FINAL NARRATIVE REPORT

Ethiopia

Thematic window
Children, Food Security & Nutrition

Programme Title:
National Nutrition Programme/ MDG-F

September | 2013

Prologue

The MDG Achievement Fund was established in 2007 through a landmark agreement signed between the Government of Spain and the UN system. With a total contribution of approximately USD 900 million, the MDG-Fund has financed 130 joint programmes in eight Thematic Windows, in 50 countries around the world.

The joint programme final narrative report is prepared by the joint programme team. It reflects the final programme review conducted by the Programme Management Committee and National Steering Committee to assess results against expected outcomes and outputs.

The report is divided into five (5) sections. Section I provides a brief introduction on the socio economic context and the development problems addressed by the joint programme, and lists the joint programme outcomes and associated outputs. Section II is an assessment of the joint programme results. Section III collects good practices and lessons learned. Section IV covers the financial status of the joint programme; and Section V is for other comments and/or additional information.

We thank our national partners and the United Nations Country Team, as well as the joint programme team for their efforts in undertaking this final narrative report.

MDG-F Secretariat

FINAL MDG-F JOINT PROGRAMME
NARRATIVE REPORT

Participating UN Organization(s)	Sector(s)/Area(s)/Theme(s)
UNICEF(lead agency) *WFP* *WHO* *FAO*	Ethiopia, Children, Food Security and Nutrition

Joint Programme Title	Joint Programme Number
National Nutrition Programme/ MDG-F	

Joint Programme Cost [Sharing - if applicable]		Joint Programme [Location]
[Fund Contribution):	US$ 67,825,000	**Region(s): Oromia, Amhara, SNNP and Tigray regions**
Govt. Contribution:	US$	**Governorate(s):**
Agency Core Contribution: US$ 10,969,214 **Other: US$ 28,377,750.7**		**District(s) 16 districts**
TOTAL:	US$ 107,171,964.92	

Final Joint Programme Evaluation	Joint Programme Timeline
Final Evaluation Done Yes ☐ No ☐ **Evaluation Report Attached** ☐Yes ☐No **Date of delivery of final report 15 July 2013**	**Original start date** *11 September 2009* **Final end date** *31 May 2013*

Participating Implementing Line Ministries and/or other organisations (CSO, etc)

Federal Ministry of Health (FMoH), Regional Health Bureau (RHB), Woreda Health Bureau, Addis Ababa University, Mekelle University, Bahirdar University, Haramaya University and Hawassa University

Report Formatting Instructions:

- Number all sections and paragraphs as indicated below.
- Format the entire document using the following font: 12point _ Times New Roman.

I. PURPOSE

a. Provide a brief introduction on the socio economical context and the development problems addressed by the programme.
b. List joint programme outcomes and associated outputs as per the final approved version of the joint programme Document or last agreed revision.
c. Explain the overall contribution of the joint programme to National Plan and Priorities
d. Describe and assess how the programme development partners have jointly contributed to achieve development results

Ethiopia, located in the North Eastern part of Africa, also known as the Horn of Africa, lies between 3 and 15 degrees north latitude and 33 and 48 degrees east longitude. The total area of the country is around 1.1 million square kilometres. As of 2007, Ethiopia's population has been growing at a rate of 2.6 per cent per annum (CSA, 2007). At this growth rate, the total population is estimated to reach 88.4 million by 2015. The majority of the population (84 per cent) lives in rural areas. This rapid population growth exacerbates critical gaps in basic health services, and in food and nutrition security (MoH, 2008).

The Government has been implementing a comprehensive economic reform programme over the past decade. The reform programme has resulted in remarkable economic performance in which macroeconomic stability was attained. A real gross domestic product (GDP) growth rate of 11 per cent per annum has been achieved since 2003. The poverty level as measured by the total population under the poverty line has declined from 49.5 per cent in 1994/95 to 29.2 per cent in 2009/10. The food poverty head count index also declined from 38 per cent to 28.2 per cent between 2004/05 and 2009/10. However, poverty still affects one third of the population (MoFED, 2010a).

Ethiopia has developed a five-year development plan, the Growth and Transformation Plan (GTP), for the period 2010/11 to 2014/15. Key objectives of the GTP are ensuring high economic growth and achieving the Millennium Development Goals (MDG). Within the framework of the GTP, five-year sectoral development programmes have been outlined (MoFED, 2010b). Vital to the attainment of this plan are the systems and structures to reach communities and households.

Community-based service delivery platforms have been made available in both the health and agriculture sectors to ensure decentralized and democratized public services. The Health Extension Programme (HEP) deploys two Health Extension Workers (HEWs) per Health Post (HP), who together reach a population of roughly 5,000. The Agricultural Extension Programme has a similar community-level structure called the Agriculture Extension Programme. To strengthen and accelerate social and behavioural changes and the overall wellbeing of the population, a community-level development army has been established using a "one-to-five network," wherein out of every six household's one person takes a leading role, functioning as a key link with both health and agriculture extension workers. Five such leaders comprise a development team. Each development team looks after 25 to 30 households. This arrangement is contributing to Ethiopia's sprint toward the achievement of MDGs as we approach 2015 (MoH, 2011).

