



FINAL NARRATIVE REPORT

Mozambique

Thematic window
Children, Food Security and Nutrition

Joint Programme Title:

Promotion of a multi-level approach to child malnutrition

June | **2012**

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)
FAO, UNICEF (coordinating agency), WFP and WHO	Children, Food Security and Nutrition

Joint Programme Title	Joint Programme Number
Children, Food Security and Nutrition	MDG-F-1993

Joint Programme Cost [Sharing - if applicable]	Joint Programme [Location]
[Fund Contribution]: USD 5,500,000 Govt. Contribution: USD 0 Agency Core Contribution: USD 0 Other: USD 0 TOTAL: USD 5,500,000	Region (s): National scale for some interventions; Provinces: Maputo and Nampula cities for some interventions

Final Joint Programme Evaluation	Joint Programme Timeline
Final Evaluation Done Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Evaluation Report Attached Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Date of delivery of final report 29 June 2012	Original start date 1 October 2009 Final end date 30 June 2012

Participating Implementing Line Ministries and/or other organisations (CSO, etc)
 Ministry of Health, Ministry of Agriculture, Municipal Councils of Maputo and Nampula and CSOs: Kulima Nampula and Kulima Maputo, UGCAN (União Geral dos Camponeses de Nampula), Solidariedade Zambezia, Nivenyee, AES (Association of Educational activities for Health) and Kuyakana.

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.

At the time the joint programme was drafted, the Demographic and Health Surveys (DHS) showed little change in the nutritional status of children between 1997 and 2003, during a period when Mozambique experienced rapid poverty reduction and a reduction of 19 per cent in the under-five mortality rate. In the DHS 2003, stunting prevalence among children under five was documented as 41 per cent, which was above the sub Saharan average of 38 per cent. Underweight prevalence was documented as 24 per cent and wasting prevalence as four per cent (when the DHS 2003 was drafted, the reference population in use was the NCHS reference population. In 2006, WHO published its Multicentre Growth Study and published new global growth standards based on this study. An adjustment of the DHS 2003 data to the 2006 WHO growth standards gave the following prevalence data for 2003, which have been in use in Mozambique since 2009: stunting: 48 per cent, underweight 18 per cent and wasting four per cent).

Micronutrient deficiencies were also documented to be high, with high levels of anaemia and vitamin A deficiency in children under five (75 per cent and 69 per cent respectively) and high levels of anaemia in mothers (almost 50 per cent). The under five mortality rate in Mozambique was 168 per 1,000 live births when the proposal was drafted, with malnutrition being a key underlying factor.

The HIV epidemic has made large population groups vulnerable. When the joint programme was drafted, over 1.6 million people in Mozambique were estimated to be living with HIV, and approximately 470,000 children were estimated to have lost their father, mother or both parents to AIDS related illnesses. In areas affected by food insecurity and high levels of HIV infection, maternal orphans were 50 per cent more likely to be chronically malnourished than the general child population in Mozambique.

The joint programme was conceived at the peak of the food and fuel crisis, at a time that the Government's Secretariat for Food and Nutrition Security (SETSAN) and the Famine Early Warning Network had document steep increased in food prices. Another reason for concern was the fact that the reduction of poverty levels in urban areas (51.6 per cent)¹ remained significantly slower than in rural areas (12 points compared to 16 points in the rural areas). Urban and peri-urban populations are very dependent on markets, so the increase in food prices meant a severe threat for their food security.

In order to address the above mentioned challenges in terms of food security and nutrition, particularly relating to children in Mozambique, the joint programme includes both short-term mitigating efforts (scaling up and strengthening the treatment of acute malnutrition), preventative interventions (vitamin A supplementation and deworming) and interventions with a long-term impact (improving the food security and nutritional knowledge and skills of vulnerable households in urban and peri-urban areas and improving families' and health workers' knowledge and skills on infant and young child feeding). Nutritional surveillance was also included as a key supportive intervention.

