

DFID's Contribution to Improving Nutrition







Independent
Commission
for Aid Impact

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The Independent Commission for Aid Impact (ICAI) is the independent body responsible for scrutinising UK aid. We focus on maximising the effectiveness of the UK aid budget for intended beneficiaries and on delivering value for money for UK taxpayers. We carry out independent reviews of aid programmes and of issues affecting the delivery of UK aid. We publish transparent, impartial and objective reports to provide evidence and clear recommendations to support UK Government decision-making and to strengthen the accountability of the aid programme. Our reports are written to be accessible to a general readership and we use a simple 'traffic light' system to report our judgement on each programme or topic we review.

	Green: The programme performs well overall against ICAI's criteria for effectiveness and value for money. Some improvements are needed.
	Green-Amber: The programme performs relatively well overall against ICAI's criteria for effectiveness and value for money. Improvements should be made.
	Amber-Red: The programme performs relatively poorly overall against ICAI's criteria for effectiveness and value for money. Significant improvements should be made.
	Red: The programme performs poorly overall against ICAI's criteria for effectiveness and value for money. Immediate and major changes need to be made.

Executive Summary

This thematic review assesses the Department for International Development's (DFID's) rapidly expanding support to nutrition. It focusses on DFID's overall strategy and the coherence of its nutrition portfolio, excluding humanitarian projects. DFID spent £192.8 million on nutrition in 2012. This is expected to more than double by 2015. DFID has committed £3.3 billion to nutrition in 2013-20 and aims to contribute to a dramatic reduction in the high levels of global undernutrition. To achieve this, DFID has supported global action, invested in projects and generated evidence on new solutions.

We reviewed DFID's overall portfolio of 114 nutrition projects and its programmes in Zambia and India. We also examined six projects in these countries. We reviewed DFID's global advocacy work. We assessed whether DFID's support to nutrition is on track to bring meaningful results for its intended beneficiaries. We focussed on children under the age of five – who are undernourished or at risk of becoming so – and their mothers.

Overall *Assessment: Green-Amber*

DFID has a globally recognised and effective nutrition programme. It has played a key role in mobilising the global community to combat undernutrition and in setting the global agenda. DFID started scaling up its nutrition work in 2010. The pace and scale of DFID's global work is good but implementation at the country level has been too slow. As a result, it is too early to show impact, though we saw some promising signs. Although DFID's work is based on sound evidence, DFID's projects do not always focus on interventions with the greatest impact on stunting. DFID should improve the monitoring of its programmes and ensure results are not over-reported. Greater focus is needed on the most vulnerable and 'hard-to-reach' mothers and children.

Objectives *Assessment: Green-Amber*

DFID's nutrition work generally has clear and relevant objectives. There is an appropriate balance between nutrition-specific projects that seek to combat undernutrition directly (through health interventions) and nutrition-sensitive ones that do so indirectly (through investments in food security, sanitation and hygiene and social welfare). DFID's work is based on strong evidence but greater focus is needed on interventions that will maximise impacts on stunting in the local context. Beneficiaries are appropriately involved in the design of projects but projects should be tailored to target better the most vulnerable and 'hard-to-reach' children. Theories of change need to be more detailed, setting out what needs to be done, by whom and at what stages.

Delivery *Assessment: Green-Amber*

DFID's pace of delivery at the global level is good. DFID has scaled up its portfolio of investments significantly but

could have done so more quickly. Project implementation has been slow. Tighter project management at the country level is needed. Given that it is tackling critical national priorities, DFID has made the right choice to work with governments. It provides valuable technical assistance to build government delivery capacity. DFID effectively co-ordinates with other donors at the country level. It has mobilised and leveraged additional funding for nutrition. DFID should, however, select delivery partners better. Specifically, it should consider delivery options in addition to UNICEF. As yet, DFID has not engaged the private sector effectively on nutrition. DFID involves beneficiaries in delivery but could do more.

Impact *Assessment: Amber-Red*

DFID's programme is relatively new. There are some promising signs of future impact. DFID's work is based on generally sound theories of change but should focus on interventions that will reduce stunting and improve cognitive development. DFID has designed high-quality and appropriate evaluations to assess impact. Monitoring is less effective. Some projects do not monitor adequately short-term results and some results have been over-estimated. We are disappointed that some of DFID's oldest projects cannot yet demonstrate results. We are concerned that reporting against corporate 'reach' targets can set inappropriate incentives for project management. Dramatic reductions in global undernutrition will take 15-20 years to achieve. It will require sustained high-level commitment by DFID, developing country governments and other aid providers, as well as longer-term projects.

Learning *Assessment: Green-Amber*

DFID encourages and supports global learning. It uses global evidence to define its policies and design its programmes but it has been slow to act on emerging evidence on delivery methods. DFID has actively encouraged learning internally. It needs experienced advisors to turn learning into action in country offices.

Recommendations

Recommendation 1: DFID should make long-term commitments to maintain the pace and scale of its nutrition investments through its country programmes.

Recommendation 2: DFID should implement nutrition interventions which will have the greatest impact on stunting and cognitive development.

Recommendation 3: DFID should ensure that its interventions target better the nutritional needs of the most vulnerable mothers and children.

Recommendation 4: DFID should work with partners globally and in developing countries to ensure systems are in place to measure the impacts of its programmes.

Recommendation 5: DFID should actively explore ways in which to engage the private sector in reducing undernutrition.

1 Introduction

Background to this review

- 1.1 This review assesses DFID's contribution to nutrition. We examined DFID's efforts to influence global action to combat undernutrition and we reviewed its overall portfolio of investment programmes in developing countries and its efforts to develop new evidence-based solutions. We also focussed on two countries with high levels of undernutrition: Zambia and India (Madhya Pradesh State). In each of these two countries, we examined three projects in detail.
- 1.2 The purpose of this review is to establish whether or not DFID's support to nutrition through its bilateral programmes is strategic, coherent and likely to achieve meaningful results for its intended beneficiaries.
- 1.3 We concentrated on DFID's decision-making processes, the quality of its delivery mechanisms, the ways in which it learns and the impact of nutrition funding.
- 1.4 We focussed on DFID's nutrition work within its development programmes. We did not consider DFID's emergency humanitarian interventions because these have been addressed in other ICAI reports.^{1,2}

Why invest in nutrition?

Undernutrition is a global challenge

- 1.5 Undernutrition is a major challenge to human development and to the future economic prosperity of developing countries. It causes the deaths of more than three million children and more than 100,000 mothers each year.³ It accounts for 45% of all child deaths globally.⁴ Undernutrition makes children more susceptible to infections than healthy children and less able to recover from disease. It also blocks development by inhibiting cognitive

growth⁵ in children, leading to lower educational attainment and reduced productivity.⁶

- 1.6 The United Nations (UN) estimates that 842 million people – approximately 1 in 8 people globally – do not consume sufficient food to lead an active life.⁷ Another one billion people do not intake sufficient vitamins and minerals. This can lead to complications such as child blindness, caused by Vitamin A deficiency.⁸
- 1.7 This report focusses on children, who are particularly at risk from undernutrition. The United Nations Children's Fund (UNICEF) estimates that 25% of children globally are chronically malnourished and 8% are acutely malnourished. Chronic undernutrition results in 'stunting', which is where children are shorter than expected for their age and the risk of cognitive impairment is high.⁹ Acute malnutrition results in 'wasting', with children becoming dangerously thin. Severe wasting generally results from sudden reductions in food intake or disease. It significantly increases the risk of child mortality. Figure 1 on page 3 outlines the categories of undernutrition and their prevalence in developing countries.
- 1.8 Many children are born underweight because their mothers are undernourished. In this way, poor nutrition can be passed from generation to generation. There is also a strong body of evidence that the status of women, childcare practices, poor hygiene and sanitation, lack of access to basic health services and food insecurity contribute to undernutrition.¹⁰ Poor hygiene and sanitation can lead to frequent infections, which damage the child's intestinal tract, hindering

¹ See, for example, *DFID's Emergency Response in the Horn of Africa*, ICAI, September 2012, <http://icai.independent.gov.uk/wp-content/uploads/2013/12/ICAI-report-FINAL-DFIDs-humanitarian-emergency-response-in-the-Horn-of-Africa11.pdf>.

² In some countries (for example Yemen, Ethiopia) there is overlap, with some nutrition expenditure being directed to both development and humanitarian ends.

³ *The Neglected Crisis of Undernutrition: DFID's Strategy*, DFID, 2010, <http://collections.europarchive.org/tna/20100423085705/http://dfid.gov.uk/Documents/publications/nutrition-strategy.pdf>.

⁴ *Executive Summary of the Lancet Maternal and Child Nutrition*, The Lancet, June 2013, http://globalnutritionseries.org/wp-content/uploads/2013/07/Nutrition_exec_summ_final.pdf.

⁵ Cognitive development is the development of intelligence, conscious thought and problem-solving ability that begins in infancy. See, <http://medical-dictionary.thefreedictionary.com/cognitive+development>.

⁶ Shane Starling, *Undernutrition Cripples Global Economic Growth and Development* (The Lancet), Nutraingredients.com online news, 7 June 2013, <http://www.nutraingredients.com/Industry/The-Lancet-Undernutrition-cripples-global-economic-growth-and-development>.

⁷ *The State of Food Insecurity in the World*, Food and Agriculture Organisation of the United Nations (FAO), International Fund for Agricultural Development and World Food Programme (WFP), 2013, page 8, <http://www.fao.org/docrep/018/i3434e/i3434e.pdf>.

⁸ *Micronutrient Deficiencies*, WHO, <http://www.who.int/nutrition/topics/vad/en/>.

⁹ United Nations Children's Fund, World Health Organisation, The World Bank, UNICEF-WHO-World Bank Joint Child Malnutrition Estimates, 2013, http://www.childinfo.org/malnutrition_status.html.

¹⁰ *The Neglected Crisis of Undernutrition, Evidence for Action 2009*, DFID, 2009, <https://www.gov.uk/government/publications/the-neglected-crisis-of-undernutrition-evidence-for-action-2009>.

1 Introduction

absorption of nutrients by the body. This condition is known as tropical enteropathy.¹¹

Figure 1: Categories of undernutrition and prevalence in children under five years of age in developing countries¹²

	Characteristic	Children globally		Indicator*
		Number (millions)	%	
Chronic malnutrition	Stunting (children are too short for their age and risk cognitive impairment)	162	25	Low height for age
Acute malnutrition	Wasting (children are dangerously thin for their height)	51	8	Low weight for height
Underweight	Underweight (children weigh less than expected for their age)	99	15	Low weight for age

* These indicators are measured statistically as being more than two standard deviations below the World Health Organisation (WHO) Children Growth Standard.

1.9 Many countries will not achieve the first Millennium Development Goal (MDG) of eradicating poverty and hunger by 2015. There was some progress on this between 1990 and 2011, with the proportion of underweight children under the age of five globally declining from 25% to 16%.¹³ Despite this, only 26% of countries have achieved the goal of halving malnutrition or are on track to do so by 2015.¹⁴ Undernutrition is also the major reason why many countries – especially in sub-Saharan Africa – will not reach the fourth MDG on reducing child mortality.

1.10 Undernutrition is concentrated in sub-Saharan Africa and South Asia. Some 80% of stunted children in the world live in just 14 countries in

these two regions. Of these countries, only China will have achieved the first MDG by 2015.¹⁵ South Asia has the highest incidence of child undernutrition in the world. India alone is home to 38% of the world's stunted children, despite having a higher level of economic development than most sub-Saharan countries.¹⁶

Global responses

1.11 Although most developing countries and donors have recognised nutrition as a development priority for decades, they have ramped up their efforts in the last six years. This change was due to:

- the sudden rise in global food prices in 2007-08, which seriously affected poor people and significantly increased the number of undernourished children in developing countries;¹⁷
- better evidence on the extent of undernutrition, especially stunting and its impact on the cognitive development of children; and
- increased evidence on the causes of undernutrition and what can be done to tackle it (for example the 2008 Lancet series on Maternal and Child Undernutrition).¹⁸

1.12 Since 2009, three high-level international commitments were made to mobilise global financing to achieve global food and nutrition security. These are:

- the L'Aquila Food Security Initiative (AFSI), launched at the 2009 Group of Eight (G8) Summit;
- the 2010 Scaling Up Nutrition (SUN) Movement, co-ordinated by the UN Secretary General's Office; and
- the New Alliance on Food Security and Nutrition, launched at the 2012 G8 Summit.

¹¹ Tropical enteropathy is caused by frequent infections of various types (viral, bacterial or protozoal). See, <http://inthehealth.oxfordjournals.org/content/2/3/172.full>.

¹² United Nations Children's Fund, World Health Organisation, The World Bank, UNICEF-WHO-World Bank Joint Child Malnutrition Estimates, 2013, http://www.childinfo.org/malnutrition_status.html.

¹³ *The Millennium Development Goals Report*, UN, 2013, page 11, <http://www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013-english.pdf>.

¹⁴ *Millennium Development Goals*, World Bank, http://www.worldbank.org/mdqs/poverty_hunger.html.

¹⁵ Bangladesh, China, Democratic Republic of the Congo, Egypt, Ethiopia, India, Indonesia, Kenya, Nigeria, Pakistan, Philippines, Sudan, Tanzania and Uganda. *Improving Child Nutrition*, UNICEF, 2013, page 9, http://www.unicef.org/media/files/nutrition_report_2013.pdf.

¹⁶ *Improving Child Nutrition: The achievable imperative for global progress*, UNICEF, 2013, page 9, http://www.childinfo.org/files/NutritionReport_April2013_Final.pdf.

¹⁷ *The State of Food Insecurity in the World*, FAO, 2010, <http://www.fao.org/docrep/013/i1683e/i1683e.pdf>.

¹⁸ *Maternal and Child Undernutrition*, The Lancet, January 2008, <http://www.thelancet.com/series/maternal-and-child-undernutrition>.

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1.13 SUN is the main global initiative for tackling undernutrition. It aims to bring together developing country governments, donors, the private sector and civil society to combat undernutrition. Currently, 50 developing countries have joined SUN. The other two initiatives focus more on agricultural production and food security.

1.14 DFID actively has supported the establishment of these three initiatives and has committed approximately £1.7 billion to them in on-going and new projects.¹⁹ This is consistent with the recommendations of the 2013 IDC report on Global Food Security.²⁰ They are described in the Annex.

DFID's nutrition strategy

1.15 The International Development Committee (IDC) noted in 2008 that 'DFID and other donors have given nutrition insufficient priority'.²¹ At the time when the IDC reported, DFID had no nutrition policy, though a number of its projects included nutrition components.²²

1.16 In response, to the IDC, DFID published, in 2009, *The Neglected Crisis of Undernutrition: DFID's Strategy*.²³ This was accompanied by an evidence paper, which argued the case for investing in nutrition.²⁴ In 2011, DFID published a position paper, *Scaling Up Nutrition*,²⁵ which outlined the actions DFID would take to tackle undernutrition. DFID also strengthened its own nutrition capacity by appointing nutrition advisors to work in the UK and some of its country offices.

¹⁹ DFID contributed £1.1 billion to AFSI, £375 million to the New Alliance for Food Security and approximately £5 million to support co-ordination by the SUN Movement. DFID contributions to AFSI and the New Alliance for Food Security included on-going and new investments.

²⁰ *Global food security*, House of Commons IDC, 2013, First Report of Session 2013-14, page 41, <http://www.publications.parliament.uk/pa/cm201314/cmselect/cmintdev/176/176.pdf>.

²¹ *The World Food Programme and Global Food Security*, House of Commons IDC, 2008, Tenth Report of Session 2007-08, page 45, <http://www.publications.parliament.uk/pa/cm200708/cmselect/cmintdev/493/493.pdf>.

²² Sumner, A., J. Lindstrom and L. Haddad, *Greater DFID and EC Leadership on Chronic Malnutrition: Opportunities and Constraints*, Institute of Development Studies, 2007, http://www.ids.ac.uk/files/Greater_DFID_EC_Leadership_Chronic_Malnutrition.pdf

²³ *The Neglected Crisis of Undernutrition: DFID's Strategy*, DFID, 2010, <http://collections.europarchive.org/tna/20100423085705/http://dfid.gov.uk/Documents/publications/nutrition-strategy.pdf>.

²⁴ *The Neglected Crisis of Undernutrition: Evidence for Action (2009)*, DFID, 2009, <https://www.gov.uk/government/publications/the-neglected-crisis-of-undernutrition-evidence-for-action-2009>.

²⁵ *Scaling Up Nutrition: The UK's Position Paper on Undernutrition*, DFID, September 2011, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67466/scal-up-nutr-uk-pos-undernutr.pdf.

DFID's nutrition strategy has four pillars

1.17 DFID's goal is to 'reach' 20 million children under five years of age, pregnant and breastfeeding women with nutrition programmes between 2011 and 2015.²⁶ It aims to achieve this by:

- **investing in nutrition-specific interventions**, which directly address the immediate causes of undernutrition by, for example, supplementing mothers' and children's diets with key vitamins and minerals and promoting exclusive breastfeeding for the first six months;
- **investing in nutrition-sensitive interventions**, which indirectly address undernutrition, including poverty reduction and food security projects, agricultural research, access to safe drinking water and sanitation facilities and stronger health systems;
- **generating evidence on what works** and does not work as a basis for action; and
- **encouraging a global effort** to tackle undernutrition by donors working in partnership with country governments.

1.18 DFID's programme focusses on the first 1,000 critical days (from conception to the child's second birthday) because interventions over this period have been shown to have the greatest impact on reducing stunting and improving cognitive development. DFID also emphasises integrated approaches involving both nutrition-specific and nutrition-sensitive projects. Recent evidence indicates that nutrition-specific interventions will only deal with 20% of stunting. Nutrition-sensitive projects are needed to tackle the remaining 80%.²⁷

1.19 DFID's programme focusses on stunting (chronic undernutrition) but also addresses wasting (acute undernutrition). The emphasis on stunting is in line with SUN and other international organisations. It recognises the important links between stunting and cognitive growth in children and the impacts on broader economic development.

