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Annex 1: Review of individual MSNP evaluations

Evaluation #1: Integrating Nutrition in Value Chains Project (INVC), Malawi, 2012-2016 [57,112]	
Study Design/Level of Evidence	Full cluster randomised trial & DD approach (1a) was planned. A baseline survey was conducted in 2014 and an interim assessment in 2015 by different partners but using a harmonised approached. A final evaluation planned in 2017 was not completed due to unexplained challenges with the project. The final impact evaluation as designed would have focused on two districts- Lilongwe and Mchinji with each district randomly assigned into either receiving the value chain (VC) only intervention or the VC + Nutrition intervention. The review of the impact of this project is based on the 2015 assessment thereby downgrading the study design to **a repeated cross-sectional surveys (Baseline-end line) 3b** in this case baseline- interim. The interim assessment was not designed to measure changes from baseline with statistical precision or support conclusions of causality or programme attribution. In lieu of a final quantitative impact assessment, a qualitative assessment using the most significant change MSC technique was undertaken.
Theory of Change	A modified Agriculture Value Chain framework[1] integrating nutrition Behaviour Change Communication (BCC) and health monitoring to improve field productivity and nutritional *outcomes but this was not depicted or described.*
Intervention	Nutrition BCC was integrated (via Community Care Groups -CCG) in 3 primary Agricultural Value Chains, namely the cultivation, consumption and sale of nutrient rich value change commodities (NRVCCs), soy, groundnuts and orange-fleshed sweet potatoes.
Mode of Delivery and Convergence	The two components of the intervention were delivered separately. Locally recruited and trained community nutrition promoters provided mentorship and support to local volunteers (lead mothers) on nutrition BCC and growth monitoring within established community care groups. Each group was composed of at least 10-12 families from a village. Associations of small holding farmers worked together with support from the programme to promote cultivation of NRVCCs by investing in seed and fertilizer and improving soil and water management in a bid to increase field productivity.
Coverage	The intervention covered 7/28 districts in central and southern regions of Malawi. No other indicators measuring coverage of the programme by any other definition were provided in the interim assessment or the qualitative final assessment.

[1] In agriculture, a value chain (VC) program may increase value by improving the supply of agricultural inputs; planting and harvesting practices; and transport, storage, and marketing of farm products

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Evaluation #1: Integrating Nutrition in Value Chains Project (INVC), Malawi, 2012-2016 [57,112]	
Impact on Nutritional Outcomes	Unknown impact. Statistically significant reduction in prevalence of stunting (49% to 42%) and wasting (6.4%-3.6%) but not in underweight[2].
Impact on Secondary outcomes	Using the same approach of looking at non-overlapping con Cis, there were reductions in the following additional indicators- prevalence of poverty, three Women's Empowerment in Agriculture Index (WEAI) indicators namely ownership of assets, control over use of income, and workload and the % of households with moderate or severe hunger. There was no statistically significant change for the following secondary outcomes: Daily per capita expenditures (as a proxy for income) in USG-assisted areas; Depth of Poverty; Women's Dietary Diversity; % of children 6-23 months receiving a minimum acceptable diet (MAD); % of exclusive breastfeeding among children under 6 months of age; % of women of reproductive age who consume targeted nutrient-rich value chain commodities (NRVCCs); % of children 6-23 months who consume targeted NRVCC; and % of underweight women;
Scale up beyond evaluation	Correspondence with USAID and the final qualitative assessment indicates challenges with the programme which resulted in the final assessment being cancelled. It is unlikely the project will be scaled up. A review of the executive summary of the qualitative assessment drawn from interviews with 277 HH in the project highlighted the following key challenges: *Participants requested more inputs, particularly seeds, farm animals, and small loans. The late provision of poor-quality seeds was a major issue for many participants. Participants also felt that they could improve their nutrition and their livelihoods more effectively if small farm animals or small loans for business development or agricultural inputs were included in the programme. Lack of monitoring and supervision affected all nutrition promoters and nearly half of the participants. Because supervision and field visits were rare, promoters did not feel supported in their activities, and community members did not think that the programme managers understood issues at the ground level or adequately addressed them. In addition, about one-quarter of the participants wanted men to be more involved in the nutrition component of the programme and requested evening meetings for men about nutrition.*

[2] Although the sample for the Malawi ZOI interim assessment was not designed to measure change from baseline indicator values, for a few indicators, non-overlapping confidence intervals (CIs) between the 2010-2012 baseline indicator value and comparable 2015 interim indicator value point to a statistically significant change over time. When CIs do overlap, however, which is the case for most indicators, conclusions cannot be made regarding statistically significant change from baseline to interim without conducting a statistical test of the difference

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Evaluation #2: Enhanced Homestead Food Production (EHFP) for Improved food security and Nutrition in Burkina Faso , 2010-2012 [67,109]	
Study Design/Level of Evidence	Full cluster randomised trial & DD approach (1a). 55 villages in 4 departments in Gourma province were randomly assigned to 3 groups as follows: 1) Control group that received no interventions from HKI (25 control villages), 2) Treatment group that received the agricultural production intervention with the BCC strategy implemented by older woman leader (15 OWL villages), and 3) Treatment group that received the same agricultural production with the BCC intervention implemented by health committee members (15 HC villages). Randomization was stratified by department and village size. Villages were selected for inclusion if they were located in the 4 selected departments, had access to water in the dry season to enable participation in the agricultural intervention, and met the population size criteria (#4000 inhabitants).
Theory of Change	Essential Nutrition Action BCC Framework. Available.
Intervention	Integrating Nutrition BCC with Village Model Farm production of food rich in Micronutrients Increasing the availability of micronutrient-rich foods through 1. Increased household production of these foods; 2. Income generation through the sale of surplus production; and 3. Increased knowledge and adoption of optimal nutrition practices, including the consumption of micronutrient-rich foods with focus on the 1st 1000 days encompassing early pregnancy to the child's second birthday.
Mode of Delivery and Convergence	The project was delivered as two separate components working toward the same goal however there was a common target- in the form of mothers in those 1st 1000 days for both components. HKI provided agriculture inputs and training to establish village model farms (VMFs) cared for by four village farm leaders (VFLs). VMFs goal was to grow a variety of micronutrient-rich foods year-round and raise small animals e.g. chickens and/or goats. VMFs also served as training sites for participating women to learn best practices in homestead food production, e.g. the

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	use of raised beds, compost, natural pest control methods, and the importance of vaccinations for poultry, among others. Participating women were provided with agriculture inputs and encouraged to establish their own home gardens and small animal production following the practices learned at the VMFs. The BCC strategy was developed using the Essential Nutrition Action (ENA) framework. This framework focuses on improving health (including WASH) - and nutrition-related knowledge with a specific emphasis on encouraging the consumption of micronutrient-rich foods by women and young children. The BCC strategy also used the negotiating for behaviour change approach, which was designed to further encourage participants to implement and adhere to optimal practices such as the increased consumption of micronutrient-rich foods and to help them find ways to overcome any barriers that may have prevented them from adopting and adhering to these best practices. The BCC strategy was implemented by two distinct groups— the health committee (HC) group consisting of male and female village members, and the older women leader (OWL) group comprised of older influential women from the villages.
Coverage	Undertaken in 30 villages in Gourma Province located in the eastern region which is 1/45 provinces in Burkina Faso. No indicators measuring coverage of the programme by any other definitions were provided.
Impact on Nutritional Outcomes	No statistically significant impact on nutritional status by anthropometry in children Significant reduction in prevalence in underweight amongst mothers
Impact on Secondary outcomes	• Reduction in prevalence of children with anaemia and diarrhoea in younger children comparing treatment vs control villages. The prevalence of underweight was significantly reduced among mothers in treatment compared with control villages by 8.7 percentage points ($P < 0.01$) • Increased mothers' intake of fruit and meat/poultry comparing treatment vs control villages. • Significant increase in overall score on women's empowerment in treatment vs control villages. • HC groups were effective at improving children's nutritional status, whereas the OWL group was not.
Scale up beyond evaluation	The project appeared to have been adopted spontaneously by neighbouring non participating families and villages. In addition, the initial project targeting pregnant women and families with children under 12 months in 30 villages was extended under the 2013-2016 CHANGE project funded by Global Affairs Canada, to cover an additional 30 villages.

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	https://www.hki.org/wp-content/uploads/2019/10/HKI-Stories-of-CHANGE_Spontaneous-Adoption.pdf https://www.ennonline.net/fex/51/ag4nutprojectburkinafaso Additional research was done using this cohort of children following provision of lipid-based nutrient supplement (LNS) in 15 villages to all children six-23 months for an 18-month period. LNS provision was being tested based on the experience that food-based approaches may not be sufficient to reduce the high burden of micronutrient deficiencies, in particular anaemia. Small-Quantity Lipid-Based Nutrient Supplements, regardless of their Zinc content were found to increase growth and reduce the prevalence of stunting and wasting. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0122242

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Evaluation #3: TUBARAMURE "let's help them grow" Preventing Malnutrition in Children under 2 Approach (PM2A), Burundi, 2009-2014 [77-82]	
Study Design/Level of Evidence	Full cluster randomised methods & quasi-experimental methods + DD approach (1a). The evaluation was designed to answer questions about the optimal timing and duration of food supplementation. Four-arm, cluster-randomized controlled study to assess programme impact following baseline and follow-up 4 years later of ~3550 children in each round. Treatment arms received food rations (corn-soy blend and micronutrient-fortified vegetable oil) for the first 1000 days (T24), from pregnancy through the child reaching 18 months (T18), or from birth through the child reaching 24 months ["no food during pregnancy" (TNFP)]. All treatment arms received BCC for the first 1000 days. The control arm received no food rations or BCC.
Theory of Change	Available
Intervention	Distribution of food rations coupled with improved provision and increased use of health services and a BCC strategy focused on improving health, hygiene, and nutrition practices. The programme targeted pregnant and lactating women and their children who were identified, enrolled and followed up following community sensitization by local government officials and colline chiefs on the programme and eligibility criteria. Beneficiaries were organised into beneficiary mother care groups (BMCGs) led by a leader mother (LM)
Mode of Delivery and Convergence	The project was delivered via three components using a trainer of trainer (TOT) approach but using the same team of facilitators for each component at the various levels. • The food component's primary intervention was distribution of a food ration that included corn-soy blend (CSB) (a micronutrient fortified flour) and oil at distribution centres by Catholic Relief Services (CRS) There was an agricultural sub component which involved LMs received training from Tubaramure health promoters (THPs) on planting vegetable seeds, planting fruit trees, and breeding hens. Interventions in this sub component included; culinary demonstrations emphasizing the importance of locally grown nutritious foods; savings and lending communities; initial seed and livestock distributions and keyhole gardens to demonstrate how to plant and maintain home gardens and livestock which was not at first a part of the planned activities but became useful and integral as part of the training's done by THPs and LMs. • The health component was designed to improve the provision of preventive health services by health staff and to increase utilization of these services by pregnant and lactating women and children between 0 and 24 months of age. It involved training/re-training health care personnel at health facilities by a local partner (International Medical Corps- IMC)

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Evaluation #3: TUBARAMURE "let's help them grow" Preventing Malnutrition in Children under 2 Approach (PM2A), Burundi, 2009-2014 [77-82]	
	• The care component aimed to address many of the underlying causes of undernutrition in Burundi and to encourage the adoption of best practices in health, hygiene, and nutrition. This was delivered by LMs trained by THPs who in turn were trained by CRS and Food for the Hungry (FH)
Coverage	Undertaken in two eastern provinces of Cankuzo and Ruyigi out of 18 provinces nationally. No indicators measuring coverage of the programme by any other definitions were provided.
Impact on Nutritional Outcomes	Significant protective effect on child stunting relative to the control arm in 2/3 treatment arms- T24 and T18 but not TNFP. Between 2010 and 2014, there was an increase in child stunting rates (from 68% to 75%) in the control area but no change in the treatment arms (64% at both time points). The Tubaramure programme thus had a significant protective effect on child stunting, relative to the control arm, of 7.4 pp in the T24 arm and 5.7 pp in the T18 arm. There was a non-significant 4.6-pp reduction in the TNFP arm.
Impact on Secondary outcomes	• Increased Maternal and Child Haemoglobin and reduced prevalence of Anaemia in treatment vs control groups. • Improved maternal knowledge of optimal hygiene, child feeding during illness, micronutrients and undernutrition, and complementary feeding practices. There was no impact on breastfeeding knowledge, which was moderately high at baseline. At follow-up, hygiene, complementary feeding and breastfeeding knowledge was significantly higher among LM compared to beneficiary mothers- BM. Qualitative data shows that the programme's health promoters were generally very knowledgeable about recommended practices, and they conducted higher quality care group meetings for the LM, with higher participation, than those conducted by the LM for the BM. • Increased prevalence of food secure households and increased household energy and micronutrient consumption. The programme had a positive effect on maternal dietary diversity and increased the % of children aged 6-23.9 months consuming ≥4 food. The effects on many outcomes were attributable to the food rations. Post programme effects were found on household food security, maternal dietary diversity, and younger sibling's complementary feeding practices. • At first follow-up, positively affected language among children aged 4–23.9 months. Positively affected motor development among 12–23.9 months. At second follow-up, among children aged 24–41.9 months, Tubaramure marginally affected motor development. In age subgroup analyses, programme impacts were limited to children aged 24–29.9 months and one language. Pathway analyses revealed significant positive impacts on diet, health, and nutritional indicators of children aged

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Evaluation #3: TUBARAMURE "let's help them grow" Preventing Malnutrition in Children under 2 Approach (PM2A), Burundi, 2009-2014 [77-82]	
	12–23.9 months and health and nutritional indicators of children aged 24–29.9 months, supporting the plausibility of programme impacts on child development.
Scale up beyond evaluation	No indication in documents reviewed if Tubaramure has been scaled up in Burundi or if there are plans to scale it up.

Evaluation #4: The Haiti Title II Multi-year Assistance Program, 2008- 2012 [83]	
Study Design/Level of Evidence	Full cluster randomised trial & non-DD approach. (1b) The evaluation was completed using a mix of data collection methods, combining quantitative and qualitative data collection, as follows: 1) review and analysis of relevant documents; 2) an extensive household-level quantitative survey, with random sampling of households, conducted with similar sample frames as the 2008 baseline survey, to measure progress since 2008; 3) as part of the randomized survey, measurement of the anthropometric indices of nutrition status of 1,912 children; 4) qualitative surveys involving extensive focus-group discussions; and 5) field visits that included key informant interviews, including discussions with implementing staff and local authorities. Used confidence intervals to test for statistically significant change.
Theory of Change	CRS has various theories of change which they apply to projects and are based on five core competencies: organizational development, natural resource management, credit/savings, innovation/experimentation, and markets/marketing. [3]
Intervention	Three cooperating sponsors (CS) delivered intervention packages drawn from multiple sectors in different parts of Haiti. CRS, World Vision and ACDI/VOCA all adopted and pursued an approach common for USAID partners referred to as "preventing

[3] https://www.crs.org/sites/default/files/tools-research/17os188_toc_brochure_update_online.pdf

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Evaluation #4: The Haiti Title II Multi-year Assistance Program, 2008- 2012 [83]	
	malnutrition for under-2 year olds" (PM2A) similar to the Tubaramure project. The goal was to improve nutritional indicators in multiple sectors for pregnant and lactating women in the first 1000 days. Programme objectives are as listed below. 1. Improve the nutritional and health practices of targeted vulnerable populations via mother's groups 2. Improve the quality of and access to health services- package of integrated priority services for MCH 3. Increase food production and household assets and enhance market-based livelihoods by microfinance and agricultural training 4. Rehabilitate natural resource resiliency and local response capabilities- develop early warning system" Each CS took a distinctive approach to achieve coverage of their respective populations but all used some form of mother's club or care group for the MCHN component. *Specific activities to meet programme objectives across the three programmes included*; (1) natural resources management, crop productivity, livestock, fishing, post-harvest handling, commercialization and microfinance projects with farmers and farming associations ; (Livelihoods) (2) providing an package of integrated priority services to support maternal and child health service providers, including pre-natal care, delivery, new born and post-natal maternal care, supporting improvements in water and sanitation through BCC in mother's clubs or care groups; (MCHN) and (3) developing and implementing an early warning system and a disaster response plan in local communities working with local authorities and other community groups. (Resiliency)
Mode of Delivery and Convergence	Note that all three organisation worked independently on a variety of interventions drawn from the same sectors to meet programme objectives. Each CS worked on at least 2 sectors. The evaluation noted that interventions in the 2 sectors may not have been well integrated in each CS's operations.