The joint programme was drafted to contribute to the United Nations Development Assistance Framework (UNDAF) outcome to improve health, nutritional and education status of poor and vulnerable groups in Mozambique by 2011, and to contribute towards Mozambique's achievement of Millennium Development Goals (MDGs) 1, 4 and 5.

¹ 51.6% of households in Maputo City lived in absolute poverty at the time of proposal development (2003 Household Budget Survey)

b. List joint programme outcomes and associated outputs as per the final approved version of the joint programme Document or last agreed revision.

The joint programme outcome was formulated as: *Improved health, nutritional and food security status for children by 2011*. The following outputs were formulated to achieve the programme outcome:

Output 1: An effectively functioning and expanded system to treat severely and moderately malnourished children is operational in programme areas by the end of 2011;

Output 2: An effective way of delivering key preventative interventions to children under 5; and

Output 3: An effectively functioning and expanded system to promote improved and diversified diets and knowledge on nutrition included in infant and young child feeding (IYCF).

c. Explain the overall contribution of the joint programme to National Plan and Priorities

The UNDAF 2007-2009 (which was subsequently extended up to 2011), as well as this joint programme, were drafted to contribute to, among others, the implementation of the Food Security and Nutrition Strategy (ESAN II) and its Action Plan and the achievement of results set in the National Poverty Reduction Strategy Paper 2006-2009 (PARPA in Portuguese), which meant to directly impact on the attainment of the MDGs.

Since the initiation of this joint programme, a new Government Five Year Plan 2010-2014 and PRSP have been drafted. The UNDAF 2012-2015 is fully aligned with these documents and the joint programme continues to be in line with the Government priorities as well. After the initiation of this joint programme, several partners, including UNICEF and WFP, under the leadership of the Ministry of Health, developed guidelines for health centre based management of acute malnutrition which were approved in 2010 by the Minister of Health. Old guidelines were updated and the former programme was expanded to include the treatment of acute malnutrition as both in-patients and outpatients (severe and moderate cases) and also pregnant and lactating women and adults with HIV and/ or TB, in addition to children.

d. Describe and assess how the programme development partners have jointly contributed to achieve development results

The four collaborating UN agencies held regular meetings to discuss progress and agree on key aspects like monitoring mechanisms and coordination with Government. When needed, bilateral meetings were also held. WFP and UNICEF worked closely together in supporting the Ministry of Health (MoH) to merge the tripartite agreement for supplementary feeding of moderate acute malnutrition with the existing interventions for the treatment of severe acute malnutrition into the Nutrition Rehabilitation Programme. Instead of the earlier Tripartite Agreement which only involved MoH, UNICEF and WFP, an implementation plan for the nutrition rehabilitation programme was drafted by all partners (under the leadership of the MoH), in which responsibilities and support of many other partners were also described. Discussions with WHO were held on specific technical matters.

The three other agencies provided inputs to several of the interventions supported by FAO (screening for the selection of beneficiaries, baseline study). On specific occasions, synergies between the activities supported by the different organisations were established (for example, the CSOs supported by FAO supported the National Health Week interventions in the neighbourhoods where they are operational).

The four agencies worked very closely together for the Multisectoral Action Plan for the Reduction of Chronic Undernutrition which was approved by the Council of Ministers in September 2010. This plan is not related to the joint programme as such, but is a new Government initiative in which the four agencies worked closely together as an extension to the work in the context of this joint programme.

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 joint programme outcome is: *Improved health, nutritional and food security status for children by 2011*. The preliminary results of the DHS 2011 indicate that the prevalence of underweight (one of the two outcome indicators of the joint programme) is 15 per cent, compared to the target of 16 per cent. The other outcome indicator is “Percentage of households with improved dietary diversity”. The endline survey undertaken by FAO in the intervention areas of Maputo and Nampula cities did not find a significant difference in dietary diversity in the studied households. It did, however, find an increase of about 100 per cent in intake of plant sources of vitamin A in both cities.

