Public Disclosure Authorized
Public Disclosure Authorized
Public Disclosure Authorized
Public Disclosure Authorized

PROJECT PERFORMANCE ASSESSMENT REPORT

MALAWI

Nutrition and HIV/AIDS Project

Report No. 167299
APRIL 11, 2022



IEG
INDEPENDENT EVALUATION GROUP

WORLD BANK GROUP
World Bank • IFC • MIGA

WHAT WORKS

© 2022 International Bank for Reconstruction and Development / The World Bank
1818 H Street NW
Washington DC 20433
Telephone: 202-473-1000
Internet: www.worldbank.org

Attribution—Please cite the work as follows:
World Bank. 2022. Malawi—Nutrition and HIV/AIDS Project. Independent Evaluation Group, Project Performance Assessment Report 167299. Washington, DC: World Bank.

This work is a product of the staff of The World Bank with external contributions. The findings, interpretations, and conclusions expressed in this work do not necessarily reflect the views of The World Bank, its Board of Executive Directors, or the governments they represent.
The World Bank does not guarantee the accuracy of the data included in this work. The boundaries, colors, denominations, and other information shown on any map in this work do not imply any judgment on the part of The World Bank concerning the legal status of any territory or the endorsement or acceptance of such boundaries.

RIGHTS AND PERMISSIONS
The material in this work is subject to copyright. Because The World Bank encourages dissemination of its knowledge, this work may be reproduced, in whole or in part, for noncommercial purposes as long as full attribution to this work is given. Any queries on rights and licenses, including subsidiary rights, should be addressed to World Bank Publications, The World Bank Group, 1818 H Street NW, Washington, DC 20433, USA; fax: 202-522-2625; e-mail: pubrights@worldbank.org.

IEG | WORLD BANK GROUP
Independent Evaluation Group | World Bank • IFC • MIGA

Report No.: 167299

PROJECT PERFORMANCE ASSESSMENT REPORT

Malawi

Nutrition and HIV/AIDS Project
(IDA-50680, IDA-D1330, IDA-H7610, TF-12631)

April 11, 2022

Human Development and Economic Management

Independent Evaluation Group

Abbreviations

ANCC	Area Nutrition Coordination Committee
CLAN	Community Leaders Action group for Nutrition
DNCC	District Nutrition Coordination Committee
DNHA	Department of Nutrition, HIV and AIDS
ICR	Implementation Completion and Results Report
IEG	Independent Evaluation Group
IYCF	infant and young child feeding
M&E	monitoring and evaluation
MDD	minimum diet diversity
NAC	National AIDS Commission
NGO	nongovernmental organization
NECS	National Nutrition Education Communication Strategy
PDO	project development objective
PMTCT	prevention of mother-to-child transmission
PPAR	Project Performance Assessment Report
TWG	technical working group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VNCC	Village Nutrition Coordination Committee
WASH	water, sanitation, and hygiene

All dollar amounts are US dollars unless otherwise indicated.

IEG Management and PPAR Team

Director-General, Independent Evaluation	Ms. Alison Evans
Director, Human Development and Economic Management	Mr. Oscar Calvo-Gonzalez
Manager, Corporate and Human Development	Ms. Galina Sotirova
Task managers	Ms. Ann Elizabeth Flanagan Ms. Mariana Branco

This report was prepared by Ms. Aliza Belman Inbal, who assessed the project from November to December 2019 under the supervision of Ms. Ann Elizabeth Flanagan and Ms. Mariana Branco. The report was peer reviewed by Ms. Maria de las Mercedes Vellez and panel reviewed by Mr. Salim J. Habayeb. Ms. Gaby Loibl and Ms. Yezena Yimer provided administrative support.

Note: IEG = Independent Evaluation Group; PPAR = Project Performance Assessment Report.

Contents

Abbreviations ii

Data vi

Summary viii

1. Project Background, Context, and Design 1

Malawi's Nutrition Outcomes and Institutional Context 1

Malawi's Care Group Model 4

Malawi's HIV/AIDS Context 6

Project Objectives, Design, and Financing 6

Project Objectives and Design 6

Project Financing 7

Theory of Change 7

2. What Worked, and Why? 11

Results 11

Objective 1: Increase Coverage of Selected Nutrition Services 11

Objective 2: Increase Coverage of Selected HIV and AIDS Services 14

Objective 3: Strengthen Disease Outbreak Preparedness 14

Design and Preparation 15

Objective 1: Increase Coverage of Selected Nutrition Services 15

Objective 2: Increase Coverage of Selected HIV and AIDS Services, and Objective 3: Strengthen Disease Outbreak Preparedness 16

Implementation and Supervision 16

Objective 1: Increase Coverage of Selected Nutrition Services 16

Objective 3: Strengthen Disease Outbreak Preparedness 19

3. What Didn't Work, and Why? 19

Results 19

Objective 1: Increase Coverage of Selected Nutrition Services 19

Objective 2: Increase Coverage of Selected HIV and AIDS Services 26

Objective 3: Strengthen Disease Outbreak Preparedness 27

Design and Preparation 27

Objective 1: Increase Coverage of Selected Nutrition Services 28

Other Considerations 33
Implementation and Supervision 34
Objective 1: Increase Coverage of Selected Nutrition Services 34
Objective 2: Increase Coverage of Selected HIV and AIDS Services 36
4. Conclusions 36
5. Key Lessons 37
Bibliography 39

Tables

Table 3.1. Children under Two Benefiting from Monthly Care Group Services 21
Table 3.2. Field Testimonials 22

Boxes

Box 1.1. Definition of Malnutrition 1
Box 1.2. Malawi's Care Group Model 4
Box 3.1. Testimonials from End Beneficiaries 32

Figures

Figure 1.1. Malawi's Institutional Landscape for Nutrition 3
Figure 1.2. Theory of Change to Increase Coverage of Nutrition Services (Objective 1) 5
Figure 1.3. Theory of Change to Increase Coverage of HIV/AIDS Services and Disease Outbreak Preparedness (Objectives 2 and 3) 10
Figure 2.1. The Project's Contribution to Institutional Capacity Development 13
Figure 3.1. Feeding Behaviors Before and After the Project 21
Figure 3.2. Children Receiving Minimum Diet Diversity 23
Figure 3.3. Malawi Project Timeline and Theory of Change for World Bank Nutrition Support 25
Figure 3.4. Contribution of Factors to Stunted Growth (height-for-age z-score) Changes, 2013–18 26
Figure 3.5. Voluntary Medical Male Circumcision in Malawi, 2008–18 27

Appendixes

Appendix A. Project Rating 41
Appendix B. Fiduciary, Environmental, and Social Aspects 58

Appendix C. Methods and Evidence 59
Appendix D. Project Objectives and Design 60
Appendix E. Project Components 63
Appendix F. Results and Monitoring Framework 67
Appendix G. Project Achievement 76

Data

This is a Project Performance Assessment Report (PPAR) by the Independent Evaluation Group (IEG) of the World Bank Group on the Malawi Nutrition and HIV/AIDS Project (P125237) and additional financing (P156129). This instrument and the methodology for this evaluation are discussed in appendix C. Following standard IEG procedure, copies of the draft PPAR were shared with relevant government officials for their review and comment. No comments were received.

This report focuses on lessons learned from the International Development Association's support to maternal and child health and nutrition under the Malawi Nutrition and HIV/AIDS Project. Project ratings and a detailed discussion of the project, including its support for HIV/AIDS and disease preparedness components, are provided in appendix A.

Malawi Nutrition and HIV/AIDS Project (P125237)

Basic Data

Country	Malawi	World Bank financing commitment	$114,952,729
Global Practice	Health, Nutrition, and Population	Actual project cost	$107,161,353
Project name	Nutrition and HIV/AIDS Project	Expected project total cost	$124,952,779
Project ID	P125237	Actual amount disbursed	$117,161,352
Financing instrument	Investment project financing	Environmental assessment category	Category B
Financing source (all dollar amounts in report are US$)	IDA credit of $102.6 million and multidonor trust fund in the amount of $12.4 million		

Note: IDA = International Development Association.

Dates

Event	Original Date	Actual Date
Approval	December 15, 2011	March 27, 2012
Effectiveness		October 17, 2012
Restructuring		December 14, 2014
Midterm review		April 13, 2015
Closing	August 31, 2017	August 31, 2018

Key Staff Responsible

Management	Appraisal	Completion
Project team leader	John Paul Clark	Ziauddin Hyder, John Bosco Makumba
Practice manager	Jean J. De St Antoine	Jean J. De St Antoine
Sector director or senior Global Practice director	Ritva S. Reinikka	Timothy Grant Evans
Country director	Kundhavi Kadiresan	Bella Deborah Mary Bird

Summary

Project Background and Description

At the time of project approval, Malawi had made substantial gains in reducing the prevalence of underweight children. However, chronic undernutrition remained high; 47 percent of Malawi's children under the age of five exhibited stunted growth (low height for age), exceeding Sub-Saharan Africa's average of 40 percent. The underlying causes of malnutrition included poverty, nutrition-deficient household behaviors, inadequate food preparation, and care practices.

The government of Malawi's response to the high rate of chronic malnutrition began in 2004, when it created the Department of Nutrition, HIV and AIDS (DNHA) and implemented a nutrition policy. In 2011, Malawi joined the Scaling Up Nutrition movement to mobilize resources and support for the implementation of the National Nutrition Policy and Strategy Plan 2007–15, which focused on broad-based nutrition interventions implemented at the community level. The Scaling Up Nutrition initiative required coordination with a variety of partners, including the Canadian International Development Agency, the United States Agency for International Development, and Irish Aid.

The Nutrition and HIV/AIDS Project (the project) was approved in 2012 and financed through an International Development Association credit ($32 million) and an International Development Association grant ($26 million). It also received contributions from the following donors: the Canadian International Development Agency ($13 million); the Global Fund, for the country's HIV Pool to support implementation of the National HIV and AIDS Strategic Plan ($87 million); and the borrower ($10 million). Total estimated project financing was $190 million. The project development objective (PDO) was "to increase access to, and utilization of, selected services known to contribute to the reduction of child stunting, maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults" (World Bank 2012b, 5).

In 2016, the government asked the World Bank to restructure the project and provide additional financing to address disease outbreaks (Ebola) and acute malnutrition in drought-affected districts. The restructuring aimed to increase coverage of selected nutrition and HIV/AIDS services, and a new disease preparedness component was included in response to the 2014 Ebola outbreak in West Africa. At the time of the outbreak, Malawi had no disease surveillance system, no isolation units, and no specialized equipment for dealing with an outbreak. The project made available

emergency financing to implement World Health Organization–recommended measures for Ebola preparedness.

Project Components

Component A: Support for Nutrition Improvement. This component supported community interventions by nongovernmental organizations (NGOs) in 14 out of 28 Malawian districts. This component adopted a community-based care group model, first introduced in Mozambique, that used volunteer facilitators to promote healthy behaviors and the use of key health services. The component also supported institutional capacity development of the DNHA. At the time of restructuring, the component was expanded to include support for integrated management of acute malnutrition in drought-affected districts.

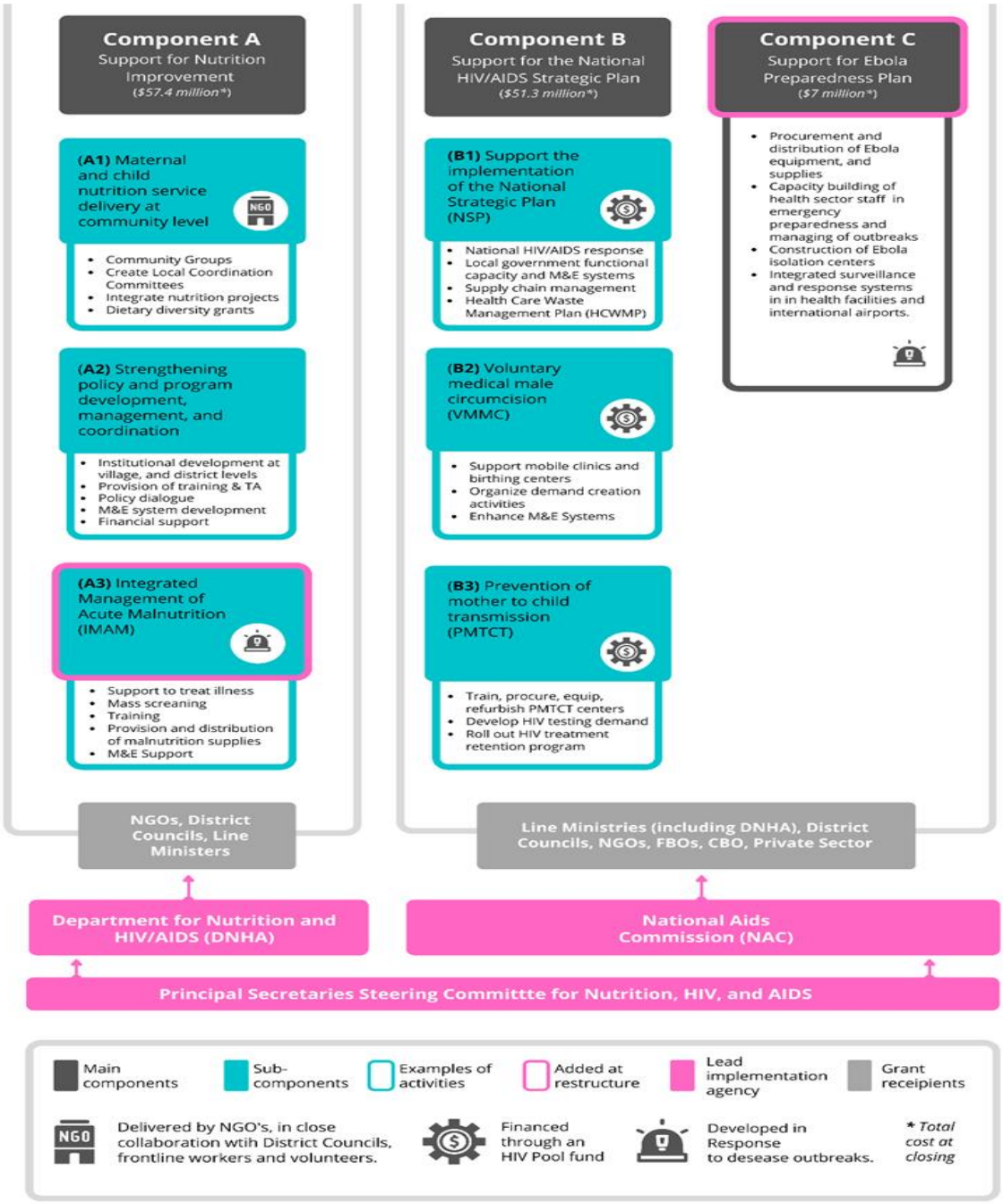
Component B: Support for the National HIV/AIDS Strategic Plan. This component supported (i) district hospitals that offer voluntary male medical circumcision services and (ii) birthing centers for neonatal male circumcision and prevention of mother-to-child transmission. World Bank financing for this component was channeled through a pooled donor funding mechanism (the HIV Pool).

Component C: Support for Disease Preparedness. This component was added in the 2014 restructuring to support the construction of Ebola isolation centers strategically located in border districts and the establishment of an integrated surveillance and response system linking health facilities and two international airports. Figure S.1 summarizes the intervention model.

The project was implemented by two separate government agencies. The DNHA was the lead agency for nutrition and the National AIDS Commission led implementation of the HIV/AIDS prevention and disease preparedness activities.

This assessment reviewed all three components. It confirmed that overall outcome achievement under the project was below satisfactory; performance was uneven under the different components and objectives. However, a deep dive on the achievements in improving coverage of the nutrition services (component A) was conducted to focus more concretely on the care group model, behavior change, and the institutional framework for a coordinated, multisectoral approach to nutrition (interventions with extensive research and evidence linked to improving nutrition outcomes). The assessment found that the project achieved outcomes related to institutional development and management of acute malnutrition but did not achieve expected health and nutrition outcomes. Although the main text of this PPAR discusses all components, the main conclusions on what worked, what didn't work, and lessons are drawn from the deep dive assessment under component A.

Figure S.1. Project Intervention Model



Source: Independent Evaluation Group.
Note: CBO = community-based organization; DNHA = Department of Nutrition, HIV and AIDS; FBO = faith-based organization; M&E = monitoring and evaluation; NGO = nongovernmental organization; PMTCT = prevention of mother-to-child transmission; TA = technical assistance.
* Total cost at closing.

What Worked, and Why?

Overall, this assessment concluded that the project achieved outcomes related to institutional development and management of acute malnutrition levels but did not achieve expected health and nutrition outcomes.

Malawi's institutional framework for nutrition improved. The project developed durable multilevel and multisectoral mechanisms for the planning and execution of nutritional policy. There was a consolidation of nutrition efforts at all levels, with all ministries, stakeholders, districts, and donors operating under the same policy, coordinating body, strategic plan, behavior change strategy, and monitoring and evaluation framework. The project set up sustainable institutional structures that remain active at the time of this assessment. District Nutrition Coordination Committees are still active, and area- and village-level nutrition coordination committees set up during the project, although less durable, are still influential.

Integrated management of acute malnutrition in project districts financed by the project mostly achieved its goals of treating children ages 0–59 months with severe acute malnutrition and of mass screening under-five children in all 14 project districts.

There were three factors behind the achievements described above. First, at an institutional level, the project invested strongly in developing the capacity of the DNHA and district-level nutrition officers to design, manage, and evaluate nutrition policies and programs. Although the DNHA had been operational since 2004, the training and support financed through the project was instrumental in fostering high-level ownership and leadership of nutrition policy in Malawi. Second, throughout project implementation, the World Bank team remained proactive and responsive to the changing context and restructured the project twice at the government of Malawi's request. Third, the results frameworks for the integrated management of the acute malnutrition treatment subcomponent, the disease preparedness component, and the HIV/AIDS component were mostly appropriate and sufficient for tracking project achievements.

What Didn't Work, and Why?

The project was not successful at adequately improving behaviors known to contribute to the reduction of stunted growth and mother and child anemia. Nationally, there was little improvement, or even a worsening in some cases, in feeding practice measures (such as breastfeeding, dietary diversity, and iron consumption). The percentage of children ages 6–23 months receiving minimum diet diversity in treatment districts fell during the project period. The 2018 endline survey reported that feeding practices in the project districts had declined over the project period from a national minimum diet diversity baseline of 33 to 23 percent. Although the rate of stunted growth reduction

slowed as compared with the period before the project, reductions in stunted growth during the project period could be largely attributable to improvements in hygiene and sanitation practices that resulted from other interventions beyond the project.

Shortcomings in the design, implementation, and exit strategy of the World Bank explain the project's limited achievements related to maternal and child nutrition service coverage. The project design did not adequately estimate the time and resources that would have been necessary for full implementation of the care group model. The time given to NGOs for the project was insufficient, and the training package provided to care groups and their facilitators was inadequate and not properly monitored. NGO contracts were not clear with respect to expected outputs, and it appears that no exit strategy for NGO support was defined. At the same time, the use of NGOs as project subcontractors was controversial and harmed the project's sustainability. Local government officials felt bypassed by NGOs, local agricultural and veterinary officers complained that inputs were not distributed in coordination with them, and communities were surprised by the abrupt exit of the NGOs.

Moreover, the results framework and indicators were inadequate for monitoring the project's progress and assessing its achievements, especially at the engagement and learning levels. The project has not tracked the extent to which beneficiary mothers attended community sessions, received training or counseling on adequate nutrition practices, or even effectively acquired new knowledge. As a result, the project team and its partners had limited capacity to understand and adjust to the project's evolving needs, making it hard to expect changes in nutrition practices.

IEG project ratings are described in table S.1 and in appendix A. The evaluation methodology and evidence sources are described in appendix C.

Table S.1. Project Ratings Summary

Indicator	ICR	ICR Review	PPAR
Outcome	Moderately unsatisfactory	Moderately unsatisfactory	Moderately unsatisfactory
Overall efficacy	Original: modest Revised: substantial	Original: modest Revised: modest	Original: modest Revised: modest
Bank performance	Moderately unsatisfactory	Moderately unsatisfactory	Moderately unsatisfactory
Quality of monitoring and evaluation	Modest	Modest	Modest/negligible

Sources: World Bank 2019a, 2019b.
Note: The Implementation Completion and Results Report (ICR) is a self-evaluation by the responsible Global Practice. The ICR Review is an intermediate Independent Evaluation Group product that seeks to independently validate the findings of the ICR. PPAR = Project Performance Assessment Report.

Lessons Learned

This assessment offers the following five lessons and recommendations:

1. Although the care group model might be a viable option for nutrition communication and potential behavior change, it is critical to focus on the conditions that can make the model successful. Interventions via home visits, community groups, and interpersonal communication have proven effective in improving several nutrition outcomes. However, organizing sectoral and community actors to integrate the delivery of services and the provision of ongoing support over an extended period remains a challenge.

2. Developing community-based activities at a large scale takes time and continuous support, and it is fundamental to adequately estimate the time and resources needed for full implementation. The care group component was underfunded, and the two years accorded by the project to NGOs to develop, train, and manage care group structures was not nearly enough to support real behavior change. This contrasted with districts where the United States Agency for International Development, rather than the project, funded the development of care groups. This agency has been continually funding care groups for over eight years. Care group coverage is presently close to 100 percent of target households. More provisions should have been made for the pooled financing of continuing activities. The pooled funding mechanism was used on the HIV/AIDS component but not on the nutrition component.

3. The care group model requires intensive stakeholder engagement and sensitivity to the social context. Specifically, (i) care group volunteers require incentives to remain motivated and in regular contact with support structures; (ii) village-level activities help reinforce behaviors advocated by lead mothers; (iii) cellphone-based systems, data gathering, and monitoring and evaluation can facilitate long-term management of care groups and mitigate high transportation costs; and (iv) the use of NGOs as project subcontractors at the district level can harness effective project delivery but can disempower local government structures.

4. To track output delivery and expected change, the PDO, results framework, and indicators need to be well tailored. The PDO, in its revised format, had the following shortcomings: (i) it was overly vague; (ii) the results framework was inadequate for monitoring project progress and assessing its achievements; (iii) the project was not successful at adequately improving behaviors; and (iv) indicators did not systematically track desired behavior change.

5. Project structures that are sufficiently flexible to adjust to donor and government needs can help implementation and achievement of results. In the HIV/AIDS component, the project adeptly responded to shifts in donor funding commitments to ensure efficient deployment of project resources in needed areas.

