategic competencies resulting in the development of local leadership for nutrition.

For instance, in the case of Senegal, the country experienced strikes, resulting in a significant neglect of data collection activities. When the Project started, the national system was inefficient and several districts weren't feeding the system at all. The Project re-energized the capacity of the districts to feed the National surveillance, but the Senegal's Ministry of Health does not yet systematically analyze nutrition data in order to make the necessary decisions for crisis prevention or to curb emerging crises.

With respect to enabling routine surveillance, a review of case study countries revealed that these countries examined all nutrition indicators for the purpose of integrating those relevant indicators, i.e., global targets indicators, into the HMIS system. Overall, new nutrition surveillance activities rely on a participatory approach as the preferred methodology for implementation.

However, apart from Senegal, the approach remains "top-down" wherein the central administration leads, guides and ultimately imposes the implementation strategy. In Senegal, especially for the sentinel sites component, the methodology for tool design and validation involved convening key participants from the community level up to the central level to discuss the approach and the tools. Our observations strongly indicate that this "bottom-up" approach was greatly appreciated by participants and led to a greater ownership and commitment of staff involved in the implementation of surveillance in the field.

ANI provided standardized equipment to districts health centers consisting of weighing scales, height/length measuring boards, and mid-upper arm circumference (MUAC) tapes. Standardized and precise equipment remains important for the quality of data collected. Without adequate equipment, health centers use whatever means available and possibly

interfering with the quality. For instance, a district health center in Mutare in Zimbabwe reported that without their new height measuring board, they were forced to adapt with a hand drawn measuring scale on the wall. The quality of weighing scales is also as an important factor. In some instances, the quality or amount of the equipment was unsatisfactory indicating a flawed procurement process or weal resource management.

Funds have not yet been allocated for systematic printing and distribution of the revised HMIS tools to all ANI supported health facility on a consistent basis. In fact, even when data are systematically integrated in the HMIS, as is the case in Senegal, other new tools have not yet been made available to health staff in the field.

Currently, routine surveillance is supported at the national level and at some, but not all, districts. As a result of this integrated approach, training included key staff across all positions – Ministry of Health officers, biostatisticians, nutrition focal points at regional and district levels, registration officers (for example, heads of health posts and nurses), community health officers, and others.

The quality control of data is critical for the project's success because nutrition intervention is based on the accuracy and treatment of nutrition measurements collected in the field. As a consequence, the Project has dedicated significant resources towards national capacity building including staff training at all levels, to enable accurate evidence-based information for identifying intervention priorities. Several guidelines, training packages and modules have been developed, reviewed and updated throughout all countries targeted for intervention. Key informants who participated in the trainings report that trainings and capacity building activities were of high quality and that they developed the relevant skills, aptitudes and competencies for their project responsibilities. And while many participants reporting increased confidence in performing surveillance responsibilities, at both the district and community levels requested more training sessions.

Quality has also improved but still requires some reinforcement. As evaluators only visited a few sites, it is not possible to state absolutely whether the quality has improved. However, several key people overseeing data quality control acknowledged that certain errors occur regularly and suggested that capacity strengthening or supervision on a more regular basis is needed. This work is ongoing and requires continuous support, supervision, mentoring, and monitoring. The continuous lack of funds is frequently invoked by ministries and unfortunately often results in a lack of field supervision. This lack of financial resources figures is among the weaknesses regarding the issue of sustainability.

Concretely, this means that key staff is proficient in measuring anthropometric data. Accurate anthropometric measurement requires specific instructions as step-by-step procedures must be followed when taking measurements. The Project also contributed to standardize methods to ensure that measurements are accurate and make possible automatic comparisons with standard reference points. Determining proper nutritional status at this moment can lead to the following: early warning of malnutrition, immediate treatment, or reference to services in the case of severe malnutrition cases.

As mentioned above, the Ministry of Health in Senegal insisted in establishing sentinels sites as a complement of nutrition surveillance routine (See Box 3 adjacent). Others activities, such as the support of national nutrition surveys were implemented upon request of the nutrition division (DAN) at Ministry of Health. Overall, establishing sentinel sites and the unplanned activities of surveys have taxed almost half project resources, and withdrawn from the funds to support existing (routine) nutrition surveillance systems, which is far from the operational level necessary to inform nutrition programs in Senegal. The Team

concludes that the most concerning issue is the absence of a clear strategy for execution of this approach. Even if the work accomplished was of high quality, the inability to complete key activities compromises overall project the sustainability of nutrition surveillance. Currently, the first phase of implementation is not yet complete and there is no plan to complete implementation.

However, it is critical to determine the precise role of the project and furthermore, the position of the CO in respect to the Ministry of Health's choice of activities when those selected aren't wholly in line with project objectives.

Additionally, in the case of Senegal, when the Project was running out of money, the project required support from major partners involved in the nutrition sector to continue activities for both routine surveillance and sentinel sites. Establishing such partnerships in Senegal is considered a relevant strategy for success.

Similarly, in Zimbabwe, despite the great achievements, the Project struggled to achieve its targets due to long sequencing of its implementation plan. For instance, government and stakeholder agreed on nutrition indicators and processes prior to the development of training materials and subsequent trainings on surveillance. Indeed, Zimbabwe only started to train the health workers in 2015 with the help of additional funds for capacity reinforcement since the budget was depleted due to overspending on the food consumption survey component. Consequently, ANI trained fewer than 50% of the targeted districts (only 4 of the 10 targeted for surveillance activities). The planning was unquestionably too ambitious regarding the timeline and the resources allocated. Such miscalculations resulted in massive delays and in Zimbabwe's case jeopardized the results regarding routine surveillance activities.

Box #3: Sentinel surveillance tools in Senegal

The main goal of sentinel surveillance is to conduct household surveys on a quarterly basis to gather additional information. Implementation resulted in a strategic partnership with UNICEF who shared its expertise to conduct surveys using smartphones. This innovative approach used electronic surveys that contribute to greater efficiency, i.e., data accuracy and faster processing as the raw data is automatically compared to nutrition variables. These variables can quickly generate a nutritional status index and transform the figures into Z-scores so that the prevalence of nutritional conditions, such as being underweight and stunted, can be calculated almost immediately. However, this process is new for the country team and requires additional training and support to guarantee mastery of the technical aspects.

Source: Field mission, Senegal, September 2015

3.4.3 Scale up nutrition interventions

Finding #8: *Scaling-up activities implemented, produced interesting results such as strong community mobilization in regards to nutrition activities, mothers' increased knowledge of malnutrition determinants and prevention, active participation of leaders and husband in sensitization activities and improved understanding of the nutritional needs of pregnant and lactating women*.

According to the WHO and stakeholders, scaling-up nutrition actions are considered a perfect match for nutrition surveillance system strengthening. Evidence-informed nutrition actions are highly relevant to complement surveillance activities as part of comprehensive programming. The project was viewed as unique by providing resources to implement and follow all nutrition system strengthening processes with the corresponding collection of data throughout the implementation of scale up interventions and including the delivery of specific training(s) and development of adequate tools.

According to WHO's 2015 Annual report, ANI has strengthened government officials and nearly 1800 health workers in the three scale-up countries: Uganda, Ethiopia and Tanzania.

ANI has worked closely with governments to develop and adopt the scale-up programmes. ANI technical support was intended to accomplish the following: (i) assist with the design or adaptation of scale-up programmes guidelines; (ii) contribute to strengthening the technical capacity of health workers; (iii) collaborate with different partners for the implementation of the health component of scale-up programmes; and (iv) enable the provision of appropriate care at the facility and community levels. Capacity building has been provided based on several guidelines, training packages and modules developed, reviewed and updated by ANI among countries targeted for intervention.

In Uganda, the proposed material and tools concern, among other issues:

- Integrated management of acute malnutrition (IMAM);
- Facilitators and participants manual on community growth monitoring and promotion (GMP);
- Inpatient Therapeutic Care (ITC) for Severe Acute Malnutrition (SAM);
- Village Health Team (VHT) register for growth monitoring and promotion; and
- Training of trainers (TOT) and facilitators materials.

Based on discussions and observations in the field, the training enhanced capacity of health workers and government officials. Health workers and the Village Health Team (VHT) met by the Evaluation Team in the visited districts were very pleased with the support they've received. These interlocutors expressed satisfaction with the training, in particular, although everybody agreed that 4 days training isn't sufficient for VHT. However, all feel confident in performing GMP and infant, child and youth nutrition (ICYN) activities.

In fact, based on the Team's discussions with health workers and VHT they quite clearly explain GMP's role as a prevention activity using growth monitoring measurements and growth interpretation. The VHT report that it is used to facilitate communication and interaction with mothers in promoting the adoption of adequate actions that can contributes to promote child growth. Others examples provided by the VHT is that GMP can:

- Improve utilization of other health services by mothers when these are promoted, supported, and offered through GMP counseling.
- Increase awareness of the importance of proper practices for adequate growth, and the link between adequate growth and child health.
- Increase knowledge and skills and subsequently improve child feeding and health care practices by mothers.

The ANI scale-up component also includes the ICYN program to promote practical approaches for advancing social and behavioral change. An essential component of this work is strengthening BCC programs to prevent malnutrition. To accomplish this, the Uganda partner (CDFU) identified both barriers and incentives through a Knowledge, Attitude and Practices (KAP) study to develop activities that will guide households in adapting new behavior with the potential to improve nutrition. Targeted communications are used as well to encourage change and reinforce messages with health workers, communities, and caregivers.

Training and capacity-building activities in close collaboration with health facilities targeted trainers, health workers, community workers, led to changes in their practices, and ensured that community caregivers receive accurate, actionable advice on child feeding. Tools and guidelines to promote local recipes were developed. Community workers were trained to use them in cooking demonstrations to teach families how to prepare more nutritious and often less expensive meals for children. An interesting strategy is also to engage fathers, community and religious leaders to support improved feeding. Communications activities with educational messages designed to target households were also organized for radio

spots, community and social events, and door-to-door activities, etc. The Team met with people who reported that community mobilization activities are more suitable to reach them because they feel free to talk and are more opened to receive messages.

At the community level, including women and leaders, we've seen, on the basis of our discussions that people that have beneficiated from sensitization activities and understand the importance of the nutrition. They can explain its importance and briefly describe how to improve their nutrition.

However the two visited districts in Uganda aren't at the same stage of improvement:

The District of Namutumba experienced a food crisis in 2011. Consequently, communities already had basic knowledge of nutrition issues before the arrival of the ANI project. This has influenced positively Namutumba's commitment to ANI project activities. This district has more rapidly integrated new feeding practices and both women and men speak clearly about the positive changes they have started to experience.

Women clearly described the various stages of their nutrition practice(s) evolution. At first, the majority admitted that they felt sad upon learning that they weren't properly feeding properly their own children. Some women even expressed frustration but nevertheless listened to the nutrition related communications. They realized that these messages neither accused nor blamed, rather, the messages provided them with interesting information. So the women accepted the introduction of new practices on a day basis and report that they have begun to see changes following full adoption of the practices.

The men of Namutumba (the Team spoke with a group of leaders), also revealed how sensitization activities have effected their behaviour with respect to the sale of nutritional items, e.g., vegetables, cereals, without sharing any provision with the family. While the men were eating properly outside of the house they gave very little to the women and children. The majority of men the Team met shared that due to the sensitization activities they understood that their attitude(s) and accompanying practices were the source of family problems (sickness, high costs for health consultations to see traditionalists and health center agents, medicines, frequent arguments and fights at home, etc.). Thus, they started to change their attitude(s), which means to keep sufficient food provisions for the family. Finally, the men reported, it costs them less to feed their families, everybody is healthier and happier and they even started to spend more time at home with their own family.