²⁶ This is in addition to those reached through humanitarian response.

²⁷ Bhutta, Z. et al, *Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done and at What Cost?* The Lancet, August 2013, Volume 382, Issue 9890, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60996-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60996-4/fulltext).

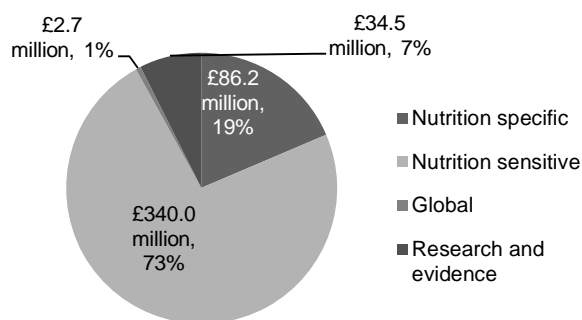
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1.20 Over-nutrition is also becoming a significant problem in some developing countries. It leads to obesity and chronic diseases, including diabetes, hypertension and coronary heart disease.²⁸ Although DFID recognises that some countries face the 'double burden' of undernutrition and over-nutrition, it focusses its efforts on undernutrition.

DFID has made major financial commitments on nutrition

1.21 In 2010, DFID began to scale up its investments in nutrition. Over the three-year period from 2010 to 2012, it invested a total of £463 million in nutrition across 28 countries. Annual expenditure rose from £115.8 million in 2010 to £192.8 million in 2012, a 66% increase (see Figure 2). In 2012, DFID's rapidly rising expenditure on nutrition accounted for 3.4% of DFID's overall bilateral expenditure of £5.7 billion. It should be noted that the majority of this investment is not exclusive to nutrition; it includes investment in other sectors, such as agriculture or health, which are likely to impact indirectly on nutrition.

Figure 2: DFID expenditure by pillar, 2010-12²⁹



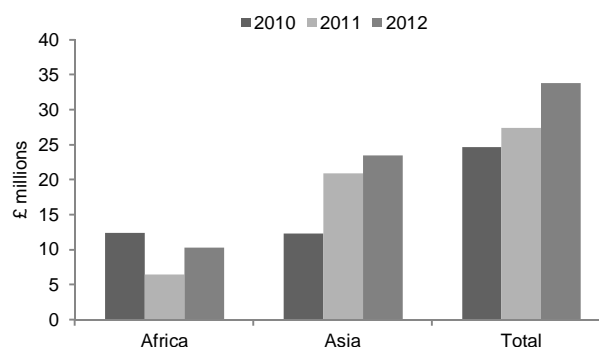
Source: Development Initiatives data, analysed by ICAI.³⁰

1.22 Since our review does not cover DFID's humanitarian work, we have excluded all expenditure on humanitarian projects, which accounted for 35% of total nutrition spend in 2012. Our figures consequently understate DFID's total investment in nutrition. They do, however, give a

clear understanding of DFID's more recent investments in development programmes.

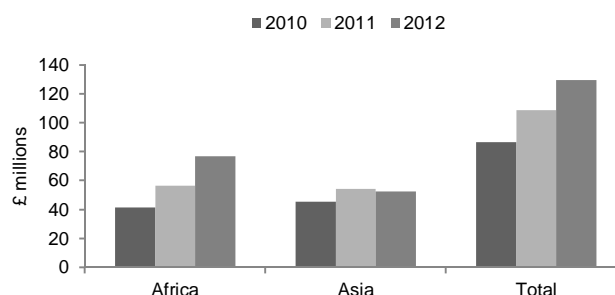
1.23 The majority of DFID's new investment between 2010 and 2012 was in nutrition-sensitive projects, although DFID also significantly scaled up its investment in nutrition-specific programmes. Most of the growth in nutrition-specific expenditure was in India, while the growth in nutrition-sensitive expenditure took place mainly in Africa. This is shown in Figures 3 and 4.

Figure 3: Nutrition-specific expenditure by region, 2010-12³¹



Source: Development Initiatives data, analysed by ICAI.³²

Figure 4: Nutrition-sensitive expenditure by region, 2010³³



Source: Development Initiatives data, analysed by ICAI.³⁴

1.24 The nutrition-sensitive investments were mainly in agriculture (14%), food aid and food security (20%), health (44%), rural development (12%), social protection (8%) and other programmes (3%) (see Figure 5 on page 6).

²⁸ See <http://www.who.int/nutrition/challenges/en/>.

²⁹ 'Global' programmes were narrowly defined by DFID as those supporting the global governance of nutrition and the broader enabling environment, including leadership and co-ordination. It excluded regional programmes, which often do similar activities to global ones.

³⁰ DFID's categorisation of expenditure into the four pillars of its strategy, using as a basis the data in *DFID's Aid Spending for Nutrition: 2010-2012*, Development Initiatives, February 2014.

³¹ The total in this graph excludes expenditure on global projects.

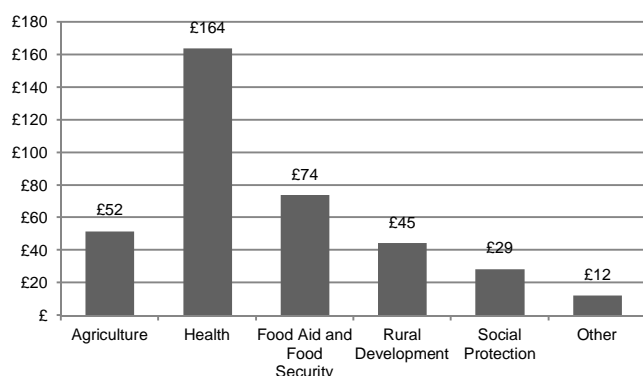
³² *DFID's Aid Spending for Nutrition: 2010-2012*, Development Initiatives, February 2014.

³³ The total includes some expenditure in other regions but excludes expenditure on global projects.

³⁴ *DFID's Aid Spending for Nutrition: 2010-2012*, Development Initiatives, February 2014.

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Figure 5: Nutrition-sensitive expenditure by sector in £ millions, 2010-12



Source: Development Initiatives data, analysed by ICAI.³⁵

1.25 The data used for Figures 2 to 5 are currently only available for 2010-12, although 2013 data should become available by late 2014.³⁶

1.26 In addition to its bilateral expenditure, DFID provided £90.5 million of core support in 2013-14 to UN agencies with specific nutrition mandates.³⁷ It is not possible to estimate what proportion of these funds is allocated to nutrition programmes.

Our approach and methodology

1.27 This review focusses on DFID's investments in nutrition since it started scaling up its work in 2010. DFID's programme has expanded rapidly and most of its current projects started in the last three years.

1.28 The review involved five steps. We reviewed:

- DFID's policies and its overall nutrition portfolio to understand its approach to nutrition;
- DFID's programmes in India and Zambia to assess how DFID's strategy is implemented at the country level;
- six projects in India and Zambia to assess objectives, delivery and whether these projects are likely to improve nutrition for intended beneficiaries (see Figure 6 on page 7);

³⁵ *DFID's Aid Spending for Nutrition: 2010-2012*, Development Initiatives, February 2014.

³⁶ This is for two reasons: firstly, donors only agreed with the approach they would use to classify nutrition-sensitive projects in December 2013; and secondly, the data required to calculate donor spend for nutrition in 2013 will not become available through the OECD DAC Creditor Reporting System until the end of 2014

³⁷ These were UNICEF, FAO, WHO and WFP.

- a selection of nutrition-specific and nutrition-sensitive projects in other countries to test the extent to which we could generalise findings from Zambia and India; and
- DFID's work to build an effective global response to undernutrition.

1.29 At each step, we interviewed a range of stakeholders from DFID; national, state and district governments in developing countries; other donors; the UN; the private sector; and civil society. We also interviewed a number of leading international experts on undernutrition in the UK and overseas. Interviews took place in Geneva, India, Zambia and the UK.

1.30 We reviewed relevant DFID policies and project documents and examined a range of other studies on nutrition. We analysed DFID's database on its 114 nutrition-specific and nutrition-sensitive projects. We also reviewed the evidence DFID used to justify its investments.

1.31 In India and Zambia, the core review team interviewed a total of over 250 mothers and front-line government workers from the India Health and Nutrition project and the three Zambian projects.

1.32 We also worked with local teams of researchers to conduct more detailed field research. This was carried out in UNICEF Partnership villages in India and in Indian and Zambian Nutrition project villages. The exercise had two aims: the first was to assess the extent to which intended beneficiaries benefitted from the projects and the second was to assess the reliability of the monitoring data used by DFID. The results of the research are summarised in the Impact section (see Figure 7 on page 19). The methodology is described in the Annex. The field research teams interviewed over 1,000 mothers and over 100 other stakeholders, including local government officials. They also held focus group discussions.

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Figure 6: Project descriptions

To assess how DFID's nutrition strategy is implemented at the country and project level, we focussed on two countries: Zambia and India.

Zambia has one of the highest stunting rates in sub-Saharan Africa, with 45% of children stunted. It was one of the first countries to join SUN. Over the next decade, Zambia aims to halve the number of stunted children. It has committed to increase its annual nutrition budget by 20%. DFID supported the Government of Zambia to develop its nutrition strategy and co-chairs the SUN donors within the country.

India has the largest number of malnourished people in the world. Over 60% of DFID's overall expenditure on nutrition-specific projects is spent in India, mainly in the states of Bihar, Madhya Pradesh and Odisha. We focussed on Madhya Pradesh because of its exceptionally high rates of undernutrition. Some 49% of children in the state are stunted and 26% are wasted.³⁸ India is not a member of SUN.

In the two countries, we focussed on six projects.

Zambia

Tackling Maternal and Child Undernutrition Project, Phases 1 and 2 (Budget: £14.5 million, 2011-16). In Phase 1, DFID financed UNICEF to support the Government of Zambia in delivering Vitamin A and deworming tablets in nine under-performing districts. It also undertook pilot projects on innovative approaches and supported capacity building on nutrition. Phase 2 will support implementation of the Government of Zambia's 1,000 Most Critical Days programme. We will refer to this project as the **Zambia Nutrition project**.

Zambia Sanitation and Hygiene Programme (Budget: £19 million, 2011-15). DFID is funding UNICEF to provide rural communities with hygiene and sanitation promotion services. The programme aims to increase the use of improved toilets and hand-washing. We will refer to it as the **Zambia Sanitation and Hygiene project**.

Zambia Social Protection Expansion Programme (Budget: £37.6 million, 2010-20). It aims to support the Government of Zambia to implement its cash transfers programme. The programme aims to reduce poverty and vulnerability in Zambia. We will refer to it as the **Zambia Cash Transfer project**.

In addition to the India Health and Nutrition project and the Zambia Nutrition project, we examined nutrition-specific projects in five other countries: Bangladesh, Ethiopia, Nigeria, Pakistan and Yemen. These are referred to in the

report as the 'Bangladesh Nutrition project', the 'Ethiopia Nutrition project' and so forth.

India

Madhya Pradesh Health Sector Reform Programme (Budget: £120 million, 2007-15). This aims to increase the use of health, nutrition and sanitation services by the poor. Phase 1 (2007-11) focussed on health systems strengthening, while Phase 2 (2011-15) focusses on maternal health, child health and nutrition services. We will refer to this as the **India Health and Nutrition project**.

DFID-UNICEF Strategic Partnership in India (Budget: £75 million, 2006-13). This aimed to improve progress towards child related MDGs and strengthen government capacity for planning, monitoring and implementation. In the final three years, DFID support focussed on nutrition. We will refer to this as the **India UNICEF Partnership**.

Water, Sanitation and Hygiene (WASH) in Madhya Pradesh and Odisha (Budget: £13.5 million, 2012-16). This aims to help communities to demand and use WASH services in order to improve health. Delivery of the programme in Madhya Pradesh is integrated with support to the state government's Health Sector Reform Programme. We will refer to this as the **India WASH project**.

³⁸ *Nutritional status of under 5 year old rural children in the districts of Madhya Pradesh*, National Institute of Nutrition, New Delhi, 2010.

2 Findings

Objectives

Assessment: Green-Amber 

DFID has been effective in galvanising action to combat undernutrition and in setting the global agenda

2.1 DFID has played a leading role in mobilising the international community to tackle undernutrition. It has also successfully influenced the global agenda on nutrition and ensured that the global development community's priorities are based on sound evidence.

DFID has actively engaged in global dialogue and has mobilised the international development community

2.2 DFID has been a leading supporter of the SUN Movement since it was set up in 2010. It co-chaired the SUN Donor Network with Canada and Germany and has successfully brokered agreements among donors on a number of key issues that were blocking progress. In these various ways, DFID has helped to build a political commitment for change.

2.3 The UK Government maximised the opportunities provided by the 2012 London Olympics and the 2013 G8 Summit in the UK to drive global efforts on undernutrition. Prime Minister David Cameron hosted the 2012 Olympic Hunger Summit and the Nutrition for Growth: Beating Hunger through Business and Science conference prior to the UK 2013 G8 Summit. An important outcome of the Nutrition for Growth high-level meeting was that developing countries, donors, the UN, the private sector and civil society agreed to co-operate to combat undernutrition. In total, participants at the event committed £15.2 billion to tackle undernutrition between 2013 and 2020, of which the UK committed £1.3 billion (9% of the total) in new funds³⁹ (see Annex A1). The first global nutrition report will be published in November 2014 and will report on how far commitments have been met. India took part in the 2012 Olympic Hunger

Summit and announced its decision to increase – from £2.2 billion to £4.1 billion – its annual commitment to its flagship nutrition programme, Integrated Child Development Services.

DFID has been influential in setting the global agenda on undernutrition

2.4 DFID has worked closely with the UN and other donors to set the global agenda for combating undernutrition. DFID, along with others, advocated for the SUN Movement and others to promote evidence-based interventions. It worked closely with like-minded donors to influence SUN and other organisations to focus on:

- stunting – by drawing attention to evidence on its links to cognitive impairment, which adversely impacts economic development;
- the first 1,000 critical days of life because evidence shows that sound nutrition during this period can have a profound impact on a child's ability to grow, learn and rise out of poverty;⁴⁰ and
- addressing undernutrition, through approaches which integrate nutrition-specific and nutrition-sensitive programmes. Such approaches are important. Both nutrition-sensitive and nutrition-specific interventions are needed to reduce stunting significantly.⁴¹

2.5 All three of these objectives have been adopted by the SUN Movement and by other organisations, including the World Bank.

DFID works well with other donors

2.6 DFID works closely and effectively with a number of donors, including Canada, the European Union (EU), Ireland and the USA. It also collaborates with the Bill & Melinda Gates Foundation (hereafter, the Gates Foundation) and the Children's Investment Fund Foundation. All the donor representatives we

³⁹ Overall, at Nutrition for Growth, 15 governments committed to increase nutrition budgets and donors made commitments to increase nutrition-specific and nutrition-sensitive spending, totalling £15.2 billion. Donors made commitments of up to £2.7 billion to tackle undernutrition and £12.5 billion for nutrition-sensitive investments between 2013 and 2020. *Nutrition for Growth Commitments: Executive Summary*, Nutrition for Growth, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207274/nutrition-for-growth-commitments.pdf.

⁴⁰ For example, by promoting good nutritional practices (breastfeeding and sound complementary feeding); ensuring mothers and young children get necessary vitamins and minerals; and treating malnourished children with special therapeutic foods.

⁴¹ Bhutta, Z. et al, *Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done and at What Cost?* The Lancet, August 2013, Volume 382, Issue 9890, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60996-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60996-4/fulltext).

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interviewed reported positively on DFID's work in mobilising support for action on undernutrition. One major bilateral donor stated 'we would not be where we are now without DFID'.

DFID has high-level political support and is working to ensure nutrition remains a global priority

2.7 In our view, the DFID nutrition team was able to operate effectively at the global level because it had high-level political support from the Prime Minister and strong backing from DFID Ministers and senior management. DFID was thus able to influence other governments and donor organisations at all levels, which increased the likelihood of success.

2.8 DFID is working to ensure that nutrition remains a high global priority in future. In our view, this is essential since it will take at least 15-20 years to overcome widespread undernutrition. The Prime Minister was a member of the High-Level Panel on the post-2015 development agenda. Australia, the Netherlands and the UK have called for nutrition to be included as a target under the new Sustainable Development Goal to end hunger. DFID has also called for the mandate of the SUN Movement to be extended from 2015 to 2020. Both of these changes would help to maintain momentum. DFID is also working with the Government of Brazil to sustain the commitments made at the London 2012 Olympic Hunger Summit and Nutrition for Growth high-level meeting at the 2016 Rio de Janeiro Olympic Games.

DFID's programme is coherent and generally well-balanced

2.9 DFID's nutrition programme focusses coherently on the same evidence-based priorities at the global, country portfolio and project levels. At each level, DFID targets improvements in the nutrition of children and their mothers during the first 1,000 days and promotes integrated approaches, involving nutrition-specific and nutrition-sensitive investments. We also found that DFID planned its Indian and Zambian Nutrition projects coherently with other donors.

2.10 While DFID's Nutrition programme focusses on stunting, most of its nutrition-specific interventions also address wasting, which is a major cause of

child death and under-five mortality. This can be seen, for example, in the India Health and Nutrition project, which focusses on stunting but includes treatment of severely and acutely undernourished children in Nutrition Rehabilitation Centres.

2.11 We found that few DFID business cases recognise that children who become wasted in seasonal lean periods often go on to become stunted. DFID's Yemen Nutrition project, which focusses on wasting and stunting, is a good example of how this problem can be addressed.

2.12 DFID's portfolio of 114 projects in 2010-12 was well-balanced, with 15% of projects nutrition-specific, 77% nutrition-sensitive and 8% including nutrition-specific and nutrition-sensitive components. In terms of expenditure in 2010-12, 19% (£88.9 million) was spent on nutrition-specific and 81% (£374.5 million) on nutrition-sensitive projects. A similar balance is also found in country portfolios, which generally include both nutrition-specific and nutrition-sensitive projects.

