INCEPTION REPORT

UNICEF UGANDA END OF PROJECT EVALUATION ENHANCED RESILIENCE KARAMOJA PROGRAM

Report Provided to UNICEF by GHLiaisons
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Acronyms

CUAMM	Collegio Universitario Aspiranti Medici Missionari
DNCC	District Nutrition Coordination Committee
DHO	District Health Officer
DHT	District Health Team
CMAM	Community Management of Acute Malnutrition
DHS	Demographic and Health Survey
DRR	Disaster Risk Reduction
FAO	Food and Agriculture Organization
FHD	Family Health Day
FGD	Focus Group Discussion
FSNA	Food Security and Nutrition Security Assessment
GAM	Global Acute Malnutrition
GoU	Government of Uganda
HC	Health Centre
HH	Household
HMIS	Health Management Information System
IMAM	Integrated Management of Acute Malnutrition
IGAD	Intergovernmental Authority on Development
IPF	Inpatient Facilities
IP	Implementing Partner
ITC	Inpatient Therapeutic Centre
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
MNP	Micronutrient Powders
NFNP	National Food and Nutrition Policy
NGO	Non-Governmental Organization
OTCs	Outpatient Therapeutic Centers
SAM	Severe Acute Malnutrition
UMoH	Uganda Ministry of Health
UDHS	Uganda Demographic and Health Survey
UNAP	Uganda Nutrition Action Plan
UNICEF	United Nations Children's Fund
VFM	Value for Money
VHT	Village Health Teams
WASH	Water Sanitation and Hygiene
WFP	World Food Program
WHO	World Health Organizations

EXECUTIVE SUMMARY

Background
Despite investments in improving security and infrastructure, the Karamoja sub-region of Uganda remains highly volatile in terms of maternal and child nutrition, food security and human development. Causal factors of malnutrition are multiple, ranging from sub-optimal dietary intake, poor knowledge, poor child rearing practices to frequent illness, limited access to health, food insecurity and widespread poverty, all of which have been exacerbated by successive climate and weather irregularities. In a bid to reduce vulnerability and help communities to cope with the effects of climate change and levels of acute malnutrition, DFID supported the Enhanced Resilience Karamoja Program (ERKP). The program has been collaboratively implemented by UNICEF, FAO and WFP since November 2013 to date. In order to guide future programing, an end term evaluation of the UNICEF supported components of the broader ERKP shall be conducted with a goal of understanding the effectiveness and impact of UNICEF's work for the period November 2013 to December 2015.

Objectives
Specifically, the evaluation will:
1. Assess program relevance, appropriateness, efficiency and quality of services
2. Assess program effectiveness, sustainability and equity
3. Document evidence based lessons, good practices and recommendations

Methodology
The evaluation shall be conducted within the seven districts of Karamoja sub-region, namely Abim, Kaabong, Kotido, Moroto, Nakapiripirit, Napak and Amudat districts. A cross-sectional study design with purposive and random sampling of evaluation sites shall be used. Both quantitative and qualitative data shall be collected. Quantitative data collection shall comprise of semi-structure interviews and data abstraction whilst qualitative data shall include a desk review, key informant interviews, focus group discussions as well as unobtrusive observations.

Descriptive quantitative analysis will be conducted to assess changes in the district-level nutritional outcomes. Results will be presented graphically in tables, figures and charts. Two methodologies namely Multi -Criteria Analysis (MCA) and Cost Benefit Analysis (CBA will be explored to demonstrate which interventions have highest value for money (VfM). Value for money analysis will be undertaken in order to assess cost per child and cost per trainees. Qualitative analysis will involve cross checking primary and secondary data sources for methodological triangulation as well as stakeholder mapping so as to increase validity and enhance understanding of the ERKP nutrition components and of linkages and gaps between different nutrition programmes operating in the region. Results will be presented in text form and process flowcharts where relevant.

Findings shall be documented in a final evaluation report, policy brief as well as PowerPoint presentation.

1.0 INTRODUCTION

1.1 Background

Evidence suggests that drought is becoming increasingly frequent in some parts of Uganda, resulting in progressive depletion of livelihood assets, human suffering, decreased productivity and reduced access to learning and health opportunities, particularly for children and women, who are forced to struggle for survival. The frequent occurrence of drought has also become a major contributory factor to worsening food insecurity[1] which in turn has increased the vulnerability of people living in areas prone to drought and inadequate nutrition[2]. Due to drought, the North Eastern part of the country faces the highest levels of food insecurity due in part to low levels of household income, low agricultural production and unique climate challenges (6 months of dry season & 6 months of rainy season)[3]. These factors impact nutrition intake.

Good nutrition is essential to health and human development. Poor nutrition increases the chances of anemia, reduced immunity, and impaired physical and mental development.[4] According to the 2011 Uganda Demographic and Health Survey (UDHS)[5], 33 percent of the children under 5 years are chronically malnourished, 5 percent acutely malnourished and 14 percent underweight. This figure represents an improvement from 38.1 percent as reported in the 2006 Uganda Demographic and Health Survey[6]. Though the rates of undernutrition in Uganda have declined, Karamoja region still has the highest rates of child stunting at 45 percent (UDHS, 2011), SAM (2.6 percent) and GAM (7.1 percent) in the country[7]. According to a Food Security and Nutrition Assessment conducted in Karamoja in 2015, GAM rates were at their highest since 2010.

The DFID supported Enhanced Resilience Karamoja Program (ERKP) is aimed at "closing the gap" between short-term humanitarian response efforts and longer long-term investment for sustainable development by increasing the resilience of targeted communities in the Karamoja region to climate extremes and weather events. It aims at reducing vulnerability by engaging in preventative action for malnutrition and illnesses, providing effective and scaled package of high impact nutrition interventions (including, treatment for acute malnutrition and strengthening the management and adaptive capacities of systems and communities to anticipate) which will help communities to withstand and bounce back from shocks. The ERKP also aims at complementing and expanding upon previous on existing initiatives and accelerating what is done by government and partners in the field of nutrition while reinforcing linkages with efforts in health, water, and sanitation and food security.

1 Kisamba-Mugerwa, W. (2001) Rangelands Management Policy in Uganda: A paper prepared for the International Conference on Policy and Institutional Options for the Management of Rangelands in dry areas

2 Twinomugisha, Ben (2005). A content analysis report on climate change impacts, vulnerabilities and adaptation in Uganda. CLACC-Fellow DENIVA-Uganda, March 2005

3 Pomeroy, Amanda, Alexis D'Agostino. 2014. Snapshots of Nutrition in Uganda: 2014 Compendium. Arlington, VA. USAID/Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) Project.

4 AUC, NEPAD, UNECA, UNWFP. The Cost of Hunger in Uganda. Implications on National Development and Prosperity. UNECA, 2014

5 UBOS and ICF International Inc. 2012. Uganda Demographic and Health Survey 2011. Kampala, Uganda: UBOS and Calverton, Maryland: ICF International Inc.

6 UBOS and Macro International Inc. 2007. Uganda Demographic and Health Survey 2006. Calverton, Maryland, USA: UBOS and Macro International Inc.

7 Namugumya, Brenda; Sethuraman, Kavita; Sommerfelt, A. Elisabeth; Oot, Lesley; Kovach, Tara; and Musiimenta, Boaz. 2014. Reducing Malnutrition in Uganda: Estimates to Support Nutrition Advocacy – Uganda PROFILES 2013

At the country level, UNICEF is engaged with UN sister agencies (primarily WFP and FAO) in implementing the ERKP since November 2013 to date. This cooperative effort builds on the shared understanding of the local context and includes the following three pillars:

- Strengthening productive sectors: household level, livelihoods, market access
- Improving basic social services; and
- Establishing/strengthening predictable safety nets, including through social transfers (food, or cash), to address the most vulnerable people's basic needs

Traditionally, both the Government of Uganda (GoU) and donor community has strictly separated emergency response and development programming. As a result, preparedness and recovery from emergency situations has sometimes received little attention leaving a vital gap. The focus on resilience provides a framework for DFID to work with development partners and the Government of Uganda (GoU) to support a substantive shift away from emergency food relief, towards interventions that improve livelihoods in the medium-to-long-term while protecting the most vulnerable in the short-to-medium-term.

Specific to UNICEF, the four key ERKP objectives were to:

1. Increase access to high impact nutrition interventions for mothers and children
2. Improve coordination and partners' interaction for nutrition services and capacity to respond to increase/ change in needs
3. Increase knowledge and understanding of the underlying causes of poor nutrition in mothers and children in Karamoja and secure timely and quality information on the changing needs for improved programming
4. Strengthen contingency planning and emergency preparedness for nutrition within Karamoja region.

In the December 2016 annual ERKP review, UNICEF met and exceeded most goals, including the engagement of VHTs, and the enrollment of SAM cases in therapeutic programs. Regarding dietary diversity, reaching 36.5% of the targeted 48% (Dec 2014) and minimum dietary diversity – 3.1% (Dec 2014) with a target of 5% increase for children 6-23 months receiving foods from 3 or 4 food groups. The report also noted that WFP and UNICEF Food and Security and Nutrition Assessment (FSNA December 2014) indicated an overall prevalence of GAM among children 6-59 months in Karamoja region of 12.8%, (95% CI (11.7 – 14.0). The same survey reported SAM rates at 3.2% (95% CI (2.7-3.9). These reports demonstrate a decline in malnutrition rates and highlights the effort of all stakeholders in the region to stabilize the situation to some extent. However, rates remain above 10%[8].

Against this background, an end term evaluation of the UNICEF supported components of the broader ERKP specifically the 7 districts of Karamoja region, shall be conducted with a goal of understanding the effectiveness and impact of UNICEF's work for the period November 2013 to December 2015 in order to guide future programing.

8 Interview with World Food Programme Dr. Siti Halat, 18 Aug 2016

1.2 Rationale for the Evaluation

Per the Terms of Reference (Annex 1), this evaluation seeks to obtain an unbiased assessment of whether or not the planned activities with inputs invested have led and/or contributed to the achievement of the expected results. It will focus both on program accountability by learning from the program and key stakeholders about those aspects that worked, what worked well, where, why and under what circumstance.

1.3 Audience

It is a mandate of each institution collaborating in the ERKP to ensure that each institution carries out its own evaluation. In this regard, WFP and FAO had commenced theirs, hence the reason why this evaluation focuses only on UNICEF supported components. The audience for this evaluation is UNICEF, DFID and ERKP representatives.

1.4 Evaluation Objectives

General Objective
To evaluate the overall success of the UNICEF supported components of the ERKP in the targeted 7 districts of Karamoja Region.

Specific Objectives
Specifically, the evaluation will:
1. Assess program relevance, appropriateness, efficiency and quality of services
2. Assess program effectiveness, sustainability, and equity
3. Document evidence based lessons, good practices, and recommendations.

1.5 Evaluation Questions

In order to determine if program objectives were met, the specific evaluation objectives shall form the priority evaluation themes for which information shall be sought. The evaluation framework outlines these major evaluation questions and evaluation strategy for addressing the evaluation questions. The evaluation questions and sub-questions are detailed in the Evaluation Framework (Annex 2)

1.6 Evaluation Management

As per the Terms of Reference (Annex 1), following are the roles and responsibilities of Evaluation Management.

