

Maternal and Young Child Nutrition Security Initiative in Asia

External Evaluation of the EU-UNICEF Partnership 2011-2015



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TABLE OF CONTENTS

PREFACE	5
ACRONYMS	6
EXECUTIVE SUMMARY	7
1 INTRODUCTION	11
1.1 MYCNSIA scope, objectives and conceptual framework	11
1.2 Purpose, objectives, scope and management of the MYCNSIA-ETE	12
1.2.1 Purpose of the set of evaluations	12
1.2.2 Objectives of this evaluation	12
1.2.3 Scope of the set of evaluations	12
1.2.4 Management of the MYCNSIA-ETE	12
1.3 Evaluation methodology for MYCNSIA ETE	13
1.3.1 Methodological approach (selection) including limitations	13
1.3.2 Evaluation framework	13
1.3.3 Reports and reporting standard	14
1.3.4 Quality assurance	14
1.4 Background and context of the MYCNSIA initiative	15
1.4.1 EU commitment to nutrition security: The first 1,000 days	15
1.4.2 MYCNSIA's raison d'être: continuing need to reduce undernutrition	16
1.4.3 Stakeholders and development partners in nutrition	17
1.4.4 Regional policy framework in nutrition security	18
1.5 UNICEF/ EU response - description of MYCNSIA	20
2 FINDINGS OF THE END-TERM EVALUATION	25
2.1 Overall relevance and appropriateness	25
2.1.1 Programme design	25
2.1.2 Coherence, completeness and complementarity	26
2.1.3 Uptake of the MTE lessons, conclusions and recommendations	27
2.1.4 EU-MYCNSIA partnership in practice	27
2.2 Equity focus	28
2.2.1 Equity focus	28
2.2.2 Responsiveness to barriers and bottlenecks	29
2.3 Effectiveness: Pillar 1 Policy development	30
2.3.1 Nutrition governance	30
2.3.2 Relevant policies developed and/ or modified	31
2.3.3 Communication and visibility	31
2.3.4 Partnerships and collaboration	32
2.3.5 Integration of nutrition in other sectors	32
2.4 Effectiveness: Pillar 2 Capacity development	33
2.4.1 Capacity of planners and decision-makers	33
2.4.2 Capacity within different sectors	33
2.4.3 Nutrition training materials	34
2.5 Effectiveness: Pillar 3 Information systems and knowledge	35
2.5.1 Strengthened nutrition monitoring systems	35
2.5.2 Results of accompanying studies and surveys	35
2.6 Effectiveness: Pillar 4 Scaling up	36
2.6.1 Coverage and quality of interventions	36
2.6.2 Results at outcome level: Scaling up	37
2.6.3 Formulation of a minimum package	38
2.6.4 Embedding nutrition in systems at decentralized levels (province/ district)	38

2.7	Efficiency	40
2.7.1	Operational efficiency	40
2.7.2	Financial efficiency	41
2.8	Impact	44
2.8.1	Reduction of stunting and anaemia in the MYCNSIA intervention areas	44
2.8.2	Broader potential and unintended effects at the various levels of implementation – opportunities and challenges	45
2.9	Sustainability	47
2.9.1	Capacities and ownership for sustained results	47
2.9.2	Comprehensive and inter-sectoral stunting reduction strategies	49
2.9.3	UNICEF/ MYCNSIA legacy	50
3	CONCLUSIONS	51
3.1	Overall conclusions at programme level	51
3.2	Detailed conclusions at programme level	52
4	LESSONS LEARNED AND IMPLICATIONS FOR FUTURE PROGRAMMING	54
4.1	Criteria and categories; implications for future programming	54
4.2	Programme design (1–4)	54
4.3	Equity/effective coverage (5–8)	54
4.4	Nutrition specific/sensitive linkages – convergence and/or mainstreaming (9–13)	55
4.5	Programme monitoring systems (14–16)	55
4.6	Learning with and for Governments: What works and what does not (17–20)	55
5	RECOMMENDATIONS FOR FURTHER PROGRAMMING	56
ANNEXES		57
	Annex A1: Evaluation framework MYCNSIA ETE (2015); data collection methods; strength of combined methods, across regions/countries	58
	Annex A2: MYCNSIA 2011 overall logical framework; evaluability and relevance as judged by ETE	62
	Annex A3: Overall conclusions (regions; countries)	68
	Annex A4: Recommendations for further programming (regions; countries)	74

PREFACE

The European Union (EU) and United Nations Children's Fund (UNICEF) Partnership on Nutrition in Asia undertook two joint action programmes on nutrition security: the Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA) and the Africa Nutrition Security Partnership (ANSP). UNICEF entered into a Long-Term Agreement with the ETC Netherlands for a series of external evaluations of both programmes. The ETC conducted the mid-term evaluations (MTE) in 2013 after two years of programme implementation. This report concerns the end-term evaluation (ETE) of MYCNSIA for which the field work was done in April/May 2015, in all five MYCNSIA countries: Bangladesh, Indonesia, Lao PDR, Nepal and the Philippines. Three of the four MTE team members also took part in the ETE. The team tried to build as much as possible on the MTE experience.

In the years 2013–2015 the world's focus on nutrition has increased considerably. There is a mounting body of evidence on the topic of chronic malnutrition. The report refers to this with a view to both judge MYCNSIA's continued relevance

and to assess if MYCNSIA has been responsive to lessons and new standards as they evolve.

The MTE in 2013 was tasked to answer the question of the initiative's "overall relevance to tackle malnutrition in general, in a sustainable manner" and to assess if it contributed measurably to the eradication of malnutrition. This question was included more formally in the Terms of Reference for the ETE, with a related requirement regarding the added value of the Regional Programmes. Thus, the ETE investigates the extent to which such programmes can reduce the level of stunting. In some countries stunting has not declined, or has declined insufficiently, while in other countries stunting (and anaemia) have declined. The ETE aims to determine to what extent MYCNSIA played a meaningful role in reducing stunting and anaemia.

The evaluation team was keen to look into these questions at the meta level and we appreciated the opportunity to contribute to this important agenda.

On behalf of the ETC team

Joanne Harnmeijer

ACRONYMS

ANSP	Africa Nutrition Security Partnership
APBD II	Local Government Revenue and Expenditure Budget (Indonesia)
APEC	Asia-Pacific Economic Cooperation
ASEAN	Association of Southeast Asian Nations
BMS	breast milk substitute
CMAM	Community Managed Treatment of Acute Malnutrition
CSANN	Civil Society Alliance for Nutrition in Nepal
DAC	Development Assistance Committee (OECD)
DGFP	Directorate General of Family Planning (Bangladesh)
DNI	Direct Nutrition Interventions
EAPRO	East Asia and Pacific Regional Office (UNICEF)
EBF	exclusive breastfeeding
ECD	Early Childhood Development
ETE	end-term evaluation (of MYCNSIA)
EU	European Union
EWS	Early Warning System
FAO	Food and Agricultural Organization of the United Nations
FHSIS	Family Health Services Information System (Philippines)
FWA	Family Welfare Assistant (Bangladesh)
GMP	growth monitoring and promotion
HINI	High Impact Nutrition Interventions
HMIS	Health Management Information System
IFA	iron-folic acid
IMAM	Integrated Management of Acute Malnutrition
IYCF	Infant and Young Child Feeding
LNAP	Local Nutrition Action Planning (Philippines)
M&E	monitoring and evaluation
MDG	Millennium Development Goal
MFNSAP	Multi-sectoral Food and Nutrition Security Action Plan (Lao PDR)
MIS	Management Information System
MNP	m micronutrient powder
MoHFW	Ministry of Health and Family Welfare (Bangladesh)
MoRES	Monitoring Results for Equity Systems (UNICEF)
MSNP	Multi-sector Nutrition Plan (Nepal)
MTE	mid-term evaluation (of MYCNSIA)
MUAC	mid upper arm circumference
MYCNSIA	Maternal and Young Child Nutrition Security Initiative
NGO	non-governmental organization
NNFSS	National Nutrition and Food Security Secretariat (Nepal)
NNC	National Nutrition Centre (Lao PDR)
NNS	National Nutrition Services (Bangladesh)
NPC	National Planning Commission (Nepal)
OECD	Organisation for Economic Co-operation and Development
PKH	Family Hope Programme (Program Keluarga Harapan, Indonesia)
PMU	Programme Management Unit (MYCNSIA)
PNPM	National Community Empowerment Programme (Program Nasional Pemberdayaan Masyarakat, Indonesia)
REACH	Renewed Efforts to End Child Hunger and Undernutrition
ROSA	Regional Office for South Asia (UNICEF)
RPJMN	National Medium Term Development Plan (Indonesia)
RUTF	ready-to-use therapeutic food
SAARC	South Asia Association for Regional Cooperation
SAM	severe acute malnutrition
SUN	Scaling Up Nutrition
SURCH	A House of Survey Research (Bangladesh)
ToT	training of trainers
WASH	water, sanitation and hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

Improving nutrition security in Asia

High levels of stunting and/or wasting among children under age 5, as well as high (>30 per cent) or very high (>40 per cent) levels of chronic malnutrition in some Asian countries are persistent and complex problems. In response to these challenges, a joint programme of the European Union (EU) and the United Nations Children's Fund (UNICEF), devised an initiative to improve maternal and young child nutrition. The five-year programme (2011–2015) was known as the Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA). The initiative aimed to reduce undernutrition, particularly stunting and anaemia, in Bangladesh, Indonesia, Lao PDR, Nepal and the Philippines. MYCNSIA was based on the 'first 1,000 days' approach which promotes good nutrition for pregnant and lactating women and infants up to 2 years of age as the best and most cost-effective intervention for avoiding irreversible damage to physical growth and intellectual capacities from undernutrition.

Aims of MYCNSIA

The overall target of MYCNSIA was to achieve a 5 percentage point reduction in stunting and a 15 per cent reduction in anaemia among pregnant women and children in each of the five countries through work under four pillars: (pillar 1) upstream policy development; (pillar 2) capacity development; (pillar 3) nutrition information systems and knowledge management; and (pillar 4) direct nutrition interventions. The interventions fell into two broad categories. The first category included high impact nutrition interventions such as maternal, infant and young child feeding, micronutrient supplementation, fortification of staple foods and management of acute malnutrition; and mainstreaming and promoting nutrition sensitive strategies in agriculture, food security, social protection, gender, health, water, sanitation and hygiene (WASH) and so on. The second category of interventions aimed to position nutrition security high on regional agendas and was implemented by the Programme Management Unit (PMU) located in the UNICEF Regional Office for South Asia (ROSA) in Kathmandu and the East Asia and Pacific Regional Office (EAPRO) in Bangkok.

The objectives of the end-term evaluation (ETE) were as follows: to assess the contribution of MYCNSIA to the achievement of the anticipated outputs and outcomes; to identify programme barriers, challenges and study determinants for success; and to provide recommendations based on solid evidence and lessons learned on how best to improve nutrition security among women and young children in South Asia and South East Asia. The recommendations of the evaluation are intended to strengthen and guide the ongoing and future efforts of UNICEF and the EU to improve nutrition security in the region.

MYCNSIA end-term evaluation methodology

Evaluations of MYCNSIA were undertaken in 2013 at the

mid-point of the initiative (mid-term evaluation (MTE)) and in 2015 as the initiative came to an end (ETE). A uniform framework of questions for the ETE was developed during the inception phase (February – April 2015). The norms and standards established by the United Nations Evaluation Group provided overall guidance while the evaluation criteria (relevance, equity, effectiveness, effectiveness, impact and sustainability) of the Organisation for Economic Co-Operation and Development (OECD) Development Assistance Committee (DAC) formed the evaluation framework. Mixed methods were used to answer the specific evaluation questions of the ETE. As per the Terms of Reference, the ETE emphasized lessons learned and good practices to inform future programmes. Data collection took place during week-long site visits to each of the five MYCNSIA countries (April – May 2015) and meetings were held in Bangkok and Kathmandu with regional stakeholders. The data gathered through visits and meetings were complemented by a review of documentation made available by UNICEF and collected through web searches.

Findings

Relevance

In implementing MYCNSIA, UNICEF had strategic and competitive advantages, particularly its capacity to support governance institutions. At the national and regional level, MYCNSIA made relevant contributions to mainstreaming nutrition and forging intersectoral links to advance nutrition related objectives. Steps were taken following the MTE to implement its recommendations, although these efforts were incomplete.

Equity

Direct nutrition interventions implemented at the country level (pillar 4) were targeted to the needs of low-income populations. Although this aspect of implementation had a clear equity focus, there was limited focus on equity in the design as only one indicator in the logframe referred to 'equity' as such. Better use could have been made of data gathered through baseline and endline surveys to overcome bottlenecks and enhance the equity component of MYCNSIA.

Effectiveness

At the national and regional level, UNICEF/ MYCNSIA leveraged existing government and institutional systems for nutrition-related objectives. The initiative forged strong partnerships with government ministries, influenced policies at the regional and national level, and worked to integrate nutrition into other sectors (pillar 1). Capacity development efforts achieved strong results at the country level, but regional capacity building results were weaker (pillar 2). Integrating nutrition into national HMIS systems was an effective way to achieve multi-sectoral cooperation on nutrition. By contrast, the effort and resources invested in a one-for-all monitoring and evaluation framework, intended to serve MYCNSIA and the five countries, were less effective and had an opportunity cost (pillar 3). A range of methods were used in the MYCNSIA

countries for scaling up nutrition, reflecting differing contexts and needs (pillar 4).

MYCNSIA aimed to establish a minimum package of nutrition services, and this was achieved in Bangladesh and Nepal and is underway in Lao PDR; elements of a minimum package were also implemented in Indonesia and the Philippines. Results at the outcome level are difficult to judge because endline data were only available for two of the MYCNSIA countries (Bangladesh and Indonesia) at the time the ETE was conducted.

Efficiency

Overall, the budget was implemented as planned. Operational efficiency in terms of time and resources varied between the PMU and the country offices. Implementation challenges impacted operational efficiency, yet through strategic thinking and acting, four of the five MYCNSIA countries went beyond implementing pre-defined outputs.

Sustainability

Strong indicators of sustainability are present at the regional level and national level where Governments have signalled their commitment to nutrition by enacting national plans and policies. Mainstreaming nutrition in the health sector has proven a formidable task, yet remarkable success was achieved when the four pillars operated in unison at different levels. Data from all five countries indicate that MYCNSIA functioned as part of a continuum.

Impact

Impact could not be properly measured throughout all areas of intervention as data were only available for two of the five countries at the time of the evaluation. The existing data show that stunting was reduced in MYCNSIA project areas of both countries while anaemia was reduced in one country. The initiative achieved strong results in strengthening institutions and shaping policies that plausibly contributed to the reduction of stunting and anaemia. There were significant positive spin-offs from MYCNSIA despite challenges in the operating environments. The EU-MYCNSIA partnership was most productive where the EU and UNICEF cooperated to adapt the initiative to changing conditions.

Main conclusions

1. **UNICEF is widely appreciated and acclaimed for its role in helping national Governments to develop policies and support them all the way to implementation.** 'Nutrition governance' was not explicit in the MYCNSIA programme monitoring instruments, but the ETE team found that most UNICEF country offices provided considerable attention and support to nutrition governance and that this contributed to enhancing the results of MYCNSIA.
2. **Achievements in 'mainstreaming nutrition' in the health sector have been convincing. This in itself is a formidable success and one that should not be underestimated.** The programme exceeded expectations in scaling up, within and through the health system in Nepal and Bangladesh.
3. **The programme design had multiple implications for**

programme relevance, effectiveness, efficiency and sustainability:

- a. **The four pillar design was relevant and in some cases it enabled effective synergies among core components.** Linkages between the pillars plus tailored governance support yielded good results, particularly for policy development and multi-sectoral approaches to nutrition. This design was so successful that it served as a template for the SAARC South Asia Regional Action Framework for Nutrition.
 - b. **The main programmatic objectives of MYCNSIA (reduction of stunting and anaemia) were overambitious.** The partial data available at the time of the ETE indicated that in some cases the targets were met, but also suggested that UNICEF underestimated the complexity of designing and implementing such impact studies. Attempting to achieve 'coherence' of methodology across very different implementation contexts added to the complexity.
 - c. **Equity was not explicit in the MYCNSIA logframe, yet underprivileged populations were targeted and reached** (through site selection, linkages with social protection schemes and national planning instruments). Other opportunities to highlight equity were missed: a more substantial link with UNICEF's MoRES instrument could have been made and only one country used the MYCNSIA baseline-endline analysis to explore and understand the equity dimensions of effective coverage.
 - d. **Opportunities to link with nutrition sensitive endeavours have increased over the duration of MYCNSIA, yet there was insufficient drive toward making stronger linkages with food security interventions as a necessary complement to MYCNSIA's nutrition specific focus.** However, in Nepal such linkages are still possible, as per design. In Bangladesh there is clear potential to bridge the divide between nutrition specific endeavours and food security starting from routines MYCNSIA established such as the DNI package and the HMIS.
 - e. **Following the MTE, some country offices adapted their outputs and workplans (Indonesia, Lao PDR and Nepal) and this improved programme focus, relevance, reporting and evaluability.** As reported in the MTE, the MYCNSIA design was overly complex, and the dissociation of logframe and outputs increased the complexity. A third frame, the logic model, intended to come to a common framework, but this did not work. The transaction costs of having many frames were considerable.
4. **Typical regional functions were not well defined and as a consequence they were insufficiently pursued. Moreover, the MTE conclusion on meagre ("mixed") results of capacity development still stands.** The regional function of learning lessons and identifying common drivers for success (and failure) was shifted to the programme's very end and was given to external actors (consultants). The country offices were not given time to draw lessons which could have benefited other country programmes

in Asia within the span of MYCNSIA. These and other tasks would have contributed to regional level capacity development and knowledge management and would have helped MYCNSIA remain more flexible and relevant.

More detailed conclusions can be found in section 3.2.

Lessons learned

The ETE team drew 20 lessons learned, chosen for their potential applicability and relevance to future programming. The lessons are clustered in five categories as follows:

- Programme design;
- Equity/effective coverage;
- Nutrition specific/sensitive linkages (convergence and/or mainstreaming);
- Programme monitoring systems; and
- Learning with and for Governments, with design implications for future programmes.

Recommendations

UNICEF

1. In future programme design UNICEF should outline strategic and competitive advantages for which the organization is known and widely appreciated. UNICEF should thus profile its programmes as professional and reliable technical assistance and support to government endeavours.
2. Operationalize the argument that nutrition sensitive actions can follow on and benefit from a nutrition specific foundation. The ETE's three-phase model is presented in Annex C (Bangladesh), section 2.9.2.
3. Use data and knowledge on 'what works' and why it

works to boost evidence based regional programming in order to help governments address persistent chronic undernutrition.

4. Ensure the programme design includes indicators for the regional office(s) on typical regional functions, such as learning lessons and identifying common drivers for success. Ensure the programme design specifies the point in time and the forum for sharing knowledge and experience.

Funding agency (EU)

1. The funding agency should require that future regional joint action with UNICEF to address persistent chronic undernutrition:
 - a. Link nutrition specific interventions with nutrition sensitive initiatives and build in the flexibility to respond to opportunities as they arise. Food security should be included in nutrition sensitive initiatives.
 - b. Clarify what nutrition sensitive means in multi-sectoral practice, within the country context and relative to the comparative advantages of each country delegation.
 - c. Are flexible enough to benefit from UNICEF's global, regional and country programmes and initiatives even if these were not included in the original design. UNICEF's MoRES approach is a case in point.
2. The funding agency should require the regional office(s) to demonstrably act as knowledge hubs. This should include the use of data and knowledge on 'what works' and why it works to boost evidence based regional programming. Country offices should be supported to mobilize, analyse, use and share data and the lessons they imply to this effect (see recommendations 3 and 4 for UNICEF).

INTRODUCTION

1.1 MYCNSIA scope, objectives and conceptual framework

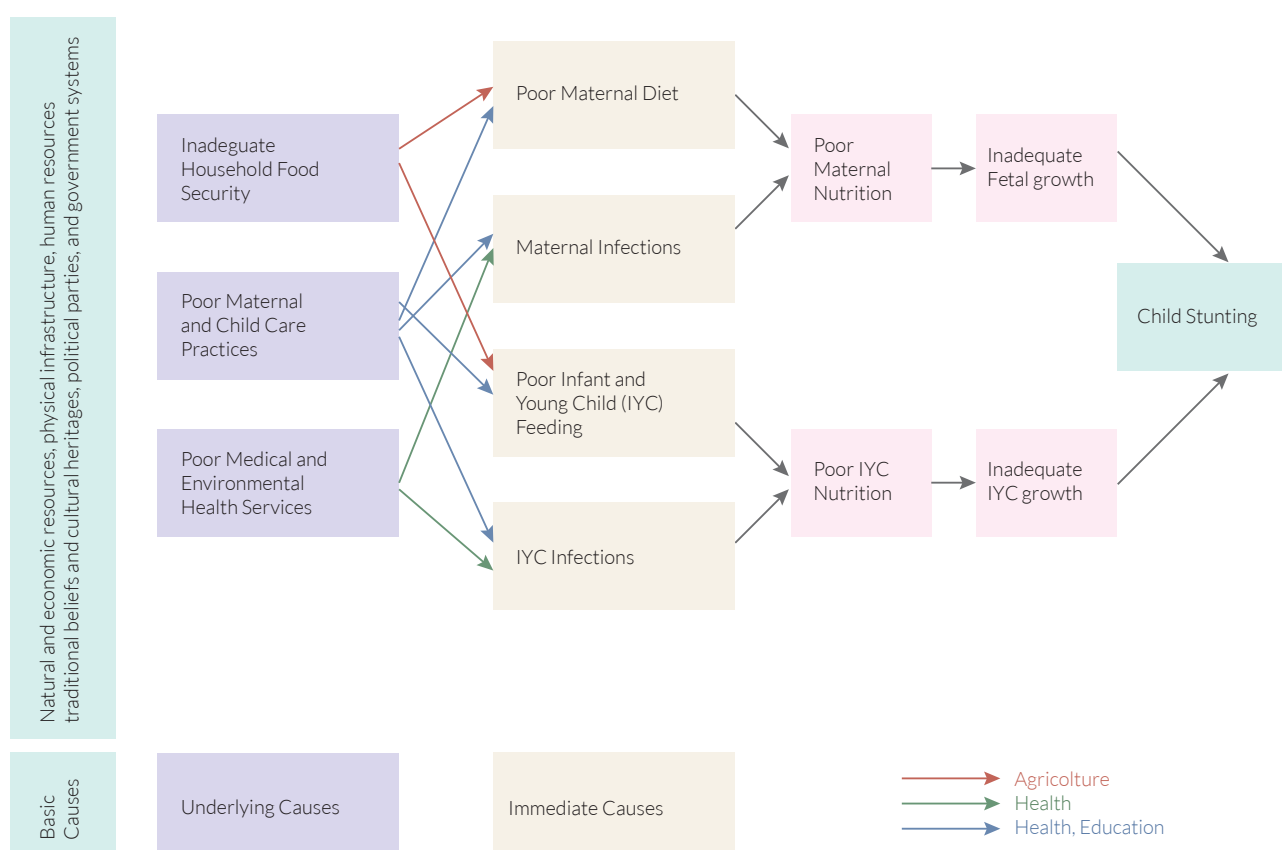
The Maternal and Young Child Nutrition Security Initiative (MYCNSIA) aimed to improve nutrition security among women and young children in the South Asia and South-East Asia regions. The programme was based on the conviction that sustained improvements in nutrition require coordination with multiple sectors, namely health, education, agriculture, water and sanitation. From 2011 to 2015 with support from a European Union (EU) grant, MYCNSIA was implemented at the Asian sub-regional level (in Bangkok and Kathmandu) and in five countries of these sub-regions (Bangladesh, Indonesia, Lao PDR, Nepal and the Philippines). UNICEF closely collaborates with Governments and other national and regional stakeholders to implement the initiative.

MYCNSIA aimed to reduce stunting by 5 percentage points (children aged 0–3 years) and to reduce anaemia among women and children aged 6–23 months by 15 per cent from the baseline in each of the targeted countries. The original

target for anaemia reduction was more ambitious, namely a reduction by one third. To achieve the revised target, the initiative focused on key evidence-based interventions for women and young children, specifically during the critical window of opportunity between conception and 2 years of age – the first 1,000 days¹. More specifically, MYCNSIA aimed to reduce the proportion of stunted young children by improving the care and feeding practices children receive up to age 2; and reduce anaemia rates of pregnant and lactating women, as well as of young children through the provision of micronutrients and deworming.

The overall conceptual framework for MYCNSIA is derived from the well-known 1990 UNICEF framework; it has not changed since programme inception, although there were numerous adaptations in the form of ‘logic models’ (see Figure 1).

Figure 1. Conceptual framework for MYCNSIA



1.2 Purpose, objectives, scope and management of the MYCNSIA-ETE

1.2.1 Purpose of the set of evaluations

UNICEF entered into a long-term agreement with ETC Netherlands for a series of external evaluations of joint action programmes on nutrition security, including MYCNSIA in South Asia and South-East Asia. The mid-term evaluation (MTE) of MYCNSIA was implemented in 2013 and entailed a review of the design and implementation process in the first two years of operation. The aim was to identify enhancing and limiting factors at regional, national and local levels and to highlight results that were achieved. The end-term evaluation (ETE) is intended to meet accountability obligations towards the donor (EU) and identify best practices and lessons learned as input for future policymaking and programming on nutrition security. The main users of the information generated in the ETE are the implementing partners in the evaluated countries, UNICEF regional and country offices, and the EU and other donors that contributed to MYCNSIA.

1.2.2 Objectives of the evaluation

The Terms of Reference for the ETE build on the evaluation criteria of the Development Assistance Committee (DAC) of the Organisation for Economic Co-Operation and Development (OECD).² This external evaluation was commissioned to do the following:

- Obtain an unbiased assessment of whether policy and programme inputs have led and/or contributed to the achievement of the anticipated programme results, such as outputs, outcomes and impact;
- Examine programme achievements, identify programme barriers, challenges and study determinants for success; and
- Provide recommendations based on solid evidence and lessons learned on how best to improve nutrition security among women and young children in the South Asia and South-East Asia sub-regions.

1.2.3 Scope of the evaluation

Components of the programme/project/ intervention to be evaluated (and what is excluded)

The MYCNSIA ETE evaluated all components of the programme (for details refer to subsequent sections).

Geographical coverage

The ETE reviewed the full geographical coverage of the five country programmes. Details are provided in the methodology section.

Time boundaries

This ETE assessed the entire time-span of the 2011–2015 MYCNSIA initiative. It builds on the MTE findings and concentrates on changes and achievements during the last two years. The baseline-endline comparison is a case in point where the ETE studied the entire time span (see section 1.3).

Scope of the activities

The ETE concentrates on the EU-funded activities and their results. An attempt was made to distinguish between MYCNSIA activities and UNICEF activities which would have taken place regardless of the MYCNSIA initiative. The methodology section includes a discussion on the difficulties of making this distinction.

Stakeholders and beneficiaries included/ excluded

The evaluators attempted to get the views of all relevant stakeholders and of a proper sample of the beneficiaries. This was easier in some countries than in others.

1.2.4 Management of the MYCNSIA-ETE

Overall management of the evaluation was the responsibility of the UNICEF Regional Nutrition Specialist (based in Kathmandu), with the support of the Regional Nutrition Security Programme Coordinator (based in Bangkok). The UNICEF Regional Office for South Asia (ROSA) led the evaluation in close coordination with the Evaluation Reference Group, and put in place a quality assurance system of all deliverables, provided administrative and substantive backstopping support, and ensured the liaison with the evaluation focal points in concerned agencies. It also ensured that the evaluation was conducted in accordance with the Code of Conduct for Evaluation in the UN System, as approved by the members of the United Nations Evaluation Group (2007), including norms and standards (see section 1.3.3).

The Evaluation Reference Group provided guidance throughout the evaluation process and Universalialia³ provided external quality assurance. The members of the group include:

- UNICEF Regional Nutrition Advisors, East Asia and the Pacific Regional Office (EAPRO) and ROSA.
- UNICEF Regional Evaluation Advisors, EAPRO and ROSA.
- EU Programme Officer (Cooperation), Delegation to Bangkok.
- EU Nutrition Advisory Service.
- UNICEF MYCNSIA Programme Coordinator, EAPRO.
- UNICEF Regional Nutrition Specialist, Monitoring and Evaluation (M&E) Advisor, ROSA.

1.3 Evaluation methodology for MYCNSIA ETE

1.3.1 Methodological approach (selection) including limitations

Methodological approaches

The ETE's approaches were extensively discussed in the Inception Report and are summarized here. The UNEG norms and standards are the overall guidance while the OECD-DAC criteria form the guiding framework for this evaluation's methods and methodology. The methodology is directly derived from the Evaluation Framework as the main skeleton on which the MTE and ETE are based. The framework is rather ambitious because of the 'meta' dimensions of the questions. Annex A1 contains the evaluation questions. In the last column of the table in Annex A1 the ETE team assesses the 'strength' of the combined data collection methods which the team used. 'Strength' is a judgement and therefore subjective. It was, however, scored after the ETE had finished its field work and thus with the benefit of hindsight. An evaluability assessment was carried out beforehand (see section 1.3.2 and Annex A2) helped by the fact that the same team of evaluators had done the MTE. The Table of Contents of the ETE report became an additional tool as it set the structure for all reports – both the main report and the country reports in volume II. In it, the four-pillar structure of the programme was adhered to, firstly because this is how the programme is known and secondly because the programme itself had consistently followed the four-pillar structure for its own reports. Thirdly, this is how also the MTE had reported and the ETE thus followed the request expressed by the former EU/NAS adviser to strive as much as possible for alignment between the different reports (MTE and ETE) of both MYCNSIA and ANSP.

Limitations of the evaluation

The ETE foresaw that where evidence would be weak it would be 1) due to programme design and/or 2) because evidence is just starting to emerge – as for most intersectoral aspects. More than in other evaluations the ETE evaluators needed to use their judgement 'en route' according to the evaluation framework (see below). This was because the programme's main instruments – the logical framework and the set of outputs – do not do full justice to concepts such as sustainability and equity, which the ETE was asked to assess. (As argued elsewhere the MYCNSIA instruments focus on activities and outputs). MYCNSIA-specific evidence was bound to be weaker for the regions than for the countries. This is because the ambitions at the regional level were very limited and yet the ETE Terms of Reference emphasized aspects of added value precisely because of the regional dimensions.

Specific limitations and risks

· Dependence on survey results

The availability and quality of endline data was a constraint. At the time of writing the evaluation reports three out of the five Country Offices had sent in their reports.

