ACF INTERNATIONAL

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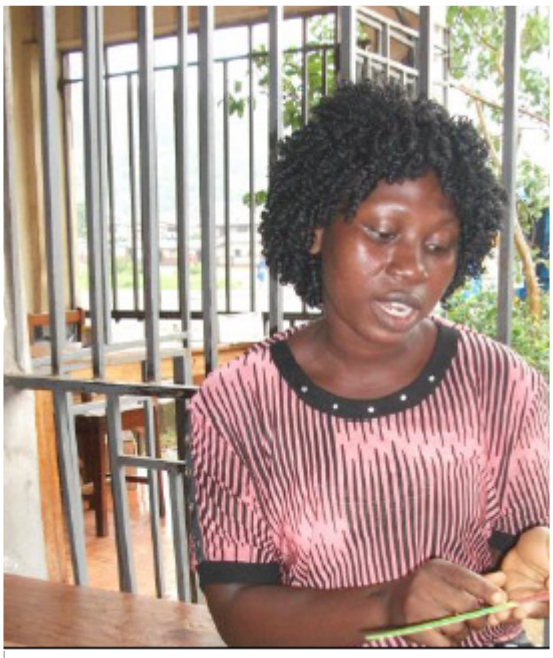
INDEPENDENT FINAL EVALUATION

SEPTEMBER 2015

Reinforcing Institutional Capacity for Treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western area and national sensitization for nutrition security in Sierra Leone



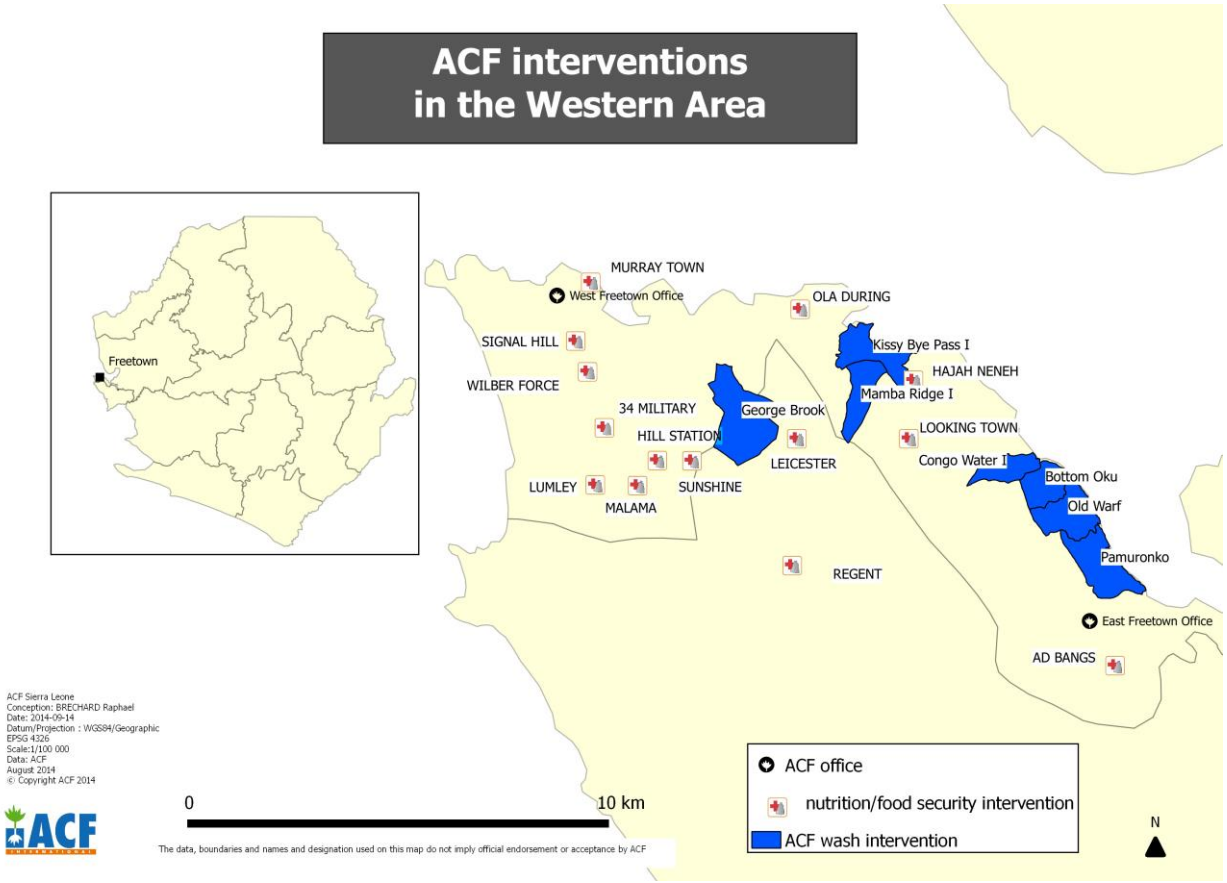
By Kathleen Linda Weeb

Funded by ACF, **AFD, IRISH AID**

SUMMARY PAGE

Project Name	Reinforcing Institutional capacity for treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western area and national sensitization for nutrition security in Sierra Leone.
Location	Freetown peninsula, Western Area, Sierra Leone
Contract Reference	E4A - FFB/C - H0A/B/C
Sector	Nutrition and Food Security
Local Partners	
Duration	3 years
Starting Date	1 July 2012
Ending Date	31 August 2015
Programme Language	English
Donor & Contribution/s	AFD, Irish Aid and ACF
Project Budget	Irish Aid (€ 647,393); AFD and ACF (€ 880,874)
Mission administering the Project	ACF Sierra Leone
Responsible ACF HQ	ACF France
Evaluation Type	Independent External Final Evaluation
Evaluation Dates	03/09/2015 – 21/10/2015

Map 1



Source: ACF, Western Area Intervention Map

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ACRONYMS AND ABBREVIATIONS

ACF	Action Against Hunger
BPEHS	Basic Package of Essential Health Services
CBN	Capacity Building Nurse
CHO	Community Health Officer
CHW	Community Health Workers
CMAM	Community Based Management Acute Malnutrition
CSP	Civil Society Platform
DAC	Development Assistance Committee
DHMT	District Health Management Team
ENA	Essential Nutrition Action
ENU	Emergency Nutrition Updates
EOP	End of Project
EVD	Ebola Virus Disease
FAO	United Nations Food and Agriculture Organization
FGD	Focus Group Discussion
FND	Food and Nutrition Directorate
FNIP	Food and Nutrition Implementation Plan
FSWG	Food Security Working Group
GBV	Gender-Based Violence
GI	Group Interview
HSS	Health System Strengthening
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude, Practices
KII	Key Informant Interview
LFA	Logical Framework Analysis
MAFFS	Ministry of Agriculture, Forestry and Food Security
MoHS	Ministry of Health and Sanitation
MLGCD	Ministry of Ministry of Local Government and Community Development
M2M	Mother to Mother
MUAC	Mid Upper Arm Circumference
NGO	Non-governmental Organization
OTP	Outpatient Therapeutic Programme
PHU	Peripheral Health Unit
PLwHA	People Living with HIV and AIDS
RUTF	Ready to use therapeutic food
SADD	Sex and Age Disaggregated Data
SAM	Severe Acute Malnutrition
SC	Stabilization Centre
SFP	Supplementary Feeding Programme
SLAES	Sierra Leone Association of Ebola Survivors
SLEAC	Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage
SLNNS	Sierra Leone National Nutrition Survey
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SQUEAC	Semi Quantitative Evaluation of Access and Coverage
SUN	Scaling up Nutrition
TOR	Terms of Reference
ToC	Theory of Change
UNICEF	United Nations Children's Fund
WA	Western Area
WFP	World Food Programme

1. EXECUTIVE SUMMARY

The three year "Reinforcing Institutional Capacity for treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western Area and national sensitization for nutrition security in Sierra Leone" was funded by Irish Aid for € 647,393 while *Agence française de développement* (AFD) and Action Against Hunger (ACF) funded € 880,874.[1] A final evaluation was conducted from September 3 – October 23, 2015 with focus on the funding from Irish Aid.

According to UNICEF,[2] Sierra Leone ranks number one globally for under five mortality (U5MR), which stood at 182 deaths of under-fives per 1000 births in 2012.[3] Poor Infant and Young Child Feeding (IYCF) practices are the main contributing factor to malnutrition. Peripheral Health Units (PHUs) run by the Ministry of Health and Sanitation (MoHS) remain underequipped to handle acute malnutrition, a situation worsened by the 2014 Ebola outbreak. Due to the worrying nutrition situation in Western area of the country, ACF conducted a Needs Assessment in 2012 and approached the MoHS, who then requested that the ACF implement a nutrition program in Western urban and rural areas from July 1st 2012 – June 30, 2015[4]. The program objective was: To reinforce institutional capacity for the treatment of acute malnutrition, improve prevention strategies for malnutrition and raise national awareness on nutritional security by building capacity of health and volunteer staff working or living near 26 PHUs in Western Area.

After document review (DR) of 102 documents, the evaluation consultant carried out a fourteen day field study in Western Area, visiting 14 of the 26 PHUs and their environs, using qualitative tools such as 57 Key Informant Interviews (KIIs) and Group Interviews (GIs). These were directed at 92 persons, namely staff at ACF, the Food and Nutrition Directorate (FND), and PHUs. Forty-five KII and GI interviews were held with beneficiaries such as Mother to Mother groups. Quantitative data was gathered from databases provided. A Stakeholder workshop on September 25, 2015 helped clarify the preliminary findings. The consultant faced some limitations due to poor weather and the high volume of documents.

In terms of **Findings**, the three year project was found to be aligned to the implementation plans for Government of Sierra Leone strategies, especially the "Agenda for Prosperity-Road to Middle Income Status" Sierra Leone's Third Generation Poverty Reduction Strategy paper, 2013-2018; the Scaled up Nutrition (SUN) Initiative, a global initiative which culminated in the "Food and Nutrition Implementation Plan (FNIP) 2013-2017. The ACF project activities strengthened capacity and partnerships with the national and district governments and there developed a renewed sense of trust of ACF by the government and local communities. The funding built the capacity of the Ministries of Health and Sanitation and Agriculture Forestry and Food Security as it supported training of national and district staff involved in nutrition and food security activities. The support to community volunteers revived PHU outreach services and increased attendance and referral of cases of acute malnutrition. The budget lines were not directed enough at focussed in-depth theoretical classroom training particularly on Integrated Management of Acute Malnutrition (IMAM) and Community Management of Acute Malnutrition (CMAM). This is evidenced in the below average level of recall of

[1] Although the project was co-funded by the three donors, the Irish Aid funding provided full support to the food security component contributing to integration of nutrition and food security activities. Funding was 39% AFD; 18% ACF and 43% Irish Aid.

[2] UNICEF, "Improving Child Nutrition-the achievable imperative for global progress", UNICEF Global Nutrition Report, April 2013, pages 96-97.

[3] The infant mortality rate (IMR) is the number of deaths of infants under one year old per 1,000 live births. This rate is often used as an indicator of the level of health in a country. The infant mortality rate of the world is 49.4 according to the United Nations and 42.09 according to the CIA World Factbook.

[4] A February 2015 amendment to the proposal allowed for 2 month extension due to Ebola to accommodate VSLA and provide food to Ebola survivors. The new end of project was changed to August 31, 2015.

IMAM and Community Management of Acute Malnutrition CMAM theory amongst nursing staff in sampled PHUs. A comparison of classroom training with on-the-job and coaching methodologies indicates it has advantages when compared to on-the-job training or coaching.[5]The high recall of Infant and Young Children Feeding (IYCF) and its application by community volunteers indicated they gained new knowledge. VSLA training was introductory only as it was implemented late in the project[6]. There was also less evidence of some expected agricultural activities which have the potential to address food security, such as seed multiplication[7] and composting.

The project did not set a Theory of Change for the project in the proposal. This could have clarified the causal-effect links and hypotheses of the project. ACF identified the needs and activities for mothers and their malnourished babies, but there was less identification of the needs (by sex and age) of potential community members such as men, youth, pregnant teenage girls and Ebola affected persons. The positive end point effects of increased breastfeeding to six months and introduction of healthy complementary food, suggest there is added value for the government of Sierra Leone to work with ACF applied in a future Integrated Management of Childhood Illnesses (IMCI) program. There is ongoing integration of the IMAM program into university nursing curriculums. This can further build the IMAM skills of nurses in addressing acute malnutrition in the long term. However increasing community volunteer demands for incentives remains a threat to sustainability of the outreach services they support.

The **Conclusions** of the evaluation are that the project achieved scores indicated very positive results especially for Relevance/Appropriateness and Coherence, which were rated as "Highly Satisfactory[8]" as the positive aspects stood out and the project showed itself as innovative and attractive to the communities. For the evaluation criteria of Design, Coverage, Efficiency, Effectiveness and Sustainability/Likelihood of Impact, the project scored "Satisfactory[9]" in that the positive aspects were higher than negative aspects (such as lack of a ToC in the design). A positive example with respect to "Design" is that the project effectively reached pregnant and lactating women and their under-five children, in their homes, although it did not specifically target men, and youth (especially Teenage Mothers) with activities. Some of the key **Lessons Learned** are: It is easier to implement IMAM/CMAM and IYCF in PHUs already integrated with the ACF WASH program as there is improved sanitation; and, Men play a key role in household decision making with respect to food purchases and health seeking behaviour, so they should be part of nutrition security interventions. A recommended Good Practice is application of innovative space saving gardening to address nutrition security.

Some key **Recommendations** are that ACF should engage donors to support a second phase of the program in additional PHUs in Western Area. A new program should include IMCI and food security interventions to benefit pregnant, lactating women & teenage mothers, their children under five, EVD survivors and male farmers. ACF has to more stringently adhere to the ACF Gender Policy and ensure future proposals include gender markers in the design. The ACF technical and management capacity

[5] See Annex XII, UNISA table on 'Types of training opportunities'. Classroom training has an advantage over on –the-job and coaching training. It is best suited for iidentifying the appropriate staff capability gap and clarity about what is to be developed; ensuring full course attendance and completion of course activities; giving opportunities to put learning into practice after the training and provides focused and targeted learning and development.

[6] VSLA introductory training was introduced from February 2015.

[7] Seed multiplication was identified by ACF as one of the activities for the intervention on gardens. This technology can save money as seeds do not need to be purchased. However it requires time and enough space to be implemented. In many cases the gardens were too small to do seed multiplication.

[8] A program is rated as "Highly satisfactory" with respect to evaluation criteria when it is performing strongly full according to plan or better. Very few or no improvements are needed. (adapted from Europa rating system)

[9] A programm is rated "Satisfactory" with respect to evaluation criteria when on balance it was implemented according to plan and positive aspects outweigh negative aspects. (adapted from Europa rating system)

has to be addressed so that it can better support PHU and community capacity building in IMCI, IMAM/CMAM, IYCF and VSLA.

2. BACKGROUND INFORMATION

2.1. Background to the Project

The three year "Reinforcing Institutional Capacity for treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western Area and national sensitization for nutrition security in Sierra Leone" was implemented from July 1st 2012 – August 31st, 2015. Funding was provided by Irish Aid for €647,393 while *Agence française de développement* (AFD) and Action Against Hunger (ACF) provided €880,874. The project is part of a larger regional project in West Africa co-financed by the AFD implemented in three countries for operational implementation (Niger, Burkina Faso and Sierra Leone) and seven countries for advocacy actions (Mauritania, Guinea, Liberia, Ivory Coast, Nigeria, Chad and Mali). The overall goal is to contribute to the improvement of maternal and child nutrition in West Africa.

The specific objective of the "Reinforcing Institutional Capacity for treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western Area and national sensitization for nutrition security in Sierra Leone" project in Sierra Leone was**:** To reinforce institutional capacity for the treatment of acute malnutrition, improve prevention strategies for malnutrition and to raise national awareness on nutritional security. According to UNICEF,[10] in terms of health indicators, Sierra Leone ranks number one globally for under five mortality (U5MR). This stood at 257: 1000 births in 1990 and 182: 1000 births in 2012[11]. Sierra Leone is also one of 21 countries with the highest level of stunting: 44% of children are estimated to be stunted with stunting highest amongst the poor (47% of the stunted children <5 years are from the very poor communities where 49% of poor children under five are stunted). The causes of under-five deaths in Sierra Leone have been traced to under nutrition in one third of child deaths. Poor Infant and Young Child Feeding (IYCF) practices are the main contributing factor to malnutrition: Exclusive breastfeeding of infants <6 months old stood at 32% in Sierra Leone in 2010. There were also disparities in nutrition with respect to complementary feeding. In 2010, only 25% of children in Sierra Leone received adequate nutrition after the age of six months.

Results from a UNICEF SMART survey conducted from June – August 2010 showed there were high acute malnutrition levels in Western area of the country. For children five years and under, SAM stood at 1.5% in urban areas, 2.1% in urban slums and 1.8% in rural areas. However the GAM[12] level in Western Area urban slums stood highest for Sierra Leone at 8.1%. A 2014 SMART survey[13] (Annex XIII) indicates that SAM in Western Area urban dropped to 0.5%. Urban slum SAM dropped to 0.9% and rural area SAM dropped to 1.2%. The 2014 study also showed that exclusive breastfeeding stood at 50 % in 2014 for Western urban, 52.5% for urban slums and 43% for rural areas. A minimum dietary diversity for infants and young children stood at 59.7% for Western urban, 38.4 % for urban slums and

[10] UNICEF, "Improving Child Nutrition-the achievable imperative for global progress", UNICEF Global Nutrition Report, April 2013, pages 96-97.

[11] The infant mortality rate (IMR) is the number of deaths of infants under one year old per 1,000 live births. This rate is often used as an indicator of the level of health in a country. The infant mortality rate of the world is 49.4 according to the United Nations and 42.09 according to the CIA World Factbook.

[12] Global Acute Malnutrition (GAM) is a measurement of the nutritional status of a population that is often used in protracted refugee situations. Along with the Crude Mortality Rate, it is one of the basic indicators for assessing the severity of a humanitarian crisis.

[13] Annex XIII shows results from the 2014 SMART on malnutrition as well as breastfeeding and dietary practices.

36.9% for rural areas. The 2014 SMART study attributes the improvements in MAM and SAM to significant improvements in early initiation of breastfeeding and improvements in dietary diversity.[14]
The 2010 SMART study did not gather statistics on exclusive breastfeeding and minimum dietary diversity for infants and children. However, the ACF needs assessment conducted in 2012 determined that 70% of children in Western area were not exclusively breastfed and only 19% of infants and young children were fed with a minimum acceptable complementary diet.[15] A comparison of the 2012 ACF results with the 2014 SMART survey, indicate improvement in exclusive breastfeeding and complementary feeding.

After ACF conducted the 2012 needs assessment, they approached the Ministry of Health and Sanitation (MoHS) and the Food and Nutrition Directorate (FND). It was then agreed that ACF would be one of the main actors in the Integrated Management of Acute Malnutrition (IMAM) strategy, working to build IMAM capacity in 26 Peripheral Health Units (PHUs). In addition, the project was expected to support the MoHS in prioritizing nutrition security in national strategies and frameworks and implement interventions directed at the prevention of malnutrition through gardens for health and Infant and Young Children Feeding (IYCF). There were four expected results to be achieved by August 31, 2015.[16]

Irish Aid funded the salaries and consultancy services, support to the District Health Management Teams (DHMTs) for on the job coaching, refresher training and training materials. There was also support to the national government towards communication and advocacy activities such as radio discussions and jingles, and yearly events. Funding was also directed towards improved nutrition training, surveillance and two studies (Cost of Diet and Teenage Pregnancy). Funding for the Prevention of Malnutrition and Vegetable gardens was directed towards IYCF training, gardens, vegetable kits and VSLAs (Annex IX).

In terms of organizational arrangements for the project, it was agreed that the MoHS would provide sufficient staffing and supervision for the Outpatient Therapeutic Programs (OTPs) Supplementary Feeding Programs (SFPs) and Stabilization Centres (SCs) in the PHUs, participate in training PHU staff and volunteers, ensure support of therapeutic products and drugs from UNICEF, and organize nutrient coordination meetings between partners working in nutrition and food security. ACF was expected to provide staffing to support surveillance, national policy, protocols and guidelines, equipment and materials, sensitization programs through radio on detection and treatment of acute malnutrition, and technical and logistic support for DHMT staff.

In the first year of the project, twenty peripheral health units were identified for start-up CMAM activities, including Outpatient Therapeutic Programmes (OTPs) and Stabilization Centres (SCs)[17]An

[14] Asfaw, Addisa, "Sierra Leone National Nutrition Survey (SLNNS) SMART survey 2014, June – August 2015, page xi, xii, 51 and 56. Annex xiii shows tables from the 2014 SMART reflecting changes in SAM, MAM, breastfeeding and complementary feeding.

[15] The Findings on Effectiveness make reference to additional statistics from the ACF EOP survey results and 2015 MoHS statistics.

[16] There were four expected results which were to be achieved by August 31, 2015. These are:
Result 1: Institutional capacity building – technical and management – for treatment of acute malnutrition, as per national CMAM program, in Sierra Leone western area, Freetown.
Result 2: Government of Sierra Leone and major donors prioritize nutrition security in their strategies, frameworks, and financial commitments by 2015;
Result 3: Improve at central level initial training for health staff and nutrition surveillance and propose innovative study related to nutrition security;
Result 4: Prevention of malnutrition through gardens for health and IYCF mother to mother support groups, and nutritional support to EVD affected individuals.

[17] The PHUs identified for OTPs were: Adbangs Quarry Community Health Post, Signal Hill Community Health Post, Goderich Community Health Centre, Haja Neneh Community Health Post, Hastings Community Health Centre, Hill Station Community

additional six PHUs were identified as scale up PHUs pending endorsement of the IMAM protocol in the country. These received support in late 2014 and in 2015.[18] CMAM/IMAM training for the first 20 PHUs was conducted over three day periods by the district nutritionists using a peer to peer approach. This was followed up by one day refresher training conducted by the District Health Management Teams (DHMTs). The communities in the catchment areas identified potential community health workers, and lead mothers. These were trained in two day district level workshops, after which they were deployed to identify and refer malnourished infants and children to the PHUs. In the second and third years of operation, the project conducted research studies and also started vegetable space saving gardens at PHU and Lead Mother levels.

Lead Mothers formed groups of 10-14 Mother to Mother groups (M2M). The M2M groups then formed additional groups, of which some received VSLA training and equipment from the project and started a savings and loans program for Mothers. In late 2014, the Ebola outbreak caused serious delays and bottlenecks to PHU referral as people feared coming to the PHUs and contracting the disease. At this time, the ACF surveillance officer was deployed to support the DHMT surveillance of the Ebola virus, later resuming the expected role of nutrition surveillance. In February 2015, the project was extended an additional two months from the original time frame of June 2015 to accommodate the delays caused by the Ebola outbreak. Support to establish VSLAs and provide support to EVD survivors was also provided in February 2015.

2.2. Background to the Evaluation

As the project was due for completion on August 31, 2015, it was agreed that an independent final evaluation would be conducted from September 3 – October 23, 2015, with a focus on Irish Aid funding, but also taking into consideration the part funded by AFD and ACF. The evaluation was expected to cover all geographical areas (See Map 1) and also cover all levels of the project (national and district MoHS, and communities surrounding the 26 PHUs). The evaluation was directed at all aspects of the project (capacity building, training, prevention activities) and focused on the multi-sectoral approach used to integrate nutrition and food security. In terms of cross-cutting issues, an analysis of gender was expected but not of HIV and AIDS or in-depth findings on advocacy and surveillance activities. The main audience of the study is Irish Aid as funding agency of the evaluation as well ACF France, AFD and the MoHS. Annex VII shows the evaluation work plan. It shows the dates, events and sequencing of the evaluation.

3. METHODOLOGY

3.1. Scope of the Evaluation

As shown in the detailed agreed upon work plan (Annex VII) a total of 30 days were allocated for the evaluation between September 2, 2015 and October 23, 2015. Fourteen days were dedicated to field work in Western Area of Sierra Leone. At the time of the Final Evaluation, all project activities were expected to be completed by 31st August 2015. The project had been twice revised and an amendment (two month no-cost extension) was made in February 2015 to enable project completion in light of delays caused by the Ebola virus disease (EVD). At this time, activities were added. These were the

Health Post, Leicester Community Health Post, Looking Town Community Health Post, Lumley Community Health Centre, Malama Community Health Post, Murray Town Community Health Centre, Tissana Community Health Post, Tombo Community Health Centre, Regent Community Health Centre, Sunshine Community Health Post, and Wilberforce Community Health Centre. (In Congo town Community Health Post only IYCF was implemented). Two of the PHUs were hospitals and ACF was asked to support Stabilization Centres (SCs). These were 34 Military Hospital and Ola during Hospital.

[18] These were: Thompson Bay Community Health Post, Grafton Bay Community Health Centre, Blessed Makoba East Community Health Centre, Susan's Bay Community Health Centre, Jenner Wright Clinic, and the Well Body Community Health Post.

VSLAs, and nutritional support for EVD survivors[19].

As is the standard for evaluations, especially final evaluations, the evaluation was conducted for accountability and learning purposes to meet the needs of the users specified in the TOR. There were two evaluation objectives: To assess the overall contribution of the project towards reinforcing institutional capacity for the treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western area and national sensitization for nutrition security; and, To provide operational and strategic recommendations for the continuation of the project.

The focus on the evaluation was on the part of the project funded by Irish Aid, but also taking into account the parts funded by AFD and ACF. The evaluation was expected to cover all geographical areas (See Map 1) as well as the different community levels linked to each other (community, district and national stakeholders). The evaluation was also expected to focus on the selected target groups. These were 1420 target beneficiaries (government, CHWs, Lead mothers and Mother-to-Mother (M2M) groups. The indirect beneficiaries were 19,300 persons: children under five years, pregnant and lactating women and the communities. Although emphasis was placed on the assessment of the multi-sectoral approach and integration of nutrition and food security, there was less emphasis expected to be placed on HIV/AIDS, advocacy and surveillance components. The consultant evaluated the results of the project against Development Assistance Committee (DAC) criteria specified in the TOR. These were; Design, Relevance/Appropriateness, Coherence, Coverage, Efficiency, Effectiveness, and, Sustainability and Likelihood of Impact. The TOR also included evaluation questions for each of the criteria which were applied to an evaluation matrix. This matrix is shown in Annex VIII.

Over the 14 day field period (September 9 – 23rd, 2015), the consultant used a participatory approach to administer qualitative tools (KIIs, GIs with Free listing) using an agreed upon program and convenience sampling[20] to select 14 PHUs and their environs for study. ACF was invited to, and did attend, many interviews. An interpreter was also contracted to support the translation needs of the consultant.[21]The expected 21 persons to be interviewed were listed in the TOR, reviewed and additional persons were then added so as to gather enough information for evaluation. A total of 92 persons were interviewed in all. The findings from interviews were triangulated for different levels and against the narrative and quantitative data found in the documentation reports and databases. The documents and databases are listed in Annex III. This method enabled ensured that the findings were accurate as they were validated using triangulation.

As the project was due for completion on the 31st August 2015 and a mid-term review was carried out in August 2014, the final evaluation was directed at the assessment of the degree of achievement of the expected project results against the general specific objectives set in 2012. The consultant then rated the achievements of the project against the evaluation criteria and the identified Good Practices. These are shown in Annex I and Annex II, respectively. Each evaluation criteria in the TOR included a series of questions designed to capture the various dimensions of the project from 2012-2015. The IASC Gender marker scoring was also being applied to the project design in the selection of beneficiaries and activities and outcomes. This is discussed in the findings for 'Design'. Gender is also part of the findings on 'Effectiveness'. Theory of change was discussed in the Stakeholder Workshop held on September 25th, 2015 and is discussed under 'Relevance' findings. The consultant produced a

[19] See the logical framework outputs 4.5. and 4.6.

[20] A **convenience sample** is one of the main types of non-probability **sampling** methods. A **convenience sample** is made up of people who are easy to reach. In the case of Sierra Leone, ACF attempted to reach all 26 PHUs and their surrounding community volunteers. This enabled the consultant to understand the support to PHUs and their linkage with local community leaders, community volunteers, Lead Mother groups, M2M groups and VSLAs. At the same time, the consultant wanted to visit sites where the spaces saving gardens were in place.

[21] The translator was from the private sector, not from ACF to ensure impartiality.

ToC flow chart for future projects directed at nutrition and food security. This chart is part of the recommendations.

3.2. Document Review (DR)

The first key source of data was documents, such as reports, training records and minutes of meetings. The document review for the evaluation was mainly the background documents provided by ACF and other documents such as global studies. These complemented and substantiated the analysis and recommendations for the report. A total of 102 documents were studied.

3.3. Key Informant Interviews (KIIs)

Key Informant Interviews are face to face interviews or one on one interviews (using skype or phone). They are used to fully understand someone's impressions or experiences. The advantage of this method is that a full range and depth of information can be gathered. When skype or phone interviews are conducted as a KII, they also allow flexibility with respondents' busy programs. The disadvantages are that it is time consuming and the interviewer or respondent can show bias. Using questionnaire guides the consultant gathered information on all aspects of the project. This meant interviewing respondents such as ACF and DHMT staff, and others such as heads of M2M support groups and VSLAs. A total of 57 KIIs were carried out. Forty five of these interviews were with direct and indirect beneficiaries, while 12 interviews were with ACF staff and other non-beneficiary stakeholders, such as GOAL and the Civil Society Platform.

