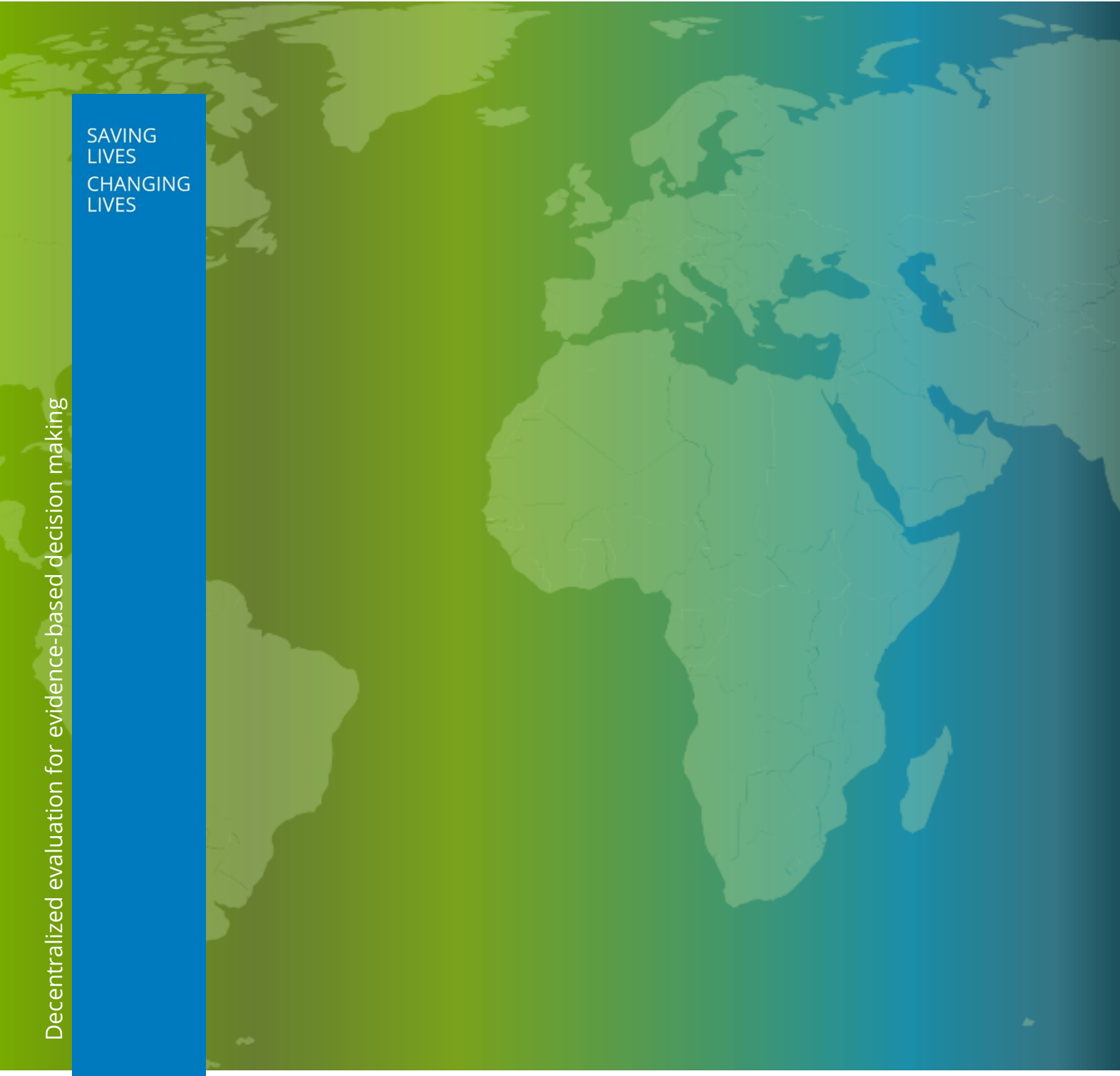

SAVING LIVES
CHANGING LIVES

Decentralized evaluation for evidence-based decision making

Decentralized Evaluation

Evaluation of the Intervention for the Treatment of Moderate Acute Malnutrition in Ngozi, Kirundo, Cankuzo and Rutana

2016–2019

Final Report, 22 May 2020
WFP Burundi
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WFP
World Food Programme

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DISCLAIMER

Table of contents

Tables

Figures

Boxes

Maps

Executive Summary

Subject of the Evaluation

E1. This evaluation, commissioned by the World Food Programme (WFP) country office in Burundi, took place from September 2019 to May 2020. The evaluation covered the Moderate Acute Malnutrition (MAM) treatment program implemented in the provinces of Ngozi, Kirundo, Cankuzo and Rutana during the period 2016 to 2019 to benefit children under five years of age and pregnant and lactating women (PLW). The evaluation was conducted in order to achieve the two objectives of *Accountability* and *Learning*.