Due to the decision not to undertake stand-alone monitoring activities, it is difficult to determine if this outcome has been achieved in a way that is specifically linked to the joint programme. Some of the interventions, like the support to nutrition rehabilitation, were supported at a nationwide level, in addition to training of health workers in specific provinces and districts, meaning that national processes (including technical support, training of trainers) were supported. The National Health Weeks is an intervention with a nationwide coverage which was supported for three rounds. The promotion of breastfeeding had national coverage and the capacity building of health and community workers was done in specific localities. The urban and peri-urban horticulture and tree planning activities had a very small geographic coverage.

In summary, it can be assumed that the joint programme activities have contributed to an improved weight by age situation in the country, but attribution is difficult.

- 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?**

In general terms, capacities have been strengthened at different levels (communities, civil society organisations, health workers). The impact could be seen during the subsequent round of National Health Weeks and also in the support to urban and peri-urban families benefitting from horticulture activities. There have also been challenges, however, due to the high turnover of staff within the Government, particularly at the health facility level.

Intensive and extensive trainings have been carried for the Nutrition Rehabilitation Programme (PRN) for both provincial level program managers, district levels focal points and health center based staff. In addition, at frequent intervals, on the job-trainings were carried out. Supervision and monitoring visits by national and provincial Government staff also added to this effort to increase capacity. An effort is still being made to simplify recording and reporting tools and standardize them throughout the country.

Within the participating agencies, capacities have been strengthened in the application of specific approaches (such as urban gardening) and for the development of comprehensive protocols (like in the case of the Nutrition Rehabilitation Programme).

- 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.**

Output 1 (An effectively functioning and expanded system to treat severely and moderately malnourished children is operational in programme areas by the end of 2011):

Performance indicators:

1. Number of moderately malnourished children reached with nutritional supplementation nationwide (baseline Sept. 2008: 5,577 children, annual target: 8,000 children and 4,000 adults); and
2. Number of severely malnourished children and pregnant women reached nationwide (baseline Sept. 2008: 11,527, annual target: 40,000).

To date, at least (11,471 (2010) + 28,162 (2011) + 6,746 (May, 2012) = 46,379 children with Moderate Acute Malnutrition (MAM) have been reached with interventions supported by the joint programme, and (37,280 (2010) + 21,145 (2011) + 7,596 (2012) =) 66,021 children with Severe Acute Malnutrition (SAM). The numbers of MAM children are below the target, while the reported numbers of SAM children are above the target. It should be noted that the reports are often not complete (not covering all health centres and all months of the year, and no data on outpatient treatment for MAM and SAM with RUTF was available for 2012).

While the interventions for MAM and SAM started out as two separate programmes, these were merged in the course of the joint programme. Capacities built in the course of the joint programme focused on duty bearers (health care providers), with some specific capacity building efforts for caregivers (nutrition education). The joint programme also provided for nutrition supplements (corn soy blend (CSB)).

Output 2 (An effective way of delivering key preventative interventions to children under 5):

Performance indicator:

1. Number of children <5 reached with a comprehensive package of preventative interventions in Child Health Week (baseline 2008 second round: 3,503,905, target: 3.5 million)

The joint programme supported three rounds of Child Health Weeks (later renamed to National Health Weeks), covering 3,440,770, 3,788,289 and 3,352,132 children respectively (the numbers should not be added up since they might include the same children. Capacities built in this context include those of facility and community based health worker, and to some extent to caregivers (about the importance of vitamin A and deworming).

Output 3 (An effectively functioning and expanded system to promote improved and diversified diets and knowledge on nutrition included in Infant and Young Child Feeding):

Performance indicators:

1. Number of households with improved diversified diets (baseline 2008: N/A, target: 15,000)

The endline survey undertaken by FAO in the intervention areas of Maputo and Nampula cities did not find a significant difference in dietary diversity in the studied households. It did, however, find an increase of about 100 per cent in intake of plant sources of vitamin A in both cities (from 15 per cent to 30 per cent). The information in the survey report is presented in percentages of the survey sample and cannot be translated into a total number of households.