· Contribution of MYCNSIA

The questions 'What activities have been done because of MYCNSIA?' and 'What results can be attributed to MYCNSIA?' have remained sensitive issues. The reason is that MYCNSIA is to some extent a construct, in the sense that 'mainstream', or 'core' activities of UNICEF are combined in MYCNSIA as if it is a separate programme. External stakeholders view the activities as 'UNICEF' rather than as 'MYCNSIA'. This was the case at the time of the MTE and remained so when the ETE was conducted. It is for this reason that the evaluation team focused on the added value of the programme design, namely in the coherence of the four pillars.

· Multiple frames

The programme has had a large number of 'frames' some of which have in addition been adapted over time. They are:

1. The programme's logic model (derived from Figure 1)
2. The programme's contractual logical framework (Annex 2A)
3. The programme's four pillars
4. The programme's 73 outputs; arranged by pillar

As the ETE was primarily guided by the evaluation questions (described below) this was not a major hindrance.

The programme did not have a one-for-all theory of change. This is not surprising as programmes all over the world are grappling with this; the diagrams they present as their Theories of Change have grown increasingly complex.⁴

1.3.2 Evaluation framework

For this evaluation the main instruments were:

- the (26) evaluation questions framed in;
- the five OECD-DAC criteria (plus equity).

Annex A1 contains the evaluation questions and the data collection methods, including the ETE's assessment of the strength of the combined methods across regions and countries on a scale of 1 to 3. The ETE acknowledges that 'strength' is a judgement and therefore subjective. It was, however, scored with the benefit of hindsight after the ETE finished its field work.

The evaluation questions and the OECD-DAC criteria are in themselves clear and coherent. As indicated above, the programme itself was defined in various and overlapping ways which each have their merits. In the MTE the multitude of frames did not constitute a methodological problem, because the logical framework was not evaluated. Ignoring the logical framework in a final evaluation seemed, however, unacceptable.

The ETE drafted an annotated version of the logical framework in which the ETE judgements regarding programme evaluability and relevance are drawn (Annex A2). The team used the document for the narrative of the main report, taking the logical framework into consideration. The country and regional annexes of this report focus on

programme outputs. The ETE followed the approach used in the most recent MYCNSIA Progress Report.

The ETE sought to establish a theory of change that will be helpful also for future reference. This was not part of the ETE methodology, but was an outcome of the ETE observations. It is therefore presented in the findings (see Chapter 2).

1.3.3 Reports and reporting standard

Application of the UNEG norms and standards

The final evaluation reports were prepared taking into account the UNICEF-Adapted UNEG Evaluation Report Standards (July 2010).⁵ These standards give clear guidance on report structure where findings are presented in direct correspondence to the evaluation criteria and questions, and where detailed conclusions and recommendations are referenced to the findings. While all standards are adhered to, particular attention was given to standards 4.15 and 4.16:

4.15: Conclusions need to be substantiated by findings consistent with data collected and methodology, and represent insights into identification and/ or solutions of important problems or issues.

4.16 Recommendations should be firmly based on evidence and analysis, be relevant and realistic, with priorities for action made clear.

Length of the reports; focus and readability

The MTE for MYCNSIA resulted in a bulky report. It is exceptionally difficult to do justice to a programme of this complexity, size and number of diverse outputs. To deal with this challenge, country and regional reports on outputs are annexed to the ETE main report. Building on work presented in Annex A2, a selection was made for the main report by prioritizing indicators at the level of outcome, impact and sustainability. The main report used MYCNSIA's overall logframe as a reference.

The seven reports are compiled in two volumes: a main report (volume I); and the regional report and the five country reports (volume II) compiled as Annexes B-G.

Standardized reporting frames with identical tables of content

Annexes B-G and the main report were guided by the single set of evaluation questions. The tables of contents of all reports – annexes and main report – were standardized for easy reference. The style of reporting followed the recommendations of the EAPRO after the MTE, with bold sentences summarizing findings, again for easy reference and for coherence between the seven reports.

Emphasis on good practices and lessons learned

The MYCNSIA initiative was extended in some countries; in other countries a new programme is envisaged. For obvious reasons 'lessons learned' are a major deliverable. Lessons and good practices were distilled from the individual reports and were checked and elaborated by the entire team. In several cases the opinion and confirmation of the country offices were sought to ensure that the ETE's selection reflected country realities. Lessons learned are compiled in Chapter 4 of the main report. The ETE team was instructed that 'lessons learned' have wider relevance and can be extrapolated to new situations elsewhere. 'Good practices' are interspersed in the country and regional reports and the main report.

1.3.4 Quality assurance

The steps for quality assurance follow standard procedures. Draft reports were peer-reviewed before they were submitted to the client. This is a standard procedure within ETC as part of ISO 9000.

The ETE has undergone several rounds of review. A first round was peer review by all team members. This ran in parallel with a round of review and clarification by the Country Offices. This round in some countries took considerable time and then overlapped with a third round, by the ROSA evaluation manager who provided suggestions for a subsequent draft. (This procedure was followed for the six country/regional reports). The next round of review by the Evaluation Reference Group resulted in an edited version of main report and the regional annex (Annex B). UNICEF's ROSA has provided for a parallel external review through the services of Universalis, a consultancy firm.

1.4 Background and context of MYCNSIA

1.4.1 EU commitment to nutrition security:

The first 1,000 days

In 2011 the EU Reference Document on undernutrition was published.⁶ More recently the EU increased its focus on and commitment to fight undernutrition worldwide. Nutrition is a priority on the international development agenda, as reflected in several of the Millennium Development Goals (MDGs), especially MDG 1 (Eradicate extreme poverty and hunger), MDG 4 (Reduce child mortality) and MDG 5

(Improve maternal health).⁷ In March 2013 the EU issued a Communication on Maternal and Child Nutrition which aimed to achieve a reduction of undernutrition among children under 5 years of age, indicated by stunting and wasting. Formulated strategic priorities are: (a) to enhance mobilization and political commitment for nutrition; (b) to scale up actions at the country level; and (c) to strengthen technical expertise on nutrition and knowledge on nutrition for decision-making (see Box 1).⁸

Box 1 EU targets and priorities for maternal and child nutrition

The targets that are set in the 2013 EU Communication on Maternal and Child Nutrition on reduction of wasting and stunting concur with the global targets for 2025 that were set during the 2012 World Health Assembly:

- 40 per cent reduction of the global number of children under 5 years of age who are stunted (Note: implying a reduction in number of stunted children by more than 70 million); and
- Reducing and maintaining wasting among children under 5 years of age to less than 5 per cent.

Although the Communication acknowledges the impor-

tance of the first 1,000 days, there is no explicit reference to other targets of the World Health Assembly on maternal and child nutrition.* Three strategic priorities were set:

1. Enhance mobilization and political commitment for nutrition.
2. Scale up actions at country level (through strengthening human and institutional capacities, increasing nutrition interventions, increasing nutrition sensitive actions).
3. Strengthening the expertise and the knowledge base (Knowledge for nutrition).

** Other targets are reduction of low birth weight by 30 per cent, reduction of anaemia among women of reproductive age by 50 per cent, an increase in exclusive breastfeeding rates to reach a minimum of 50 per cent globally, and zero increase in prevalence of child overweight.*

The 2013 Communication builds on the common framework for the EU and the Member States in combating malnutrition, which was provided in earlier EU communications on global health, food security and food assistance. It follows up to the abovementioned 2011 EuropeAid Reference Document on undernutrition which formed the background for the formulation of the MYCNSIA and ANSP programmes.⁹ The Reference Document emphasized that, in line with the priorities of the Scaling Up Nutrition (SUN) movement, the period during pregnancy and from birth up to 2 years of age is the crucial window of opportunity to ensure optimal growth.

In 2014 the European Commission published its Action Plan on Nutrition explaining how it will reach its commitment to reduce stunting in children under 5 years of age by at least 7 million children, or 10 per cent of the World Health Assembly goal by 2025.¹⁰ The Action Plan addresses how the strategic objectives in the areas of governance, scaled up interventions

and research are to be attained. It underlines the need to work closer with development players and partner countries. The EU will commit as much as €410 million (US\$533 million) for nutrition specific interventions between 2014 and 2020, an increase of €340 million (US\$442 million) over the average financial commitment for nutrition specific interventions in 2009–2012. The EU also committed to spend up to €3.1 billion (US\$4.03 billion) for nutrition sensitive programmes between 2014 and 2020.

To support these objectives, the EU launched the Nutrition Advisory Service under a four-year service contract. The Service supports EU Delegations through multi-annual indicative programmes at the country level and strengthens the EU as a global leader in the field of nutrition, in particular to work towards a more effective global accountability framework for nutrition.

1.4.2 MYCNSIA's raison d'être:

Continuing need to reduce undernutrition

Despite considerable progress in stunting reduction in the period 1995–2010 the level of stunting in particular in South Asia remains high at 38 per cent, which is comparable to the level in sub-Saharan Africa (38 per cent), and more than three times higher than the level in East Asia and the Pacific region (12 per cent including China, or 30 per cent excluding China). Approximately 40 per cent of all stunted children live in South Asia.

In the period 1990–2011 the overall levels of stunting in South Asia declined, yet disparities in stunting between wealth quintiles increased. The prevalence of stunting among children under 5 years of age from the poorest quintile is at present 2.5 times higher than among children from the richest quintile. Disparity in stunting in South Asia is higher than in any other region of the world (see Figure 2). In Bangladesh the decrease in stunting among children from the richest quintile was much higher (35 per cent) than the decrease among children under 5 years of age from the poorest quintile (16 per cent) during the period 1997–2011.¹¹

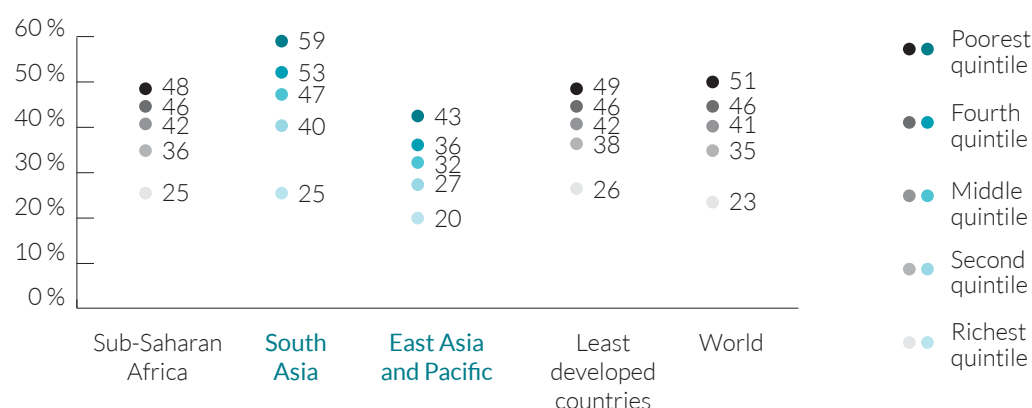
Table 1. Key statistics, Asia

Key economic, nutrition and social characteristics	Least developed countries	South Asia	East Asia and the Pacific
Total population (millions)	898	1 672	2 081
Under-five mortality rate/ infant mortality rate (2013)	80/ 55	57/ 45	19/ 16
Life expectancy at birth in years (2013)	62	67	74
Gross national income per capita in purchasing power parity US\$ (2013)	2 046	5 007	11 795
	Percentage of total		
Income below international poverty line of US\$1.25 per day (2009–2012)	40	33	12
Children (2009–2013) early initiation of breastfeeding	53	39	44
Children (2009–2013) exclusively breastfed (age <6 months)	46	47	30
Children (2009–2013) introduced to solid, semi-solid or soft foods (age 6–8 months)	62	58	79*
Antenatal care coverage / at least four times (age 15–45)	38	35	80*
Vitamin A supplementation full coverage age 6–59 months (2013)	81	60	85
Households consuming iodized salt (2009–2013)	50	69	86
Infants with low birth weight (2009–2013)	14	28	n.a.
Children under age 5 (2009–2013) suffering from underweight (WHO)	22	32	5
Children under age 5 (2009–2013) suffering from wasting (WHO)	9	15	4
Children under age 5 (2009–2013) suffering from stunting (WHO)	37	38	12

Note: Key economic, nutrition and social characteristics extracted from UNICEF (2015), *State of the World's Children, Statistical tables, Economic and social statistics on the countries and areas of the world, with particular reference to children's well-being*, Nov. 2014; some data are from 2013, others from the period 2009–2013.

* Excludes China.

Figure 2. Stunting by wealth quintiles in various regions



Source: Adapted from UNICEF, 2015, *Progress Report Six Headline Results for Children in South Asia, Stop Stunting*.

Nepal shows a similar pattern, with a decrease of 13 per cent in stunting among children from the poorest wealth quintile (from 64 per cent to 56 per cent) and a 40 per cent decrease among children from the richest wealth quintile (from 43 per cent to 26 per cent).¹² In Lao PDR stunting in children under 5 years of age from the highest wealth quintile was reduced by over half (56 per cent) in the period 2006–2011 while stunting among children of the lowest wealth quintile increased from 49 per cent to 53 per cent.³

Stunting levels of children under 5 years of age in Asia remain closely linked to maternal education, as a disparity ratio of nearly 3:1 between children whose mothers had no education and children with mothers who finished secondary or higher education demonstrate.¹³ The case of Thailand, where 34.1 per cent of children under 5 years of age whose mother had no education were stunted as compared to 12.6 per cent of the children with a mother who had finished higher education suggests that disparities remain despite substantial gains in development. Available figures suggest that disparities in stunting between boys and girls are not significant.⁵ However, stunting among children under 5 years of age from rural areas tends to be higher than among urban children, with disparity ratios ranging from some 1.2 (Bangladesh) to 1.6 (Nepal) and 1.8 (Lao PDR) in the MYCNSIA countries.⁵

Anaemia affects some 250 million women of reproductive age. The prevalence of iron-deficiency anaemia (IDA) in Asia ranges from 14 per cent in Viet Nam to 51 per cent in Pakistan.¹⁴ The negative impact of IDA on the economic well-being of individuals, families and national economies is considerable. For example, according to the United Nations Standing Committee on Nutrition the economic costs of anaemia in Bangladesh amounted to an estimated 7.9 per cent of the country's gross domestic product (GDP).

1.4.3 Stakeholders and development partners in nutrition

The Association of Southeast Asian Nations (ASEAN), was established on 8 August 1967 in Bangkok.¹⁵ At the 12th ASEAN Summit in January 2007, the leaders signed the Cebu Declaration on the Acceleration of the Establishment of an ASEAN Community by 2015, comprising three pillars,

namely the Political-Security Community, the Economic Community and the Socio-Cultural Community. Each pillar has its own Blueprint which, together with the Initiative for ASEAN Integration (IAI) Strategic Framework and IAI Work Plan Phase II (2009–2015), form the Roadmap for an ASEAN Community 2009–2015 (<http://www.asean.org/asean/about-asean/overview>).

A cooperation agreement between the UNICEF Regional Office for East Asia and the Pacific (EAPRO) and ASEAN was signed in 2014 following several years of negotiation. The Framework Agreement for Cooperation, which outlines cooperative actions between ASEAN and UNICEF, aims to pursue the common goals of ensuring sustainable survival, growth, full development and participation of children in line with the Convention on the Rights of the Child, the Millennium Declaration and the MDGs, as well as the United Nations development agenda beyond 2015.

The South Asian Association for Regional Cooperation (SAARC), established in 1983.¹⁶ Over the years SAARC has evolved from a trade bloc into a concept of extensive cooperation in many fields ranging from agriculture, energy, environment to poverty alleviation, tourism, education. UNICEF's main partner in SAARC is the Director of Social Affairs, who is responsible for health, nutrition, HIV/AIDS, social policy and sanitation. In 2014 ROSA and SAARC signed a new cooperation agreement. The agreement outlines in which fields and how SAARC and UNICEF will collaborate. In the field of nutrition the following has been agreed: soliciting high-level political commitment to improve nutrition governance; advocating multi-sectoral policies and programmes; and scaling up cost effective evidence-based, sustainable nutrition specific and sensitive interventions that address all determinants of malnutrition.

Asia-Pacific Economic Cooperation (APEC), a platform of 21 economies, was established in 1989 to promote free trade. Over the years, the platform developed a much more comprehensive agenda and now also includes food security. A special website (the Asian Pacific Information Platform (APIP) on Food Security) for sharing information on food and nutrition security online was developed based on the

APEC Action Plan on Food Security following an agreement to strengthen information sharing at the APEC Ministerial Meeting on Food Security, in 2010 (<http://www.apip-apec.com/>). The APEC Food Security Road Map Towards 2020 (version 2013) does not, however, mention nutrition security, the need to mainstream nutrition into food security, or the importance of nutrition sensitive programming. UNICEF is not mentioned in the list of links on the APIP website, although the Food and Agriculture Organization of the United Nations (FAO) and the World Food Programme are.

At the regional level, the Nutrition Security Coordination Committee was first organized in December 2011 by UNICEF under MYCNSIA, originally comprising four UN partner agencies (UNICEF, FAO, WHO and the World Food Programme), the World Bank's South Asia Food and Nutrition Security Initiative and Renewed Efforts to End Child Hunger and Undernutrition (REACH). By 2014, the Committee had grown to also include NGOs, academic institutions and civil society organizations (see Table 3). The Committee was established as a venue for sharing, discussing and strengthening partnerships and joint activities, elaborated in section 2.3.2.

The South Asia Food and Nutrition Security Initiative was established in March 2010 as a multi-donor trust fund administered by the World Bank. It focuses on food and nutrition security taking an explicit political economy approach to influence policy and programmes. The Initiative generates innovative and evidence-based approaches, and fosters stakeholder platforms that can operationalize cross-sectoral action and enable effective domestic stewardship of the food and nutrition security agenda. The Initiative targets the poorest and most vulnerable, especially women and socially excluded people.

Alive and Thrive (A&T) is an initiative funded by the Bill and Melinda Gates Foundation and the Governments of Canada and Ireland, managed by Family Health International 360. A&T headquarters are in Washington, D.C., with offices in Africa and Asia including in Bangladesh, India and Viet Nam. A&T focuses on three technical areas: (i) early initiation of breastfeeding and exclusive breastfeeding (EBF) for the first six months of life; (ii) timely, adequate, and appropriate complementary feeding; and (iii) maternal nutrition. The framework for large-scale programmes consists of four main components: advocacy, interpersonal communication and community mobilization, mass communication, and strategic use of data. A&T builds on lessons learned through its partnership with the International Food Policy Research Institute, Bangladesh Rehabilitation Assistance Committee and World Vision, and A&T applies global, scientific guidance from WHO and UNICEF. In its programme implementation A&T uses a strategic and harmonized combination of four components: advocacy, mass communication, interpersonal communication and community mobilization and strategic use of data, as exemplified by a module describing tools for face-to-face communication to achieve scale and quality in improving feeding practices in Bangladesh.¹⁷ A&T and UNICEF EAPRO have a formal Memorandum of Understanding (MOU) that outlines areas of joint work.

The Sustainable Micronutrient Interventions to Control Deficiencies and Improve Nutritional Status and General Health in Asia (SMILING) programme (2012–2014) was a consortium of research institutions and implementation agencies in five countries in South-East Asia, namely, Cambodia, Indonesia, Lao PDR, Thailand and Viet Nam, with European partners. It supported the application of state-of-the-art knowledge to alleviate micronutrient malnutrition in children and women. Using a multidisciplinary approach and multi-sectoral support, the project aimed to translate the latest scientific findings on improving micronutrient status into new policy and programming. Participating countries were chosen based on a range of social and economic development parameters, the prevalence of micronutrient malnutrition, as well as capacity and success in efforts to improve nutrition. The consortium mapped the prevalence of micronutrient malnutrition, past and present interventions and lessons learned, and new interventions that are potentially effective. Innovative tools were used to support nutrition policy-making and programming. Findings were disseminated and provided to the Governments of the respective countries to integrate into their road maps or national action plan(s).

1.4.4 Regional policy framework in nutrition security

The only regional policy for nutrition in Asia which has been officially endorsed thus far is the South Asia Regional Action Framework for Nutrition, developed by the SAARC secretariat with technical support from UNICEF ROSA. Launched in 2014, the Action Framework encourages the eight SAARC member countries to prioritize the reduction in child undernutrition and provides guidance on coherent approaches that can be applied across the region to address undernutrition. Building on the experience of countries which have been able to reduce undernutrition by reaching mothers and children through a focus on the first 1,000 days, the Action Framework emphasizes that a successful outcome requires national policies and programmes based on sound situation analysis and a multi-sectoral approach. The Action Framework is built around the following four pillars:

1. Solicit high-level political commitment to improve nutrition governance, strengthen programme planning and implement multi-sectoral policies and plans addressing all determinants of undernutrition;
2. Scale up cost-effective evidence-based, sustainable nutrition specific and nutrition sensitive interventions for all, with a focus on women and children;
3. Increase human and institutional capacity to manage nutrition programmes at the national and sub-national level.
4. Increase effectiveness and accountability of stakeholders implementing nutrition interventions through a coherent monitoring framework, reporting and knowledge management system.

The Action Framework also details SAARC's role in supporting countries to improve their nutrition situation by providing a platform for countries to do the following: (i) work collaboratively, advocate, share experiences and learn from each other; and (ii) discuss certain cross border issues

pertaining to nutrition including harmonization of food standards and quality control of food commodities.

In South-East Asia, the ASEAN Economic Community (AEC) Blueprint and the Socio-Cultural Community Blueprint address nutrition. Moreover, the ASEAN Integrated Food Security Framework (AIFS) and the Strategic Plan of Action on Food Security in the ASEAN Region (SPA-FS), adopted following the ASEAN Summit in Thailand in 2009, provide guidance for work with the AEC on improving food security. This consists of mainstreaming nutrition in food security, notably food production and value chains. The implementation of the first AIFS resulted in significant achievements in food accessibility and availability. In February 2014, it was suggested that the second phase of AIFS (2015–2019) should address nutrition, food safety and poverty alleviation issues in line with the ASEAN Roadmap on the AEC Blueprint and the ASEAN Socio-Cultural Community Blueprint. It was also agreed that existing ASEAN regional food security and nutrition strategies, frameworks and initiatives should be harmonized and implemented to prevent and manage malnutrition and alleviate the double burden of malnutrition among the most vulnerable population groups.

In the ASEAN strategic framework for Health Development (2010–2015), nutrition was addressed within the scope of maternal and child health, with a focus on promoting healthy diets and a nutrition surveillance system. The strategic framework, however, was confined to food safety and promoting healthy diets in relation to non-communicable diseases, with a specific output on ASEAN regional strategy and work plan on non-communicable diseases. Maternal, infant and young child feeding was included as one of the issues in the strategy on information sharing and evidence-based advocacy. The ‘first 1,000 days’ was not explicitly specified as a high priority in the strategic plan. According to

the Secretariat of Health of the ASEAN Health Community, nutrition strategies have recently been incorporated in the regional strategy formulation as per the third Senior Officials Meeting on Health Development (SOMHD) work group meeting for ASEAN health development agenda beyond 2015, endorsed by the Health Ministers in September 2014. The regional strategy includes vision, mission and goals for 2020 and the twenty health priority areas include nutrition and child health.

A number of countries in Asia have joined global initiatives to advance nutrition. At present, ten countries are members of the SUN movement. At the start of MYCNSIA only Lao PDR, Indonesia and Nepal had joined the SUN movement. Sri Lanka and Bangladesh joined in 2012. Thereafter, Pakistan and Myanmar joined in 2013 and Cambodia, the Philippines and Viet Nam joined in 2014. At present, half of the eight SAARC and six out of the ten ASEAN member countries are members of the SUN movement. A substantial number of these SUN countries endorsed multi-sectoral coordinating mechanisms and frameworks for nutrition sensitive development or are in the process of doing so. These countries include Bangladesh, Cambodia, Indonesia, Lao PDR, Nepal, Pakistan, the Philippines and Viet Nam.

Two MYCNSIA countries are also REACH programme countries: Bangladesh (since 2009) and Nepal (since 2012). The REACH programme is currently being evaluated and continuity may depend on the outcome. Bangladesh and Nepal were also selected for the “Feed the Future” (FTF) initiative of the United States Government. This initiative focuses on inclusive agricultural sector growth, gender integration, improved nutrition, private sector engagement and research and capacity building. It provides opportunities to boost multi-sectoral approaches to reduce malnutrition and has the potential to link up with MYCNSIA.

1.5 EU-UNICEF response – description of MYCNSIA

The 2011–2015 MYCNSIA initiative positioned nutrition security on the regional and national agendas while contributing to the overall achievement of nutrition-related targets of MDGs 1, 4, 5 and 8. The programme aimed at convergence with the efforts of other UNICEF sectors and external partners working in multiple sectors that contribute

to reduction of undernutrition, including mother and child health; WASH; cash or social transfer programmes to alleviate poverty; and the agriculture sector (e.g. homestead food production). In each of the countries targeted by MYCNSIA there is a specific undernutrition profile and institutional context.

Table 2. Budget of country level programmes within MYCNSIA

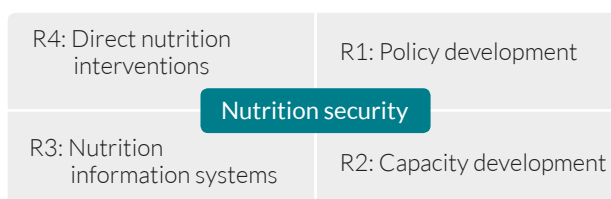
Country	Budget original	Budget after 2014 revisions	Key interventions
Regional	€ 4.00 million	€ 4,639,693.38	Regional level advocacy and coordination on nutrition security. Capacity development of regional and national institutions on nutrition information systems as input for policy development and planning. Establishment of forums for sharing experiences and good practices in nutrition. Overall management of MYCNSIA and liaison with EU. <i>*Net gain due to addition of UNICEF funds</i>
Bangladesh	€ 5.88 million	€ 4,901,252.79	Implementation by multi-sectorial Governmental structures together with national and international NGOs. Field activities in 9 districts in 6 divisions with diverse food security and nutrition stressors. <i>*Net loss due to removal of other donors.</i>
Indonesia	€ 5.65 million	€ 5,089,932.65	Main partner for the programme is the Government, at central and de-central levels. Field activities geographically concentrated in 3 districts in various parts of the country (Central Java, Eastern Nusa Tenggara, and Papua). <i>*Net loss due to removal of other donors, despite increased contribution of UNICEF.</i>
Lao PDR	€ 2.52 million	€ 3,124,394.29	Field activities concentrate on the three southern provinces, with implementation by the Government activities are complemented by activities supported by other UN agencies, as well as World Bank and EU funded NGOs. <i>*Net gain due to 1.5M EUR top-up, including some losses from removal of other donors.</i>
Nepal	€ 6.30 million	€ 5,440,062.37	Support for introduction of the Multi-sector Nutrition Plan (MSNP). Geographical targeting of field-level activities is done separately for IYCF/ micronutrient powders (MNP), IYCF/Child cash grant, Community Managed Treatment of Acute Malnutrition (CMAM) and Adolescent Iron Folate supplementation. Through the roll-out of the MSNP the various activities will be brought together. <i>*Net loss due to removal of other donors, despite increased contributions of EU (1M EUR top-up) and UNICEF.</i>
Philippines	€ 4.095 million	€ 3,228,912.51	Core focus on micronutrient fortification of rice and flour, IYCF, and the roll-out of a social protection scheme in a total of 194 priority municipalities in three regions of the country. <i>*Net loss due to removal of other donors.</i>
Total	€ 28.44 million of which € 20 million by EU	€ 26.42 million of which € 22.5 million by EU	

Source: Expanded Country Summary Sheets provided by UNICEF EAPRO and updated by the PMU, EAPRO.

The original MYCNSIA budget was €28.44 million, of which €20 million provided by the EU, €3.07 million by UNICEF, and €5.37 million by other donors (see Table 2). After the 2014 budget revision the total budget was reduced to €26,423,957, of which €22.5 million was provided by the EU, including “top-ups” amounting to €2.5 million for MYCNSIA in Nepal and Lao PDR. In the revised budget contributions of other donors were excluded at the request of the EU in 2013. In addition the programme was extended by just over one year, through March 2016.

The programme has four pillars: (1) upstream advocacy and policy influencing work regarding nutrition security; (2) capacity development of decision-makers, service delivery personnel and communities; (3) monitoring, data analysis and knowledge sharing; and (4) scale up of key proven interventions (see Figure 3). At the country level the four pillars reflect the country context in compliance with existing UNICEF programmes.

Figure 3. Four pillars of MYCNSIA



Structure and role of the regional component in MYCNSIA

The UNICEF Regional Programme Management Unit (PMU) for MYCNSIA has three staff in the EAPRO in Bangkok, and three staff in the ROSA in Kathmandu. In EAPRO staff include the Regional Nutrition Advisor, a programme specialist/coordinator and a research assistant; in ROSA staff consist of the Regional Nutrition Advisor, a nutrition specialist and a programme assistant. A summary of the workplan for the regional component is presented in Table 3.

Table 3. Summary programme design MYCNSIA regional component

Pillar	Result areas ('outputs') specified in workplan (no pillar 4)
1. Policy development	Coordination of overall programme
	Advocacy at regional level
2. Capacity development	Support for roll-out of training on nutrition sensitive programming for district managers and training on community-based IYCF counselling
3. Nutrition Information Systems	Common M&E framework with indicators disaggregated by sex and age developed and adopted by countries to document impact and guide actions for future scale up.
4. Direct nutrition interventions	Inter-linked structured forums to share experience and good practices in nutrition established at regional and national level.
5. Cross-cutting and administrative issues	On-time submission of donor reports

Pillar 1 – Policy development

Under pillar 1, MYCNSIA aimed to develop policy instruments at the national and regional level. As outlined above (see section 1.4.4) SAARC and ASEAN are vital partners in regional policy development and advocacy. At the national level, MYCNSIA worked to embed nutrition in plans of action

and encourage multi-sectoral approaches to nutrition. Table 4 summarizes per country which policies/guidelines or national programmes were in place at the time of the 2013 MTE (green means in existence, orange stands for partly achieved/ in progress, and red for no progress).