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Evaluation #4: The Haiti Title II Multi-year Assistance Program, 2008- 2012 [83]	
Coverage	Implemented in 1/10 national departments and 12/19 communes with the South Department. This evaluation did look into programme coverage as a % of target population accessing interventions in the various sectors and compared coverage from baseline to final evaluation across all CS interventions and comparing the CS implementers.
Impact on Nutritional Outcomes	There was no impact on stunting as measured by height for age but a positive impact on linear growth as measured by weight for age with a decrease from 20% to 10% prevalence in underweight comparing the 2008 survey to the 2013 survey.
Impact on Secondary outcomes	The study found that improvements in secondary outcomes i.e. household food/dietary diversity and adoption of agricultural innovations were higher for the integrated MCHN/agriculture than for the MCHN-only and the agriculture-only intervention. **This is one of 3 studies that actually looked at the relative impact of converging sectors as part of the intervention on outcome indicators**
Scale up beyond evaluation	There is no indication that any of the three CS's interventions were scaled up in Haiti from the report or elsewhere.

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Evaluation #5: PROCOMIDA (PM2A-GUATEMALA), 2011-2015 [84-85]	
Study Design/Level of Evidence	Full cluster randomised trial & non-DD approach comparing 6 treatment groups to a control group. The evaluation was designed to answer questions related to the optimal size of the family food ration and the type of micronutrient-fortified individual food ration. Treatment groups varied on the basis of family ration sizes for the food ration component of the intervention. These were; [full (FFR), reduced (RFR), and none (NFR)] and individual ration types provided to mothers (pregnancy to 6 months postpartum) and children (6–24 months of age) [corn-soy blend (CSB), lipid-based nutrient supplement (LNS), micronutrient powder (MNP)]. The sample distribution was as follows: 1) FFR + CSB (n = 576); 2) RFR + CSB (n = 575); 3) NFR + CSB (n = 542); 4) FFR + LNS (n = 550); 5) FFR + MNP (n = 587); 6) control (n = 574). Programme impacts compared with control, and differential impacts between groups varying family ration size or individual ration type, were assessed through the use of linear mixed-effects models and post hoc simple effect tests
Theory of Change	The theory framework is described in the process evaluation.
Intervention	Targeted pregnant women and children during the first 1000 days at convergence centres by 1) food rations, 2) a behavior-change communication (BCC) strategy to increase mothers' knowledge and adoption of optimal health, nutrition, and Practices, and 3) interventions to improve the quality and use of government-funded health services by mothers and children.
Mode of Delivery and Convergence	The programme was delivered jointly for all sectors, with beneficiaries only being able to access food rations and supplements after they attended the BCC session and had their health cards checked at the designated health convergence centre. hygiene Monthly group BCC sessions were led by trained staff and held at HCCs, ideally in three groupings of pregnant women, mothers with children under 6 months and mother with children 6-24 months. This was not always feasible due to staffing and other constraints. The BCC strategy itself contained 5 modules which included cooking demonstrations: 1. PROCOMIDA food commodities, 2. Pregnant and breastfeeding mothers (including diet and health of women during pregnancy and early breastfeeding practices), 3. Exclusive breastfeeding, 4. Feeding and care of children aged 6–24 months, and 5. Feeding (including hygiene practices) and care of sick and/or malnourished children.

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Evaluation #5: PROCOMIDA (PM2A-GUATEMALA), 2011-2015 [84-85]	
	Preventive health component consisted of additional training provided to health service providers to improve quality of service delivery, and the promotion of use of preventive health services by programme participants
Coverage	Selected communities within 1/22 departments nationally. There were reports on coverage with regard to proportion of target population accessing the intervention as reported in the household survey component. Among those enrolled in PROCOMIDA, >95% of participants in all study groups reportedly participated in the monthly BCC sessions and food distributions at all time points and this did not vary by treatment group (*unpublished data*). Use of the individual rations, however, varied by the size of the family ration and by the type of individual ration .
Impact on Nutritional Outcomes	• Significantly reduced the prevalence of stunting at 24m by **11.1 percentage points (pp)** in the FFR + CSB • and **6.5 pp** in the FFR + MNP group • Significantly reduced stunting at 1 month in FFR + CSB, RFR + CSB, and FFR + MNP groups compared with control • Stunting impact increased by age 24 months in FFR + CSB and FFR + MNP relative to control • For CSB recipients, the FFR compared with RFR or NFR significantly reduced stunting • CSB reduced stunting significantly more than LNS at age 24 months • Large family rations with individual rations of corn soy blend (CSB) or Micronutrient Powder (MNP) were most effective. • The widening of impact as children age highlights the importance of intervening throughout the full first 1000 days
Impact on Secondary outcomes	A midterm evaluation reported that : ▪ The % of mothers demonstrating increased nutritional knowledge exceeded the target of 10% by more than 4-fold (45.7%). ▪ Among mothers with increased nutritional knowledge, however, there was no significant association with better average household dietary diversity score (HDDS), the dietary diversity of children aged 6-24 months, or in the practice of exclusive breastfeeding of children aged 0-6 months, compared to mothers with no increase in nutritional knowledge.

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Evaluation #5: PROCOMIDA (PM2A-GUATEMALA), 2011-2015 [84-85]	
Scale up beyond evaluation	There is no indication that there were plans for PROCOMIDA to be scaled up in Guatemala from the report but a separate website mentioned as 8 months were left on the project that the implementing partner- Mercy Corps was piloting the use of video and cordless projectors to create content that would facilitate potential expansion into new programmes.[4]

[4] https://www.illuminaid.org/projects/2017/6/12/mercy-corps-wings-guatemala

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Evaluation report(s) # 6: Realigning Agriculture to Improve Nutrition (RAIN), Zambia, 2011-2015 [73]	
Study Design/Level of Evidence	Quasi-experimental, random allocation in treatment arms (2), non-random selection of control but advanced statistical analysis with DD. (2a) Impact evaluation were designed to help address a critical gap in the evidence base regarding the degree to which agricultural interventions, either alone or when combined with nutrition and health interventions, can improve child nutrition, and ultimately reduce the prevalence of stunting in young children. An RCT was not feasible, hence a hybrid design was adopted that combined a cluster randomized probability design comparing the two intervention packages, with a plausibility design that compared the RAIN intervention arms (Ag-Only and Ag + Nutrition) to a non-randomized control group. Randomization was carried out at the level of the census supervisory area (CSA), a sampling unit used by the Central Statistics Office of Zambia.
Theory of Change	The process evaluation outlined the theory of change.
Intervention	The project targeted children during the critical period from conception through 24 months of age, roughly equivalent to the first 1,000 days of life, through integrated agriculture, nutrition and health community based interventions. The objective of sector interventions were to increase year round availability of, and access to, nutrient rich foods at the household level, in some areas accompanied by promotion of optimal health, nutrition, and care seeking behaviour through the delivery of social behaviour change communication in others.
Mode of Delivery and Convergence	Sector interventions delivered separately through local women's groups created by the programme. A female Smallholder Model Farmer (SMF) nominated by her group to receive agricultural training and inputs and pass these on during monthly meetings. BCC component led by an existing Community Based Volunteer (CBV) who receives additional training in nutrition topics to pass on to the group.
Coverage	Implemented in 1/117 districts nationally. Intervention *coverage* was referred to as *participation* in the evaluation. The evaluation presented results both on *participation* (whether and to what extent a household was participating in RAIN project components) and *delivery* (RAIN implementation being received as planned). The results were as follows: ▪ 31 % of households participated in the Ag-only group, ▪ 34 % in the Ag-nutrition group ▪ No difference in reported participation when restricting analysis to households with a child < 2 years of age, at end line

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Evaluation report(s) # 6: Realigning Agriculture to Improve Nutrition (RAIN), Zambia, 2011-2015 [73]	
	Among the 1/3rd of households participating intensity varied ▪ 50% of all households received medium or high levels of programme delivery ▪ In terms of intensity of delivery, SMF attendance at RAIN groups was high (approximately 90%), ▪ CBV attendance was low (38-45%); ▪ In terms of spill over between study arms, leakage of CBV participation to the Ag-only group was fairly common as some clinics where RAIN-trained CBVs were based were sited on the border between project areas, ▪ Leakage of the project to control areas was not common ▪ The overall pattern and magnitude of results did not differ between all households sampled, and households with a child < 2 years of age, when sampled at end line.
Impact on Nutritional Outcomes	▪ No discernible impacts on reducing the prevalence of stunting between treatment and control arms. Magnitude of stunting reduction smaller in intervention vs. control group. ▪ No additional benefit of the Ag-Nutrition arm, vs the Ag-only arm for impacts achieved
Impact on Secondary outcomes	▪ No discernible impact on maternal factors such as prenatal visits, dietary diversity, and BMI across the three groups ▪ Both the Ag-Nutrition and the Ag-only arms, had greater increases over time, compared to the control group, on the total number of foods produced, the total number of agricultural activities engaged in by the households, and the number of months producing Vitamin A rich foods, and dairy. ▪ Ag-Nutrition group had significant positive impacts on household dietary diversity, with an increase of about 1 food group, based on a 12 food group scale, in both intent-to-treat, and per-protocol analyses ▪ Overall, no attributable programme impact on improving IYCF practices in both intent-to-treat and per protocol analyses with exception of consumption of legumes/nuts which was higher in both intervention arms compared to control. With regard to household determinants/perceptions; ▪ There was a significant positive impact on households reporting "severe hunger" in the Ag-Only group.

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Evaluation report(s) # 6: Realigning Agriculture to Improve Nutrition (RAIN), Zambia, 2011-2015 [73]	
	▪ Of interest was a significant decrease in the prevalence of households reporting "little to no hunger" in the Ag-Nutrition group vs. control group, this was coupled with an increase in the level of "moderate hunger in the same group[5]
Scale up beyond evaluation	There was no indication that the project was scaled up in the evaluation. A key challenge of the intervention was the very low coverage of the Ag-Nutrition arm as CBVs were a lot less active than agricultural counterparts as shown in the coverage results. A process evaluation found that SMF which were new positions dedicated to the programme were better incentivised and more focused than CBVs who already worked in the community. The intervention was unable to adequately account for general improvements in government health services across the district, which seem to have occurred even in the control and agriculture only group.

Evaluation report(s) # 7: Feed The Future-Western Highlands Integrated Program (WHIP) GUATEMALA-Interim assessment, 2013-2015 [71,110]	
Study Design/Level of Evidence	Quasi-experimental, advanced methods for control selection, DD approach (2c). The study design resulted in three distinct arms: ▪ RVCP (Rural Value Chain Project) direct beneficiaries, who are exposed to the health programme interventions and also enrolled in the agricultural intervention; ▪ RVCP indirect beneficiaries, who are exposed to the health interventions and exposed indirectly to the agricultural interventions, and ▪ Health Only beneficiaries, who receive only the health interventions. Baseline indicators were collected by survey in 2013, and were measured again in 2015 and 2017. Note: Unlike other Feed the Future focus countries, a full report is not available for the 2015 Guatemala ZOI interim population-based survey due to complex sample weighting issues impacting comprehensive data analysis and reporting. A full report for

[5] Does increased awareness of optimal nutrition increase perception of hunger?

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Evaluation report(s) # 7: Feed The Future-Western Highlands Integrated Program (WHIP) GUATEMALA-Interim assessment, 2013-2015 [71,110]	
	end line estimates of indicator values for the Feed the Future Guatemala Zone of Influence is expected in 2020. Used confidence intervals to test for statistically significant change. **For this reason this study is downgraded to a baseline-end line design 3b**
Theory of Change	RVCP is expected to improve household income, which in turn should improve household dietary quality/quantity. The second component seeks to improve families' nutritional status through education and information communication in RVC members' households. Combining education with income generation should generate positive changes in nutrition-related behaviour; improved household food availability, and increase children's and women's dietary diversity and quality, resulting in improved nutritional status
Intervention	Feed the futures Agricultural Value Chain approach which aims to improve access to markets, product quality and competitiveness combined with nutritional education and BCC
Mode of Delivery and Convergence	Interventions delivered separately ▪ Technical assistance (TA) and training to agricultural producers' associations on; horticultural and coffee value chains, TA to handicraft producers on how to increase their production, improve the quality of their products, expand their market competitiveness, and gain access to national and international markets. ▪ The health component seeks to improve families' nutritional status through education and information communication in RVCP members' households.
Coverage	The RVCP and the health and nutrition programme– form the basis for the sampling strategy used in the baseline survey and for the impact evaluation design. The health and nutrition programme covers the entire population in the 30 priority municipalities (Guatemala has 340 municipalities), while the *RVCP focuses only on selected producers' associations. RVCP is mainly expected to generate effects among the producer-members of associations participating in the programme, and to yield indirect effects on households located in the same census tracts (sectores in Spanish) as association members, through increasing incomes and local expenditures, and by generating employment from increased productive activities.*
Impact on Nutritional Outcomes	Unknown impact as final report pending. Improvement on stunting on preliminary/draft interim report (Stunting prevalence reduction from 67.7% to 60.5%). No improvement on wasting or underweight in children

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Evaluation report(s) # 7: Feed The Future-Western Highlands Integrated Program (WHIP) GUATEMALA-Interim assessment, 2013-2015 [71,110]	
Impact on Secondary outcomes	▪ Improvement on daily per capita spending in USG assisted areas ▪ Improvement on exclusive breast feeding ▪ Improvement on reported moderate to severe household hunger ▪ No improvement on any of the other poverty indicators ▪ Negative direction on prevalence of women of reproductive age getting the minimum dietary diversity ▪ Negative direction on prevalence of children 6-23 months receiving minimum acceptable diet
Scale up beyond evaluation	*Unknown*

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Evaluation report(s) # 8: Nutrition at Centre (N@C), Bangladesh, May 2013 to Dec 2017 [68]	
Study Design/Level of Evidence	Designed as a standard quasi-experimental & DD approach (2e) **but downgraded to a single arm baseline-end line (repeated cross-sectional) design (3b)** because controls selected were improper and impact assessment could not be made. Baseline survey conducted in 2014 and follow up survey in 2017. Control and treatment groups drawn from two intervention sub-districts of Sunamgonj (Derai and Biswamberpur) and two control sub-districts of Kishoreganj (Itna and Nickly) districts. Survey collected quantitative information on the status of nutrition related indicators.
Theory of Change	*Not explicitly outlined.* The project aimed to integrate nutrition into the existing community health system to support effective Maternal and infant and young child feeding nutrition (MICYN). It also aimed to facilitate sub-district multi-sector coordination platforms using existing committees within the government system at community, union and sub-district levels.
Intervention	Community centred integrated approach addressing Food Security, Water Sanitation and Hygiene, Infant and Young Child Feeding and Women' Empowerment. The following sectors worked together to achieve the listed objectives; ▪ Maternal and infant and young child feeding nutrition (MIYCN) education was integrated into existing platforms, such as ▪ women's empowerment groups ▪ Water, sanitation and hygiene (WASH) education was included as part of infant and young child feeding (IYCF) counselling; ▪ The health department launched school handwashing campaigns to complement school-based iron and folic acid (IFA) distribution programmes; and ▪ The Women's Affairs department provided vouchers to allow poor pregnant and lactating women (PLW) to access health and nutrition services.
Mode of Delivery and Convergence	Intervention was delivered separately via facilitation of improved practices and capacity in different parts of the health sector: family planning, nutrition and family welfare. In the existing health system; ▪ CARE trained government frontline health workers (FLWs) and family planning supervisors in the project area and their first and second line supervisors on optimal IYCF practices using supportive supervision, mentoring and monitoring

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Evaluation report(s) # 8: Nutrition at Centre (N@C), Bangladesh, May 2013 to Dec 2017 [68]	
	▪ N@C advocated with the Institute of Public Health and Nutrition (IPHN) to ensure supplies to support GMP, including arranging a one-day refresher training on GMP for community health care providers (CHCPs) based at community clinics (the lowest primary healthcare structure in Bangladesh) ▪ Breastfeeding corners were established at community clinics working with the Ministry of Health and Family Welfare (MoHFW) to create space for CHCPs, family welfare assistants and health assistants to counsel mothers on breastfeeding techniques and MIYCN and to provide privacy for mothers At the committee levels referenced in theory of change; ▪ CARE facilitated a participatory process to develop terms of reference (TOR) for each of the committees, ▪ built the capacity of committee members through awareness and training sessions, and ▪ provided on-the-job support to make the committees functional and effective
Coverage	2/10 upazillas in Sumanganj district which is 1/64 nationally. The intervention achieved 100% coverage for the following components; MIYCN training at all levels, Growth Monitoring Programme training, supportive supervision, mentoring and monitoring for government family planning 1st and 2nd line workers and community support group training on leadership, management and nutrition. No coverage estimates were provided for sessions provide in schools or to pregnant and lactating women.
Impact on Nutritional Outcomes	Found an overall decrease in stunting by 14.2 percentage points but this was also evident in control group. Decreases in prevalence of underweight children Limited changes for wasting or prevalence of anaemia in children. Other actors in the control area may have been contributed to similar decreases in control area? No statistical tests attached to baseline vs end line comparisons though statistical approaches to comparing results were outlined in baseline.
Impact on Secondary outcomes	There were several secondary outcomes included in this evaluation, which can be reviewed with regard to improvements in the intervention households from baseline to end line:

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Evaluation report(s) # 8: Nutrition at Centre (N@C), Bangladesh, May 2013 to Dec 2017 [68]	
	Decrease in reported household hunger Substantial increase in % participating in food for work programme- not clear if this is desirable? Modest increase in kitchen gardens Increase in women's dietary diversity Decrease in chronic energy deficiency Increases in use of ANC and PNC Increase in prevalence of anaemia among women Substantial increase in exclusive breast feeding and improvements in initiating breast feeding on time. Substantial increases in feeding practices indicators for children aged 6-23 months Substantial improvements in the use of safer drinking water, use of soap or soap agents after using the toilet, use of pit latrines Decrease in reported postnatal depression
Scale up beyond evaluation	The findings of the evaluation of N@C were shared with national stakeholders and policy makers have begun to prioritise and incorporate multi-sector nutrition committees in the country's second National Plan of Action for Nutrition

Evaluation report(s) # 9: SPRING-Bangladesh, 2012-2016 [70]	
Study Design/Level of Evidence	Standard quasi-experimental & DD approach, improper control (2e) The assessment included 26 upazilas, or sub-districts: 15 from the area where SPRING operated and 11 from other areas of the Feed the Future zone. The baseline and end line surveys

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Evaluation report(s) # 9: SPRING-Bangladesh, 2012-2016 [70]	
	were done a year apart in households with children under 5 years of age in the poorest two wealth quintiles, with a focus on SPRING's target population of pregnant and/or lactating women (PLW) and children under 2 years of age.
Theory of Change	Logic model with Inputs, Processes, Outputs, Outcomes and Impact provided.
Intervention	Homestead food production training alongside nutrition BCC/education for target population, agricultural extension workers and within health system
Mode of Delivery and Convergence	Joint delivery using peer community nutrition champions of both food production and nutrition information ▪ Farmer nutrition schools (FNS) approach- Training women in target group on homestead food production including inputs such as seedlings ▪ HH dietary diversity training ▪ Essential Nutrition Actions (ENA) training for Agricultural extension workers ▪ Strengthening of existing PH system by providing training in nutrition counselling at family welfare clinics and community clinics for frontline health workers and family planning workers ▪ Expanding reach by partnering with other USAID projects in an effort to scale up
Coverage	Implemented in 40 Upazillas across 9/64 districts nationally. SPRING estimates that they reached approximately 60 % of PLW in the two poorest wealth quintiles living in the 40 upazilas over our five-year implementation period
Impact on Nutritional Outcomes	*It is important to note that the ability to isolate SPRING's impact in the assessment is limited because many other nutrition programmes were active throughout the Feed the Future zone at the same time as SPRING—there were no working areas where SPRING was the sole implementing project and no areas of the Feed the Future zone where no other projects were operating. This assessment can best be seen as measuring impact as the value added by the SPRING package of activities on key indicators, when compared to other Feed the Future areas where SPRING was absent but other health and nutrition projects were active* In SPRING areas, severe stunting decreased significantly from 16 percent to 10 percent, while increasing in other Feed the Future areas from 7 to 12 %. Limited changes for wasting or prevalence of anaemia in children, but not moderate stunting or wasting No impact but substantial improvement in women's body mass index (BMI)

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Evaluation report(s) # 9: SPRING-Bangladesh, 2012-2016 [70]	
Impact on Secondary outcomes	Impact on children's dietary diversity, food production through household gardens, some breastfeeding indicators, and maternal nutrition. Improvement in food security.
Scale up beyond evaluation	The project reported scaling up from 15 upazillas or districts to 40 during the 5 year period.

Evaluation report(s) # 10: Millennium Village Project-Ghana, 2012-16 [52,64-65]	
Study Design/Level of Evidence	Standard quasi-experimental design & DD approach; advanced analysis approach (2e). c
Theory of Change	The central hypothesis is that by addressing the most immediate capital deficiencies in communities and households through a form of local 'big push', this provides the necessary conditions for reaching the threshold required to move towards local resilience and self-sustaining economic growth. A key part of the approach is to improve agricultural productivity and market development, enabling people living in rural areas to save and accumulate wealth, stimulating investment and diversification into non-farm work. However, the report also notes that, *it is very difficult to pin down the overall theory of change for the northern Ghana MVP. The project itself does not have an overarching theory of change underpinning the programme logic to articulate how the inputs-to-outputs-to-outcomes achievements result in MDG-level impacts. This is partly because of the programme's complexity since multiple interventions are designed to lead to multiple outcomes, but also because the MVP adjusted its interventions each year rather than delivering a fixed package of projects.* The theory for change in the health and the agricultural sectors were outlined.
Intervention	Simultaneous package of community based interventions and packages in the following sectors: infrastructure; business development; agriculture; health; and education. MV-Ghana's stated goal was to -accelerate progress towards the MDGs', with the goal to have a regional impact on poverty in the Northern/Upper East regions; with the of the population living below the

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Evaluation report(s) # 10: Millennium Village Project-Ghana, 2012-16 [52,64-65]	
	extreme poverty line reducing from 52.3% (Northern Region) and 70% (Upper East region) to 33% overall by the end of 2016. The target for under-five mortality is that it will fall from 124 deaths per 1,000 (Northern) and 98 deaths per 1,000 (Upper East), to 54 by the end of 2016
Mode of Delivery and Convergence	Assuming knowledge of what works generally, but not knowing with certainty what works in different specific circumstances, the project required a process of learning-by-doing in every community in order to select the right mix of development interventions specific. In Ghana, the following interventions were delivered separately within each sector during project implementation in the health and agricultural sectors which impact most immediately on nutrition ▪ Health facility improvements in infrastructure and equipment ▪ Training of health providers ▪ Resource distribution (bed nets) and community level health education for beneficiaries ▪ Provision of resources; fertiliser, seed and agricultural tools and equipment ▪ Training/information and extension i.e. crop diversification, agricultural extension service, access to equipment/services ▪ Infrastructural development- setting up drip irrigation systems and cultivate land ▪ Establishing and strengthening cooperatives- credit, linkage to suppliers, market access, management capacity
Coverage	Implemented in 3/260 districts (Selected cluster of communities within this up to 25k people). Overall coverage rates of the interventions were not presented in the report, with the exception of participation in farmer member's groups and attendance of training in agriculture. Generally participation rates increased to a peak midway through the project and fell back toward baseline levels by the end of the project. Farmer groups from 10% to 20% and attendance of training from 20 to 50%. There was a significant difference when comparing MV to control villages in participation in these groups/activities with more participation in groups and trainings in the MV than control areas. Members of farmers groups and those attending agricultural training at midline were predominantly older, married males
Impact on Nutritional Outcomes	Significant positive impact on stunting (~28% to 13%). No impact on underweight. Wasting increased in MV areas in comparison to CV areas, but this was posited not as a negative effect of MV but rather a consequence of children's height improving at a faster rate than weight

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Evaluation report(s) # 10: Millennium Village Project-Ghana, 2012-16 [52,64-65]	
Impact on Secondary outcomes	▪ Positive impact on increased protein content of children's diets, and children eating more meals overall - confirmed by assessment of dietary indices ▪ Incomes have grown at the same rate for all households, leaving inequality unchanged ▪ Increased the proportion of births attended by professionals and the number of women said to be using contraceptive methods, although it is not possible to assess the effect on maternal health; ▪ Increased access to and use of improved toilets although there is qualitative evidence that this is unsustainable ▪ Study was designed to look at spill over effects of the intervention, overall findings do not, however, support the hypothesis of geographic spill over effects
Scale up beyond evaluation	The MVP model by design was a 10-year initiative with two 5-year phases, the second of which was a scale up of activities started in the first phase- this is not what appears happened in Ghana. This project was run for 5 years and the overall impact of the MVP model in Ghana was not impressive and resulted in some key recommendations that are useful for interventions using a multi sectoral approach to address interrelated challenges.

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Evaluation report(s) # 11: Livelihood Empowerment against Poverty (LEAP) 1000 program, Ghana, 2015-17 [72,111]	
Study Design/Level of Evidence	Designed as a standard quasi-experimental & DD approach (2e) **but downgraded to a single arm baseline-end line (repeated cross-sectional) design (3b)** because despite selecting control households based on their similarity to LEAP households at baseline using a statistical technique known as propensity score matching, they were not representative when triangulated with data from the Ghana Living Standards Survey (GLSS) with extraordinarily large improvements in consumption and other indicators that are well above those implied by GLSS or per capita GDP growth during this period.
Theory of Change	Not stated or outlined in the report but the programme's objectives are to alleviate short-term poverty and encourage long-term human capital development.
Intervention	LEAP is a social cash transfer programme which provides cash and free access to health insurance to extremely poor households across Ghana. The programme is the flagship of Ghana's National Social Protection Strategy and is implemented by the Department of Social Welfare (DSW) in the Ministry of Gender, Children and Social Protection (MoGCSP)
Mode of Delivery and Convergence	Sector activities are converged to identify beneficiaries and fund relevant facilities prior to reaching beneficiaries; ▪ Selection of households done through a community-based selection process and verified centrally with a proxy means test (PMT). ▪ Beneficiaries are entitled to free health insurance through the National Health Insurance Scheme (NHIS), which began in 2004-2005, allowing card-holders access to basic health services. This is facilitated through a Memorandum of Understanding between the MoGCSP and MoH, under which funds to cover enrolment in health insurance are transferred directly to the local health authority, who then issues cards to all members of LEAP households.
Coverage	National coverage rates for the NHIS increased from 28% to 52% for adults and 23% to 57% for children in LEAP households.
Impact on Nutritional Outcomes	Unknown because comparisons could not be made to control group. No mention of stunting in report. There was no mention of any anthropometric outcomes.
Impact on Secondary outcomes	There were several secondary outcomes included in this evaluation, which can be reviewed with regard to significant improvements in the intervention households from baseline to end line: ▪ Increased household consumption, primarily on food with diversification in diet to include more protein

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Evaluation report(s) # 11: Livelihood Empowerment against Poverty (LEAP) 1000 program, Ghana, 2015-17 [72,111]	
	▪ increases in the proportion of LEAP households with any productive assets (e.g. implements) or livestock, and fertilizer and seed use ▪ Limited improvements in schooling ▪ Improvements in access to NHIS amongst adults and children in LEAP households
Scale up beyond evaluation	LEAP started a trial phase in March 2008 and then began expanding gradually in 2009 and 2010, followed by a rapid scale-up in 2015- 2016. As of April 2017, the LEAP programme reaches over 213,000 households across Ghana.

Evaluation report(s) # 12: Action Against Malnutrition through Agriculture (AAMA), Nepal, 2008-2012 [86]	
Study Design/Level of Evidence	Standard quasi-experimental & DD approach (2e). The project, called Action Against Malnutrition through Agriculture (AAMA) targeted three districts in Far West Nepal: Kailali, Baitadi and Bajura. The EHFP intervention was the same in all districts, but Baitadi served as the Operations Research (OR) district. Kailali, the district chosen for the scale-up model, is one of the most populous and one of the largest geographically in all of Nepal. In Baitadi the EHFP intervention was implemented as a community randomized effectiveness trial. Four intervention Ilakas, or sub-regions were randomly selected and matched with four control Ilakas on economic, health and food security indicators; baseline and end line measures of both arms were compared (double-difference estimates) to allow for probability assessment of the impact of the intervention.
Theory of Change	Helen Keller Institute Program Impact Pathways for AAMA in Nepal were provided.
Intervention	Helen Keller Institute's (HKI) Enhanced Homestead Food Production (EHFP) model coupled with ENA information and skills as part of nutritional BCC training/counselling from FCHVs and targeting pregnant and lactating women and those with children under 2 years of age.

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Evaluation report(s) # 12: Action Against Malnutrition through Agriculture (AAMA), Nepal, 2008-2012 [86]	
Mode of Delivery and Convergence	Joint delivery where FCHVs (below) shared ENA information at group meetings convened by VMFs (below). FCHVs were given the option of being VMFs, if they had enough land, or of joining the HFPB. All affiliated FCHVs received training intended to expand their basic nutrition knowledge around the ENA and, skills for nutrition counselling. The VMFs provided a platform to facilitate their education efforts regarding nutrition, and enabled them to reach mothers of children under two who are not currently in their traditional mother's groups. At beneficiary level ▪ Volunteers selected to serve as Village Model Farmers (VMF), receiving training, inputs, and supportive supervision to start models of vegetable gardening and poultry raising. ▪ Two groups of ~ 15 women (either pregnant or having children under two years of age). ▪ Household Food Production Beneficiaries (HFPBs), received inputs of seeds, seedlings and chickens of improved breeds. ▪ In addition to agricultural training under the EHFP model, there was the promotion of the Essential Nutrition Actions using a health communication/BCC approach via Female Community Health Volunteers (FCHV) who already exist in the national health system At community level ▪ Governance component which served to bring together various government entities at the national, regional, district and local levels to collaborate on addressing food security and nutrition. ▪ This component empowered local stakeholders to advocate through local governance channels for funding to support AAMA activities or replication of the activities in adjacent wards.
Coverage	3/74 districts nationally. In Kailali district where coverage was estimated, the intervention reached 15% of the target population of PLW with children up to 2 years of age.

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Evaluation report(s) # 12: Action Against Malnutrition through Agriculture (AAMA), Nepal, 2008-2012 [86]	
Impact on Nutritional Outcomes	▪ Significant reduction in stunting and anaemia in Kailali ***but this was an improvement over time not in comparison to control group***[6] ▪ Among the Dalit (disadvantaged) population in Baitadi there was a significant reduction in both anaemia and underweight in women of reproductive age. Total anaemia prevalence among the women in the intervention group was significantly reduced with an adjusted odds ratio of 0.59 (0.45 – 0.76); $p<0.05$. Which means the odds of being in the control group and having anaemia was twice that of women in the intervention group. ▪ No significant improvements or impact on anthropometric outcomes for children in Baitadi and Bajura ▪ There was no change in these anaemia or anthropometric measures for Bajura where exposure to project activities was limited to two years and there are other factors such as extremely poor sanitation that may affect nutritional status.
Impact on Secondary outcomes	Significant improvements on changing IYCF practices for all indicators at all three sites maternal health behaviours and adoption of HFP practices for raising vegetables
Scale up beyond evaluation	The governance component, although limited, was very successful in promoting citizen participation in influencing budget allocations, and in bringing together cross-sectoral working groups to plan, to coordinate, and to influence VDC and District-level funding. Its success was evident in the appointment of Village Health Focal persons (VHFs) as Local Resource Persons and in replication of some AAMA activities to many other wards and to marginalized populations.

[6] It is important to review summary findings keeping in mind that HKI contracted different research firms to conduct the final evaluation in Kailali and Baitadi which may have led to some issues in comparability of the baseline and final results. To address this, the firm working with Kailali data re-calculated all the baseline data. This, however, would not compensate for possible differences in data collection by end line enumerators compared to the work done by baseline enumerators

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Evaluation report(s) # 13: Chars Livelihood program (CLP), Economic Empowerment of the Poorest programme (EEP)/Economic and Social Empowerment of the Extreme Poor (ESEP) & Urban Partnership Poverty Reduction Programme (UPPR), 2010-16 [87]	
Study Design/Level of Evidence	Standard Quasi-experimental design & DD approach (2e) The evaluation employed mixed quantitative and qualitative methods within a strong theory-based design to assess the impact of the integrated programmes on nutritional status. The three arms of the study were as followed: ▪ Livelihood only ('L only'); ▪ Livelihood intervention combined with a nutrition-specific intervention ('L+N'), ▪ No livelihood or nutrition-specific intervention (control) Statistical testing looking at double-difference impacts undertaken for key and secondary indicators.
Theory of Change	The overall programme and evaluation theory of change was provided.
Intervention	Livelihood support composed of infrastructure improvements, transfer of productive assets (cows and goats) and short-term social protection (cash stipends) coupled with Behaviour change communication (BCC) and micronutrient supplementation. The target group was identified from extremely poor households living on island chars on the Jamuna River in Northern Bangladesh. ▪ The Chars Livelihood programme (CLP) provided the direct household support ▪ Empowerment of the Poorest Programme (EPP) worked via two challenge funds: the Scale Fund provided non-governmental organisations (NGOs) with opportunities to lift large numbers of people out of poverty, while the Innovation Fund challenged NGOs to implement innovative approaches. Modalities towards these objectives included; ✓ Input support and technology transfer for livelihoods (including guidance on new cropping and cropping patterns, training and assets for livestock, fishing, bamboo working, small businesses and tailoring); ✓ Capacity building (including setting up self-help groups; facilitating community-based organisations (CBOs) and links with local government); and ✓ Support to beneficiaries for innovation and linkage to markets and/or value chains ▪ Urban Partnership for Poverty Reduction Programme (UPPR) used a community-centred approach to urban poverty reduction by: ✓ Supporting habitat and settlement improvement (including sanitation);

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	✓ Providing resources to improve incomes and assets, and support for urban food production (household/community-based vegetable production, and poultry and dairy cow rearing) and small business management; encouraging inclusion in education, for example through grants for vulnerable children to prevent school drop-out; ✓ Facilitating community banking; and enhancing social development and protection, including by helping beneficiaries achieve security of tenure
Mode of Delivery and Convergence	• Asset Transfer Program (ATP) for eligible households which comprises £100 of productive assets to 50,000 of the poorest households. Assets include livestock, rickshaws or sewing machines followed by a monthly stipend ▪ Provision of physical infrastructure e.g. plinths to raise homesteads above flood lines, latrines and tube wells ▪ Social development training and other types of support e.g. village savings and loans, community health care and enterprise development training ▪ **Micronutrient supplementation** (for children and pregnant women) delivered via community nutrition workers (CNWs) or Char Pushti Karmis (CPKs) who also ▪ Provided household level counselling on a monthly basis on IYCF and WASH The process evaluation found that implementation of most nutrition interventions largely occurred across all sites but with notable early teething problems, especially with household counselling. There was a tendency to just deliver 'hard' inputs (the supplements) instead of the 'soft' activities of counselling and promotion. Often, the L and N interventions were run as separate programmes at a community level, with little interaction between staff.
Coverage	3 programmes working with specific target groups- "highly vulnerable and poor- urban and rural groups" at sub national levels but across the country for 2 of the programmes and in only 2 districts for one programme Participation rates at end line varied for the various indicators with the highest being 27% of targeted households still owning a dairy cow and the lowest being production of food in their homestead gardens in the last year at 3% of target households.

