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SUMMARY EVALUATION REPORT ON DEVELOPMENT PROJECT NIGER 2072.03

Support to MCH activities, nutritional rehabilitation and education

Total food cost	8,712,245 dollars
Total cost to WFP	15,191,018 dollars
Date approved	27 May 1991
Date plan of operations signed	14 November 1991
Date of first distribution	1 July 1992
Project duration	Six years + six months
Official termination date	31 December 1998
Date of evaluation[1]	February 1998

All monetary values are expressed in United States dollars, unless otherwise stated. One United States dollar equalled 608 CFA francs (CFAF) at the time of the evaluation.

[1]The mission consisted of a senior official from the Office of Evaluation, WFP (chief of mission); a nutrition specialist (consultant), WFP; and a public health specialist (consultant), WHO.

ABSTRACT

The project aims at improving the coverage of prenatal and infant care consultations by increasing the number of regular visits by at-risk expectant and nursing mothers. At this stage, it cannot be considered a success. Health centres have effectively registered a significant increase in visits, but on a very irregular basis. Despite the fact that the project's performance leaves much to be desired, the mission considers that food aid is justified on condition that adjustments are made to the future programme's design, and on the understanding that the recommendations made in respect of management and monitoring are scrupulously followed. These adjustments include improved targeting of intervention areas and of beneficiaries. After reformulation, the project should not start up until the internal monitoring and evaluation system has become operational.

NOTE TO THE EXECUTIVE BOARD

This document is submitted for consideration to the Executive Board.

Pursuant to the decisions taken on the methods of work by the Executive Board at its First Regular Session of 1996, the documentation prepared by the Secretariat for the Board has been kept brief and decision-oriented. The meetings of the Executive Board are to be conducted in a business-like manner, with increased dialogue and exchanges between delegations and the Secretariat. Efforts to promote these guiding principles will continue to be pursued by the Secretariat.

The Secretariat therefore invites members of the Board who may have questions of a technical nature with regard to this document, to contact the WFP staff member(s) listed below, preferably well in advance of the Board's meeting. This procedure is designed to facilitate the Board's consideration of the document in the plenary.

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THE PROJECT AS PLANNED

1. Despite the Government's efforts in the health sector, Niger's high rates of childbirth, infant and infant-juvenile mortality, together with a chronic rate of malnutrition, remain of serious concern. In order to improve the health of women and of pre-school children, the Government has set itself a number of specific objectives in its health development plans. Project Niger 2072.00 which is supported by WFP, is part of those plans. In the long term, the project aims at supporting the Government's attempts to improve the coverage of rural populations by the health services and to develop preventive health activities while also enhancing curative health care (nutritional rehabilitation).

2. Immediate objectives of the present phase are to: i) to increase regular attendance by expectant and nursing mothers and children aged between 0 and 59 months in mother and child health (MCH) centres; and ii) to improve nutritional recovery activities on behalf of severely or moderately malnourished children in mobile nutritional rehabilitation centres (CRENAs) or in intensive nutritional rehabilitation centres (CRENIs).

3. Original beneficiaries of the project were to be 76 health establishments (out of the 310 when the current project was formulated), four nutritional rehabilitation centres and eight paediatric centres. Calculations were that an annual average of 23,000 expectant or nursing mothers and at-risk or malnourished children, together with women accompanying children attending CRENAs or CRENIs, would benefit from rations consisting of sorghum or millet, pulses (niébé), vegetable oil, sugar and skim milk powder. Specific criteria were included in the plan of operations to target participating centres and beneficiaries.

4. WFP aid was intended to encourage expectant and nursing mothers and their children to attend health centres on a more regular basis, and to serve as an income transfer and a nutritional supplement.

5. In accordance with the Country Strategy Outline (CSO) presented to WFP's Executive Board in October 1997, WFP intends to continue its aid to the mother and child health sector in the next four years, as this is one of the priorities set out in Niger's National Strategy Note. In the meantime, the project's present phase has been extended to December 1998.

PERFORMANCE ASSESSMENT

Progress towards achievement of objectives

6. Niger's public health development plan aims at achieving—by the year 2000—improved health coverage within a range of five kilometres, i.e., increasing coverage from 32 percent to 45 percent. At the same time, it is planned to monitor 80 percent of children aged up to three years. The mission had no data relating to conditions at the time when the project started up, and was therefore only able to analyse the situation from 1996 onwards, when the project's monitoring and evaluation system was set up by a national consultant.