Table 4. Existing national policy context in relation to nutrition security – MTE 2013

	Bangladesh	Indonesia	Lao PDR	Nepal	Philippines
High Impact nutrition interventions					
IYCF	Yes	Yes	Partly	Yes	Yes
Supplementation (IFA, MNP)	Yes	Yes	Partly	Yes	Yes
Food fortification	Partly	Partly	Partly	Partly	Yes
Management of Acute Malnutrition	Partly	Yes	Yes	Yes	No
Nutrition-sensitive sectoral strategies					
Agriculture	Yes	Yes	No	Yes	Yes
Cash-based safety nets	Yes	Yes	Partly	Yes	Yes
Food-based safety nets/ Food subsidy programmes	Partly	Yes	No	Partly	Yes

International Code of Marketing of Breast-milk Substitutes, baby friendly hospital initiative, baby friendly place at work	Yes	Yes	Yes	Partly	Yes
Health (mainstreaming)	Yes	Yes	Yes	Yes	Yes
Water and sanitation	No	No	Yes	Yes	No

Pillar 2 – Capacity development

MYCNSIA focused on capacity development as a national and a regional function. It supported the roll-out of training on nutrition sensitive programming for district managers and training on community-based IYCF counselling. The training of (master) trainers approach greatly expanded the impact of capacity building activities. In addition, the regional workplan also foresaw capacity building in multi-sectoral nutrition security programming.

Pillar 3 – Nutrition information systems

The focus of work undertaken under pillar 3 was a mixture of, firstly M&E for MYCNSIA itself (notably impact measurement through baseline and endline studies) and secondly, support to national M&E systems. Table 5 illustrates this for the five countries. In two countries local M&E systems were intended to be adopted upstream (mainstreamed) even though in Bangladesh this was not explicitly mentioned in the workplan.

Table 5. Pillar 3 outputs across the five MYCNSIA countries – MTE 2013 overview

	Internal (project modality)	External (programme support)	
		Local	Upstream spin-off and/or mainstream
Bangladesh	3.2: Baseline and end line surveys are implemented according to time line and protocol and results are made available by the end of 2014	3.1: By 2014, 80% of targeted districts submit monthly reports containing nutrition data and annual national report is compiled within 3 months of the year end	(MTE: Here there is clear potential for adoption of the innovative web-based monitoring of nutrition indicators into the mainstream.)
Indonesia	3.3: Baseline and final evaluations of the project are conducted	3.1: Monitoring mechanisms established to assess progress on breastfeeding and complementary feeding, maternal nutrition and health practices 3.2: Nutrition surveillance system strengthened to ensure early detection of malnutrition	
Lao PDR	3.1: Survey data available for EU project provinces based on the common MYCNSIA framework		3.2: A national monitoring system is developed and functional with standard nutrition and food security indicators included in data collection system by December 2013
Nepal	3.1: (national survey) Data available to monitor effectiveness of the maternal, infant and young child nutrition programme to enhance maternal and child feeding and reduce adolescent anaemia, through Micronutrient Survey by mid-2013 multi--sectoral approach at district level to scaling up nutrition 3.2: (impact study) Subclinical level nutrition data and information available for assessing effectiveness of MIYCN programme to enhance maternal and child feeding and care and to reduce anaemia, including links with the piloting of		
Philippines	3.1: Baseline and end line survey representative of EU project Regions and in line with the Common Monitoring and Evaluation Framework	3.2: Standard nutrition, food security and early warning indicators are included in routine data collection systems by December 2013	

Pillar 4 – Direct nutrition interventions

The main focus in pillar 4 activities has been on scaling up direct nutrition interventions. Basically, the programmes focused on support to IYCF roll-out, distribution of MNPs,

and piloting/ scaling up of Community Managed Treatment of Acute Malnutrition (CMAM) (see Table 6).

Table 6. MYCNSIA Pillar 4 interventions in the country programmes – MTE 2013 overview

Intervention	Bangladesh	Nepal	Indonesia	Lao PDR	Philippines
CMAM	Screening MUAC* and CMAM in two upazilas (one year only)	CMAM in eleven districts	CMAM in two districts	CMAM as part of emergency programme	No CMAM**
IYCF	Counselling of pre-pregnant, pregnant and lactating women	Promotion of range of MYC feeding practices	MYC nutrition as part of conditional cash transfer; IYCF counselling	Mother support groups; IYCF guidelines developed	MYC nutrition as part of conditional cash transfer; IYCF counselling cards
Micronutrient powder (MNP) distribution	Integrated in IYCF programme	Integrated in IYCF programme	Integrated in IYCF programme	MNP delivery study	Financial support and procurement
Iron-folic acid (IFA) distribution	Type of tablets and distribution mode; Counselling and follow-up through home-visiting	Adolescent girls (yet to start)	Multiple micronutrient supplement distribution	Support to IFA distribution to pregnant women through outreach activities	Financial support
Food fortification			Universal salt iodization; advocacy to improve the standard for wheat flour fortification		Rice fortification
Local nutrition plan	Multi-sectorial meetings at district level	Multi-sectorial nutrition plan	Provincial (3) and District (2) Food and Nutrition Plans	Participatory Learning and Action	Local Nutrition Action Plan

* Mid-upper arm circumference (MUAC); **In the Philippines UNICEF has implemented CMAM related activities from other sources of funding (source: UNICEF Regional Office BKK comments).

Pillar 4 – Geographical coverage

The geographical spread of MYCNSIA scaling up activities in the five countries has varied substantially, ranging from relatively small (Indonesia) to rather ambitious (the Philippines). An analysis of the outreach of the scaling up

approaches in the five MYCNSIA countries shows that there have been considerable differences in geographical coverage of the main direct nutrition interventions. Table 7 gives an overview.

Table 7. Pillar 4 coverage in the country programmes – MTE 2013 overview

	Bangladesh	Nepal	Indonesia	Lao PDR	Philippines
Total population (millions)	148.7	30.0	239.9	6.2	93.3
Target population (millions)	4.5 (3,0%)				
		1.6 (0,7%)	0.6 (9,7%)	ca. 10 (10.7%)	

Geographical coverage	16 out 428 upazilas (sub-districts)	28 out of 75 districts	3 out of 497 districts	3 out of 17 provinces	3 out of 17 regions
(194 out of 324 districts)					
CMAM	3 upazilas				
	11 districts	2 districts	3 provinces	-	
IYCF	16 upazilas				
	15 districts	3 districts	3 provinces	194 districts	
MNP	16 upazilas	15 districts	2 districts	1 province	194 districts

2 FINDINGS OF THE END-TERM EVALUATION

2.1 Overall relevance and appropriateness

MYCNSIA combined tailored support for nutrition governance with support for policy development, capacity building, information and knowledge management and scaling up nutrition. In implementing MYCNSIA, UNICEF had competitive and strategic advantages, particularly in supporting governance institutions. At the national and regional level, MYCNSIA contributed to nutrition mainstreaming and intersectoral links to advance nutrition related objectives. Steps were taken following the MTE to implement its recommendations, although these efforts were incomplete. The EU-MYCNSIA partnership was most relevant and appropriate where both parties were active in adapting the initiative to changing conditions.

2.1.1 Programme design

Frames and theories of change

The programme's original intentions were well captured

in the 2011 MYCNSIA brochure as follows, "Nutrition Security is more than just food security. It is the outcome of good health, a healthy environment, and good caring practices. Food security is necessary, but it is just one part of nutrition security."¹⁸ Box 2 lists the key interventions as they were drafted for the entire programme, in five countries. The phrase 'direct interventions' in the heading of Box 2 is nowadays reserved for nutrition specific interventions, so-called Direct Nutrition Interventions (DNI), also called High Impact Nutrition Interventions (HINI), with the exception of the links to agriculture, poverty reduction and water and sanitation which are nowadays referred to as nutrition sensitive interventions. The UNICEF/ MYCNSIA initiative was designed and operated under the implicit assumption that nutrition specific interventions would be the most appropriate starting point.

Box 2 MYCNSIA Programme as it was originally conceived: Evidence-based direct interventions to prevent and treat undernutrition

The initiative will include a large number of actions and practices that have already proven their worth and are highlighted in the Lancet Series, and by the World Bank and the Scaling Up Nutrition (SUN) movement.

Promote good nutritional practice

- Exclusive breastfeeding for first 6 months of life
- Appropriate complementary feeding for children aged 6–23 months Improved hygiene practices, including hand washing

Increase intake of vitamins and minerals

- Multiple micronutrient powder for children aged 6–23 months IFA/ multiple micronutrient supplements for pregnant and lactating women
- Iron fortification of staple foods

Therapeutic zinc supplements for diarrhoea management

- Periodic vitamin A supplements
- Salt iodization
- Therapeutic feeding for malnourished children with special foods
- Prevention or treatment of moderate undernutrition
- Treatment of severe acute undernutrition with ready-to-use therapeutic foods (RUTF)

Link nutrition to agriculture, poverty reduction, and water and sanitation

- Encouragement of home production of foods and animal products rich in nutrients
- Inclusion of nutrition services in social protection and cash transfer programmes
- Better access to safe water and improved sanitation facilities

Drawn from The Lancet's Series on Maternal and Child Undernutrition (2008); the World Bank's: Scaling Up Nutrition – What will it cost? (2010); and Scaling Up Nutrition – A Framework for Action (2010).

The initiative did not have a univesal theory of change, but was defined in various and overlapping ways which have made reporting and evaluation more challenging. Part 1 of the logframe is the only instrument where the regions and the five countries come together in one frame. The basic logframe was

inappropriate as an overarching strategic framework for each country. Instead, countries were guided by their workplans/ outputs. Since 2013, the programme's main Progress Report used the basic frame, but the countries and region reported according to the outputs of their respective workplans.

Box 3 UNICEF's strategic advantage as an 'honest broker'

The Indonesia team succinctly listed its comparative advantages (and the evaluation team agrees):

- Technical team with expertise on nutrition, health, WASH, social policy and education (very few organizations with dedicated nutrition staff)
- Close position of trust with the Government and partners, with access to high-level government officials (assigned Donor Convenor)
- UNICEF is proactive in fostering close working relations with strategic contacts at all levels of government, include senior level
- UNICEF encourages government and partners to take

the lead, does not seek recognition for its support, and considered "neutral"

- No UNICEF "projects" – we support the implementation of the Government's programmes.
- UNICEF is responsive to the needs of the Government and partners (e.g. promote response to requests for technical support)
- Proven ability to support the Government in the application of global guidelines and recommendations on nutrition
- Convening ability – UNICEF often called upon to facilitate stakeholder consultations.

Source: Indonesia Country Office briefing of ETE team.

The UNICEF/ MYCNSIA programme attempted to operate within the set boundaries of its frameworks: the logframe and the set outputs (amended by some countries). Within those frameworks, there was some room for interpretation. For example, efforts related to the 'first 1,000 days' could have included the double burden of malnutrition that includes both undernutrition and overweight. This was not done, perhaps because MYCNSIA was formulated in 2011, before the double burden became a UNICEF priority. It was addressed in the 2014 EAPRO regional strategy, but MYCNSIA did not respond to the double burden or other new priorities.

MYCNSIA was a hybrid between a project with objectives to reduced stunting and anaemia, and a programme that acts as a change agent supporting the Government to reduce undernutrition in a systemic way. The original write-up of the MYCNSIA programme in the EU-UNICEF website¹⁹ led the ETE team to draft a fitting theory of change: *If a judicious mix of nutrition specific and nutrition sensitive interventions is achieved ... then accelerated reduction of chronic undernutrition (anaemia and stunting) is possible (Lancet 2008; 2013).*

Strategic advantages

In implementing MYCNSIA, UNICEF had competitive and strategic advantages. Some of these advantages were provided to the evaluation team by the Indonesia Country Office (see Box 3). Moreover, the quality of 'being there when needed' is something UNICEF, and by implication MYCNSIA, has been much appreciated for. Respondents at the national level (and local level, as in Nepal) in four of the five MYCNSIA countries emphasized that UNICEF has the competence and the readiness to assist when needed, and did not necessarily seek the limelight. In addition the historical ties with UNICEF and thus the continuity were appreciated. These qualities were not captured in logical frameworks or workplans.

2.1.2 Coherence, completeness and complementarity

Regional policies and partnerships

In terms of upstream policy development, MYCNSIA made considerable progress in profiling nutrition at the regional level through collaboration with strategic partners. Collaboration with ASEAN and SAARC has been formalized through agreements (and workplans), which provide a solid basis for strengthening nutrition policy development and advancing multi-sectoral approaches particularly in South Asia (such as the SAARC South Asia Regional Action Framework for Nutrition). Furthermore, the regional Nutrition Security Coordination Committee was expanded into an appropriate mechanism for joint initiatives and coordinated enhanced support, joint missions and guidance to countries.

UNICEF EAPRO worked to ensure that the 'first 1,000 days' was explicitly mentioned in the ASEAN Action Plan for Social Protection. This will enable integrated action on early childhood development and nutrition in social protection programmes around the region. EAPRO used the example of Indonesia's nutrition-WASH integration and the Lao PDR theory of change – which includes WASH – to promote linkages between nutrition and WASH. Interest in extending this model to other countries is increasing.

National policies and partnerships

Undernutrition in most MYCNSIA countries attracted new actors in the past two years, and MYCNSIA has forged new partnerships. The SUN movement is a driving force and forum to consolidate new actors (see Box 4). **MYCNSIA supported the relevant forums and movements and helped them become established and gain momentum** (see section 2.3.1: Nutrition governance).

Box 4 Increasing the diversity of actors (Nepal)

Activities under the SUN framework have expanded during the last two years, contributing to a national voice and community-driven support for scaling up nutrition. In 2014 the Civil Society Alliance for Nutrition in Nepal (CSANN) was established and currently consists of more than 30 national and international NGOs, civil society organizations and research institutions. UNICEF closely collaborates with CSANN and its members. CSANN focuses on the first 1,000 days for advocacy

and campaigning through multi-sectoral approaches. Its objectives include the following: (i) ensure qualitative, extensive and inclusive participation of civil society in the nutrition movement of Nepal; (ii) increase public and relevant sectors' awareness on nutrition, ensure increased funding and improve nutrition governance; and (iii) advocate an increased focus on nutritional outcome in national policies and programmes.

Source: Annex F (Nepal); and <http://166.62.41.120/nnp/OngoingInitiatives.aspx>.

In most countries the concept of the 'first 1,000 days' has become common knowledge. Donor-funded projects are increasingly centred on this period and naturally connect with MYCNSIA's nutrition specific efforts. In countries with few externally funded projects the opportunities for linkages are reduced. There have been occasions, however, to link with state-funded programmes, particularly social protection schemes. In Indonesia the integration of the nutrition intervention package into the National Community Empowerment Programme (PNPM) was made possible with Millennium Challenge Corporation funding in 64 districts.

The nutrition focus in UNICEF country offices has grown, but the speed and intensity of integrating nutrition into country programmes varied between countries. Placing nutrition coherently within UNICEF country programmes is currently happening in several MYCNSIA countries and the Nepal Country Office has gone furthest in mainstreaming nutrition in its Country Programme Action Plan 2013–2017.

2.1.3 Uptake of the MTE lessons, conclusions and recommendations

The 2013 MTE lessons, conclusions and recommendations were relevant and well received at the time of the dissemination, yet follow-through was variable. After the MTE some countries revised their MYCNSIA outputs and replaced targets in the form of numbers (policy documents, persons trained and so on) with more strategic targets in the form of improved nutrition governance through which decentralized levels could be reached and more sustained coverage would be possible. **When countries acted on the recommendations and revised their outputs, the relevance and appropriateness of MYCNSIA outputs improved.**

All in all the evaluation team was satisfied with the follow-up. It was clear that countries were free to decide whether to act on the MTE recommendations. The evaluators expected that follow-up would at least partly be a regional function, but this was not so. As will be discussed elsewhere in this report, many MTE recommendations were not taken up, including the recommendation to the PMU to concentrate on the exchange of information and experience and to exploit

synergies between countries on capacity development and mutual learning. Implementation of this recommendation was deferred to the very end of the programme.

2.1.4 EU-MYCNSIA partnership in practice

As the programme was regional, the country-level EU Delegations were not directly responsible for overall programme management. This responsibility resided with the Bangkok Delegation. The evidence is that the contacts between the Bangkok Delegation and UNICEF EAPRO were largely administrative. **The relationship with the Delegation was primarily the traditional relationship between funder and recipient. Closer and more content-oriented relationships formed at country level when the person in charge of the Delegation took an active interest; when there was a request for extension; or when there was a high-potential request for a new follow-up programme, as occurred in Nepal.**

The relationship could become increasingly collaborative when the Delegation itself took on so-called delegated authority from other (European) donors, for the sector. This is currently happening in Lao PDR where the Delegation, including the Head, uses every possible opportunity to support the country's efforts to address undernutrition. The distribution of sectors across the donors deepens the focus, which in turn increases interest when 'things start moving'. In Lao PDR the Delegation has taken an active role in co-designing the new EU-funded follow-through programme of MYCNSIA – not as co-author, but rather because points of view and preferences have been shared as a matter of course, in formal and informal meetings attended by both UNICEF staff and the EU Delegation.

In 2013 MYCNSIA activities which received (co-)funding from donors other than the EU had to be 'written out' of the MYCNSIA initiative. In Nepal this apparently did not impact the workplans, but in Indonesia one running programme had to be removed from the MYCNSIA workplan.²⁰ The objection of the EU to the co-funding arrangement had clear costs to the programme and ought to be avoided in future programmes (see section 2.7.1).

2.2 Equity focus

Country-level implementation of MYCNSIA, particularly under pillar 4, was targeted to the needs of low-income populations. Although this aspect of implementation had a clear equity focus, only one indicator on the logframe mentions 'equity'. The lack of formal outputs and indicators meant that the equity dimensions were not reported on and valuable work was not recognized for replication in other countries.

2.2.1 Equity

The logframe does not mention equity in its 73 outputs, and only 1 out of 34 indicators mentions 'equity' in a rather oblique way. Neither the logframe nor the outputs included 'gender' or 'rights'. This is not to say that these dimensions were not addressed, but the lack of formal outputs and indicators meant that the dimensions were not reported on. This in turn meant that valuable work was not recognized for replication in other countries.

The ETE reaffirms the 2013 MTE observations regarding the equity focus of MYCNSIA. **The evidence from all five MYCNSIA countries is that the intervention areas for pillar 4 (scaling up) activities were chosen with a view to address needs of underprivileged populations.** In most countries the main focus was on rural areas. In some cases prioritization was done based on the United Nations Development Assistance Framework. Priority districts were marked by large inequities in terms of poverty, health services and so on. In Bangladesh the typical (but limited) multi-sectorial interventions targeted poor and destitute populations. Specifically noteworthy is that engagement with social protection schemes in Indonesia and the Philippines enabled the initiative to reach poor households at a substantial scale.

The equity focus is usually embedded in national planning instruments. In Indonesia and the Philippines national decrees and directives are followed up at the local level to allow for local implementation. In Nepal the equity dimension is embedded in the MSNP and is routinely incorporated in

new/revised policies. In Bangladesh the Government spends about 2-3 per cent of the country's GDP on some 100 social protection schemes aimed at the poor. In Lao PDR the ETE team learned that the Ministry of Health has existing rules to ensure the 1,274 villages without road access are not excluded from health services. The rules provide for resident Village Health Volunteers and trained Lao Women's Union workers.

There is potential for undernutrition to be an equitable selection criteria for targeting deserving population groups in social protection schemes. The ETE team notes that targeting is complex and not risk free, whether it is done based on wealth criteria, health status or other factors.

The focus on equity was strengthened by recent developments within UNICEF and in Asia. For instance, UNICEF emphasized equity for impact in its strategy for reducing stunting in South Asia. Moreover, a **rights-oriented angle to undernutrition can be found in Early Childhood Development (ECD)**. Decision makers increasingly recognize the need to address undernutrition, yet there also is substantial evidence that parents and other close family members are more interested in a child's development than in his or her height. Work on ECD in Nepal has potential for use in other countries.

Baseline and endline data from Bangladesh show the programme did little to reduce disparities. Disparities in food security and minimum diet diversity increased, while disparities in stunting remained constant. This deserves further study and possibly publication.²¹ Preliminary endline data in Indonesia demonstrate the opposite: the poorest quintiles improved as compared to wealthier quintiles. The SAARC South Asia Regional Action Framework for Nutrition recommends to monitor disparities in wealth quintiles, population groups and gender of all impact indicators. To facilitate actual implementation, the agenda of the 2015 annual meeting of the UNICEF regional nutrition advisors included monitoring equity in nutrition.

Box 5 An interactive website with a rights perspective (ROSA)

The report: "Improving children's lives, transforming the future" launched in New York in 2014 in preparation of the Stop Stunting conference. The report highlights changes in the lives of children in South Asia during the last 25 years in various aspects including nutrition. For the report UNICEF conducted a data analysis of determinants of stunting and wasting in the South Asia region. Results

provide a baseline to measure progress and were used to develop the UNICEF ROSA regional strategy for the prevention of child stunting, as part of an overall strategy to improved children's rights in South Asia by 2017.* Progress is reported through a booklet on stunting, to be produced annually. An interactive website provides real-time information on these results.

Note: All eight SAARC countries have agreed on this common results framework (endorsed April 2015).

**The strategy consist of six headline results on stunting, newborns, education, ending child marriage, stopping open defecation and eradicating polio.*

2.2.2 Responsiveness to barriers and bottlenecks

A link with UNICEF's new Monitoring Results for Equity Systems (MoRES) instrument was taken up by some of the countries, but the overall MYCNSIA programme design was not adapted to this instrument to address inequality. One application of MoRES is to identify barriers and bottlenecks. For example, the Bangladesh Country Office monitored tracer interventions for each UNICEF sector through MoRES for their levels of coverage and explored bottlenecks for effective

coverage (see Annex C, section 2.2.2). Iron-folic acid (IFA) was one such tracer indicator for nutrition. Data are needed on availability but also on access to and use of services (effective coverage). In Bangladesh endline data showed a significant difference between 'coverage' and 'effective coverage' (also called compliance) for key indicators (see Table 8). This difference was not identified in the usual definition of the indicator as in MYCNSIA's logframe.

Table 8. Endline data on coverage of IFA in Bangladesh

MYCNSIA logframe indicator	Results
Coverage of IFA in pregnant women and MNP in children aged 6–23 months is increased by 30% in MYCNSIA programme areas	IFA: Yes (by 72%) · BUT pregnant women receiving ≥ 100 IFA supplements (recommended dose) was only 20.2% MNP: Yes (seven fold increase) · BUT MNP effective coverage (completed full course) was only 0.6%

The Nepal Country Office achieved better collaboration between the various sectors and integration of nutrition in other sectors through the equity focus and bottleneck analysis approach. The WASH, education, health and nutrition sections collaborated in 2013 to support the Government in conducting a bottleneck analysis of WASH in schools based on secondary (previously documented) information. Even before MoRES was formally introduced, the Country Office had conducted an equity-focused Situation Analysis of Children, Adolescents and Women as part of the preparation for the Country Programme 2013–2017, which has a strong equity focus. Consequently, although equity was absent in the MYCNSIA instruments (outputs and reporting), it was there in the overall Country Office toolbox and via this route influenced the Government.

The MYCNSIA baseline surveys could have been better used to explore and understand equity dimensions of effective coverage but they were not (with the exception of Indonesia). The surveys were regarded primarily in their

function of measuring the impact of the programme at a later date. In Indonesia, MYCNSIA produced a number of analytical documents (see Box 6).

In Indonesia MYCNSIA prioritized delivery platforms that more effectively reached the poorest quintiles. Endline data from Indonesia suggest that IYCF practices have improved significantly in the poorest quintiles and that this is causally linked to mothers' participation in the community level Posyandu sessions. MYCNSIA introduced new interventions, including MNP/ multiple micronutrient supplement distribution and IYCF counselling through Posyandu community-based delivery points within walking distance of almost all households. MYCNSIA supported the addition of other nutrition interventions during twice-yearly "vitamin A months" to make more effective use of existing momentum. MYCNSIA also supported the development of Family Development Sessions on health and nutrition that were introduced during monthly administrative meetings of Family Hope Programme (PKH) beneficiaries.

Box 6 Equity focused analysis and policy briefs (Indonesia)

UNICEF/ MYCNSIA in Indonesia produced analytical documents featuring:

- Investigation of geographic and economic disparities in nutrition status, gender concerns and underlying determinants;
- Recommendations that interventions focus on the first 1,000 days, and address over-nutrition, which increasingly affects the poor;
- Approaches to reach the most disadvantaged populations (including through social protection programmes such as

PKH, National Community Empowerment Programme (PNPM) and universal health coverage.

For example:

- 2013 Policy Brief on Universal Health Coverage and Nutrition
- 2014 Background Study on Nutrition, which informed the development of the RPJMN (2015–2019)
- 2014 analysis on the linkages between stunting and sanitation, using 2013 RISKESDAS and 2011 MYCNSIA baseline data

Source: Indonesia Country Office.

2.3 Effectiveness: Pillar 1 – Policy development

Pillar 1 concerns nutrition governance and the development of nutrition-related policies, especially in non-nutrition/non-health sectors. All five UNICEF/ MYCNSIA countries used the pathway of nutrition governance to leverage existing systems for improved approaches to nutrition. The initiative forged strong partnerships with government ministries, influenced many policies at the regional and national level, and worked to integrate nutrition into other sectors. Partnerships with government and non-government entities were essential to MYCNSIA's results under pillar 1.

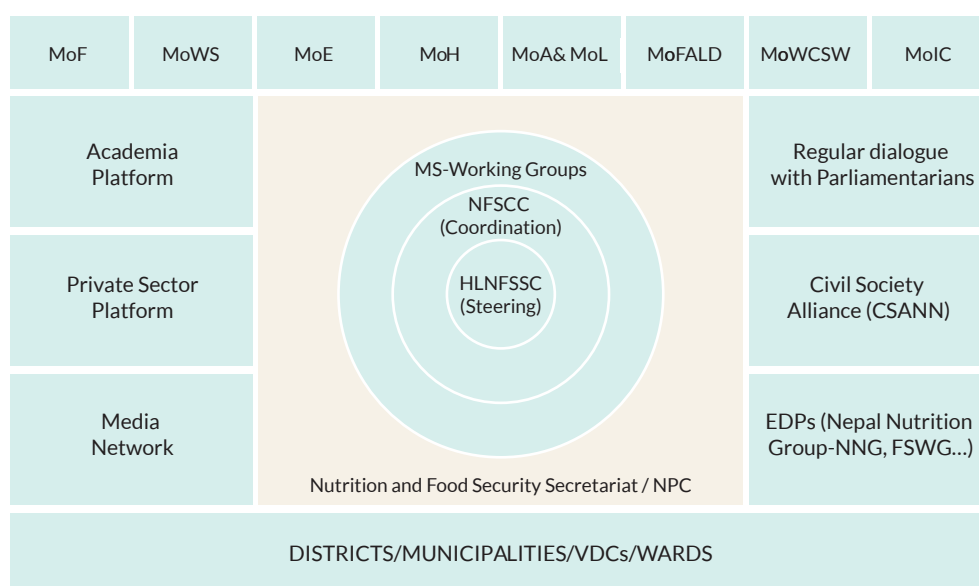
2.3.1 Nutrition governance

Although not an explicit aim of MYCNSIA, **all five UNICEF/ MYCNSIA countries contributed to what may be called 'nutrition governance'**, which proved to be a necessary pre-condition for the programme to achieve its results. The institutions which MYCNSIA helped to single out and support differ from one country to another. In several cases they were secretariats of pre-existing Government bodies. In Indonesia

SUN has become the dedicated platform to coordinate nutrition security, with strong support from key ministries. The institutions have in common that they are dedicated to addressing nutrition insecurity, sometimes in combination with food insecurity. Most have a strong health sector focus and have started to make the link with other sectors. The level of ambition varies, but the institutions all support a decentralized response to undernutrition.

Nutrition governance at decentralized levels depends on the systems in place. These systems differ markedly between countries. In Nepal multi-sectoral planning was incorporated ('mainstreamed') in existing planning at the Village Development Council (VDC) level. This has become a mutual process in which national and bottom-up processes inform each other. The main national level institution is the National Nutrition and Food Security Secretariat (NNFSS), under the National Planning Commission (NPC). The complexity of the multi-sectoral mechanisms is best captured in a visual form (see Figure 4).

Figure 4. The complexity of the multi-sectoral mechanisms (Nepal)
Nepal - Multisector, Multistakeholder, Multilevel (3M) Coordination Architecture



In Lao PDR multi-sectoral planning is nascent. It follows the hierarchy of the existing Government system and is incorporated into it. Multi-sectoral planning is no small task given that Government departments have little experience cooperating and deciding together, let alone adjusting their procedures. The evaluation team observed that stakeholders were uncertain and were waiting for each other. With UNICEF/ MYCNSIA assistance, support for institutions at the national level is expected to pay off.

In the Philippines the Nutrition Action Officers at district and provincial levels coordinate with the other sectoral staff on mainstreaming nutrition into other sectors. In particular, the Guidelines on Local Nutrition Planning – as developed by the National Nutrition Council – require local governments to act.

A general phenomenon is that ministries are not ready to share and give up part of their sovereignty even though they are in fact engaged in addressing nutrition insecurity,

as in Bangladesh. To overcome this there must be an active overarching **coordination platform for multi-sectoral and multi-stakeholder** nutrition as exists in countries such as Senegal, Peru, Brazil and Nepal. In Nepal, UNICEF/ MYCNSIA played a pivotal role to make this happen.

In Indonesia and the Philippines UNICEF/ MYCNSIA used the pathway of nutrition governance to mainstream nutrition while targeting underprivileged populations. Nutrition action planning at decentralized levels is another nutrition governance pathway. It provides a shortcut to existing planning mechanisms and dedicated human resources to address undernutrition. It has been used successfully in MYCNSIA especially in Indonesia, Nepal and the Philippines.

Nutrition was prominently incorporated into national development instruments. These include the 2013–2017 Multi-sector Nutrition Plan (MSNP) of Nepal, the 2015–2019 National Medium-Term Development Plan (RPJMN) of Indonesia and the 7th Five Year Plan of Bangladesh, due for 2015/2016.

Inclusion of stunting as an indicator in high-level development plans demonstrates the commitment of policymakers and also has spin-off at decentralized levels. This is a typical example where MYCNSIA's across-the-pillars support contributed to nutrition governance. Stunting was included as a high-level indicator for development in Indonesia's RPJMN (2015–2019). This is strongly related to the momentum around SUN and UNICEF advocacy and was specifically supported under MYCNSIA through: 1) the development of a background paper on nutrition to advocate the integration of nutrition in the RPJMN, including recommendations on targets and indicators; and 2) the recruitment of a consultant in 2015 to assist Bappenas to develop the National Food and Nutrition Action Plan which is multi-sectoral, integrates the SUN Policy Framework and addresses the double burden of malnutrition in Indonesia. The SUN framework has contributed to an enabling environment to both improve nutrition specific interventions and develop links with nutrition sensitive activities.