Oscar Calvo-Gonzalez
Director, Human Development and Economic Management Department
Independent Evaluation Group

1. Project Background, Context, and Design

Malawi's Nutrition Outcomes and Institutional Context

1.1 Despite progress in reducing childhood malnutrition, overall rates remained high (see box 1.1 for definitions of malnutrition). Between 2000 and 2010, the proportion of underweight children dropped from 22 percent to 14 percent. The prevalence of stunted growth declined from 55 percent to 48 percent, still well above the Sub-Saharan African average rate of 38 percent in 2010. In 2015, stunted growth increased to 63 percent.

1.2 Anemia in women, which is associated with low birthweight, remained persistently high. More concretely, 41 percent of women were anemic in 2016. Further, 63 percent of children under the age of five were anemic as a result of inadequate nutrition, among other factors. Malawi's Health Sector Strategic Plan 2011–16 identified childhood and maternal underweight as the second most important (16.5 percent) risk factor for mortality (Government of Malawi 2011a).

Box 1.1. Definition of Malnutrition

Chronic malnutrition, also called stunted growth, indicates low height for age. It is the result of chronic or recurrent undernutrition, usually associated with disadvantaged socioeconomic conditions, low levels of maternal health and nutrition, frequent illness, or inappropriate feeding and care in early childhood. Growth is considered stunted if a child is more than two standard deviations below the mean based on age and sex.

Acute malnutrition, also termed wasting, is low weight for height. It usually indicates recent and severe weight loss, often caused by a lack of food or infectious diseases.

Underweight is low weight for age. A child who is underweight may have stunted growth, wasting, or both.

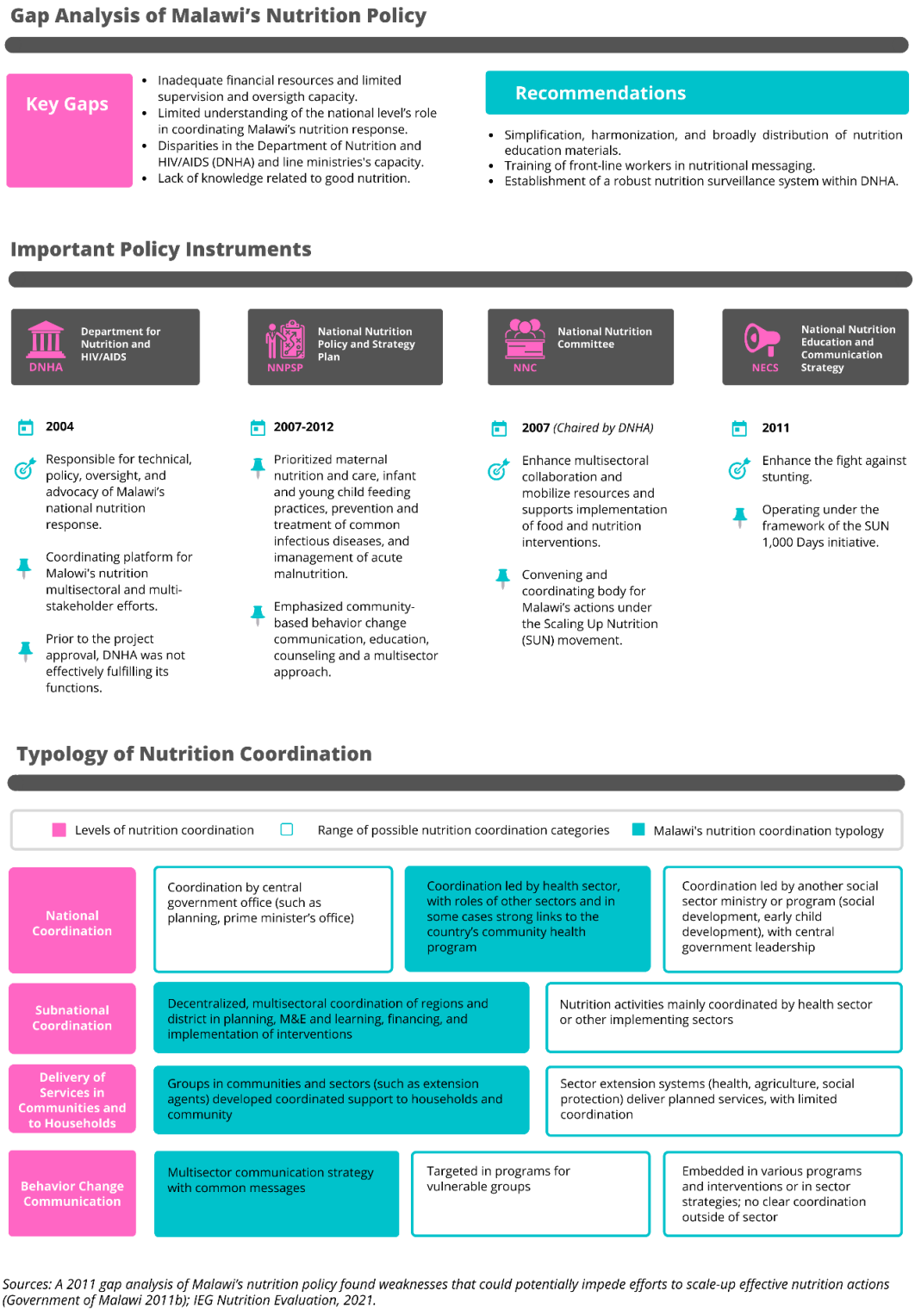
Micronutrient malnutrition is caused by inadequate intake of vitamins and minerals (such as iodine, vitamin A, and iron), which enable the body to produce enzymes, hormones, and other substances.

Source: World Health Organization 2021.

1.3 Multiple factors played a role in Malawi's inadequate nutrition outcomes. First, Malawi is an impoverished country, and poverty is highly correlated with inadequate nutrition. Second, there are several specific barriers to optimal feeding, including breastfeeding behaviors, limited knowledge of food processing, limited dietary diversity in food preparation, the need for iron supplements and fortified foods, and nutrition-deficient cultural practices (USAID and World Bank 2011). Malawi's institutional framework for nutrition also contributed to unsatisfactory nutrition outcomes. Figure 1.1

frames the institutional setting of Malawi's nutrition policy by providing insights from a gap analysis conducted by the government of Malawi, which informed the project design. The figure also offers an overview of the key Malawian nutrition policy instruments and types of nutrition coordination.

Figure 1.1. Malawi's Institutional Landscape for Nutrition



Sources: A 2011 gap analysis of Malawi's nutrition policy found weaknesses that could potentially impede efforts to scale-up effective nutrition actions (Government of Malawi 2011b); IEG Nutrition Evaluation, 2021.

Sources: Government of Malawi 2011b; World Bank 2021.
Note: DNHA = Department of Nutrition, HIV and AIDS; M&E = monitoring and evaluation; SUN = Scaling Up Nutrition.

Malawi's Care Group Model

1.4 As part of its efforts to improve nutrition outcomes, Malawi's Department of Nutrition, HIV and AIDS (DNHA) created two strategies anchored in the principles of community-based nutrition education (figure 1.2). These strategies rely on behavior change communication through the medium of care groups (box 1.2).

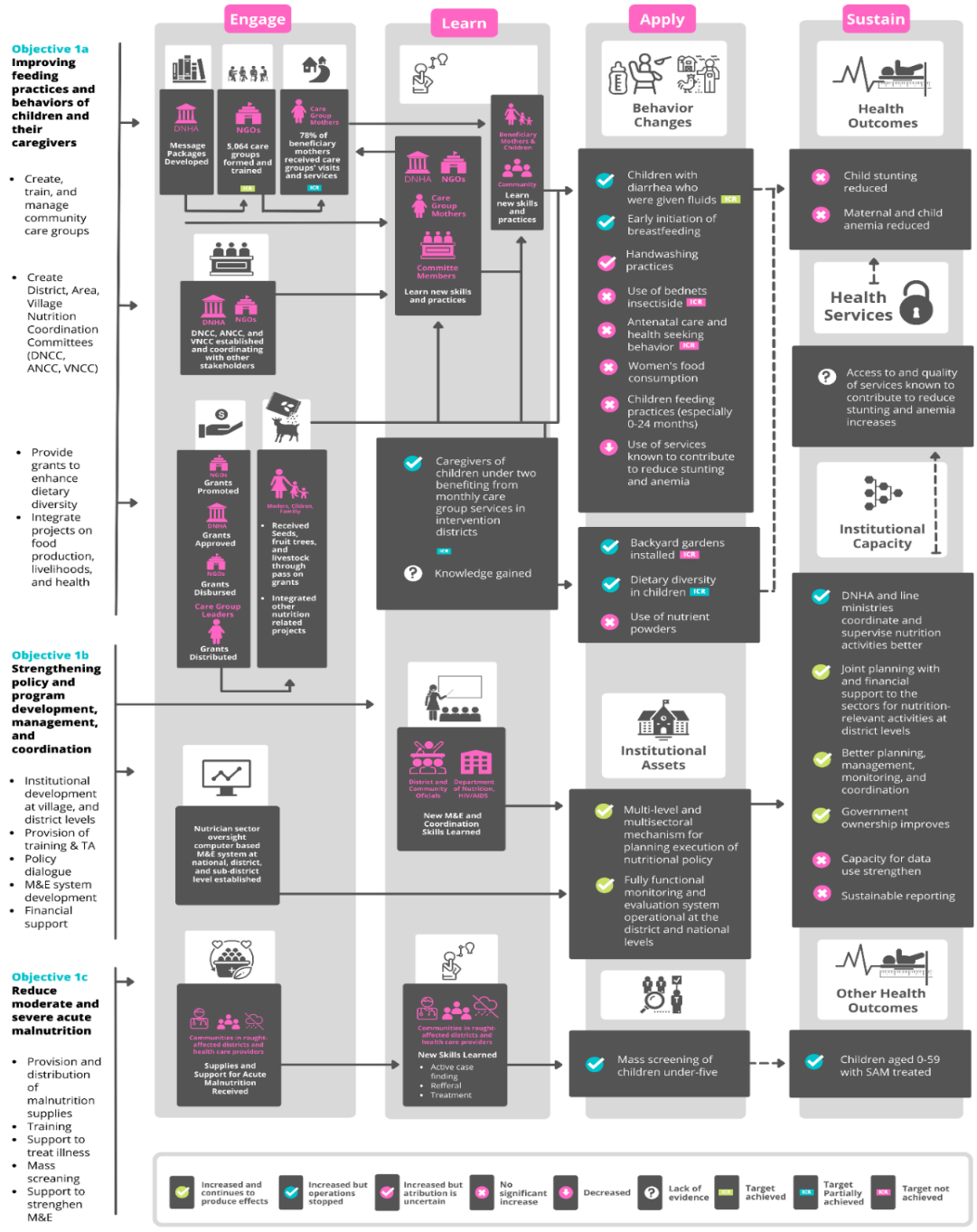
Box 1.2. Malawi's Care Group Model

A care group consists of 10–15 volunteers. These volunteers receive training to become community-based health educators. Care groups regularly meet with care group promoters to receive behavior change messaging to share with their communities. They are different from typical mothers' groups in that each volunteer is responsible for regularly visiting 8–15 of her neighbors to share what she has learned and facilitate behavior change at the household level. First used successfully in Mozambique for a child survival and health project, care groups are intended as a medium for behavior change communication and community support for behavior change.

Source: Perry et al. 2015.

1.5 In 2013, it was decided to extend the care groups approach to all districts in Malawi. Donor-supported financing fell under the auspices of the DNHA and different lead donors—principally the World Bank, the United Nations Children's Fund (UNICEF), and the United States Agency for International Development (USAID). The World Bank was responsible for 14 districts in Malawi (out of 28 total), where other donors were not already active and there was a high burden of stunted growth.

Figure 1.2. Theory of Change to Increase Coverage of Nutrition Services (Objective 1)



Source: Independent Evaluation Group.
Note: ANCC = Area Nutrition Coordination Committee; DNCC = District Nutrition Coordination Committee; DNHA = Department of Nutrition, HIV and AIDS; M&E = monitoring and evaluation; NGO = nongovernmental organization; SAM = severe acute malnutrition; TA = technical assistance; VNCC = Village Nutrition Coordination Committee.

Malawi's HIV/AIDS Context

1.6 For over a decade, the prevalence of people living with HIV/AIDS in Malawi has declined steadily, but it remains high. In 2010, over 10 percent of Malawi's adult population between the ages of 15 and 49 lived with HIV/AIDS, compared with the Sub-Saharan African average of 4 percent. According to the 2010 Malawi Demographic and Health Survey, the most common mode of transmission was heterosexual sex, and HIV prevalence was higher for women (13 percent) than for men (8 percent). HIV prevalence was also more than twice as high in the southern region (15 percent) as in the northern (7 percent) and central regions (5 percent).

1.7 At the time of appraisal, Malawi had one of the highest rates of pregnant women living with HIV. In 2009, approximately 60,000 pregnant women were living with HIV and needed antiretroviral therapy for the prevention of mother-to-child transmission (PMTCT). In 2010, mother-to-child transmission of HIV accounted for approximately 25 percent of new infections.

1.8 The World Bank has contributed to an HIV/AIDS pooled funding mechanism (the HIV Pool) since 2003. Before the project, the World Bank's HIV/AIDS–related support—the Multisectoral AIDS Project—was channeled through the HIV Pool. World Bank financing was pooled with financing from the Global Fund for AIDS, Tuberculosis, and Malaria and the United Kingdom's Department for International Development. The HIV Pool was administered by the National AIDS Commission (NAC). The HIV Pool was the primary source of funding for the government's Malawi National HIV and AIDS Strategic Plan (2011–16), accounting for 60 percent of the total budget allocated to the fight against HIV/AIDS in 2011. The remainder of the funds supporting the plan was disbursed at the time through line ministries and discrete projects of donors such as the United States President's Emergency Plan for AIDS Relief and UNICEF.

Project Objectives, Design, and Financing

Project Objectives and Design

1.9 The original project development objective (PDO) targeted improving nutrition and preventing the spread of HIV/AIDS in Malawi. The original PDO was "to increase access to, and utilization of, selected services known to contribute to the reduction of child stunting, maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults" (World Bank 2012a, 5). In 2016, the PDO was substantively revised as "to increase coverage of selected nutrition, HIV, and AIDS services and strengthen disease outbreak preparedness in project areas" (World Bank 2016, 4). The revised PDO reflected activities already in progress. In January 2015, funds

were reallocated from activities under the HIV/AIDS component of the project to disease preparedness interventions, specifically targeting Malawi's ability to respond to the emerging threat of the Ebola virus.

1.10 The PDOs can be summarized as follows:

1. Increase coverage of selected nutrition services:
    a. Improve feeding practices and behaviors of children and their caregivers;
    b. Improve the government's capacity to plan and execute nutrition interventions;
    c. Reduce moderate and severe acute malnutrition.
2. Increase coverage of selected HIV and AIDS services.
3. Strengthen disease outbreak preparedness.

1.11 The Project Performance Assessment Report (PPAR) summary contains an overview of the restructuring actions and a note on how the project was designed to meet the above objectives. For finer details on these two elements, please consult appendix D, Project Objectives and Design.

Project Financing

1.12 At closing, $57.4 million was disbursed by the project to support nutrition improvement (129 percent of the originally planned component budget); $51.3 million for HIV/AIDS (107 percent of the original component budget) and $7 million for Ebola preparedness.

Theory of Change

1.13 The theory of change was reconstructed by the Independent Evaluation Group (IEG). It is an enhanced, more granular version of the results chain presented in the Implementation Completion and Results Report (ICR), based on project documentation and interviews. It presents a fuller picture of how the activities were linked to outputs and intermediate outcomes. The project's theory of change is presented, by objective, in figures 1.2 and 1.3. It is aligned with the evaluation scope and offers a deep dive on component A while providing a simplified articulation of components B and C. (See appendix F for a detailed description of the project's components.)

1.14 **Objective 1.** Original: Increase access to, and utilization of, selected services known to contribute to the reduction of child stunting, maternal and child anemia. Revised: Increase coverage of nutrition services.

1.15 The project's theory of change was based on the premise that increasing access to and use of selected nutrition services improves some nutrition outcomes, such as maternal and child anemia and child stunted growth. Activities were centered on implementing nutrition service delivery at the community level by offering a minimum package of nutrition and nutrition-sensitive interventions with a strong emphasis on social and behavior change communication. Likewise, training at the district and community levels was provided to strengthen sectoral policy, program management, coordination, monitoring, and project management. The changes resulting from the implementation of the care groups model and institutional strengthening could reasonably be expected to contribute to creating knowledge on child feeding and care, food processing, and cultural practices. In addition, the delivery of therapeutic food, oral rehydration salts, and essential nutrition commodities, as well as increased screening in drought-affected districts, could presumably contribute to the implementation of integrated management of acute malnutrition.

1.16 In addition to the care group development, the project invested in building the capacity of the DNHA and the coordination structures associated with it to implement, monitor, and evaluate a national nutrition strategy. This was accomplished through budgetary support to the DNHA, training, capacity building, and advisory services. The project also provided funding for national-level coordination meetings and for the establishment of a nationwide computer-based monitoring and evaluation (M&E) system for nutrition. This system facilitates data gathering at a district level for use by the DNHA and other national-level nutrition policy makers.

1.17 A supplementary nutrition subcomponent, to address severe and acute malnutrition, was added in May 2016. The government requested emergency financing to combat an increase in moderate and severe acute malnutrition caused by unexpected crop losses and a decline in food production after two natural disasters—floods, followed by a prolonged drought.

1.18 **Objective 2.** Original: Increase access to, and utilization of, selected services known to contribute to the prevention of HIV and AIDS in children and sexually active adults.

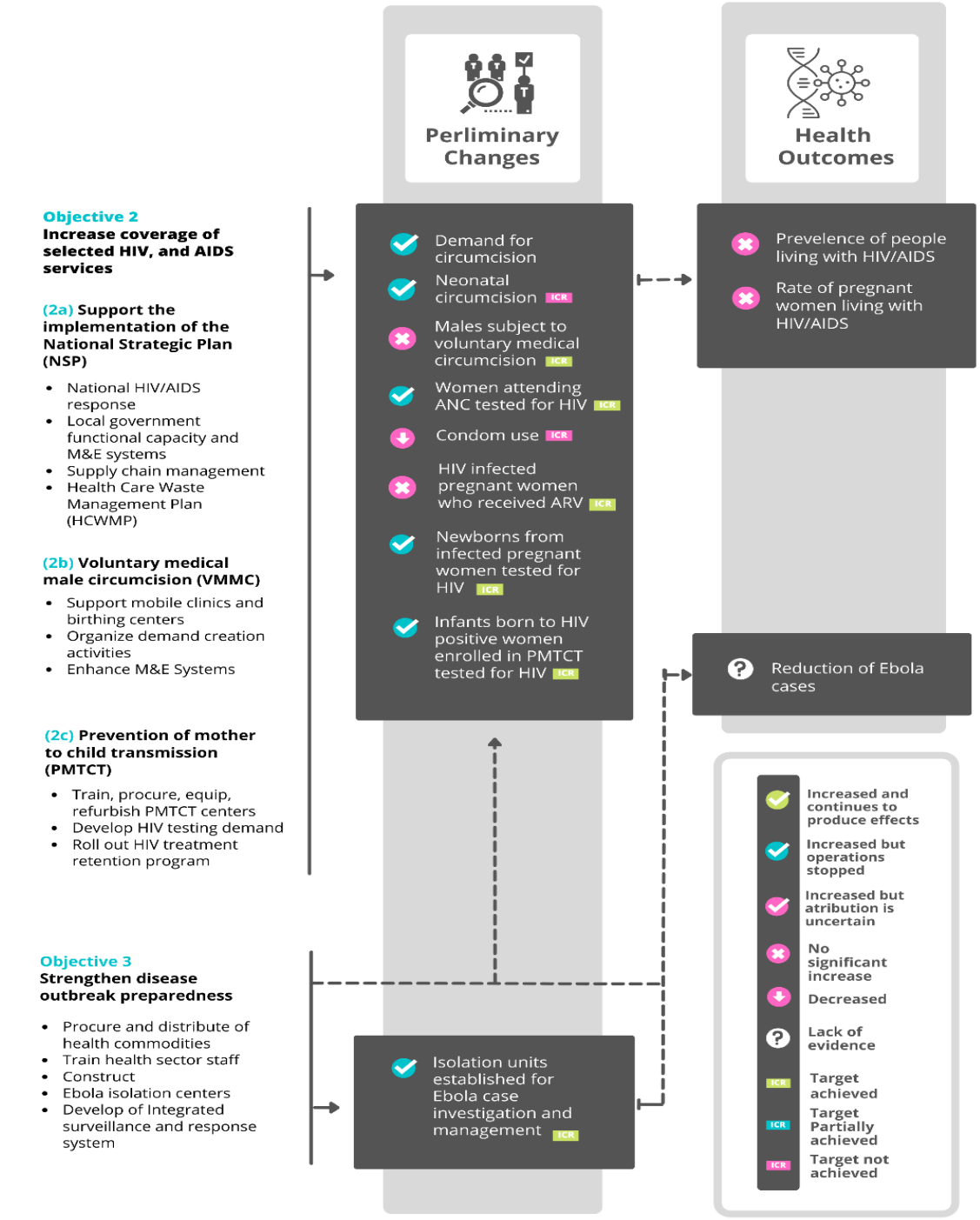
1.19 The project's theory of change was based on the premise that increased access to and use of selected services, such as promoting the use of condoms, voluntary male medical circumcision, and PMTCT, was a cost-effective approach to reducing new

infections. Accordingly, the priorities of the HIV/AIDS National Strategic Plans 2011–16 were implemented, and M&E systems were strengthened. Also, the project (i) supported the implementation of a voluntary male medical circumcision operational plan aimed at increasing voluntary male medical circumcision services, with a focus on districts not served by the United States President's Emergency Plan for AIDS Relief; and (ii) funded the equipment of PMTCT centers to increase the provision of PMTCT services.

1.20 **Objective 3.** Original: Increase access to, and utilization of, selected services known to contribute to the prevention of HIV and AIDS in children and sexually active adults.

1.21 The government of Malawi considered it crucial to strengthen Malawi's capacity to respond to disease outbreaks because of the risk of an Ebola epidemic in the country. The theory of change assumed that building infrastructure, supplying commodities and critical goods, and training health sector and other staff to respond to an Ebola emergency could reasonably be expected to contribute to strengthening Malawi's capacity to control and prevent the spread of communicable diseases and manage outbreaks. Also, the implementation of a new surveillance system to process and analyze information in real time would improve decision-making capacity and the national response to a health threat.