The MDG Joint Programme (JP) is implemented by four UN agencies (FAO, UNICEF, WFP and WHO) and the Federal Ministry of Health (FMoH) as the lead national counterpart for the last three years. The FMoH has been given the mandate to ratify the National Nutrition Strategy (NNS) as most of the components in the nutrition strategy are already being coordinated and implemented by this Ministry. Thus, as the components of the National Nutrition Programme (NNP) are developed from the conceptual framework of the NNS, the organizational and management structure for NNP is housed in the FMoH.

With a contribution of US$ 7 million, the JP supports the efforts of the Government of Ethiopia in its national strategy in the areas of malnutrition, nutrition and food security.

2.2.1. Specific objectives of the programme

The objective of the JP is to enhance and scale up implementation of the NNP by filling the existing gaps and giving priority to community-based nutrition (CBN) interventions and contributing to the following four outcome areas:

i. Improved management of children with severe acute malnutrition (SAM) at the HP and community level;
ii. Improved caring and feeding behaviours/practices of children and mothers;
iii. Improved quality and utilization of locally available complementary foods; and
iv. Improved nutrition information and M&E system.

The main components of the JP are the following:

i. Rollout and sustainability of Out Patient Treatment (OTP) services for severe acute malnutrition. Expected results: improvement of the screening, awareness and treatment of acute malnutrition in the primary health care facilities and at community level;
ii. CBN interventions. Expected results: community capacity is built for assessment, analysis and action to improve child care and feeding behaviour and practices, and this is considered essential to prevent malnutrition. It will also provide integrated and preventive nutrition services as part of HEP; and link with agricultural extension workers and food security interventions;
iii. Pilot on local production and utilization of complementary food: This innovative component consists in a pilot/operational research on local production and utilization of complementary food using local cereals/foods intended for the prevention of growth faltering/malnutrition at the most critical age. Expected results: the management of malnutrition by families at community-level is demystified; and
iv. Strengthening the nutrition information system and M&E mechanism: Expected results: improvement of the current nutrition information system that in turn will redefine the information needs and mechanisms for data collection, analysis, dissemination and utilization. It also includes the monitoring mechanisms and the baseline, midline, and end line evaluation of the JP.

The JP is very relevant considering that it complements government strategies and plans as articulated in the NNP and the Health Sector Development Plan (HSDP IV). In addition, it contributes to: (a) the NNP target of reducing underweight from 38 per cent to 30 per cent by 2013, and the non-income Target 2 of MDG 1, meaning halving malnutrition from 1990 levels (halving underweight in under-five children by 2015); (b) ensure that boys and girls complete a full course of primary schooling (MDG 2) and improve the children's educational capacity; (c) reduce by two-thirds the mortality rate among children under-five (MDG 4) and reduce 57 per cent of malnutrition-related deaths; and (d) reduce by three-quarters the maternal mortality ratio (MDG 5) through empowering women, and improve maternal nutrition and reduce maternal deaths associated with malnutrition.

The JP is also aligned with the United Nations Development Assistance Framework (UNDAF 2007 – 2011) outcomes, especially the two outcomes on: (i) Humanitarian Response, Recovery and Food Security, and (ii) Basic Social Services and Human Resources. The Food and Agriculture Organization (FAO), United Nations Children's Fund (UNICEF), World Food Programme (WFP) and World Health Organization (WHO) already support the country in implementing the NNP through their country action plans.

The four UN organizations have been focusing the area of their competency, and all the planned activities of the project were implemented in 16 woredas. The convergence of implementation of activities has helped to achieve the intended results, and it has contributed towards the improvement of nutrition status of children under five and pregnant and lactating mothers. Preventive and curative activities that address malnutrition were implemented in the MDG-F supported 16 woredas in Oromia, Amahara, SNNP and Tigray regions.

II. ASSESSMENT OF JOINT PROGRAMME RESULTS

a. Report on the key outcomes achieved and explain any variance in achieved versus planned results. The narrative should be results oriented to present results and illustrate impacts of the pilot at policy level.

The project implementation was effective from September 2009, with preparation and orientation to the target woredas through workshops during the initial stages and development of annual work plans in consultation with regional health bureaus of the four regions. As per the plans, the implementation of several activities aligned with the NNP has led to the following outcomes:

Outcome 1: Community-based management of acute malnutrition expanded to 430 HPs in the targeted woredas. Since the beginning of the project, 37,552 (Target 14,640) children under five received treatment for Severe Acute Malnutrition (SAM). The performance of the programme remained within national and international SPHERE standards, with a recovery rate of 85.3 per cent and mortality and defaulter rates of 0.3 per cent and 4.3 per cent, respectively; the reason for over achievement is due to the continued expansion of the HP structure by the Government.

