

# PROJECT EVALUATION REPORT

Enhancing the capacity of CSOs,  
district level staff and communities  
in scaling up nutrition initiative in  
Malawi



**Cover Photo:** Sanida, a project beneficiary from Dowa district having lunch with her daughter. Photo: Watipaso Kaliwo/Oxfam

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# LIST OF ACRONYMS

<b>ADCs</b>	Area Development Committees
<b>AEDO</b>	Agricultural Extension Development Officer
<b>ANCCs</b>	Area Nutrition Coordinating Committees
<b>CCFL</b>	Community-led Complementary Feeding and Learning
<b>CCJP</b>	Catholic Commission for Justice and Peace
<b>CDAs</b>	Community Development Assistants
<b>CHC</b>	Catholic Health Commission
<b>CISANET</b>	Civil Society Agriculture Network
<b>CMAM</b>	Community-Based Management of Acute Malnutrition
<b>CSO</b>	Civil Society Organisations
<b>CSONA</b>	Civil Society Organisation Nutrition Alliance
<b>DAC</b>	Development Assistance Committee
<b>DAES</b>	Department of Agriculture and Extension Services
<b>DEC</b>	District Executive Committee
<b>DHMT</b>	District Health Management Teams
<b>DHO</b>	District Health Office
<b>DNCC</b>	District Nutrition Coordinating Committee
<b>DNHA</b>	Department of Nutrition, HIV and AIDS
<b>ENA</b>	Emergency Nutrition Assessment
<b>ENA</b>	Essential Nutrition Actions
<b>EU</b>	European Union
<b>FANTA</b>	Food and Nutrition Technical Assistance
<b>FAO</b>	Food and Agriculture Organisation
<b>FGD</b>	Focus Group Discussion
<b>FIDP</b>	Farm Income Diversification Programme
<b>FPAM</b>	Family Planning Association of Malawi
<b>GVH</b>	Group Village Headman
<b>HAZ</b>	Height-for-Age
<b>HDDS</b>	Household Dietary Diversity Score
<b>HSA</b>	Health Surveillance Assistant
<b>IFA</b>	Iron Folic Acid supplementation
<b>IHF</b>	Integrated Homestead Farming
<b>KII</b>	Key Informant Interviews
<b>LISAP</b>	Livingstonia Synod AIDS Program
<b>LOP</b>	Life of Project
<b>MAICC</b>	Mponela AIDS Information and Counselling Centre
<b>MDHS</b>	Malawi Demographic and Health Survey
<b>MEAL</b>	Monitoring, Evaluation, Accountability and Learning
<b>MICS</b>	Multiple Indicator Cluster Survey
<b>MoAIWD</b>	Ministry of Agriculture Irrigation and Water Development
<b>MUAC</b>	Mid Upper Arm Circumference
<b>MVAC</b>	Malawi Vulnerability Assessment Committee
<b>NECS</b>	Nutrition Education and Communication Strategy

<b>NGO</b>	Non-Governmental Organization
<b>PPS</b>	Probability Proportionate to Size Sampling
<b>SEP</b>	Social Economic Plan
<b>SMART</b>	Standardised Monitoring and Assessment of Relief and Transitions
<b>STAR</b>	Societies Tackling AIDS through Rights
<b>SUN</b>	Scaling Up Nutrition
<b>TA</b>	Traditional Authority
<b>TFD</b>	Theatre for Development
<b>ToT</b>	Trainers of Trainers
<b>UNICEF</b>	United Nations Children’s Fund
<b>USAID</b>	United States Agency for International Development
<b>VDCs</b>	Village Development Committees
<b>VHCs</b>	Village Health Committees
<b>VNCCs</b>	Village Nutrition Coordinating Committees
<b>WAZ</b>	Weight-for-Age
<b>WFP</b>	World Food Programme
<b>WHO</b>	World Health Organization
<b>WHZ</b>	Weight-for-Height

# EXECUTIVE SUMMARY

This report summarizes the results of a three-year EU-funded Scaling Up Nutrition (SUN) project implemented by Oxfam and Catholic Health Commission (CHC) from December 2016 to January 2020 (Cooperative Agreement Number FED/2016/378-966). The SUN project aimed at contributing towards improved nutritional status of 26,000 rural households in 49 communities from 6 Traditional Authorities (TAs) in Lilongwe, Salima, Nkhotakota and Dowa districts of central Malawi. The project planned to achieve this by enhancing the capacity of Civil Society Organisations (CSOs), district level staff and communities in nutrition, health and agriculture.

The main anticipated outcomes were:

1. Enhanced understanding and management capacity of government, district level structures and CSOs on household nutrition and other nutritional issues related to agriculture and SUN.
2. Improved coordination and networking among SUN implementing stakeholders.
3. Enhanced community members' understanding of nutrition and the relationship between agricultural production and the Malawi six food groups in line with the Essential Nutrition Actions (ENA) and Nutrition Education and Communication Strategy (NECS) of the SUN initiative.
4. Improved regulatory framework on food security and nutrition.

The evaluation took place in March 2020 and elicited responses from 520 households, 26 key persons and 8 groups of interest at community level. The household survey also measured 515 children 6-59 months of age to assess their



One of the Care Groups having a meetings

Photo: Eldson Chagara/  
Oxfam



nutrition status. Enumerators were trained in Lilongwe for three days. A pre-testing exercise was carried out in Group Village Headman (GVH) Chauwa of TA Mkukula in Dowa before the actual data collection. A cross-sectional baseline survey carried out in June 2017 and a mid-term evaluation in January 2019, involving samples of 711 and 385 households respectively, also assessed nutritional status and underlying causal factors in the same communities.

Analysis of anthropometric data from the evaluation show that the SUN project has achieved its goal of improving nutritional status of rural households in the targeted districts. For example, stunting (<-2 HAZ z-scores) has reduced from 39.4% at baseline to 35% (midterm) and finally 34.2%. This figure is 2.9% lower than the national rate estimated at 37.1% by the Malawi Demographic and Health Survey (MDHS) of 2015/2016. The evaluation also found that underweight has declined from 11.6% (baseline) to 10.1% and 9.7%, with the majority of children being moderately affected (8.0%), while wasting has decreased from 4.7% to 2.5% and 1.8% at midterm and end of project respectively. Marasmus, kwashiorkor and oedema, which are severe forms of acute undernutrition, have dropped down hugely to 0.4% from 18% at baseline. At the national level, wasting remained at around 5% from 5.4% in 1992 to 5% in 2004, a period of 12 years, and only declined to 3.6% in 2010 and 2.7% in 2015/2016.

Several factors worked very well in the project and contributed to the gains registered. Interviews with mothers and caregivers of young children under five years of age contributed the gains mainly to the high uptake and practice of key nutrition and health behaviours promoted by care groups. The evaluation found that the proportion of children 6-23 months of age consuming 4 of the recommended 6 Malawi food groups, considered as high dietary diversity, almost doubled to 43.4% from 22.7% at baseline. One third (33.5%) of the children had minimum acceptable diets. This figure is 4.5 times higher than that of the nation at 7.5% as reported by the MDHS of 2015/2016.

All children 0-23 months were breastfed at some time in the project districts and 92%, compared to 76% by the MDHS (2015/2016), initiated breastfeeding within an hour of children's birth. More than three quarters of the mothers (77.3%) breastfed infants 0-5 months exclusively and 91.7% of them continued to breastfeed children at 2 years of age. In addition, 89.9% of the mothers, compared to 84.7% for the country (MDHS, 2015/2016), introduced complementary feeding timely when infants were 6-8 months of age. Improvements registered are a good indication that women understand the benefits of appropriate IYCF in the child growth and development in the project area.

Food consumption based on the 24 hour dietary recall shows that 57.9% of the households had well diversified diets and met the minimum level of dietary energy consumption compared to 32.7% at baseline. The improvement in diets is huge because the evaluation, unlike the baseline, was conducted during the pre-

harvest period. Foods consumed most were cereals, in particular stiff maize porridge locally known as nsima, which households were eating with a variety of dark green leafy vegetables and other indigenous vegetables and fresh beans as relish. Other foods consumed commonly between meals were boiled and roasted fresh maize, pumpkins and fruits that were in season, mainly guavas, cucumbers and bananas. A review of project documents shows that a total of 6,964 households established backyard gardens, 7,916 households were rearing small livestock, and 8,741 had planted grafted fruit trees, which were contributing to food security.

Using core Water, Sanitation and Hygiene (WASH) indicators by the WHO and UNICEF Joint Monitoring Program (JMP), the evaluation found more improvements in the area of WASH. A total of 91.6% of households have access to safe water for drinking compared to 87.2% for the country (MDHS, 2015/16). Care groups promoted the use of safe water for drinking drawn from improved sources such as taps, boreholes as well as protected dug wells and springs. A total of 94.2% had toilets, 92.3% disposed children's stools properly into the toilets and 62.5% constructed tippy taps for hand washing. The percentage of children under five years of age who had diarrhoea in the 2 weeks before the survey, following improvements in WASH, was 16.2% compared to 22% registered by the MDHS (2015/16). Ninety four percent (94%) of the population has toilets and 85.5% dispose child's faeces safely in Malawi (MDHS, 2015/2016).

Desk review further indicated that by end of January 2020, the project benefited 27, 119 households ( 22,385 had under 5 children, 17 556 had lactating mothers and 4,734 households had pregnant women) against a target of 143,000 people and 26,000 households (16000 HH with U/5 children, 10000 pregnant / lactating mothers) across the 4 targeted districts.

Key persons interviewed corroborated that the SUN project was relevant and implemented in an efficient and sustainable manner. From the very beginning, the project selected remotest areas of the targeted districts, where the need for humanitarian assistance was greatest. Few NGOs were working there before, but without specific emphasis on nutrition and social behaviour change. The project valued good coordination, cooperation and communication with various stakeholders, evidenced by joint implementation, reviews and monitoring of activities. It worked very well with all partners to avoid duplication of activities that could result in wastage of resources. As an example, OXFAM, CHC and FAO (Afikepo) were working with the same care groups and in Salima the project produced two counselling cards for complementary feeding and exclusive breastfeeding, while FAO developed counselling cards for six food groups and sanitation and hygiene. Oxfam and CHC provided seeds and seedlings to households for backyard gardens. FAO distributed seeds and seedlings to villages

for demonstration plots where cluster leaders and communities were learning about agriculture and how to construct and take care of backyard gardens.

The evaluation found that the District Nutrition Coordinating Committees (DNCCs), frontline workers and community volunteers were still implementing SUN activities after the project had already ended. This demonstrated the interest and commitment that the local structures have in continuing to support project beneficiaries. Other evidences and indicators of sustainability according to key persons and groups at district and community levels are: 1) the institutionalisation of activities in the daily routine work of government frontline workers, 2) the presence of CSOs and community volunteers already trained by the project, 3) continuation of care group work since the model is embedded in the government structures, 4) reductions in child undernutrition, morbidity and mortality perceived that motivate beneficiaries to continue participating in care groups and project activities 5) copying of positive behaviours by neighbouring villages not targeted by the project. This means that some communities already started doing SUN activities without relying on any support.