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Evaluation report(s) # 13: Chars Livelihood program (CLP), Economic Empowerment of the Poorest programme (EEP)/Economic and Social Empowerment of the Extreme Poor (ESEP) & Urban Partnership Poverty Reduction Programme (UPPR), 2010-16 [87]	
Impact on Nutritional Outcomes	No impact on stunting on either intervention arms. Authors note this was always an ambitious goal in 2 yrs. Evidence for the causal chain breaking down due to implementation problems with the nutrition arm likely also contributed to this lack of impact on stunting
Impact on Secondary outcomes	Limited evidence of behaviour change resulting from the nutrition-specific intervention with exception of iron intake but this was provided as part of the micronutrient supplementation for free.
Scale up beyond evaluation	This intervention was an extension of a previous intervention which was modified as described. The first phase of the programme ('CLP-1') which cost £50 million, ran from 2004-2010 and was funded by DFID. It was succeeded by a second phase ('CLP-2') which began in 2010 and was due for completion in 2016, with AusAID joining as a funding partner. There is no indication that the programme was scaled up beyond this evaluation in the documents reviewed.

~~Evaluation report(s) # 14: Sustainable Undernutrition Reduction in Ethiopia, 2017-2019~~ [66]	
Study Design/Level of Evidence	Standard Quasi-experimental design & DD approach (2e). The SURE evaluation aims to demonstrate the extent to which complementary feeding and dietary diversity for young children are increased and stunting reduced among SURE intervention districts versus comparison districts. The baseline survey was completed in July 2016. The first round of process evaluation data collection was conducted in June 2017 and the second round in December 2017. A third round of process study data collection was planned in 2018, to be followed by the end line survey in 2019. Baseline data has been published but publication of the final evaluation is pending.
Theory of Change	The intervention's impact pathways were outlined.

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~~Evaluation report(s) # 14: Sustainable Undernutrition Reduction in Ethiopia, 2017-2019~~ [66]	
Intervention	A community /household approach to promoting nutrition-sensitive agricultural training, coupled with IYCF counselling and promoting the important role that men play in influencing nutritional outcomes for their households
Mode of Delivery and Convergence	Nutrition information was integrated into agricultural training and delivered to beneficiaries ▪ IYCF counselling for mother-father pairs ▪ Nutrition-sensitive advice on agricultural practices ▪ Men's and Women's Groups for dissemination of information on nutrition including, cooking and agricultural demonstrations and joint household visits (female and male head of houses) ▪ Coordination and monitoring by multi-sectoral committees at district level ▪ Media Campaign
Coverage	Implemented in 150/770 districts nationally in four agrarian regions (Amhara, Oromia, Tigray and SNNPR)
Impact on Nutritional Outcomes	*Evaluation pending.* However, baseline found that: ▪ Child dietary diversity (children consuming 4 + food groups) was positively associated with higher mean levels of LAZ ▪ Mean levels of LAZ were positively associated with age, socio-economic status, maternal education, fruit and vegetable production, and land ownership.
Impact on Secondary outcomes	▪ Child dietary diversity was also positively associated with socio-economic status, maternal education, women's empowerment, paternal childcare support, household food security and land ownership ▪ Household production of fruits and vegetables was associated with both increased child dietary diversity
Scale up beyond evaluation	*To be determined- Evaluation pending*

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Evaluation report(s) # 15: "Feed the Future Cambodia Helping Address Rural Vulnerabilities and Ecosystem Stability (HARVEST) Project, 2010-2016 [88]	
Study Design/Level of Evidence	Standard Quasi-experimental design & DD approach (2e). Baseline (2012) and end line (2016) data were collected from a sample of farmers from villages designated as the treatment group, and from villages designated as the comparison group. The propensity score matching method was applied to the baseline data first to create treatment and comparison groups that matched on propensity score. This was followed by estimating the average effect of HARVEST interventions across all the sampled households that had received direct technical assistance from Cambodia HARVEST compared with the effects across all the sampled households in the comparison villages. *Given, the presence of other donors and government programmes in the study area, and potential contamination from close proximity of treatment and comparison villages—this study cannot arrive at any conclusions about the relative effectiveness of Cambodia HARVEST, other donor programmes, or no interventions.*
Theory of Change	Programme Effects Pathways are outlined.
Intervention	HARVEST programme interventions focused on increasing incomes to influence nutrition outcomes. This was achieved through an approach that integrated activities from a range of sectors—agriculture, fisheries, forestry, nutrition and more—to help families in rural areas grow, purchase, and prepare more nutritious foods and reduce rates of malnutrition and poverty.
Mode of Delivery and Convergence	Used a comprehensive and intensive extension methodology to deliver hands-on technical assistance to smallholder farmers (including women and youth) and other programme clients which included: ▪ Agriculture value chain activities (rice, horticulture and aquaculture) ▪ Nutrition education including demonstrations , home gardens and mobile kitchens ▪ Strengthening post-harvest systems from input supply sector, to microfinance, marketing and social inclusion ▪ Improving natural resource management and resilience to climate change ▪ Increasing the capacity of local partners via policy development, formation of food security and nutrition groups , savings funds and research and extension
Coverage	Selected districts in 4/25 provinces nationally. The evaluation looked at the coverage of the interventions as part of its assessment. Overall, about two-thirds of the households participated as clients for home gardening, about 50% in the rice value chain, and about 20% in the aquaculture value chain. For all types of interventions, the rate of participation was higher among male-headed than female-headed households. For the nutrition component, five intervention posters were developed covering

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Evaluation report(s) # 15: "Feed the Future Cambodia Helping Address Rural Vulnerabilities and Ecosystem Stability (HARVEST) Project, 2010-2016 [88]	
	hygiene and nutrition, an assessment of exposure to these found that there was a high level of awareness and familiarity with these posters. Both amongst the Cambodia HARVEST intervention villages and the comparison villages. In the treatment group, 65% to 84% of women reported having seen these posters before, and 55% to 71% of women in the comparison group reported having seen the sample poster
Impact on Nutritional Outcomes	Overall Unknown impact- control villages seem to have had the same increases over time as there were other interventions in those areas. No apparent impact on stunting but improvements from baseline to end line in treatment and control groups. Potential positive impact on the prevalence of wasting and underweight among children younger than 5 years The prevalence of stunting, wasting, and underweight among children younger than 5 was, respectively, in the range of 30%, 10%, and 20% among the treatment group in 2016, which was a reduction from the observed rates (i.e., 45%, 10%, and 30%, respectively) in 2012. Possible negative impact on the reduction of the prevalence of underweight in children
Impact on Secondary outcomes	Apparent impact on rice yield per household Increased value of vegetable production for female-headed households No impact on income, expenditures, poverty status and dietary diversity
Scale up beyond evaluation	A second phase of this project was launched after this evaluation- https://www.usaid.gov/cambodia/press-releases/sep-27-2017-new-project-boost-cambodian-horticulture in the same areas- it does not reference this evaluation so it's not clear if it's scaling up activities in the first phase.

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Evaluation report(s) # 16: Yaajeende Agricultural Development project, Senegal, 2010-2017 [89]	
Study Design/Level of Evidence	Standard quasi-experimental & non-DD approach (2f). The statistical impact analysis uses a difference-in-differences (DID) regression approach, coupled with statistical matching via entropy weighting, to estimate the project's impact on outcomes of interest. However, authors also noted that analyses are underpowered to detect a small significant effect. This is done for an analytical sample of 1,830 households in 115 villages in the treatment group, and 640 households in 42 villages in the comparison group. Yaajeende impacts are assessed and reported for both the midline to end line (ML-EL) period (2015 to 2018), and across baseline to end line (BL-EL, 2011 to 2018).
Theory of Change	Aimed to improve food security at the local level and enhance nutrition outcomes for pregnant women and children under five through an approach known as Nutrition Led Agriculture (NLA).
Intervention	Intervention promoted the emergence of an agricultural sector focused on the improved production, trade, and consumption of highly nutritious foods, especially foods that resolve priority nutritional deficiencies such as vitamin A, zinc, iodine and iron. Expanding access to agricultural inputs, fortified foods, improved technologies, and services was a major focus, as was increasing the availability of nutritious foods on local markets while building demand and promoting their proper utilization in local households
Mode of Delivery and Convergence	Yaajeende staff work with and train a cadre of community-based local resource persons (LRPs) to deliver an integrated package of interventions, supported by a range of government, private sector, and community institutions ▪ Organised poor farmers into producer groups or producer organizations, enabling them to take advantage of economies of scale and gain access to new skills, technologies, and financial resources. This included the innovative approach of establishing locally elected as Community Based Solution Providers (CBSPs) and linking them to suppliers of quality agricultural, health and nutrition products. CBSPs are then trained on how to sell these products based on the needs of their communities in addition to commercial activities such as making loan applications to local banks. ▪ Behaviour Change Communication with mothers using community nutrition volunteers who are part of the Nutrition Enhance Program
Coverage	Yaajeende was implemented in 790 villages across 49 municipalities ("communes" in French) in the regions of Matam, Kédougou and Kolda and the department of Bakel in Tambacounda. According to project documentation, the geographic

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Evaluation report(s) # 16: Yaajeende Agricultural Development project, Senegal, 2010-2017 [89]	
	coverage of the project was substantial, reaching 84 % of Matam, 70 % of the department of Bakel and 40 % in each of Kédougou and Kolda. Implemented in 4/14 regions nationally- targeting areas with arable land and water but high rates of malnutrition
Impact on Nutritional Outcomes	*The authors noted that while, the evaluation often found moderate to no evidence of Yaajeende programme impacts beyond the comparison situation, the interpretation for many of the evaluation results does not necessarily mean that Yaajeende had no impact, but rather that the Yaajeende programme's effects were similar to those of other programmes implemented in comparison group villages.* No impact on stunting but positive impact on the reduction of the prevalence of underweight in women (a 5.6pp decrease)
Impact on Secondary outcomes	Increase in minimum acceptable diet in children- no other discernible impact compared to comparison villages for other outcomes. These included; household food security; dietary diversity; economic well-being; Household water, sanitation and health (WASH) practices; and Household agricultural practices.
Scale up beyond evaluation	Given the positive health impact and commercial success at the entrepreneur-level of Yaajeendee's approach, the CBSP grew organically. Working with *Spring Impact,* after assessing the networks ability to scale a bespoke social franchise business model, branded as CultiVert, was designed and is being piloted in Matam and Bakel, areas in the North Eastern part of Senegal to see if the Yaajende model can be scaled up further. https://www.springimpact.org/2016/07/yaajeende/. See- https://www.facebook.com/cultivert/

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Evaluation report(s) # 17: SUAAHARA II, Nepal, 2016-18 [74-75]	
Study Design/Level of Evidence	Standard Quasi-experimental design & non-DD approach (2f) Annual cross section surveys with no control group comparison so now way of evaluating impact of the intervention but can track improvements in outcomes
Theory of Change	Suaahara, aims to reduce undernutrition among women and children in the 1,000-day period, while simultaneously addressing inequities to reduce the prevalence of stunting, wasting and underweight among children under 5 years of age and to reduce the prevalence of anaemia among WRA and children 6-59 months of age using the impact pathways outlined in report.
Intervention	Agricultural and health interventions aiming to: ▪ Improve household nutrition, sanitation and health behaviours; ▪ Increase use of quality nutrition and health services by women and children; ▪ Improve access to diverse and nutrient rich foods by women and children; ▪ Accelerate roll-out of the Multi-Sector Nutrition Plan (MSNP) through strengthened local governance
Mode of Delivery and Convergence	▪ Food production activities which include increased production, improved post-harvest storage, and processing diverse nutritious food using HKI's Enhanced Homestead Food Production Model (EHFP) with Village Model Farms (VMF) which includes agricultural inputs ▪ Intensive behaviour change strategy for nutrition and WASH including interpersonal communication activities, radio programmes, and the use of mobile technology at the community level working with local authorities and in particular with Female Community Health Volunteers (FCHVs) ▪ Training/Capacity Building for committees linked to nutrition in the health sector and for community level committees
Coverage	Increased from 14% to 31% participation in any Suaahara activity from 2017 to 2018. 42/77 districts nationally
Impact on Nutritional Outcomes	Unknown impact on stunting- no control group in design. 2nd annual survey makes no mention of stunting or other nutritional status indicators though sample was powered to detect these
Impact on Secondary outcomes	Significant improvements in intervention group in the following secondary outcomes: ▪ % of children 6-23 months and WRA receiving foods from 4 or more groups ▪ % of households practicing correct use of water treatment and ensuring availability of soap at handwashing facilities

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Evaluation report(s) # 17: SUAAHARA II, Nepal, 2016-18 [74-75]	
	▪ % of pregnant women weighed during most recent antenatal care (ANC) visit (among those who received ANC) ▪ % of children 0-2 years weighed in the past month increased ▪ % of new-borns receiving postnatal check-up within 24 hours of birth ▪ % of households with homestead gardens meeting minimum criteria
Scale up beyond evaluation	National Multi-Sectoral Nutrition Program (MSNP), with the support of external development partners. Suaahara II is aligned with Nepal's MSNP, being implemented in 42 of Nepal's 77 districts from 2016 to 2021.

Evaluation report(s) # 18: SPRING-Ghana, 2014-2017 [69]	
Study Design/Level of Evidence	Single arm baseline-end line (repeated cross-sectional) design. (3b) Baseline survey in 2015 and End line in 2017. No statistical testing done to check significance of changes.
Theory of Change	Multi –sectoral approach in 4 sectors is depicted in reporting about the project.
Intervention	Social and behaviour change communication (SBCC) across four sectors: education, agriculture, nutrition and WASH to address underlying determinants that are linked to malnutrition and targeting households with pregnant and lactating women with children under 2 years of age in the critical window of 1000 days when it is optimal to intervene to prevent stunting in young children during a time of rapid growth and development.
Mode of Delivery and Convergence	Intervention was delivered separately by teams working in the various sectors but targeting the 1000 day household at the community level and targeting providers and management at facility level; ▪ Training and support of health facility providers and community based health volunteers (CHVs on IYCF to improve nutrition counselling including update and revision of training/counselling resources. CHVs provided household level peer education on IYCF, WASH and other topics ▪ Father to father support group to engage fathers in particular on malnutrition prevention and IYCF ▪ Quality Improvement (QI) training approach to improving nutrition service delivery at health facilities ▪ Anaemia reduction programme to improve both diagnosis and treatment in health facilities in the intervention area

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Evaluation report(s) # 18: SPRING-Ghana, 2014-2017 [69]	
	▪ WASH approach embedded in the 1000 day household model to improve sanitation and hygiene using Community-led total sanitation ▪ Farmer field school model to promote improved cultivation skills including aflatoxin reduction in groundnuts ▪ WASH component and Anaemia awareness in schools However, key messages on nutrition and hygiene related behaviour were delivered at each point of contact with beneficiaries, from health service to formation of mothers groups and farmer field schools. This was done by using media such as videos shown at community events, radio, and short instructional videos and photo aids, in addition to broad nutrition communications and advocacy.
Coverage	The programme was delivered in selected communities in 15/260 districts nationally and household participation rates in SBCC increased from 66% to 95% from baseline to end line.
Impact on Nutritional Outcomes	Unknown impact given no control group for comparison. However with no statistical tests for significance in differences from baseline to end line the evaluation noted a reduction in stunting for children under 2 years of age
Impact on Secondary outcomes	▪ Increase in EBF for children <6 months, in appropriate introduction of complementary foods and in children's minimum acceptable diet age 6- 23 months ▪ Increases in functional taps for WASH and knowledge of critical handwashing times ▪ Increases in knowledge regarding aflatoxin and in % of households with appropriate groundnut storage systems
Scale up beyond evaluation	No scale up mentioned in evaluation but the intervention engaged partners at multiple levels, particularly at the district and regional levels. SPRING also invested in building and expanding the technical capacity of government sector departments and community organizations supporting nutrition-specific and nutrition-sensitive interventions to ensure the existence of institutional capacity to enable future scale-up of activities beyond the life of SPRING. As envisioned/designed SPRING is an initiative to scale high impact nutritional programmes.