In the District of Iganga, in the Buyanga sub county, the picture is different. As they haven't faced similar food crises, hearing about nutrition issues is more recent. As a result of various sensitization and educational activities, community members (women and leaders) seems to understand nutrition messages. However, they haven't yet integrated these new practices. Communities have asked for more information to better understand the importance of changing their feeding practices. We believe that our findings in Buyanga are more representative of the actual situation across ANI districts of intervention. BCC activities are too recent.

As for Surveillance activities, the Project planning was ambitious and could not have been all implemented. For instance, CDFU could not implement the complete Behavior Change and Communication (BCC) program as planned because of the delays to the start of the project. Again, the sequencing of activities was crucial and delays to complete the first data collection and analysis compromise the implementation of the following activities. CDFU reported not have trained as many health workers as planned or reached as much beneficiaries. Another NGO implementer, the Mwanamugimu nutrition unit from Makare University also reported an underestimation of the effort needed to complete their mandate.

Scale-up programme must be completed and sufficient monitoring and supervision are also required to assess concrete results. The pilot initiative must be completed to be able to measure concrete evidences of its contribution within communities and to promote it with other partners.

3.4.4 Nutrition surveys

Finding #9: ***Generally, meaningful data were gathered through the nutrition surveys, but some exercises should have been more rigorously planned and budgeted to establish useful baseline data to inform the government and stakeholders.***

Overall, Ministries of Health of implementing countries perceive surveys as an important and relevant tools to gather meaningful baseline data that guide nutrition strategy or design initiatives. ANI funds supported nutrition surveys in four countries: Zimbabwe, Sierra Leone, Zambia and Rwanda, but other surveys were also supported by the ANI project.

In Zimbabwe, the WHO Country office supported an ongoing Micronutrient survey (data analysis and reportwriting) and a National Nutrition, Food Consumption and dietary pattern survey. In the assessed countries, Senegal WHO Country office supported the Standardized Monitoring and Assessment of Relief and Transitions nutrition survey (SMART) in 2014 ($US 10,000; in collaboration with UNICEF) and also the national food security and nutrition survey in 2013 (US$ 48,000), which was not planned in the CIP. In Uganda, the project supported a nutrition and food consumption survey (US$ 130,000), which was completed in 2014 to support the development of food/based dietary recommendations.

The objective of conducting these surveys was to collect baseline data to guide the development of nutrition strategy or initiatives, and especially scaling-up nutrition interventions. Indeed, the surveys have been used generally to inform the government and the stakeholders, such as the micronutrient survey in Zimbabwe and the surveys conducted in Uganda and Senegal. For instance, the micronutrient survey in Zimbabwe helped the government develop the National Nutrition Strategy and identify stakeholders, such as the WFP to inform their activities.

Nevertheless, the main survey product in Zimbabwe, the Nutrition and Food Consumption Survey is not yet completed as of September 2015, notwithstanding an expected publication date of October 2015. According to the Zimbabwe government and stakeholders, the window of opportunity for comprehensive use of the data survey is decreasing rapidly and the survey is at risk of being useless if it is published later than the expected date. WHO reported that given that food consumption surveys are done every ten years, even in developed countries, the window of opportunity to use the data is not closing since it would be still useful early next year.In general, sequential planning to implement surveys wasn't always optimal in case study countries. The process was very resource heavy and time-consuming, especially in Uganda and Zimbabwe, and caused a negative impact on the project because of these delays. For instance, the procurement process in Uganda to conduct the survey was long and costly due to preparation of the proposal, technical reviews, local contract reviews, and revision of the bid when the successful bidder ultimately did not meet the requirements. The Social Behaviour Change and communication activities were implemented only in 2014 because of the delays, which has limited the effectiveness of the scale up interventions.

In Zimbabwe, the WHO Country office hired an international expert on non-ANI funds (a free donation to WCO through IST/ESA). Specific and very specialized expertise was required to undertake such a large-scale study as the food consumption survey. Generally, initial budget allocations, expertise and competencies were underestimated to conduct such large-scale

surveys. Operating procedures for program implementation were also significantly underestimated (See Chapter 3.5 on Efficiency). Note that it is not specific to ANI; national surveys in these countries generally require considerable time and resources.

3.4.5 Global and regional activities

Finding #10: ***The ANI Global and regional activities mainly support the ANI Country Office(s) and contribute to maintain and expand the access of WHO database, especially the ongoing project of expanding the access of the e-Library of Evidence for Nutrition Actions (eLENA) which is funded by the Bill and Melinda Gates Foundation.***

ANI associated the implementation of Surveillance and Scale up activities with regional and global activities. WHO planned to provide supervision and technical advice on all aspect of Surveillance and Scale up nutrition interventions, to define and review the list of core nutrition indicators, identifying good practices and improve and expand the WHO databases eLENA and GINA.

Indeed, activities were mostly to provide supervision and technical support to the countries from the HQ and the regional offices, especially from the Inter-country Support Teams (ISTs) based in Harare and Ouagadougou. This support to ANI countries was crucial to the success of the project since WHO ANI employees hired for the project were new to WHO and the work environment, very complex. That was particularly true for the Scale up project that benefited from strong support by the IST and the HQ (See Chapter 3.5.2 on Management process).

Other than providing technical support, this ANI component contributes to maintain and expand access of the following database(s):

- The Global database on the Implementation of Nutrition Action (GINA) that is providing information on the implementation of nutrition policies and interventions.
- The WHO e-Library of Evidence for Nutrition Actions (eLENA), an online library of evidence-informed guidance for nutrition interventions.

According to WHO, the use of GINA is growing steadily since its launch in November 2012 http://www.who.int/nutrition/gina/en/ and since its launch in 2011, the eLENA website has been more than 1 million times by visitors from all over the world. However the Team notes that it was too early in the process for the SUN focal point in the Office of the prime Minister in Uganda and at the President Office in Zimbabwe met with during the field mission to know of or make any use of the GINA and eLENA platforms.

The Project contributed to an ongoing plan of expanding access to the e-Library of Evidence for Nutrition Actions (eLENA), which is funded by the Bill and Melinda Gates Foundation. Not everyone has regular or reliable internet access, however, and many may not may be able to easily access eLENA. To reach those in settings without internet access, an eLENA mobile phone application (mobile app) was developed to deliver eLENA content to smartphones and can be accessed anywhere – no internet connection required. When the team met with the manager of the eLENA project, WHO was field-testing the eLENA mobile phone application.

According to ANI Annual reports 2013 and 2014, the Project updated GINA database with information coming from all countries worldwide, including ANI countries. WHO headquarters specified that for GINA, data on nutrition policy and actions are gathered via three main sources: (i) existing WHO databases or WHO surveys and via Ministries of Health or

relevant partners, such as The International Baby Food Action Network (IBFAN) in Uganda; (ii) partner data bases, via partners' implementing or supporting programmes, to upload information about these (e.g. Global Alliance for Improved Nutrition (GAIN) or Coverage Monitoring Network (CMN), or with partners monitoring policy and action (e.g. ILO, FAO, WCRF) for data sharing; and (iii) Wiki approach. Registered users can also upload data, which then undergoes a verification process involving regional, country and government counterparts

Specifically, Regional and Global activities in Surveillance included:

- Paper on a monitoring framework and additional background papers
- Regional reports
- Workshops (3 workshops convened: Addis-Ababa, 2012; Zanzibar, 2013, and Uganda (2015))
- Development of GINA (updated with information coming from ANI countries)

Travel and technical support on CIP, designing surveys, capacity, policy dialogue etc.
The Regional and Global activities in Scale up were the following:

- Dissemination of eLENA
- Coverage map (1 workshop convened in 2014)
- Report on best practices (not done yet)
- Travel, technical support and dissemination (web)

Note that the report on best practices was not completed when the evaluation team visited the ANI countries; it was scheduled for Fall 2015.

3.4.6 Equity

Finding #10: ***The ANI project supports women in the full exercise of their fundamental rights and includes gender considerations into nutrition programming that are very promising.***

ANI's project documents and reports do not explicitly provide a comparative gender analysis. However, program data throughout the collection and survey process is disaggregated by sex and other variables associated with vulnerability, such as age or socioeconomic status (for scale-up activities) as part of routine surveillance activities.

ANI's methodology arrived at gender awareness by concluding that pregnant and nursing women, and infants and young children are disproportionately affected by malnutrition due to their increased physiological needs. Accordingly, ANI emphasized programming to strengthen service delivery for those most vulnerable to malnutrition – women, infants and young children. These groups were specifically targeted for monitoring and prevention activities.

In addition to evidence-based knowledge substantiating that pregnant women and nursing mothers are at a higher risk of malnutrition, the Team observed the impact of cultural norms on nutrition issues. Anecdotally, local actors referred to the cultural perception that nutrition was a women's issues – not only because certain women were at a higher risk of nutrition, but also because women are traditionally responsible for attending to the children's eating habits and schedule. In at least two of the case study countries, community health workers discussed the importance of enhancing men's awareness of malnutrition risks.

In Uganda, for example, ANI programming addressed the cultural element by crafting trainings for men, in particular. During interviews with the Team, men candidly reported that they often acted to assure their own access to nutritious food outside of the home, but did not prioritize the same for women and children in their home. Through sensitization activities

implemented under the ANI project, these men discovered the implications of their inequitable treatment of women and children (whether intentional or unintentional) when it comes to proper nourishment. Indeed, the approach taken in Uganda was particularly effective because the programming also educated the men on supplemental benefits of nutrition equity, such as, an improvement in the overall health of the family; decreased medical visits; and less bickering in the home. Although these results are not quantified and appear to be positive, the Team finds that the shift in the men's attitudes indicates the importance of integrating gender considerations into nutrition programming.

In Senegal, the majority of community health workers the Team met with were women. However, health workers (of all genders) stressed the importance of men's support – especially local secular leaders and religious leaders – in endorsing nutrition programming. Although the participation of male leaders did not appear to be a formal action step in the implementation phase, health workers indicated the necessity of an endorsement from local leaders – all men with one exception – to successful perform surveillance activities. These on-the-ground practices demonstrate both a clear appropriation of project activities by local actors and community members and a strategic approach to addressing inherent gender bias for nutrition in vulnerable areas. These anecdotes are supported by the Team's conversations with the heads of medical centers who report that the surveillance systems provides a fast mechanism for identifying interventions to address cultural and behavioral practices, which may be adversely affecting the nutrition of the vulnerable groups targeted by ANI.

Field visits and engagement with health workers and beneficiaries demonstrated the significance of integrating gender sensitivity for ANI activities. Men's participation is a chief aspect for fostering men's improved understanding of women's needs, thus establishing sustainable changes in nutrition practices.

Finally, the Team did not find any particular strategy proposed by the Project in order to encourage greater participation of women in the management and implementation of the project. Nevertheless, the Team engaged with women involved with ANI at all levels – in the WHO country office, at the ministry level and within the ministries' nutrition division(s), at the regional level where women served as focal points for health centers, and at health centers where women served as community health workers and as the coordinators of community health teams.