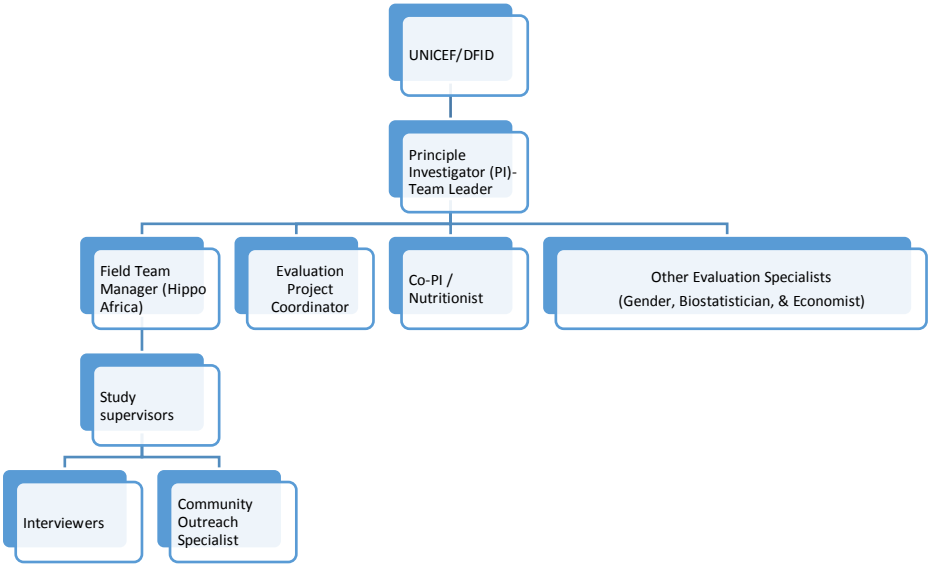
GHLiaisons (GHL) is to revisit the overall approach, methods, and core elements to the evaluation including refinement of the proposed evaluation questions and make any modifications as agreed with UNICEF and the Evaluation Reference Group. In addition, GHL will finalize the detailed protocol and work plan for the ERKP evaluation based on desk review

of ERKP documents as well as interact with the Evaluation Reference Group (formed of UNICEF and DFID) as illustrated the envisioned evaluation management interactions.

UNICEF Uganda will provide background documents for ERKP, as well as names and contact details of the Evaluation Reference Group and of implementing partners for the program.

Evaluation Reference Group will review and provide timely feedback to the proposed protocol, methods, etc. Full clarity and agreement will be received from all the ERKP Reference Group members on the inception report and methodology before the data collection phase begins.

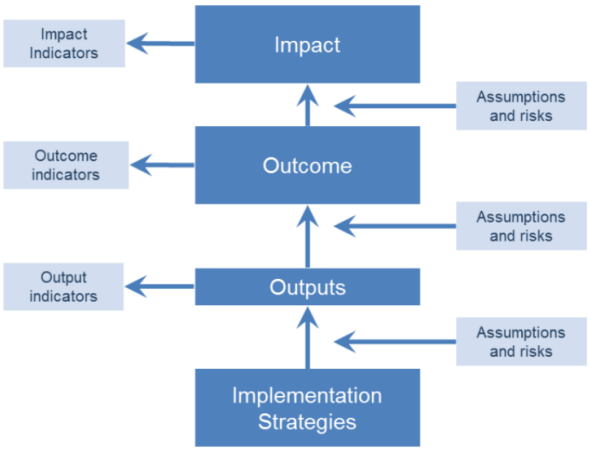
Figure 1 Evaluation Management Organogram



2.0 NATIONAL CONTEXT AND ERKP APPROACH

In a bid to elaborate on the evaluation scope, this chapter reviews UNICEF's implementation approach to achieving the four previously mentioned key ERKP objectives within the framework of Uganda nutrition programming, government priorities, and contextual challenges experienced as they relate to reducing malnutrition.

Figure 1 UNICEF Supplementary Program Note on Theory of Change Meeting



The purpose of the theory of change is to provide the big picture and serves as a foundation for program guidance. The idea is to determine why UNICEF is focusing in certain areas and approaches and how they will achieve results set out in causal pathways. UNICEF strategies are founded in the guiding principles that promote development of clear and robust results frameworks demonstrating complete results change at output, outcome and impact levels. These include measurable indicators with baselines, milestones and targets for monitoring. These theories of change support management decision-making, evaluation and performance management frameworks.

To achieve their goals, UNICEF has worked closely with the Uganda Ministry of Health (UMoH) to apply a theory of change model framed by implementation of change strategies that seek to impact malnutrition in Uganda. [9] This model has involved advocacy at the policy level, which directs attention on outcomes in childhood malnutrition in Uganda. Using advocacy to effect change, UNICEF has worked with the UMoH to put policies in place that will bring about such changes. Theory of Change guides the UNICEF Program model (Figure 1). [10] UNICEF has identified local partners, such as CUAMM, to implement program strategy outputs, with outcomes that impact communities. By supporting the development of a joint nutrition strategy, and theory of change for Karamoja region together with WFP, FAO and other key stakeholders.

In the effort to achieve a reduction in malnutrition, UNICEF has worked with policy-level organizations and departments to work with high-level theories of change that cover sectors and policy areas at a generic level. UNICEF works in partnership with the Government of Uganda (GoU), local organizations and other partners such as FAO and WFP and other stakeholders to apply a results framework that identifies output, outcome, and impact indicators, as is outlined by the ERKP program. The three main areas of focus include increasing high impact nutrition interventions, improving partners' coordination and interaction for nutrition services as well as enhancing and sharing knowledge about

[9] Theory of change, UNICEF https://www.unicef-irc.org/publications/pdf/brief_2_theoryofchange_eng.pdf
[10] UNICEF Supplementary Program Note on Theory of Change

malnutrition.

2.1 High impact nutrition interventions

2.1.1 Nutrition specific interventions targeting children and women

Recognizing the poor state of child and maternal nutrition in the country, through support from UNICEF, the Government of Uganda has made nutrition a priority in its current five-year *Poverty Reduction Strategic Plan* for the period 2013 -2017. The GoU is committed to implementing nutrition specific interventions to improve the nutrition status of women of reproductive age as well as that of children starting from conception to their second birthday which is characterized as the 1,000 days[11] of opportunity to effectively and sustainably address malnutrition.

Nutrition specific interventions are those that which have a direct impact on the immediate causes of undernutrition (inadequate food intake, poor feeding practices and high burden of disease). The core nutrition specific interventions fall under the following three broad categories:

- Infant and Young Child Feeding (IYCF) such as breastfeeding and complementary feeding
- Integrated management/treatment of acute malnutrition as well as nutrition in emergencies
- Nutrition assessment, counselling and support that which encompasses growth monitoring and promotion, nutrition education, micronutrient supplementation, deworming plus and disease management

a) Infant and young child feeding

Since 2001, the Government of Uganda has put in place several policies such as, Policy Guidelines on the Feeding of Infants and Young Children in the Context of HIV/AIDS. As new information arose in related to exclusive breastfeeding, there arose a need to formulate a comprehensive IYCF policy. Optimal IYCF is a key strategic area of UNICEF's equity focus and thus UNICEF has played a key role in IYCF programming and provision of operational guidance. The Uganda Policy Guidelines on Infant and Young Child Feeding (IYCF) were first developed 2010, with support from UNICEF, WHO and WFP. The IYCF guidelines which were later updated in 2012[12], noted that optimal IYCF is essential for child growth, HIV free survival and development. It thus recommended that under normal circumstances, exclusive breastfeeding for the first six months of the child's life should be promoted as it is the most economical, safest, most optimal feeding mode critical for the infant's nutrition and survival. Appreciating that above 6 months of age, the child's nutritional requirements increase beyond what breast milk alone can provide, in order to meet the growing infant's nutritional needs, introduction of other foods at that stage in appropriate frequency and density were recommended. The guidelines emphasized that breastfeeding should continue for up to 2 years of age or beyond as it continues to provide a substantial portion of the baby's requirements.

11 SUN self-assessment 2014

12 MoH, 2012 - Policy Guidelines on Infant and Young Child Feeding - 2nd Edition January 2012

According to these policy guidelines, the role of UNICEF and other United Nations agencies (WHO, UNFPA, UNDP, FAO, UNAIDS, WFP), as well as other bilateral agencies was to:

- Enhance advocacy for IYCF
- Contribute to the mobilization of resources
- Provide technical support for implementation of the policy, especially to support training and development of appropriate IYCF, management of malnutrition, low birth weights etc. manuals, tools and job aides in an integrated manner
- Support Uganda MoH at national and district levels to implement their roles and responsibilities.

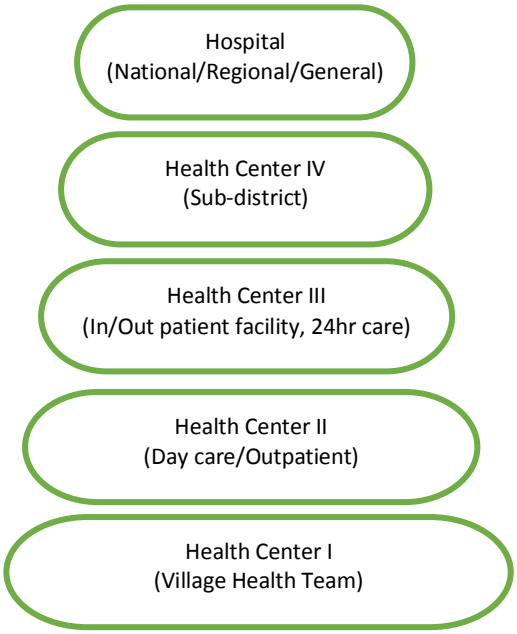
b) Treatment of acute malnutrition

Statistics from the 2011 Uganda Demographic Health Survey show that an estimated of 300,000 children (about 5% nationally) are acutely malnourished and nearly 120,000 (2%) of them have severe acute malnutrition. The HIV pandemic in the country has exacerbated the situation as more than 15% of acutely malnourished children presenting to inpatient facilities are HIV-positive. Acute malnutrition is a rapid onset condition characterized by bilateral pitting oedema or sudden weight loss caused by a decrease in food consumption and/or illness. There are two forms of acute malnutrition namely:

i) Severe acute malnutrition (SAM) which is characterized by the presence of bilateral pitting edema or severe wasting. A patient with SAM is highly vulnerable and has a high mortality risk.

ii) Moderate acute malnutrition (MAM) which is characterized by moderate wasting.

Figure 2 Existing health structure in Uganda



Integrated management of acute malnutrition (IMAM) is an approach to address identification, treatment and management of acute malnutrition through integration into the on-going routine health services at all levels. In Uganda, the delivery of health services by public health facilities is at five levels namely hospitals, Health Center (HC) IV, HC III, HC II and HC I (Figure 2). Previously, management of acute malnutrition was primarily hospital-based with minimal community involvement. This approach however limited timeliness of case finding and treatment, coverage and access to services, provision of appropriate care as well as follow-up. The IMAM current approach thus aims at broadening the scope of current management as well as decentralizing management of acute malnutrition to lower levels (HCIII and HCII levels) depending on capacity within the individual facility. This will be combined with linking with the VHTs and other community level preventative programs[13].