3.4. Group Interviews (GIs) with free listing

Group interviews were utilized to interview larger numbers of community volunteers, such as Lead mothers, mothers from M2M support groups and carers. The advantage of this method is that a full range and depth of information can be gathered in a short period of time. Free listing is a simple technique where an individual or group can be asked to "list as many ideas (or items) on [Topic X] as you can". Free listing tested beneficiaries' level of recall of the subject matter. The data collected was used to rank factors such as quality, coherency and quantity of training provided by the project. Thirty four persons were interviewed in nine group interviews.

Table 1 below shows the PHUs supported by the project and those visited during the evaluation.

TABLE 1: ACF Project-Supported PHUs & 12 PHUs visited during the Final Evaluation (September 9-18, 2015)

NO.	Western Area location	CENTRE NAME	PROGRAMME	Comments	12 PHUs (46% of total) Visited during Final Project Evaluation PHU and environs)
1	Urban	34 Military Hospital – EPI	OTP	Implemented from Feb 2013	✓
2	Urban	Adbangs Quarry CHP	OTP/SFP	Implemented from August 2014	
3	Urban	Blessed Makoba East CHC	OTP	Implemented from July 2015	✓
4	Urban	Congo town CHP Health Post	IYCF	No OTP/SFP only IYCF activities	
5	Urban	Signal Hill CHP	OTP/SFP	Implemented from Feb 2013	✓
6	Rural	Goderich CHC	OTP/SFP	Implemented from April 2015	
7	Rural	Grafton CHC	OTP	Implemented from July 2015	✓
8	Urban	Haja Neneh CHP	OTP	Implemented from Feb 2013	✓

9	Rural	Hastings CHC	OTP/SFP	Implemented from April 2015	✓
10	Urban	Hill station CHP	OTP/SFP	Implemented from Feb 2013	
11	Rural	Jenner Wright Clinic	OTP	Implemented from July 2015	✓
12	Rural	Leicester CHP	OTP/SFP	Implemented from Feb 2013	
13	Urban	Looking town CHP	OTP/SFP	Implemented from Feb 2013	
14	Urban	Lumley CHC	OTP/SFP	Implemented from Feb 2013	
15	Urban	Malama CHP	OTP/SFP	Implemented from Feb 2013	✓
16	Urban	Murray Town CHC	OTP/SFP	Implemented from Feb 2013	✓
17	Urban	Ola During Children Hospital	IPF/OTP/SFP	Implemented from Feb 2013	✓
18	Rural	Regent CHC	OTP/SFP	Implemented from Feb 2013	✓
19	Urban	Sunshine CHP	OTP/SFP	Implemented from Feb 2013	
20	Urban	Susan's bay CHC	OTP	Implemented from July 2015	
21	Urban	Thompson Bay CHP	SFP	Implemented from July 2015	✓
22	Rural	Tissana CHP	OTP/SFP	Scaling-up OTP	
23	Rural	Tombo CHC	OTP/SFP	Implemented from April 2015	
24	Rural	Waterloo CHC	OTP/SFP	Implemented from April 2015	✓
25	Urban	Well Body clinic CHP	SFP/OTP	Implemented from July 2015	
26	Urban	Wilberforce CHC	OTP/SFP	Implemented from Feb 2013	✓

3.5. Limitations

The consultant faced several limitations carrying out the evaluation. First of all, some of the national and district government staff were not available for an interview until after the field work at community level was completed. This meant some necessary clarifications on their role could not be determined until after the community stakeholders (direct and indirect beneficiaries) were interviewed.

There were also time constraints during interviews due to commitments of some staff and also due to severe flooding which took place during the evaluation. Many PHUs were difficult to access due to poor infrastructure and damages due to the flooding. Another limitation was the large number of documents given to the consultant by ACF. Each of these had different file names but upon opening them, many were found to be the same document. This meant much time taken to open and scrutinize documents. The list of 21 persons to be interviewed shown in the TOR did not include donors such as UNICEF, WFP and WHO. There was a plan to visit the donors, but time did not allow it. There was also an intention to interview EVD survivors, and groups of indirect beneficiaries, but the interviews were not possible due to flooding encountered during the field.

4. FINDINGS

4.1. Findings on Design

- **ACF identified beneficiary needs (by age and sex) for indirect beneficiary children under five years.** Some direct beneficiaries (Lead mothers, mothers from M2M groups, women and men volunteers) were identified by sex, but not by age. Carers, EVD affected individuals, pregnant and lactating women and the general community were not identified by sex and age. Annex X shows the intended direct and indirect beneficiaries of the three year program as stated in the revised project proposal[22]. The direct beneficiaries were identified in seven categories[23].

  Community volunteers were identified as males and females, with an expected 65 women and 65 men as community volunteers. There was no differentiation of the beneficiaries by male, females or youth in the databases. Lead mothers and mothers from the M2M support groups were women of childbearing years (15-49 years) although this was not stated. The indirect beneficiaries were identified in three categories.[24] Children under five were identified by age and pregnant and lactating women were women of childbearing years.

  "People" in the communities were not specific in terms of community volunteers and carers. There was no mention in the indirect category of beneficiaries of sex, age and state of health (e.g. Ebola affected individuals, teenage mothers and youth). A DR of the ACF Needs Assessment of 2012 shows there was identification of needs prior to the project implementation, but these were general, not specified by age and sex.[25]. The study also identified barriers to change, but did not make conclusions as to their effect on the beneficiaries' needs.[26]. A DR of the CHW Mapping Worksheet (12.6.2013) shows Community Health Workers (including Lead Mothers and Mothers) identified by sex (336 females: 55 males). In the mapping 220 persons were identified by age while 172 were not identified by age. A GI held with ACF staff on September 10 and September 15, 2015, indicated that CHW Mapping was one of several means of identifying and tracking beneficiaries' needs[27]. The "Knowledge Assessment of PHUs identifies needs of health staff and gaps in equipment, for 14 PHUs, but not clear if up to date as it was dated September 16, 2006[28].

- **Gender was not mainstreamed in the project design to address needs of men, girls (especially teenage girls) and boys, but the needs of pregnant, lactating women and their under-five children were factored in the proposal design.** The activities for each of the four expected results were directed at nutrition and food security support to meet their general needs. To name one example, the project does not specify the differences between men, women, girls and boys, with respect to food taboos, preferences and consumption patterns. These patterns have a direct impact on the nutritional status and normally have a gender dimension, almost universally to the disadvantage of women29. **Sex and age disaggregated data (SADD) was not gathered, and a gender analysis was not done at the start of the project, or periodically**. In terms of the ACF gender markers for nutrition programming, focus group discussions (FGDs) conducted during the

[22] DR of Narrative-Irish Aid ACF project proposal -revised clean, p. 9, ACF Needs Assessment 2012 and Revised Logical framework.
[23] These were DHMT staff, high level people from the government, community volunteers, lead mothers, mothers from M2M groups, carers and EVD affected individuals.
[24] These were children under five years, pregnant and lactating women and people in the area.
[25] ACF, Needs Assessment CMAM, Western Area, January-March 2012. Needs are specified in six pillars: Service delivery, health workforce information, medical products, financing and leadership. See p. 6.
[26] Guevarra, E, Report on SLEAC and SQEAC 20 February-25 April 2011, pages 12-16.
[27] KIIs, HOD and Deputy Nutrition and Acting Project Manager, Nutrition and Health.
[28] PHU needs were identified in 6 areas-detecting acute malnutrition, nutrition and medical protocols, documentation, stock management, nutrition and health education and hygiene prevention and promotion.
[29] ACF Gender Policy, "Increasing the impact of ACFs work through gender equity and programming", March 2014.

project implementation period, did not identify different needs, constraints, concerns and capacities related to nutrition activities of women, girls, boys and men. A study on teenage mothers care practices was carried out in June 2014. It identified care practices for teenage mothers and recommended these be programmed but this was not planned for.[30]

- **In terms of SMART, the project objective was specific and relevant, but less measurable and attainable.** The specific objective of the project was: "Reinforcing institutional capacity for treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western area and national sensitization for nutrition security in Sierra Leone.[31]" The performance indicator set for Result 1 (Institutional capacity building, technical support for management of the DHMT for treatment of acute malnutrition) was that 80 % of children would be screened in the area of intervention. However, only output 1.3 responds to this indicator. On the positive side, the measurement of screening was identified as an indicator of attainment of the results and it followed the precision of SPHERE standards. However, the data collection remained the task of the DHMTs who faced a challenge gathering surveillance data during the life of the project.[32]

  The indicators for Result 2 ("Government of Sierra Leone and major donors prioritize nutrition security in their strategies, frameworks and financial commitments by 2015") were less SMART than those for Results 1, 3, and 4, as the indicators relate mostly to ACF activities, not government changes in prioritization. The issue of "donor prioritization" as an indicator was not practical as this area could not be controlled by the project and therefore was not attainable or trackable. Result 3 "Improve at central level initial training for both health staff and nutrition surveillance and propose innovative study related to nutrition security", was not clear with respect to 'nutrition surveillance' or whether it applied to training or innovative studies. The indicators for Result 3 with respect to the Cost of Diet and Teenage Mother studies appear also not to be relevant to the expected result or the overall specific objective.

  Result 4 "Prevention of malnutrition through gardens for health and IYCF mother to mother support groups and nutritional support to EVD affected individuals" has SMART indicators. **One of the indicators for Result 4 was "40 % of households improve their dietary diversity" was not fully relevant as the project activities did not significantly address affordability and accessibility to foodstuffs.** This finding was reflected in KIIs with community leaders carried out in the informal settlements, who reported there was lack of space to grow diverse crops and the crops were also unaffordable to most families.[33]

- **There were causal-effect links and hypothesis behind the project intervention with respect to capacity building and training for formal and volunteer staff but these were not identified as a Theory of Change in the project design and therefore not fully addressed during the life of the project.** There was an assumption stated in KIIs with ACF staff that nutrition security for under-fives would improve due to efforts of trained PHU nurses and M2M groups, but this may not be attainable on the short term or sustainable in the long run, as there are other factors affecting nutrition security, such as poverty.

[30] ACF, "Teenage Mothers Care Practices", June 2015, p. 6.
[31] ACF Revised project proposal
[32] KIIs on September 19 and 22nd with the District Nutrition Officer and former ACF Nutrition surveillance officer, suggested that collecting accurate data was not always possible due to skills gaps at district and PHU levels in collecting the data.
[33] KIIs on September 15 and 17 with CHW Leader, Moa Wharf, and Chairlady Health Committee, Murray Town suggested that knowledge of the need for nutritious foodstuffs is important, but many households cannot afford them.

Result 1 was directed at capacity building of the health staff through CMAM and later IMAM training[34]. The MoHS, Food and Nutrition Directorate developed the 2014 National Protocol on the Integrated Management of Acute Malnutrition (IMAM). This protocol for training content was used by the District Nutritionist training team, supported by the ACF Capacity building nurses in 20 of the 26 PHUs. Most theoretical training was carried out over a 3 day period (2 days theory and 1 day practical) at the PHUs. This was called peer-to-peer training and was the preferred methodology according to the District Nutritionist (KII on September 11, 16, and 21, 2015 with the District Senior Nutritionist Western urban/rural). The District Nutrition Officer, and the Director FND (and Deputy, IMAM Officer) confirmed this was the preferred approach for the 3 day IMAM training whereas the one day refreshers were conducted in classroom setting away from the workplace. **The nurses in charge of the 14 sampled PHUs stated that they preferred the on-site, peer-to-peer training as it was hands-on and motivating, but the proposal makes no underlying assumption/justification as to the benefits of this type of training over other methods.[35]**

There was concern expressed in a KII with the Director of the FND as to the quality of the ACF Nutrition trainers (Capacity building nurses), and the accuracy of the pre and post-tests carried out by ACF on them to reflect knowledge gained. The capacity building nurses were also relatively inexperienced as they were hired immediately after graduation. [36]In terms of cause and effect, the IMAM protocol was applied by District Nutritionists to train PHU staff (who also had to undergo supervision and refresher training). This in turn was expected to reduce the incidence of MAM and SAM, as mothers would bring their children in before MAM became SAM and children would also receive treatment. **The IMAM/CMAM intervention was also dependant on a regular supply of plumpynut and Benimix (from UNICEF) but the KIIs with ACF and PHU staff indicated there were shortages.** There was an assumption made in the MOU between ACF and the MoHS that the government would ensure that UNICEF maintained supplies. It was also assumed that there would be enough qualified trainers[37] and PHU staff on duty at all times. It was also expected that the basic infrastructure for a PHU would be in place.

With respect to the gardens, there was no defined causal-effect benefits as to whether or not the new foodstuffs were affordable or accessible and information was not gathered in this area. **The design assumption was that saving space gardens would make foodstuffs more accessible for all beneficiaries. Although demand for the gardens was high, it was noted that they were generally small in size, so the produce and new technologies (such as seed multiplication) could not support all the Mothers who needed them.**

The flow chart below shows how the IMAM capacity building intervention was applied at the PHUs. In the flow chart, the community comes to the PHUs (usually by referral from CHWs) to be treated in the PHU OTP screening room, or referred to one of the hospital SCs.

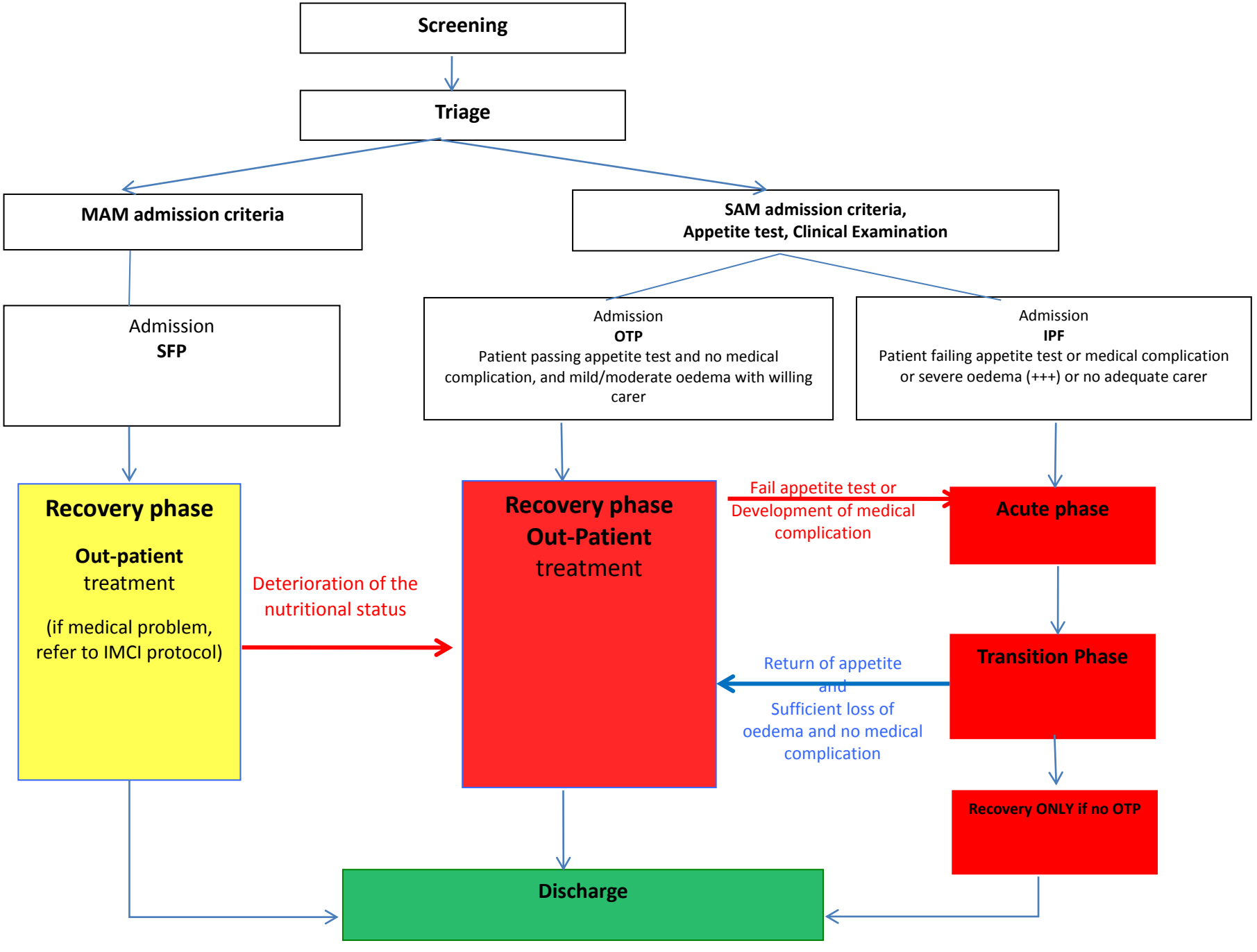
[34] MoHS, " IMAM training protocol" 2014

[35] A table in Annex XII is drawn from the UNISA template on learning opportunities. It shows advantages of classroom training over on-the-job or coaching such as: Identifying the appropriate staff capability gap and clarity about what is to be developed; ensuring full course attendance and completion of course activities and provides opportunities to put learning into practice after the training. It also provides focused and targeted learning and development.

[36] ACF, "Pre and Post testing" 2012. Testing was carried out on the capacity building nurses employed by ACF (seconded from the MoHS).

[37] DR was conducted of the IMAM 3 day training program (OTP and SC), 2 day Refresher IMAM training program, pre and post tests for IMAM trainees.

Flowchart 1: IMAM Screening and Triage. (Source: PowerPoint Slide 31-IMAM IPF Refresher Training Day 1, April 2015).



- **There is a causal-effect link between peer-to-peer training of Lead Mothers/M2Ms and community change (in breastfeeding and complementary feeding practices, and partly with MAM and SAM) but the hypothesis was not well explored in that a combination of factors needed to be addressed, such as poverty. The project results show that when the community leaders/stakeholders were engaged and lead mothers and M2M mothers received IYCF knowledge and incentives, they influenced mothers of children with MAM and SAM to go to PHUs. Another factor is that where mothers are identified by their peers for training and volunteerism, they were more likely to gain and impart knowledge of infant breastfeeding and supplementary foods and encourage mothers to seek help at PHUs.** KIIs conducted with PHU heads, community leaders and Lead Mothers from September 9-24, 2015, indicated that IYCF was made simple to understand with the pictorial guide (funded by ACF and UNICEF) which Lead Mothers carried with them. Lead mothers were also able to convince mothers to form M2M groups of 10-14 women, who would then go out in the community to influence mothers to bring malnourished children to the PHU and also change practices regarding breastfeeding and complementary feeding. According to PHU heads and Community Leaders interviewed in the 14 PHUs and their catchment areas, **the M2M Support groups stimulated community awareness on IYCF and increased the number of PHU referrals, which in turn saved the lives of many malnourished children. At the September 25, 2015 Stakeholder workshop, the FND participants stated they planned to put more emphasis on the M2M model used by ACF inclusive of the packages of gardens and VSLAs.**

4.2. Findings on Relevance/Appropriateness

- **The project fits into the implementation plans for three Government of Sierra Leone strategies: The "Agenda for Prosperity-Road to Middle Income Status" Sierra Leone's Third Generation Poverty Reduction Strategy paper, 2013-2018; and "Food and Nutrition Implementation Plan 2013-2017.** The Agenda for Prosperity Vision for 2035 is directed at the reduction of stunting among children under two years of age, and building on the Free Health Care and Scaled-up Nutrition Initiatives (SUN), poor child care and dietary practices, shortage of skilled manpower and inadequate training, and the incomplete and untimely availability of data. The nutrition services in the FNIP strategy emphasize an improved surveillance system, and the promotion of IYCF. There is also emphasis on dietary diversity. According to KIIs with the MoHS, **the ACF project added value to the FNIP: It fit well into the Government of Sierra Leone, Nutrition and Food Security Implementation Plan 2013-2017, as it included three priority areas: advocacy for food and nutrition security; promotion and facilitation of adequate national and household food security, adoption of feeding practices for vulnerable groups.** The KIIs and GIs in the sample sites also indicated that the VSLA and market garden activities integrate nutrition with food security.

- **One aspect of the FNIP which is not in the ACF project logical framework is the FNIP recommendation that male support was necessary for effective female health care service delivery.[38]** There was no "active targeting of men to increase their participation in food and nutrition security interventions for them to better provide support to women."

- **The Government of Sierra Leone current domestic budget cannot finance the national food and nutrition security plans adequately[39] and needs the added value of ACF.** The government requires resource mobilization through donor partners to continue the implementation of new global initiatives such as SUN and REACH. The government budget is expected to be increasingly complemented by the Civil Society (C.S) Platform SUN activities and interaction with the DHMTs. The C.S. Platform currently relies on financial support from the Global Alliance for Vaccination and

[38] Government of Sierra Leone, "Agenda for Prosperity" p.66
[39] Government of Sierra Leone, " Food and Nutrition Implementation Plan, 2013-2017" p.103-104

Immunization (GAVI). These funds will be mostly directed at 2016 immunization activities. The Platform also receives funding from the Multi Partner Trust Fund for the activities of the SUN Civil Society. So far it has engaged government and NGOs, but has limited staff.[40] NGOs such as ACF and GOAL have experience in nutrition security and a strong presence in Western area where each supports some of the 100 plus PHUs[41]. **There is an added value for the government to work with NGOs such as ACF that have experience in nutrition and food security as these can address the needs of targeted groups such as MoHS staff, pregnant and lactating women, their under five children and community volunteers.**

According to the MoHS, the FND and PHU staff, [42]there remains a gap in staffing of nutritionists who can build the capacity of PHU nursing staff. There was also need for support for transport and materials. The ACF project provided significant support. The collapse of the MoHS PHU outreach system over time meant that PHU staff could not go out frequently to the communities, so support was important in order to train and equip community volunteers. The Ebola crisis also meant that the general public and mothers of malnourished children were not willing or able to come to the PHUs so trained volunteers were needed to alleviate this.

- **A strong sense of Program ownership was expressed by local stakeholders.** The nutritionist training support provided by the ACF capacity building nurses and the facilitation to transport and materials enabled the implementation of IMAM/CMAM in the 26 PHUs. September 11, 2015 KII with the Senior Nutritionist, KII on September 14, 2015 with the SUN National Coordinator, KII on September 19, 2015 with the District Nutrition Officer, and the KII on September 22, 2015 with the Director, FND confirmed that the IMAM/CMAM and IYCF training followed the protocols of the government and enabled the government take greater control over PHU activities. The support to facilitation of nutritionist staff enabled them to carry out on site training and supervision and refreshers to health staff in the 26 PHUs. At the same time KIIs and GIs with the staff at the 14 sampled PHUs and local communities sampled by the consultant, indicated that the CHW training (Lead Mother and M2M) created trust and a sense of ownership. The CHW training made it possible for the MoHS to revive previously existing outreach services. This ensured a sense of ownership of the program.[43]

  Local stakeholders were part of the project from the start. KIIs with ACF staff indicated they developed a guide in 2012 to work with stakeholders and their commitment entitled "Agenda for Community Stakeholders Meeting guide." In June and July 2015, ACF held Exit Strategy Meetings with Community Stakeholders for ACF to officially exit the project. These meetings were attended by the government. **The volunteers and government agreed to take over the project in the 2015 exit meetings organized by ACF. There was no agreement in the meetings on how incentives would be managed. However, there were some positive outcomes with respect to local ownership when communities agreed to continue with outreach activities**. A KII on September 15, 2015 with the Chairman of the Hastings Health Committee, KII on September 17, 2015 with the Chairlady of the Murray Town Health Committee, and KII on September 18, 2015 with the Loko tribal chief confirmed that the exit strategy meetings were held. Now that the project had ended, the stakeholders would take over ownership from the end of August 2015, including (a) Assisting in

[40] KII September 11, 2015, Coordinator CS Platform

[41] ACF supports 26 PHUs, while GOAL supports 19 PHUs.

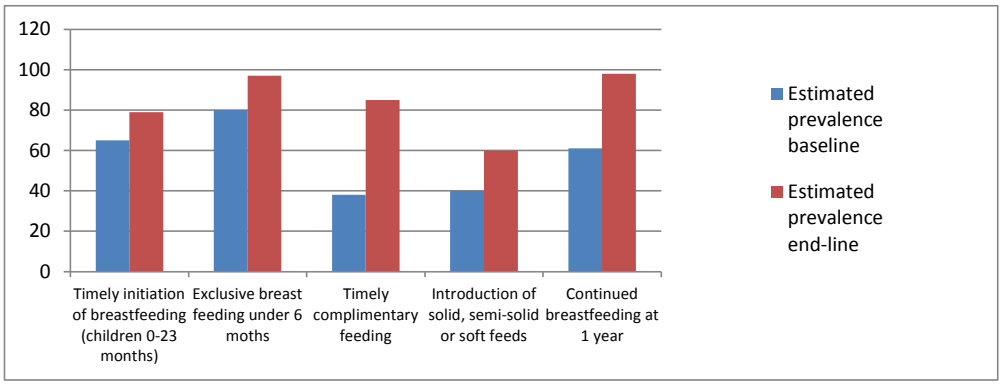
[42] KIIs and GI with the national, district level staff and PHU staff and volunteers conducted from September 9-23, 2015, revealed the seriously of shortages of trained staff, and gaps in outreach and surveillance.

[43] A DR of the some of the training manuals confirmed that the training content followed the government protocols. Examples are: ACF, "Detection and Referral Community Volunteer Training Manual" January 2013; ACF " Analysis Pre and Post test Lead Mothers; ACF " District Monthly Reporting form"; ACF "IMAM Training and Refresher Training Days, 1,2, & 3". There was also an MOU with the government of Sierra Leone which specifies their ownership of the program.

finding possible solutions to challenges faced by CHWs. (b) Monitoring peer supervisors on community activities and (c) Act as a liaison between the PHU and the Community and should also attend monthly meetings with CHWs and PHU In charges[44]. During these meetings the community also donated garden tools to replace older ones.

- **There are Beneficiary needs partially met for increased continuous breastfeeding and timely addition of complementary feeding to infants and young children. However, solutions to the continued MAM and SAM will have to be addressed by future project interventions.** At the time of the evaluation, ACF had recently conducted an End of Project (EOP) survey which is still under analysis. However the preliminary results shown below indicate significant improvements in the communities, especially with complementary feeding. The Irish Aid Intermediary Report from 31st August 2014 – 28 February 2015 refers to the period of July – October 2015 as the hunger months, accounting for significant admissions. The MoHS attributes increased attendance and incidence of MAM and SAM at EOP to the EVD outbreak. The IYCF indicators at EOP are compared with those gathered in the ACF Needs Assessment of 2012 in Figure 1 below.

Figure 1: IYCF indicators prevalence at project baseline and end-line



Source: *ACF EOP Survey August 31, 2015-(still under analysis)*

The findings of the evaluation show strong evidence of a reinforced MoHS and FND due to the project support to technical skills development including surveillance skills for 174 DHMT management and health team members by August 31 2015 (Result 1). In the Intermediary Report to Irish Aid (up to February 2015), ACF expressed concern it would not be able to give the necessary training, and refreshers to the six scale up PHUs. However, the evaluation confirmed this had been done. The consultant visited 14 PHUs of which seven were scaled up from February 2015. KIIs in the PHUs confirmed nursing staff had received the training expected. At the same time five high level people from the MoHS had the opportunity to attend national and international conferences, e.g. ICN International Conference in Rome, Italy was attended in May 2015 and the June 2015 Roundtable on SUN was organized with ACF and attended by UNICEF, FAO and others. KII on September 21, 2015 with the Director, FND, confirmed there was attendance by the MoHS and this improved their capacity. The KII on September 19, 2015 with the District Nutrition Officer confirmed he received support in surveillance from the ACF surveillance expert. This support largely met Result 2 at least for the government: **The project supported the Government of Sierra to prioritize country nutrition security**

[44] DR Stakeholders Exit Review Meeting, June 2015.

in strategies and frameworks, by supporting them in attending key conferences and developing protocols.

The project expected to identify and train 130 community volunteers, half of them men. An ACF database on community volunteers shows this figure was surpassed and that there were a total of 392 community volunteers, of which 336 were female and 55 were men[45]. This figure may reflect some of the 1000 mothers from M2M and carer groups. The consultant noted during KIIs and GIs that many people served multiple roles in the community, e.g. being a volunteer, carer and being a Lead Mother. The visits to 14 PHUs (including seven scaled up from February 2015) confirmed that there were 10 Lead mothers per PHU. Each of the Lead Mothers had 10-14 mothers working under them. This makes a total of 100 per PHU, or 2600 women. The consultant did not interview any of the expected 80 EVD affected individuals due to flooding on the day when they were to be interviewed, but there is some evidence they were supported in 2015: With the outbreak of Ebola in late 2014, the project introduced nutritional support for EVD affected persons in February 2015. This is reflected in the LFA where Output 4.6 activities were added. Although KIIs and GIs were not held with the EVD survivors, a DR review of ACF monthly reports to Irish Aid indicate that they received support. [46]Lead mothers and their groups worked with CHWs to detect and refer those affected by the virus. **An unspecified number of EVD affected persons received rain gear and back packs and counselling from the community volunteers. ACF project staff and volunteers worked with the Sierra Leone Association of Ebola Survivors (SLAES) to provide this support.**

The incidence of MAM and SAM continue to be an issue of concern across the country and also in the 26 project sites. The MoHS Quarterly Nutrition Report April 1stJune 30, 2015, provides some information on nutrition indicators related to MAM and SAM. The results are not disaggregated for PHUs served by ACF from PHUs served by other NGOs, or PHUs not supported at all. Table 2 below indicates the number of children (0-59months) screened in the peripheral health unit (PHUs) on a monthly basis using the WHO growth standards. According to the MoHS, "Out of a cumulative total of **459,982** children screened during the second quarter, **83.4**% had good nutritional status, **12.8%** with moderate acute malnutrition (MAM) and **3.8%** were severely malnourished (SAM). From the analysis, Bonthe **(26.1%),** Port Loko (**25.9%),** Kenema (**22.7%),** Kailahun **(21.0%)** and Kambia district (**20.7%)** shows high malnutrition rate in the second quarter. The high malnutrition in the above five districts is a course for concern but needs further investigation".