E2. The intended users of this evaluation include WFP, UNICEF, WHO and other UN agencies, the donor Food for Peace (FFP), the Government of Burundi and national and international non-governmental organizations (NGOs) involved in the prevention and treatment of different forms of malnutrition in the country.

Background

E3. Burundi is a country in the East Africa Region, ranking 185 out of 189 on the 2019 Human Development Index. With an estimated population of 11.7 million in 2017, Burundi has the second-highest population density in sub-Saharan Africa, with more than 400 inhabitants per square kilometer. More than 65 percent of the population live below the national poverty line estimated at $1.90 per day.

E4. The prevalence of global acute malnutrition (GAM) ranges between 5 and 8 percent, with pockets of prevalence above 10 percent in some localities. In the provinces of Cankuzo, Kirundo, Ngozi and Rutana, the prevalence of MAM is 4.9, 5.2, 3.4 and 4.3 percent respectively. Globally, the country has the highest level of chronic malnutrition, with a current prevalence rate of 56 percent.

E5. Although the ratio of boys to girls at the primary level is equal to 1, the school dropout rate is higher for girls than boys, partly due to pregnancies that began during schooling. Approximately 16 percent of women of childbearing age have Chronic Energy Deficiency (CED), with adolescent girls aged 15–19 and women aged 40–49 slightly more likely to be affected. Despite progress in women's political participation in the country, gender inequalities remain significant. These gender disparities affect household food security in Burundi.

E6. The Government of Burundi's efforts to find long-term solutions to the problems of food and nutrition insecurity in the country are reflected in the availability of relevant policies, adherence to international initiatives such as the Scale Up Nutrition (SUN) movement, and the fight against poverty.

E7. As WFP's long-term vision in Burundi is to support the government's efforts to achieve the Sustainable Development Goals, the organization aims to reshape the food system in Burundi by promoting a multisectoral and systemic approach to food access and utilization. The UN family, international and national NGOs and government agencies are collaborating to implement a comprehensive package of nutrition interventions and to strengthen government capacity in nutrition.

Methodology

E8. The evaluation was designed to assess the MAM treatment program according to the following evaluation criteria: relevance, coherence, effectiveness, efficiency, impact, sustainability. Evaluation questions were developed under each of these criteria. It followed the United Nations Evaluation Group (UNEG) codes of conduct, ethics guide, guidelines, norms and standards, and specifically integrated human rights, gender and equity under each evaluation criterion and question, as well as data collection tools.

E9. In order to answer these questions, the evaluation team used a combination of qualitative and quantitative methods to triangulate the information obtained through (1) literature review and quantitative secondary data analysis and (2) qualitative primary data collection using three techniques: (a) semi- structured individual interviews with key informants; (b) focus group discussions (FGDs); and (c) direct observation of MAM processing operations.

E10. *Secondary quantitative data* collection was conducted in 20 randomly selected health centers (simple random sampling) in Ngozi and Rutana provinces, while *primary qualitative data* collection took place in the four provinces in eight health centers selected using a purposive sampling approach. Quantitative data collection was conducted in two of the four provinces, owing to the limited budget of the evaluation. However, the quantitative data collected from the 20 health centers in these two provinces was sufficient to make pertinent conclusions and recommendations for the evaluation. Data collection took place from 15 to 31 January 2020 in the four provinces.

E11. Limitations included the unavailability of data disaggregated by sex, age group and locality, as well as the absence of data on prevention and screening activities, but steps have been taken to mitigate these to the extent possible, including conducting analyses on aggregate data, and considering qualitative data only in the absence of quantitative data.

Key Results

E12. The key findings of the evaluation team are summarized below, structured according to the evaluation criteria, and indicating the type and reliability of evidence supporting each finding.

Evaluation Criterion 1 – Relevance

E13. The MAM treatment program meets the government's priorities and the expectations of recipients. It is implemented in accordance with national policies and protocols. However, with the significant reduction in the prevalence of acute malnutrition and the continued high prevalence of chronic malnutrition, it is important to combine the treatment of MAM with prevention interventions, in order to optimize the results in regard to stunting in the country. Other categories of beneficiaries such as the physically and mentally disabled, orphans and street children should be taken care of by the program (as part of social protection, for example), since they are also among the most vulnerable groups in society. The current implementation modalities of the program (which mean that beneficiaries spend most of the day at the health centers on the day of distribution) constitute a security risk for some PLW and mothers of children.