2. Number of households with improved nutrition knowledge (baseline 2008: N/A, target: 15,000)

The nutrition and urban horticulture components of the joint programme was implemented using the cascade-training model with three categories of capacity development: (1) Trainers of Trainers (ToT) 62 *extension staff* from the government and from community-based organisations (CBOs) were trained as ToT in both home gardening techniques, nutrition and basic health and hygiene; (2) the ToT trained 450 *community activists* who worked directly with the families; 3) at the end of the programme, 11,558 households (HH) had benefited from the nutrition education sessions, and 11,340 HH had at least one season of implementation of their own home gardens. The training sessions at all levels were based on practical exercises, cooking demonstration, preparation of enriched porridge for the children and conservation of food.

3. Number of neighbourhoods with tree planting programme (baseline 2008: 0, target:10)

The ten elected neighborhoods in the cities of Maputo and Nampula were reached with the fruit tree plantation programme and 10,838 HH have planted the trees in their yards.

4. Number of provinces implementing the MoH Infant Feeding Policy and Strategy on the Promotion, Protection and Support of Breastfeeding (baseline 2008: 0, target: 11)

The Infant Feeding Policy has been drafted but not yet been finalised. This does not create a barrier for the implementation of activities since the main purpose of the policy is the consolidation of existing guidance. All provinces have implemented some activities based on the Strategy for the Promotion, Protection and Support of Breastfeeding with support of the joint programme. All provincial hospitals have benefitted from training in the Baby Friendly Hospital Initiative (training of trainers, training of staff, and/or training of evaluators). In nine provinces, training of trainers on community based counselling for leaders of mother support groups took place. The promotion of breastfeeding via television and radio spots, World Breastfeeding Week commemorations had nationwide coverage.

Capacity building of rights holders in this context focuses on mothers and other caregivers. The activities included behaviour change activities like radio spots and the training of community leaders with the final goal of reaching mothers and other caregivers.

5. Number of districts with nutritional surveillance in place (baseline 2008: 0, target 20)

The Ministry of Health has 38 districts registered as having a nutrition sentinel sites. The joint programme aimed to improve the quality of data collection, recording and reporting. Up-to-date equipment was procured for 11 sentinel sites, and a national training of trainers in the use of ANTHRO software was conducted in which seven technical staff from the MoH central level were trained. The funds for the training of districts have been disbursed to the MoH and the training will take place shortly, so that it is in line with the revision process of the nutritional surveillance system undertaken by the MoH.

6. Number of districts implementing actions improving food safety and nutrition practices (baseline 2008: 0, target 20)

The funds for this activity have been disbursed to the MoH to for the training of trainers at central level to incorporate the topic of food safety into the existing complementary feeding package.

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)

For the majority of the interventions, the primary beneficiaries/right holders are families. Families have been engaged as participants in activities such as National Health Weeks (this involved mostly women), the nutrition rehabilitation activities (also mostly women) and in urban and peri-urban

gardening (both women and men). They have mostly been engaged in joint programme implementation as participants. It is understood that the final beneficiaries of the joint programme interventions are the children who these families take care of.

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:

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

The revised nutrition rehabilitation protocol includes a strong emphasis on community based screening, which is aimed at detecting malnourished children who have not (yet) been in touch with the health system. In addition, the National Health Weeks are set up to reach national coverage (i.e. including socially excluded populations) and the administrative data showed a very high coverage.

ii. 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?

This joint programme was not set up to increase the decision making power of excluded groups and this aspect has not been measured. The urban and peri-urban horticulture activities have enabled previously excluded groups to get an income and/or improve their nutrition, which increases the likelihood that they participate actively in society.

iii. Has the programme and its 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.

As said above, this was not measured specifically, but the involvement of citizen and civil society as such and the strengthening of linkages between these groups and the municipal governments will have strengthened their capacity to advocate for their rights.

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

Although this was not measured specifically, it is assumed that socially excluded groups have benefitted from the joint programme either because of the outreach activities (National Health Week, malnutrition screening and treatment) or because of targeting (peri-urban horticulture).