Figure 1.3. Theory of Change to Increase Coverage of HIV/AIDS Services and Disease Outbreak Preparedness (Objectives 2 and 3)



Source: Independent Evaluation Group.
Note: ANC = antenatal care; ARV = antiretroviral; M&E = monitoring and evaluation; PMTCT = prevention of mother-to-child transmission.

2. What Worked, and Why?

Results

Objective 1: Increase Coverage of Selected Nutrition Services

Objective 1a: Improving Feeding Practices and Behaviors of Children and Their Caregivers

2.1 The project was largely successful in the initial production of knowledge materials and establishment of the targeted number of care groups. A total of 5,064 care groups were formed and trained, against a target of 5,000. The project produced a wide range of information materials in local languages that are still in use today. These included (i) a key message booklet for frontline workers and care group members; (ii) counseling materials on breastfeeding, infant and young child feeding (IYCF) and complementary feeding, water, sanitation, and hygiene (WASH), and maternal nutrition; (iii) recipe books for the promotion of the six food groups; and (iv) posters with key messages. Further modules of counseling materials on family planning and malaria (a significant driver of anemia in Malawi) were planned but finalized too late in the project period to be disseminated to the care groups.

Objective 1b: Improving the Government's Capacity to Plan and Execute Nutrition Interventions

2.2 Malawi's institutional framework for nutrition improved. The subcomponent, whose purpose was to strengthen the capacity of the DNHA to coordinate multisectoral nutrition efforts at the central, district, and subdistrict levels, succeeded in setting up the institutional infrastructure for all subsequent nutrition interventions in Malawi. As a DNHA leader interviewed during the field mission said: "The whole nutrition landscape was shaped and changed by the project. When government is empowered to do something, it is able to influence."

2.3 Figure 2.1 summarizes the project's main achievements at this level and what contributed to them. The left-hand side of the diagram introduces the project's activities, and the right-hand side summarizes the main outcomes achieved. The pink area explains the role played by institutional capacity development in strengthening policy coordination and increasing cohesion within different levels of governance (village, district, sector, and national levels), among community leaders, and with civil society. The blue area describes the effects of three key enabling systems implemented: policy dialogue, M&E, and funding. The outcomes on the right are reasonably expected to

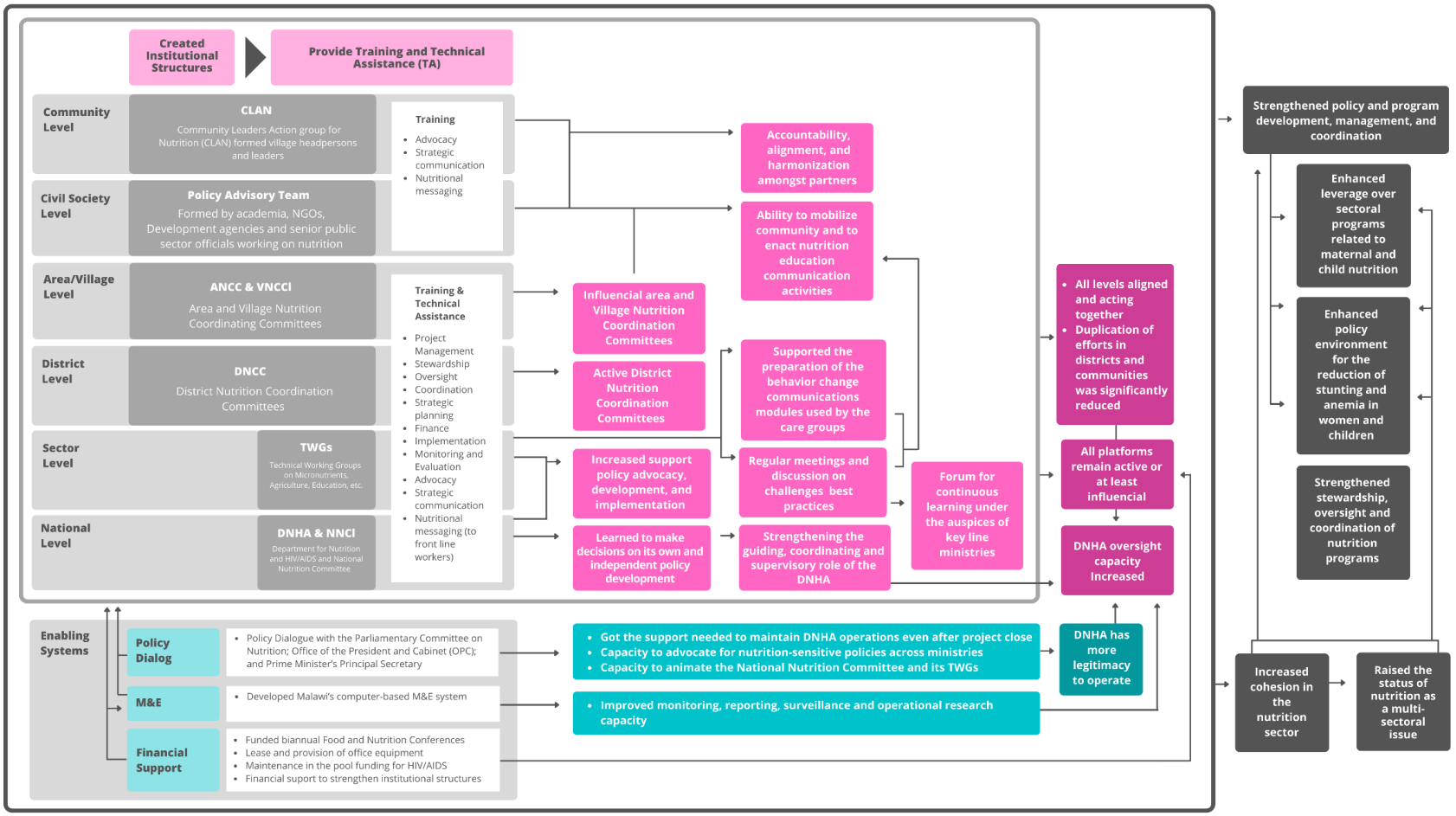
contribute in the long run to improved supply of and access to nutrition services and ultimately to better health outcomes.

2.4 The capacity of the DNHA to serve as a coordinating body improved substantially with support from the project. This finding is in sharp contrast to the 2011 government of Malawi gap analysis, which found that the DNHA was not effectively fulfilling its functions (Government of Malawi 2011b). Our team heard consistently positive praise for the efficacy of the DNHA as a convener and coordinator of donor efforts from a wide range of key informants. To quote one donor, "It is just fantastic to see the capacity of the DNHA" for national nutrition coordination and leadership. A lot of the success can be attributed to how capacity was built. The evaluation team was also told that "There was huge government ownership because of training—it helped them to learn how to make decisions on our own. The leadership training was very helpful."

2.5 The project successfully supported the development of durable multilevel and multisectoral mechanisms for planning and executing nutritional policy. Evidence gathered in the three PPAR field visits and in multiple interviews with donors and government nutrition stakeholders indicates that the national- and district-level structures that were established through the project have improved government ownership and enhanced effective multisectoral coordination on nutrition. As pointed out by a member of the World Bank country team, the project managed to raise the status of nutrition as a multisectoral issue.

2.6 The DNHA was largely successful at consolidating nutrition efforts at all levels so that there is one policy, one coordinating body, one strategic plan, one behavior changes communication strategy, and one M&E framework for all ministries, stakeholders, districts, and donors. According to the 2015 National Nutrition Education Communication Strategy (NECS) evaluation: "The period 2011 to 2016 was characterized by cohesion in the nutrition sector, whereby duplication of efforts in districts and communities was significantly reduced, hence there was rational and effective use of limited resources" (Kalimbira and Siyame 2017, 14). Several interviewees, including donors and district-level officials, referred to the success of the strategy in getting all stakeholders working together. Notably, the modules that were developed over the course of the project are still in use today in a range of donor funding projects; the district and subdistrict coordination structures developed by the project have become active partners in all current donor-funded nutrition initiatives. Among the development partners presently supporting care group structures and using instructional materials whose development was supported by the project are the following: UNICEF, the World Food Programme, the Food and Agriculture Organization, Kreditanstalt für Wiederaufbau, and USAID.

Figure 2.1. The Project's Contribution to Institutional Capacity Development



Source: Independent Evaluation Group.
Note: ANCC = Area Nutrition Coordination Committee; CLAN = Community Leaders Action group for Nutrition; DNCC = District Nutrition Coordination Committee; DNHA = Department of Nutrition, HIV and AIDS; M&E = monitoring and evaluation; NGO = nongovernmental organization; TWG = technical working group; VNCC = Village Nutrition Coordination Committee.

2.7 Field visits in three districts found that District Nutrition Coordination Committees (DNCCs), involving all district-level stakeholders responsible for nutrition-related interventions (for example, agriculture, fisheries, gender, education), were still active as of January 2020. In each of the field visits, evaluators were told that the DNCCs, set up during the project period, still meet regularly. They were universally found to be helpful for designing and coordinating nutrition-sensitive interventions and for donor coordination.

Objective 1c: Reduce Moderate and Severe Acute Malnutrition

2.8 The third nutrition subcomponent, added in 2016 to finance integrated management of acute malnutrition in project districts, mostly achieved its goals. The project financing was extended to procure inputs for treating moderate to severe acute malnutrition. This occurred in 2016, against the backdrop of a severe drought that led to an increase in health facility admissions for acute malnutrition of 34 percent from January–March 2015 to January–March 2016. According to the ICR (World Bank 2019a), 75.4 percent of children ages 0–59 months with severe acute malnutrition successfully received treatment, as compared with a target of 80 percent. Mass screening of 1,312,316 under-five children was undertaken in all 14 project districts. Of these children, 1,796 were referred for treatment of moderate acute malnutrition and 9,253 for severe acute malnutrition.

Objective 2: Increase Coverage of Selected HIV and AIDS Services

2.9 The project promoted access to and use of HIV and AIDS services, particularly voluntary male medical circumcision. The project funded the equipping of 30 public and private facilities for voluntary male medical circumcision in 20 selected project districts. It also procured 228,514 disposable male circumcision kits, 760 reusable kits, 40 autoclaves, 36 tents, one vehicle each for the 21 districts, and one vehicle for the HIV/AIDS department. In addition, to promote voluntary male medical circumcision awareness, the project successfully funded a demand creation team, which trained and supervised demand creation officers in all project districts, health facilities, and communities. PMTCT-related project activities were reduced because of the unanticipated increase of donor funding from other sources. However, the project continued to fund some limited PMTCT activities, including refurbishment of some PMTCT centers, provision for HIV DNA polymerase chain reaction equipment for infant testing, and implementation of a mentorship program for PMTCT center staff.

Objective 3: Strengthen Disease Outbreak Preparedness

2.10 At the disease preparedness level, the project delivered the outputs planned. It established an Ebola Coordination Unit under the Ministry of Health, developed a

disease preparedness plan, and supplied and procured the health commodities and critical goods for managing disease outbreaks. It also installed an electronic integrated disease surveillance and response system and instituted an SMS alert system, in addition to six nationwide rapid response teams trained in Ebola detection, surveillance, and contact tracing. This component was successful in instituting an improved disease surveillance system for Malawi.

Design and Preparation

2.11 The main design and preparation success factors involved the World Bank's high-quality planning and results frameworks for institutional capacity development, with integrated management of the acute malnutrition treatment subcomponent, the disease preparedness component, and the HIV/AIDS component.

Objective 1: Increase Coverage of Selected Nutrition Services

Objective 1a: Improving Feeding Practices and Behaviors of Children and Their Caregivers

2.12 The causal approach to improving feeding practices and behaviors of children and their caregivers was well aligned with the literature. A major proportion of the project activities was devoted to supporting social and behavioral change communication via home visits, community groups, and interpersonal communication. According to the global literature, this has proven to be effective to improve several nutrition outcomes, such as child undernutrition and development; child feeding and caring practices; maternal and child health; access to health services; WASH and nutrient-rich food; and social norms and behaviors (World Bank 2021). Also, literature suggests that the community-based design of the nutrition component tends to facilitate synergized support across sectors to tackle multiple beneficiary needs, which was the intended result.

Objective 1c: Reduce Moderate and Severe Acute Malnutrition

2.13 The results frameworks for the integrated management of the acute malnutrition treatment subcomponent, the disease preparedness component, and the HIV/AIDS component were mostly appropriate and sufficient for tracking project achievements. As one of the village chiefs said: "The children that joined the community-based childcare centers are better off than before. And in school they perform better than before. They have benefited from childcare practices." Data were also sufficient to enable the government to track progress and respond to problems promptly.

Objective 2: Increase Coverage of Selected HIV and AIDS Services, and Objective 3: Strengthen Disease Outbreak Preparedness

2.14 In the HIV/AIDS and disease outbreak preparedness component, the project adeptly responded to shifts in donor funding commitments to ensure efficient deployment of project resources in needed areas.

Implementation and Supervision

2.15 Supervision was positively perceived by the government of Malawi, building on a strong professional relationship between the World Bank team and government officials. Throughout project implementation, the World Bank team remained proactive and responsive to the changing context and restructured the project twice at the government of Malawi's request.

Objective 1: Increase Coverage of Selected Nutrition Services

Objective 1b: Improving the Government's Capacity to Plan and Execute Nutrition Interventions

2.16 Policy development and coordination mechanisms were implemented successfully and sustained after the project period. They became central mechanisms for Malawi's nutrition policy formulation and execution. The DNHA emerged during the project period as the leading body for the development and implementation of a multisectoral nutrition policy. As mentioned in the Design and Preparation section above, this was due in part to the project's capacity-building support. The project invested in developing the capacity of the DNHA and district-level nutrition officers to design, manage, and evaluate nutrition policies and programs. Although the DNHA had been operational since 2004, the training and support financed through the project was instrumental in fostering high-level ownership and leadership of nutrition policy in Malawi. The project also supported district-level training in project management, in the care group model, Scaling Up Nutrition's 1,000 Special Days "13 high-impact interventions," and M&E. Discussions with DNHA staff suggest the leadership training they received was particularly helpful, and they reported preparing policy development and strategic development independently. The leadership and coordination capacity of the DNHA was commented on in several of the evaluation team's conversations with donors and can be seen as one of the principal achievements of the project.

2.17 The DNHA's role as nutrition convener and coordinator was bolstered by the strong political support that it got during the project period. Its location in the Office of the President and Cabinet and the strong support of the prime minister's principal secretary enabled the DNHA to advocate for nutrition-sensitive policies across

ministries and to animate the National Nutrition Committee and its technical working groups (TWGs). In addition, the backing of the Parliamentary Committee on Nutrition helped the DNHA get the support needed to maintain its operations, even after the project closed. At the end of 2014, there was concern that the DNHA's convening power would be weakened with the decision to move the department from the Office of the President and Cabinet to the Ministry of Health. However, even in this context, because of strong leadership from the DNHA and high levels of stakeholder commitment, the multisectoral coordination structures initiated by the DNHA continue to be effective.

2.18 Malawi, with the support of the project, developed institutional mechanisms that significantly enhanced coordination and collaboration on nutrition-specific and nutrition-sensitive policy and programming. The project introduced a multilevel nutrition program coordination structure where none had existed before the project (Kalimbira and Siyame 2017). This structure has been rolled out in all districts of Malawi. Each DNCC is chaired by the principal DNHA officer based at the district commissioner's office and has representatives from various sectors, including health, agriculture, education, and the civil society organizations working in the district. The DNCC enables multisectoral coordination of nutrition-relevant activities and provides technical support for the operationalization of the NECS. According to a 2017 evaluation of the NECS, the strategy and its coordination structures "led to a large increase in resources at the national level, which has also trickled down to districts, to facilitate roll-out" (Kalimbira and Siyame 2017).

2.19 At the subdistrict level, Area Nutrition Coordination Committees (ANCCs) and Village Nutrition Coordination Committees (VNCC) were organized, bringing together frontline workers from the ministries of agriculture, health, gender, and education, along with other civil society organizations, to enact nutrition education communication activities. In parallel, village headpersons and other village leaders were organized in a Community Leaders Action group for Nutrition (CLAN) structure, responsible for community sensitization and mobilization. To quote one informant, "The whole nutrition landscape was shaped and changed by the project. When government is empowered to do something, it is able to influence." During the field visit, our PPAR team observed varying levels of engagement in the structures that had been set up by the project. On all levels, stakeholders reported that the creation of these coordination structures had an overwhelmingly positive effect on the capacity to develop and execute nutrition interventions, although meeting regularity and attendance varied somewhat from district to district, with the lower levels (ANCCs and VNCCs) showing greater variance in regularity of meetings than DNCCs.

2.20 The National Nutrition Committee and its TWGs supported policy advocacy, development, and implementation. The National Nutrition Committee was established

to strengthen coordination and networking mechanisms in the national response to nutrition in Malawi. Chaired by the DNHA and co-chaired by the chair of the donor group on nutrition security, the committee is an advisory body to the DNHA and considers reports from the DNHA and partners. The National Nutrition Committee comprises a cross-section of stakeholders, including sector ministries, development partners, civil society organizations, and academia.

2.21 The TWGs emerged during the project period as important actors on the nutrition policy landscape. The TWG platforms allow for coordination, accountability, alignment, and harmonization among partners supporting nutrition in Malawi for improved performance. When first set up, the TWGs were primarily conceived as forums for progress reports. However, with the aid of technical advice funded through the project, they were able to broadly expand the functions of the working groups to be a forum for continuous learning (for example, the DNHA for IYCF, the Ministry of Agriculture for Agriculture-Nutrition, and so on) to include discussions on common challenges, sharing best practices and collaborating on common goals. Preparation of the behavior change communications modules used by the care groups was largely facilitated by the IYCF TWG, with TWG members donating their time to the common project of drafting key messages and training districts and nongovernmental organizations (NGOs) to use the prepared materials. TWGs meet at least once every quarter and more frequently as the need arises. Technical working groups meet a minimum of every quarter but more frequently as the need arises. The National Nutrition Committee has the following thematic TWGs, with multisectoral representation that includes government departments, development partners, civil society, research, and academia: Maternal Infant and Child Feeding; Micronutrients; M&E, Research, and Surveillance; Targeted Nutrition Program; Agriculture-Nutrition; and Nutrition Education.

2.22 The project seeded cross-sectoral knowledge sharing and dialogue mechanisms that have since been institutionalized with government funding. The project funded twice-yearly food and nutrition conferences to present research and encourage dialogue on policy. The conferences are still being held, although now only every two years. In addition, the government has now taken over the financing of the annual Scaling Up Nutrition Learning Forum, with all districts and partners attending. The two- to three-day forum enables the DNHA to present new policies and strategies, and districts to share their activities and learning. Finally, a policy advisory team comprising representatives of academia, NGOs, and development agencies and senior public sector officials working on nutrition was revived by the project and has now been institutionalized. The team meets at least twice a year, with additional meetings convened as needed. All these forums, in combination with the strong leadership role of

the DNHA, have led to a well-coordinated and inclusive nutrition policy and programming structure in Malawi.

2.23 Finally, the project helped develop Malawi's computer-based M&E system, including through financing computer purchases, technical advice, and training for M&E officers at both the district and national levels.

Objective 3: Strengthen Disease Outbreak Preparedness

2.24 The World Bank team showed flexibility and agility in responding to external shocks, including the 2015–16 food crisis, the outbreak of Ebola in West Africa, and the shifting donor landscape for HIV/AIDS. The World Bank team is to be commended for its work with the NAC to continue to support the AIDS Pool.

3. What Didn't Work, and Why?

Results

Objective 1: Increase Coverage of Selected Nutrition Services

Objective 1a: Improving Feeding Practices and Behaviors of Children and Their Caregivers

3.1 The project was largely successful in the initial establishment of the targeted number of care groups, but this did not translate into a fully sustainable network of care group services. A total of 5,064 care groups were formed and trained, against a target of 5,000. Based on data collected from implementing NGOs on the number of care groups formed, the ICR reported 78 percent coverage of caregivers of children under the age of two benefiting from monthly care group services, against a revised target of 82 percent. However, although the indicator was supposed to represent mothers receiving monthly care group services, it appears that this number represented the number of mothers assigned to care groups without reference to whether they indeed received monthly services until the project end.

3.2 In fact, the degree to which care groups of community mothers were established, received materials and training, and were fully operational varied substantially by project district. The endline survey of the project, conducted in February 2018, found that districts with a shorter exposure to the project activities had a much higher average coverage rate of care groups—66 percent for districts with approximately 18 months of exposure (phase 2 districts) versus 28 percent for districts with approximately 36 months exposure (phase 1 districts; table 3.1).

3.3 Not all planned materials were produced during the project period, even though the project produced a wide range of information materials in local languages that are still in use today. These included (i) a key message booklet for frontline workers and care group members; (ii) counseling materials on breastfeeding, IYCF and complementary feeding, WASH, and maternal nutrition; (iii) recipe books for the promotion of the six food groups, and (iv) posters with key messages. Further modules of counseling materials on family planning and malaria (a significant driver of anemia in Malawi) were planned but were finalized too late in the project period to be disseminated to the care groups.

3.4 Data suggest a lack of sustainability in service coverage, including during the period when NGOs were receiving funding to manage the care groups. This finding is further reinforced by the March 2015 midterm review of the project, which reported care group coverage of 66 percent for mothers with children in the target age range in the districts where the project was active (Rabeneck 2015), suggesting that care group coverage was lower at the project end than at its midpoint. Our PPAR team conducted field visits to 3 of the 14 project districts in November–December 2019, all of which had been recommended as particularly successful districts under the project, including two districts that received support in both the first and second phases of the project and one that received support only in the second phase. In none of the three districts visited were the DNCC or the district nutrition officer able to confirm how many care groups were still active, although all presumed that only a small percentage of the original groups were.

3.5 Continued contact between the care groups and the nutrition officer after the project was maintained only in traditional authorities where other donor-funded projects were continuing to use the care groups. Even in the Mangochi district, which reported the highest care group coverage across project districts at the time of the endline survey, only a few care groups were operational. According to the DNHA, no care groups are currently submitting reporting forms to the DNCC for upload to the national nutrition M&E system, as they had done during the project period.

