FINAL INDEPENDENT EVALUATION JULY 2018

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

SIERRA LEONE

FUNDED BY Irish Aid;

Agence Française de Développement

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Summary Page

Intervention Name	Reinforcing Institutional Capacity for Treatment of Acute Malnutrition, Prevention of Malnutrition and National Sensitization for Nutrition Security in Western Area District, Sierra Leone.
Contract Number	SLE.Action Against Hunger.2017.03
Partners (if applicable)	N/A
Location (country/is, region/s)	Western Area Urban (Freetown) and Western Area Rural districts
Duration	2 years (+ 2 months extension)
Starting Date	1st June 2016
Ending Date	31st July 2018 (the project has been extended to 31/7/2018 through a No Cost Extension)
Intervention/ Country Office Language	English
Donor and Contribution/s	Irish Aid: € 1,466,942 AFD: € 389,974
Country Office administering the Intervention	Action Against Hunger Sierra Leone
Responsible Action Against Hunger HQ	ACF France
Evaluation Type	External evaluation
Evaluation Dates	30 May – 12 July

This report was commissioned by Action Against Hunger International. The comments contained herein reflect the opinions of the evaluator only.

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List of Acronyms

AFD	Agence Française de Développement - French Development Agency
BA	Barrier Analysis
BCC	Behavior Change Communication
CBN	Capacity Building Nurses
CHWs	Community Health Workers
CM	Community Mobilizers
CMBS,	Code of Marketing for Breast milk Substitutes
DAC	Development Assistance Committee
DAO	District Agriculture Office
DBC	Designing Behavior Change
DFN	Directorate of Food and Nutrition
DHMT	District Health Management Team
ELA	Evaluation, Learning and Accountability
EVD	Ebola Virus Diseases
EWS	Early Warning System
FANSI-SL	Food and Nutrition Security Initiative – Sierra Leone
FCS	Food Consumption Score
FGD	Focus Group Discussion
FM	Field Monitors
FMC	Facility Management Committee
FSG	Father Support Group
FSL	Food Security
HMIS	Health Management Information Systems
HoD	Head of Department
HoP	Head of Project
IASC	Inter-Agency Standing Committee
IGA.	income generating activity
IMAM	Integrated Management of Acute Malnutrition
IPF	In-Patients Facility
IYCF	Infant and Young Child Feeding
KAP	Knowledge Attitude and Practice
KII	Key Informant Interviews
LF	Lead Father
LM	Lead Mother
MAFFS.	Ministry of Agriculture Forestry and Food Security
MoHS	Ministry of Health and Sanitation
MSG	Mother Support Group
MUAC	Mid-Upper Arm Circumference
NaSCA	National Committee on Social Action
NID	National Immunization Day
NNS	National Nutrition Survey
OTP	Outpatient Therapeutic Program
PDM.	Post-distribution monitoring
PHU	Peripheral Health Unit
PWLM	Pregnant Women and Lactating Mother
RUTF	Ready-to-use Therapeutic Food
SAM	Severe Acute Malnutrition
SLA	Service Level Agreement
SUN	Scale-up Nutrition
SUNI-CSP	Scale-up Nutrition and Immunization Civil Society Platform
TBA	Traditional Birth Attendant
VSLA	Village Savings and Loan Association

Executive Summary

This two year project “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” which is the continuation of the project Action Against Hunger was implemented during 2013 - 2015 in Western Area of Sierra Leone, with the aim of strengthening the capacities of the MoHS at local and national level to ensure quality implementation of the Integrated Management of Acute Malnutrition (IMAM), with funding support of Irish Aid and Agence Francaise de Development (AFD)

A final evaluation was conducted from May 30 to July 30, 2018 for Action Against Hunger and Irish Aid, the most direct users, as well as other wide-ranging indirect users. The purpose of the evaluation was to assess the overall performance of the project and determine if the intervention has reached its intended outputs and objectives. It focused on the entire project for the entire project period and covered all geographical areas and all selected target groups of beneficiaries; in the Western Urban and Western Rural districts of Western region.

The evaluation approach followed Action Against Hunger Evaluation Policy and Guidelines and adhered to the Development Assistance Committee (DAC) criteria for evaluating its programmes and projects. The evaluation used qualitative methodologies such as Key Informant Interviews (KII) with project staff and stakeholders at national and district levels and Focus Group Discussion (FGD) with mother support groups and father support groups for primary data collection. Besides, desk review and secondary data analysis were also performed using available data such as project reports/records and beneficiary database. Major limitations of the evaluation included delayed availability of the endline survey report, suspension of interviews on the Eid holiday and unavailability of a few intended interviewees at district level.

Evaluation Findings

Designs: Needs were assessed but without gender analysis. More efforts were made than before to take into account gender in the project design as illustrated by Father Support Group (FSG). There were several indicators that Action Against Hunger staff found difficult to report against. The exit strategy discussion was still not matured and need to be further detailed. The project applied very solid M&E systems. Apart from men’s participation, some other recommendations were not considered in the project. Barrier Analysis was conducted but the results were not integrated into the project BCC strategy.

Relevance/Appropriateness: The project designs were based on understanding of the local context and aligned and contribute to the national policies and strategies of nutrition. Training methods were all considered relevant in terms of local practice and culture. Several needs assessments were conducted before the implementation of activities and the assessment results informed needs, current knowledge, experiences, skills and gaps which were useful for taking into account the beneficiary needs in the project implementation. Several considerations needed in terms of timing and contents for increased usefulness of the assessments.

Coherence: The project was designed through consultation process with key stakeholders and regular updates were shared at the coordination meetings. Delay of Service Agreement Contract caused the project starting without formal inception to stakeholders. Integration of this project with other Action Against Hunger program existed in the target area. However, there has been very limited integration with WASH projects. The project was implemented with well integrated and synergetic linkages between health/nutrition, food security and advocacy. Some challenges still remained in actual integration of the activities of the health/nutrition team and food security team.

Coverage: IMAM coverage was estimated to be 51.2%, below the SPHERE standard. The current targeting of Western area was considered appropriate. But the targeted 32 Primary Health Units (PHUs) may not be the most vulnerable ones among all the others. Mother Support Group (MSG) members was still a small part of the total women and most vulnerable women in many cases may not be participating in MSG. 25% of MSG received Income Generation Activities (IGA) supports and the selection was mainly based on tvulnerability. Referrals of SAM children were practiced with improved accurately. MSG members were with or without inclusion of teen-ager pregnant women while husbands were rarely member of MSG. The selection criteria and methods of Lead Mother (LM) and MSG members were well understood by local stakeholders. On the other hand, the selection criteria and method of IGA target groups was not uniformly understood.

Efficiency: Resources were generally properly allocated with minor over or under spendings. All target health facilities were provided with adequate equipment and materials. Exception was equipment not distributed according to caseload which differed significantly between the two IPF. Cash transfer was more effective and efficient than in-kind provision. Use of service provider was effective. The project activities were delayed due to several reasons such as the new Community Health Worker (CHW) policy of Ministry of Health and Sanitation (MoHS), mudslide and procurement procedures. The current management set-up was efficient and the position of Nutrition Security Expert was considered important. Group based IGA support was considered more effective. Consideration of food security factor and inclusion a vice-leader in MSG member selection would contribute to better IGA performance. IMAM training approaches used were very participatory hence enhanced learning among the participants. Selection of participants and duration of IGA training could be improved for better training outcomes. Identification of IGA types could be improved to maximize nutrition-sensitivity while maintaining interest of members.

Effectiveness: Most of the project activities were implemented according to plan and the intended outputs were achieved. Effective linkage between CHW and LM was established and supported. Some challenges still remained in IMAM coverage, improvement of some IYCF practices and advocacy works. The project faced several negative external factors but the project team responded to them with effective and focused trainings, on-the-job coaching and communication. The project applied very solid M&E systems and resource coordination has been well organized. At national level coordination, Action Against Hunger took part in several technical coordination mechanisms and Nutrition Security Expert was seconded to DFN-MoHS. Several difficulties were experienced in monitoring and partnership agreement with FANSI-S which was completed due to capacity of the agency.

Sustainability: The project was very much based on the long-term context. Through capacity building focuses, health workers, CHW, LM and District Health Management Team (DHMT) have increased their skills and knowledge to continue their respective services and management. As compared to a good likelihood of sustaining MSG activities, sustainability of IMAM services is negatively affected by relatively poor supporting environment. Financial sustainability of Harmonized Framework is questionable.

Impact: Likely positive impact of IGA included 1) increased Food Consumption Score (FCS) among the beneficiaries, 2) perceived sense of empowerment, improved health and better breast milk among mothers, 3) increased passion among the MSG members for their activities. IGA could also give some negative impacts. Other impacts included positive change of some IYCF and maternal nutrition practices among MSG members and improved access to quality OTP/IPF services. Challenges still remained in complementary feeding practices. Those likely impacts were not yet translated into change of nutritional status. Some testimonies indicated FSG's contribution to activities related to nutrition and food security. Largest contribution of the project for SUN and SUNI-CSP was Budget Tracking Analysis

Conclusions

The project achieved scores indicated very positive results especially for Relevance/ Appropriateness and Effectiveness, which were rated as “Exceptional” as the performances consistently met expectations due to high quality of work. The project was based on the understanding of the local context and aligned with and contribute to the national policy while most of the project activities were implemented according to plan and outputs were achieved. For the evaluation criteria of Design, Coherence, Efficiency and Sustainability and Likelihood of Impact, the project scored “Meets expectations” in that the performance consistently met expectations. The project was designed with careful needs assessment and took into account gender role of men and implemented with well integrated linkages between health/nutrition, food security and advocacy. Sustainability was enhanced though the focuses on capacity building. Likely impact of the project included improved food consumption scores among income generation activities participants, positive change of some IYCF and maternal nutrition practices among MSG members and improved access to quality OTP/IPF services. Finally, IMAM coverage was estimated to be 51.2%, below the SPHERE standard although data was not available to confirm the latest coverage.

