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## **Synthesis report on four evaluations of the impact of WFP programmes on nutrition in humanitarian contexts in the Sahel**

### **Executive summary**

Acute malnutrition in the Sahel affects an estimated 6 million children under 5, of whom about 1.4 million require treatment for severe acute malnutrition. While there is considerable evidence of the effectiveness of interventions to treat moderate acute malnutrition under optimal conditions, there is insufficient and equivocal understanding of the relationship between malnutrition treatment and prevention work.<sup>1</sup> In addition to examining the impacts of various components of WFP programming on core outcomes, this series of impact evaluations synthesized in this report also contributes evidence on the value of the interrelationship between programmes for preventing and programmes for treating moderate acute malnutrition in emergency and post-emergency contexts.

This report is a synthesis of the main findings and lessons from four WFP-funded impact evaluations of nutrition and food security interventions in four countries of the Sahel region of sub-Saharan Africa: Chad, Mali, the Niger and the Sudan. The evaluations examined aspects of WFP's programmes for food security and the treatment and prevention of moderate acute malnutrition and the impact that they had on nutrition and food security outcomes and identified lessons for improving programme effectiveness to achieve core WFP objectives in food security and nutrition.<sup>2</sup> The synthesis provides cross-cutting evidence to inform strategic choices on future programming to address moderate and severe acute

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<sup>1</sup> Office of Evaluation (OEV). 2013–2015 impact evaluation series on MAM programming.

<sup>2</sup> The impact evaluations are part of the Humanitarian Assistance Thematic Window of the International Initiative for Impact Evaluation (3ie), which was launched in 2014 with the overall objective of generating high-quality evidence for improving the quality of life of those in humanitarian crises.

*In line with the Evaluation Policy (2016–2021) (WFP/EB.2/2015/4-A/Rev.1), to respect the integrity and independence of evaluation findings some language contained in this report may not be standard WFP terminology; please direct any requests for clarification to the WFP Director of Evaluation.*

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malnutrition as a tool for improving overall nutrition and food security outcomes. The impact evaluations considered the following main questions:

1. *Chad*: What is the impact of interventions for preventing moderate acute malnutrition on the incidence and prevalence of moderate acute malnutrition in children under 2 with varying levels of access to moderate acute malnutrition treatment?<sup>3</sup>
2. *Mali*: What are the impacts of conflict and food assistance on child malnutrition and other development outcomes?<sup>4</sup>
3. *The Niger*: What are the impacts on nutrition outcomes of various combinations of programme components in WFP's protracted relief and recovery operation?<sup>5</sup>
4. *The Sudan*: What are the impacts of various interventions for treating and preventing moderate acute malnutrition on the incidence and prevalence of moderate and severe acute malnutrition in children under 5 years and pregnant and lactating women?<sup>6</sup>

The evaluations identify lessons relevant to WFP programmes and provide insights into how various components of WFP programming interact with one another; the evaluation results are situated, however, within the particular context of each study area. WFP implemented food security and nutrition-related protracted relief and recovery operations in the Sahel region because of high rates of poverty coupled with fast population growth, climate change, recurrent food security and nutrition crises, and violence due to armed conflicts.

The impact evaluations also contribute to the literature on effective ways to improve nutrition and food security outcomes in humanitarian contexts. Although acute malnutrition has been identified as a major driver of child mortality in the developing world, large evidence gaps remain.<sup>7</sup> The International Initiative for Impact Evaluation carried out an assessment of various existing synthesis-type studies of the evidence base for humanitarian interventions and identified significant knowledge and evidence gaps regarding the prevention and treatment of acute malnutrition.

The impact evaluations covered in this synthesis reported various effects, depending on the context and the combination of programmes implemented. The impact evaluation for Chad found that the prevention programme – blanket supplementary feeding – had a positive effect on the incidence of moderate acute malnutrition during the lean season, particularly for households supported by seasonal work. When looking at the interaction between the prevention and treatment programmes, the blanket supplementary feeding programme had a larger positive impact on moderate acute malnutrition incidence among households with poorer than average access to the treatment programme – targeted supplementary feeding. The evaluation for the Sudan found a significant reduction in the prevalence of children at risk of malnutrition where food-based interventions for preventing moderate acute malnutrition were added to the treatment programme (targeted supplementary feeding). The Niger evaluation concluded that continued provision of food assistance for assets in combination with treatment and/or prevention programmes significantly reduced the incidence of moderate acute malnutrition, serving as a

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<sup>3</sup> 3ie. 2016. *Impact evaluation of WFP programmes targeting moderate acute malnutrition in humanitarian assistance situations in Chad*, by M. Saboya, J. Rudiger and J. Frize.

<sup>4</sup> 3ie. *The impact of humanitarian aid on food insecure populations during conflict in Mali*, by A. Gelli, J.-P. Tranchant, E. Aurino, L. Bliznashka, A.S. Diallo, M. Sacko, E. Siegel and E. Masset.

<sup>5</sup> 3ie. *Impact evaluation of WFP malnutrition interventions in Niger*, by T. Brück, N.T.N. Ferguson, J. Ouédraogo and Z. Ziegelhöfer.

<sup>6</sup> 3ie. 2017. *Impact evaluation of the World Food Programme's moderate acute malnutrition treatment and prevention programmes in Kassala, Sudan*, by E. Guevarra, E. Mandalazi, S. Belagamire, K. Albrekstan, K. Sadler, K. Abdelsalam, G. Urrea and S. Alawad.