2.13 We reviewed 14 business cases for nutrition-sensitive projects – started since 2010 – and found that nutrition was well integrated into the project designs. We also examined the business cases for seven nutrition-specific projects from different countries and found that all of them focus on the first 1,000 days. Some also address the nutrition and health of adolescent girls before they become pregnant. This is important because underweight mothers generally give birth to underweight babies.

2.14 We were impressed by DFID's use of 'nutrition audits' to identify and determine opportunities to scale up nutrition-sensitive interventions. Nutrition audits in Malawi, Pakistan and Zambia have helped DFID to develop coherent nutrition programmes.

2.15 We noted that some audits recommended adding nutrition activities to projects, which were already likely to reduce undernutrition. In such cases, it is important to ensure that new activities do not detract from the projects' main objectives or undermine performance. For example, an external nutrition audit conducted in Zambia identified ten projects where nutrition activities could be added but DFID decided – correctly in our view – to go

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ahead only in a few specific projects. DFID country programmes should focus on integrating nutrition into a few key projects, where the impact will be greatest.

DFID's project objectives are generally well-founded but it does not focus sufficiently on interventions that will reduce stunting

2.16 DFID's development, research and global advocacy projects, in general, have relevant and realistic objectives. In most cases, objectives are clearly stated, based on sound evidence and relevant to the needs of undernourished children and their mothers.

2.17 Despite this, we found that DFID does not always select project interventions which will have the greatest impact on stunting. DFID's nutrition-specific projects generally emphasise the delivery of Vitamin A and deworming, which will contribute to reducing under-five mortality. These interventions will not directly reduce stunting or improve cognitive development.⁴² To do this, additional interventions are needed, including zinc supplements to reduce stunting and iron-folate supplementation for children to reduce iron-deficiency anaemia, which directly improves cognitive development.⁴³ These interventions were included in DFID's Bangladesh Nutrition project and the India Health and Nutrition project. They should be adopted, where appropriate, across all DFID programmes.

2.18 The 2013 Lancet series indicates that mortality could be reduced by 15% and stunting by 20% by implementing 10 proven interventions.⁴⁴ Due to shortages of human and financial resources, most countries – especially in Africa – are unable to

implement all ten interventions. DFID's country programmes should thus analyse the main causes of malnutrition in their particular context and scale up the specific bundles of interventions which will have the greatest impact on stunting and cognitive development and which can be sustained by government and other service providers.⁴⁵ This is currently not done sufficiently rigorously. In doing so, it is important that DFID distinguishes between the interventions that will reduce disease and those that will maximise the impact on undernutrition, including improved child feeding practices.⁴⁶

2.19 DFID emphasises the importance of investing in nutrition-sensitive interventions, such as agricultural development, food security and social protection projects, to reduce stunting (see Figure 3 on page 5). This is important because there is a strong consensus that nutrition-sensitive interventions are necessary to tackle the 80% of stunting that will not be addressed by nutrition-specific interventions.⁴⁷ The ways in which nutrition-sensitive interventions can improve nutritional status are more complex and less well understood. DFID is undertaking impact evaluations to build the evidence on this.

Theories of change are sound but could be more detailed

2.20 DFID's overall theory of change⁴⁸ for its nutrition strategy is robust and is based on sound evidence. Theories of change for projects are generally strong and outline, in broad terms, how outputs will be translated into outcomes and impacts. In the case of nutrition-specific projects, the link between project intervention and impact on undernutrition is direct. For nutrition-sensitive projects, the theories of change are more complex and impact will take longer to achieve.

2.21 Although project theories of change are generally sound, we believe they should be more detailed

⁴² Countries providing Vitamin A and deworming include Bangladesh, Ethiopia, India, Nigeria and Zambia.

⁴³ Bhutta, Z. et al. *What Works? Interventions for Maternal and Child Undernutrition and Survival*, The Lancet, February 2008, Volume 371, Issue 9610, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)616936/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)616936/fulltext). Mayo-Wilson, E. et al, *Zinc Supplementation for Preventing Death and Disease, and for Growth, in Children Aged Six Months to 12 Years of Age*, Cochrane Summaries, 2014.

<http://summaries.cochrane.org/CD009384/zinc-supplementation-for-preventing-death-and-disease-and-for-growth-in-children-aged-six-months-to-12-years-of-age#sthash.dJkpWguA.dpuf>). See also Annex, Figure A4.1.

⁴⁴ Bhutta, Z. et al, *Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done at What Cost?* The Lancet, August 2013, Volume 382, Issue 9890, page 453, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60996-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60996-4/fulltext).

⁴⁵ Bryce, J. et al, *Maternal and Child Undernutrition: Effective Action at National Level*, The Lancet, February 2008, Volume 371, Issue 9611, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61694-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61694-8/fulltext).

⁴⁶ Such analyses also should look at the strength of the health system, as many countries are relying on volunteer health workers to deliver many of the nutrition interventions.

⁴⁷ *Improving Child Nutrition: The Achievable Imperative for Global Progress*, UNICEF, April 2013, http://www.unicef.org/media/files/nutrition_report_2013.pdf.

⁴⁸ A theory of change 'defines all building blocks required to bring about a given long-term goal', <http://www.theoryofchange.org/what-is-theory-of-change>.

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and focus better on the risks that could prevent DFID achieving an impact on undernutrition. We reviewed the theories of change of seven nutrition-specific projects. None of the projects describe, in sufficient detail, the intervening steps or 'intermediate outcomes' required to achieve a successful outcome - nor do they assess the risks involved.

- 2.22 A good theory of change would do this and would focus attention on what needs to be done, by whom and at which stages to achieve impact. It would also encourage teams to challenge the logic of their design and check that the best package of interventions has been selected. For example, the process of developing a sound theory of change would make it more likely that the team designing a project to deliver Vitamin A and deworming tablets would consider the other interventions required to impact on stunting and cognitive development. It would also encourage the design team to consider the intermediate outcomes, which would need to be measured to indicate progress towards project outcomes and impacts on undernutrition. These might include, for example, increased Vitamin A levels in children.

Project designs are responsive to beneficiary needs but should focus more on the most vulnerable groups

- 2.23 Although DFID's nutrition-specific projects are generally responsive to the needs of intended beneficiaries, there is only limited scope to involve beneficiaries in the design of the projects. This is because nutrition-specific projects generally use pre-existing delivery mechanisms, such as weekly clinics at government health centres. There are also only limited opportunities to involve beneficiaries in the choice of interventions because these are generally selected based on scientific evidence.
- 2.24 We saw examples of DFID involving intended beneficiaries well in the design of nutrition-sensitive projects. For example, in the Zambia Sanitation and Hygiene project, communities are fully involved in the process of planning the type and siting of toilets and hand-washing facilities. In

pilot projects, such as ColaLife,⁴⁹ intended beneficiaries were actively involved in designing the best way to package oral rehydration solution (ORS) for diarrhoea treatment. Additionally, HarvestPlus in Zambia involved farmers in its trials of Vitamin A-rich maize to identify varieties likely to be popular with farmers and consumers.

- 2.25 We found that DFID needs to do more to involve the most vulnerable groups in project design. The India Health and Nutrition project, for example, focusses on districts with high levels of child undernutrition but it does not adequately address the needs of the most vulnerable families. Thousands of tribal farmers and their families migrate in the dry season to work on construction sites in other states. Their children often suffer from high levels of stunting and wasting. They find it difficult to access government health and nutrition services in these other states. This should have been taken into account in designing the project.⁵⁰ We also found in our field research of the Zambia Nutrition project that services do not yet extend to 'hard-to-reach' households.⁵¹ These households include ethnic minorities and people living a long way from facilities, who find it difficult to come to clinics, especially in the rainy season when roads may be impassable.

Delivery Assessment: Green-Amber 

DFID's pace of delivery globally has been good; however, it should have been better at the portfolio and country levels

DFID's pace at the global level has been good

- 2.26 DFID has taken the lead in co-ordinating donors to take action and accelerate global progress in tackling undernutrition. DFID's support to SUN has been essential. DFID has financed the SUN Secretariat and provided consultants to support SUN's member countries in developing fully costed national nutrition plans. DFID consultants have

⁴⁹ ColaLife is a project funded as part of the Zambia Nutrition project, Phase 1.

⁵⁰ DFID was aware of this problem from earlier work it had commissioned on migrant labour and it should have taken this into account in the project design. See Learning section, paragraph 2.106.

⁵¹ Hard-to-reach households include ethnic minorities, often living outside villages and remote communities.

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also provided short-term capacity building, such as in Zambia, to assist with workforce planning.⁵²

2.27 Following the Nutrition for Growth high-level meeting, DFID is supporting annual global progress reports on nutrition to analyse progress against commitments.⁵³ DFID has also helped to establish a consensus on how nutrition should be managed globally. For example, as co-facilitator of the SUN Donor Network, DFID has helped to broker an agreement among donors on the best way to track nutrition investments.

The pace of DFID's scale-up of investments at the portfolio level should have been faster and on a larger scale

2.28 Given DFID's strong commitment to tackle undernutrition, we would have expected to see a comprehensive and rapid scale-up in DFID's expenditure across both Africa and Asia since 2010. This did not happen. Although DFID's annual nutrition expenditure increased by 66% between 2010 and 2012, the new investment was mainly on nutrition-sensitive projects in Africa. The limited growth in nutrition-specific expenditure over this period was focussed on three large projects in India. Nutrition-specific expenditure in Africa was static. Although nutrition-specific expenditure in Africa is expected to triple between 2012 and 2015, we would have expected it to start rising earlier.

At the country level, DFID's pace has been slow

2.29 We noted delays at the country level in project implementation. Some delays were for reasons beyond DFID's control. For example, building the relationships needed to influence governments and other donors to prioritise nutrition – which DFID did successfully in many countries – takes time. Other delays, however, were within DFID's control and it should have managed them better across its portfolio. These delays were mainly caused by:

- DFID's business case approval and other procedures – in some cases, it took over two years until new projects could be implemented;⁵⁴ and
- the lack of advisors in DFID country offices who understand nutrition and are able to put knowledge into action adversely affected the pace of the programme.

2.30 DFID scaled up its nutrition programme most effectively in countries where it had trained advisors to act as nutrition champions. Since 2009, DFID's Policy Division has financed the equivalent of three full-time advisors responsible for nutrition, in a selection of country offices each year. They have played a critical role in working with governments to develop nutrition policies and in scaling up programmes. In Zambia, at the time of our review, a full-time nutrition advisor was in post. In India, a full-time nutrition advisor was in post when DFID scaled up its nutrition work.

2.31 Even where staff capacity is strong, DFID needs to manage its partners and projects more robustly to prevent delays. In Zambia, implementation of the 2011-15 National Nutrition Strategy only started in 2013, making it difficult to achieve its objectives by 2015. By February 2014, the Indian Health and Nutrition project had spent only 12% of DFID's £9 million financial assistance budgeted for the Integrated Child Development Service in the year ending March 2014.⁵⁵ This aid is mostly for infrastructure, such as building village mother and child centres. DFID should have anticipated the time this would take and should have devised more realistic plans. DFID should also have acted more promptly to address the delays once they were identified. Furthermore, contractual and recruitment issues mean that the contractor for the India WASH project now has under two and half years to implement its planned three-year programme. We are concerned about how much

⁵² *Tackling Maternal and Child Undernutrition in Zambia (Phase 2), Annual Review 2014*, DFID, 2014 page 8, unpublished.

⁵³ *Nutrition for Growth Accountability*, Nutrition for Growth, Draft 3, September 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257062/Nutrition_for_Growth_Accountability_18_09_2013.pdf.

⁵⁴ This issue was also identified by the ICAI review of child mortality in Kenya. It recommended that DFID speed up the approval process for business cases and allow for greater flexibility in the process. *DFID's Contribution to the Reduction of Child Mortality in Kenya*, ICAI, March 2014, page 41, <http://icai.independent.gov.uk/wp-content/uploads/2014/03/ICAI-Child-Mortality-FINAL-120714.pdf>.

⁵⁵ *Financial assistance status update*, Integrated Child Development Services, February 2014.

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can be achieved in this time and whether the value-for-money assessment in the business case remains valid.

- 2.32 We also noted examples of agile decision-making by DFID's managers at the country level. For example, DFID began Phase 2 of the Zambia Nutrition project while Phase 1 was still being implemented, in order to reach a larger number of beneficiaries more quickly.

DFID's choice to work with governments is the right one for sustainability

- 2.33 DFID recognises that to achieve impact on nutrition at scale it needs to work with governments. There is strong evidence that national ownership is needed for programmes to be effective and sustainably delivered at scale. This is especially the case where an integrated approach, involving different sectors, is required – as with nutrition.⁵⁶ DFID implements through government systems where possible. In the India Health and Nutrition project, for example, DFID funds the Government of Madhya Pradesh to deliver nutrition programmes.

- 2.34 There are challenges in working with partner governments. Ensuring necessary co-ordination between ministries which are not used to working together can be a problem. We found this in Zambia, especially at the district level, where it constrains effective implementation of the Zambia Nutrition project. Co-ordination between government, the private sector and civil society can also be difficult to achieve.

- 2.35 Weak government financial and human resource management systems also present challenges. DFID provides technical assistance consultants to build the capacity of governments to deliver nutrition programmes. We saw consultants being used to fill human resource gaps and strengthen systems, such as monitoring and evaluation. In

India, DFID used consultants to strengthen national, state and district-level nutrition monitoring systems under the India Health and Nutrition project. In Zambia, DFID is building the capacity of the National Food and Nutrition Commission, which has historically been institutionally weak and unable to influence policymakers.⁵⁷ The Zambia Nutrition project also supported development of the first BSc course in Human Nutrition at the University of Zambia, in order to build long-term national capacity.

Where government is unable to deliver, DFID delivers effectively through civil society

- 2.36 DFID is agile and implements through civil society partners when appropriate. On the Accelerating Improved Nutrition for the Extreme Poor in Bangladesh programme, DFID partnered with non-governmental organisations (NGOs) to reach more beneficiaries at a faster pace. While this will not strengthen government capacity directly, DFID aims to link beneficiaries to government services in order to ensure sustainability.⁵⁸

DFID needs to keep its technical assistance focussed

- 2.37 DFID should use its consultants to focus on strategic issues where change is possible. On the India Health and Nutrition project, we noted that the technical assistance contractor had responded to some government requests for assistance, which were not strategic. DFID should work with the contractor to ensure it shares DFID's vision for the project and its key strategic objectives. On the Zambia Nutrition project, a SUN Fund Manager has been contracted to manage the fund and minimise the risk of financial mismanagement by government. It also provides technical assistance. We are concerned that the contractor may become overburdened by its financial management responsibilities, which could compromise its ability to provide strategic technical assistance. DFID should minimise this risk by providing high-level

⁵⁶ *Scaling Up Nutrition (SUN) Movement Strategy (2012-2015)*, SUN, September 2012, <http://scalingupnutrition.org/wp-content/uploads/2012/10/SUN-MOVEMENT-STRATEGY-ENG.pdf> and *Improving Nutrition through Multi-Sectoral Responses*, World Bank, 2013, http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/05/000356161_20130205130807/Rendered/PDF/751020WP0Impro00Box374299B00PUBLIC0.pdf.

⁵⁷ *Tackling Maternal and Child Undernutrition in Zambia (Phase 2)*, Business Case, DFID, November 2012, http://iafi.dfid.gov.uk/iafi_documents/3739615.doc.

⁵⁸ *Accelerating Improved Nutrition for the Extreme Poor in Bangladesh*, February 2012–December 2015, DFID, February 2011, page 24, http://iafi.dfid.gov.uk/iafi_documents/3367878.doc.

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support to the contractor in discussions with government ministries on financial management.

By working with other donors, DFID has mobilised resources and facilitated co-ordination

2.38 DFID has successfully encouraged donors to increase funding on nutrition and to co-ordinate their programmes. DFID provided catalytic finance to the SUN Secretariat when it could not fund its country-level activities.⁵⁹ DFID also acts as donor convenor in seven SUN countries and facilitates co-ordination on nutrition.⁶⁰ In Zambia, DFID played a key role in setting up the SUN Multi-Partner Trust Fund to mobilise donor resources for the Government's 1,000-day plan. In India, it worked with donors, such as the World Bank, to avoid duplication. DFID also participates in global efforts through the WHO and the EU to standardise monitoring and evaluation. We note, however, that co-ordination among donors on monitoring can be a challenge in countries where donors are significantly scaling up their nutrition programmes, such as Zambia.

DFID needs to consider a wider range of delivery partners

2.39 DFID generally procures contractors competitively, where a choice of suppliers makes it feasible or it provides strong justification otherwise. On the India health and nutrition project and the Zambia nutrition project, DFID selected its service providers on a competitive basis.⁶¹ On the Nigerian Nutrition project, DFID pre-selected its partners, as it felt that their collective expertise might not have been secured through a tender.⁶²

DFID should consider alternatives to implementation through UNICEF

2.40 DFID often partners with UNICEF to implement nutrition projects. UNICEF has some notable strengths. It has nutrition, health and water/sanitation/hygiene (WASH) expertise. It produces valuable research to influence policymakers. UNICEF can also procure at scale.

2.41 Despite its strengths, we noted cases where UNICEF was selected to implement DFID projects without competition. In a number of these cases, other organisations should have been considered. An example of this is the Ethiopian nutrition project,⁶³ where UNICEF was selected to implement the project through the Government of Ethiopia's health extension programme and to channel funds for field operations to international NGOs. A private sector contractor or an international NGO could also have been considered. We reviewed four business cases for nutrition-specific projects with UNICEF. Only in the Yemen Nutrition project were alternatives considered.⁶⁴ ICAI's earlier review of DFID's work through UNICEF also found that DFID did not systematically consider alternatives to UNICEF for programme delivery or procurement.⁶⁵

2.42 DFID's assumptions about UNICEF's capacity are not always accurate. UNICEF's weak management of the Zambia Sanitation and Hygiene project resulted in DFID putting it on a performance improvement programme.⁶⁶ In India, DFID aimed to strengthen UNICEF's results management capacity; however, we saw little evidence of this being achieved.⁶⁷ We also found that DFID offices sometimes use the generally positive assessment of UNICEF's capacity in the DFID Multilateral Aid Reviews to justify selecting UNICEF without

⁵⁹ *Strengthening International Co-ordination and Leadership on Nutrition and Food Security, Annual Review 2012*, DFID, 2013, page 22, http://iati.dfid.gov.uk/iati_documents/4246410.docx.