Table 2: Breakdown of weight for height Z score by district (April– June 2015) – 2nd quarter data

District	Total Screened	Normal (>-2 z-score)		Moderate (<-2 z to -3 z-score)		Severe (<-3 z-score)	
		No.	%	No.	%	No.	%
Bo	55,307	50339	91.0	4099	7.4	869	1.6
Bombali	45,698	37751	82.6	6008	13.1	1939	4.2
Bonthe	12,067	8912	73.9	2182	18.1	973	8.1
Kailahun	37,697	29769	79.0	6717	17.8	1211	3.2
Kambia	24,576	19479	79.3	4023	16.4	1074	4.4
Kenema	53,380	41281	77.3	9602	18.0	2497	4.7
Koinadugu	27,596	24541	88.9	1944	7.0	1111	4.0
Kono	16,602	14255	85.9	1920	11.6	427	2.6
Moyamba	38,999	34306	88.0	3634	9.3	1059	2.7

[45] The sex of one entry was not filled in.

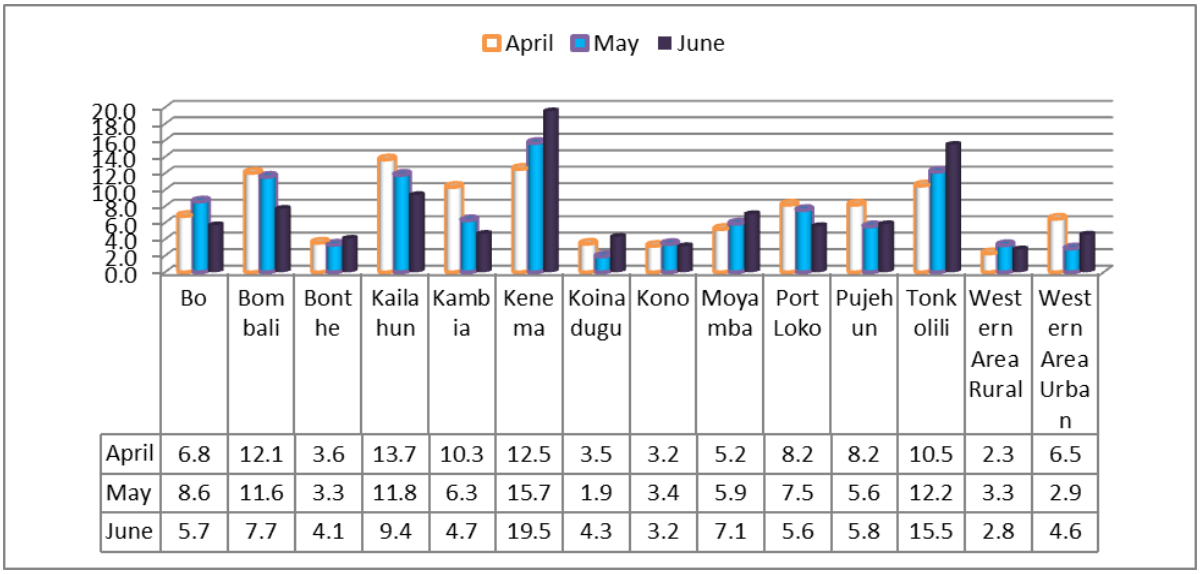
[46] See Irish Aid Intermediary Report by ACF for the period 31st August 2014 – 28th February 2015. Page 1 refers to the Lead Mothers and CHWs carrying out detection and referral, while page 9 refers to provision of rain gear. The Irish Aid Activity Progress Report by ACF for August 2015 refers to nutrition counseling and working with the SLAES.

Port Loko	21,299	15791	74.1	4108	19.3	1400	6.6
Pujehun	24,772	19751	79.7	3455	13.9	1566	6.3
Tonkolili	59,677	50002	83.8	7663	12.8	2012	3.4
Western Area Rural	18,669	16381	87.7	1653	8.9	635	3.4
Western Area Urban	23,903	20837	87.2	1920	8.0	1146	4.8
National	**459,982**	**383395**	**83.4**	**58928**	**12.8**	**17659**	**3.8**

Source: MoHS Districts routine nutrition data collated by the district Nutritionists.

The figure below from the MoHS report shows some improvement of the malnutrition in Western rural when compared to the rest of the country. One reason given by the government in the quarterly report for high MAM cases nationally is due to the fact that more care givers were accessing the health facilities but there were no supplementary feeding programmes (SFP) at some of the facilities to combat the situation.

Figure 2: Monthly Percentages of MAM children identified per district in the second Quarter 2015



	Bo	Bombali	Bonthe	Kailahun	Kambia	Kenema	Koinadugu	Kono	Moyamba	Port Loko	Pujehun	Tonkolili	Western Area Rural	Western Area Urban
April	6.8	12.1	3.6	13.7	10.3	12.5	3.5	3.2	5.2	8.2	8.2	10.5	2.3	6.5
May	8.6	11.6	3.3	11.8	6.3	15.7	1.9	3.4	5.9	7.5	5.6	12.2	3.3	2.9
June	5.7	7.7	4.1	9.4	4.7	19.5	4.3	3.2	7.1	5.6	5.8	15.5	2.8	4.6

Source: 2nd Quarterly Report, MoHS 2015

4.3. Findings on Coherence

- **The ACF program interventions were consistent with the Scaled up Nutrition strategy (SUN) and the Food and Nutrition Implementation Plan (FNIP).** A DR of the FNIP showed that the role of the FND, was "Coordinating the national food and security action plans[47]. The same report (confirmed in KIIs with the FND) indicate that the government cannot independently finance the investments and depends on external resources from donors, such as Irish Aid[48]. The KII on September 21, 2015 with the Director, FND and KIIs on September 10th, 2015 with the ACF HOD and Deputy, Food and Nutrition, confirmed that **ACF ensured that the MoHS, and FND were able to carry out its expected coordinating role and that the linkage of the ACF program was strong. An MOU with the DHMT increased commitment of both ACF and the government as it clearly spelled out each other's role.** A DR of the MOU between the MoHS, DHMT Freetown, specifies the linkage between the Ministry and SUN. According to the MOU, the MoHS is expected to organize coordinating meetings between partners working in nutrition and food security following the recommendation

[47] MoHS, "FNIP p. 6 –Development Partners.
[48] This project was funded 43% by Irish Aid, 39% from AFD and 18% ACF.

of SUN. Both the ACF and the MoHS, DHMT were expected to meet regularly and respect the National Nutrition Protocol in the treatment of malnutrition and to communicate any changes or discrepancies to all actors for consistencies in the treatment of malnutrition in the OTPs and SCs[49].The KII on September 14, 2015 with the SUN Coordinator, showed **that there were regular bi-monthly coordination meetings of ACF and other NGOs with SUN and there has been sharing with SMART surveys. This is expected to continue.**

KIIs and GIs with beneficiaries of the project confirmed that **the "Prevention of Malnutrition through gardens for health" activities were found to fit in well with the government strategies on nutrition and food security. In some cases, they addressed poverty. The gardens were attractive and visible to the public and took up little space. In addition the produce could be used for cooking demonstrations at the premises of the PHUs. The PHU staff interviewed in KIIs stated that the nursing staff were more aware of the seasonality of the health foodstuffs due to the ACF project. The KIIs with Lead Mothers and M2M Mothers confirmed that they received training on how to garden and cook. They also received vegetable kits.[50]**

- **ACF has supported the rolling out of CHW activities by supporting the MoHS proposal for a national strategy on CHWs.** KIIs on September 21, 2015 with the Director, FND, September 19, 2015, the District Nutrition Officer, KIIs and with the 14 PHU staff and volunteers (September 9-23, 2015) indicated that in the past the CHWs have supported the MoHS, mainly through the Primary Health Care Directorate. The role of CHWs carrying out IYCF and working with the FND has been enhanced, but at the same time mothers are coming to the clinics more for MCH/FP, a change the MoHS attributes to their enhanced role.

  The KIIs showed that during the ACF project, the CHWs served a role to reverse non-attendance of pregnant and lactating mothers of malnourished children at the PHUs. **The general public attends the 26 supported PHUs more now, due to the project support. This has increased now that Ebola is under control.** ACF also did an official exit from the project. The community agreed to take over the activities and conduct CHW supervision in line with the proposed CHW policy[51]. However a DR of the CHW Policy and the 2nd Poverty Reduction Plan (Ministry of Finance and Economic Development" November 2012) indicates several ministries and directorates need to be involved if CHWs are to be financed through various incentives, and motivated[52]and that specific areas of intervention by NGOs such as ACF need to be identified to support this in the future.

  The ACF project worked closely with the MoHS and the MAFFS (FND), but not with other key ministries and directorates linked to nutrition security, such as the Ministry of Local Government and Community Development (MLGCD),[53]and the Directorates of Primary Health Care, Reproductive and Child Health, Disease Prevention and Control, and Planning and Information.

4.4. Findings on Coverage

- **Support to the MoHS and FND created an enabling environment for them to address nutrition and food security.** A DR of the revised project proposal and the March 2102 Need Assessment conducted by ACF indicate the activities and expected outputs are in line with the needs of pregnant, and lactating women and their under-five year children. The general objective of the project was appropriate and activities contributed to the improvement of maternal and child

[49] MOU, MoHS, ACF 8 pages specifically page 5, "Joint responsibilities" November 12, 2015.
[50] DR of the ACF reports to Irish Aid (bi-annual and monthly) confirm that cooking training was carried out.
[51] MoHS, "Policy for Community Health Workers in Sierra Leone" June 2012, page 14.
[52] MoHS, "Policy for Community Health Workers in Sierra Leone" June 2012, pages 5-13, 15
[53] Government of Sierra Leone, "2nd Poverty Reduction Plan" p.64

nutrition situation in West Africa. **The ACF needs assessment of 2012 identified gaps in service provision such as non-appropriate anthropometric tools, old and broken MUAC tapes and broken height boards, to name a few. The project provided this necessary equipment to the 26 PHUs.** This was confirmed during the September field work interviews at 14 sampled PHUs, where working equipment for anthrometry was found to be in place and nurses and acting in-charge staff confirmed that ACF provided the equipment to replace broken down equipment. The needs assessment also identified poor knowledge of CMAM (now IMAM) guidelines and this was also confirmed in the field, where staff stated that they had gained knowledge and improved their skills due to training on CMAM/IMAM provided by district nutritionists and ACF nutritionists, all funded by the project. The active case screening, referral and follow-up was limited in the 26 selected PHUs and according to the nurses could only be done during immunization campaigns**. The MoHS lacked resources for outreach services. This was addressed by the ACF project when CHWs (and Lead Mothers) were trained in IYCF and conducted outreach and referrals, thereby filling the gap in outreach services.**

The needs assessment pointed out that government health centres were difficult to access and had less drugs delivered, and a lower quality of reception, compared to private health centres. The consultant sampled 14 PHUs and noted **many PHUs remain difficult to access due to the poor infrastructure**. Foodstuffs expected to be supplied by UNICEF and WFP were supplied but shortages occurred due to the high influx of women attending. Changes in the poor nutritional care practices (breastfeeding and supplementary food practices) show they were addressed by the IYCF training for CHWs and partly by the gardens filled with nutritional crops situated near the PHUs and Lead Mother homes, which some mothers had access to.

- **<u>There are potential beneficiaries such as teenage mothers and fathers of malnourished children who were not assisted or included in VSLA and gardening activities</u>**
  Potential beneficiaries could have included teenage mothers and more fathers of the malnourished children. Men and youth could also have benefited more from the VSLA activities and the competitions. The GIs and KIIs with Community Volunteers held between September 9-23 2015, confirmed that VSLA and competitions were very empowering for the Lead Mothers and M2M, but men, teenage mothers and youth were not part of this. Men and youth (males) involved in farming activities could have also been beneficiaries but were not included. According to KIIs with ACF head and deputy heads on September 10, 2015, it was expected that men and youth would benefit indirectly, but that there were some male CHWs and local male leaders who were very involved.

  Noting that women cannot own land in Sierra Leone, male farmers could be potential beneficiaries to develop small, medium and large healthy farms selling healthy produce to Lead Mothers and M2M at low prices and donating some produce to PHUs for the cooking demonstrations. Farmers could agree to participate in research on their farms on techniques such as seed multiplication and composting and teach others. Seed banks could be established and the seeds distributed to Mothers and VSLAs. The consultant noted that few kitchen gardens/small farms had carried out seed multiplication and given the seeds to M2M members. Without these seeds, the M2M members had to purchase additional seeds.

  A DR of the MoHS Nutrition and Food Security Implementation Plan 2013-2017 stressed "Active targeting of men to increase their participation in food and nutrition security interventions for them to better provide support to the women[54]". The same study notes that "Women often have to go through men to access land[55], negotiate prices and deals, or technology/inputs. While

[54] MoHS, "Nutrition and Food Security Implementation Plan" 2013-2017, p.20.
[55] Under Sierra Leone laws women cannot own land.

women participate in all household agricultural activities, they often have little control over income, particularly for high-value crops and cannot own land. Many women have to find additional income generating activities in order to generate 'fast cash' within their control to meet daily household expenses (e.g. purchase food), particularly in the lean season. Establishment of vegetable gardens is one of the options identified in the FNIP." (See page 23).

- **There are possibilities of extension of beneficiaries to other PHUs not supported by ACF or other NGOs.** A DR of the 2012 ACF Needs Assessment indicates that there are 108 PHUs in the Western Area of which 26 were assisted by ACF and a smaller number were supported by other NGOs such as GOAL and Helen Keller. **This means the current NGO nutrition security projects have not yet reached the estimated 300,000 children in Sierra Leone who are chronically malnourished, a situation that is worsening in the eastern and southern regions.**[56]Using additional PHUs as entry point, there is the possibility of extending the intervention to additional communities. However on exploring this issue in KIIs with the district nutritionist (September 11, 2015), the District Nutrition Officer (September 19, 2015) and the Director, Food and Nutrition Directorate (September 21, 2015), it was suggested that this would also require more Nutritionist staff. The table below is drawn from the Food and Nutrition Implementation Plan (Page 20), shows national staffing of nutritionists is only 13 persons. As these would need to be integrated at district level, but still reporting to the FND, there could be shortages of government staff, unless NGOs are ready to provide more support. Another approach could be that under nutrition is addressed at DHMT level as a Stand-alone activity.

TABLE 3: NATIONAL STAFFING OF GOVERNMENT FACILITIES

Sector	Facilities/Channels	First Line Human resources
Health	CHC 201 CHP 233 MCHP 620 Hospitals 147 Tertiary 8	Community Health Centres: 229 Community Health Nurses: 196 MCH Aides: 1876 Midwifes: 81 Nutritionists: 13
Agriculture	Agricultural Business Centres: 192 Extension training centres: 2 (Kenema and Tonkolili)	District Agricultural Officers: 13 Subject Matter Specialists: 78 District Extension Coordinators: 26 Block Extension Supervisors: 65 Field/block Extension workers: 520

Source: FNIP

During the Evaluation Stakeholder Workshop (September 25, 2015), it was also suggested that **Medical doctors should be trained on management of SAM. The need to train doctors is well known, but there have been limited opportunities for NGOs to participate in this area, as it remains under UNICEF**[57]. Finally, the workshop also recommended that the program expand to the PHUs already supported by ACF with WATSAN.

- **Ten M2M groups (10-14 members each) were created in the 26 catchment areas surrounding the assisted PHUs. It was expected that each of the ten groups would create additional M2M groups, i.e. a cascading effect. This did not occur in most cases. Mothers attributed this to lack of time.**

[56] MoHS, "Nutrition and Food Security Implementation Plan" 2013-2017, p 10.

[57] The mid-term evaluation recommended nutrition be included in the pre-service syllabus for medical staff I collaboration with partners (See Recommendation 13). While this has now been done for nurses, it could be done for doctors.

Field work from September 9-23, 2015 confirmed there were 140 Lead Mothers at the 14 sampled PHUs. Each Lead Mother had received training IYCF over a period of 2days and had then recruited 10-14 other mothers as M2M support groups. This process shows the multiplier effect of the project as mothers were willing to be part of groups. Each of the member mothers were then expected to cascade the membership by forming additional groups of M2M support members. Although Lead Mothers and M2M support members stated they had recruited a few new mothers who had then formed groups, they faced time constraints. Lead and member mothers said they were motivated to support their community needs and also motivated by the numerous incentives, such as umbrellas and seeds. The competitions were very empowering and motivating. They competed with each other at PHU level using drama and other means of communication. Lead Mothers in the environs of the 14 sampled PHUs, had set up the kitchen gardens at PHU level and also at or near their own homes. They also formed VSLA groups to save money and give each other loans. A modest amount of training had been provided on administrative aspects of VSLAs, which was not introduced until 2015. At PHU and Lead Mother levels, cooking demonstrations had been carried out to illustrate to mothers at PHUs or in the community, how to cook healthy food. According to the mothers this was new knowledge for them and also motivating.

4.5. Findings on Efficiency

- **Resource Allocation was mostly adequate to carry out the interventions. This facilitated conversion of the resources into the four expected results especially resources directed towards coordination, partnerships and expertise.** The project was funded by Irish Aid for Euros 647,393. AFD and ACF also provided funded for Euros 880,874. The project started 6 months late. It was expected to start in July 2012 but started in January 2013. A DR of the Irish Aid budget indicates the largest budget item was directed towards national staff salaries and support. This was appropriate as nurses, agriculturalists and other staff were important for the successful implementation of project activities over the three year period. Examples of national and international staff that were essential for successful implementation of the project are the (International) staff for health, surveillance and food security and advocacy, and national positions such as the communications officer, the capacity building nurses and the agricultural staff.

  The Program Managers for Health and Nutrition and Food Security were key to Result 1 and 3 activities[58], amongst them the identification of 26 PHUs and the Needs Assessment (January – March 2012) as well as general coordination of nutrition and food security activities . The 26 PHUs were expected to have a basic functioning infrastructure, but in one of sample sites visited (Thompson Bay PHU) the PHU was in very poor shape. **Investment in PHU with poor infrastructure may not be practical as the PHUs could prove to be a risky physical environment for delivering OTP services to vulnerable malnourished infants and children.**

  The Capacity Building Nutritionists employed by ACF were fresh university graduates. They worked with district nutritionists and conducted the training of health staff and volunteers working in OTP and SC in the PHUs. The government nutritionists led the training with support from the Capacity Building Nutritionists. The investment in fully salaried capacity building nutritionists may not have been practical, considering that if they seek employment with the MoHS they would not receive the same salaries as provided by ACF when they return to government jobs. The alternative could have been to attach experienced government nursing staff to work with the project.

  ACF supported transportation and communication costs for the training. This filled a gap the government had with respect to those line items. **The budget line for on the job coaching,**

[58] There should not have been Investment in the Teenage Pregnancy study and Cost of Diet study as these were costly and were not integrated into the project.

refresher training and training didactic materials for CMAM/IMAM was very important for capacity building, but a higher investment in structured classroom teaching was needed for the initial CMAM/IMAM training due to its benefits in providing focussed training and ensuring full course attendance and completion of course activities[59]. The project proposal makes reference to peer-to-peer and mentoring of nursing staff in PHUs on IMAM, but documentation in general does not refer to the specific success factors and benefits of the different types of learning provided. For example, there are differences in formal training, on the job training (peer-to-peer), coaching and mentoring, but these were not discussed or documented[60].

In the sampled PHUs and their catchment communities, it was noted that there was a higher recall of the IYCF training (delivered to community volunteers) than of the IMAM/CMAM training provided to the PHU nurses. The Community Volunteers had a high recall of the IYCF whereas the nurses had an average or below average recall when asked to free list training content. This may be a reflection of the training methodology which was mainly conducted on site for the main training. Classroom training was reserved for the refreshers. The incentives to the community volunteers were very motivating and innovative, e.g. uniforms, mobiles, umbrellas, and boots. KIIs with the Community Volunteers conducted from September 9-23, 2015, confirmed the incentives were very motivating. Means to continue incentives was not defined by EOP.

The ACF surveillance officer provided an important role at district level, providing training to support the collection of end of the month surveillance data for 5 districts using MS Excel. According to the KII on September 19, 2015 with the District Nutrition Officer, this support was key to Ebola surveillance and for the district staff to carry out nutrition surveillance documentation. **An assessment of PHUs was conducted by the District Officer of the Freetown DHMT. This confirmed there was a gap in the PHU staff ability to accurately complete the data forms. Support to PHU data collection was not funded by the project. It was suggested that this type of support required more investment from donors, so that M & E officers from the government could give more support to help the PHU staff complete data forms.**

The ACF Advocacy and Communication Officers were key to the project meeting some of the outputs of Result 2. They supported to launching and coordinating Nutrition Coordination Meetings (REACH/SUN), and the CHW Task Force, to name a few[61]. There was also support to the drafting and revision of some of the MoHS policies and protocols, such as the "No touch policy", the "IMAM Protocol revision" and the "Ebola Protocol". At the World Health Assembly held in May 2014, ACF supported the MoHS by drafting recommendations on maternal and child nutrition. The MoHS also participated in the ACF side event on nutrition. The 2015 SUN Roundtable meeting was organized by ACF and SUN CSP. It discussed achievements of Sierra Leone with respect to the Nutrition for Growth Initiative. According to the KIIs with the FND, these activities increased the visibility of the government and the issues of nutrition and food security. Other advocacy activities undertaken by ACF were the coordinating role on Ebola advocacy, capitalization of the ACF work, a documentary and the training of journalists to ensure that nutrition and health are discussed in the media. **The radio discussions on food and nutrition funded by the project were considered to be very helpful. They quickly changed the KAP of the general public including people assisted and those who were not directly assisted.** The KIIs and GIs at the 14 PHUs and in the communities

[60] UNISA, "Organizational learning and development" template shows the differences in targeting, success factors and benefits for different learning interventions. It is also suggested that on the job training may be more suitable for new staff, whereas the nurses were experienced.

[61] The Advocacy officer was part of the international staff while the Communication Officer was part of the national staff.

confirmed that most of the community heard the radio discussions and jingles and were motivated by the new knowledge.

- **There were many appropriate resources specific to community nutrition activities.** These included training (on gardening, weeding, seed multiplication and organic pesticides) and materials (seeds and tools) to prepare gardens at PHU and Lead Mother levels. The consultant visited the tended gardens at 14 sampled PHUs, including one in an informal settlement using car tires in small spaces. The Lead Mothers interviewed from September 9-23, 2015 stated they managed the PHU gardens using a roster system, where Mother took turns weeding the gardens and conducting cooking demonstrations at the PHUs and in the communities. KIIs with local leaders, such as the Loko tribal chief (September 18, 2015) and the Chairlady of the Petty Traders Association (Waterloo) on September 17, 2015, confirmed that the new technologies were very useful.

4.6. Findings on Effectiveness

- **The four project results were mostly consistent and linked to each other in that they contributed to the improvement of the government capacity to address nutrition security and the community capacity to be part of nutrition and food security. This is reflected in the completion of many project activities.** Annex XI shows the degree of achievement of the results as documented in the August 2015 monthly activity follow-up report (The consultant notes that the report does not make reference to all the expected results, but it is still indicative of the degree to which some of the targets set for the results were met by EOP). The specific objective of the project was directed towards reinforcing both the government and community capabilities to treat and prevent acute malnutrition in Freetown and Western area. The worrying levels of SAM in 2010 in urban slums and western rural communities attest to the urgency of the situation. **The high percentage of children under five years who were underweight, stunted and wasted in Sierra Leone in 2010 is evidence of the need for nutrition education on exclusive breastfeeding and complementary foods.** The four results are more consistent in reinforcing the formal institutional capacity to develop national nutrition strategies and treat SAM at PHU level. They are less consistent with addressing the issues of accessibility and affordability of healthy foodstuffs for poorer households. The cost of food is also a factor in the Freetown and Western area communities where poverty is high and inflation rising. With respect to poverty, the project conducted research on key areas such as teenage pregnancy and cost of diet, but there were no activities to address the emerging issues from the two studies. The 4th expected result "Prevention of malnutrition through gardens for health and IYCF mother to mother support groups, and nutritional support to EVD affected individuals" addressed the issue of accessibility of foodstuffs but at a small scale, as it mainly supported the Lead Mothers and M2M groups.

- **There is an added value of extending the IMAM training into an IMCI package** there is added value of extending IMAM training (job coaching and formal classroom training) into IMCI training. The Integrated Management of Childhood Illnesses (IMCI) strategy was developed by the WHO and UNICEF to address the disease burden for children, such as malaria, Acute respiratory infection (ARI), diarrhoea and pneumonia. The WHO noted in 2008 that malnutrition played a role in deaths of under five children in the country. In 2010, Sierra Leone adapted the IMCI strategy and received IMCI case management training courses. It is not clear if any training was given in Freetown and Western Area[62]. The KII on September 19, 2015 with the District Nutrition Officer, indicated that in the future PHU staff and volunteers will be required to collect monthly data on common diseases as well as malnutrition.

[62] WHO, "2014 Global Report on IMCI" p.2.

- **By EOP, there were important challenges in sustaining community mobilization** CHWs were identified for each of the 26 PHUs. These included Community Volunteers, Lead Mothers and M2M Members. The volunteers worked in referring mothers of malnourished babies to the PHUs for treatment. They also participated in gardening and cooking demonstrations. This support revived the outreaches previously carried out by PHU health staff on a regular basis. Although the project had provided incentives during the life of the project and community members had agreed in the exit strategy meetings to continue with activities, the KIIs with ACF staff in the East officers interviewed from September 14-18, 2015, suggested that the community volunteers were becoming somewhat discontent with working gratis.

- **The communities and the government had positive perceptions of ACF.** The KIIs and GIs conducted from September 9-23, 2015, indicated a high satisfaction with the support provided by ACF. The government national and district nutrition and health staffs were very satisfied with support to training and development of government strategies. The support to PHUs (equipment, training of CHWs) was also considered very important as it addressed the needs of malnourished children referred to the PHU OTPs and SCs. According to the Director of the FND, this support has improved the situation on the ground, increasing 6 months of breastfeeding and timely introduction of complementary foods.

- **There is a high level of appreciation of the usefulness of the project at central and district levels of the MoHS.** The government would like to see a new project expanded into more PHUs. At district level, the quality of monthly reporting on health indicators has improved the health management information system (HMIS). These results have contributed to the high level of appreciation of the project.

- **The PHU and Lead Mother gardens were very visible and gave local mothers new knowledge on the best type of foods to grow and feed their children.** At each of the sampled sites, the gardens at PHUs, and some Lead Mother homes were found to be well maintained. Mothers stated they now knew more about diets for their children and families and some stated they had started up small gardens themselves. The gardens in the informal settlement visited was found to be space saving but too small to have an impact other than its visibility.

  The consultant did not see market gardens and there was no evidence the PHU and Lead Mother gardens made the foodstuffs more available, as seed multiplication was implemented on a very scale, due to the gardens being too small for it to succeed. In the KII and GIs, Some mothers indicated they had multiplied seeds and given them to member mothers, but there was no documentation to show this. As stated in the KII September 15, 2015 with a health committee chairman at Moa wharf (an informal settlement) the space is too limited to grow vegetables and fruits, and most households cannot afford to buy them. According to KIIs with PHU head and acting heads the cookers who cooked for demonstrations at the PHUs were hospital staff and trained in hygiene,. They were found to be using charcoal instead of other fuels due to its availability. This can be risky to the health of mothers and their babies.

  The consultant did not see cooking demonstrations at Lead Mother homes, so cannot comment on the level of hygiene. Due to the IYCF booklet and the outreach by the Lead Mothers, many mothers said they were more aware of the need for vegetables in the baby diet, but in some cases, could not afford to buy the products or did not have land to grow them. The consultant noted there was no special program to involve men in the intervention, and no meetings were held with men/male youth only, to come to a finding on whether or not the KAP of men has changed towards special food needs of pregnant lactating women and infants. There were male CHWs, but no special interventions had been taken by them to involve men more.

- **ACF developed several databases to monitor the activities** The ACF databases were found to be mostly up to date. ACF documented activity plans,[63] Pre and post testing of Lead Mothers trained in IYCF,[64] Assessment of 6 PHUs for scale up,[65] PHU Assessments,[66]and CHW Mapping Worksheets,[67] to name a few. There was documented Training feedback from the Lead Mothers, Volunteers and Mothers who showed satisfaction with the IYCF book, which was considered simple and attractive to the community. KIIs and GIs conducted with Lead Mothers and Community leaders from September 9-23, 2015, confirm this finding. According to the volunteers, ACF had a strong presence on the ground, so feedback was rapidly provided which added to satisfaction.