Lessons Learnt and Good Practices

The lessons learnt from the project were; 1) continuous capacity support for accessible and quality OTP/IPF service increase the confidence of caregivers in the program; 2) prevention focus needs Behaviour Change Communication (BCC) strategy with clear target audience and population-based M&E strategy; 3) systematic evaluation of the capacity linked with IMAM is necessary for exit strategy; 4) rigorous design of impact assessment is needed for operation research of multi-sector approach. Good practices are; a) supporting effective linkage between CHW and LM for community mobilization structures helps improving health seeking behaviours; b) MSG with adequate technical and financial support for income generation enhances the potential for functionality of their activities, and c) Nutrition Budget Tracking can contribute to government’s accountability and commitments for financing for nutrition:

Recommendations

The following recommendations are made, based on the Findings and the Conclusions of the evaluation.

Short-term recommendations:

1) Promote integration of health/nutrition and food security within Action Against Hunger teams through joint training, monitoring and review workshop.
2) Respective Head of Department (HoD) and expert, in consultation with HQ, revise the design and tools of baseline and end-line surveys.
3) Health/Nutrition HoD, Expert and the team assess training and capacity support needs of IMAM at DHMT.
4) Action Against Hunger-SL teams, in consultation with HQ and potentially with support of external consultant or positioning of a dedicated person to focus on BC at mission level, develop BCC strategy using the BA recommendations.
5) Action Against Hunger and DHMT review caseload of IPF and apply necessary resource re-allocation between the two facilities.
6) Respective HoD and expert review indicators of LFA based on feasibility, relevance

Medium-term recommendations

7) Action Against Hunger Health and Nutrition team discuss and design non-material incentive for MSG.

8) Exit strategy is further detailed and elaborated by Action Against Hunger-SL mission in consultation with key stakeholders..

9) TOR of the secondment to DFN-MoHS is reviewed by Health and Nutrition HoD, in consultation with MoHS as well as HQ

10) Action Against Hunger food security HoD and the team develop a list of IGA based on market analysis with consideration of DO NO HARM principle for nutrition-sensitivity.

11) Health and Nutrition HoD, expert in consultation with DHMT and MoHS, review IMAM protocol for response procedures in case of RUTF shortage.

12) Increase the level of working with CSOs partners to strengthen their capacity for increase impact and sustainability of advocacy strides made.

Long-term recommendations

13) Consider integration of WASH through WASH support for selected PHU.

The next sections of the report elaborate the points listed in the Executive Summary.

1. Background Information

The health status of Sierra Leoneans is still amongst the poorest in the world. As of 2015, Sierra Leone ranks fifth for under-five mortality rate (119 deaths/1000 live births), and the worst for maternal mortality (1,360 deaths/100,000 live births). Overall, from 2010 to 2014, stunting and wasting rates improved. Stunting among children under-five decreased from 34.1% to 28.8%. During the same period, wasting among children under-five decreased from 6.9% to 4.7%. The 2017 findings indicate a plateau and no significant improvement from 2014 results; stunting at 31% and wasting 5.1%. 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 were the main contributing factor to malnutrition. Exclusive breastfeeding of infants <6 months old has been improving but still stood at 62% in 2017. There also remained also disparities in nutrition with respect to complementary feeding. With respect to feeding for infants and children - In 2017, only 44% and 30% of children in Sierra Leone received adequate number and diversity of feeding respectively. Additional efforts were needed to build on this progress towards scaling up nutrition and to reach the N4G targets by 2020.

This project was the continuation of the project Action Against Hunger implemented from September 2013 to October 2015 in Western Area. The areas of interventions were chosen along with representatives of the Ministry of Health and Sanitation (MoHS), Ministry of Agriculture Forestry and Food Security (MAFFS). The specific objective of the project was to reinforce institutional capacity for quality treatment of acute malnutrition, improve preventive strategies and to raise national awareness on nutritional security in the communities. The aim of the project was to strengthen the capacities of the MoHS at local and national level to ensure quality implementation of the Integrated Management of Acute Malnutrition (IMAM) protocol following its national revision in 2014.

As per phase I, this project was part of a larger regional intervention in West Africa, co financed by Agence Française de Développement - French Development Agency (AFD) which concerned 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 was to contribute to the improvement of maternal and child nutrition in West Africa. Through this intervention Action Against Hunger aimed to improve the nutritional status of children under-five and Pregnant Women and Lactating Mothers (PWLM) by intervening to strengthen the health system, at community and health facility level, and by implementing preventive approaches tackling the direct causes of undernutrition.

Whilst this intervention represents the second phase of a project co-funded by Irish Aid, implemented in the period 2013-2015 in Western Area, which had proven to be effective in improving the nutritional knowledge and status of the targeted communities, it also took in consideration the recommendations highlighted in the external evaluation conducted in September 2015, and the needs expressed by stakeholders and the communities.

The specific objectives of the project were:

1. Improving the nutritional status of children under-five and PWLW through the integration of nutrition in a strengthened health system and in preventive approaches to the direct causes of undernutrition;
2. Mobilizing contributing sectors to address the underlying causes of under nutrition in a holistic, integrated and sustainable way;
3. Enabling political, social and sectorial environment is created for the scaling-up of the fight against acute malnutrition based on the experiences of Action Against Hunger and civil society in Sierra Leone

Under the specific objective-1, technical supports were provided to Directorate of Food and Nutrition (DFN) within MoHS at national and district level and the health staff in Peripheral Health Unit (PHUs) and Hospitals in the implementation of the IMAM protocol. District Health Management Team (DHMT) was also supported for strengthened coordination. Community Health Workers (CHWs) were trained and provided with the tools to conduct community activities while Mother Support Groups (MSGs) were trained and supported to promote IYCF practices and monitoring nutritional status of the children. Community health clubs and Father Support Groups (FSGs) were also supported with specific behaviour change approaches. SQUEAC, Knowledge Attitude and Practice (KAP) surveys and Barrier Analysis (BA) were conducted to assess IMAM coverage and understand deeper the reasons for undernutrition. Cooking demonstrations were organized at PHU level targeting pregnant women and mothers of children under two. Ad hoc secondment of an international nutrition expert was provided to the DFN. The DFN was directly involved in joint supervision visits at the implementation sites.

Under the specific objective-2, technical support was provided for inclusion of nutrition indicators in early warning systems and food security situation analysis. At community level, community groups (MSG/FSG) were supported to prevent malnutrition through vegetable production and to improve their livelihoods through income generating activities (IGAs). Village Savings and Loan Association (VSLA) groups were also established and provided with equipment and training. Photo-based counselling cards for MIYCF counselling are planned to be developed.

Under the specific objective-3, advocacy works were conducted at national level for better integration of nutrition in the strengthened health systems through supports for media campaigns, the endorsement of the Code of Marketing for Breast milk Substitutes (CMBS), budget tracking, production of case stories, and analysis of policy documents. Civil society's role is facilitated in national policy influencing processes, conducted awareness raising activities and high level events with the local civil society.

2. Evaluation Background

This evaluation was conducted as an exercise of accountability towards the donor and the beneficiaries. It is also expected to contribute to better understand the strengths and weaknesses of the intervention, drawing lessons learnt and making operational and strategic recommendations that can be used to improve the implementation of a potential next phase or similar interventions in the future. While the most immediate user of the evaluation will be Action Against Hunger (Head quarters, SL Country Teams) and Irish Aid, indirect users are wide-ranging including Action Against Hunger's International Network, relevant ministries and government in Sierra Leone, donors, partner organizations, UN agencies, Global Clusters and NGOs.

The overall purpose of the evaluation is to assess the overall performance of the project and to determine if the intervention has reached its intended outputs and objectives. In particular, it will assess to what extent (and the reasons why) the project's outputs have contributed to the improvements in the nutritional security of children and mothers in Western Areas.

The specific objectives of the evaluation are:

- To assess whether the design of the project is based on beneficiaries needs (sex and age disaggregated), recommendations from previous projects and studies, has a sustainability strategy and allows for Results-Based Monitoring
- To assess whether the project is relevant and appropriate given the local context, culture and needs of the population
- To assess whether the project is aligned with other interventions by Action Against Hunger

and with interventions by other actors and to what extent the different technical sectors were integrated in this project

- To assess whether the project was able to reach the most vulnerable groups
- How efficient was the use of resources in achieving the project objectives?
- To assess to what extent the project objectives were achieved and what was the quality of the achievements?
- To assess the sustainability of the project interventions
- To assess the impact of the project

The evaluation focused on the entire project funded by Irish Aid and AFD for the entire project period (1/6/2016 - 31/5/2018 [1]). It covered all geographical areas and all selected target groups of beneficiaries; in the Western Urban and Western Rural districts of Western region, Sierra Leone, these were 5,532 target beneficiaries (government health workers, CHWs, Lead Mothers (LMs) and MSG/FSG. The indirect beneficiaries were 1,517,194 persons, including children under five years, pregnant and lactating women and the communities. It also looked at different levels of the intervention (community level, district level, and national level) and at the links between those levels and cover. It examined the implementation of all activities and the degree of achievement of all outputs and objectives and included a gender analysis, explored the differences in vulnerabilities between men, women, boys and girls, how the project addressed these gender equalities and how a new project can improve on this. Furthermore, the evaluation assessed any potential negative consequences of the project on the gender equality situation.