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Evaluation report(s) # 19: Protective Safety Net Program, Ethiopia, 2005-2011 [90]	
Study Design/Level of Evidence	Single arm baseline-end line (repeated cross-sectional) design (3b). This evaluation included both a randomized household survey, replicating data collected in these areas at the start of the programme in 2005, and the collection of qualitative data through the standard methodologies of interviews, document review, focus group discussions and group interviews.
Theory of Change	The evaluation did not provide a theory of change or impact pathways which would have been useful given the breadth of the programme.
Intervention	Developed in response to the recognition that the repeated cycle of emergency appeals and donor responses, in place in Ethiopia since the mid-1980s, did not provide a foundation for long term planning to deal widespread chronic food insecurity affecting up to 10% of the national population. The Government developed a national Food Security Program (FSP), to create a framework for food insecure households to attain a level of food security which would allow them to 'graduate' from food aid assistance. The FSP had three major components: ▪ **The Protective Safety Net Program, which was the largest and in which individuals in food insecure households would carry out public works (PW) labour for five days a month in return for a monthly ration of food or a cash payment, direct support was available to household that did not have able bodied adults to participate in the PW programme** ▪ Support to Re-settlement, which provided packages for households wishing to leave scarce and degraded areas and settle permanently in more fertile parts of the same or neighbouring regions, and ▪ Other Food Security Programs (OFSP), including small scale credit and household packages of inputs and other resources
Mode of Delivery and Convergence	The intervention had five key objectives within with there were several activities aimed at meeting the objectives listed below: 1. Improved **food security in chronically food insecure households** by way of food transfers, public works and strengthening of local government's technical and institutional capacity to address food insecurity 2. Improved and **protected household assets and livelihoods in targeted areas** via training on diversification and improved agricultural practices to increase food production and productivity, support to market produce, access to savings and credit and small scale irrigation

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Evaluation report(s) # 19: Protective Safety Net Program, Ethiopia, 2005-2011 [90]	
	3. Enhanced **community resilience to shocks** and reduced vulnerability by development and management of community infrastructures to strengthen the community's ability to withstand shocks through mitigation of environmental factors such as erosion, and to strengthen a community's social capital through increased access to education and health facilities. Another key component was community mobilization, enabling early warning systems to function effectively in response to shocks having the potential to undermine food security. 4. Improved **community health and nutrition** via a community health and nutrition programme, and WASH interventions 5. A **pastoral area specific pilot** programme which included commodity transfers, PW, Livelihood support, local government capacity building
Coverage	There was some coverage information provided in the document. These included ; ▪ **Water shed** management which aims to protect and rebuild natural sources of water in communities where it is at threat by taking measures such as erosion control through construction of gullies, check dams and other physical structures amongst other activities. The evaluation found **that two-thirds** of the target population participated in watershed activities. ▪ **40%** of target households participated in **crop production training** in the last 5 years with **39% r**eporting they had **access to crop extension services** in the **last year** and **29%** saying they actually **participated** in these services in the past year.
Impact on Nutritional Outcomes	Unknown impact given design, however evaluation reported that there were no improvements on children's nutritional status from baseline to end line in particular on stunting or underweight
Impact on Secondary outcomes	▪ Significant increase in duration of food sufficiency ▪ Noted improvement in dietary diversity score in households, ▪ Varied reports on value of assets which the intervention hoped to increase, with this improving in some areas and declining in others
Scale up beyond evaluation	The project moved on to a third phase which ran until 2014 with ongoing support from USAID. The evaluation does not describe this phase further. Other evaluations have not found PSNP to have had a positive impact- in fact they indicate that it has had a negative impact on beneficiaries. https://www.developmentpathways.co.uk/blog/oliver-twist-ethiopias-psnp-workfare-become-productive/

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Evaluation report(s) # 20: MYAP-Katanga, DRC, 2008-2011 [91]	
Study Design/Level of Evidence	Single arm baseline-end line (repeated cross-sectional) design (3b) Mixed methods: The quantitative component took the form of a comprehensive survey that was conducted along the same lines as that which established the programme baseline for SO1 (agriculture) and SO2 (health and nutrition). It was conducted in both the Kalemie and Moba sites, inclusive of all target areas. Qualitative information was gathered through meetings will all concerned programme staff as well as focus group meetings with programme beneficiaries, community leaders and key stakeholders in both sites i.e. concerned representatives of government line ministries, United Nations Organizations and International and Local NGOs. No statistical testing to check significance of changes.
Theory of Change	*There was no stated impact pathway or theory of change stated in the evaluation*
Intervention	Farmers Field and Life Groups FFLG with the aim of increasing yields coupled with community based BCC run through community care groups and other structural improvements to impact on nutrition and health of pregnant and lactating mothers and children.
Mode of Delivery and Convergence	Members of the FFLG groups were trained in : ▪ the cultivation of improved varieties of seeds and cassava cuttings; the cultivation of goats and ducks; and the production of tree seedlings for agro-forestry production ▪ improved agricultural and soil and water management technologies, postharvest storage management practices and value chain analysis Within the agricultural sector the intervention also: ▪ Posted and maintained market price billboards outside of markets in all villages in the MYAP area of implementation ▪ households deemed to be particularly vulnerable/food insecure were provided improved seeds and tools through MYAP organized seed fairs and were provided three monthly seed protection (food aid) rations (SPR) to ensure that they had enough food for consumption to allow them to save seed from their harvests for future planting Separately for the health and nutrition component working within Care Group (CG) model :

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<table>
<tr><th colspan="2">Evaluation report(s) # 20: MYAP-Katanga, DRC, 2008-2011 [91]</th></tr>
<tr><td></td><td>Behaviour change at the household level related to Essential Hygiene Actions, Essential Nutrition Actions, and disease prevention was addressed in small group sessions
Structurally:
Food for the Hungry (FH) who implemented the intervention also constructed and/or upgraded water points and school/market latrines, while ensuring WATSAN committees sustained and cared for the new and existing structures Intervention also established and Community Development Committees (CDCs) to encourage greater grassroots participation in health and agricultural activities linked to improving nutrition</td></tr>
<tr><td>Coverage</td><td>With regard to coverage estimates the project achieved the following:
188 CGs in all 179 villages comprising Kalemie and Moba districts. This target was achieved at 100% though it is not clear how active each of these CGs were-
54.4% (short of the 70%) target of women reported meeting with a health promoter on a biweekly or more frequent basis. This was up from 3% at baseline
36% as opposed to the target of 45% female participation in CDCs was reported at end line
100% coverage for vitamin A supplementation and deworming in the intervention districts (this was not one of the project's initial indicators)
27% of villages benefited from an additional water source, 67% say they have improved year round access to water up from 47% at baseline</td></tr>
<tr><td>Impact on Nutritional Outcomes</td><td>Unknown Impact of intervention. No improvements in rates of stunting, underweight or wasting- in fact nutrition status appeared to have gotten worse, but this could have been due to both poor implementation, timing and design of the evaluation [7]</td></tr>
</table>

[7] The evaluation was conducted just as the main harvest of maize was concluding in Moba and had already concluded in Kalemie, whereas the baseline survey was conducted in January/February which represented the tail end of the "hungry season". As a result, crops were, for the most part out of the ground at the time of the evaluation, making a physical crop assessment impossible. Example of poor implementation was that the survey instruments were not translated into Swahili. However, enumerator training included sessions in which Swahili translation of key questions and phrases was reviewed, discussed and standardized.

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Evaluation report(s) # 20: MYAP-Katanga, DRC, 2008-2011 [91]	
Impact on Secondary outcomes	▪ No increases in revenue from crop or livestock activities by end line ▪ No increase in number of months of adequate household food provision ▪ Improvement in household dietary diversity score ▪ Increase in % of children receiving Vitamin A supplements, being breastfed immediately after birth and EBF in first 6 months from baseline levels ▪ Increase in % mothers who continued to breastfeed their children longer while improving weaning practices and ensuring age-appropriate dietary diversity from 6 to 23.9 months
Scale up beyond evaluation	There was no mention of scale up of the intervention and it is important to note that the evaluation was undertaken with only 1.5 years of effective implementation from the perspective of the evaluation team.

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Evaluation report(s) # 21: Wellness and Agriculture for Life Advancement (WALA), Malawi, 2009-2014 [92]	
Study Design/Level of Evidence	Single arm baseline-end line (repeated cross-sectional surveys) design (3b).
Theory of Change	Not stated- evaluation indicates that the *"intervention design did not invest enough in understanding and documenting the linkages and relationships between the various components of the WALA model at the various units of analysis, or in investigating various development pathways"*
Intervention	Care Group model, a community-based health service provision model to increase coverage and quality of health and nutrition service alongside establishment of farmer or producer groups implementing demonstration sites, small-scale irrigation with a focus high-quality, nutritious crops and inclusive of village Savings and Loans and promotion of farming as a business
Mode of Delivery and Convergence	Activities seem to have been delivered by separate teams within each sector, however it was noted in a discussion about synergy across the different components and partners that ; lead farmers and (Farm Extension Facilities) FEFs advised the health and nutrition CGs on the establishment of homestead gardens; the engagement of successful (Village Savings and Loans) VSL groups to invest in livestock, small stock, and fish farming; Under the Health Sector: ▪ Community Complementary Feeding and Learning Sessions approach was used to enhance the nutritional skills of mothers of children under five and pregnant and lactating women ▪ Ministry of Health (MoH) strengthened through capacity building, provision of resources, and collaboration in key activities ▪ Capacity of community-based organizations (CBOs2) enhanced to undertake and sustain development activities, such as village health committees via training and support Under the Agriculture Sector ▪ Formation of farmer groups or producer groups ▪ Demonstration sites approach to enhance agricultural production and promote improved farming practices, e.g., crop diversification, and watershed management.

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Evaluation report(s) # 21: Wellness and Agriculture for Life Advancement (WALA), Malawi, 2009-2014 [92]	
	▪ Small-scale irrigation, focusing on high-quality, nutritious crops, scaled up and integrated with other WALA components. E.g. stream diversions for gravity systems and shallow wells for treadle pump systems. ▪ Village Savings and Loans (VSLs) to increase household incomes and facilitate linkages with micro-enterprises in order to boost economic development ▪ Farming promoted as a business through agribusiness groups by strengthening linkages between small-scale farmers and the private sector and helping farmers to take part in collective marketing ▪ Formation of livestock groups to boost the number of households with livestock including goat, pig, chicken, and fish ▪ Increase capacity of CBOs to undertake and sustain development activities, such as formation of water users committees and marketing clubs Under Disaster Risk Management: ▪ Food safety net: provision of food aid to chronically ill beneficiaries who are targeted for other WALA interventions. ▪ Empowerment of communities on Disaster Risk Reduction and mitigation ▪ Good governance elements such as the Participatory Planning, Monitoring and Evaluation exercises, and conflict management ▪ Enhancing the capacity of local governance structures such as Village Civil Protection Committees (VCPC) and Area Civil Protection Committees
Coverage	Coverage of the intervention is discussed as reported participation and was part of the evaluation survey. 87% of respondents indicated they had engaged in at least one WALA intervention- 47% without prompting and an additional 40% after prompting.
Impact on Nutritional Outcomes	Unknown impact- no control but significant improvements: % stunted (HAZ < -2) children 6-59 months of age BL-42.4% and EL. 37.1%. % underweight (WAZ < -2) children 0-59 months of BL-17.6% and EL-11.3%.
Impact on Secondary outcomes	No improvement on average months of adequate household food provisioning Improvement on average household Dietary Diversity Score (DDS)

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Evaluation report(s) # 21: Wellness and Agriculture for Life Advancement (WALA), Malawi, 2009-2014 [92]	
	No improvement on % of households with reported losses of livelihood assets due to shocks and stresses
Scale up beyond evaluation	Authors note that scale-up is dependent on the support of partners at the district level. *At present, it is clear that, despite their willingness and effective engagement at district level, the MoH will not be able to pick up all current WALA activities in 2014, even in districts where the SUN rollout is starting. WALA has not managed to orient all Health Surveillance Assistants (HSAs) in their programme areas on the MCHN activities and their capacity is limited, particularly by competing work demands.*

~~Evaluation report(s) # 22: Health Practices, Strong communities (HPSC), Uganda, 2008-2013~~ [93]	
Study Design/Level of Evidence	Single arm baseline-end line (repeated cross-sectional surveys) design (3b). Baseline survey in 900 HH in 2008, followed by a reduced sample at end line in 2011 of 207 HH. The authors note that *"This is because population-level impacts in programme indicators are likely difficult to achieve in the limited timeframe and the focus of the evaluation was more on implementation processes and lessons learned. The reduced survey sample allowed for relatively greater effort to be placed on qualitative techniques in order to analyse and improve upon implementation for the next phase. The weight of the quantitative results should be considered accordingly."* **This is an interim report but there appears to be no final evaluation- requested one from Mercy Corps but what they sent was a different project all together.**
Theory of Change	*Not defined in this evaluation or elsewhere*
Intervention	Provision of support to families transitioning from camps to resettle in more permanent locations to address food security, nutritional behaviour and hygiene (including access to water) for pregnant and lactating women and children under five

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~~**Evaluation report(s) # 22: Health Practices, Strong communities (HPSC), Uganda, 2008-2013**~~ **[93]**	
Mode of Delivery and Convergence	Intervention was delivered to the beneficiaries via the mother care groups and women's gardening groups. Interventions included: • Supply of seeds and tools, training in improved agricultural technologies and Distribution of food aid • BCC on supplemental feeding at facilities and households • Rehabilitation access roads and building WASH facilities closer to homes
Coverage	Programme began in six sub-counties of Acholiland (Kitgum and Pader Districts) in August of 2008. A year after inception, the programme expanded its geographical coverage to two additional sub-counties in Karamoja (Kaabong District) and an additional subcounty in Kitgum and Pader Districts no actual estimates of programme coverage relative to target group was provided.
Impact on Nutritional Outcomes	Unknown impact- No control group and no significant improvement in any of the anthropometric indicators- Remember **samples at baseline and mid-term were not comparable though comparisons were made!**
Impact on Secondary outcomes	• Variable production improvement for key food value chains due to farmers planting cotton for sale instead of recommended crops- this also applied to adoption of improved agricultural technologies • No improvement in HH DDS, score did not change much from 3.8/12@ baseline compared to 3.6/12 @interim • Diarrheal prevalence reduced from 70% to 38.2% • Statistically significant reduction in perceived months of adequate food in 12 preceding months from 10 months and 8 months in the tow intervention areas to 8.9 and 7.8 months @ interim • 90% + of pregnant women attend first ANC visit, lower rates for all 4 recommended visits • Improvements in IYCF 11% to 38% from baseline to midterm receiving adequate • Almost all HH use water from boreholes or covered wells, decrease in use of pit latrines relative to baseline
Scale up beyond evaluation	No indication that project was scaled up with the exception of the expansion into an additional district one year after inception.