3.4.7 Factors affecting the project's performance and results

Finding #11: ***Although ANI has achieved significant results and good progress in the three implementing countries, certain factors affected the project's performance and results.***

In general, the participatory approach adopted by ANI positively contributed to the Project's performance as it has resulted in active engagement, commitment and ownership. However, several factors challenged the Project's performance: (i) WHO lacked the time to implement properly ANI; (ii) ANI's country-based project teams benefitted from IST's guidance to implement the CIP, but staff were sometimes inexperienced and the operational environment appears unclear (without clear operating guidelines); (iii) WHO underestimated the technical needs specific to nutrition to support more efficiently the strengthening of national nutrition surveillance system(s); and, (iv) ANI's country-based project teams experienced challenges in regards to administrative processes and timely access to financial resources.

As discussed in earlier chapters, WHO successfully developed a strong basis for collaboration with key partners, especially national Ministries of Health, to establish a

common view on the project's strategic approach, priorities, selected nutrition surveillance indicators, implementation plan and methodology, etc. This first step took longer than expected, and one reason for this is that ministry nutrition teams were often understaffed, even in countries where nutrition is officially considered an important health issue. Moreover, based on the case study countries, nutrition issues attract many partners and national teams track numerous activities across the country simultaneously requiring a complex exercise to plan and coordinate. A Ministry's capacity for project implementation should be carefully assessed as a first step, even when a project plan calls for implementation in the field (here, the district level) and especially since the mobilization of a ministry's nutrition team may also depend on the amount of donor investments.

WHO technical support from the IST or the HQ was highly appreciated, but the operational environment led to some confusion. More guidance on some project management aspects (procedures, reporting) would have helped. Country teams did not always know how and where to start with the ANI implementation. The "Standard Operating Procedure for the ANI Project" document informed discussions (especially during an orientation meeting held in Zanzibar in 2013), which ultimately clarified and helped establish processes for communications, reporting, coordination, etc. Implementing large-scale projects across several countries presents operational challenges, which necessitates strong management and coordination mechanisms.

WHO has extensive expertise in disease surveillance, and nutrition surveillance has been a key domain of intervention for decades. WHO works with competent and experimented specialists, however, very few are actual nutritionists. External nutritionist consultants often provide guidance to the project because of the complexity of the development, establishment and strengthening of nutrition surveillance routines that must follow precise steps, and the WHO was obliged to provide "on-job learning" during the project's implementation, positive from a capacity building perspective, but on the other hand further delaying the activity timeline. However, ANI is reviving WHO's interest in the topic and providing a model for WHO's support to countries.

Administrative processes and access to financial resources on a timely basis was also a challenge during the implementation phase. The problems occurred at both the levels of WHO's internal administrative processes and the country's administrative processes. Procedures for establishing formal partnerships with governments are well defined and operational, and WHO was sometimes obliged to suspend disbursements channeled to governments until it received the precise justification. Some activities were consequently slowed down, suspended or postponed although in some cases WHO agreed to take responsibility for the activity's implementation. The NGOs partnerships also demanded specific contracting arrangements – the establishment of which took a while and generated delayed access to financial resources. Moreover, governments do not budget sufficient funds for their nutrition sectors and national nutrition teams often lack the financial resources to perform with any regularity their monitoring and supervision activities in the field. This also affected the project's overall timeline.

3.5 Efficiency

3.5.1 Cost-effectiveness of the ANI project

Finding #12: ***Across the board, resources and inputs of ANI project were not converted into outputs according to schedule and within the given budget, especially the Scale up component, which was nevertheless the most efficient in achieving significant results. Most of t*****he countries however succeeded to disburse the ANI**

funds budgeted despite the short timeframe. ***It is unlikely that the ANI project will disbursed the remaining funds by December 2015, the Project's end date.***

Output costs (Efficiency)

ANI resources and inputs were not generally converted into outputs on time and within the planned budget. Case study countries either overspent in some activities, ran out of budgeted funds before the end of the project or didn't disburse or implement all the activities as scheduled in the CIP. In general, the countries however succeeded to disburse the ANI funds budgeted despite the short timeframe.

The Scale up country, Uganda, experienced the most difficulties to disburse the planned budget, and to implement the activities in time. Uganda's Scale up interventions were far more complex with a very large budget in comparison to the Survey and Surveillance budgets of the ANI countries. Nevertheless, Uganda delivered their integrated package to the six selected districts. These packages achieved the most significant and sustainable results, in comparison to Zimbabwe and Senegal. The WHO Uganda Country office showed flexibility to adapt the activity timeline and readjust the budget according to the districts' needs, which were seen as crucial to the process. The WHO and Ministry of Health were perceived as very supportive by the districts and contracted NGO who cited the organization of workshops and development of guidelines as examples. However, the WHO's management modalities were not optimal for implementing the Scale up project (challenges included understaffing; new employees learning ANI's procedures without much preparation; long procurement procedures, bureaucracy, etc.), the level of effort attributed to the implementing partners was underestimated and the delayed start of the project reduced the available timeframe for the overall ANI implementation in the country.

In Zimbabwe, the Country office has to manage a smaller amount ($574,000) for Surveillance project (with the Survey component), i.e. a quarter of the Scale up project budget. The achievement of the results was below expectations, but the project succeeded however to disbursed all the amount budgeted. Time, funds and expertise required for effective implementation were underestimated, especially to complete the Food and Consumption Survey. As discussed, capacity building activities have been implemented in fewer districts than planned, and the delivery of the main survey, which cost 60% of ANI total's country budget, was delayed. Its late delivery, rescheduled for October 2015) threatens project gains if the data collected are no longer valid — and no longer of any use according to stakeholders. During the Team's visit in September 2015, stakeholders expressed concern because the window of opportunities to use the data in the survey was rapidly closing. WHO however contested this concern, since this kind of surveys are made every ten years and, consequently, data will be useful for a long period.

ANI project just received additional funding from the headquarters in order to continue implementing the planned training in the 4 pilot districts.

The budget to deliver the Surveillance project in Senegal was the smallest as were the activity results, especially since part of the budget was used to cover other activities than those planned and approved in the CIP. Almost half of the ANI budget in Senegal finances was consumed by unplanned interventions such as the national nutrition surveys. Much remains be done in Senegal to assure sustainability of the national nutrition surveillance system, including continuous supervision by the Ministry of Health, data quality control, data analysis, in real time and the resulting informed decision-making. In the Senegal case-study, we concluded again that WHO modalities weren't optimal to manage the procurement process, especially concerning contracting of nutrition staff.

Disbursement rates

The project's total disbursement rate from the start of the project in 2012 and the September 2015 evaluation reached 80%, or an amount of US$14.4 million of the US$18 million ANI grants, as shown in Table 6 hereafter. In September 2015, the total remaining funds was $3.6 million ($1.76 million for Scale up and $1.87 million for Surveillance). It is unlikely that the project will disburse the remaining funds by December 2015, the termination date of the project.

Two of the three case study countries, Zimbabwe and Senegal, depleted their entire budget at the evaluation moment in September 2015. Uganda disbursed 80% of their CIP budget. Although all three countries evaluated did not disburse the funds as planned in their Country Implementation Plan (CIP) 2012-2015, as presented in Table 7 here after. Uganda only spent 6%, Senegal 63%, and Zimbabwe 76% of their planned first year budgets. The countries overspent in the second year (2013-2014). In the Scale-up Uganda, the current rate of disbursement is 81 % for the Scale up component and 45% for the Surveillance component between 2012 and 2015.

Some budget discrepancies were observed in Zimbabwe and Uganda.

The Zimbabwe Implementation Plan (CIP) budgeted an amount of $625,400, but presented a total of $574,000, which was the amount granted (and finally disbursed at 100%). The Zimbabwe Country office also charged 10% on the total to cover ''Operations costs'', i.e. ''bank charges, office operations, stationery, equipment, fuel and so on''. According to the Country office, the projects always incur these administrative operational costs and the WHO operations team has advised that ANI should always budget up to 10% operations costs for project activities. However, an amount of 13% on the ANI Total Budget was already budgeted as an administrative fee to cover the administrative costs for WHO incurred by the project, as explained below in accordance with the World Health Assembly Resolution WHA 34.17 (See Input costs - Economy). Hence, if one follows the advice of WHO operations team, WHO receives two times the administrative fee.

In Uganda, an amount of $1,875,000 was originally planned for the CIP out of a total grant of $2,350 million. An additional amount of 475,137 CAD has been allocated to Uganda at the end of 2013, following a reprogramming exercise with DFATD, available for Scale up interventions, but hasn't been planned and allocated yet. These are mainly savings coming from salary costs that have been reduced.

More details are presented in the detailed project budgets in Detailed Budgets Appendix B.

Input costs (Economy)

The relative costs of delivery in Uganda, Zimbabwe and Senegal are moderate, namely 33%. The ANI project spent $5.9 million of the total budget to deliver the project (project administration, ANI WHO staff and travel and per diem to provide support and technical expertise for the ANI planning and implementation, consultant fees for regional reports). The Scale up countries spent overall an amount of $3.0 million[24] on the $10.2 million grant on personnel, travel and per diem for technical expertise and administration, i.e. 30% of the total program costs. The Surveillance countries spent $2.9 million[25], i.e. 37% of the total on $7.8 million grant (See Detailed Budgets in Appendix B).

[24] Total disbursed 08.09.15 under i) Project administration, ii) country and HQ staff, iii) Travel

[25] Total Disbursed 08.09.15 under i) Project administration, ii) Regional and HQ staff, iii) Technical support (travel and per diem), iv) Consultants for regional reports such as presented in Detailed Budgets Appendix B

The project attributed about the same amount on staff salaries to each of the two components, but the regional staff (that are paid by the Surveillance budget) spent a greater amount of their time on Scale up countries. Indeed, the Uganda Country office needed fare more support than the other two countries visited because of the size of the budget and the cumbersome implementation modalities such as contracting various local NGOs to implement the project.

In line with the allocation planned in the two Estimated Grant Budgets and agreed between the Government of Canada and the WHO, the total grant budgets for the ANI project of Surveillance and Scale up allocated 62% of the funds to the planned Direct, Regional and Global activities between 2012 and 2015, as shown in the Table 6 on the Total ANI Budgets. A quarter of the grant (25%) was to pay salaries in Headquarters (2), Regional Office (3) and Country Offices (3), and 13% % covered administrative cost, according to the WHO legal framework.

The overall Regional and Global activities budgets mostly pay salaries of regional and HQ staff, i.e. 75% and 60% respectively of the Surveillance and Scale up budgets. Other Regional and Global activities concern workshops, data bases and mobile application for the WHO database eLENA, travel and technical assistance etc. as detailed below in Table 8 and 9.