OTP services were established in 418 HPs (131 per cent of targeted 320 HPs, and 97.2 per cent of the total number of HPs (430) in the 16 woredas). This has resulted in an increased number of HEWs available in the woredas and related training activities. Moreover, the overall government (MoH) direction to expand the decentralization of management of SAM to the HP level has created an enabling environment – facilitating in the overachievement of targets than initially planned. Quarterly Child Health Days were undertaken for nutritional screening. Since the project started, 17,994 children were provided with discharge rations and 11,029 pregnant and lactating women received targeted supplementary feeding rations through WFP and the Disaster Risk Management Food Security Sector (DRMFSS).

Outcome 2: Improved care and feeding behaviours/practices of children and mothers and under two children growing normally.

On average per year, over the period of the JP, 53,760 children under two years of age (50 per cent) in the targeted woredas participated in growth monitoring and mothers/caregivers received counselling on improved care behaviour. Consequently, there is a reduction of prevalence of underweight in the MDG-F supported woredas from 50 per cent in 2010 to 9 per cent in January 2013.

For these outcomes to be reached by the programme, the following outputs have been achieved:

Output 2.1 Build community capacity for assessment-analysis-action specific to preventing child malnutrition

In total, 512 HEWs were trained on the Integrated Refresher Training (IRT) package in the MDG-supported woredas (all woredas in Amhara, Tigray, Oromia, and SNNP). Some 44 per cent of the under-two children in the targeted woredas are weighed every month and mothers/caregivers are counselled to improve infant and young child feeding practices (IYCF). In addition, issues that need communal action are brought to the community conversation sessions for deliberation and agreement on the way forward.

Output 2.2 Under-two children growth improved

There is significant reduction of underweight among children under-two years of age participating in the growth monitoring session in the 16 woredas. The reduction is due to increased nutrition management capacity of the Health Workers (HWs) and HEWs.

The reduction is also attributed to the counselling provided by the HEWs to the mothers with children under-two years during the monthly growth monitoring sessions as well as improvements in IYCF practices.

A preliminary analysis of the 2010 Ethiopian Demographic and Health Survey (EDHS) results conducted in 2012 by Tulane University indicates that Ethiopia is moving towards achieving reductions in underweight prevalence Anaemia levels have decreased by almost 10 percentage points among both women and children in the last five years. In the 2005 EDHS, 54 per cent of children and 27 per cent of women had anaemia, compared to 44 per cent of children and 17 per cent of women in 2011.

The quantitative performance exceeded the expected results by about 63 per cent for the number of children introduced to Complementary Food (CF), and more than 20 per cent for the participation in Growth Monitoring and Promotion (GMP).

Outcome 3: Local production of Complementary Food (CF). In the local production of CF, two pilot models for implementation were developed and three sites/kebeles were selected in each of the four regions (production of CF started in eight kebeles in rural areas); For the semi urban model, four sites were identified in the four regions (Wadla, Laelay Maichew, Kedida Gamilla and Chinakson), with processing units procured and mills installed in the four sites (mills have started operating in Wadla, Chinakson, Kedida Gamilla and Laelay Maichew woredas). A systematic review and evaluation of the complementary feeding pilot has been completed and key recommendations for improving the implementation models for the production of complementary food at community level were put forward. The recommendations are considered in the scaling up of the production of complementary food at community level that will be implemented in 20 woredas through other funding.

Outcome 4: Improved nutrition information and monitoring and evaluation of the project. Baseline (2010) and mid-line (2011) assessments were conducted to recommend adjustments to programme implementation – to achieve maximum impact. The funding was also used to build the capacity of federal, regional, woreda and health centre staff on routine data management and reporting; therefore, training was provided at all levels. Currently, a monthly routine data is collected from the HP and analysed; feedback is given by the woreda health office for improving implementation as needed.

At the beginning of 2012, a slight drop in the number of children participating in growth monitoring was observed. This was attributed to the changes in government policy which gives the responsibilities of weighing and counselling to the HEWs as opposed to the volunteers. The lack of guidance for the transition and the delay in cascading the IRT to the HEWs has resulted in a decrease in coverage of the participating children. A guidance note was sent to all implementing woredas and orientation on the note was cascaded to the HEWs. This has resulted in an increase in the rate of children's participation in the Growth Monitoring Participations as well as in the quality improvement of data.

b. In what way do you feel that the capacities developed during the implementation of the joint programme have contributed to the achievement of the outcomes?

Capacity building of the HEWs and health centre staff for the treatment and preventative aspects (CMAM and CBN) (using training packages that were designed to health workers at different levels) has contributed to skill development enabling improved service delivery. The initial training was followed by refresher training every six months and on-job mentoring by the supervisors, which helped to address the skill gap. In addition, quarterly review meetings were conducted during the project cycle, where lesson learned and best practices were shared. The voluntary community health workers also received refresher training every six months as well as continuous mentoring and support by the HEWs, which greatly contributed to the

achievement of the outcome. In 2011, the government of Ethiopia also developed the IRT for both health and nutrition. IRT for integrated Childhood Community Case Management (iCCM) covering the treatment aspects and included CMAM, and Community – maternal Newborn and Child Health for preventive aspect of health and nutrition (CMNCH), which included CBN. The IRT was cascaded to all HEWs in the four regions in 2011 and 2012.

c. Report on how outputs have contributed to the achievement of the outcomes based on performance indicators and explain any variance in actual versus planned contributions of these outputs. Highlight any institutional and/ or behavioural changes, including capacity development, amongst beneficiaries/right holders.