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~~Evaluation report(s) # 23: Ramba Kibondo Child survival program, Burundi~~ [94]	
Study Design/Level of Evidence	Repeated cross-sectional surveys (baseline -end line) (3b) Not much detail provided on actual design in reporting- available report was actually a case study and **impact evaluation is referenced but I have not been able to retrieve it to date.**
Theory of Change	*Not defined in this evaluation or elsewhere*
Intervention	Community approach to MCHN by training care groups in Nutrition (including CMAM and MAM) and IMCI coupled with family planning
Mode of Delivery and Convergence	Joint delivery of MCHN including nutrition BCC, Family planning information/commodities by referral to PHC system. Care groups consisted of 10 to 12 volunteer community health educators, mainly female, referred to as care group volunteers. Each care group was trained and supervised by a paid World Relief health promoter, who was in turn supervised by a World Relief supervisor. The programme paired these promoters and supervisors with a health promotion technician in specific Ministry of Health (MOH) health centres to facilitate care group–health system integration. The programme trained MOH community health workers, primarily male, who were integrated in the care groups and also served as the link to the health centre. Some care group volunteers were also elected into health centre staff management committees made up of community health workers, a primary school teacher or pastor, the head of the health centre, and local leaders.
Coverage	Programme in four communes of Kibuye Health District, Gitega Province, in Burundi but no coverage estimates provided.
Impact on Nutritional Outcomes	From baseline to final evaluation, the programme reported that % of children who were underweight was reduced from 16.4 percent to 4.2 percent. No mention of other anthropometric indicators or statistical tests evident.
Impact on Secondary outcomes	• % of children exclusively breastfed increased from 86.4 percent to 95.8 percent; • % of infants and young children fed according to minimum appropriate feeding practices increased from 25.6 percent to 92.7 percent
Scale up beyond evaluation	No indication of scale up

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Evaluation report(s) # 24: Enhancing Nutrition, Stepping Up Resilience and Enterprise (ENSURE), Zimbabwe, 2013-2018 [95]	
Study Design/Level of Evidence	Repeated cross-sectional surveys (baseline in 2014 –end line in2019 (3b). Household survey, alongside a qualitative analysis to review programme performance "on the ground". **Results unlike the majority of evaluations reviewed included multiple regression to look at which programme factors were correlated with outcomes**. Key limitations stated by the authors included; (i) parts of several survey questions were skipped in three modules; consequently analysts used baseline data to impute the missing data and estimate values where necessary; ii) the ongoing currency crisis makes comparison over time of monetary indicators difficult, and iii) a difference in seasonal timing between baseline and end line quantitative surveys may contribute to differences in some of the indicator estimates.
Theory of Change	Defined
Intervention	Focused on improving nutritional health seeking practices, improving household income and environmental risk identification and mitigation.
Mode of Delivery and Convergence	Qualitative assessment of integration of interventions indicated that the various components though delivered by separate teams contributed to improvements in outcomes from the perspective of the beneficiaries and programme staff. • Care groups to share and encourage behaviour change for health and nutrition with a focus on pregnant and lactating women • Training of farmer groups to impact on agricultural value chains in order to increase production, reduce losses and increase market access • Civil Protection units and environmental sub-committees engaged in asset construction and rehabilitation, environmental resource management, Disaster Risk Reduction (DRR) and early warning mechanisms, and sanitation and water management activities that benefit the whole community
Coverage	The evaluation reported some coverage estimates of the for the agricultural component as presented below @ end line household survey: • 28% of farmers surveyed reported using financial services which was a significant increase from 14% at baseline • 73% of farmers practiced value chain activities promoted by the project this did not change significantly from baseline

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Evaluation report(s) # 24: Enhancing Nutrition, Stepping Up Resilience and Enterprise (ENSURE), Zimbabwe, 2013-2018 [95]	
Impact on Nutritional Outcomes	Unknown impact on stunting- no control group in design. The authors noted in line with the evaluation design: • Stunting significantly decreased from 28.1% to 19.6% in children under 5 years of age. • Prevalence of underweight significantly decreased from 8.6% to 5% • No improvements on wasting • Decrease in prevalence of underweight women 5.9% to 4.3%
Impact on Secondary outcomes	• Decrease in HH dietary diversity from 5 to 4.5 • Increase in moderate to severe hunger • Some improvements in WASH indicators-drinking water source and use of soap but no changes in others like improved sanitation facilities and water treatment • Improvements in breast feeding indicators but not in MAD or young children's dietary diversity • Improvements in all women empowerment indicators on achieving adequacy for decision making and asset ownership • Possible increase in per capita daily expenditure
Scale up beyond evaluation	The Ministry of Health and Child Care has begun to roll out the Care Group methodology in non-ENSURE wards using evidence of effectiveness from ENSURE.

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~~**Evaluation report(s) # 25: Feed The Future FEEDBACK, Nepal, 2013-15**~~ [96]	
Study Design/Level of Evidence	Desk review with analysis of DHS data; unmatched time period (5b). Baseline and interim survey conducted in 2011 and 2014 respectively. Report draws on different sources of data to provide point estimates of outcomes including DHS and NLSS**. Interim survey sample sizes were calculated to provide point estimates of indicator values rather than detect change** in indicator values over time. Point estimates measure indicators for a point in time with a given amount of precision.
Theory of Change	*Not stated*
Intervention	Intervention focused on increasing food production and incomes and improving nutrition and hygiene behaviour in target population
Mode of Delivery and Convergence	• Smallholder farmers aiming to establish profitable businesses that are able to provide inputs, extension services, and market linkages sustainably • Nutrition and hygiene BCC interventions targeting diet composition, feeding practices, and spending patterns
Coverage	The only intervention related coverage estimates provided were those on women empowerment indicators from the household survey. Nearly all surveyed women (98.8 percent) in the Nepal ZOI report participating in a productive activity, and of these women, nearly all (99.3 percent) report having input into the decisions made about the activities.
Impact on Nutritional Outcomes	Unknown impact on stunting- no control group in design. For a subset of indicators significance tests were conducted to compare baseline and interim estimates: Wasting in children decreased from 12% to 8.4% No improvements in stunting or underweight Anaemia was one of the indicators not reported on but collected at baseline and to be collected for final evaluation
Impact on Secondary outcomes	Daily expenditure did not improve during the time period 5/9 women's empowerment indicators increased from baseline to end line

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~~Evaluation report(s) # 25: Feed The Future FEEDBACK, Nepal, 2013-15~~ [96]	
Scale up beyond evaluation	Expanded from 20 to 24 districts since baseline data collection. A second ZOI was added after the devastating April 2015 earthquake to include an additional four highly affected districts in the Central Region: Kavre, Makwanpur, Nuwakot, and Sindhupalchowk.

~~Evaluation report(s) # 26: Project for Improving Child Nutrition in Four Countries in Sub-Saharan Africa, Ethiopia, Burundi, Mozambique, Rwanda, 2013-17~~ [97]	
Study Design/Level of Evidence	Desk review and national period survey data (5b). Qualitative rather than quantitative indicators were used in this evaluation due to the absence of regular monitoring of the PMF indicators by both UNICEF and implementing partners and due to the reporting frequency- some indicators were every 5 years in line with DHS.
Theory of Change	Theory of change planning was included at inception of each project but not explicitly defined in this report
Intervention	Nutrition-sensitive interventions targeting households in Ethiopia, Rwanda and Burundi and a scale up of the Nutrition Rehabilitation Programme which involves screening in Mozambique.
Mode of Delivery and Convergence	Government of Netherlands funded projects working with NGOs and local private organisations and/or government ministries. Mode of delivery in each country not explicitly stated
Coverage	Not indicated
Impact on Nutritional Outcomes	This was not designed as a quantitative evaluation- it is therefore not possible to report on impact on or improvement of outcomes in any way given the design and presentation of results
Impact on Secondary outcomes	*See above*

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~~Evaluation report(s) # 26: Project for Improving Child Nutrition in Four Countries in Sub-Saharan Africa, Ethiopia, Burundi, Mozambique, Rwanda, 2013-17~~ [97]	
Scale up beyond evaluation	Not indicated

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~~**Evaluation report(s) # 27: Integrated Food Security Programme, Malawi, 1997-2004**~~ **[98]**	
Study Design/Level of Evidence	Post-programme evaluation with comparison to project targets (5b). The methods used evaluate the intervention included: I. Documented evidence (project, consultant, and published reports); second, insights shared by various experts and stakeholders; and third, direct (first-hand) experience from the village visits. Documented evidence derived from a number of sources, including: GTZ internal reports, consultancy reports, government of Malawi publications and unpublished data, and information gained from many donor, NGO, and other agency sources. II. Documentary evidence was complemented by interviews with multiple stakeholders in Mulanje, as well as in Blantyre and Lilongwe. The field visits included interviews with ministry personnel at district level, as well as extensive focus group and one-on-one interviews in villages across Mulanje and also Phalombe District.
Theory of Change	Logic model presented
Intervention	Interventions to promote adoption of new farm technologies and make greater investments in agriculture - Intervention packages targeting HHs to improve access to services and increase positive health and nutrition practices
Mode of Delivery and Convergence	Interventions delivered separately included: • Improving food production via demonstration farms and agricultural training • Income transfers via food for work • Health and Nutrition education • Training of community committees in management skills, conflict resolution, and resource management/accounting this included inputs such as roads, trees, and water points
Coverage	Not indicated
Impact on Nutritional Outcomes	This was not designed as a quantitative evaluation- it is therefore not possible to report on impact on or improvement of outcomes in any way given the design and presentation of results
Impact on Secondary outcomes	*See above*

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~~**Evaluation report(s) # 27: Integrated Food Security Programme, Malawi, 1997-2004**~~ **[98]**	
Scale up beyond evaluation	Not indicated

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Evaluation report(s) # 28: Karnali Zone, Nepal government-funded Targeted Resource Transfers (TRTs), Nepal, 2009- 2015 [99]	
Study Design/Level of Evidence	Single arm baseline-end line (repeated cross-sectional) design (3b). The five districts of the Karnali Zone received standard social welfare services in the form of targeted resource transfers for eligible families, plus an unconditional child cash payment, augmented by a capacity building and behavioural change education. Repeated cross-sectional surveys, with measures taken at baseline (2009, N=3750), midline (2013, N=3750) and end line (2015, N=3647), were carried out using a two-stage cluster sampling method. Multi-level Generalized Linear Mixed Models (GLMMs) with normal, binomial, Poisson, or multinomial link were performed to detect the unadjusted and adjusted trends.
Theory of Change	No impact pathways described?
Intervention	An unconditional child cash grant (CCG) added on to the Nepalese government's existing Targeted Resource Transfer Program (TRT) which included allowances for senior citizens -70+, single women and widow, people with disabilities 16 or older, endangered ethnicities and a maternity incentive scheme for women living in specific areas of the country.
Mode of Delivery and Convergence	• The CCG provides Nepal Rupee 200 per month per child for up to two children for families with children under five for eligible households • Capacity building to enhance the capacity of local bodies in the project districts to deliver the child grant, through orientations for Village Development Committee (VDC) leaders, Traditional Healers and mothers/caretakers, and capacity-building for health workers and Female Community Health Volunteers (FCHVs) and VDC secretaries; • Enhancing networking between local bodies, health facilities and communities in the project districts to improve child nutrition; • Social behaviour change communication on child nutrition including the provision of nutrition related counselling services; • Awareness raising for timely birth registration, to identify all eligible households and inform them about the availability of the CCG; • Assisting mothers and others caring for children to identify the best possible locally available food and encouraging them to use the CCG for nutritious foods and the improvement of the nutritional status of children; • Improving the knowledge and skills of CCG beneficiaries in the areas of Infant and Young Child Feeding (IYCF) practices, hygiene, sanitation, and other key behaviours linked to child nutrition

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Evaluation report(s) # 28: Karnali Zone, Nepal government-funded Targeted Resource Transfers (TRTs), Nepal, 2009- 2015 [99]	
Coverage	Not reported
Impact on Nutritional Outcomes	Unknown impact- not control group but the following results between 2009 and 2015: • Decrease in prevalence of stunting from ~65% to ~ 55% • Decrease in prevalence of underweight ~49% to ~33% • Decrease in prevalence of wasting from ~12% to ~8%
Impact on Secondary outcomes	• Deterioration in dietary diversity, with the % of households reporting high dietary diversity decreasing significantly • Improvements in access to clean water, improved sanitation facilities, and safe disposal of children faeces but not in water treatment • Early initiation of BF significantly increased, however prevalence of bottle feeding also increased significantly • No significant changes for other IYCF indicators • % of households classified as food secure increased steadily from 42.8% in 2009 to 46.8% in 2013 and 59.8% in 2015 • % of households purchasing foods increased significantly, while receipt of food aid decreased • Decline of crop farming as a source of income but this was compensated by an increase in income from livestock farming
Scale up beyond evaluation	In 2016, the government made a commitment to expand the Child Grant beyond the initially targeted group (under-fives in Karnali region and in poor Dalit households elsewhere in the country) and, along with the other cash transfer schemes, to double the benefit level (MOF, 2016).[8]

[8] http://eprints.lse.ac.uk/85326/1/Garde_Mathers_Dhakal_The%20evolution.pdf

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Evaluation report(s) # 29: SPRING-Kyrgyz republic, 2014-18 [53]	
Study Design/Level of Evidence	Standard Quasi-experimental design & non-DD approach (2f). 6 | For each of the four surveys in this study Baseline, two interim studies and the end line, a longitudinal design was used, with the intervention areas covered in all four surveys and comparison areas covered for the baseline and end line survey only. No statistical testing done. The z-test was also used to measure significance when comparing proportions of columns. Column mean tests were applied to tables in which scale variables existed in the rows and categorical variables existed in the columns. The results were based on two-sided tests with a significance level 0.05.
Theory of Change	Not stated
Intervention	11 Evidence based strategies aimed at reducing malnutrition and anaemia in women and children, mainly in the health sector but with partnerships to introduce nutrition sensitive programming in other sectors. Intervention targeted women and children in the first 1,000 days (from pregnancy to two years). Strategies included; • Consumption of iron–folic acid (IFA) supplements by pregnant women. • Dietary diversity for women and children with an emphasis on consumption of food sources of iron and foods that enhance iron absorption. • Optimal meal frequency for children 6–23 months of age • Early initiation of breastfeeding, including exclusive breastfeeding from birth through the first six months • Timely introduction of appropriate complementary foods • Reduced consumption of low-nutrient-value (junk) food • Presumptive treatment of helminth infections for pregnant women and children • Handwashing at five critical times: after using the latrine, after changing a baby's diaper/cleaning a child, after handling animals, before preparing food, and before feeding a child • Adoption of methods for safe and prolonged storage of nutrient-dense produce for the winter.
Mode of Delivery and Convergence	Separate implementation of the following programmes:

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Evaluation report(s) # 29: SPRING-Kyrgyz republic, 2014-18 [53]	
	• Development of national protocols and guidelines working with MOH on antenatal care and prevention of anaemia and helminth infections • Training of health care workers (HCWs) and community volunteers on nutrition including supportive supervision for HCWs on nutrition counselling and behaviour change communication • Prioritizing nutrition in pre-service education • Mother and baby friendly hospital certification • Guidebook on homebased food preservation and cookbook with health recipes to improve Dietary Diversity • Media and social media campaign on nutrition • Helped education and agricultural projects to integrate nutrition elements in to their programmes to address direct and underlying cause of malnutrition
Coverage	Intervention coverage estimates were not presented. The project was implemented in 11 *rayons* (districts) and townships in Jalalabad *oblast* (region), all six *rayons* and townships in Naryn *oblast*, and Bishkek.
Impact on Nutritional Outcomes	*Not applicable not presented*
Impact on Secondary outcomes	The project reported the following significant improvements: • Increased in Women's DDS from 4.1 to 5.4 food groups • Proportion of women taken Iron and Folic Acid tablets increased from 22% to 40% • Exclusive breastfeeding increased from 29% to 63% • Reduction in consumption of sugary foods for children under 1 year from 34% to 26% • Children meeting minimum dietary diversity requirements 42% to 54%. • Decline in proportion reporting recommended hand washing practices • Decline in % of children being dewormed • Increase in children 6 -23 months consuming sugary or process foods
Scale up beyond evaluation	In FY16, SPRING expanded its programme from one rayon to all six *rayons* and townships in Naryn *oblast*.