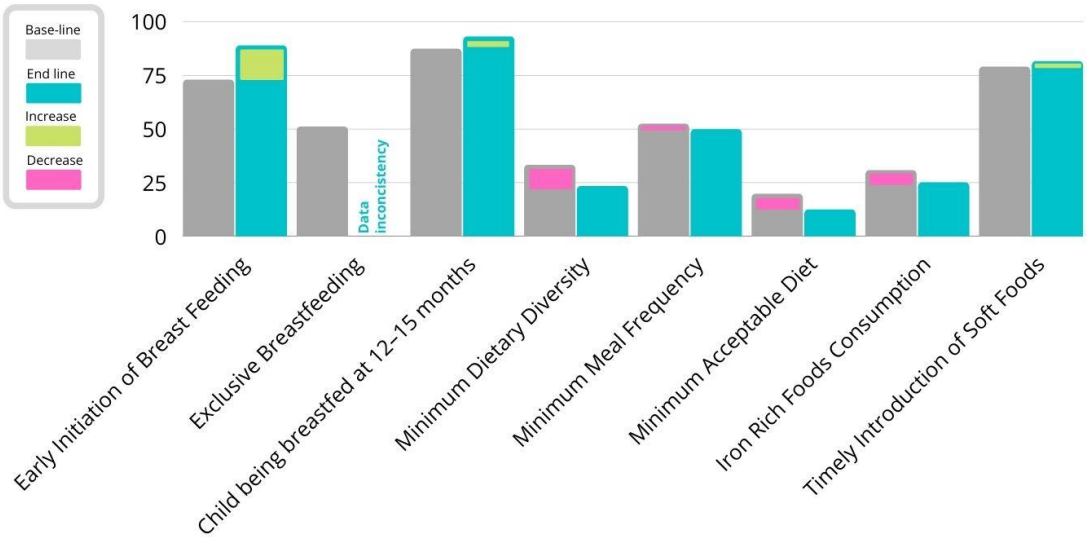
Table 3.1. Children under Two Benefiting from Monthly Care Group Services

District	Share of Children Benefiting (%)
All Phase 1 districts	27.7
Rumphi	50.0
Mchinji	35.3
Ntcheu	7.1
Zomba	5.3
Ciradzulu	66.7
Blantyre	45.5
Mwanza	13.3
All Phase 2 districts	65.4
Mzimba	62.5
Nkotakota	0.0
Ntchisi	75.3
Mangochi	88.9
Machinga	58.8
Thyolo	22.2
Mulanje	16.7

Source: Osendarp et al. 2019.

3.6 Evidence from the endline survey on feeding practices in project areas is uneven. Indicators of breastfeeding and initiation of soft foods registered improvements (figure 3.1).

Figure 3.1. Feeding Behaviors Before and After the Project



Source: Osendarp et al. 2019.

3.7 Communities interviewed during field visits also reported improved feeding behaviors (table 3.2). However, minimum dietary diversity, minimum meal frequency, minimum acceptable diet, and consumption of iron-rich foods decreased, and a question remains on whether these testimonials reflect interview bias, the implementation model failed, or there simply was not enough time for change to produce results.

Table 3.2. Field Testimonials

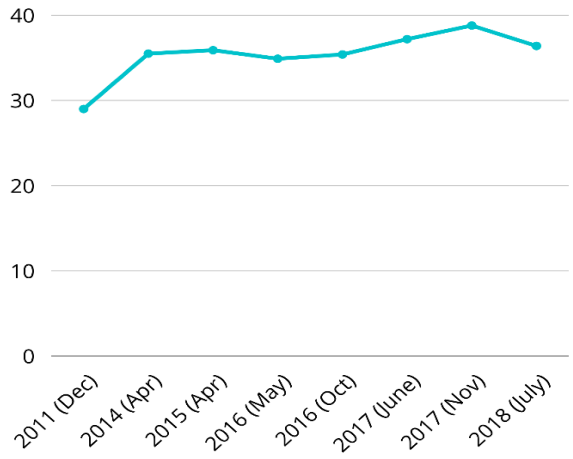
Source	Comments
Care group participants, Ntcheu district	It has transformed the way we feed our children. Now we prepare foods differently. Six food groups are all available locally. Most of the women said that they couldn't get all six food groups but could get at least four. One-third managed six; three-quarters managed four.
Care group promoter, Mangochi district	At first, they had so many malnourished children in the households; with the coming of the care group, the situation has improved. The care group is the forum where they share experiences, and those who might have forgotten good practices for nutrition, sanitation, and hygiene are reminded. Cooking demonstrations show us how to cook a variety of food. They understand that they [should] eat at least four food groups.
CLAN, Rumphi district	What is the difference now? Children are less malnourished because [parents] know what children should eat. There are backyard gardens so there is more food. They now know that they can eat foods that previously they thought were dangerous for kids, like eggs.

Source: Independent Evaluation Group.

3.8 Data regarding minimum diet diversity (MDD) are inconsistent. The percentage of children ages 6–23 months receiving MDD in treatment districts declined during the project period. The 2018 endline survey reported that feeding practices in the project districts had gotten worse over the project period; nationally, MDD fell from a 2013 baseline of 33 percent to 23 percent, with no significant differences overall between project and nonproject districts. This failure to achieve adequate improvements in MDD is curious, given that food access remained stable or improved during the project period (see appendix H).

3.9 The ICR reported some improvement, though below target, but its sources for this are unclear. According to the ICR, from a December 2011 baseline of 29 percent, the project achieved 36 percent MDD as compared with the target of 40 percent. However, a midterm review of the project in March 2015 reported that based on DNHA data, 38.8 percent of children ages 6–23 months had achieved MDD, suggesting that in the final years of the project, when care group coverage was greatest, feeding practices remained stable or backslid (Rabeneck 2015). The DNHA was unable to explain the discrepancy between the numbers reported in the ICR and those in the endline survey (figure 3.2).

Figure 3.2. Children Receiving Minimum Diet Diversity



Source: Independent Evaluation Group.

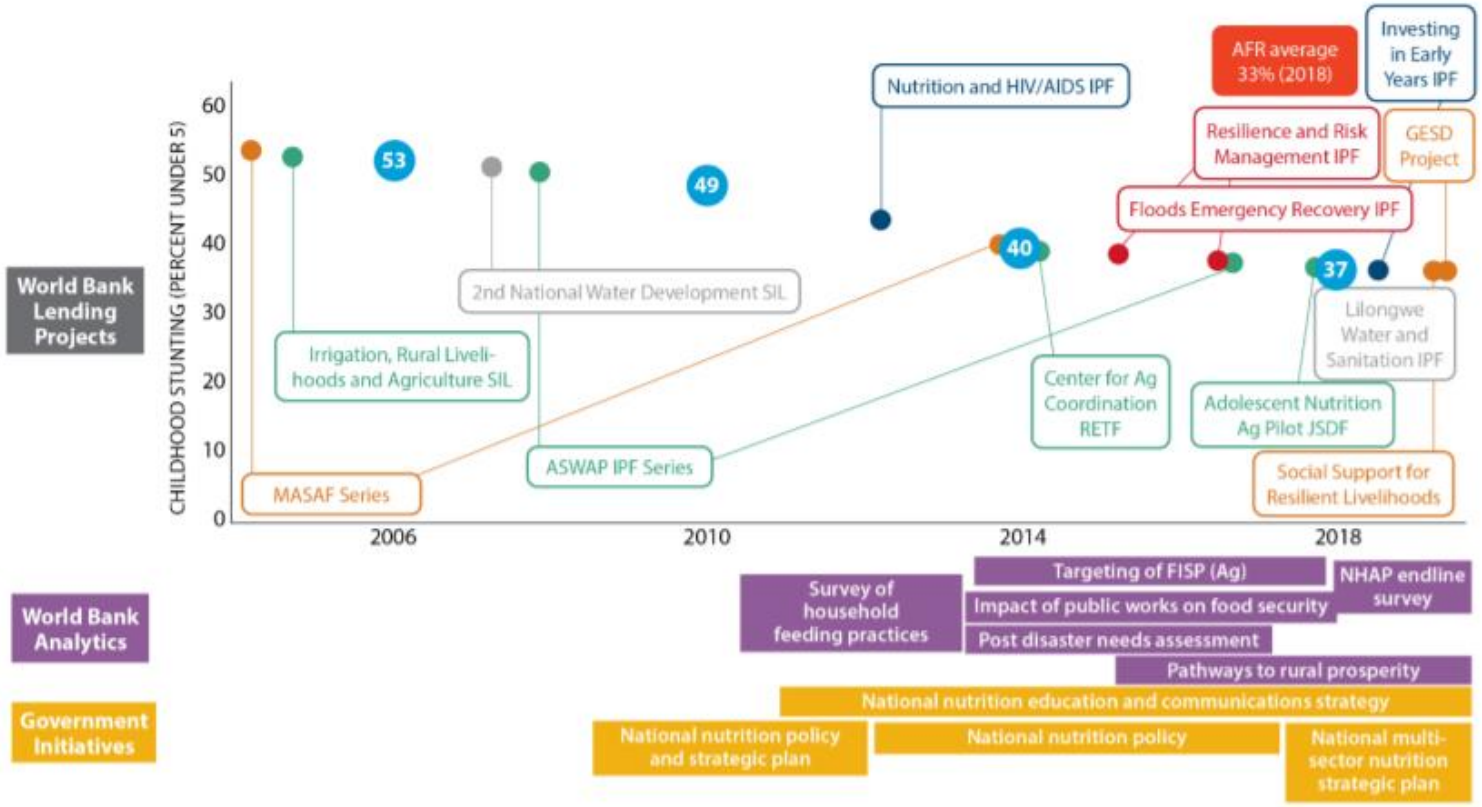
3.10 Grants for agricultural production and health care–seeking behaviors also present mixed results. A total of 17,556 backyard gardens were established in the intervention districts, not reaching the original target of 30,000 but exceeding the revised target of 13,000. This statistic did not monitor the extent to which established gardens were maintained, but field visits suggested that many of the originally established gardens were not kept through the project period. In the case of health care behaviors, the number of people with access to a basic package of health, nutrition, or population services in the project districts was 26,747 as of 2016, far below the target of 186,615. Although the indicator was dropped because achievement could not be fully attributed to the project, the borrower reported 197,123 people with access to a basic package of health, nutrition, or population services in the project districts (World Bank 2019a).

3.11 On the high end of the results chain, stunted growth was reduced somewhat in Malawi during the project period. However, the rate of reduction of stunted growth slowed as compared with the period before the project. Malawi's NECS for Preventing Child Stunted Growth (2011–16) and the government's strategy document guiding the project set a national goal to reduce the prevalence of stunted growth among children under the age of two years to less than 20 percent over the strategy's five-year period. Of the several donor-funded initiatives supporting this goal, the project was by far the largest. Nevertheless, during the project period, Malawi did not come near to achieving this goal. On the contrary, the pace of stunted growth reduction during the project period slowed slightly, as compared with the period before implementation of the project. According to the endline survey for the project, the rate of stunted growth fell during the years when the project was active at a district and village level, from

42 percent at the time of the 2013 baseline study to 37 percent in 2018 (Osendarp et al. 2019). The project districts reported reductions in stunted growth similar to those of other projects where other donors (principally USAID) took the lead in organizing care groups. It is important to note, however, that in Malawi, repeated crises and worsening food insecurity likely limited improvements in nutrition indicators (World Bank 2021; table 3.4).

3.12 Evidence suggests that reductions in stunted growth during the project period could be largely attributable to improvements in hygiene and sanitation practices delivered outside the project. An analysis of the project based on the endline survey concluded that over 70 percent of reductions in stunted growth during the project period were because of handwashing, thanks to a strong WASH focus in donor financing overall, including a WASH module in care group activities. Significant improvements in handwashing practices nationwide during the project period (figure 3.4). In all three districts visited, village chiefs and care group members noted that the project had helped them organize to introduce better sanitation and hygiene facilities. Advances in WASH were supported in large part by UNICEF's Community Led Total Sanitation and Hygiene Project between 2013 and 2018, which was responsible for the construction of 256,350 latrines and 155,000 handwashing facilities in 15 districts (including 7 project districts), alongside community-based sanitation promotion programming.

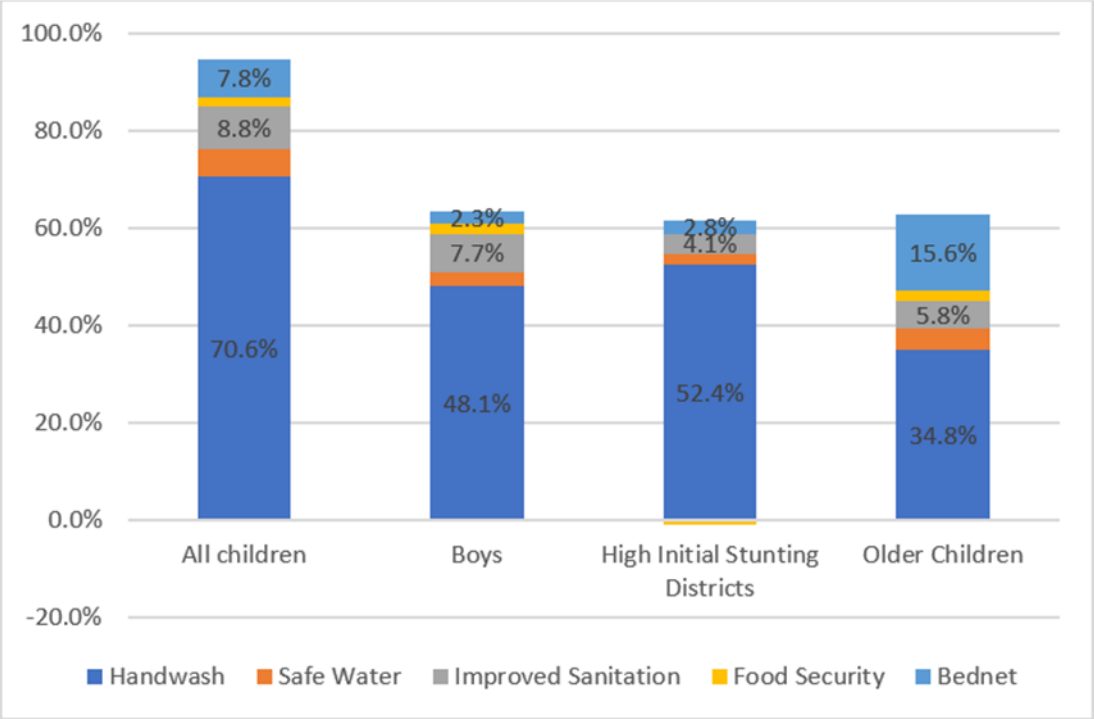
Figure 3.3. Malawi Project Timeline and Theory of Change for World Bank Nutrition Support



PROJECTS: MASAF APL Series (P075911, P110446, P121065, P131648, P133620, P148617, P160519); Irrigation, Rural Livelihoods and Agriculture SIL (P084148, P121120, P131760); Second National Water Development Project SIL (P096336, P110157, P124486); Agricultural Sector Wide Approach Project SIL Series (P105256, P128576, P148964, P164445); Nutrition and HIV/AIDS IPF (P125237, P156129); Center for Coordination of Agricultural Research and Development for Southern Africa RETF (P113629); Resilience and Disaster Risk Management IPF (P161392, P171877); Floods Emergency Recovery IPF (P154803); Adolescent Nutrition Sensitive Agriculture Pilot IPF (p163923); Lilongwe Water and Sanitation Project IPF (P163794); Investing in Early Years for Growth and Productivity (P164771); Governance to Enable Service Delivery Project (P164961); Social Support for Resilient Livelihoods (P169198).
STUNTING DATA SOURCE: UNICEF, WHO, and World Bank 2019.

Source: Independent Evaluation Group.
Note: AFR = Africa Region; ASWAP = ; FISP = Farm Input Subsidy Programme; GESD = Governance to Enable Service Delivery; IPF = investment policy financing; JSDF = Japan Social Development Fund; MASAF = Malawi Social Action Fund; NHAP = Nutrition and HIV/AIDS Project; RETF = recipient-executed trust fund; SIL = specific investment loan.

Figure 3.4. Contribution of Factors to Stunted Growth (height-for-age z-score) Changes, 2013–18



Source: Osendarp et al. 2019.
Note: A Z-score is a numerical measurement that describes a value's relationship to the mean of a group of values. Z-score is measured in terms of standard deviations from the mean. A Z-score of 0 indicates that the data point's score is identical to the mean score. "All children" refers to the survey population of children ages 6–60 months. "Older children" refers to children ages 24–60 months.

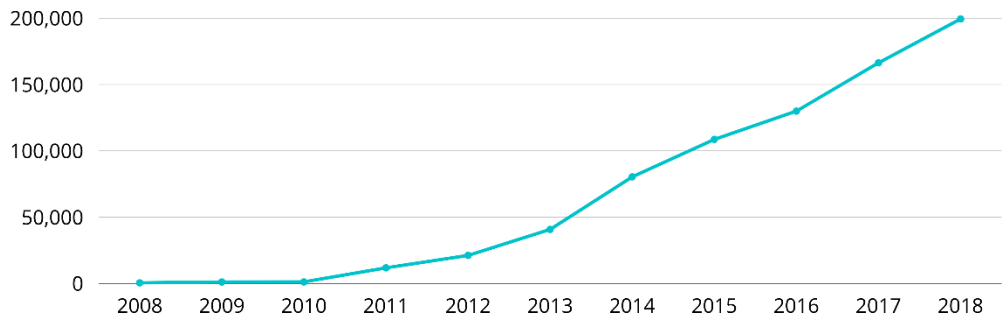
Objective 2: Increase Coverage of Selected HIV and AIDS Services

3.13 Over the course of the project, emphasis shifted from PMTCT to voluntary male medical circumcision in response to a changing donor landscape. During the project, activities and indicators were reviewed because of an overlap of investments from the United States President's Emergency Plan for AIDS Relief and the project. For example, financing fixed mobile service units to provide a minimum package of male circumcision and PMTCT. Moreover, numerous donors withdrew their funding to the HIV Pool and channeled support to the sector through a parallel system that contributed to the achievement of some HIV outcomes but led to a lack of funds for some activities; for instance, PMTCT activities were decreased in the latter part of the project.

3.14 The awareness-raising activities on male medical circumcision during the project period were successful, as evidenced by the growth in demand for voluntary male medical circumcision over the project period (figure 3.5). However, the pace has not been sustained because of a lack of sustained funding. For example, in Rumphi,

circumcisions have dropped from 200 per month at the height of the project period to the present level of 15 to 20 per month. The significant drop in circumcision rates since the project end is attributable to a lack of the following: (i) financing for circumcision procedures (during the project period, the procedure was free); (ii) transportation to voluntary male medical circumcision facilities (mobile voluntary male medical circumcision clinics had made it easier for men in remote areas to come); and (iii) demand creation and information activities.

Figure 3.5. Voluntary Medical Male Circumcision in Malawi, 2008–18



Source: 2019 Global AIDS Monitoring.

Objective 3: Strengthen Disease Outbreak Preparedness

3.15 At the disease preparedness level, the project delivered on the expected outputs but without the expected quality standards, which most likely hindered the achievement of expected results. The isolation centers constructed as part of the project are of extremely low quality and do not meet basic standards for such units. For example, one of the six units, Blantyre, was never connected to electricity and stands empty and unused, and the $1 million electronic integrated disease surveillance system installed as part of the component has never been fully operational. This raises questions on the actual effectiveness of the intervention and its actual contribution to the expected results. A good measure of results achievements would be whether these structures have been used to support Malawi during the coronavirus (COVID-19) pandemic.

Design and Preparation

3.16 Shortcomings in the design, implementation, and exit strategy of the World Bank limited its achievement, particularly related to maternal and child nutrition service delivery.

3.17 Before unpacking the project, it is important to note that it was designed as essentially three projects combined into one. The original and revised objective statements reflect this. The Project Appraisal Document notes the synergy between the nutrition activities and objectives, and those related to HIV/AIDS—women of reproductive age targeted for improved nutrition would also benefit from services intended to prevent the transmission of HIV from mother to child (World Bank 2012b, 7). However, the ICR suggests the two projects were merged to reduce transaction costs associated with parallel interventions (World Bank 2019a, 8). The rationale provided to our PPAR mission team was that the World Bank wanted to reduce the size of its health portfolio in Malawi.

3.18 The combination of the three projects into one was not a fatal flaw, but there were missed opportunities to promote synergies among components, and the arrangement caused institutional inefficiencies. A major missed opportunity was that the care group model was not leveraged to deliver HIV testing to pregnant women and women of childbearing age during visits to health centers. Care groups were not leveraged to enhance project support for PMTCT of HIV; to promote the benefits of voluntary male medical circumcision; or to distribute condoms. Rather, each component operated separately, using two separate government counterparts and implementing agencies.

3.19 From an institutional perspective, the attribution of coordination functions to two different government agencies complicated implementation. The DNHA was the lead agency for nutrition and the NAC led implementation of the HIV/AIDS prevention and disease preparedness activities. This approach created a bottleneck when it came to strengthening policy and program development, management, and coordination. This was noted by reviewers at appraisal, and the recommendation was made (but not acted on) to have one entity responsible for coordinating overall implementation. Instead, the DNHA and NAC operated separately, each with a project implementation team and parallel reporting mechanisms.

Objective 1: Increase Coverage of Selected Nutrition Services

Objective 1a: Improving Feeding Practices and Behaviors of Children and Their Caregivers

3.20 One of the most important findings of this evaluation is that the results framework for the nutrition component was wholly inadequate for monitoring the project's progress and assessing its achievements. Adequate M&E is an important driver of success in project achievements. However, the original PDO was overly ambitious and the revised PDO was overly vague. In both cases, this led to a lack of clarity of what the project was intended to accomplish. The original PDO for nutrition, to "increase

access to, and utilization of, selected services known to contribute to the reduction of child stunting, maternal and child anemia," was insufficiently supported by project activities to be fully achievable. The project's main vehicle for achieving this goal was behavior change communication through the care group model, which ideally could have improved access to information about nutrition and, thereby, use of services such as antenatal care. However, to the extent that the PDO implied increased access to services beyond nutritional behavior change communication, this was not supported by the project.

3.21 The project indicators were also deficient in several ways. Despite the project's primary aim to change behavior, only one of the PDO-level indicators that survived until the end of the project measured a key behavior change goal (children ages 6–23 months receiving MDD in component A intervention districts). The interim-level indicators were similarly inadequate. The only behaviors taught through the care groups that were measured were children ages 0–59 months with diarrhea being given increased fluids and the establishment of backyard gardens. In addition, the number of children sleeping under treated bed nets was counted, even though the project did not distribute bed nets and the planned malaria module was not distributed to the districts during the project period.

3.22 The project design did not sufficiently address the conditions under which the care group model would succeed in Malawi. For example, it did not adequately estimate the time and resources necessary for full implementation of the nutrition component's goals. Procurement delays led to the first contracts being signed only in February 2014, two years after project launch. Implementing NGOs were on contract for two to three and a half years. During this time, NGOs received approximately $10 million to fulfill a wide range of functions beyond care group instruction, including (but not restricted to) the following:

- Conducting district mapping in the districts to identify needs, problems, constraints and opportunities that could be addressed through the project and identifying specific community-level interventions, services, beneficiaries, implementing actors, and their roles and responsibilities.
- Establishing and managing community implementation platforms, including the financial and administrative systems. This included organizing CLANs, village- and area-level nutrition coordination committees, and the care groups themselves.
- Organizing training for staff and community structures or workers on community-level planning, information and education communication and

behavior change communication, growth monitoring and promotion, community component management, and community monitoring and reporting.