13 MoH 2016, Guidelines for integrated management of acute malnutrition in Uganda

Based on developments and lessons learnt through application of previous guidelines, the MoH released updated IMAM guidelines that address two key issues.[14]

I) Early identification and referral of the acutely malnourished
II) Early discharge of acutely malnourished with transfer from facility to community based care

In Uganda IMAM thus has the following four components:

1. Community services: These involve early identification, referral, and follow-up of the acutely malnourished at community level using the VHTs. The goal of the community services is to empower community by increasing knowledge, access and uptake, and strengthen early care, new referrals, and follow-up on problem cases. Community-based management of acute malnutrition (CMAM, when implemented in full, has a better impact on management of SAM than the traditional inpatient model because of increased coverage and improved timeliness of treatment.)
2. Supplementary Feeding Programs (SFP): This manages and treats MAM in children of 6-59 months and other vulnerable groups that include pregnant women, lactating women with infants less than 6 months, those with special needs such as the elderly.
3. Outpatient Therapeutic Care (OTC): This provides home-based management and rehabilitation of SAM patients as well as MAM patients with HIV/TB who have an appetite and no medical complications
4. Inpatient Therapeutic Care (ITC) programs which are for the management of SAM with medical complications

Good coordination and communication between community, SFP, OTC and ITC is essential to ensure that patients remain in the system during the treatment process for acute malnutrition. Overall, the primary focus of the IMAM program is in eight key areas. These include:

i) Nutrition screening, diagnosis and clarification of acute malnutrition
ii) Management of acute malnutrition with supplementary feeding
iii) Outpatient therapeutic care for the management of SAM clients with no medical complications
iv) Inpatient therapeutic care for the management of SAM with complications
v) Inpatient care for SAM management in infants 0-6 months
vi) Emergency nutrition response
vii) Nutrition information, education and communication
viii) Monitoring, reporting and supervision

c) Nutrition assessment, counselling and support

Nutrition assessment, counseling, and support (NACS) is a client-centered programmatic approach for integrating a set of priority nutrition interventions into health care services and

14 Government of Uganda, Ministry of Health. January 2016. Guidelines for Integrated Management of Acute Malnutrition in Uganda

strengthening health systems.[15] It comprises of prevention, detection, and treatment of malnutrition as well as maintenance of improved nutritional status to prevent relapse[16]. Key features of NACS include defining a standard of care; bringing together existing nutrition services, protocols, actors, and stakeholders at the community and health facility levels; and emphasizing referrals and effective coordination between all partners for optimal quality and impact.[17]

Nutrition assessment essentially involves collecting information about a client's medical history, dietary patterns, anthropometric measurements, clinical and biochemical characteristics as well as social and economic situation. Common nutrition assessments conducted include growth monitoring/weighing of children and pregnant women. Nutrition assessment helps guides diagnosis of nutritional status and subsequently selection of appropriate nutrition interventions. Interpretation of the nutrition assessment results, as well as, barriers to behavior change and ways to address those barriers are identified through an interactive nutrition counselling process between a client and a trained counselor. Thus aids the planning and implementation of appropriate interventions as well as nutrition education and promotion content.

Nutrition support can include amongst others specialized food products to treat malnutrition, micronutrient supplements to prevent or treat micronutrient deficiencies, deworming as well as referral to economic strengthening and livelihood support. The nutrition support should ideally be provided at the health facility and community level to ensure maximum coverage. As such, an important component of NACS is ensuring health facilities and community linkage to ensure that populations at risk and those malnourished receive the needed treatment. For best results, it is imperative to combine nutrition assessment, counseling, and support.

2.1 Increasing access to high impact nutrition interventions in Karamoja

A joint resilience strategy was developed as a commitment and collaborative focus for UNICEF, FAO, and WFP's resilience building efforts in the Karamoja region of Uganda. Building on existing and new partnerships in the ERKP, UNICEF committed itself to continue supporting the District Health Officers (DHOs) in Karamoja and the Ministry of health (MoH) to prevent and manage acute malnutrition in pregnant lactating mothers and children below five years old by scaling up the full package of high impact nutrition interventions (HINI) namely:

a) Micronutrient supplementation including vitamin A, therapeutic zinc, multiple micronutrients, deworming, iron and folic acid;
b) Supporting good nutritional practices including breastfeeding, complementary feeding, and hygiene practices and

15 Food and Nutrition Technical Assistance (FANTA) III, April 2016 – NACS User Guide

16 Yourchuck, Amanda et al. 2014. Health System Performance Assessment for IMAM/NACS in Uganda: Considerations for Delivery of Nutrition Services. Washington, DC: FHI 360/FANTA

17 Nekatebeb H., K. Kappos, A. Pomeroy, M. Kyenkya, A. Mokori, A. D'Agostino, and W. Maina. 2013. Report on Findings from an Assessment of Nutrition Assessment, Counseling and Support (NACS) Services in Southwestern Uganda. Washington DC: USAID/Strengthening Partnerships, Results and Innovations in Nutrition Globally (SPRING) Project.

c) Treatment and follow up for children with acute malnutrition.

UNICEF and WFP have supported for delivery of nutrition services targeting national, district, health facility and community health structures (VHTs/ HC I). In addition, community outreaches that took the form of Family Health Days (FHD) or Child Health Days (CHD) were held, in which a package of micronutrient supplementation, growth monitoring and screening were offered. Overall, broad categories of the key planned activities to increase access to high impact nutrition interventions for mothers and children included intervention roll out, technical support, capacity building, provision of nutrition commodities as well as research.

2.2 Improving coordination and partnership for nutrition service delivery

2.2.1 Framework for nutrition service coordination in Uganda

Uganda policymakers have over the last few decades recognized the importance of developing a strong effort involving cross-sectoral, inter-agency collaboration to address maternal and young child malnutrition in the country. This thus led to the development and launch of the 2011–2016 Uganda Nutrition Action Plan (UNAP) in November 2011[18]. The nutrition interventions outlined in UNAP have a specific focus on women of reproductive age, with the aim of reducing undernutrition as well as the burden of care that malnourished children present to mothers. In addition, the UNAP has set its own targets and goals for nutrition.

The UNAP builds on previous national and regional policies, most notably the National Development Plan, the Uganda Food and Nutrition Policy, and nutrition sections of the Health Sector Strategic and Investment Plan and the Agricultural Sector Development Strategy and Investment Plan. In March 2011, Uganda joined Scaling up Nutrition (SUN)[19], a global movement that unites national leaders, civil society, bilateral and multilateral organizations, donors, businesses and researchers in a collective effort to improve nutrition. The UNAP considers the agreed-upon targets and goals with SUN and other international coordinating bodies and developed within the context of national policies. The Office of the Prime Minister is the convening body for SUN and coordinates UNAP's implementation.

The UNAP focuses on the 1,000-day period from conception to the child's second birthday. Its framework comprehensively addresses the following five objectives:

- Objective 1: Improve access to and utilization of maternal, infant, and young child feeding.
- Objective 2: Enhance consumption of diverse diets comprehensively addresses food availability, access, use and sustainability for improved nutrition.
- Objective 3: Protect households from the impact of shocks and other vulnerabilities that affect their nutritional status.

18 Government of Uganda. 2011. Uganda Nutrition Action Plan 2011–2016: Scaling Up Multi -Sectoral Efforts to Establish a Strong Nutrition Foundation for Uganda's Development

19 Scaling Up Nutrition 2015 http://scalingupnutrition.org/wp-content/uploads/2015/10/SUN_Report2015_EN_Uganda1.pdf

- Objective 4: Strengthen the policy, legal and institutional frameworks and the capacity to effectively plan, implement, monitor and evaluate nutrition programs.

Coordination and partnership for nutrition service delivery embraces the implementation of nutrition sensitive interventions which primarily address the underlying determinants of fetal and child nutrition development. It is thus appreciated that improvements in nutritional status may come from policies or changes in sectors such as Agriculture, Education, Water and Environment, Trade and Industry, and Gender and Social Development, and not just the Health sector. Many of the required actions are already within the mandates of the various sectors illustrating that no single sector can effectively address nutrition issues unless it works collaboratively with others[20]. The causes of malnutrition in Uganda are multi-dimensional and require an integrated approach involving line Ministries including MoH, MAAIF, MoES, MTTI, MoJCA, MoLG, MoGLSD, MWE and other stakeholders such as Universities, Hospitals, NGOs and CBOs.[21] The UNAP seeks to minimize duplication of effort and conflicts of interest that tend to misdirect scarce public and private resources.

In the recently launched NDPII, a central development strategy is to integrate essential cross-cutting issues of gender, HIV/AIDS, environment, nutrition, climate change, human rights, social protection, and child welfare into national programmes and projects[22]. A Multi-Sectoral Nutrition Technical Committee, comprised of experts from government, academia, private sector organizations and civil society organizations, was formed to oversee technical policy.

To overcome issues arising from frequent changes in stewardship direction, the GoU enacted a policy on public-private partnership to guide effective partnership and coordination with private sector in health service delivery[23].

2.2.2 Coordination of nutrition and health programmes in Karamoja

Coordination of nutrition programmes and activities in Karamoja are conducted at the regional, district, health facility and community level. This is in line with the commitment by UNICEF as well as other partners to strengthen institutional capacities, including the decentralized structures to address nutrition issues through improved coordination, planning, monitoring and evaluation, workforce capacity, development and supply of nutrition commodities.

At a regional level programme implementation is guided by the Karamoja Integrated Development Plan (KIDPII). The KIDP is a development framework specifically tailored to address the unique context and development challenges in Karamoja. The Karamoja Multi-Sectoral Nutrition Implementation Strategy (2015-2020) was based on the findings of the Karamoja Nutrition Programme Review (May 2015). The strategy outlines key priority nutrition specific issues to be addressed across sectors, and was developed as part of a consultative multi-partner approach to development and design of strategies to address

20 National Planning Authority July 2015, National Planning Guidelines for Uganda

18 Poverty Reduction Strategic Plan for the period 2013 -2017.

22 Uganda Nutrition and Development Plan 2011-2016

23 Government of Uganda, Ministry of Health. September 2015. Health Sector Development Plan 2015/16 – 2019/20

nutrition. The Northern Uganda Social Action Fund II programme is also a part of the larger programmes that drive development in the Karamoja region. Critical to all national and regional efforts to address nutrition, is the role of the Office of the Prime Minister; Ministry of Karamoja Affairs, who overseers of all programmes in Karamoja.