<sup>7</sup> Black, R.E. *et al.* 2008. Maternal and child undernutrition: global and regional exposures and health consequences. *The Lancet*, 371(9608): 243–260; Bhutta, Z.A. *et al.* 2008. What works? Interventions for maternal and child undernutrition and survival. *The Lancet*, 371(9610): 417–440; Victora, C.G. *et al.* 2008. Maternal and child undernutrition: consequences for adult health and human capital. *The Lancet*, 371(9609): 340–357; Bryce, J. *et al.* 2008. Maternal and child undernutrition: effective action at national level. *The Lancet*, 371(9611): 510–526; Morris, S.S., Cogill, B. & Uauy, R. 2008. Effective international action against undernutrition: why has it proven so difficult and what can be done to accelerate progress? *The Lancet*, 371(9612): pp.608–621.

nutrition-sensitive form of assistance. The impact evaluation in Mali found that access to general food distribution led to increases in households' non-food and food expenditures and in micronutrient availability. The evaluation examined the delivery of a package of multisector nutrition interventions and found that households living close to conflict and receiving at least two forms of assistance – particularly general food distribution and school feeding – registered statistically positive effects on nutrition outcomes, while the effects were not significant for households that received only one form of food assistance. Disaggregating by degree of exposure to conflict, the evaluation also uncovered that the effects on children's nutrition outcomes were concentrated mostly in areas that were not in the immediate vicinity of conflict and that this might in part be because these households had greater access to aid.

This synthesis report is based on a systematic analysis of the four impact evaluations and identifies several operational and policy-related lessons. Based on these lessons, the recommendations identified in the synthesis report relate to improving operational efficiency and coverage, tailoring programme components according to context, increasing inter-agency cooperation and improving monitoring and cost data.

### **Draft decision\***

The Board takes note of the synthesis report on four evaluations of the impact of WFP programmes on nutrition in humanitarian contexts in the Sahel set out in document WFP/EB.1/2018/5-C and the management response set out in document WFP/EB.1/2018/5-C/Add.1 and encourages further action on the recommendations presented in the report, taking into account the considerations raised by the Board during its discussion.

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\* This is a draft decision. For the final decision adopted by the Board, please refer to the Decisions and Recommendations document issued at the end of the session.

## 1. Introduction

### 1.1 Background

1. Aligned with the WFP Strategic Plan (2017–2021), WFP’s nutrition policy for 2017–2021 articulates WFP’s expansive work to increase the availability of, access to, demand for and consumption of safe and nutritious diets. Building on lessons from the 2008 Lancet series on maternal and child undernutrition,<sup>8</sup> the 2010 framework for action of the interagency, inter-governmental Scaling Up Nutrition (SUN) movement<sup>9</sup> and the Renewed Efforts Against Child Hunger and Undernutrition (REACH) project,<sup>10</sup> the policy reiterates WFP’s commitment to including nutrition interventions in emergency responses and addressing moderate acute malnutrition (MAM) through prevention and treatment programmes. WFP’s approach includes food assistance for both the treatment and prevention of MAM and selected complementary activities to address the causes of malnutrition. The approach builds on a base of evidence of the effectiveness of interventions, an understanding of the multi-causal nature of malnutrition and a focus on the first 1,000 days following conception as critical for child survival and the attainment of an individual’s potential for physical and cognitive development and hence health and income earning in the future.
2. WFP implemented food security and nutrition-related protracted relief and recovery operations in the Sahel region because of high rates of poverty coupled with fast population growth, climate change, recurrent food and nutrition crises and violence due to armed conflicts. The convergence of these factors affects an estimated 30 million people, almost 12 million of whom require emergency food assistance. In the Sahel, acute malnutrition affects an estimated 6 million children under 5, of whom about 1.4 million require treatment for severe acute malnutrition (SAM).<sup>11</sup> In certain zones of Chad and northeast Nigeria, the prevalence of global acute malnutrition (GAM) is double the emergency threshold of the World Health Organization – 15 percent. In the Sahel region, conflict has resulted in hundreds of thousands of families becoming dependent on aid. A report by the Office for the Coordination of Humanitarian Affairs notes that about 24 million people in the Sahel will need food assistance in 2017, requiring a response that will be one of the world’s largest humanitarian operations.<sup>12</sup>
3. WFP has several ongoing context-specific interventions aimed at preventing and addressing MAM and overall food insecurity in the Sahel region. Under the broad umbrella of humanitarian assistance, WFP implements food-based interventions. Blanket supplementary feeding (BSF) and targeted supplementary feeding (TSF) are intended to support the prevention and treatment of MAM in food-insecure households through various forms of assistance tailored to the local context. Targeted food assistance (TFA), school feeding, food assistance for assets (FFA) and general food distribution (GFD) are aimed at contributing to improving nutrition outcomes.
4. *Chad* is one of the poorest countries in the world, with 87 percent of the population living in multidimensional poverty and life expectancy as low as 51.2 years.<sup>13</sup> The 2017 national nutrition survey revealed a GAM rate of 13.9 percent.<sup>14</sup> In *the Sudan*, undernutrition is not only a serious socio-economic and health problem, but also one of the least adequately addressed. According to estimates by the United Nations Children’s Fund (UNICEF) in 2017, GAM rates of 15.7 percent

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<sup>8</sup> Horton, R. 2008, Maternal and child undernutrition: an urgent opportunity. *The Lancet*, 371(9608): 179. <https://www.ncbi.nlm.nih.gov/pubmed/18207569>

<sup>9</sup> <http://scalingupnutrition.org/>

<sup>10</sup> <http://www.reachpartnership.org/>

<sup>11</sup> This burden value is only for acute malnutrition and the estimate would be much higher if chronic malnutrition was also taken into consideration. Furthermore, prevention efforts should support prevention of both types of malnutrition.

<sup>12</sup> Office for the Coordination of Humanitarian Affairs. 2016. *2017 Sahel – Overview of humanitarian needs and requirements*. [https://www.humanitarianresponse.info/system/files/documents/files/hnro\\_sahel-2017-en\\_2.pdf](https://www.humanitarianresponse.info/system/files/documents/files/hnro_sahel-2017-en_2.pdf).

<sup>13</sup> WFP. 2017, Chad. <http://www1.wfp.org/countries/chad>.