The overall design of the evaluation is to look at those who participated in the project and assess changes over time before and after the project without including any comparison with units (people, communities, etc.) that did not participate in the intervention. The evaluation approach follows Action Against Hunger Evaluation Policy and Guidelines and adheres to the Development Assistance Committee (DAC) criteria for evaluating its programmes and projects. In addition, Action Against Hunger applies “Design” criteria: Hence, the applied criteria are Relevance/Appropriateness, Coherence, Coverage, Efficiency, Effectiveness, Sustainability and Likelihood of Impact. The pre-designed evaluation questions included in TOR and the criteria guides key information to be gathered and data source / means of data collection which is summarized in the evaluation matrix (**annex**). For each of the main evaluation questions, several sub-questions were formulated to be asked to different data source to ensure triangulation. In particular, theory of change associated with the Mother Support Groups was critically reviewed in order to frame appropriate questions to test the assumption. The Inter-Agency Standing Committee (IASC) Gender marker scoring was applied to the project design in the selection of beneficiaries and activities and is discussed in the findings for ‘Design’ and ‘Coverage’. The external and independent consultant was recruited to conduct a final independent evaluation between 30 May 2018 and 12 July 2018. The assignment is for approximately 29 work days during that period including 21 days in Sierra Leone.

3. Methodology

Qualitative methodologies such as Key Informant Interviews (KII) and Focus Group Discussion (FGD) were used for primary data collection for the evaluation. At the same time, secondary data analysis was performed using available data such as project records and beneficiary database. All collected data were triangulated to ensure validity of conclusions. Qualitative information was compared and as well as complementing quantitative analyses. Efforts were made to ensure collecting sex and age disaggregated data when possible. Data tools were developed by the consultant for review and

[1] Although the project has been extended to 31/7/2018 through a No Cost Extension, most of the project field activities have been already completed

necessary revisions and modifications by Action Against Hunger Sierra Leone Team and Evaluation, Learning and Accountability (ELA) Team in UK.

- **Desk review**: Review of project materials, including the project documents and proposals, progress reports, outputs of the project (such as publications, communication materials, case stories, etc.), results of any internal planning process and relevant materials from secondary sources which include government policy and strategy documents, Action Against Hunger program policies, survey reports, related technical protocol and literatures.
- **Interview with ACF staff:** Key individuals of Action Against Hunger Sierra Leone mission and project staff (expatriate/national project staff), were interviewed to collect necessary information. Also, any additional project records and data were collected for review and analysis. Aside from the questions for evaluation grid, focus was also put on the implementation process of project activities, role performed by different stakeholders, perceived challenges and constraints as well as appreciated strengths of the project.
- **Interview with project stakeholders at national and district levels:** A proposed list of key stakeholders and main questions to be asked were shared with Action Against Hunger mission before departure to help making relevant appointments in time. Main stakeholders interviewed included DHMT, MoHS, MAFFS, District Agriculture Office (DAO) and donors.
- **Interviews with project participants**: Field visit was organized to carry out 1) KII with PHU staff, CHW, LM, Lead Father (LF) and Facility Management Committee (FMC) members, and 2) FGD with MSG and FSG members. Both used interview guides prepared before the field visit. Selection criteria and method of selection of FGD participants were determined based on document review and discussion with Action Against Hunger staff.
- **Observation**: Project related activities such as Outpatient Therapeutic Program (OTP), In-Patients Facility (IPF), gardens, etc and facilities were observed.

Sampling: Given the timeframe for the evaluation and requirement of diverse information to be collected, it was not possible to exhaustively visit all programme areas; therefore, it was necessary to take a sampling of locations. A random sampling of 12 (38%) of the PHUs in the programme was conducted. Distance and direction and the day for OTP were considered in formulating day-to-day visit schedule. Interviews with health workers were conducted at the PHU while mothers were interviewed mainly at community. Observation and focus group discussion were conducted at communities where MSG/FSG are engaging in income generation activities.

Data collection and analysis: Action Against Hunger and local staff supported appointment and arrangement of the interviews. A translator accompanied the consultant during the field visits, for translating Krio/English during interviews. All the interview notes were taken and kept as backup. The gathered data was analyzed using EXCEL and summarized according to the evaluation grid to answers each of the evaluation questions. The rating was carried out based on the summary table. Lessons learnt and good practices were identified and described following the pre-specified format.

Stakeholder workshop: Preliminary findings were shared for discussion at a half-day workshop to gather feedback on the findings and build consensus on recommendations.

Limitations: At the time of document review, endline survey reports were not yet available for review. Since the reports were made available around the end of the evaluation, sufficient time could not be spent for detail analysis. Also, interviews planned on June 15 could not be done due to Eid holiday. Therefore, those interviews planned on the day were shifted to other days. Due to engagement with other works, some of the intended interviewees (such as District Medical Officers and District Agriculture Officer) were not available.

4. Evaluation Findings

4.1 Findings on Design

Are beneficiaries needs (by sex and age) well identified and in which way? Nutritional needs of beneficiaries were identified based on secondary data, namely the National Nutrition Survey (NNS) 2014. The NNS included age and sex disaggregated data. Other direct beneficiaries were lead mothers and MSG members whose needs were identified by KAP survey at baseline. However, review of the KAP survey found the results did not identify age-specific needs such as those of teen-age mothers. Community volunteers were newly selected in 2017 according to the MoHS guideline. The database of CHW indicated the sex ration of CHW of almost 50% male and 50% female. Similar to MSG, CHW needs were assessed by KAP survey without analysis by sex and age. Overall, gender analysis was not carried out before designing the project.

Is gender properly taken into account in the project design? The project activities were directed at service delivery to meet the health and nutrition needs of pregnant, lactating women and their children under five. Review of the project records (OTP database) and reports (APR) found the project collected data of coverage and access to IMAM services as well as participation of other beneficiaries (MSG, FSG, CHW and FMC members) disaggregated by sex. Following the lessons learnt from of the previous phase project, the project made more efforts than the previous phase to take into account gender in the project design. Considering men's role at households which influence care practice especially related to food purchase and supports for child care when mothers are busy, FSG was included in addition to MSG and counselling cards were designed for the role of husbands and gender. Also, men's participation was encouraged in stakeholder meeting. However, the FSG still remained at small scale (20 groups in total), participation of the group members and other male members of the community in child care need to be critically examined.

Are project objectives and indicators SMART? Are sources of verification realistic? Indicator of the project specific objectives was "Reduction in the prevalence of severe acute malnutrition in the area of intervention". Since nutritional status of the project area was not measured at baseline and endline surveys, secondary data such as NNS and Health Management Information Systems (HMIS) were the main data source for this indicator. Although NNS provided district specific average prevalence of malnutrition among children under five, it included areas not covered by the project. Only the number of new admissions from HMIS was the proxy indicator for the prevalence of malnutrition, of which data, however, fluctuates seasonally. Therefore, it was challenge to assess this indicator.

According to Action Against Hunger staff interviews, there were several indicators that Action Against Hunger staff found difficult to report against. For example, the indicator of Result-1.2, "80% of children U5 screened quarterly in the communities of intervention" needed clearer definition of the denominator and timeframe. One of the indicators for Result1.3, "3% reduction in the defaulter rate of the IMAM program" did not match the activities. Also, relevance of the indicator of the specific objective-3, "Determinants of nutritional vulnerability are well understood and taken into account at national level analysis" was questioned as it mainly represented the achievement of Result-2.1 while linkage with other results was not clear.

Is the design of the exit strategy realistic? The project proposal included the description "an exit strategy promoting government and community ownership will be developed and used at the end of the project". However, the exit strategy discussion was postponed to the Lesson Learnt Workshop which was conducted during the time of this evaluation. Some of the key discussions around the exit strategy included 1) increasing focus on prevention at community level (so that workload and supply needs of IMAM is reduced in the long run) 2) shift of focus from direct support at PHU to support to

DHMT with integration of nutrition into other health services and 3) experience sharing across community groups (networking and institutionalization). Obviously, the discussion was still not matured and need to be further detailed. Advocacy efforts at national and district levels for integration of nutrition into health services would make contribution to for the exit strategy.

Is there a good design of the M&E system in place? The project applied very solid M&E systems including regular monitoring by Action Against Hunger staff and joint monitoring. From reviewing the progress reports, it was found that the monitoring by the Action Against Hunger used various tools for monitoring such as APR , KAP surveys, Baseline /Endline surveys, SQUEAC, Pre- and Post-training test, training feedback, price monitoring system and Post-distribution monitoring (PDM).

Were the recommendations from the external evaluation of Phase 1 of the project taken into account? The project design included new components which were designed based on the recommendations of from the external evaluation of Phase 1 of the project. Firstly, the project started FSG and men's participation was promoted in stakeholder meeting and media programs. Those were based on the recommendations "*to actively target men to increase their participation in food and nutrition security activities*. *The men …also be on radio programs*". Another recommendation was "*conducting a gender analysis to identify the different roles of men and women*". For this, gender analysis was not carried out; however, information collected from the Barrier Analysis helped understanding a part of the issues. Also, IGA for mothers and their families was derived from the recommendation. With regard to the recommendation of "expanding the project coverage to some of the remaining PHUs in Western Area", the number of PHUs under the project was scaled-up from 26 to 32. Other recommendations such as considering feasibility of indicators were not well considered in the project.

Were the recommendations from the barrier analysis taken into account? Barrier Analysis was conducted in February 2017 focusing on six behaviours to provide evidence and increased understanding of the main obstacles and enablers of health, nutrition and food security practices based on mothers and caregivers' perceptions about these behaviours. Target behaviours were1) exclusive breastfeeding, 2) timely introduction of complementary food, 3) health seeking behaviours by mothers/caregivers for sick child, 4) feeding diversity for children, 5) meal variety for women, and 6) hand washing. The key findings of the BA indicated the importance of (adult) family members and neighbours who were supportive for mother in her work/chores. Inspired by the study, the team designed posters showing several images of the importance of husband and family support. The printing was delayed and not yet printed (waiting for validation) as it was not initially budgeted. Besides, however, recommendations of BA study have not been integrated into the design for behaviour change communication activities.