TABLE 6: PLANNED AND DISBURSED TOTAL ANI PROJECT BUDGETS 2012-2015 (IN $CAN), DISBURSEMENT RATE BY CATEGORIES FOR ALL 11 ANI COUNTRIES (SURVEILLANCE AND SCALE UP PROJECTS)

	Total Grant Budgets*	Total Planned on Budget (%)	Disbursed 2013	Disbursement rate 2013 (%)	Disbursed 2014	Disbursement rate 2014 (%)	Disbursed 08.09.15***	Disbursement rate 08.09.15 (%)	Total Disbursed as on 08.09.15	Total Disb. rate as on 08.09.15 (%)	Balance as on 08.09.15	% of Remaining Funds as on 08.09.15
All Activities (Direct and Reg & Global)**	11 189 503	62%	1 177 049	11%	4 524 246	40%	2 817 227	25%	8 518 522	76%	2 670 982	24%
Staff (All)***	4 419 700	25%	1 125 904	25%	1 510 466	34%	867 060	20%	3 503 430	79%	916 270	21%
Monitoring and Evaluation	320 000	1,8%	6 262	2%	74 557	23%	198 494	62%	279 313	87%	40 687	13%
Project Administration	2 070 797	13%	300 198	14%	794 205	38%	976 394	47%	2 070 797	100%	0	0%
Total ANI Budget	18 000 000	100%	2 609 413	14%	6 903 474	38%	4 859 175	27%	14 372 062	80%	3 627 939	20%

*Two grant arrangements have been signed for the ANI project in an total amount of US$18 million, US$7,8 million for Surveillance and US$10,2 for Scale up;
** Exclude salaries staff (3 Country's staff, 3 Regional and 2 Headquarters);
*** Staff include HQ ($600,000) and Regional staff ($1,8 million) salaries from Surveillance project and HQ ($600,000) and Country staff (1.4 million) salaries from Scale up.
Source: WHO's Surveillance and Scale up management financial report 08.09.15 and Annual WHO ANI reports 2013 and 2014.

TABLE 7: PLANNED AND DISBURSED COUNTRY ANI PROJECT BUDGETS 2012-2015 (IN $CAN), DETAILED DISBURSEMENT RATE BY PROJECT FOR UGANDA, ZIMBABWE AND SENEGAL

	Total Grant	CIP Planned Budget	CIP Budget gap*	CIP Planned 2013	Disbursed 2013	Disb. rate 2013 (%)	CIP Planned 2014	Disbursed 2014	Disb. rate 2014 (%)	CIP Planned 2015	Disbursed 08.09.15***	Disb. rate 08.09.15 (%)	Total Disbursed 2015	Total Disb. Rate on CIP (%)	Balance as on 08.09.15
Uganda	2 350 137	1 875 000	475 137	1 160 000	73 172	6%	485 000	1 085 458	224%	230 000	359 010	156%	1 517 640	81%	632 497
-Scale up	n/a	1 675 000	n/a	1 010 000	73 172	7%	450 000	995 458	n/a	215 000	n/a	n/a	1 361 000	81%	
-Surveillance	n/a	200 000	n/a	150 000	0	0%	35 000	90 000	n/a	15 000	0	0%	90 000	45%	
Zimbabwe	574 000	625 400	51 400	193 800	147 670	76%	370 800	367 148	99%	60 800	59 162	97%	573 980	100%	20
-Surveillance	200 000	251 400	51 400	109 800	42 694	39%	80 800	35 452	44%	60 800	57 357	94%	135 503	54%	
-Survey	374 000	374 000	0	84 000	149 226	178%	290 000	265 202	91%	0	0	-	414 428	111%	
Senegal	200 000	200 000	0	127 000	80 418	63%	39 000	113 423	291%	34 000	5 358	16%	199 199	100%	801

* Gap: In Uganda, an additional amount of $475,000 has been added in a reprogramming exercise with the donor, but not yet planned and disbursed; In Zimbabwe, the amount in italic is the one that has been budgeted: i.e. $625,400 and not US$574,000 as presented in the Zimbabwe Implementation plan budget.

Source: Scale up and Surveillance Management Financial Reports 08.09.15 and Annual WHO ANI reports 2013 and 2014

TABLE 8: REGIONAL AND GLOBAL ACTIVITIES SURVEILLANCE ANI PROJECT BUDGET 2012-2015 (IN $CAN)

Regional and Global Activities	Planned	Disbursed 2012-2015	Proportion of Activities on Total	Disb. rate (%)
GINA data base	60 000	94 892	23%	158%
Indicators	40 000	53 862	13%	135%
Regional reports and consultancy	100 000	48 737	12%	49%
Workshops	100 000	52 283	13%	52%
Travel and technical support on CIP, designing surveys, capacity, policy dialogue etc.	177 700	167 238	40%	94%
Total	477 700	417 012	100%	87%

Source: Scale up management financial report 08.09.15 and Annual WHO ANI reports 2013 and 2014

TABLE 9: REGIONAL AND GLOBAL ACTIVITIES SCALE UP ANI PROJECT BUDGET 2012-2015 (IN $CAN)

Activities	Planned	Disbursed 2012-2015	Proportion of Activities on Total	Disb. rate (%)
eLENA (mobile app and translations)	70 000	112 000	36%	160%
Coverage map (workshops)	30 000	30 000	10%	100%
Report on Best Practices	30 000	0	0%	0%
Travel, technical support and dissemination (web)	245 867	165 000	54%	67%
Total	375867	307000	100%	82%

Source: Scale up management financial report 08.09.15 and Annual WHO ANI reports 2013 and 2014

3.5.2 Administrative and Management Efficiency

Finding 13: The efficiency of the Project's management is suboptimal, principally because ANI has not been sufficiently mainstreamed into the WHO. A parallel project management system was established, but with insufficient capacity to reach the objectives in the given timeframe, in particular concerning the labor-intensive scale-up component.

ANI is a highly complex project, operating in eleven African countries, executing two different types of programs (surveillance and scale-up) and with designated staff at four WHO governance levels. In order to manage such a level of complexity, a clear operational framework is necessary. However, at the general organizational level, WHO does not have guidelines and rules for project management. A legal framework for donor funding exists, rules and regulations for financial management of its regular budget have been developed, and a general accountability framework has been defined, but the e-manual with the WHO rules and regulations lacks clear standard instructions for project management, and thus doesn't facilitate the task for Award Managers.

In this complex and uncharted operational environment, the ANI Award Manager has made a laudable effort to develop a standard operating procedure (SOP) for the project. However, the document is incomplete, as it describes the roles but hardly the responsibilities of the various staff involved, and is silent on financial control and financial reporting. Moreover, the status and legitimacy of this SOP is not clear because the document is still a draft and hasn't been validated by the Project Steering Group, which did not want to deal with a matter of competence of the WHO Secretariat.

The reporting system proposed by the draft SOP is based on the logframe which was presented in the Project Concept Note (which serves as the Project Document in absence of a full-fledged PAD), and is geared towards the annual report to the donor. However, the country teams logically report on progress with respect to the CIPs. In the absence of a standard reporting instruction to the country teams, the country reports differ both in format and time-frame, and the nutrition experts are obliged to submit duplicitous reports – one for the WHO Country Representative, and one for the Regional Office and/or Inter-regional Support Team.

The lack of a straightforward project accountability framework ("who is responsible for what") is a crucial issue in the ANI-project. At the country level the ownership of the project isn't clear. Logically the WHO Country Representative should bear the final responsibility for the CIP, but the country offices haven't fully mainstreamed the ANI-activities in their planning, resource-allocation, control, and monitoring process. The designated country nutrition officer is performing most of the project-management work with support from the regional nutrition experts hired by the project, but without much formal mentoring from the country offices itself.

In particular procurement and contract-management are a burden for the nutrition officer in the Country Office, tasks for which they lack the necessary experience. No training was given to them and no clear instructions were given to procurement and administrative staff of country and regional offices to execute procurement and contract-management within ANI.

The ANI staff attached at the Inter-country support team and regional office carried a great deal of the project, as did the headquarters team for the Scale up countries, especially to support the country staff dealing with those issues of procurements. WHO-Geneva adopted a flexible and pragmatic approach for supervision and support missions. Participation in workshops is combined with field visits and the intensity and regularity of supervision depends on the needs of the country team and thus varies per country.

A priori financial control (before commitment of the expenditure) by financial officers of country office and/or regional office is inadequate, and left to the designated nutrition expert, who accumulates responsibilities, which should be separate according to financial orthodoxy. The financial officers in the country team perform an *a posteriori* control (just before payment) and do the bookkeeping. Within ANI, the nutrition expert in the country office plans the expenditures according to the CIP, and doesn't need to request clearance from IST neither from Geneva, and then commits the expenditures, and authorizes payment.

In certain cases, the absence of *a priori* financial control has led in certain cases to expenditures going beyond the planned expenditures, such as the food consumption survey in Zimbabwe.

The Award Manager at headquarters in Geneva is accountable vis-à-vis the donor, but has few tools to leverage quality of performance, due to the layered WHO-organizational structure. In fact, the office in Geneva is not a Headquarters but rather the Secretariat of the Director General. Regional Directors are appointed by member countries and operate autonomously from the Geneva office, except for the management of funds coming from Geneva, where they are accountable to HQ. Country officers report to the Country Representatives, who at their turn report to the Regional Director, as do the regional officers. In addition to his influence on financial management, the Award Manager also uses the workplans to exercise authority, as these are discussed collegially.

Although involved in the selection process, the Award Manager in Geneva thus has no formal responsibility with respect to the selection of the ANI-experts in the field – acting as

an observer – cannot be accountable for the financial and technical country office reports, including ANI financial country reporting, and has no influence on financial management either. His sole leverage is his role in the approval of the CIPs, and the transfer of project funds to the eleven countries. In hindsight with the WHO's actual organizational structure, it would likely have been better to sign the financial agreement with the Regional Director of WHO and have Geneva playing its usual normative and supportive role.

A specific example of the limited power of the Award Manager is the two-year contracts given to the ANI-staff in the region and in the countries despite the wish of the Award Manager to provide them contracts for the full project period of three years. At the end of the two year contracts, the officers were obliged by WHO-rules to take a leave period before getting a contract extension, which caused, of course, another delay of the Project's execution.

A specific example of ANI that has not been sufficiently mainstreamed in the WHO-organization is the fact that none of the Country Office representatives from Uganda, Tanzania or Ethiopia that participated on the Project Steering Group (PSG) were involved in the meetings or in the selection of the nutritionist ANI staff.

The Project Steering Group is the highest governance body of the Project, and given its composition, could have fostered Project mainstreaming and strengthened the leverage of the Award Manager. However, the PSG hasn't functioned well and didn't regularly meet according to the WHO documentation provided.

From a results-based management perspective, the CIPs are the key documents, and much time was taken to develop and validate these plans. However, the progress reports on the implementation of the CIPs, are input/activity-based rather than output/outcome-based and the financial reporting follows the standard nomenclature of the WHO country office budgets and doesn't permit linking the expenditures to the project results. Consequently it is not possible to qualify the efficiency and difficult to evaluate the effectiveness of the project activities, as discussed in the Chapter 3.3 on Aid Effectiveness.

ANI is a project that has successfully fostered attention for nutrition within WHO at all levels, and has increased the operational capacity of the organization to deal with nutrition issues. Up to 40 WHO Country offices have sent formal request for nutritionist to NHD headquarters. However, the Nutrition Department hasn't developed yet a strategy to sustain the additional expertise engaged by the project.

Table 10 on the next page summarizes the strengths and weaknesses of the Project.