All of the above have been recent developments. Over time the nutrition governance support role of UNICEF/ MYCNSIA shifted, from (co)-originator, to provider of technical assistance, to resource persons in the background, depending on the needs of the institutions. When Country Offices adapted their planning and redefined their outputs to match these new realities, the UNICEF/ MYCNSIA workplans stayed relevant and up-to-date, which improved programme effectiveness.

A role which was not taken up

The difficulty of applying standardized tools to calculate the budget for 'nutrition sensitive' actions is a major issue for SUN. An increased budget allocation for nutrition was one of the MYCNSIA specific objectives, although it was formulated in an unspecific way in the 2011 logframe as: "Increased budget allocation for nutrition in health and other sectors such as rural local development and education". With the exception of Nepal, it has not been reported on under MYCNSIA, thus the ETE team cannot draw conclusions.

2.3.2 Relevant policies developed and/ or modified

The regional offices influenced nutrition policies at the regional level.

- Achievements in policy development by ROSA over the last two years are rated as excellent, at times going well beyond the planned outputs such as in the case of the endorsement of the SAARC South Asia Regional Action Framework for Nutrition.
- EAPRO has made significant progress in developing tools to advocate nutrition security, with the two-volume ASEAN/ UNICEF Joint Regional Reports on nutrition security.
- There was a spin-off effect from MYCNSIA countries to non-MYCNSIA countries including Afghanistan, Bhutan, Pakistan (using the Nepal Multi-sector Nutrition Plan (MSNP) as a model) and Sri Lanka.
- Policy development has gone hand in hand with advocacy and representation at high-level meetings. In 2014 the regional offices participated in 13 high-level meetings, which is more than in the first three years of MYCNSIA combined.
- Both EAPRO and ROSA worked to link nutrition with other sectors, namely WASH, ECD, Education and Social Protection. In both offices multi-sectoral collaboration for nutrition is being strengthened.

At the country level UNICEF/ MYCNSIA focused its support under pillar 1 (upstream work) in the health sector. Where pillar 1 support included a multi-sectoral governance mechanism – as in Nepal, PDR Lao and to some extent Indonesia – MYCNSIA directly or indirectly opened the way to intersectoral nutrition endeavours.

The logframe for pillar 1 specifies two multi-sectoral indicators; one of these is indirectly achieved in two MYCNSIA countries, through support to multi-sectoral governance mechanisms.

The indicator "Number of countries where nutrition has been newly incorporated into non-nutrition/non-health sector plans, budgets, etc., (target: 4; baseline: 0)" was achieved in Nepal and is likely to be achieved in Indonesia through support to nutrition governance (through SUN). A direct contribution of MYCNSIA is plausible in both cases (see section 2.3.1). In Lao PDR the process is under way. As for the indicator, "Joint advocacy plan developed with other sectors targeting non health sector (target: plan available by end 2012)" the latest Progress Reports state progress is constrained.

2.3.3 Communication and visibility

As part of the global Communication and Visibility Plan for the EU-UNICEF partnerships on Nutrition Security, finalized in 2012, various communication and visibility activities were undertaken. On the EU-UNICEF web portal (http://www.unicef.org/eu/devaid_nutrition.html), nutrition is one of the themes. Videos highlighting MYCNSIA and the issue of nutrition insecurity were produced from Nepal, Lao PDR, and Bangladesh (two different ones) in 2012 and 2013, and from Indonesia and from the Philippines (again two different ones) in 2013/2014. All of these also feature on this web portal. Footage for new videos from Bangladesh and Nepal was shot

in 2014, but to date these have not appeared on the web portal. Other visibility has included:

- Poster presentations and/or power point presentations of MYCNSIA at international conferences, for example IUNS 20th ICN in Granada, Spain, 2013; the 37th Water, Engineering and Development Centre (WEDC) International Conference, September 2014, Hanoi; (2) FAO-ILO Regional Consultation on Social Protection, Rural Employment, and Food Security, September 2014, Bangkok; (3) ASEAN Senior Officials Meeting on Health and Development, June 2014; Chiang Rai, Thailand; (4) 3rd Micronutrient Forum Global Conference, June 2014, Addis Ababa.
- The EU logo on banners, brochures including advocacy briefs, and training materials produced under MYCNSIA, throughout the five countries and at regional level

The EU-UNICEF web portal does not have a separate section for resources (although some resources do appear there, such as the MYCNSIA brochure and the five-part series of advocacy briefs on multi-sector approaches to nutrition). At the time the ETE was prepared, other nutrition advocacy materials developed by ROSA and EAPRO under MYCNSIA were not available on the web-portal, although many materials did appear on separate sites such as the Stop Stunting website and the UNICEF EAPRO website. The web-portal would have been an opportunity to (better) link communication and advocacy (both arguably cross-cutting).

2.3.4 Partnerships and collaboration

Partnerships were established in all five countries with the ministries of health, where strong linkages already existed. Intersectoral partnerships in some countries opened the way to collaboration which has yet to be fully leveraged. Cases in point are Indonesia (through SUN); Lao PDR (through the Nutrition Core Group); and Nepal (through NPC/ NNFSS).

2.3.5 Integration of nutrition in other sectors

Good sectoral linkages between health and nutrition already existed (nutrition often being part of the health departments sections within UNICEF in the first place), which was beneficial for scaling up nutrition specific interventions. In terms of UNICEF country programmes, the momentum to mainstream nutrition increased considerably in Lao PDR, Indonesia, Nepal and the Philippines.

Examples of external integration in MYCNSIA countries are few and far between. The evidence is that agriculture and food security are critical parts of 'nutrition sensitivity', although other nutrition sensitive sectors are also important. The clearest case at the regional level of integrating nutrition into other sectors is the compilation of food and nutrition security data for 29 countries, which was carried out jointly by UNICEF EAPRO, FAO and WHO.

2.4 Effectiveness: Pillar 2 – Capacity development

Capacity development efforts under pillar 2 achieved strong results at the country level, particularly in Supportive Supervision training and IYCF training. Some regional capacity building activities were delayed and thus results were weaker.

2.4.1 Capacity of planners and decision-makers

Regional level performance on capacity development differed from country level performance. In addition to capacity development in IYCF, the regional workplan also foresaw capacity building in multi-sectoral nutrition security programming through three inter-related activities: (1) conducting a needs assessment on “readiness” of Governments to implement multi-sector nutrition security programmes, and make recommendations for capacity development on nutrition integration within the relevant sectors; (2) conducting a regional training of trainers (ToT) for at least 15 participants on management of multi-sectoral nutrition security programmes for non-nutrition/non-health sector district managers in the fourth quarter of year 2 and; (3) developing a guide book and training packages for district managers of different sectors, based on the assessment of readiness to implement multi-sectoral activities. Activity 1 took place but activities 2 and 3 have not taken place and will not materialize within the timeframe of MYCNSIA. To summarize:

- Capacity development at the institutional level started off well with an EAPRO-led capacity needs assessment in three countries for which results were presented at a regional dissemination workshop and regional recommendations for action were discussed. UNICEF considers the capacity needs assessments in four countries (2012-2013) as the first of three planned activities. Follow-up was not undertaken by the regional offices, yet various follow-up activities took place at the country level.
- There were no regional outputs achieved in terms of capacity building in 2014. Capacity development in multi-sectoral nutrition security programming did not take place.
- A network of national and regional academic and research institutions was not developed despite the fact that there are a good number of academic/research institutions in MYCNSIA countries that participated in the regional Nutrition Security Coordination Committee meeting of 2014 providing an opportunity to establish such a network.
- Systematic approach to capacity development of national and regional institutions in collecting, analysing and evaluating sex disaggregated data to inform policies and programmes did not materialize as planned. Instead, the focus was on tailor-made technical backstopping and mentoring of staff (UNICEF and its national partners) directly involved in MYCNSIA.

IYCF training and Supportive Supervision training took place in the early MYCNSIA years and follow through, if any, took place at the country level. The country-level IYCF training of (master) trainers was highly effective. The roll out during the

first years of MYCNSIA was significant and masters continue to be in high demand to support IYCF capacity building in MYCNSIA countries and beyond MYCNSIA target areas and interventions. The aim was to provide necessary skills to supervise/ mentor community workers. For the training in 2012, a Supportive Supervision module was produced by UNICEF headquarters as part of the ongoing evolution of the Community IYCF Counselling training package. Easy to use tools, including checklists, observation schedules and job aids (counselling cards) were introduced and distributed.

The Supportive Supervision training follow-up was organized in 2013 with “Supportive Supervision” trainings for the same group of master trainers led by the same two expert trainers in four out of the five MYCNSA countries. Over 17,000 people had been trained in IYCF community counselling by the end of 2012, and the most recent estimate is that to date over 31,000 people have been trained. Overall, 75 per cent of all participants rated the training as very relevant.

As further follow up, UNICEF EAPRO routinely disseminates the latest global materials and guidelines, promotes their use, reviews national adaptations and provides guidance on how capacities and the interventions for which capacities have been built can be fully institutionalized within health systems.

Some countries participating in the **Supportive Supervision training have begun to integrate it within their ongoing IYCF programmes while other countries have not. Supportive Supervision worked where there was a meaningful link to the health system and/or where it was introduced along with a meaningful addition to the system.** When it was integrated into the official governmental system, capacity development in Supportive Supervision contributed to the quality of performance and has the potential to sustain nutrition capacity.

Country level ‘models’

Capacity needs assessments have generally pointed to serious gaps in knowledge and awareness of nutrition. The evidence is that gaps need filling in a special way which under MYCNSIA has invariably consisted of tailored packages in which the MYCNSIA pillars were combined. The cascade approach was used to advantage in Indonesia, Lao PDR and Nepal.

2.4.2 Capacity within different sectors

Of the 11 indicators for pillar 2 (capacity building), two indicators pertain to capacity building beyond the health sector. They were not consistently pursued. In Bangladesh linking with the agricultural (food security) sector has not been pursued despite many opportunities. In Indonesia, the IYCF training of 220 agricultural extension workers in Klaten District was a first attempt towards nutrition sensitive agriculture and aims to lead to a replicable model which will then be advocated at the national level. However so far this

activity was limited to Klaten District. In the Philippines, MYCNSIA expanded the Early Warning System (EWS) in partnership with FAO. Through the EWS awareness has been raised on food security and nutrition and local councils have allocated (more) funds for related activities. Linking up to the Agricultural sector has been a challenge for UNICEF/ MYCNSIA because of low receptiveness at the national level and limited person power in UNICEF. In Nepal the process of rolling out the MSNP ensured that all relevant sectors under the Plan are engaged. UNICEF/ MYCNSIA supported the MSNP as well as the roll-out and systematically supported the NNFS in undertaking this task (see section 2.9).

2.4.3 Nutrition training materials

In all countries training packages were often prepared as a 'work in progress', as in Nepal. The revision of the training package of antenatal care for health staff and strengthening the performance of health workers on maternal nutrition by the end 2014 progressed but was not finalized. A review of the existing evidence and package of IFA for adolescent girls using both integrated health and community-based

approaches was finalized. The findings were incorporated into the maternal nutrition strategy, the revised/ updated anaemia strategy, the national five-year anaemia control plan and the draft guideline on adolescent IFA supplementation. The draft technical manual on IFA for adolescent girls has been submitted to MoHP for their final approval.

In Bangladesh the introduction and roll-out of the so-called DNI package has been a typical MYCNSIA four pillar success in that country, detailed further in sections 2.6.3, 2.6.4 and 2.9.2.

The evaluation team did not have sufficient information to assess a logframe indicator under pillar 2 that was not included in the scheduled outputs of any of the countries. This was the indicator: "Number of countries where IYCF is included in pre-service and in-service training curricula of health and nutrition professionals (Target: at least 1 country)". The 2014 Progress Report states that "IYCF is already included in the pre-service and/or in-service training curricula of health and nutrition professionals in Bangladesh, Indonesia, and Lao PDR."

2.5 Effectiveness: Pillar 3 – Information systems and knowledge

Integrating nutrition into national HMIS systems was a successful means of mainstreaming nutrition. HMIS was crucial in MYCNSIA at the country level, as HMIS extends to the entire health sector, and has its foundation at the implementation level. It is thus both horizontal in scope, and vertical in encompassing all levels, down to community level services. Poor populations are automatically included if interventions are mainstreamed in blanket coverage and are part of the health system. In this way, pillar 3 could make the link with equity and enable intersectoral cooperation if it was well leveraged. In short, pillar 3 gave MYCNSIA the opportunity to distinguish itself if all of the above were understood and used to advantage. This took place in Nepal and Bangladesh, but in the other MYCNSIA countries investments of efforts and resources in a one-for-all M&E framework ultimately proved less effective.

2.5.1 Strengthened nutrition monitoring systems

In Nepal and Bangladesh outstanding results were achieved in mainstreaming nutrition in HMIS. The processes leading to these results differed considerably. In Nepal the new web-based HMIS is a major result. Within two years all health facilities were able to provide nutrition and other data on a monthly basis. The HMIS is significantly contributing to timely knowledge on nutrition problems and/or trends. Monitoring the progress of the MSNP implementation was advanced through the development of an M&E framework with different activities for contributing sectors but with common outcome indicators.

Pillar 3 information systems were MYCNSIA's strongest legacy in Bangladesh. Around 10 indicators have already been included in the HMIS of the entire country, from a baseline of 0 (zero) indicators, thus this is a remarkable achievement. Perhaps the greatest change has taken place at the community level where family welfare assistants (FWAs) have been instructed to carry out certain functions, notably MUAC screening, at the household level and report the results. The full implementation of this task awaits the further distribution of the MUAC tape and refresher training of the FWAs. When that happens the FWAs will finally be in a position to screen and refer children aged 6–59 months who are wasted (SAM) to the next level, which is usually the community clinic or a facility with services for Integrated Management of Childhood Illnesses-Nutrition. Household level IYCF counselling is not yet in the system, but was provided at the time of MYCNSIA by NGO staff.

A common M&E framework serving both MYCNSIA and MYCNSIA countries' information systems proved unrealistic, as stated in the MTE. The indicator was phrased as "Number of countries that were considered to have appropriately integrated the common M&E framework to their project by external evaluators at mid-term (Target: 5; baseline: 0)". Eventually the common M&E framework developed under the regional MYCNSIA component was

integrated into the programmes in only two of the five countries; but even in these countries it was not actively used. As discussed elsewhere in this report the effort and resources invested in a one-for-all M&E framework, which did not work out, had an opportunity cost.

2.5.2 Results of accompanying studies and surveys

In several countries UNICEF/ MYCNSIA was set up to prompt evidence-based changes, based on 'learning by doing and seeing'. Clear examples of this were found in Indonesia, Lao PDR and Nepal.

In Bangladesh some findings of studies and surveys – executed outside the MYCNSIA domain – have the potential to upset routines. One such finding was the high iron content of groundwater, with implications for iron supplementation. Another is the poor nutritional status indicators of children living in slums. Similarly, in the Philippines iron deficiency fell sharply over the period 1998–2013 (Annex G, section 1.1). The downward trend of iron deficiency in children between 1 and 5 years old and in pregnant and lactating women is very significant, and research (either by NNC, FNRI or other agencies) to determine which factors led to this will have important implications for programmes throughout the Philippines. UNICEF will continue to advocate for such research to be done post-MYCNSIA.

The five Country Offices each selected and prepared highlights from their MYCNSIA experience for presentation at the final dissemination workshop in October 2015. In addition, an Organizational Network Analysis commissioned by ROSA in 2015 documented two or three cases per country (apart from Lao PDR) of how MYCNSIA's pillar 1 work translated into implementation. Further, some countries have also proposed to document selected achievements for dissemination at the national level, which could then be shared regionally as well. For example, the Indonesia Country Office and the Ministry of Health discussed documenting the following MYCNSIA highlights:

- Maternal Nutrition and IYCF Counselling Package;
- CMAM: lessons learned from the introduction of CMAM in Kupang;
- SIMPOS-GizKIA: experiences on application of SIMPOS-GizKIA in Klaten;
- Maternity protection: documentation of Bank of Central Asia (BCA) experience in introducing baby-friendly practices in the workplace to encourage other private sector companies to follow suit; and
- Resources: experiences under MYCNSIA to leverage various funding pots for nutrition.

Like the Indonesia highlights above, the cases provided by the Country Offices were all hands-on, 'how-to' examples of good practice. At the time the ETE was conducted these cases had not been shared in a structured way.

2.6 Effectiveness: Pillar 4 – Scaling up

A range of methods were used in the MYCNSIA countries for scaling up nutrition, reflecting differing contexts and needs. MYCNSIA aimed to establish a minimum package of nutrition services, and this was achieved in Bangladesh and Nepal and is underway in Lao PDR. Some interventions took place too late to yield outcome level effects (as in the Philippines). Results at the outcome level are difficult to judge because endline data were not available for each country.

2.6.1 Coverage and quality of interventions

The size of pillar 4 interventions differed substantially across the five countries and was adjusted over time. In Indonesia and Nepal service delivery was strategic and model-oriented, while in the Philippines it was coverage-oriented, at least initially. In addition in the Philippines MYCNSIA ‘inherited’ the former MDG-F project and was generally perceived as a continuation and expansion of this former programme. This made it hard for MYCNSIA to distinguish itself.

The implementation modality of pillar 4 interventions differed across the countries. In Bangladesh and the Philippines extensive use was made of NGOs. In the other countries existing Government health systems were used. In Bangladesh the entire pillar 4 was originally entrusted to NGOs as contract partners. The recommendation of the MTE was to focus the role of NGOs on capacity building rather than service delivery while phasing in the Government system for direct implementation at the most peripheral level. In the Philippines NGOs (including Helen Keller International) implemented the Enhanced Local Nutrition Interventions (ELNI) programme to improve breastfeeding and complementary feeding practices in selected provinces and municipalities, as recently as 2014–2015. NGOs and the private sector took the lead in promoting breastfeeding in the workplace.

The implementation modality chosen was a determinant for the phasing in of ‘new’ interventions by Government systems. In Nepal and Lao PDR new routines were piloted within the government system and required extensive preparation. This included piloting technical manuals so that practical implementation and reporting followed seamlessly after the training. This modality differs from the one in Bangladesh where pillar 4 was implemented through NGOs such as CARE. There was a lack of institutional routines for managed treatment of moderate acute malnutrition. The NGO volunteers could do no more than advise mothers on adapted diets, which they did without data collection or reporting. Here a functional link with nutrition sensitive endeavours – such as the current SPRING project – would have been helpful. Eventually, however, the entire package of interventions was adopted by the Ministry of Health. Now, well over a year later, the Ministry is implementing and rolling out the interventions in a systematic way, including designing and printing adapted registers and forms, and instructing the districts’ senior health staff.

All modalities have pros and cons. Although the Nepal modality is coherent, evidence-based and optimal for Government ownership, it constitutes individual IYCF components which do not necessarily add up to a package. The extension of IYCF and CMAM activities to other districts in year two and three of MYCNSIA did not necessarily take place in tandem with or complement MSNP implementation. UNICEF supports both IMAM and IYCF-MNP in only two of the MSNP districts. The full package, including adolescent nutrition, was implemented only in Achham District. This has consequences for the overall impact on the pillar 4 interventions and made it difficult to extrapolate results of the baseline and endline surveys to other districts.

The implementation modality was a determinant for mid-term (interim) results; the interim results in Bangladesh were more positive than the endline data. Mid-term results in Bangladesh, as monitored by International Centre for Diarrhoeal Disease Research, were very encouraging. For example: “As of December 2014, 92 per cent (126,890) of children aged 6–23 months received MNP supplementation as per recommended dosage. In areas supported by the European Commission, as of December 2014, 88 per cent of children aged 6–23 months received food with minimum diversity.” The endline (see Table 9) gave far less positive results.

In Nepal the piloted new interventions or additions to existing packages were evaluated and the results measured. The Government used the evaluation results to decide if the interventions should be adopted and scaled up. As the interventions were piloted through and by the health system, the results were reckoned to be indicative for the system at large.

An important characteristic of MYCNSIA is the capacity to scale up successful models. In Nepal models were developed in an organic way, with strong knowledge sharing and linkages between the different pillars. The introduction of new policies goes hand in hand with capacity building for which special manuals are developed, implementation is piloted, experience is documented (evaluated), findings are again used to revise guidelines (and policies and plans if this is feasible time-wise), to fine-tune/ adapt the content of trainings and manuals and to facilitate scaling up. Telling examples include scaling up CMAM and later IYCF/ MNP, and implementing the MSNP (see Annex F). In Indonesia, the implementation of IYCF/ MNP in three MYCNSIA districts is being scaled up in over a 100 districts with financial support from the Government, NGOs and the Millennium Challenge Corporation.

Nepal used UNICEF/ MYCNSIA to pilot interventions with a view to scaling up. Box 7 illustrates this as a good practice for CMAM. It is noteworthy that Nepal is the only MYCNSIA country where CMAM was implemented as intended, as community-based management. Nepal is also the only MYCNSIA country where CMAM was upgraded to IMAM (see section 2.9.2).

Box 7 Good Practice – the case of CMAM/ IMAM in Nepal

Based on the recommendations from the 2012 CMAM evaluation,* the CMAM programme was transformed into an IMAM programme which integrates facility-based and community-based approaches as well as IYCF, WASH and ECD in managing acute malnutrition. IMAM in Nepal consists of the following components: 1) Community Outreach (screening, referral, follow-up, and community mobilization); 2) Outpatient treatment for children with SAM without complications; 3) Inpatient treatment in stabilization centres; (4) management of moderate acute malnutrition through IYCF counselling; (5) supply chain management of IMAM commodities; and (6) IMAM monitoring and reporting. Moderately malnourished children do not receive supplementary feeding, but

mothers/ caregivers are counselled on IYCF. The programme originally started in five mid- and far western regions and was scaled up to six additional districts in 2012 through facilities to treat 75 outpatients (15 in each of the 5 new districts) and one stabilization centre in each new district as of February 2013. The quality of the programme is excellent, with indicators far better than the minimum standards (SHPERE). Death rates are extremely low, indicating that an important objective of CMAM – early detection and treatment of acute malnutrition – is being achieved. Recovery rates are good as well, while default rates are well below what is considered acceptable. The current intention of the Government is to scale up to at least 50 of the most affected districts by 2017.

*Note: See Annex F (Nepal) for more details. *http://www.unicef.org/evaldatabase/index_69858.html*

In Lao PDR MYCNSIA had a slow start following the 2014 approval of the IYCF Guidelines. Both MTE and ETE judged that it was justified to wait for official approval of the IYCF Guidelines, but it has made progress extremely slow. Initial results in Saravane Province are encouraging; the combination of information, education and communication materials with the actual provision of MNPs is exemplary. Now that a routine has been established the programme can be rolled out in any province in only four months. At the time the ETE team visited, the IYCF programme had been rolled out in Attapeu Province.

In the Philippines pillar 4 activities were both stalled and disrupted. Pillar 4 activities which were undertaken in close collaboration with regional offices of the National Nutrition Council and reached out to all provinces in the three regions, came to an end in July 2014 with the MYCNSIA Exit Conference and Sustainability Workshops. With the break of activities due to the national emergencies in 2014 (Bohol, Zamboanga and Typhoon Haiyan/ Yolanda) the effective net time of pillar 4 activities was reduced to about 14 months. Based on another new strategy focusing on one target province in two regions, scaling up started again in December 2014 with the Helen Keller International programme

called Enhanced Local Nutrition Interventions (ELNI). This programme will come to an end in June or July 2015.

2.6.2 Results at outcome level: Scaling up

The baseline/endline data demonstrate the difficulty of doing proper baseline/endline studies for an initiative such as MYCNSIA. The evaluation team received endline data for three countries. MYCNSIA grappled with the typical difficulties of doing such studies, but the situation is even more complex than in 'normal' impact studies, given that MYCNSIA was not set up for attribution of results. Moreover, for obvious reasons it aimed for coherence of the surveys in all five countries. This has proven difficult, time-wise, but also in terms of design and the desire of some countries to have surveys serve a wider purpose than measuring the results of MYCNSIA.

The desired outcome effects for pillar 4 (scaling up) are disappointing, particularly for the important indicators of age appropriate complementary feeding of children aged 6–23 months (minimum acceptable diet; 4+ food groups; and minimum acceptable meal frequency). Table 9 provides the six selected core IYCF practices indicators as listed in MYCNSIA's logframe on which all five countries were meant to report, as a minimum (see Annex A2).

Table 9. Selected pillar 4 core indicators in project areas

Logframe: Core IYCF Practices Indicators	Bangladesh	Indonesia	Philippines*
1. Number of countries where the prevalence of early initiation of breastfeeding has increased by at least 10 percentage points from baseline (target: 5 countries, Baseline: 0)	Yes (+ 27.6%)	No: -0.5%	Yes (varying from +14.6% to +26.2%)
2. Number of countries where % children aged 6–23 months who receive minimum acceptable diet has increased by at least 10 percentage points from baseline (target: 5 countries; baseline: 0)	No (- 2.3%)	No: +0.6%	No (varying from -13.4%, to -6.6%)

3. Number of countries where % of children aged 6–23 months with the minimum diet diversity (who receive foods from 4 or more groups) has increased by at least 10 percentage points from baseline; (target: 5 countries; baseline: NA)	No (- 1.9%)	No: +1.3%	No (varying from -4.9%, to +0.3%)
4. Number of countries where % of children aged 6–23 months with minimum meal frequency (who receive solid semi-solid or soft food the minimum number of times per day) has increased by at least 10 percentage points from baseline; (target: 5 countries, baseline: NA)	No (- 0.3%)	No: +0.8%	No (varying from -4.1%, to +2.8%)
Anaemia control: 5. Number of countries where coverage of IFA in pregnant women and MNP in children aged 6–23 months is increased by 30% in MYCNSIA programme areas (target: 5 countries; baseline: NA)	IFA: Yes (72%)** MNP: Yes (seven fold)**	No: IFA only (- 25.4%) MMN*** only (5.5%) IFA and MMN (16.7%) MNP: no (20.3%)	IFA: Yes, in 2 out of 3 regions, ranging from +26%, to +37.5% MNP: Yes Baseline NA Endline 10.1%
CMAM: 6. Number of countries where the number of delivery points for CMAM has increased by at least 30% from baseline in MYCNSIA project areas (target:2; baseline: NR)	NA	NA	NA

* Data lacking quality control; ** Effective coverage (completed full course) only 0.6%; ** IFA pregnant women receiving ≥ 100 IFA supplements (recommended dose) only 20.2%; *** Multiple micronutrient supplement (MMN).

2.6.3 Formulation of a minimum package

In Bangladesh and Nepal there was a concerted effort to achieve a package of necessary and sufficient nutrition specific interventions. Bangladesh adopted the entire package in one go. It is now driven by the MoHFW and will eventually be country-wide. Although the interventions are named as DNI and have been adopted by the MoHFW there are clear linkages with nutrition sensitive endeavours. Pillar 4 interventions in Nepal were scaled up during the reporting period, amounting to the delivery of a minimum package to reduce stunting and micro-nutrient deficiencies (expanding from 6 to 15 districts) and CMAM, expanding from 5 to 11 districts. Based on the results of an evaluation focusing on formative aspects carried out in 2011, the CMAM programme was transformed into an IMAM programme, while results from a second evaluation on the impact of CMAM were critical in the decision to further scale up the programme to an additional six districts. The concept is to eventually have a combined package of all interventions (CMAM/IMAM; IYCF/MNP; and Integrated Management of Newborn and Childhood Illness), starting with the MSNP districts.

In Lao PDR the Country Office started rolling out the IYCF/MNP package in 2015. When the ETE team visited in April 2015, roll-out had just been completed in the first province, Saravane. In Sekong Province, earlier work had been on CMAM and exclusive breastfeeding.

Maternal nutrition

In the period between MTE and ETE maternal nutrition was further integrated into the various programmes. In several countries, UNICEF/ MYCNSIA leveraged the strengthening of health systems and in particular the increased and hands-on focus on reproductive health. In at least three countries

(Bangladesh, Lao PDR and Nepal) the evidence is that both antenatal care (ANC), postnatal care and institutional deliveries are increasing. For example in Nepal the indicator “at least four times % ANC coverage” has gone up from 29 per cent to 50 per cent. The ETE team saw in its field visits how this was used by health staff for timely delivery of dietary advice, for bringing in spouses, and for advice on taking rest. A similar pattern was observed in Bangladesh. These developments are present throughout the health system, including the bottom of the pyramid where basic services are provided. In one country (Indonesia) this has become a strategy to deliberately achieve effective coverage of the poorer strata of the population (see section 2.2.2).

The ETE team saw very little evidence of growth monitoring and promotion in the MYCNSIA countries. Annex F (Nepal) explains that an opportunity was missed to integrate growth monitoring and promotion (GMP) in community based nutrition pilots. Although GMP is and has been part and parcel of mother and child health in Nepal, HMIS figures indicate that many districts do not carry out growth monitoring very well. In addition, growth monitoring is only carried out at the facility level and in some outreach clinics, resulting in low coverage (one third) and bias (ill children are more likely to come). UNICEF/ MYCNSIA missed opportunities to pilot approaches for strengthening GMP, for example by strengthening linkages between GMP and IYCF and/or CMAM.

2.6.4 Embedding nutrition in systems at decentralized levels (province/ district)

In Nepal pillars and levels acted in synergy, over time. MYCNSIA built and continues to build well on existing structures; the set of activities is relevant and complete. In

line with the original plan, the initiative expanded capacity building and information systems in the six MSNP pilot districts, thus linking pillars 1, 2 and 3 at the district level, and contributing to the development of a model to further roll out (pillar 4, scaling up). The planned sequence was appropriate and in line with the original plan (see Annex F).

In Nepal the entire health pyramid was involved (and trained) down to the community level. In addition multi-sectoral workers are engaged at the community level as social mobilizers, employed by either the local government or by large projects such as the Suaahara programme. As key informants told the ETE team “Every VDC has a social mobilizer. These people are crucial for the planning process and its monitoring”.

In Bangladesh there is a strong drive within the health sector to accommodate nutrition as an integral part of its systems. It is partly apparent in the way DNIs are introduced and scaled up. From an initial 16 upazilas under MYCNSIA the Directorate General of Family Planning (DGFP) expanded the programme to all 91 upazilas (16 MYCNSIA + 75 new) in 11 districts (out of the total of 64 districts). Pillars 3 and 4 are taken in synergy and together have enabled policy changes, with pillar 2 (capacity building) now in the hands of the Government.