With the support of UNICEF, quarterly Regional Nutrition Technical Working Group (NTWG) meetings are held monthly. These meetings are attended by representatives from the MoH, UN agencies (WFP, FAO, WHO) and NGOs working on food security and nutrition. The numerous other partners working to address the challenging situation in Karamoja include, but are not limited to USAID projects, RWANU, ACDI / VOCA 1, and Mercy Corps. Key issues arising from the NTWG meetings are reported to the quarterly regional health, nutrition & HIV/AIDS coordination meetings for discussion and further action.[24]

In support of multi sectoral implementation and coordination as stipulated in the UNAP, District Nutrition coordination committees (DNCCs) were established by UNICEF in collaboration with the Office of the Prime Minister (OPM). The DNCC membership is drawn from all the respective district technical departments and is chaired by the Chief Accounting Officers (CAOs). Regular review and feedback meetings are held to ensure functionality of the DNCCs.

Health sector working group meetings are also held at district level by District Health Officers (DHOs). These are attended by the District Health Team (DHT), implementing partners and NGOs working on health, nutrition and HIV/AIDS. Furthermore, at district level, UNICEF supports DHOs to hold quarterly health review meetings with CUAMM in which data on health units' performance on all health activities including nutrition is compiled and presented to the participating DHTs, heads of health units and NGOs.

To discuss nutrition activities conducted at the health unit and community levels, monthly meetings are held at the health facility. These meetings are attended by the health facility staff, VHTs as well as DHT members and NGOs working on health, nutrition & HIV/AIDS.

2.3 Enhancing knowledge and understanding of causes of malnutrition

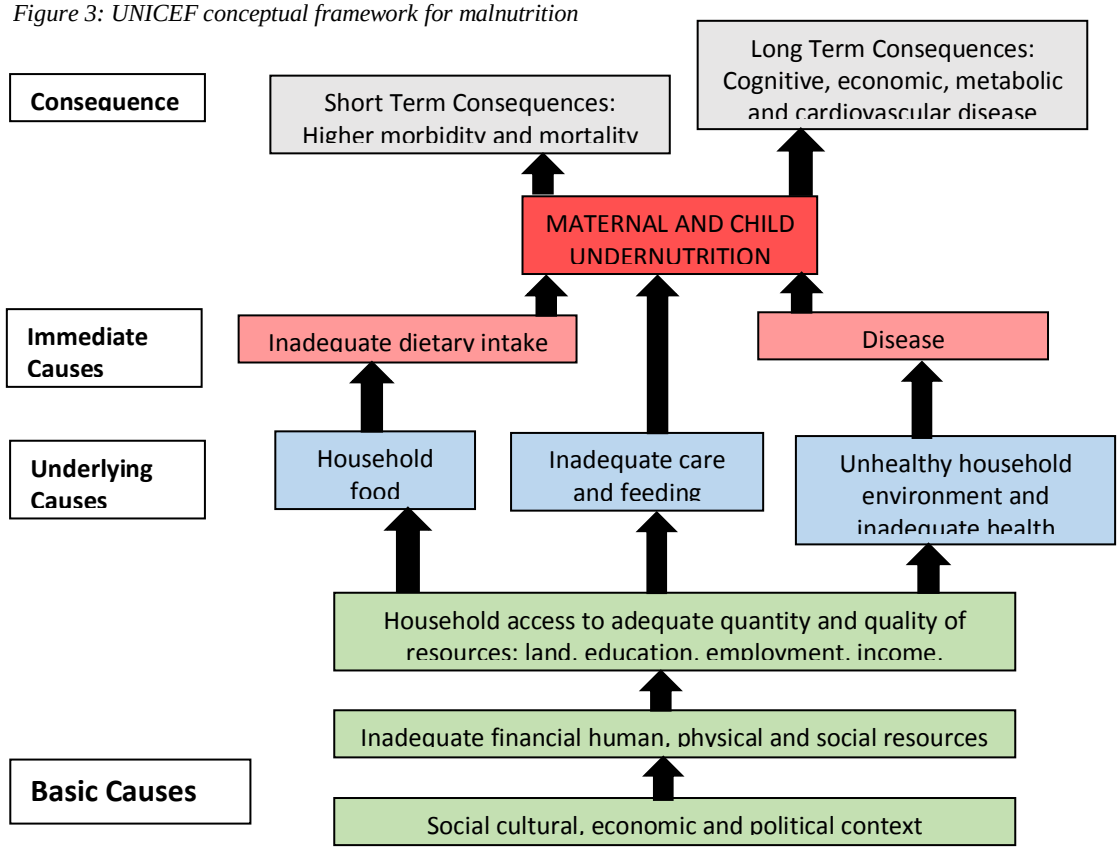
2.3.1 Identification of causal factors for malnutrition

The conceptual framework on the causes of malnutrition was first developed in 1990 as part of the UNICEF nutrition strategy to help analyze the causes of the nutrition problems as well as identify the most appropriate mixture of actions plan to improve nutrition. The framework recognizes that the determinants of malnutrition are multifaceted, multi-sectoral and interrelated falling in three major levels (Figure 3). The basic causes are related to the political, social, ecological and economic context. The underlying causes are household food insecurity, inadequate care and feeding practices as well as unhealthy household environment and inadequate health services. These ultimately lead to inadequate dietary

[24] Interview with WHO 18Aug2016

intake and the high disease burden, which are the immediate causes. The resultant maternal and child undernutrition has both long-term as well as short term consequences.

Figure 3: UNICEF conceptual framework for malnutrition



Source: UNICEF (2013) Improving Child Nutrition: The Achievable Imperative for Global Progress

2.3.2 Causal factors for malnutrition in Karamoja

Karamoja sub-region is known to suffer from recurrent food insecurity and high levels of malnutrition influenced by several factors, including unpredictable climatic conditions, insecurity, crop and livestock pest, parasite and disease incidences, lack of safe water, poor hygiene and sanitation, sub-optimal feeding practices and poor social and economic capital among others. In order to meet with UNICEF objectives to improve knowledge sharing, these factors have led to the need for frequent surveys and studies by government, WFP, UNICEF and other stakeholders in order to understand the situation, and make appropriate and timely interventions.

Identification of the root causes of vulnerability and poverty in Karamoja, has led UNICEF's engagement in numerous studies. Most notably, UNICEF has funded technical support for the development and biannual conduct of the Food Nutrition Security Assessments which provide comprehensive information on the nutrition, health and food security status of the population.

The FNSA has identified the following main drivers of food malnutrition in the Karamoja

region.[25]

- Reduced availability of food at regional and household level
- Diminished ability to purchase food due to inadequate income
- Reduced ability to cope with shock (mainly sickness and high food prices) within households
- Poor IYCF practices including early introduction of supplementary foods
- Lack of safe water, and poor sanitation and hygiene practices

The FSNA effort supported by UNICEF and WFP culminated in the installation of Nutrition Technical Assistants (provided by CUAMM) to improve data collection at the community level on nutrition indicators and support of District Health Officers in intervention implementation.

According to the 2014 ERKP Annual review, "UNICEF uses the data collected in the FSNA to demonstrate progress in food and nutrition outcomes. UNICEF data is collected by the implementing partners (including government works - District Health Officer, health facility workers and VHTs. The data is entered into the GoU Health Management Information System (HMIS) at the district office by the district biostatistician, who also validates this data by going to the field to sample from time to time as supported by CUAMM. The report generated from the HMIS is shared with UNICEF (and other stakeholders). In addition, CUAMM shares a separate report to UNICEF regional office on the activities they are conducting for UNICEF." [26]

Over the years, the usefulness of the FNSA in improving the understanding of the magnitude of malnutrition has been highly acknowledged by both providers and decision-makers. To enhance the usefulness of the information gathered by the FNSA, UNICEF commissioned the review and re-analysis of FSNA data collected in 2014 and 2015 to get better understanding of the factors responsible for observed changes in nutritional status outcomes and complementary feeding practices in the region.

To enhance the body of knowledge and evidence related to underlying causes of malnutrition in Karamoja, identify triggers for early response as well as strengthen resilience at the household, community and system levels, UNICEF committed to increase its investment in operational research. In this regard, UNICEF also supports DHOs to participate in joint assessment analyses with World Food Program (WFP) and FAO, and surveillance meetings with UNAP. Other efforts to understand causal factors of malnutrition included the initiation of the Nutrition Causal Analysis for the Moroto District by UNICEF and WFP in March, 2016. Some additional potential areas of focus identified included strengthening the Nutrition Information System in the region as well as review of the surveillance program.

2.4 Strengthening nutrition contingency planning and preparedness

The Karamoja region has been continually affected by multiple shocks and stresses, often occurring in combination or sequence hence making recovery between episodes difficult. These shocks have resulted in the Karamoja region being the most food insecure and amongst the most vulnerable in Uganda. This has led to increased attention on Karamoja with

25 UNICEF/WHO- Food Security and Nutrition Assessment in Karamoja Region, 2015

26 ERKP Annual Review 2014

development of several policy initiatives which provide greater opportunities for engagement, heightened donor funding and more implementing agencies[27].

Up to 95 percent of the Karamoja population is reliant on UN donor, and NGO support through nutrition and food security interventions for decades. While food security and livelihood oriented programs and funds are increasingly channeled to Karamoja, the continued seasonal spikes in severe malnutrition in the last 3 years indicates that these programs are not yet reaching the most vulnerable families and young children who remain exposed to the effects of climate change and widespread poverty. With more than 20 years of experience working in the Karamoja region, FAO, UNICEF and WFP have actively contributed to resilience building at scale. UNICEF in particular has committed itself to emphasizing an approach to nutrition support which reduces disaster risk, and mitigates potential impact.

The overall policy environment has evolved significantly to focus on resilience not only at international, but also at the national level, with a focus on Karamoja specifically. A number of common themes are found within the local policy initiatives including the need to: shift from emergency response to development oriented investments; to focus on addressing the root causes of vulnerability and poverty; to scale up multi-sectoral efforts as a foundation for improving food and nutrition security; and to shift from large infrastructure projects to investing in households and resilience activities.

In terms of policy initiatives, UNICEF has an agreement with the International Institute of Rural Reconstruction (IIRR) to support the review of district emergency, preparedness and response plans with a view to integrate nutrition. While UNICEF's focus is on nutrition, the effort is jointly undertaken with FAO, which is focused on food security. The effort is coordinated with the office of the Prime Minister Disaster Risk Reduction (DRR) department. The DRR focuses on preparedness, prevention, response and recovery activities formulated in response to potential disasters. One output of this effort is to develop a comprehensive contingency and response plan for Karamoja.

To enable timely nutrition response based on emergency requirements both at the central and district levels, there is dire need for the preparedness and response plans to be clear, well-coordinated ensure adequate integration of harmonized nutrition activities. In addition, there is need to avail finances for their implementation, build human resource capacity and ensure active participation of nutrition stakeholders in contingency planning/updating, early preparedness and response.

Some of the critical actions required include the incorporation of disaster risk assessments into existing nutrition assessments and monitoring, reduce vulnerability through promoting improved care practices, as well as strengthen community health systems for early diagnosis, and referrals and follow-up on cases of undernutrition. In addition, it is imperative to link nutrition actors and services to disaster early warning systems at national, subnational and community levels, secure vital nutrition supplies as well as scale up communication for behavior change in vulnerable communities.