TABLE 10: SWOT ANALYSIS OF ANI PROJECT MANAGEMENT

STRENGTHS ▪ Nutrition expertise reinforced at all administrative levels of WHO (Geneva, Region, Country); ▪ Strong alignment with country policies and needs: Country Implementation Plans validated by stakeholders; ▪ Strong commitment of staff involved; ▪ Initiative to develop a Standard Operating Procedure for the project. ▪ Broad composition of Project Steering Group, chaired by Regional Office	WEAKNESSES ▪ WHO lacks operational framework for project management: responsibilities of various staff involved unclear; a priori financial control absent; no real buy-in by Country Office and project creates a management structure parallel to the CO; ▪ Accountability framework inefficient: Award Manager no real leverage on project execution and on project performance; ▪ ANI not well mainstreamed into the WHO organization, specifically at the regional and country levels, and hence can't fully rely on the regular WHO-staff, leading to a capacity burden (e.g. procurement); ▪ Procurement is a burden; too much project management responsibilities for the nutrition expert in the Country Office; ▪ Main project governance body, the Project Steering Group, doesn't meet on a regular basis; ▪ No standard for reporting and accounting nomenclature not adapted to results-based management; ▪ Contracts for staff recruited under ANI not aligned with project duration, which causes delays due to forced leaves in between contracts.
OPPORTUNITIES ▪ Strong country engagement; ▪ Field-experience gained with the scaling-up part of the project; capacity of implementation partners strengthened; ▪ WHO has developed relationships with Non-government partners; ▪ Need felt within WHO to develop operational framework for project management. THREATS OR RISKS ▪ Lack of strategy to sustain the nutrition expertise brought in by the project.	RECOMMENDATIONS ▪ Develop a Standard Operational framework for Project Management (Operational Rules and Guidelines), such as ANI using the draft Standard Operation Procedure for ANI as a start; ▪ Develop a strategy to sustain the nutrition expertise the WHO has been able to attract thanks to the ANI-project; ▪ Request ANI country WRs for suggestions on how to mainstream ANI activities and to propose an operational framework for project management at country level to facilitate similar project work in the future; ▪ Mainstream the remaining project activities in the regular planning and management of the Country Offices and use the procurement experts and financial controllers in the country's and / or regional offices; ▪ Organize an independent external financial and management audit at the end of the project.

4 Lessons learned

The following lessons and best practices are observations from the field and from NGOs implementers:

Adequacy of project design:

- Adopt a "bottom up" approach, including CSOs, to ensure that funding and project interventions adequately adapt to the needs of districts and health facilities for a stronger and better nutrition surveillance.

Adequacy of interventions designed and planned:

- Integrate data quality assurance at district and facility levels as an ANI project component;
- Adopt a realistic sequence diagram: taking into account how processes operate with one another; in what order and realistic timing required for each sequence;
- Adopt a realistic project timeline: take into account the necessity of 1-2 year preparatory phase for a behavioral change program; effective training shouldn't include more than 15 participants per class.
- Strengthen the multi sectoral approach to ensure crop diversification; food availability for household consumption;
- Train nurses aids and community workers;
- Associate surveillance to scale up activities, specifically growth monitoring and promotion (clinics and community).

Implementation mechanisms:

- Use of Direct Disbursement Mechanism (DDM): allow fund management by Districts conditioned upon validation of district's annual ANI project workplan by WHO and Ministry of Health Nutrition Department.

Alignment with country nutrition priority:

- Assess the Ministry's capacity to implement the first stage(s) of projects or programs: even if project implementation is planned by the field (district level), the central administration will have to do some planning and coordination, which remains a key issue for program/project success, and often represents ministry weaknesses.

BCC interventions:

- Implementation of community-based BCC projects requires time to engage communities more effectively in order to monitor and gain sustainable changes;
- Integration of GMP with other interventions such as food demonstrations, dialogues and health education helps reach the target audience with more interventions at ago;
- Home visits by VHTs help reach those who do not go for GMP sessions within the community;
- VHTs are motivated through recognition and respect from the community.

5 General conclusions

5.1 Relevance

Conclusion #1: ***The ANI Project responds to a real need felt by actors dealing with malnutrition in Sub-Saharan Africa, and was guided by a participatory approach that leads to strong country ownership.***

The outcomes are valid and the activities are coherent with Project objectives, in particular the strengthening of existing nutrition surveillance systems to ensure sustainability.

Although specifically required by the donor, the association of the Scale up and the Surveillance components proved to be a good idea, because the integration of practical activities and data-gathering appeared to reinforce each component. The formulation of scale-up activities demonstrates the need for good data, and data-gathering was reinforced by the practical interventions.

On the other hand, the short project duration imposed by the donor compromised the success of the project and the Country Implementation Plans, undergoing a long preparation process, could not be fully implemented.

Information systems and statistics for nutrition in Sub-Saharan Africa are usually weak and underfunded. Government and United Nations agencies, donors, global health partnerships, are generally requesting for more and better health data.

ANI responds to this long term issue in nutrition and more importantly, sparked the interest of the government and the donors, as it was sometimes the only project dedicated to strengthening existing nutrition surveillance system(s), as in Zimbabwe. The coordinated process — country-led, using a participatory approach and working with multiple partners[26] — was long and sometimes cumbersome, but led to one of the strongest results of the evaluation: real ownership of the ANI Project by government counterparts.

Indeed, the project was viewed as a Ministry of Health project rather than WHO's in all case study countries.

Project activities were generally coherent and responsive to the needs of governments, districts and health facilities, especially in countries such as Uganda, where the scale up project is coupled with surveillance. That design was highly valued by governments, the WHO and other donors, because of the complementarity of the interventions. All ANI activities were not, however, implemented, due to a lack of time and/or lack of resources. Despite the meticulous project preparation process, the planning did not adequately consider the time and resources allocated to the ANI Project. ANI's contractual duration was far too short; as an evidence: the length of the CIP approval that increased the complexity of the Project, and reduced the effective implementation time to less than two years, contradicting the general understanding that capacity building and health system strengthening requires a long-term perspective[27].

[26] Ministry of Health and close UN partners: REACH, FAO, UNICEF and WFP and the SUN movement.

[27] WHO, Everybody's Business – WHO's Response to the Health systems challenges, p.30.

5.2 Sustainability criteria

Conclusion #2: ***ANI produced sustainable outputs, such as tools, guidelines, training modules, and the inclusion of nutrition indicators into DHIS2. Despite its potential, it did not have the time and resources needed to attain the ambitious goal of establishing sustainable information systems in partner countries (as expected in the project's logical framework). As a consequence of the short timeframe, known from the start, ANI should have developed an end-of-project strategy to sustain Project results.***

The ANI Project design ensures sustainability in supporting existing nutrition surveillance systems as required by the donor. In the three valuated countries, only Senegal supported at the same time the existing Health Monitoring Information System (HMIS) and a sentinel surveillance system upon the Ministry of Health's request. Considering the unsustainability of a parallel system, it questions the position of WHO when a conflict arises between supporting sustainable interventions as requested by the project design, and respecting the country leadership over their program.

ANI implemented its interventions in fewer districts than the project initially considered, i.e. 8% and 7%, respectively, in Uganda and Zimbabwe instead of the 25% objective. That coverage is too low to consider any sustainable impact on heath surveillance system strengthening. In Senegal, the ANI project covered 100% of the districts with UNICEF, but according to the WHO and stakeholders activities implemented were still not sufficient to ensure a sustainable nutrition surveillance system.

ANI interventions delivered sustainable outcomes, such as incorporation of additional elements into HMIS, Registers and Health Reports, and increasing the availability of adequate tools for evidence based decisions, such as a revised list of nutrition indicators, routine surveillance guidelines, an adequate allocation of funds for printing and distribution of the revised HMIS tools to health facilities and key staff capacity building. Some strategic training has been complementary, for instance, in planning and budgeting to help districts to advocate for their funds.

Long term commitments are particularly important in strengthening institutional country systems, and continuing the project timeline and resources is thus important to make training activities sustainable, i.e. effectively enhancing the capacity of the health workers. The ANI project should consider mainstreaming core nutrition activities into the regular planning of the WHO country offices and develop an end-of-project strategy (building on the investments in the local institutions) considering the very short timeframe, especially since the nutrition package raised high interest in the donor community.

Fostered by ANI, the WHO Regional Office (AFRO) provided WHO country offices the opportunity to streamline nutrition interventions and incorporate them into their biannual budgets. Yet, the WHO and the Ministry of Health haven't launched formal discussions with other donors and the Ministry of Finance to secure continuous funding for the Surveillance and Scale up activities of ANI.

ANI also successfully fostered attention for nutrition within WHO at all levels, and has increased the operational capacity of the organization to deal with nutrition issues. However, the Nutrition Department hasn't developed yet a strategy to sustain the additional expertise engaged by the project.

5.3 Aid effectiveness

Conclusion #3: ***WHO generally respected the agreed principles on Aid Effectiveness, but can improve the focus of its results management. The financial reporting is not linked to results and the annual CIP reports are activity-based rather than results-based, and don't follow the logframe. Moreover, the PMF framework hasn't been used by the project.***

As discussed above, all case study countries regarded the ANI project as a Ministry of Health project. WHO collaborated with the Ministry of Health by aligning the project with national programs, institutions and procedures, i.e. strengthening national capacity in nutrition and channelling funds to the Ministry of Health and/or districts whenever possible. In absence of these conditions, WHO implemented the activities with NGOs, but not without bureaucratic complications.

ANI harmonized its interventions according to CIPs, especially with REACH and SUN movement with uneven results according to the platform in each country. Roles and responsibilities aren't well defined which led to competency problems between the SUN focal point structure and the Ministry of Health. The question is whether the SUN focal point at the PM's or President's office, should have an operational role (e.g. fund allocation, project management, training, stakeholder mapping, etc.) or restrict himself to a political and coordination role.

Coordination in Zimbabwe operates well in comparison to Uganda where national nutrition funds committed by government and donors more than quadrupled Zimbabwe's funding. Harmonization among the UN organizations, especially between UNICEF and WHO should be strengthened particularly for surveillance activities with UNICEF and scale up interventions going on in the country. This collaboration provides an opportunity to harness approaches through the leadership of resource center, especially since strengthening HMIS was an approach recommended by the government to generate the routine nutrition information system. In general, SUN coordination is emerging rather than fully operational, and REACH, which was created to improve coordination in nutrition between the major UN players, still has work to do in order to harmonize agency initiatives. In line with the WHO RBM policy, ANI developed several planning tools, including the monitoring framework of the CIPs that duplicate the detailed PMF. In the end, the PMF was a parallel RBM framework with limited practical value even though WHO spent a great deal of money and time to produce it. The ANI financial reports were prepared according to the WHO's usual expenditure nomenclature for operational budgets, and not by ANI results as planned in the CIP — not an optimal way to manage project efficiency.

5.4 Performance issue: Achievement of expected outcomes

Conclusion #4: ***The project achieved most of its outputs and some outcomes, even if the activities were not implemented as scheduled in the CIPs; but its timeframe was too short to measure real impact. Indeed, only an involvement on a longer term should lead to effective nutrition surveillance systems able to informing action plans and being used for managing nutrition issues on a countrywide basis.***

Scaling-up nutrition actions were considered the best complement for surveillance system strengthening, according to Ministries of Health, the WHO and all stakeholders. Evidence-

informed nutrition actions were highly relevant to accompany surveillance activities as part of comprehensive nutrition programming.

Nutrition surveillance systems that were usually neglected by donors reignited interest from donors interested in robust and reliable health information systems in Sub-Saharan Africa countries, which are able to report on results and generate quality data to monitor health programmes, including nutrition. Upon further analysis of nutrition surveillance, the ANI project has been a starting point to propel large scale initiatives.

The surveys completed in Senegal, Uganda and Zimbabwe generally informed the government and the stakeholders in these countries. For instance, ANI's contribution to the Micronutrient Survey in Zimbabwe helped the government develop the National Nutrition Strategy, which stakeholders, such as the WFP, use to inform their organization's activities.

Even if the project hasn't met all its goals yet, ANI project have made a major contribution to revitalize the national health information system.