⁶⁰ These seven countries are Bangladesh, Burma, Ethiopia, Nigeria, Pakistan, Yemen and Zambia. SUN Donor Network, <http://scalingupnutrition.org/the-sun-network/donor-network>.

⁶¹ DFID first selected options to provide technical assistance on the India Health and Nutrition project. In 2012, DFID put the contract out for tender, selecting FHI 360. CARE is the SUN Fund Manager for the Zambia Nutrition project.

⁶² *Improving Maternal, Newborn and Child Nutrition in Northern Nigeria, Business Case*, DFID, June 2011, page 34, http://iati.dfid.gov.uk/iati_documents/3717693.doc.

⁶³ *Intervention Summary: Accelerating Reductions in Under Nutrition in Ethiopia*, DFID, 2013, http://iati.dfid.gov.uk/iati_documents/3988488.doc.

⁶⁴ The projects relating to Ethiopia Nutrition, Nigeria Nutrition, Yemen Nutrition and Zambia Nutrition. *Business Case: Improving Nutrition in Yemen 2012-15, Intervention Summary*, DFID, page 26, http://iati.dfid.gov.uk/iati_documents/3755652.docx.

⁶⁵ *DFID's work through UNICEF*, ICAI, March 2013, page 1, <http://icai.independent.gov.uk/wp-content/uploads/2010/11/ICAI-report-DFIDs-work-with-UNICEF.pdf>.

⁶⁶ *Annual Review, Zambia Sanitation and Hygiene Programme*, DFID, November 2012, page 19, http://iati.dfid.gov.uk/iati_documents/3787635.docx.

⁶⁷ *India: Time Extension of the DFID India Strategic Partnership with UNICEF*, DFID, 8 June 2011, unpublished.

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assessing its capacity in the specific country.⁶⁸ An example is the Zambia Nutrition project, Phase 1 business case.⁶⁹

DFID needs to articulate more clearly its objectives in using the private sector as a delivery agent

2.43 DFID recognises the potential of the private sector in improving nutrition in developing countries. The private sector has a role to play in producing and distributing food to the poor and providing the inputs to produce nutritious food.⁷⁰ For example, the private sector could fortify foods with micro-nutrients and distribute them through its supply chains.

2.44 Despite this, DFID's pace in working effectively with the private sector has been slow. DFID has yet to develop or support the kinds of public-private partnerships needed to test ways for businesses to engage in addressing global undernutrition in commercially viable ways. A reason for this is that, as yet, there have been few independent evaluations of how the private sector can be most effectively engaged as a delivery agent for nutrition services.⁷¹ A 2012 evaluation of HarvestPlus found that the private sector was not prepared to take on the commercial production of bio-fortified seed following successful trials.⁷²

2.45 DFID is funding some innovative work with the private sector. In Zambia, it is supporting Musika, an NGO, which aims to link smallholder farmers better to markets, in order to raise agricultural productivity and diversify cropping systems and diets. Musika works by encouraging and supporting networks of agents to work with poor smallholders. DFID is also financing a small private

sector pilot project, through the Zambia Nutrition project, to bring ORS to rural areas.⁷³ DFID's Agriculture Pull Mechanism Initiative is also testing mechanisms to leverage the private sector to deliver technologies to the poor.^{74,75} DFID has already evaluated the Zambia pilot project and has planned evaluations for the other initiatives.

2.46 DFID is also intending to link to the private sector through SUN's global and country business networks. Progress, so far, has been slow. DFID is also funding the Global Alliance for Improved Nutrition (GAIN), an NGO, to mobilise private sector investment for nutrition. GAIN is making progress in implementing delivery models for fortified products and in building public-private partnerships.⁷⁶ Large and small companies took part in the Nutrition for Growth high-level meeting. They focussed on how to improve the nutrition of their workers and how to address undernutrition in their core business operations.

2.47 DFID should consider the risks of private sector engagement, such as public policy being distorted towards private sector interests,⁷⁷ and establish risk mitigation strategies. DFID also needs to understand the incentives of the private sector and use this understanding to shape how it can scale up innovative pilots. DFID should contribute more to building an evidence base on private sector engagement in nutrition.

DFID needs to articulate how the New Alliance for Food Security and Nutrition might shape the delivery of nutrition

2.48 The New Alliance for Food Security and Nutrition involves partnerships between private sector

⁶⁸ *Multilateral Aid Review: Ensuring Maximum Value for Money for UK Aid through Multilateral Organisations*, DFID, March 2011, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67583/multilateral_aid_review.pdf.

⁶⁹ *Tackling Maternal and Child Undernutrition in Zambia, Business Case*, DFID Zambia, October 2011, page 29, http://iati.dfid.gov.uk/iati_documents/3717065.docx.

⁷⁰ Bryce, J. et al, *Maternal and Child Undernutrition: Effective Action at National Level*, The Lancet, 2008, Volume 371, 2008, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61694-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61694-8/fulltext).

⁷¹ Gillespie, S. et al, *The Politics of Reducing Malnutrition: Building Commitment and Accelerating Progress*, The Lancet, August 2013, Volume 382, page 562, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60842-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60842-9/fulltext).

⁷² *Evaluation of HarvestPlus Phase II*, prepared for the Bill & Melinda Gates Foundation, ABT Associates, page xi, unpublished.

⁷³ ColaLife project, *Annual Review, Tackling Maternal and Child Undernutrition in Zambia, Phase 1*, DFID, January-February 2014, page 18, unpublished.

⁷⁴ *DFID's Support to Agricultural Research*, ICAI, 2013, <http://icai-independent.gov.uk/wp-content/uploads/2013/12/ICAI-Agricultural-Research-report-FINAL.pdf>.

⁷⁵ *Agriculture Pull Mechanism Initiative - Stimulating Innovation in Agricultural Research and Development, Intervention Summary*, DFID, 2012, http://iati.dfid.gov.uk/iati_documents/3538207.doc.

⁷⁶ *GAIN – Global Alliance for Improved Nutrition (Programme Partnership Arrangement (PPA)), Annual Review*, DFID, June 2013, page 4, http://iati.dfid.gov.uk/iati_documents/4212457.doc.

⁷⁷ *Mid-term Independent Progress Review of GAIN's Programme Partnership Agreement, 2011-14, Final Report*, Cambridge Economic Policy Associates Ltd., 2012, unpublished.

⁷⁷ Shrimpton, R., *Private Sector Contributions to Ending Child Hunger and Undernutrition*, SCN News, 2007, Volume 34, 32–36, <http://www.unscn.org/layout/modules/resources/files/scnnews34.pdf>.

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companies, governments and donors, including DFID, in ten African countries. It aims to stimulate commercial agriculture and 'to raise 50 million people out of poverty by 2022, whilst contributing to improved food and nutrition security'.⁷⁸ DFID is supporting the New Alliance through £600 million, which it had already committed to 40 on-going and planned projects. Some components of these projects will be tailored to address New Alliance priorities.

- 2.49 DFID has not yet developed a detailed theory of change outlining how its proposed investments and those of New Alliance partners will reduce undernutrition. There is a lack of information in the public domain on DFID's support for the New Alliance. This makes it difficult for others to judge whether DFID's support is likely to contribute to large-scale reductions in undernutrition anticipated by DFID and its partners.

DFID generally involves beneficiaries well in delivery

- 2.50 DFID takes beneficiaries' needs into account and involves them in delivery, where feasible. On the India Health and Nutrition project, DFID's financial aid is focussed on building health facilities in remote areas to reach beneficiaries.⁷⁹ Women's self-help groups in communities in Madhya Pradesh are devising local solutions to combat undernutrition. In Zambia, the HarvestPlus project involves beneficiaries as model farmers to demonstrate dietary diversification.⁸⁰
- 2.51 DFID could do more, however, to ensure that services are accessible to beneficiaries. For example, on the Zambia Nutrition project, mothers reported that they had not been consulted about clinic timings. As different services were being offered on different days, repeat visits were required. This is difficult for mothers who are also engaged in agriculture and other activities. Project

managers need to understand better the challenges mothers face and to develop appropriate interventions for them.

Financial management, fiduciary risk and value for money

- 2.52 We saw examples of good financial management at DFID. For example, DFID's review of the Zambia Sanitation Hygiene Programme's financial reports identified that UNICEF had spent too little on staffing. DFID was able to make a direct link from this to UNICEF's slow progress.⁸¹

DFID is monitoring well the risk of government misuse of funds

- 2.53 Working with governments presents financial management risks and challenges. Internal controls can vary among ministries, as can the risk of financial mismanagement, fraud and corruption. There is a greater risk of financial mismanagement in nutrition projects because they generally involve working with a number of different government departments. Also, in countries with decentralised government, such as Zambia and India, internal controls need to be considered at the national and state or district levels. There may also be challenges around financial management when, for example, government supply chains are used to distribute commodities to beneficiaries.

- 2.54 We found DFID had taken appropriate steps to mitigate fiduciary risk and the risk of corruption. DFID uses fiduciary risk assessments well to identify key areas of risk and it manages these. On the Zambia Nutrition project, DFID passes funds through the SUN Fund Manager, who is responsible for ensuring that government partners have the capacity to use and manage funds appropriately. In India, DFID was monitoring controls at the Department of Public Health and Welfare and the Department of Women and Child Development. We noted that the state government had taken positive actions to improve public accountability. The Government of Madhya Pradesh, for example, has launched an online

⁷⁸ *New Alliance for Food Security and Nutrition: 2013 Progress Report Summary*, DFID,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205885/New_Alliance_progress_report_May_2013.pdf.

⁷⁹ For Integrated Child Development Services, 79% of financial assistance in 2013-15 was allocated to infrastructure.

⁸⁰ DFID's support to HarvestPlus is assessed in the ICAI report on *DFID's Support to Agricultural Research*, ICAI, October 2013, <http://icai.independent.gov.uk/wp-content/uploads/2013/12/ICAI-Agricultural-Research-report-FINAL.pdf>.

⁸¹ *Annual Review, Zambia Sanitation and Hygiene Programme*, November 2012, DFID, page 15, http://iati.dfid.gov.uk/iati_documents/3787635.docx.

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public grievance redress system and a public hearing process.

- 2.55 DFID monitors government financial management capacity closely and provides technical assistance to strengthen systems in India and Zambia. For example, in Madhya Pradesh, DFID provides assistance to strengthen financial management processes. In Zambia, DFID is working with the government to strengthen public financial management. DFID should continue to assess the risk of financial mismanagement – especially when working with many different government departments in a country – and ensure appropriate risk mitigation. DFID also needs to learn lessons from the delays by the Government of Madhya Pradesh in spending financial assistance on the India Health and Nutrition project. Unspent funds are vulnerable to misuse and DFID needs to ensure that it can hold government partners to account.

Impact

Assessment: Amber-Red 

It is too early to assess the impact of DFID's portfolio

- 2.56 DFID's nutrition projects are based on robust evidence from the Lancet series and other sources and generally have sound theories of change. As a result, if the projects are designed and implemented well, they should contribute to reductions in undernutrition and child mortality.
- 2.57 It is too early to assess whether DFID's portfolio of projects has had the expected impact on undernutrition. Since DFID only started to scale up its nutrition work in 2010 and the pace of delivery has been slow, most of its projects are at an early stage of implementation. We would expect to see some sustained project-level improvements in stunting and wasting in the next two to three years. DFID has commissioned evaluations of some of its post-2010 projects. These evaluations will report in 2015 and should provide evidence of impact.
- 2.58 There is also, as yet, only limited evidence on the extent to which DFID's projects are delivering short-term results – in line with their theories of change – and whether they are on track to achieve their outcomes. There are two reasons for this. Firstly, most of DFID's nutrition projects were only

started in the last few years and have had only one or two annual reviews.⁸² Because the reviews were of the early stages of each project, they focussed on the delivery of activities and outputs and did not generally assess whether short-term results and outcomes had been achieved. Secondly, many of DFID's projects focus insufficiently on monitoring of short-term results (see paragraphs 2.82-2.86).

- 2.59 DFID has only evaluated a couple of the earlier nutrition projects, started before 2010. Two evaluations of nutrition-sensitive projects found positive nutritional outcomes and impacts. These are the Economic Empowerment of the Poorest project in Bangladesh and the Zambia Cash Transfer project. Unfortunately, DFID has not evaluated its older nutrition-specific projects, such as the India Health and Nutrition project and the India UNICEF Partnership, so it is not possible to assess their impacts on undernutrition.
- 2.60 Since it is too early to assess the impact of DFID's nutrition portfolio, we reviewed progress to date, the trajectory of change and the likelihood of achieving impact.

DFID has contributed to a revitalised global emphasis on undernutrition

- 2.61 DFID has succeeded in encouraging a global effort to tackle undernutrition by donors and country governments working in partnership. Its support for the SUN Movement has improved co-ordination and built global momentum. DFID has effectively used the 2012 London Olympics and the 2013 UK G8 Summit to increase financial and political commitment to undernutrition by both donors and partner governments.⁸³ It has also helped to maintain the momentum for change, set the global agenda and ensured that most governments and donors focus their programmes on the first critical 1,000 days.
- 2.62 While the essential foundations have been laid, it would be unrealistic to expect DFID's global advocacy programme, which only started in 2009,

⁸² We examined seven of DFID's nutrition-specific projects. Six of the seven projects had had only one annual review.

⁸³ Gillespie, S. et al, *The Politics of Reducing Malnutrition: Building Commitment and Accelerating Progress*, The Lancet, August 2013, Volume 382, page 562, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60842-9/fulltext#article_upsell](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60842-9/fulltext#article_upsell).

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already to have resulted in reductions in stunting. It is important that DFID keeps up the momentum and does not get distracted by other development 'fads'.

DFID has taken positive steps to improve nutrition services in India and Zambia

Nutrition-specific projects are showing positive trends

2.63 DFID's India Health and Nutrition project aims to reduce undernutrition by providing financial and technical assistance to the Government of Madhya Pradesh to improve the provision and use of nutritional services. Surveys conducted in Madhya Pradesh in 2010-11 and 2011-12 show an improvement in early and exclusive breastfeeding, Vitamin A coverage in children and iron folate coverage in pregnant women. These changes would be expected, ultimately, to contribute to a reduction in undernutrition.⁸⁴

2.64 A key reason for the improvements in service delivery in India was the integration of health and nutrition services at the community level, encouraged by DFID. This has enabled a faster scale up than would otherwise have been the case and it is likely to result in greater impact than an isolated nutrition project would have made.

2.65 Senior government officials we interviewed stated that DFID's flexible and catalytic funding has made it possible for the Government of Madhya Pradesh to increase the quality and pace of its scale up of nutrition services. Although DFID financed only 2.6% of the Madhya Pradesh nutrition budget from 2010-11 to 2013-14,⁸⁵ it funded government pilot projects to develop and test innovative approaches, which the Government later took to scale. It also strengthened the quality of service delivery by training frontline staff and monitoring implementation.

2.66 DFID does not adequately monitor the short-term results of this project. Consequently, we cannot be

confident of the extent to which DFID has contributed to improvements in nutrition services, although our overall impressions were positive. We are surprised that the India Health and Nutrition project – one of DFID's largest and oldest nutrition projects – cannot demonstrate results or impact more conclusively. DFID did not build an evaluation study into the design of the project. If it had done so, preliminary indications of the impact of the project on stunting would have been available by the time of this review. Such an evaluation would also have increased DFID's understanding of the local context and the main causes of undernutrition in study areas. This would have made it possible to tailor the package of interventions, where appropriate, to maximise reductions in stunting.

2.67 The first phase of DFID's Zambia Nutrition project aims to improve nutrition by delivering Vitamin A and deworming tablets to children in nine remote districts through child health weeks. These are organised by the Government of Zambia, with support from UNICEF. A recent assessment concluded that child health weeks in Zambia were 'very cost effective' and provided higher coverage than otherwise would have been achieved.⁸⁶ Our field research, however, indicated that coverage of child health weeks may be considerably lower than reported. In the districts we visited, we found that many children had not received the recommended two doses of Vitamin A and deworming tablets each year (see Figure 7 on page 19).

2.68 The Zambia Nutrition project also undertook two innovative pilots. One pilot provided treatment for diarrhoea through the private sector. A well-designed evaluation concluded that the product increased rates of treatment with ORS and zinc from 1% to 45%.⁸⁷ Another output of the project was the design of a more comprehensive multi-sectoral Phase 2 project, which has recently commenced. Although the Phase 1 project will not significantly impact on stunting, we agree with

⁸⁴ Annual Health Surveys, 2010-11 and 2011-12, undertaken by the Government of India's Registrar General across 9 states and 284 districts, including 50 in Madhya Pradesh. These two surveys use the same methodologies and, therefore, are directly comparable. They show a small change of between 4-8% in each indicator.

⁸⁵ This reduced between 2010-11 and 2013-14 from 4.1% to 2%, as the government increased its budget allocated to the Integrated Child Development Services budget and DFID reduced its support.

⁸⁶ Fielder et al, *Child Health Week in Zambia: Costs, Efficiency, Coverage and a Reassessment of Need*, Health Policy and Planning, December 2012, 1-18, <http://heapol.oxfordjournals.org/content/early/2012/12/14/heapol.czs129.full.pdf+html>.

⁸⁷ *ColaLife Operational Trial Zambia*, ColaLife, January 2014, <http://unicefinnovation.org/projects/colalife-operational-trial-zambia-cotz>.

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DFID's approach to delivering required services quickly to under-served communities, while developing an integrated approach.