4.2 Findings on Relevance/Appropriateness

Were the actions undertaken relevant and appropriate given the local context and needs of the target population? Since this project was continuation of the previous phase (2012 - 2015), it has been almost 6 years from the beginning. Hence, the project designs were based on understanding of the local context gained from the previous phase of the project. Nutritional needs and policy contexts were also well taken into consideration. NNS 2017 results indicated high prevalence of malnutrition. In Western area, it has even worsened recently. According to DFN-MoHS and DHMT, the project was aligned and contributed to the national policies and strategies of nutrition particularly in the area of 1) support transport of Ready-to-use Therapeutic Food (RUTF) from district to PHU, 2) community-based activities for prevention and 3) training and capacity building of health workers.

Was the assistance relevant and appropriate in relation to the practices / culture of the target population? Interviewed health workers, CHW and LM appreciated usefulness and effectiveness of

the training provided by the project. The training used participatory methods including demonstration, practice and interactive sessions, accompanied by follow up after training. During FGD, MSG members mentioned that experienced matured women were respected and listened to by other women in the community. Hence, training and use of LM to support CHW in referrals and follow up were considered relevant in local practice and culture. Small business was a common practice among women in the target area. Therefore, supporting IGA for MSG was considered appropriate by community. According to suggestion by District Agriculture Office, however, some IGA of FSG such as assorted food items and fish selling may better be considered in terms of their local cultural relevance.

To what extent were the needs of beneficiaries and stakeholders take in to account in project implementation? According to review of the project document and interviews with Action Against Hunger staff, several needs assessments were conducted before implementation of activities. For the specific objective-1, PHU and IPF material need assessment at the targeted PHU/IPF which focused on measurement tools, basic equipment and necessary supplies helped identifying the equipment / material to be supported. OTP and IPF performance assessments identified the gaps in to be filled in human resources available at each facility and their level of knowledge and skills related to OTP/IPF. The assessment results informed training needs. Also, KAP survey was conducted to assess knowledge, attitudes and practices of child care, feeding, pregnancy care, hygiene among MSG members. FSL team assessed capacity and needs of the MSGs, which were targeted for IGA, on their current knowledge, experience and skills related to IGA. From the assessments, several types of IGAs were identified and selected. SQUEAC survey was carried out to estimate coverage, revealed boosters and barriers to access and withdrew several recommendations.

Those assessments were useful for taking into account the beneficiary needs in project implementation. Many interviewed health workers appreciated usefulness of the equipment. Action Against Hunger staff mentioned several considerations needed in terms of timing and contents of the equipment procurement for increased usefulness of the assessments. The PHU/IPF assessments were carried out at an early stage of the project. However, health workers and condition of the materials/supply may change constantly over time. Hence, follow up assessments would have provided further benefit. Despite the careful Food Security (FSL) assessment, some MSG changed their IGAs, namely palm oil, because of the market price change. Although market prices are often unforeseeable, this element should also be considered in the assessment. Earlier implementation of SQUEAC, which was carried out at the mid point of the project, would have benefited more. Results of the KAP survey were useful for measuring impact but not influenced much the design of key messages and communication channels. Main purpose of Barrier Analysis was to help design an effective behaviour change communication strategy, which was not been accomplished.

4.3 Findings on Coherence

Are other stakeholders informed or aware about Action Against Hunger activities/ approach/ strategy of the project? According to the project document as well as interviews with DHMT, the project was designed through consultation process with key stakeholders (key ministries, UN, NGOs, etc). DFN-MoHS recognized that the project was not designed by Action Against Hunger alone. Regular updates of the project were also shared at the coordination meeting at district and national levels. Interviews with the key stakeholders at district and national levels found most of them were informed of the project activities and wish to continue the regular updates. According to the Lessons Learnt Workshop as well as the interviews with Action Against Hunger staff, delay of Service Agreement Contract (SLA) caused the project starting without formal inception to stakeholders, which posed challenges among Action Against Hunger staff and partners during the project implementation.

How activities of this project have been integrated with other Action Against Hunger sectors/ programs in the operational area? Interviewed Action Against Hunger staff revealed there has been no other FSL projects in Western area, but integration of this project with other Action Against Hunger programs existed in the target area to certain degree. Reproductive health project had been operated in the area until recently and the team conducted CHW training. The CHWs trained by the reproductive health team worked for this project later. Six of the eight mudslide affected PHU areas were the target areas of the project. During the emergency response, health and nutrition team was called by DHMT to support screening of children and rapid assessment over almost 2 months. During the emergency operation, the health team was set up by recruiting new staff and the work was handed over to the new team. Some of the LMs were recruited as field staff by the new health team. WASH project has supported some areas in Western area. However, there has been very limited integration with WASH.

The project had three technical areas, nutrition, food security and advocacy and communication, to what extent were there synergized and integrated during implementation? From project document review and interviews with Action Against Hunger staff, it was obvious that the project was implemented with well integrated and synergetic linkages between health/nutrition, food security and advocacy. Health/nutrition and food security targeted the same beneficiaries, namely the households of pregnant women and lactating mothers in the target area, to address underlying causes of malnutrition. Evidence-based advocacy work was promoted under this project by strategically utilizing field experiences in the form of case stories and voices of beneficiaries which were utilized through workshop, media and policy revision. Nevertheless, some Action Against Hunger staff reported as remaining challenges the actual activities of health and nutrition team and food security team which were vertically managed. Interviewed MSG members who received only nutrition interventions commonly reported their interest in IGA while some of the Action Against Hunger field health and nutrition staff may not clearly understand IGA. Similarly, nutrition knowledge of food security field staff was still limited.

4.4 Findings on Coverage

Were the most affected groups covered with the limitation of the resources available? According to SQUEAC survey, IMAM coverage was estimated to be 51.2%, which was below the SPHERE standard for urban settings of 70%. One of the conclusions of the report was that prevalence of Severe Acute Malnutrition (SAM) across the districts is highly variable and localised. Those suggested the existence of several areas within the districts where number of affected children was higher than others. Therefore reforming of the current project approach was suggested as it provided similar levels of support for PHUs in high burden and low burden areas. As describe in the effectiveness section, the field visit and rapid review of the OTP database found diverse level of service performance across the PHUs. More focused allocation of resources such as supervision and on-the-job coaching on high burden and/or low performance PHU would benefit affected groups with increased coverage under the limited resources although it requires a strong follow up system.

Current number of MSG members (4,620) was still a small part of the total numbers of pregnant and lactating women in the target area. MSG members were selected by LMs in the community mainly based on their interests and willingness to participate. Therefore, most vulnerable mothers or pregnant women were in many cases may not be participating in MSG. Main assumption of MSG methodology was that members cascade the messages to other women including the most vulnerable in the community. During FGD, MSG members reported their efforts to talk to other women. However, this part of information could not be validated with other sources as KAP survey which collected data from MSG members only. Out of 462 MSG, 115 (25%) received the IGA support. The selection was

mainly based on vulnerability ranking based on group-based assessment using criteria such as food consumption, types of foods consumed and number of children.

Was the geographical coverage of the project appropriate? According to NNS in 2010, 2014 and 2017, nutritional status in Sierra Leone has not improved over the past 10 years and national average prevalence of malnutrition remained at high level. In Western area, it has even worsened recently. Therefore, the current targeting of Western area was considered appropriate in terms of food and nutrition security needs. Within the two target districts, there were a total of 128 PHUs, among which 72 PHUs were selected for OTP target based on nutritional status (high burden areas). Within the 72, Action Against Hunger project targeted 32 based on 1) responsibility sharing with other NGO (GOAL) and 2) vulnerability. In the previous project, only 26 PHUs were supported. In consideration of the recommendations from the previous project, the number of PHUs was increased to 32. Since GOAL's withdrawal from its IMAM support in the area in October 2016, their targeted PHUs have been running OTP without external supports.

Some of those PHUs previously targeted by GOAL were selected because of high burden of SAM caseload. Also, as described in the above, SQUEAC survey pointed out prevalence of SAM across the districts was highly variable and localised. Those facts implied the currently targeted 32 PHU may not be the most vulnerable among all the other PHUs in the 2 districts. The SQUEAC survey included recommendation to expand the coverage. The similar idea was also highlighted at the interview with District nutritionists.

Were beneficiaries correctly and fairly identified and targeted and to what extent were local communities involved in beneficiary identification? SAM children were identified by screening and referrals done by CHWs with the support of LMs. Some of the interviewed health workers reported that despite remaining inaccuracy of the Mid-Upper Arm Circumference (MUAC) measurement and eventual rejection at OTP, the training for CHW and LM helped referrals practiced with improved accuracy.

According to MoHS protocol for MSG, LM selection criteria includes staying in community, speaking local language, experienced in breastfeeding and child care, having willingness to help other mothers, etc. LMs in the project were selected based on the criteria by participation of community. One FMC member reported he recommended two LM. The MoHS protocol described that MSG members should include LM, CHW, Traditional Birth Attendants (TBA), male/fathers in the community, teenage pregnant women, pregnant women and lactating women. Therefore, the member should include both teenage and elders who have experience in child bearing. Members of MSG in the project were selected by LM who informed widely at community to invite interested women. Through the initial meetings, several women often defaulted from participation and those with interests remained in the groups. During the FGD with MSG members, it was found that the member selection differed across the groups. One MSG mentioned they often invited husbands. Members were with or without inclusion of teen-ager pregnant women. According to Action Against Hunger staff, IGA target groups were selected mainly by Action Against Hunger staff based on the vulnerability assessment.

How the targeting was understood or perceived by local communities? From interviews with CHW, LM and MSG members, the selection criteria and methods of LM and MSG members were well understood by them. On the other hand, the selection criteria and method of IGA target groups were not uniformly understood. Some of them understand it was random selection. It could be due to miscommunication across health/nutrition and food security teams and the lack of integration between the two teams.

Were gender and vulnerable populations with in the target community considered in Action Against Hunger's assessment/identification of the beneficiary and in the implementation of the project? It was described in the Design section.