Yet, the project did not implement all activities due to time and budget constraints and an over ambitious planning. The targeted country coverage and number of beneficiaries are unlikely to be attained, and must be re-examined in WHO's final report. Specifically:

- In the Scale up country, Uganda, the results are the most promising. All targeted districts were covered (amounting to 8% of the country's districts - instead of target of 25% as planned in the Logic model); CIP planned activities have been implemented but on a lesser scale because of the delay of the project start date and the lengthy procurement process, especially the BCC component;
- In Zimbabwe, surveys consumed a great deal of the budget, especially the food consumption survey that wasn't yet delivered when the evaluation team visited the country, raising some concerns among the partners. The process to develop the list of nutrition indicators agreed upon for inclusion in the HMIS took two years, which slowed the sequence for implementation. Training only began in 2015 and does not fulfill what was planned in the CIP. Ministry of Health already undertook planning, especially concerning securing funds to pursue ANI activities and training.
- In the Surveillance country Senegal, all districts were covered. Senegal support some activities that were not within the initial program design implemented, such as the national nutrition surveys, that drained important resources away, almost half the Senegal budget, from those advancing ANI's objective: to strengthen the existing surveillance system.

5.5 Performance issue: Demonstration of efficiency and economy (managerial process)

Conclusion #5: ***The resources needed to implement the ANI Project and attain the intended outcomes were underestimated. In addition, the Project's timeframe was overambitious and not all inputs were thus converted into outputs on time and within the scheduled budget, particularly regarding the Scale up component, which was nevertheless the most efficient in achieving significant results. Most of t*****he countries however succeeded to disburse the ANI funds budgeted despite the short timeframe.** ***It is unlikely that the Project will disburse the remaining funds by December 2015, the termination date of the project.***

ANI had to operate in a complex WHO environment, with an Award Manager at Headquarters accountable to the donor, but without any real influence on Regional

and Country offices. Moreover, WHO doesn't have a clear Standard Operational Framework for Project management, notably projects cross-cutting all layers of the organization (such as ANI).

Around 20% of the total ANI budget remains to be disbursed before December 2015, i.e. $3.6 million as of September 2015.

In the assessed countries, Senegal and Zimbabwe disbursed the entirety of all budgeted funds, but not always as scheduled. Uganda disbursed 80% of its planned budget and achieved the most significant results with the integration of Surveillance and Scale up components. An additional amount of $475,000 USD is still available, but hasn't been planned or allocated yet.

Generally, the CIPs were planned carefully with the Government and the donors, ensuring quality of the document. However, the planning did not systematically take into account the very short timeframe allocated in consideration of the allocated resources, as previously discussed.

With an allocation of approximately 33% of its budget used for project delivery costs, which included administration costs, travel, technical assistance and consultant fees, the ANI project can be considered as moderate cost-efficient when compared to standard benchmarks. The Scale up component costs more than the Surveillance because of the important technical assistance requested by the country to execute the Project. ANI benefited from a very strong commitment of staff involved, but management modalities were not optimal: understaffing; sub-optimal contractual modalities for ANI-staff; no preparation period for new staff; long procurement procedure; administrative burdens; and the level of effort attributed to the implementing partners that was underestimated.

The ANI-project could have been more effectively mainstreamed into the WHO itself, as a core activity of the institution, instead of a project with parallel management and reporting systems.

Although WHO hired nutritionists in country offices, the staff faced reasonable challenges in becoming operational and quickly knowledgeable with the complexity of the WHO culture, local context, and all details of the ANI project – governance and management structure and program design. More favorably, WHO provided country teams access to its pool of experts at all levels of offices involved (CO, RO, IST, HQ). Indeed, the WHO inter-country support team was instrumental in the success of ANI Project by providing solid support to country offices, Ministries of Health and NGO implementers.

6 Recommendations

The following recommendations are derived from the evaluation findings and conclusions.

Recommendation #1: No-cost extension of the ANI program

That WHO pursue its activities with a no-cost extension given by DFATD between six months and one year.

- ***That the ANI Country offices analyze their remaining financial needs and plan their activities according to their priorities, supported by dedicated staff in HQ and the Regional Office.***

It is highly recommended to complete ANI, making it possible to measure concrete outcomes at the level of targeted communities and to promote the approach with partners and other donors. The remaining funds primarily concern the scale-up component, and although the scale-up activities aren't part of the usual WHO-programme, they are considered key to fostering sustainable changes in the practices of the target groups. WHO should be enabled to complete properly this pilot initiative.

That extension would also facilitate the establishment of monitoring and supervision of districts health centers and community health facilities, which are supported to ensure improved quality data control.

Recommendation #2: Sustainability strategy

That WHO develops a sustainability (end-of-project) strategy to ensure that the Project's results will sustain.

- ***That the ANI Country Offices prepare an end-of-project strategy, and incorporate key nutrition-related support to the Health ministry in their core workplan, supported by dedicated staff in HQ and the Regional office*.**

For the remaining period of the ANI-project WHO should mainstream the key project activities in the regular planning and management of the country offices involved. WHO should also utilize its procurement experts and financial controllers in the countries and / or region to apply principles of financial orthodoxy and bridge observed capacity gaps (e.g. procurement).

ANI is a project that has successfully fostered attention for nutrition within WHO at all levels, and has increased the operational capacity of the organization to deal with nutrition issues. WHO's Nutrition Department should therefore develop a plan to sustain the nutrition expertise the WHO has been able to attract thanks to the ANI-project. A reactivation of the Project Steering Group could be helpful in this respect.

Recommendation #3: Standard Operational Framework for Project management

That WHO develops a Standard Operational Framework for Project management, particularly for projects such as ANI, cross-cutting all the layers of the organization.

A Standard Operational Framework for Project management provides guidance and rules to project teams on roles, responsibilities and the way of doing, with regard to project preparation; financing agreement; contract management; procurement and financial management; technical and financial reporting; monitoring and supervision; auditing, and project closing.

Anticipating such a framework, the ANI Award Manager should further develop and finalize the Standard Operation Procedure for the ANI-project, and discuss this with WHO Management. This SOP should also include guidance on the interplay between Geneva and the Region (ROs and Cos) for projects with both global and regional elements. The finalized SOP for ANI could form the basis for a general Standard Operational Framework for Project Management.

- ***That ANI Country Offices evaluate their current practices with respect to the management of externally financed projects and provide input to the development of a Standard Operational framework.***

Recommendation #4: Audit

That WHO uses its own auditing rules to organize the mandatory end-of-project audit.

Both an internal or external audit is possible, but we recommend organizing an independent external financial and management audit at the end of the project, because of the magnitude of the project, but also because such an exercise will produce useful guidelines for an operational framework for project management.

Recommendation #5: Gender considerations

That WHO continues integrating gender considerations into nutrition programming.

Considering the high impact of cultural norms on nutrition issues, ANI programming that addressed gender issues, for instance by crafting specific training for men, gave positive results and should be promoted.

Appendix A Evaluation Framework

ACCCELERATING NUTRITION IMPROVEMENTS IN SUB-SAHARAN AFRICA: SCALE UP OF NUTRITION INTERVENTIONS EVALUATION FRAMEWORK				
Evaluation Criteria & Issues and Questions a/p TOR	**Evaluation Indicators**	**Data Sources (See questionnaire for details)**	**Data Collection & Analysis Techniques**	**Evaluation Team Responsibility**
A. Evaluation Issue of Relevance				
To what extent are the project objectives justified in relation to the country needs? Do they correspond to local, national and global priorities?	-Extent to which appropriate partners were involved in the program design, using participatory approaches that were inclusive of primary stakeholders' needs - Extent to which the selected initiatives were coherent with national and sub-national priorities (country-specific)	Program documents Country nutrition and health policy documents Academic literature Prominent experts Implementing partners (NGO) WHO program staff at HQ, regional and in-country level Direct partners (Health ministry) Donor: DFATD	Content analysis Literature review Telephone interviews Site visits: F2F interviews	**Lead : MJ N'GBESSO** With MC Rioux and M Guay
Are the approaches and strategies still relevant in the context of the changes in the global, regional and country nutrition landscape? If not, what changes should the stakeholders make to make it relevant?	- Extent to which the approaches and strategies (logic and objectives) are still valid to improve nutritional status of women and children in sub-Saharan Africa - Extent to which the selected initiatives were consistent with WHO's mission, especially the Nutrition for Health and Development (NHD) - Views on whether the assumptions made to determine the design of the project were adequate and what changes should the stakeholders make to make it relevant		Content analysis Literature review Telephone interviews Site visits: F2F interviews	**Lead : MJ N'GBESSO** With MC Rioux and M Guay
Evaluation Issue of Effectiveness (Quality of performance and extent of results at the Country Level)				
Lead: MC Rioux With MJ N'GBESSO and M Guay , 1300.	1100. 1) Perception of the Health worker's capacity to do surveillance 2) Number of WHO Essential Nutrition Actions (ENAs) being implemented by the total number recommended 3) Number of strategies with objectives and goals (establishing a results framework that includes programs to scale up the ENAs – in Zimbabwe only). National programs align with a results framework that includes the ENAs 1200. (200,000) women and (150,000) children received nutrition intervention Data collected on four coverage indicators that were collected through coverage surveys 4) Proportion of children < 6 months who are exclusively breastfed; 5) Proportion of children receiving a minimum acceptable diet at 6 to 23 months of age; 6) Proportion of pregnant women receiving iron and folic acid	1100 a. Secondary data including Program documents (PMF Baseline Data, Annual reports) and Primary data (Health workers; NGO implementers, WHO country offices) b. Secondary data (GINA and country policy and actions plans.) c. Secondary data and Primary data (national governments) 1200 (covered as an intermediate results 1210) 1300 Secondary data including Program documents (PMF Baseline Data, Annual	Literature review Site visits: F2F interviews, focus group when possible with health workers Content analysis Telephone interviews	

ACCCELERATING NUTRITION IMPROVEMENTS IN SUB-SAHARAN AFRICA: SCALE UP OF NUTRITION INTERVENTIONS EVALUATION FRAMEWORK				
Evaluation Criteria & Issues and Questions a/p TOR	**Evaluation Indicators**	**Data Sources (See questionnaire for details)**	**Data Collection & Analysis Techniques**	**Evaluation Team Responsibility**
	supplements; 7) Proportion of children with SAM having access to appropriate treatment including TFs 1300. 8) Appreciation of the quantity and quality of nutrition data that are (i.) collected, (ii.) analyzed, and (iii.) disseminated – at a) national and subnational levels and hard-to-reach population, b) disaggregated by gender and age, and c) at which frequency of data collection (at least once a year). 9) Perception of Policy-makers, development partners, media and district officials of the importance of nutrition - on whether stakeholders recognize prevailing problems relevant to the Global Nutrition Targets.	reports) and Primary data (national and subnational governments; WHO country offices and HQ)		
To what extent have the interventions produced the expected results (outcomes) of ANI funded interventions being achieved? More specifically, what evidence is there of the intervention and ANI instruments in the expected immediate results and effects of: 1110. Ability of governments to monitor changes in nutrition status and to target interventions to those most in need 1120. Capacity of governments to plan and implement nutrition strategies that can be targeted and modified. 1210. Access to evidence-informed nutrition interventions for women and for children less than five years of age, 1220. Capacity of health workers delivering preventive and curative nutrition interventions	10) Country's status on collecting national level representative data on the WHA targets (all evaluated countries score 3 to 1) 11) Perception of the government's capacity to collect, analyze and report nutrition data through routine data and through surveys by stakeholders (target of 70 %) 12) Number of health workers trained in nutrition surveillance Output 1111: Baseline data on core indicators established (all 7 outcome indicators are tracked nationally.) Outputs 1121: i. Nutrition surveillance systems strengthened, i.e. activities are in place to support data collection data analysis and dissemination (score 3 to 1). ii. Ability of district systems to feed into national systems, with a focus on incorporating district---level data into the national system. iii. National information systems for health are assessed and gaps are identified iv. Nutrition and coverage indicators have been identified and integrated into national information systems V. Number of government staff trained under the ANI project to collect and analyze data 13) Number of beneficiaries (women and children less than 5 years of age, indicating whether interventions are reaching the most vulnerable) reached in the supported interventions areas (Target of 75%) 14) Health worker's perception of their capacity (quality of their	1110 (Covered as an Output 1111) 1120 Secondary data (Baseline and Annual reports) and Primary data (WHO country offices, national governments; NGO implementers, other key stakeholders) 1210 Primary data (WHO country offices, national government) 1220 Secondary data including Program documents (PMF Baseline Data, Annual	Literature review Site visits: F2F interviews Content analysis Telephone interviews Focus group with health workers when possible	**Lead: MC Rioux** With MJ N'GBESSO and M Guay