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**
- **Involvement of CSO and citizens**
- **Alignment and harmonization**
- **Innovative elements in mutual accountability (justify why these elements are innovative)**

In this joint programme, national (Ministry of Health) and local (provincial and district health directorates and municipalities) government institutions were in the lead and the programme supported Government-run activities. The urban and peri-urban horticulture activities were implemented by CSOs, but this was done in close collaboration with and in agreement of the local authorities. CSOs were also involved in the implementation of the

National Health Weeks, and in some of the infant and young child feeding activities (capacity building of mother support groups). All activities of the joint programme are aligned with Government priorities and plans.

Due to the urban and the peri-urban gardening programme the municipalities of Maputo and Nampula strengthened their agricultural sectors and created new units in their structures for urban gardening.

b. Delivering as One

- **Role of Resident Coordinator Office and synergies with other MDG-F joint programmes**
- **Innovative elements in harmonization of procedures and managerial practices (justify why these elements are innovative)**
- **Joint United Nations formulation, planning and management**

The Resident Coordinator's Office regularly monitored progress of this and the other MDG-F joint programmes, including via an annual review of joint programmes. This was useful to take stock of the achievement of the programme and to share lessons learned with colleagues implementing other joint programmes (MDG-F and others).

In this joint programme, procedures and managerial practices were not very harmonised since the agencies maintained their own management and procedures. The management of the joint programme as a whole was done by staff members of the coordinating agency and not by staff specifically recruited for this purpose. This facilitated mainstreaming of activities across agencies and additionality of the MDG-F funds.

The proposal was formulated jointly by the participating agencies and could build on the existing UNDAF. The development of the UNDAF for 2012-2015 benefitted from the participating agencies' experience in working together and it also facilitated the drafting of joint outcomes in the area of food security and nutrition.

III. GOOD PRACTICES AND LESSONS LEARNED

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

Lessons learned:

1. It is important to ensure linkages between intervention areas so that the target population benefits optimally (in this case, the neighbourhoods benefitting from urban and peri-urban horticulture and fruit trees could have been linked better with the respective health centres).

Good practices:

1. The use of one protocol for the detection and treatment of acute malnutrition with a continuum of care ranging from detection in the community via inpatient treatment to those who need it and outpatient treatment for those eligible, and discharge upon cure. This protocol was finalised with support of this JP and its implementation supported by the JP.

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

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

a. Internal to the joint programme

- Staff constraints (delays in recruiting, under staffing in some agencies).
- Lack of a simple and standardised reporting tools and data base for the nutrition rehabilitation programme.

- Timeliness and quality of monitoring data of the nutrition rehabilitation programme.
- Low capacity for implementation at health center level (low number of staff with high workload, high turnover).
- Lack of material for implementation of PRN (i.e. working and calibrated anthropometric tools).
- Delays in the production of CSB and dispatch to Mozambique.
- Delays in the delivery of CSB to health centres by the Provincial Health Directorates.

b. External to the joint programme

- There were no external difficulties.

c. Main mitigation actions implemented to overcome these constraints

- The extension of the joint programme was undertaken to compensate for the delays in recruitment of staff.
- Technical support was provided to health staff at different levels, for recording and reporting on the nutrition rehabilitation programme.
- Capacity building efforts increasingly include supervision and on-the-job training, which can be more effective in strengthening capacities than classroom trainings.

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

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

The annual review of data highlighted the areas with progress and the areas requiring more technical assistance.

Improvement in transparency and mutual accountability

The Government counterpart was involved in the selection and recruitment of the project staff, procurement of goods and services were applicable.

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

The bi-annual data collection and review highlighted some gaps in data management for the nutrition rehabilitation programme. These could be addressed in training sessions and materials subsequently supported by the joint programme.

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

The mid-term evaluation was undertaken after two years of the original 27 months of implementation. Due to the six months extension, there was more time left after the completion of the evaluation. The evaluation pointed to some weaknesses that could still be addressed (like the selection of CSOs for the urban and peri-urban horticulture).