In Nepal and Bangladesh the ETE team found that having to fill out the registers and forms made medical staff more nutrition-conscious, in particular if systematic feedback is provided.

In Indonesia MYCNSIA achieved the set target of integrating IYCF in the annual plans of the Ministry of Health and in food and nutrition plans of three districts (Klaten, Sikka and Pematang). For Jayawijaya District, no Food and Nutrition Action Plan was developed. However, the district did allocate its own resources to further roll out maternal nutrition and IYCF counselling in 2015. The case of Indonesia illustrates how MYCNSIA attention at all levels, and in a coordinated way, was effective for ‘embedding’ IYCF in health systems.

In the Philippines Local Nutrition Action Planning (LNAP) was MYCNSIA’s most promising activity, but could have been better leveraged. This would have required the flexibility to make LNAP a multi-pillar project in which all dimensions of MYCNSIA would have operated in synergy, including innovative peer-review and horizontal learning, M&E of implementation, feedback loops and so on. In the Philippines MYCNSIA attention to the LNAP process resulted in 116 updated Municipal or City Nutrition Action Plans. However, the quality of the Plans has not been assessed nor the budget attached to the plans. Furthermore there is no information available on the implementation of the LNAPs.

2.7 Efficiency

Operational efficiency in terms of time and resources varied between the PMU and the country offices. Implementation challenges impacted operational efficiency, yet through strategic thinking and acting, four of the five MYCNSIA countries went beyond implementing pre-defined outputs. Overall, the budget was implemented as planned.

2.7.1 Operational efficiency

Operational efficiency at the regional level differed substantially between the pillars. Progress on pillar 1 was excellent during the last two years. However, progress on pillars 2 (capacity building) and 3 (information systems) was off track in 2013 and 2014 with a number of activities delayed or deferred or restructured in ways not fully captured in the workplan. Overall operational efficiency was not optimal.

Operational efficiency in terms of optimizing and accelerating outputs based on lessons learned was a distinctive feature in some MYCNSIA countries, however, it was not steered by the PMU. The same was concluded in the MTE. The lack of responsiveness and alertness can partly be attributed to the programmatic format and its requirements. There are, however, notable exceptions at the country level. Three countries (Bangladesh, Indonesia and Lao PDR) redefined their outputs according to what they were realistically aiming to achieve, judging from lessons learned during implementation. The Indonesia Country Office went as far as negotiating with the EU Delegation how best to report on new activities that were integrated in the 2013 (and 2014) workplan but which were not formally part of it.

All country programmes had to decide on the use of external resource persons and institutions (consultants; international NGOs) vis à vis the somewhat slower pathway of using indigenous resources. In Nepal these choices duly changed over time. In Nepal the evidence suggests that UNICEF's approach in capacity building struck a balance between creating the right momentum and ownership. The current strategy of the NNFSS is to include the regional Government training institutions as 'trainers of trainers', which is an extra step in the capacity building trajectories. This is a more indigenous, but slower route. 'Quick results' were justified at the beginning of MSNP implementation, but nowadays the balance is more towards even distribution of training capacity and competence.

At the country level, strategic thinking and acting ('responsiveness') combined efficiency and effectiveness and went beyond implementing pre-defined outputs. In four of the five MYCNSIA countries there are strong examples of this mindset. In all cases they exemplify teamwork within the country offices.

UNICEF/ MYCNSIA leveraged results beyond its formulated outputs in two cases in Indonesia. Advocacy with the Government and cooperation with development partners yielded other resources to reduce stunting and anaemia. Support to social protection programmes further leveraged

nutrition support beyond UNICEF/ MYCNSIA districts. In Indonesia the Country Office made the most of the activities of partners and derived added value out of shared learning, constituting a 'win-win'. The search for better solutions was built into the process.

Several situations affected the original timing of MYCNSIA outputs.

a) Outputs are rescheduled for better effect

National Advocacy and Communication Strategies are a good example of an output that is put on hold until it can be combined with a major event such as the launch of national nutrition policy as is currently the case in Bangladesh and Nepal.

b) Outputs are put on hold until a satisfactory solution is found

The MTE noted that output 2.4 was intentionally delayed in Nepal until a satisfactory solution was found to have out-of-school adolescents benefit from IFA supplementation.

c) Outputs take more time than project duration allows

The achievement of some predefined outputs is protracted by nature and/or is dependent on new insights as they develop. Progress may have been made towards the achievement, yet it cannot be assessed as 'completed'. Examples are food fortification programmes in Indonesia and the Philippines.

d) Outputs take more time since high-level commitment is required

High-level commitment is a clear strategy for UNICEF/ MYCNSIA. For example, it took several years for the Government of Lao PDR to approve the IYCF Guidelines. Likewise, the new National Nutrition Policy and Action Plan in Bangladesh were expected to be approved by mid-2013, but as of mid-2015, Cabinet endorsement is still pending.

e) Outputs require continuous vigilance, and in that sense they cannot ever be considered fully "complete"

The International Code of Marketing of Breast-milk Substitutes (BMS code), is a typical example of an output that requires continuous vigilance. The Philippines has a legal framework to protect and promote breastfeeding (Rooming-in and Breastfeeding Act of 1992, Expanded Promotion of Breastfeeding Act of 2009, and Executive Order No. 51 of 1986 (The Milk Code). The Guidelines for the Expanded Breastfeeding Promotion Act were finalized and adopted as early as 2011. Over the past years the BMS Code was challenged in Congress, but the amendments were rejected after a very intensive campaign in 2013. Despite all this the expected result (output 1.3) was not updated and instead marked as 'completed', from the very start of MYCNSIA. In Lao PDR and in Indonesia the output was rephrased to reflect new developments.

f) Outputs await partners' engagement

Sometimes coordination among agencies is the key challenge: while joint and coordinated efforts are welcome, it may also

imply that some activities cannot be completed within the planned timeframe because of the competing priorities of other agencies. For example, progress was slow on Food and Nutrition Security Country Profiles developed by EAPRO in collaboration with FAO and others, which were considerably delayed in 2012–2013 and affected the timeliness of two indicators under pillar 1.

g) Outputs are based on (what have turned out to be) incorrect assumptions

The clearest example of an output based on incorrect assumptions is Regional Output 3.1: “Common Monitoring and Evaluation framework with indicators disaggregated by sex and age developed and adopted by countries to document impact and guide actions for future scale up”. This output presumes that MYCNSIA’s M&E framework is meaningful both for the initiative itself and for the countries concerned and also that countries will adopt it. These incorrect assumptions resulted in high transaction and opportunity costs for MYCNSIA.

Learning lessons and knowledge management

Learning lessons was envisaged to be part of programme implementation; it has in actual fact been moved to a post programme event. The agreed MTE recommendation on this topic was not pursued. Indicator 3.3 in the logframe has June 2012 as the target date for “Mechanism for experience sharing and best practices across countries adopted”. A subsequent indicator is “Number of countries that received information on ‘Lessons Learned’ from integrated multi-sector nutrition programmes. (Target: at least 25; baseline: 0)” Both indicators were postponed till end-of-project. The Progress Reports have been somewhat opaque on this.²²

Transaction costs in programme administration

Programme administration consumed valuable time at the expense of other regional functions. The recent reformatting of the budget from an activity-based budget of over 200 line items to a results-based budget of less than 40 line items – all in line with the four pillars, or result areas – apparently put an

end to the tedious routine of back-and-forth comment rounds on annual financial reports. The budget rewrite was called for midway through the programme to write ‘other donors’ out of the budget. The issue was that MYCNSIA was not a case of Joint Co-Financing nor a clear case of Parallel Co-Financing. UNICEF had placed relevant donor-funded activities under the MYCNSIA flag where the activities fitted one or more MYCNSIA pillars (this was not done in all countries, however). The EU objected in November 2013, thus UNICEF had to “embark upon an extensive contract and budget amendment to remove the ‘other donors’ from the Joint Action, and to keep EU and UNICEF contributions only” (Source: MYCNSIA Progress Report 2011–2013, submitted 26 June 2014).

Design issues on regional role in a regional programme

The UNICEF/ MYCNSIA initiative lacked a description of what is expected from the PMU in terms of leadership and guidance. This role was not spelled out in the logframe, nor in the set of outputs other than that donor reports should be submitted by the specified deadlines. The ETE team declined to evaluate the Regional Programme against independent criteria, as this could easily be perceived as unfair as there were no criteria in the programme design.²³

2.7.2 Financial efficiency

Almost two thirds of the budget went to personnel costs (staff and consulting) and sub-contracting. After the budget revision of June 2014 the overall budget for MYCNSIA 2011–2015 was US\$35,951,156 (€26,423,958) including 7 per cent overhead. The EU contributed €22,500,000 including top-up funds for the Lao PDR and Nepal programmes (€2,500,000) and UNICEF contributed about €3,924,000. After the budget revision of June 2014 the budgets in the three other countries remained constant (in euros) whereas there was a slight increase of the regional budget of about 16 per cent. Figure 5 shows that 35 per cent of the funds were budgeted for staff and consultant costs and 28 per cent for the contracting of service providers. Supplies (18 per cent) and training costs (12 per cent) make up another 30 per cent.

Figure 5. MYCNSIA distribution of budget per category

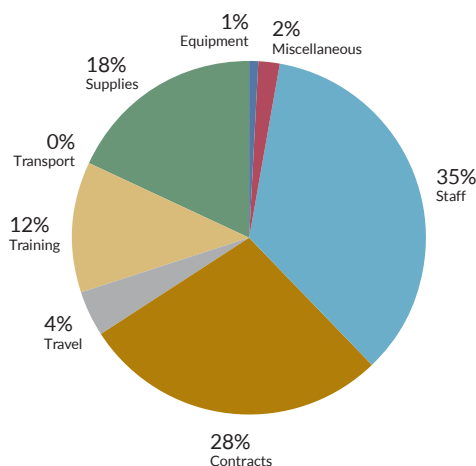
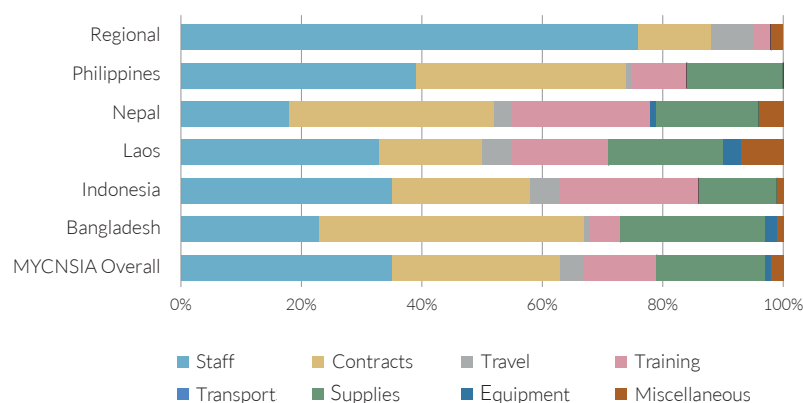


Figure 6 shows that the Regional Programme stands out with regard to the share of personnel costs (76 per cent) and travel (7 per cent) as compared to the individual countries. This is understandable as the Regional Programme does not implement direct activities in the target countries. The Philippines stands out for its share of personnel and contract costs (respectively 39 per cent and 35 per cent). Bangladesh opted to implement a substantial part of their programme

as contracts, representing 44 per cent of their budget well above the other countries. Indonesia and Lao PDR stand out for the allocated share of their budgets to training activities; 23 per cent of the budget in both countries. Bangladesh also stands out for the share of 23 per cent for the purchase and distribution of supplies, despite the fact that they opted not to purchase ready-to-use therapeutic food (RUTF).

Figure 6. MYCNSIA budget and expenditure 2011–2014 per category



The expenditure rate for MYCNSIA was in line with the allocated budget (after the June 2014 revision). The expenditure rate during 2011–2014 as compared to the proposed budget, was 87.8 per cent. This implies that 12.2 per cent or US\$4,113,674 was available for the extension of the programme in 2015. The expenditure rate for the five

countries varies from 84 per cent for Lao PDR to 102 per cent for Nepal. The latter implies that virtually no funds were available for implementation in 2015. The expenditure rate for the Regional Programme was 74 per cent at the time of the evaluation (see Figure 7).

Figure 7. MYCNSIA budget and expenditure 2011–2014 per country (dollars)

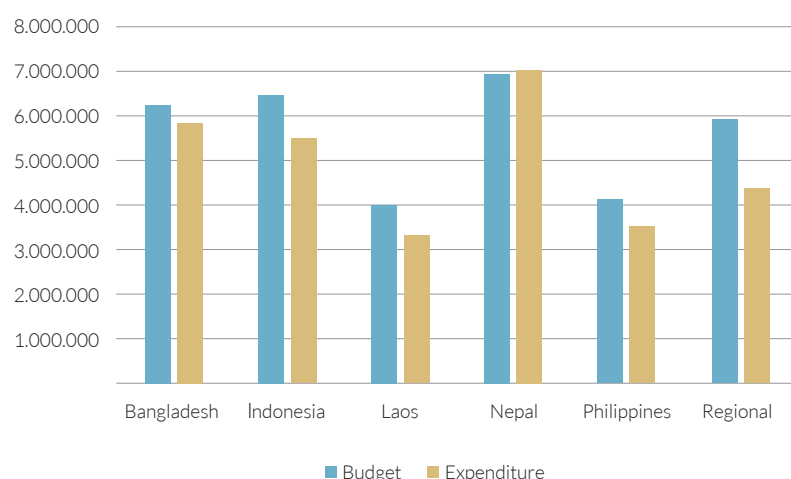
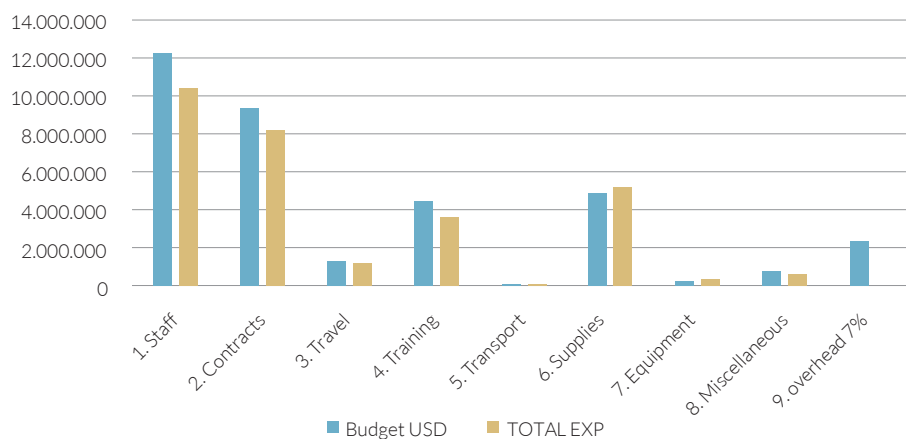


Figure 8 presents the expenditure rate per category. It can be concluded that there was no major deviation in expenditure with regard to the budget. As expected, the budget items for supplies – and to a lesser extent training – were depleted

as there were no scaling up activities implemented in 2015. Personnel and contracts still had funds to finalize the studies, endline and reporting.

Figure 8. MYCNSIA budget and expenditure 2011–2014 per category



Overall, it can be concluded that the budget was implemented as planned. More details of the budgeting and expenditure rate per country can be found in the individual country annexes.

2.8 Impact

Attribution and contribution describe the relationship between an intervention and the outcome. As noted in section 2.6.2, MYCNSIA was not set up for attribution of results. To establish attribution, strong causal links must be found between the intervention and the observed outcome. Direct links establish that the outcome was achieved through the intervention and not through other factors in the environment. By contrast, contribution is established by indirect links between the intervention and the outcome.

Available data on stunting and anaemia are insufficient to attribute results to MYCNSIA. It is clear, however, that the initiative achieved strong results in strengthening institutions and policies. There were significant positive spin-offs from MYCNSIA despite challenges in the operating environments.

2.8.1 Reduction of stunting and anaemia in the MYCNSIA intervention areas

The intended pillar 4 (scaling up) overall MYCNSIA impacts are as follows:

1. Reduction of anaemia among pregnant women, lactating women and adolescent girls, and
2. Reduction of stunting and anaemia in children aged 6–35 months.

At the time of the evaluation data were available for Bangladesh and Indonesia. Results for Nepal and Lao PDR were delayed, while data from the Philippines were beset with methodological issues and thus could not be interpreted. As shown in Table 10, MYCNSIA's overall objectives were achieved in Bangladesh, but intermediate indicators do not provide a coherent causal chain of validation. In Indonesia the target was reached for stunting but not for anaemia.

Table 10. Fulfilment of overall objectives: Baseline/endline in project areas

Overall objectives	Bangladesh**	Indonesia***
Reduction in stunting (target: by 5 percentage points from baseline) · children aged 0–35 months	4.8% (from 41.1% to 36.3%)	5.7% (from 29.6 to 23.9)
Reduction in anaemia (target: by 15 per cent from baseline*) · pregnant women	22.4% (from 53.4 to 41.4%)	3.3% increase (from 44.9 to 46.4)
Reduction in anaemia (target: by 15 per cent from baseline*) · children aged 6–35 months	26.1% (from 77.7% to 57.4%)	4.1% (from 58.3% to 55.9%)

* Original target: by one third from baseline, children aged 6–24 months; ** To be compared with national statistics: BDHS 2014; *** To be compared with national data Riskesdas 2010–2013.

In Bangladesh MYCNSIA results for stunting match overall population trends as data from the Bangladesh Demographic Health Survey (BDHS) show a similar decrease in stunting. For anaemia there are no population data to compare with, thus the gains are hard to judge.

Results in Bangladesh indicate:

- The reduction of stunting by 4.8 per cent was close to the 5 percentage points reduction target.
- The 15 per cent anaemia reduction target in children was amply reached with a reduction of 26.1 per cent (from 77.7 per cent to 57.4 per cent).
- Anaemia in pregnant women was reduced by 22.4 per cent (from 53.4 per cent to 41.4 per cent) while anaemia in lactating women was reduced by 14.5 per cent (from 54.8 per cent to 46.8 per cent).

Stunting was reduced by nearly 5 percentage points in the MYCNSIA pillar 4 upazilas, from 41.1 per cent to 36.3 per cent. A similar reduction was found in the 2014 BDHS data for the overall population of this age, as compared to the 2011 BDHS, from 38.8 per cent to 32.5 per cent. The

comparison with a country trend is possible only for stunting (and other nutritional status indicators not presented here). The population data for anaemia are either highly confusing (as described in Annex C, section 2.5.2, findings of the micronutrient survey) or are not available, at least not for the MYCNSIA target age groups.

In Indonesia, MYCNSIA results for stunting (5.7 percentage point reduction) exceeded the 5 percentage point stunting reduction target. This result was not matched by overall population trends. For anaemia the target was not met. As there are no accurate population data to compare the minimum gains with, these results are difficult to judge. For anaemia among children, a decrease by 4.1 per cent was measured between the baseline and endline, while the prevalence of anaemia in pregnant women increased by 3.3 per cent over this period. The Indonesia Country Office has questioned the accuracy of available national data indicating a considerable increase in anaemia in pregnant women, thus it is difficult to judge the impact of MYCNSIA on anaemia in Indonesia.

The Philippines data received by the evaluation team clearly show methodological issues. There was, for example, no explanation why baseline data were recalculated and adapted in the endline exercise. The baseline prevalence of anaemia in pregnant women more than doubled in this recalculation, from 18.3 per cent to 38.2 per cent. The prevalence of anaemia (both for children aged 6–35 months and pregnant women) as reported in the endline indicates a systematic methodological difference from the baseline. The endline reports an increase – instead of an expected decrease – of respectively 41 per cent and 55 per cent, which is not plausible in a period of four years without a major crisis in the surveyed provinces. The impact indicator can therefore not be used for any conclusion.²⁴

2.8.2 Broader potential and unintended effects at various levels of implementation

Further changes in programme context

The results on institutional strengthening (not all of which were intended) were stronger than the behaviour change and anthropometric results that were aimed for in the logframe. In the five MYCNSIA countries there is a wealth of nutrition-oriented projects and initiatives. For example, in Bangladesh an endline study undertaken by A House of Survey Research (SURCH) listed 4–12 other active programmes in any of the six endline study upazilas.²⁵ In Nepal there are likewise many sizeable projects.²⁶ Each has its own ambitions and indicators; many aim for proof of impact that goes further, or is achieved faster, than in non-intervention areas. MYCNSIA was a hybrid between a project that aimed to achieve impact on nutritional status, and a programme that aimed to strengthen institutions over a longer period of time.

The first 1,000 days has become a focus of many projects and this is a positive development. The opportunity to link up with such projects has yet to be seized. MYCNSIA's strength was its consistent role as a support to Governments, notably in nutrition specific programmes. The ETE concluded in Bangladesh that projects which, for example, aim to mainstream nutrition and pursue effective coverage – such as the SPRING project – appear to be the most suitable partners as they naturally complement support to Government.

There was a form of 'acceleration' in all five countries during 2013–2015 to which MYCNSIA contributed and from which it also benefited. The MYCNSIA contribution is clearest where the four pillars worked in synergy by design, and in a framework of improved governance, as numerous examples in this report and its underlying reports have demonstrated.

Spin-off

The design of the SAARC South Asia Regional Action Framework for Nutrition closely resembles MYCNSIA with its four pillars, making it the clearest example and most far-reaching result of work in the regional offices under MYCNSIA in support of pillar 1 (upstream work).²⁷

UNICEF/ MYCNSIA acted as a role model in Nepal, not least for the widely acclaimed 2012 MSNP which accelerated scaling up nutrition nationally and at decentralized levels.

Nepal functioned as a role model for MYCNSIA countries and for other countries in South Asia and South-East Asia. It is not known to what extent the role model function impacted other countries or if the MSNP was emulated as a result. Given the experience in the other four MYCNSIA countries the ETE postulates that each country needs to find accelerators that suit its particular context and that there is no such thing as a single recipe for success.

Challenges and taboos

In any programme there are challenges beyond a programme's control which affect the programme's ability to reach the desired impacts. Usually challenges are not named as they are sensitive or even taboo, nevertheless, the first five were explicitly named by several respondents as 'issues'. The sixth comes from the ETE team.

1. **Some global programmes and priorities have an unclear relationship with national programmes.** An example named in Nepal and Bangladesh is the Zero Hunger Challenge. In Nepal it is unclear how to align the Zero Hunger Challenge with the country's own MSNP.
2. **Closely related programmes can have an approach that is incompatible with agreed national strategies.** Spear-headed by UNICEF, Lao PDR now has the Government endorsement of the IYCF Guidelines, which include MNPs. However, in parts of the country there is blanket provision of Plumpy'Doz, a ready-to-use-supplementary food.²⁸ Meanwhile United Nations development partners jointly issued recommendations for the Multi-sectoral Food and Nutrition Security Action Plan 2014–2020, advocating for a multi-sectoral approach the convergence of efforts of all actors, notably health, agriculture and education. Blanket provision of supplementary food is clearly at variance with the multi-sectoral strategy, which is geared to self-reliance. This topic is not touched upon in the recommendations.
3. **In most countries the gap between the wealth quintiles is increasing for reasons beyond a nutrition programme's sphere of influence.** One example highlighted is the case of ethnic minorities in Lao PDR. A main underlying reason for persistently poor nutrition among these groups is the impact of commercial farms and logging, among others, on their livelihoods. Interviews revealed their misgivings on the potential effectiveness of nutrition interventions given the underlying challenges.
4. **The multitude of nutrition projects has caused a coordination problem for national and/or local authorities in some countries.** The problem is perhaps best illustrated by the fact that in one country a project staff member introduced himself to the ETE team as the District Agricultural Officer. Some projects are indeed large and well-resourced to an extent of overshadowing their government counterparts. As expressed at the district level in Nepal, one problem is that projects come with their own objectives and rules yet they are moreover temporary. To its credit, MYCNSIA avoided this problem, but it did not exploit the opportunity to cooperate with such projects which could have been cost effective and yielded better results. For ex-

ample, in one case in Uganda's ANSP, systematic cooperation with one such project was cost-effective and in many ways a 'win-win'.

5. **Two MYCNSIA countries are not among the least developed countries (LDCs). This has implications for these countries' nutrition programmes and ability to attract external funding and connect with externally funded projects.** As noted by the Indonesia Country Office in a personal communication, "Aside from World Bank funds in 2012–2013, we have not been able to secure any additional donor funds for nutrition, and this looks set to continue." This situation has also meant that in these countries

EU-MYCNSIA funding was the sole or at least the major source of external funding.

6. **In the Philippines, MYCNSIA-related work came to a standstill for a period of at least six months due to the Haiyan typhoon of November 2013. Meanwhile MYCNSIA-supported staff together with their colleagues were deployed for emergency work.** The ETE team observed that the Progress Reports were not entirely transparent on the implications of the natural disaster in the Philippines. There also is an issue of pursuing the costly baseline/end-line study in a situation where effects cannot be expected.

2.9 Sustainability

Indicators of sustainability were mixed at the regional level, but were stronger at the national level where Governments have signalled their commitment to nutrition by enacting national plans and policies. Mainstreaming nutrition in the health sector has proven a formidable task, yet remarkable success was achieved when the four pillars operated in unison at different levels. Data from all five countries indicate that MYCNSIA functioned as part of a continuum. It was linked to previous projects and new projects and initiatives will follow after it.

2.9.1 Capacities and ownership for sustained results

Regional level

MYCNSIA's regional efforts demonstrated a mixed picture in terms of the potential for sustainability. At the policy level the term 'work in progress' is applicable.

- Under MYCNSIA, UNICEF ROSA effectively contributed to sustainable ownership of multi-sectoral nutrition programming in South Asia through its contribution to the development and endorsement of the SAARC Action Framework for Nutrition and (ongoing) support to the SAARC secretariat.
- There is clear evidence that efforts by UNICEF EAPRO contributed to a (renewed) policy in ASEAN to reduce stunting and other undernutrition, but impacts at the policy level are still a work in progress. The ASEAN nutrition profiles, nutrition report and the three-volume East Asia and the Pacific strategic approach documents developed under MYCNSIA provide solid evidence-based advocacy tools which can also be used in the coming years to ensure that regional policies are endorsed and followed up.
- The Regional Nutrition Strategies for ROSA and EAPRO developed under MYCNSIA provide a common strategy and shared narrative for policy, programme, advocacy and research action across UNICEF programmes in the two regions.
- The training of (master) trainers in IYCF was successful, effective and cost-effective in terms of numbers trained and ongoing demand. The decision not to build capacity in multi-sectoral nutrition security programming through a regional ToT was a missed opportunity.
- The success of creating and expanding a regional Nutrition Security Coordination Committee has yet to be capitalized on by transforming the committee into a platform for in-

novative learning and knowledge sharing, as is now being planned.

Systems, capacities and partnerships, country level

A multi-sectoral environment is usually groomed from existing routines, thereby increasing the chances of sustainability. At the country level MYCNSIA helped to develop complex and costly frameworks for change that encompassed all dimensions of food and nutrition security. Nevertheless MYCNSIA was also practical and supported the selection of priority interventions which already were part of the participating ministries' tasks, or which integrated a pro-nutrition angle into existing tasks. In Lao PDR over 90 interventions were originally identified and costed, but the tendency toward practicality eventually resulted in a reduction to just 22 interventions. The selected interventions are commonly known as 14+4+4, for the Ministry of Health, including WASH (14); agriculture (4) and education (4).

The characteristic of practicality is clear in the definition of the common results frameworks (CRFs) and the approach of using what works already to draw in key actors is gaining terrain even though it was not an official strategy of MYCNSIA. It is an implicit recognition that cooperation in multi-sectoral endeavours requires an awareness that they are already nutrition sensitive, but with some effort they could achieve more.

Hands-on capacities and resources dedicated to nutrition governance are both a sign of commitment and a requirement. There are commonalities in the institutional nutrition trajectory of various MYCNSIA countries. There now are institutions such as secretariats (Nepal; Lao PDR) and/or nutrition centres (Lao PDR) or nutrition services which are exclusively focused on mainstreaming nutrition in the health sector (Bangladesh) and beyond (Nepal; Lao PDR). A common, Government-adopted multi-sectoral plan, like the MSNP in Nepal, attracts actors and projects and is assisted by institutions such as secretariats. Official commitment at the highest level is important and is even seen as a precondition for multi-sectoral mainstreaming to have a chance to 'work'. This is expected to happen 'sometime soon' in Bangladesh.

Establishing multi-sectoral cooperation on nutrition can be accelerated by combining existing routines and instruments. The ETE team saw commonalities in the priorities secretariats took on. We may call these priorities the drivers, or even good practices (see Box 8).

Box 8 Routines and instruments which apply to all actors form a common foundation for a conducive multi-sectoral environment

Mainstreaming nutrition in multiple sectors is accelerated by having stakeholders agree on standards – routines, instruments, campaigns – they each are willing to accept and accommodate as their own. This includes international NGOs and projects. The (joint) preparatory work to arrive at these standards has itself solicited cooperation.

The following three drivers, alone or in combination, bring actors together:

1. **Same and jointly selected information, education and communication materials and messages** – partners ‘co-ordinate’, which means they sacrifice part of their ‘own’ approach. The sacrifice in itself is a sign of commitment. In Bangladesh the National Nutrition Services (NNS) was going to take the lead in this alignment exercise. UNICEF already identified 17 types of materials and job aides, for nutrition alone.
2. **Jointly agreed MIS under one, same ‘umbrella MIS’** –

commitment to as a minimum report on a selection of agreed indicators. In Nepal it was the NNFSS taking this on; the process has taken well over a year.

3. **Jointly performed Planning under one, same ‘umbrella Plan’** – commitment to as a minimum adhere to existing Government planning procedures, at the right level. In Nepal this is the 14 step VDC level planning, with Local Government in the driving seat. The secretariat supports from a distance.

A fourth driver is a jointly developed National Advocacy and Communication Strategy. Once endorsed this shall In Nepal be the one-for-all advocacy and communication strategy guiding all MSNP stakeholders with regards to their advocacy and communication plans. In Bangladesh the launch of the communication strategy will be synchronized with the Cabinet’s endorsement of the National Nutrition Policy, expected in 2015.

Source: Field observations and interviews, ETE 2015.

Local Nutrition Action Plans were an excellent pathway to mainstream nutrition. In the Philippines the July 2014 approval of the National Nutrition Council Guidelines on Local Nutrition Action Planning directed the nutrition action plan process at provincial, municipal and city levels. With it came National Nutrition Council efforts to develop a monitoring system for local government units, including a database on functional local nutrition committees. Most action is currently taking place at the municipality level though some funding of nutrition interventions may be provided by provincial government.