ACCCELERATING NUTRITION IMPROVEMENTS IN SUB-SAHARAN AFRICA: SCALE UP OF NUTRITION INTERVENTIONS EVALUATION FRAMEWORK				
Evaluation Criteria & Issues and Questions a/p TOR	**Evaluation Indicators**	**Data Sources (See questionnaire for details)**	**Data Collection & Analysis Techniques**	**Evaluation Team Responsibility**
1310. Access to information on national and global level(s) on nutrition progress, innovative options for nutrition programming, and good practices in delivering nutrition interventions.	knowledge and skills) to deliver nutrition interventions Output 1211: Nutrition action plan adopted by government (within the last 5 years; score 1 to 6) Uganda already reached the target-doc review) Output 1221: Number of healthcare workers trained in the delivery of trained interventions. 15) Proportion of the population covered by nutrition surveillance activities supported by the ANI project. 16) Number of ministry of health (Ministry of Health) staff trained in the use of eLENA. Output 1311 a) Nutrition reports provided to the SUN Secretariat. b) SUN networks in countries are aware of and discuss ANI activities on a regular basis.	reports) and Primary data (Health workers, NGO implementers, WHO country offices) 1310 Primary data (WHO country offices, national government)		
Could more results be obtained by using different instruments?	- Views on whether more results can be obtained by using different instruments and alternative strategies/approaches		Literature review, content analysis Telephone interviews Site visits: F2F interviews	**Lead: MC Rioux** With MJ N'GBESSO and M Guay
- **Evaluation Issue of Efficiency and Managerial process**				
Have the objectives been achieved at the lowest cost? Could there be a greater effect at the same cost? • How economically are resources/inputs (funds, expertise, time) converted to outputs? • Have outputs been achieved on time and on budget?	- Program Planned Budgets and Disbursed Budgets / consolidated by (evaluated) country and by objectives (if RBM apply) - Rate of disbursement / real and planned (gap); - Human resources / # consolidated by country and type of competencies. - Activities planning versus realized (Gantt chart or equivalency) - Proportion of ANI costs attributable to administrative overhead - Overall cost of in-country sub-project management and operations	-Administrative Agreements, Procedures Manual -Meeting minutes -Financial and human resource management plans file review -Annual financial statements, financial reports -Implementing partners, HQ, regional and in-country staff	Content analysis Literature review Telephone interviews Site visits: F2F interviews	**Lead: M. Guay** With MC Rioux and MJ N'GBESSO
Are program governance structures and management process conducive to efficient and effective administration of activities?	- Extent to which appropriate oversight has been exercised on initiatives and decision-making authority has been appropriately exercised and/or delegated to implementing partners. - Extent to which program management procedures were clear, streamlined and flexible enough to meet the needs of ANI and the needs of its developing country partners - Extent to which country partners have the appropriate framework and tools, especially RBM principles and practices, to make decisions and take action with regards to program implementation.	-SWOT analysis	Content analysis Literature review Telephone interviews Site visits: F2F interviews	**Lead: M. Guay** With FH Toornstra and MC Rioux
- **Cross-cutting themes of Equity and Gender**				
Does the project contribute to	- Extent to which the project outcomes promoted equity in access	Annual Report and other monitoring	Content analysis	**Lead: MC Rioux**

ACCCELERATING NUTRITION IMPROVEMENTS IN SUB-SAHARAN AFRICA: SCALE UP OF NUTRITION INTERVENTIONS EVALUATION FRAMEWORK				
Evaluation Criteria & Issues and Questions a/p TOR	**Evaluation Indicators**	**Data Sources (See questionnaire for details)**	**Data Collection & Analysis Techniques**	**Evaluation Team Responsibility**
promoting equity in access, equity in gender equality? Has it used equity principles through out the project?	- Extent to which the project outcomes benefited boys and girls in an equitable manner - Extent to which the project used equity principle through out the project	data available Funding and performance tracking system Implementing partners HQ, regional and in-country staff/ government staff Beneficiaries (proxy: mothers of the children)	Literature review Telephone interviews Site visits: F2F interviews, Focus groups	With MJ N'GBESSO and M Guay
- **Sustainability**				
Are the results and impacts, including institutional changes, durable over time? Will the impacts continue if there is no more public funding?	- Existence of specific measures planned and implemented, monitored and reported on - Extent to which the outcome-level results achieved are sustainable and/or present good potential for sustainability.		- Site visits: F2F or tel. interviews	**Lead: MJ N'GBESSO** With MC Rioux and M Guay
- **Evaluation Issue of Ownership, Harmonization, Alignment, and Results-Based (Aid Effectiveness)**				
Does the program respect the relevant principles of Ownership, Harmonization, Alignment, and Results-Based Management?	- **Ownership**: The program supports national development strategies with clear strategic priorities (Indicator 1)28. - **Alignment:** The program is aligned with national development strategies to provide support for capacity development? (Indicator 4) Country structures are used to implement the program rather than parallel structures created by donors (Indicator 6)? - **Harmonization**: Aid is provided through harmonized programs coordinated among donors (9) Donors conduct their field missions together with recipient countries (10a). Donors conduct their country analytical work together with recipient countries (10b) - **Managing for results**: Countries have transparent, measurable assessment frameworks to measure progress and assess results (11).	DAC documentation, Primary data	Content analysis Literature review Telephone interviews Site visits: F2F interviews, Focus groups	**Lead : M Guay and MJ N'GBESSO** (Uganda and Zimbabwe) and **MC Rioux** (Senegal)

[28] Indicator numbers under this section relate to those in the OECD's Paris Declaration on Aid Effectiveness: http://www.oecd.org/dac/effectiveness/34428351.pdf

Appendix B Detailed Budgets

PLANNED AND DISBURSED SURVEILLANCE ANI PROJECT BUDGET 2012-2015 (IN $ CAN), DISBURSEMENT RATE BY ACTIVITIES FOR THE 11 PROJECT COUNTRIES

	Total Grant Budget*	Budget Planned Aug. 2013**	Disbursed 2013	Disb. rate 2013 on Total Grant (%)	Disbursed 2014	Disb. rate 2014 on Total Grant (%)	Disbursed 08.09.15 ***	Disb. rate 2015 on Total Grant (%)	Total Disbursed 08.09.15	Total Disb. rate (%)	Balance 08.09.15	Remaining Funds (%) 08.09.15
1. Direct Project activities	**5 697 905**	**3 885 525**	**826 308**	**21%**	**1 259 907**	**32%**	**693 813**	**18%**	**2 780 028**	**72%**	**1 105 497**	**28%**
-Burkina Faso		200 000	42 187	21%	39 198	20%	47 252	24%	128 637	64%	71 363	36%
-Ethiopia		200 000		0%	305	0%	0	0%	305	0%	199 695	100%
-Mali		200 000	28 357	14%	67 151	34%	21 928	11%	117 436	59%	82 564	41%
-Mozambique		200 000	0	0%	73 764	37%	36 997	18%	110 761	55%	89 239	45%
-Rwanda		574 000	118 207	21%	299 606	52%	108 667	19%	526 480	92%	47 520	8%
-Senegal		200 000	80 418	40%	113 423	57%	5 358	3%	199 199	100%	801	0%
-Sierra Leone		574 000	213 662	37%	63 816	11%	283 634	49%	561 112	98%	12 888	2%
-Uganda		200 000		0%		0%	0	0%	-	0%	200 000	100%
-Tanzania		200 000		0%		0%	0	0%	-	0%	200 000	100%
-Zambia		574 000	195 807	34%	235 496	41%	130 815	23%	562 118	98%	11 882	2%
-Zimbabwe		574 000	147 670	26%	367 148	64%	59 162	10%	573 980	100%	20	0%
2. Regional and Global	**1 119 750**	**2 882 130**	**761 140**	**26%**	**859 543**	**30%**	**553 450**	**19%**	**2 174 133**	**75%**	**707 997**	**25%**
-Regional staff		1 812 380	468 484	26%	500 699	28%	267 835	15%	1 237 018	68%	575 362	32%
-HQ staff		592 050	163 315	28%	226 024	38%	130 765	22%	520 104	88%	71 946	12%
- Activities		**477 700**	**129 341**	**27%**	**132 820**	**28%**	**154 850**	**32%**	**417 011**	**87%**	**60 689**	**13%**
1. Indicators' package		40 000	14 038	35%	39 824	100%	0	0%	53 862	135%	-13 862	-35%
2.Regional report		50 000	-	0%	0	0%	10 214	20%	10 214	20%	39 786	80%
3.Consultants (regional reports)		50 000	-	0%	21 100	42%	17 423	35%	38 523	77%	11 477	23%
4.Sub-regional workshops		100 000	52 283	52%	-	0%	-	0%	52 283	52%	47 717	48%
5.Database maintenance (GINA)		60 000	32 374	54%	7 417	12%	55 101	92%	94 892	158%	-34 892	-58%
6.Technical support (travel and per diem)		177 700	30 646	17%	64 479	36%	72 113	41%	167 238	94%	10 462	6%
3. Monitoring & Evaluation	85 000	**135 000**	**6 262**	**5%**	**74 557**	**55%**	-	**0%**	**80 819**	**60%**	**54 181**	**40%**
4. Project Administration	897 345	**897 345**	**207 182**	**23%**	**285 221**	**32%**	**404 942**	**45%**	**897 345**	**100%**	0	**0%**
Total	**7 800 000**	**7 800 000**	**1 800 891**	**23%**	**2 479 228**	**32%**	**1 652 206**	**21%**	**5 932 325**	**76%**	1 867 675	**24%**

* According to the Grant Agreement between the Government of Canada and the WHO on March 29, 2012

** In August 2013, Direct project activities were replanned and approved with a addition of $189,525 from the original planning, which amount was not programmed. The 189,525 has not been distributed across countries and it is supposed to be distributed on a need basis; In addiiton, 200,000$ was transferred to Surveillance activities from Scale-up . The 200,000 remaining under Surveillance will be used to complete Scale-up activities.