The NNP places a significant emphasis on the CBN programme to prevent child malnutrition before children's nutritional status declines to critical levels requiring more intense and immediate medical attention. CBN aims to build on the community's capacity to improve daily child caring and feeding practices, and mitigate the impact of livelihood shocks that might affect children's nutritional status acutely and chronically. CBN is implemented as part of the HEP; HEWs deliver monthly growth promotion and nutrition counselling services at the community and household levels with support from Health Development Army (HDA) who play an important promotional role in delivering key health and nutrition messages to the community.

The expansion and decentralization of management of Severe Acute Malnutrition to the HP level has created an enabling environment and contributed to the attainment of results beyond the initial targets set. The distribution of supplementary food for those children discharged from treatment of SAM was a new innovative trial through this project, and this contributed to ensuring the full recovery of the children and in minimizing the relapse of cases. Currently, WFP is scaling up this approach to other woredas through its own budget.

d. Who are and how have the primary beneficiaries/right holders been engaged in the joint programme implementation? Please disaggregate by relevant category as appropriate for your specific joint programme (e.g. gender, age, etc.)

Mothers with children under two-years of age (male and female) participate in monthly growth monitoring sessions (GMP). During the GMP sessions, mothers are counselled by the HEWs to discuss why their children are malnourished and finally come up with agreed solutions based on household food availability. In addition, all mothers with children under five years who were attending community health days also receive vitamin A and deworming tablets for the children. Moreover, all Pregnant and Lactating (PLWs) and children under five years are screened for malnutrition; those children and mothers who are moderately malnourished are given supplementary fortified food ration (Corn Soya Blend).

e. Describe and assess how the joint programme and its development partners have addressed issues of social, cultural, political and economic inequalities during the implementation phase of the programme:

a. To what extent and in which capacities have socially excluded populations been involved throughout this programme?

   The selected 16 woredas are food insecure rural communities in the four highly populated regions in Ethiopia, where rates of incidence of stunting (Tigray 51 per cent, Amhara 52 per cent, SNNPR 44 per cent and Oromia 42 per cent) are higher than in urban settings. Within the selected woredas, the programme targeted the most vulnerable children and mothers by also covering pregnant and lactating mothers as well as mothers and children under five years.

b. Has the programme contributed to increasing the decision making power of excluded groups vis-a-vis policies that affect their lives? Has there been an increase in dialogue

and participation of these groups with local and national governments in relation to these policies?

Through the MDG contribution, UNICEF has supported the initiation of the preventive CBN approach to affect improved infant and young child feeding practices at scale by making nutrition a priority agenda for families and communities and influencing sustainable behavioural changes in child care practices and health-seeking behaviours. The model applies the Triple A approach to empower and increase community capacity, to assess and analyse their situation and come up with concrete actions that can be implemented using the available resources at community levels. In addition, monthly community conversion is conducted to address issues that need communal action to address malnutrition in their community. During the community dialogue, issues that need the attention of the local administration are discussed with kebele officials.

c. Has the programme and it development partners strengthened the organization of citizen and civil society groups so that they are better placed to advocate for their rights? If so how? Please give concrete examples.

The community based nutrition programme focuses on establishing volunteer community groups that will be capacitated and empowered to support the HEWs in the implementation of the CBN programme. In addition, the joint programme supported women groups through the provision of income generating activities as well as resources for small enterprise development on local production of complementary food.

d. To what extent has the programme (whether through local or national level interventions) contributed to improving the lives of socially excluded groups?

The programme is mainly focused in addressing the most vulnerable community residing in food insecure woredas. Pregnant and lactating mothers and children under five years were receiving nutrition service in their vicinity. In addition, in woredas where the production of complementary food was piloted, women groups were organized to generate income to improve their livelihood of their HHs as well their children under two.

f. Describe the extent of the contribution of the joint programme to the following categories of results:

a. Paris Declaration Principles

- Leadership of national and local governmental institutions
- Alignment and harmonization of innovative elements in mutual accountability (justify why these elements are innovative)

The JP was developed to support the efforts of the Ethiopian Government to achieve the MDGs. The JP programme was developed by the FMoH through technical support of the UN agencies. The FMOH has coordinated the implementation, and assigned one focal person to coordinate the programme implementation. For the implementation of the activities, annual work plans were developed with regional health bureaus under the leadership of FMoH with technical support of the participating UN agencies. The implementations of the activities in Annual work Plans (AWPs) were closely monitored by the health bureaus at zonal, woreda and kebele levels.

The JP is aligned with the following Government policies and strategies:

- Plan for Accelerated and Sustained Development to end Poverty (PASDEP) (2005/2010)
- Health Sector Development Programme (HSDP IV) (2010/2015)
- United Nation Development Framework (UNDAF)
- Health Extension Programme (HEP). It is an innovative community based health care delivery system and platform.
- The National Nutrition Strategy (NNS) and its programme, the National Nutrition Programme (NNP) 2008-2012/13, which gives priority to young children under 2 years, pregnant and lactating women, and adolescents.