<sup>14</sup> Ministry of Health/*Direction de la Nutrition et de la Technologie Alimentaire* (National Nutrition and Food Directorate), Chad, September 2017.

were found in the Jabel Marra area.<sup>15</sup> *The Niger* ranks at the bottom of many development indices, including the Human Development Index and the United Nations Gender Inequality Index. Challenges facing the country include systemic institutional weakness, a range of internal and external security threats, relatively porous borders, episodes of involuntary migration and several recent food crises in recent history. The GAM rate in the Niger is estimated at 15 percent for children aged 6–59 months.<sup>16</sup> *Mali* is one of the most food-insecure countries in the world, ranking 179th of 188 in the 2015 Human Development Index. UNICEF’s 2017 SMART<sup>17</sup> survey reveals a GAM prevalence of 10.7 percent.<sup>18</sup> Mali has suffered a series of political, constitutional and military crises since January 2012; the situation there was aggravated by the loss of government control in northern territories from April 2012 to January 2013, causing the displacement of more than 135,000 people.<sup>19</sup>

5. The evaluations in Chad and the Niger focused on the PRROs in the two countries, with each evaluation looking at different components such as MAM treatment through TSF and the prevention of acute malnutrition through BSF, TFA and FFA. In Chad, participation in community awareness raising sessions was encouraged, and particularly aimed at pregnant women and mothers of young children. WFP activities in the Niger peaked in the lean season, when children and households are the most vulnerable. In the Sudan, the evaluation focused on the community-based nutrition integrated programme, which is part of a PRRO and includes components for MAM treatment, malnutrition prevention, home-based food fortification and social and behaviour change communication (SBCC). The Mali evaluation looked at various types of WFP food assistance activities in emergency operations and PRROs implemented over the five years following the 2012 conflict.

## 1.2 Objectives and methodology of the synthesis

6. The synthesis has been prepared for the Executive Board to serve accountability and learning purposes and to provide lessons that are useful to WFP country offices and the Nutrition Division, among others. An important objective of the synthesis is to examine the relationships among malnutrition treatment and prevention programmes and other nutrition and food security programmes in humanitarian contexts. Following current practice for synthesis reports, this document involves a systematic analysis of four impact evaluations in Chad, Mali, the Niger and the Sudan. The synthesis aims to identify cross-cutting themes, findings and lessons from the four evaluations and to provide useful insights into the effectiveness of programmes that aim to improve nutrition and food security outcomes for people in humanitarian assistance environments.
7. The report synthesizes evaluation results and recommendations in the areas of programme targeting and implementation, evaluation design and implementation and potential explanatory factors influencing programme performance. To the extent possible, it includes comparisons of cost analyses among the various programmes. While there is considerable evidence of the effectiveness of MAM treatment interventions under optimal conditions, there is insufficient and equivocal understanding of the relationship between malnutrition treatment and prevention work.<sup>20</sup> In addition to examining the impacts of various aspects of WFP programming on core outcomes, this series of impact evaluations also contributes to evidence on the value of the interrelationship between MAM prevention and treatment programmes in emergency and post-emergency contexts.
8. The report informs WFP, partner agencies, policymakers and other major stakeholders regarding the effectiveness of programmes and interventions in humanitarian and conflict settings. It is also

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<sup>15</sup> UNICEF. May 2017. *Sudan humanitarian situation report*.

<sup>16</sup> WFP. 2017. Niger. <http://www1.wfp.org/countries/niger>.

<sup>17</sup> Standardized monitoring and assessment of relief and transitions.

<sup>18</sup> UNICEF. September 2017, *Mali humanitarian situation report*.

<sup>19</sup> United Nations Development Programme. 2016. *Human Development Report 2016; Human Development for Everyone*. [http://hdr.undp.org/sites/default/files/2016\\_human\\_development\\_report.pdf](http://hdr.undp.org/sites/default/files/2016_human_development_report.pdf).

<sup>20</sup> WFP’s 2013–2015 OEI Impact Evaluation Series on MAM programming.

relevant for the donors supporting 3ie's Humanitarian Assistance Thematic Window, which supports impact evaluations of similar programmes in challenging humanitarian environments.

## 2. Methodology and limitations

### 2.1 Methodology and core evaluation questions

9. The impact evaluations synthesized in this report used various types of data and employed a range of methodologies, including various quasi-experimental methods combined with qualitative methods. The evaluation questions aimed to assess the impact of various components of WFP programming on various nutrition and food security outcomes. The questions were tailored to the programming context in each country and to the availability and quality of data. Table 1 presents a summary of the evaluation design, the main questions and the key outcomes for each of the four evaluations.
10. The impact evaluation in the Sudan assessed the impact of different MAM treatment and prevention interventions on the incidence and prevalence of MAM and SAM in children under 5 and pregnant and lactating women. The evaluation design used variation in the timing of introduction of MAM prevention components – such as food-based prevention or SBCC – and home fortification in various localities (clusters) where treatment activities were under way. The impacts were assessed by undertaking a cross sectional comparison across clusters, as well as a comparison over time within the same cluster. Data were collected at two-month intervals over a period of nine months (May–December 2016), enabling an assessment of how the addition of varying combinations of malnutrition prevention programming, including to address micronutrient deficiency, interacted with MAM treatment. This is a good example of a methodology that can be employed for robust causal analysis when baseline data are not available, and when withholding a programme from a group of potential beneficiaries is either undesirable or not feasible.
11. The impact evaluation in Chad asked a related but slightly different question: What is the impact of MAM prevention on the incidence and prevalence of MAM in children under 2 with different levels of access to MAM treatment? Impact was assessed by comparing the outcomes for beneficiaries who received all the planned BSF distributions in the prevention programme with the outcomes for a control group of people who were not covered by the programme. The evaluation then compared the difference in impact for both groups when their access to the treatment programme (using distance to the nearest health centre as a proxy) is good or poor.<sup>21</sup> Two waves of quantitative data were collected in June and November 2016. Regression and treatment effect models were used along with propensity score matching to estimate the average effect on people who were targeted by the programme.
12. The impact evaluation in the Niger focused on a broader set of questions with the primary aim of understanding the impact of WFP's PRRO – a multifaceted group of nutrition interventions – on the prevalence of MAM in the Niger. The interventions included TFA, BSF, TSF and activities designed to increase poor households' access to food and assets through land rehabilitation, water harvesting and local purchases, particularly through FFA. The evaluation used two waves of panel survey data and econometric techniques to estimate impacts at the household level on children aged 6–59 months at the start of the evaluation, one wave in March 2014 to establish a baseline, and one in September 2016 for the end line. The difference-in-differences analysis in the Niger evaluation makes use of secondary data collected during regular monitoring and evaluation work in the country.
13. The evaluation in Mali had a longer horizon for comparisons, with data collected in January 2012 and January 2017. The evaluation combined qualitative and quantitative methods, the latter including interviews with core stakeholders in the provision of humanitarian assistance, which informed the detailed survey design and descriptive data analysis. The study population was divided according to two criteria: the extent of humanitarian assistance received over the years

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<sup>21</sup> Distance to the nearest health centre also indicates differences in access to infrastructure, urban amenities and other health services.

since the conflict; and the extent to which areas where population groups lived were affected by conflict. The evaluation uses difference-in-differences combined with propensity score matching to assess the impact of various forms of food assistance – particularly GFD and school feeding – on food expenditures, food and nutrient consumption and the nutrition status of children at the household level.