At the community level, continuation of the SUN project activities is guaranteed because most of them are simple, community driven and low-cost. Interviews with cluster leaders and women showed that care groups, backyard gardens, cooking demonstrations, appropriate infant and young child feeding using local foodstuffs, growth monitoring and construction of tippy taps are examples of simple activities that communities are already doing with little investment and can easily sustain them. The future looks promising and is contingent upon all key actors continuing to play their roles in a synergistic manner and addressing challenges in the implementation process.



Lusiyi from Lilongwe Rural picking vegetables from her backyard garden

Photo: Aurelie Marrier d'Unieville/Oxfam

Major challenges that affected performance of this project are delays in the disbursement of funds due to internal processing procedures by Oxfam and CHC, work overload and pressure on resources after adopting the harmonised care group model and extending intervention areas, mobility problems and volunteer dropouts due to higher expectation for incentives. Additional challenges were dependency syndrome on the part of beneficiaries, low participation by men in care groups, weak resilience, literacy and economic empowerment components of the care group model and, as a consequence, inability by a large majority of adolescent mothers and ultra-poor households to diversify diets for children based on the Malawi six food group guide. While 91.6% of the households had access to safe water for drinking, the general sanitation and hygiene were relatively poor at times, evidenced by an outbreak of cholera in Lilongwe and Salima during the project lifespan. If remain unaddressed, these challenges have a high potential of reversing the gains already made.

One key lesson learned is that beneficiaries have the capacity to change for the better using own resources once they have been empowered with knowledge and skills to lead in the whole process. Another lesson that follows from the first one is that government and community structures should be involved in all the stages of development projects to make meaningful and lasting change in the lives of poor people. Thirdly, this project has shown that flexibility, responsive and collective investment to address problems and emerging issues affecting the targeted population are key to success.

In summary, the SUN project was a success looking at the impact made. However, its three-year lifespan was short to change people's long-standing behaviours, beliefs and habits completely. The general recommendation is that Oxfam and CHC should mobilize additional funds to implement another 3 or 4-year project targeting the same areas and beneficiaries to deepen and consolidate the impact.

The evaluation also recommends review of the care group model to improve its efficiency and make it more appropriate for rural communities. Another recommendation is that the District Councils, DNCCs and CSOs trained by the project should continue to mobilize resources for implementation of various activities. To improve diets for children, there is need to scale up implementation of integrated homestead farming (IHF) that includes production of small livestock, irrigation farming to complement yields from rain-fed agriculture, Village Savings and Loans (VSLs), cooking demonstrations and food processing and preservation to minimize post-harvest losses of the already produced food. The report concludes by suggesting that the remaining local structures and government frontline workers should continue with training, refreshing and incentivizing care group and other community volunteers on a regular basis to keep them motivated since they work on voluntary basis.

# 1.0 INTRODUCTION

Oxfam and Catholic Health Commission (CHC) implemented a three-year project on enhancing the capacity of Civil Society Organisations (CSOs), district-level staff and communities on the Scaling Up Nutrition (SUN) initiative in Malawi. The goal was to contribute towards improved nutritional status of rural households in Lilongwe, Salima, Nkhotakota and Dowa districts.

The European Union (EU) funded the project, from December 2016 to January 2020, under the second phase of the Farm Income Diversification Programme (FIDP II) – Cooperative Agreement Number FED/2016/378-966.

The main outcomes of the project were:

1. Enhanced understanding and management capacity of government, district level structures and CSOs on household nutrition and other nutritional issues related to agriculture and SUN.
2. Improved coordination and networking among SUN implementing stakeholders.
3. Enhanced community members' understanding of nutrition and the relationship between agricultural production and the Malawi six food groups in line with the Essential Nutrition Actions (ENA) and Nutrition Education and Communication Strategy (NECS) of SUN.
4. Improved regulatory framework on food security and nutrition.

The project used the care group model to deliver key messages about nutrition, agriculture, health and hygiene to the targeted communities. In line with the government's SUN NECS, key partners in the implementation of care groups were District Nutrition Coordinating Committees (DNCCs), Area Nutrition Coordinating Committees (ANCCs), Village Nutrition Coordinating Committees (VNCCs), government frontline workers, CSOs, lead farmers, Village Health Committees (VHCs), promoters and lead parents (cluster leaders). Care Groups worked hand in hand with community platforms such as Societies Tackling AIDS through Rights (STAR) Circles and Theatre for Development (TFD) to widen coverage of messages.

The SUN project expanded the intervention area in the second year after adopting the harmonized care group model promoted by the government. It included all the 49 Group Village Headman (GVH) areas in the six Traditional Authorities (TAs) available in the targeted districts instead of 12 GVHs as initially planned. Administratively, every district in Malawi is divided into TAs, which are further sub-divided into GVHs and then villages as the smallest administrative unit.

**Table 1 shows primary beneficiaries that the project planned to work with before the extension.**

**Table 1: A summary of planned primary beneficiaries for the SUN project**

26,000 households (6,500 per district): 16,000 households with children under five years of age 10,000 households with lactating and pregnant women
4 District Nutrition Coordinating Committees (DNCCs)
4 District Nutrition Officers
8 Area Development Committees and Village Development Committees
206 Government frontline workers (Health Surveillance Assistants)
16 Extension Workers
113 Community Nutrition Promoters
2,481 Lead Parents or Cluster Leaders
8 Health Centres
160 STAR Circles and
8 TFD Groups

## 1.2 Purpose of the Evaluation

The main purpose of this evaluation was to assess the relevance, impact, effectiveness, efficiency and sustainability of the SUN project and how these together have helped to improve the nutritional status of rural households in the targeted districts.

### Specific Objectives

1. Establish if the project was effective, efficient and relevant to the needs of the people it served as well as government priorities for development.
2. Establish if the project has positively impacted on targeted communities in line with its goal, the four expected outcomes, including assessing the degree of satisfaction by the key stakeholders and beneficiaries, and the extent to which activities have been implemented with sufficient quantity, quality and timeliness.
3. Identify key lessons learned as well as project challenges during the implementation process, and those related to the use of care groups.
4. Assess the level of community and other stakeholders' participation, ownership of the implementation process, and sustainability of the interventions and the behavioural practices.
5. Identify any unintended outcomes registered.
6. Assess internal and external factors that have positively or negatively influenced the project, including enabling factors for sustainability of the behavioural practices
7. Based on the findings, draw targeted and actionable recommendations for future programming. **Annex 1** presents quantitative results obtained.

## 2.0 EVALUATION DESIGN AND METHODOLOGY

The evaluation used mixed methods and the DAC criteria to assess the relevance, impact, effectiveness, efficiency and sustainability of behavioural practices in the SUN project areas. Quantitative data were collected from a survey of 520 beneficiary households selected at random from 112 villages in all the four districts and anthropometric measurements of 515 children 6-59 months of age. Qualitative data were obtained from discussions with 26 key persons, and 8 groups of interest at community level (**Annex 2**).

The evaluation adapted the English-Chichewa back-translated household survey questionnaire used at baseline to make comparisons and tracking of changes from project inception to conclusion easy. The questionnaire was uploaded into Open Data Kit (ODK) to minimize errors during data collection. A three-day training of the enumerators took place in Lilongwe. The training dwelled on the administration of electronic questionnaires, basic interviewing techniques, the evaluation design and methodology, work performance expected, roles and responsibilities, anthropometric measurements and ethics in data collection. A pre-testing exercise was carried out on Monday, 9 March 2020, in GVH Chauwa of TA Mkukula in Dowa. The actual data collection was conducted in 7 days from 10-17 March 2020 (**Table 2**). Supervision in the field involved ensuring that the survey methodology was followed closely, ensuring that anthropometric measurements were taken correctly as well as organising evening wrap-up sessions to discuss any problems encountered and observations made.

**Table 2: Number of households surveyed in each TA and district**

District	TA	Targeted Households	Sample Size
Lilongwe	Chitekwele	5655	138
Dowa	Mkukula	5874	154
Salima	Kambalame	1890	50
	Kambwiri	4285	100
Nkhotakota	Malengachazi	1098	24
	Mwadzama	2148	54
Total		20,950	520

Electronic data from the household survey were exported, cleaned and analysed in SPSS (Version 21, IBM Corp. IBM SPSS Statistics for Windows, Armonk, NY: IBM Corp. Released 2016). Child anthropometric data were analysed in ENA for SMART. The quality of anthropometric data was very good based on the plausibility checks performed. Conversely, the evaluation analysed the qualitative data by verifying the information collected, compiling and summarising it and identifying key findings to contextualize the quantitative findings.

To remain ethical in the whole process, Oxfam oriented the evaluation team on the Child Protection and Safeguarding policy as part of the training. Each member of

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the team signed and observed the do no-harm principle during field work. Enumerators obtained consent and informed respondents that participation was voluntary, highlighting on people's rights to refuse, skip questions they did not want to answer or discontinue interviews at any time.

One key limitation faced was the inability to find field project staff on the ground after their contracts had already been terminated. Another constraint was the failure to meet all key stakeholders for interviews given the short period scheduled for field work. Some questionnaires sent by email to allow the stakeholders fill during their own time, were not returned even after making several reminders arguably due to busy schedules. The evaluation also faced problems typical of the rainy season in Malawi. Rural roads became muddy and respondents were busy with farm activities and not always available for interviews as planned, which was delaying the data collection exercise.



## 3.0 KEY FINDINGS

### 3.1 Relevance of the SUN Project

This evaluation found that the SUN project was relevant in the context of Malawi because it was implemented in the remotest areas of the targeted districts, where the need for humanitarian assistance was greatest. Few NGOs were working there before, but without specific emphasis on nutrition and social behaviour change.

Nevertheless, the needs assessment and baseline study conducted in the districts showed that several maternal practices needed improvements such as premature introduction of food to children below 6 months of age, meaning failure to practice exclusive breastfeeding; giving children water with herbs as required by culture; provision of watery porridge to infants; inadequate frequency of feeding; lack of food diversity characterized by low provision of foods from animal sources, vegetables, fruit, legumes, nuts and fats; and frequent child and maternal illnesses. For example, less than one third of the children (32.1%) had diversified diets in the past 24 hours to the baseline study and 18% suffered from multiple illnesses in the past two weeks. As a consequence, the targeted districts had one of the highest rates of stunting that fell above the national prevalence (37.1%), ranging from 37.3% in Lilongwe, 37.4% Nkhotakota, 37.9% Salima and 42.4% in Dowa.

A gender and power analysis study that the project conducted from October to November 2017 revealed that nutritional problems were compounded by gender inequalities and imbalances at household and community levels. Gender-based violence (GBV) was reported and related to heavy workload, physical and psychological abuse and disparities in intra-household food distribution in times of scarcity. Women, girls and young children were the most affected.