Evaluation Criterion 2 – Coherence

E14. There is a lack of close coordination among donors and different sectors in the planning and implementation of nutrition-sensitive interventions. The continuum of care from severe acute malnutrition (SAM) to MAM, and from centers for nutritional rehabilitation and learning (FARN)[1] to Supplementary Feeding Programmes (SFP) is taking place in all four provinces, as is the continuity between treatment and prevention activities in Kirundo and Ngozi provinces, thanks to collaboration between WFP, UNICEF and NGOs supporting community-based prevention activities.

Evaluation Criterion 3 – Effectiveness

E15. The geographical coverage of the program is 100 percent in the four provinces. Apart from in 2016, when admissions were low as a result of the slow start of the program, admission rates were as expected or even exceeded expectations, in particular in 2017. There was consistency between the increase in the number of children and PLW admitted to the program and the quantities of PlumpySup and Corn Soya Blend (CSB)++ distributed over time. There was also a seasonal annual variation in admissions, with peaks in admissions corresponding to peaks in childhood diseases and the lean season in Cankuzo, Ngozi and Rutana provinces. The median length of stay of children admitted to the program until recovery was six weeks. For all provinces, the performance indicator scores were above the standard requirements of Burundi's national protocol for the management of malnutrition (cure rate >70 percent, death rate <3 percent, default rate <15 percent), which endorses the program's effectiveness. Analysis of the data, however, revealed some data quality issues that need to be taken into account when interpreting the program effectiveness data. The availability of nutritional supplements presented a significant incentive for beneficiaries. However, unexpected negative consequences included close pregnancies (Kirundo province) and family sharing of food supplements, as well as illicit sales of these supplements. Irregular monitoring and supervision of program activities resulted in poor-

[1] Foyers d'apprentissage et de réhabilitation nutritionnelle

quality of service delivery, which affected the upkeep of the CMAM (community-based management of acute malnutrition) registration books and the individual record cards, and the reliability of the data transmitted.

Evaluation Criterion 4 – Efficiency

E16. The time lapse between the ordering and delivery of the food supplements was approximately six months. This long period delayed the start of treatment of beneficiaries admitted to the program. The "non-involvement" of government health workers in the estimation of nutritional supplement needs led to a lack of consideration of local factors, resulting in higher than expected admissions, as observed in 2017. The key causes of stock-outs include the insufficient storage capacity of health centers as well as the fact that the number of beneficiaries exceeded expectations, the illicit sale of food supplements and the admission of SAM cases into the MAM treatment program (admissions criteria were not always observed). Operational costs related to dietary supplements represented the largest item of expenditure (67.4 percent) of the MAM treatment program in Burundi during the period 2016 to 2019. Based on the calculations made by the evaluation team from the database provided by WFP, the average cost per beneficiary admitted was USD 24, and the cost per beneficiary cured was USD 26. Using the national supply chain or purchasing food supplements produced in neighboring countries would have made it possible to reduce the costs of the program and treat a larger number of beneficiaries.

Evaluation Criterion 5 – Impact

E17. The intertwining of the MAM treatment program and prevention interventions has reduced the prevalence of acute malnutrition in Kirundo province and kept it at a low rate. The inclusion of men as recipients of awareness-raising messages has increased their understanding of the importance of their role in family nutrition and of the support they need to provide to their pregnant and breastfeeding wives and children. Program planning was not conducted collaboratively, which was unconducive to government ownership of the program. Government capacity needs to be strengthened at the national, province and district levels for the design of, and budget-allocation and fundraising/mobilization for the MAM treatment program and other nutrition programs in general.

Evaluation Criterion 6 – Sustainability

E18. With the exception of the health information system, the integration of the MAM treatment program into Burundi's health system is generally incomplete. Major efforts still need to be made in terms of financial ownership of the program by government authorities; much effort also needs to go into the strengthening of the national supply chain of the Burundi medicine purchasing center (CAMEBU). Building the capacity of the multisectoral nutrition platform is important in order to sustain the achievements of the program, both at the institutional and the community levels. Thanks to the awareness-raising messages received, mothers of children under five years of age and the PLW have made positive changes to the eating habits in their households, despite the financial difficulties they experience in obtaining all the necessary foods for preparing balanced meals.