7. At present, the project covers 68 percent of infants aged up to 11 months, which corresponds to the objectives set out in the plan of operations. But the rate for children aged between one and five is much lower—around 22 percent. It should be noted that after reaching two years of age children are seldom taken to the health centres as their mothers

become pregnant again and stop going. The project thus only reaches those children when they fall ill and are taken in for treatment.

8. Children under one attend health clinics just over twice a year on average, while those aged between one and five do so even less often. The mission's opinion is that such attendance rates make it impossible to monitor children's growth properly. Available data indicate that at-risk children receive on average only two monthly food rations, which is not enough to prevent malnutrition.

9. Coverage of expectant mothers is 72 percent, which also corresponds to the plan of operations. For cultural reasons, however, expectant mothers tend to visit the centres only after their sixth month of pregnancy, and generally do so only twice during pregnancy, according to internal monitoring and evaluation data covering the period January 1996 to September 1997.

10. Nursing mothers also seldom visit the centres more than twice a year on average.

11. The CRENAs' programme for moderately malnourished children covers 13 percent of children aged between 0 and 11 months, i.e., nine percent of children aged up to five, which corresponds roughly to the moderate malnutrition rate reported by a nutritional survey in 1992. Attendance is a little higher than for at-risk children, but is marked by a 26 percent drop-out rate. The recovery rate is only 35 percent. In centres which are poorly supervised or equipped, prevention activities are often neglected in favour of curative treatment. Almost 10 percent of cases are referred to the nearest CRENI or hospital with facilities for treating serious malnutrition.

12. The only CRENI where the mission was able to witness nutritional rehabilitation activities was that at Zinder hospital, which is run by Médecins sans Frontières (MSF). It may be that the mission visited the other centres too early or too late, but what is certain is that such activities were not operational there. In some centres, monitoring and evaluation (M&E) documentation proved impossible to find or had not been filled in for several months. According to a 1997 MSF report, patients dismissed as cured in the seven CRENAs supervised by MSF in Tanout district amounted to some 64 percent. This is fairly acceptable but, despite the quality of the services offered, the drop-out rate remains relatively high, underscoring the CRENAs' limitations.

13. As regards Zinder's CRENI, dismissal indicators were acceptable given the quality of the services provided. However, the CRENIs focus mainly on providing curative treatment, as do the eight hospital paediatric centres.

14. It should be mentioned that UNICEF has stopped assisting the CRENAs and CRENIs to concentrate on more community-based, participatory and preventive activities. This is in line with WFP's objectives in such programmes.

Role and justification of food aid

15. Under present conditions, WFP aid cannot play an effective role. The fact that aid has been provided to a much larger number of expectant and nursing mothers than planned has reduced the project's impact in terms of feeding, nutrition, and income transfer.

16. Food aid has attracted populations attending neighbouring, non-beneficiary centres, thus complicating the beneficiary centres' activities and overloading personnel with work. Given the large number of applicants for aid, the number of consultation days no longer matches the days of food distribution. Food aid has therefore become disconnected from preventive health activities.

17. It may be asked why WFP aid does not encourage women to visit the centres more regularly. In nomadic or semi-nomadic zones, the explanation is that populations are on the move, but in sedentary areas, limited attendance may be explained, aside from certain cultural factors, by the inadequate size of the rations, in turn stemming from the excessive number of beneficiaries. This is perhaps the reason why women are discouraged from coming in for consultations, though the lack of any relevant data makes it impossible to verify this hypothesis.

18. At the CRENIs, food rations represent a form of budgetary support making up for the insufficient resources allocated to regional hospitals. Aside from the risk of the CRENIs becoming dependent on WFP assistance, the rations' effectiveness is limited by the fact that hospital treatment has to last a long time to be useful. The result is that patients are often withdrawn from the centres and that children relapse or even die. It should be noted that WFP assistance in the paediatric wards is provided not only to malnourished children but to all children undergoing treatment.