One advantage of decentralized planning is that it can tap into existing multi-sectoral mechanisms in which (local) government departments routinely take part. Another advantage is that these mechanisms can be equity-oriented. At the municipal level in the Philippines, Local Nutrition Action Planning, monitoring of food and nutrition security through the FAO EWS and the Helen Keller International intervention on ‘lot quality assurance sampling’ have become more poverty focused. In Indonesia it was the provincial and district planning but also village level planning and budgeting that enlightened both staff and stakeholders on the importance of multi-sectoral action for nutrition. In Nepal’s MSNP existing decentralized planning mechanisms sufficed for different government stakeholders to concur on incorporating nutrition dimensions, with a focus on the poorest VDCs and the involvement of all sectors.

UNICEF/ MYCNSIA efforts benefited from concurrent health system strengthening in some, but not all countries. In Nepal the Ministry’s focus on institutional deliveries helped to bring in the first part of the first 1,000 days in a

systemic way; rates of antenatal care and postnatal care had increased everywhere the ETE team visited. This suggests nutrition interventions will be sustained. In Bangladesh the MoHFW focused on incorporating nutrition in its routines at the bottom of the health pyramid. In Lao PDR important health system routines are undecided. In practice the system is in flux which makes it difficult to build on.

Systems, capacities and partnerships specifically serving the most disadvantaged were prominent in social protection schemes through increased effective coverage of poorer quintiles enrolled in the schemes. Indonesia offers the clearest case of scaling up and out of IYCF/ maternal nutrition through the channel of social protection schemes.²⁹ Preliminary MYCNSA endline results in Indonesia show significant improvement in complementary feeding in the lowest wealth quintile (minimum acceptable diet, minimum diet diversity, use of animal products), and this was not the case in the other quintiles. The Country Office chose to focus on community-based services through Posyandu, in which the lower quintiles participate more actively, in combination with PKH-Prestasi for Sikka District. If these data are confirmed the case deserves wide publicity since these indicators are notoriously difficult to improve. MYCNSIA efforts gave the initial leverage in the target districts. Once established, scaling the nutrition component up and out can happen throughout the scheme, and throughout the entire country (in principle). The rationale is effective coverage, the same as the argument for MoRES.

It appears that in the Philippines MYCNSIA had a similar opportunity to link with social protection schemes, but did not pursue it fully as the output (R2.2) was reported as completed in 2013 (see Annex G, section 2.4.2).

2.9.2 Comprehensive and intersectoral stunting reduction strategies

Countries' readiness to provide a conducive environment for stunting reduction is for obvious reasons linked to factors such as economic growth, yet economic growth does not necessarily tally with population-wide stunting reduction. In Nepal, gross national income nearly doubled from 2007 to 2014, while the population living below the poverty line decreased from 55 per cent to 25 per cent (see Annex F). Nepal has risen from 157 to 145 on the Human Development ranking. The under-five and infant mortality rates have declined significantly and low birth weight has declined. IYCF practices have improved and the coverage of antenatal care and vitamin A supplementation as well as the consumption of iodized salt have continued to grow, while low birth weight and malnutrition have further decreased. However, data suggest that disparities in stunting of children under 5 years of age from the poorest and richest wealth quintiles have increased in the period 2011–2014. The poorest quintile is more than three times as likely to be stunted as the richest (as compared to twice as likely in the period 2006–2011).

UNICEF/MYCNSIA contributed to an enabling environment for comprehensive and ultimately intersectoral stunting reduction strategies. The nature of the enabling environment differed across the five countries. In Nepal the adoption of the MSNP, in which UNICEF/ MYCNSIA was instrumental, contributed to coherence across strategies, policies and plans to support nutrition. Coherence in policies and increasing leadership in nutrition by the Government was critical in creating an environment to move forward the nutrition development agenda at all levels. At the national level, with MYCNSIA support through the REACH programme, collaboration across six sectors resulted in an M&E framework with common impact indicators for the first time ever. This in turn facilitated district level planning of MSNPs. The formulation of the intersectoral strategy is summarized in the evaluation of MYCNSIA in Nepal (Annex F, Box 5).

CMAM/ RUTF

In four MYCNSIA countries CMAM was an explicit output. The results have been mixed but have also suffered from confusion in terminology.

- Indonesia: CMAM was treated as a vertical programme, and there were inadequate linkages between CMAM services and other health and nutrition services including IYCF counselling, immunization and the integrated management of childhood illnesses. RUTF is not routinely available, and in acknowledgement of that problem, the output was rephrased to read "Implementation model for CMAM is developed".
- Bangladesh: As in Indonesia RUTF is not routinely available. In Bangladesh there is a powerful lobby against packaged therapeutic food, thus RUTF is an inherently sensitive product.³⁰ In Bangladesh the outputs concerning CMAM were all reported on as being 'on track'.
- Lao PDR: A diagnosis of acute malnutrition (moderate

and severe) is made during outreach visits of the health facility staff and there is no self-referral or community-led diagnosis. This is a fragile arrangement. In addition RUTF has been repeatedly out of stock, often for prolonged periods.

- Nepal: CMAM was introduced in five districts and rolled out to a further six districts. The combination of CMAM with IYCF and MNPs as an integrated package has thus far happened in only three districts, but is planned for in all MSNP districts.

The experience in three of the four countries raises the following questions:

- Can CMAM be considered sustainable when RUTF is not available?
- What alternatives has UNICEF helped to develop and implement as contingencies when there are structural uncertainties on RUTF availability?
- How meaningful can CMAM be if a response to moderate acute malnutrition (with a view to prevent the occurrence of SAM) is not taken?
- Should CMAM be promoted in the absence of IYCF?

Health staff interviewed by the ETE team in the MYCNSIA countries saw a decrease in moderate acute malnutrition and SAM cases as a sign of progress in tackling undernutrition. Yet MUAC screening was not always implemented. MUAC screening would have ensured early cases of moderate acute malnutrition were identified and managed at home. Early cases of moderate acute malnutrition can be resolved through the caregiver's compliance with dietary advice alone. In terms of options for local production to ensure the availability of RUTF (in Indonesia), companies indicated they would be interested only when there is a guaranteed demand. Yet 'the irony of success' is that if SAM cases decrease, lower demand for RUTF could make local production unprofitable.

MNPs

The future provision of MNP as a routine through government services is uncertain.

- In Indonesia UNICEF/ MYCNSIA aims for blanket distribution of MNP for children under age 2 nation-wide while present Ministry of Health guidelines restrict this to only poor children in 15 provinces. The ETE team observed that MNPs were expired or out of stock in two districts.
- In Bangladesh DGFP is in the process of instructing 11 districts to implement the full DNI package of 16 nutrition interventions. It is highly unlikely that DNI 7 (MNP supplementation for children aged 6–23 months) will be implemented across the country. It is more likely to be introduced as per 'special need' of certain households or locations.
- In Nepal challenges in procurement of MNP have negatively impacted coverage and hand-over to the Government.
- In the Philippines barriers and bottlenecks in access to MNPs are not taken into consideration in project interventions. The ETE team observed that the programme had not addressed the complex issue of MNP purchase and

distribution in municipalities and barangays. The quality and composition of MNP was uncertain and the current system of door-to-door distribution was clearly unsustainable.

- In Lao PDR the MNP intervention is still too recent to report trends.

There are serious uncertainties on interventions related to CMAM/ RUTF and MNPs. These uncertainties appear to be underestimated and under-reported in MYCNSIA.

Mainstreaming nutrition in the health sector has proven a formidable task, yet remarkable success was achieved when the four pillars operated in unison at different levels. In all MYCNSIA countries the ministries of health played a lead role. **There is potential to reach out from a nutrition specific foundation in the health system to other sectors.** Similarly, the complexity of 'creating' enabling environments for comprehensive stunting reduction strategies in the health sector has been generally underestimated, but once elements are established it is easier to make multi-sectoral progress. In all five countries the health sector has been the natural stronghold for UNICEF/ MYCNSIA. Although 'health' and 'nutrition' are relatively close it does not follow that nutrition is easy to integrate into health systems. In both Nepal and Bangladesh including nutrition indicators in the HMIS coincided with and benefited from the introduction of web-based reporting. In Bangladesh this was complemented by the provision of laptops and other support at peripheral levels of the health sector.

2.9.3 UNICEF/ MYCNSIA legacy

Continuity – financial

Contributions of other donors are no longer visible in the MYCNSIA budget. Yet in Nepal these very funds have allowed a smooth transition from MYCNSIA to a successor programme. The ETE team had access to the relevant data only for Nepal. The data show UNICEF was very successful in leveraging financial resources from other donors than the EU to reduce stunting. UNICEF succeeded in leveraging funds from the Government both for the implementation of the MSNP as well as for IYCN/ MNP. At present, with EU funds having been used in full, the programme continues on funding from other donors. Donors include USAID and the United States Center for Disease Control for IYCF/ MNP and other micronutrient programmes, the Micronutrient Initiative for micronutrient interventions, the Asian Development Bank for the IYCF-cash grant programme, and UNICEF regular resources and thematic funds to fill gaps. Donor support to the Government for nutrition has increased as well. Last but not least, UNICEF has succeeded in leveraging donor support for its own efforts to reduce stunting and anaemia beyond 2015.

Continuity – programmatic

UNICEF/ MYCNSIA is part of a continuum linking pre-existing projects and follow-through by new projects and initiatives. This pattern is evident in all countries. Programmes such as MYCNSIA are part of the continuum but also can accelerate the speed at which the continuum

performs. The question on the legacy of MYCNSIA should be seen in this light.

- In Bangladesh, the concept of DNSOs (District Nutrition Support Officers) was suggested and initiated under pillar 2 (capacity building) of MYCNSIA. DNSOs were initially posted in 20 districts, and are currently in 42 districts. Implementation is continuing with different funding, and it is expected that the Government will incorporate DNSOs as a line function in all districts.

Continued advocacy is needed for issues such as the BMS code and MNPs (see section 2.7.1) as illustrated by the Lao PDR data.³¹ The issue has also been taken up by EAPRO in a regional effort where the experience of Viet Nam is taken as the starting point.³² This raises the question of how a future programme should deal with such long-term issues requiring ongoing maintenance. Programme goals should be phrased to encourage and support ongoing advocacy and effort as required. MNPs in Indonesia are another example of work in progress, undertaken by the Country Office.

There is good potential to take up issues that are closely related to the first 1,000 days, building on the MYCNSIA legacy. One example is adolescent nutrition/obesity in Indonesia. Adolescent nutrition was not part of MYCNSIA in Indonesia. However, in 2014, with separate funding, UNICEF commissioned an analysis of future support to adolescent nutrition during the next country programme (2016–2019).

MYCNSIA follow-through projects have been funded by the EU in two MYCNSIA countries. At the time of the field visits, Nepal and Lao PDR were in the process of designing, submitting and negotiating a MYCNSIA successor programme with EU funding. In Nepal UNICEF will be the sole recipient while in Lao PDR UNICEF will be the recipient for two of the three programme components (the third component will be tendered). In both countries the funding is substantial. It is self-evident that the funding is granted on the foundation of the MYCNSIA achievements and the solid role UNICEF has played. It is also evident that the EU expects UNICEF to make the next move of stepping out of the health domain.

In countries with ample nutrition sensitive projects there is scope for reaching out to these projects. In Nepal the EU-funded successor programme is aptly described as "filling in the blanks" (personal communication with Country Office nutrition staff). One of the blanks was the connection with typical nutrition sensitive projects. Linkages are potentially strongest where projects share the first 1,000 days as a connecting principle. Projects such as Suaahara have had a steep learning curve and are well versed in practical IYCF solutions such as egg consumption. In Bangladesh the same applies to the SPRING project which links to relevant ministries and departments, including the health sector. In Nepal UNICEF staff appeared ready to reach out to go and see these projects and explore potential linkages, notably in non-familiar domains such as agriculture and livestock. UNICEF itself is meanwhile also developing its own multi-sectoral readiness and approaches. A typical practical example in Nepal are the ECD materials which will be ready in 2015, and which make the link between undernutrition and cognitive development.

3 CONCLUSIONS

3.1 Overall conclusions at programme level

1. **UNICEF is widely appreciated and acclaimed for its role in helping national Governments to develop policies and support them all the way to implementation.** ‘Nutrition governance’ was not explicit in the MYCNSIA programme monitoring instruments, but the ETE team found that most UNICEF country offices provided considerable attention and support to nutrition governance and that this contributed to enhancing the results of MYCNSIA.
2. **Achievements in ‘mainstreaming nutrition’ in the health sector have been convincing. This in itself is a formidable success and one that should not be underestimated.** The programme exceeded expectations in scaling up, within and through the health system in Nepal and Bangladesh.
3. **The programme design had multiple implications for programme relevance, effectiveness, efficiency and sustainability:**
 - a. **The four pillar design was relevant and in some cases it enabled effective synergies among core components.** Linkages between the pillars plus tailored governance support yielded good results, particularly for policy development and multi-sectoral approaches to nutrition. This design was so successful that it served as a template for the SAARC South Asia Regional Action Framework for Nutrition.
 - b. **The main programmatic objectives of MYCNSIA (reduction of stunting and anaemia) were overambitious.** The partial data available at the time of the ETE indicated that in some cases the targets were met, but also suggested that UNICEF underestimated the complexity of designing and implementing such impact studies. Attempting to achieve ‘coherence’ of methodology across very different implementation contexts added to the complexity.
 - c. **Equity was not explicit in the MYCNSIA logframe, yet underprivileged populations were targeted and reached** (through site selection, linkages with social protection schemes and national planning instruments). Other opportunities to highlight equity were missed: a more

substantial link with UNICEF’s MoRES instrument could have been made and only one country used the MYCNSIA baseline-endline analysis to explore and understand the equity dimensions of effective coverage.

d. **Opportunities to link with nutrition sensitive endeavours have increased over the duration of MYCNSIA, yet there was insufficient drive toward making stronger linkages with food security interventions as a necessary complement to MYCNSIA’s nutrition specific focus.** However, in Nepal such linkages are still possible, as per design. In Bangladesh there is clear potential to bridge the divide between nutrition specific endeavours and food security starting from routines MYCNSIA established such as the DNI package and the HMIS.

e. **Following the MTE, some country offices adapted their outputs and workplans (Indonesia, Lao PDR and Nepal) and this improved programme focus, relevance, reporting and evaluability.** As reported in the MTE, the MYCNSIA design was overly complex, and the dissociation of logframe and outputs increased the complexity. A third frame, the logic model, intended to come to a common framework, but this did not work. The transaction costs of having many frames were considerable.

4. **Typical regional functions were not well defined and as a consequence they were insufficiently pursued. Moreover, the MTE conclusion on meagre (“mixed”) results of capacity development still stands.** The regional function of learning lessons and identifying common drivers for success (and failure) was shifted to the programme’s very end and was given to external actors (consultants). The country offices were not given time to draw lessons which could have benefited other country programmes in Asia within the span of MYCNSIA. These and other tasks would have contributed to regional level capacity development and knowledge management and would have helped MYCNSIA remain more flexible and relevant.

3.2 Detailed conclusions at programme level

Readers are referred to Annex A3 for detailed conclusions at the regional and country level.

Relevance

(2.1.2) Collaboration with ASEAN and SAARC enabled UNICEF/ MYCNSIA to strengthen nutrition policy development and advance multi-sectoral approaches to nutrition through regional mechanisms. At the national level, MYCNSIA forged partnerships with relevant NGOs and government entities that supported the focus on the 'first 1,000 days' and other objectives of the initiative.

(2.1.3) The 2013 MTE lessons, conclusions and recommendations were pertinent, although follow-through was variable. The country offices which revised the MYCNSIA outputs brought in programmatic dimensions of sustainability and discarded typical short-term project objectives. Where the recommendations were taken up and workplans adjusted, the relevance of the programme improved. A formal revision was not undertaken for the logframe. As part of the contractual agreement with the EU, the logframe was considered less flexible to respond, which detracted from its relevance over time.

(2.1.4) The active engagement of key personnel of the EU Delegations in the design phase of MYCNSIA successor programmes at the country level had considerable advantages in terms of continuity and relevance of EU-UNICEF support to national development agendas.

Equity

(2.2.1) Although the logframe did not emphasize equity, UNICEF implemented MYCNSIA with a clear equity focus. UNICEF advocated and ensured the equity focus was embedded in national planning instruments and policies, consistent with its regional strategies.

(2.2.1) Evidence from all five MYCNSIA countries indicates that intervention areas for pillar 4 (scaling up) activities were targeted to those in greatest need. Equity of MYCNSIA interventions was supported by mainstreaming nutrition into social protection schemes in countries where social protection schemes are strong (Indonesia and the Philippines).

(2.2.2) MYCNSIA baseline surveys were regarded primarily in their function of measuring the impact of the programme. These could have been better used to explore and understand equity dimensions of effective coverage (as was the case in Indonesia).

Effectiveness

Pillar 1 – Governance

(2.3.1) Partnerships with Government bodies proved to be an effective mechanism for UNICEF/ MYCNSIA to support multi-sectoral nutrition governance at the national level but also at decentralized levels. UNICEF leveraged these partnerships to mainstream nutrition in national development instruments, with spin-offs at decentralized levels.

(2.3.1) Applying standardized tools to calculate the budget for nutrition sensitive actions can be difficult (a major issue for SUN). The Bangladesh DNI package is a good example where nutrition specific and nutrition sensitive fit together in one and the same package, thereby serving as a good model for nutrition costing.

Pillar 1 – Policy Development

(2.3.2) The endorsement of the SAARC South Asia Regional Action Framework For Nutrition is a significant achievement for UNICEF ROSA and far exceeded the expectations of MYCNSIA and has had spin-off effects in non-MYCNSIA countries in South Asia.

(2.3.2; 2.3.4) MYCNSIA support to nutrition governance added value and directly or indirectly paved the way for multi-sectoral coordination and progress, as in Lao PDR, Indonesia and Nepal. At the country level, pillar 1 (upstream work) focused on the health sector, where strong linkages already existed. Multi-sectoral and multi-actor partnerships such as SUN in Indonesia, NPC/NNFS in Nepal and the Nutrition Core Group in Lao PDR are relatively new and therefore are still gaining momentum.

Pillar 2 – Capacity building

(2.4.1) Supportive Supervision and IYCF training were most effective as part of a full package implemented in synchrony and in meaningful sequence, combined with support to nutrition governance. It required country-specific tailoring and follow-through rather than regional-level steering.

(2.4.1) When Supportive Supervision training was integrated into the official governmental system, and/or where its introduction was combined with a substantial addition to the health system it raised the quality of performance and has the potential to sustain nutrition capacity.

(2.4.1; 2.4.2) Of the 11 indicators for pillar 2, only two indicators pertain to capacity building beyond the health sector, and they were not consistently pursued as planned from the regional level. The response to MTE recommendation to take advantage of MYCNSIA's multi-sectoral potential was not as strong as desired.

Pillar 3 – Information systems and knowledge

(2.5.1) Integrating nutrition indicators into new or existing national HMIS was a highly effective way to improve monitoring, information availability and management of childhood illnesses and nutrition.

(2.5.1) The original aim for MYCNSIA to have a common M&E framework was ultimately proved ineffective, and the pursuit of that aim had opportunity costs in the first years of the programme.

(2.5.2; 2.7.1) Country level cases of good practices were generated but they had not been shared in a structured way or through relevant forums at the time of the ETE. This was a missed opportunity to share information that could have improved the effectiveness of implementation.

Pillar 4 – Scaling up

(2.6.1) An important characteristic of MYCNSIA is the capacity to scale up successful models and respond to local conditions. Effective mechanisms for scaling up (either through the health system or through social protection schemes) were identified within each country context, exemplified by CMAM/IMAM implementation in Nepal and IYCF implementation in Indonesia.

(2.6.3) Bangladesh and Nepal formulated and implemented a minimum package of necessary and sufficient nutrition specific interventions, and Lao PDR is progressing toward it.

(2.6.4) Country-level pathways for 'effective mainstreaming of nutrition' differed substantially and each country office identified and exploited opportunities for synergy. There is no one-for-all approach, yet in all three countries which were able to mainstream nutrition, the country office supported multi-level synergy, M&E and fine-tuning to scale up interventions.

(2.6.4) Integrating nutrition into the health system promoted effective coverage of prevention-oriented nutrition interventions at the community level particularly in Nepal and Indonesia.

Efficiency

(2.7.1) MYCNSIA had high transaction costs, at least at the regional level. To some extent this 'saved' effort on the part of country offices. The transaction costs would have been lower if the logframe had been simpler and more flexible, and the 2014 contract/budget amendment process had not been so time-consuming.

(2.7.1) The conventional logical framework was inefficient for MYCNSIA, a long-term initiative in the fast-paced field of nutrition. Concepts of timeliness and responsiveness to changing contexts were not captured in the design nor reflected in the evolution (or lack thereof) of the official programme documents.

(2.7.1) MYCNSIA lacked a description of what was expected from the PMU in terms of leadership and guidance, or taking an active steering role in forging practical linkages between the countries. Practical linkages would have enhanced operational efficiency as UNICEF moved into new territory, and thus beyond its comfort zone, in mainstreaming nutrition beyond the health sector.

Impact

(2.8.1) In all MYCNSIA countries, baseline and endline surveys (and in some cases midline) were commissioned to external institutions, with varying levels of involvement of the country offices. Issues related to the timing and methodology of baseline and endline surveys prevent the ETE from drawing conclusions about MYCNSIA's impact on stunting and anaemia in intervention areas. This conclusion has no absolute meaning in the sense of MYCNSIA's 'real' contribution.

(2.8.2) The best way to characterize the unintended impact of MYCNSIA is that it achieved a greater impact at a policy level than was anticipated in the original programme design. UNICEF/ MYCNSIA served as a policy role model at the national level and at the regional level, for example with the shaping of the MSNP (Nepal) and the SAARC South Asia Regional Action Framework for Nutrition. The MSNP and the Action Framework have far-reaching impact on nutrition policies.

(2.8.2) Unforeseen challenges required the country offices and PMU to respond, yet the way MYCNSIA was formulated inhibited the response to unforeseen challenges. If the desired impact is too specifically prescribed, as it was for MYCNSIA, then the challenges are a problem.

Sustainability

(2.9.1) At the regional level, MYCNSIA created the capacity for sustained results by contributing to the development and endorsement of frameworks and policies in support of nutrition. UNICEF ROSA and EAPRO developed Regional Nutrition Strategies to guide programmes, advocacy and research.

(2.9.1) At the national and local/decentralized level, integration of nutrition into multi-sectoral strategies and official government commitments, and strong financial and policy support are positive indicators of sustainability.

(2.9.2) Serious uncertainties and fundamental issues with mainstreaming the use of packaged supplements (MNPs and RUTF) have hindered the sustainability of these important DNIs.

(2.9.3) Programmes such as MYCNSIA are part of the continuum of service provided by UNICEF. MYCNSIA accelerated the pace and volume of those services, while also changing the nature of some activities. The legacy of MYCNSIA is that it leveraged greater results from the UNICEF continuum of service.

4 LESSONS LEARNED

4.1 Criteria and categories

The Terms of Reference for this ETE emphasized the importance of using the final evaluation as an opportunity to draw lessons according to the criteria and interests expressed in briefing and debriefing in Bangkok. The ETE team selected lessons learned that were: (i) observed in multiple MYCNSIA countries; (ii) relevant for programmes conducted in the future or in other locations; (iii) pertinent to a wider audience including the EC; (iv) focused on the original aims of the programme; (v) of interest for the design of future programme; and (vi) complementary to MYCNSIA lessons gathered in the course of 2015 by the country offices.

The ETE team clustered the lessons in five categories as follows:

- Programme design;
- Equity/effective coverage;
- Nutrition specific/sensitive linkages (convergence and/or mainstreaming);
- Programme monitoring systems; and
- Learning with and for Governments, with design implications for future programmes.

All lessons exemplify and illustrate this report's findings and conclusions (chapters 2 and 3). The lessons have implications for future programming, and the recommendations are compiled in chapter 5.

4.2 Programme design (1–4)

Lesson 1 (design) UNICEF's key strengths and role as an honest broker may be limited by predefined indicators and outputs. To gain the greatest advantage from UNICEF's key strengths, the programme design and reporting mechanism must be adjustable and incorporate UNICEF's ability to be there when needed, but withdraw when other strong actors are prepared to take over.

Lesson 2 (design) Projects typically have a short-term time frame, but this is not in line with UNICEF core strengths and is out of sync with priorities such as defending the International Code of Marketing of Breast-milk Substitutes (BMS code) which requires ongoing vigilance. The most effective projects will capitalize on UNICEF programmes as

part of a continuum of professional and reliable support to government endeavours.

Lesson 3 (design, pillars 1–4) Mainstreaming nutrition specific packages (DNIs/HINIs) is a formidable task, the complexity of which is easily underestimated. Nevertheless, the complexity can be circumvented by mainstream nutrition in the health system. Including nutrition in the HMIS promotes and accelerates further mainstreaming.

Lesson 4 (design, pillars 1, 2) When programmes create or support national level institutions, the programme modality should build these institutions so they can gradually take over policy implementation and support functions fulfilled by UNICEF. In support of institutions at decentralized levels, UNICEF's subnational offices provide a strategic advantage.

4.3 Equity/effective coverage (5–8)

Lesson 5 (design, pillars 3, 4) Baseline surveys should follow in-depth stratified analyses of recent data, using equity criteria such as gender, age-group, wealth, geographical area. It is cheap (the data are available) and reveals a wealth of information on what new data are needed. This type of data reveal disparities which should be used and acted upon upfront to inform the original problem analysis which should in turn inform programme design.

Lesson 6 (design, all pillars) Mainstreaming nutrition services into large scale social protection programmes enables initiatives to reach a large percentage of the target group. With social protection schemes as the starting point, shortcuts to nutrition sensitive approaches are also more feasible.

Lesson 7 (design, all pillars) Government partners such as the Bureau of Statistics can be allies in an equity approach. Opportunities for strategic alliances are not always evident at the start of a programme, but should be explored in the design phase and remain on the agenda throughout the programme.

Lesson 8 (design, pillars 1, 3 and 4) Significant differences between an intervention's coverage and effective coverage can be masked by indicators that are not carefully constructed. The principles of effective coverage (MoRES/Tanahashi) promoted by UNICEF can reveal poor effective coverage and should be built into the design of all projects to evaluate whether interventions are in fact reaching targeted beneficiaries.

4.4 Nutrition specific/sensitive linkages - convergence and/or mainstreaming (9–13)

Lesson 9 (design, pillars 1 and 4) Nutrition specific approaches can be leveraged as a foundation for nutrition sensitive approaches, including food security.

Lesson 10 (mainstreaming, pillars 1 and 4) Programmes should support nutrition specific approaches in such a way that nutrition sensitive linkages and interpretations become explicit. In partnership with national Governments, UNICEF can support institutions and frameworks that act as an enabling environment to both improve nutrition specific interventions and develop (their links with) nutrition sensitive activities.

Lesson 11 (design, pillars 1 and 4) The method of introducing and scaling nutrition sensitive initiatives at decentralized levels depends on the prevailing Government systems.

Through local level entry points it is possible both to reach poorer populations and to create linkages between nutrition specific and nutrition sensitive packages.

Lesson 12 (design, pillars 1 and 4) Extensive multi-sectoral planning and costing exercises can help identify key interventions, yet such an exercise is time consuming and many of the results are eventually discarded when a choice is made for more feasible and affordable shortcuts.

Lesson 13 (design, all pillars) Mainstreaming nutrition in multiple sectors is accelerated by having stakeholders agree on standards for routines, instruments and campaigns. The (joint) preparatory work to arrive at these standards has itself solicits cooperation between all relevant actors (ministries, projects and local authorities).

4.5 Programme monitoring systems (14–16)

Lesson 14 (design) Every programme requires a theory of change which brings out the strengths of the implementing entity. A midpoint review should assess the programme from the perspective of its original aspirations. This step can identify mechanisms to accelerate progress and enables course corrections. If this step is omitted, the programme misses the opportunity to identify and pursue areas of improvement.

Lesson 15 (design) Within UNICEF, nutrition mainstreaming has clear advantages. Multi-sectoral teams (health, nutrition,

WASH, ECD and social protection) are conducive to the development and support of nutrition sensitive activities. Integrated programming and monitoring builds on the key strengths of UNICEF across sectors.

Lesson 16 (design) Tailored and hands-on support to nutrition governance is a role UNICEF can play by being there when needed but withdrawing when other strong actors are prepared to take over. The changing role of UNICEF itself and the shift to Government ownership is a monitoring issue.

4.6 Learning with and for Governments: What works and what does not (17–20)

Lesson 17 (design, all pillars, notably pillar 3) UNICEF nutrition related research, data collection and analysis, and capacity building for Governments can target 'what works and what does not' in practice to generate evidence to inform policymaking, revise training materials and guidelines, improve the targeting of interventions and scale up successful initiatives. This would fill an important gap.

Lesson 18 (pillars 3 and 4) New knowledge and information is continuously emerging in the field of health and nutrition, and this may necessitate changes in intervention strategies. In anticipation of this ongoing concern, the most optimal programme design is adaptive and supports Government agencies in seeking the best possible response to new information.

Lesson 19 (design, pillar 3) Regional programmes generate many hands-on, 'how-to' examples of good practice, often reflecting positive experiences in country-specific contexts. Sharing and taking full advantage of knowledge generated within the programme supports efficient and effective outcomes. The programme design should specify the best forum to share such examples, and at what point in time.

Lesson 20 (design, all pillars, especially pillars 2 and 3) Data collected through baseline/endline surveys can be analysed to gain more information for Governments seeking to find 'what works' in practice to reduce anaemia and stunting. Speaking of the need for learning of this kind, Lawrence Haddad of the International Food Policy Research Institute commented, "I remain amazed at how few country or state level case studies there are of change. Why did stunting go down in this country? Why is wasting static? Why is overweight declining? Why is anaemia static? [...] The nutrition journals currently dis-incentivise this kind of study, presumably because it is not methodologically pure enough. This is a real shame. Slicing and dicing research may help researchers get published, but who is going to weave all the strands back together again?" Baseline/endline research need not be limited to determining if the programme achieved its desired impact (such as a significant reduction of anaemia and stunting), but can be leveraged to yield lessons for the reduction of anaemia and stunting which have wider application.

5 RECOMMENDATIONS FOR FURTHER PROGRAMMING

The following strategic recommendations to improve future programming are based on the findings and conclusions presented in the preceding chapters. The recommendations are divided in five categories, chosen for their scope to improve on future programming. These are:

- Programme design;
- Equity/effective coverage;
- Nutrition specific/sensitive linkages (convergence and/or mainstreaming);
- Programme monitoring systems; and
- Learning with and for Governments.