Oxfam and CHC designed the SUN project to prevent the situation from deteriorating. The targeting criteria involved the communities themselves taking a leading role in identifying the most vulnerable households to benefit from the project. Each household with a child under five years of age and pregnant or lactating woman was considered eligible and included. Communities realised the need to address undernutrition and welcomed the SUN project because it appeared responsive to the situation at hand. Care groups reached out to the targeted communities with life-saving information about nutrition, health and agriculture. Knowledge and skills acquired have resulted in a high uptake of simple positive behaviours by mothers and caregivers of children under five years of age that has in turn led to reductions in undernutrition.

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Our district was chosen because it had high rates of child undernutrition. Now the prevalence has reduced as a result of the various nutrition interventions the project [SUN] has implemented. Most of the cases of admission at the district hospital were of children with severe acute malnutrition, but now the situation has changed for the better—Yolamu Sefasi, a Health Surveillance Assistant (HSA) at Nkhotakota District Health Office (DHO) acknowledged that,

Interviews with mothers, caregivers of young children and communities showed that many of them feel that their situation has changed.

The project came at the right time when people needed it most to address child malnutrition. A high uptake of positive infant and young child feeding (IYCF) behaviours have helped to reduce the problem. In the past, we thought nutritious foods are the ones purchased from the market and had no knowledge on how to prepare and utilize our own local foods well to make them nutritious and suitable for children.” - Enelesi Uzi, a care group promoter from TA Kambwiri in Salima appreciated that

Various key persons corroborated that the SUN project has built the capacity and improved networking of nutrition stakeholders as required by the National Multi-sector Nutrition Policy (2018-2022) and Nutrition Education and Communication Strategy (NECS) of 2012-2017. By improving the nutritional status of rural people in the targeted districts, the project has also provided synergy to the newly launched Malawi Growth and Development Strategy (MGDS) III (2017-2022) and the global Sustainable Development Goals (SDGs), in particular goals number 1 (no poverty), 2 (zero hunger) and 3 (good health and well-being), 5 (gender equality) and 10 (reduced inequalities).

## 3.2 Impact of the Project

### 3.2.1 Project Goal: To improve nutritional status of rural households

#### 3.2.1.1 Prevalence of Stunting in Children

Analysis of anthropometric data obtained shows that the SUN project has achieved its goal of contributing towards improved nutritional status of rural households in the country. For example, stunting (<-2 HAZ z-scores) has reduced to 34.2% (30.2-38.4 95% CI), 25.3% moderate and 8.8% severe, from 39.4% (33.6-45.5 95% C.I.) found at baseline in June 2017 (**Table 3**).

The contribution of the project is seen when the results are compared to the national trends of child undernutrition. To illustrate, for the first time according to the results from the Malawi Demographic and Health Survey (MDHS) of 2015/2016 stunting declined from 47.1% in 2010 to 37.1% in 2015, a drop of 10 percentage points in a period of five years after the country adopted the SUN movement. Otherwise, stunting persisted at around 48% for years - from 48.7% in

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1992 to 49% in 2000 and then 47.8% in 2004. By implication, the country has reduced stunting only by 11.6 percentage points from 1992 to 2015. **Table 3** shows that the SUN project has reduced stunting by 5.2 percentage drop points only in a period of three years.

**Table 3: Stunting rates among children under five years of age in the project districts**

District	Situation at the onset			Results	Achievement	
	Baseline (%)	Project Target (28%)	Variation (Baseline -Target)		End of Project (EOP)	Variation (Baseline -EOP)
Lilongwe	37.3	26.9	10.4	37.6	-0.3	-0.8
Dowa	42.4	30.5	11.9	41.0	1.4	3.3
Salima	37.9	27.3	10.6	27.1	10.8	28.5
Nkhotakota	37.4	26.9	10.5	28.9	8.5	22.7
Total	39.4	28.4	11.0	34.2	5.2	13.2

By reducing stunting with 5.2 percentage drop points, the SUN project has achieved a 13.2 of the 28 percent reduction target it planned at the onset (**Table 3**). Stunting is difficult to reverse once a child reaches the age of 2 years. Failure to meet the 28% target simply means that the project grappled to rehabilitate the problem in children it found already stunted and were closer or older than two years. When it closed, some of these children were still below 5 years and were found stunted in this evaluation.

Stunting affected boys (33.2%) and girls (35.2%) equally in the targeted districts. However, it increased with age and was a problem mainly in the age group of 24-59 months at 37.7 % (32.0-43.7 95% CI) compared to 29.8% (24.3-36.1 95% CI) for the 6-23 months counterparts. These results were expected because SUN concentrates on the first 1000 days and by implication most of the children that the evaluation measured in the 24-59 months age group were born before the project started. It became difficult therefore to reverse stunting that had already occurred.

<sup>1</sup>**Note:** The second column in the table presents the baseline situation in each district. The third column shows the prevalence that the project expected to achieve in three years after reducing stunting by 28 percent. The fourth column gives percentage drop points between baseline values and targets set. Column number five contains the results from this evaluation, which have been subtracted from baseline values in column two to find percentage drop points that the project has actually achieved (column six). The last column shows the percentage that the project has achieved out of the 28 percent it planned at the beginning. All tables constructed like this in the report have similar interpretation.

## KEY FINDINGS

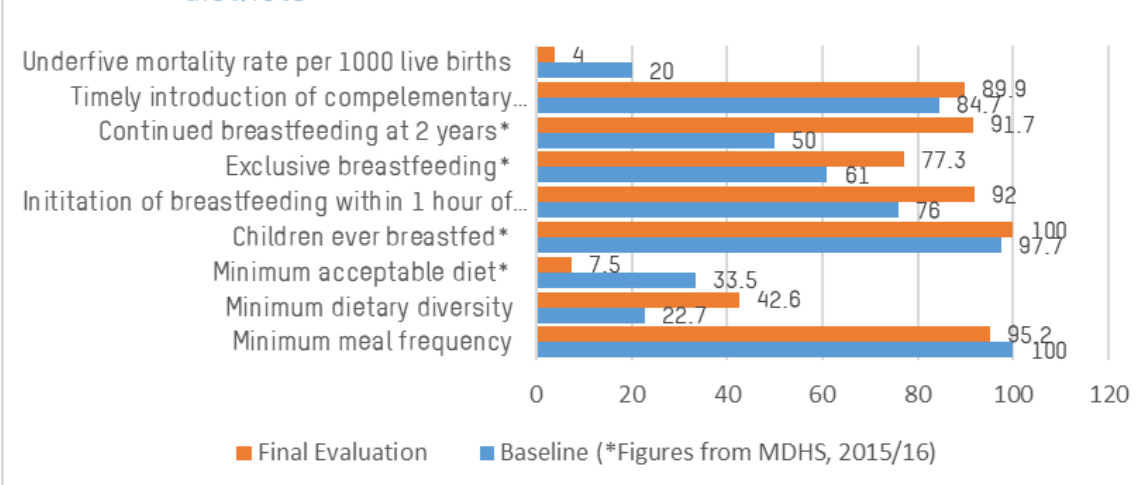
For children under five years of age, the World Health Organisation (WHO) sets a low prevalence of stunting at <20%, while 20-29% indicates medium, 30- 39% high and >40% very high prevalence.

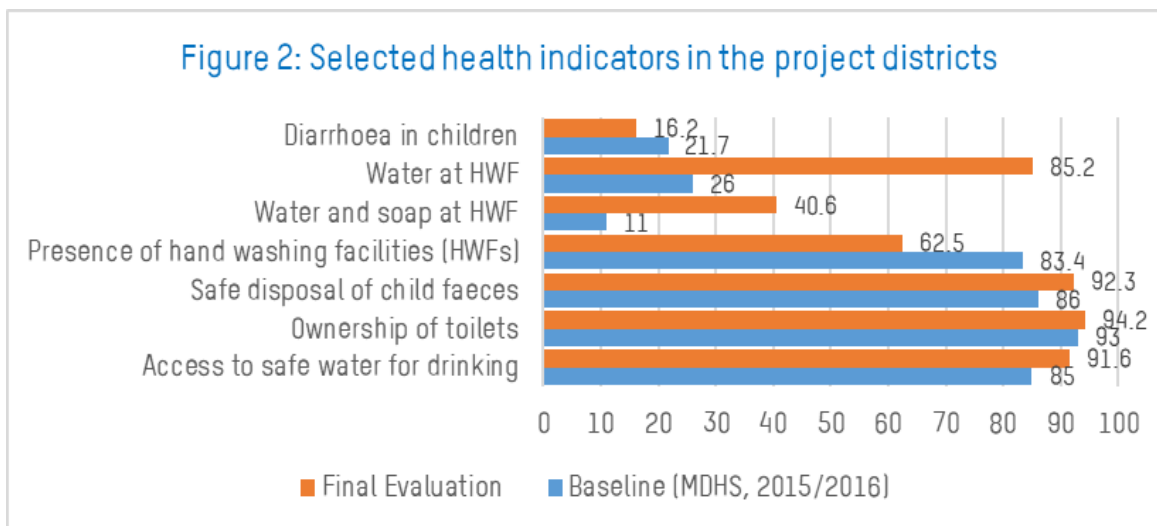
The SUN project has made huge strides in Salima and Nkhotakota where it has left medium rates of stunting that are getting closer to becoming acceptable. The project has exceeded the 28% target in Salima and nearly met it in Nkhotakota (**Table 3**). Malengachazi in Nkhotakota is one outstanding community that has reached acceptable levels of stunting at 11.1%. Chagunda (21.6%) and Suzi (29%) in Salima also showed satisfactory results. Several factors worked very well in these communities and contributed to these gains. **Figures 1 and 2** compares nutrition and health practices at baseline and final evaluation of the project to showcase the progress made.

The evaluation found that stunting has remained unacceptably high in Dowa and Lilongwe. The project already found a very high prevalence, particularly in Dowa at 42.4% as already stated and consequently struggled to reduce it. Key activities that worked well in the other districts lagged behind in these districts due to several factors. For example, descriptive analysis of the evaluation data showed that Dowa led in the proportion of children who were not exclusively breastfed (53.8%), had poor diets composed of only 1 to three food groups (50.8%) and suffered from fever (49.4%), coughs (50%) and loss of appetite (13.6%) in the past two weeks to the household survey. A total of 11.7% of the households in the district had no toilets and 43.6% did not have hand washing facilities to use after visiting the toilet.

The topography in the district is a combination of mountainous and flat areas that limit land availability for agriculture. The roads are poor and largely inaccessible, which does not only limit access to markets, health centres and other social amenities, but also hinder supervisory visits by project staff as most of the areas are hard to reach.