The MDG fund contributes to the implementation of different nutrition interventions of the NNP in an integrated approach in the 16 woredas in Oromia, SNNP, Amhara and Tigray regions. The NNP targets the most vulnerable– children under 5 years, particularly those under 2 years, pregnant and lactating women, and adolescents. The programme also supports piloting the local production of complementary food at community level. Four regional Universities (Hwassa, Mekelle, Bahir Dar and Haramaya) and Addis Ababa University have been involved in the assessment and the pilot production of community based complementary food – an innovative approach supported jointly by UN agencies which includes engagement of multi-sectoral stakeholders including teachers, health woreda administration, extension workers and agriculture development agents as well as women associations at woreda and kebele levels. The objectives of the assessment were: to identify existing local complementary foods/recipes with basic information on how they are prepared and consumed; to identify locally consumed foods/recipes that may be suitable for complementary feeding with basic information on how they are prepared and consumed; to identify existing home and community based technologies in the four regions enhancing the nutrient density, bioavailability and micronutrient content of complementary foods; and to collect samples of those existing/potential complementary foods for laboratory analysis. Based on the assessments implementation models were designed and piloted in the four woredas of the four agrarian regions.

b. Delivering as One

- Role of Resident Coordinator Office and synergies with other MDG-F joint programmes.

The MDG-F uses a joint programme mode of intervention operating through the UN teams, promoting increased coherence and effectiveness in development interventions through collaboration among four UN agencies (UNICEF, FAO, WFP and WHO). To sight examples:

- The pilot project of complementary feeding initiatives has enforced an effective and coordinated partnership between the four UN agencies to attain results for children. It has also managed to profile the importance of complementary feeding initiatives, and this has and will probably result in increased resource mobilization for this important intervention for children under two years. In addition, the pilot project offered an opportunity to share lessons learned and to begin to generate discussion in Ethiopia on how to scale up similar interventions across the country.
- UN Resident Coordinators provide the strategic direction and guide the operations of the Joint Programme. The head of UN agencies together make up the UN Country Team (UNCT). The UNCT oversee the overall programme coordination and implementation.

The following are some of the key achievements made through engaging all the four UN agencies:

- A strong programming and direct link between Ministry of Agriculture and the Ministry of Health.
- NNP used to be component based (separate and not integrated components and activities), but due to the advocacy of UN joint actions through the programme and the REACH [1]mechanism, the NNP is now based on a life cycle approach. It focuses from food production and preparation and other preventive measures to screening, treatment and monitoring, with specific focus both on women and children and the community at large.
- The pilot project of complementary feeding initiatives has enforced an effective and coordinated partnership between the four UN agencies (WFP, FAO, WHO and UNICEF) to attain results for children. It has also managed to profile the importance of complementary feeding initiatives, and this has resulted in increased resource mobilization for this key intervention for children under two years. In addition, the pilot project offered an opportunity to share lessons learned and to begin to generate discussion in Ethiopia on how to scale up similar interventions across the country.

III. GOOD PRACTICES AND LESSONS LEARNED

a. Report key lessons learned and good practices that would facilitate future joint programme design and implementation

Best practices:
Over the period of the JP implementation, the following are some of the processes and approaches that are considered as best practices:

i. The combined strategies focussing on curative as well as preventive measures for addressing malnutrition and food insecurity; and
ii. The pilot project is a major achievement to move towards preventive nutrition. The complementary food production initiative and dissemination of knowledge is considered as a good practice by ensuring that children aged between 6 and 24 months get access to improved complementary food made from local and available resources. The review of the pilot project identified key recommendations which include the scale up of the model in 20 woredas supported by others sources.

Lessons learned
A number of lessons learned have been mentioned by stakeholders during the evaluation; they are listed randomly as follows:

Lesson 1
The joint programme was designed under the leadership of the Government and in partnership with UN agencies and other stakeholders, enabling ownership and sustainability. While multi-sector partnering may be complex, it has been a learning process in which the national counterpart showed high commitment.

Lesson 2
For the four UN agencies, expanding the UN strategy of "Delivering as One" is an important lesson from the implementation of the JP, most of all, considering that this was their first experience in the Ethiopian context. As they said, this lesson will certainly help them towards making the needed changes and adjustments in how they should jointly carry out actions. They have also learned the need to examine and analyse the comparative advantages of each organization. In addition, instead of assigning the role and activities based on budget

[1] REACH - Renewed Efforts Against Child Hunger

allocations, the needs expressed by each agency based on its mandate, capacity and ongoing programme in the country should first be taken into consideration.