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~~Evaluation report(s) # 30: Sustainable Nutrition and agriculture promotion (SNAP), Sierra Leone, 2010-15~~ [60]	
Study Design/Level of Evidence	The Mid Term Evaluation of the SNAP programme was designed as a qualitative exercise. The final evaluation is pending- ACDI/VOCA has an RFP out for this currently.
Theory of Change	Not indicated
Intervention	Intervention providing food aid to pregnant women and children under the age of two following the preventing malnutrition in children under two (PM2A) approach.
Mode of Delivery and Convergence	• Provide monthly trainings in mother care groups and conditional food ration distribution for targeted pregnant and lactating women and children up to 23 months of age • Engage local health services and communities with trainings and rehabilitation projects to ensure that all children under five in the rural communities where SNAP operates benefit from improved health opportunities, nutritional and hygienic knowledge, and superior family decision making. • Conduct farmer field schools where participants receive hands-on training and demonstration plots to improve agricultural production and post-harvest handling techniques • Form cluster groups of farmer field school graduates to receive business development, business planning, governance and gender training, and agricultural input support to engage in the cultivation of larger acreages of nutritious, high-value crops • Develop vegetable gardens for mother care groups to ensure food security for families after the end of the SNAP project • Establish and support village savings and loan associations to promote individual and community savings in areas without access to commercial or community banks • Provide vocational training on soap-making and gara tie-dying to expand opportunities for households to diversify their income sources
Coverage	*Not applicable not presented*
Impact on Nutritional Outcomes	*Not applicable not presented*
Impact on Secondary outcomes	*Not applicable not presented*

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~~Evaluation report(s) # 30: Sustainable Nutrition and agriculture promotion (SNAP), Sierra Leone, 2010-15~~ [60]	
Scale up beyond evaluation	TO address the economic and social impacts of Ebola in Sierra Leone, USAID's Office of Food for Peace awarded funding for ACDI/VOCA's SNAP+ in April 2015. As an Ebola response and recovery programme, a key component involved direct, unconditional cash transfers to Ebola-affected households. **The SNAP+ programme also included activities designed to complement ACDI/VOCA's pre-existing Title II SNAP programme.** After ACDI/VOCA's much larger development programme, SNAP, came to an end in December 2016, the SNAP+ project was renamed the Emergency Food Security Program (EFSP) to avoid confusion

~~Evaluation report(s) # 31: Multi-sector Nutrition & Food Security Project, Democratic People's Republic of Korea (DPRK) 2012-14~~ [63]	
Study Design/Level of Evidence	Desk review and use of programme routine M &E data, Interviews, Focus Group Discussions and Field Visits (5a)
Theory of Change	Not indicated- reference made to log frame which was not provided
Intervention	The interventions objectives were to (i) stabilize food production and availability; (ii) improve access to & use of food: and (iii) enhance people's nutritional status with complementary water, sanitation and hygiene (WASH) actions in urban and rural Singye and Kumchon Counties in North Hwanghae Province, DPRK.
Mode of Delivery and Convergence	Agricultural infrastructure and production working with government, the Korean Workers Party (KWP) and local beneficiaries to construct and establish: winter greenhouses, fish hatcheries and ponds, soy factory rehabilitation, goat factory, composting centre, solid waste collection blocks, DEWATS facilities (to treat black and grey waters to discharge water of an adequate quality to return to the environment), sewers, man holes, open drains, VIP latrine blocks, Nutrition, Health & Hygiene education for nursery caregivers; child-to-child hygiene promotion and strengthened capacity to construct and manage new food processing facilities.
Coverage	No estimates given

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~~Evaluation report(s) # 31: Multi-sector Nutrition & Food Security Project, Democratic People's Republic of Korea (DPRK) 2012-14~~ [63]	
Impact on Nutritional Outcomes	Unknown impact or progress. The report indicates that the team was unable to assess project outcomes and impact due to both political context of DPRK that prohibits meaningful communication between CW DPRK staff and beneficiaries, and due to challenges inherent in evaluating causation in programmes given the inevitable presence of confounding factors.
Impact on Secondary outcomes	See above
Scale up beyond evaluation	Unknown but unlikely given the social and political context in DPRK

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Evaluation report(s) # 32: BIHAR RURAL LIVELIHOODS PROJECT- "JEEViKA", India, Bihar, 2007-16 [62]	
Study Design/Level of Evidence	Full cluster randomised trial, non-DD approach (1b) A cluster-randomized controlled trial was used to assess the impact of the intervention on the two primary outcomes of the evaluation: women's BMI and child dietary diversity. Statistical analysis completed.
Theory of Change	Theory of Change presented
Intervention	JEEViKA's health and nutrition strategy is centred on empowering women to bring about a change in health and nutrition practices within their households and the community. The approach focuses on the implementation of a comprehensive behaviour change communication (BCC) strategy along with strategic interventions to build linkages with existing government nutrition and sanitation programmes, as well as JEEViKA's income support efforts, specifically promotion of household kitchen gardens and livestock for better diet diversity. BCC topics include (a) ensuring early registration of pregnancy, ante and postnatal check-ups, identification of high-risk cases; (b) counselling for maternal nutrition (iron folate tablet consumption, diet diversity and rest during pregnancy); (c) institutional delivery and birth preparedness; (d) early initiation and exclusive breastfeeding, complementary feeding practices, and immunisation; and (e) sanitation and hygiene.
Mode of Delivery and Convergence	• Behaviour Change Communication via in Self Health Groups (SHG) ▪ At the household level, BCC is facilitated through targeted household visits and inter-personal counselling by HSC members every month and by CMs and CNRPs during CNRP drives ▪ At the SHG level, one meeting every month is focused on health, nutrition and sanitation. CMs use participatory learning methods, picture-cards, games, role play and story-telling to create awareness of the relevance of recommended health, nutrition and sanitation practices and encourage discussions on these issues, including on overcoming barriers to practice. ▪ At the community level, CNRP drives such as campaigns and rallies, as well as screening of community videos, are used to create awareness and generate a supportive environment for behaviour change. Wherever possible, service providers and frontline workers such as ASHA, auxiliary nurse midwife (ANM), and AWW are also involved and encouraged to participate in these events.

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Evaluation report(s) # 32: BIHAR RURAL LIVELIHOODS PROJECT- "JEEViKA", India, Bihar, 2007-16 [62]	
	• Establishing household kitchen gardens and livestock interventions again via SHGs with the primary aim of improving dietary diversity and food security with the secondary and additional possibility of generating household income. Intervention provided agricultural inputs • Revolving Fund for members of SHG to support with financial investments and impact on household income/expenditure • Strengthening linkages with Government health, nutrition and sanitation programmes with focus placed within the SHG meetings to make members aware of nutrition specific and sensitive services provided by the various Government departments • A Management Information System (MIS) to track the progress of the various components of the intervention
Coverage	Impact report focused on poverty and empowerment found over 60% of households in the intervention area joined SHG compared to 10% in control areas.
Impact on Nutritional Outcomes	No impact on women's BMI comparing intervention to control but improvements in both cohorts from baseline to end line
Impact on Secondary outcomes	• Impact on proportion of women attaining MDD in treatment arm as indicated by an increase from 28% to 47% from baseline to end line, this took the form of an improvement in number of food groups women consumed with the increased consumption by end line of pulses, dairy, other fruits, and other vegetables. • No impact on children's dietary diversity but significant improvements in both intervention and control arms • No impact on women's empowerment • No impact on household assets/income
Scale up beyond evaluation	Project was scaled up during the 8 years implementation period

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Evaluation report(s) # 33: Sustainable Nutrition for all (SN4A), Zambia & Uganda, 2015-17 [100]	
Study Design/Level of Evidence	Single arm baseline-end line (repeated cross-sectional-3b) A cross sectional cluster design without control group was used for both questionnaire-based surveys. The study areas were the villages targeted in SN4all phase I, in Kasese and Kyenjojo district in Uganda, and in Isoka and Chinsali district in Zambia, and the villages that were new targets in SN4all phase II, in Kakumiro (Uganda) and Kasama (Zambia). In Kasama, two separate samples were used, representing the urban and rural areas. Within the villages, households with children of 6-23 months were randomly sampled. The sample unit was a household with a child of 6-23 months and the female caregiver.
Theory of Change	Theory of change presented
Intervention	SNV's unique Triggering model, drawn from a modified community-led total sanitation (CLTS) methodology, motivates people to work together to improve the nutritional status of women and children. Triggering makes clear that under-nutrition is a community-wide problem, and it helps individuals to identify the factors that lead to malnutrition. Triggering addresses men's and women's roles in the household and how these patterns affect the food family members eat. The project was designed with a focus on intra-household dynamics and how they impact on nutrition in particular dietary diversity.
Mode of Delivery and Convergence	• Community generates and uses data, including Community Mapping and Convergence Planning, to develop their own plans of action to address challenges. • This culminates in a call for action and the establishment of the Nutrition Action Group (NAGs) • Activities included nutrition BCC, nutrition sensitive agriculture, and women empowerment. The report indicates that field staff were encouraged to ensure that both men and women participate in sessions on agriculture as well as nutrition counselling (SBCC), or that nutrition and agricultural training messages would be combined in the same training. • DNCC members are trained in the triggering methodology and follow up SBCC activities via training, mentoring and frequent follow up to help committees understand their roles and link them directly to ward and village levels to implement activities. SN4A trains district staff from nutrition, agriculture, WASH and community development sectors in

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Evaluation report(s) # 33: Sustainable Nutrition for all (SN4A), Zambia & Uganda, 2015-17 [100]	
	multi-sectoral SBCC strategies, which increases buy-in and supports them to develop an integrated plan in which they all have a role
Coverage	Not indicated
Impact on Nutritional Outcomes	*Not applicable not presented*
Impact on Secondary outcomes	Substantial improvements in dietary diversity for infants and women in all districts as reported in policy paper on page 6
Scale up beyond evaluation	A second phase of SN4A started in 2018, wherein the project was scaled up to two new districts, one in each country

~~Evaluation report(s) # 34: Nepal Flood Recovery Program (NFRP), 2008-2012~~ [56]	
Study Design/Level of Evidence	Single arm post evaluation household survey design- 3c & qualitative study. Also included additional methods e.g. literature review, field visits including qualitative data collection. The evaluation employed a Stratified, *Quota*, Random sampling approach to the household survey. The sampling design covered all three NFRP districts which were taken as individual Stratum from which a certain *Quota*, based upon the proportion of the district beneficiaries, was sampled.
Theory of Change	Not indicated
Intervention	Nepal Flood Recovery Program (NFRP) was a USAID/Nepal initiative designed to respond to substantial damage caused by heavy flooding of 2007 and 2008 in a number of Terai districts of Nepal. This was planned for an initial 24-month period to address livelihood recovery and reconstruction/rebuilding needs of infrastructures damaged/destroyed by the floods. In 2011, USAID-

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~~Evaluation report(s) # 34: Nepal Flood Recovery Program (NFRP), 2008-2012~~ [56]	
	NFRP extended its operation for a second time, refocused its economic assistance from a disaster recovery programme to an integrated approach.
Mode of Delivery and Convergence	• Commercial Agriculture (called Livelihoods Income Generation in earlier Phases) included constructing irrigation systems; One on-site Field Technician (FT) was assigned to train farmers on various topics including nursery and production management, plant protection, composting, and post-harvest marketing; • Productive Infrastructure • Nutrition and Hygiene
Coverage	Not indicated
Impact on Nutritional Outcomes	*Not applicable not presented*
Impact on Secondary outcomes	Unknown impact and improvement as this was only post evaluation study.
Scale up beyond evaluation	The programme received a 10-month extension in 2009 referred to as Phase II, with an objective to provide recovery and rehabilitation assistance to 16 additional VDCs of Sunsari and Kanchanpur districts in the Terai. Phase II included the integrated approach describe here.

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~~Evaluation report(s) # 35: Uganda Livelihoods and Enterprises for Agricultural Development (LEAD) 2008-2013~~ [58]	
Study Design/Level of Evidence	Repeated cross-sectional surveys (baseline –end line- 3b) Mixed methods approach that entailed both quantitative and qualitative data collection techniques
Theory of Change	See link
Intervention	The aim of the LEAD programme is to help integrate farmers and related micro- and small and medium enterprises (SMEs) into commodity value chains so that they gain improved access to markets, and more empowered relationships with suppliers, processors and traders. The overall objective of LEAD is to improve rural livelihoods and increase transformation of the rural agricultural economy through: a) improving agricultural productivity; b) increasing trade capacity; and c) enhancing competitiveness of selected agricultural value chains
Mode of Delivery and Convergence	Working with producer organisations formed to increase value chains in the intervention area, training was provided to increase production and improve marketing. The only integrated activities appear to be among the Orphans and Vulnerable Children and Youth subgroup. By way of the Farmer Field Schools (FFS) approach and Technology Observation Plots (TOP) for joint learning by LEAD and Grantee POs as well as OVC groups additional sectors covered in the intervention included nutrition promotion through household gardening, and provision of enrolment guidance and formation of groups for children and youth,
Coverage	Not indicated
Impact on Nutritional Outcomes	*Not applicable not presented*
Impact on Secondary outcomes	*Not applicable not presented* – Only programme indicators in the form of output of agricultural production presented in baseline –end line format
Scale up beyond evaluation	Not indicated

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~~Evaluation report(s) # 36: Food for the Hungry MYAP-Mozambique, 2010-13~~ [59]	
Study Design/Level of Evidence	Repeated cross-sectional surveys (baseline –end line 3b). The baseline data that was available at the time of analysis due to significant turn over at FH between the two evaluations. **What was used was unverified data from an excel spreadsheet with no data dictionary and dummy composite variables for key indicators. For this reason the reported increases from baseline to end line are not reported in this summary**
Theory of Change	Not provided
Intervention	The intervention improve aimed to improve the health and nutritional status of children 0- 5 years of age; to increase agricultural productivity and strengthen agricultural value chains; to increase community resiliency to shocks for 31,577 Households (HH) across the districts of Nangade, Mocimboa da Praia, and Palma.
Mode of Delivery and Convergence	• Use of Farmer Field and Life Groups (FFLG) to increase productivity and diversification of crops • Care group model by way of group sessions to improve nutrition behaviours and practices including IYCF, management of childhood illness and hygiene and sanitation • Training of community committees to improve leadership and infrastructure, with the aim of increasing capacity to mitigate shocks that impact on food security,
Coverage	Not indicated
Impact on Nutritional Outcomes	*Not applicable not presented*
Impact on Secondary outcomes	**Impact on Nutritional Outcomes**
Scale up beyond evaluation	Not indicated

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~~Evaluation report(s) # 37: Accelerated healthy agriculture and Nutrition (AHAN), PDR of Laos, 2016-2020~~ [108]	
Study Design/Level of Evidence	Repeated cross-sectional surveys (baseline –end line- 3b)
Theory of Change	No evaluation documents reviewed yet.
Intervention	Aims to address: SO1: Improved access to and availability of sufficient and/or diverse foods year-round SO2: Improved dietary and care practices among Women of Reproductive Age (WRA) (15-49 years) and Children Under 5 (CU5). SO3: Reduced incidence of selected Water, Sanitation and Hygiene (WASH) related diseases/illnesses linked to undernutrition SO4: Improved gender equitable relations at the household level, particularly in decision-making and distribution of workload SO5: Strengthen multi-sector coordination and support for nutrition
Mode of Delivery and Convergence	Working with target households interventions include: • Saving Groups to save money and access credit for nutrition • Training on improved and sustainable farming techniques • Labour saving technologies- improved cook stoves and clean safe water trucks • Community WASH facilities and promotion •
Coverage	Unknown
Impact on Nutritional Outcomes	*Interim Assessment Pending*
Impact on Secondary outcomes	*Interim Assessment Pending*
Scale up beyond evaluation	*Project ongoing*

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~~Evaluation report(s) # 38: SPRING-UGANDA 2012-17~~ [101]	
Study Design/Level of Evidence	Programme Performance Evaluation (4a). Used Lot Quality Assurance Sampling (LQAS) surveys in intervention areas to assess coverage of nutrition indicators including IYCF, MAD, DDS, micronutrient consumption and deworming.
Theory of Change	Not indicated
Intervention	High-impact nutrition interventions primarily targeting women of childbearing age and children under two years of age. This includes nutrition assessment, counselling, and support NACS integration into routine health service delivery and increase community awareness and BCC. **It is not clear beyond attempting to strengthen coordination across different health departments across the sector how this is an MSNP?**
Mode of Delivery and Convergence	• Industrial food fortification and anaemia control at the national level; • Trained health workers in NACS, infant and young child feeding (IYCF), and integrated management of the acute malnutrition (IMAM) • Working e.g. with District Health Teams(DHIT) to provide technical assistance, training, and support focused on quality improvement (QI) processes and ensuring the availability of nutrition supplies to revive and strengthen nutrition treatment services. These included emphasizing improved screening and assessment, and counselling and support, under the IMAM framework • Community mobilization; and social and behaviour change communication (SBCC) for nutrition at the health facility and community-level

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~~Evaluation report(s) # 38: SPRING-UGANDA 2012-17~~ [101]	
Coverage	Provided estimates of coverage estimates for intervention activities including % of children having MUAC assessed, getting counselling and being linked to OTP programmes
Impact on Nutritional Outcomes	*Not applicable not presented*
Impact on Secondary outcomes	Indicated improvements in IYCF, MAD, Iron Consumption and Deworming but not DDS.
Scale up beyond evaluation	Not indicated

~~Evaluation report(s) # 39: Mother and Child Health Integrated Program (MCHIP)-SMART project, Egypt, 2011-14~~[55]	
Study Design/Level of Evidence	Programme Performance Evaluation (4a)
Theory of Change	**Yes this is provided on page 2 of the evaluation**
Intervention	Integrating FP and Nutrition via Community Development Associations (CDAs), which are Grassroots/Community-based NGOs, commonly manage and fund social welfare activities that serve their community members.
Mode of Delivery and Convergence	• Community health outreach and communication activities, which aimed at increasing target families' awareness and knowledge about the importance of adopting **proper MNCH-FP-Nutrition** behaviours; Using Community Health Workers (CHWs)

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~~Evaluation report(s) # 39: Mother and Child Health Integrated Program (MCHIP)-SMART project, Egypt, 2011-14~~[55]	
	• Nutrition education and rehabilitation classes, which aimed to address maternal malnutrition and childhood malnutrition and stunting (6-24 months); • Home-based neonatal care through a package of simple interventions using trained Community Health Workers (CHW) to counsel mothers for new-born care, including resuscitation, cord care, kangaroo mother care for low birth weight, and initiation and exclusiveness of breastfeeding; • Build capacity of local CDAs to respond to health needs with focus on sustainability. • SMART identified one "umbrella" CDA (UCDA) per district to serve as a mentor organization to smaller, local CDAs and trained them in financial, administrative and programme management systems • An in-depth study to understand the underlying issues for the increased stunting levels in Egypt.
Coverage	Not indicated
Impact on Nutritional Outcomes	*Not applicable not presented*
Impact on Secondary outcomes	*Not applicable not presented*
Scale up beyond evaluation	Not certain if it can be scaled up nationally but partnerships built over time with between SMART and agencies/associations in health and community development were instrumental in allowing SMART to expand beyond its initial geographical coverage.