The ETE recommendations for the individual countries and the two regions are presented in Annexes B-G (volume II). For easy reference they are compiled in Annex A4 of this report (volume I).

Recommendations

UNICEF

1. (Programme design) In future programme design UNICEF should outline strategic and competitive advantages for which the organization is known and widely appreciated. UNICEF should thus profile its programmes as professional and reliable technical assistance and support to government endeavours.
 - Ideally such programmes should also incorporate UNICEF's role of 'being there when needed, but withdrawing when other strong actors are prepared to take over', which has been clear particularly in MYCNSIA's tailored and hands-on support to nutrition governance.
 - Indicators and outputs should no longer be phrased as one-off events.
2. (Equity/effective coverage and learning with and for Governments) Ensure that data informing programme design include in-depth stratified analysis and are used to improve programme design, quality and coverage as applicable. This will contribute to improve coverage and equity in current and future programmes with national governments.
3. (Convergence) Operationalize the argument that nutrition sensitive actions can follow on and benefit from a nutrition specific foundation. The ETE's three-phase model is presented in Annex C (Bangladesh), section 2.9.2.
4. (Learning with and for Governments) Use data and

knowledge on 'what works' and why it works to boost evidence based regional programming in order to help governments address persistent chronic undernutrition. This could be described as capacity building driven by a common and unifying purpose.

5. Ensure the programme design includes indicators for the regional office(s) on typical regional functions, such as learning lessons and identifying common drivers for success. Ensure the programme design specifies the point in time and the forum for sharing knowledge and experience.

Funding agency (EU)

1. The funding agency should require that future regional joint action with UNICEF to address persistent chronic undernutrition:
 - a. (Convergence) Link nutrition specific interventions with nutrition sensitive initiatives and build in the flexibility to respond to opportunities as they arise. Food security should be included in nutrition sensitive initiatives.
 - b. (Convergence) Clarify what nutrition sensitive means in multi-sectoral practice, within the country context and relative to the comparative advantages of each country delegation, including practical aspects of using existing partnerships and resources such as local/ decentralized delegations; and ethical aspects such as equity, rights and gender dimensions, by using existing programmes, mechanisms and drivers.
 - c. (Equity/effective coverage) Are flexible enough to benefit from UNICEF's global, regional and country programmes and initiatives even if these were not included in the original design. UNICEF's MoRES approach is a case in point.
2. (Learning with and for Governments) The funding agency should require the regional office to demonstrably act as a knowledge hub. This should include the use of data and knowledge on 'what works' and why it works to boost evidence based regional programming. Country offices should be supported to mobilize, analyse, use and share data and the lessons they imply to this effect (see recommendations 3 and 4 for UNICEF). This should include the following:
 - (Programme monitoring systems) Bringing out lessons of equity/effective coverage.
 - Taking joint learning as the core of a programme uniting participating countries and regional bodies such as ASEAN and SAARC.

ANNEXES

[Annex A1.](#) Evaluation framework MYCNSIA ETE (2015); data collection methods; strength of combined methods, across regions/countries

[Annex A2.](#) MYCNSIA 2011 overall Logical Framework; evaluability and relevance as judged by ETE

[Annex A3.](#) Overall conclusions (regions; countries)

[Annex A4.](#) Recommendations for further programming (regions; countries)

Annex A1

Evaluation framework MYCNSIA ETE (2015); data collection methods; strength of combined methods, across regions/countries

Main evaluation criteria	Key Evaluation Questions as per Terms of Reference	Data collection methods				Strength
		Docs a. Govt. b. UNICEF c. others	Interviews a. Regional ext. funded programmes b. Regional Authorities	Interviews a. Govt.; b. UN c. donors; d. NGOs / IPs e. research inst.; f. private sector	Field visits a. Govt. b. NGOs c. Community	On a scale of 1 (low) to 3 (high)
Relevance and appropriateness	What strategies have been followed within UNICEF (regional and national level) to address child stunting and anaemia reduction among young children and women? What implicit or explicit theories of change have informed these strategies?	all of the above	all of the above	a; b; c; d; (e);	all of the above	3
	What strategic advantages does UNICEF have (at the regional and country level) for upstream policy development, facilitating and establishing intersectoral linkages and partnerships, developing capacity of programme managers and decision makers to implement programmes; strengthen nutrition information systems; and support the scale-up of an integrated package of high impact interventions for children and women in the target countries?	all of the above	all of the above	a; b; c; d; (e);	all of the above	3
	To what extent is the EU-supported MYCNSIA initiative aligned with global and national priorities and plans of programme countries? Has the programme added value and complemented other efforts?	all of the above	all of the above	a; b; c; d; (e);	all of the above, but limited exposure to 'other efforts'	2
	Have sufficient intersectoral linkages been established?	all of the above	all of the above	a; b; c; d; (e);	all of the above	3
	To what extent have the recommendations of the mid-term evaluation been incorporated in the programme design and has helped to accelerate results for pregnant and lactating women and young children?	b		Interviews UNICEF nutrition staff		2-3
	To what extent has the regional component of MYCNSIA been relevant and able to respond to the regional level priorities/needs?	all of the above	all of the above	a; b; c; d; (e);	-	2

Main evaluation criteria	Key Evaluation Questions as per Terms of Reference	Data collection methods				Strength
		Docs a. Govt. b. UNICEF c. others	Interviews a. Regional ext. funded programmes b. Regional Authorities	Interviews a. Govt.; b. UN c. donors; d. NGOs / IPs e. research inst.; f. private sector	Field visits a. Govt. b. NGOs c. Community	On a scale of 1 (low) to 3 (high)
Equity	Is there enough focus within MYCNSIA on equity issues (geographical, gender, income, ethnic disparities)? in access and coverage of key nutrition interventions?	all of the above, but limited information		all of the above, but limited information	a; b,	
	but limited	1-3 (varies by country)				
	To what extent do UNICEF partnership strategies and practices (at different levels) support the delivery of results for women and young children in South and East Asia, with equity?	all of the above, but limited information	all of the above, but limited information	a; b; c; d; (e);	all of the above, but limited information	1-3 (varies by country)
	To what extent has the programme design and implementation addressed the rights and needs of worst-off groups and responded to barriers and bottlenecks to inequalities	all of the above, but limited information	all of the above, but limited information	a; b; c; d; (e);	all of the above, but limited information	1-3 (varies by country)
Efficiency	Were the resources (funds, expertise and time) made available through this programme at the regional and country level appropriate to support the planned activities and results to date?	b; c (for the sake of comparison)	UNICEF ROSA; EAPRO	a; b; c; d; (e);- limited to expertise		3
	Is the overall financial expenditure rate of the programme consistent with the planned progress? Has the programme been able to achieve the results as planned?	all of the above; endline study results yet to be received	UNICEF ROSA; EAPRO			3
	To what extent has the existing programme management structures (regional and country level) been able to enhance the operational efficiency of MYCNSIA? What are the lessons learned and recommendations for the future?	b; c (for the sake of comparison)	UNICEF ROSA; EAPRO	c		2

Main evaluation criteria	Key Evaluation Questions as per Terms of Reference	Data collection methods				Strength
		Docs a. Govt. b. UNICEF c. others	Interviews a. Regional ext. funded programmes b. Regional Authorities	Interviews a. Govt.; b. UN c. donors; d. NGOs / IPs e. research inst.; f. private sector	Field visits a. Govt. b. NGOs c. Community	On a scale of 1 (low) to 3 (high)
Effectiveness	After 4 years of the MYCNSIA initiative, have efforts in the key result areas of: upstream work, capacity building, data analysis and scale-up of interventions been implemented with sufficient quantity, quality and timeliness and adequacy? Have the programme targets been met at the regional and national level?	all of the above	all of the above	a; b; c; d; (e);	all of the above	(targets): should not be judged where these are arbitrary or where indicator lacks relevance – see Annex A2
	At the regional and national levels, to what extent has MYCNSIA been able to influence policies (develop new policies/ modify existing ones), strengthen partnerships and intersectoral collaboration (health, nutrition, agriculture, water and sanitation) and enhance integration of nutrition in programmes in the allied sectors to make them nutrition sensitive?	all of the above, but limited information	all of the above, but limited information	a; b; c; d; (e);	all of the above, but limited information	1-3 (varies by country); Intersectoral: in most cases just starting
	At the regional and national levels, to what extent has MYCNSIA been able to develop the capacity of programme planners and decision makers in effective nutrition planning? Enhance the nutrition capacities of different sectors? Develop nutrition training materials and develop standardised training for health staff?	all of the above	all of the above	a; b; c; d; (e);	all of the above	1-3 (varies by country); Intersectoral: in most cases just starting
	Has the programme been successful in strengthening the government system in planning, implementing and monitoring nutrition programmes?	all of the above	limited information; indicators for regional aspects not comprehensive and/or not well conceived	a; b; c; d; (e);	All of the above	3 (strength differs for nutrition specific and nutrition sensitive)
	To what extent have the countries been able to strengthen the nutrition monitoring systems? Have any models been developed that can be scaled up?	all of the above	limited since indicators for regional aspects ill-conceived	a; b; c; d; (e);	All of the above	3 (strength differs for nutrition specific and nutrition sensitive)
	At the regional level, to what extent has MYCNSIA been successful in creating an enabling environment to address the problem of chronic malnutrition? Been able to influence the regional policy environment and influence the other countries to address chronic malnutrition?	all of the above, but limited information	all of the above, limited MYCNSIA-specific information	d		1–2 (differs for the two regions)

Main evaluation criteria	Key Evaluation Questions as per Terms of Reference	Data collection methods				Strength
		Docs a. Govt. b. UNICEF c. others	Interviews a. Regional ext. funded programmes b. Regional Authorities	Interviews a. Govt.; b. UN c. donors; d. NGOs / IPs e. research inst.; f. private sector	Field visits a. Govt. b. NGOs c. Community	On a scale of 1 (low) to 3 (high)
Impact	Based on the findings of the endline survey results, highlight the contribution of the MYCNSIA project on stunting and anaemia in the intervention areas	all of the above, but incomplete				1 (expected score based on quality of reports received)
	To what extent has MYCNSIA contributed to changes in the regional and country level policies? At the regional level, to what extent has MYCNSIA improved the environment for programme funding and at the country level influenced programme budgets within the countries?	all of the above, but limited information	all of the above, but limited MYCNSIA-specific information	c; d		Region: 1 Countries: 1–2 Reason: changes still at an early stage; part of a longer-term process
	Has the programme shown broader unintended effects, positive or negative, direct or indirect, at any level? (e.g. environmental, economic, social, political, or technical)	all of the above, but limited information	all of the above, but limited MYCNSIA-specific information	a; b; c; d; (e);	all of the above	1 Reason: by nature incidental findings
	What has been the added value of MYNCSIA and what are the lessons learned that can influence the broader regional and global policy environments?	all of the above	all of the above, but too little comparison	a; b; c; d; (e);	all of the above	2-3
Sustainability	What systems and partnerships has UNICEF put in place with governments, civil society and other development partners that will address child stunting as well as maternal and child anaemia, especially among the most disadvantaged (equity)? Have the interventions created capacities for sustained results?	all of the above, but limited information	all of the above, but limited information	a; b; c; d; (e);	all of the above, but limited information	1-3 (varies by country)
	During the MYCNSIA intervention, to what extent has the UNICEF's upstream policy and advocacy contributed to an enabling environment for comprehensive and intersectoral stunting reduction strategy – with respect to adoption/revision of key policies, strategies, coordination mechanisms, funding allocations, etc.? What are the lessons and good practices that can be transferred to other countries?	all of the above	all of the above; limited information for lack of key informants	a; b; c; d; (e);	all of the above, but limited information	1–2
	In what ways were MYCNSIA interventions integrated into existing national / local efforts? (Give details for each result area)? Is good ownership created for MYCNSIA activities by government partners and/or other partners?	all of the above		a; b; c; d; (e);	All of the above	2 (since often still 'in progress')
	To what extent can evidence/ learning improve the design and implementation of future regional level programmes addressing undernutrition? Using the regional platform, how can the learning of MYCNSIA be leveraged to enhance efforts across countries and build upon positive movements in order to address the high levels of child stunting in Asia?	all of the above	all of the above; limited information for lack of comparisons	a; b; c; d; (e);		2 (tentative) Reason: MYCNSIA not set up to learn lessons en route and many lessons are yet to be drawn

Annex A2

MYCNSIA 2011 overall Logical Framework; evaluability and relevance as judged by ETE

MYCNSIA 2011 Logical Framework			Evaluability and relevance as judged by ETE		
Intervention logic	Objectively verifiable indicators of achievement	Verification possible	Contribution can be argued/ is plausible	Relevance at outcome level and above	Target commensurate with programme objectives
Expected Result # 1 Upstream Policy and Nutrition Security Awareness with coherent and appropriate goals, targets, policies, strategies, guidelines / protocols and tools adopted / revised by regional institutions and their Member States.	1. Number of high-level regional meetings (ASEAN/ SAARC) that include nutrition on the agenda leading to policy recommendations; (target: 2; baseline: 0)	Yes	Yes	High	No, unless it represents a significant change from 'normal'.
	2. Number of evidence-based policy/programme papers related to nutrition security and equity (target: 3; baseline: 0)	The addition of 'equity' makes it ambiguous. None of the papers reported has a specific equity angle	To some extent only.	Moderate ie: necessary but in itself insufficient unless embedded in pertinent activity or event	No, appears arbitrary.
	3. Number of MYCNSIA committees established and meetings convened by UNICEF; (BL: 0, Target: 2 – Steering Committee and Coordination Committee established; baseline: 0; target: 3 meetings per year (1 CC, 2 SC); baseline= 0)	Yes	Yes	Moderate ie: necessary but in itself insufficient	No
	4. Number of meetings where (i) MYCNSIA briefing materials and (ii) key nutrition advocacy messages are made available and disseminated (target: at least 4 regional meetings in Y2-Y4; baseline 0)	Yes	Yes	Moderate ie: useful but in itself insufficient	No; countries should be included; and for (ii): no, unless it represents a significant change from normal
	5. Number of countries using Advocacy tools to position Nutrition (target: 5; baseline: none)	Hard to verify. Production and dissemination must be timely enough to verify use.	Yes	High	Yes, but ought to have included non-MYCNSIA countries Baseline 'none': doesn't seem realistic (eg Nepal was already doing this before MYCNSIA)

MYCNSIA 2011 Logical Framework			Evaluability and relevance as judged by ETE		
Intervention logic	Objectively verifiable indicators of achievement	Verification possible	Contribution can be argued/ is plausible	Relevance at outcome level and above	Target commensurate with programme objectives
	6. Number of countries with a new or revised National Nutrition Plan/Policy (target: 4 countries; 2 in 2011 and 2 in 2013); baseline: 0)	Yes	Soft information since many actors	High, depending on quality and inclusion of nutrition sensitive approaches	Yes, but ought to have included non-MYCNSIA countries
	7. Joint advocacy plan developed with other sectors targeting non health sector (target: plan available by end 2012)	Yes	Yes (but plan not produced)	High	No target set, apparently regional level only
	8. Number of countries where nutrition has been newly incorporated into non-nutrition/non-health sector plans, budgets, etc., (target: 4; baseline: 0)	Yes	Soft information since many actors	High	Yes, but ought to have included non-MYCNSIA countries
	9. Number of new or revised strategic documents (IYCF/ anaemia control/ CMAM/ micronutrients/ maternal nutrition/etc.) adopted for implementation (target: 11; baseline: 0)	Yes	Yes, for nutrition specific interventions	High, but should not be formulated in absolute terms, but rather as progress from country-specific starting point	Yes, but appears arbitrary.
	10. Number of new legislations adopted/ or existing ones revised (BMS code/food fortification) (target: 4; baseline: 0)	Yes, but formulation is ambiguous. Legislation on what? Does fortification of edible oil with vitamin A count?	Yes	Moderate ie: necessary but in itself insufficient	Yes, but ought to have included non-MYCNSIA countries; target of less than 1 per country is under-ambitious
	11. Number of countries where programmes to support EBF have been implemented in the workplace (target: at least 1 country; baseline: 0)	Yes, to some extent ('the' workplace?)	Soft information since many actors	High	No, target of 1 country is under-ambitious
	12. Number of countries that have a communication strategy which includes key nutrition topics (IYCF, maternal nutrition, food fortification, etc.) (target: 5, baseline: 1)	Yes	Yes	High, under some conditions (that strategy is implemented and sustained and the effect monitored)	Yes, but ought to have included non-MYCNSIA countries

MYCNSIA 2011 Logical Framework			Evaluability and relevance as judged by ETE		
Intervention logic	Objectively verifiable indicators of achievement	Verification possible	Contribution can be argued/ is plausible	Relevance at outcome level and above	Target commensurate with programme objectives
Expected Result # 2 Capacity Development of Decision-Makers and Nutritionist Communities with enhanced capacities at all levels (community, district, and central) to address maternal and child undernutrition in collaboration with selected regional/national institutions to create a strong nutrition community network.	1. Number of countries with capacity needs and readiness assessment and recommendations for capacity development of multiple sectors	Yes Interestingly no clear OVI for the region	Yes	Low/ moderate, unless put to use	NA
	2. Number of people trained as trainers for building nutrition planning and programming skills of district managers (target: 25 baseline: 0)	Yes, to some extent	Yes	Low/ moderate, unless put to use	No; appears arbitrary; 5 per country is very modest.
	3. Number of people trained as trainers of community-based IYCF counsellors (target: 25 baseline: 0)	Yes, to some extent, but MYCNSIA will be one among many projects	Yes	Low/ moderate	No; appears arbitrary; 5 per country is very modest
	4. Per cent of trained trainers of district managers and IYCF counsellors who met their Plan of Action targets every year (target: 50%; baseline: 0)	Yes, to some extent	Not readily – requires survey or personal interview	Low/ moderate	Does not capture the essence
	5. Number of national and regional institutions that will have received support to collect and analyse nutrition data (target: 1 per targeted county +; baseline: 0)	Yes	Yes	High, provided support is put to use	No; appears insufficiently ambitious; Region missing
	6. Number of countries that have completed the targeted n. of training sessions on CMAM for gov't health staff, NGOs, and community workers (target: 3; baseline: 0)	Yes	Yes, to some extent	This depends on the feasibility of CMAM which determines the training's use and usefulness	
	7. Number of countries that have completed the targeted no. of training sessions on IYCF counselling and MNP programmes (target: 5; baseline: 0)	Difficult, in practice	Yes	High, if accompanied by the actual programme initiations and their follow up	No; appears arbitrary
	8. Number of countries that have completed the targeted no. of training sessions on planning, management and monitoring of nutrition programmes (target: 4; baseline: 0)	Unclear; targeted by whom, for whom, at what levels, in which contexts and sectors?	-	Possibly, in local context	Yes, but ought to have included non-MYCNSIA countries

MYCNSIA 2011 Logical Framework			Evaluability and relevance as judged by ETE		
Intervention logic	Objectively verifiable indicators of achievement	Verification possible	Contribution can be argued/ is plausible	Relevance at outcome level and above	Target commensurate with programme objectives
	9. Number of countries where IYCF is included in pre-service and in-service training curricula of health and nutrition professionals (target: at least 1 country)	Yes	Yes	High	No, target of 1 country is under-ambitious
	10. Number of countries that have increased capacity within relevant sectors to integrate nutrition objectives into their programming (target: 5; BL: 0)	Yes	Yes, although possibly indirectly (many actors)	High, if accompanied by the actual programme initiations and their follow up	Yes, but ought to have included non-MYCNSIA countries
	11. Number of countries that have undertaken the targeted no. of field monitoring visits (target: 5; baseline: 0)	Unclear; monitoring by whom? What for?	?	?	?
Expected Result #3 Data Analysis and Knowledge Sharing with strengthened information systems, data collection and analysis, and mechanisms for knowledge sharing and management established	1. Number of countries that were considered to have appropriately integrated the common M&E framework to their project by external evaluators at mid-term (target: 5; baseline: 0)	There is considerable confusion about such a framework.	-	No, this appears an ill-conceived result	-
	2. Number of countries with a strengthened nutrition monitoring system and/or models which can be scaled up (target: 4; baseline: 0)	Yes	Yes, but will differ for nutrition specific and nutrition sensitive indicators. Scaling up in practice not applicable, unless countries use each other's models as an example.	High	Yes, but ought to have included non-MYCNSIA countries
	3. Date when mechanism for experience sharing and best practices across countries was adopted (target: June 2012; baseline: none)	In practice the date appears to have been shifted to the very end of 2015.	No	Low when coming at the programme's end, and when lessons are generated externally	Yes, if there was a way to effectively share lessons

MYCNSIA 2011 Logical Framework			Evaluability and relevance as judged by ETE		
Intervention logic	Objectively verifiable indicators of achievement	Verification possible	Contribution can be argued/ is plausible	Relevance at outcome level and above	Target commensurate with programme objectives
	4. Number of countries that received information on "Lessons Learned" from integrated multi-sector nutrition programmes (target: at least 25; baseline: 0)	Yes, but see shift in date	Yes	Low when the assumption is that 'receiving information' suffices.	Yes (the two regions)
	5. Number of countries that contributed and participated in the final review meeting to share good practices, lessons learned and innovations from MYCNSIA (target: at least 10 countries; baseline: 0)	Yes	Yes	Dubious, see above	-
Expected Result #4 Scaling Up Interventions Direct improved infant, child and women's nutrition	Selected core IYCF practices indicators among young children Number of countries where the prevalence of early initiation of breastfeeding has increased by at least 10 percentage points from baseline (target: 5 countries, baseline: 0)	Yes, if baseline/ endline design is appropriate	Partly only	High	Increase of 10 percentage points should be compared with overall country statistics in the same period Five countries ought to read 'MYCNSIA programme areas in 5 countries'.
	Number of countries where % children aged 6–23 months who receive minimum acceptable diet has increased by at least 10 percentage points from baseline (target: 5 countries; baseline: 0)	Yes, if baseline/ endline design is appropriate	Partly only	High	As above
	Number of countries where % of children aged 6–23 months with the minimum diet diversity (who receive foods from 4 or more groups) has increased by at least 10 percentage points from baseline; (target: 5 countries; baseline: NA)	Yes, if baseline/ endline design is appropriate	Partly only	High	As above
	Number of countries where % of children aged 6–23 months with minimum meal frequency (who receive solid semi-solid or soft food the minimum number of times per day) has increased by at least 10 percentage points from baseline; (target: 5 countries, baseline: NA)	Yes, if baseline/ endline design is appropriate	Partly only	High	As above

MYCNSIA 2011 Logical Framework			Evaluability and relevance as judged by ETE		
Intervention logic	Objectively verifiable indicators of achievement	Verification possible	Contribution can be argued/ is plausible	Relevance at outcome level and above	Target commensurate with programme objectives
	Anaemia control: Number of countries where coverage of IFA in pregnant women and MNP in children 6–23 months is increased by 30% in MYCNSIA programme areas (target: 5 countries; baseline: NA)	Yes, if baseline/ endline design is appropriate, which means here: that compliance ('effective coverage') is factored in	Yes, if no other programmes active	High	As above

Annex A3

Overall conclusions (regions, countries)

Overall conclusions for the regional analysis

Expected Results as in Logframe	Conclusions
Expected Result # 1 - Up-Stream Policy & Nutrition Security Awareness with · Coherent and appropriate goals, targets, policies, strategies, guidelines / protocols and tools · Adopted / revised by regional institutions and their Member States.	· Excellent progress · Endorsement of the South Asian Regional action framework for nutrition (NAF) was well beyond planned outputs · Substantial output in terms of advocacy tools · Significant increase in representation and advocacy at high level meetings in 2014, contributing to an enabling environment · Spin-off effect of up-stream work through multi-sectoral approaches in non-MYCNSIA countries · Linkages between the nutrition section and other UNICEF sections (WASH, health, ECD, Education and Social protection) and multi-sectoral collaboration strengthened
Expected Result # 2 - Capacity Development of Decision-Makers & Nutritionist Communities with · Enhanced capacities at all levels (community, district, and central) to address maternal and child undernutrition · In collaboration with selected regional/national institutions · To create a strong nutrition community network.	· Effective capacity building of (Masters) TOT in IYCF with substantial roll-out in MYCNSIA countries · Well appreciated training in supportive supervision, but limited follow-up in MYCNSIA countries · No capacity building in multi-sectoral nutrition security at regional level through TOT · Limited regional activities to advance capacity building of national and regional institutions in collecting, analysing and evaluating sex disaggregated data · Significant progress in advancing a regional nutrition network (as demonstrated by the expanding nutrition security coordination committee established under MYCNSIA (and other platforms) · New knowledge partnerships with IFPRI, Tufts and Harvard to enhance knowledge and develop capacities of those working in public health nutrition on stunting reduction in South Asia, updating them with latest knowledge and also latest evidence for synergies between nutrition and education to inform nutrition sensitive education programmes · Good consolidation and dissemination of nutrition capacity needs assessments in MYCNSIA countries at regional level but very poor follow-up
Expected Result #3 - Data Analysis & Knowledge Sharing with · Strengthened information systems, · Data collection & analysis, and · Mechanisms for knowledge sharing and management established	· Common M&E framework developed under the regional component not really used and there was no spin-off beyond MYCNSIA · Substantial technical support and back-stopping to MYCNSIA countries (UNICEF and national institutions) with base-line surveys and analyses · Knowledge sharing also at existing platforms (regional high level senior management meetings and workshops) · No new interlinked structured fora except the annual regional meeting for MYCNSIA · Recommendations of the MTE to strengthen mechanisms for the exchange of information and experience between the MYCNSIA countries not followed-up
Expected Result #5 - Cross Cutting and Administrative · All donor reports submitted by the deadlines	· The time and effort that were required for administrative and contractual management was to the detriment to the programmatic aspects of regional component of MYCNSIA

Overall conclusions Bangladesh

MYCNSIA logframe	Logframe OVI	Results Bangladesh
Overall objective To improve child survival, growth and development through life cycle and nutrition security interventions in Asia contributing to the achievement of MDGs 1, 4, 5 and 8 targets related to nutrition	- Reduction in stunting (target: stunting among children aged 0–3 years reduced by 5 percentage points from baseline) - Reduction in anaemia (target: by 15 per cent from baseline) - pregnant women - children aged 6–35 months	4.8% (from 41.1% down to 36.3%)
		22.4% (from 53.4 to 41.4%) 26.1% (from 77.7% to 57.4%).
Expected results as in logframe	Conclusions Bangladesh	
Expected Result # 1 - Upstream Policy and Nutrition Security Awareness with - Coherent and appropriate goals, targets, policies, strategies, guidelines / protocols and tools - Adopted / revised by regional institutions and their Member States.	- UNICEF/ MYCNSIA has played a distinctive role for embedding nutrition in the health sector; - This has included 'translation' into protocols and tools; - No apparent linkages were made with other countries.	
Expected Result # 2 - Capacity Development of Decision-Makers and Nutritionist Communities with - Enhanced capacities at all levels (community, district, and central) to address maternal and child undernutrition - In collaboration with selected regional/national institutions - To create a strong nutrition community network.	- Capacities were enhanced, but largely as a result of stronger nutrition governance, at least in the health sector; - UNICEF collaborated with DGFP and the National Nutrition Services (NNS), and the new 'institution' of DNSOs; - MYCNSIA made clear contribution to a nutrition community network; - Connection with other sectors yet to be made.	
Expected Result #3 - Data Analysis and Knowledge Sharing with - Strengthened information systems, - Data collection and analysis - Mechanisms for knowledge sharing and management established	- Information systems were strengthened, and impressive progress was made within the health system; - Yes, for data collection; No for analysis; - No mechanism was established for knowledge sharing and management. Connections with other sectors have yet to be made.	
Expected Result #4 - Scaling Up Interventions Direct improved infant, child and women's nutrition	- With the exception of early initiation of breastfeeding (+28%) the end-term results do not show improvement for IYCF indicators; - Effective coverage MNPs and IFA is a concern; - Connections with other sectors have yet to be made; - CMAM discourse not addressed; focus instead on improved SAM diagnosis and treatment as part of health system improvement. Where this has reached down to the community clinics it can be judged as 'a next best option' where CMAM proper is not possible.	