Lesson 3

Also some interviewees in the evaluation mentioned how much they realized the relevance and the effectiveness of the inter-sectoral strategy which consists of integrating/combining sectors like Health, Education and Agriculture, while enabling the communities and other local structures to take control through awareness and capacity building and development. The experience of the MDG-F has proved that multi-sectoral interventions, when applied in a coordinated manner, are more efficient in achieving results. This inter-sectoral collaboration resulted in the launch of the revised NNP on 24 June 2013, which was signed by all sector ministries that contribute to the nutrition sensitive actions with full endorsement of the Deputy Prime Minister.

b. Report on any innovative development approaches as a result of joint programme implementation

Production of community based complementary food to prevent malnutrition for children 6 to 23 months was an innovative approach piloted through the JP. For implementation, three kebeles in each of the four regions were selected and two models for processing the CF were developed as pilot project in close collaboration with the regional universities (Hawassa, Mekelle, Haramaya, and Bahir Dar), and with the assistance of UN agencies. The places to establish grain banks and install the milling machines are provided by the communities in the selected kebeles. As a result:

i) Production of CF started in eight kebeles in rural areas (Meley and Yewetet in Amhara; Dura and Hatsebo in Tigray; Wolenso and Kocher in Oromia; and Dega Keidda and Aze Debeao in SNNPR). Each unit has the capacity to produce up to 100kg/month. With bartering system, mothers are supposed to bring 2Kg of raw grain and receive 3Kg of processed food. But over time the system was considered as causing deficit, thus there have been some changes to adjust the formula to 1kg CF = 1kg grain to limit loss and increase sustainability of the project.

ii) For the semi-urban model, four sites in the four regions (Woadela, Laelay Maichew, Kedida Gamella and Chinakson) were identified, processing units procured, and mills installed in the four semi urban towns. The mills started operating and producing complementary food, which is distributed to children under the age of two as per agreed price. Currently, the women groups are selling the processed CF (packed with 1 kg bag), to the community at minimum cost with close follow up by the kebele administration. The units are running just a few days/month and face challenges to fully access the market, have improved sales and to achieve a critical mass for profitability and sustainability. The quality of the product is supervised by the universities involved.

Some of the other findings about the pilot project are as follows:

- Essential stakeholders were involved in the implementation of the pilot project; and this is very critical due to the multi-sectoral nature of the project that required involvement of other sectors to insure ownership and sustainability. The partners involved included representatives from woreda and kebele administrations, agriculture sector and women affairs offices and NGOs;
- During the whole implementation period, the main achievement for Targeted supplementary food (TSF) was the linkage of the treatment continuum between SAM management and Moderate Acute Malnutrition (MAM). Children discharged from the OTP receive discharge rations to protect them from relapsing back into severe malnutrition;
- The project has some attributes that may contribute to its sustainability such as the knowledge and skill based intervention, the community participation and use of locally available crops. But the financial aspect (adequate resources to keep the models

running) and the motivation of women group members who work as volunteers may not be sustained. The project is also contributing to the capacity building of HEWs on local level food processing;

- The involvement of the agriculture sector (with the support of FAO) help to provide training to produce and improve local complementary foods, and agro-based opportunities for selected crops, targeting the most vulnerable communities;
- Although the pilot project presents some interesting advantages, further analyses are certainly needed to ascertain the safety of the production, the hygiene requirement (that seems not to be taken into consideration from the evaluation observation), and storage system of the complementary food under various conditions.
- In addition, giving the complementary food for free to those who cannot afford even bartering by bringing grain in exchange of CF, may open doors to frustration to other persons and cause adverse effect.

The pilot project is about to be extended to 60 of CIDA-supported woredas in the second half of 2013. A national scale-up plan is under development. The quantitative performance in terms of number of processing units exceeded the expected results by about 66 per cent.

c. Indicate key constraints including delays (if any) during programme implementation

The JP implementation did face some challenges and experienced difficulties, although most of them have been overcome. Some examples are as follows:

Preventive and curative measures:

- Children and women can only be identified for malnutrition once every three/six months through CHDs, which are a low frequency mainly due to constraints regarding logistics and transportation. Also, food is distributed in the best case scenario three weeks after screening and sometimes after up to four months. But, currently this is being changed and a monthly process is being considered.
- On other hand, as stated in the progress report, the number of community-level workers has increased recently posing a challenge on how to roll out the training and whether the HDAs will be undertaking GMP. This has delayed the implementation of the trainings in the designated areas.
- Screening: the process linking CBN and health facility is very good, but still the child can relapse. This may mean that:
  - there is a necessity to have a better integration of all the steps of the system approach from preventive measures to screening and full recovery;
  - the follow up may not be close and systematic enough;
  - there should be in built measures to guarantee that the complementary food is getting to the level where it is needed

Change in the role and responsibility of HEW and HDA:

The Government has changed the modality of health service delivery at community level. As a result, the role of weighing children and conducting community conversations, which was previously done by Volunteer Community Health Workers (VCHWs), has been transferred to the HEWs. Before, each volunteer would cover around 30-50 households. With this transition, the role of undertaking monthly GMP has shifted from community volunteers to HEWs. This change contributed to temporarily increase the workload on the HEWs and thus caused a decrease in the participation of children under the age of two in GMP sessions. In order to address the issue, UNICEF and partners worked very closely with MoH to develop a HEP implementation guide to facilitate the new assignments given to HEWs.