Did the project include special components for women, if so; were these systematically designed and monitored during implementation? The entire project targets pregnant and lactating women who are the main direct beneficiaries. Therefore, the evaluation question can be answered in other parts of the report.

4.5 Findings on Efficiency

Were the resources properly allocated to reach the objectives? According to the project budget amendment, the project budget was amended several times in order to adapt changes of the plan. One of the major amendments was under-spending of staff and some activity cost due to delay of the implementation. One overspending was the cost of providing specific materials and anthropometric tools for the OTPs and IPFs. The assessment indicated poor conditions of equipment in most of the facilities which needed replacement and the needs of an increased quantity resulted in overspending in this sub-category.

How efficiently are the project implementers utilizing the project's inputs to conduct activities and achieve the project's intended results? All target health facilities (32 OTPs and 2 IPFs) were provided with anthropometric equipment such as weighing bowls and tripod stands and feeding and other materials. These were observed during the visits to PHU during this evaluation and health workers reported usefulness of those supplied equipments. According to visits to the 2 IPF facilities (Ola During hospital and 34 military hospital), caseload was very high and exceeding the capacity at Ola During while it was very low at 34 military hospital. Therefore, material support would have been more efficient if they were distributed according to the caseload (it was not the case).

How efficient is the overall management set up of the project. or, in other words, how is the suitability of management arrangements in place? At the Eastern Freetown office, Action Against Hunger teams for this project were structured for health/nutrition and food security separately but managed by Nutrition Security Expert who oversaw the two teams. For the health and nutrition team, under Nutrition Project Manager, there are three Head of Projects (HoP); one for IMAM and the other two for community mobilization. Under the HoP-IMAM, seven Capacity Bulding Nurses (CBN) were positioned and each responsible for fine to six OTP or two IPF. Under HoP-Community Mobilization, there were six Community Mobilizers (CM) and each responsible for fine or six communities. For food security team, under Food Security Project Manager, there were two Head of Projects (HoP); both for IGA, but each responsible for different areas. Under one HoP-IGA, there were five or six Field Monitors (FM), each responsible for five or six communities.

According to interviews with Action Against Hunger staff, this management set-up was efficient in ensuring intensive monitoring and supervision of IMAM, community mobilization and IGA separately. CBN visited OTP/IPF on a rotational basis to monitor and supervise the responsible facilities at least once a week. Due to OTP days of different PHU scheduled sometimes on a same day, CBN had to make prioritization. CM or FM visited five or six communities on a rotational basis so that she or he could visit one community at least once per week. Give the challenges of integrating the two sectors of health/nutrition and food security, the position of Nutrition Security Expert was considered important in ensuring the linkages of health/nutrition and food security.

Is the project being implemented in the most efficient way compared to other eventual alternatives (e.g. cash transfer, inputs purchased and distributed, training and staff)?

[Management of cash] Cash was transferred to and managed by groups instead of individuals. Some of the interviewees (Action Against Hunger and District Agriculture Office) mentioned individual management of IGA, instead of using group approach, can be more efficient in terms of an economic aspect. In fact, some FSG defaulted from IGA partly because of their interests in and familiarity with individual business approach. However, given the project purpose which was nutrition security, group

approach was considered more effective as t it helped ensure collaboration among group members and empowering them.

[Group member selection] Another concern raised during KII with Action Against Hunger staff and stakeholders was about selection of LM and members which was done mainly based on health and nutrition perspectives without taking account business interests among them. Therefore, beneficiaries' selection criteria could be balanced on both food security and health/nutrition indicators. Also, during training on business and financial literacy, challenges were faced among some members whose education level was limited. Therefore, it could be recommended to include vice-leader with better education level who receive the training.

[Training methods for IGA] According to KII with Action Against Hunger project manager, training approaches used were very participatory hence enhanced learning among the participants. Since the selection of training participants was regardless of their educational background, it limited effective interactions during sessions. Trainings duration was inadequate for some participant to fully grasp the training concepts. Beneficiaries could have learnt faster by using interactive sessions like exchange visit for knowledge exchange and motivating each other.

[IGA types selection] IGA types were identified by the assessment for each group. During the assessment, nutrition sensitivity was considered and some activities such as charcoal selling, trading in building materials, trading in imported second hand cloth and textile were not opted for. This reduced group members' motivation in IGA implementation among those who were not interested in the business idea proposed. Some of the Action Against Hunger staff and stakeholders claimed the needs of removing this restriction and increasing flexibility in terms of IGA selection to allow for beneficiaries to select IGAs which are within their skills and interests as it helps promote ownership and encourage participation of group members in IGA activities. On the other hand, others expressed concern over challenges of management of too many different IGA types. For this reason, a list of approved IGA types to be supported by Action Against Hunger could be developed and shared with the groups prior to the capacity assessment. DO NO HARM principle should be applied to restrict some types of IGA when developing the list.

Are the project activities being implemented as planned and scheduled? From KII with Action Against Hunger staff, it was found some of the project activities were delayed due to several reasons. Health and nutrition activities delayed during the initial period mainly due to launching of the new CHW policy of MoHS and mudslide (see effectiveness section for detail). Procurement of some equipment, namely anthropometric measurement tools and some other medical equipment, delayed as they needed procurement from the head quarter. Cash transfer was divided in two rounds due to Irish Aid instructions. Therefore, all the IGA process of selection of beneficiary groups, assessment, IGA type identification and training needed to be done twice, which reduced efficiency.

Of the two modalities of cash transfer used by the project, direct cash and transfer through a service provider, which one was most efficient? The IGA component of the project applied cash transfer to groups. Cash transfer was considered more effective and efficient than in-kind provision considering the availability and access to materials at nearby markets. Cash transfer was initially managed by the project team directly. Later, it was sub-contracted to a service provider to whom the work was delegated. Direct management was very time- and labour-consuming and resulted in delays in completing the exercise while the use of service provider was with verification methodology, transparent and effective (based on Lessons Learnt Workshop).

4.6 Findings on Effectiveness

- *What is the quality of the project outputs and/or project activities?*

[Result-1.1] Strengthening the health system allows for better quality of care of acute malnutrition

Output indicators	Target value	Achievement (from project records/reports)		
Output-1	Cure rate: >75% Defaulter rate: <15% Death rate : <10%		BL	EL
		Cure rate	85%	96%
		Defaulter rate	11%	1%
		Death rate	4%	1%
Improved treatment outcomes in targeted PHUs exceeded the target value				
Output-2	126 health staff participated in initial training and 94 staff in refresher training during the first year of the project	100% achieved. 126 (96 OTP and 30 IPF) staff trained and 94 (64 OTP and 30 IPF) staff received refresh training on IMAM In addition, 64 OTP staff trained on LMIS for IMAM and 32 health facility in-charges trained on IMAM 66 OTP staff from 33 OTP (not presently supported by the project) trained on IMAM		
Most of KII interviewees at the visited OPT reported this activity was most helpful for them Those activities filled the capacity gap among them). KII with OTP in-charge found the training and on-the-job coaching were perceived effective for them. Also, under this output, the project supported DHMTs with transportation of supplies from DMS to OTPs weekly stock monitoring of RUTF, F100, F75 and ReSOMAL in 32 OTPs and 2 IPFs, with stock out.				
Output-3	32 OTPs and 2 IPF supported with anthropometric equipment	100 % achieved. 32 OTPs and 2 IPF provided with anthropometric equipment (plus other materials)		
Facility material and equipment provided at the target PHU included medical equipment, anthropometric equipment, feeding equipment, bed materials and furniture, play sets, reporting materials, IEC materials. Interviewed health workers all appreciate the usefulness of the equipment				

[Result-1.2] Strengthening community mobilization improves the coverage of the management of acute malnutrition

Output indicators	Target value	Achievement (from project records/reports)
Output-1	80% (45,982) children U5 screened quarterly in the communities of intervention	Not achieved: 21,800 - 35,942 were screened quarterly.
Output-2	50% for rural and 70% for urban area (IMAM Coverage) as per the SPHERE standard	Not confirmed: As of 2017, the coverage estimated at 51.2%, hence the target was not achieved. There was no coverage survey since then.
Output-3	320 of community health worker (CHWs) trained and working on early detection, referral and follow up of under nutrition	100% achieved.
18 monthly meetings conducted. All CHWs received tools (Back Packs, Tally sheets, Referral slips and MUAC tapes) and weekly on-job support provided during screening. According to KII with CHW, training improved their knowledge and skills of screening, referrals and follow up.		
Output-4	462 of MSGs trained on MIYCF messages	100% achieved.
4,620 member of MSG (462) improved knowledge and practice of child care and feeding through regular meeting. FGD with MSG members found the members learnt key messages of IYCF and maternal nutrition from the group meeting. Also, according to DFN-MoHS, it contributed to "social empowerment" of mothers.		
Output-5	80 % of mothers targeted demonstrate increased knowledge and practices of recommended	Achieved partly for some practices: KAP survey found improvement of some IYCF practices such as immediate breastfeeding,

	maternal, infants and young feeding practices	frequency and type of foods for meal during pregnant women, ANC visit during pregnancy,
20 Father Support Groups and 12 Community Health Clubs were established as a pilot to promote recommended nutrition practices through change agents at community. FSGs received training on the roles and responsibilities of the FSG and basic concepts in nutrition using a newly development counselling cards for fathers.		