Overall conclusions Indonesia

MYCNSIA logframe	Logframe OVI	Results Indonesia
Overall objective To improve child survival, growth and development through life cycle and nutrition security interventions in Asia contributing to the achievement of MDGs 1, 4, 5 and 8 targets related to nutrition	- Reduction in stunting (target: stunting among children aged 0-3 years reduced by 5 percentage points from baseline) - Reduction in anaemia (target: by 15 percent from baseline) - pregnant women - children aged 6-35 months	Achieved: baseline: 29.6 endline: 23.9
		- From 44.9 to 46.4 - From 58.3 to 55.9
Logframe results	Conclusions Indonesia	
Expected Result # 1 - Up-Stream Policy & Nutrition Security Awareness with - Coherent and appropriate goals, targets, policies, strategies, guidelines / protocols and tools - Adopted / revised by regional institutions and their Member States.	- UNICEF/MYCNSIA has substantially contributed to 'mainstreaming nutrition', not only in the health sector but also in other sectors through prominent inclusion in the medium term development plan. - Awareness on need for multi-sectoral approach prevails at all government levels in MYCNSIA target areas and is reflected in the position of stunting as a main development indicator in the National Medium Term Development Plan and the multisector Food and Nutrition Plans of Action at national, province and district level. - Numerous relevant policies and guidelines have been developed/adopted - The IYCF package is successfully adapted to Indonesia and rolled out far beyond MYCNSIA target areas through GOI and dev partners - NA (no apparent linkages with other countries)	
Expected Result # 2 - Capacity Development of Decision-Makers & Nutritionist Communities with - Enhanced capacities at all levels (community, district, and central) to address maternal and child undernutrition - In collaboration with selected regional/national institutions - To create a strong nutrition community network.	- Yes, notably at central, provincial and district level regarding the implementation of the IYCF strategy; need for multi-sectoral action - Yes, substantial at district level and below thanks to capacity building in combination with improvement of Posyandu services, facilitated by an enabling environment - Little collaboration with institutions due to insufficient in-country nutrition capacity at institutional level. Instead: successful focus on masters TOT for staff within the health system - MYCNSIA has connected with other sectors at policy level (notably in their support role for SUN accession and introduction) - CHW trained; and follow up through Supportive Supervision	
Expected Result #3 - Data Analysis & Knowledge Sharing with - Strengthened information systems, - Data collection & analysis, and - Mechanisms for knowledge sharing and management established	- Inclusion of EBF, IFA/MMN in HMIS, successful introduction of new SIMPUS software to support nutrition services at health facility level - Opportunities were seized to develop and release essential information in support of MYCNSIA interventions and goals. - MYCNSIA has systematically documented progress by pillar and is in the process to document successful models - MYCNSIA allowed UNICEF to play role of lead advisor to GOI in accession to SUN and development of platform and framework - UN Nutrition working group and the Donor and UN Country Network on Nutrition (DUNCNN) were established - Bottlenecks are discussed with GOI in the six monthly Country Programme review meetings	
Expected Result #4 - Scaling Up Interventions Direct improved infant, child and women's nutrition	- Reduced stunting achieved in MYCNSIA districts but unclear results for anaemia - Impressive roll out of IYCF package beyond MYCNSIA districts - Successful advocacy to mobilise decentralized funding for nutrition - Successful models developed for nutrition sensitive social protection programmes, opportunities for WASH linkages identified and CMAM pilot underway (hampered by delays around MOH procurement of RUTF) - Decentralised budgets were allocated for MNP but recent challenges in procurement negatively impact on coverage - Mainstreaming of 1,000 days, stunting and the multisectoral approach culminated in the FNAPs in most target districts	

Overall conclusions Lao PDR

Overall Objective		
To improve child survival, growth and development through life cycle and nutrition security interventions in Asia contributing to the achievement of MDGs 1, 4, 5 and 8 targets related to nutrition		
Impact indicators logframe	Baseline data 2012	Endline data 2015
- Reduction in stunting (target: stunting among children aged 0–3 years reduced by 5 percentage points from baseline) - Reduction in anaemia (target: by 15 per cent from baseline) - pregnant women - children aged 6–35 months	Stunting Saravane 54,4% Sekong 62,7% Attapeu 39,7% Reduction anaemia pregnant women Saravane 40,8% Sekong 9,6% Attapeu 39,7% Reduction anaemia children aged 6–35 months Saravane 45,4% Sekong 30,9% Attapeu 44,2%	Endline not yet available
Expected results as in logframe	Conclusions	
Expected Result # 1 - Upstream Policy and Nutrition Security Awareness with - Coherent and appropriate goals, targets, policies, strategies, guidelines / protocols and tools - Adopted / revised by regional institutions and their member states.	- UNICEF contributed to the overall improvement of nutrition governance through its continued effort to put nutrition on the national agenda of the Government; - The contribution was significant to the development of the Multi-sectoral Food and Nutrition Security Action Plan 2015–2020 and the accompanying Common Results Framework and Monitoring Framework; - The National Guidelines for IYCF have – after some delays – were adopted by the Government and form a basis for its further introduction; - Through clear advocacy efforts funding for nutrition supplies was increasingly incorporated in the national budget.	
Expected Result # 2 - Capacity Development of Decision-Makers and Nutritionist Communities with - Enhanced capacities at all levels (community, district, and central) to address maternal and child undernutrition - In collaboration with selected regional/national institutions - To create a strong nutrition community network.	- UNICEF contributed to improved capacity on a wide number of relevant interventions at the various levels related to EBF, IYCF, WASH and MNPs. However, a systematic assessment of the enhanced capacity was not done; - UNICEF is working closely with and providing technical assistance to the National Nutrition Centre (NNC). The capacity of NNC to accomplish its tasks and duties has improved greatly but it still needs support in the years to come; - The Country Office and the EU Delegation were recognized by the Government and FSN Development Partners as the lead and co-convening partners of the Development Partners Nutrition Group.	
Expected Result #3 - Data Analysis and Knowledge Sharing with - Strengthened information systems - Data collection and analysis - Mechanisms for knowledge sharing and management established	- In terms of strengthening nutrition in the HMIS not much progress was realized; - With support from UNICEF the M&E Framework of the Multi-sectoral Food and Nutrition Security Action Plan 2015–2020 was developed; - Unfortunately and despite early preparations by UNICEF, the MYCNSIA endline was postponed till the end of the year 2015.	
Expected Result #4 - Scaling Up Interventions Direct improved infant, child and women's nutrition	- UNICEF introduced in a coordinated way an important package of nutrition-relevant messages concerning IYCF/ WASH and MNPs. - The introduction of CMAM made it possible to identify and treat acutely malnourished children in a comprehensive way; however, SAM cases are not being treated in the community but are referred to the Health Centres.	

Overall conclusions Nepal

Overall Objective	OVI
Overall objective To improve child survival, growth and development through life cycle and nutrition security interventions in Asia contributing to the achievement of MDGs 1, 4, 5 and 8 targets related to nutrition	- Reduction in stunting (target: stunting among children aged 0–3 years reduced by 5 percentage points from baseline) - n.a. (baseline survey: Achham: 46.6% Kapilvastu: 38.9%)
	- Reduction in anaemia (target: by 15 per cent from baseline) - pregnant women - children aged 6–35 months - n.a (no baseline) - n.a. (baseline survey: Achham: 32.5% Kapilvastu: 48.7%)
Results	Conclusions
Expected Result # 1 - Upstream Policy and Nutrition Security Awareness with - Coherent and appropriate goals, targets, policies, strategies, guidelines / protocols and tools - Adopted / revised by regional institutions and their Member States.	- Substantial contribution to ‘mainstreaming nutrition’, not only in the health sector but also in other sectors including agriculture, education and social protection. Improving nutritional outcomes for women and children is the new norm for nutrition programming. - An array of new or revised policies, plans and guidelines was produced including updated guidelines on IYCF, IMAM and anaemia control which addresses nutrition in a multi-sectoral manner. - M&E frameworks for six different sectors are being/have been aligned towards one common impact indicator: improved MIYC nutritional status.
Expected Result # 2 - Capacity Development of Decision-Makers and Nutritionist Communities with - Enhanced capacities at all levels (community, district, and central) to address maternal and child undernutrition - In collaboration with selected regional/national institutions - To create a strong nutrition community network.	- At the central level (Ministries and NPC) and the district level notably on the implementation of the MSNP, including measuring progress with the newly developed M&E; - Substantial capacity building at the district level and below in combination with system strengthening including resource development and management, facilitated by an enabling policy environment; - Collaboration with some private organizations, the Government and NGOs, but little collaboration with academic/learning institutions due to insufficient in-country nutrition capacity. Instead: master ToT for staff within the Government (conducive for ownership). - Ministry of Health and Population to establish soon a National Nutrition Centre, thanks to (among others) MYCNSIA/ World Bank documented nutrition capacity assessment cum advocacy - Good connection with other sectors at policy level (including implementation of the MSNP); better linkage between nutrition specific and nutrition sensitive interventions at district level is needed to further strengthen pillar 4 models.
Expected Result #3 - Data Analysis and Knowledge Sharing with - Strengthened information systems - Data collection and analysis - Mechanisms for knowledge sharing and management established	- Impressive progress within the health system; new HMIS established and functioning within 2 years. - Web-based data collection is enabling designated HMIS staff (including District Health Offices and HMIS staff at the Ministry of Health and Population) to provide timely feedback and analyse data. Trends are compiled. - Systematic documentation of what works and what does not regarding pillar 4 interventions. - At the field level the review meetings/ workshops function as platforms for mutual learning, performance improvement and expanding/ institutionalizing high impact nutrition interventions. - Timing (two years after start of MYCNSIA) and design of the baseline survey were unsuitable to demonstrate impact on stunting/ anaemia.
Expected Result #4 - Scaling Up Interventions Direct improved infant, child and women's nutrition	- Demonstrating evidence-based impact resulted in roll out of integrated IYCF programme that included IMAM (from 5 to 11 districts) and MNP-IYCF (from 6 to 15 districts). - Budget increases from the Government and donors for sustained scaling up of the MSNP and nutrition interventions across the country. - Implementation of MSNP at district and VDC level facilitated multi-sectoral linkages and collaboration (but impact yet to be demonstrated). - Excellent quality of IMAM, but met needs are not monitored and overall effectiveness remains to be demonstrated - Challenges in procurement of MNP negatively impacted coverage.

Overall conclusions Philippines

Overall Objective		
To improve child survival, growth and development through life cycle and nutrition security interventions in Asia contributing to the achievement of MDGs 1, 4, 5 and 8 targets related to nutrition		
Impact Indicators	Baseline data 2012	Endline data 2015
- Reduction in stunting (target: stunting among children aged 0–3 years reduced by 5 percentage points from baseline) - Reduction in anaemia (target: by 15 per cent from baseline) - pregnant women - children aged 6–35 months	Stunting: Region V 31.3% Region VI 35.8% Region IX 35.9% Baseline data on anaemia cannot be compared with endline data (see 2.5.2. and 2.8 Impact)	Stunting: Region V 29.3% Region VI 33.2% Region IX 29.1% Baseline data on anaemia cannot be compared with endline data (see 2.5.2. and 2.8 Impact)
Expected results as in logframe	Conclusions Philippines	
Expected Result # 1 - Upstream Policy and Nutrition Security Awareness with - Coherent and appropriate goals, targets, policies, strategies, guidelines / protocols and tools - Adopted / revised by regional institutions and their Member States.	- Policy development activities to get nutrition security on the political agenda led to modest results: UNICEF contributed to and advocated SUN membership in the Philippines and to the review of the Philippine Plan of Action for Nutrition. - UNICEF was not able to contribute to the Food Fortification Law review - The substantial contribution to advocating EBF enhanced support at the national level and led to the formulation of local ordinances.	
Expected Result # 2 - Capacity Development of Decision-Makers and Nutritionist Communities with - Enhanced capacities at all levels (community, district, and central) to address maternal and child undernutrition - In collaboration with selected regional/national institutions - To create a strong nutrition community network.	- The application of the ToT approach for the IYCF training of large numbers of health and nutrition staff has been implemented in all regions but has not been followed by an assessment of the results and application of the acquired knowledge. - The same applies for the training for Local Nutrition Action Planning where the number of plans has been reported but not the quality of the produced plans. - The training in the context of the ILO- Nutrition Security and Maternal Protection programme has been implemented as planned. - The expected capacity building for the introduction of a new rice food fortification has not materialized	
Expected Result #3 - Data Analysis and Knowledge Sharing with - Strengthened information systems - Data collection and analysis - Mechanisms for knowledge sharing and management established	- UNICEF has provided technical assistance to the introduction of standard FSN indicators in routine data collection systems at field level (FSHIS). - The implementation of the endline has been done in 2015 but due to some methodological differences between the baseline and endline data collection not all data including the impact indicators for anaemia or some IYCF practices, can be compared - Knowledge sharing has not systematically taken place whereas there has been scope for documentation of good practices	
Expected Result #4 - Scaling Up Interventions Direct improved infant, child and women's nutrition	- In the Philippines UNICEF has worked on a wide range of Scaling up activities for improved nutrition security, but with mixed success. - R4.1 The use of i-Rice which was targeted at 80% at the end of the project was not a success as the programme was stopped mid-2013 - R4.2/ R4.3 The distribution of MNPs and IFA has been partially successful with respectively 10% and 37.6%, well below the specific targets (of 60% and 80%) - R4.4 (counselling of caregivers; target 80%) has been achieved with 83,9% of mothers and 81% of pregnant women) reported to have been counselled. - R4.5 Peer support groups have not been established; the approach of IYCF counselling has continued to be individual through midwives and BHW/ BNSs	

Annex A4

Recommendations for further programming (regions; countries)

The regional analysis

Relevance and Appropriateness

(2.3.3) UNICEF's use of in-house intersectoral expertise in WASH; health; education; nutrition; ECD and social protection – should be exploited and manifest in the design and M&E framework of future programmes; such programmes should include nutrition outcome indicators.

(2.4.1 and 2.6.2) Future programmes should build on and add value to existing support functions of Regional Offices towards countries. This should entail among others:

(i) capacity building including training of (Master) ToT in multi-sectoral nutrition programming and nutrition sensitive programming in WASH, child protection/cash grants and education.

(ii) the development of common advocacy/ communication plans and tools in support of nutrition and support for fine-tuning at (MYCNSIA II) country level.

(2.5.2) Because the Regional Offices (and by default any regional component) as “hubs of information” are well positioned to ensure mutual learning during programme implementation, mechanisms for the timely exchange of information and experiences should be built in and costed up front.

Equity

(2.2.1) Programming for equity ought to be made more explicit in the design and M&E framework of future programmes. The latter should include an appropriately disaggregated data collection system and include effective coverage for both monitoring and evaluation (including baseline and endline surveys).

Efficiency

(2.7.2) Future programmes should include a clear description of the role and function of the PMU which clarifies (among others) how programme management structures enhance the operational efficiency of the programme.

Broader effects and sustainability

(2.4.2 and 2.4.1 and 2.8.1) UNICEF Regional Offices should strengthen South-South collaboration by:

- (i) assessing which opportunities exist to exploit synergies between countries on nutrition capacity development; and
- (ii) investing more in regional networks of national and regional academic and research institutions.

(2.6.2 and 2.8.2) Documenting what ‘works’ (and what does not) and disseminating lessons should not be restricted to the end of the programme but should be documented on an ongoing basis using a standard format and new media for timely and interactive exchange; together with ROSA, the Nepal Country Office should explore how this is best done and, if need be, incorporate funds to this end in a MYCNSIA II budget.

Bangladesh

Relevance

(2.3.3) Should there be a MYCNSIA successor then UNICEF's extra-ordinary and intersectoral country-wide expertise – WASH; health; nutrition; ECD and social protection – ought to be leveraged.

(2.5.2) Programmes such as UNICEF/ MYCNSIA should be designed to be and remain adaptive and should support Government agencies in seeking the best possible answers to ‘new’ knowledge.

(2.6.2 and 2.9.2) A next step could be to assess each and every DNI in the DNI kit for its complementarity with nutrition sensitive behaviour change communication messages, and vice versa. Preferably this would go hand in hand with cooperation with projects such as SPRING, which are well positioned to execute and support the nutrition sensitive dimensions of the DNI kit. Since such projects tend to cover only small parts of the country cooperation with several such projects should be foreseen.

Equity

(2.2.2) To work towards, and report on, effective coverage as a precondition for a country to achieve both more equitable results and improved coverage of its nutrition interventions.

(2.2.2 + Outcome and impact data) For a future programme's emphasis: Use of undernutrition as an equitable and fair selection criterion both for targeting deserving population groups in social protection schemes and in measuring the schemes' results – as is already happening in schemes in Bangladesh (and Indonesia).

(2.2.2) For a future programme's emphasis: To use the MoRES equity approach as one of the possible links between nutrition specific and nutrition sensitive programmes, by adhering to the categorization used both in MoRES and by the Ministry of Food, namely: availability; access; utilization. (MoRES goes even further by specifying utilization to next levels, of adequate and effective coverage. See footnote 60.)

Operational efficiency

(2.7.1) The Programme's favourable cost-effectiveness ought to be established in terms that appeal to Government decision makers and funding agencies for scaling up.

(2.7.1) UNICEF's strength in setting norms and standards (such as the DNI package) should be used to inform locally-suited (and affordable) adaptations thereof, which conceivably include nutrition sensitive linkages.

(2.7.1 + 2.7.2) UNICEF should take part in the discourse of resource generation for nutrition and in doing so establish a more prominent place for nutrition specific interventions. The current divide between nutrition specific and nutrition sensitive endeavours should be exposed as somewhat artificial as is also shown in the DNI package which in fact combines the two.

Impact

(2.3.4; 2.6.1; 2.8.1; 2.8.3) UNICEF should better exploit its strength and comparative advantages in supporting institutional health sector reforms as is currently demonstrated in the progressive inclusion of nutrition in the health sector. (This comparative advantage distinguishes UNICEF from typical projects.)

(2.8.2) UNICEF should do far more than has happened thus far with the wealth of data generated in the baseline/endline surveys. The most salient potential use is in:

- Establishing differences in terms of equity/effective coverage between the upazilas;
- In a selection of upazila data establish how the basic causes, the underlying causes and the immediate causes of undernutrition have apparently reinforced each other
- Use the above to profile 'success stories' like Lohagara upazila in much the same way as was done in the Global Nutrition Report for Maharashtra State in India but add the equity/effective coverage perspective.

(2.8.2) Based on the above, and in concurrence with it, UNICEF should explore the possibility, or even desirability, of using undernutrition as an equitable and fair selection criterion both for targeting deserving population groups in social protection schemes and in measuring the schemes' results. This then could become an advocacy item for prolongation of such schemes.

Sustainability

(2.9.2) UNICEF should together with appropriate authorities advocate meaningful Common Results Framework (CRF) indicators that are based on MYCNSIA experience. A good one would be GoB's effective commitment to take over procurement of nutrition-relevant supplies. UNICEF's own role as a back-up agency where GoB for one reason or another cannot deliver merits a case study. (Note this is relevant for multiple MYCNSIA countries).

(2.9.2) UNICEF to design and undertake a phase 3 project which addresses effective coverage of DNIs, by linking up with nutrition sensitive endeavours, without, however, sacrificing on cost-effectiveness and sustainability.

(2.9.2) If UNICEF has to operate within an (EU) project frame it should heed the MYCNSIA lessons. One lesson is that lessons are effectively learned, on time.

Indonesia

Relevance

(2.5.2) A certain flexibility is needed for effective and efficient implementation that enables the team to seize opportunities. In a four year programme a description of roles or action areas may work better than detailed outputs and activities.

(2.8) Future advocacy efforts should continue to include institutional monitoring and enforcement of the BMS code which requires continuous vigilance by UNICEF and GOI.

(2.3) The PLA experience should be revisited in view of the

"Village Law" which will substantially increase decentralized budgets thus opening opportunities for nutrition specific and nutrition sensitive interventions.

(2.4.1) It is important to look again at the recommendations of the capacity assessment in 2013 and implement those which have a high potential to develop necessary capacities on nutrition to address the high burden and prevalence of all forms of malnutrition.

(2.4.2) UNICEF is well positioned to develop further linkages between nutrition specific interventions and (nutrition sensitive) agriculture which enables reaching out to a large percentage of the disadvantaged Indonesian population. The impact of the IYCF training for agricultural extension workers should be well-analysed and compared with related interventions in the country (e.g. current SNV project on nutrition sensitive agriculture) for documentation to enable wider scaling up.

(2.4.2) Sensitization of both management/board and teachers in training institutes for midwives, as well as relevant professional associations is required for adequate integration of IYCF and BMS code in the curriculum.

(2.5.2) Future interventions should focus more on WASH-nutrition linkages which is likely to reduce stunting in the geographical areas identified by UNICEF/MYCNSIA mapping exercise.

Equity

(2.1.2) It is worthwhile to team up with large scale or national social protection programmes to provide nutrition services as it enables reaching a large percentage of the most relevant target group.

(2.6) To further study the use of stunting both as a composite indicator of well-being for updating and improving PKH beneficiary lists and for measuring impact.

Operational Efficiency

(2.7.1) Multi-sectoral teams in UNICEF (health, nutrition, WASH, ECD, social protection) at the national and sub-national level need to be structurally integrated to enhance nutrition sensitive efforts.

Impact

(2.8) Baseline and endline surveys should aim for sufficient sample size to allow comparison between districts to enable evidence based learning and should therefore collect data in similar non-intervention areas.

(2.3.2) To ensure impact of MYCNSIA's intensive support to the development of the SUN framework UNICEF should continue their support as lead advisor to GOI in nutrition.

(2.6) Advocate with MoH/GOI to change the target age group and treatment regimen for MNPs.

(2.9.2) Analyse impact and document the high potential integration of nutrition in the two social protection programmes to inform countries in the region and support future scaling up

Lao PDR

1. Nutrition Policy Framework is still to be further developed or strengthened. Based on its position as a lead nutrition advisor to the Government, UNICEF could provide further technical support.
2. In a programme with a strong Capacity Development focus there should be much more attention to the monitoring of outcomes of capacity enhancement. Regular follow-up and refresher courses should be part of Capacity Development in order to assure sustainability of the effort.
3. It is important to continue support to the NNC for some years to come in order to strengthen their capacity to fulfil their mandate
4. Appropriate coordination with national authorities and other Development Partners in the field of nutrition should take place with regard to the type of supplementation, their logistics and the financing of these items.
5. With respect to vulnerable and poorer groups – in particular the ethnic minorities – it is important to respond to their specific livelihood needs and requirements, to understand better the barriers and bottlenecks to reach out to these groups and to monitor closely their nutrition outcomes.
6. There is a need to assure that relevant nutrition interventions such as CMAM and EBF promotion are mainstreamed so that they remain a central focus of health centre staff during outreach.

Nepal

Relevance

(2.2.1 and 2.7.1) A MYCNSIA follow-up should be designed to be and remain adaptive and seize opportunities for developing models and generate 'new' knowledge along the relevant pillars in a synergistic manner.

(2.1.2) In a MYCNSIA successor linkages with agriculture and food security should be strengthened and activities to this end clearly spelled out.

(2.3.3) In addition UNICEF's exploitation of in-house available intersectoral expertise – WASH; health; education; nutrition; ECD and social protection – should be manifest in the design and M&E framework including nutrition outcome indicators.

Equity

(2.2.2) Programming for equity ought to be made more explicit in the design and M&E framework (which should consist of an appropriately disaggregated data collection system and include effective coverage).

(2.2.1 and 2.5.2) Consider to incorporate in a MYCNSIA successor a (follow-up) pilot for a child cash-grant cum nutrition component based on recommendations of the Karnali endline evaluation.

Operational efficiency

(2.7.1) The programme's favourable cost-effectiveness due to timely results (far more in scope and volume than planned) should be used to (continue) to leverage funds (even if these don't appear in the MYCNSIA budget) to implement

complementary activities in MYCNSIA II districts and scale up interventions in non MYCNSIA (II) districts if need be.

Impact

(2.8.1) UNICEF Nepal can and should do much better in collecting district level baseline (before the start of the programme) and endline (during the last trimester of the programme) data; data collection should not only include outcome and impact indicators but also process indicators; UNICEF may wish to consider to carry out nutrition surveys (annually) or midline surveys in between

(2.6.2 and 2.8.2) Documenting what works and not and disseminating lessons should not be restricted to the end of the programme but be documented on an ongoing basis using a standard format and the new media for timely and interactive exchange; together with ROSA the Nepal CO should explore how this is best done and, if need be, incorporate funds to this end in a MYCNSIA II budget.

(2.5.3 and 2.6.2). Any follow up programme should (continue to) include an inbuilt design to demonstrate evidence-based models for scaling up. The budget should reflect that a one time off evaluation/ assessment is insufficient and additional funding is needed to generate practical, context relevant and specific information to facilitate implementation.

Sustainability

(2.9.1 and 2.9.2) UNICEF NCO should consider to document successful approaches for sustaining results including:

- Building ownership through a capacity-building approach which is broad in scope and targeting (all levels through a cascade approach), yet limited in duration.
- Leveraging funds from the GoN by advocating with local governments to allocate funds for the implementation of evidence-based successful pillar 4 interventions (IYCF/ MNP, CMAM) or the central GoN for the release of block-funding for activities at district level (the Ministry of Federal Affairs and Local Development for the implementation of the MSNP).

Philippines

1. UNICEF could consider to develop together with the National Nutrition Council a joint agenda for priorities of strengthening the Nutrition Policy Framework in particular in the context of the SUN membership of the Philippines. The role of UNICEF would be confined to providing technical support and advocacy.

2. In a programme with a strong Capacity Development focus there should be much more attention to the monitoring of outcomes of capacity enhancement at the local level. Regular follow-up to the ToT and refresher courses should be part of Capacity Development in order to assure sustainability of the effort.

3. It is important to continue support to the regional and municipal health offices to strengthen the process of to the formulation and implementation of Local Nutrition Action Plans. The simple method of local monitoring (EWS or LQAS) should be further mainstreamed in order to enhance awareness with municipal authorities.

4. Appropriate coordination with provincial and municipality authorities and the National Nutrition Council in the field of nutrition should take place with regard to the type of supplementation (MNP/ IFA), their logistics and the financing of these items. An inventory should be made of the financing, processes, decision-making and bottlenecks of supply should be made in order to streamline logistics.
5. Given the fact that the use of MNPs is still relatively low, there should be looked into the specific bottlenecks for further expansion of this programme.
6. With regard to IYCF counselling there should be more emphasis to the role of midwives in the transfer of knowledges as not all important key messages are being transferred to pregnant women and mothers.
7. The programme of EBF in the workplace (ILO-Nutrition Security and Maternal Protection) should be further elaborated and scaled up through the participating partners.
8. There should be a thorough analysis of the methodological differences between the baseline and endline approach in order to understand some of the inconsistencies observed.
9. A study should be commissioned about the reduction in anaemia and its causes as observed in the period 1998–2013 in particular the sharp decline since 2008. Methodological issues should be taken into consideration as well.
10. Given the fact that the Philippines is one of the countries in the region with the highest caseload of number of stunted children (together with Indonesia) UNICEF CO should pursue future funding for nutrition security in a regional context.

ENDNOTES

1. The Lancet, 2008, Maternal and Child Undernutrition. Available at: <http://www.thelancet.com/series/maternal-and-child-under-nutrition>.
2. DAC criteria are relevance, efficiency, effectiveness, impact and sustainability. See: <http://www.oecd.org/dev/development/evaluationofdevelopmentprogrammes/dcdndep/41612905.pdf>.
3. UNICEF ROSA has a long-term agreement with Universalia – a management consulting firm that helps UNICEF with the peer review processes, programme evaluations and helps to improve programme performance. Universalia specializes in monitoring and evaluation, strategic management, results based management, institutional and organizational performance assessment, capacity building and programme management.
4. One example: <http://www.ids.ac.uk/publication/mqsun-inception-report-and-design-document-impact-evaluation-of-the-dfid-programme-to-accelerate-improved-nutrition-for-the-extreme-poor-in-bangladesh-phase-ii>, Figure 3.1.
5. UNICEF, 2010, UNICEF-Adapted UNEG Evaluation Reports Standards. Available at: http://www.UNICEF.org/evaluation/files/UNEG_UNICEF_Eval_Report_Standards.pdf.
6. EuropeAid, 2011. Addressing undernutrition in external assistance, and integrated approach through sectors and aid modalities, Tools and Methods Series, Reference Document No. 13, Brussels, Sep.
7. Nutrition is also related to MDG 2 (Universal primary education), MDG 3 (Gender equality and empowerment of women) and MDG 6 (Combat HIV/AIDS, malaria and other diseases).
8. EU, 2013, Enhancing Maternal and Child Nutrition in External Assistance: an EU Policy Framework, Communication from the Commission to the European Parliament and the Council, SWD (2013) 72 final, Brussels, Mar. Available at: http://ec.europa.eu/europeaid/documents/enhancing_maternal-child_nutrition_in_external_assistance_en.pdf.
9. <http://capacity4dev.ec.europa.eu/t-and-m-series/blog/reference-document-nr-13-%E2%80%93-addressing-undernutrition-external-assistance-%E2%80%93-integrated-approach>.
10. https://ec.europa.eu/europeaid/sites/devco/files/action-plan-nutrition-2015_en.pdf
11. Global Nutrition Report, 2014, Nutrition Country Profile Bangladesh.
12. Global Nutrition Report, 2014, Nutrition Country Profile Nepal.
13. Bangladesh DHS, 2014; India NHFS, 2005–2006; Maldives DHS, 2009; Pakistan DHS, 2012–2013; Nepal DHS, 2011; Timor Leste DHS, 2009–2010; USAID, 2010, Nutrition Update; and UNICEF, 2014, Approach to Nutrition Programming in the Southeast Asia and Pacific Region 2014–2025, Vol. 2.
14. Global Nutrition Reports, 2014, Country Profiles.
15. The ten current members of ASEAN are Brunei Darusalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Viet Nam.
16. The eight current members of SAARC are Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka.
17. A&T, 2014, Getting strategic with interpersonal communication to improve feeding practices. Available from: <http://alive-andthrive.org/wp-content/uploads/2014/11/Getting-strategic-with-IPC-Bangladesh-June-2014.pdf>.
18. Improving Nutrition Security in Asia: An EU-UNICEF Joint Action. Available at http://www.unicef.org/eu/files/EU-UNICEF_Nutrition_security_in_Asia.pdf.
19. Improving nutrition security in Asia; An EU-UNICEF Joint Action. Available at: http://www.unicef.org/eu/files/EU-UNICEF_Nutrition_security_in_Asia.pdf.
20. See Progress Report 2014, Annex 7. Indonesia output 2.3: Improved technical capacity of province/district on planning, management and monitoring of nutrition programme. Output was removed in 2014 due to exclusion of 'other donors' from the joint action.
21. For a recent reference see <http://www.developmenthorizons.com/2015/07/guest-blog-from-stuart-gillespie-from.html>. See also Maharashtra's Extraordinary Stunting Declines: What Is Driving Them? Findings of a Multidisciplinary Analysis. Available at http://globalnutritionreport.org/files/2014/11/gnr14_pn4g_02haddad.pdf.
22. The 2014 report says: "The intention of upstream work is to strengthen government systems within countries to deliver essential nutrition interventions effectively and at scale. In 2014, the tools for documenting upstream work were being finalized, and data collection will start by mid-March 2015, with case studies expected to be ready for broad circulation by the end of 2015."
23. The ANSP programme was interested in having these aspects reviewed in their final evaluation.
24. It is quite likely that there has been a serious flaw in the 2011 anaemia data collection. The sharp decrease in 2013 also cannot be explained. The National Nutrition Survey 2013 was implemented by the same organization.
25. SURCH, 2015, Endline Assessment Report on Nutritional Status and Related Key Indicators among Women and Under-three Children of MYCNSIA Interventions in Selected Rural Sub-Districts of Bangladesh. Annex 4: List of social and other programmes likely to be operating in programme areas to be assessed.
26. SPRING, 2015. In 2014: Suaahara/USAID \$46 million; G1000D/WB \$42 million; and AFSP \$46 million.
27. The SAARC Action Framework for Nutrition was developed by the SAARC secretariat with technical support from UNICEF ROSA.
28. See http://m.wfp.org/sites/default/files/Factsheet_Nutrition_Mar2015.pdf.
29. Caroline Fitzwarryne, Independent Review of PKH-Prestasi Program Pilot. Draft, June 2014.
30. The debate has meanwhile if anything become more heated. See <http://www.thedailystar.net/op-ed/misleading-parents-managing-child-malnutrition-98095>.
31. See <http://www.babymilkaction.org/archives/489>.
32. South East Asia Policy Advocacy Plan; Positioning Breastfeeding as a 21st Century Agenda in Southeast Asia. Bangkok, 2014.