<b>TABLE 1: STUDY DESIGNS, EVALUATION QUESTIONS AND MAIN OUTCOMES</b>			
<b>Country</b>	<b>Primary evaluation question(s)</b>	<b>Methodology</b>	<b>Main outcomes</b>
<b>Chad</b>	<ul style="list-style-type: none"> <li>What is the impact of MAM prevention on the incidence and prevalence of MAM in children under 2 with different levels of access to MAM treatment?</li> </ul>	<ul style="list-style-type: none"> <li>Analysis of covariates and propensity score matching</li> <li>Use of qualitative data to inform and interpret results</li> </ul>	Nutrition status of children under 2
<b>Mali</b>	<ul style="list-style-type: none"> <li>What are the impacts of conflict and food assistance on child malnutrition and other development outcomes?</li> </ul>	<ul style="list-style-type: none"> <li>Use of qualitative and quantitative data to characterize exposure to conflict and humanitarian assistance</li> <li>Natural experiment, difference-in-differences and propensity score matching</li> </ul>	Nutrition status of children under 5
<b>Niger</b>	<ul style="list-style-type: none"> <li>What are the impacts on nutrition outcomes of different combinations of programme components in WFP's PPRO?</li> </ul>	<ul style="list-style-type: none"> <li>Difference-in-differences</li> <li>Instrumental variables</li> <li>Qualitative analysis</li> </ul>	Nutrition status of children under 5
<b>Sudan</b>	<ul style="list-style-type: none"> <li>What are the impacts of different MAM treatment and prevention interventions on the incidence and prevalence of MAM and SAM in children under 5 and in pregnant and lactating women?</li> </ul>	<ul style="list-style-type: none"> <li>Stepped wedge cluster controlled trial design</li> <li>Qualitative analysis</li> </ul>	Nutrition status of children under 5 years and pregnant and lactating women

## 2.2 Limitations and implications for synthesis

14. All four evaluations were carried out in areas that are in need of urgent humanitarian assistance, particularly because of recurrent shocks and seasonal peaks in malnutrition. Despite this core similarity, however, various factors – such as the nature of the four studies, the insecurity in many target areas, the interrelated engagement of various organizations, and country-specific factors – limit the overall comparability of results from the four evaluations. In Chad, obtaining a large sample was a challenge because of the difficult operational and cost factors involved. In the Sudan, plans to follow an experimental approach for the evaluation had to be abandoned because WFP needed to start implementation in three specific locations, meaning that the use of randomization into clusters was not feasible. Similarly, given the high attrition in the Niger data, the original research questions could not be answered empirically and the focus of the evaluation had to be modified. The main limitation for the evaluation in Mali was in assessing the accuracy of triangulation of data on conflict with data on the delivery of timely and adequate food assistance to conflict-affected populations. Given the retrospective nature of the exercise conducted over a five-year period, the analysis has some limitations in terms of the accuracy of recall.
15. The country-specific challenges faced by the evaluations have implications for the validity of the synthesis. The evaluations used a wide array of data collection tools and followed timelines that varied from a few months to a few years, resulting in differential effects on the measurement of outcomes. Restrictions imposed by timelines were a continuous challenge throughout the

four evaluations, suggesting that more foresight and planning before conducting the evaluation might have eliminated some of the issues that arose. Although most of the evaluations had a broad focus, primary outcome measures differed among them, limiting the ability for one-to-one comparisons of estimates.

16. Although these limitations necessitate some caution, the evaluation designs enable careful causal inferences to be drawn and provide a basis for policy recommendations and conclusions related to various issues. The conduct of the evaluations, and observations made in that regard, also offer operational and policy lessons that are elaborated in section 4.

### **3. Findings and results**

#### **3.1 Highlights**

17. The four evaluations in this synthesis examining impact on MAM incidence reported varying effects depending on context and the combination of programmes implemented. The impact evaluation in Chad found that the BSF-based prevention programme had a positive effect on MAM incidence during the lean season. When looking at the interaction between the BSF and TSF programmes, BSF had a larger positive impact on MAM incidence among households with poorer access to the TSF-based treatment programme and households with seasonal livelihoods – agriculture and livestock. The evaluation in the Sudan found that the addition of MAM prevention components to MAM treatment programmes had no effect on the incidence or prevalence of MAM or SAM. The evaluation found a significant reduction in the prevalence of children at risk of malnutrition where food-based MAM prevention was added to the TSF-based treatment programme. The Niger evaluation concluded that continued provision of FFA in combination with MAM treatment and/or prevention programmes significantly reduced the incidence of MAM and served as a nutrition-sensitive form of assistance, but there was no evidence of positive impacts of treatment and/or prevention programmes alone. The impact evaluation in Mali found that households receiving at least two forms of assistance – GFD and school feeding – registered statistically positive effects on nutrition outcomes, while the effects were not significant for households that received only one form of aid. Disaggregating by degree of exposure to conflict, the evaluation also revealed that the effects on nutrition outcomes for children were concentrated mostly in areas outside the immediate vicinity of a conflict, and that this may in part be because these households have greater access to aid. The following discussions present major evaluation results regarding targeting, uptake, nutrition outcomes and cost effectiveness.