- Building capacity of District Councils and community structures in project management, M&E, and supervision for nutrition activities.

3.23 Implementing NGOs discussed the insufficient time given to them for the project. They noted that this was a new approach, and more time was needed for trial and error. They also noted that they had barely completed organizing the structures when the contract ended, and there was not enough time to complete all the training. DNHA concurred that, in retrospect, time was insufficient and noted that in later donor-funded programs employing care groups, contracts lasted up to five years. Moreover, because of delays in producing the modules, as of the project's March 2015 midterm survey, only one module was available for use—a WASH module that had previously been produced by UNICEF. At the time of the midterm review, NGOs had requested permission from the DNHA to use their own instructional materials in lieu of government ones, but this request was pending approval (Rabeneck 2015, 11). By the end of the project, only four modules had been disseminated (WASH, maternal nutrition, IYCF, and breastfeeding). Planned modules on malaria and family planning were finalized toward the end of the project period, but they were not disseminated to the districts because of lack of time. This could be a contributing factor to the lack of achievement in antenatal care use.

3.24 Project activities focused on care group formation, with inadequate attention given to ensuring that the care groups were trained in the full package of planned social and behavior change communication messages. The project's results framework counted the number of care groups formed and trained without monitoring the extent of training they received. As noted above, according to project plans, care groups were supposed to receive a package of six social and behavior change communication modules covering maternal nutrition, breastfeeding, complementary feeding, WASH, malaria, and family planning. However, NGO contracts required that they do training without specifying what training needed to be completed to fulfill contractual obligations. In addition, where NGOs received follow-on contracts after the initial two-year contract, they were expected to further extend the coverage of care groups to more traditional authorities, which impeded their ability to focus on deepening their training activities and service provision to existing ANCCs, VNCCs, and, by extension, care groups. As a result, in all three districts visited, care groups reported not having received training in all four modules, and we were told of some care groups that were formed and received initial training without receiving any further instruction in any of the behavior change communications modules.

3.25 The use of NGOs as project subcontractors at the district level disempowered local government officials and harmed the project's sustainability. The project was launched at a time where there were real concerns about mismanagement of public finances in Malawi. Given these concerns, World Bank staff insisted that NGOs be used as subcontractors for disbursing all district-level project funds for developing and running the care group structure. Although understandable under the circumstances, this decision had significant negative implications:

- The implementation of community-based nutrition activities using NGOs not only created a parallel system to that of government but also carried a large administrative cost to support the NGO overhead of offices, administrative services, and so on.
- There were considerable differences across NGOs in the extent to which they saw their role as empowering DNCC members to train and supervise ANCCs and VNCCs, as opposed to circumventing government structures altogether to do the training themselves. As a result, NGOs left behind uneven capacity for continuing action.
- The NGOs were responsible for collecting M&E forms and giving them to the district and were supported with financial resources for transportation costs. When the NGOs pulled out, the M&E system at a subdistrict level collapsed because the DNCCs did not have the logistic capacity to distribute and collect the paper forms consistently.

3.26 There was a strong perception at the district level that the use of NGOs to fulfill functions that would normally be under the district's mandate was disempowering district officials. At the time of the project, the districts had no operational nutrition financing independent of donor-funded projects. In the case of the project, this meant that DNCC members could only visit the traditional authorities where care groups were being formed and trained if the NGOs covered their transportation costs. Moreover, even when a district had technical officers who could have been involved in care group management (for example, agricultural extension workers or health care frontline workers), the NGOs often hired their own field staff to fulfill needed functions. To quote one DNCC member: "They [NGOs] recruited a lot of staff. I didn't understand why they needed all that staff because all the resources they were using came to us (for example, in booklets). If that was the arrangement, there was no need to have so many staff because there was already staff in the field. When NGOs recruit staff it hurts ownership. When NGOs are understaffed, they know they have to work with government structures." The use of NGO facilitators created a parallel system to the government frontline workers, who were less incentivized than the NGO facilitators. To quote

another DNCC member: "The project had their own frontline workers, sometimes they worked with the frontline health workers and sometimes not. They had the advantage of transportation and laptops. We don't have them. They were supposed to hand over the system to the primary health care workers, but there was no handover."

3.27 NGOs were not held accountable on the distribution of inputs within the communities. Although NGOs were given budgets for pass-through grants to distribute inputs, such as chickens, goats, soya bean seeds, and sweet potato vines to care groups, they did not generally do so in coordination with the local agricultural and veterinary officers. In every location visited, the IEG was told that most of the livestock they had been given did not survive. One cluster of villages had been given goats that were brought from another region and could not survive the variation in climate. In another cluster of villages, all of the chickens died within weeks of arrival, possibly because they had been diseased to begin with and the package did not include veterinary support. In a third cluster of villages, seedlings were received in the wrong season. Where livestock died, no evidence was found that they were replaced.

3.28 This is not surprising, given that NGOs were given a lump sum for distribution of these inputs and were not held accountable for their survival. In addition, we were told of several instances where NGOs promised inputs that were never delivered, such as carrier bags for cluster leaders and other livestock. Where this happened, NGOs were not held accountable. During the field mission, community leaders reported how lack of inputs affected the effectiveness of the groups: "They had full day trainings but were not given money to buy food. Most of the goats didn't survive. It is difficult for CLANs to move about because no transport costs are funded."

3.29 Moreover, there were profound shortcomings in how NGOs exited the project. Although NGOs were contractually obligated to hand over equipment such as computers and vehicles to the district on their departure, they were not obligated to ensure an orderly transition of responsibilities. In all three of the districts visited, NGOs left abruptly, often without advance warning, and without any provisions made for the ongoing sustainability of the traditional authority and village-level structures that they had built (box 3.1).

Box 3.1. Testimonials from End Beneficiaries

"Our expectation was that after two years of massive investments, there would be an opportunity to reflect and understand why there wasn't the impact we expected. No opportunity to analyze. The exit just landed, boom."

"It was like somebody died in an accident and we woke up and said 'Oh, someone is gone.'"

"They didn't even say goodbye."

"We called to invite [nongovernmental organization] staff to a cooking demonstration, and we were told they had closed the office."

"The end was painful. It ended so abruptly. If the exit was well managed other donors would have come in. The [traditional authorities] were left hanging."

"It was like a blackout."

Source: Reports from the field mission in the Rumphi district.

3.30 With the sudden exit of the NGOs, most care groups disintegrated. The abrupt exit and lack of logistic capacity at the DNCC level to supervise care groups led to a situation in which many or most care groups disintegrated where there were no other donor projects to revive and maintain them. "When sustainability measures are not put in place, we backslide. At the end of the project 10 out of 11 [traditional authorities] (in Mangochi district) were open-defecation free. If we would go back today, it would be much less." Interviewed NGOs attribute their abrupt departure to lack of clarity toward the end of the project with regard to whether the funding would be extended or not. Some NGOs reported a long period of uncertainty with regard to the project end date, followed by the abrupt announcement of the project end date.

3.31 The World Bank country team recognized that the option of hiring NGOs to deliver the first project subcomponent was perhaps not the best decision. The World Bank team acknowledged that the NGOs were implementing with the community, but the financial management sat with the NGOs. This meant, for example, that the government could do M&E only with financial resources from the NGO. In the face of challenges and ownership issues caused by this architecture, the country team mention that in subsequent projects, financial flows would go through the government structure.

Other Considerations

3.32 The main caveat in the design of the malnutrition component was that in some instances, indicators measured activities beyond the scope of the project. As mentioned in the Results section, a significant lack of financing implied a discontinuity of activities. Mitigation strategies to suppress this foreseeable challenge could have been envisioned at the design stage. Despite the positive results, the design of the Ebola component was critical. There were extreme delays in the construction of isolation centers because of safeguards noncompliance, fragmented institutional arrangements, lack of ownership, and capacity constraints. Many of the delays could have been anticipated at the design stage.

Implementation and Supervision

Objective 1: Increase Coverage of Selected Nutrition Services

Objective 1a: Improving Feeding Practices and Behaviors of Children and Their Caregivers

3.33 The major pitfall in implementation and supervision was on the delivery of nutrition services. Supervision of care groups during the project was not sustained. According to a member of a district CLAN, "They [district care groups] got a lot of supervision visits 2015–16, mostly from [the project] team, sometimes from health surveillance assistants. Since then, nothing." The same was reported by the DNHA: "I think that care groups stopped because suddenly nobody was checking on them. All of a sudden nobody went." The World Bank team kept track of care group implementation through an online survey that only monitored the number of groups and their geographic location. District governments were also not fully involved in the establishment, management, and funding of care groups.

3.34 Lack of support for the care groups immediately after the project closed has impaired sustainability. The government has tried to address this by enlisting donor support for reviving care groups in the context of their projects, and the World Bank is expected to revive some of the care group structures within the current Investing in Early Years Project. As mentioned by the DNHA during our field visit, "It is unclear though to what extent the care groups are being managed well and getting adequate support. Care groups functioned as long as there was capacity at the districts to manage them. Once that was withdrawn, care groups became weak. Care groups seem to work as long as there is capacity at all the levels. Including funding."

3.35 Care groups received less than the full package of planned training modules. Only four of the six planned behavior change modules were prepared and disseminated during the project period, and many care groups did not receive all four modules. In all three of the visited districts, IEG met care groups who had received only one or two modules. IEG was told of other care groups that had been formed in the later stages of the project that had not been trained in any of the modules because of lack of time. As will be discussed below, the results framework did not track what training the care groups received, only whether they were formed and had received initial training, and NGO contracts were not specific about what training content they were supposed to deliver.

3.36 Although the project provided for the procurement and dissemination of micronutrient powders, these were never distributed except in a few pilot districts. After multiple procurement delays, the October 10–21, 2017, implementation support mission

reported that a plan to include micronutrient powder distribution as part of the Essential Drug List had been scrapped and that the decision had been taken to "socially market the product."

3.37 There were also major accountability issues. There were frequent delays in submitting quarterly Interim Financial Reports. Audited financial statements raised several issues on control and accountability, particularly with the NGOs contracted by the NAC. NGOs were given a lump sum for distribution of these inputs and were not held accountable for their dissemination.

Objective 1b: Improving the Government's Capacity to Plan and Execute Nutrition Interventions

3.38 The project missed the opportunity to strengthen policy analysis capacity and data use. Before the project, there was no coherent M&E of nutrition activities, outputs, and outcomes in Malawi, save for periodic large national surveys such as the Demographic and Health Survey, Multiple Indicators Cluster Survey, and National Micronutrient Survey (Government of Malawi 2011b). The system developed with the project support is in use, at least partially, today. However, the system, although providing access to important data that previously were unavailable, functions less than optimally. During the project period, all districts reported on a monthly basis; however, since the end of the project, reporting has been uneven. Thanks to efforts of the DNHA to improve reporting, 21 out of 28 districts reported at least some nutrition data from the health, agriculture, gender, and education sectors and data on coordination and monitoring. Reasons given for districts not reporting include weak internet connectivity in most districts; staff turnover, especially among those who were trained in the use of the reporting system; and weak coordination among nutrition players in reporting within districts. The M&E officer of one district mentioned that during her three-year tenure, she had only reported data once, during her training session, and never again because she did not know how to log on to the reporting system.

3.39 The project did not ensure sustainability of data collection at the subdistrict level. Care group– and village-level data were collected using paper forms that were delivered by hand by contracted NGOs and the district governments. Once the NGO contracts ended, collection of the paper forms largely ceased. Today, no districts are reporting care group data.

3.40 The project emphasized data collection, not data use. At all levels, particularly at subnational level, data gathered by the districts through the M&E system informed policy only to a limited extent**.** When the project was operational and data were being received from care groups and villages, the data were collected as large stacks of paper forms, which the M&E officer would manually enter into the system at the district level.

Officers would not use the data but would wait to receive quarterly reports from the DNHA. This emphasis on data collection only was noted in a project midterm review in 2015 and confirmed in the NECS evaluation, which similarly found weak data use, particularly at the district level, causing nutrition responses to sometimes be "based on general wisdom instead of evidence" (Kalimbira and Siyame 2017, 13). According to the DNHA, there is limited use of the collected M&E data because of weak internet connectivity in most districts and staff turnover of those trained in the M&E system. As such, the primary data used for policy-making remained household surveys, rather than data gathered through the computer-based M&E system.

3.41 The data analysis done at the national level in most cases provided only district-level data. This meant that the data were not useful for DNCC members who could have used subdistrict data to better understand what sorts of resources and interventions would be useful in their districts. For the three districts visited, the annual Lot Quality Assurance Sampling Surveys proved more useful to inform programming than did the routine data from care groups.

Objective 2: Increase Coverage of Selected HIV and AIDS Services

3.42 Site visits in three districts indicated that voluntary male medical circumcision provision (the largest subcomponent of the HIV/AIDS component) had largely or completely ceased because of lack of follow-on funding. One district reported that thanks to a successful demand creation campaign as part of the project, it succeeded in generating considerable demand for free circumcisions, which it no longer has the capacity to meet because of the lack of funding. Another district hospital reported that it no longer does voluntary male medical circumcisions, but its staff sometimes travel to other districts to support voluntary male medical circumcision interventions there.

4. Conclusions

4.1 Although the project overall has been assessed as moderately unsatisfactory in terms of outcome, it is worth highlighting the elements that worked well and those that didn't work well:

- The project helped improve Malawi's institutional framework for nutrition by developing durable multilevel and multisectoral mechanisms for planning and execution of nutritional policy. There was a consolidation of nutrition efforts at all levels with all ministries, stakeholders, districts, and donors operating under the same policy, coordinating body, strategic plan, behavior change strategy, and M&E framework.

- The Integrated Management of Acute Malnutrition in project districts mostly achieved its goals of treating children ages 0–59 months with severe acute malnutrition and mass screening of under-five children in all 14 project districts.

- The project was not successful at adequately improving behaviors known to contribute to the reduction of child stunted growth and mother and child anemia. There was little improvement, or even a worsening in some cases, nationally in feeding practice (such as breastfeeding, dietary diversity, and iron consumption). Shortcomings in the design, implementation, and exit strategy of the World Bank explain the limited achievements related to maternal and child nutrition service coverage.

- The project's results measurement system was inadequate for monitoring project progress and assessing its achievements, especially at the engagement and learning levels: the PDO, in its revised format, was overly vague; indicators did not systematically track desired behavior change.

5. Key Lessons

5.1 **Community-based care group approach for nutrition outcomes:** According to IEG's recent evaluation of World Bank support to reducing child undernutrition (World Bank 2021), social and behavior change communication interventions have proven to be effective to improve several nutrition outcomes (such as child undernutrition and development; child feeding and caring practices; maternal and child health; access to health services; WASH and nutrient-rich food; and social norms and behaviors). Strong community-based implementation is the most consistent success factor in countries to achieve nutrition results, since it facilitates a synergistic support across sectors. Learning to organize sectoral and community actors to integrate the delivery of services and provision of ongoing support over an extended period remains a challenge. Thus, continuity of community interventions is important to successfully influence nutrition results (World Bank 2021).

- Time and resources are needed for full implementation of community-based activities. The time allocated to implement community-based activities was not adequate (two years) for NGOs to develop, fully train, and manage care group structures to support real behavior change.

- The care group model requires intensive stakeholder engagement and sensitivity to the social context. Care group volunteers require incentives to remain motivated and need regular contact with support structures. Village-level activities are an important complement to household visits of care groups to

reinforce needed changes in behavior. Bypassing district (local) government institutions hampers the sustainability of activities and results.

- To track output delivery and expected change, the PDO, results framework, and indicators need to be well tailored.
- Project structures sufficiently flexible to adjust to donor and government needs help implementation and achievement of results. In the HIV/AIDS component, the project adeptly responded to shifts in donor funding commitments to ensure efficient deployment of project resources in needed areas.

Bibliography

George, Christine Marie, Emilia Vignola, Jim Ricca, Tom Davis, Jamie Perin, Yvonne Tam, and Henry Perry. 2015. "Evaluation of the Effectiveness of Care Groups in Expanding Population Coverage of Key Child Survival Interventions and Reducing Under-5 Mortality: A Comparative Analysis Using the Lives Saved Tool (LiST)." *BMC Public Health* 15: 835. doi:10.1186/s12889-015-2187-2.

Government of Malawi. 2007. *National Nutrition Policy and Strategic Plan 2007–2012*. Lilongwe: Department of Nutrition, HIV and AIDS.

Government of Malawi. 2011a. *Health Sector Strategic Plan 2011–2016.* Lilongwe: Ministry of Health.

Government of Malawi. 2011b. *Scaling Up Nutrition (SUN) in Malawi: Gap Analysis Report.* Lilongwe.

Government of Malawi. 2013. *Baseline Survey Report of Community Based Nutrition Programs in Malawi.* Lilongwe: Department of Nutrition, HIV and AIDS.

Government of Malawi. 2015. *Cost of Hunger in Malawi: Implications on National Development and Vision 2020.* Lilongwe: Ministry of Finance, Economic Planning and Development.

Government of Malawi. 2018. *National Multi-Sector Nutrition Policy 2018–22*. Lilongwe: Department of Nutrition, HIV and AIDS.

Kalimbira, Alexander A., and Edwin W. P. Siyame. 2017. *Evaluation of the 2011–2016 National Nutrition Education and Communication Strategy (NECS) in Malawi.* Submitted to the NECS Review Taskforce. Lilongwe: Department of Nutrition, HIV and AIDS.

Malabo Montpellier Panel. 2017. "Nourished: How Africa can build a Future Free from Hunger and Malnutrition. Malawi." Malabo Montpellier Panel, Dakar. https://www.mamopanel.org/resources/Nutrition/reports-and-briefings/nourished-case-studies-africa-can-build-future-3/.

NSO (National Statistical Office) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, MA: NSO and ICF Macro.

Osendarp, Saskia, Forhad Shilpi, Timothy Gondwe, Innocent Pangapanga-Phiri, Alexander Kalimbira, Beatrice Mtimuni, Deusdedit Kafere, Gabriella Chuitsi, Felix Phiri, and Ziauddin Hyder. 2019. "Determinants of Reductions in Childhood Stunted Growth in Malawi's Community-Based Nutrition Programs: Health, Nutrition, and Population." Health, Nutrition, and Population Discussion Paper, World Bank, Washington, DC.

Perry, Henry, Melanie Morrow, Sarah Borger, Jennifer Weiss, Mary DeCoster, Thomas Davis, and Pieter Ernst. 2015. "Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource Constrained Settings." *Global Health: Science and Practice* 3: 358–69.

Rabeneck, Sonya. 2015. *Mid Term Project Implementation Assessment Of Nutrition, HIV and AIDS Project.* Lilongwe: Department of Nutrition, HIV and AIDS; Ottawa: Department of Foreign Affairs, Trade and Development Canada; and Washington, DC: World Bank.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2012. *Global Report: UNAIDS Report on the Global Aids Epidemic 2012*. Geneva: UNAIDS.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2018. *Global AIDS Monitoring 2019 Guidance: Indicators for Monitoring the 2016 Political Declaration on Ending AIDS.* Geneva: UNAIDS.

UNICEF (United Nations Children's Fund). 2019. *Evaluation of the Community Led Total Hygiene and Sanitation Project in Malawi.* Lilongwe: UNICEF.

USAID (United States Agency for International Development) and World Bank. 2011. *Consulting with Caregivers: Formative Research to Determine the Barriers and Facilitators to Optimal Infant and Young Child Feeding in Three Regions of Malawi*. Washington, DC: USAID and World Bank.

World Bank. 2007. *Malawi—Country Assistance Strategy for the Period FY07–10*. Report No: 38326-MW. Washington, DC: World Bank.

World Bank. 2012a. *Malawi—Country Assistance Strategy for the Period FY13–16*. Washington, DC: World Bank.

World Bank. 2012b. *Republic of Malawi—Nutrition and HIV/AIDS Project. Financing Agreement.* World Bank, Washington, DC

World Bank. 2012c. "Republic of Malawi—Nutrition and HIV/AIDS Project." Project Appraisal Document No. 66860-MW, World Bank, Washington, DC.

World Bank. 2016. "Republic of Malawi—Nutrition and HIV/AIDS Project: Additional Financing." Report No. PAD1878, World Bank, Washington, DC.

World Bank. 2019a. "Republic of Malawi—Nutrition and HIV/AIDS Project." Implementation Completion and Results Report ICR00004538, World Bank, Washington, DC.

World Bank. 2019b. "Republic of Malawi—Nutrition and HIV/AIDS Project." Implementation Completion and Results Report Review ICR00004538, Independent Evaluation Group, World Bank, Washington, DC.

World Bank. 2021. *World Bank Support to Reducing Child Undernutrition: An Independent Evaluation.* Independent Evaluation Group. Washington, DC: World Bank.

Project Rating
Nutrition and HIV/AIDS Project

Table 0.1. ICR, ICR Review, and PPAR Ratings

Indicator	ICR	ICR Review	PPAR
Outcome	Moderately unsatisfactory	Moderately unsatisfactory	Moderately unsatisfactory
Overall efficacy	Original: modest Revised: substantial	Original: modest Revised: modest	Original: modest Revised: modest
Bank performance	Moderately unsatisfactory	Moderately unsatisfactory	Moderately unsatisfactory
Quality of monitoring and evaluation	Modest	Modest	Modest/negligible

Sources: World Bank 2019a, 2019b.
Note: The Implementation Completion and Results Report (ICR) is a self-evaluation by the responsible Global Practice. The ICR Review is an intermediate Independent Evaluation Group product that seeks to independently validate the findings of the ICR. PPAR = Project Performance Assessment Report.

A split rating is allocated to the HIV/AIDS objective but not to the nutrition component, despite the revised project development objectives (PDOs). A split rating is required for the HIV/AIDS objective, not because of the rewording of the objective, but because a key outcome indicator was revised. The added objective of disease preparedness was added to the split assessment. The split assessment affects the project's rating through efficacy, given that the revised objectives remained the same. A split rating is not required for the nutrition-related objective. The substance of the nutrition-related objective did not change; increasing access to and use of nutrition services is equivalent to increasing coverage of nutrition services. And, although the explicit reference to services that contribute to reducing stunted growth in children and maternal and child anemia was deleted in the revised PDO, this Project Performance Assessment Report maintains that the goals of the objective related to nutrition did not change with the rewording and, therefore, a split rating for the assessment of nutrition-related objectives is not warranted.[1] In addition to disease preparedness, the PDOs expanded the scope of the project, and the targets related to the additional objective were met.