5. Describe and assess how the communication and advocacy functions have contributed to the:

a. Improve the sustainability of the joint programme

The sustainability strategy is based on capacity building and on identifying additional sources of funds. Communication efforts were not related to sustainability, but advocacy has facilitated the leveraging of other funding that was made available to the Ministry of Health.

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

The PRN component is a MoH programme that is already being implemented nationwide. Quality of implementation and reporting are still an issue that needs to be improved and of which the technical group has been working on.

c. Providing information to beneficiaries/right holders

Communication has been crucial to inform beneficiaries and rights holders of available services like the National Health Weeks and about important child feeding practices (via tv and radio spots and interpersonal communication)

6. 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?

Reports of the National Health Weeks.

1. Report of the Baseline Survey.
2. Report of the Endline Survey.
3. Reports of the NGO implementing partners.

b. Describe example, if any, of replication or scaling up that are being undertaken

The nutrition rehabilitation programme continues to be implemented with support from a broad range of partners (including UNICEF and WFP) and funding sources. The National Health Weeks are still implemented. The last round of 2011 was 90 per cent financed by funds managed by the Ministry of Health.

Other partners have also come on board to support the implementation of the Baby Friendly Hospital Initiative. The training of mother support groups for improved infant feeding practices was a joint undertaking from the beginning, with several partners supporting the activities.

c. Describe the joint programme exit strategy and assess how it has improved the sustainability of the joint program

The exit/sustainability strategy document is attached as a separate document. It describes a combination of strategies, mainly based on capacity building, systems development and the identification of alternative funding sources.

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

			Totals
Total approved budget	FAO	1,590,662	5,500,000
	UNICEF	1,805,090	
	WFP	1,978,430	
	WHO	125,818	
Total transferred	FAO	1,590,662	5,500,000
	UNICEF	1,805,090	
	WFP	1,978,430	
	WHO	125,818	
Total committed	FAO	1,590,662	5,500,000
	UNICEF	1,805,090	
	WFP	1,978,430	

	WHO	125,818	
Total disbursed	FAO	1,590,662	5,500,000
	UNICEF	1,805,090	
	WFP	1,978,430	
	WHO	125,818	

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

V. OTHER COMMENTS AND/OR ADDITIONAL INFORMATION

N/A

VI. CERTIFICATION ON OPERATIONAL CLOSURE OF THE PROJECT

By signing, Participating United Nations Organizations (PUNO) certify that the project has been operationally completed. **Attached in an Annex**

PUNO	NAME	TITLE	SIGNATURE	DATE
FAO				
UNICEF				
WFP				
WHO				

VII. ANNEXES

1. List of all document/studies produced by the joint programme
2. List all communication products created by the joint programme
3. Minutes of the final review meeting of the Programme Management Committee and National Steering Committee (minutes of the PMC meeting attached as a separate document)
4. Final Evaluation Report (attached as a separate document)
5. M&E framework with update final values of indicators (attached as a separate document)

Annex 1. List of all document/studies produced by the joint programme

No.	Title and description	Responsible agency
1.	Baseline study on Knowledge, Attitudes and Practices	FAO
2.	Endline study on Knowledge, Attitudes and Practices	FAO

Annex 2. List all communication products created by the joint programme

No.	Title and description	Responsible agency
1.	Vamos comer –nutrition education for schools	FAO
2.	Guia Prático para o Estabelecimento da Horta Urbana Familiar _ Practical guide for setting up and running home gardens	FAO
3.	Manual da Horta Urbana – Manual for urban garden	FAO
4.	Manual do Cultivo da Alface na Agricultura Urbana Familiar – manual for growing lettuce in urban family agriculture	FAO
5.	Trípticos das principais hortícolas (alface, acelga, espinafre, repolho,, salsa, pimento, aipo, cebola, beterraba, pepino, cenoura, beterraba, nabo, rabanete e morango)	FAO
6.	Poster National Health Week	UNICEF
7.	Leaflet National Health Week	UNICEF
8.	Folder of job aids for PRN	WFP and UNICEF