**Figure 1: IYCF practices by the mothers in the project districts**





Like in Dowa, the main causes of child undernutrition in Lilongwe were inappropriate infant and young child feeding (IYCF) practices, poor diets and illnesses due to poor water, sanitation and hygiene (WASH). The evaluation found that 16.7% of the children 0-6 months were not exclusively breastfed, 47.7% of children 6-23 months had undiversified diets in the past 24 hours, 30.4% and 13% of children 0-59 months suffered from fever and diarrhoea in the past two weeks respectively, and some of them were from households without access to safe water for drinking (11.6%) and facilities for washing hands after visiting the toilet (40.8%).

### 3.2.1.2 Levels of Child Underweight in the Project Areas

The WHO classification of underweight is: <10%, low; 10-19%, medium; 20-29%, high; and >30%, very high prevalence.

**Table 4** shows that the SUN project reduced child underweight from 11.6% at baseline (8.0-16.6 95% C.I.) to 9.7% (7.4-12.6 95% CI), with the majority of children being moderately affected (8.0%, 5.9-10.6 95% CI). Rates of underweight in the targeted TAs were as follows: Kambwiri (Salima) 7.1%, Chitekwele (Lilongwe) 9.4%, Mkukula (Dowa) 11.4% and Mwadzama and Malengachazi in Nkhotakota 11.8%.

District and community structures that the project has left should accelerate the gains registered and put extra efforts in Dowa and Nkhotakota. Routine growth monitoring and promotion (GMP) can help frontline workers continuing with the project activities to detect growth faltering in children on time and counsel mothers on appropriate feeding and care of young children.

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**Table 4: Underweight prevalence in the project areas (%)**

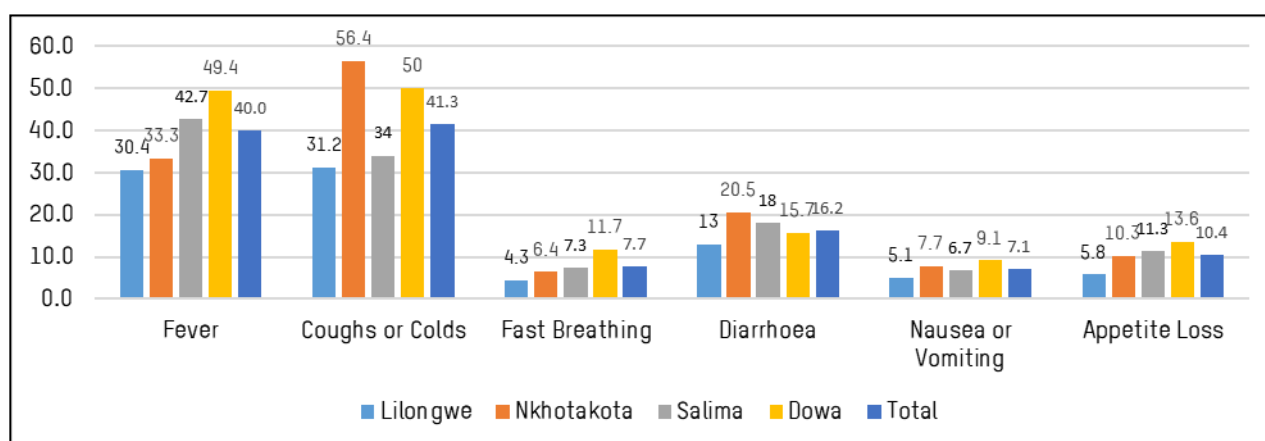
District	Baseline (%)	End of Project (EOP)	Variation (Baseline-EOP)
Lilongwe	11.3	9.4	1.9
Dowa	6.6	11.4	-4.8
Salima	12.2	7.1	5.1
Nkhotakota	16.8	11.8	5.0
Total	11.6	9.7	1.9

Our health centre is far from here. People take an hour or so to get there and it becomes very difficult when one is sick or pregnant. Many mothers simply buy panadol or aspirin from grocery stores for malaria because they cannot afford to seek treatment from the available health centres. Mosquitoes bit not only when one is sleeping, but at any time during the night when you are waiting for food and chatting outside before going to bed, - Erick Kachikoti, HSA, Mkukula, Dowa.

For Lilongwe rural, the main causes of child undernutrition are lack of food and poor diets due to poverty since the project targeted ultra-poor households. People have knowledge, but are unable to meet the six food groups due to food shortages. The project addressed the problem by promoting village savings and loan (VSL) groups, backyard gardens and rearing of small livestock, but more positive results are yet to be seen—Maggie Musukwa, CSO member trained by the project in Lilongwe.

Illnesses in the past two weeks preceding the evaluation affected children's weight. Main illnesses that children suffered from are presented in **Figure 3**. Dowa, Nkhotakota and Salima were the most affected. Long walking distances to health centres were a major barrier to health seeking behaviours by mothers for the sick children based on the interviews with HSAs.

**Figure 3: Proportion of children with illnesses in the past two weeks before the study**



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**Table 5** shows that only 1.8% (0.9- 3.3 95% CI) of the children were wasted (<-2 weight-for-height z-score). This finding means an improvement from the baseline when the prevalence was two and half times as much e.g. 4.7% (2.4 - 9.1 95% CI). The WHO thresholds for wasting are: <5% acceptable, 5-9% poor, 10-14% serious and 15% or more critical.

**//** Apart from HSAs screening children for undernutrition during monthly growth monitoring sessions, care group volunteers were doing active case finding using mid-upper arm circumference (MUAC) tapes when they visited households and referring undernourished children to health centres for further diagnosis and assistance. This approach worked very well and cured cases of acute malnutrition on time before they became complicated to manage - Maggie Musukwa. Lilongwe.

No cases of wasting were found in Chagunda, Malapa and Suzi communities in Salima, Malengachazi in Nkhotakota, Masinje in Lilongwe and Keliyasi and Mgwedula in Dowa. The elimination of wasting means that the project has reduced the numbers of children suffering from multiple forms of undernutrition as well as morbidity and mortality in the targeted districts.

Wasting or acute malnutrition reflects the current nutritional deficit. It is usually a result of recent food shortages, poor nutritional and diet practices and current illnesses that result in rapid loss of weight and body tissues. At the national level, wasting remained at around 5% from 5.4% in 1992 to 5% in 2004, a period of 12 years, and only declined to 3.6% in 2010 and 2.7% in 2015/2016.

**Table 5: Wasting among children under five years of age (%)**

District	Baseline (%)	Evaluation (EOP)	Variation (Baseline-EOP)
Lilongwe	3.8	2.6	1.2
Dowa	1.7	2.5	-0.8
Salima	2.1	0.6	1.5
Nkhotakota	12.0	1.3	10.7
Total	4.7	1.8	2.9

### 3.2.2 Population below the minimum level of dietary energy consumption

Like at baseline and midterm evaluation, determination of dietary energy consumption was based on the Household Dietary Diversity Score (HDDS)<sup>2</sup> and the Malawi six food groups guide. According to this guide, a Malawian adult needs to consume approximately 2,100 kilocalories daily consisting of 38 percent starchy

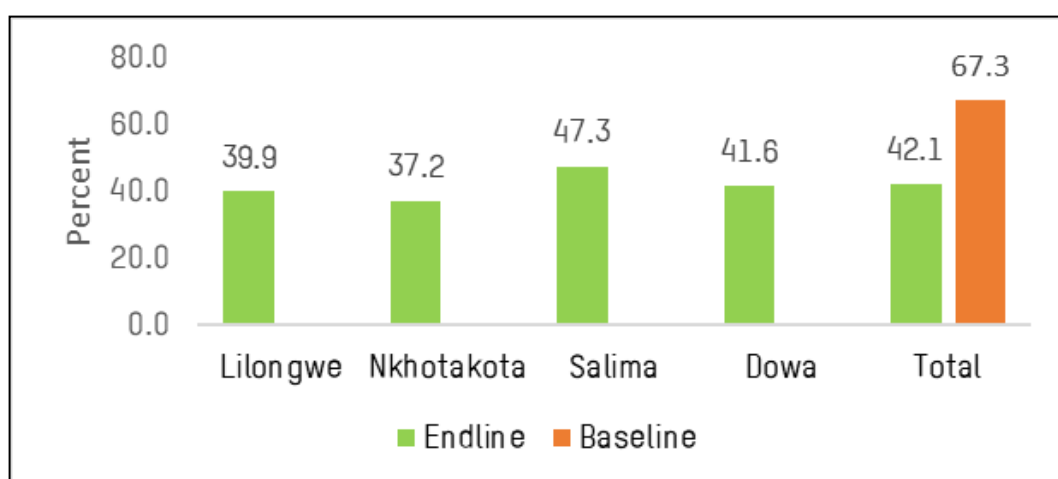
<sup>2</sup>To assess HDDS, respondents were asked to remember and mention all the foods that their households consumed on the day preceding the survey. The Malawi six food groups were used in this regard, namely staples and cereals, animal foods, legumes and nuts, fats and oils, vegetables and fruits.

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staples, 35 percent legumes and nuts, 13 percent fats and oils, 6 percent fruits, 4 percent non-starchy vegetables and 4 percent animal foods.

Diets improved over the three-year life span of the SUN project. Food consumption based on the 24 hour dietary recall shows that 57.9% of the households had well diversified diets and met the minimum level of dietary energy consumption compared to 32.7% at baseline. The improvement in diets is huge because the evaluation was conducted during the pre-harvest period unlike the baseline carried out in June 2017 after households had already harvested. Foods consumed most were cereals, in particular stiff maize porridge locally known as nsima, which households were eating with a variety of dark green leafy vegetables and other indigenous vegetables and fresh beans as relish. Other foods consumed commonly between meals were boiled and roasted fresh maize, pumpkins and fruits that were in season, mainly guavas, cucumbers and bananas. A review of project documents showed that a total of 6,964 households established backyard gardens, 7,916 households were rearing small livestock, and 8,741 had planted grafted fruit trees, which were contributing to food security. The population below the minimum level of dietary energy consumption was therefore 42.1% compared to 67.3% at baseline (Figure 4). Table 6 shows that the number of meals consumed by adults and children 6-23 months of age continued to increase over the project life.

**Figure 4: Households below the minimum level of dietary energy consumption (%)**



**Table 6: Number of meals taken by adults and children a day before the study**

Number of meals	Adults		Children 6-23 months	
	Baseline (%)	EOP (%)	Baseline (%)	EOP (%)
One	12.3%	1%	0.0%	4.8%
Two	61%	18%	0.0%	14.0%
Three	26.1%	23%	97.6%	24.2%
More than three	3%	58%	2.4%	57.0%



### 3.2.3 Reduction in malnutrition levels by EOP Target Value 001

The baseline survey reported that the percentage of children suffering from multiple forms of malnutrition in the targeted districts was 18.6% on average. Through various interventions implemented, the SUN project reduced this figure to 15.2% and made an achievement of 18.1% over the 15% target it proposed at the onset (**Table 7**). Stunting and underweight were the forms of malnutrition that most likely occurred together in children.