#### **3.2 Targeting and uptake**

18. Typically, food-based nutrition programmes target food-insecure regions. In the Sudan, the intervention first targeted specific localities and interventions were implemented in a rolling manner in the selected localities. Two localities received the intervention from the outset, with others gradually following. In Chad, WFP used geographic targeting to select priority districts that were found to be structurally vulnerable according to a combination of food security indicators, nutrition indicators, aggravating factors, livelihood strategies, population movements and infrastructure. Geographic targeting was also prevalent in the Niger, where selected villages were in food-insecure districts. Indicators for school completion, prevalence of nomadism, agricultural potential and convergence of partners' activities were also integrated into the geographic targeting process.
19. The evaluation in Mali looked at several interventions targeting various groups of beneficiaries. The BSF programme targeted children aged 6–59 months and pregnant and lactating women. The TSF programme focused on children aged 6–59 months with MAM and malnourished pregnant and lactating women. The school feeding programme targeted primary schoolchildren in areas with high food insecurity.
20. The evaluation in the Sudan estimated that the TSF programme covered between 15 and 28 percent of children in the study areas. The effectiveness of case finding for the programme, that is, the identification of eligible beneficiaries, was between 9 and 12 percent. Coverage of the MAM prevention activity was estimated at 10 percent of children in the study areas. In Chad, coverage of the TSF programme was estimated at 13.1 percent in the three Sahelian regions of



Batha, Bahr el Gazal and Kanem, despite an increase in the number of health facilities able to provide MAM interventions; prevention coverage was not reported.

21. Regarding targeting success, descriptive statistics for the evaluation sample in the Niger indicated that household size and education level of the household head were positively correlated with receipt of assistance. Overall, the evaluation found mixed evidence of the success of targeting of WFP programming in the Niger. Children – or their households – receiving no FFA but receiving BSF, TSF or TFA may have had better nutrition indicators, *a priori*, than children in households that did not receive any form of assistance at the end line. This implies either that there were errors in the targeting strategy or that uptake of the assistance was lowest among the people who may have benefited most from it. This is in contrast to FFA programming, which appears to have been well targeted in the Niger.
22. WFP activities in Mali, including school feeding, GFD, TSF and resilience-related programming, covered approximately 10 percent of the population of Mopti in 2014 and 6 percent in 2015. In the evaluation sample, 67 percent of households reported not receiving any food assistance, 23 percent reported receiving GFD, 14 percent reported having children who received school feeding, 2 percent reported having children or pregnant women receiving TSF and 2 percent had reported participating in food for work programmes.<sup>22</sup>
23. Regarding access, all four evaluations highlighted the importance of geographic proximity to health centres or food distribution centres and a high level of awareness among potential beneficiaries and communities in helping to increase the uptake of the programme. The issue of geographic proximity is particularly complicated when dealing with migrating populations. Other barriers to good coverage include limited routine community-based screening, heavy workloads for staff from various implementing agencies – WFP, government and other partner agencies – issues with maintaining case data and the need to improve case finding effectiveness.

### 3.3 Nutrition outcomes

24. The impact evaluation in Chad concluded that the BSF-based MAM prevention programme had a positive effect on MAM incidence in children aged 6–23 months during the lean season. The programme protected especially the upper range of this age group (18–23 months) and households supported by seasonal work. On the other hand, households that were closer to health centres and had easier access to TSF-based treatment programmes also had lower MAM incidence. When looking at the interaction between the two programmes, as expected the BSF programme had a larger positive impact on MAM incidence among households with poorer access to the TSF programme.
25. The evaluation in the Sudan found no significant impact on the prevalence of MAM, SAM or GAM in children under 5 years or in pregnant and lactating women. In rounds two, three and four of data collection, however, a significant reduction of up to 12 percent was seen in the prevalence of children at risk of malnutrition in areas where food-based MAM prevention was added to TSF, the treatment component.<sup>23</sup> The evaluation hypothesized that the lack of effect on prevalence could be the result of a number of factors, including a time lag in the reduction of the number of children at risk, SAM discharged cases becoming MAM and the low coverage of the prevention programme. While these factors were not analysed statistically, the findings highlight important areas for further research.
26. The evaluation in the Niger found that certain modalities of WFP assistance significantly improved the MAM situation in the country. Specifically, children in households receiving FFA plus treatment and/or prevention assistance were 19 percent more likely to recover from MAM at end line. The evaluation also found that children in households receiving a combination of assistance – treatment, prevention and FFA – were 15.5 percent less likely to experience MAM than those in households that received only treatment and/or prevention assistance without

<sup>22</sup> The baseline information on food for work predates WFP's shift in focus towards FFA.

<sup>23</sup> WFP's field guide to the Sudan's community-based nutrition integrated programme defines at risk children as children aged 6–23 months with middle-upper-arm circumference of 125–135 mm.

FFA. The combination of nutrition-sensitive and nutrition-specific assistance provided by WFP turns out to have had the strongest positive impact on MAM among children in the Niger.

27. The evaluation in Mali found that access to GFD led to an increase in households' non-food and food expenditures and micronutrient availability. When differences in the level of exposure to conflict are taken into account, improvements in child height and calorie consumption were found primarily in areas that were not in the immediate vicinity of conflict. Households receiving at least two forms of assistance – GFD and school feeding – registered statistically positive effects on calorie intake and micronutrient availability, while the effects were not significant in households that received only one form of assistance. Disaggregating the data by degree of exposure to conflict showed that the effects on the height of children under 5 were concentrated mostly in areas outside the immediate vicinity of conflict. Households located in close proximity to armed groups were found to have relatively higher increases in food expenditures and lower access to assistance. The drivers of higher food expenditure require further analysis and may not be related to higher food consumption in targeted households; for example, they may be driven by higher food prices close to conflict areas, or by leakage.