In addition, a guidance note on the transfer of GMP responsibilities from the VCHWs to the HEWs has been finalized with the MoH and cascaded to the level of HEWs to support a smooth transition and to give guidance on how to increase GMP coverage through different

strategies. These strategies include integrating GMP into other outreach activities such as the Expanded Programme on Immunization (EPI) and community mobilization through the established HDA. Thus, there has seen an improvement in the number of children participating in growth monitoring sessions, as well as in the quality of data.

In reference to the complementary food (CF) pilot project:

Based on the evaluation observation and interview with groups of women in charge, some difficulties were identified. Some of them are:

- Volunteers' involvement may serve as an incentive and motivation strategy within the community, and as most or all of them are women, they are assumed to (i) have better knowledge in the area of health and nutrition, as well as positive skill towards food processing and production, and (ii) be more concerned about the mothers and children's issues. However, involving volunteers in the project may have some shortcomings: They are currently required to work devoid of any direct financial motivation /remuneration;
- The units experience some difficulties: (i) for urban model for example: the access to the market, the mode of distribution and the profitability aspect (there is not even book keeping, so it is difficult to estimate the result profit or loss); (ii) as to the rural model, the bartering formula is challenging and is still being adjusted; women groups try to figure out the best way to deal that work for them without compromising the project;
- There are problems with equipment: the women groups said that there is no mechanic at hand in case of breakdown; they have to search for one at long distances. There is also a problem with availability of original spare parts;
- The units, both models, are far from reaching a critical mass in their functioning and production;
- Also, it does not appear that there is a systematic and regular quality control of the final product as it should for a complementary food destined to children.

d. Describe and assess how the monitoring and evaluation function has contributed to the:

a. Improvement in programme management and the attainment of development results.

Quality of interventions / results – Supported capacity building and a participatory approach lead to quality interventions and visible results. When communities and individuals see the positive changes (e.g., healthier mothers and children, etc.) they are more likely to self-support the continuation of activities.

Focus on behaviour change – Involving local communities, as well as individuals, in understanding the situation and managing solutions augurs well for sustainability; in essence, community involvement can both stimulate and support individual actions. The programme uses multiple, mutually supporting channels to promote behaviour change to ensure sustainability of messages and activities. The behaviour change communication happened during household visits, at community dialogue sessions, and at local HPs. The activities targeted directly to women/caregivers and children as well as to other community members (often men) who need to be involved as they play decision-making roles in the household and community.

b. Improvement in transparency and mutual accountability

Joint Monitoring – Regular monitoring and evaluation of programme indicators demonstrated progress towards elements that positively influence sustainability, and allow the programme to identify and address issues as they arise with responsible body or agencies. In addition, review meetings that were conducted at different levels to discuss constraints and lessons learned and formulate concrete actions to address it, have improved transparency and resulted in improving mutual accountability.

c. Increasing national capacities and procedures in M&E and data.

Improved nutrition information and monitoring/evaluation of the project: Baseline (2010) and mid-line (2011) assessments were conducted to recommend

adjustments to programme implementation to achieve maximum impact. The funding was also used to build the capacity of federal, regional, woreda and health centre staff on routine data management and reporting. Training was provided at federal level, regional as well woreda level. Currently, monthly routine data is collected from the HP and analysed; feedback is given by the woreda health office for improving implementation as needed.

d. To what extent was the mid-term evaluation process useful to the joint programme?

Midterm evaluation has been conducted in 2010 at the mid tem of the project. The key recommendations were included in the last phase of the project. This has helped to accelerate implementation. The key recommendations from the midterm evaluation were instrumental for the accelerated implementation of the final phase of the project.

e. Improve the sustainability of the joint programme

Women groups were established to participate in the design, location, management, processing and distribution of the complementary food. Communities involved contributed the raw material for complementary food and provide the space for the grain bank and for the installing of the milling equipment in the semi urban model (in cash and in-kind). The mid-term evaluation of the CBN programme was recently completed (after the end of the 2 years project implementation), and it concluded that there is significant improvement in stunting prevalence - improving 4.3 ppts/yr[2] compared to the expected 1.3 ppts/yr. The changes in stunting prevalence are associated with the high quality of the CBN implementation and presence of TSF with change in underweight prevalence dropping as expected in CBN implementing clusters. Infant and young child feeding practices also improved in the majority of clusters, particularly in dietary diversity. In addition, WASH indicators showed an improvement in access to drinking water and sanitation methods.

f. Improve the opportunities for scaling up or replication of the joint programme or any of its components

Four regional university coordinators were engaged in the local production of complementary food, and they were responsible for advocating and communicating with all stakeholders to ensure their participation and contribution to the programme as well as communication with women groups that were involved in food production. The universities, under the leadership of Addis Ababa University, developed communication materials which resulted in improving the quality of the produced food.

g. Providing information to beneficiaries/right holders

The community conversions conducted as part of the CBN programme provided the forum or knowledge sharing. The community growth monitoring chart was used to trigger discussion at community level about children's nutritional status and allows communities to analyse the underlying factors and come up with solutions to address it.

e. Please report on scalability of the joint programme and/or any of its components

a. To what extent has the joint programme assessed and systematized development results with the intention to use as evidence for replication or scaling up the joint programme or any of its components?