  With respect to IMAM training, the trainees interviewed in the same time period indicated they needed more training, but the combination of the training and the equipment improved their diagnostic skills for MAM and SAM. Although there was some documentation confirming that pre and post testing had been conducted for the nurses which confirmed there was knowledge gained, proper feedback mechanisms on the training intervention (theoretical and practical) were not in place.

- **The project created a multiplier effect in that M2M groups were quickly formed but the Mothers faced a challenge in cascading more members into new groups.** The consultant sampled PHUs supported from 2013 and those recently scaled up. It was noted that in the older PHUs, there was a strong presence of Lead Mothers, who had created a multiplier effect, by bringing in 10-14 mother members. These mothers became Lead Mother and formed 10 more groups. They met weekly or bi-monthly in many cases in the PHU itself, where the PHU head or acting head could attend and give feedback. The project expected the mothers to then form more groups, but the number was not specified. From the KIIs and GIs, cascading was not extensive, beyond the formation of 10 groups per PHU.

- **ACF gave support to the MoHS during the Ebola Outbreak (from May 2014) by making recommendations on protocol and supporting EVD survivors with items such as raincoats.** These included the "No-touch" policy, and the distribution of MUAC tapes to mothers to do their own measurements. At the same time, the ACF surveillance officer assigned to the DHMT gave support to the nutrition surveillance system to enable it track the Ebola Outbreak. Some other examples are the ACF contribution to the No touch policy design, and country level discussions on IYCF protocol (which led to revision of the IYCF to reflect the Ebola context). ACF also supported the development of IEC material on nutrition and Ebola and the content of television and radio scripts.

- **There is potential for ACF to go beyond health facilities and embrace a broader HSS approach** ACF has the potential to go beyond health facilities and embrace a broader HSS approach as evidenced in its roles in coordination, communication and advocacy. Some examples of the strength of the ACF role are the ACF support to the MoHS in revising the IMAM protocol, the development of IEC material on nutrition and Ebola and the content of television and radio scripts. The background of ACF in working in Sierra Leone addressing WASH, nutrition security and now food security, may give them the potential to embrace a broader HSS approach, working with traditional partners and increasingly through the CS Platform.

[63] ACF, "Activity Plan EFT NUT"
[64] ACF Sierra Leone, "Analysis Pre- and Post Test Lead Mothers"
[65] ACF, "Nutrition Assessment Tools-Assessment of 6 PHUs for Scale up" 2014-2015.
[66] ACF, "PHU Assessment forms"
[67] ACF, "CHW Mapping Worksheet EFT ACF" February 2013 and April 2015"

4.7. Findings on Sustainability and the Likelihood of Impact

- **There is less likelihood of impact of on the job coaching of health staff then of training of community volunteers** The District Nutritionists and Capacity Building Nurses carried out on the job coaching of nursing staff at the 26 PHUs over 3 day periods. This method was considered to be more beneficial than training nursing staff in a classroom setting as the staff could continue working. More time was consumed carrying out this type of training. Refreshers were then carried out in a classroom setting over a one day period. The KIIs and GIs indicated that the recall of IMAM training was average or below average, suggesting the knowledge gained may need reinforcing.

  The IYCF training to Community Volunteers (CHWs, Lead Mothers) was conducted in a classroom type setting. The KIIs and GIs showed there was high recall of the training, which the trainees attributed to it being simple and easy to learn. This type of training is more likely to be sustained.

- **There is limited Sustainability of Lead Mother to M2M training being passed on to more Mothers.** After the IYCF training was delivered to the Lead Mothers, they were then required to pass the knowledge on to the Mothers. In the KIIs and GIs, they maintained this was a challenge to deliver, due to time constraints and that refreshers would be needed. There was no detailed documentation on the results of Lead Mother to Mother training being passed on to other mothers.

- **Sustainability can be best addressed through new community mobilization activities.** The community was mobilized due to a commitment to address nutrition insecurity. ACF provided a wider range of incentives, which cannot last over time. During the 2015 exit meetings, the communities agreed to continue with the program. However, in KIIs and GIs, they stated they would face a challenge in transportation and refreshments. Means to sustain community mobilization through local councils or through the VSLAs could be identified.

- **The Exit strategy gets commitment but not means to sustain activities over time**. The DR of the exit strategy indicates that ACF handed over the project activities to the CHWs from June-August 2015. The communities appointed 'supervisors' and agreed to work with the DHMTs, local councils and PHU staff to sustain the activities. The exit strategy did not address incentives or identify the means to do this. However, the government, local leaders and community accepted to take over the project as ACF had gained their respect and trust. The government saw the role of ACF as strong with respect to its advocacy/communication role and its initiatives on other aspects related to nutrition and food security such as the right to food.

TABLE 4: ENDLINE SURVEY RESULTS		
Indicator	Estimated prevalence baseline	Estimated prevalence end-line
Timely initiation of breastfeeding (children 0-3 months)	65	79
Exclusive breast feeding under 6 months	80	97
Timely complimentary feeding	38	85
Introduction of solid, semi-solid or soft feeds	40	60
Continued breastfeeding at 1 year	61	98

Source: ACF Endline Survey August 2015

- **Future Likelihood of impact is possible if expansion of support is addressed** First of all, ACF has contributed to functioning OTP and SC centres in the 26 PHUs (out of a total of 108 PHUs). According to the KIIs and GIs, there is now improved coverage in active case-finding, outreach, passive screening, referrals and follow-up. Patient relations have improved and mothers feel welcomed. The supplies from UNICEF and WFP will sustain if there are improvements in their distribution system. The shift to sustained six month breastfeeding and healthier complimentary foods (as per the ACF EOP survey-still under analysis) will sustain if the Lead Mothers and M2M groups continue with their activities. Finally, unless men get more involved in the program through men and male youth groups, their own practices related to the health of their families may not sustain. At the same time, unless innovative food security and income generating activities are created, such as more VSLAs, the new practices may revert due to coping mechanisms for families to survive. Table 4 shows positive impact of the project based on baseline results from the Needs Assessment of 2012 and the recent ACF Estimated Prevalence Endline study. Although analysis is still underway, the results suggest positive impact of the project on breastfeeding and complementary feeding practices. These will benefit health of infants and children in the long run.

5. CONCLUSIONS

5.1. Conclusions on Design[68]

The project is rated as "Satisfactory" as there was significant systematic identification of the needs, perceptions, priorities, capacities and opportunities for the indirect beneficiaries, especially 2600 pregnant, lactating women and 4200 children under five years of age. There was also a significant identification for the 174 DHMT staff, 5 high level people in the government, 130 Community Health Workers, 260 lead Mothers, 1000 M2M Mothers. **There was less systematic identification of the needs, perceptions, priorities, capacities and opportunities for the 1000 carers and 80 EVD affected individuals (direct beneficiaries) or of the 12,500 people in the area of intervention (2300 women, community volunteers and carers) who would benefit indirectly from vegetables garden kits and trainings.** There was no differentiation in the design of specific needs, perceptions capacities and opportunities for males, females and youth for the 130 Community Volunteers or 80 EVD affected individuals, in terms of their needs, based on gender. (Part 4.1 Findings on Design- Table 2)

Stakeholder meetings and CHW mapping was carried out, which documents the perceptions of communities. A joint ACF/MoHS "Knowledge assessment of the PHUs" was carried out and documented which identified needs of health staff and equipment and if the necessary equipment was in place. **The KIIs and GIs showed that the government and local communities contributed to the planning of the solutions to meet the specific objective. Gender was not well mainstreamed in the projects in that it did not specify the needs and opportunities for teenage pregnant girls, men and the youth.**

In terms of whether or not the project objective was 'SMART', the project objective is specific and relevant but less measureable and attainable especially for Result 2 as the outputs do not respond in all cases to the performance indicator. With respect to Result 4, the project assumed "improving dietary diversity' would prevent malnutrition, and did not consider other factors such as affordability and accessibility to foodstuffs (KIIs with community leaders conducted from September 8-23, 2015).

[68] As stated in the TOR, "Design" refers to four areas: 1. Participatory systematic identification of needs, perceptions, priorities capacities and opportunities for men, women, boys and girls; 1 the identification of a hierarchy of project goals and objectives linked by causal relationships; 3. The planning of solutions in terms of inputs, activities, outputs, outcomes and overall objective, and 4. The assessment of project outcomes

The design did not define a theory of change (ToC) with respect to the effect of the project capacity building activities on the KAP of caregivers and volunteers and ultimately the general public. The causal effect link between the hypothesis on capacity building of caregivers and beneficiaries was not explored enough. The IMAM/CMAM training provided to nurses remains an issue with respect to its quality. Nurses preferred on the job training during their working hours as opposed to classroom training (other than for refreshers), but alternative approaches should have been identified and planned for to get the best approach to create change in the communities.

Finally, as there was no defined theory for change in the project proposal; issues such as poverty and its effect on affordability of foodstuffs and the accessibility to health services were not factored into the proposal.

5.2. Conclusions on Relevance/Appropriateness[69]

The project scored "Highly Satisfactory" with respect to this criterion as the project interventions fit well into national policies and strategies. The nutrition interventions fit into the implementation plans for activities drawn from three key government strategies, namely the "Food and Nutrition Implementation Plan 2013-2017", the "Agenda for Prosperity-road to Middle Income Status", and the "Third Generation Poverty Reduction Paper." There is also the Agenda for Prosperity vision for 2035 directed at reduction of stunting amongst children under two years of age, building on the Free Health Care and the global strategy of SUN which address poor child care and dietary practices, shortages of skilled manpower, to name a few. The recommendation for male support to management of infant and child malnutrition, was not included in the project. **The government cannot finance the national food and nutrition security budgets with donor support. Therefore as a key NGO, ACF involvement adds value at central level as well as at community level (for communities surrounding the 26 PHUs assisted).**

A strong sense of community ownership was visible in the 14 field sites sampled by the consultant and documented in the project exit report. These showed district and PHU level health staff, volunteers and community leaders support ACF. The KIIs, GIs and DR indicated support was high due to the project meeting the needs of pregnant, lactating women and their under-fives, especially children with MAM and SAM. A sense of trust was apparent amongst nursing staff and the communities as the project had revived outreach services and increased referrals and attendance at the PHUs.

However, although the ACF project improved the breastfeeding and supplementary feeding practices in the environs of the 26 PHUs as of August 31, 2015 (See Figure 1- Findings on Relevance/Coherence), the 2015 MoHS surveys indicate that SAM and MAM cases remain high for Western Area (See Table 2 and Figure 2). This is attributed in the MoHS report to the lack of OTP in many PHUs. The findings also indicate that a higher number of mothers with MAM and SAM children attended the PHUs in 2015, which would also raise the number of reported SAM and MAM cases. There may be other factors related to poverty not factored into the design and the project activities.

5.3. Conclusions on Coherence[70]

The project is rated as "Highly Satisfactory" as the intervention as a whole is linked to national strategies and global initiatives such as SUN and the FNIP. The KIIs, GI and DR confirm that the FND has worked closely with ACF in its coordinating role and that the linkage is very strong. ACF has

[69] Relevance/Appropriateness as defined in the TOR is the measure of whether the interventions fit into the policies and strategies to ensure consistency and avoid duplication.

[70] Coherence is defined in the TOR: as the need to assess existing interventions, policies and strategies to ensure consistency and minimize duplication.

provided technical expertise into coordinating meetings for SUN and has respected the National Nutrition Protocol. There has also been sharing with SMART surveys. **ACF has a strong potential in rolling out additional activities to fit the national strategies and ensure sustainability.**

5.4. Conclusions on Coverage[71]

The project is rated as "Satisfactory" as it responded to the high level of stunting, MAM and SAM in the project sites. Together with the MoHS 26 PHUs and their surrounding beneficiaries were identified as entry points to address nutrition and food insecurity. A needs assessment confirmed the PHUs were well selected. This was confirmed in the consultant field work in 14 PHUs and interviews with the local communities and caregivers. The Ebola crisis had hit the 103 government PHUs hard and paralysed outreach as well as outpatient services based in the PHUs. **The project addressed the government lack of resources to build the capacities of government staff and community volunteers. Many potential beneficiaries still exist (men, youth, and teenage mothers) for future projects to address, including a means to set an achievable cascading effect. There is also high potential to extend beneficiaries to other PHUs and their communities.** Table 5 shows the government health facilities and number of staff.

5.5. Conclusions on Efficiency[72]

The project was rated "Satisfactory" with respect to efficiency as mostly the resources funded by Irish Aid[73] were put to maximum use. See Annex IX. Key positions for the project fit the expectations for meeting the four results. The project started late by six months and faced delays and challenges due to the Ebola crisis. **The ACF Program Managers were very efficient and had a constant presence on the ground.** This was confirmed in the KIIs and GIs conducted during the evaluation. At the same time, DR review of the databases indicated that skills in documentation and surveillance were satisfactory.

There should not have been investment in the Teenage Mother study[74] as there were no interventions specific to teenage mothers implemented. It was noted that the report was never launched due to the Ebola outbreak; however there was still opportunity to introduce some activities for teenage mothers in the February 2015 amendment. The Cost of Diet study is another example of an investment which should not have been made. **More financial resources and expertise should have been directed at provision of quality training on IMAM for the nursing staff. Finally, the incentives provided by the project, such as mobile phones and competitions, were very efficient and stimulated a strong spirit of volunteerism. This in turn made volunteers work harder to reach mothers of malnourished children.**

The contributions of the ACF surveillance and advocacy officers were key to supporting the gathering of surveillance data for the project and to detect Ebola, and to supporting the government with policy development and conducting the radio discussions. These were advocacy by ACF on coordination and strengthening of the national government with respect to nutrition security. This included being part of the Community Health Protocol (CHP) where ACF encouraged recognition of the CHWs as part of the national strategy and their formal inclusion in community based health care.

[71] Coverage is defined in the TOR as the need to reach the major population facing life threatening suffering.

[72] Efficiency is defined in the TOR as the measure of how resources/inputs were converted into results.

[73] Irish Aid funded 43% of the project budget, with 18% from ACF and 39% from AFD.

[74] This study was carried out by ACF, Save the Children and Concern to understand the impact of teenage pregnancy and care practices on nutrition and under nutrition. It was not launched due to the Ebola outbreak. It was also suggested that turnover of the coordination team combined with the response to Ebola affected ownership of the teenage pregnancy and the Cost of diet studies.

5.6. Conclusions on Effectiveness[75]

The project was rated "Satisfactory" with respect to effectiveness as the results as defined in the proposal were mostly achieved and documented (See Annex XI). At the same time the ACF Endline survey data indicates improvements in the timely initiation of breastfeeding, exclusive breastfeeding under six months, timely complementary feeding and introduction of solid, semi-solid or soft foods, and continued breastfeeding to one year. The 26 PHUs and their communities received the same package of activities related to food and nutrition security. **The continuing high number of cases of stunting indicates that the activities of capacity building and training, development of strategies to address these and preventive activities such as gardens for health and IYCF were effective in addressing breastfeeding and complementary feeding practices, but not in addressing all factors causing MAM and SAM.**

Means were not identified to address a growing discontent amongst volunteers for formal recognition and incentives. Multiplier effects occurred in that women readily joined M2M groups, but there was less cascading of new M2M groups due to women's' workload. There remains continued food and nutrition insecurity, which an IMCI package or broader HSS could address. The evaluation KIIs, GI and DR indicate that ACF has the capability to be part of a national effort in an IMCI package. The government and community perception of ACF is positive and there is a high satisfaction on the ground.

5.7. Conclusions on Sustainability and the Likelihood of Impact[76]

The project is rated as "Satisfactory" for this criterion as, while the benefits need external funding to be sustained, the positive effect of the project can be built on for future projects. Examples are the M2M interventions which fit into the UNICEF IYCF strategy as well as IMAM, the space-saving gardens and the VSLAs. The KIIs and GIs conducted during the evaluation revealed lives are changing when people adapt the technologies of M2M, space saving gardens and VSLA. The space saving gardens and VSLAs were viewed very positively and in the samples studied by the consultant, both gardens and VSLAs were still in place. **The positive perception of the activities has the potential to change community practices in the future.**

There are some exceptions. Unless the Teenage Pregnancy and Cost of Diet studies are applied to future interventions, the findings of the two studies may be lost. At the same time, unless men and youth become more involved in nutrition and food security activities, a level of resistance could emerge and affect the project benefits.

6. LESSONS LEARNED AND GOOD PRACTICES

6.1. Lessons learned

There are several lessons learned from the implementation of the ACF project:

- **Project entry points (such as PHUs) should have the necessary infrastructure for IMAM, SC and IYCF.** Twenty-six government PHUs were identified as the community entry points for the project to support capacity building of staff and the PHUs' OTP and SC rooms, and then capacity building of the community volunteers. The MOU with ACF and the MoHS states that the government would ensure that the PHU infrastructure is to the standards expected for treatment of malnourished and therefore vulnerable infants and children. The approach focussed more on establishing IMAM, SC and IYCF and less on the general condition of the PHU. The consultant visit to Grafton PHU showed

[75] Effectiveness refers to the extent to which the interventions' objective was achieved or is expected to be achieved, taking into account importance.

[76] This criteria is defined in the TOR as : a measure of whether the benefits are likely to continue after donor funding has withdrawn and missions operations cease and their likelihood of producing positive, negative, primary secondary effects.

the infrastructure was too low standard to safely care for vulnerable children. The project should have prioritized integrating the nutrition and food security activities at PHUs where ACF was already implementing WASH activities due to the quality of water and sanitation services, as well as other PHUs with an ample supply of water and other sanitation equipment. This lesson is significant as it deals with an important matter. This is the safe treatment of vulnerable children and protecting them from infection. The lesson is directed at ACF and the MoHS.

- **Inclusion of Men in specific activities is important to sustain the benefits of a project.** The FNIP and other studies including global reports identified the importance of including men in project planning and implementation. This is important considering that the society is patrilineal and men have control over decision making related to food purchases and health seeking behaviour. Not including men, youth, pregnant mothers and EVD survivors in decision making capacities, not only as beneficiaries, meant many opportunities were missed to integrate the knowledge in the communities and therefore sustain them. This lesson is important for ACF for future programming of project activities directed at health seeking behaviour and involving communities in volunteerism.

- **Community level participation strategization is necessary.** Where a project's outcomes are perceived by the community to be beneficial to all parties, participation is quickly generated. In the case of the ACF project, significant community participation was generated from the environs of the 26 PHUs, to address both nutrition and food security. Over time, despite highly innovative practices (space saving gardens, VSLA, competitions, incentives), the level of participation became at risk due to the community's own dynamics and emerging issues such as the Ebola crisis. Built in mechanisms are necessary to sustain participation, such as cost sharing on garden tools. This lesson is important due to its implications for sustainability and engagement of communities in new projects.

- **MOUs with stakeholders at central, district and community levels are important as they define roles and responsibilities**. An MOU was signed with the DHMT of Freetown in which agreement was made on roles, staffing and other issues. An MOU with the central and council level governments were not signed. These could have specified better the roles of government at different levels. Nutrition security strategies are increasingly being implemented at district level and council levels. There are also specific areas where only the central government can take action, such as curriculum changes. For example, if the CHW protocol recognizes the CHWs as health staff, the council level of government is expected to take a strong role and responsibility for CHWs. With the new Civil Society Platform, there will be additional stakeholders from the private sector and from religious organizations working under its umbrella. MOUs will need to be signed as each new stakeholder comes forward. Projects also need to anticipate the changes when new strategies are implemented by the government and factor this into MOUs.

- **Disease morbidity for U5s has to be addressed in its entirety**: The project focussed on malnutrition amongst children under five, not on other diseases which children are susceptible to. IMAM, and CMAM and IYCF do not include childhood illnesses whereas the IMCI program does. Sierra Leone has the highest level of Infant mortality in the world and many other diseases such as pneumonia and malaria play a role in child morbidity. These were not considered or factored into the project, yet they have an impact on IMR and CMR.

6.2. Good Practices

The following Good Practices can be utilized by ACF in future programming:

- **Use PHUs as Entry Points**: ACF engaged the nursing & medical staff in CMAM/IMAM training, and providing the necessary equipment for the staff to provide OTP and SC. The selection of the PHUs

was made in collaboration with the FND of the MoHS. At the same time, the PHU heads and deputy heads identified Community volunteers along with the local leaders (chiefs, development committee members, business persons), agreeing to support them in referring mothers of malnourished babies to the PHU. These were subsequently trained as CHWs, Lead Mothers and M2M Mothers and tasked with identification of vulnerable babies, preparing healthy gardens and conducting food demonstrations. This approach was very effective as it could be implemented within the PHU facilities. The friendliness and support of the PHU staff created trust in the communities towards the PHU staff and also ACF. .

- **Systematic IEC using radio jingles and moderated discussions can reach a wide audience in a short period:** Illiteracy remains high in Sierra Leone. However most households have a radio or can listen to radio in the local market. ACF trained local journalists on how to organize and moderate discussions on nutrition, with an emphasis on breastfeeding to six months and use of complementary and healthy foods. The programs were broadcast several times a day using several radio stations. They featured jingles on good practices for care of pregnant and lactating women and their babies. Many people heard the jingles and enjoyed the discussions on the issues. They were influenced by the new knowledge and changed their practices towards feeding infants. This lesson has implications for ACF future programming and collaboration with civil society. The trained journalists can be used in future programs.

- **Setting up sustainable community structures to stimulate income generation for Mothers and their families also stimulates volunteerism**: The challenge of engaging local communities to participate in activities designed to improve their health status is sustained by the community changing their attitude and practices after new knowledge is gained. For the CHWs (Volunteers, Lead Mothers) who take a strong role in 'management' activities such as campaigns, surveillance, tending gardens, and carrying out cooking demonstrations, engagement remains a challenge. It is usually addressed with periodic incentives by the NGO, community and others. However, in the ACF project, VSLAs were set up in most of the PHUs selected. These were led by Lead Mothers and most members were female CHWs. For the VSLA members this was a first chance to save money and then get a short term loan to generate income or pay debts off. It has a great potential to save money and sustain the spirit of volunteerism at the same time.

Annex I shows the Good Practice of "Healthy Space-Saving Gardens at PHUs and in Communities"

7. RECOMMENDATIONS

The following recommendations are made, based on the Findings (Part 4) and the Conclusions (Part 5) of the evaluation. There are priority areas to be addressed by ACF in the immediate future as shown below.

- **Design and implement a second phase to the project. A high priority recommendation is that ACF should engage Irish Aid and other interested donors to support a second phase of the program under evaluation, expanding it to some of the remaining PHUs and their catchment communities in Western Area**. The issue is the ongoing MAM and SAM, and continued gaps in exclusive breastfeeding and dietary diversity for infants and young children. These remain high and can affect the quality of life for the communities living in Western area of Sierra Leone. The ACF programme/project department is addressed for this recommendation. A new program should expand IMAM/CMAM capacity building to IMCI for PHU nursing staff. Any new project interventions should benefit and include pregnant, lactating women & teenage mothers, their children under five, EVD survivors and male farmers. ACF has to more stringently adhere to the

ACF Gender Policy and include gender markers in the design. The ACF technical and management capacity has to be addressed so that it can better support PHU and community capacity building in IMCI, IMAM, IYCF and VSLA. The multi-sectoral gain of working with the key ministries of Health and Sanitation and Agriculture, Forestry and Food Security, should be expanded on to include other ministries. There are resource implications as the proposed project will need funding and ACF human resources department may need to hire international staff (Findings on Effectiveness 4.6 and Conclusions on Effectiveness).

- **It is recommended as a high priority that the ACF programme/project department work closely with the MoHS, universities and other experts to evaluate the best type of training for theory, practical and refreshers for IMCI, IMAM and IYCF.** It is important that training for PHU in-charge nursing and medical staff be of the highest quality to ensure delivery of health services to the expected standards. A clear identification of training methodologies combined with high standard entry and documentation can ensure that PHU nursing and medical staff have the technical and practical skills needed for OTP and SC. A training of facilitators (TOF) course is also needed to ensure an umbrella of experienced trainers is available. This has resource implications as funding will be needed to support training materials and trainers (Findings on sustainability and Likelihood of Impact 4.7 and Conclusions on sustainability and Likelihood of Impact).

- **All beneficiaries should be identified by sex and age in projects and linked to specific activities A medium priority recommendation is that ACF programme/project department should ensure that future similar projects identify beneficiary needs and activities for men, youth (including teenage mothers), pregnant women and others affected by HIV and AIDS such as People living with HIV and AIDS (PLwHA), and EVD.**. This will mean conducting a new needs assessment expanding nutrition and food security variables to include those related to childhood disease morbidity as outlined in the IMCI strategy. There will be resource implications as a needs assessment will require researchers and other experts (Findings on Design 4.1. and Conclusions on Design).

- **Indicators for expected results should be SMART. A medium priority recommendation is that ACF LFAs incorporate achievable indicators.** If the indicators are not SMART, the results cannot be achieved. This can affect the degree of achievement by EOP and also be a waste of the investment. For example, the project alone could not reduce SAM and MAM by capacity building as there were other factors affecting malnutrition such as poverty. Increased breastfeeding to six months and timely complementary feeding was more achievable, but there remain other factors out of control of the project, such as male head of household control over health seeking behaviour and decision making on use of household funds. This issue should be addressed by the ACF programming project department. As ACF has programme/project staff, there are no resource implications. This issue is presented in Findings 4.2 Relevance/Appropriateness and Conclusions on Relevance/Appropriateness. See also finding on Effectiveness 4.6 and Conclusions on Effectiveness.

- **A medium priority recommendation is that ACF actively target men to increase their participation in food and nutrition security activities and in community groups such as CHWs and in VSLAs.** This issue is important as involvement of men in future similar projects can increase positive impact of the project and create behaviour change. The ACF programme/project department cannot address this issue without close collaboration with the CS Platform, and community enterprises. Men and youth participation should also be addressed working with male farmers, or market staff owners, and getting more male local leaders to play a stronger role in campaigning for support to mother and child health and nutrition and also be on radio programs. There are resource implications as ACF will need to conduct community participatory meetings to

gain trust and encourage male participation (Findings on Coverage 4.4 and Conclusions on Coverage).

- **A medium priority recommendation is that ACF program support department ensures that project budgets factor in realistic staff salaries and volunteer incentives, aligning them to other NGOs and government budgets for salaries and incentives.** Not addressing incentives means that volunteerism runs the risk of declining, which in turn will negatively affect the outreach services. This will ensure that employers and stakeholders are able to afford their services. At the same time appropriate staff should be hired, such as the continuing need for surveillance support to the completion of data forms at district level. This has cost implications with respect to budgets. There are presently on-going government discussions on CHWs'remuneration and ACF should be a part of these discussions (Findings on Efficiency 4.5 and Conclusions on Efficiency). See also Findings on Effectiveness 4.6. and Conclusions on Effectiveness.

The following recommendations are listed as '**important**'. They should be implemented by the ACF programme/project and program support departments in the medium term. These will require the concerted effort of ACF at headquarters and country levels. They can point the way forward for future ACF operations.

- **Conduct gender analysis prior to project implementation** It is important that ACF conduct a gender analysis for future similar projects to identify the different roles of men and women in health seeking behaviour and decision making on how much household income is directed towards the purchase of healthy complementary foods for mothers and children. Getting men and male youth more involved can ensure their inclusion and continued positive perception of ACF and PHU staff. The data collected should be disaggregated by sex and age (SADD). ACF staffing resources already in place to address gender analysis (Findings on Design 4.1. and Conclusions on Design).

- **Research studies should be limited and conducted early in a project's first six months and activities factored into the LFA expected results.** It is important that ACF research studies be applied to project activities. For example the Cost of Diet and Teenage Mother studies were conducted at considerable cost, yet the results were not used in the project. See Findings on Design 4.1. and Conclusions on Design. If research studies are limited, this can reduce project costs.

- **It is important that ACF develop a theory of change (ToC) flow chart to test the causal pathways for change of future project.** A ToC can ensure that the LFA expected results and their indicators are achievable and address beneficiaries' needs. Annex XIV shows a ToC for a future similar project

8. ANNEXES

ANNEX I: GOOD PRACTICE

Title of Good Practice
"Healthy Space-Saving Gardens at PHUs and in Communities"
Innovative Features & Key Characteristics
The gardens were developed at the PHUs (Some were also developed at the homes of Lead Mothers. ACF Agricultural technicians provided technical skills in composting, organic pesticides and fertilizers and seed multiplication. ACF also provided seeds for healthy crops such as potato leaves and cucumbers, to name a few. The gardens were also space saving in that seeds could be planted in sacks, tires and other small containers.
Background of Good Practice
The rationale behind the good practice was that mothers attending the PHUs with their malnourished children or coming for MCH services could see the crops growing and also regularly see cooking demonstrations. They would be influenced to start their own gardens or purchase the healthy crops for their children. The space saving aspect was designed for informal settlements where there was overcrowding or homesteads with little arable land. This practice came about to meet the need to give knowledge to mothers on complementary foods, how to introduce them to their babies and how to cook them. It was designed to address SAM and MAM, which was particularly high in Freetown and Western Area.
Further explanation of chosen Good Practice
Some of the features included land preparation, planting of seeds, weeding, application of pesticides and fertilizer (from composting), harvesting, cooking. In reality many PHUs faced a challenge in finding time to manage the gardens. This challenge was soon overcome with agricultural technicians' encouragement. Soon Lead Mothers began gardens and held demonstrations to encourage the use of complementary foods. The local communities received it well, but there remained issues of affordability of the foodstuffs and challenges in seed multiplication meant people had to purchase seeds. Tool banks were set up and the technology spread quickly to the PHUs and communities where ACF worked.
Practical/Specific Recommendations for Roll Out
The practice can be easily replicated if crops are planted on both kitchen gardens and larger plots. This means local councils need to support M2M groups to get land. Seed multiplication can reduce the cost of purchasing seeds if it is implemented on larger gardens and with adequate technical expertise. The practice can also be replicated if it is applied in school programs and at places of workshop. At practical level it takes experienced farmers to support upcoming ones. Groups also need to promote the intervention more at the PHU level. It would also work at policy level for IYCF and IMAM program and applied to policy.
How could the Good Practice be developed further?
It can be developed further if done on a larger scale, if poorer mothers get the harvest free or at discount prices and if it could be expanded further in the informal settlements. There should be cooking demonstrations and competitions.