**Table 7: Children suffering from multiple forms of malnutrition in the project areas**

Indicator	Baseline (%)	Project Target (15% reduction)	Variation (Baseline-Target)	EOP Results	Variation (Baseline -EOP)	% of the 15% Target
Wasting	4.7	4.0	0.7	1.8	2.9	62.1
Underweight	11.6	9.9	1.7	9.7	1.9	16.8
Stunting	39.4	33.5	5.9	34.2	5.2	13.2
Total	55.7	47.4	8.3	45.7	10.0	18.1
Average	18.57	15.8	2.77	15.23	3.34	18.1

### 3.2.4 Reduction in nutrition-related diseases by EOP Target Value 001: 15% reduction (average score for anaemia, marasmus, kwashiorkor and oedema)

Bilateral oedema is a sign of kwashiorkor, a form of severe acute malnutrition. It is a result of recent (short-term) deficiency of protein, energy together with minerals and vitamins leading to loss of body fat and build-up of fluids, mainly water, in the muscles tissues. Marasmus, on the other hand, is a form of severe malnutrition characterized by energy deficiency.

Severe acute malnutrition (marasmus and kwashiorkor) and anaemia affected 18% of the children at baseline. Interventions implemented by the SUN project improved the situation. Analysis of anthropometric data from the evaluation showed that no cases of oedema and kwashiorkor existed in the targeted areas after the project closed, and only 2 of the 509 children measured (0.4%) were marasmic, extremely thin. Baseline, midterm and final evaluation studies did not assess iron deficiency anaemia because it is expensive as the assessment requires drawing blood samples and measuring blood haemoglobin or haematocrit levels.

### 3.2.5 Targeted communities registering reduction in under 5 mortality

Under 5 mortality rate is calculated as deaths that have occurred in the past 90 days per 1,000 live births. It encompasses neonatal and infant mortality - the

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probability of death in the first year of life. Over the past 3 years between the baseline and endline studies, the under 5 mortality rate reduced five times from 20 to 4 deaths per 1,000 live births. This reduction represents 80 percentage drop points and exceeds the projects target set at 10%. **Table 8** shows that 14, 13 and 2 deaths of children under five were recorded by the baseline, midterm and final evaluation studies with sample sizes of 711, 385 and 520 respectively. The two deaths occurred due to fever and headache. These results help to confirm that the SUN interventions have been more effective in reducing child morbidity and mortality in the project districts.

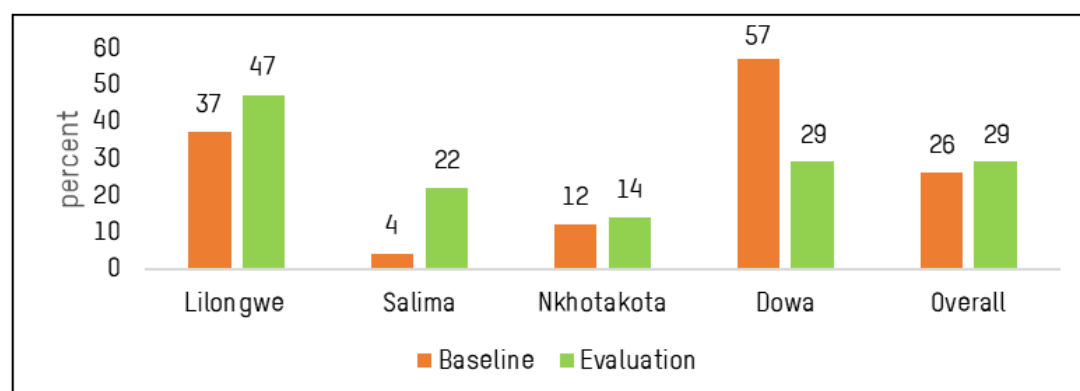
**Table 8: Under five mortality rates in the project districts**

Under five mortality	Baseline	Midterm	Endline
Sample size	711	385	520
Period of assessment (months)	12	12	3
Under five mortality rate per sample (# of deaths)	14	13	2
Under five mortality rate per 1,000 live births	20	34	4

### 3.2.6 Proportion of targeted households producing diverse nutritious foods (including biofortified crops) increased

The evaluation found that the SUN project increased the proportion of households growing at least three types of nutritious crops to 29% from 25.9% at baseline (**Figure 5**). This result was expected because: 1) biofortified crops included in the questionnaires for this indicator are newly introduced and not fully adopted by smallholder farmers and 2) preference of traditional crops that are less nutritious such as white than orange flesh sweet potatoes. Disaggregation of the data obtained by district showed that Lilongwe led (47%) in growing at least three nutritious crops and Nkhotakota was last at 14%, while Dowa was the highest at baseline (57.4%).

**Figure 5: Households growing at least 3 types of nutritious foods**



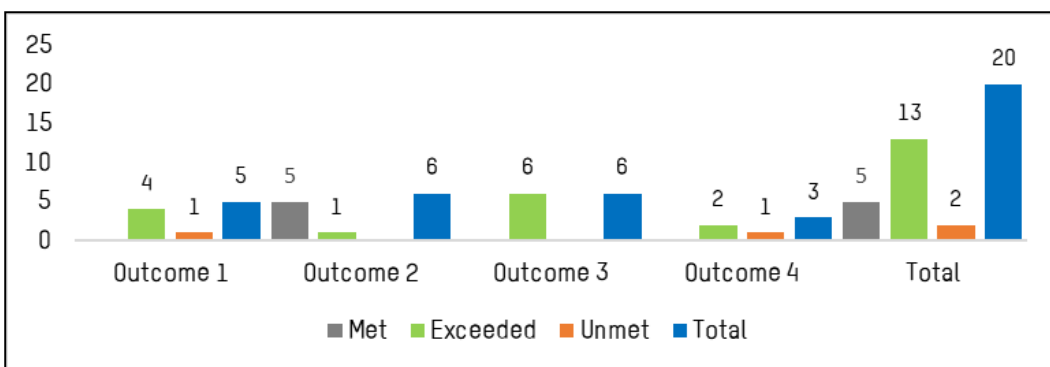
### 3.2.7 Unintended Impacts

One positive and indirect impact achieved unintentionally is that other households which were ineligible to be part of the project adopted some of the interventions like the hygiene practices, integrated homestead farming, using mud stoves and the backyard gardens after seeing how the beneficiary households were benefiting. The other one relates to the adoption of the harmonised care group model that requires 100 percent coverage of the TAs, which in turn increased the impact areas as opposed to the 12 GVHs the project initially planned to target in the six TAs (2 GVHs per TA).

### 3.3 Effectiveness of the SUN Project

The evaluation assessed effectiveness of the SUN project by examining the extent to which its interventions achieved outcome indicators as described in the MEAL framework. The results showed that the project exceeded life of project (LOP) targets in 13 of the 20 indicators, met 5 and was close to reaching the two remaining indicators (Figure 6). The overall achievement for outcome indicators met and exceeded is therefore 90 percent, which represents a high level of performance. The over achievements were due to the extended coverage after the project adopted the harmonized care group model in the second year.

Figure 6: Number of outcome indicators met, exceeded or unmet



#### 3.3.1 Outcome 1: Enhanced understanding and management capacity of government, district level structures and CSOs on household nutrition and other nutritional issues related to agriculture and SUN

The SUN project found very low capacities of extension workers in the nutrition sector in all the targeted districts. Only 5 government staff were trainers of trainers (ToTs) for nutrition and agriculture. Similarly, only 10 frontline workers were providing extension services related to Essential Nutrition Actions (ENAs) and the Nutrition Education and Communication Strategy (NECS). These frontline workers were Health Surveillance

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Assistants (HSAs), Agricultural Extension Development Officers (AEDOs) and Community Development Assistants (CDAs).

A review of routine monitoring reports show that the SUN project has increased numbers government district-level staff, CSOs, frontline workers and lead parents with an understanding and capacities to implement nutrition, agriculture and SUN activities (**Annex 1**). From 2017 to 2018, the project engaged DNHA accredited trainers and trained all the 4 DNCCs, 234 government district level staff (107 males and 127 females) against the target of 206, 1,305 community health promoters from all the CSOs in the districts, 209 frontline workers (HSAs, AEDOs and CDAs) and 6 ANCCs.

Community health promoters that the project trained include 131 care group promoters, 830 lead farmers, 336 growth monitoring volunteers and 8 child protection workers. In turn the promoters, frontline workers and ANCCs cascaded the training to 30 VNCCs, Village Health Committees (VHCs), 20 local leaders and 2,524 care group leaders (lead parents). Interviews with the M&E officer for the project, Tiyezge Zimba Kalima, revealed that the trainings covered the 13 high impact SUN interventions (**see Box 2**), SUN NECS, micronutrient powders, iron folic acid (IFA) supplementation for adolescents, nutrition advocacy, the harmonised care group model, Community-Based Management of Acute Malnutrition (CMAM), Integrated Homestead Farming (IHF) as well as monitoring and evaluation of the SUN activities. With support from the DNHA, the project translated the harmonized care group manual, local recipe leaflets from the Ministry of Agriculture and M&E data collection tools into vernacular Chichewa and used them in the trainings. Self-reports by district-level staff, frontline workers and various community volunteers trained concurred that the trainings have increased their competence and motivation in undertaking different day-to-day roles and duties.

The use of adult methodologies and Information, Education and Communication (IEC) materials in the local language has improved the quality and timeliness of



Tiwonge Enock listening to an explanation on proper breastfeeding

Photo: Aurelie Marrier d'Unieville/Oxfam

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reporting across the districts because promoters and care groups find the revised tools simple and easy to complete. The evaluation found that reports have started to move easily and in a timely manner from communities by cluster leaders to promoters, VNCC, ANCC and DNCC for compilation and final submission to the DNHA for consolidation in the National Multi-sector Nutrition Information System (NMNIS).

At baseline, available literature show that a large majority of stakeholders, including DNCC members, were only not clear on the channels for reporting nutrition data but they were also using old versions of the data collection tools, which was affecting feeding of data into the NMNIS.

### Behaviour Change Interventions

1. Improved women's nutrition and care before, during and after pregnancy
2. Promotion of optimal breastfeeding
3. Promotion of optimal complementary feeding from 6 months
4. Optimal feeding of a sick child during and after illness
5. Improved hygiene (e.g. hand washing)

### Micronutrients and Deworming

1. Prevention and control of Vitamin A deficiency
2. Zinc supplementation for diarrhoea management
3. Multiple micronutrient powders
4. Deworming and prevention and control of malaria
5. Prevention and control of iron deficiency anaemia
6. Prevention and control of iodine deficiency disorders

### Complementary and Therapeutic Feeding Interventions

1. Prevention and treatment of moderate acute undernutrition
2. Treatment of severe acute malnutrition with ready-to-use therapeutic food

## Box 2: The 13 SUN high impact messages

### 3.3.2 Outcome 2: Improved coordination and networking among SUN stakeholders

By January 2020, the SUN project revamped and improved the functionality of DNCCs in all the 4 districts. Meetings to revamp the DNCCs took place in Mponela and Salima and were attended by 138 people, 87 males and 51 females. The meetings oriented the DNCCs on their roles and responsibilities in taking forward the national nutrition agenda. After the orientation, all DNCCs in the targeted districts demonstrate ability to coordinate, implement, supervise, monitor, evaluate and report SUN activities competently. Over its three-year lifespan, the SUN project also conducted a mapping exercise of government agencies, CSOs and other stakeholders working on nutrition. Each district now has an updated directory and database of the SUN stakeholders to coordinate with. The Food and Agriculture Organisation (FAO) and DNCCs provided support for the whole exercise.