The pilot community local production of complementary food project was assessed and lessons learned were documented which will be used to modify the current model for scaling up.

[2] The historical trend in stunting (proxied by 10 years of DHS data) shows an average decreased in stunting prevalence of 1.3 percentage points per year (ppt/yr). The improvement seen in CBN areas between baseline and midline, exceeding this trend, showing a 4.3 percentage point per year improvement in stunting prevalence

b. Describe example, if any, of replication or scaling up that are being undertaken
UNICEF received funding from CIDA and the Netherland Embassy for implementation of local production of complementary food in 60 of the supported woredas in 2013/2014.

c. Describe the joint programme exit strategy and assess how it has improved the sustainability of the joint programme
Building local capacity and systems within existing government programmes – The programme works to build the capacity of government workers (e.g. HEWs) and communities (e.g. women development army and women groups) within already existing government programmes (e.g. NNP) and structures. Local communities are actively involved in the planning and implementation of the programme, which helps to ensure ownership and the sustainability of the interventions.

IV. FINANCIAL STATUS OF THE JOINT PROGRAMME

a. Provide a final financial status of the joint programme in the following categories:

1. Total Approved Budget
2. Total Budget Transferred
3. Total Budget Committed
4. Total Budget Disbursed

b. Explain any outstanding balance or variances with the original budget

Budget Summary	
Total Approved Joint Programme Budget[3]	UNICEF: US$ 5,711,032 WFP: US$ 626,592 FAO: US$ 400,180 WHO: US$ 262,080 Total: US$ 6,999,884
Total Amount of Transferred to date[4]	UNICEF: US$ 5,711,032 WFP: US$ 626,592 FAO: US$ 400,180 WHO: US$ 262,080 Total: US$ 6,999,884
Total Budget Committed to date	UNICEF: US$ 5,337,530.52 WFP: US$ 585,600 FAO: US$ 374,000 WHO: US$ 228,801 Total: US$ 6,525,931.52
Total Budget Disbursed to date	UNICEF: US$ 5,337,530.52 WFP: US$ 582,600 FAO: US$ 374,000 WHO: US$ 228,801 Total: US$ 6,525,931.52

V. OTHER COMMENTS AND/OR ADDITIONAL INFORMATION

[3] Amounts are inclusive of indirect costs retained by headquarters.
[4] Amounts are programmable amounts, net of the indirect costs retained by headquarters.

VI. ANNEXES

1. List of all documents/studies produced by the joint programme
   The studies are attached in the MDG-F website
2. List all communication products created by the joint programme
   Videos are attached in the MDG-F website
3. Final Systematic review and lesson learned from local complementary food production pilot project (*Attached)*
4. Final MDG-F Evaluation Report (*Attached)*
5. Final narrative report up to May 2013 *(Attached)*

List of Acronyms

AEW	Agricultural Extension Worker
BCR	Benefit Cost Ratio
BF	Breast Feeding
BoFED	Bureau of Finance and Economic Development
CF	Complementary Feeding
CHD	Community Health Days
C-IMCI	Community - Integrated Management of Childhood Illness
CPAP	Country Programme Action Plan
DHS	Demographic and Health Survey
DMFSS	Disaster Management and Food Security Sector
DPPB	Disaster Prevention and Preparedness Bureau
ENA	Essential Nutrition Action
EOS	Enhanced Outreach Strategy
EWS	Early Warning System
FDA	Food Distribution Agents
FMOH	Federal Ministry of Health
GMP	Growth Monitoring and Promotion
JP	Joint Programme
JCCC	Joint Core Coordinating Committee
HDA	Health Development Army
HEP	Health Extension Programme
HEW	Health Extension Worker
HSDP	Health Sector Development Programme
IDA	Iron Deficiency Anaemia
IDD	Iodine Deficiency Disorder
IYCF	Infant and Young Child Feeding
NNC	National Nutrition Coordination Body
NNP	National Nutrition Programme
NNS	National Nutrition Strategy
NSC	National Steering Committee
MDG	Millennium Development Goal
MDG-F	Millennium Development Goal Achievement Fund
MI	Micronutrient Initiative
MOARD	Ministry of Agriculture and Rural Development
MOFED	Ministry of Finance and Economic Development
MOU	Memorandum of Understanding
OTP	Outpatient Therapeutic Programme
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PMT	Programme Management Team
PMC	Programme Management Committee
PSNP	Productive Safety Net Programme
RC	Resident Coordinator
RHB	Regional Health Bureau
RUTF	Ready-To-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SNNPR	Southern Nations Nationalities and Peoples Region
TFP	Therapeutic Feeding Programme
TSF	Targeted Supplementary Food
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistant Framework
USAID	United States Agency for International Development
USI	Universal Salt Iodization
VCHW	Volunteer Community Health Workers
VAD	Vitamin A Deficiency
WASH	Water Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization
WoFED	Woreda Office of Finance and Economic Development
WoHo	Woreda Health Office