Beneficiaries

19. The plan of operations provides for an annual average of 21,794 expectant and nursing mothers, at-risk children and women accompanying malnourished children attending CRENAs and CRENIs to receive food aid, plus 1,140 moderately malnourished and 350 seriously malnourished children. Overall, the number of beneficiaries has been much larger than forecast, with 102,363 in 1996 and 139,508 in 1997. Given the fact that food rations for expectant and nursing mothers and at-risk children were calculated on the basis of 360 days a year but that each individual beneficiary received an average of only two monthly rations a year, the project was able to provide for nearly six times as many beneficiaries as originally intended. Some 57 percent of expectant mothers attending prenatal consultations benefited, together with 66 percent of all women attending infant-care consultations.

20. An erroneous interpretation of the selection criteria[1] for expectant and nursing mothers is the reason why the number of beneficiaries has far exceeded the total planned, and is at the root of the difficulties encountered by the project. The criteria are not in themselves complicated. The main problem is that the criterion of multiparity (more than four deliveries) applies to most expectant or nursing mothers in Niger. Unlike the other criteria, it is not nearly restrictive enough if it is applied separately. Nor does the plan of operations specifically state that multiparity may not be considered a valid criterion for selection on its own.

21. At-risk children (six to 59 months): selection criteria are precise and fully understood by personnel (flat or dropping weight curve, twins). Although the number of beneficiaries varies significantly from one centre to the next, the average is not much larger than the number specified in the plan of operations. As mentioned in paragraph 7 above, the project has a problem reaching children aged between two and five unless they are brought in because of illness.

[1] Expectant mothers: age (over 16 years and under 35); multiparity (more than four deliveries); twins expected; weight under 45 kilograms.

Nursing mothers: age (over 16 years and under 35); multiparity (more than four deliveries); mothers of twins; nursing mothers weighing under 45 kilograms; mothers with children weighing less than 2.5 kilograms at birth.

Benefits

22. Benefits of the project are confined mainly to an income transfer to beneficiaries. The transfer would have been larger if more distributions had taken place per beneficiary. As measured against the poverty threshold fixed before the CFA franc was devalued in January 1994, the transfer is more attractive in rural than in urban areas.

23. From a feeding and nutritional point of view, the triple daily take-home rations provide 2,965 kilocalories and should, if effectively distributed every month, largely satisfy the needs of expectant or nursing mothers—this despite the fact that the rations are in part consumed by the rest of their family.

Beneficiary health centres

24. When the current phase of the project was formulated in November 1990, the list of beneficiary health centres had already been drawn up. That list does not appear to have been revised in accordance with selection criteria for the centres following the appraisal mission.

25. As regards the criterion of "chronic food-deficit zones in rural areas", the evaluation notes that national project managers had to take other criteria into account, such as high rates of chronic malnutrition and extreme poverty. In order to facilitate project management, they mostly selected centres located in the chief towns of districts, and did so long before the present phase got under way. Up to 1996, some 51 percent of centres were to be found in chronic food deficit areas. Then, in 1997, a number of those centres, most of them in rural areas, were eliminated owing to poor management or absence of activity reports or again because of communications difficulties making it hard to transport food there. As a result, only 21 percent of beneficiary centres are currently located in rural, chronic food-deficit areas.

26. A recent study by the Club de Sahel[1] confirms that the five centres in Niamey are not eligible for food aid as they fail to conform to the criteria (rural area, high chronic malnutrition or extreme poverty). The six centres in Dosso province are likewise not eligible *a priori*, but a high rate of extreme poverty does exist there.

Project management and utilization of commodities

27. The project covers the country's seven departments plus the urban municipality of Niamey, which means that food aid is dispersed over a very wide geographical area, making monitoring and evaluation very difficult. The project's execution capacity is weak. The national project director combines her duties with management of the national mother-and-child health care programme. At the department level, health management personnel does not appear sufficiently involved in executing and monitoring the project. Moreover, cooperation with other aid organizations such as UNICEF and WHO has failed to materialize.

28. Personnel varies significantly from one centre to the next, with urban centres being better staffed than rural ones. The workload (preventive, curative and educational activities plus food distribution) is heavy and this has negative repercussions on the quality of activities and of the reports filed.

[1] Food Aid to Niger, Spatial Analysis 1993–1995, Club de Sahel, Organization for Economic Cooperation and Development (OECD), June 1997.

29. Food aid management is divided between the project directorate at the Ministry of Public Health and the WFP unit at the Ministry of Planning, the latter being responsible for coordinating all WFP projects in Niger. The plan of operations fails to define the duties, priorities or specific tasks pertaining to the two bodies. In the framework of WFP's Country Programme approach, the project's management and logistics structure should be defined more clearly.