27 FAO, WFP and UNICEF 2015, Joint resilience strategy for Karamoja Region

2.4 Contextual Challenges

Karamoja livelihood patterns are complex, transitional and subject to a complex combination of sudden shocks and continuous stresses. There are six livelihood zones that correlate with Karamoja region being hotter and drier to the east, and wetter and cooler to the west. In addition, to the harsh climatic conditions that often affect crop yields, poor post-harvest handling, general economic hardships and unequal gender relations characterized by heavy domestic chores for the women combine to grossly undermine the capacity of mothers to cater for appropriate nutrition at the various stages of the nutrition continuum for themselves and their children.

The Joint Resilience Strategy (2015), indicates that despite a significant reduction in national poverty levels, Karamoja lags far behind – and remains dangerously vulnerable to shocks. Although absolute poverty in Uganda has continued to fall, Karamoja is far behind with 74% of households in Karamoja are classified as poor.[28] The region seriously trails the nation in all major socio economic indicators including literacy rates, access to safe water and sanitation facilities. Currently life expectancy is 47.7 years vs. 59.2 years nationally.

Climate shocks, poverty, low literacy, and lack of safe water and sanitation, are complicated by local cultural practices that contribute to high rates of malnutrition in the region. Karamoja lags behind the national average in the area of nutrition[29]:

- Acute undernutrition (wasting): 12.8%Karamoja[30] vs. 4.7% nationally[31]
- Chronic undernutrition (stunting): 36.9% Karamoja vs. 33.4% nationally[32]
- Underweight prevalence: 28% Karamoja vs. 13.8% nationally[33]

The 2015 Assessment of Maternal and Child Feeding Practices identified nutritional practices among caregivers in the Karamoja region increase the difficulty of addressing malnutrition in Karamoja. These include:

1. Introduction of solid foods before six months
2. Mothers breastfeed less or even stop earlier than the recommended two years
3. Poor feeding practices
4. Children in many cases feed on that which everybody else feeds on in the household
5. Perceptions that a child will not learn to eat foods early
6. Busy breastfeeding mothers leave their babies under the care of other children or the elderly
7. Belief that breast milk is not sufficient for the baby's feeding needs

In the Western area of Karamoja, there were additional challenges. These related to:

[28] UNDP 2014 Poverty Assessment
[29] UDHS, 2011
[30] FSNA, Dec 2014
[31] UDHS, 2011
[32] ibid
[33] ibid

1. Foodstuffs for pregnant mothers at household level
2. Economic hardships and household demands on mothers
3. Stereotypes leading to disregard for some domestically available yet essential foods
4. Lack of male Support
5. Taboos and cultural beliefs
6. Consumption of herbal medicines/concoctions

In the healthcare setting in Karamoja, under staffing in health units remains a challenge. This is confounded by weak community VHT referral systems and coordination. The Nutrition Progress Report (2015) indicates the following as major challenges to program implementation:

- Under staffing in health units is a key challenge to all health service provision initiatives (including IMAM capacity building efforts in the region).UNICEF is working with CUAMM to bridge critical staffing positions in the health facilities in Karamoja region as an interim measure with conditionality that these health workers (mainly midwives) will eventually be absorbed into the district pay roll. Nutrition Technical Assistants provided by UNICEF's Implementing Partner (IP) CUAMM, are also meant to bridge this gap.
- VHT functionality still a problem, with continued high defaulter rates in the program.
- There is also a need for better nutrition coordination among players in the region.

3.0 EVALUATION METHODOLOGY

3.1 Evaluation Site

The evaluation shall be conducted in the DFID supported Enhanced Resilience Karamoja Program (ERKP). Karamoja Region, in north-eastern Uganda administratively divided into seven districts: Kaabong, Abim, Kotido, Moroto, Amudat, Napak and Nakapiripirit (Figure 4). The Region borders Kenya to the east, South Sudan to the north and the districts of Kitgum, Pader, Lira/Agago, Amuria and Katakwi to the west; and Kumi, Sironko and Kapchorwa to the south. It has an estimated population of 965,008 people. The majority of the population

Figure 4: Map of the Districts of Karamoja Sub-Region

Source: UBOS, National Population and Housing Census 2014

3.2 Population

The majority of the population subsists through agro-pastoral or purely pastoral livelihoods. There are six livelihood zones that have been identified. The traditional pastoralist livelihood, which has provided a natural adaptive approach to climate change, is becoming marginalized and the natural resources on which the population depends are increasingly degraded. Source: UBOS, National Population and Housing Census 2014.

3.3 Evaluation Design

A cross-sectional evaluation design employing both quantitative and qualitative data collection methods will be used to obtain information on program implementation and effectiveness. It is anticipated that the evaluation will be conducted between July and October 2016 as outlined in the evaluation work plan (Annex III).

3.4 Evaluation Population

The population will include three main levels, program funders and policy makers, implementers and beneficiaries as outlined in the Inclusion Criteria.

3.5 Inclusion and Exclusion Criteria

3.5.1 Inclusion Criteria

I. PROGRAM FUNDERS & POLICYMAKERS

This will include those individuals from agencies involved in policy making at GoU level, UN Agencies, District and implementation of ERKP as well as program funders.

- At GoU, the evaluation will target Ministry of Health, Office of the Prime Minister/UNAP Secretariat and Ministry of Karamoja Affairs, Ministry of Agriculture Animal Industry and Fisheries, Ministry of Education and Sports and the Ministry of Gender, Labor and Social Development.

- UN Agencies will include the FAO, WFP, UNICEF, UNFPA, UN Women and UNDP.
- Program funders at the wider level will include the EU, World Bank, Irish Aid Government and DFID.

II. IMPLEMENTERS

REGIONAL LEVEL IMPLEMENTERS - At the regional level we will include ERKP implementing agencies (UNICEF, WFP and FAO), Implementing Partners (CUAMM, AFC, IIRR, ACDI/VOCA, other organizations implementing nutrition programs in the region including Mercy corps, World Vision, RWANU, TUFTS, CONCERN, Community action for health, ACTED, Save the Children and GIZ.

DISTRICT LEVEL IMPLEMENTERS - The evaluation will include district level individuals involved in implementation and monitoring of ERKP nutrition activities namely the CUAMM Nutrition TA, District Health Officers (DHOs), District Community Development officers, and Nutrition focal persons in each of the 7 districts.

FACILITY LEVEL IMPLEMENTERS - We will include implementing staff at health facilities as follows:

In-Charge – The person who oversees the health facilities activities

Health workers

- Health facility staff working at the OTC sites as well as doing outreach in the catchment communities.
- Health facility staff working at the ITC sites primarily involved in the management of SAM children and inpatient care.

COMMUNITY LEVEL IMPLEMENTERS

1. The Village Health Teams (VHTs) who support nutrition activities e.g. screen children under five, identify SAM children and refer to OTC, provide IYCF counseling and conduct outreach. nutrition activities
2. Mother Support Groups (MSGs) who provide social support to women in the community including caregivers with malnourished children.
3. Assistant Community Development Officers (ACDOs)/Health assistants who are responsible for community social protection issues e.g mobilizing communities to participate in developmental programs; advocacy, sensitization and training/capacity building

III. BENEFICIARIES

These are caregivers of children 0-2 years who have benefited from the program at the health facility level (ITC and OTC) as well as community.

3.5.2 Exclusion Criteria

PROGRAM FUNDERS & POLICYMAKERS - We will exclude those national level individuals at agencies not involved in funding, policy making and implementation of ERKP.

REGIONAL AND DISTRICT LEVEL IMPLEMENTERS - We will exclude regional and district level

individuals' not involved or unfamiliar with the ERKP nutrition activities.

FACILITY LEVEL IMPLEMENTERS - We will exclude health facility staff not involved with the ERKP nutrition activities.

COMMUNITY LEVEL IMPLEMENTERS – VHTS, MSGs and ACDOs not involved with the ERKP nutrition activities will be excluded.

BENEFICIARIES - We shall exclude beneficiaries whose children have aged beyond two years as well as those who are very ill

3.6 Sampling and Sample Size Determination

Program funders, policy makers, regional and district level implementers

In order to assess implementation, scale-up of the program, staff knowledge, and emergency preparedness, we will sample individuals at agencies involved in funding, policy making and implementation of ERKP at a national level, regional and district level. A minimum of one respondent will be purposively selected from each organization/ministry.

Facility level implementers

The sampling unit will be the health facility taking into consideration the livelihood zones (Annex IV) and UNICEF support to the health facilities. The delivery of health services is at five levels namely hospitals, Health Center (HC) IV, HC III, HC II and HC I (VHTs). All hospitals and HC IV (5 Hospitals and 5 HC IV) will be purposively selected as part of the evaluation. In addition we shall randomly select up to 3 HC III and 3 HC II based on livelihood zones, facility location and UNICEF support. In total 51 health facilities supported by UNICEF will be selected distributed as follows:

District	Hospital	HC IV	HC III	HC II	Total
Kotido	0	1	3	3	**7**
Moroto	1	1	3	3	**8**
Kaboong	1	1	3	3	**8**
Nakapiripirit	0	2	3	3	**8**
Napak	1	0	3	3	**7**
Amudat	1	0	2	3	**6**
Abim	1	0	3	3	**7**
Total	**5**	**5**	**20**	**21**	**51**

A maximum of three staff will be selected as interview respondents each of the 51 health facilities. These will include: The In-charge of the health facility/relevant department as well the in-patient and outpatient care staff taking into considering gender aspects where applicable. Overall, a total of 112 health facility implementers will be interviewed.

Community level Implementers

1. **VHTs:** These are attached to HC IV, III and II. At one HC III per district, we shall randomly select 2 VHTs as interview respondent taking into consideration gender making a total 14 VHTs.

2. **MSGs:** We plan to interact with one MSG per district. The MSGs have a leadership structure and we shall target to interview a maximum of two people in the MSG leadership per district taking gender into consideration. This will make a total of 14 interviews with MSG leaders.

3. **ACDOs:** These are found at the sub-county level. We shall thus randomly select 1 ACDOs per district taking into consideration gender making a total 7 ACDO interviews.

Beneficiaries

1. **Caregivers of children aged 0-2 years seeking health services:** Within each of the 51 health facilities, convenience sampling method shall be used to select male and female caregivers of children aged 0-2 years in the IPC and OTC respectively. In situations where male caregivers are not present at the IPC or OTC, female caregivers shall be interviewed. Amongst the UNICEF supported health facilities, 10 have IPCs whilst all 51 health facilities have OTCs distributed as follows.

Health facility level	Number of IPCs	Number of OTCs
Hospitals	5	5
HC IV	4	5
HC III	1	20
HC II	0	21
Total	**10**	**51**

Taking gender into consideration, at each IPC, up to six caregivers shall be interviewed giving a maximum of 60 IPC caregiver interviews. Two caregiver interviews will be conducted at each OTC giving a maximum of 102 OTC caregiver interviews. Interviewing more caregivers at OTC will ensure that caregivers of children aged 0-2 years who have never been admitted into the program and/or those discharged as cured/defaulted from the program are interviewed. Overall, a total of 162 caregiver interviews shall be conducted.