Figure 7: Field Research in India and Zambia

ICAI commissioned field research in India and Zambia. The aim was to assess the extent to which communities have benefited from key DFID-funded projects and to assess the reliability of the monitoring data used by DFID. Our teams assessed the India UNICEF Partnership, the Zambia Nutrition project (Phase 1) and the Zambia Sanitation and Hygiene project. Our field researchers did not visit the India Health and Nutrition project, because it was covered by the ICAI core team during its field visits.

Our researchers conducted 1,042 household interviews, 101 key informant interviews and 18 focus group discussions. We utilised direct observation from trained researchers and gathered qualitative and quantitative information. Findings from the field research contributed to the key findings listed in this report. In particular:

DFID projects are showing positive signs: In Zambia, the Nutrition project had delivered Vitamin A and deworming tablets to women and children. Local health officials believed that DFID support had contributed to health improvements and mothers believed it had contributed to health improvements. Some 90% of households in the research areas had latrines, many recently built as a result of the sanitation and hygiene project. In India, DFID-supported nutrition rehabilitation centres (NRCs) were generally clean, well-staffed and well-stocked. All health and nutrition workers had received training on infant and young child feeding, of which approximately 70% was full classroom training. The majority of nutrition workers (55%) had good knowledge of severe acute malnutrition, while the rest had some knowledge.

Monitoring data is often of low quality: In Zambia, our research found that coverage of Vitamin A and deworming had increased but significantly less than DFID had reported. In Mbala district, only 25% of children had received two doses a year of Vitamin A, while in Mufumbwe district 75% of children had. DFID reported coverage of 65% and 100%, respectively – but this referred to children receiving Vitamin A and deworming once, which is not the recommended annual dose.⁸⁸ In the India UNICEF Partnership villages we visited, 15 villages were reported as having 100% coverage of latrines. Only seven villages actually did. Some 20% of households in these villages did not have latrines.

The quality of nutritional services is mixed: In Zambia and India, we found that mothers did not sufficiently understand the services being provided to them and their children. Focus groups revealed that many mothers do not believe two doses a year of Vitamin A and deworming are necessary, indicating a need for better communication and training. Some mothers also requested that health workers should provide better information. In the Zambia Sanitation and Hygiene project, only 51% of latrines had a hand-washing station and only 28% had soap or ash for hand-washing. Latrines were being washed away by rain. Without continual and long-term government commitment, the improvements are unlikely to be sustainable. In India, mothers had poor knowledge of breastfeeding and treatment of severe acute malnutrition. Staff at the NRCs for severely wasted children provided good medical care. Only 10% of mothers, however, reported that they received good counselling or training. Few mothers returned to the NRCs for follow-up monitoring of their children's progress.

It is crucial to tailor services to the local context. In each country, we saw challenges in reaching certain groups. In Zambia, young mothers did not want to mix with older mothers for fear of stigmatisation. Some families migrated to distant fields to work and, therefore, missed child health weeks and are unlikely to use latrines. In India, the picture is mixed. In the India UNICEF Partnership villages, gender and caste barriers prevented people from accessing nutrition services. We noted, however, that this was less of a problem in the predominantly tribal districts covered by the India Health and Nutrition project.

Nutrition-sensitive projects show positive trends, although more needs to be done on WASH and agriculture

2.69 DFID is implementing nutrition-sensitive projects in both countries. This is important since nutrition-specific projects, alone, will only reduce stunting by 20%. Some nutrition-sensitive projects are sufficiently mature to show results. In Zambia, a rigorous impact evaluation of the Zambia Cash Transfer project demonstrated that it increased expenditure on food, expanded the diversity of diets and improved infant and young child feeding practices.⁸⁹ Although, as yet, there is limited evidence on the impact of nutrition-sensitive investments in India, in Bangladesh the Economic Empowerment of the Poorest programme has

⁸⁸ *Tackling Maternal and Child Undernutrition in Zambia, Annual Review*, February 2014, DFID, unpublished.

⁸⁹ Seidenfield et al, *Zambia's Child Grant Program: 24-Month Impact Report*, American Institutes for Research, September 2013, http://www.air.org/sites/default/files/Zambia_Child_Grant_Program_Report_20131.pdf.

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reduced stunting. Between 2010 and 2013, the incidence of child stunting fell from 50% to 42%, although wasting remained constant at 18%. Anaemia rates also fell significantly.⁹⁰ Another evaluation of a livelihoods project in Bangladesh found that it had diversified diets and improved food coping strategies, which could lead to improvements in nutrition.⁹¹

- 2.70 DFID is implementing WASH projects in India and Zambia. These are expected to contribute to improved nutrition by reducing the incidence of diarrhoea and tropical enteropathy.⁹² Progress is slower than we would have expected. The Zambia WASH project, implemented by UNICEF, was started in late 2011. It was given strict targets for improved performance by DFID after an adverse annual review in 2012. It is now performing better, with 2,212 villages verified as fully using and maintaining toilets by January 2014.⁹³ Our field research confirmed that toilets are being used more. We noted, however, that this was not always accompanied by better hygiene practices, such as hand-washing. DFID's three-year India WASH project was due to start in September 2012. It was delayed and only commenced in October 2013. It will now be implemented over two and a half years, ending in March 2016. We are concerned that the project will not fully engage communities or achieve the planned hygiene behaviour change in the time now available.

Nutrition projects should be implemented in an integrated way for maximum effectiveness.

- 2.71 To maximise impact, nutrition-specific and nutrition-sensitive interventions should be implemented in an integrated way. DFID encouraged this in India and Zambia by supporting integrated district-level planning. DFID will include nutrition-sensitive agriculture in Phase 2 of its

Zambia Nutrition Project. In India, it decided not to do so because agriculture and food security are covered by other large government and donor programmes. We note, however, that better co-ordination is needed to integrate the DFID-supported government health and nutrition programme into these other programmes. We also found that DFID needs to encourage greater integration in all countries of its nutrition and education programmes.

DFID's nutrition projects in India and Zambia do not always communicate effectively with mothers

- 2.72 DFID is aware of the importance of communicating with mothers about nutritious behaviour and mentions this in policy papers and project designs.⁹⁴ For example, DFID supported a BBC Media Action series in India on birth spacing, which reached an estimated 10 million people. A follow-up survey found that 4.4% of women of reproductive age visited a health facility as a result of exposure to the campaign.⁹⁵
- 2.73 The projects we visited, however, did not always communicate well with mothers. In Zambia, our field research found that government workers at child health weeks do not have the time or skills to educate mothers about the importance of regularly giving Vitamin A and deworming tablets to children. As a consequence, many mothers did not realise that their children need to be treated twice a year, which contributes to low coverage rates. Our core field team also noted that community health workers in Zambia had little training in nutrition.
- 2.74 In the India UNICEF Partnership, we found that staff at nutrition rehabilitation centres do not spend sufficient time speaking with mothers about their child's nutritional status. A third of mothers left the facilities with a poor knowledge of nutrition. An effective response to undernutrition will not only involve medical treatment. It will also include a

⁹⁰ Mascie-Taylor, N. and Goto, R., *Change Management System (CMS)*, Shire Project, 2013, <http://www.shiree.org/wp-content/uploads/2012/02/10-CMS-3-October-20131.pdf>.

⁹¹ *Bangladesh: Independent Impact Assessment of the Chars Livelihoods Programme – Phase 1 – Final Report*, HTSPE Limited, August 2011, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/204635/Evaluation-chars-livelihoods-prog-bangladesh.pdf.

⁹² Damage to the child's intestinal tract, which hinders absorption of nutrients by the body, caused by frequent infections of various types (viral, bacterial or protozoal). <http://inthehealth.oxfordjournals.org/content/2/3/172.full>.

⁹³ *Zambia Sanitation and Hygiene Project Annual Review*, DFID, February 2014, page 4, http://iati.dfid.gov.uk/iati_documents/4405351.docx.

⁹⁴ *Scaling Up Nutrition: The UK's Position Paper on Undernutrition*, DFID, September 2011, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67466/scal-up-nutr-uk-pos-undernutr.pdf.

⁹⁵ *BBC Media Action Global Grant Annual Review 2013: Detailed Health Logframe Narrative Report (Country Impact and Outcome)*, BBC Media Action, 2013. The programme was implemented in Madhya Pradesh and Odisha.

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range of behaviour change and communication activities.

DFID's programme should improve child nutrition but is unlikely to have expected impacts on stunting

2.75 Although DFID's nutrition projects are based on sound evidence and are expected to have a positive impact on child nutrition, they are unlikely to have the expected impacts on stunting and wasting. We noted three reasons for this:

- DFID's nutrition-specific projects are not using packages of interventions designed to have the greatest impact on stunting. Although the Lancet series highlighted zinc supplements for children as an effective way to reduce stunting none of the seven nutrition-specific projects we reviewed included this intervention (see paragraphs 2.17 to 2.18, above);⁹⁶
- our field researchers found that DFID's project partners do not always communicate well with mothers. This is likely to reduce DFID's impact on infant and young child feeding practices. Such practices have been shown to be important for preventing stunting (see paragraphs 2.72 to 2.74);⁹⁷ and
- nutrition-specific interventions and nutrition-sensitive programmes are not always implemented in the same communities. An integrated approach, involving both nutrition-specific and nutrition-sensitive interventions, is needed to maximise impact on stunting.

⁹⁶ The Lancet Series in 2008 and 2013 advocated zinc supplementation to improve growth in children under five years of age. A recent 2014 Cochrane Review examined growth in children, from six months to 12 years of age. It also found that zinc supplementation is associated with a small significant increase in height but less than reported in the Lancet. There was also significant heterogeneity in the results of the different studies reviewed. Further research is needed to determine the most effective ages at which to provide zinc supplements and the doses to be given. Mayo-Wilson E. et al, *Zinc Supplementation for Preventing Death and Disease, and for Growth, in Children Aged Six Months to 12 Years of Age*, Cochrane Summaries, 2014, <http://summaries.cochrane.org/CD009384/zinc-supplementation-for-preventing-death-and-disease-and-for-growth-in-children-aged-six-months-to-12-years-of-age#> and Bhutta, Z. et al, *Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done at What Cost?* The Lancet, August 2013, Volume 382, Issue 9890, page 453, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60996-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60996-4/fulltext).

⁹⁷ Bhutta, Z. et al. *What Works? Interventions for Maternal and Child Undernutrition and Survival*, The Lancet, February 2008, Volume 371, Issue 9610, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61693-6/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61693-6/fulltext).

2.76 We believe that DFID should modify the design of its projects to strengthen its impact on stunting and cognitive development of children.

DFID has designed high-quality project evaluations and is supporting global efforts to measure overall impacts on stunting

2.77 DFID will spend over £21 million over the next six years evaluating its own nutrition-related projects. The design of these evaluations is good and the programme of evaluations is far more comprehensive than those done earlier. We expect DFID to use them to assess its impact, improve the management of ongoing projects and contribute to the evidence base on nutritional programming. The evaluations use quantitative and qualitative methods, based on explicit theories of change. This should allow DFID to understand how and why change is occurring. For example, the evaluation of a Nutrition project in Bangladesh includes a well-designed quantitative assessment, which uses a control group to assess whether the impact would have occurred, even in the absence of DFID's involvement. It combines this with a qualitative component, which gathers information from intended beneficiaries and other key stakeholders.⁹⁸

2.78 Although these evaluations will make it possible to assess the impacts of specific projects on stunting and wasting, it is difficult for DFID and other organisations to assess overall progress on stunting. This is because most countries only conduct nutrition surveys every three to five years. To monitor its programme effectively, DFID needs more frequent and targeted surveys on stunting and wasting. Because stunting and wasting are difficult to measure, this cannot be done routinely by community health and nutrition workers, as part of general monitoring activities. More frequent and targeted national nutrition surveys, carried out by trained specialists, are required to provide accurate information.

2.79 The two main surveys currently undertaken internationally are the Demographic and Health

⁹⁸ *Terms of Reference - Impact Evaluation of a DFID Programme to Accelerate Improved Nutrition for the Extreme Poor in Bangladesh*, DFID, 2012.

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Surveys – funded by USAID – and the Multiple Indicator Cluster Surveys, supported by UNICEF.⁹⁹ They use a standardised methodology and their results are thus comparable. They both measure stunting and wasting.

- 2.80 A possible risk that would need to be managed in introducing more frequent surveys is that methodological differences could make it difficult to compare key nutritional indicators over time. There is evidence of this happening with the Annual Health Survey in India and in Pakistan. In some countries, we are also concerned that the rapid scale-up of nutrition work is exacerbating similar co-ordination problems. In Zambia, for example, we noted that three different donors were independently supporting the National Food and Nutrition Commission of Zambia to develop a monitoring plan without effective co-ordination among them.
- 2.81 DFID is aware of these challenges and is taking steps to mitigate them at the global level. It is supporting initiatives through the WHO to standardise nutrition indicators. It is also working with SUN and the EU on a new programme to track progress at the country level. DFID is also supporting nutrition surveys in India and Zambia, which are needed to assess changing nutritional status. The lack of co-ordination we observed, however, will reduce the ability of the international development community (and DFID) to show impact. Given DFID's leadership in the field, there is a real opportunity for DFID to drive co-ordination and standardisation in this area.

DFID needs to strengthen some of its project monitoring systems

Nutrition projects need to monitor short-term results better

- 2.82 It is essential for projects to monitor short-term results. For example, if a project conducts training,

⁹⁹ Demographic and Health Surveys are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health and nutrition. See <http://www.who.int/bulletin/volumes/90/8/11-095513/en/>. Since the mid-1990s, UNICEF has supported Multiple Indicator Cluster Surveys to enable many developing countries to produce statistically sound and internationally comparable estimates of a range of indicators in the areas of health, education, child protection and HIV/AIDS, http://www.unicef.org/statistics/index_24302.html.

it should assess the resulting changes to knowledge and behaviour and whether or not health and nutritional outcomes have improved. This would allow project managers to manage their activities to improve results and assess whether or not the changes in nutritional status are due to their work.

- 2.83 DFID's nutrition projects often have logical frameworks with weak indicators which focus on processes and activities rather than outputs and intermediate outcomes. For example, nutrition projects in Bangladesh, India, Yemen and Zambia use the number of people trained as the indicator for increased capacity, rather than improvements in competency. The Ethiopia and Nigeria Nutrition project logical frameworks mistakenly use a low-level indicator – number of people reached – at the outcome level.
- 2.84 Despite these problems, several of DFID's newer projects are going beyond the logical framework to monitor short-term results. In Yemen, the logical framework is supplemented by additional indicators.¹⁰⁰ Operational research in Ethiopia, Nigeria and Zambia promises to provide additional information on the achievement of outcomes to inform project implementation.
- 2.85 We saw examples of DFID working with the Government of India and the Government of Zambia to improve their monitoring systems. In India, DFID consultants have developed a web-based management information system for the main government nutrition programme. It provides data on service delivery collected by the front-line health and nutrition workers. This has improved the quality of information available to the Government of India, including by front-line workers. In Zambia, the WASH project explicitly aims to build district capacity for planning, supervision and monitoring.¹⁰¹ DFID is largely working through government systems, which reduces duplication and can improve government ownership.

¹⁰⁰ Dashboard indicators for Integrated Multi-Sectoral Approach to Improve Nutrition in Yemen.

¹⁰¹ The third output in the logical framework is that 'national, provincial and district level administrations have capacity to plan, implement and monitor sanitation promotion'. See http://iati.dfid.gov.uk/iati_documents/4404567.xls.

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2.86 In India, we had some concerns regarding the quality of the monitoring systems because they pay insufficient attention to assessing the short-term results of improved service delivery. Also, the technical assistance component of DFID's Health and Nutrition project in Madhya Pradesh had no monitoring plan. Finally, although DFID had supported UNICEF's capacity to measure results, we saw little evidence that the India UNICEF Partnership effectively monitored short-term outcomes. A large survey to 'quantify UNICEF's unique role in making progress towards the MDGs'¹⁰² did not achieve that aim.

Monitoring data is sometimes of low quality

2.87 Our field research cast doubt on the quality of some of the monitoring data being reported to DFID (see Figure 7 on page 19 and Annex A3). In the Zambia Nutrition project, child health weeks had a reportedly high coverage of Vitamin A and deworming.¹⁰³ Our research found, however, that only 25% of sampled children in Mbala and 70% of sampled children in Mufumbwe had received the recommended two annual doses. UNICEF monitors the coverage of each child health week but the system is not able to monitor whether children get two doses annually. Without this, DFID will not know whether it is supporting effective services.

2.88 DFID appears to trust the quality of the monitoring data it is given by partners and seems not to check that it has been independently validated. In the Zambia Nutrition project, we believe that UNICEF should have externally validated its data, given the unreliability of existing monitoring systems. It is a common finding that reported coverage rates in national health programmes are lower than survey data.¹⁰⁴ DFID should have checked that the data was validated. If it was not, it should have validated the data itself.

2.89 DFID uses monitoring data to calculate the number of beneficiaries reached through its nutrition-related projects. This allows DFID to report, both internally and externally, against its key target of reaching 20 million children. While we recognise the usefulness of 'reach' figures at the corporate level, we are concerned that they can set inappropriate incentives for project management and consume valuable staff time (see Figure 8).

Figure 8: Reach

DFID reports annually on the number of beneficiaries reached by its programmes. In the case of nutrition, 'reach' is defined as 'the number of children under five, breastfeeding and pregnant women reached through DFID's nutrition-relevant projects'.¹⁰⁵ DFID requests 'reach' figures from each department. It takes many weeks for results advisors to assemble and check the data.

Reach figures serve useful purposes. They are valuable for external communication and advocacy. They also help to keep nutrition on DFID's agenda and align country offices around common targets. They allow DFID to set long-term targets which will direct funding in the future.

Despite this, reach figures have severe limitations. First, they do not measure quality. They only measure a single intervention. For example, a child who receives a single deworming tablet is categorised as 'reached' to the same extent as one who receives a full set of interventions. Secondly, we found that 'reach' calculations are often based on unverified assumptions.¹⁰⁶ In complex projects, where DFID supports government to deliver services, it is not clear whether a meaningful 'reach' figure can be calculated.