*** The figures have been extrapolated from Scale up management financial report 08.09.15 and Annual WHO ANI reports 2013 and 2014 (Total Disbursed on 08.09.15 - Total Disbursed 2013 and 2014)

Source: Scale up management financial report 08.09.15 and Annual WHO ANI reports 2013 and 2014

PLANNED AND DISBURSED SCALE UP ANI PROJECT BUDGET 2012-2015 (IN $ CAN), DISBURSEMENT RATE BY ACTIVITIES FOR ETHIOPIA, TANZANIA AND UGANDA

	Total Grant Budget*	Disbursed 2013	Disb. rate (on Total Grant) 2013 (%)	Disbursed 2014	Disb. rate (on Total Grant) 2014 (%)	Disbursed 08.09.15***	Disb. rate (on Total Grant) 2015 (%)	Total Disbursed as on 08.09.15	Total Disb. rate as on 08.09.15 (%)	Balance as on 08.09.15	Remaining Funds (%) 08.09.15
Direct Project actvities	**7 872 798**	**438 351**	6%	**3 543 634**	45%	2 205 371	28%	6 187 356	**79%**	1 685 442	21%
-Ethiopia	2 150 137	39 632	2%	529 426	25%	1 189 561	55%	1 758 619	82%	391 518	18%
-Tanzania	2 150 137	0	0%	1 365 883	64%	336 332	16%	1 702 215	79%	447 922	21%
-Uganda	**2 150 137**	**73 172**	**3%**	**1 085 458**	**50%**	**359 010**	**17%**	**1 517 640**	**71%**	**632 497**	**29%**
-Staff (3P3)	1 422 387	325 547	23%	562 867	40%	320 468	23%	1 208 882	85%	213 505	15%
Regional and Global	**968 750**	**277 154**	29%	**371 628**	38%	231 653	24%	880 435	**91%**	88 316	9%
-HQ Staff (1P3)	**592 883**	**168 558**	**28%**	**220 876**	37%	**147 992**	25%	**537 426**	**91%**	**55 457**	**9%**
-Activities**	**375 867**	**108 596**	**136%**	**150 752**	**40%**	**83 661**	**22%**	**343 009**	**91%**	**32 859**	**9%**
1.eLENA (mobile app)	40 000	-	0%	40 740	102%	0	0%	40 740	102%	-740	-2%
2.eLENA (Translations)	30 000	9 887	33%	32 290	108%	29 948	100%	72 125	240%	-42 125	-140%
3.Coverage maps (2014)	30 000	-	0%	30 391	101%	0	0%	30 391	101%	-391	-1%
4.Programmatic practices	30 000	-	0%	20 937	70%	0	0%	20 937	70%	9 063	30%
5.Travel	170 000	96 741	57%	24 009	14%	43 891	26%	164 641	97%	6 226	4%
6.Project dissemination	75 000	1 968	3%	2 385	3%	9 822	13%	14 175	19%	60 825	81%
Monitoring & Evaluation	**185 000**					198 494	107%	198 494	**107%**	-13 494	-7%
Project Administration	**1 173 452**	93 016	8%	508 984	43%	571 452	49%	1 173 452	**100%**	0	0%
Total Budget	**10 200 000**	**808 521**	**8%**	**4 424 246**	**43%**	**3 206 970**	**31%**	**8 439 737**	**83%**	**1 760 264**	**17%**

* According to the no 1 Amendement to the Grant Agreement between the Government of Canada and the WHO signed June 27, 2014

** Initial budgets for Travel and Project dissemination were $185,867 and $60,000 have been reallocated

*** The figures have been extrapolated from Scale up management financial report 08.09.15 and Annual WHO ANI reports 2013 and 2014 (Total Disbursed on 08.09.15 - Total Disbursed 2013 and 2014)

Source: Scale up management financial report 08.09.15 and Annual WHO ANI reports 2013 and 2014

Appendix D List of Documents

#	Document Description	Status / Source	Date Received and/or Available for Review	Format
1	Agreement with the NGOs in Uganda selected to implement the ANI Scale up project.	WHO Regional	2015	
2	ANI Annual work plan and annual budgets for WHO country offices in Zimbabwe, Uganda and Senegal Quarterly and/or annual progress reports -Copy of Nutrition funding (Zimbabwe)	WHO Regional	2015	
3	ANI PMF Baseline Report 12 May	WHO	2015	Electronic
4	ANI Update Final 29052015 (UG)	WHO	2015	Electronic
5	ANI CIP Approval Package, Ethiopia ANI CIP Approval Package, Uganda ANI CIP Approval Package, Tanzania ANI CIP Approval Package, Zambia ANI CIP Approval Package, Zimbabwe ANI CIP Approval Package, Mozambique ANI CIP Approval, Rwanda ANI CIP Approval Package, Burkina Faso ANI CIP Approval Package, Mali ANI CIP Approval Package, Senegal ANI CIP Approval Package, Sierra Leone	WHO	2015	Electronic
6	Agreement with the NGOs in Uganda selected to implement the ANI Scale up project.	WHO Regional	2015	
7	CDFU Progress Report 1 for July 2014 to January 2015 (UG)	CDF Uganda	2015	Electronic
8	CIDA report Y1 Scale Up 31 December 2013	WHO	2015	Electronic
9	CIDA report Y1 Surveillance 31 Dec 2014	WHO	2015	Electronic
10	Consultant contacts to implement ANI project in Senegal and Zimbabwe.	WHO Regional		
11	Copy of Country selection table rev 7	WHO	2015	Electronic
12	Copy of Revised ANI Workplan 2014-Additional Budget (UG)	WHO	2015	Electronic
13	Core Nutrition Indicators (Zim)		2014	Electronic
14	Department of Health Statistics and Information Systems	WHO	2015	Online
15	DFATD_ No cost extension Surveillance	WHO	2015	Electronic
16	DFATD_ Scale up Amendment	WHO	2015	Electronic
17	DFATD_ Scale up Grant Agreement	WHO	2015	Electronic
18	DFATD_ Surveillance Amendment	WHO	2015	Electronic
19	DFATD_ Surveillance Grant Agreement	WHO	2015	Electronic
20	DFATD report Y2 Scale Up 31 December 2014	WHO	2015	Electronic
21	DFATD report Y2 Surveillance 31 December 2014	WHO	2015	Electronic
22	Documents développés sous ANI au Sénégal	WHO	2014	Electronic
23	Documents for Senegal	WHO regional	2015	Electronic
24	Document for Uganda	WHO Regional	2015	Electronic
25	Document for Zimbabwe	WHO regional	2015	Electronic
26	ENPS II, Senegal	Demographic and Health Surveys	2015	Online
27	Everybody's Business, Strengthening Health Systems to Improve Health Outcomes	WHO	2007	Online
28	Food Based Dietary Survey Final Report April 1st 2014 (UG)	Uganda MoH, WHO	2015	Electronic
29	Food security and Humanitarian implication in West Africa	Food and Agriculture Organization of the United Nations	2015	Electronic

#	Document Description	Status / Source	Date Received and/or Available for Review	Format
30	Guide Methodologique de la surveillance notionnelle au Sénégal	Senegal MoH	2014	Electronic
31	IBFAN Report on the Baseline Assessment (UG)	Uganda MoH	2014	Electronic
32	Integrating gender equality in monitoring and evaluation of projects	International Labour Organization	2014	Electronic
33	Maintaining high vitamin A supplementation coverage in children: Lessons from Niger; 26(1), 26–31; Aguayo, V. M., Baker, S. K., Crespin, X., Hamani, H., & MamadoulTaïbou, A.	Food and Nutrition Bulletin	2005	Electronic
34	Micronutrient Survey Report (Zim)	Zimbabwe MoH	2015	Electronic
35	Minutes of the Subcommitte on Nutrition Surveillance (Zim)	Zimbabwe MoH	2014	Electronic
36	Notes ANI-PSG meetings 2nd meeting- February 3rd meeting – May 4th meeting – September	WHO HQ (Meeting minutes will be taken by the budget and finance officer in WHO/HQ – ToR for PSG)	Outstanding	Electronic
37	Notes ANI-PSG meeting 4Dec12 (first meeting)	WHO	2015	Electronic
38	Nutrition surveillance and scaling up draft 27 December 2011 ANI Inception report	WHO	2015	Electronic
39	Nutrition surveillance Review of Findings (Zim)	Zimbabwe MoH	2015	Electronic
40	Nutrition surveillance Training Facilitator's Manual (Zim)	Zimbabwe MoH?	2015	Electronic
41	Official Development Assistance for Health to Senegal	WHO	2010	Online
42	Official Development Assistance for Health to Uganda	WHO	2010	Online
43	Official Development Assistance for Health to Zimbabwe	WHO	2010	Online
44	Outline of Country Implementation Plans	WHO	2015	Electronic
45	Outline of Global and Regional Implementation Plans	WHO	2015	Electronic
46	Paris Declaration on Aid Effectiveness	OECD	2005	Online
47	Plan de la mise en œuvre de la surveillance sentinelle des problèmes nutritionnels au Sénégal		2014	Electronic
48	Preliminary agenda 2 May	WHO	2015	Electronic
49	Preliminary agenda 26 November	WHO	2015	Electronic
50	Preliminary agenda 18 December	WHO	2015	Electronic
51	Process countries have gone through to develop CIPs for scaling up	WHO	2015	Electronic
52	Protocole National de Prise en Charge de la Malnutrition Aigue (Sen)	Senegal MoH	2013	Electronic
53	Rapport d'activité: Enquête Ménage du Site Sentinelle de Sourah/Touba	Senegal MoH, DAN	2015	Electronic
54	Rapport d'activité: Formation des Enquêteurs du Site de Sourah	Senegal MoH, DAN	2015	Electronic
55	Rapport de l'Analyse Situationnelle de la Surveillance Nutritionnelle au Sénégal	IPDSR, MoH, WHO	2013	Electronic
56	Recensement Géneéral de la Population et de l'Habitat,, Senegal		2013	Online
57	Roles, responsibilities and matrix management	WHO	2014	Online
58	Scaling Up Nutrition, Information Systems for Nutrition	WHO	2014	Online
59	Seven Behaviours, How Development partners can change for the better	International Health Partnerships	2013	Online
60	SCONS Meeting 28 January 2014 (Zim)	Zimbabwe MoH	2015	Electronic

#	Document Description	Status / Source	Date Received and/or Available for Review	Format
61	SCONS Meeting 6 March 2014 (Zim)	Zimbabwe MoH	2014	Electronic
62	SEN Indicateurs de la Surveillance Nutrionelle (SIMR) (Sen)	Senegal MoH	2015	Electronic
63	SoP CIDA project 14Aug	WHO	2015	Electronic
64	Summary Results Nutrition Data Quality Self (Zim)	Zimbabwe MoH	2015	Electronic
65	SUN Progress Report Eng 2013	SUN Movement Secretariat	2013	Electronic
66	SUN Progress Report Eng 2014	SUN Movement Secretariat	2014	Electronic
67	Terms of Reference ANI Evaluation	WHO	2015	
68	TOR for Project Steering Group (PSG)	WHO	2015	Electronic
69	ToR TWG Subcommittee on Nutrition Surveillance Final 1 (Zim)	Zimbabwe MoH	2015	Electronic
70	Training Report - Training of Facilitators for Acute Malnutrition (UG)	WHO	2015	Electronic
71	WHO Child Growth Standards	WHO	2015	Online
72	Zimbabwe MoH 26 March 2014	Zimbabwe MoH	2014	Electronic
73	Zimbabwe National Nutrition CTP (Zim)	Zimbabwe MoH	2015	Electronic
74	Zimbabwe Vulnerability Assessment (ZVAC)	Zimbabwe Government	2014	Electronic