ANNEX II: EVALUATION CRITERIA RATING TABLE

1-Highly Unsatisfactory 2-Less than Satisfactory 3-Satisfactory 4-Highly satisfactory

TABLE 6: EVALUATION CRITERIA RATING TABLE							
		Rating (1 low, 4 high)					**Rationale**
No.	Criteria	**1-Highly Unsatisfactory**	**2-Less than satisfactory**	**3-Average**	**4-Satisfactory**	**5-Highly Satisfactory**	
1	Design						**Satisfactory**: Needs, perceptions, opportunities for women, not men, boys, girls. No disaggregation by age. Gender not well mainstreamed; Hierarchy of project goals and objectives mostly linked to each other; Solutions to overall objective well planned for some of the results; Assessment done of project outcomes. Specific objective relevant but less measurable and attainable especially for result 2.
2	Relevance/ Appropriateness						**Highly Satisfactory:** Interventions, policies, strategies are measured as consistent, no duplication; Project fits government strategies; Project gives added value as government cannot finance its strategies without outside assistance; Strong sense of community ownership; Pregnant and lactating women and their under-fives needs met-some can be covered by other projects.
3	Coherence						**Highly Satisfactory:** Intervention assessed to ensure consistency and avoid duplication; Project linked to SUN and FNIP; Rolled out CHW activities fit CHW Proposed national strategy.
4	Coverage						**Satisfactory:** Needs for IMAM program well identified to meet SAM (equipment, training); potential beneficiaries needed more targeting; Possibilities exist to extend beneficiaries in a similar program; Project has covered communities needs for Lead Mothers and M2M-less

							cascading after those groups formed.
5	Efficiency						**Satisfactory**: Resources mostly well directed in terms of funds, expertise, time, for nutrition security, less funds for food security (gardens, tools); Resources specific to community nutrition innovative-space saving tires, organic pesticides
6	Effectiveness						**Satisfactory:** Objectives mostly achieved, but interventions needed for Teenage mothers, Cost of Diet not identified; Some added value of extending IMAM into IMCI; Challenges in community mobilization, Positive perception of ACF by communities, government; High acceptance level; PHU gardens very visible and gave knowledge to mothers on diet; Monitoring well done-databases used; Cascading not as successful-but 10 groups per PHU still a high achievement; ACF flexible and gave support during Ebola climax.
7	Sustainability and the Likelihood of Impact						**Satisfactory:** Less likelihood of impact of health staff training, than of community volunteer training; IYCF training of Lead Mothers sustainable if incentives founds; Recommendations of KAP/Needs Assessment mostly met.

Adapted from EUROPA[77] STANDARDS:

5 Highly satisfactory: A program is rated as "Highly Satisfactory" (with respect to a specific evaluation criteria) if it is performing strongly full according to plan or better. Very few or no improvements are needed.

4 Satisfactory: A program is rated as "Satisfactory" (with respect to a specific evaluation criteria) if on balance it was implemented according to plan and positive aspects outweigh negative aspects.

3 Average: A program is rated "Average" (with respect to a specific evaluation criteria) if it achieved some positive results, but could have achieved more.

2 Less than Satisfactory: A program is rated "Less than Satisfactory" (with respect to a specific evaluation criteria) if it was not sufficiently implemented according to plan and there are few positive aspects outweighed by negative aspects.

1 Highly unsatisfactory: A program is rated "Highly Unsatisfactory" with respect to evaluation criteria, if on balance it is seriously deficient with very few or no positive elements.

[77] Europa Standards have four categories Highly Satisfactory, Satisfactory, Less than Satisfactory and Highly Unsatisfactory)

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ANNEX IV: LIST OF PERSONS INTERVIEWED

Persons Interviewed September 7-25, 2015 (in order of interview date)

No.	Date	Name	Title	Interview type
1	Sep 4, 2015	Hannah Wichterich	ACF Headquarters, Paris	KII, Skype
2	Sep 7, 2015	Fabienne Rousseau	Nutrition and Food Security Advisor, ACF Headquarters, Paris	KII, Skype
3	Sep 8, 2015	Celine Sinitsky	ACF Headquarters, Paris	KII, Skype
4	Sep 10, 2015	Suzanne Fuhrman	HOD, Health and Nutrition, ACF Sierra Leone	GI (S. Fuhrman, M. Kallon)
5	Sep 10, 2015	Mumin M. M. Kallon	Deputy Head Health and Nutrition, ACF Sierra Leone	GI (S. Fuhrman, M. Kallon)
6	Sep 10, 2015	Isotta Pivato	Advocacy Expert, ACF, Sierra Leone	KII
7	Sep 10, 2015	Melvin M. Conteh	Former Food Security Staff-Gardens for Health	KII
8	Sep 10, 2015	Samuel C.B. Pyne	Former head of project, Agricultural Technician	KII
9	Sep 11, 2015	Isata Conteh	Senior Nutritionist Western urban rural, MoHS	KII
10	Sep 11, 2015	Alhassan Conteh	Volunteer, Thompson Bay H.P. Scale up PHU	KII
11	Sep 11, 2015	Hannah Kamara	MCH Aide, Thompson Bay H.P. Scale up PHU	KII
12	Sep 11, 2015	Rebecca Swaray	MCHA, Thompson Bay H.P. Scale up PHU	GI (R. Swarnay, A. Demburger, F. Sesay)
13	Sep 11, 2015	Adama Dumbuya	MCHA, Thompson Bay H.P. Scale up PHU	GI (R. Swarnay, A. Demburger, F. Sesay)
14	Sep 11,	Fudia Sesay	MCHA, Thompson Bay H.P.	GI (R. Swarnay, A.

	2015		Scale up PHU	Demburger, F. Sesay)
15	Sep 11, 2015	Edna Moseray	SECHN, 34 Military Hospital, SC, Scale up PHU	KII
16	Sep 11, 2015	Nyan de Moh	SECHN, 34 Military Hospital, SC, Scale up PHU	KII
17	Sep 11, 2015	Jamestina P. Younge	CHO, Grafton Health Centre, Scale up PHU	KII
18	Sep 11, 2015	Hawanatu F. Kamara	SECHN, Grafton Health Centre, Scale up PHU	KII
19	Sep 11, 2015	Mariatu Kamara	SECHW, Grafton Health Centre, Scale up PHU	KII
20	Sep 11, 2015	John Kamara	CHW, Grafton Health Centre, Scale up PHU	KII
21	Sep 11, 2015	Mohamed Sam	SECHW, Blessed Mokabba Integrated, Scale up PHU	GI (M. Sam, B. Sagerri, K. Kamara)
22	Sep 11, 2015	Botteh Sagerri	SECHW, Blessed Mokabba Integrated, Scale up PHU	GI (B. Sagerri, K. Kamara, F. Rogers)
23	Sep 11, 2015	Kadiatu Kamara	SECHW, Blessed Mokabba Integrated, Scale up PHU	GI (B. Sagerri, K. Kamara, F. Rogers)
24	Sep 11, 2015	Fatamata Rogers,	MCHA, Blessed Mokabba Integrated, Scale up PHU	GI (B. Sagerri, K. Kamara, F. Rogers)
25	Sep 11, 2015	Ramatu Jalloh	Coordinator, Civil Society Platform	KII
26	Sep 14, 2015	Sasha Ekanayake	Country Director, ACF Sierra Leone	KII
27	Sep 14, 2015	Dennis Njagi Njoka.	Finance Manager, ACF Sierra Leone	KII
28	Sep 14, 2015	Mohammed Foh	Coordinator, SUN National Secretariat	KII

29	Sep 14, 2015	Gibril Kargbo	Programme Officer ,Irish Aid, Sierra Leone	KII
30	Sep 14, 2015	Allesandro Dalle Carbonare	HOD, Food Security, ACF Sierra Leone	KII
31	Sep 14, 2015	Mwasi Asaog Armogast	Field Coordinator, ACF East Office	KII
32	Sep 15, 2015	Abu Desmond Kamara	Acting Project Manager, Nutrition, Health	KII
33	Sep 15, 2015	Samuel C.B. Pyne	Head Security, Former Head, AVF East Office	KII
34	Sep 15, 2015	Matilda J. Macarthy	Capacity Building Nurse, ACF, Sierra Leone	GI (M. Macarthy, S. Bancoyra, C. Kallon, B. Bancoyra)
35	Sep 15, 2015	Baindu S. Bancoyra	Capacity Building Nurse, ACF, Sierra Leone	GI (M. Macarthy, S. Bancoyra, C. Kallon, B. Bancoyra)
36	Sep 15, 2015	Catheirne K. Kallon	Capacity Building Nurse, ACF, Sierra Leone	GI (M. Macarthy, S. Bancoyra, C. Kallon, B. Bancoyra)
37	Sep 15, 2015	Nessie Foday	Nutritionist, ACF, Sierra Leone	GI (M. Macarthy, S. Bancoyra, C. Kallon, B. Bancoyra)
38	Sep 15, 2015	Edward B. Sesay	Agricultural Technician Food Security	GI (E.Sesay, A. Bangura, M.Kolloh)
39	Sep 15, 2015	Ahmid Bangura	Agricultural Technician Food Security	GI (E.Sesay, A. Bangura, M.Kolloh)
40	Sep 15, 2015	Mohamed A. Kalokoh	Agricultural Technician Food Security	GI (E.Sesay, A. Bangura, M.Kolloh)
41	Sep 15	Atilious Ndanema	Community Mobilizer	KII

42	Sep 15	Augusta Kamara	MCH Aide, Haja Neneh CHP	KII
43	Sep 15	Ramatu Mansarray	CHW leader, Haja Neneh CHP	KII
44	Sep 15	Kadiatu S. Kamara	Lead Mother, Haja Neneh CHP	KII
45	Sep 15	Sister Ency M.M. Coker	In-Charge, Ola During Hospital	KII
46	Sep 15	Frederica Powers	Nutritionist, Ola During Hospital	KII
47	Sep 15	Abubakar Mansarry	CHW Leader, Moa Wharf	KII
48	Sep 15	Nurse Musu Mansaray	SECHN, OTP, Hastings Health Centre	KII
49	Sep 15	Nurse Finder H. Caulker	SECHN, MCH Aide, Nutritionist Hastings Health Centre	KII
50	Sep 15	James Bunduka	Health Committee Chairman, Hastings Health Centre	KII
51	Sep 16	Adama S. Korama	Chairlady, VSLA, Lead Mother, Regent Health Centre	GI (A.Korama, M. Kamara, S. Tholley, J. Rashid, M.Gibla, M.Bangura)
52	Sep 16	Marie Kamara	Member VSLA, Key holder, Regent Health Centre	GI (A.Korama, M. Kamara, S. Tholley, J. Rashid, M.Gibla, M.Bangura)
53	Sep 16	Salamatu Tholley	Financial Secretary, Regent Health Centre	GI (A.Korama, M. Kamara, S. Tholley, J. Rashid, M.Gibla, M.Bangura)
54	Sep 16	Jennifer Rashid	Member VSLA, Regent Health Centre	GI (A.Korama, M. Kamara, S. Tholley, J. Rashid, M.Gibla, M.Bangura)

55	Sep 16	Musa Gibla	Lead Mother, Regent Health Centre	GI (A.Korama, M. Kamara, S. Tholley, J. Rashid, M.Gibla, M.Bangura)
56	Sep 16	Marie Bangura	Mother, VSLA Box Controller, Regent Health Centre	GI (A.Korama, M. Kamara, S. Tholley, J. Rashid, M.Gibla, M.Bangura)
57	Sep 16	Juliet K.Jawara	Community Volunteeer, Nurses Aid, Gloucester Health Center	KII
58	Sep 16	Hawa Bonah	Lead Mother Gloucester Health Center	KII
59	Sep 16	Nanah Turay	Lead Mother, Ward Committee member, Wilberforce Health Center	GI (N. Turay, M. Fortune, E. Kalakoh, C. Mamie)
60	Sep 16	Marian Fortune	Lead Mother, Ward Committee member, Wilberforce Health Center	GI (N. Turay, M. Fortune, E. Kalakoh, C. Mamie)
61	Sep 16	Emelian Kalakoh	Lead Mother, Wilberforce Health Center	GI (N. Turay, M. Fortune, E. Kalakoh, C. Mamie)
62	Sep 16	Cecilian Mamie	Lead Mother, Wilberforce Health Center	GI (N. Turay, M. Fortune, E. Kalakoh, C. Mamie)
63	Sep 17	Fatmata Kamara	Money Counter Mother, Community Stakeholder, Waterloo Health Center	KII
64	Sep 17	Yamma Samura	Chairlady VSLA Lead Mother, Chairlady Petty Traders Association, Waterloo Health	KII

			Center	
65	Sep 17	Memunatu Kamara	Mother, VSLA Member, Waterloo Health Center	GI (M. Kamara, A. Bendu, O. Sesay, Y. Kargbo)
66	Sep 17	Elizabeth Bangara	KeyHolder VSLA, Waterloo Health Center	GI (M. Kamara, A. Bendu, O. Sesay, Y. Kargbo)
67	Sep 17	Adeline Bendu	Mother, VSLA Member, Waterloo Health Center	GI (M. Kamara, A. Bendu, O. Sesay, Y. Kargbo)
68	Sep 17	Emma Kamara	Host Box Keeper, Assistant Lead Mother, Proprietess Heakam Properiety School, Waterloo Health Center	KII
69	Sep 17	Osman Sesay	Key Holders VSLA, Community Volunteer, Waterloo Health Center	GI (M. Kamara, A. Bendu, O. Sesay, Y. Kargbo)
70	Sep 17	Yeabu Kargbo	Community Volunteer, VSLA Member, Waterloo Health Center	GI (M. Kamara, A. Bendu, O. Sesay, Y. Kargbo)
71	Sep 17	Kadiatu Korama	Mother, Volunteer, VSLA member, Waterloo Health Center	GI (M. Kamara, A. Bendu, O. Sesay, Y. Kargbo, K. Korama, M. Marrah, F. Kargbo)
72	Sep 17	Mabintry Marrah	Mother, Volunteer, VSLA member, Waterloo Health Center	GI (M. Kamara, A. Bendu, O. Sesay, Y. Kargbo, K. Korama, M. Marrah, F. Kargbo)
73	Sep 17	Fatmata A. Kargbo	Mother, Volunteer, VSLA member, Waterloo Health	GI (M. Kamara, A. Bendu, O. Sesay,

			Center	Y. Kargbo, K. Korama, M. Marrah, F. Kargbo)
74	Sep 17	Isatu Momoh	MCH Aide, CHW, SECHN, Volunteer, Wilberforce Health Center	KII
75	Sep 17	Jane Davies	CHA, Nurse, Wilberforce Health Center	KII
76	Sep 17	Isatu John	Acting In-Charge Nurse, Wilberforce Health Center	KII
77	Sep 17	Sue Kabuat	Lead Mother, Wilberforce Health Center	KII
78	Sep 17	Acey Cole	Lead Mother, Chairlady Health Committee, Community Stakeholder, Murray Town	KII
79	Sep 17	Elizabeth Coker	In-Charge, Malama Health Post	KII
80	Sep 17	Sia Momoh	Community Leader ,Chairlady Ward Development Committee Member, Lead Mother, Malama Health Post	KII
81	Sep 18	Mary Josiah	Lead Mother, Gardener, Sunshine Health Post	KII
82	Sep 18	Chief Poi Alimamy Sesay	Loko Tribal Chief (Wilberforce environs)	KII
83	Sep 18	Naomi Swarray	Caregiver, Business Woman, (Wilberforce environs)	KII
84	Sep 19	James Ponga Moriba	District Nutrition Officer, Food and Nutrition Directorate, Ministry of Health and Sanitation	KII

85	Sep 21	Aminata Shamit Koroma,	Director, Food and Nutrition, MoHS, Sierra Leone	KII
86	Sep 21	Solade Pyne Bailey	Deputy Program Manager, MoHS, Food and Nutrition Directorate, Sierra Leone	KII
87	Sep 21	Mariama Ellie	National MIYCU Officer, MoHS, Food and Nutrition Directorate, Sierra Leone	KII
88	Sep 21	Sia Manyeh	IMAM Officer, MoHS, Food and Nutrition Directorate, Sierra Leone	KII
89	Sep 22	Sabrina Pillay	Health Manager, GOAL, Sierra Leone	KII
90	Sep 22	Aminata Kapagoi	Health Team Leader, GOAL, Sierra Leone	KII
91	Sep 22	Noriko Kitamura	Nutrition Surveillance Officer, Formerly with ACF, Sierra Leone	KII
92	Sep 24	Haja L. B. Sesay	District Director of Agriculture Western	KII Skype

*17 persons attended the Evaluation Workshop held on September 25, 2015, including Irish Aid and the MoHS.

ANNEX V: DATA COLLECTION INSTRUMENTS

QUESTIONNAIRE GUIDES

A. **KII/FGD/GI Questions for Government (MOH, DHMT, Other health staff)**

*** Icebreaker:** The project was implemented from 2012-2015, much of it directed towards capacity building. Is the government satisfied with this support? How is ACF perceived? Explain. What was done best? What could have been better done? How did the project support the government strategy, frameworks and financial commitments towards nutrition security?

1. (Gov) To what extent is the program linked with other national strategies/ initiatives (SUN, FNIP...)?
2. (Gov) Did the project address the needs of all targeted groups (by sex and age when it apply) and how could it be improved? Gov)-management, nutrition program manager, trainers)
3. (Gov) Which departments of the ministry and other ministries were involved in the program? How was this involvement coordinated?
4. (Gov) Does the project fit into the implementation plan of the Government's Agenda for Prosperity and Food and Nutrition Implementation Plan?
5. (Gov) Which activities best complement the work of the ministry towards nutrition security? (E.g. supply system providing RUIF and UHT milk, urban garden displays and demonstration gardens, VSLAs, M2M, etc.
6. (Gov) Is there an added value of ACF involvement at central level, or should involvement have been at district, community level only? Is there acceptance of the program at central and district levels?
7. (Gov) From onset, what was the level of program ownership by local stakeholders: health facilities, DHMT staff, community health workers, community volunteers, and beneficiaries? Are there important challenges in community mobilization? Are there important challenges in community mobilization?
8. (Gov) Compare the support/coverage provided by GOAL with that of ACF?
9. (Gov) How effective was the Mother to Mother Support Groups & CHWs in increasing coverage?
10. (Gov) Is he government now better able to ensure implementation of CMAM according to the national protocol? Explain.
11. (Gov) Were the number of staff, the time invested and the overall resources allocated for each activity efficiently invested by the project, given the results achieved?
12. (Gov) Comment on the quality of the training provided to health staff? Was the duration, quality adequate?
13. (Gov) Comment on the quality of support towards advocacy, e.g. documentary on under-nutrition usefulness. How is the government collaborating with the local partner (radio, etc.) on disseminating messages?
    Ask to see the documentary, IEC materials and capitalization report on gardens.
14. (Gov) How does support to REACH/SUN push forward action related to nutrition security in the country?
15. (Gov) Was the nutrition surveillance system set up? Explain.
16. (Gov) Was monthly market monitoring carried out by the government? Who coordinates this?

17. (Gov) Was the cost of diet survey carried out? The teenage mother care practices study? How will these be integrated in the MoH?
18. Is the M2M or peer to peer methodology used by ACF likely to improve the level of service delivery in Health facilities?
19. (Gov) What was the ability of ACF to respond to the Ebola outbreak by adapting the programme and supporting MoHS in adapting protocols and awareness raising? Evaluate the potential of ACF to go beyond nutrition in health facilities to embrace a broader HSS approach (basic health services?)
20. (Gov) Any other recommendations?

B. Questionnaire Guide for ACF Staff

1. How did this project come about? What activities was ACF carrying out before 2012? (Get overview on organigram and new staff hired). What were the setbacks? (e.g. Ebola outbreak required adapting the programme and supporting MoHS in adapting protocols and awareness raising)
2. Were the number of staff, the time invested and the overall resources allocated for each facility efficiently invested given the results achieved?
3. What research did ACF do in advance to ensure proposal was sound? E.g. The children and Women Dietary Diversity Score proof that vegetable is part of the diet, or the Knowledge Attitude and Practice of the adults towards children and pregnant and lactating women special food needs was accurate?
4. How well did the project succeed in meeting its objectives? The four expected results? Give reasons for your answers.
5. How well was gender mainstreamed in the project design? (Beneficiary selection, planning, management?) What could have been done better?
6. What databases/records are maintained for the indicators of the project?
7. How effective was the ACF involvement at various levels (central, district, local)?
8. What was the level of program ownership by local stakeholders: health facilities, DHMT staff, community health workers, community volunteers, beneficiaries at community level?
9. Were the resources well invested in community nutrition activities (MSGs) efficient given the result achieved (especiarry cascading M2M groups)?
10. How is ACF and its activities perceived by the community, by the health workers and by the authorities, including DHMT?
11. What is the level of acceptance of the program at central and district level?
12. There are several activities which appear innovative, e.g. the market gardening, cooking activities, Cascading M2M groups, (intended to prevent malnutrition by creating diet diversity). What was the scope of these activities, entry point and how linked to the other activities, e.g. VSLA?
13. How will the activities be sustained now that the project is ended? CHWs, VSLA, vegetable and market gardens, radio promotions, community worker incentives, etc.?
14. How does ACF ensure the vegetables produced are really available and used for household consumption, and that the cookers know how to prepare vegetables in a hygienic manners and in an edible way according to food habits? How will this be sustained?
15. Please review the monitoring carried out (databases, files). How much monitoring was done by ACF, government, community? Has the activity and indicator monitoring provided timely and useful feedback to the project implementation? Why or why not?
16. Training was provided to health staff and community: Who designed the training? Was it tested? Were learning materials gender sensitive? What feedback was received (evaluation forms) and how was it used to adjust/improve the training quality? Why or why not?

17. Was PDM done? (Ask for records) Have the outputs of the Post-distribution monitoring (PDM) helped track changes in income from vegetable sales? And on the quantity of vegetables grown, sold, exchanged and consumed by the household?
18. How does the community (especially beneficiaries) give feedback?
19. What is the likelihood impact? (e.g. On the job coaching of health staff and mobilization of community volunteers-M2M support group leaders and peer to peer methodology)? If no likelihood why? And what should be changed? Should on the job coaching of health staff to other services provided at health facility level be expanded (e.g. broader package on top of IMAM like IMCI)?
20. What should be the steps to undertake to ensure a proper exit strategy/linking with the support of the DHMT for the treatment of malnutrition and at community level for the prevention and detection-e.g. integrating nutrition and FS in MSG?
21. To what extent is the program linked with national strategies/initiatives (SUN, FNIP)?
22. As a new national strategy is currently developed for CHWs, how could ACF roll out activities in order to fit the strategy and ensure sustainability?
23. Evaluate the future potential of ACF to go beyond nutrition in health facilities to embrace a broader HSS approach (basic health services?)
24. Any other comments or recommendations?

C. Questionnaire for FGDs/GIs/Free listing Exercise for Beneficiaries (Take photos)

1. How did the project help you? How satisfied are you with the support (Highly Satisfied, Satisfied, Dissatisfied and Highly Dissatisfied). Explain.
2. What was your contribution? Is it challenging to mobilize the community? Explain.
3. How were you identified? Was it fair? Are beneficiaries needs (by sex and age) well identified and in which way? How do you give feedback?
4. What training did you receive? (Duration, quality, learning materials) Get evaluation forms, reports, and curriculum.
5. State XX things you learned? Why did you make that choice? How do you plan to use the learning?
6. Were you employed by the project? Government? ACF? Were you a volunteer? If yes, did you receive incentives? How satisfied are you with the support (Highly Satisfied, Satisfied, Dissatisfied and Highly Dissatisfied) Explain.
7. Were you a trainer? How satisfied are you with this activity (Highly Satisfied, Satisfied, Dissatisfied and Highly Dissatisfied) Explain
8. How often did you see ACF staff? Government staff? How satisfied are you with the support (Highly Satisfied, Satisfied, Dissatisfied and Highly Dissatisfied). Explain.
9. Were the beneficiaries' needs (by sex and age) addressed by the intervention? Are there needs/gaps that might be covered with further interventions?
10. Any other comments or recommendations?

(Get Free listing on training received to test level of recall)

ANNEX VI: TERMS OF REFERENCE (ToR)

For the Independent Final Evaluation of ACF's

Reinforcing Institutional capacity for treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western area and national sensitisation for nutrition security in Sierra Leone

Summary Table

Project Name	**Reinforcing Institutional capacity for treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western area and national sensitisation for nutrition security in Sierra Leone.**
Location	Freetown peninsula, Western Area, Sierra Leone
Contract Reference	E4A - FFB/C - H0A/B/C
Sector	**Nutrition and Food Security**
Local Partners	
Duration	3 years
Starting Date	1 July 2012
Ending Date	31 August 2015
Programme Language	English
Donor & Contribution/s	AFD, Irish Aid and ACF
Project Budget	Irish Aid (€ 647,393); AFD and ACF (€ 880,874)
Mission administering the Project	ACF Sierra Leone
Responsible ACF HQ	ACF France
Evaluation Type	Independent External Final Evaluation
Evaluation Dates	01/09/2015 – 13/10/2015

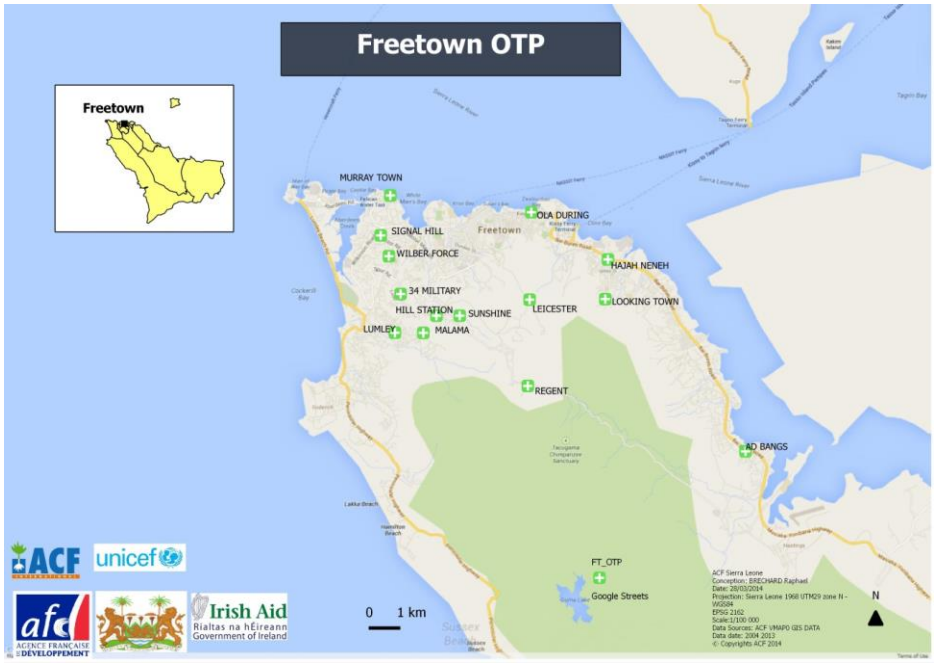
ACRONYMS

CMAM: Community-based management of acute malnutrition.
DHMT: District Health Management Team
EVD: Evola Virus Disease
FND: MoHS Food and Nutrition Directorate
FGD: Focus Group Discussion
IYCF: Infant and Young Child Feeding
M2M: Mother to mother
MoHS: Ministry of Health and Sanitation
PHU: Peripheral Health Unit
PLWHA: person leaving with HIV and AIDS
SMART (survey): Standardized Monitoring and Assessment of Relief and Transitions
SLEAC: Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage
SQUEAC: Semi Quantitative Evaluation of Access and Coverage

1. PROJECT BACKGROUND

Map of Project Area

The project is being implemented in Western Urban and Rural districts, Freetown Peninsula, Sierra Leone.



Rational for the Project

Sierra Leone, one of the poorest countries in the world according to the Human Development Index 2011 (180/187 countries), faces huge challenges in progressing towards the Millennium Development Goals in relation to access to water and sanitation, and child mortality rates. The 2014 SMART survey[78] showed a 4.7% prevalence of wasting and a 28.8% prevalence of stunting. Improvements were seen since the 2010 survey which showed rates of 6.9% wasting and 34.1% stunting.

The National Nutrition Survey and the SQUEAC Survey done in 2014 showed that although the situation has improved nationally, there are key communities in Freetown and the Western Area peninsula which do not yet have access to a nutrition treatment program. The prevalence of GAM in Western Area was 4.8% in Slums and 2.3% in Western Rural, and 1.9% in Western Urban.