30. Despite its economic problems, the Government does what it can to make funds available for food aid management. However the fact remains that most of the logistics and monitoring costs are covered by WFP through an internal transport, storage and handling (ITSH) subsidy. The level of the subsidy should be reviewed to take account of the devaluation of the CFA franc in January 1994.

31. Out of a total of 42,170 tons (millet/sorghum, pulses, skim milk powder, vegetable oil and sugar) committed by WFP, the project had, as at 30 September 1997, received 35, 827 tons, i.e. 84 percent of the total committed; of this, 34,660 tons had been utilized, representing 97 percent of quantities received. Post-c.i.f. losses, as noted in quarterly reports, amounted to 114 tons, i.e., 0.3 percent of commodities received. These data were approximate, however, as food borrowed from or loaned to other WFP-assisted projects was not systematically accounted for during the first few years of the project.

32. The mission recommends local purchasing of millet/sorghum and of pulses (niébé), providing the cost is no higher than that of imports. Such purchases help stimulate regional markets, while the combination of millet and niébé in the food basket is positive in terms of nutritional education.

33. Apart from niébé, which is not included in the food basket of any other WFP-assisted project in Niger, the consequences of delays in shipments of commodities have been mitigated through borrowing from other projects. At the level of individual health centres, reported pipeline disruptions are chiefly due to the high number of beneficiaries compared to forecasts, rather than to supply problems.

34. As regards the regional warehouses shared by the three WFP-assisted projects in Niger, the mission found that storage conditions and arrangements were satisfactory. Quarterly joint inventories (WFP/WFP Unit/Project Directorate) were generally carried out regularly and correctly filled out on stocks forms and inventory reports.

35. However, storage conditions were precarious in the health centres visited. In most cases, an ordinary room was used as a storehouse. Storage regulations were not respected and the situation was complicated by lack of space and equipment.

36. While it is clear that food does reach the centres, it is difficult to demonstrate that it does in fact reach its intended beneficiaries. The accounting system used makes it impossible to check whether beneficiaries receive their rations and fails to establish links with any health care received.

37. The daily food ration for expectant and nursing mothers as well as for women accompanying children to CRENIs or CRENAs consists of three individual rations of 250 grams of sorghum/millet, 15 of oil, 40 of niébé and 10 of sugar. The triple, take-home ration represents an advantage since, in this kind of project, WFP rations are usually consumed by the family as a whole. All the same, the rations are probably too large. If nursing mothers effectively received their 12 specified monthly rations, the quantity of cereals contained alone would be enough to feed one adult per family for a year.

38. The daily ration (100 grams of sorghum/millet, 20 of niébé, 10 of oil, 10 of sugar and 40 of powdered skim milk) for malnourished children attending CRENAs is intended to be consumed on the spot and is enough to prepare two dishes of porridge and nearly half a litre of enriched milk. But in most cases personnel simply prepare a milk-based porridge or a niébé puree, which is not the best way of using the rations. If children live more than five kilometres away they do not visit the centres every day. The mission's view is that they should be given take-home dry rations, since it is impossible for them to consume all the food on the spot.

39. Regarding the daily rations at the CRENIs (200 grams of sorghum/millet, 20 of niébé, 20 of oil, 20 of sugar and 60 of powdered skim milk), the quantities of milk provided are not enough to prepare the four energized milk drinks of 400 ml given by MSF to children. At the same time, the other ingredients intended to prepare porridge exceed MSF's recommendations. Thought should be given to readjusting the rations accordingly.

40. Educational activities are undertaken by paramedical personnel when children come in for consultations. Only a limited number of nutritional issues are covered. In order to remedy the mothers' almost complete ignorance about nutrition, it is essential that a global approach based on literacy courses for women and schooling for girls be adopted.

41. Family planning activities are not systematically linked to the project. This is regrettable in view of the high rate of local population growth. The mission must admit, however, that the project criterion of multiparity does not encourage such activities and should be dropped under the project's new phase.