1. Relevance of the Objectives

Objectives

The original PDO, as stated in the Financing Agreement, was "to increase access to, and use of, selected services known to contribute to the reduction of child stunting, maternal

[1] For more information, see *Guidelines for Reviewing World Bank Implementation Completion and Results Reports: A Manual for IEG ICR Reviewers*, 44–51.

and child anemia, and the prevention of HIV and AIDS in children and sexually active adults" (World Bank 2012, 5).

The revised PDO, as stated in the Financing Agreement, was "to increase coverage of selected nutrition, HIV, and AIDS services and strengthen disease outbreak preparedness in project areas" (World Bank 2016, 4).

Relevance of the Objectives

The relevance of objectives is rated **high.**

The project development objectives were highly relevant to country conditions at the time of appraisal. The project, in its original form, addressed two of Malawi's most pressing health problems: one of the highest levels of child stunted growth globally, and HIV/AIDS. At the time of appraisal, research had indicated that limited diet diversity, frequent illness (for example, diarrhea, malaria), and low birthweight were key determinants of stunted growth prevalence, all of which could be addressed through successful behavior change (Government of Malawi 2011). A further study at the time found that behavior change was a dominant underlying factor to improving inadequate dietary diversity (USAID and World Bank 2011). Both of these findings suggested an approach to nutrition focusing on behavior change communications. Moreover, the accession of Malawi to the Scale-Up Nutrition movement in 2011, alongside Malawi's success in reducing stunted growth levels in the years before the project onset, from 55 percent in 1992 to 47 percent in 2010, according to Demographic and Health Survey statistics, suggested that there was potential for the project to leverage the momentum to amplify nutrition gains.

With regard to HIV/AIDS, although its prevalence had dropped considerably over the preceding years, at the time of appraisal it was still high at 10.6 percent for adults ages 15–49 years. According to the 2010 Malawi Demographic and Health Survey, the most common mode of transmission was heterosexual sex, and HIV prevalence was higher for women (13 percent) than for men (8 percent; NSO and ICF Macro 2011). Significantly, Malawi had one of the highest rates worldwide of pregnant women living with HIV. According to the Joint United Nations Programme on HIV/AIDS statistics, in 2009, approximately 60,000 pregnant women were living with HIV and needed antiretroviral therapy for the prevention of mother-to-child transmission (PMTCT). In 2010, the mother-to-child transmission rate was 25 percent. At the time of project appraisal, the Global Fund for AIDS, Tuberculosis, and Malaria was adequately funding the distribution of antiretrovirals to affected populations, so that the project focus on detection of mother-to-child transmission and prevention was highly relevant. The HIV/AIDS component of the project was a continuation of the World Bank's previous Multisectoral AIDS Project 2003–12. That project included funding for the HIV Pool,

which was continued in the current project, and PMTCT that had not achieved the targets set in the previous project. Voluntary male medical circumcision was introduced as a new prevention strategy in the current project.

The Malawi Growth and Development Strategy (MGDS) II (2011–16) listed public health, sanitation, and HIV/AIDS management as one of its nine key priority areas. Nutrition was considered a subtheme of this priority area, with the following action areas highlighted: low household incomes, insufficient child feeding and care practices, inadequate education, and lack of knowledge, which lead to inadequate food processing and use, and sometimes cultural beliefs that deny women and children consumption of highly nutritious foods. Other constraints include low institutional capacity and inadequate mainstreaming of nutrition in sectoral programming. Increasing numbers of circumcised males—the primary HIV/AIDS prevention strategy funded by the project—was not listed as a goal in the MGDS II, but PMTCT was. The MGDS III (2017–22) continued with these priorities, specifically referring to strengthening implementation of community-based nutrition care as a strategy for reducing the prevalence of stunted growth. The MGDSs highlighted the importance of nutrition support for people living with HIV/AIDS, but although the project had components addressing both, it did not undertake nutrition of people living with HIV/AIDS as part of its objectives.

Project aims were consistent with the World Bank's Country Assistance Strategy for fiscal years 2007–10. Pillar 3 of the Country Assistance Strategy aimed at "decreasing vulnerability at the household level to HIV/AIDS and malnutrition" (World Bank 2007, 11). It was also in line with theme 2 of the Country Assistance Strategy for fiscal years 2013–16, enhancing human capital and reducing vulnerabilities, which committed to achieving "specific measurable outcomes while helping to address system-wide concerns. HIV/AIDS and nutrition interventions will focus on the capacity to work effectively with other sectors, such as agriculture, education, and social protection, to ensure an integrated approach to improving the health and nutrition of Malawians" (World Bank 2012, 33).

The decision to add a third objective to support Ebola and general disease preparedness was at the request of the government of Malawi and in line with World Health Organization recommendations. The World Bank responded to an urgent need to reinforce disease preparedness against the backdrop of the 2014 West African Ebola outbreak. As the direct threat of Ebola waned, the objectives of this component were modified from Ebola preparedness to more general disease preparedness.

2. Efficacy

The overall efficacy is rated **modest.**

The assessment of efficacy will evaluate the project's performance against the official PDOs. The original PDO was "increase access to, and use of, selected services known to contribute to the reduction of child stunting, maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults." In the 2016 restructuring, this PDO was altered to read "To increase coverage of selected nutrition, HIV and AIDS services and strengthen disease outbreak preparedness in project areas." The justification given for the change in the wording of the PDO in the additional financing project paper (World Bank 2016) was to (i) include an Ebola preparedness component; (ii) encompass provision of additional support for integrated management of acute malnutrition through component A; and (iii) reflect a more targeted geographic focus of project implementation (apparently referring to a reduction in the number of districts with voluntary male medical circumcision interventions). As the restructuring paper did not suggest that the change in wording from "access to and utilization of" to "coverage" reflected a change in PDOs, this evaluation will regard the terms to have equivalent intent. For similar reasons, the evaluation will assume that "nutrition services" in the revised PDO implied the original wording "known to contribute to the reduction of child stunted growth, maternal and child anemia." The following analysis will reference the official PDOs after the 2016 restructuring, adding in language from the first PDO where we take it to be implied in the PDO at project close.

Objective 1: Increase Access to, and Utilization of, Selected Services Known to Contribute to the Reduction of Child Stunted Growth and Maternal and Child Anemia in Project Areas

Activities to increase coverage of nutrition services assumed that the behavior of beneficiaries, rather than the availability of maternal and child health and nutrition services, was the primary determinant of low nutrition outcomes for children in the first 1,000 days of their development. The project identified a "minimum package" of behavioral messages that, if followed, could significantly improve nutrition outcomes and reduce anemia and stunted growth. These messages included guidance on maternal and early child nutrition, breastfeeding, encouragement of practices such as growth monitoring, and antenatal care visits in the first trimester. The project relied on care groups to deliver information, education, and behavior communication to the target populations. Community mobilization efforts involved village chiefs and other community leaders. The care group structure was managed by NGOs contracted in each of the program districts. The NGOs were supposed to work in coordination with the district-, area-, and village-level nutrition coordination committees to leverage the support of frontline workers. Alongside the behavioral messaging, NGOs provided care group members with pass-through grants of seeds, fruit trees, and livestock to supplement available foods, organized cooking demonstrations, and mobilized

community action for building sanitation facilities. Distribution of other nutritional inputs such as iron supplementation, micronutrient powders, and growth monitoring services was done through existing health facilities, community health days, or other community events rather than being outsourced to care group lead mothers to conduct and were not, with a few minor exceptions, funded through the project.

Activities and Outputs

Care Group Formation and Institutional Capacity Building

The project actively supported the capacity development of the Department of Nutrition, HIV and AIDS (DNHA), funding technical assistance as needed, training for DNHA leadership and nutrition officers at all levels, and office rental fees. The project supported the DNHA's efforts to develop Malawi's nutrition policy and strategy and to establish coordinating mechanisms for planning and implementation of nutrition policy, both nationally and at a district and subdistrict level, including enhancing technical working groups under the National Nutrition Committee and establishing and training district-, area-, and village-level nutrition coordination committees. The project supported the development of the Multisector Nutrition Policy, Multisector Nutrition Education Communication Strategy, Multisector Maternal, Infant and Young Child Nutrition Strategy, Agriculture Sector Food and Nutrition Strategy, Micronutrient Strategy, and Multisector Adolescent Nutrition Strategy, and a web-based monitoring and evaluation (M&E) system. The project also initially funded and helped develop multilateral coordination and learning mechanisms that have since been institutionalized and allocated government funding, such as the annual Scaling Up Nutrition Learning Forum, a semiannual national food and nutrition conference, and a policy advisory forum.

These coordination and cooperation mechanisms developed through the project at the national and district level have proven, according to several informants, robust, sustained, and significant for Malawi's ability to develop and carry out nutrition policy. However, although the M&E framework developed through the project met the results framework target of all districts reporting during the project period, it has only been used partially by the districts to report data since the project end. IEG found no evidence in the field visit that the M&E computer system presently informs policy, which is unsurprising given the incomplete nature of the data collected from the districts.

The project, as part of the care group rollout, supported the development and standardization of behavior change communication materials that remain in use in various donor-funded projects today (table A.2). A total of 55,000 counseling cards, 42,700 posters, and 15,000 key message booklets were distributed. Growth monitoring

equipment was also distributed by the project to health facilities across the project districts.

Table A.2. Scaling Up Nutrition: List of Malawi Districts by Donor

Donor	District
USAID	Chitipa, Karonga, Kasungu, Salima, Dowa, Lilongwe, Machinga, Mangochi, Phalombe, Chikhwawa, and Nsanje
UNICEF	Nkhatabay and Neno
World Bank/CIDA	Mchinji, Dedza, Ntcheu, Balaka, Rumphi, Mzimba, Likoma, Nkhotakota, Ntchisi, Zomba, Chiradzulu, Blantyre, Mulanje, Thyolo, and Mwanza

Source: World Bank 2012a, 33.
Note: These data were current at project approval (2012). UNICEF = United Nations Children's Fund; USAID = United States Agency for International Development.

According to the Implementation Completion and Results Report (ICR), 78 percent of caregivers of children under two in project districts were benefiting from monthly care group services by the end of the project (World Bank 2019). This is slightly under the target of 82 percent. Moreover, 5,064 care groups were formed and trained, against a target of 5,000. It should be noted, however, that this number refers to the total number of care groups that received introductory training, not to the number of care groups trained in at least one behavior change communications module. Moreover, no effort was made to track the survival of care groups beyond the end of the NGO contracts for managing them (approximately six months before the end of the project). As a result, although 78 percent may be an accurate reflection of how many caregivers were covered at some point during the project's duration by care groups, it is not known what percentage of caregivers were still benefiting from monthly services at the time of the project end. Similarly, the project tracked backyard gardens established (17,556, as compared with a downward-revised target of 13,000), although this statistic did not monitor the extent to which established gardens were maintained, and field visits suggested that many of the originally established gardens were not maintained through the project period.

Intermediate Outcomes: Behavior Change

The project was not successful at adequately improving behaviors known to contribute to the reduction of child stunted growth and mother and child anemia.

Minimum diet diversity: As discussed in section 2, there is some discrepancy in data between the project endline survey and the project reporting framework with regard to minimum diet diversity (MDD). The endline survey found that MDD prevalence went down over the project period, with a project district average of 21.5 percent of children 6–23 months of age reporting MDD (Osendarp et al. 2019, 49), as opposed to 25.3 percent in nonproject districts, representing a drop over the project period from a national

average of 33.2 percent in 2013. The ICR found that MDD had improved slightly, from a baseline of 29 percent at appraisal to 35.5 percent at project close. However, an analysis of Implementation Status and Results Report data shows the reported gains for MDD happened before the rollout of the first care groups over the course of 2014, so that to the extent that there were gains, these were not attributable to the project.

Iron supplementation for pregnant women: The project endline survey found no significant improvement in iron and folic acid supplementation for pregnant women (table A.3).

Table 0.3. Iron Supplementation for Pregnant Women

		All	Nonproject District	Project District Phase 1	Project District Phase 2
		Baseline *n* = 4,397 Endline *n* = 4,762	Baseline *n* = 2,248 Endline *n* = 2,271	Baseline *n* = 1,075 Endline *n* = 1,276	Baseline *n* = 1,074 Endline *n* = 1,215
Received IFA during pregnancy (share of pregnant women, %)	Baseline	92.4	92.3	93.8	91.4
	Endline	90.4	92.1	90.3	87.3
IFA taken during pregnancy (no. of supplements; mean no. of months [SD])	Baseline	2.79 2.16	2.88 2.48	2.76 1.61	2.63 1.97
	Endline	2.76 3.22	2.85 3.87	2.87 1.75	2.44 3.01

Source: Osendarp et al. 2019.
Note: IFA = iron and folic acid supplementation; SD = standard deviation.

Similarly, the project was not successful in persuading more women to go for checkups at antenatal care facilities earlier and more frequently. In Malawi, although nearly all pregnant women go for at least one visit to an antenatal care facility, only half of all pregnant women go in their first trimester, because of cultural traditions about not disclosing pregnancy. The project aimed to get women to go for a full four antenatal care visits, including one in the first trimester, where they would receive iron and folic acid supplementation for the critical early phases of pregnancy. However, although the PDO-level indicator of the percentage of pregnant women attending antenatal care in the first trimester was deleted in the 2016 restructuring, ostensibly because of attribution difficulties, and even though encouraging antenatal care attendance was one of the care group messages, the endline survey determined that the percentage of women in the project districts going for four or more antenatal care visits dropped slightly over the project period and rose slightly in nonproject districts (table A.4). The number of visits of pregnant women to antenatal care, a proxy indicator for iron and folic acid supplementation, did not change between the 2013 baseline and the 2018 endline survey.

Table 0.4. Pregnant Women Visiting Antenatal Care Four or More Times (percent)

	Phase 1	Phase 2	Nonproject
Baseline	55.2	51.2	52.9
Endline	53.2	50.2	53.7

Source: Osendarp et al. 2019, 51.
Note: Phase 1 includes project districts that received treatment beginning in the first phase of the project (2014). Phase 2 includes project districts that received treatment beginning in the second phase of the project (2016).

Childhood illness: Two other interim-level indicators in the results framework tracked behaviors related to childhood illness known to have an effect on be correlated with stunted growth levels: malaria and diarrhea. According to both the endline survey and the ICR, the number of children ages 0–59 months sleeping under treated bed nets dropped slightly during the project period as compared with the baseline, which is unsurprising considering that the project never disseminated the planned malaria module and did not distribute bed nets. The number of children with diarrhea who were given increased fluids in project districts did rise somewhat, from a baseline of 22 percent to 32 percent at project close, below the 38 percent target.

Overall, the endline survey found few significant positive changes in behaviors either in the project districts or outside them, where other donors were managing rollout of the care groups.

The endline survey completed in 2018 tracked nutrition indicators and compared them with the 2013 baseline, before rollout of activities in project areas. The endline survey found a 3 percent reduction in stunted growth in Malawi between 2013 and 2016 (from 40 percent to 37 percent) and no reduction in stunted growth between 2016 and 2018. This represents a slowing in the pace of stunted growth reduction from the period before project launch. Between 2010 and 2013, stunted growth was reduced from 49 percent to 40 percent. Some of this slowing may be attributable to severe food shortages in 2015 and 2016, although the endline survey found that overall, there was an improvement in food availability over the project period. No difference was found between the pace in reduction of stunted growth in project districts and that in nonproject districts. The endline survey attributed the improvements in stunted growth levels primarily to better water, sanitation, and hygiene practices, as other behaviors remained stable or worsened.

Community-based integrated management of acute malnutrition services: During 2015–16, the country was hit by a drought that led to acute food shortages and a rise in cases of acute malnutrition among children. A third subcomponent was added to the nutrition component of the project to identify and treat both moderate and severe acute malnutrition. Mass screening of 1,312,316 under-five children was undertaken in all 14 project districts. From these, 1,796 were referred for treatment of moderate acute

malnutrition and 9,253 for severe acute malnutrition. The project procured ready-to-use therapeutic foods, rehydration solutions for malnutrition, and corn-soya blend through the United Nations Children's Fund and the World Food Programme, and three containerized trucks and trailers for distribution of essential foods and delivery of medical supplies.

By the end of the project period, 75.4 percent of children ages 0–59 months with severe acute malnutrition had been successfully treated, as compared with a target of 80 percent.

Objective 2: Increase Coverage of Selected Services for the Prevention of HIV/AIDS in Children and Sexually Active Adults in Project Areas

The project identified two prevention interventions as particularly relevant for the goal of prevention: voluntary male medical circumcision and PMTCT. Over the course of the project, emphasis shifted from PMTCT to voluntary male medical circumcision in response to a changing donor landscape. For voluntary male medical circumcision, the project began by equipping and training 30 facilities, both public and nonprofit. However, when faced with lack of demand, efforts were largely directed toward developing and rolling out demand creation. Numerical targets for circumcisions were cut from 636,900 to 264,200, and target districts were decreased from 28 to 20. With regard to PMTCT, program activities were decreased on the unanticipated increase of donor funding from other sources. However, the project continued to fund some limited PMTCT activities, including refurbishment of some PMTCT centers, provision for HIV DNA polymerase chain reaction equipment for infant testing, and implementation of a mentorship program for PMTCT center staff.

Outputs

The project funded the equipping of 30 voluntary male medical circumcision facilities in 20 selected project districts; training of voluntary male medical circumcision staff; demand creation activities, such as printing and distribution of informational materials; provision of travel vouchers; and mobile voluntary male medical circumcision clinics. The project procured 228,514 disposable male circumcision kits, 760 reusable kits, 40 autoclaves, 36 tents, one vehicle each for the 21 districts, and one vehicle for the HIV/AIDS department. In addition, the project funded a demand creation team that trained and supervised demand creation officers in all project districts, health facilities, and communities. In addition, the project funded technical support for preparation of the new National HIV and AIDS Strategic Plan.

Did Access to, Use of, and Coverage of Services for Prevention of HIV/AIDS in Children and Sexually Active Adults Increase?

The proportion of infants born to HIV-positive women enrolled in PMTCT services who received the DNA polymerase chain reaction test for HIV within two months of birth increased sharply from 25 percent in December 2011 to 73 percent by the end of March 2018, surpassing project targets. The project also surpassed its target for voluntary male medical circumcision but only after the target was considerably reduced. The original target of 636,900 circumcisions was reduced to 264,200 when it became apparent that the original target was unachievable because of delays in the launch of the component activities and the need for investment in demand creation. Once demand creation activities were launched, however, the project resulted in a steady and significant increase in circumcision rates. In addition to circumcisions in World Bank–supported districts, support from the United States President's Emergency Plan for AIDS Relief also contributed to a significant growth in the number of circumcisions each year (figure 3.5).

Despite the success of awareness-raising activities during the project period, as evidenced by the growth in demand for voluntary male medical circumcision over the project period, the pace of voluntary male medical circumcisions has not been sustained because of lack of sustained funding for voluntary male medical circumcision. Thus, for example, in Rumphi, circumcisions have dropped from 200 per month at the height of the project period to the present level of 15 to 20 per month. The significant drop in circumcision rates since the project end is attributable to a lack of the following: (i) financing for circumcision procedures (during the project period, the procedure was free); (ii) transportation to voluntary male medical circumcision facilities or mobile voluntary male medical circumcision clinics that made it easier for men in remote areas to attend; and (iii) demand creation and information activities. Because of the lack of financing for what was, during the project period, an easily accessible, free good, we found little or no continuing activity in all three of the project sites visited during the field visit. In one of the districts, clinic staff reported that because of the success of demand creation activity during the project period, they now had excess demand for affordable, accessible circumcisions that they could in no way meet. The National AIDS Commission (NAC) reports that in the six months after the close of the project, only 6,058 circumcisions were performed from July to December 2018, and 10,134 in all of 2019. Voluntary male medical circumcision continues today primarily in the context of projects funded by the United States President's Emergency Plan for AIDS Relief in only three districts in Malawi, or for Muslim children, in keeping with cultural traditions.

Objective 3: Strengthen Disease Outbreak Preparedness in Project Areas

After the 2014 Ebola outbreak in West Africa, the government of Malawi requested World Bank support to implement World Health Organization Ebola preparedness recommendations. Funds were made immediately available through the project in 2014, and the goal of disease preparedness was subsequently incorporated into the PDO in the 2016 project restructuring. Ebola preparedness measures included equipment purchase, construction of facilities, and training for Ebola identification and treatment. Although originally conceived as measures for Ebola preparedness, by the time of the 2016 restructuring, with the reduction of the Ebola threat, the component was repurposed as general disease outbreak preparedness.

Outputs

Among the many interventions financed by the component were establishment of an Ebola Coordination Unit under the Ministry of Health (later expanded in scope to address disease surveillance in general); development of a disease preparedness plan; suppling health commodities and critical goods for disease outbreak, such as personal protective equipment—suits, gloves, masks, gowns, soap, and alcohol; renovating and equipping six isolation centers throughout the country; procuring medical incinerators; printing paper copies of disease surveillance manuals for border posts; procuring vehicles; training health care workers; equipping border control points with disease surveillance equipment, including body scanners for airports and infrared thermometers; implementing an electronic integrated disease surveillance and response system; and instituting a text message alert system. In addition, the component helped build six nationwide rapid response teams, trained in Ebola detection, surveillance, and contact tracing.

Did Disease Preparedness Improve?

The Ebola component was successful in instituting an improved disease surveillance system for Malawi. The disease surveillance manuals printed and distributed to border posts are still in use today, and the disease surveillance system is still in place and functioning effectively. These improvements, according to the World Health Organization, have proven both durable and significant.

The isolation centers constructed as part of the project were of extremely low quality and do not meet basic standards for such units. One of the basic requirements for isolation centers is that the floors, walls, and ceilings be without cracks where infectious materials can lodge. In the case of the Malawi units, prefabricated facilities were installed with substandard, easily cracked floors. In addition, cracks appeared in the walls and ceilings almost immediately after completion. One of the six units, Blantyre, was never connected to electricity and stands empty and unused. The government is

presently engaged in replacing the floors in the isolation units so that they can be used in future for infectious diseases.

Similarly, the $1 million electronic integrated disease surveillance system has never been fully operational. Instead, disease surveillance is done manually, using paper forms and WhatsApp, which, given the lack of actual cases of Ebola, has proven to be sufficient for Malawi's needs.