[Result-1.3] Specific approaches to high-impact nutrition are implemented to reduce the direct causes of under nutrition

Output indicators	Target value	Achievement (from project records/reports)
Output-1	10% (from 71.3% to 81.3%) increase in the proportion of targeted mothers who demonstrate knowledge of timely initiation of complementary feeding	Not achieved: % of caregivers demonstrating knowledge of timely complementary feeding was 71.3 at baseline as well as end-line (KAP survey)
Six barrier analyses (BA) were conducted focusing on six behaviours.		
Output-2	3% reduction in the defaulter rate of the IMAM program	>100% achieved: Defaulter rate was 1% at the end as of the latest quarter, representing a 10% reduction since the start of the project
The defaulter rate of the IMAM program in the communities of intervention continued to drop. Nutrition Security Expert was seconded (40%) to support DFN to update the national MSG database. It is not sure how the secondment work contributed to the reduction of defaulter rate.		
Output-3	64 of cooking demonstration sessions conducted in 32 PHUs	>100% achieved: 72 cooking demonstrations organized in both communities and health facility level in 32 communities attended by 2328 pregnant and lactating women
FGD with MSG members found some mothers appreciated usefulness of cooking demonstration while others reported challenges such as recipe a bit expensive and time consuming (so difficult to apply at home).		
Output-4	8 rounds of joint monitoring and supervision done with DHMT	Partly achieved: As compared to the joint supervision with DHMT, MOH participated only partly (one time against target which was quarterly)
KII withy DHMT found the support satisfied their needs and contributed. Those included Stationery, fuel, modem and internet subscription. Also, support for 5 rounds of NIDS with transportation refund for vaccinators during trainings and house to house movements, fuel for DHMT official supervisions.		

[Result-2.1] Improve the comprehension of vulnerabilities and the consideration of nutrition in contexts analysis, in surveillance and in Early Warning Systems in order to inform an integrated response to under nutrition multi sectoral causes.

Output indicators	Target value	Achievement (from project records/reports)
Output-1,2	• 75% of Harmonized Framework analysis integrate phasing of nutrition situation when valid data are available	100% achieved: All of the 3 Harmonized Framework Analysis conducted had included analysis of nutrition situation.
	• Early Warning System bulletins integrate analysis on nutrition	Technical support was provided to the National Early Warning System to analyze and integrate nutrition data
Disaster Response Platform was coordinated by the Office of National Security and there were several pillars among which one is FSN. EWS led by MAFFS with contribution of National Task		

Force. Action Against Hunger and MAFFS are the technical back stops and FAO and Irish Aid provided funding. EWS data is collected from sentinel sites managed by Rapid Response Team organized at district level (MoHS, MAFFS, IPs) and validated by the Task Force at national level. Harmonized Framework (CH) use outcome indicators of EWS (nutrition, FSL and market) as well as other source (CFSVA, SMART survey, Household Economic Analysis, etc) and CH managed by team (MoHS, MOFFS, UN, NGO, SUN, etc). CH analysis results are fed into regional (13 countries) analysis.CH and Action Against Hunger have been very helpful for all the above process and CH outputs. CH has contributed to emergency response, planning, policy decision, resource allocation and targeting interventions.

[Result-2.2] Food security and livelihood complementary activities with high impact on nutritional status are set for under five children and PWLM.

Output indicators	Target value	Achievement (from project records/reports)
Output-1,2	• 55% of targeted beneficiaries increase their FCS • 75% of targeted beneficiaries increase their monthly income	Achieved: Proportion of households with FCS more then 35 ("acceptable") increased from 44% at baseline to 94% at endline. Not available: Monthly income data has not been made available by the time of evaluation

A total of 115 MSGs and 20 FSG received training on technical matter and business and inputs to start IGA. According to KII with MSG and FSG, they perceived benefit of the training and inputs. Provided training and VSLA kits for 107 VSLA groups among which 87 groups became fully operationalzed

[Result-2.3] Good practices in contributing sectors are adopted for sustainable behaviour change to improve the nutritional status at Community level.

Output indicators	Target value	Achievement (from project records/reports)
Output-1,2	• 80% of caregivers have knowledge and adoption of at least 3 key IYCF messages • 80% attendance of targeted mothers at IYCF sensitisation and counselling sessions	Achieved partly for some practices: KAP survey found improvement of some IYCF practices such as immediate breastfeeding, frequency and type of foods for meal during pregnant women, ANC visit during pregnancy,

Delayed implementation of developing counselling cards for MSGs using live photo. Design was completed. According to Action Against Hunger staff interview, waiting for validation by MOH.

[Result-3.1] Nutrition is better integrated in the strengthened health system in Sierra Leone

Output indicators	Target value	Achievement (from project records/reports)
Output-1	Action Against Hunger recommendations on how to better integrate prevention and treatment of malnutrition within the health system are reflected within relevant health strategies/policies	Since no health policies or strategies have been reviewed during the project period, the advocacy and communication work paves the way to and creates an enabling environment for future changes in policies and strategies.

In coordination with representatives from either national or local authorities, organised radio discussions aired through various radio stations. Working with DFN and Civil Society on the joint advocacy initiative for the Code of Marketing of Breast-milk Substitutes (CMBS).

[Result-3.2] Nutrition is better integrated in contributing sectors' policies in Sierra Leone

Output indicators	Target value	Achievement (from project records/reports)
Output-1	Action Against Hunger recommendations on how to better integrate nutrition within contributing sectors are reflected within those sectors' relevant strategies/policies	Partly achieved: The nutrition multi-sectorial approach is mainly mainstreamed through Food and Nutrition Security Implementation Plan (FNSIP). Also, influenced the Inclusive and Comprehensive Agriculture Development Programme, (ICADEP) by mobilizing civil society in order to mainstream nutrition sensitivity in it.

Besides, conducted communication work to raise awareness about the multisectoral nature of malnutrition, such as airing of jingles and radio discussions. Meetings at district level took place in order to see how the district development plans could be made more nutrition sensitive.

Output-2	The budget dedicated to nutrition at national level increases	Partly achieved: Budget tracking exercise shows that the overall budget spent for nutrition by the Government of Sierra Leone in 2016 decreased compared to 2015. However, some ministries have spent more on nutrition interventions: Ministry of Social Welfare, Gender and Children Affairs; Ministry of Agriculture, Forestry and Food Security; Ministry of Health and Sanitation

Completed the budget tracking for nutrition specific and nutrition sensitive expenditures of the Government of Sierra Leone and produced the final report of the budget tracking in September 2017 and distributed it at the national and regional levels. KII with SUN and SUNI-CSO found they see this output is the largest contribution of the project.

[Result-3.3] The coordination of the civil society is strengthened so that they can effectively influence government and institutions for more commitments and more accountability in the benefit of nutrition

Output indicators	Target value	Achievement (from project records/reports)
Output-1	At least 2 advocacy actions are organised in collaboration with the SUN CSP	100% achieved: 2 advocacy events (ICADEP Workshop and CMBS Workshop) were organised in collaboration with SUN CSP; A number of other forms of support were delivered to the civil society in Sierra Leone.

Participation in the SUN meetings at national and district level (Secretariat and Civil Society Platform), Action Against Hunger together with the SUN CSP organized MPs workshop on CMBS. Also, The project facilitated the participation of two CSO representatives in a regional CSO Capacity building workshop. Through the workshop, the project provided capacity building of various CSO through technical support in developing advocacy materials, briefings and presentations to be delivered during the workshop.

What are the major internal and external factors influencing the achievement or non-achievement of the intended outputs and objectives? The project suffered from several external factors which affected the implementation negatively according to interviews with Action Against Hunger staff and district stakeholders. Those factors included 1) prolonged election process during which period most of the project activities were suspended, 2) Mudslide for which emergency operation was carried out in the target area and many project staff participated in it, 3) inflation negatively affect food access among target households, 4) RUTF stock-out negatively affected performance of OTP, 5) high turnover of health workers which necessitated training to be done for new health workers as gap filling, 6) new CHW policy of MoHS which delayed training for CHW, 7) delayed incentives provision by the

government for CHW which created disappointment among CHW, 8) delay of Service Level Agreement (SLA) approval, because of which the project started without formal inception for stakeholders, and 9) poor access to land in Western urban district posed challenges for MSG who are interested in vegetable production.

How effectively have the project performance and its outputs and objectives' indicators being monitored? The project applies very solid M&E systems including regular monitoring by Action Against Hunger staff and joint monitoring. Close monitoring by Action Against Hunger field staff was conducted with standard monitoring systems and tools. The results were regularly discussed at staff review meeting to make necessary actions to overcome challenges. DHMT member reported during the interview that joint monitoring was very effective and also contributed to their capacity building. Despite those strengths, monitoring and supervision of the project also faced several challenges (KII with Action Against Hunger staff and DHMT). The first challenge was difficulty of coordinating and scheduling the joint supervision with DHMT and MoHS. Secondly, although more regular and intensive monitoring was needed to ensure MSG functionality, limited number of staff was available to conduct effective monitoring and support. Thirdly, monitoring for health/nutrition and food security teams was conducted separately. Action Against Hunger joint staff team of health and nutrition team and food security team would have benefited the project by providing insight of existence or absence synergy between health/nutrition and food security interventions at individual or community level.

How is the adequacy of control mechanisms to limit fraud and corruption? How has the feedback mechanism in place worked? What could be improved? As complaint mechanism, a complaint box was placed at most of the target PHU and health workers were aware of it. Many of them reported that they informed and explained it to mothers and other beneficiaries. According to the project proposal, the complaint box was supposed to provide a safe and anonymous way for the communities to express themselves. The data collected were supposed to be registered, followed up and also analysed to evaluate the project's impact. During the interviews at PHUs, complaint boxes were observed at most of the visited PHUs. However, some of them were placed in invisible place and none of them were actually utilized, so not collected and analyzed. Some health workers and most of mothers were not much aware of the box and its importance. Therefore, it suggested the needs of sensitization and training on the purposes and importance of complaint box to raise awareness. Also, more visual system would be useful, as illustrated by coloured token to be placed in the boxes.