This project is part of a larger regional project in West Africa co-financed by the *Agence Française de Développement* (AFD). That regional project concerns three countries for operational implementation of activities (Niger, Burkina Faso and Sierra Leone) and seven countries for advocacy actions (Mauritania, Guinea, Liberia, Ivory Coast, Nigeria, Chad, Mali). The overall goal of the project is to contribute to the improvement of maternal and child nutrition situation in West Africa.

ACF's first priority in Sierra Leone is to be involved in detection and treatment of malnutrition and coordination through capacity building programs and collaboration with the Food and Nutrition Directorate supported by UNICEF for the roll out of the community-based management of acute malnutrition (CMAM) protocol, with the approach of promoting local ownership and progressive phasing out. ACF interacts both at central level with the Nutrition Division of the Ministry of Health

[78] Sierra Leone National Nutrition Survey 2014, October 2014, UNICEF MoHS Irish Aid.

(policy influencing, advocacy, coordination, empowerment) and at decentralized level with the District Health Medical Teams (DHMT) of Freetown peninsula. ACF teams work at field level in the Peripheral Health Units and hospitals involved in treatment of acute malnutrition, with a capacity building approach. This positioning aims at a progressive phasing out of the activities for the Freetown Peninsula.

Project Objectives

General Objective: Contribute to the improvement of maternal and child nutrition situation in West Africa.

Specific Objective**:** Reinforce institutional capacity for the treatment of acute malnutrition, improve prevention strategies for malnutrition and to raise national awareness on nutritional security.

Result 1: Institutional capacity building – technical and management – for treatment of acute malnutrition, as per national CMAM program, in Sierra Leone western area Freetown.

Result 2: Government of Sierra Leone and major donors prioritize nutrition security in their strategies, frameworks, and financial commitments by 2015.

Result 3: Improve at central level initial training for health staff and nutrition surveillance and propose innovative study related to nutrition security.

The project aims to strengthen the capacities of the Ministry of Health and Sanitation (MoHS) at local and national level to ensure implementation of CMAM following the national protocol. It works with the MoHS to incorporate nutritional training into university curriculum and improve the national nutrition surveillance system. It also plans a Cost of Diet study (pilot project in Sierra Leone) in order to calculate the cost of the cheapest diet that meets the nutritional requirements of families using just the foods available locally. Finally, ACF proposes to focus on sustainable prevention of malnutrition through vegetable gardens and Infant and Young Child Feeding (IYCF) education and to study/compare the cost of a nutritional diet for the populations of Freetown urban slums.

The number of direct beneficiaries is of 1420 people, made up of 115 DHMT staffs, 5 high level people from government, 50 women and 50 men as community volunteers, 200 Lead mothers, 1,000 mothers from Mother-to-Mother (M2M) support groups, and 1,000 carers. The number of indirect beneficiaries is estimated in 13,400 people.

ACF will work in partnership with the decentralized services of health in charge of Freetown (DHMT), and community workers at community level.

The Project logframe is attached in Annex I.

At the ACF level, Sierra Leone Mission is under the responsibility of ACF France Pool Desk Staff in Paris, where a multidisciplinary team assures support to the local staff in charge of the implementation of the project. The project is implemented by program and support staff (both national and international) based at ACF East Freetown office with the support of the coordination staff and support staff (both national and international) based at ACF West Freetown office. ACF France Pool desk provide technical support to the West Freetown office staff. The project is implemented in line with the government's agenda for prosperity and the food and nutrition implementation plan.

Project Current Status
All the project activities are planned to be completed within the 31st August 2015. The project had been revised and amended twice, last amendment was done in Feb 2015 as consequence of the delays and constraints that evola virus disease (EVD) outbreak generated and the project timeframe was extended for six months which will finally end in August. Some of the constraints and delays were caused by the bye-law restrictions put in place in order to control the spread of the EVD outbreak (no gathering of people, no touch, quarantines, curfew, etc), and by the fear of contagion (people was afraid to go to Health Centres and to gather). However, with some restriction waved out, the program is now on its sound footing for completion by the end of August.

2. PURPOSE AND OBJECTIVES OF THE EVALUATION

Evaluation Background
A Midterm Evaluation has been conducted in August 2014. A summary of its recommendations is stated in Annex II.

Rational for the Evaluation
The evaluation is being conducted for accountability and learning purposes taking the chance that the project is close to its final month of implementation.

Objectives of the Evaluation
1. To assess the overall contribution of the project towards **reinforcing institutional capacity for treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western area and national sensitisation for nutrition security.**
2. To provide operational and strategic recommendations for the continuation of the project.

Users of the Evaluation
Direct Users: ACF France HQ (ACF France Pool Desk Staff), Country Director, Health and Nutrition Head of Department, Food Security and Livelihoods Head of Department, Advocacy Expert, Nutrition Surveillance Expert, East Freetown Field Coordinator, Nutrition Programme Manager and Irish Aid.

Indirect Users: AFD, MoHS, WARO, ACF International Network, Others.

Use of the Evaluation
Learn from experience to develop new strategies at the global level, collect lessons learnt and good practices for future project in country.

3. EVALUATION SCOPE

Evaluation Focus
The evaluation will focus on the part of the project funded by Irish Aid, but will also take in consideration the part funded by AFD and ACF. It will cover all geograpghical areas, looking at different levels of the intervention (community level, district level, and national level) and at the links between those levels. It will also cover all selected target groups of beneficiaries and both technical areas of the project (Nutrition and Food Security). In particular, the evaluation will cover all aspects including capacity building at facility level, advocacy at the national level, nutrition surveillance/studies, and prevention of undernutrition through mother to mother support groups, gardens and support for EVD affected individuals. The evaluation will also focus on the multi-sectoral approach used, integrating nutrition and food security.

Cross-cutting issues
As per ACF Gender Policy and Toolkit, the evaluation is expected to carry out a gender analysis, also assessing the few strategies implemented to address gender inequalities. Also, in what regards to HIV/AIDS, the evaluation is supposed to assess the management of people living with HIV and AIDS (PLWHA) through the support of DHMT for CMAM activities in PHUs and health facilities, and how well has ACF ensured the management of PLWHA with acute malnutrition[79].

Elements not covered in depth by the evaluation

- The cross-cutting issues of HIV/AIDS was not a focus of this project, this element will not be evaluated in depth.
- The evaluation will not cover the Advocacy and Nutrition Surveillance components in depth as these will be covered more in depth by the AFD evaluation taking place later in the year.

4. EVALUATION APPROACH

As per ACF Evaluation Policy and Guidelines[80], ACF adheres to the Development Assistance Committee (DAC) criteria for evaluating its programmes and projects. Specifically, ACF uses the following DAC **criteria: Relevance / Appropriateness, Coherence, Coverage, Efficiency, Effectiveness, Sustainability and Likelihood of Impact**[81]. To the latter list ACF adds an additional criterion, **Design**. ACF also promotes a systematic analysis of the **monitoring system in place** within the aforementioned criteria.

Evaluation questions have been developed to help the evaluator/s assess the project against these seven criteria (refer to Annex III). The evaluator may adapt the evaluation criteria and questions, but any fundamental changes should be agreed between the ELA at ACF-UK and the evaluator/s and reflected in the inception report.

All independent external evaluations are expected to use **DAC criteria** in data analysis and reporting. In particular, the evaluator/s must complete the DAC criteria rating table (refer to Annex VI) and include it as part of the final evaluation report.

Given the recurrent reference to the need to **better understand** the and strengthen the effectiveness of the mother-to-mother support groups, for this evaluation it would also be requested to articulate a **theory of change** associated with the mother-to-mother support groups, testing to the extent possible the **assumptions** made in that theory.

5. EVALUATION METHODOLOGY

This section outlines the suggested methodological approach for the evaluator/s to collect quantitative and qualitative data. The evaluator/s will to the extent possible develop data gathering instruments and methods which allow collecting sex and age disaggregated data. The instruments need to make provision for the triangulation of data where possible.

[79] ACF is supposed to coordinate with Solthis (INGO specialised in HIV) to make sure children with HIV are admitted in Stabilization Centre for Severe Acute Malnutrition and the protocol is well followed.
[80] http://www.alnap.org/resource/6199

[81] As a thorough impact assessment is linked to the estimation of attribution, which can only be measured through experimental or quasi experimental evaluation designs, the criterion has been rephrased to "Likelihood of Impact".

Evaluation Briefing
Prior to the evaluation taking place, the evaluator is expected to attend an evaluation technical briefing with the ELA ACF-UK. Briefings by telephone must be agreed in advance.

Desk review
The evaluator/s will undertake a desk review of project materials, including the project documents and proposals, progress reports, outputs of the project (such as publications, communication materials, videos, recording etc.), results of any internal planning process and relevant materials from secondary sources.

ACF HQ and Mission Briefing
As part of the evaluation, the evaluator will attend a briefing with HQ and Mission stakeholders (Country Director and/or Health and Nutrition Head of Department) to get preliminary information about the project being evaluated. Briefings by telephone must be agreed in advance.

Inception Report
At the end of the desk review period and before the field mission, the evaluator/s will prepare a brief inception report. The report will be written in English and will include the following sections:

- Key elements of the TORs to demonstrate that the evaluator will adhere to the TORs;
- Present the methodological approach to the evaluation (including an evaluation matrix in annex to specify how the evaluator/s will collect data to answer the evaluation questions) and point out the limitations to the methodology if any;
- Provide a detailed evaluation work plan and;
- State adherence to ACF Evaluation Policy and outline the evaluation report format.

The inception report will be shared with stakeholders, and discussed and approved by the ELA in ACF-UK.

Field Mission
Primary data collection techniques
As part of the evaluation, the evaluator will **interview key project stakeholders** (expatriate/national project staff, local/national representatives, local authorities, humanitarian agencies, or donor representatives) as per the list in Annex V. The evaluator will use the most suitable format for these interviews as detailed in the inception report. The evaluator is also **expected to collect information directly from beneficiaries**. Towards enriching triangulation, **if budget and timeframe allows,** the evaluator could also conduct **Focus Group Discussions** (beneficiaries, non-beneficiaries, key informants – health workers, teachers and leaders) and **surveys.**

Field visits
The evaluator/s will visit the project sites and the facilities provided to the beneficiaries (if any).

Secondary data collection techniques: Desk review
The evaluator/s will further review complementary documents and collect project monitoring data or of any other relevant statistical data.

Debriefing and stakeholders workshop

The evaluator shall facilitate a learning workshop in country to present preliminary findings of the evaluation to the project and key stakeholders (including DHMT and National actors); to gather feedback on the findings and build consensus on recommendations; to develop action-oriented workshop statements on lessons learned and proposed improvements for the future.

Evaluation Report

The evaluation report shall follow the following format and be written in English:

- **Cover Page**;
- **Summary Table** (to follow template provided);
- **Table of Contents**;
- **Executive Summary** (must be a standalone summary, describing the project, main findings of the evaluation, and conclusions and recommendations. This will be no more than 2 pages in length);
- **Background Information;**
- **Methodology** (describe the methodology used, provide evidence of triangulation of data and presents limitations to the methodology);
- **Findings** (includes overall assessment of the project against the evaluation criteria, responds to the evaluation questions, all findings are backed up by evidence, cross-cutting issues are mainstreamed and; unintended and unexpected outcomes are also discussed);
- **Conclusions** (conclusions are formulated by synthesizing the main findings into statements of merit and worth, judgements are fair, impartial, and consistent with the findings);
- **Lessons Learnt and Good Practices** (presents lessons that can be applied elsewhere to improve project performance, outcome, or impact and; identify good practices: successful practices from those lessons which are worthy of replication; further develop on one specific good practice to be showcased in the template provided in Annex VII);
- **Recommendations** (Recommendations should be as realistic, operational and pragmatic as possible; that is, they should take careful account of the circumstances currently prevailing in the context of the action, and of the resources available to implement it both locally. They should follow logically from conclusions, lessons learned and good practices. The report must specify who needs to take what action and when. Recommendations need to be presented by order of priority);
- **Annexes** (These should be listed and numbered and must include the following: Good practice template, Evaluation Criteria Rating Table, list of documents for the desk review, list of persons interviewed, data collection instrument, evaluation TORs).

The whole report shall not be longer than 30 pages, 50 pages including annexes. The draft report should be submitted no later than 10 calendar days after departure from the field. The final report will be submitted no later than the end date of the consultancy contract. Annexes to the report will be accepted in the working language of the country and project subject to the evaluation.

Debriefing with ELA ACF-UK

The evaluator should provide a debriefing to the ELA in ACF-UK to discuss any issues related to the evaluation report.

Debriefing and ACF HQ Presentation

The evaluator should provide a debriefing and a presentation with the relevant ACF HQ on her/his draft report, and on the main findings, conclusions and recommendations of the evaluation. Relevant comments should be incorporated in the final report.

6. KEY DELIVERABLES

The following are the evaluation outputs the evaluator/s will submit to the ELA in ACF-UK:

Outputs	**Deadlines**
Inception Report	*07/09/2015*
Stakeholders workshop (Field)	*22/09/2015*
Presentation (ACF-France HQ)	*24/09/2015*
Draft Evaluation Report	*30/09/2015*
Final Evaluation Report	*13/10/2015*

The quality of the inception report and the evaluation report will be assessed against ELA quality checklist.

All evaluation outputs will be delivered in english. The evaluator will follow the format, structure and length defined in the ELA template. All outputs must be submitted in English and under Word Document format.

The quality of the inception report and the evaluation report will be assessed by the ELA in ACF-UK. The evaluator is expected to follow the format, structure and length as defined under section 5.4 and 5.6 above.

7. MANAGEMENT ARRANGEMENTS AND WORKPLAN

These evaluation TORs have been developed in a participatory manner, by the ELA in ACF-UK based on inputs from relevant stakeholders.

The evaluator will directly report to the ELA in ACF-UK. The evaluator will submit all the evaluation outputs directly and only to the ELA in ACF-UK. The ELA in ACF-UK will do a quality check (ensure required elements are there) and decide whether the report is ready for sharing. The ELA will forward a copy to key stakeholders for comments on factual issues and for clarifications. The ELA will consolidate the comments and send these to the evaluator/s by date agreed between the ELA and the evaluator/s or as soon as the comments are received from stakeholders. The evaluator will consider all comments to finalize report and will submit it to the ELA who will then officially forward to relevant stakeholders.

Once the evaluation is completed the ELA ACF-UK will prepare the management response follow-up form to track implementation of the recommendations outlined in the evaluation report. A review of the follow-up process will be undertaken six months after the publication of the evaluation report.

Tentative Work plan[82]

Activities	**Evaluator Working Days**	**Dates**
Evaluation briefing with ACF-UK ELA	0.33	01/09/2015 (tu)
Evaluation briefing with HQ	0.33	01/09/2015 (tu)
Evaluation briefing with Mission	0.33	01/09/2015 (tu)
Desk review	2	02/09/2015 (we) – 03/09/2015 (th)
Desk review, preparation of field work and prepare **Inception Report**	3	04/09/2015(fr) 07/09/2015 (mo)
Travel to the field		08/09/2015 (tu)
In country interviews with project staff	1	09/09/2015 (we)
Field work, collection of primary data, analysis of secondary data & meeting with stakeholders	10	10/09/2015 (th) – 21/09/2015 (mo)
Stakeholders Workshop in country	1	22/09/2015 (tu)
Travel back from the field		23/09/2015 (we)
Evaluation debriefing / presentation with HQ	0.5	24/09/2015 (th)
Evaluation debriefing with ACF-UK ELA	0.5	24/09/2015 (th)
Draft Report	5	25/09/2015(fr)- 30/09/2015(we)
ACF-UK: Quality check and initial review by ELA, circulate draft report to key stakeholders, consolidate comments of stakeholders and send to evaluator		01/10/2015 (th) – 09/10/2015 (fr)
Final report on the basis of stakeholders, Mission, HQ, and ACF-UK comments	3	10/10/2015 (sa)- 13/10/2015 (tu)
Total Consultant Working Days:	**27**	

Profile of the evaluator/s

The evaluation will be carried out by an international evaluation consultant with the following profile:

- Good Knowledge of Nutrition and Health projects, particularly CMAM, and on integrated approaches including integration with Food Security projects
- Significant field experience in the evaluation of humanitarian / development projects;
- Relevant degree / equivalent experience related to the evaluation to be undertaken;
- Significant experience in coordination, design, implementation, monitoring and evaluation of programmes;
- Good communications skills and experience of workshop facilitation;
- Ability to write clear and useful reports (may be required to produce examples of previous work);
- Fluent in English

[82] *Consultants are expected to work 6 days a week (either Sundays/Fridays or whatever day the field office has off will not be paid) during their consultancy contract. Travel days are not paid as they are not working days as such.*

- Understanding of donor requirements;
- Ability to manage the available time and resources and to work to tight deadlines;
- Independence from the parties involved.
- Good knowledge of Sierra Leone or at least West Africa context (desirable).

8. LEGAL AND ETHICAL MATTERS

The ownership of the draft and final documentation belong to the agency and the funding donor exclusively. The document, or publication related to it, will not be shared with anybody except ACF before the delivery by ACF of the final document to the donor.

ACF is to be the main addressee of the evaluation and its results might impact on both operational and technical strategies. This being said, ACF is likely to share the results of the evaluation with the following groups:

- Donor(s)
- Governmental partners
- Various co-ordination bodies

For independent evaluations, it is important that the consultant does not have any links to project management, or any other conflict of interest that would interfere with the independence of the evaluation.

Intellectual Property Rights
All documentation related to the Assignment (whether or not in the course of your duties) shall remain the sole and exclusive property of the Charity.

9. ANNEXES TO THE TORs

I. Project Logframe
II. Recommendations of the Midterm Evaluation (August 2014)
III. Evaluation Criteria and Detailed Evaluation Questions
IV. List of Project documents for the desk review
V. List of people to be interviewed
VI. Evaluation Criteria Table
VII. Good practices Format

Annex I: Project Log frame

General Objective
Contribute to the improvement of maternal and child nutrition situation in West Africa.

Specific Objectives/Results
Reinforcing Institutional capacity for treatment of acute malnutrition, prevention of malnutrition in Freetown Peninsula, Western Area and national sensitisation for nutrition security in Sierra Leone. **Result 1:** Institutional capacity building – technical and management – of the DHMT for treatment of acute malnutrition, as per national CMAM program, in Sierra Leone western area Freetown. Indicators related to result 1: - 80% of children are screened in the area of intervention - SPHERE standards will be attained and will progress in the health centres supported (Cure rate > 75%, Defaulter rate <15% and Death rate < 10%) - Annual increase of CMAM coverage **Result 2:** Government of Sierra Leone and major donors prioritize nutrition security in their strategies, frameworks, and financial commitments by 2015 Indicators related to result 2: - Advocacy strategy is defined - Indicators to measure advocacy strategy impact are defined and agreed with Irish Aid - ACF recommendations are included in main nutrition security related documents adopted/reviewed in the country and in main positionings on nutrition security presented at international level (i.e. WHA) - ACF updates on activities and recommendations are shared with national and international stakeholders influencing the discussion and decision making process on the EVD secondary impacts and on nutrition security - Technical support provided to the SUN and different ministries enable them to integrate nutrition sensitive activities in the policies/strategies **Result 3:** Improve at central level initial training for health staff and nutrition surveillance and propose innovative study related to nutrition security Indicators related to result 3: - CMAM/IMAM and IYCF practices is integrated in the curricula of health and nutrition training schools and university (for nurses, CHO, MCH-Aid and Nutritionist) - Cross fertilising visits are organised between schools and health facilities to train the students on CMAM and IYCF - Nutrition program data is high quality and published systematically (evolution of admissions, quality programs, absenteeism rates etc.) - The CoD is determined for the minimum of one livelihood zone in Freetown - The Cost of Diet report is prepared in a timely manner and to high quality - Results of the CoD are shared with MOHS and MAFFS at both national and district-level staff - The teenage mother care practices study report including findings and recommendations is shared with key stakeholders **Result 4:** Prevention of malnutrition through gardens for health and IYCF mother to mother support groups, and nutritional support to EVD affected individuals Indicators related to result 4: - 60% of mother enrolled in the M2M support groups improved their knowledge on IYCF - Over 40% of households improve their dietary diversity (according to an adapted food consumption score) from improved nutrition knowledge and vegetable growing - At least 80% of the urban garden displays and demonstration gardens planned are

developed and functional at community level
- Over 40% of households improve their dietary diversity (according to an adapted food consumption score) from improved nutrition knowledge and vegetable growing
- Over 50% of households are successfully growing vegetables in the growing season following training and provision of kits
- 80% of VSLA members attend regularly the meetings
- Households of EVD affected infants are supported on infant and young child feeding and care practices

Programme Activities

Programme activities fall under the 4 results.

Result 1: Institutional capacity building – technical and management – of the DHMT for treatment of acute malnutrition, as per national CMAM program, in Sierra Leone western area Freetown.

Output 1.1: Initial assessment of decentralised services' needs for support

- Description: The objective of the assessment will be to identify the discrepancy between the national policy and the reality of implementation. Because the national program promotes community management of acute malnutrition, ACF will measure the actual implication and needs of the community and civil society during the induction phase of the project. This will also help ACF to list the exact needs (logistic, trainings…) of each health facility. Today, ACF supports the curative component of the treatment of acute malnutrition in Moyamba. In Freetown, prevention, detection and referral components have little or no support; ACF will propose a strategy based on community mobilisation.
- Activity:
    - Meeting with MoHS (Nutrition program Manager), DHMT and UNICEF to identify the PHUs to support
    - Assessment of 26 PHUs and 2 SC, to identify needs for support in collaboration with DHMT

Output 1.2: Practical training of 124 health staff and 130 community volunteers in OTP and SC (coverage of 26 PHUs)

- Description: ACF will organise technical training for health staff in the health facilities. Community volunteers will be coached on the job on detection and referral of acutely malnourished children within their communities and sensitisation on nutrition and malnutrition. Detection activities will include training of mothers at community level on self-assessment methof to fit with the "no touch" policy formulated by the MoHS to address the challenges linked to EVD outbreak. MUAC measurement and check of oedema will be done by the mothers themselves under the supervision of the community volunteers. ACF will develop tools, in collaboration with MoHS, to improve data collection: report formats, data communication and compilation systems through health facilities. These two levels of intervention implemented jointly aim to improve prevention interventions, early detection and treatment of acute malnutrition due to improved community involvement.
- Activities:
    - Train 130 community volunteers to support community mobilization efforts for active case finding (detection and referral) as well as community sensitizations per the national nutrition protocol adapted to Ebola outbreak
    - Provide tools to the community volunteers and to mother to mother support groups for detection and referral (Tally sheet, referral slip, MUAC[83]) and for

[83] Middle Upper Arm Circumference

sensitisation and awareness.
    - Train 124 health staff working in health facilities on management of severe acute malnutrition with and without complication following the CMAM protocol/IMAM protocol adapted to the Ebola outbreak.
    - Provide tools and anthropometric material through DHMT to ensure proper management of acute malnutrition

Output 1.3: Decentralised services support for supervision of health staff

- Description: ACF will help the District Health Management Teams organise and implement supportive supervision of health structures and staff. The goal of this support will be also to reinforce DHMT capacities to organise and implement refresher trainings. ACF will also support the DHMT to organise and monitor community mobilisation for detection and referral of acute malnourished cases.
- Activities:
    - District Health Management Teams support to organise and implement supportive supervision of health staff
    - Quarterly joint supervision visits to PHUs, SC and communities with ACF, the DHMT and other NGO partners in Freetown

Output 1.4: Decentralized services support for management of acute malnutrition in the district

- Description: ACF will support the DHMT on improvement of reporting, monitoring and evaluation systems and timely transmission of needs at central level. ACF will focus on supply follow up and management to avoid stock out of routine drugs and RUTF. Also ACF will support DHMT to organize bi-monthly Nutrition Technical Coordination with other stakeholders.
- Activities:
    - Development of tools, in collaboration with MoHS, to improve data collection: report formats, data communication and compilation systems through health facilities
    - Support DHMT on launching of Nutrition Coordination meeting at district level following the SUN recommendation.
    - Support the DHMT on the scaling up of CMAM/IMAM activities through training and supportive supervision of new OTP
    - Work on capacity building and transfer of skills in order to plan an exit strategy, jointly with DHMT and MoHS, at the end of the project.

Result 2: Government of Sierra Leone and major donors prioritize nutrition security in their strategies, frameworks, and financial commitments by 2015

Output 2.1: A national advocacy strategy is defined internally to enhance nutrition security in Sierra Leone

- Description: The first step will be to define advocacy strategy and action plan to enhance nutrition security. A literature review, meetings with stakeholders and internal meetings will be done to build a baseline and define objectives. An analysis will then be done to define major topics to include in the strategy and action plan in order to make sure that Sierra Leone prioritise nutrition security especially for mother and children.
- Activities:
    - Literature review of the different policies, guideline and protocols link to nutrition security in Sierra Leone with emphasis on the Food and Nutrition Implementation Plan
    - Internal meeting to define key messages and advocacy target
    - Meeting with different stakeholders working in nutrition and other sector linked to nutrition security in order to understand their position and share advocacy strategy.
    - Develop the baseline in regard to the literature review and stakeholders meeting.
    - Define advocacy strategy and action plan up to September 2015

Output 2.2: Develop advocacy activities and support MoHS in advocacy and communication material development

- Description: ACF will focus on awareness raising towards as many local national actors as possible regarding the necessity to fight under-nutrition in Sierra Leone. Better understanding, analysing and dissemination of the factors and dynamics promoting nutrition security notably through ACF work at district level will be done. Action mode will be defined in order to ensure the most proper way to deliver the messages. Radio jingles and discussion, documentary, case studies and publication, could be done to support the advocacy activities. Also one of the main focus of advocacy will be link to the Food and Nutrition Policy Implementation Plan (FNIP) in order to make sure that stakeholders at Central and District level are involved on nutrition security. In the same time ACF will support the Food and Nutrition programme at MoHS to develop advocacy strategy and will support them to define key messages, targets and mode of action for yearly event like the breastfeeding week and the World Food Day, as well as for nutrition related public health issues (e.g messages in infant feeding in Ebola context, health seeking behaviour etc.).
- Activities:
    - ACF to engage in relevant national fora to influence the programmatic interventions across country in order to fight against under-nutrition and to promote nutrition sensitive focused actions at national and district level
    - ACF to engage with MoHS ahead of relevant international fora to ensure ACF International recommendations (adapted to the national context) are supported by MoHS/GoSL
    - ACF to develop, update and disseminate (nationally and internationally) briefing papers on the impact of EVD on Food Security, Nutrition and Health System to advocate for adequate actions to be taken to mitigate secondary impacts on EVD (study previously conducted by ACF in SL will serve as baseline)
    - Identify a local partner (journalist organisation; community radio…) to disseminate messages to the community and representatives of the civil society and nourish the debates on nutrition security (topics adapted to reflect the Ebola epidemic)
    - ACF to engage with MoHS to develop a documentary on under-nutrition (subject yet to be defined)
    - ACF to support the MoHS in producing and disseminate advocacy and communication (including IEC) material
    - ACF to develop a capitalization report on the Freetown Project "gardens for health" identifying lessons learnt and recommendations for main stakeholders.
    - Articles and reports on the ACF activities and EVD secondary impacts are shared nationally and internationally and are used to feed regional and international ACF advocacy initiatives

Output 2.3: REACH and SUN initiative participation in SL and West Africa

- Description: Support in the implementation of advocacy activities and participation in technology platforms such as REACH / SUN to push forward action related to nutrition security in the country. ACF will actively participate in the different meetings related to nutrition security and will share his expertise in order to push forward nutrition security in Sierra Leone.
- Activities:
    - Actively participate to the different meetings linked to nutrition security and specially Nutrition Technical committee and Nutrition Coordination meeting (at national and district level)
    - Capitalisation and dissemination of information internally and to partners
    - Central level support for development of technical documents and/or coordination (revision of CMAM protocol…)

Result 3: Improve at central level initial training for health staff

Output 3.1: The training material for university is developed

- Description: ACF will support MoHS to revise university curriculum for nurses, CHO[84], nutritionist, MCH[85]-Aid in order to integrate training on CMAM and IYCF. This revision of curriculum will allow the new health workers to address nutrition cares after their diploma.
- Activities:
    - Participation in the development of training material (by attending the related workshop) in collaboration with MoHS and WHO[86]:
    - Development of innovative material to support lecturers at university: CD-ROM
    - Propose cross fertilizing visits for University and Health Facilities in order to improve practice and knowledge related to CMAM programmes and protocol

Output 3.2: Define, develop and establish officially a nutrition surveillance system

- Description: ACF will support MoHS at central and district level to develop a harmonised system for data collection and analysis regarding nutrition activities. It will be also necessary at the beginning of the project to meet with MoHS to help identify the priorities and design the specific activities for this output. ACF will adapt activities depending on the needs and will support the MoHS to improve the nutrition surveillance system. According to needs, ACF will also support the Early Warning System pilot project as we are already involved in this surveillance system. Also ACF will help the MoHS in the integration of community volunteers into the nutrition surveillance system for collection of data related to detection and referral of acutely malnourished children in the community.
- Activities:
    - Meet with MoHS (Nutrition Program) and identify weaknesses and gaps in the nutrition surveillance system
    - Regarding data collection, ACF previously helped develop and implement a reporting format with the Moyamba district and will propose using this format at the national level. The partnership will be done with MoHS and UNICEF.
    - Advocacy at national and local level for the recognition of the role of the community volunteers and community health workers in the nutrition surveillance system
    - Contribution to nutritional surveillance through the support of the district and health centres in the management and monitoring of community screening activities for detection and referral of malnourished children
    - Carry out monthly market monitoring in Freetown to monitor the impact of Ebola outbreak on the food security situation

Output 3.3: A Cost of Diet (CoD) survey is conducted for selected livelihood zones for Freetown

- Description: the CoD survey is meant to estimate the affordability of a healthy diet, and the gap between income and the cost of buying a nutritious diet plus other essential needs. It takes into account seasonal variation in prices when costing the diet, identifies nutrients that cannot easily be met by the diet, and strives, if possible, to identify foods that could meet nutrient gaps. It is therefore meant to also inform nutrition education programmes, as well as to examine the potential effects of changes in food prices and of homestead food production including gardens on the cost of a nutritious diet.
- Activities:
    - Initial discussions with MOHS, MAFFS, WFP, FAO and other stakeholders
    - Train team on CoD methodology and key stakeholders

[84] Community Health Officer

[85] Maternal and Child Health

[86] World Health Organization

- Carry out CoD survey in selected parts of Eastern Freetown
- Prepare survey presentation and report
- Present the findings to coordination meetings, relevant line ministries and other stakeholders

Output 3.4: A Teenage mother care practices study is done 2 districts and 6 city sections in Sierra Leone

- Description: Save the Children, Concern Worldwide and ACF, already operating in the areas of Infant and Young Child Feeding and Adolescent Sexual Reproductive Health, have defined together with the MOHS Nutrition Department the need to gain a deeper understanding of the infant and young child feeding practices and more specifically on care practices of teenaged mothers in Sierra Leone. This study follows discussions between these 3 NGOs regarding the problematic of teenage mothers with SAM children found in OTP and SC in different districts. The results of the study will inform evidenced based programming and help design national level recommendations on improving support for teenaged mothers. This study will be done in partnership with MoHS and with Njala University. The proposition is also to include a child led aspect during the data collection and Focus group discussion and to involve teenagers during interviews.
- Activities:
  - Undertake a short review of literature related to Teenaged Mothers and IYCF/ Care Practices in Sierra Leone and internationally to highlight the key areas
  - Train data collector with specific focus for teenager who will be part of data collector
  - Design and coordinate a field study in 2 districts and 6 City Sections with NGO and DHMT staff
  - To hold a stakeholder meeting to present and discuss key findings from the study
  - Write a report with analysis of the results with practical recommendations of way to support teenaged mothers to improve their IYCF practices.