Monitoring, evaluation and reporting

42. The monitoring and evaluation system only became operational at the end of 1995. The delay was due to the fact that the first candidate selected to set up the system had to back out after being appointed to a management post at the Ministry of Public Health. This was followed by the departure of a second candidate on a two-year study mission. In addition, the situation was complicated by frequent personnel changes at the WFP office in Niamey. It should further be noted that monitoring and evaluation ran into serious difficulties despite training courses organized by the national consultant and the distribution of a reference manual. The large amount of data to be collected, lack of supervision, frequent turnover of trained personnel and the many different activities engaged in by health operators were at the root of those problems.

43. Monitoring of commodity movements and of the number of beneficiaries, as well as compilation of two-monthly and half-yearly reports, was complicated by the fact that the field reports received by national management were irregular and inaccurate.

CONCLUSIONS AND RECOMMENDATIONS

44. Since the mission had no comparative data regarding attendance at the centres at the start of the project, it could not evaluate whether or not the current phase had attained its objectives. It is clear, however, that dispersal of the food aid for the reasons mentioned earlier had a negative effect. If beneficiaries had really received the food rations specified under the plan of operations, the impact in terms of food, nutrition, and income transfer would have been more positive. It is also clear that the project's outdated design no longer

corresponds to WFP's current philosophy and approach. It is thus recommended that a new project be formulated along the lines below.

45. In addition to providing a nutritional supplement, WFP assistance should represent an incentive and a revenue transfer, thus helping achieve a wider coverage for prenatal and infant consultations. In order to be effective, the future project should focus on 13 districts in four departments marked by extreme vulnerability in terms of food security, chronic malnutrition and extreme poverty. In order to avoid the negative consequences registered under the current project, centres should benefit from WFP assistance only if they conform to the criteria established by the mission.

46. For the reasons mentioned above, WFP should terminate its assistance to curative treatment in CRENIs and hospitals. This component should be taken over by the Government or covered by other sources of assistance.

47. WFP should continue its assistance to the CRENAs, but tackle the issue differently. Insofar as local conditions make it possible, WFP should strengthen mothers' participation and the community-based approach, involving midwives and female paramedics to identify and track at-risk or malnourished children and refer them to health centres.

48. After eliminating the multiparity criterion for expectant and nursing mothers for the reasons mentioned earlier, other criteria should be added in order to ensure that the most vulnerable women are reached. It is recommended that the selection criteria for this target group should be redefined when the future project is formulated.

49. A single monthly ration of 15 kilograms of sorghum/millet, four kilograms of niébé and 900 grams of oil should be supplied to expectant or nursing mothers . The ration provides 2,069 calories a day and includes 65 grams of protein and 44 grams of fat. Pre-school children should receive enriched flour to be made into porridge: 3.5 kilograms of locally-produced BITAMINE or corn-soya blend (CSB) a month (120 grams a day) and one kilogram of sugar (30 grams a day).

50. In order to improve the performance of the project's new phase, the mission recommends that:

a) A full-time director, to ensure regular project monitoring and supervision, be appointed at the national level. A full-time regional coordinator be appointed at the regional level.

b) An associate expert in nutrition and public health be appointed to the WFP office in Niamey to deal exclusively with the project.

c) The duties, prerogatives and tasks of the project's national directorate and management unit be clearly defined.

d) Given the high rate of mobility of health operators, continuous, on-job training in monitoring and evaluation be provided not only as regards commodity storage but also concerning commodity movements and beneficiaries.

e) Beneficiaries be involved in commodity management, and specifically in the construction of storehouses, as recommended by a previous evaluation mission. Moreover, female paramedics and midwives should be involved in the preparation and daily distribution of the rations on the days when pre-school children come in for consultations.

f) Other partners, such as UNICEF and the World Bank, be approached to secure their collaboration in maternal and infant-care activities in assisted centres, especially as regards the vaccination programme and the distribution of micronutrients.

g) Food aid be more closely integrated with preventive and educational activities. For example, rations should be distributed on days when consultations are held.

h) Beneficiaries attend the centres regularly or risk being struck off the programme.

i) On project start up, all elements required for its monitoring and evaluation, as defined in the course of formulation, should be in place. An internal, mid-term review should be carried out by the WFP office in Niamey. The new project should not begin unless the monitoring and evaluation system is in place.

j) Regarding the redeployment of health personnel, it is recommended that sufficient and stable personnel be allocated to beneficiary centres on a priority basis.

k) The mission's recommendations have been accepted by WFP and the Government.