How was the project team able to adapt to the constraints of the project? The project team of OTP/IPF adapted to supply shortage of RUTF/Resomal with logistic management training and on-the-job support for stock control. They also facilitated communication between PHU and DHMT for smooth and timely transport of RUTF. With regard to frequent staff relocation, the project organized training to fill the gaps of health workers. Also, for some health workers who still have difficulty in following IMAM protocol, the team provided on-the-job coaching to address the constraints. According to KII with health workers, many respondents reported RUTF support and on-the-job coaching were the most useful and helpful supports. One health worker at IPF reported she still needed technical advices on protocol of HIV-TB infected SAM children.

The team of community mobilization responded to the constraints of CHW. For one of the largest constraints of incentives, the team provided weekly visits for close supervision and refresh training. During KII with CHW, many reported the project team's regular and frequent visits and their support for encouragement and other advices on record keeping. The team also faced challenges of poor health seeking behaviours of mother and pregnant women at community which was negatively affected by Ebola Virus Diseases (EVD). For this issue, the team promoted additional training on collaboration between CHW and LM for screening, referrals and follow up. Maintaining motivation of MSG members was another challenge. At the Lessons Learnt Workshop, Action Against Hunger staff

reported it was due to poor diversification of bi-weekly counselling activities. Initiation of IGA, although only a part of MSG participated, has brought more interest and passion among the members.

FSL team faced challenge of four FSG not following the IGA purpose for the use of cash transfer. For this issue, the team investigated the situation and terminated the support for them[2]. One big challenge faced by the advocacy team was the change of government after the election. All the key officials of related ministries changed, meaning they had to repeat all the past activities targeted to previous persons need to be repeated for new persons. According to KII with Action Against Hunger advocacy expert, he considered this as one opportunity for better influence on policy and strategy as the new person may have better understanding and issues.

What steps were taken by the implementing Agency (Action Against Hunger) to ensure that its responses were coordinated with other organizations and local authorities? DHMT as well as Action Against Hunger staff shared common ideas that the resource coordination between Action Against Hunger and DHMT has been well organized. With regard to the resource coordination for the project implementation, there is a clear responsibility sharing under which DHMT contributes health staff, medicines and RUTF while Action Against Hunger supports training, supplementary equipment and on-the-job coaching. Specifically with regard to DHMT, Action Against Hunger support was provided for transport and office equipment of DHMT which was appreciated by DHMT as effective. DHMT members participated in joint monitoring and supervision on a quarterly basis. District nutritionists worked as trainer to facilitate project trainings. Apart from the project related coordination, resources (fuel, transport, staff) were coordinated among stakeholders including Action Against Hunger at district coordination meeting for campaigns such as breastfeeding promotion and National Immunization Days (NID). During the Lessons Learnt Workshop, discussions were made over the concern that joint supervision and other project activities have been mainly participated by district nutritionists with very little involvement of other members of DHMT.

Resource coordination with other agencies or authorities has not been with lesser degree. Partnership agreement with Food and Nutrition Security Initiative – Sierra Leone (FANSI-SL) was planned in the beginning in order to contribute to expanded coverage. However, it has not been completed due to capacity of the agency which was assessed to be not sufficient to achieve intended purposes. Coordination with DAO was mainly over joint monitoring and training for which DAO contributed human resources. Secondment was sent to MOH which ended with shorter duration than initially planned.

To what extent does Action Against Hunger take part in technical coordination mechanism at all level of project implementation? According to interviews with Action Against Hunger staff, FSL-Head of Department (HoD) regularly participates in several different coordination meetings held at national level. Those are Food Security-Working Group (monthly, led by FAO), MAFFS NGO meeting (led by MAFFS, suspended for sometime) and Cash Transfer Working Group (led by National Committee on Social Action (NaSCA) and the National Task Force undertaking the Harmonized Framework analysis conducted every 6 months. Health and Nutrition HoD also participate in several meetings, including Nutrition Coordination Meeting (members are multi-sectors from government, UN, NGOs), Nutrition Technical Meeting (NGO, UN), and Micronutrient Coordination Meeting. Advocacy expert participates in Scale-up Nutrition (SUN) coordination meeting and Scale-up Nutrition and Immunization Civil Society Platform (SUNI-CSP) meetings. At district level, there is no technical coordination for nutrition partly because Action Against Hunger is the only one NGO supporting nutrition in the districts. General coordination meeting for health is held at district where Action Against Hunger liaison officer regularly participates.

[2] Both the investigation and decision to terminate the IGA support to them was done jointly and in agreement with MAFFS. The termination of support was related only to the IGA support, not to the support on nutrition activities.

What is the effectiveness of FSG activities and how does this compare to MSGs? Since FSG is at smaller scale (20 groups) than MSG (115), their effectiveness for health/nutrition and food security have been less obvious than MSG. In terms of effectiveness of IGA, several interviewees reported relative effectiveness of MSG as compared to FSG. After the establishment, FSG and MSG received the same training on technical matter and business and inputs to start IGA. There was miss-use of cash transfer money among four FSG, resulting in their leave from IGA program (remaining 16 FSG still continuing).

What was the role of MSGs in preventing relapse of SAM children in the OTP/IPF program? KII with CHW and LM revealed that CHWs got effective supports of LM for follow up children in OTP program and after discharge. Through FGD with MSG members, members of MSG may or may not included those whose child was admitted to OTP. In case of one MSG, a child of MSG members admitted in OTP and mother of the child were advised by LM to improve child care to prevent relapse at MSG meeting or home visit. In other MSGs interviewed, MSG members have not included SAM child. In these cases, health workers informed CHW and LM to follow up discharged child by home visit or if possible let them join MSG. When discharging a child from OTP, address was given to CHW. One CHW mentioned when the discharged child was close to LM, CHW asked LM to follow up. Another CHW reported it was usually LM who followed up first and told CHW when difficult cases were found. Many CHW reported LM was helpful for their work as mothers did not refuse LM who was usually a matured woman. As such, complementarities was promoted between CHW and LM by the project.

What was the role of MSGs in preventing deterioration of children from MAM to SAM? SFP of WFP has not been implemented in the area. Therefore, MAM child was supposed to receive nutrition counselling without provision of supplementary foods. Both CHW and LM were instructed to follow this protocol. According to FGD with MSG, there was no special activity focused on MAM children in the group. The MOH guidance document for MSG did not include any instructions related to MAM children.

To what extent did the project promote linkages between the CHW and MSG approaches and how did this contribute towards achieving the project objectives? The project provided special training focusing on the collaboration between CHW and LM. Interview with HW, CHW and LM also found the main linkage was the collaborations between CHW and LM for 1) referrals, 2) defaulter tracing and 3) follow up. Some LM and CHW reported they conducted community sensitization together. There were several ways of referrals reported by CHW and LM. At one case, if LM identified a SAM child, she informed CHW who measured MUAC and referred to PHU. At another case, LM refered directly to PHU. At Looking Hill MCHP, CHW mentioned that he referrd PW to LM. Defaulter tracing and follow up during OTP and after discharge was as already described above. During KII, some health workers reported decrease of defaulters and increase of referrals due to the collaboration between CHW and LM. Despite the MoHS guidance on MSG, none of the CHW interviewed were a member of MSG. CHW usually did or did not participate in MSG meeting, but at least knew what MSG was doing. Many MSG members interviewed mentioned no participation of CHW while some MSG reported active participation of CHW. Therefore, the linkage between CHW and MSG on bi-monthly meeting was not yet sufficient.

How effective was the secondment of the Nutrition Expert to the DFN? Nutrition Security Expert was seconded (40%) to DFN-MoHS. The Expert supported the DFN-MoHS to update the national MSG database and worked on compilation and review of district feedback in the national IMAM database. KII with DFN found DFN-MoHS appreciated the secondment and felt the support was useful for them. On the other hand, from KII with the Expert, it was also found that the secondment could have been more effective. The agreed TOR included a broad range of works which did not match the part-time arrangement. There were other two full-time secondments from international organizations (HKI and WFP) working at DFN-MoHS during the time of this secondment. Partly because of these situations,

DFN-MoHS did not ask specific technical tasks to the secondment. In stead, the assigned task was clerical works. In the mean time, as the expert's work for field project increase the burdens on her, it became gradually difficult to focus on the secondment. If the TOR focused on a few specific tasks which added value to DFN-MoHS (examples include training material development based on needs assessment, or other technical tasks utilizing the project lessons learnt) and it matched the working condition, preferably fulltime, the secondment could have been more effective.

4.7 Findings on Sustainability

Was the project assistance provided in a way that took account of the long term context? The project was very much based on long-term context through partnership with DFN-MoHS with gradual shift from direct to indirect support over several years (phase1,2). According to the project proposal, the project operates a long-term strategy whose main objectives are: 1) Capacity building of health authorities at national and district level; 2) Capacity building of health staff on the detection and management of severe acute malnutrition as well as monitoring tools; 3) Operational capacity building at nutritional rehabilitation centres. Thus, the project aimed to work to develop a capacity building plan of the institutional partners to ensure they have the needed capacities on prevention, screening, referral and management of acute malnutrition as well as independent monitoring capabilities.

Similarly, the project supported for harmonized framework and Early Warning System (EWS), which involved capacity building of the government partner, MAFFS. Lastly, in order to ensure sustainability in the work carried out in advocacy, the advocacy team closely worked with the SUN CSP to ensure capacities in advocacy were built and the SUN CSP Secretariat became capable to carry out advocacy activities in a strategic and coordinated manner for the achievement of the expected results.

How suitable are these plans and are they being implemented? Through the capacity building focus maintained throughout the project, health workers, CHW, LM and DHMT has increased their skills and knowledge to continue their respective services and management. However, their perceptions have not reached the point where they are ready to run the services without external support. They still rely on Action Against Hunger staff when some problems arise. Also, as represented by the fact that exit strategy has never been discussed until the end of the project, the idea of gradual phasing out of the project support have not yet been considered seriously among stakeholders.