3. Efficiency

The project efficiency is rated **modest.**

The ICR cost-benefit analysis found a strong economic rationale for the project, based on research on the cost-effectiveness of community-based nutrition programs targeting children under two and research on the cost-effectiveness of PMTCT and voluntary male medical circumcision. On the basis of this research, the analysis found a positive net present value of $101 million and an internal rate of return of 15 percent. No cost-benefit analysis was done on the Ebola component, as the lack of Ebola cases in Malawi made it difficult to estimate the impact of preparedness measures.

Adverse aspects of design and implementation reduced efficiency, as follows:

- The institutional arrangements, composed of two implementing entities (NAC and DNHA), contributed to inherent implementation inefficiencies. This was noted by reviewers at appraisal, and the recommendation was made (but not acted on) to have one entity responsible for coordinating overall implementation. Instead, the DNHA and NAC operated in silos, each with a project implementation team and parallel reporting mechanisms.

- The nutrition subcomponent had an unrealistic implementation schedule. In most cases, contracted NGOs did not have adequate time to complete training for the care groups in all the modules and did not make sufficient efforts to transfer nutrition-related project responsibilities to District Councils. As there was no follow-on project, this meant that investments in the development of the modules and organization of care groups were essentially lost, as nothing was done postproject to continue instruction of the care groups in untaught behavior change modules or to ensure their continued operation. Moreover, during the project, the NGOs hired parallel frontline workers to execute and support the project rather than adequately using existing district personnel, which drove up the component costs.

- In the Ebola component, there were extreme delays in the construction of isolation centers, from an original target completion date of March 31, 2015, to a

revised date of August 31, 2018, because of safeguards noncompliance, fragmented institutional arrangements, lack of ownership, and capacity constraints. In part, difficulties ensued because government procurement officials were not adequately trained by the World Bank to understand World Bank guidelines and standards. Consequently, construction of isolation facilities began without developing environmental and social management plans and then had to be stopped after the contractor had already been deployed to the sites. This had significant time and cost implications.

4. Risk to Development Outcome

The risk to development outcome is substantial. In both the nutrition subcomponent and the HIV/AIDS subcomponent, no provisions were made for the financing of continuing activities. In the case of the care groups, no data exist on the number of care groups still functional in project districts. Lack of supervision and support has led to the demise of many or most of the care groups. The government has tried to address this by enlisting donor support for reviving care groups in the context of their projects, and the World Bank is expected to revive some of the care group structures within the current Investing in Early Years for Growth and Productivity in Malawi project. However, the lack of any form of support for the care groups immediately after the project close has impaired the sustainability of development outcomes. Similarly, for the largest subcomponent of the HIV/AIDS component—voluntary male medical circumcision—site visits in three districts indicated that voluntary male medical circumcision provision has largely or completely ceased because of the lack of follow-on funding. One district reported that thanks to a successful demand creation campaign as part of the project, it succeeded in generating considerable demand for free circumcisions, which it no longer has the capacity to meet because of lack of funding. Another district hospital reported that it no longer does voluntary male medical circumcisions, but its staff sometimes travel to other districts to support voluntary male medical circumcision interventions there.

Conversely, the institutional structures in all three components have generated a high degree of stakeholder ownership and commitment, so that in all three components, nutrition, HIV/AIDS, and disease preparedness, policy development and coordination mechanisms have proven themselves to be impressively sustained after the project period and have become central mechanisms for Malawi's nutrition policy formulation and execution.

5. Bank Performance

The Bank performance is rated **moderately unsatisfactory.**

Quality at Entry

There were several design flaws inherent in the project that substantially reduced the likelihood of project success.

- The time given for the care groups to be operational was too short to be effective. Care groups, to lead to effective behavior change, need to be operational for several years. The NGO contracts, as designed, were initially for two-year periods, with some NGOs receiving follow-on contracts for a further 18 months. According to NGO reports, most of their time was spent organizing care groups and associated structures, with insufficient time remaining for instructing the care groups in the modules that were supposed to form the basis of their behavioral change messaging.

- The care group component was also underfunded relative to similar interventions. According to the DNHA, Kreditanstalt für Wiederaufbau, which is presently financing the revival of care groups in selected districts, has a budget three times the size of the project per district. This can partly be attributed to lack of experience with management of care group structures at the outset of the project.

- NGOs had no contractual obligation to ensure the orderly transition of care groups from NGO management to government results structures, and indeed they did not invest in managing the transition and exit in a manner likely to lead to continued care group operation.

- The need for demand creation activities as a prerequisite to voluntary male medical circumcision activities was not anticipated in advance and led to significant delays.

Quality of Supervision

There were two task team leaders during the implementation period. Supervision was positively perceived by the government of Malawi, building on a strong professional relationship between the World Bank team and government officials. Throughout project implementation, the World Bank team remained proactive and responsive to the changing context and restructured the project twice at the government of Malawi's request. Moreover, the World Bank team showed flexibility and agility in responding to external shocks, including the 2015–16 food shortage, the outbreak of Ebola in West Africa, and the shifting donor landscape for HIV/AIDS. The World Bank team is to be commended for its work with the NAC to continue to support the HIV Pool when other donors pulled out and for its prioritization of voluntary male medical circumcision over PMTCT in response to shifts in donor funding. Conversely, the World Bank team did

not adequately identify and address threats to the continued sustainability of the project results after project close in both the nutrition and HIV/AIDS subcomponents. On the nutrition component, evidence suggests that one of the major reasons behind the lack of success of the nutrition service delivery was the lack of supervision. Care groups received less than the full package of planned training modules, and although the project provided for the procurement and dissemination of micronutrient powders, these were never distributed in more than a few pilot districts. There were also frequent delays in submitting quarterly Interim Financial Reports. Audited financial statements raised several issues on control and accountability, particularly with the NGOs contracted by the NAC. NGOs were given a lump sum for distribution of these inputs and were not held accountable for their survival.

6. Quality of Monitoring and Evaluation

Quality of monitoring and evaluation is rated **modest/negligible.**

Design

As documented in the main text of this report, the project results framework for nutrition was insufficient for monitoring and evaluation of the project. The revised PDO was overly vague in its aims. Moreover, on an outcome level, the indicators did not systematically track desired behavior change—at the PDO level, there was only one behavior change indicator (children receiving MDD) and one output indicator (caregivers benefiting from monthly care group services), which would have been more appropriate as an interim indicator. In addition, the results framework tracked only care groups formed, without monitoring the extent to which the care groups were trained in the project's behavior change modules. As a result, World Bank staff and the DNHA were unaware until project close that many of the care groups had not received the mandated training.

Conversely, the results frameworks for the moderate and severe acute malnutrition treatment subcomponent, the disease preparedness component, and the HIV/AIDS component were mostly appropriate and sufficient for tracking project achievements in their components, although in some instances, indicators measured activities beyond the scope of the project.

Implementation

Data were collected through the DNHA's and the NAC's computerized M&E systems. In the case of the DNHA, the project supported the establishment of the system. At a district level, districts reported on paper-based data gathered from the care groups by the NGOs and then fed into the computer system by the district M&E officer. For the NAC, data were gathered at the facility level and entered into the system. Data were

aggregated and analyzed by the DNHA and the NAC. In addition to the World Bank results framework, baseline and endline surveys gathered data on the nutrition component.

The Project Performance Assessment Report found some minor discrepancies between reporting and realities in the field. For the Ebola component, it was reported that all six of the planned Ebola isolation centers were established, even though one of the six centers was never connected to electricity. Similarly, the electronic disease surveillance system installed as part of component C was never fully operational but was reported as such.

For the indicator of children ages 6 to 23 months who receive MDD, there are large discrepancies between data gathered in the endline survey (an average of 21.5 percent in project districts) and that reported in the results framework (36.4 percent).

Data for the results framework were processed by the DNHA and NAC. In the case of the DNHA, district-level data were then reported back to the districts on a quarterly basis. In the case of the HIV/AIDS component, these data were sufficient to enable the government to track progress and respond to problems promptly. In the case of the nutrition component, however, the indicators were inadequate for giving an accurate picture of anything other than the formation of new care groups. As a result, the Implementation Status and Results Reports positively rate progress to the nutrition targets, without there being any awareness of the substantial delays in the rollout of the learning modules that were supposed to be the content of care group messaging, and without any understanding of what behaviors were being by the project.

Use

M&E findings were not sufficiently used to inform strategic redirections of the project and its resource allocations. M&E was used for restructuring the project to address evolving circumstances and better reflect attribution and changes in scope. However, there is no evidence that M&E evidence supported course correction of the nutrition component. Better extraction and use of data regarding nutrition engagement, intermediary learning outcomes, and behavioral changes could have help prevent the dismantling of the care group model.

The project also missed the opportunity to strengthen policy analysis capacities and data use. Before the project, there was no coherent monitoring and evaluation of nutrition activities, outputs, and outcomes in Malawi. The system developed with the project support has been in use, at least partially, up to the date of this report. However, the system, although providing access to important data that previously were unavailable, functions less than optimally. Although all districts reported monthly in the project

period, reporting has been uneven since the end of the project. Only 6 of the 14 project districts were reporting regularly in 2017, according to the DNHA.

References

Government of Malawi. 2007. *National Nutrition Policy and Strategic Plan 2007–2012*. Lilongwe: Office of the President and Cabinet, Department of Nutrition and HIV and AIDS.

Government of Malawi. 2011. *Scaling Up Nutrition (SUN) in Malawi: Gap Analysis Report*. Lilongwe.

NSO (National Statistical Office) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, MA: NSO and ICF Macro.

Osendarp, Saskia, Forhad Shilpi, Timothy Gondwe, Innocent Pangapanga-Phiri, Alexander Kalimbira, Beatrice Mtimuni, Deusdedit Kafere, Gabriella Chuitsi, Felix Phiri, and Ziauddin Hyder. 2019. "Determinants of Reductions in Childhood Stunted Growth in Malawi's Community-Based Nutrition Programs: Health, Nutrition, and Population." Health, Nutrition, and Population Discussion Paper, World Bank, Washington, DC.

USAID (United States Agency for International Development) and World Bank. 2011. *Consulting with Caregivers: Formative Research to Determine the Barriers and Facilitators to Optimal Infant and Young Child Feeding in Three Regions of Malawi*. Washington, DC: USAID and World Bank.

World Bank. 2012. *Malawi—Country Assistance Strategy for the Period FY13–16*. Washington, DC: World Bank.

World Bank. 2016. "Republic of Malawi—Nutrition and HIV/AIDS Project: Additional Financing." Report No. PAD1878, World Bank, Washington, DC.

World Bank. 2019. "Republic of Malawi—Nutrition and HIV/AIDS Project." Implementation Completion and Results Report ICR00004538, World Bank, Washington, DC.

Fiduciary, Environmental, and Social Aspects

Financial Management

Financial management was rated moderately satisfactory for most of the project until the final year of implementation when it was downgraded to moderately unsatisfactory due to outstanding ineligible expenditures incurred during implementation of the previous, closed MAP project. This was resolved before the final mission. The ICR, described the financial accounting, auditing, and reporting of the project as adequate and consistent with the World Bank's financial management guidelines World Bank 2019, 32). There were, however, frequent delays in submitting quarterly Interim Financial Reports (IFRs). Audited financial statements raised several issues on control and accountability, particularly with the NGOs contracted by the NAC. To address those concerns, the NAC developed and implemented an action plan. The borrower's ICR noted that a lack of training on project management, financial management, and accountancy led to errors and delays in the submission of IFRs.

Procurement

Procurement was rated as satisfactory for most of the project's duration. Overall, the implementing entities followed World Bank procurement guidelines and updated their procurement plans into the World Bank procurement system. DNHA was responsible for procurement on Component A, and NAC for Components B and C. UNICEF was the procurement agent for most of the medical commodities and supplies for all three components. However, delays in processing procurements, lack of staff capacity, a high turnover of staff at DNHA, and limited compliance with the procurement guidelines were described in both the ICR and the borrower's ICR.

Environmental and Social Safeguards

According to OP 4.01 on Environmental Assessment the project was given a Category B rating due to the collection, storage, and disposal of medical waste generated by clinical activities. A Health Care Waste Management Plan (HCWMP) was prepared, and the final plan was disclosed on February 6, 2012. When the project was restructured in December 2014, the World Bank team was not advised that site-specific Environmental and Social Management Plans for each of the new isolation centers would have to be prepared, which resulted in construction delays of at least 4 months. In the final year of the project implementation, the Environmental Assessment rating was downgraded from satisfactory to moderately satisfactory and then moderately unsatisfactory in the final ISR due to the challenges in implementing the Environmental and Social Management Plans. Hospital staff were inadequately trained in waste disposal and tree replacement was not carried out as required.

Methods and Evidence

This report is a Project Performance Assessment Report. This instrument and its methodology are described at https://ieg.worldbankgroup.org/methodology/PPAR.

This report was prepared after document review, online literature review, and a field visit to Malawi in 2019. In the documentary review, data from the baseline and endline surveys were particularly useful, providing detailed information on progress toward nutrition goals over the project period. The team also reviewed preparatory research that informed the design of the project, including a World Bank–supported study on Infant and Young Child Nutrition and the DNHA's Nutrition Education Communication Strategy, and several publications on care group good practice.

During the field visit in Malawi, the PPAR team conducted in-depth interviews in Lilongwe with government officials, World Bank personnel and contracted NGOs, and with other donors familiar with the project. Three field visits were conducted to three districts: Rumphi in the North, Ntcheu in the Center, and Mangochi in in South-Central of Malawi. These three regions were chosen after consultations with the DNHA and the endline survey authors, and with reference to endline survey results, as three districts that had been particularly successful. Due to the considerable implementation difficulties documented in the PPAR, we attempted to visit the relatively more successful districts to take advantage of all possible opportunities to learn from good practice. In each site, the PPAR team met with DNCC, ANCC, VNCC, and CLAN members as well as care groups and their promoters. In addition, efforts were made to speak with medical personnel in all districts familiar with the voluntary male medical circumcision. Unfortunately, in none of the districts visited were voluntary male medical circumcisions still being performed at any significant scale.

Interviews were related to the cycle of project operations, results, implementation experience, challenges encountered, quality aspects, contextual factors, views on what worked and didn't work and why, and the role played by other sectors in nutrition promotion. In discussions with lead mothers (care groups) and promoters, particular attention was paid to the extent to which mothers were aware of and able to practice recommended behaviors. Discussions covered both the project implementation period and postproject period.

Project Objectives and Design

Objective 1: Increase Coverage of Selected Nutrition Services

Nutrition activities focused on changing behaviors, building capacity, identification, and treatment of severe and acute malnutrition. To achieve nutrition-related objectives, the project initially supported a two-pronged approach to improving nutrition in Malawi. The project focused on (i) improving feeding practices and behaviors of children and their caregivers via effective use of care groups to change behaviors associated with low nutrition and (ii) improving the government's capacity to plan and execute nutrition interventions with an emphasis on developing multilevel and multisectoral capacity and strengthening policy and program development, management, and coordination.

Objective 1a: Improving Feeding Practices and Behaviors of Children and Their Caregivers

The project's first nutrition goal was to increase coverage of selected nutrition assumed that the main driver of Malawi's persistently high stunted growth rate was behavioral. Project design was informed by a 2011 study; World Bank, USAID, and Bunda College of Agriculture found that information and communication were critical for mothers to improve feeding practices and use available resources to positively impact their children's health and nutrition. Based on recommendations from the study, the project developed messaging materials for community-based nutrition interventions by care groups. Care groups were meant to learn and pass on to households a "package" of nutritional messages in the form of six planned modules of instruction, including breastfeeding; maternal nutrition; infant and young child feeding (IYCF); malaria prevention; water, sanitation and hygiene (WASH); and family planning. Care group mothers were each responsible for paying monthly visits to 8–12 households, to pass on learned messages and give advice to mothers of young children. Care group mothers were also trained to advise mothers on available health and nutrition services such as growth monitoring and supplementation but were not authorized to do growth monitoring or distribute supplementation themselves.

In each of the project districts, locally active NGOs were contracted to manage the rollout and capacity building of care groups. In total, there were seven NGOs contracted to roll out the community-based nutrition plan in the 14 the project districts. NGOs contracted to roll out the care groups were also given budgets to enhance dietary diversity through encouraging planting of backyard gardens and provision of pass-through grants of seeds, fruit trees and livestock to care groups. The grants were provided by contracted NGOs to care group lead mothers, with the expectation that plant cuttings and offspring of the original grant would be spread throughout the

community. The NGOs were also expected to help set up the institutional infrastructure for community-based nutrition interventions. This infrastructure included District Nutrition Coordination Committees (DNCC), Area Nutrition Coordination Committees (ANCC), Village Nutrition Coordination Committees (VNCC) and Care Groups.

Objective 1b: Improving Government's Capacity to Plan and Execute Nutrition Interventions

In addition to the care group development, the project invested in building the capacity of the DNHA and the coordination structures associated with it to develop, implement, monitor and evaluate a national nutrition strategy. This was accomplished through budgetary support to DNHA, training, capacity building and advisory services, as well as funding for national-level coordination meetings and for the establishment of a nationwide computer-based monitoring and evaluation system for nutrition, facilitating data gathering at a district level for use by DNHA and other national-level nutrition policy makers.

Objective 1c: Reduce Moderate and Severe Acute Malnutrition

A supplementary nutrition subcomponent, to address severe and acute malnutrition, was added in May 2016. The government requested emergency financing to combat an increase in moderate and severe acute malnutrition caused by unexpected crop loss and a decline in food production after two natural disasters—floods followed by a prolonged drought.

Objective 2: Increase Coverage of Selected HIV/AIDS Services

HIV/AIDS activities focused on preventing new HIV infections and building capacity. This support was complemented by funding for treatment provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria. In line with the objectives of the National HIV/AIDS policy and National Strategic Plan for HIV/AIDS (2011–16; NSP) the project prioritized the reduction of new infections through (i) scaling up voluntary medical male circumcision and neonatal circumcision; (ii) reducing pediatric infections by increasing access to an effective Prevention of Mother-to-Child Transmission program (World Bank 2012, 35). Fifty percent of World Bank funds were earmarked for voluntary medical male circumcision (voluntary male medical circumcision) and the prevention of mother-to-child transmission (PMTCT) of HIV. A further fifty percent of the project HIV/AIDS funding directly supported the NSP. A detailed description of the project's activities, a theory of change for HIV/AIDS and disease preparedness are presented in appendix C and figure 1.3).

Objective 3: Strengthen Disease Outbreak Preparedness

The project's revised design supported a third component. In response to the 2014 Ebola outbreak in West Africa, a disease preparedness component was added to the project. At the time of the outbreak, Malawi had no disease surveillance system, no isolation units, and no specialized equipment for dealing with an outbreak. In this context, the World Bank agreed to make available emergency financing through the project to implement WHO-recommended measures for Ebola preparedness. Initially, support was diverted from the project's HIV/AIDS component to Ebola preparedness activities. The 2016 restructuring formalized disease preparedness as an objective with associated activities and replenished funding for the nutrition component that had been reallocated to disease preparedness.

Project Components

Box 0.1. Detailed Project Activities by Component

Component A: Support for Nutrition Improvement. The project's nutrition component promoted the prevention of stunted growth and maternal and child anemia, focusing on cost-effective interventions targeting the nutrition of a child's first 1,000 days, including the nutrition and wellbeing of the pregnant mother. The primary mechanism was a community-based model of nutrition behavior change communication at the community and household level, and enhanced coordination at the local and central levels. It originally had two subcomponents:

Subcomponent A.1. Maternal and child nutrition service delivery at community level. This component will directly support the improvement of access to, and utilization of nutrition services known to reduce child stunted growth and maternal and child anemia. Community-based development is the key mechanism for channeling nutrition interventions. A "minimum package" of evidence-based nutrition interventions will be the core of services offered in the targeted communities. The minimum package is aligned with the Scaling Up Nutrition (SUN)/1,000 Special Days Initiative and the Nutrition Education and Communication Strategy (NECS 2011–16) including the promotion of: (i) improved infant and young child feeding practices by caregivers; (ii) improved care seeking and home based care for common infectious diseases; (iii) improved hygiene (personal, food and environmental) and sanitation; (iv) improved prevention of malaria, helminthic infections and all other parasitic infections; (v) improved iron intake through consumption of iron-rich foods and iron supplementation to women and children; (vi) improved dietary intake by women before, during and after pregnancy; (vii) improved household care of pregnant women and use of antenatal care services; (viii) increased spacing of pregnancy for mothers postpartum; and (ix) adequate weight gain in children under two and pregnant women. The strategies will be implemented through Information and Education Communication and Behavior Change Communication (social and behavior change communication) interventions, such as group education, individual counseling, home visits, and growth monitoring and promotion; demonstrations of healthy cooking; promotion of production and consumption of fruits, vegetables and small livestock; community grants of livestock, seedlings and fruit trees; promoting latrine use and the use of safe water. The core target group is composed of mothers and young children, and pregnant women. However, to effect and sustain change, other groups in the community can be as important and will be mobilized, including grandmothers and husbands.

The community interventions will be implemented through District-level subprojects by NGOs; that is, one NGO contract per District, The scope of services in the terms of reference will lay down specific requirements such as minimum coverage of under two and pregnant women with regular (selected) service delivery to be attained; use of Nutrition Education and Communication Strategy (NECS) registrar; and conducting regular community restitution. The project implementation performed by NGOs will be guided by the following principles: (i) integrate and build on existing program structures; (ii) coordinate with other stakeholders and NGOs in the targeted districts; and (iii) partner with District Councils and departments. Project Integration: The implementing NGOs will integrate the minimum package of activities into their ongoing project activities, such as food production projects (that is, diversification, irrigation), livelihood interventions (that is, income generating activities, saving and credit schemes, social protection), health projects (that is, maternal and child health, family planning). Similarly, NGOs will seek

possible synergy with existing programs and projects in the district that could potentially converge with maternal and child nutrition, for example, projects on maternal and child health, family planning, food production, food processing and conservation, income generation, saving and credit, social protection and gender status of women.

Stakeholder Coordination: The coordination of project activities at the community and district level with existing stakeholders is an important external accountability measure of the new project. In building on existing program structures, the project will work and coordinate with the District Councils, the traditional authorities, the Area Development Committees, district-based extension workers from health, agriculture and gender, and NGOs, FBOs and CBOs (see Annex 3). The role of the NGO is to facilitate innovative ways of collaborations among the existing actors in the districts. The comparative advantage of NGOs is their capacity to scale-up and expedite this process. The establishment of formal and informal relationships with current stakeholders is a key step in gaining a better understanding of social, cultural and economic differences in targeted districts that can influence the opportunities for project impact.

DC Partnership: The District Council coordinates the activities among sectoral Departments. Through partnership among District Councils and NGOs the project will provide capacity-building in community-based nutrition, which will be described in subcomponent A.2.