<b>TABLE 2: MAJOR RESULTS</b>	
<b>Chad</b>	
<ul style="list-style-type: none"> <li>• There was a positive effect of the BSF-based prevention programme on MAM incidence in children aged 6–23 months during the lean season.</li> <li>• The prevention programme was more effective in reducing MAM incidence among beneficiaries with poorer access to the treatment programme (4 percentage points versus 7.4 percentage points).</li> <li>• Percentage of MAM cases at end line – 14 percent – was half of the baseline result of 28 percent. Change was seen for both genders.</li> </ul>	
<b>Mali</b>	
<ul style="list-style-type: none"> <li>• Access to GFD was found to significantly increase calorie intake by 52 percent and zinc consumption by 64 percent; access to school feeding was found to increase vitamin A intake by 48 percent.</li> <li>• Analysis suggests that food assistance had protective effects on household total and food expenditures, on food consumption and on changes in height in children aged 2–5 years at baseline. Positive impacts were particularly pronounced in households receiving two forms of food assistance.</li> </ul>	
<b>The Niger</b>	
<ul style="list-style-type: none"> <li>• Children benefiting from the provision of FFA along with treatment and/or prevention of MAM were 19 percent more likely to recover from MAM at end line.</li> <li>• Agriculturally sensitive programming in the Niger had a large positive impact on a child's probability of recovering from MAM.</li> </ul>	
<b>The Sudan</b>	
<ul style="list-style-type: none"> <li>• No significant impact was observed on the prevalence of MAM, SAM or GAM in children under 5 or pregnant and lactating women.</li> <li>• Significant reductions of up to 12 percent were seen in the prevalence of children at risk of malnutrition where food-based MAM prevention was added to the treatment programme.</li> <li>• No change in feeding behaviours and practices were attributable to the behavioural SBCC intervention.</li> </ul>	

### 3.4 Cost effectiveness

28. A cost effectiveness analysis is an effective methodology for comparing the impacts and costs of various interventions aimed at achieving the same objective and for informing decisions regarding resource allocation.<sup>24</sup> Three major constraints emerge when conducting a cost effectiveness analysis: the availability and reliability of data for analysis; the lack of data on

<sup>24</sup> Gold, M.R. *et al.*, eds. 1996. *Cost-effectiveness in health and medicine*. Oxford University Press.

cost per activity; and the difficulty in apportioning costs when programmes comprise multiple interventions affecting multiple outcomes. Full cost effectiveness analyses were not conducted in all the evaluations covered in this synthesis report, mainly because of difficulties in compiling disaggregated costing information.

29. In the Niger evaluation, cost effectiveness was calculated based on the number of beneficiaries and the amount of food to be provided under each type of intervention. The emerging findings showed that interventions that combined BSF, TFA and FFA activities led to an improvement in nutrition indicators by 0.28 standard deviations per USD 100. The average cost of bringing a child with MAM to non-MAM status is thus estimated at USD 352.6 when MAM prevention and food assistance interventions are coupled.
30. In Chad, it was estimated that the cost of providing BSF to children aged 6–23 months during the lean season was USD 46.36 per child. Using the difference in MAM and/or SAM cases between children receiving BSF treatment and children in control groups, the estimated number of MAM and/or SAM cases avoided through BSF was calculated at 827, yielding an estimated global cost of USD 597 per MAM/SAM case avoided.
31. While cost effectiveness analysis focused on one core outcome – malnutrition – programmes also had impacts on outcomes beyond malnutrition, such as the reduction of micronutrient deficiencies and their consequences and improved household resilience. The evaluations in Chad and the Niger provided estimates of cost effectiveness for the specific interventions under study, but these estimates cannot be directly compared and a more detailed analysis must be undertaken in order to derive broader recommendations on cost effectiveness applicable to other similar cases both within and outside the countries under discussion.

### **3.5 Gender impacts**

32. All of the impact evaluations were designed to consider the heterogeneity of impacts for various vulnerable groups, including women. Of the total study sample of children in Chad, 48 percent were girls, with a similar distribution in all age groups. The evaluation undertook a heterogeneity analysis and found no statistical evidence of differences in the effect of BSF on MAM incidence between boys and girls. Similarly, the evaluation in the Sudan found no differences by gender in MAM admission trends or outcomes for children. Results for pregnant and lactating women mirrored those for children overall, with the evaluation finding no significant decrease in pregnant and lactating women GAM but a significant decrease in the number of pregnant and lactating women at risk.
33. Because anthropometric data on women were not available and the overall small sample size, the Niger evaluation reported core outcomes only for children overall. The evaluation found that households that identified themselves as being headed by a woman exhibited significantly better nutrition status than those identifying themselves as being headed by a man.
34. Qualitative research undertaken in Mali highlighted the important consequences that the fleeing of government staff and the subsequent closing of health centres had on basic health services for pregnant women, infants and young children. Interruptions in the few services available at the community level were likely to have directly affected the nutrition and health of these vulnerable age groups. Many pregnant women who were unable to flee found their antenatal care suspended, which exposed children to higher risks of infection and morbidity. Respondents facing this situation said that malnutrition in children and lactating women had increased considerably.

## 4. Broad lessons and recommendations

35. The four evaluations covered in this synthesis presented estimates of the causal impact on nutrition outcomes of a variety of nutrition-related interventions. While the impact evaluations led to specific recommendations for a variety of stakeholders in each of the four countries, implementation of these recommendations led in turn to some broad operational and policy-related lessons, which are outlined in the following subsection. Recommendations drawn from the broad lessons are presented in subsection 4.2 based on the sum of the analysis.

### 4.1 Broad lessons

36. The following are the primary lessons drawn from the synthesis exercise:<sup>25</sup>

- Lesson 1: Greater attention to the timing, sequencing and roll out schedule of a package of interventions is likely to result in enhanced effectiveness.
- Lesson 2: Closer partnerships and coordination can support more effective and efficient delivery.
- Lesson 3: Barriers to achieving better coverage and access include, but are not limited to, infrastructure deficits. Awareness of the availability of quality services is also important.
- Lesson 4: The quality, availability and lack of monitoring and evaluation (M&E) data are problematic.

37. These lessons are implied in the preceding sections of this report and are elaborated in the following paragraphs.

38. Lesson 1 – *greater attention to the timing, sequencing and roll out schedule of a package of interventions is likely to result in enhanced effectiveness* – arose from all four evaluations, albeit from different vantage points.

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<sup>25</sup> These lessons are evident from a close reading of the individual evaluations, although individual lessons are not necessarily explicitly supported by all four evaluations.