2. **Caregivers of children aged 0-2 years who have never been admitted into the program and/or those discharged as cured/defaulted from the program:** Caregivers within this category shall be interviewed at the OTC. In addition, two focus group discussions shall be held per district, one of men (7 discussions) and the other with MSG members of the (7 discussions) making a total 14 discussions.

The summary of the data collection strategies, targeted participants and sample size is presented in Annex V and VI.

3.7 Evaluation variables and indicators

Evaluation of the program will focus on three broad categories namely: (a) relevance, appropriateness, efficiency and quality of services (b) effectiveness, sustainability and equity (c) good practices and evidence based lessons. The evaluation variables to be considered will thus be aligned to the aforementioned categories and tied in with the research questions and program indicators as outlined in the Evaluation Framework (Annex 2).

Data for the first set of questions related to program relevance, appropriateness, efficiency and quality will come primarily from decentralized monitoring and primary data collection in the districts, health facilities and from program beneficiaries.

The second set of questions related to program effectiveness, sustainability and equity will rely mainly on quantitative analysis of secondary cross-sectional nutrition and health surveys and UNICEF/IP data as well as data from program policy makers, regional and district implementers, implementers at the health facility and in the community as well as program beneficiaries.

Identification of good practices and evidence based lessons will be drawn in relation to the UNICEF four key ERKP objectives. These will form the third and final set of questions which will draw mainly on primary data and UNICEF/partner data.

3.8 Data Collection Methods & Procedures

Both primary and secondary data will be collected using quantitative and qualitative data collection methods and tools (Annex VII).

3.8.1 Quantitative data

Quantitative data will come from two sources: 1) primary data from semi-structured interviews and 2) secondary data abstraction from at health facility level for the two year evaluation period.

Semi- structured interviews will be conducted with district, facility and community level implementers as well as program beneficiaries. Semi-structured interviews provide a good opportunity for the evaluators to seek and fill-in information gaps (if any). For each type of respondent group to be interviewed, a semi-structured questionnaire derived from the evaluation framework shall be used.

Abstraction of facility and community level hard copy and electronic data will be conducted to obtain a deeper understanding of data collected, record keeping/monitoring and linkages between varied service delivery points as well as implementing partners. Sources of data for abstraction will be obtained from CUAMM, the Nutrition focal persons, District Store Assistant as well as the District Biostatistician.

Some of the data to be abstracted via physical count and photos will include:

- Stock levels of vital nutrition supplies e.g RUTF, micronutrients, ReSomal etc
- Nutrition related clinical parameters monitored at community and facility level (IPC and OTC)
- Nutrition services and information provided
- Referral processes and follow-up
- Data collated for reporting to UNICEF, MoH and IPs
- Trainings in IMAM and IYCF conducted for health facility workers and VHTs

3.8.2 Qualitative data

Four qualitative data collection methods will used, namely desk review, Key Informant Interviews (KII), Focus Group Discussions (FGDs), as well as unobtrusive observations at health facility service delivery points.

a) Desk review

Desk review will be conducted based on documents provided by UNICEF Uganda office. The documents shared with the contracting agency include Annual Interim Reports, monitoring frameworks and monitoring data during the 2.5-year program period, financial data and any other information needed for the desk review. Specifically, documents include FSNA reports semi-annually, Nutrition Progress, reports, national guidelines. For more detailed outline of documents to be reviewed refer to Annex VIII.

b) Key Informant Interviews

Key Informant Interviews (KIIs) will be conducted with selected policy makers and funders, regional and district level implementers such as DFID, EU, WHO, UNICEF, WFP, FAO, USAID, district local authorities, IPs (CUAMM and Baylor) amongst others. The purpose of the KII will be to explore the evaluation variables as well as determine interconnectedness between the various components of the program. Data from national-level key informant interviews will be incorporated in an evaluation report which will explore any emerging issues.

c) Focus group discussions

In a bid to get additional information on community perceptions of the quality of the services, their effectiveness, the program linkages, including strengths and weakness, as well as perceived barriers, outputs, outcomes and results, Focus Group Discussions (FGDs) will be conducted with key community stakeholders' namely caregivers of children who have never been admitted into the program and/or those discharged as cured/defaulted from the program. Two focus group discussions shall be conducted held per district, one of men (7 discussions) and the other of women members of the MSG (7 discussions) making a total 14 discussions.

d) Unobtrusive Observations

During semi-structured interviews with heath facility staff, unobtrusive observations will be made to assess service delivery (IMAM and IYCF) process at OTC in relation to the recommended standard process of care.

3.9 Data Analysis Plan

3.9.1 Quantitative Results

3.9.1.1 Primary and secondary data analysis

Quantitative analysis of both primary data sources will generally be descriptive in nature. In our analysis of the primary data, overall and district-specific will be estimated for key survey questions of interest, e.g., ratings of program effectiveness and implementation. For a subset of indicators, we will produce graphic displays of data, including pie charts and bar charts, to show variation in outcomes across time and/or place. Where sample and cell sizes permit, we will test for statistically significant differences both within and between districts using chi-squared tests using the household survey data. Quantitative analysis of secondary data will allow us to assess changes in the district-level nutritional outcomes alongside timing of program initiation and scale-up. All quantitative analysis will be conducted using Stata 13.

3.9.1.2 Value for money analysis

Based on the key outcome indicators stemming from the framework, we will conduct value for money analysis by focusing on the cost of food and delivery of the nutrition services (per child treated for SAM) and the cost per trainee.

The indicator related to the cost of food and delivery of the nutrition services (per child treated for SAM) has been already computed in the 2016 review and accounts to $53 dollars in 2015. Hence, our analysis will focus specifically on the cost per trainees.

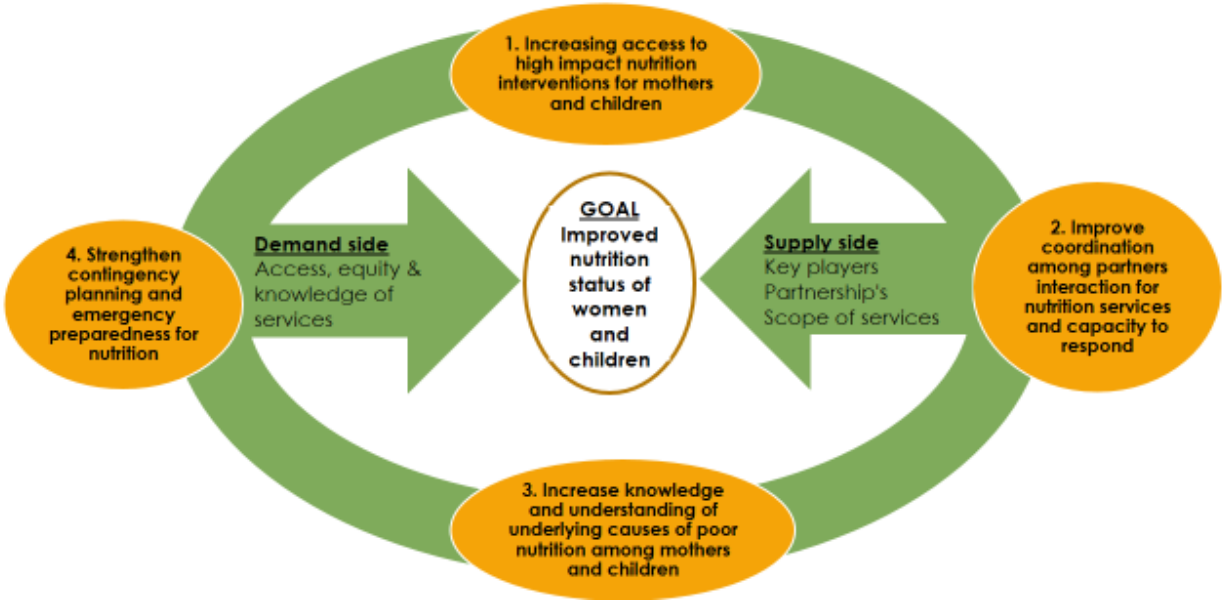
3.9.2 Qualitative Results

Qualitative analysis will involve cross checking primary and secondary data sources for methodological triangulation, which will be beneficial in providing confirmation of findings, more comprehensive data, increased validity, and enhanced understanding of the ERKP nutrition components. Primary and secondary data sources will also result in context for triangulation and address concerns about the reliability and validity of results. Qualitative analysis will result in process flow diagrams to demonstrate linkages and will result in contextual descriptive woven into results to depict and focus areas requiring improvement.

Improving nutrition outcomes among women and children in Karamoja region requires a well-coordinated stakeholder engagement. Inadequate coordination of the planning and implementation of nutrition programmes and projects can result in duplication of services and programmes which can lead to wasteful resource use. Stakeholder mapping will be conducted to examine the “supply” side of ERKP programming whilst taking stock of all key program implementers and exploring the linkages being harnessed to improve nutritional outcomes among women and children malnutrition in Karamoja region. Use of mapping in program evaluation emphasizes generation of information about existence of stakeholders, their distribution, documentation of their program linkages, profiling of availability of structures and resources to address beneficiaries’ needs, and to garner insights about what

works and what does not (Bartholomew et al, 2011)[34]. With the aid of Global Position System (GPS), a map will be generated for all the 7 ERKP districts to offer a visual impression of diverse partners engaged with nutrition programming in this region and implication of stakeholder distribution on equity, access and service coverage. In particular, the mapping component will assess for:

- Existing coordination mechanism between partners (joint planning meetings, program financing, feedback/reporting mechanisms)
- Efforts to increase knowledge and understanding of underlying causal factors for malnutrition within Karamoja region
- High impact nutrition vital supplies and intervention service coverage, access and equity
- Joint programming such as capacity building activities offered to district personnel, facility health workers, Village Health Teams (VHTs) and program beneficiaries
- Feedback mechanism E.g. routine report sharing or use of standardized monitoring and evaluation frameworks such as national nutrition indicators



Good practices related to the UNICEF four key ERKP objectives will be identified by looking at both quantitative and qualitative data that can provide more information about cultural, unpredictable, and behavioral changes in the involved implementers and beneficiaries. Best practices aspects to be documented will include strengths in the

- high impact nutrition intervention (IMAM and IYCF) delivery process, linkages at community and facility level as well as mechanisms used to enhance access and improve outcomes; quality of reporting and referral

[34] Planning Health Promotion programs: An intervention mapping approach ... 3rd ed. San Francisco, CA. Jossey-Bass, 2011.

- partner's compliance with UNAP's recommended coordination activities and guidelines,
- knowledge and information sharing systems and data use
- Level of nutrition integration into contingency planning and response

3.10 Quality Control

The following quality control measures will be put in place to address varied risks that could potentially be experienced during implementation of the survey.

Electronic Tools
Actual data collection will be conducted using 8" android tablets with software designed and uploaded specifically for this program. The data collection tool, is called the ODK System, and will be modified with uploads of the approved questionnaires. These will be converted to an easy mobile data entry system for use by data collectors. Training tools and program materials have been developed from existing systems used for previous IMAM/CMAM program evaluations. The team will test and launch the evaluation's electronic data collection tool prior to in-field training.