Furthermore, 'reach' figures are not appropriate for project management. They do not provide incentives for staff to achieve outcomes or spend money wisely. We also note that monitoring systems often focus on producing 'reach' figures, which may come at the expense of measuring quality or gathering beneficiary feedback. Calculating 'reach' has risks as well as benefits, which need to be considered.

¹⁰² Quote from *UNICEF-DFID Strategic Partnership 2006-2011 Annual Review*, DFID, February 2012, http://iati.dfid.gov.uk/iati_documents/3488341.doc.

¹⁰³ *Tackling Maternal and Child Undernutrition in Zambia, Annual Review*, February 2014, DFID, unpublished.

¹⁰⁴ Christopher Murray et al, *Validity of Reported Coverage Rates in 45 Countries*, *The Lancet*, September 2003, Volume 362, Issue 9389, <http://download.thelancet.com/pdfs/journals/lancet/PIIS014067360314411X.pdf?id=baaCy7CSEa3w2cV Eydvu>.

¹⁰⁵ *DFID's Results Framework: Managing and Reporting DFID Results*, DFID, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175945/DFID-external-results.pdf.

¹⁰⁶ For example, approximately 60% of DFID India's 'reach' figures come from UNICEF, which assumed that they would train a large number of nutrition workers, each of whom 'reach' 43 children. No evidence was available to justify this assumption.

2 Findings

DFID is working towards sustainability but its projects are too short-term

- 2.90 While impacts on stunting may be achieved by well-designed and well-implemented projects in five to seven years, dramatic reductions in global undernutrition will take at least 15-20 years to achieve – possibly longer. This will require sustained and long-term commitment by DFID, governments and other aid providers. Stunting – a key indicator of improved nutrition – changes slowly and will only show impact in the medium-to-long term. Although nutrition is currently high on the development agenda, there is a risk that this could change, which would make sustainable impact unlikely.
- 2.91 DFID is working to build national and international commitment. At a national level, DFID is working to ensure that governments have ownership of Nutrition projects. DFID is, in addition, driving efforts to ensure that other governments, businesses and civil society organisations also honour the pledges they made at the Nutrition for Growth high-level meeting.
- 2.92 Despite these efforts, many DFID projects are planned to last for three years or less and none for more than six years. This is too short to address the challenges of undernutrition. Short-duration projects do not give partners the confidence that DFID and the international development community are committed to achieve sustainable impact.

Learning

Assessment: Green -Amber 

DFID is encouraging and supporting global learning

- 2.93 DFID has actively supported global learning. DFID spent £34.7 million on nutrition-sensitive research between 2010 and 2012, not including research undertaken as part of larger projects. It plans to spend £20 million on evaluation of its nutrition projects over the next six years. Its research focusses on nutrition-sensitive interventions, where evidence is limited. It includes a number of systematic reviews of evidence on key issues, such as the relationship between agricultural

interventions and nutrition.¹⁰⁷ DFID ensures that its research findings are widely published and available on its own and other websites.

- 2.94 DFID also supports research activities by other organisations. It actively participated in the planning and development of the 2013 Lancet Series on Maternal and Child Nutrition.¹⁰⁸ DFID has also contributed learning by publishing research findings at the country level.^{109,110} UNICEF India has published examples of good practice in academic journals, partly financed by DFID.¹¹¹
- 2.95 DFID's country programmes also undertake research to inform national policy. For example, DFID India has commissioned research on the effectiveness of 'ready-to-use therapeutic foods' in India. Although there is strong global evidence¹¹² on the effectiveness in community management of acute malnutrition of using such foods, this is not currently Government of India policy. If DFID's research demonstrates the benefits of using energy-dense foods for this, it may inform the debate in India.

DFID generally makes good use of evidence to design and refocus its programme

- 2.96 DFID's nutrition strategy, which is outlined in DFID's 2011 Scaling Up Nutrition position paper,¹¹³ is based on strong evidence from credible sources.

¹⁰⁷ *Can Agriculture Interventions Promote Nutrition? Agriculture and Nutrition Evidence Paper*, DFID, March 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292727/Nutrition-evidence-paper.pdf and, for example, *Water, Sanitation and Hygiene Evidence Paper*, DFID, May 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193656/WASH-evidence-paper-april2013.pdf.

¹⁰⁸ *Maternal and Child Nutrition Series*, The Lancet, June 2013, <http://www.thelancet.com/series/maternal-and-child-nutrition>.

¹⁰⁹ Seco et al, *Reflections on the Role of Donors in Scaling Up Nutrition in Zambia from 2010 to 2013: Successes, Challenges and Lessons Learnt*. In 'Turning Rapid Growth into Meaningful Growth: Commitment to Nutrition in Zambia', Institute of Development Studies, forthcoming.

¹¹⁰ Amery, J. and A. Philpott, *Undernutrition under Attention: The Changing Approach of the UK Department for International Development to Nutrition*, Institute of Development Studies, 2009, <http://www.ids.ac.uk/publication/lifting-the-curse-overcoming-persistent-undernutrition-in-india>.

¹¹¹ Aguayo, V. et al, *Integrated Program Achieves Good Survival but Moderate Recovery Rates among Children with Severe Acute Malnutrition in India*, American Journal of Clinical Nutrition, November 2013, 1335-42, <http://www.ncbi.nlm.nih.gov/pubmed/24067666>.

¹¹² *Community-Based Management of Severe Acute Malnutrition*, WHO, revised January 2013.

¹¹³ *Scaling Up Nutrition: The UK's Position Paper on Undernutrition*, DFID, September 2011, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67466/scal-up-nutr-uk-pos-undernutr.pdf.

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This includes two series of papers, published in The Lancet in 2008 and 2013.¹¹⁴ DFID also published a comprehensive and publicly available 'evidence summary' in 2009 and an update in 2012.¹¹⁵

2.97 We found that DFID also generally makes good use of evidence in developing its country portfolios and projects. For example, DFID India decided to refocus its three major health projects on nutrition as a result of new evidence on the extent of undernutrition in India and weaknesses in the Government of India's Integrated Child Development Services nutrition programme.¹¹⁶ We also examined seven business cases for nutrition-specific projects from different country offices.¹¹⁷ They all involved evidence-based interventions,¹¹⁸ designed to address the underlying causes of undernutrition.¹¹⁹ We did note, however, that DFID does not always select bundles of interventions that will have the greatest impact on stunting and cognitive development (see paragraphs 2.17 and 2.18).

DFID is learning how to implement complex multi-sectoral programmes

2.98 DFID has actively sought to learn from HIV/AIDS and other programmes on how governments can most effectively co-ordinate implementation of multi-sectoral programmes that involve a range of stakeholders and ministries. DFID has also commissioned research on governance in six countries to identify ways to strengthen governance and co-ordination of nutrition programmes.

2.99 DFID has also learnt by supporting multi-sectoral projects and organisations. DFID is a member of the multi-stakeholder Coalition for Sustainable Nutrition Security,¹²⁰ which is working to influence policy and programming in India. The evidence generated by the Coalition and its members has helped inform the Government of India's strategies for its flagship programmes on health and nutrition – the National Rural Health Mission and the Integrated Child Development Services programme. This led to a focus on the first 1,000 critical days and integration of health and nutrition programmes at the community level.¹²¹ DFID has also advocated the establishment of a Nutrition Mission in Madhya Pradesh,¹²² which is co-ordinating a multi-sectoral approach to nutrition in the state. This drew on learning from initiatives in other countries and is viewed as an example of good practice by the Government of India.¹²³

2.100 The DFID-funded South Asia Food and Nutrition Security Initiative (SAFANSI) has also been catalytic in influencing the development of large integrated nutrition programmes in the region.¹²⁴ In addition, it has fostered multi-sectoral working within the World Bank's South Asia Department.

DFID has been slow to act on some of the evidence

2.101 Although its use of evidence is generally good, DFID continues to fund some delivery models which evidence indicates are not fully effective. These include child health weeks and growth monitoring of children.^{125,126}

¹¹⁴ *Maternal and Child Nutrition Series*, The Lancet, June 2013, <http://www.thelancet.com/series/maternal-and-child-nutrition> and *Maternal and Child Undernutrition Series*, The Lancet, January 2008, <http://www.thelancet.com/series/maternal-and-child-undernutrition>.

¹¹⁵ *The Neglected Crisis of Undernutrition: Evidence for Action*, DFID, 2009, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67717/nutrition-evidence-paper.pdf and *An Update of 'The Neglected Crisis of Undernutrition: Evidence for Action'*, DFID, October 2012, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67319/undernutrition-finalevidence-oct12.pdf.

¹¹⁶ The evidence was published as part of the Government of India's National Family Health Survey (NFHS3). See http://pdf.usaid.gov/pdf_docs/PNADK385.pdf.

¹¹⁷ Bangladesh, Ethiopia, India, Nigeria, Pakistan, Yemen, Zambia.

¹¹⁸ Breastfeeding, Vitamin A, deworming, better complementary feeding, community management of acute malnutrition and iron for pregnant women.

¹¹⁹ Bhutta, Z. et al, *What Works? Interventions for Maternal and Child Under-nutrition and Survival*. The Lancet. February 2008, Volume 371, Issue 9610, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61694-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61694-8/fulltext).

¹²⁰ Coalition for Sustainable Nutrition Security in India, <http://www.nutritioncoalition.in/>.

¹²¹ The Poverty Monitoring and Policy Support Unit, *Impact Assessment of ICSD in Madhya Pradesh*, 2009.

¹²² The Atal Bihari Bajpai Bal Arogya Evam Poshan Mission, known as the Atal Bal Mission.

¹²³ *India Nutrition Situation Report*, DFID India, February 2014, page 19.

¹²⁴ *Independent Evaluation and Strategic Review of the South Asia Food and Nutrition Security Initiative (SAFANSI)*, Health and Education Advice and Resource Team, 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283977/South-Asia-Food-Security-Initiative-SAFANSI.pdf.

¹²⁵ Doherty, T. et al. *Moving Forward from Vertical to Integrated Child Health Programmes: Experience from a Multi-Country Assessment of the Child Health Days Approach in Africa*. Tropical Medicine and International Health, Volume 13, April 2010, http://www.hki.org/research/nna_en_april10.pdf.

¹²⁶ Bryce, J. et al, *Maternal and Child Undernutrition: Effective Action at National Level*, The Lancet, 2008, Volume 371, Issue 9611, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61694-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61694-8/fulltext).

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2.102 Child health weeks are campaigns which are generally run twice a year to provide a package of high-impact health and nutrition interventions to children under five years of age. Recent research highlights that while child health weeks provide opportunities to increase coverage of certain interventions (Vitamin A and deworming), they can undermine sustainable and long-term delivery of routine services.¹²⁷ Concerns have also been raised about the equity of the approach.¹²⁸ Additionally, many of the important behaviour change interventions required to reduce stunting cannot be delivered effectively during busy child health weeks. DFID commissioned a review in 2013 to identify research priorities. The review concluded that there is limited evidence that child health weeks are effective.^{129,130} Despite this, DFID continues to use them to deliver nutrition interventions, especially through UNICEF in Africa. Mothers interviewed during our field research in Zambia reported that child health weeks were ‘too short to adequately cover all eligible children’.

2.103 DFID projects also use growth monitoring to identify babies who are not gaining weight. This involves weighing a child and carefully checking its weight for age on a chart. While this is effective when done by well-trained health workers, there are doubts as to whether it is appropriate in countries with poorly trained health workers.^{131,132} In Zambia, we found that growth monitoring was carried out by overworked volunteers, who often failed to identify babies who required referral. In India our research study found that while 70% of community nutrition workers ‘know how to use’ the

growth monitoring card, less than 20% did so frequently. This would suggest that in countries with untrained or poorly educated health workers, other ways must be sought to identify wasting. This could include measuring the mid-upper arm circumference.¹³³

2.104 In our view, DFID should review the effectiveness and value for money of child health weeks and growth monitoring, as well as make recommendations on best practice. This should be done with the SUN Movement to make the results widely available in developing countries.

DFID generally learns well from on-going projects but is missing some opportunities to learn more

2.105 Despite the limitations of project monitoring systems noted earlier,¹³⁴ we saw many examples of DFID learning well from its projects. For example, DFID India learnt from a successful pilot on community mobilisation for nutrition in Bihar and transferred it to the India Health and Nutrition project in Madhya Pradesh. Similarly, DFID Zambia has actively sought to learn from other donors’ projects and the experience of the SUN civil society network in developing its country portfolio. We also noted cases of DFID learning from annual reviews and staff visits. As yet, however, there have been too few annual reviews of nutrition projects for us to comment on their routine use. We noted that the India Health and Nutrition project collects substantial monthly monitoring data – using its recently introduced management information system – but DFID does not yet make effective use of it to re-focus its programme. This information should be used to identify under-performing areas and the extent to which the programme effectively covers all social groups.

2.106 Although DFID generally learns well, we noted several ways in which it could improve its learning:

- DFID should encourage more systematic learning among its project teams. We noted that learning across DFID India’s three state-level

¹²⁷ Doherty, T. et al. *Moving Forward from Vertical to Integrated Child Health* Wasting is often ignored because it is seen as a humanitarian rather than development issue.

¹²⁸ Bhutta, Z et al. *Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done and at What Cost?* The Lancet. August 2013, Volume 382, Issue 9890, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60996-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60996-4/fulltext).

¹²⁹ The National Embedding Evaluation Programme, funded by DFID and managed by PATH.

¹³⁰ Doherty, T. et al. *Moving Forward from Vertical to Integrated Child Health programmes*, 2009. Wasting is often ignored because it is seen as a humanitarian rather than development issue.

¹³¹ Bryce, J. et al, *Maternal and Child Undernutrition: Effective Action at National Level*, The Lancet, 2008, Volume 371, Issue 9611, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61694-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61694-8/fulltext).

¹³² Panpanich R. and Garner P., *A review of growth monitoring in children*. The Cochrane Collaboration. Issue 4. 1999, <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001443/pdf>.

¹³³ Mid Upper Arm Circumference measures the size of muscle in the mid-upper arm of children. Children are graded as green; yellow; or red. Children found to be yellow or red should be referred to a trained health worker for a full assessment.

¹³⁴ See paragraphs 2.82-2.89.

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Health and Nutrition projects was not systematic and partners were insufficiently involved. Similarly, in Zambia we noted that DFID and its partners were not aware of on-going nutrition work in Malawi and Zimbabwe. We also found, in general, that technical assistance teams work in isolation and DFID does not involve them sufficiently in its learning initiatives. This was also a finding of the ICAI review of DFID's use of contractors;¹³⁵ and

- DFID should learn from its earlier projects. For example, from 2002-07, DFID India supported innovative work to help migrant labourers from Madhya Pradesh access services in neighbouring states. Its findings should have informed design of the India Health and Nutrition project. DFID India also has extensive experience of working with communities and self-help groups through Livelihoods projects¹³⁶ and other projects but these groups are not being used in on-going nutrition projects.

2.107 Additionally, DFID should evaluate its main projects in a timely way. We note that DFID did not incorporate an impact evaluation into the India Health and Nutrition project when it decided, in 2009, to refocus it on nutrition. Similarly, the India UNICEF partnership, which ended in 2013 and focussed on nutrition, also was not evaluated.

DFID has actively encouraged and promoted learning internally

2.108 DFID has promoted learning on nutrition across the organisation in a number of ways. It has supported the London School of Hygiene & Tropical Medicine to launch an innovative nutrition e-learning course to increase understanding of nutrition issues, which DFID staff are encouraged to take. DFID also holds monthly 'nutrition hub' meetings to share experience and information among advisors and it makes consultants available to country offices to develop strategies, business cases and carry out nutrition audits.

2.109 Despite DFID's efforts to promote internal learning, on average only one advisor from countries with high levels of undernutrition has participated in the e-learning course. This is insufficient. DFID should train a critical mass of advisors from different disciplines across its country offices to ensure an adequate multi-sectoral response.¹³⁷

2.110 In our view, DFID should increase the number of experienced advisors in country offices who can turn learning into action. This point was also made in the recent ICAI review, 'How DFID Learns'.¹³⁸ The e-learning course should focus more on putting theory into practice. DFID should also mentor new in-country advisors to ensure they develop coherent and strategic evidence-based programmes.

Learning is based on good use of beneficiary feedback

2.111 DFID has used beneficiary feedback well to improve programming. It has done this mainly in pilot projects and nutrition-sensitive programmes. We saw less evidence of beneficiary involvement in learning in nutrition-specific programmes.

2.112 In Zambia, the ColaLife Operational Trial¹³⁹ on packaging of ORS and zinc used feedback from beneficiaries to improve packaging. This resulted in the size of the ORS package being reduced from 1 litre to 200 mls, which women found more convenient. DFID also carried out extensive discussions with beneficiaries in order to improve targeting of the Zambia Cash Transfer project. The findings of this study have been adopted by the Government of Zambia.

2.113 Despite these successes, DFID should learn more from beneficiaries in designing nutrition-specific projects. It is important to understand the challenges facing mothers when advising them to change how they care for and prepare food for their children.

¹³⁵ Review of DFID's Use of Contractors to Deliver Aid Programme, ICAI, May 2013, <http://icai.independent.gov.uk/wp-content/uploads/2010/11/ICAI-REPORT-DFIDs-Use-of-Contractors-to-Deliver-Aid-Programmes.pdf>.

¹³⁶ Impact Assessment of Migrant Labour Support Programme, Gramin Vikas Trust, Noida, 2007.

¹³⁷ For example health, livelihoods, WASH, education, private sector.

¹³⁸ How DFID Learns, ICAI, April 2014, <http://icai.independent.gov.uk/wp-content/uploads/2014/04/How-DFID-Learns-FINAL.pdf>.

¹³⁹ ColaLife Operational Trial: Draft End-Line Survey, RuralNet Associates, January 2014.