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Interviews with DNCC members showed that they now meet every month to consolidate issues before monthly DEC meetings where they share progress reports, lessons, experiences, best practices, challenges and solutions for the future.

Before closure, the project supported 8 DEC and 8 DNCC meetings (2 in each district) that brought together 190 (142 males and 48 females) participants, and conducted joint quarterly review meetings with DNCC members. The first meeting was held in December 2017 at Safari Lodge in Nkhotakota, the second one in June 2018 at the same lodge and the third one in November 2018 at Mbolebole Motel in Dowa.

As a consequence, DNCCs in the targeted districts have gained the necessary capacity and are able to provide technical and backstopping assistance to NGOs, extension workers and beneficiaries through trainings. For example, Nkhotakota successfully hosted the World Food Commemoration Day in the country on 23 October 2018. The theme for the day was, "Zero hunger means working together to ensure that everyone, everywhere, has access to the safe, healthy and nutritious food that they need." The event was organized by the Government of Malawi's Ministry of Agriculture, Irrigation and Water Development (MoAIWD) in collaboration with FAO, the WFP and other partners, including those from the private and non-governmental organisations. Similarly, Dowa DNCC mobilized resources from different stakeholders and hosted the District Breastfeeding Day commemorated at Matekenya Primary School on 15 August 2016 in TA Msakambewa, with the national theme, "Breastfeeding: Key to Sustainable Development."

Under Outcome 2 also, the project supported the development of 16 working aids which DNCCs have been using in their daily activities. These materials include 4 advocacy plans, 4 harmonized stakeholder schedules, 4 joint work plans and 4 joint monitoring checklists. It conducted all the planned 8 monitoring visits and the DNCCs interacted with 120 people (72 males and 48 female) from care groups, VNCCs, Village Development Committees (VDCs), Theatre for Development (TFDs) and STAR circles during these visits. Aside from this, the project initiated and supported the DNCCs to review the communication and networking strategy. The strategy was finalized in the first quarter of year 3 and is being used by the SUN stakeholders in the districts.

### **3.3.3 Outcome 3: Enhanced community members' understanding of nutrition and the relationship between agricultural production and the six food groups in line with the ENAs and NECS of the SUN**

The evaluation found that the project has trained 2,524 cluster leaders (lead parents) and 131 promoters on ENAs and NECS. The trainings have enhanced understanding of nutrition and the relationship between agricultural production and the six food groups by communities. By the time it ended, cluster leaders and

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care group promoters cascaded nutrition and health messages to a total of 101,732 people in the 4 districts that include 62,987 women, 17,727 men and 21,018 boys and girls.

Besides care groups, the project aired messages about ENAs and NECS once per week for 12 weeks on community radios in each district, and once per quarter on community and national radios to widen coverage. The project also developed and distributed 3,000 brochures with messages on ENA and SUN NECS, 600 posters, 1000 T-shirts, 6,000 meters of wrappers, 250 stickers and 500 copies of care group training manual translated in Chichewa. In addition, the SUN project printed and distributed 1,500 care group counselling cards with complete visual aids and 5,000 copies of local nutritious meals leaflets as communication and training packages for communities. Through these materials, care group promoters and cluster leaders have disseminated key nutrition and health messages to mothers and caregivers of children under five years of age and consequently increased the adoption of positive behaviours. **Table 9** shows some of the achievements under outcome 3 of the project.

**Table 9: Some of the achievements made under outcome 3 of the project**

Indicator	Situation at the onset			Results	Achieved	
	Baseline	Target Value	Variation	EOP	Variation	%
Number of the hhs aware of and consuming at least four food groups by EOP	25%	100%	75%	57.9%	32.9%	43.9 %
Number of hhs producing a diverse of at least three nutritious crops by EOP	25.9%	60%	34.1%	29%	3.1%	5.5%
Knowledge, attitudes and practices (KAP) on nutrition among targeted communities	25%	30%	5	87.2%	62.2%	373.2 %

### 3.3.4 Outcome 4: Regulatory framework on food security and nutrition improved

Under Outcome number 4 and with technical advice from the DNHA and DNCCs, Oxfam and CHC have oriented 120 frontline workers and promoters (95 males and 25 females) on the newly enacted National Multi-Sector Nutrition Policy (2018-2022). The frontline workers and promoters in turn oriented 30 VNCC members and 20 community leaders who cascaded the orientation further to 3,212 care groups and beneficiaries (803 males and 2409 females). Nutrition messages that communities have received are therefore those from the policy.

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Oxfam in collaboration with the DNHA and Civil Society Agriculture Network (CISANET) also contributed to the consultative workshop for the Food and Nutrition Bill tenable in Salima. One hundred and eighteen (118) participants attended the workshop and reviewed the bill for submission to cabinet ministers. The attendees included principal secretaries, government directors, deputy directors and other technical staff at national and district levels.

In addition, the SUN project has also strengthened the capacity of 8 DNCC members and 4 staff on public sector budgeting and budget analysis for nutrition in the national budget. The outcomes for the training were the national budget analysis and the development of nutrition issues papers for the 4 districts. The project used the findings of the budget analysis to engage relevant parliamentary committees to support the enactment of the Food and Nutrition Bill in parliament and lobby for resource allocation towards implementation of the nutrition policy and activities.

The DNCCs are using the nutrition issues papers for advocacy of resource allocation. For example, Salima district held two engagement meetings with the District Health Management Teams (DHMT) to lobby for resources for nutrition activities. Lilongwe district made 10 engagements with NGOs to mobilize resources for the second-round of Child Health Days for 2017-2018 financial year. The districts managed to acquire the resources and supported implementation of the two rounds of Child Health Days Campaign and joint nutrition work plans. The campaigns provided vitamin A supplementation and deworming, which are vital for a child's health, growth, immunity against diseases and good eyesight. The campaigns benefited children even those in the remote and hard-to-reach areas with no or poor access to health services. A total of 96 HSAs from 24 health facilities, supported by the project, participated in the campaigns.

**///** In communities where similar interventions were operating, collaborations were made to make sure that the project and its counterpart stakeholders worked together to avoid duplication of work and resources. As an example, Oxfam, CHC and FAO were working with the same care groups. In Salima, Oxfam and CHC produced two counselling cards on complementary feeding and exclusive breastfeeding, while FAO (Afikepo) developed counselling cards for six food groups and sanitation and hygiene. Oxfam and CHC provided seeds and seedlings to households for backyard gardens. FAO distributed seeds and seedlings to villages for demonstration plots where cluster leaders and communities were learning about agriculture and how to construct and take care of the backyard gardens.—  
Tiyezge Zimba Kalima, M&E officer.

### 3.4 Efficiency of the Project

The SUN project was not only effective, but also efficient in the use of resources. The project minimized numbers of paid staff and relied on local structures and community volunteers to do most of the work on the ground. This enabled it to



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implement activities at low cost and stay within the allocated budget as agreed upon with the donor. Every effort was made to prioritize activities with tangible impacts such as capacity building of local structures and investments in IEC materials. The project valued good coordination, cooperation and communication with various stakeholders, evidenced by joint implementation, reviews and monitoring of activities. It worked very well with partners to leverage efforts, resources experiences for wider impact.

Other organisations that collaborated well with the SUN project are the National Authorizing Officer Support Unit (NAO-SU), Catholic Commission for Justice and Peace (CCJP), Story Workshop and the government of Malawi through the DNHA and DNCCs in the targeted districts.

The project also demonstrated a very good culture of shifting resources to do other activities deemed relevant. As examples:

- I. There were a number of organisations involved in the training of DNCCs in the targeted districts. In cases where DNCCs were trained by another organisation, OXFAM and CHC were re-allocating resources to train other nutrition structures, such as community promoters and cluster leaders.
- II. Similarly, OXFAM and CHC were requesting DNCCs to identify areas they would want to be trained in and providing the necessary support.

### 3.5 Sustainability of the SUN Project Activities

By design, the SUN project was inherently about sustainability and scalability of activities. The evaluation looked at sustainability as a measure of whether the interventions and benefits are likely to continue after closure of the project, particularly by examining if conditions for continuity were created. The results showed that active involvement and capacity building of local structures, implementation of simple, low cost and community-driven interventions and the distribution of working aids in vernacular language to the communities as reference materials are the main pillars of sustainability of the activities implemented by this project.

#### 3.5.1 Involvement of local structures

There is strong evidence from the SUN project that most of the interventions and approaches used to promote behaviour change will likely continue because of the knowledge and skills gained by local volunteers and communities. The evaluation was conducted after the project had already closed, but DNCCs, frontline workers, promoters, lead parents and lead farmers were still implementing activities on the ground. Other evidences and indicators of sustainability under this theme according to interviews conducted with key persons and groups at district and community levels are: 1) the institutionalisation of activities in the daily routine work of government frontline workers, 2) the presence of CSOs and community volunteers already trained by the project, 3) continuation of care group work since

the model is embedded in the government structure, 4) reductions in child undernutrition, morbidity and mortality perceived that motivate beneficiaries to continue participating in care groups and project activities 5) copying of positive behaviours by neighbouring villages not targeted by the project. This means that some communities already started doing SUN activities without relying on any support.

### **3.5.2 Capacity building initiatives**

Sustainability of the SUN activities is also underpinned by capacity building of the local structures that have already demonstrated the capacity to work with minimum supervision. The trainings that the project offered to DNCCs trickled down and have empowered communities with the necessary knowledge and skills to fight against undernutrition even during times of no external support from the donor. As evidence of capacity in them, DNCCs have already started mobilizing resources and holding regular meetings, where they review progress and draft work plans for the months to come. Nkhotakota has included nutrition issues in its Social Economic Profile (SEP). Likewise, Lilongwe and Dowa DNCCs have already started conducting mapping exercises without external support owing to the benefits seen.

Most importantly, the project has trained 34 CSO field staff (24 males and 10 females) as community promoters on nutrition and SUN in relation to agriculture. The staff were drawn from CHC, World Relief, United Purpose, World Vision, World Food Programme, Hope, Feed the children, United Nations Children's Fund (UNICEF), Family Planning Association of Malawi (FPAM), CARE Malawi, PLAN, Mission for Jesus, DAP, Action Aid and government. The trained CSOs are still present in the impact districts and by virtue of their obligations they will continue with implementation of the SUN activities.