Data collected using this mobile application, will have an easy user interface that gives users a choice-by-number selection and easy dropdown menus to avoid entry and spelling errors. In the absence of internet, the data can be transferred through compressed code.

Data will be transferred without error into the central database located on a secure server, which will offer ready access to all team members. There will be no need for a paper trail system, which is historically fraught with potential for error. Authenticated data will immediately reflect in the database and can be analyzed by the GHLiaisons data analyst.

Paper tools will be available for emergency situations, such as tablet power outage. These will be entered directly into the ODK tool with supervisor oversight.

Selection of data collection team
The selection of the quantitative and qualitative data collectors will take into consideration knowledge of the local language, education status, district of origin within the Karamoja region given the diversity among the districts in Karamoja, experience in research within Karamoja especially nutrition research. The data collection team will include 12 data collectors led by 2 supervisors hence 14 persons altogether. The data collection teams will be split into 2 with team one will cover North Karamoja that is Kaabong, Kotido and Abim districts. Team two will cover south Karamoja that is districts of Moroto, Napak, Nakapiripirit and Amudat. Team one will have 5 data collectors and one supervisor while team two will have 7 data collectors and one supervisor. The difference in numbers is intended to cater for the extra district in south Karamoja. Team one will work in North Karamoja whilst team two will work in South Karamoja.

The EKRP stakeholder mapping will be conducted by two research assistants supervised by a Global Positioning System (GPS) consultant.

Training of the data collection team
For quantitative data collection, the Training Plan is designed to skill-up the data collectors and supervisors in the use of the questionnaire and electronic data collection tool. The draft training manual for the software application has been created. Training will include a careful review of all questions and familiarization with the use of the mobile application system and specific data gathering requirements. It is expected the training will take three workdays

Pre-testing: Data collection tools for all structured questionnaires will be pre- tested by all data collectors and supervisors to ensure that the tools capture the intended information and the entire data collection team understands the questions and other requirements. Pre-testing and review of the l questionnaire will take two workdays.

Field Supervision: There will be an overall data collection supervisor who will work with support from the UNICEF Karamoja team to conduct spot checks on data collectors and review data collected to ensure accuracy and completeness. To add further to data integrity, the data collection tool will be designed to use geo-positioning to confirm that interviews are actually being conducted and document the geo-position where they took place. This will add to the correction of GPS locations previously documented. A progress report will be provided to UNICEF at the end of the first week of data collection.

Data Entry: Questions will be designed around the key evaluation variables questions and uploaded into the electronic system for use in the tool. Data will be entered directly into an electronic data system and uploaded when internet connection is established. In the absence of internet, the data can be transferred through compressed code. Data collected using this mobile application will have an easy user interface that gives users a choice-by-number selection and easy drop down menus to avoid data entry and spelling errors.

3.11 Ethical Considerations

Ethical approval to conduct the evaluation will be obtained from the ERKP Evaluation Reference Group. Before the actual data collection, participating partners in each district will be contacted with an introductory letter from UNICEF. The purpose will be to introduce the evaluation and also to seek permission from local authorities for security reasons.

While in the field, informed consent (Annex VII) will be obtained from all the participants prior to participation in the evaluation. In the event that consent is not granted, the interviewer will thank the respondent and leave. Confidentiality for all evaluation participants shall be ensured by conducting interviews in places with privacy and not using their names for data analysis. In addition, evaluation participants are given information about the evaluation purpose, the risks and benefits, and emphasis on the protection of confidentiality. In as far as possible, female respondents will be interviewed by female field staff, while male respondents will be interviewed by male field staff.

Cooperation from community members at the district level is imperative to ensure effective implementation of the evaluation. The strategy to inform and gain by-in from local authorities on the planned evaluation activities will involve meeting local stakeholders; such as, DHOs, and Chief Administrative Officers and heads of targeted health facilities. UNICEF will contact IPs to inform them of the evaluation. IPs will be asked to contact and organize meetings with VHTs.

3.12 Limitations

Limitations for this evaluation include time, environmental and statistical challenges. Given the road conditions, distances, and time constraints, it is anticipated that approximately two health facilities may be covered per day on average. Based on this assumption, actual data collection is will take place over a period of 12 workdays. This may be interrupted prolonged travel time as well as by other risks associated with travel to hard-to-reach health facilities, unanticipated rains and vehicle breakdowns. Efforts will be made to mitigate this limitation by assigning specific roles members of data collection team which will either be conducted individually, pairs or the group.

The sampling unit will be the UNICEF supported health facilities. While this is the most cost-effective and efficient given the time and resource constraints, it is possible that sampling method within the health facilities will produce a selection bias and omit those who had not visited the health facility. Efforts will however be made to reach selected community beneficiaries through the VHTs as well as FGDs with men and MSGs. We will be limited in our ability to test within-district geographic variation in program effectiveness and efficiency, resulting in an overestimate of program effects (to the extent that there is regional variation). Additionally, because sample sizes will be small, our ability to estimate inferential statistical models is limited.

Other potential limitations include problems with internet connectivity in many areas of Karamoja. To ensure that this does not hamper data collection, both paper and electronic tool format shall be used by the data collectors.

Another limitation is that comprehensive and/or uniform information could not be obtained for the entire evaluation from the documents reviewed e.g. UNICEF progress reports, DFID web based reports etc. In addition, the limited period of project implementation (2 years) is likely to be insufficient to discern responses to all the evaluation questions. The field visits will thus be crucial in complementing the information from records.

3.13 Evaluation Results Dissemination and Use

A 2-day workshop drawing key stakeholders in Kampala and Karamoja respectively shall organized by UNICEF to disseminate the evaluation results. The dissemination shall highlight the evaluation methodology, key findings with specific focus on the evidence based lessons learnt, good practices, and recommendations. The workshop shall adopt a participatory and

interactive format to ensure key stakeholders discussion, as well as building of consensus and commitment on actions to be taken in the next programming cycle and to strengthen existing government programs.

4.0 GENERAL OUTLINE OF FINAL EVALUATION REPORT

The evaluation findings shall be documented in a final evaluation report which will contain a summary and synthesis of the overall ERKP progress, lessons learnt, best practices, challenges and recommendations'. Relevant illustrative case studies shall be included in the final report.

From the final report, a PowerPoint presentation to aid dissemination of evaluation methodology and findings as well as a policy brief summarizing key evaluation findings and recommendations shall be developed.

The following is the proposed outline for the final evaluation report:

Title page
Table of Contents
Executive Summary
Acknowledgements
Abbreviations and acronyms
Chapter 1: Introduction
Chapter 2: National context and EKRP approach
Chapter 3: Methodology
Chapter 4: Results
- 4.1 Program relevance and appropriateness
- 4.2 Program efficiency and coherence
- 4.3 Quality of services
- 4.4 Program effectiveness
  - 4.4.1 Results related to program indicators and targets
  - 4.4.2 Effectiveness of partnerships in program execution/implementation
- 4.5 Program equity related to coverage, access and gender
- 4.6 Partnerships and collaborations
- 4.7 Sustainability
- 4.8 Challenges
- 4.8 Lessons Learnt

Chapter 5: Good practices
- 5.1: Increasing access to high impact nutrition Interventions for mothers and children
- 5.2 Improving coordination and partnership for nutrition service delivery
- 5.3 Enhancing knowledge and understanding of the underlying causes of malnutrition
- 5.4 Strengthening nutrition contingency planning and emergency preparedness

Chapter 6: Recommendations
References
Annexes
- Evaluation terms of reference
- Evaluation framework
- Evaluation work plan
- Data collection tools
- List of interviewers and interviewees

ANNEXES

ANNEX I: EVALUATION TERMS OF REFERENCE

TOR 9124546_End_of_Proj

ANNEX II: EVALUATION FRAMEWORK

UGA_Evaluation framework-submitted (see attachment)

ANNEX III: WORK PLAN

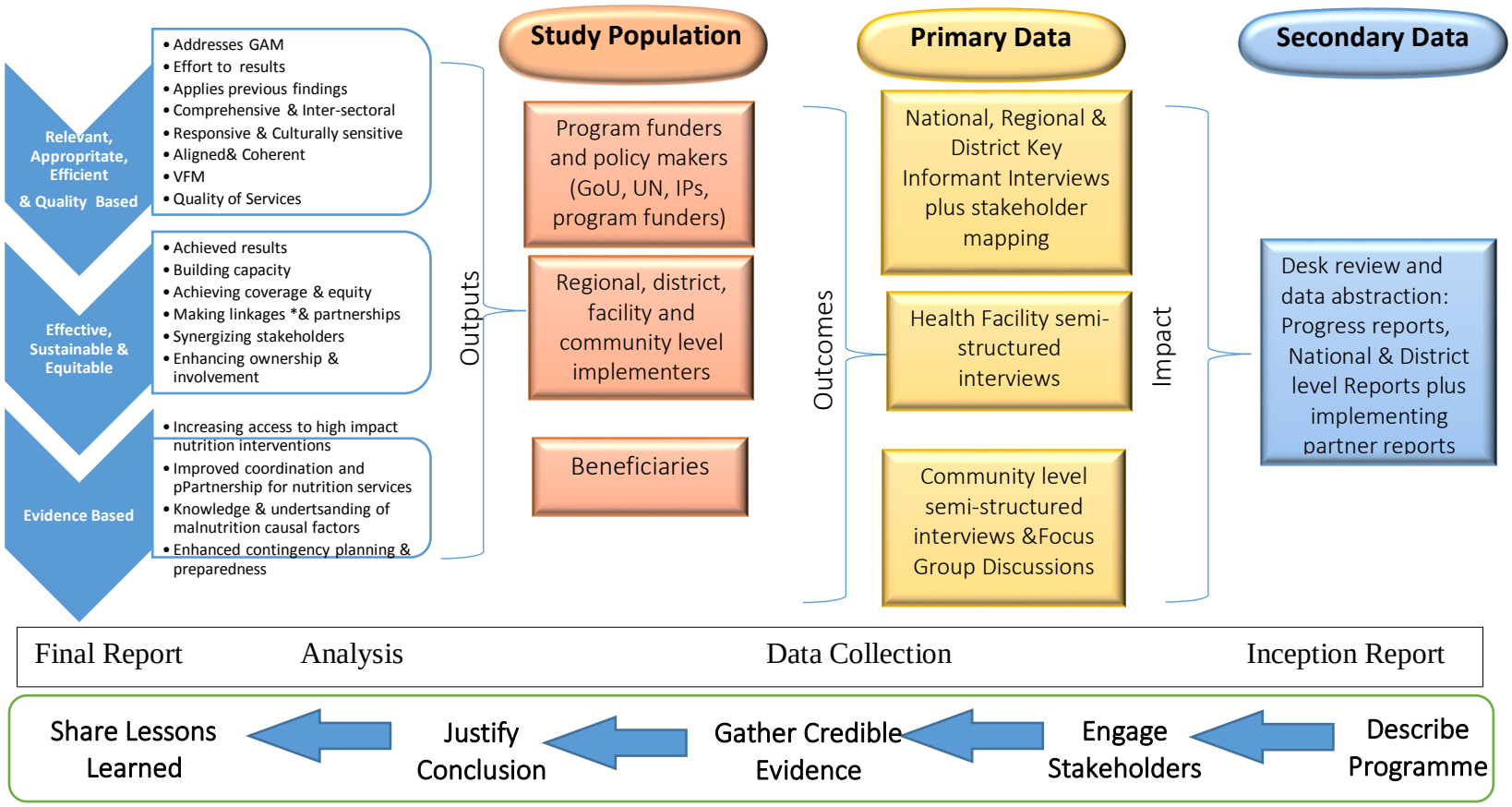
Dates	Duration	Activity
PHASE 1: INCEPTION REPORT PREPARATION AND NATIONAL LEVEL DATA COLLECTION		
July 22nd	1 day	• Introduction GHL team members based in Uganda to UNICEF Evaluation focal person and nutrition team
July 26th – 29th	1 week	• Evaluation team meeting in Uganda (PI, Co-PI and team members) • Commence desk review and compilation of draft inception report
August 1st – 5th	1 week	• Continue desk review and compilation of draft inception report • Preliminary briefing between UNICEF Evaluation focal person/ nutrition team and Uganda GHL team members
August 8th – 12th	1 week	• Conduct key informant interviews with selected national level program funders and policy makers as organized by UNICEF • Submit draft inception report for UNICEF internal review
August 15th – 20th	1 week	• Conduct key informant interviews with selected national level program funders and policy makers as organized by UNICEF • Receive and address inception report comments from UNICEF internal review • Submit revised IR for UNICEF 2nd internal as well as external review
August 23rd	1day	Conduct key informant interviews with DFID
August 24th	1 day	• Attend dissemination of preliminary evaluation findings of WFP component • Hold debrief with UNICEF to strategize on ERKP stakeholder consultative meeting
August 25th	1 day	Travel to Moroto for Stakeholder consultative meeting
August 26th	1 day	Conduct stakeholder consultative meeting in Moroto
August 29th – September 9th	2 weeks	• Receive and incorporate inception report 2nd review comments; • Submit final inception report and data collection tools for UNICEFapproval • Conduct key informant interviews with selected national level program funders and policy makers as organized by UNICEF • Prepare for field activities
PHASE 2: KARAMOJA FIELDWORK		
September 12th - 16th	1 week	• Train data collectors • Pre-test data collection tools • Revise and finalize tools as necessary
September 19th – 23th	1 week	Upload final data collection tools on the electronic system