Prior to NGO selection and proposal development, District Mapping will be conducted to collect data on: demographic indicators; public services for health, social protection and agriculture (for example, number of and distance to health center; number of outreach and village clinics; number of extension workers); available institutions (for example, Village Development Committees, Community-Based Organizations, Area Development Committees, NGOs); and existing sectoral programs. This assessment will provide the basis for the design of subprojects and the identification of capacity-building activities.

Subcomponent A.2. Strengthening policy and program development, management, and coordination focused on providing the enabling institutional environment for effective community-based development. It aimed to provide the support necessary to improve supervision, monitoring and coordination at both at central and district levels. For example, strengthening the guiding, coordinating and supervisory role of the DNHA, through line ministries, NGOs, DCOs, as well as strengthening district-based capacity for nutrition program planning, management, monitoring, and coordination. The assumption being that strengthening policy and program development, management, and coordination will contribute to (i) enhanced leverage over sectoral programs related to maternal and child nutrition; (ii) enhanced policy environment for the reduction of stunted growth and anemia in women and children; and (iii) strengthened stewardship, oversight and coordination of nutrition programs at central and district level. This subcomponent intended to support the following activities:

a. *joint planning with and financial support to the sectors (notably, health and agriculture) for nutrition-relevant activities at the central and district levels;

b. *orientation and training workshops with stakeholders;

c. *monitoring, reporting, surveillance and operational research, including a project specific gender analysis, particularly with gender-related perceptions of nutrition and care-giving roles and responsibilities at the household level;

d. *advocacy and strategic communication;

e. *technical assistance for key responsibilities to fill gaps relevant to project management and implementation and the stewardship, oversight and coordination function at central and district level; and

f. *improved office space for DNHA through lease or provision of office equipment.

Subcomponent A.3 Integrated Management of Acute Malnutrition. This subcomponent was added to the project in the 2016 restructuring, in response to a request from the government of Malawi, against the backdrop of acute food shortages in 2015 and 2016 caused by drought and flooding. The component covered a financial gap to treat high rates of Moderate and severe acute malnutrition stemming from the drought. Support was provided for the Integrated Management of Acute Malnutrition (integrated management of acute malnutrition) in 14 districts supported by the project, including community-based capacity development for active case finding/screening, referral to nearby health centers, and treatment of moderate and severe acute malnutrition cases. Support was also provided to treat acute illnesses that are commonly associated with acute malnutrition, including respiratory tract infections, diarrheal disease, and malaria, and recover direct costs associated with service delivery. Specific activities that were supported include the following: (i) mass screening of all under-five children at household levels in the 14 project districts; (ii) referrals of those children with SAM and MAM to health facilities and the Nutrition Rehabilitation Unit for treatment; (iii) procurement and distribution of nutrition commodities that are required for the treatment of Moderate and severe acute malnutrition; (iv) monitoring stocks of all nutrition commodities and supplies at the rural health facility level; (v) mentorship of health surveillance assistants on screening and identification of Moderate and severe acute malnutrition; and (vi) strengthening data collection, analysis, and reporting on the CMAM program. The operation builds on existing services provided by the MOH, with technical and logistics support from UNICEF and the World Food Programme (WFP). Although UNICEF focuses on the treatment of SAM, WFP works with the MOH in treating MAM.

Component B: Support for the National HIV/AIDS Strategic Plan (US$41.0 million). Implementation of the plan and supported the NAC aimed to help achieve the objectives of the National HIV/AIDS Policy and the National Strategic Plans (NSPs) for 2011–16 and 2015–20 by focusing on evidence-based HIV prevention interventions that will have a high impact on both national and international efforts to significantly reduce HIV incidence rates.

Subcomponent B.1. This subcomponent financed activities designed to support the implementation of priority HIV/AIDS prevention and care interventions as outlined in the National Strategic Plan for HIV/AIDS (2011–16), including enhancing the (i) implementation, efficiency, and governance of the national response to HIV/AIDS; (ii) functional capacity of the local government to plan, implement, and monitor activities at the local level; (iii) M&E systems; (iv) supply chain management system; and (v) implementation of the Health Care Waste Management Plan (HCWMP).

Subcomponent B.2 Voluntary Medical Male Circumcision. The project is supported a program of activities designed to enhance the rollout of the voluntary male medical circumcision through public health public health facilities in Malawi, including demand creation for and provision of voluntary male medical circumcision services.

Subcomponent B.3: Prevention of Mother-to-Child Transmission. Originally, was an important strategic goal of the project, however, this subcomponent was reduced in size after the April 2015 Midterm Review noted the availability of significant funding for PMTCT by other

donors. The project support for PMTCT after the restructuring focused on (i) minor refurbishment of 15 PMTCT facilities; (ii) provision for HIV Deoxyribonucleic acid (DNA) polymerase chain reaction equipment for testing infants and associated supplies; and (iii) implementation of a program to promote retention of pregnant women with HIV in HIV treatment after they give birth to their infants.

Component C: Support for Disease Preparedness. Implemented by the NAC, this component financed:

a. The procurement and distribution of Ebola-specific health commodities and other needed equipment and supplies;

b. *the capacity building of health sector staff to improve overall disease outbreak preparedness; and

c. *the construction of seven isolation units/treatment centers using prefabricated materials in two central hospitals of Mzuzu (Mzimba District) and Kamuzu (Lilongwe District) and in five district hospitals of Blantyre, Karonga, Mchinji, Dedza, and Mwanza.

Source: World Bank 2012a; World Bank 2016b

Results and Monitoring Framework

Table 0.1. Expected Outcomes and Indicators (original and revised)

Project Development Objective (PDO): To increase access to, and utilization of, selected services known to contribute to the reduction of stunted growth of children and maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults												
PDO-Level Results Indicators*	**Core**	**Unit of Measure**	**Baseline**	**Cumulative Target Values****					**Frequency**	**Data Source/Methodology**	**Responsibility for Data Collection**	**Description (indicator definition etc.)**
				YR 1	**YR 2**	**YR 3**	**YR 4**	**YR 5**				
PDO#1: Children under two receiving a monthly minimum package of community nutrition services in the Component A intervention districts	☐	Percentage	0%	0%	7%	14%	25%	33%	Quarterly	Program reports	DNHA	Measured by participation in growth monitoring and promotion sessions; average monthlyresults
PDO#2: Children 6–23 months ofage who receive minimum diet diversity in the Component A intervention districts	☐	Percentage	29%	29%		32%		40%	Every 2 years; baseline/ endline	Routine surveys(DHS, LQAS); baseline/ endline surveys	DNHA, NSO	Percentage of children 6–23 months of age who received foods from ≥4 food groups during the previous day

Project Development Objective (PDO): To increase access to, and utilization of, selected services known to contribute to the reduction of stunted growth of children and maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults												
PDO#3: Pregnant women attending ANC in first trimester inthe Component A intervention districts	☐	Percentage	12%	12%	13%	15%	17%	20%	Quarterly; every 2 years; baseline/ endline	Program reports; routine surveys (DHS, LQAS); baseline/ endline surveys	DNHA, NSO	Percentage of women who had a live birth in the [1–2] or [5] years preceding the survey who initiated antenatal care before the fourth month of pregnancy. [This is a proxy indicator measuring access to iron supplementation during pregnancy]
PDO#4: People with access to a basic package of health, nutritionor population services (percent increase based on number of people)	☒	Number	0	0	38,610	77,220	141,570	186,615	Quarterly	Program reports	DNHA	Refer to target group of children under two participating in growth monitoring and promotion sessions

Project Development Objective (PDO): To increase access to, and utilization of, selected services known to contribute to the reduction of stunted growth of children and maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults											
PDO #5: Neonatal and post-neonatal males circumcised	Number	N-TBC PN-10,000	N-0 PN-25,000	N-9,900 PN-75,000	N-34,900 PN-175,000	N-76,900 PN-325,000	N-136,900 PN-500,000	Quarterly	Program reports (facility and project registers)	NAC, MoH	Number of males who are circumcised according to SOPs disaggregated by neonatal (less than 2 months old) and non-neonatal (adolescent/ adult) males
PDO #6: Infants born to HIV-positive women enrolled in PMTCT services in the target districts who receive a DNA PCRtest for HIV within two months of birth	Percentage	25%	30%	35%	40%	45%	50%	Quarterly	Program reports	NAC, MoH	Percentage of children born to HIV-positive women enrolled in PMTCT for whom an HIV DNA PCR test is initiated within the first two months of life. (Harmonize with EMTCTstrategy)

Project Development Objective (PDO): To increase access to, and utilization of, selected services known to contribute to the reduction of stunted growth of children and maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults											
PDO #7: Men and women aged between 15 and 49 who have had more than one sexual partner in the past 12 months, reporting the use of a condom in their last sexual intercourse	Percentage	27.3% Women 24.6% Men	29% Women 26% Men	31% Women 28% Men	33% Women 30% Men	36% Women 32% Men	40% women 35% Men	At most five years DHS planned for2015, however MICS and/or AISto be available before or after DHS	DHS or equivalent MICS or AIS	NAC, NSO	Among women and men who had two or more sexual partners in the past 12 months, the percentage who reported using a condom during the most recent sexual intercourse
Intermediate Results											
IOI#1: Direct project beneficiaries (number) of which female(percentage)	Number (Percent)	0 (0%)	70,500 (53%)	196,904 (40%)	406,652 (32%)	746,198 (29%)	1,088,470 (26%)	Quarterly	Program reports	DNHA, NAC	Direct project beneficiaries of component A and B that include children < 2 participate in GMP, pregnant womanreceive ANC, mothers attend monthly education, neo/postnatal circumcision, HIV+ pregnant women receive ARV and infant born to HIV + women
Intermediate Results (Component A): Support for Nutrition Improvement											

Project Development Objective (PDO): To increase access to, and utilization of, selected services known to contribute to the reduction of stunted growth of children and maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults												
IOI#2: Group village adopting the community nutrition program inthe intervention districts	☐	Number	0	0	112	224	412	538	Quarterly	Program reports	DNHA	The number of villages in each group village ranges from 4–18 villages
IOI#3: Backyard gardens established in the intervention districts	☐	Number	0	0	4,000	10,500	18,000	30,000	Quarterly	Program reports	DNHA	The backyard gardens are irrespective of size or variety
IOI#4: Children 0–59 mo from households with ITNs who slept under ITNs last night in the intervention districts	☐	Percentage	59%	59%		63%		69%	Every 2 years; baseline/ endline	Routine surveys (DHS, LQAS); baseline/ endline surveys	DNHA, NSO	The denominator is children 0–59 mo from households with ITNs
IOI#5: Children 0–59 mo who had diarrhea and were given increased fluids in the intervention districts	☐	Percentage	22%	22%		28%		38%	Every 2; baseline/ endline	Routine surveys (DHS, LQAS); baseline/ endline surveys	DNHA, NSO	Fluids does not include ORS (oral rehydrationsalts)
IOI#6: Mothers attending monthly group education in the intervention areas	☐	Percentage	0%	0%	40%	60%	75%	75%	Quarterly	Program reports	DNHA	Mothers of children under two; average per quarter

Project Development Objective (PDO): To increase access to, and utilization of, selected services known to contribute to the reduction of stunted growth of children and maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults												
IOI#7: Pregnant women receiving antenatal care during a visit to a health center	☒	Number	0	0	8,000	20,000	40,000	65,000	Quarterly; every 2 years; baseline/ endline	Program reports; routine surveys (DHS, LQAS); baseline/ endline surveys	DNHA, NSO	Percentage of women who had a live birth in the five years preceding the survey who received antenatal care at least once during the pregnancy
IOI#8: District Councils reporting on key nutrition indicators to DNHA on a quarterly basis	☐	Number	0	0	1	5	8	13	Quarterly	Program reports	DNHA	DC reporting 3 out of 4 quarterly reports
IOI#9: National Nutrition Policy and Strategic Plan (2007–12) reviewed and updated	☐	Yes or No	N	N	N	Y	Y	Y	Once	Annual report	DNHA	Do not include the launch of NNP
Intermediate Result (Component B): Support for National Strategic Plan (2011–16)												

Project Development Objective (PDO): To increase access to, and utilization of, selected services known to contribute to the reduction of stunted growth of children and maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults												
IOI#10: Persons seeking MC services tested for HIV on site	☐	Percentage	50% (based on BLM indicators)	60%	70%	75%	80%	85%	Quarterly	Program reports	NAC, MoH	Of all men enrolling in a voluntary male medical circumcision program the percentage who are tested for HIV on site using a rapid diagnostic test. (Reasons for not receiving an HIV test include stock-outs, refusal, or known HIV + status).
IOI#11: Fixed and mobile service units providing minimum packages for MC	☐	Number	0 fixed sites; 0 mobile units	3 fixed sites; 2 mobile units	12 fixed sites; 2 mobile units	20 fixed sites; 4 mobile units	28 fixed sites; 5 mobile units	28 fixed sites; 6 mobile units	Quarterly	Program reports	NAC, MoH	Minimum package includes MC kits, HIV test kits, STI drugs, and condoms
IOI#12: Fixed sites offering MC services reporting no stock-outs of one week or more of MC kits during the reporting period.	☐	Percentage	N/A	60%	70%	80%	90%	90%	Quarterly	Program reports	NAC, MoH	
IOI#13: Women attending ANC who are tested for HIV		Percentage	74%	76	78%	80%	82%	85	Quarterly	Program reports	NAC, MoH	Denominator based on estimate of the number of pregnant women

Project Development Objective (PDO): To increase access to, and utilization of, selected services known to contribute to the reduction of stunted growth of children and maternal and child anemia, and the prevention of HIV and AIDS in children and sexually active adults											
											and the numerator based on ANC program reporting (Harmonize with EMTCT strategy)
IOI #14: HIV-positive pregnant women who receive ARV to reduce the risk of mother-to-child transmission	Annual Number	32,000	35,000	37,000	38,000	39,000	40,000	Quarterly	Program reports (patient and facility registers)	NAC, MoH	Number of HIV-positive pregnant women who received ARV during the past 12 months to reduce mother-to-child transmission. (Harmonize with EMTCT strategy)
IOI#15: PMTCT sites in target districts offering minimum EID package to exposed infants	Percentage	40%	40%	50%	60%	70%	80%	Quarterly	Program reports	NAC, MoH	Harmonize with EMTCT strategy
IOI#16: Sexually active respondents who had sex with a nonregular partner within the previous 12 months (by gender)	Percentage	Female 1% Male 9.2%	Female 0.8% Male 8.5%	Female 0.7% Male 7.8%	Female 0.6% Male 7.1%	Female 0.5% Male 6.4%	Female 0.4% Male 5.5%	At most five years DHS planned for 2015, however, MICS and/or AIS to be available before or after DHS	DHS or equivalent MICS or AIS	NAC, NSO	

Source: World Bank 2012a; World Bank 2016

Project Achievement

Phase I: Table G.1 summarize achievements against the PDOs for the phase before the June 2016 restructuring.

Table 0.1. Achievement of PDO Indicators by PDO

PDO#	PDO indicators	Baseline	Original end of project target	Results achieved (based on latest available data)	Level of achievement
1	Percentage of children under 2 receiving a monthly minimum package of community nutrition services (indicator revised in phase II)	0	33	36.1	Surpassed (109%)
1	Percentage of children 6–23 months of age who receive minimum diet diversity (MDD)	29	40	36.4	Partially achieved (67%)
1	Number of people with access to a basic package of health, nutrition, or population services (indicator dropped in phase II)	0	186,615	26,747	Not Achieved (14%)
2	Percentage of pregnant women attending ANC in first trimester (indicator dropped in phase II)	12	30	15.70	Not Achieved (21%)
3	Number of neonatal and post-neonatal males circumcised (target revised in phase II)	10,000	636,900	272,189	Not Achieved (42%)
3	Percentage of infants born to HIV-positive women enrolled in PMTCT services who receive a DNA PCR test for HIV within two months of birth	25	50	73	Surpassed (192%)
4	Percentage of women and men aged between 15–49 who had more than one sexual partner in the past 12 months, reporting the use of a condom in their last sexual intercourse (indicator dropped in phase II)	51.9	75	35.4	Not Achieved (149%)

Source: World Bank 2019a

Table 0.2. Achievement of IRIs by PDO for Phase I

PDO	IRI indicators	Baseline	Original end of project target	Results achieved (based on latest available data)	Level of achievement
	Direct project beneficiaries	0	1,088,470	1,104,612	Surpassed (101%)
	Direct project beneficiaries of which female	0	26	56.1	Surpassed (215%)
1	Group village adopting the community nutrition program (revised in phase II)	0	224	1,032	Surpassed (461%)
1	Backyard gardens established (target revised in phase II)	0	30,000	17,556	Not Achieved (58%)
1	Pregnant women receiving ANC during a visit to a health facility (dropped in phase II)	0	65,000	14,653	Not Achieved (23%)
1	DCs reporting on key nutrition indicators to DNHA on a quarterly basis	0	13	14	Surpassed (108%)
1	National Nutrition Policy and Strategic Plan (2007–12) reviewed and updated	no	yes	yes	Achieved/Substantially (100%)
2	Children 0–59 mo from households with ITNs who slept under ITNs last night	59	69	57.1	Not Achieved (-19%)
2	Children 0–59 mo who had diarrhea and were given increased fluids	22	38	32	Not achieved (63%)
2	Mothers attending monthly group education (dropped in phase II)	0	60	59	Achieved/ Substantially achieved (98%)
3	Fixed and mobile service units providing minimum packages for MC (revised in Phase II)	0	90	63	Partially Achieved(70%)
3	Fixes sites offering MC services reporting no stock-outs of one week or more of MC kits during the reporting period (dropped in phase II)	0	80	Not available	N/A
3	HIV-positive pregnant women who receive ARV to reduce the risk of mother-to-child transmission	32,000	40,000	55,902	Surpassed (299%)
3	PMTC sites offering minimum EID package to exposed infants (dropped in phase II)	40	60	68	Surpassed (120%)
4	Persons seeking MC services test for HIV on site (revised in phase II)	50	75	99	Surpassed (196%)
4	Women attending ANC who are tested for HIV (revised in phase II)	74	80	89	Surpassed (250%)
4	Sexually active respondents who had sex with a nonregular partner within the previous 12 months (by gender) (dropped in phase II)	10.2	8	10	Not Achieved (0%)

Source: World Bank 2019a.

Phase II: The following section and tables summarize achievements against the PDOs. Achievement data comes from the final ISR (ISR #13 dated August 2018).

Table 0.3. Achievement of PDO Indicators by PDO

PDO	PDO indicators	Baseline	End ofproject target	Results achievedat end of project	Level of achievement
1	Percentage of caregivers of children under 2 benefiting from monthly CG services in intervention districts	0	82	78	Achieved/ Substantially (95%)
1	Percentage of children 6–23 months of age who receive minimum diet diversity	29	40	36.4	Partially Achieved (67%)
2	Number of male circumcisions conducted according to national standards in the 20 selected districts	10,000	264,200	272,189	Surpassed (103%)
2	Percentage of infants born to HIV-positive women enrolled in PMTCT services who receive a DNA PCR test for HIV within two months of birth	25	50	73	Surpassed (192%)
3	Number of isolation units established for Ebola case investigation and management	0	6	6	Achieved/ Substantially (100%)

Source: World Bank 2019a.

Year 3 Target Analysis

In table G.4, the ICR team measured phase I against the Year 3 target. Achievement data comes from the last Implementation Status and Results Report (ISR) to measure the performance against the original results framework (ISR #8 dated December 2015), which is closer to the Year 3 target date.

Table 0.4. Achievement of PDO Indicators by PDO

PDO #	PDO indicators	Baseline	Year 3 target	Results achieved	Level of achievement
1	Percentage of children under 2 receiving a monthly minimum package of community nutrition services	0	14	36.1	Surpassed (100%+)
1	Percentage of children 6–23 months of age who receive minimum diet diversity	29	32	35.9	Surpassed (100%+)
1	Number of people with access to a basic package of health, nutrition or population services	0	77,220	26,747	Not Achieved (lessthan 64%)
2	Percentage of pregnant women attending ANC in first trimester	12	15	7.4	Not Achieved (lessthan 64%)
3	Number of neonatal and post-neonatal males circumcised	10,000	209,900	91,396	Not Achieved (less than 64%)
3	Percentage of infants born to HIV-positive women enrolled in PMTCT services who receive a DNA PCR test for HIV within two months of birth	25	40	37	Partially Achieved(65%–84%)
4	Percentage of women and men aged between 15 and 49 who had more than one sexual partner in	51.9	63	35.4	Not Achieved (lessthan 64%)

PDO #	PDO indicators	Baseline	Year 3 target	Results achieved	Level of achievement
	the past 12months, reporting the use of a condom in their last sexual intercourse				
	Direct project beneficiaries	0	406,652	121,617	Not Achieved (lessthan 64%)
	Direct project beneficiaries of whichfemale	0	32	Not available	
1	Group village adopting the communitynutrition program	0	224	1,032	Surpassed (100%+)
1	Backyard gardens established	0	10,500	7,151	Partially Achieved(65%–84%)
1	Pregnant women receiving ANC during a visit to a health facility	0	20,000	14,653	Partially Achieved (65%–84%)
1	DCs reporting on key nutritionindicators to DNHA on a quarterly basis	0	5	7	Surpassed (100%+)
1	National Nutrition Policy and Strategic Plan (2007–12) reviewed and updated	no	yes	yes	Achieved/Substantially (85%+)
2	Children 0–59 mo from households with ITNs who slept under ITNs last night	59	63	55	Not Achieved (less than 64%)
2	Children 0–59 mo who had diarrhea and were given increased fluids	22	28	36	Surpassed (100%+)
2	Mothers attending monthly group education	0	60	59	Achieved/ Substantially achieved (85%+)
3	Fixed and mobile service units providing minimum packages for MC	0	24	82	Surpassed (100%+)
3	Fixes sites offering MC services reporting no stock-outs of one week or more of MC kits during the reporting period	0	80	Not available	Not Achieved (less than 64%)
3	HIV-positive pregnant women who receive ARV to reduce the risk of mother-to-child transmission	32,000	38,000	41,778	Surpassed (100%+)
3	PMTC sites offering minimum EID package to exposed infants	40	60	68	Surpassed (100%+)
4	Persons seeking MC services test for HIV on site	50	75	99	Surpassed (100%+)
4	Women attending ANC who are tested for HIV	74	80	89	Surpassed (100%+)
4	Sexually active respondents who had sex with a nonregular partner within the previous 12 months (by gender)	10.2	8	10	Not Achieved (less than 64%)

Source: World Bank 2019a.