### **3.5.3 Implementation of low-cost and community-driven interventions**

At the community level, mothers and caregivers of children under five years of age will likely continue to implement the SUN project activities because most of them are simple, low-cost and community driven. Care groups, backyard gardens, cooking demonstrations, appropriate infant and child feeding using local foodstuffs and growth monitoring are examples of simple activities that communities are already doing with little investment and can easily sustain them in future.

## KEY FINDINGS

// We approached World Vision and CSONA district chapter as DNCC to mobilize funds. We received Mk 4,000,000 that we used to train 2 ANCCs, and a funding commitment of \$11,000 (Mk7, 920,000) for monitoring and supervision of nutrition activities at district, area and village levels. We also got Mk 2,000,000 from CSONA secretariat for budget analysis and trucking of Dowa district CMAM program, which is still in progress. Other district partners like World Relief, Mponela AIDS Information and Counselling Centre (MAICC), CARE and Dream are co-sponsors of the budget analysis work. The total budget is Mk 3, 600, 000— George Kaunda.

// The SUN project activities are expected to continue because there are other organizations such as FAO and World Relief that are working in the impact areas now. Since the care group structures belong to the government, the same government has the responsibility to supervise the operations of these structures regularly— Tiyezge Zimba Kalima, MSE officer.

// This project is universally accepted and sustainable. Activities started from high level meetings at national level to the DNCCs and DEC at district level. The DEC endorsed the project in areas where malnutrition was very high and where little or no nutrition projects were implemented before. Oxfam and CHC entered communities after orienting all the local structures at area and village levels. We are sure that District Councils will continue providing all the necessary support to sustain activities on the ground— Dumisani Chiwala, Lilongwe.

### 3.5.4 Availability of working aids as reference materials

As already mentioned, after every training the project distributed manuals, IEC materials and recipes to trainers of trainers and communities for them to use in future as references. All the materials are user-friendly because they are in Chichewa, and beneficiaries can understand them well.

## 3.6 Best Practices by the SUN Project

This section showcases best practices worth scaling up in future projects. It has used the criteria, such as ease of adoption, effectiveness, impact, sustainability, innovativeness, multiples use and contribution made to determine inclusion.

### 3.6.1 Care group model

Care Groups have shown to be one of the best practices for this project because they are learner-centred, wide-reaching and sustainable, yet low cost to implement even in hard-to-reach areas. Desired results are seen within the shortest period of time. In this project, 2,524 clusters leaders and 131 promoters trained reached out to a population of 101,732 people (62,987 women, 17,727 men, 21,018 boys and girls) with simple messages about nutrition and health in 2018 alone. Cluster leaders were peers in their respective communities, used the need-based approach and made door-to-door visits, which enabled households to be more open than if a group of mothers and caregivers, with varying problems,

## KEY FINDINGS

were holding discussions together. Interviews with neighbour women showed that they encourage one another to adopt positive behaviours that cluster leaders are promoting because they have seen the benefits such as reductions in child underweight, morbidity and mortality.

In this project, efforts by care groups were scaled up by the STAR circles and TFD groups. The later uniquely used drama to disseminate key health and nutrition messages. The project trained them on core elements of drama (Actors, Space, Audience, Story, Conflict, Directing and Characters), types of drama (Comedy, Tragedy, Tragi-comedy and Satire) as well as research and planning. Story Workshop supported with technical expertise during the trainings. By the time the project closed in January 2020, the 25 TFDs groups involved had conducted a total of 129 performances.

### **3.6.2 Respect for religious beliefs**

Another best practice by the SUN project was its respect for religious beliefs during implementation of activities. For example, the project allowed Zion Villages, which religiously do not allow their members including children to receive any medical treatment when sick, to still participate in other interventions not connected to health-seeking behaviours. Likewise, the project educated Muslim communities in Salima and Nkhotakota to construct tippy taps for hand washing after toilet use and stop anal cleansing in bathing shelters using small pails and cups, which has proven unhygienic, especially for young children. Local structures that have remained should continue to promote increased uptake of the tippy taps in the districts.

### **3.6.3 Community-based detection and management of acute malnutrition**

In this project, Oxfam and CHC trained cluster leaders on how to use the mid-upper arm circumference (MUAC) and assess acute malnutrition in children under five during routine household visits. If a child is found with MUAC in the red and yellow sections, the cluster leaders report to HSAs in the area for further diagnosis and action. This practice is ensuring timely detection, referrals and management of acute malnutrition; hence the reduction to 1.8% from 4.7% at baseline.

### **3.6.4 Learning by doing through demonstrations was helpful**

Another best practice by the SUN project was the Community-led Complementary Feeding and Learning (CCFL) sessions because they encouraged learning by doing. The sessions internalized cookery knowledge and skills in the communities. A total of 12 sessions were carried out for 9 days in each district where households with malnourished and health children prepared meals together based on the Malawi's six food group guide. The approach incentivized households with malnourished children to adopt good nutritional behaviours by

## KEY FINDINGS

learning from fellow mothers without being stigmatized. The key message was that nutritious, diversified and improved diets containing locally-available foods in combination with good health practices (hygiene, sanitation and early detection of and appropriate response to illness) can improve the nutritional status of young children. The project provided copies of recipes to the mothers and caregivers of children under five years at the end of each session for them to use and diversify diets at home.

### **3.6.5 Involvement of lead farmers in backyard gardens**

Backyard gardens were shown to be another community-driven, simple and easy-to-adopt intervention that is benefiting all communities. These gardens have improved access to dark green leafy vegetables, such as bean and pumpkin leaves, mustard, amaranthus (bonongwe) and okra, which households need to meet the six food groups and increase variety in diets and intake of vitamin A. In addition, having backyard gardens around the home has lessened the burden of women in fetching vegetables and spending money they need for other basic needs. The project uniquely worked with lead farmers and ensured that standard backyard gardens are constructed based on the specifications by the Ministry of Agriculture. This arrangement has helped to build a good relationship between the lead farmers and households that is enabling the latter to ask for any advice regarding integrated homestead farming, including livestock production. The project recorded that 7,916 households have small livestock and built suitable kraals with support from agricultural extension workers and lead farmers. Some of the successful backyard gardens in the project areas. Such gardens were scarce during the time of the evaluation because vegetables were plentiful - growing wildly due to the rains.

# 4.0 PROJECT IMPLEMENTATION CHALLENGES

Although the SUN project has met its goal of improving the nutritional status of rural households in the impact districts, the implementation process was challenging. The main challenges faced are:

1. **Delays in the disbursement of funds** due to internal processing procedures by Oxfam and CHC. Time and efficiency in the implementation of activities were affected in the process. In future projects, decentralize payments for small expenditures from the country office to field offices or implementing partners to speed up transactions and initiate processing of funds for the coming quarter ahead of time to avoid gaps in funding between the quarters.
2. **Work overload and pressure on the part of staff and community volunteers.** In this project, DNCC members, frontline workers and all community volunteers experienced work overload and pressure after the project extended intervention areas to abide by the requirements of the harmonized care group model. The SUN project was extremely fortunate in the devotion showed by its team of staff and partners at all levels. This devotion involved working in the new areas without additional benefits, spending weekends and longer hours in the field, cutting back on holidays and prioritising SUN activities when clashes in programs happened.
3. **Mobility problems for local structures and community volunteers.** The project suffered from lack of transport for frontline workers, community promoters and lead farmers to reach out easily to communities and households with project messages. The project had no budget to procure enough bicycles for every volunteer, although it entrusted them to reach out to every household, some of which were in the far-flung areas of the districts. Transportation was a challenge even for district staff, such as DNCC and DEC members, since the project had no specific vehicles for them to use.
4. **Failure to train all care group cluster leaders involved.** Capacity building for cluster leaders exceeded the target. However, the project was unable to train all cluster leaders on the ground because resources became limited after it extended to other areas in the second year following the adoption of the harmonised care group model.
5. **Higher expectation for incentives that led to drop out of some community volunteers.** As already stated, the project distributed a variety of IEC materials and incentives such as T-shirts and wrappers to community volunteers and project beneficiaries. However, the materials and incentives were not enough for everybody, which resulted in cases of drop out of volunteers, in particular



Project beneficiaries during World Food Day Commemoration in Nkhota-kota districts.

Photo: Chimwemwe Jemitale/Oxfam

cluster leaders and promoters, who were omitted and felt left out especially in the new impact areas. The project continued to sensitize communities about the design of social behaviour change project and the meaning of being a volunteer.

6. **Dependency syndrome.** The evaluation found that some beneficiary households also dropped from the project because they did not receive wrappers and bicycles that the project distributed to cluster leaders and promoters respectively. A large majority of the households also relied on the project to give them vegetable seeds and other material things not budgeted for every year arguably because previous projects did so.
7. **Poor rolling out of STAR circles.** In this project, the STAR circles ought to be mobilizing and empowering rural communities with messages about nutrition, gender, WASH and agriculture. However, they were not as active as expected because the project managed to train only a few people at the beginning. These people did not trickle down the information properly; hence, the other members were not well aware about what exactly was expected of them.
8. **Lack of access to nutritious foods by ultra-poor households.** The project identified these households and trained them on backyard gardens and small livestock production to enhance food availability, diversity and consumption.

Nevertheless, lack of monetary resources prevented them from putting the knowledge and skills they acquired into practice. The care group model used by the project does not have a strong resilience and economic empowerment component to improve the well-being of rural communities and consequently increase the adoption of messages disseminated.

9. **Low participation of men in care groups.** The aim of cluster leaders for home visits was to ensure that all members of the household were reached and adopting positive behaviours. However, out of the 101,732 people that the cluster leaders reached to in 2018, only 17,727 were men – representing an involvement of 17.4 percent. Men culturally considered care groups to be an affair for women since they are the ones who cook and take care of the household. The project has been involving men by including them in area and village committees so that they could also be discussing messages that are promoted in the care groups and the roles they can play as primary decision makers for their households. Other ways to address this problem in future include deliberate allocation of project tasks to men and boys, encouraging mothers to bring their husbands to nutritional activities, working with youth groups and make men champions of change and encouraging more commercialization of nutritional activities, such as home gardens and irrigation, than done now to attract men.
10. **Low literacy levels.** Another challenge that affected the work of care groups was the high illiteracy levels and inability by beneficiaries to read key messages provided by the project. Health promoters and lead parents were literate and overcoming this problem by going through all the manuals that the project translated into vernacular Chichewa clearly to ensure that all mothers and caregivers of children under five years understand. According to the MDHS (2015/2016), 29.2% of women in the project districts cannot read at all compared to 18.9% of men.
11. **Poor sanitation and hygiene.** The evaluation found that many households failed to construct improved toilets with concrete slabs. Traditional toilets built from mud fell easily during the rainy season of 2017 to 2018, resulting in open defecation which partly led to an outbreak of cholera in Lilongwe and Salima. The project was able to effectively manage the outbreak with technical support from the District Executive Committee (DEC), District Health Offices (DHOs) and other committees within the districts.