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Evaluation report(s) # 40: Title II Food Security Program PROMASA, Guatemala, 2006-2011 [102]	
Study Design/Level of Evidence	Single Arm Baseline and End Line- 3b. Powered to detect changes in chronic malnutrition (stunting) rates. This evaluation was one of four that disaggregated health and nutrition outcomes by exposure to agricultural interventions. Significance determined by looking at confidence intervals around point estimates.
Theory of Change	Not indicated
Intervention	The intervention aimed to promote good practices in health and nutrition, livelihoods, natural resources, and risk management with a goal to reducing insecurity and chronic malnutrition in boys and girls from 0 to 3 years old in 123 communities within 6 municipalities of the Department of Quiché
Mode of Delivery and Convergence	• Agricultural component targeting farmers with training on improved agricultural practices both in crop and livestock farming with an aim to improving food production and dietary diversity • Health and Nutrition component focused on BCC around IYCF and WASH during home visits or visits to facilities delivered by MoH and PROMASA personnel (mainly the latter)
Coverage	84% of the population of women surveyed reported participating in the health and nutrition intervention. This did not differ between the areas receiving the agricultural intervention as well and those that didn't receive it.
Impact on Nutritional Outcomes	Unknown impact- no control group • 7.9 % decrease in chronic malnutrition rates (length/height for age under less than two standard deviations, WHO standards) in children under five years old • Significant difference in the overall malnutrition rates among the population of boys and girls under 36 months old and the population of boys and girls from 36 to less than 60 months old ($P<0.05$). In this case, rates were higher in the older group (73.4%) versus the younger group (57.9%). These values correspond to estimates developed according to NCHS references, difference remained the same when estimates according to WHO references were developed. • No impact on underweight prevalence
Impact on Secondary outcomes	• Improved dietary diversity score from 4.8 to 8 food groups • Increased in EBF from 65.6% to 80.1%

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Evaluation report(s) # 40: Title II Food Security Program PROMASA, Guatemala, 2006-2011 [102]	
	• Increase in producers adopting two or more good agricultural practices 11% to 65% • Amongst survey respondents participating in the agricultural component dietary diversity was greater. • No reports on WASH indicators from baseline to end line but disaggregated by exposure to agricultural interventions in end line. No differences across the two groups with or without agricultural intervention.
Scale up beyond evaluation	No indication of scale up

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Evaluation report(s) # 41: Catholic Relief Services Burundi MYAP, 2008-2012 [103]	
Study Design/Level of Evidence	Single Arm Baseline and End Line- 3b.
Theory of Change	Not indicated
Intervention	Intervention composed of three components. A maternal and child health and nutrition component focused on pregnant and lactating women and children under the age of five years, a livelihoods component focused on agriculture and natural resource management using a watershed development approach, and a community resilience component which built local capacities for disaster risk reduction and promotes gender equitable decision-making at the household and community levels.
Mode of Delivery and Convergence	• Food resources were used in the MYAP for therapeutic and supplemental feeding as well as in food-for-work activities • Volunteer Community-Based Health Activists (VCBHA) were trained and equipped by the programme to disseminate health knowledge and serve as links between communities and health facilities • Over 1800 lead mothers, each working with ten to twelve other mothers in 183 Mother Care Groups, were trained to promote appropriate behavioural change for health seeking behaviour and health/hygiene • 120 Mere Lumiere (Exemplary mothers who have been identified as having well-nourished children) were selected and trained to facilitate Positive Deviance/Hearth sessions for 1,941 pairs of mothers and children incorporated into this was training/discussion aimed at empowering women to take greater leadership roles in nutrition related matters in the household • 317 Ministry of Health staff from health centres in the programme area were trained to provide **Community Management of Acute Malnutrition (CMAM) and Growth Monitoring Services (GM)** to facilitate identification and management of malnourished children including referral to Out Patient Therapeutic Services (OPT) and Stabilization Care (SC). • 134 Lead Farmers and around 6,000 farmers were exposed to improved crop and livestock technologies.
Coverage	Evaluation estimates that 15,000 of the estimated total of 16,600 households in the watershed collines benefitted from the MYAP and 60% of these, or around 9,000 households, benefitted substantially through participation in multiple MYAP activities.

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Evaluation report(s) # 41: Catholic Relief Services Burundi MYAP, 2008-2012 [103]	
Impact on Nutritional Outcomes	Unknown impact- No control. Statistically significant improvement in % of underweight children (an end line estimate of 29.7% against a baseline of 36.6%), but no improvement in stunting or wasting.
Impact on Secondary outcomes	• BCC activities effective in changing breastfeeding practices, particularly with significantly more mothers breastfeeding within one hour after birth • Threefold increase in the percentage of households using an improved toilet, from 6.8% at the baseline to 21.5% at the end line
Scale up beyond evaluation	Not indicated

Evaluation report(s) # 42: CFAARM Zambia, 2007-2011 [104]	
Study Design/Level of Evidence	Single Arm Baseline and End Line- 3b. The final evaluation made an attempt to follow the sample size and calculations performed at the baseline, to enable adequate comparisons. Both used stratified random sampling based on the programme's three vulnerability groups. However, the baseline study was a population-based survey, whereas the evaluation data was collected only from the beneficiaries, therefore the comparisons should be viewed with a certain level of reservation. For anthropometric data the number of entries for baseline is much higher than the number of entries at end line, thus a statistical significance analysis was impossible.
Theory of Change	Not presented
Intervention	Agriculture intervention to improve livelihoods, increase dietary diversity and ensure food security coupled with Nutrition BCC and a third component focused on identifying and responding to developmental issues and external shocks affecting food security at the community level
Mode of Delivery and Convergence	Vulnerable households in target districts were trained by intervention personnel on improved agricultural practices with the triple aim of increasing income, food security and dietary diversity via community gardens

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Evaluation report(s) # 42: CFAARM Zambia, 2007-2011 [104]	
	Community Health Workers (CHWS) were trained to provide improved counselling on areas such as IYCF and household dietary diversity but also in identifying and referring malnourished children for treatment At the community level the project team worked with appropriate local officials/representatives to write development relief action plans (DRAPs) and improve early warning and response systems e.g. preparations to mitigate the effects of upcoming droughts.
Coverage	No intervention overage estimates were provided. Coverage was discussed but only in terms of geographic reach of the programme
Impact on Nutritional Outcomes	Unknown impact- no control group. Analysis of the current data shows that the both severe and moderate stunting rates have increased, together with the rates of severe and moderate underweight. Evaluators note that serious limitations with data quality suggesting that the results should ideally be verified through other sources, such as the next DHS or the NNSR, or the anthropometric data should be re-collected.
Impact on Secondary outcomes	x2 as many households are able to afford food for longer than three to six months from own production, x4 more households have access to food at least one to three months of the year x2 more of household income over course of programme Average DDS increased from 3.2 to 3.27
Scale up beyond evaluation	No indication programme was scaled up

Evaluation report(s) # 43: Mid Term Review Save the Children, Nobo Jibon, Bangladesh, 2010-2015 [105]	
Study Design/Level of Evidence	Single Arm Baseline and End Line- 3b. The sample size was estimated based on the outcome indicator stunting among children 6-59 months. The indicator value and the design effect are obtained from the NJ baseline dataset. The FANTA Sampling

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Evaluation report(s) # 43: Mid Term Review Save the Children, Nobo Jibon, Bangladesh, 2010-2015 [105]	
	Guidelines2 were used to calculate a sample size capable of detecting a 15 percent reduction in the child stunting indicator over the five-year intervention. Significance of change tracked by calculating confidence intervals around estimates at end line.
Theory of Change	Not indicated
Intervention	The programme was designed "to reduce food insecurity and vulnerability for 190,000 + beneficiary households…in ten upazilas (districts) of Barisal Division over five years." It had three components outlined below
Mode of Delivery and Convergence	**Maternal and Child Health Nutrition** component seeks to change childcare behaviours, improve intra-household food allocation, and integrate MCHN services and messages with Government of Bangladesh and private institutions. Nobo Jibon will provide a food ration to households with vulnerable women or children, conditional upon participation in awareness and education sessions. BCC messaging will improve nutrition awareness and behaviours, community-based care of childhood illnesses, and hygiene practices and women's empowerment in making economic decisions **Market-based production and income generation** seeks to increase productivity and income to improve access to food for beneficiary households. Nobo Jibon organised household groups, and helped to build technical skills for increased horticultural, fish, poultry and non-farm production. It also worked with these groups by training them to improve links to markets. The programme promoted access to *khas* resources (government owned fallow land) and improved sustainable access to capital to meet input/service needs. **Disaster risk reductions (DRR)** strategy which used a food for work and/or case for work approach to provide a safety net, while helping build DRR infrastructure at the community level i.e. putting systems in place to protect lives and assets and quickly resume livelihood activities following natural disasters.
Coverage	Overall participation in the three strategic objectives was not provided as point estimate BUT the outcome indicators were disaggregated based on whether or not the household reported participating in intervention activities.
Impact on Nutritional Outcomes	Unknown impact- no control group.

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Evaluation report(s) # 43: Mid Term Review Save the Children, Nobo Jibon, Bangladesh, 2010-2015 [105]	
	• Stunting rate <2SD, 6-59 months decreased by 8.5pp from 43.9% to 35.3% with CI for the end line estimate between 33.3% and 38.2%. • Underweight rate<2SD, 6-59 months decreased by 11.1 pp from 39.4% to 27.3 % with CI for the end line estimate between 25.4 % and 29.9%. • Underweight rate<2SD, 6-23 months decreased by 12.4 pp from 31.9 % to 19.5 % with CI for the end line estimate between 15.9 % and 21.7%. • Wasting rate <2SD, 6- 59 months decreased by 4.9 pp from 15.9% to 11 % with CI for the end line estimate between 14.4 % and 17.4%. • Wasting rate <2SD, 6-23 months decreased by 1.3 pp with from 15.1% to 13.8 % CI for the end line estimate between 10% and 16.2%.
Impact on Secondary outcomes	Overall substantial and significant increases in IYCF practices however non -significant/substantial results for some WASH indicators Increased food production and decreased household food insecurity score, income and household dietary diversity score... Women were significantly more empowered at end line (67.5 %) than women at the baseline (56.3 %) as measured by a score though qualitative data indicated this was not the thrust of most *courtyard* sessions during which nutrition and maternal child issues were the predominant focus
Scale up beyond evaluation	No indication of scale up.

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Evaluation report(s) # 44: Kasai Child Survival Project, DRC, 2005-2010 [106]	
Study Design/Level of Evidence	Single Arm Baseline and End Line- 3b. However the authors not several flaws and challenges with design and implementation. *See page Chapter Two: Data Quality: Strengths and Limitations on page 11.*
Theory of Change	Not presented but authors note that *the project was designed around an unusual logical framework. Rather than designing the framework around the technical intervention areas (EPI, Malaria, pneumonia etc.), as most projects do, it was designed around target audience – mothers of U2 children, pregnant women and health centre staff.*
Intervention	Integrating nutrition with other key health services.[9]
Mode of Delivery and Convergence	To improve the quality of care (supply side) intervention: • Trained Integrated Management of Childhood Illnesses (IMCI) trainers at the national and district levels who in turn trained health care providers in the six target health zones including supervision incentives and covering transport costs • Provided the necessary inputs to make practicing IMCI possible. This included refrigerators and kerosene to support the vaccination work, and drugs, supplies and equipment essential to IMCI. Also included provision of Long-lasting insecticide treated mosquito nets to pregnant women during antenatal visits. • Select number of health care providers received training in immunizations and exclusive breastfeeding, and Community IMCI (C-IMCI) To promote demand for services and healthy practices in the home: • KCSP trained over 4000 community health workers (approximately 1 for every 15 households) in C-IMCI • Trained groups of women to promote exclusive breastfeeding. • To increase access to curative services, the project trained 312 CHWs in integrated community case management (iCCM) e.g. management of uncomplicated malaria, and diarrhoea with capacity to refer for serious cases • Radio messages and annual festivals with key message on: Breastfeeding, Immunization, Net Use, Management of Childhood illness and Hygiene

[9] Question on whether can be considered multi- sectoral because all is within the health sector, however nutrition is integrated into other health services.

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Evaluation report(s) # 44: Kasai Child Survival Project, DRC, 2005-2010 [106]	
Coverage	Coverage goals were provided but whether or
Impact on Nutritional Outcomes	Unknown impact- no control but reports by zone on changes. % of children aged 0-23 months whose weight for age z score were below 2SD were: 18.9%, 17.23%, 19.4%, 29%, 16.4% and 14% in Health Zone 1, 2, 3, 4, 5 and 6 respectively. The evaluation did not present baseline figures but reported- Declining rates of underweight in Health Zone 1, 2, 3 and 5, showing that child nutrition had improved between 2006 and 2010 in these health zones. However, Health Zone 4 registered an increase in prevalence of underweight from 27% to 29% between the two survey years. There were no changes in rate of underweight for children 0-23 months health zone 6.
Impact on Secondary outcomes	• In general, there is a decline in the percent of children aged 6 – 9 months who **receive breastfeeding and complimentary foods** within the last 24 hours preceding the KPC surveys. Only Health Zone 3 experienced an increase • Increase in prevalence of mothers **who breastfed their children aged 0 – 5 months within the first hour** of giving birth in all zones except zone 6. Other secondary indicators were mainly around childhood illnesses, immunization and malaria prevention and are not summarised for this review.
Scale up beyond evaluation	Project contributed to the scale up of IMCI in the country and the Kasai Oriental Province by training 8 trainers in IMCI. These trainers are based in Kasai Occidentale Province and Sankuru and Mwene-Ditu districts targeted by the project and the have trained providers from other districts in the province and from other provinces.

ANNEX 1

Positive impact/improvement No impact/improvement Negative impact/decline Unknown impact Joint delivery Nutrition BCC WASH IYCF Food Security DDS Anaemia Women's Emp. MAD Poverty/Income common target (1000d) Scale up Coverage Food/Cash/Asset Transfer Statistical tests for significance/Modelling

Evaluation report(s) # 45: 3-year Title II MYAP, "Health and Livelihood Initiative in Ghor" (HEALING), Afghanistan, 2008-2012-[107]	
Study Design/Level of Evidence	Single Arm Baseline and End Line- 3b. The baseline was undertaken in 2009 due to delays with starting the project. The report indicates that an end line survey was designed and conducted at the end of 2011.
Theory of Change	Not indicated in report
Intervention	HEALING was guided by three underlying themes: household (HH) resiliency, community empowerment and prevention with a focus on vulnerable households classified as those with children under 5 years of age and pregnant and lactating women. Key indicators to be evaluated included: **Agriculture**: Months of adequate food supply, value of HH assets, per capita food production, crop diversity, **Health and Nutrition:** stunting, underweight, diarrhoea prevalence, Acute Respiratory Infection rates, deliveries attended by skilled professional, HH Dietary Diversity Score
Mode of Delivery and Convergence	**SO 1. LIVELIHOOD - Livelihood Capacities Protected & Enhanced** which included improved certified wheat seed and demonstration fields, to enhance productivity and food security; and promotion of improved cultural practices in vegetable gardening and tree planting **SO 2. Health and Nutrition education** which included • A midwife outreach programme to promote antenatal and postnatal care and safe deliveries, • A Home Based Life Saving Skills (HBLSS) to enable local communities to provide basic first aid in emergencies • A Pilot Family Health Houses (FHH) programme to increase awareness about services available at health facilities • A Positive Deviance (PD) Hearth approach to encourage positive feeding practices for children under 5 years of age This report actually included a discussion about the effectiveness of sector integration. Using qualitative data collected as a part of the evaluation, the author concluded that integrating food security with improved nutritional practices was effective in one of the five target districts, but, did not expand to the other four districts due to multiple security and other challenges. Internal intervention challenges in integrating activities had to do with staffing challenges within World Vision Afghanistan who were implementing the project as well as poor oversight of the teams.

ANNEX 1

Positive impact/improvement No impact/improvement Negative impact/decline Unknown impact Joint delivery Nutrition BCC WASH IYCF Food Security DDS Anaemia Women's Emp. MAD Poverty/Income common target (1000d) Scale up Coverage Food/Cash/Asset Transfer Statistical tests for significance/Modelling

Evaluation report(s) # 45: 3-year Title II MYAP, "Health and Livelihood Initiative in Ghor" (HEALING), Afghanistan, 2008-2012-[107]	
Coverage	Not indicated in report
Impact on Nutritional Outcomes	Unknown impact- no control group. Also author did not present actual results from the end line survey with Table 1 on page 14 presents baseline estimates compared to targets as supposed to end line estimates!
Impact on Secondary outcomes	Not presented
Scale up beyond evaluation	Not indicated in report