3 Conclusions and Recommendations

Conclusions

- 3.1 DFID has played a key role in mobilising the global development community to combat undernutrition and in setting the global agenda. It is a leading supporter of the international SUN Movement and it has also organised 'game-changing' global events in the UK. These include the 2013 Nutrition for Growth high-level meeting, at which governments, donors and the private sector made significant commitments to address undernutrition.
- 3.2 DFID responded to the challenge of global undernutrition by significantly increasing its investments in nutrition. It focussed on key interventions that would have the biggest impact on undernutrition. These included focussing on the first critical 1,000 days – from conception to the child's second birthday – and implementing a balanced mix of direct (nutrition-specific) and indirect (nutrition-sensitive) interventions.
- 3.3 The pace and scale of DFID's global work is good but implementation at the country level has been too slow. As a result, it is too early to show impact but we saw some promising signs during visits to India and Zambia. Although DFID's work is generally based on sound evidence, its projects do not always focus on the mix of interventions for the greatest impact on stunting.
- 3.4 DFID has involved intended beneficiaries in the design and implementation of its programmes. Interventions should be improved to target better the most vulnerable children, such as those who live in remote areas or whose families migrate seasonally in search of work.
- 3.5 DFID generally learns well and has designed a number of high-quality impact evaluations to assess its programme. Monitoring is less effective and DFID should focus more on monitoring interim results.
- 3.6 Our conclusions to the five questions that this review set out to answer are as follows:

Are the DFID-funded approaches to nutrition coherent in their support of the strategic objective of reaching 20 million children under five years of age?

- 3.7 DFID's nutrition work is based on sound evidence and focusses on the critical first 1,000 days and integrated approaches at all levels – global, portfolio and at the country programme level. DFID expects to exceed its target of reaching 20 million under-five children by 2015. More needs to be done to select interventions that will have the greatest impact on stunting and cognitive development and are appropriate to the particular situation in each country. This means selecting the appropriate package of evidence-based interventions, taking into account the capacity of local government and other systems to deliver. Although information on 'reach' may be useful for corporate reporting, it is not a good indicator to use in assessing quality, improving programme performance or assessing real progress in combating undernutrition.

Is the pace at which DFID is implementing its nutrition programme reasonable, given the level of funding and high priority DFID commits to the work?

- 3.8 DFID's pace of delivery at the global level is good. At the portfolio level, DFID has scaled up investments significantly, although it could have done so more quickly, given the high priority it gives to nutrition. At the country level, implementation has been slow. Tighter project management, including a better selection of partners, is needed to improve the pace of implementation at the country level.

Are activities managed so as to maximise effectiveness for intended beneficiaries and value for money for the UK taxpayer?

- 3.9 DFID generally works well with beneficiaries in terms of the design and implementation of its projects. It needs to make sure, however, that its projects meet the needs of the most vulnerable and 'hard-to-reach' groups. We found that, in general, it has good financial management. It is too early to assess the extent to which DFID's nutrition

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work will achieve its outcomes and impacts. As a result, we cannot yet assess the value for money of the programme.

How well is DFID harmonising and co-ordinating at the global and country levels?

- 3.10 There is good harmonisation with other donors at the global level and DFID co-ordinates its programmes well with donors within developing countries. DFID also works well with governments and has significantly influenced nutrition policy in a number of countries. DFID has played a key role in achieving consensus on key issues at global forums.

Are there appropriate arrangements for the monitoring process? Are inputs, outputs and outcomes in place?

- 3.11 DFID is conducting a number of high-quality evaluations of key projects to assess impact and improve programme management. It did not, however, evaluate or learn sufficiently from its earlier nutrition projects. Monitoring is less effective. In some countries, DFID does not monitor sufficiently the short-term results in a robust way. The quality of monitoring data is sometimes poor and does not sufficiently capture outcomes for children.

Recommendations

Recommendation 1: DFID should make long-term commitments to maintain the pace and scale of its nutrition investments through its country programmes.

- 3.12 DFID is making efforts to ensure the sustainability of its investments. At the global level, DFID is advocating for the inclusion of nutrition in the Sustainable Development Goals. It is also working with Brazil to sustain dialogue around nutrition in the run-up to the 2016 Rio Olympics and a linked high-level nutrition event. If global undernutrition is to be overcome effectively, however, donors and governments will need to make long-term commitments. DFID's standard three-to-five-year project time frames are not sufficient to ensure that impact takes place. DFID should plan and implement longer multi-phase projects of up to ten years to ensure that its projects do impact on

stunting. It should also build its capacity to design and implement nutrition projects effectively.

- 3.13 DFID should publish a new strategy or position paper in 2015 with a ten-year time horizon to 2025. It should continue to advocate for an extension to the SUN Movement for a further five years – to 2020. Finally, it should strengthen its own capacity and ensure that there is a dedicated and trained advisor responsible for nutrition in all DFID-supported countries with a high rate of undernutrition. A critical mass of advisors from different disciplines should also be trained to ensure that DFID's country offices are able to make effective multi-sector responses to the challenge of undernutrition and put theory into practice.

Recommendation 2: DFID should implement nutrition interventions which will have the greatest impact on stunting and cognitive development.

- 3.14 Although DFID generally uses evidence well to guide its nutrition work, we found that many DFID country offices did not select the package of interventions that would have the greatest impact on stunting and cognitive development in the local context. Key recommendations from the Lancet Series, such as zinc and iron and folate supplements for children, were not implemented. Also, nutrition-specific and nutrition-sensitive interventions were not always implemented in the same communities, thus reducing the impact on undernutrition.

- 3.15 DFID should develop guidelines for country offices on selecting the best package of interventions for the local context and support staff in designing and implementing the right mix for these interventions. The new guidelines should be integrated into DFID's e-learning course. Staff should be mentored on the job and through the Nutrition Hub and professional development conferences.

Recommendation 3: DFID should ensure that its interventions target better the nutritional needs of the most vulnerable mothers and children.

- 3.16 DFID-funded projects generally focus on communities with high levels of undernutrition. Although they are also generally responsive to the

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needs of intended beneficiaries, DFID should do more to address the needs of the most vulnerable groups. Such groups generally have high levels of child undernutrition.

3.17 We found in India and Zambia that such groups were not being served adequately. Special efforts are needed to tailor projects to ensure that the needs of families that live in remote areas or migrate in search of work in the dry season are met adequately. DFID should use project management information systems to identify under-performing areas and groups that are not being served effectively.

3.18 DFID has extensive experience of working with the most vulnerable people in developing countries and should draw on this experience. It should learn from its previous work and apply those lessons effectively.

Recommendation 4: DFID should work with partners globally and in developing countries to ensure systems are in place to measure the impacts of its programmes.

3.19 It is difficult to assess impacts on stunting through regular project monitoring. This is because measuring the length of children under two years of age is difficult to do accurately without special training. Special training is also needed to measure the height of children aged three to five in a consistent manner.

3.20 Due to this, stunting impacts have to be assessed through surveys that are undertaken by skilled staff. Currently, information is mostly collected through national surveys which are carried out infrequently – generally only every three to five years.

3.21 DFID should work with the SUN Movement, responsible UN agencies and partner countries to ensure that nutrition surveys are carried out more often. This will make it possible to assess progress in achieving impacts on stunting.

3.22 DFID should also assess impacts on stunting in its own programmes to test whether or not its interventions are working. This would include careful monitoring of short-term results and assessing the extent to which they will contribute to outcomes and impacts on undernutrition. DFID should review the logical frameworks and

monitoring systems for its nutrition projects and ensure that they focus adequately on the short-term results leading from outputs to impacts. DFID should also undertake further longitudinal studies to assess impacts on cognitive development

3.23 DFID should also review the effectiveness of some delivery methods, including child health weeks and growth monitoring, in order to identify best practices.

Recommendation 5: DFID should actively explore ways in which to engage the private sector in reducing undernutrition.

3.24 DFID recognises the potential contribution the private sector could make to combatting undernutrition. As yet, however, it has made only limited progress in engaging with the private sector on nutrition in developing countries. In view of this, we recommend that DFID increase its efforts to explore opportunities for collaboration with the private sector. These should be tested in a range of countries – with local businesses, private sector associations and other stakeholders.

3.25 A major problem which DFID and other donors face is the lack of evidence on how best to engage the private sector in improving the nutrition of undernourished children and their mothers. DFID should commission further research and evaluations to help build the global evidence base for this. It should not only emphasise private sector involvement in the production, processing and marketing of nutritious food but also look at other sectors, possibly including health and nutrition services.

3.26 Working with the private sector involves opportunities and risks. DFID needs to examine clearly what it wants to achieve by partnering with the private sector on nutrition, developing a clear theory of change for this work and ensuring that associated risks are managed effectively. DFID should do this for its support to the New Alliance on Food Security and Nutrition.

Annex

This Annex provides more detailed background information to the review. This includes:

1. Global food and nutrition security initiatives (Annex A1);
2. DFID's nutrition portfolio (Annex A2);
3. Impact assessment case studies (Annex A3);
4. Lancet recommendations on maternal and child undernutrition (Annex A4);
5. Bibliography (Annex A5); and
6. List of consultations (Annex A6).

Annex

Annex A1: Global food and nutrition security initiatives

The Scaling Up Nutrition (SUN) Movement aims to catalyse global action on undernutrition in partnership with developing countries. It brings together government, civil society, donors, the UN and the private sector to address undernutrition. It was launched in 2010 by the UN Secretary-General.¹⁴⁰

As a country-led movement, SUN supports countries to take ownership of their national nutrition strategies. So far, 51 countries have joined the SUN Movement¹⁴¹ and 20 have developed national nutrition plans, with 17 countries aiming to reduce stunting by at least 2% annually.¹⁴²

The SUN Movement is run by its Secretariat in Geneva, with one Coordinator and ten full-time staff.¹⁴³ While it does not have an operational role, its job is to ensure that countries have access to the support needed to achieve their objectives.¹⁴⁴ The Secretariat reports to a Lead Group, responsible for strategic oversight.¹⁴⁵

DFID provides £5.6 million in financial assistance to SUN, as well as technical assistance.¹⁴⁶ As an active member of the SUN Movement Donor Network, which it co-facilitated for three years, DFID aims to mobilise and track resources for SUN Movement member countries.¹⁴⁷ At the country level, DFID supports member countries, such as Zambia, to develop and implement their nutrition plans. DFID also supports the SUN Movement Civil Society Network in its work to mobilise people in developing countries to tackle undernutrition.

The New Alliance for Food Security and Nutrition was launched at the G8 Summit in 2012. It is a joint initiative among African leaders, the private sector and donors.¹⁴⁸ It aims to accelerate responsible public and private sector investment in African agriculture and to lift 50 million people out of poverty by 2022.¹⁴⁹ Ten African countries have joined the New Alliance.¹⁵⁰ The USA is Co-Convener of the New Alliance Leadership Council, together with the African Union Commission and the World Economic Forum. DFID has committed £600 million to the New Alliance over the next three to five years.¹⁵¹ This includes existing or planned programmes in Ethiopia, Ghana, Malawi, Mozambique, Nigeria and Tanzania,¹⁵² investments in technology and innovation and its contribution to the Global Agriculture and Food Security Program (see below).

AFSI was launched at the G8 Summit in 2009. Its goal is to mobilise large-scale donor resources to reverse 20 years of underinvestment in agriculture and food security. Donors have committed US\$22.4 billion (£14.2 billion) to a three-year investment programme (2009-12).¹⁵³ DFID has contributed £1.2 billion million (7% of the total), which was disbursed for on-going projects (for example rural poverty alleviation projects in Bangladesh) and investments in multilateral programmes.

The Nutrition for Growth and London Olympic Hunger events

DFID has organised two key events in London that highlighted undernutrition. The Hunger Summit in 2012 used the Olympics as a platform to bring together stakeholders to discuss undernutrition. The Nutrition for Growth high-level meeting in 2013 was held under the UK's presidency of the G8 Summit.

The UK hosted the Global Hunger event, together with Brazil, bringing together representatives from governments, civil society and the private sector to address undernutrition. Participants made a range of commitments. For example, the Government of India

¹⁴⁰ *Scaling Up Nutrition: The UK's Position Paper on Undernutrition*, DFID, September 2011,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67466/scal-up-nutr-uk-pos-undernutr.pdf.

¹⁴¹ As at June 2014, <http://scalingupnutrition.org>.

¹⁴² *SUN Movement brief*, SUN, March 2014, http://scalingupnutrition.org/wp-content/uploads/2014/03/101059_SUN_2pager_v4r13.pdf.

¹⁴³ *Annual Narrative Report 1 October 2012-30 September 2013 & Provisional Financial Report 1 January 2013-31 December 2013*, SUN Movement Secretariat, 2013,

http://scalingupnutrition.org/wp-content/uploads/2014/03/SMS-Annual-Implementation-Report_Oct2012_Sept2013_FINAL.pdf.

¹⁴⁴ *Annual Narrative Report 1 October 2012-30 September 2013 & Provisional Financial Report 1 January 2013-31 December 2013*, SUN Movement Secretariat, 2013,

page 45, http://scalingupnutrition.org/wp-content/uploads/2014/03/SMS-Annual-Implementation-Report_Oct2012_Sept2013_FINAL.pdf.

¹⁴⁵ Members of the Lead Group are appointed by the UN Secretary General, <http://scalingupnutrition.org/the-sun-network/lead-group>.

¹⁴⁶ Technical assistance is provided through the Maximising the Quality of Scaling Up Nutrition consultancy draw-down contract.

¹⁴⁷ See <http://scalingupnutrition.org/the-sun-network/donor-network>.

¹⁴⁸ FAO Investment Centre, <http://www.fao.org/investment/othercollaboration/the-aguila-food-security-initiative/en/>.

¹⁴⁹ *New Alliance for Food Security*, DFID, 2012, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205883/new-alliance-factsheet.pdf.

¹⁵⁰ *New Alliance for Food Security: 2013 Progress Report Summary*, DFID, 2012,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/208284/New-Alliance-Progress-Report-May2013.pdf.

¹⁵¹ DFID breakdown of its contribution to New Alliance provided to the review team.

¹⁵² A note on DFID's New Alliance project, provided by DFID to the review team.

¹⁵³ *Thirtieth FAO Regional Conference for Asia and the Pacific - Round Table – From Declarations to Actions: Follow Up to L'Aquila Initiative on Food Security and WSFS in the Region, 21 September-1 October 2010*, 2010, <http://www.fao.org/docrep/meeting/019/k8697e.pdf>.

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announced its recent decision to double its funding to programmes that improve the health and nutrition of 100 million women and children.¹⁵⁴ The meeting also highlighted SUN's work to tackle stunting.

At the Nutrition for Growth high-level meeting, the Global Nutrition for Growth Compact was launched with the support of governments, businesses, UN, civil societies and scientific organisations. Its objective is to ensure that at least 500 million pregnant women and children under two years of age are reached with effective nutrition interventions; to reduce the number of children under-five years of age, who are stunted, by at least 20 million; and to save the lives of at least 1.7 million children under the age of five by preventing stunting, increasing breastfeeding and boosting the treatment of severe acute malnutrition.¹⁵⁵

In total, 15 governments committed new resources for scaling up nutrition and 12 announced national stunting reduction targets. Governments, businesses and civil societies together committed £15.2 billion to tackle undernutrition between 2013 and 2020.¹⁵⁶ Over 20 businesses pledged to improve the nutrition and health of workforce members in 80 countries.¹⁵⁷ The UK has committed new resources up to the equivalent of £1.25 billion (8% of the total) to undernutrition between 2013 and 2020.¹⁵⁸ At the Nutrition for Growth high-level meeting, Zambia committed to increase nutrition spending by at least 20%, annually, for ten years.

¹⁵⁴ *Hunger Event, Lasting Legacy for Children around the World*, DFID, August 2012, <https://www.gov.uk/government/news/hunger-event-lasting-legacy-for-children-around-the-world>.

¹⁵⁵ *Global Nutrition for Growth Compact*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/248760/Endorserscompact_update7_10_2013.pdf.

¹⁵⁶ Overall, at the Nutrition for Growth Summit, 15 governments committed to increase nutrition budgets and donors made commitments to increase nutrition-specific and nutrition-sensitive spending, totalling £15.2 billion. Donors made commitments of up to £2.7 billion for nutrition-specific investments and £12.5 billion for nutrition-sensitive investments between 2013 and 2020. We note that the £2.7 billion committed to nutrition-specific investments was additional to funding already committed by donors. For the nutrition-sensitive investments, however, while DFID's commitments were additional to funding already committed, not all other donors calculated their nutrition-sensitive investments in this way. *Nutrition for Growth Commitments: Executive Summary*, Nutrition for Growth, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207274/nutrition-for-growth-commitments.pdf.

¹⁵⁷ *Nutrition for Growth Commitments: Executive Summary*, Nutrition for Growth, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207274/nutrition-for-growth-commitments.pdf.

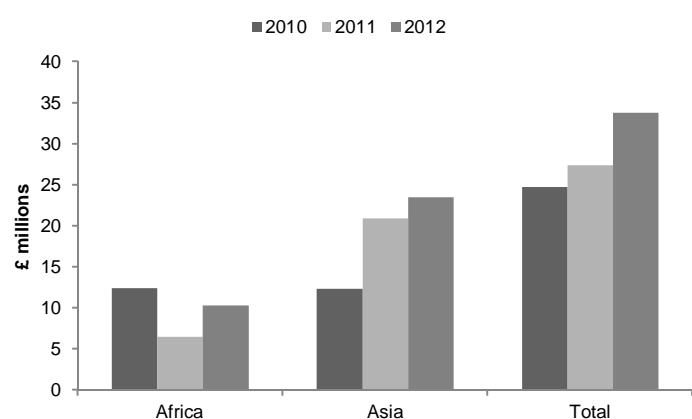
¹⁵⁸ Overall, at the Nutrition for Growth Summit, 15 governments committed to increase nutrition budgets and donors made commitments to increase nutrition-specific and nutrition-sensitive spending, totalling £15.2 billion. Donors made commitments of up to £2.7 billion for nutrition-specific investments and £12.5 billion for nutrition-sensitive investments between 2013 and 2020; *Nutrition for Growth Commitments: Executive Summary*, Nutrition for Growth, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207274/nutrition-for-growth-commitments.pdf.