## 5.0 LESSONS LEARNT FROM THE PROJECT

A key lesson drawn from this project is that beneficiaries have the capacity to change for the better using own resources once they have been empowered with knowledge and skills to lead in the whole process. One main reason why undernutrition persists is ignorance about nutrition and health in a large majority of mothers, who have the primary responsibility of feeding and taking care of infants and young children.

Another key lesson that follows from the first one is that the government and community structures should be involved in all the stages of development projects to make meaningful and lasting change in the lives of poor people. Experience has shown that project activities cease after the withdrawal of external support because of the inability by the remaining structures to sustain funding and leadership roles.

Thirdly, this project has shown that flexibility, collective investment and responsiveness to the problems and emerging issues affecting the targeted population are key to success. In this project, Oxfam and CHC engaged private companies to participate in nutrition work and achieved satisfactory results. Currently, almost 18 companies, including Malawi Mangoes, Universal Industries, Bakhresa, Sunseed Oil Company and Illovo, have registered and are actively participating in the SUN Business Network meetings organised by CSONA. Malawi Mangoes has already linked its farmers to the nutrition initiatives in Salima, while Illovo Company committed to be supporting Child Health Days in Nkhotakota if the district shares campaign schedules on time. Commercialization of nutrition activities such as backyard gardens, irrigation, rain-fed agriculture and small livestock production can motivate more private companies (depending on their area of business) to follow suit and continue supporting nutrition activities in future.

# 6.0 CONCLUSIONS AND RECOMMENDATIONS

In conclusion, the SUN project was a success looking at the impact made. The theory of change used, which involved enhancing the understanding and management capacity of district, community and village structures, has shown to work well and need to be replicated at scale in future projects of this nature. Nevertheless, the evaluation considers the three years of the project in Dowa, Lilongwe, Salima and Nkhotakota as a relative short period of time to change people's long-standing behaviours, cultural beliefs and habits completely. The general recommendation is that Oxfam and CHC should mobilize additional resources to implement another 3 or 4-year project targeting the same areas and beneficiaries to deepen and consolidate impacts at the household level. Specific recommendations from the evaluation are presented below.

## A) Oxfam and the Catholic Health Commission (CHC)

1. Advocate for the review of the care group model by the DNHA to include components of economic empowerment, adult literacy and adolescent nutrition to raise the social, economic and nutritional well-being of rural communities, in particular for the most vulnerable and ultra-poor households which are finding it hard to practice key nutrition and health messages disseminated.
2. Poor diets for children mean that the intake of macro and micronutrients -which are required in small amounts, but are crucial to children's health and development- is low. Future projects should scale up implementation of integrated homestead farming (IHF) that includes production of small livestock, irrigation farming to complement yields from rain-fed agriculture, Village Savings and Loans (VSLs), cooking demonstrations and food processing and preservation to minimize post-harvest losses of the already produced food.
3. In future, refrain from making suggestions of people as care group volunteers. Leave the whole process entirely in the hands of the communities. The community-led selection criteria will ensure that only people who are willing and have passion take part in the interventions as volunteers and in this way they will not bring problems of demanding money or unbudgeted incentives from development projects.
4. Consult the DNHA to provide policy direction on how to revitalize nutrition education and counselling at health facility level using the harmonised care group model to increase acquisition of knowledge and skills by communities.

### **B) District Councils**

1. District Councils should lobby for budgetary allocation in the District Implementation Plans (DIPs) from the government to support SUN project activities that require funding such as supervision, monitoring and evaluation, and review meetings.

### **C) Local Structures Trained by the Project**

1. DNCCs and CSOs should continue to mobilize funds together with the District Councils for implementation of different activities of SUN.
2. Care groups should continue promoting positive WASH behaviours by educating households to treat and use safe water for drinking, construct toilets and tippy taps with soap and clean water for hand washing and erect other basic sanitary facilities such as rubbish pits and bathing shelters to prevent outbreaks of cholera in future. There is also need to continue educating mothers and caregivers of children under five years of age on safe disposal of child faeces into toilets.
3. Plan to continue training, refreshing and incentivizing community volunteers on a regular basis to keep them motivated since they work on voluntary basis. Similarly, strive to increase participation of men, as primary decision makers of their households, in nutrition work by among other things encouraging mothers to bring their husbands to nutritional activities, working with youth groups and making men champions of change and commercializing activities, such as home gardens, irrigation and rain-fed agriculture to attract more men.

# ANNEX 1: INDICATOR PERFORMANCE TRACKING TABLE FOR THE PROJECT

Performance Indicators	Baseline	Targets Set	End-line	Achieved (EOP vs Baseline)
<b>Project Goal: To contribute towards improved nutritional status of rural HHs in Malawi</b>				
Stunting levels in children under-five have fallen from 42% to 30% by End of Project (EoP) Demographic Health Survey (DHS) Target Value 001: 28% reduction	39.4%	28%	34.2%	13.2%
The proportion of the population below the minimum level of dietary energy consumption reduced by EOP. Target Value 001: 10% reduction.	67.3%	10%	42.1%	37.4%
Reduction in malnutrition levels by EoP Target Value 001: 15% reduction (averaged)	18.6	15%	15.2%	18.1%
• Weight-for-height z-scores	4.7%	4.0%	1.8%	62.1%
• Weight-for-age z-scores	11.6%	5%	9.7%	16.4%
• Height-for-age z-scores	39.4	28%	34.2%	13.2%
Reduction in nutrition related diseases by EoP Target Value 001: 15% reduction ( <i>Average score for assessment on to Anaemia, marasmus, kwashiorkor &amp; oedema</i> )	17.95	15%	0.4%	97.8%
<b>Specific Objective: Strengthened capacity of rural HHs and District level staff in addressing nutrition issues related to agriculture and SUN implementation in Lilongwe, utilization and results of LDF, CDF and DDF resources</b>				
FIDP communities targeted under the project register reduction in under 5 years mortality by EOP Target Value S01: 10% point reduction	20	10%	4	80%
FIDP communities targeted under the project register reduction in children underweight by EOP Target Value S01: 5% reduction	11.6%	5%	9.7%	16.4%
Proportion of targeted households producing diverse nutritious foods (including bio fortified crops) increased by EOP Target Value S01:60% increase	25.9%	60%	29%	5.5%
<b>Outcome 1: Enhanced understanding and management capacity of government, district level structures and CSOs on household nutrition, other nutritional issues related to agriculture, and SUN</b>				
Increased number of Govt. district level staff trained as ToTs on Nutrition and Agriculture providing technical training and coaching to lead parents and VHCs on nutrition and agriculture by EOP. Target Value R1: TBD	5	206	234	229

**ANNEX 1: INDICATOR PERFORMANCE TRACKING TABLE FOR THE PROJECT**

Increased number of public extension / frontline workers (HSAs, CDAs and AEDOs) providing extension services related to nutrition and agriculture within the targeted communities by EoP Target Value R1: TBD	10	206	209	199
Increase in number of lead parents trained by district level staff that are coordinating, and monitoring operations of care groups at district level by EOP Target Value R1: TBD	33	2,481	2,524	2,491
Increase in number of CSO's Community Health Promoters providing monitoring and technical advice on nutrition and agriculture to Lead Parents and VHCs within the targeted communities by EoP Target Value R1: 48	36	36	1,305	1,269
Number of extension workers/ frontline staff demonstrating knowledge on ENAs and NECs in their day to day functions by EOP. Target Value R1: TBD	10	206	155	145
Proportion of trained star circle and radio listening club representatives, VDCs, ADCs, CSO and other marginalized groups actively participating in the tracking and reporting of development resources and development results.	19	260	379	360
<b>Outcome 2: Improved coordination and networking among SUN implementing stakeholders</b>				
Number of DNCCs established and functional by EOP. Target Value R2: 4 (1 per district)	4	4	4	none
Number of multi-sectoral coordination meetings conducted by EOP. Target Value R2: 24 (2 per district per year over lifetime of project).	0	16	16	16
Number of joint (CSOs and Govt.) monitoring visits on nutrition coordinated by DNCCs. Target Value R2: 24 (2 per year for each district over lifetime of project).	0	8	8	8
Number of jointly (CSOs and Govt-DHO, DA, Agric, DEM) developed nutrition documents at district level by EOP. Target Value: 8 (IEC, Guidelines)	1	8	16	15
Communication and networking strategy developed for SUN stakeholders at district level by EOP; Target Value R2: 4 (1 per district)	0	4	4	4
Number of updated directory/register of District level SUN stakeholders by EOP Target Value R2:4(1 per district)	0	4	4	4

**ANNEX 1: INDICATOR PERFORMANCE TRACKING TABLE FOR THE PROJECT**

<b>Outcome 3: Enhanced community members understanding of nutrition and the relationship between agricultural production and the six food groups in line with ENAs and NECS of SUN</b>				
Increase in <i>proportion</i> (number) of HHs that are aware of and consume at least 4 food groups by EOP. Target Value R3: TBDF and DDF	25%	100%	57.9%	43.9%
Increase in <i>proportion</i> (number) of HHs that produce a diverse of at least three nutritious crops by EOP. Target Value R3: TBD	25.9%	60%	29%	12.0%
Increased Knowledge, Attitudes and Practices (KAP) score on nutrition among targeted communities by EOP.	25%	30%	87.2%	373.2%
Number of nutrition awareness platforms established by EOP. Target Value R3: 1 per TA per year ( 24 campaigns, 160 star circles, 96 TFD sessions)	205	80	2908	2,703
Proportion (number) of functional Village Health Committees promoting nutrition messages at community level by EOP. Target value: VDC (no, of GVHs)	18	49	340	322
Number of demonstration plots established for practical skills transfer on agriculture diversification and nutrition promotion in line with ENAs by EOP Target Value R3: 48	18	113	260	242
<b>Outcome 4: Regulatory framework on food security and nutrition improved</b>				
Percentage increase in District Implementation Plans (DIP) budget allocation towards nutrition sector at District level by EOP. Target Value R4: TBD	0	1	0	none
Number of joint advocacy initiatives on nutrition advanced by District level CSO networks by EOP. Target Value 4: TBD (biannually)	1	4	16	15
Number of meetings/policy discussion fora/workshops conducted on nutrition and food security regulatory framework by EOP. Target Value R4: TBD ( 3 with local leaders interface, 6 national for budgetary allocation, 3 for nutrition bill)	0	4	10	10

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the 1990s, the number of people in the UK who are aged 65 and over has increased from 10.5 million to 13.5 million, and the number of people aged 75 and over has increased from 5.5 million to 7.5 million (Office for National Statistics 2000).

There is a growing awareness of the need to address the needs of older people, and the UK Government has set out a strategy for the 21st century (Department of Health 1999). The strategy is based on the principle of 'active ageing', which is defined as 'the process of optimising opportunities for health, participation in society, and security in old age' (Department of Health 1999, p. 10). The strategy is based on the principle of 'active ageing', which is defined as 'the process of optimising opportunities for health, participation in society, and security in old age' (Department of Health 1999, p. 10).

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