September 26th – October 7th	2 weeks	• Conduct field data collection • Commence data entry and analysis
PHASE 3: RESULTS COMPILATION AND DISSEMINATION		
October 10th – 31st	3 weeks	• Finalize data analysis and compilation of evaluation report Disseminate preliminary and final evaluation findings to UNICEF Kampala and ERKP stakeholders in Karamoja

ANNEX IV: LIVELIHOOD ZONE MAPPING

Livelihood Zone Maps.pdf

ANNEX V: SUMMARY OF DATA COLLECTION STRATEGIES



ANNEX VI: TARGETED PARTICIPANTS AND SAMPLE SIZE

Data collection method	Location/ Target group	Respondents	Target sample size
QUANTITATIVE DATA COLLECTION			
Semi-structured interviews	Facility level implementers	Up to 3 staff in each of the 51 health facilities • In-charge and OTC health worker in every facility – (2x51=102) • ITC health worker – (1x10=10)	112
	Community level implementers	2 VHTS linked HC III in each district	14
		2 MSG leaders of one MSG at HC III in each district	14
		1 ACDO at HC III level per district	7
	Beneficiaries	Caregivers of children aged 0 – 2 years • 6 caregivers in each of the 10 UNICEF supported IPCs = 60 • 2 caregivers in each of the 51 UNICEF supported OTCs = 102	162
Data abstraction	Regional/District level	Consolidated monthly IMAM & IYCF data from: • CUAMM • Nutrition focal persons • District Store Assistant • District Biostatistician	
QUALITATIVE DATA COLLECTION			
Key informant interviews	National level program funders and policy makers	DFID, WFP, UNICEF, FAO, WHO, USAID, OPM, EU, Irish Aid, World Bank, OPM, relevant line ministries	10
	Regional Program funders, policy makers and implementers at regional and district level	UNICEF, WFP, FAO, OPM Implementing Partners e.g CUAMM, AFC, IIRR, ACDI/VOCA, World Vision, RWANU, TUFTS, CONCERN, ACTED, Save the Children and GIZ etc	10

	District level implementers	Officers directly involved in nutrition program implementation in each of the 7 districts (DHO, Nutrition TA, Nutrition Focal person, DCDO)	28
Focus Group Discussions	District	Caregivers of children who have never been admitted into the program and/or those discharged as cured or defaulted from the program. One FGD per district with • Men (7 FGDs) • MSG members (7 FGDs)	14 FGDs
Unobtrusive observations	District	Observation of IMAM/IYCF process at selected OTCs in the following health facility levels • All Hospitals (5) • All HC IV (5) • One HC III per district (7) • One HC II per district (7)	24 observations

ANNEX VII: DATA COLLECTION TOOLS

A. Informed consent
B. Key informant guide for national, regional and district level stakeholders
C. Semi-structured questionnaires
    i. Health Facility level implementers
    ii. Community level implementers (VHT members, MSG leaders, ACDOs)
    iii. Caregivers of children aged 0 – 2 years
D. Focus Group Discussion Guide for MSG members and Men
E. Data abstraction form: District and Community level
F. Unobtrusive checklist
G. Stakeholder mapping tool

(see separate attachment)

ANNEX VIII: DOCUMENT REVIEW

Year Published	Author	Title
2001	W. Kisamba-Mugerwa	Rangelands Management Policy in Uganda: A Paper Prepared for the International Conference on Policy and Institutional Options for the Management of Rangelands in dry Areas.
2003	The Republic of Uganda	The Uganda Food and Nutrition Policy
2005	Twinomugisha, Ben	A content Analysis reports of Climate Change Impacts, Vulnerability and Adaptation in Uganda.
2005	Ministry of Agriculture, Animal Industry and Fishing	The National Food and Nutrition Strategy
2007	Uganda Ministry of Health	Uganda Policy Guidelines on Infant and Young Child Feeding
2007	The Republic of Uganda	Uganda Vision 2040
2009	Uganda Food and Nutrition Council	Food and Nutrition Bill
2009	UNDP	Handbook on Planning, Monitoring, and Evaluating for Development Results
2009	The Republic of Uganda Ministry of Health	Integrated IYCF Counselling Facilitators Guide
2009	The Republic of Uganda Ministry of Health	Integrated IYCF Counselling Participants Manual
2009	The Republic of Uganda Ministry of Health	IYCF Counselling Cards for Health Workers
2009		SPHERE Project
2010	UNICEF	2010 Progress report DFID
2010	The Republic Of Uganda Ministry of Health	IMAM Manual - Guidelines 2010
2010	UNICEF	IYCF Counselling Cards for Community Workers
2010	Office of the Prime Minister, The Republic of Uganda	The National Policy for Disaster Preparedness sand Management
2011	UNDP	Monitoring and evaluation framework for UNAP and revision of the national guidelines for acute malnutrition (UNDP, 2011).
2011	UNICEF	National Development Plan; launched the Uganda Nutrition Action Plan (2011-2016),
2011	UNDP	The National Disaster Risk Reduction and Management Policy. Office of the

		Prime Minister for Disaster Preparedness and Refugees
2011	Uganda Bureau of Statistics	Uganda Demographic and Health Survey
2012	FANTA	2012-SQUEAC-SLEAC-Tech-Reference-SQUEAC
2012	Food and Nutrition Technical Assistance II Project (FANTA-2) Bridge	National Nutrition Advocacy Plan (MoH Uganda, 2012)
2012	The Republic of Uganda Ministry of Health	Policy Guidelines on IYCF
2013		ERKP proposal
2013	UNICEF Uganda	Enhancing Increased Resilience in Nutrition and Health of Children and Mothers in Karamoja
2013	Henry, Wamani and Arthur, Bagonza	Food Security and Nutrition Assessment in the Karamoja region(May 2014)
2013	UNDP	Human Development Index: 161 out of 183
2013	Uganda Bureau of Statistics	Uganda 2013 Statistical Abstract
2014	Dr. Henry Wamani	Food Security and Nutrition Assessment (FSNA) in Karamoja (Jan 2014)
2014	Dr Henry Wamani, UNICEFNutrition Unit and WFP AME Unit	FSNA in Karamoja (Dec 2014)
2014	Yourchuck, et al., 2014	Health Systems Performance Assessment for IMAM/NACS in Uganda: Considerations for Delivery of Nutritional Services
2014	UNICEF	Indicators for assessing infant and young child feeding practices
2014	Pomeroy & Alexis, 2014	Pathways to Better Nutrition Case Study Evidence Series Uganda
2014	SPRING, USAID	Pathways to better nutrition uganda: Understanding Scale-up in the Context of the Ugandan Nutrition Action Plan
2014	Republic of Uganda Office of the Prime Minister, reference to Namugumya, et al., 2014	Reducing Malnutrition in Uganda
2014	UNAP Secretariat/Directorate of Coordination and Monitoring	SUN Self Assessment Exercise
2014	The Republic of Uganda Office of the Prime Minister	Uganda Report SUN MSP Self Assessment
2014	AUC, NEPAD, UNECA, WFP	The Cost of Hunger in Uganda, Implications on National Development & Prosperity
2015	Parlimentary Library, Uganda	Revised Child Act, Uganda

2015	UNICEF	4th Progress Report Increased Resilience in Nutrition and Health of Children and Mothers in Karamoja
2015	DFID/UNICEF	A Formative Research on Maternal and Child Feeding and Caring Practices
2015	NALYSIS, MONITORING AND EVALUATION UNIT WFP | Uganda	Food Security and Nutrition Assessment
2015	ANALYSIS, MONITORING AND EVALUATION UNIT WFP	Food Security and Nutrition Assessment June 2015
2015	UNICEF, WFP, Republic of Uganda	FSNA in Karamoja (June 2015)
2015	UNDP	Human Development Report
2015	FAO, UNICEF and WFP	Joint Resilience Strategy Karamoja
2015	The Republic of Uganda, UKAID, UNICEF	Karamoja Multi-Sectoral Nutrition Implementation Strategy
2015	Resilience Analysis Unit	Resilience to food insecurity in Karamoja Uganda
2015	The Republic of Uganda	Second National Development Plan
2015	WFP, ACF, DFID, UNICEF	Simplified LQAS Evaluation of Access and Coverage
2016	UNICEF/UNWFP	Food Security and Nutrition Assessment in Karamoja Region
2016	UNICEF, UKAID, WFP, The Republic of Uganda	Food Security and Nutrition Assessment in Karamoja Region (Jan 2016)
2016	The Republic Of Uganda Ministry of Health	Guidelines for Integrated Management of Acute Malnutrition in Uganda
2013-2015	UNICEF to ERKP	2013-2015_Enhancing Resilience in Karamoja Program-Annual review