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Annex A2: DFID's Nutrition Portfolio

This annex presents our analysis of DFID's nutrition portfolio, based on data provided by Development Initiatives. We exclude all projects which include humanitarian spend from our analysis. Our figures, consequently, understate DFID's total investment in nutrition; they do give, however, a clear understanding of DFID's more recent investments in development programmes.

Figure A2.1: Nutrition-specific expenditure by region, 2010-12 (£ millions)¹⁵⁹



Source: Development Initiatives data, analysed by ICAI.

Figure A2.2: Nutrition-sensitive expenditure by sector, 2010-12 (£ millions)^{160,161}

Sector	2010	2011	2012	Total
Agriculture	6.8	18.8	26.2	51.7
Health	35.4	53.3	75.2	163.8
Other	4.2	3.1	5.1	12.3
Food aid and Food Security	28.8	28.4	16.6	73.8
Rural Development	9.8	16.5	18.2	44.5
Social Protection	6.1	6.8	15.6	28.5
Total	91.0	126.8	156.8	374.5

Source: Development Initiatives data, analysed by ICAI.

¹⁵⁹ DFID's categorisation of expenditure into the four pillars of its strategy, using as a basis the data in *DFID's Aid Spending for Nutrition: 2010-2012*, Development Initiatives, February 2014. 'Global' programmes were narrowly defined by DFID as global programmes focussing on supporting the global governance of nutrition and broader enabling environment, including leadership and co-ordination.

¹⁶⁰ Sectors derived from purpose codes of the Organisation for Economic Co-operation and Development. If a project had disbursed money in more than one sector, all spend for that project was allocated to the sector with the greatest spend.

¹⁶¹ Please note that all figures are rounded.

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Figure A2.3: Top ten countries receiving DFID nutrition-specific disbursements, 2010-12 (£ millions)

Country	DFID disbursements 2010-12
India	56.0
Nigeria	11.0
Zimbabwe	8.4
Ethiopia	3.6
Zambia	2.8
Ghana	2.1
Tanzania	1.3
Bangladesh	0.6
Democratic Republic of the Congo,	0.1
Nepal	0.1

Source: Development Initiatives data, analysed by ICAI.¹⁶²

Figure A2.4: Top ten countries receiving DFID nutrition-sensitive disbursements, 2010-12 (£ millions)

Country	DFID disbursements 2010-12
Ethiopia	78.3
India	60.1
Bangladesh	59.4
Zimbabwe	30.0
Kenya	13.4
Democratic Republic of the Congo	13.7
Malawi	13.5
Nepal	7.5
Myanmar	7.0
Pakistan	5.0

Source: Development Initiatives data, analysed by ICAI.¹⁶³

¹⁶² DFID's Aid Spending for Nutrition: 2010-2012, Development Initiatives, February 2014, page 13.

¹⁶³ DFID's Aid Spending for Nutrition: 2010-2012, Development Initiatives, February 2014, page 13.

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Annex A3: Impact assessment case studies

ICAI field research findings

ICAI commissioned a field research team in India and Zambia to assess the extent to which communities have benefited from selected DFID projects and to assess the reliability of the monitoring data used by DFID.

Findings from Zambia

In Zambia our field researchers examined two projects:

- *Zambia Nutrition project, Phase 1:* The first phase of the Zambia Nutrition project runs from 2011 to 2015 and has a budget of £3.5 million. Our team assessed the delivery of Vitamin A and deworming tablets through child health weeks in nine underperforming districts. This component was implemented by UNICEF and cost approximately £1 million over four years; and
- *Zambia Sanitation and Hygiene project:* The goal is to benefit three million people. It follows the community-led total sanitation approach, mobilising communities to take action to improve sanitation. The programme is being implemented by UNICEF between 2011 and 2015 at a total cost of £19 million.

Our researchers visited 12 villages in two remote districts: Mbala in the North and Mufumbwe in the East. In each village, they interviewed 25 households to ask whether children had received Vitamin A, deworming and measles vaccinations, as well as whether they observed the presence and quality of toilet facilities. They held a focus group discussion with mothers in each village to gather qualitative information on the use and quality of nutrition and hygiene and sanitation services. Finally, they interviewed key stakeholders, including health officials, village chiefs and local sanitation committees to examine and triangulate findings.

In total, our field researchers interviewed 1,050 mothers individually or in small focus groups. They also interviewed 100 other key local stakeholders.

Key findings

Child health weeks were effective at delivering one dose of Vitamin A and deworming tablets to each child annually. In Mufumbwe, about 85% of eligible children received one dose or more annually and 80% received it in Mbala. Coverage rates, however, are considerably lower when we assessed how many children received the recommended two doses annually. 75% of children received two doses in Mufumbwe and only 25% in Mbala. We noted that DFID reported a 100% coverage rate in Mufumbwe, which only referred to a single child health week.

There were many reasons for not receiving Vitamin A and deworming. The most common reason was that the care-giver or child was absent and so was unable to attend. In particular, some mothers had migrated to distant fields to work and were not reached by the child health weeks. The next most common reason was that care-givers were not aware of the child health weeks, particularly in Mbala. Overall, the mothers understood the reasons for Vitamin A and deworming and they believed that they led to an improvement in health in their children. Many mothers, however, did not realise that their children needed two doses a year. Long distances and a shortage of essential drugs also discouraged mothers from attending. This was a particular challenge for mothers with more than one young child – as transport was not easily available – and they may have been unable to take both children to the centre.

Coverage and use of toilets was high. In Mbala, 95% of households owned a latrine and in Mufumbwe, 90% did. 95% of respondents said that they used the latrines and high rates of usage was confirmed by interviews with key informants, including village headmen, chiefs and health workers. Many latrines were new, indicating a strong effect of the hygiene and sanitation programme. In Mbala, WASH said that access to latrines had improved from 13% to 40% since the launch of the Zambia Sanitation and Hygiene project. Again, however, coverage was lower than DFID had reported: only two of the 12 villages sampled had 100% coverage of toilets. There were continuing challenges to reach 'hard-to-reach' communities. For example, some families migrate to fields during the rainy season, where they are unlikely to have toilets.

Quality and sustainability of toilets was weaker. Although coverage was high, the quality of toilets was often variable. 65% of toilets had no lid on top of the hole, which allows flies to spread disease. Only 50% of the toilets had a hand-washing station and only 28% had soap or ash next to it for hand-washing. Households claimed that soap and ash would easily dissolve in the rain and that

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goats would eat the soap. The latrines were built out of local cheap materials and many were being washed away in the rainy season.

Hygiene and sanitation implementation needs continual monitoring. Our field research suggested that there are currently not a sufficient number of community champions to support and monitor all villages. In particular, villages did not appear to be continually monitored after they were declared to be 'open defecation-free', which risks the gains not being sustained.

Findings from India

In India our field researchers examined the UNICEF Partnership, which aimed to strengthen government capacity to deliver services for children and excluded groups. The partnership focussed on eight disadvantaged states, including Madhya Pradesh. DFID had committed £75 million from 2006-2013 to UNICEF India. They did not examine the India Health and Nutrition project, which was visited by our core ICAI review team.

Our researchers visited Shivpuri and Guna, two blocks in Madhya Pradesh where UNICEF had concentrated their work. Within each district, our researchers spoke to local health and nutrition workers, conducted household interviews and visited local NRCs. They also visited 15 villages in which UNICEF had supported WASH work. Finally, they visited schools where UNICEF had supported hand-washing and sanitation facilities. In total, our teams visited 47 villages and 4 schools. They interviewed 62 health and nutrition workers and spoke with 720 households.

Key findings

NRCs provided good medical services but insufficient communication on behaviour change. All NRCs were well staffed, although there was not sufficient backup to cover staff on leave or absent. NRCs were typically clean and fully stocked. 90% of mothers with children with severe acute malnutrition (SAM) considered that the medical care was fair to good. Staff and mothers, however, reported that staff provided too little time to train the mother on how to handle her child in the household. Only one in ten mothers reported that training at NRCs was good. This suggests that more emphasis is needed on communication for behaviour change.

Facility-based care, which is provided by NRCs, is not sufficient and faces some challenges. For example, frontline nutrition workers and NRC staff have different definitions for undernutrition, which sometimes led to children being referred by frontline workers, who were not accepted for treatment by NRC staff. Moreover, SAM children are only allowed to stay for 14 days at an NRC. If children were not cured in that time, they would, ideally, continue treatment. The guidelines, however, require children to be sent home and then readmitted. Finally, attendance at the NRC requires the mother to spend two weeks away from her family, which is often not practical. Boys are often prioritised over girls, when the mother chooses whether to seek health care.

Training of local health and nutrition workers is moderately effective. All health and nutrition workers had been trained on infant and young child feeding practices. Only 73%, however, had received full training with classroom activities and training materials. All workers were aware of their job roles and understood essential information regarding severely undernourished children. Perceived knowledge of health workers was greater than their actual knowledge. Approximately 80% of respondents felt very confident explaining SAM. Only 30% of nutrition workers, however, had a comprehensive knowledge of infant and young child feeding practices. 40% of nutrition workers and almost 70% of health workers had little or no knowledge of SAM.

Awareness of undernutrition among households ranged from poor to fair, although they did not always put knowledge into practice. Mothers knew that they should start breastfeeding as soon as possible after birth; however, approximately a quarter did not do so. The main reasons were misconceptions about breastfeeding, such as the possibility that the mother may pass on illnesses to the child. Similarly, most mothers knew that they should introduce solid foods when their children had reached six months old. In practice, solid food was introduced earlier. Our researchers observed that the health and nutrition workers did not tailor their messages to address specific locally held beliefs.

Marginalised groups face particular barriers in accessing services. Tribal populations and other backward classes often chose not to utilise facilities due to stigma, culture, language and awareness limitations. During this assessment, the team noticed several superstitions that prevented tribal mothers from weighing their infants or bringing them to facilities. Frontline health workers are often seen to be insensitive to the particular needs of these populations. Some mothers from lower castes reported that nutrition workers discriminated against them and did not visit them in their home. On the other hand, nutrition workers reported that they would visit the homes of lower caste and tribal families but that these families were unreceptive to services.

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Annex A4: Lancet recommendations on maternal and child undernutrition

The Lancet published two special issues on maternal and child undernutrition in 2008 and 2013. (<http://www.thelancet.com/series/maternal-and-child-undernutrition>).

The Lancet series identified the most effective ways to address maternal and child undernutrition. A total of eight interventions were recommended in both 2008 and 2013 (see Figure A4.1).

Figure A4.1: Interventions recommended in both Lancet 2008 and 2013.

Promotion of exclusive breastfeeding	Starting babies on breast milk as soon as possible after birth and feeding them only breast milk for the first six months.
Management of Severe Acute Malnutrition and Moderate Malnutrition	Encouraging community care of severe and moderate malnutrition using ready-to-use therapeutic foods compares favourably with facility-based care and can reach more children cost-effectively.
Complementary feeding	Providing mothers with appropriate information on when to start giving food to children, what types of food to give and hygienic ways of preparing it.
Maternal micronutrients for pregnant women, at minimum iron and folate	Giving mothers multiple micronutrients during pregnancy, including iron and folate, which were generally given on their own.
Iodised salt	Encouraging universal use of iodised salt, which is now common practice.
Balanced energy – protein supplementation for mothers	Giving balanced energy-protein supplements for malnourished pregnant women because maternal undernutrition is a risk factor for poor foetal growth and low birth weight babies.
Preventative zinc supplements as well as using zinc for management of diarrhoea	Giving routine zinc supplements to children aged from 12 month to 59 months. In 2008, zinc was recommended as treatment during diarrhoea. The evidence now is that zinc supplements reduce mortality and suggests that they may help to improve growth of children under five years of age. ^{164 165}
Vitamin A supplementation where need exists	Although there is some new evidence that questions the impact of Vitamin A on mortality, it is recommended that it should continue be given to children at risk of Vitamin A deficiency.

¹⁶⁴ There are concerns that iron and zinc may interact, thereby reducing the potential benefit of zinc on growth and morbidity.

¹⁶⁵ The Lancet Series in 2008 and 2013 advocated zinc supplementation to improve linear growth in children under 5 years of age. A recent 2014 Cochrane Review examined growth in children, from 6 months to 12 years of age. It also found that zinc supplementation is associated with a small significant increase in height but less than reported in the Lancet. There was also significant heterogeneity in the results of the different studies reviewed. Further research is needed to determine the most effective ages at which to provide zinc supplements and the doses to be given. Mayo-Wilson E. et al, *Zinc Supplementation for Preventing Death and Disease, and for Growth, in Children Aged Six Months to 12 Years of Age*, Cochrane Summaries, 2014.

<http://summaries.cochrane.org/CD009384/zinc-supplementation-for-preventing-death-and-disease-and-for-growth-in-children-aged-six-months-to-12-years-of-age#sthash.dJkpWquA.dpuf>. Bhutta, Z. et al, *Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done at What Cost?* The Lancet, August 2013, Volume 382, Issue 9890, page 453, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60996-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60996-4/fulltext).

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Main differences between The Lancet 2008 and 2013.

In 2008, a total of 13 nutrition-specific interventions were recommended which, if implemented, could reduce mortality by 25% and stunting by 36%. In 2013, the number of recommended interventions was reduced to 10 and the impact on mortality was reduced to 15% and stunting to 20%.

The 2013, The Lancet recommended an increased focus on the nutrition of adolescents; the use of community-based delivery and nutrition sensitive interventions in areas such as agriculture, food security, health systems, water and sanitation as well as social protection. Nutrition-sensitive interventions are needed to address 80% of stunting.

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Annex A5: Bibliography

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Annex A6: List of consultations

The ICAI review team consulted a wide range of stakeholders, including DFID, other donors, UN officials, foundations, government officials in India and Zambia, civil society organisations, the private sector, leading researchers, frontline health practitioners and nutrition workers and intended beneficiaries.

During the course of the review, we met:

- **DFID staff**, including the Director and Deputy Director responsible for the nutrition programme; DFID's UK-based nutrition team; and advisors from other disciplines, including livelihoods, social development, education, WASH, evaluation and research and evidence. We also held videoconferences with DFID teams from Bangladesh, Brazil and Ethiopia. Additionally, we met the office heads and advisors involved in nutrition work in DFID's India and Zambia programmes;
- **other donors, foundations and UN agencies** by telephone or in face-to-face meetings in India or Zambia, including Canada, EU, Ireland and the USA; and the Children's Investment Fund Foundation, Clinton Foundation, Gates Foundation, UNICEF, WFP, WHO and World Bank;
- **SUN Secretariat**: the UN Secretary-General's Special Representative on Food and Nutrition – who also heads the SUN Secretariat – and his colleagues in Geneva;
- **Ministers and government officials** in India and Zambia. In India we met the Joint-Secretary and senior colleagues, Ministry of Women and Child Development (MWCD); the Principal Secretary of the Ministry of Women and Child Development in Madhya Pradesh; Commissioners responsible for the National Rural Health Mission, Integrated Child Development Services and Rural Livelihoods in Madhya Pradesh, together with other officials; District Commissioners and other district level staff in four districts of Madhya Pradesh. In Zambia we met the Vice-President, the Minister of Health and senior officials; the Permanent Secretary, Ministry of Community Development and Mother and Child Health and senior colleagues; District Commissioners and other district level staff in four districts of Zambia;
- **Civil society organisations** in India, Switzerland, UK and Zambia, including Concern GAIN, Save the Children, World Vision, the Zambian CSO-SUN Alliance and CSOs in the field in India and Zambia;
- **Private sector organisations**, including major global companies, such as DSM and InfoSys and local private sector undertakings in India and Zambia; and
- **DFID's project implementing partners** in India and Zambia, including contractors.

In India and Zambia, we split into teams and undertook field visits lasting four or five days in each country. We visited four districts in Madhya Pradesh, India (Dhar, Jabalpur, Jhabua and Mandla) and four districts in Zambia (Chipata, Katete, Monze and Mumbwa).

In India, we focussed on the India Health and Nutrition project. In Zambia we reviewed implementation of the Zambia Nutrition project, the Zambia Sanitation and Hygiene project and the Zambia Cash Transfer project. We also visited three other projects supported by DFID or its donor partners. In both countries we met local officials and front-line workers and interviewed intended beneficiaries. We also held focus group discussions in villages. In India we visited 12 child- and mother-care centres (*anganwadi*); two nutrition rehabilitation centres for children suffering from severe malnutrition; two mid-level health centres; and two district hospitals.

We interviewed a total of 170 intended beneficiaries of nutrition-specific and nutrition-sensitive projects, mainly mothers with children under five years of age. We also interviewed approximately 80 front-line workers, local officials and other stakeholders. Those interviewed on the nutrition-sensitive projects included intended beneficiaries of cash transfers, village level sanitation and hygiene committee members, as well as women engaged in growing improved, Vitamin-A rich maize and in crop and dietary diversification activities.

We also worked with field research teams who interviewed another 1,050 beneficiaries and 100 other local stakeholders in two other districts in India and two districts in Zambia (see Annex A3).

Our visits to India and Zambia lasted for two weeks. In each country, an ICAI Commissioner took part in the field visits and led the team for one of the two weeks.

Abbreviations

AFSI	L'Aquila Food Security Initiative
BBC	British Broadcasting Corporation
DFID	Department for International Development
EU	European Union
FAO	Food and Agriculture Organisation of the United Nations
GAIN	Global Alliance for Improved Nutrition
G8	Group of Eight
ICAI	Independent Commission for Aid Impact
IDC	International Development Committee
MDG	Millennium Development Goal
NGO	Non-governmental organisation
NRC	Nutrition Rehabilitation Centre
ORS	Oral Rehydration Solution
SAFANSI	South Asia Food and Nutrition Security Initiative
SAM	Severe Acute Malnutrition
SUN	Scaling Up Nutrition Movement
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organisation

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This report was prepared by ICAI with the assistance of KPMG LLP, Agulhas Applied Knowledge, Center for Effective Global Action (CEGA) and the Swedish Institute for Public Administration (SIPU International).

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