<b>TABLE 3: SPECIFIC LESSONS REGARDING TIMING, SEQUENCING AND ROLL OUT OF PROGRAMMES</b>	
<b>Country</b>	<b>Lesson</b>
<b>Chad</b>	<ul style="list-style-type: none"> <li>• TFA and BSF distributions should ideally start in April, before the lean season, to be most effective in preventing MAM, which tends to rise in July and August.</li> <li>• To be most effective, the BSF programme should cover the full 120 days of the lean season and be combined with other food assistance interventions at the household level to protect the rations of beneficiary children.</li> <li>• BSF distributions should be monthly to maximize the chances that beneficiary children are given part of the ration every day throughout the period of the intervention.</li> <li>• To improve access to targeted supplementary feeding programmes (TSFPs), WFP should explore alternative approaches to increasing TSFP coverage in a collaborative manner with agencies supporting other components of the management of acute malnutrition.<sup>26</sup></li> <li>• Sustainable reduction in the incidence of malnutrition requires the integration of short-term solutions for addressing acute malnutrition and longer-term, integrated prevention interventions in health, water, sanitation and hygiene and food security.</li> </ul>
<b>Mali</b>	<ul style="list-style-type: none"> <li>• Bundling various other forms of food assistance with GFD may be an effective strategy for supporting vulnerable populations.</li> <li>• Providing two forms of food assistance – GFD and school feeding – may be more effective than providing one form of transfer alone.</li> </ul>
<b>Niger</b>	<ul style="list-style-type: none"> <li>• The availability of FFA should be extended significantly given its strong and positive impact on MAM-related indicators; these positive effects can be further enhanced by the joint provision of FFA and prevention programming (specifically) and of prevention and treatment programmes generally.</li> </ul>
<b>Sudan</b>	<ul style="list-style-type: none"> <li>• The significant reduction in the prevalence of children at risk of acute malnutrition indicates the potential role for MAM prevention in reducing malnutrition in settings where treatment programmes for the acutely malnourished are already available and performing well.</li> <li>• A sustained (year round) package of both treatment and prevention of MAM has the potential to bring about intended effects on MAM incidence and prevalence.</li> </ul>

39. In the Chad evaluation report, the emphasis is on sequencing and periodicity and following a combined approach. The integration envisaged includes connecting short-term solutions to longer-term provision of assistance, connecting locally produced products to community-based delivery, or connecting programmes on a planned basis, recognizing the established cycles and patterns associated with food scarcity. The Niger report references positive impacts of certain combinations of assistance and synergies that result when multiple forms of assistance are provided together. The report also notes cost effectiveness analysis shows that a combined approach – such as combining nutrition-specific prevention programming with nutrition-sensitive FFA – improved the nutrition status of children. The Niger report calls for more research on how particular combinations of assistance interact with the situation on the ground. In the case of both Mali and the Sudan, the emphasis is on a more basic integration and sustained provision of, respectively, different types of food support, and of treatment and prevention.
40. Taken together, the observations suggest that there is a need to focus on connecting, layering and sequencing support and programmes in order to make them more effective.

<sup>26</sup> For example, the evaluation team suggests that adequate design, testing, validation, promotion and utilization of locally produced nutritional products could be an alternative for reducing the cost of the treatment (by reducing transport costs) and, consequently, if combined with community-based delivery approaches, increase access to treatment.

41. Lesson 2 – *closer partnerships and coordination can support more effective, timely, and efficient delivery* – is related to lesson 1. The type of operational synergies envisaged in lesson 2 require more careful planning of stand-alone programmes and greater coordination of efforts among all stakeholders. For example, the Chad report notes that early negotiations with relevant partners can improve coordination among major stakeholders – the report refers to coordination of the timing, sequencing and connectedness of provision and coverage – and that improved coordination among agencies can facilitate alternative ways of managing MAM. Although this may appear self-evident, efforts to ensure adequate lead times, skills and resources for negotiation and partnering are not always adequate in terms of extent or depth. Experience suggests that what may appear to be a cost in the early stages can, if managed correctly and resourced adequately, become a useful investment later. Examining the details of implementation, the Sudan report suggests that partners should be briefed on the importance of separating cost information from their various donors and throughout their programmes, and that M&E training and support should be provided for implementing partners, reinforcing the idea that early investment in partnerships can yield dividends later.
42. Lesson 3 – *barriers to achieving better coverage and access include, but are not limited to, infrastructure deficits* – reflects the experience in Chad, for example, where physical distance from a health centre was found to determine the likelihood of a child having access to supported services. The experience in the Sudan, however, suggests that even where health centre coverage was reasonably adequate, consistent links to communities – ideally mediated by community volunteers through local sensitization activities and routine screening – would enhance programme effectiveness. The Sudan report also highlights the criticality of ensuring that the right message is communicated to effect the desired behavioural change, including with regard to service utilization. The report notes that SBCC messages were heard by no more than 12 percent of the target audience, with radio and community mobilizers reported as the most common sources of information on community sensitization activities among people who had heard the message. Only slightly more than 40 percent of the people who heard about SBCC activities participated in them, and this figure declined to as low as 12 percent in the later period of the programme. The report suggests that coverage of both treatment and prevention could be improved through enhanced community sensitization regarding the programme, greater community understanding of malnutrition and the programme’s target groups and increased participation in SBCC activities.
43. Other factors are also relevant. For example, reflecting lesson 1, the Niger report notes a lack of understanding of how combinations of assistance interacted with the situation on the ground. In Chad, delays in the targeting process and in the establishment of agreements between WFP and its partners – Oxfam and *Action contre la faim* – were among the factors that delayed implementation. The Sudan report notes that SBCC activities faced many delays and challenges to implementation, mostly associated with the workload for community volunteers, who were required to work with programme staff at the clinics to support routine distributions of food products rather than, for example, concentrate on maintaining and updating registers and records correctly. This led to programme staff and community volunteers being unable properly to track cases and identify beneficiaries who were not followed up or who eventually defaulted; this affected data quality, which demonstrates the interrelatedness of the lessons outlined in this section.
44. Lesson 4 – *the quality, availability and lack of M&E data are problematic* – is reflected in all the evaluation reports. As noted in the section on lesson 2, the Sudan report emphasizes the need for M&E training and support for implementing partners to ensure the availability and integrity of data that facilitate accurate evaluation and research. Analysis of qualitative data generated during the evaluation in the Sudan revealed issues with record keeping and the maintenance of case registers in health centres, which could affect what is known about programme coverage. In the Niger, large initial investments in the collection of baseline data did not lead to optimal M&E because of the poor design of follow-up. The lack of availability of anthropometric data on women and the small overall sample size made it impossible to report gender-disaggregated outcomes in the Niger evaluation. The report calls for all M&E activity to be designed around the collection of panel data, with the specific aim of following up on all households included in the baseline data. Possibly of more general concern is the report’s observation that although