Output 3.5: A study on the effectiveness of Mother to Mother support group methodologies is carried out

- Description: Mother to mother support groups have been identified and promoted by the Food and Nutrition Directorate and UNICEF as an effective strategy to improve Infant and Young Child Feeding practices in Sierra Leone. This strategy is implemented by different partners in different districts, with the objective of reaching a national coverage in all the communities. While data from the different surveys conducted in the past years suggest that this strategy has achieved positive results, there has been few analysis and capitalization on the different methodologies used and lessons learnt from implementation in different contexts (rural/ urban). In collaboration with MoHS, UNICEF and partners implementing mother to mother support groups, ACF will carry out a study to capitalize lessons learnt and inform evidence based programming
- Activities:
  - Initial discussions with MoHS and UNICEF to define the scope of the study
  - Carry out the study
  - Present the findings and disseminate the report among stakeholders

Result 4: Prevention of malnutrition through IYCF mother to mother support groups

Output 4.1: Formation of at least 10 mother to mother support groups per PHU supported composed by 10 mothers each

- Description: Infant and Young Child Feeding (IYCF) Mother to mother (M2M) groups will be formed by the community and participation will be voluntary. ACF and the community will identify 10 lead women in the community to be responsible for the M2M groups. Each woman will be following 10 women in her area and will organise group session. The IYCF M2M groups will consist of pregnant and lactating mothers and mothers of children less

than 5 years of age. Groups will meet on a bi monthly basis and sessions will involve educational activities based Sierra Leone's priority nutrition intervention plan to treat and prevent the underlying causes of malnutrition at the household/family level. The different sensitisation topics are comprised of the following 7 Priorities:

1. Improve breastfeeding and complementary feeding
2. Increase micronutrient intake
3. Improve diarrhea and parasite control
4. Treat acute malnutrition
5. Improve Household food security
6. Improve maternal nutrition
7. Improve nutritional status of PLHIV/AIDS/TB and reduce prevalence of Non Communicable Diseases

- Activities:
  - Development of selection criteria for participants of M2M groups
  - Community led selection of 10 M2M lead women per PHU in the area of intervention
  - Development of IYCF and other necessary IEC materials suitable for those of all literacy levels
  - Training of the 260 lead women on IYCF and prevention of underlying causes of malnutrition
  - Training 1 PHU Nurse per community to monitor M2M groups to ensure full understanding of nutrition education initiatives as well as continuation of activities after ACF exit
  - Supportive supervision will be done by ACF staff during the group session done by the lead mother into their community
  - Attendance of bi monthly meetings of 1-2 hour each to discuss training topics related to Sierra Leone's priority nutrition intervention plan, IYCF and gardens for health

Output 4.2: 22 urban garden displays or demonstration gardens are developed at community level

- Description: Both an urban garden display and a demonstration garden will be prepared at community level. Where space is a constraint for many households living in the area, then the urban garden display will be used to show how to garden in containers and small spaces. In areas where households are more likely to be able to access land, demonstration garden beds will be used. ACF will develop group leadership structures and promote bye-laws formation to ensure sustainability and support ownership.
- Activities:
  - Determine interest from communities and/or volunteers to have an urban garden display or demonstration garden.
  - Procure materials and develop gardens at a seasonally appropriate time.

Output 4.3: At least 2300xix persons are trained in vegetable gardening and cooking

- Description: Community garden caretakers, Community volunteers and M2M women leaders will be offered training sessions for 2-4 hours of the four garden topics listed below (a - d) while cooking demonstration training (e) will be done at community and PHU/SC level. Trainings will be provided in conjunction with the seven Essential Nutrition Actions (ENAs).
  a. How to prepare your home garden in big or small spaces
  b. How to take care of your fruit and vegetables
  c. How to diversify your fruit and vegetable production
  d. How to make compost and organic pesticides
  e. How to cook vegetables to introduce new cooking techniques to retain nutrients and to diversify intake of vegetables

  The training will be abbreviated so that it can be conducted as a half-day session. All training will be conducted using practical sessions (e.g., Garden preparation and cooking demonstrations). As much as possible, depending on where carers live, we will strive to

organize a home follow-up, through the M2M groups, so that carers can be trained and coached on how they should be tending to their home garden.

- Activities:
    - Develop or adapt training materials to be relevant to the Freetown context and for participants with limited or no literacy
    - Conduct training-of-trainers (TOT) ensure a high quality of training
    - Develop a training plan
    - Pilot the training, and adjust training as necessary
    - Conduct the package of five training sessions for 20 M2M support groups leader (5 sessions x 40 times = 200 sessions) and 100 Community Volunteers (average of 5 CV per PHU) from the communities surrounding the 26 PHU supported
    - Adjust training as necessary after the first year of implementation
    - Follow-up with carers living in city sections with an ACF-supported PHU.
    - Organise cooking demonstrations and nutrition education sessions at PHU and community level promoting complementary feeding recipes using local products

Output 4.4: At least 2300 households are provided with vegetable kits

- Description: Lead women from M2M groups and Community Volunteers who attend the training will also be provided with a small household start-up vegetable kit to encourage them to start growing vegetables for home consumption. The kit, worth approximately Le 75,000, will comprise of a variety of seeds for nutritious vegetables, a hand tool and sacks. If mother to mother groups (comprised of 10 mothers each) decide that they would like to pool resources for a group kit for group vegetable farming, ACF will facilitate this process to procure a kit worth the equivalent of Le 340,500 per group. Carers will also be provided with a kit comprising vegetable seeds and sacks worth the equivalent of Le 51,000. 1000 caregivers from SC, 1000 mother from mother to mother support groups, 200 lead women into the community and 100 Community Volunteers
- Activities:
    - Provide at least 300 individual vegetable kits to women from M2M groups and CV
    - Provide at least 100 community vegetable kits to M2M groups
    - Provide at least 1000 seed kits to carers of severe and moderate acutely malnourished children
    - Conduct follow up post-distribution monitoring

Output 4.5: Village saving loans associations (VSLA) for M2M groups and community volunteers are initiated in 10 communities

- Description: Community-managed savings-led approaches to financial services for the poor have a long and successful history. The VSLA approach has been pioneered by CARE, and has been successfully adapted by several agencies in Sierra Leone. This approach will be piloted with the mother to mother support groups as a way to empower the women, to help them to build up social capital within communities, and to promote the sustainability of the M2M groups.
- Activities:
    - Identification of 40 M2M groups to be selected to pilot the VSLA approach (5 groups per community)
    - Preliminary meetings with community leaders, administration officials, and groups of potential VSLA members
    - Formation of 40 VSLA groups, establishment of procedures and supervision

Output 4.6: EVD affected individuals receive nutritional support and follow-up at community level

- Description: ACF will collaborate with treatment centres in the Western Area to identify EVD affected individuals with or at risk of acute malnutrition. This include EVD survivors (adults and children) identified as malnourished upon discharge, mothers recovered who had to stop breastfeeding, orphans and their foster families. Individuals identified with severe acute malnutrition will be referred for treatment to appropriate facilities. For EVD

affected individuals at risk of malnutrition, home visits will be conducted at community level to support and follow-up the infant and young child feeding and care practices. ACF will also collaborate with the DHMT to set-up a supply system ensuring continuous provision of RUIF and UHT milk for affected children at community level.

- Activities:
    - Collaboration with the staff of Ebola treatment centres to systematically assess the nutritional status of discharged EVD patients and identify malnourished and/or vulnerable adults and children
    - Refer EVD survivors identified with acute malnutrition to tailored facilities
    - Conduct home visits at household level to provide nutritional and social support and follow-up for EVD affected adults and children to promote recovery and/or optimize infant care practices (EVD survivors, children separated or orphans, children whose mother survived but had to stop breastfeeding…)
    - Support the DHMT to ensure continuous provision of RUIF for children less than 6 months old and UHT liquid milk for children for children aged 6-12 months of EVD affected mothers

Annex II: Recommendations of the Midterm Evaluation (August 2014)

Recommendation 1: Given the intention for the activities to endure beyond the short-term, ACF should adopt a less 'humanitarian' approach – it has started to do elements of this, but needs to do more.

Recommendation 2: Treatment of acute malnutrition at facility level has a chance of sustainability but scale-up should be less HR intensive

Recommendation 3: Peer-to-peer learning works but don't 'overdo it - use nutrition champions strategically

Recommendation 4: Give 34 Stabilisation Centre a time by which to work but explore other options whilst keeping in line with MoHS (national and district) preferences

Recommendation 5: Better understand the outcome of Stabilisation Centre discharges

Recommendation 6: Better understand the reasons for defaulting

Recommendation 7: Ensure early detection and treatment of malnutrition and childhood illnesses:
a) Assess the impact of quarterly screening on early detection and coverage
b) Better understand the barriers for accessing healthcare
c) Strengthen further collaboration with other nutrition and health NGOs

Recommendation 8: When engaging with Community Health Workers and associated stakeholders, use language and a manner that promotes government ownership

Recommendation 9: Understand and strengthen the effectiveness of mother-to-mother support groups:
a) Articulate the theory of change associated with mother-to-mother groups and test the assumptions made in that theory
b) Better understand the impact on the groups have on participating mothers,
c) Continue to strengthen the ownership and linkage of the groups with indigenous networks such as the MoHS at national district and PHU level, Ministry of Agriculture, local organisations, the community, religious institutions

Recommendation 10: Conduct an internal exercise to articulate and define ACF's competencies and limitations at community level and explore options to address gaps

Recommendation 11: The advocacy officer should stay in post to solidify this position and maximise the chance of succeeding on critical advocacy points

Recommendation 12: Continue to focus on health systems strengthening
a) Conduct a Health Systems Strengthening Assessment for Freetown
b) Continue to gather evidence relating to stock-outs and the functionality of the logistics system and convey it upstream to advocate for change
c) Explore sustainable solutions to overcome staff turnover
d) The forthcoming surveillance officer should improve the database to make manipulation easier to facilitate analysis, whilst maintaining simplicity to enable integration with HMIS in the future

Recommendation 13: Facilitate the FND to effectively plan and execute the inclusion of nutrition in the pre-service syllabus for medical staff in collaboration with partners

Annex III: Evaluation Criteria and Detailed Questions

To assess the project against each evaluation criteria, the evaluator will respond to the following evaluation questions:

Design[87]

- Are beneficiaries needs (by sex and age) well identified and in which way?
- Is gender mainstreamed in the project design?
- Are project objectives and indicators SMART? Are sources of verification realistic?
- Are there causal-effect links and hypothesis behind the project intervention realistic? Are the causal-effect links and hypothesis behind the peer to peer methodology used by ACF to improve the level of service delivery in Health facilities realistic? Are the assumptions behind the theory of change of M2M Support Groups held?

Relevance/Appropriateness[88]

- Does the project fits into the implementation plan of the Government's Agenda for Prosperity and Food and Nutrition Implementation Plan?
- Is there an added value of ACF involvement at central level? Is it addressing the needs of all targeted groups (by sex and age when it apply) and how could it be improved?
- What is the level of program ownership by local stakeholders: health facilities, DHMT staff, community health workers, community volunteers, beneficiaries at community level?
- Were the beneficiaries' needs (by sex and age) addressed by the intervention? Are there needs/gaps that might be covered with further interventions?

Coherence[89]

- To what extent is the program linked with national strategies/ initiatives (SUN, FNIP...)?
- As a new National strategy is currently developed for Community Health Worker (CHW), how could ACF roll out the activities in order to fit in the strategy and ensure sustainability?

Coverage[90]**:**

- Were the targeted beneficiaries selected appropriately compared with the kind of support that the intervention provided?
- Were there some groups of potential beneficiaries that had been not included in the targeting? Why?
- Could the intervention be extended to other group of people not considered in the project beneficiary groups?
- Was there an effect on coverage of the 'promotion' of Lead Mothers? What was the cascading effect of the Mother to Mother Support Groups on coverage?

Efficiency[91]**:**

[87] Refers to four areas: 1. The participatory systematic identification of needs, perceptions, priorities, capacities, and opportunities for men, women, boys and girls; 2. The identification of a hierarchy of project goals and objectives linked by causal relationships; 3. The planning of solutions in terms of inputs, activities, outputs, outcomes and overall objective, and; 4. The assessment of project outcomes.

[88] A measure of whether interventions, policies and strategies to ensure consistency and minimise duplication.
[89] The need to assess existing interventions, policies and strategies to ensure consistency and minimise duplication.

[90] The need to reach major population groups facing life threatening suffering wherever there are.
[91] A measure of how resources/inputs (funds, expertise, time, infrastructure, staff, leadership, coordination, financial control, procedures, partnerships, culture or planning etc.) are converted to results, not limited to a financial analysis (Value For Money - VFM).

- Were the number of staff, the time invested and the overall resources allocated for each facility efficiently invested given the results achieved?
- Were the resources invested in community nutrition activities (MSGs) efficient given the result achieved?

Effectiveness[92]

- This program has several components including four results. The evaluator should analyze the consistency of the 4 results and their contribution to the overall goal.
- Is there an added value in extending on the job coaching of health staff to other services provided at health facilty level (e.g broader package on top of IMAM like IMCI)?
- Are there important challenges in community mobilisation?
- How is ACF and its activities perceived by the community, by the health workers and by the authorities, including DHMT?
- What is the level of acceptance of the program at central and district level?
- Are the market gardening activities in the prevention of malnutrition effective towards: the means of a diet diversity ensure (vegetable are produced and are really available and used for household consumption)? The cookers know how to prepare vegetables in a hygienic manners and in an edible way according to food habits? The children and Women Dietary Diversity Score prove that vegetable is part of the diet? The Knowledge Attitude and Practice of the adults towards children and pregnant and lactating women special food needs?
- Has the activity and indicator monitoring provided timely and useful feedback to the project implementation? Why or why not? Has the training feedback helped to adjust/improve the training quality? Why or why not? Have the outputs of the Post-distribution monitoring (PDM) helped track changes in income from vegetable sales? And on the quantity of vegetables grown, sold, exchanged and consumed by the household?
- Is there a proper[93] beneficiary feedback mechanism in place?
- Are the cascading Mother to Mother Groups effective despite the limited support? Were the Lead Mothers of the cascaded groups effective in delivering messages during the sessions?
- What was the ability of ACF to respond to the Ebola outbreak by adapting the programme and supporting MoHS in adapting protocols and awarness raising?
- Evaluate the potential of ACF to go beyond nutrition in health facilities to embrace a broader HSS approach (basic health services?)

Sustainability and likelihood of impact[94]**:**

- Does the project have a real long term likelihood of impact through the on the job coaching of health staff and community volunteers? If not why? And what should be changed?
- Does the project have a real long term likelihood of impact through the on the job coaching of the Mothers Leaders in charge of the Mother to Mother support groups in the communities? If not why? And what should be changed?
- Can ACF ensure sustainability through community mobilisation activities (mother-to-mother support groups and community volunteers)?
- What should be the steps to undertake to ensure a proper exit strategy in linking with the support of the DHMT for the treatment of malnutrition and at community level for the prevention and detection?

[92] The extent to which the intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance.

[93] Continously updated, short feedback timeframe, use of feedback to adjust project implementation, etc.

[94] A measure of whether the benefits of the intervention are likely to continue after donor funding has been withdrawn and mission/programmes/projects operations officially cease and the likelihood of these interventions producing positive and negative, primary and secondary long-term effects in a direct, indirect, intended or unintended way.

- Is there a likelihood of impact of the peer to peer methodology used by ACF to improve the level of service delivery in Health facilities?
- What is the likelihood of impact based on the outputs of the adapted KAP survey?
- What is the likelihood of impact of integrating nutrition and FS in the MSGs[95]?

[95] In some MSGs we have men taking part in it. There are some concerns about this but for the interview done to the fathers it seems to have positive likelihood of impact. It would be needed to understand whether it would be good to continue like this and encourage the participation of men in the groups or to establish particular groups just for men.

Annex IV: List of Project documents for the desk review

The following documents will be reviewed by the evaluator/s during the desk review phase:

1. ACF Evaluation Policy and Guideline
2. ACF Gender Policy and Toolkit
3. Project Proposal and Reformulation
4. Project Mid-term External Evaluation (August 2014)
5. The 2014 National Nutrition Survey (SMART)
6. The 2011 and 2014 SLEAC/SQUEAC
7. 2013-2017 Food and Nutrition Security Implementation Plan
8. 2014 Mid-term Evaluation (IrishAid)
9. Ebola impact on SAM Admissions July 2014-March 2015
10. Revised IMAM protocol with Ebola annexe
11. Infant and Young Child Feeding Strategy 2014 (Ebola Context)
12. No touch Policy (2014)
13. SOP for nutrition in Ebola Context
14. MUAC by mother strategy
15. Case study Nut/FS on MSGs
16. Lessons Learnt as resulting from final workshop of the programme
17. KAP 2015
18. Position Papers related to Ebola
19. Irish Aid Final Evaluation September 2015
20. 2014 Annual Nutrition Surveillance Report

Annex V: List of people to be interviewed

The evaluator will interview the following stakeholders:

No	Name	Position	Organization
1	Sasha Ekanayake	Head of Mission	ACF
2	Suzanne Fuhrman	Nut/Health HoD	ACF
3	Alessandro Dalle Carbonare	FSL HoD	ACF
4	Isotta Pivato	Advocacy Expert	ACF
5	Mwasi Armogast	Field Coordinator	ACF
6	Mumin Kallon	Nut Deputy HoD	ACF
7	Abu D. Kamara	Nut HoP	ACF
8	Melvin Conteh	FSL PM	ACF
9	Haja Lydia Sesay	District Director of Agriculture	MAFFS
10	Isatu Conteh	Senior District Nutritionist	DHMT Western Area
11	Aminata Shamit Koroma	Director FND	MoHS
	Mohamed Sheriff	Deputy Director of Planning, evaluation, monitoring and statistic	MAFFS
12	Ramatu Jalloh	SUN CSP National Coordinator	SUN
13	Mohammed Foh	SUN National Coordinator	SUN VP
14	Mariama Ellie	IYCF Officer DFN	MOHS
15	Saidu Conteh	Councillor Ward 386	Congo town
16	Aminata Sesay	Councillor Ward 389	Wilberforce
17	Pa Alimamy Sesay	Chief	Wilberforce
18	Kadiatu S Kamara	Traditional Healer	Haja Neneh
19	Atei Cole	Mammy Queen	Murray Town
20	Amadu Kengbo	Community Leader	Malama community
21	Alpha Conteh	Community Leader	Newtwn community

Annex VI: Evaluation Criteria Table

The evaluator will be expected to use the following table to rank the performance of the overall intervention using the DAC criteria. The table should be included either in the Executive Summary and/or the Main Body of the report.

Criteria	Rating (1 low, 5 high)					Rationale
	1	2	3	4	5	
Design						
Relevance/Appropriateness						
Coherence						
Coverage						
Efficiency						
Effectiveness						
Sustainability and likelihood of Impact						

Annex VII: Good Practice Format

The evaluation is expected to provide one (1) key example of Good Practice from the project/programme. This example should relate to the technical area of intervention, either in terms of processes or systems, and should be potentially applicable to other contexts where ACF operates. This example of Good Practice should be presented in the Executive Summary and/or the Main Body of the report.

Title of Good Practice
(Max 30 words)
Innovative Features & Key Characteristics
(What makes the selected practice different?)
Background of Good Practice
(What was the rationale behind the good practice? What factors/ideas/developments/events lead to this particular practice being adopted? Why and how was it preferable to other alternatives?)
Further explanation of chosen Good Practice
(Elaborate on the features of the good practice chosen. How did the practice work in reality? What did it entail? How was it received by the local communities? What were some of its more important/relevant features? What made it unique?)
Practical/Specific Recommendations for Roll Out
(How can the selected practice be replicated more widely? Can this practice be replicated (in part or in full) by other ACF programmes? What would it take at practical level? What would it take at policy level?)
How could the Good Practice be developed further?
(Outline what steps should be taken for the practice to be improved and for the mission to further capitalise on this good practice)

ANNEX VII: DETAILED WORK PLAN (30 days)

Phase	Activities	Date	Days	Deliverables
1	**Desk Review and Inception Report:** Desk review ELA Evaluation Briefing Interviews with ACF HQ Writing inception report	02.09.15- 08.09.15	**5**	Inception Report
2	**Field Visits and National Workshop:** Travel to Sierra Leone (Sep 9) Field visits: KIIs, GIs, Free Listing, Observations at selected sites (Sep 10-21.09.15	09.09.15- 25.09.15	**16 days**	
	Preliminary Data synthesis and analysis	22.09.15- 24.09.15	2 days	
	Stakeholders Workshop to present findings and discuss ToC	25.09.15	1 day	Stakeholders Workshop
3	**Draft Evaluation Report Writing**	26.09.15- 03.10.15	**6 days**	Draft Report
	Return to Nairobi	26.09.15		
	Data analysis and Report findings synthesis	27.09.15		
	ELA (ACF-UK and ACF HQ Debriefing)	30.09.15		
	Submission of Draft Report	27.09.15- 03.09.15		
4	ACF and Stakeholders Feedback	04.10.15- 18.10.15		
	ACF Quality check and review			
	ACF Submission of comments			
5	**Finalization of Evaluation Report:**	20.10.15- 23.10.15	**3** days	Final Report
	Total Days		**30 days**	

ANNEX VIII: EVALUATION MATRIX TABLE

Criteria	Number	Evaluation Questions	Data Collection Instruments
Design	1.	Are beneficiaries needs (by sex and age) well defined and in what way?	KIIs with ACF mission and HQ staff, national and local leaders; FGDs/GI with direct beneficiaries, DR of documents and Database records. Each method will be triangulated against the others to validate findings.
	2.	Is gender mainstreamed in the project design?	DR, Project design, log frame and budget, KAP; KIIs with national and local leaders. Each method will be triangulated against the others to validate findings.
	3.	Are project objectives and indicators SMART? Are sources of verification realistic?	DR, Project design, log frame and budget, Beneficiaries' Database and records. Each method will be triangulated against the others to validate findings.
	4.	Are there causal-effect links and hypotheses behind the project intervention realistic? Are the causal-effect links and hypothesis behind the peer to peer methodology used by ACF to improve the level of service delivery in health facilities realistic? Are the assumption behind the theory of change of M2M support groups held?	DR, Project design, log frame and budget, Beneficiaries' Database and records. Each method will be triangulated against the others to validate findings.
Relevance / Appropriateness	1.	Does the project fit into the implementation plan of the Government's Agenda for Prosperity and Food and Nutrition Implementation Plan?	KIIs with national and local government leaders, DR of national reports CMAM etc.. Each method will be triangulated against the others to validate findings.
	2	Is there an added value of ACF involvement at central level? Is it addressing the needs of all target groups (by sex and age when it apply) and how could it be improved?	KIIs with national and local government leaders, DR of national reports. Each method will be triangulated against the others to validate findings.
	3	What is the level of program ownership by local stakeholders: health facilities, DHMT staff, community health workers community volunteers, beneficiaries at community level?	FGDs/GIs with local stakeholders, DR of government national strategies, frameworks, financial commitments, exit strategy. Each method will be triangulated against the others to validate findings.
	4.	Were the beneficiaries needs (by sex and age) addressed by the intervention? Are there needs/gaps that might be covered with further intervention?	FGDs/GIs with local stakeholders, direct beneficiaries. Each method will be triangulated against the others to validate findings.
Coherence	1.	To what extent is the program linked with national strategies/initiatives (SUN, FNIP, etc.)?	(Linked to question 1) KIIs with national and local government leaders, DR of SUN, FNIP. Each method will be triangulated against the others to validate findings.
	2.	As a new National Strategy is currently developed for Community Health workers (CHWs), how could ACF roll out activities in order to fit in the strategy and ensure sustainability?	(Linked to question 1) KIIs with ACF staff, national and local government leaders, DR of SUN, FNIP. Each method will be triangulated against the others to validate findings.

Coverage	1.	Were the targeted beneficiaries selected appropriately compared with the kind of support that the intervention provided?	KIIs with ACF staff, national and local government leaders, DR of project quarterly, bi-annual reports. Each method will be triangulated against the others to validate findings.
	2.	Were there some groups of potential beneficiaries that had been not included in the targeting? Why?	KIIs with ACF staff, national and local government leaders, DR of project quarterly, bi-annual reports. Each method will be triangulated against the others to validate findings.
	3	Could the intervention be extended to other group of people not considered in the project beneficiary groups?	KIIs with ACF staff, national and local government leaders, DR of project quarterly, bi-annual reports. Each method will be triangulated against the others to validate findings.
	4	Was there an effect on coverage of the 'promotion' of Lead Mothers? What was the cascading effect of the Mother to Mother Support Groups on coverage?	KIIs with ACF staff, GIs with beneficiaries, DR of project quarterly, bi-annual reports. Each method will be triangulated against the others to validate findings.
Efficiency	1.	Were the number of staff, the time invested and the overall resources allocated for each facility efficiently invested given the results achieved?	KIIs with ACF staff, national and local government leaders, Free listing with trainees, DR of Budget, records of interventions such as gardens, kits. Each method will be triangulated against the others to validate findings.
	2.	Were the resources invested in community nutrition activities (MSGs) efficient given the result achieved?	KIIs with ACF staff,national and local government leaders, DR of Budget, Free listing with trainees, records of training, gardens, etc. Each method will be triangulated against the others to validate findings.
Effectiveness	1.	(This program has several components including four results. The evaluator should analyze the consistency of the 4 results and their contribution to the overall goal.) Is there an added value in extending on the job coaching of health staff to other services provided at health facility level (e.g. broader package on top of IMAM like IMCI)?	KIIs with ACF staff, national and local government leaders, FGDs. GIs with health staff and volunteers, Satisfaction levels, Free listing, DR of monitoring records. Each method will be triangulated against the others to validate findings.
	2	Are there important challenges in community mobilization?	FGDs, KIIs with direct beneficiaries to understand role, level of participation, degree of volunteerism. Each method will be triangulated against the others to validate findings.
	3	How is ACF and its activities perceived by the community, by the health workers and by the authorities, including DHMT?	FGD/GIs, KIIs with direct beneficiaries to understand perception, satisfaction level. Each method will be triangulated against the others to validate findings.
	4	What is the level of acceptance of the program at central and district level?	FGD/GIs, KIIs with government and community staff and volunteers, DR of action and exit plan, Government strategy. Each method will be triangulated against the others to validate findings.
	5	Are the market gardening activities in the prevention of malnutrition effective towards: the means of diet diversity ensure (vegetable are produced and are really available and used for	Free listing with cookers, beneficiaries, Study of database on Women Dietary Diversity Score, DR of

		household consumption)? The cookers know how to prepare vegetables in a hygienic manner and in an edible way according to food habits? The children and Women Dietary Diversity Score prove that vegetable is part of the diet? The Knowledge Attitude and Practice of the adults towards children and pregnant and lactating women special food needs?	health facilities' records.