rich data were generated at the field level for research purposes by various research teams, the data sets were not linked and the data were often presented in hard copy only, notwithstanding that the evaluation teams had suggested that they be digitized. It was often not possible to establish whether data pertaining to a given individual were included in all data sets. Data on specific individuals were therefore likely to be entered into multiple data sets with no way of tracking or linking entries. This also means that even if individuals were subject to repeat questioning and surveys, the potential added value of generating data for use in studies of results over time may have been lost. At a more basic level, the Sudan report suggests that to facilitate the analysis of cost effectiveness cost data should be collected from the beginning of a programme in a format that distinguishes both between individual programmes and different programme components/activities (e.g. start-up costs, personnel costs, operating costs, and intervention components).

#### **4.2 Recommendations**

45. The recommendations are drawn from the analysis conducted for this synthesis and are closely aligned with the lessons outlined in the previous subsection. The recommendations cover policy, operational and technical aspects of the programmes and interventions that were evaluated in the four countries.
46. Subject to the existing *status quo*, the recommendations may require, for example, changes in policy or more robust application of existing policies or operational practices. Where appropriate, WFP policy and programme guidance should be changed or strengthened to reflect the recommendations, which address, among other things, strategic relationships with partners and stakeholders; programme planning and design and the tailoring of programme implementation based on consultations with beneficiaries; and the strategic management and use of data.

##### ***Recommendation 1***

47. To improve overall efficiency and operational effectiveness, WFP should invest in the strategic deepening of its relationships with partners and stakeholders, providing capacity strengthening where relevant. This recommendation pertains to matters such as coordination of efforts to ensure appropriate timing, sequencing, connectedness of provision, and coverage<sup>27</sup> cost management and the collection of M&E data.

##### ***Recommendation 2***

48. To improve the uptake and coverage of prevention and treatment programmes, the planning and design processes for WFP interventions should pay greater attention to communication with target groups, effectiveness of case finding, and community sensitization, all of which will help to improve the quality of targeting, achieve efficiencies and contribute to enhanced effectiveness of MAM treatment and prevention programmes.

##### ***Recommendation 3***

49. MAM programme components should be better tailored to context to facilitate the reduction of malnutrition in a sustainable manner:
  - In any context, various treatment and prevention activities may need to be integrated into longer-term, multisector solutions. For example, the studies in Mali and the Niger both emphasize the synergies among various types of nutrition-sensitive and nutrition-specific programmes and the need to design assistance packages with a variety of complementary interventions.
  - In conflict-affected situations, the critically important need to understand the political economy of food assistance is particularly important to the effectiveness of programme delivery. Enhanced understanding of the political economy can help when making critical trade-offs that involve on the one hand programme scale and cost effectiveness, and on the

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<sup>27</sup> For example, there is need to improve timelines for seasonal food assistance through earlier mobilization of resources to prevent delays in programme implementation.

other hand the practicalities of operating in areas under the control of armed groups, including security, governance and transparency issues.

- In conflict-affected situations, programme design and delivery can be enhanced to improve the scale up of food-based assistance programmes. Increasing the coverage of nutrition-specific interventions, including the provision of specialized complementary foods, appears to be a critical gap.
50. The findings also suggest that from a design perspective, appropriate bundling of various forms of food assistance, with components tailored to context, may be an effective strategy for supporting vulnerable populations, as also suggested in WFP's current guidance on nutrition-sensitive programming. For example, in households receiving two forms of food assistance, the Mali evaluation found evidence of pronounced positive impacts on food consumption and on changes in height in children aged 2–5 years at baseline. The Niger evaluation recommended the extension of FFA programming given its strong and positive impact on MAM-related indicators, which the evaluation report suggests can be further enhanced through the joint provision of FFA and prevention programming (specifically) and of prevention and treatment programmes generally.

#### ***Recommendation 4***

51. Given the common, cross-agency commitment to achieving Sustainable Development Goal (SDG) 2 – particularly in this instance SDG targets 2.1 and 2.2 – the agencies at the forefront of that effort, including WFP, need to make a greater effort to ensure that data are shared, taking into account the likely costs associated with data curation, and hosting; and to work to mainstream, to the greatest extent possible, compatibility in how they measure phenomena, including with regard to tools, methods, indicators and core demographic details. Consideration should be given to developing protocols for sharing data among agencies and studies with a view to maximizing available data sets, minimizing the duplication of effort in mutually exclusive studies of the same subjects and facilitating the efficient development of longitudinal data sets to support more in-depth analyses and assessment. This may require considerable effort in, for example, negotiating ethical concerns. The possibility of using a database mechanism to open access to what are often stand-alone sets of data and to effectively present the data as a public good is worth pursuing with the objective of enhancing overall humanitarian and development efforts in pursuit of SDG 2.

#### ***Recommendation 5***

52. Greater support and attention are needed to improve the collection and use of monitoring and cost data. This will help improve programme implementation in real-time, and support assessment of the longer-term impacts and cost effectiveness of various programme components. The studies found that, to undertake a specific cost effectiveness analysis, adequate resources need to be devoted to collecting and maintaining detailed cost data on the various components of the programme.



**Acronyms used in the document**

3ie	International Initiative for Impact Evaluation
BSF	blanket supplementary feeding
FFA	food assistance for assets
GAM	global acute malnutrition
GFD	general food distribution
MAM	moderate acute malnutrition
M&E	monitoring and evaluation
PRRO	protracted relief and recovery operation
SAM	severe acute malnutrition
SBCC	social and behaviour change communication
SDG	Sustainable Development Goal
TFA	targeted food assistance
TSF	targeted supplementary feeding
TSFP	targeted supplementary feeding programme
UNICEF	United Nations Children's Fund