	6	Has the activity and indicator monitoring provided timely and useful feedback to the project implementation? Why or why not? Has the training feedback helped to adjust/improve the training quality? Why or why not? Have the outputs of the Post-distribution monitoring (PDM) helped track changes in income from vegetable sales? And on the quantity of vegetables grown, sold, exchanged and consumed by the household?	FGDs/GIs with ACF and government field staff and trainers. DR of post-distribution monitoring records, KAP. Each method will be triangulated against the others to validate findings.
	7	Is there a proper beneficiary feedback mechanism in place?	FGDs/GIs with ACF and government field staff, local leaders, DR of minutes of meetings. Each method will be triangulated against the others to validate findings.
	8	Are the cascading Mother to Mother Groups effective despite the limited support? Were the Lead Mothers of the cascaded groups effective in delivering messages during the sessions?	FGDs/GIs with Mothers and Lead mothers, DR of messages. Each method will be triangulated against the others to validate findings.
	9.	Was the ability of ACF to respond to the Ebola outbreak by adapting the programme and supporting MoHS in adapting protocols and awareness raising?	KIIs with ACF, government staff, DR of new protocols. Each method will be triangulated against the others to validate findings.
	10.	Evaluate the potential of ACF to go beyond nutrition in health facilities to embrace a broader HSS approach (basic health services)?	KIIs/GIs with ACF staff. Each method will be triangulated against the others to validate findings.
Sustainability and likelihood of Impact	1.	Does the project have a real long term likelihood of impact through the on the job coaching of health staff and community volunteers? If not why? And what should be changed?	FGDs/GIs with trainees, DR of training records. Each method will be triangulated against the others to validate findings.
	2	Does the project have a real long term likelihood of impact through the on the job coaching of the Mothers Leaders in charge of the Mother to Mother support groups in the communities? If not why? And what should be changed?	FGDs/GIs/Free listing with trainers and Leaders. Each method will be triangulated against the others to validate findings.
	3	Can ACF ensure sustainability through community mobilization activities (mother-to-mother support groups and community volunteers)?	KIIs, FGDs/GIs with ACF staff. Each method will be triangulated against the others to validate findings.
	4	What should be the steps to undertake to ensure a proper exit strategy in linking with the support of the DHMT for the treatment of malnutrition and at community level for the prevention and detection?	KIIs with government (DHMT), ACF, DR on exit strategy. Each method will be triangulated against the others to validate findings.
	5	Is there a likelihood of impact of the peer to peer methodology used by ACF to improve the level of service delivery in Health facilities?	DR of peer to peer methodology. Each method will be triangulated against the others to validate findings.
	6	What is the likelihood of impact based on the outputs of the adapted KAP survey?	DR of KAP. Each additional method used will be triangulated against the others to validate findings.
	7	What is the likelihood of impact of integrating nutrition and FS in the MSG?	KIIs with government, ACF, DR of government strategies. Each method will be triangulated against the others to validate findings.

ANNEX IX: BUDGET

IRISH AID FUNDING
Applicant Agency: Action Contre La Faim (ACF)

Project Title:
Reinforcing institutional capacity for treatment of acute malnutrition, prevention of malnutrition & national sensitization for nutrition security in western area

Sub Category	Unit	Unit Quantity	Unit cost EUR	Duration	Total Cost EUR	Year 1 Budget (1st Sep 2012 - 31st Aug 2013)	Year 2 Budget (1st Sep 2013 - 31st Aug 2014)	Year 3 Budget (1st Sep 2014 - 31st Aug 2015)	Irish Aid Contribution: Year 1 Budget (1st Mar 2013 - 28th Feb 2014)	Irish Aid Contribution: Year 2 Budget (1st Mar 2014 - 28th Feb 2015)
A. Salaries										
A1: International Staff					**467,600**	**126,000**	**196,000**	**145,600**	**170,800**	**28,000**
Nutrition Program Manager - CMAM	Person/ month	1	5,600	36	201,600	67,200	67,200	67,200	67,200	-
Head of Nutrition and Health Department	Person/ month	1	5,600	18	100,800	11,200	33,600	56,000	11,200	-
Nutrition Program Manager - Surveillance	Person/ month	1	5,600	12	67,200	11,200	56,000	-	44,800	22,400
Head of Food Security Department	Person/ month	1	5,600	3.5	19,600	19,600	-	-	19,600	
Country Director	Person/ month	1	5,600	8	44,800	-	22,400	22,400	-	-
Head of Logistics Department	Person/ month	1	5,600	6	33,600	16,800	16,800	-	28,000	5,600
A2: Consultancy Service					**25,000**	**25,000**	**-**	**-**	**25,000**	**-**
Cost of Diet Consultant	Person/ month	1	10,000	2.5	25,000	25,000	-	-	25,000	-
A3: National Staff					**318,837**	**74,682**	**110,269**	**133,886**	**79,164**	**21,887**

Head of Project CMAM	Person/ month	1	558	33	18,142	4,745	6,698	6,699	3,349	3,349
Capacity Building Nurse	Person/ month	5	434	32	70,275	18,219	26,028	26,028	12,146	-
Community Mobilizers	Person/ month	4	358	34	47,927	13,591	17,168	17,168	8,584	-
Advocacy and Communication Officer	Person/ month	1	1,065	32	34,080	8,520	12,780	12,780	6,390	-
Deputy Nutrition & Health Coordinator	Person/ month	1	1,065	24	25,560	4,260	8,520	12,780	8,520	3,195
Local consultant	Person/ month	1	1,000	3	3,000	3,000	-	-	3,000	-
Enumerators	Person/ month	8	358	2	5,723	5,723	-	-	5,723	-
Data entry	Person/ month	1	358	2	715	715	-	-	715	-
Per diem & accommodation for Cost of Diet team	Person/ day	9	18	20	3,240	3,240	-	-	3,240	-
Head of Project - Gardens for Health & Income	Person/ month	1	558	29	16,188	2,791	6,698	6,699	6,140	3,349
Field Officers	Person/ month	3	358	29	31,117	5,365	12,876	12,876	11,803	6,438
Casual labour for the programme	Person/ day	3	6	82	1,470	882	588	-	1,176	294
Casual labour (Urban Displays)	Person/ day	1	6	96	576	432	144	-	450	150
Casual labour (Demonstration Gardens)	Person/ day	1	6	100	600	450	150	-	294	-
Casual labour (Cooking demonstration)	Person/ day	1	6	49	294	-	294	-	-	1,631

Head of Finance Department	Person/ month	1	1,631	12	19,570	-	9,785	9,785	-	1,631
Administrative Support Staff	Person/ month	3	600	6.3	11,398	-	-	11,398	-	-
HR officer	Person/ month	1	434	7	3,037	-	-	3,037	-	-
Accountant	Person/ month	1	434	7	3,037	-	-	3,037	-	-
Administrator East Freetown Base	Person/ month	1	1,065	5	5,325	-	-	5,325	-	-
Driver	Person/ month	1	358	20	7,153	1,431	2,862	2,861	2,862	1,431
IT administrator	Person/ month	1	558	2	1,116	-	1,116	-	1,116	-
Logistics Support Staff	Person/ month	2	644	8	9,663	-	-	9,663	-	-
Purchaser	Person/ month	1	434	10	4,338	-	-	4,338	-	-
Logistician East Freetown Base	Person/ month	1	1,065	5	5,325	-	-	5,325	-	5,325
Medical insurance	Year	1	3,667	3	11,000	2,200	4,400	4,400	4,400	2,200
Field allowances	Year	1	500	3	1,500	-	750	750	-	-
Sub Total Salaries					**811,437**	**225,682**	**306,269**	**279,486**	**274,964**	**49,887**
B. Project costs										
B1: Support to DHMT for CMAM Activities					**115,133**	**44,278**	**35,427**	**35,428**	**10,575**	**10,575**
On the job coaching	Year	1	1,413	3	4,238	1,413	1,412	1,413	-	-
Refresher Training	Year	1	12,865	3	38,595	12,865	12,865	12,865	-	-
Training Didactic Materials	Year	1	24,100	3	72,300	30,000	21,150	21,150	10,575	10,575
B2: Strenghtening Communication and Advocacy					**54,284**	**6,809**	**29,020**	**18,455**	**3,702**	**6,809**

Institutional Film	Movie	1	11,700	1	11,700	-	11,700	-		-	-
Publication of case studies	Lumpsum	1	8,539	1	8,539	-	3,702	4,837		3,702	-
Yearly Event	Event	2	2,983	3	17,900	3,580	7,160	7,160		-	3,580
Radio discussion and jingles	Lumpsum	1	5,382	3	16,145	3,229	6,458	6,458		-	3,229
B3: Improve Nutrition Training, Surveillance and Study					**86,347**	**75,815**	**5,266**	**5,266**		**57,107**	**2,633**
Inter-University cross fertilizing visits	Year	1	3,511	3	10,532	-	5,266	5,266		2,633	2,633
Training equipment and stationnaries	Kit	1	10,671	2	21,341	21,341	-	-		-	-
B3.1: Cost of Diet					**4,474**	**4,474**	**-**	**-**		**4,474**	**-**
Training	Kit	1	252	1	252	252	-	-		252	-
Survey	Survey	2	811	1	1,622	1,622	-	-		1,622	-
Workshop for information sharing	Workhop	1	2,600	1	2,600	2,600	-	-		2,600	-
B3.2: Teenage mother care practices study					**50,000**	**50,000**	**-**	**-**		**50,000**	**-**
Study	Study	1	46,729	1	50,000	50,000	-	-		50,000	-
B4: Prevention of Malnutrition and Vegetable Garden					**46,657**	**32,577**	**12,155**	**1,925**		**32,577**	**12,155**
Training Mother to Mother support group	Year	1	4,114	3	12,343	9,257	3,086	-		9,257	3,086
IEC Tools	Year	1	5,805	3	17,415	13,061	4,354	-		13,061	4,354

B4.1: Vegetable Garden					**16,899**	**10,259**	**4,715**	**1,925**		**10,259**	**4,715**
Gardens and displays	Displays/garden	22	232	1	5,100	3,825	1,275	-		3,825	1,275
Vegetable Kits	Kit	1	6,060	1	6,060	4,545	1,515	-		4,545	1,515
Training materials	Various	1	3,779	1	3,779	1,889	945	945		1,889	945
Training Garden for Income	Various	1	1,960	1	1,960	-	980	980		-	980
B5: Monitoring and Evaluation					**32,420**	**-**	**12,000**	**20,420**		**-**	**12,000**
Food Security Mid-term evaluation	Evaluation	1	2,000	1	2,000	-	2,000	-		-	2,000
External evaluation (Mid-term & Final)	Evaluation	2	15,210	1	30,420	-	10,000	20,420		-	10,000
Sub Total Project Costs					**334,840**	**159,479**	**93,868**	**81,493**		**103,961**	**44,172**
C. Project support costs											
C1: Transportation					**204,039**	**103,684**	**51,915**	**48,440**		**59,148**	**23,311**
Nutrition Programme car rental	Car	1	1,500	33	49,500	14,515	21,825	13,160		9,000	9,000
Coordination car rental	Car	1	1,500	24	36,000	8,250	16,500	11,250		15,000	7,500
Nutrition Fuel for cars	Car	3	220	30	19,800	3,150	3,600	13,050		3,150	-
Vehicle Maintenance and repairs	Car	1	170	32	5,440	1,020	1,020	3,400		1,020	1,020
Nutrition Motorbike Purchase	Motorbike	1	5,850	1	5,850	5,850	-	-		-	-

Nutrition Motorbike Fuel, Maintenance & Repairs	Motorbike	3	87	29.5	7,665	1,537	2,564	3,564		2,437	1,664
Car Purchase	Car	1	40,600	1	40,600	40,600	-	-		-	-
Food Security Programme car rental & fuel	Car	2	1,725	1.5	5,175	5,175	-	-		5,175	-
Food Security Pick up rental (goods & material delivery)	Car	1	1,848	2	3,696	1,848	1,848	-		1,848	1,848
Food Security Motorbike Purchase	Motorbike	3	5,850	1	17,550	17,550	-	-		17,550	-
Food Security Motorbike Fuel, Maintenance & Repairs	Motorbike	4	87	29.5	10,262	1,689	4,558	4,016		3,968	2,279
Freight or customs fees	Freight	1	2,500	1	2,500	2,500	-	-		-	-
C2: Furniture for nutrition office					**965**	**965**	**-**	**-**		**-**	**-**
Furniture	Kit	1	965	1	965	965	-	-		-	-
C3: Equipment					**8,011**	**7,891**	**120**	**-**		**3,505**	**-**
Laptop	Piece	6	900	1	5,400	5,400	-	-		1,800	-
Projector	Piece	1	585	1	585	585	-	-		585	-
Projector Screen	Piece	1	906	1	906	906	-	-		-	-
Cellphones	Piece	3	40	1	120	-	120	-		120	-
Printer	Piece	1	1,000	1	1,000	1,000	-	-		1,000	-

C4: Monthly communication					**4,571**	**965**	**1,803**	**1,803**	**660**	**902**
Nutrition Communication cost	Month	1	88	32	2,831	665	1,083	1,083	-	542
Food Security Communication cost	Month	1	60	29	1,740	300	720	720	660	360
C5: Visibility					**3,322**	**1,287**	**1,055**	**980**	**-**	**1,055**
Visibility	Kit	3	1,107	1	3,322	1,287	1,055	980	-	1,055
C6: Office running costs					**66,811**	**21,894**	**28,488**	**16,426**	**35,883**	**13,299**
Rental & Charges Coordination office	Month	1	1,275	1	1,275	1,275	-	-	1,275	-
Rental & Charges East Freetown Operational office	Month	1	1,900	12	22,800	7,600	11,600	3,600	13,600	9,200
Rehabilitation East Freetown Operational office	Lumpsum	1	8,760	1	8,760	3,440	1,720	3,600	5,160	-
Stationnary Coordination & Operational office	Month	1	600	12	7,200	1,800	1,800	3,600	-	-
Internet East Freetown Operational office	Month	1	774	15	11,610	4,644	6,966	-	9,288	2,322
Fuel & Maintenance Generator East Freetown Office	Month	1	435	15	6,525	1,935	2,370	2,220	3,360	945
Bank fees	Month	1		30				2,772	2,400	-

			204		6,107	1,200	2,400			
General administrative fees (mailing …)	Month	12	211	1	2,532	-	1,632	634	800	832
Sub Total Project Support Costs					**287,718**	**136,686**	**83,381**	**67,649**	**99,196**	**38,567**
D. Head office										
Indirect costs					100,380	36,529	33,846	30,004	33,468	9,284
Sub Total Head Office					**100,380**	**36,529**	**33,846**	**30,004**	**33,468**	**9,284**
TOTAL BUDGET					**1,534,374**	**558,376**	**517,365**	**458,633**	**511,589**	**141,911**

Other Donors Contribution (1st Sep 2012 - 31st Aug 2015)	**880,874**	206,764	219,061	455,049
Irish Aid Contribution (1st Mar 2013 - 28th Feb 2015)	**653,500**		511,589	141,911

Source: Project Revised Proposal

ANNEX X: PROJECT BENEFICIARIES

PROJECT BENEFICIARIES (Source: Revised Project Proposal)	
Direct beneficiaries	**Total: 2644 people**
174 DHMT staffs	50 members of the management team and 124 Health staff (CHO/SECHN/Nursing Aides) in Western Freetown. They will be trained and will receive supportive supervision for CMAM protocol application.
5 high level people from Government	5 person from Central Nutrition office at MoHS are supported in Nutrition Surveillance
65 women and 65 men as community volunteers	130 community health volunteers or representative of civil society will be identified with stakeholders to represent the community and will receive training for detection and referral of acutely malnourished children
260 Lead mothers	260 mothers will be identified in the community in the area of health facilities and receive training on IYCF, vegetable gardening and will receive kits.
1,000 mothers from M2M support groups	1,000 mothers from Mother to Mother support groups will receive training on vegetables garden and kits.
1,000 carers	1,000 mothers of severely and moderate malnourished children admitted in Stabilization Centre (SC), OTPs or referred to SFPs will receive training on vegetables garden and kits
80 EVD affected individuals	80 individuals directly or indirectly affected by EVD will receive nutritional counselling visits at community level (EVD survivors, children separated or orphans, children whose mother survived but had to stop breastfeeding…)
Indirect beneficiaries	**Total: 19 300 people**
4,200 children under 5 years	Children under 5 years suffering from severe acute malnutrition are admitted in OTP or SC
At least 2600 pregnant and lactating women	2600 pregnant and lactating will receive IYCF counselling through the mother to mother support groups
12,500 people in the area of intervention	Family of 2,300 women, Community Volunteers and carers will benefit indirectly from vegetables garden kits and trainings

ANNEX XI: AUGUST 2015 MONTHLY FOLLOW-UP OF ACTIVITIES

Extracted from ACF Nutrition and Health, LFA - activities follow-up monthly report, August 2015					
Results (LFA)	**Activity (LFA)**	**Goal (number)**	**Total achievement to date**	**% of achievement to date**	**sub-activities indicators**
Institutional capacity building – technical and management – for prevention and treatment of acute malnutrition, as per national CMAM program, in Sierra Leone western area	**Capacity building of health staff and community screeners on CMAM as per the national protocol**	**26**	**26**	**100%**	PHU assessment
		2	**2**	**100%**	SC assessment
		28	**28**	**100%**	PHU / SC assessment
		254	**371**	**146%**	Total trained (Initial/Refresher)
		15	**30**	**200%**	Members of management team
		124	**150**	**121%**	Health staff receiving initial/refresher trainings
		130	**191**	**147%**	Community screeners trained
		5	**0**	**0%**	people in national program
		10	**0**	**0%**	lecturers of medical university
			352		No of NEW Health staff /CHW receiving on the job coaching
	SC Activity	**2**	**2**	**100%**	Nb SC
		1	**2**	**200%**	Nb SC providing report
			1,196		Number of admission
			1,138		N discharged children
			991		N discharged "stabilised" children
			89		N discharged dead children
			58		N discharged defaulter children
			0		Ndischarged Non recovered children
			17		N discharged others (D)
		75%	**87.08%**	**116%**	*Stabilised rate*
		10%	**7.82%**	**78%**	*Death rate*

		15%	**5.10%**	**34%**	*Defaulter rate*
	OTP Activity	**26**	**26**	**100%**	Nb OTP
			20		Nb OTP providing report
		2,400	**2,378**	**99%**	Number of admission
			2,294		N discharged children (A+B+C+D)
		1,800	**1,945**	**108%**	N discharged cured children (A)
		240	**31**	**13%**	N discharged dead children (B)
		360	**297**	**83%**	N discharged defaulter children (C)
			12		N discharged Non recovered children (D)
			80		N discharged others
		75%	**85.12%**	**113%**	*Cured rate*
		10%	**1.36%**	**14%**	*Death rate*
		15%	**13.00%**	**87%**	*Defaulter rate*
			0.53%		*Non recovered rate*
	Detection and Referral Activities				Total number of children under 5 in the area of intervention
			50,478		Number of children screened per month
					Number of children screened per quarter
		80%	**156%**		Percentage of children screened in the community ~~per quarter~~
			7,164		Number of children refered to health facilities
			6,141		Number of children who arrived at the health facilities
			4,223		Number of children admitted in the programme
					% of children referred who arrived
					% of children arrived at PHU who are admitted
			59%		% of children referred who are admitted (good referral)
	Reinforce positive mother/child care practices and closely follow pregnant and lactating women, and	**260**	**210**	**81%**	Number of IYCF Mother to mother support group launch
		2,600	**2,700**	**104%**	Number of women involved in IYCF mother to mother support group
		260	**270**	**104%**	Number of lead mothers trained

	mothers and children at risk for malnutrition		**0**		Mother with improved knowledge on IYCF
	The DHMT have the capacity to manage and coordinate the nutrition program and activities in the district		**13**		Number of Joint monitoring (ACF - DHMT)
			10		Coordination meetings (quarterly)

Source: August 2015 APR monthly report submitted to grants coordinator

ANNEX XII: Types of Learning Opportunities (Extracted from UNISA)

TYPES OF LEARNING OPPORTUNITIES

Learning Intervention	Description	Target Development	Success Factors	Benefits
Formal Training	Classroom based or online training courses, workshops and seminars that are targeted toward specific staff groups or capability development areas. Can be delivered by internal or external trainers or providers, and includes attendance at the University's staff development programs.	• Functional or role-specific knowledge • Management and leadership development • 'Soft' skill development e.g. specific communication skills	• Identifying the appropriate staff capability gap and clarity about what is to be developed • Matching to appropriate training course • Ensuring full course attendance and completion of course activities • Opportunities to put learning into practice after the training and benefits are that it provides focused and targeted learning and development	• Provides focused and targeted learning and development • Can be 'just in time' instruction
On-the-job training	Training or 'just in time' instruction provided to staff by managers, supervisors and/or work colleagues. Activities align with day-to-day job tasks and responsibilities.	• Core work experience • Capability/skill development • Functional or role-specific know-how	• Identifying the appropriate staff capability gap and clarity about what is to be developed • Providing support and facilitating learning on the job	• Provides staff development without taking staff out of their role • Enables staff to learn through experience
Coaching	A collaborative relationship between a staff member and a manager or a staff member and an external professional, which enables learning	• Technical or interpersonal skills • Management or leadership	• Matching the right people as coaches • Selecting an internal or external coach • Deciding if the coaching is formal with	• Accelerates on the job development

	and development to occur, usually to enhance capability, confidence and performance in the current role, but can also facilitate career development. It is generally structured over a defined period (1 month to 1 year) and linked to specific goals.	development • Increased ability to problem solve and find creative solutions to new problems • Build professional know-how and confidence	specified learning outcomes or more informal	• Potentially provides an opportunity to work with someone outside of the organisation • Provides an opportunity for non-directive thinking and creative

ANNEX XIII: SMART SURVEY 2014

Table 1: Percentage distribution of Pregnant Women by Nutrition Status Based on MUAC cut-offs by District and National Averages, SLNNS 2014

Province	District	N	Prevalence of Acute Malnutrition (MUAC<221mm)	Prevalence of Severe Acute Malnutrition MUAC <214mm)	Prevalence of Moderate Acute Malnutrition (MUAC<221mm and MUAC>=214mm)	Percentage of PW Not Acutely Malnourished (MUAC >=221mm)
Western	Urban	1003	1.4% (0.6-2.2)	0.5% (0.1- 0.9)	0.9% (0.4- 1.4)	98.6% (97.9- 99.4)
	Slums	1213	1.7% (0.8-2.7)	0.9% (0.2-1.6)	0.8% (0.3- 1.4)	98.3% (97.3- 99.2)
	Rural	959	2.6% (1.6-3.6)	1.2% (0.6- 1.7)	1.5% (0.7- 2.2)	97.4% (96.4- 98.4)
Eastern	Kono	485	1.9% (0.7-3.0)	1.0 % (0.0-2.1)	0.8% (0.1-1.6)	98.1% (97.0- 99.3)
	Kenema	891	4.5% (2.7-6.3)	2.6% (1.3-3.8)	1.9% (0.9-2.9)	95.5% (93.7- 97.3)
Southern	Pujehun	723	3.5% (2.1-4.8)	1.8% (0.9-2.7)	1.7% (0.7-2.7)	96.5% (95.2- 97.9)
	Bo	928	2.2% (1.1-3.2)	1.0% (0.4-1.6)	1.2% (0.5- 1.9)	97.9% (96.8- 98.9)
	Moyamba	940	2.1% (1.3-2.9)	1.1% (0.4-1.7)	1.1% (0.4-1.7)	97.9% (97.1- 98.7)
Northern	Kambia	931	2.9% (1.8-4.0)	1.6% (0.8-2.4)	1.3% (0.5-2.1)	97.1% (96.0- 98.2)

	Port Loko	1062	3.1% (2.0-4.3)	1.5% (0.6-2.4)	1.6% (0.9-2.3)	96.9% (95.7- 98.1)
	Koinadugu	448	2.0% (0.7-3.4)	0.9% (0.1-1.7)	1.1% (0.0-2.3)	98.0% (96.7- 99.3)
	Tonkolili	748	3.7% (2.3-5.2)	1.9% (0.7-3.1)	1.9% (0.9-2.8)	96.3% (94.8- 97.7)
	Bombali	764	2.2% (1.2-3.3)	1.1% (0.3-1.8)	1.2% (0.4-1.9)	97.8% (96.8- 98.8)
National Average*		**11,095**	**2.6% (2.3-3.0)**	**1.3% (1.1-1.5)**	**1.3% (1.1-1.5)**	**97.4% (97.1- 97.7)**

Source: SMART SURVEY JUNE - AUGUST 2014. (Table 8.18. page 51. ***Interpretation of the results based on MUAC presented above should be taken with caution as this survey was conducted during an early stage of an Ebola outbreak in the country, where some level of systematic measurement errors in MUAC are likely to be introduced by the survey team due to biases.***

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Table 2: Infant and Young Child Feeding (IYCF) practice status indicators by district and national average, SLNNS 2014
Source: SMART 2014 (Table 8.27, page 51)

Province	District	Ever Breastfed	Colostrum Feeding	Timely Initiation of Breast Feeding	Continued Breastfeeding at 1 year	Exclusive Breast Feeding (0-5months)	Minimum Meal Frequency	Minimum Dietary Diversity
Northern	**Koinadugu**	(223)99.6% (98.7-100)	(39)88.6% (80.5-96.8)	(144)64.9%) (52.5-77.2)	(44)100% (100.0-100.0)	(23)65.7% (49.2-75.2)	(22)11.8% (6.4-17.2)	(67)35.1% (27.0-43.2)
	Bombali	(359)96.8% (98.7-100.0)	(84)92.3% (87.0-97.6)	(196)53.8% (41.1-66.6)	(60)89.6% (81.7-97.4)	(57)63.3% (53.0-72.6)	(15)5.4% (2.2-8.7)	(95)33.6% (26.3-40.8)
	Tonkolili	(233)99.6% (99.2-100.0)	(79)100.0% (100.0-100.0)	(204)58.8% (45.6-72.0)	(67)95.7% (911.3-100.0)	(49)61.3% (50.3-71.2)	(43)16.1% (4.5-27.7)	(77)28.6% (16.0-41.2)
	Kambia	(489)100.0% (100.0-100.0)	(154)93.9% (90.5-97.3)	(324)66.3% (58.7-73.8)	(80)97.6% (94.3-100.0)	(92)64.8% (56.6-72.2)	(59)17.0% (11.6-22.5)	(102)29.1% (20.9-37.4)
	PortLoko	(555)98.8% (97.6-100.0)	(132)63.8% (46.9-80.6)	(251)45.0% (34.1-55.8)	(88)93.6% (88.7-98.5)	(62)47.7% (39.3-56.2)	(61)14.4% (7.9-21.0)	(199)46.5% (36.4-56.6)
Eastern	**Kono**	(248)98.8% (97.5-100.0)	(65)89.0% (81.2-96.9)	(134)54.3% (44.6-63.9)	(35)97.2% (94.4-100.0)	(38)56.7% (44.8-67.9)	(37)20.0% (13.3-26.7)	(79)42.7% (31.0-54.4)
	Kenema	(516)98.9% (97.9-99.8)	(19)95.0% (84.9-100.0%)	(137)59.1% (47.7-70.4)	(40)88.9% (79.9-97.9)	(9)60.0% (35.8-80.2)	(54)24.9% (15.4-34.4)	(5)25.2% (16.8-33.7)
Southern	**Moyamba**	(516)98.9% (97.9-99.8)	(119)46.9% (33.6-60.1)	(278)53.9% (42.2-65.6)	(99)97.1% (93.8-100.0)	(82)68.3% (59.6-76.0)	(30)7.9% (4.3-11.5)	(110)28.4% (22.5-34.3)
	Bo	(434)99.3% (98.3-100.0)	(114)91.9% (85.8-85.1)	(283)65.8% (57.0-74.6)	(57)82.6% (74.0-91.2)	(87)68.5% (60.9-75.9)	(36)11.6% (5.0-18.2)	(97)31.2% (23.0-39.4)
	Pujehun	(363)100.0% (100.0-100.0)	(93)92.1% (85.0-99.2)	(180)49.7% (34.9-64.6)	(68)97.1% (93.9-100.0)	(56)59.0% (48.9-68.3)	(22)9.2% (5.1-13.4)	(84)34.4% (23.3-45.5)
Western	**WA Rural**	(379)98.4% (97.1-99.8)	(75)92.6% (86.8-98.4)	(179)46.7% (36.0-57.4)	(67)88.2% (80.8-95.6)	(34)43.0% (32.7-54.0)	(83)27.1% (17.2-37.1)	(113)36.9% (27.4-46.5)
	WA Urban	(329)99.7% (99.1-100.0)	(43)91.5% (84.1-99.0)	(133)40.3% (29.7-51.0)	(39)59.1% (45.5-72.7)	(23)50.0% (36.1-63.9)	(46)16.8% (10.1-23.4)	(166)59.7% (53.5-63.9)
	WA Slum	(656)99.9% (99.6-100.0)	(135)97.8% (95.5-100.0)	(379)57.7% (48.2-67.2)	(89)85.6% (77.7-93.4)	(73)52.5% (44.3-60.6)	(57)11.2% (5.3-17.1)	(198)38.4% (31.2-45.5)
National Average (N=5,173)		**(5131)99.2% (98.9-99.5)**	**(1151)80.9% (75.6-86.2)**	**(2822)54.9% (51.7-58.2)**	**(640)86.0% (83.3-88.3)**	**(685)58.8% (56.0-61.6)**	**(566)14.4% (12.4-16.4)**	**(1442)36.4% (33.7-39.0)**

ANNEX XIV: THEORY OF CHANGE

Figure 3: THEORY OF CHANGE ACF "Addressing MAM and SAM in under-fives in Western Area, Sierra Leone through Empowerment"