To what extent are the project results likely to be sustained in the long term? When this question of sustainability is asked to stakeholders and beneficiaries, one of the most common responses was services can be sustainable and they can sustain the activities but they still need support for some more years at least otherwise quality of the services cannot be ensured without support. When additional question was asked on how they can sustain after the several years, the answers were not clear. Apart from the perceptions, supporting environment is also an important factor to sustainability. The factors for OTP/IPF services include insufficient and frequently changing human resource at health facilities and unstable supply of RUTF. For CHW, incentive scheme involves sustainability of their work. Motivation of MSG members may also matter in continuing active participation. For harmonized framework, institutional sustainability has been almost ensured given the national taskforce with sufficient structure and capacity provided to carry out the framework. However, availability of data is questionable due to insufficient financial resource to continue EWS which is supposed to be the main data source.

4.7 Findings on Impact

To what extent is the project contributing to improved food and nutrition security status of vulnerable households? What does the comparison between baseline and endline suggest As described in the subsequent sections, the project baseline and endline survey showed improved household food security as represented by 1) Food Consumption Score (FCS) among the beneficiaries of IGA, 2) positive change of some IYCF and maternal nutrition practices as represented by KAP surveys among MSG members and 3) improved access to quality OTP/IPF services as represented by performance indicators. The project baseline and endline survey did not include anthropometric measurement, which made it difficult to assess any change of nutritional status. According to NNS conducted in 2014 and 2017, which was the only available secondary data for nutritional status, nutrition status of children under five in Sierra Leone has not changed significantly at national level and even worsened in Western area during the period of 2014 - 2017. Those facts could be interpreted in the way that 1) the project contributed to addressing some of the causes of malnutrition, 2) however, the positive changes were still at limited coverage, and 3) therefore, they has not yet been translated into improvement of nutritional status during the project duration.

What is the impact of Mother Support Group (MSG) activities on the communities that they work in, in particular on the nutrition knowledge and practices? A simple comparison exercise was performed for KAP surveys analysis by comparing baseline and endline figures on the same indicators (**Table-1**). Because baseline KAP survey report included limited number of indicators with only proportion figures without actual numbers, statistical test cannot be performed. The table should be seen as qualitative analysis, instead. According to the table, MSG members improved some practices and knowledge related to IYCF, pregnancy care and maternal nutrition practices. Due to the limited quality of data particularly of baseline as well as absence of control samples without intervention, this information should not be interpreted as genuine impact. Nevertheless, this indicates tendency of positive change particularly with respect to breastfeeding and pregnancy care. It should also be noticed that complementary feeding practices (timely initiation, frequency and diversity) has not changed. During FGD with MSG members, most commonly mentioned knowledge which MSG members learnt in their group meetings were; breastfeeding, followed by pregnancy are (when to attend clinic, food during pregnancy, advantage of going to clinics), care child and feeding and hygiene. Less number of members mentioned on complementary feeding.

Table-1: List of practices which improved from baseline

Indicators	**BL**	**EL**
% mother who eat protein foods regularly during your last pregnancy,	90%	98%
% mother who eat fruit regularly during your last pregnancy,	78%	93%
% mother who eat vegetables regularly during your last pregnancy,	81%	90%
% mothers attended ANC visits and presented ANC card as proof	89%	98%
% mothers had four or more meals per day during last pregnancy	41%	50%
% mother whose delivery assisted by a skilled health worker	89%	95%
% mother initiated breastfeeding within an hour after birth	70%	94%
% mother who practiced exclusive breastfeeding for 6 months	68%	80%
% mother who breastfeed multiple times on demand	67%	79%
% mother who gave Benimix for complementary feeding	33%	23%
% mother who reported health facility staff as sources of complementary feeding information	25%	59%

Those evidences suggested challenges still remained in complementary feeding practices. With regard to exclusive breastfeeding, questions used on KAP survey mainly assess knowledge of mothers. It should be reminded that in general, improved knowledge alone not necessarily brings

about behaviour change. Actual behaviour change requires addressing other barriers and requires more time. MoHS stakeholders mentioned MSG also contributed to social capacity building with empowerment of women. While this aspect of impact was very interesting and FGD with MSG found related comments from members, this could not be quantified because of the absence of related surveys.

What is the impact of Mother Support Group activities on treatment seeking behaviours for caregivers of acutely malnourished children and caregivers with IYCF complications According to APR, 2,652 children under five have been screened by mothers. There was no data of number of children referred by mothers. Endline KAP survey indicated 80% of mothers reported they brought a sick baby less than 6 months old to PHU and 67% of mothers brought their baby to the health centre for growth monitoring monthly. Great majority (98%) of mother attended ANC with ANC cards. Those numbers suggested MSG members had fairly good health seeking behaviours. According to KII with CHW and FGD with MSG, many pregnant women were previously reluctant to come for ANC clinics because of many reasons including time constraints, workload, and social stigma. They were now willing to come to ANC thanks to the efforts of LM. Many MSG members also reported they learnt form meeting the importance of attending clinic. Effective collaboration between CHW and LM for screening, referral and follow up of SAM children was as described in the effectiveness section.

What is the impact of FSG activities on the communities that they work in and how does this compare to MSGs activities? Since FSG scale was small (20 in total), many interviewed mothers and health workers were aware of the existence of FSG. Nevertheless, some testimonies were obtained during FGD with MSG and FSG members and KII with CHW, which indicates likely benefits of FSG activities on the communities. Those included FSG members 1) helped teenage pregnant girl, 2) attended wife to PHU for ANC, 3) referred a sick child to clinic, 4) helped wife by holding child when she is busy cooking, 5) assisted wife by cleaning house. One CHW reported although many fathers felt shame to support mothers according to traditional norm in the locality, FSG members were trying to model the new behaviour. FDG with FSG in Ola During found another example showing the potential contribution of FSG to the community. The previous advocacy group promoted community awareness campaigns on child rights for health mainly for women. After the FSG training, their campaigns involved more men with emphasis on gender issues. However, actual impact remained to be validated.

What is the impact of the nutrition and livelihood activities on the households of the Mother Support Group members? Proportion of households with FCS more then 35 (“acceptable”) increased from 44% at baseline to 94% at endline. Income data of baseline and endline survey was not made available by the time of evaluation. According to FGD with MSG with IGA support, many mothers reported they already received some profits from IGA. The money was used for foods, VLSA share, household’s items, medical cost and school fees. Comments form the interviewed mother about benefits of the income indicated, despite the relatively small economic impact at household economy, IGA contributed to empowerment of mothers as the income can be used by them and increased incentives to participate in nutrition session within MSG. Perceived benefit of the income for nutrition among mothers included; 1) easy to spend money by themselves (no need to get permission of husband), 2) less quarrel with husband over money, 3) no need to ask support from others, 4) can top up household income, 5) lactating mother can eat more foods which help more breast milk and 6) pregnant women and mothers have better health.

What is the impact of the nutrition and livelihood activities on the households of the FSG members and how does this compare to the MSG members households? Baseline and endline surveys on food security among IGA participants were not designed to make comparison between MSG and FSG due to different sample sizes. According to FGD with FSG, the members reported some amount of profit with range of 10,000 - 120,000. Similar to MSG, FGD participants mentioned the amount was small

but it still helped the household economy. Many of the interviewed Action Against Hunger staff and stakeholders reported business performance of MSG was higher than FSG because of many reasons as represented by the four FSG miss-used the cash. One respondent mentioned it was because fathers had more experience in individual business practices which was more profitable. In order to maintain common interest in IGA of the project, good training and preparation is needed. However, the time for preparation for FSG was shorter than for MSG before starting IGA.

What is the impact of supporting Mother Support Groups with Income Generating Activities (IGAs)? Is there a difference between Mother Support Groups who are supported with IGAs and those who are not supported with IGAs? Linkage of MSG with IGA was a part of MoHS guidance on MSG. During the Lessons Learnt Workshop, one challenge of MSG was difficulty in maintaining motivation among MSG members as the activities were not diversified (not change and repeating in the same way). Current database of MSG did not allow the comparison of participation rate between MSG with IGA and those without. However, according to KII with DHMT, health workers, CHW, LM as well as FGD with MSG, most common response was IGA gave passion among the members for their activities. At the same time, however, IGA could also give negative impact on nutrition such as distracting MSG members' interest towards business activities and creating time constraints for mothers.

What is the impact of working with SUNI-CSP and how can Action Against Hunger best support SUNI CSP going forward? According to the interviews with SUN National Coordinator and SUNI-CSP Coordinator, the both mentioned the largest contribution was Budget Tracking Analysis which was distributed to all the related line ministries and impact on the awareness about the gap between the commitment and actual budget allocation. SUN National Coordinator also referred to the importance of the revision of policy (FNSIP) in the policy context for food and nutrition security in Sierra Leone. He mentioned it is aimed to be launched in August when SUN global coordinator visit SL. Other outputs of advocacy works included evidence generation (case studies), advocacy for CMBS, community sensitization using materials with harmonized messages, capacity building of SUNI-CSP members through participation in international workshop.

5. Conclusions

Design: MSG and CHW needs were assessed by KAP survey but without analysis by sex and age. Overall, gender analysis was not carried out before designing the project. The project made more efforts than the previous phase to take into account gender in the project design. Considering men's role at households which influence care practice, counselling cards for Father Support Group (FSG) were designed for role of husbands and gender. Since FSG was still at small scale, participation of the group members and other male members of the community who were not FSG members in child care need to be critically examined. There were several indicators that Action Against Hunger staff found difficult to report against. The exit strategy discussion was postponed to the Lesson Learnt Workshop which was conducted during the time of this evaluation. The discussion was still not matured and need to be detailed further. The project applied very solid M&E systems including regular monitoring by Action Against Hunger staff and joint monitoring. Apart from men's participation promoted through FSG, other recommendations such as considering feasibility of indicators (nutritional status) were not considered in the project. Barrier Analysis was conducted and some recommendations resulted in posters showing the images of the importance of husband and family support. The printing was delayed and not yet printed (waiting for validation) but not integrated into the project design (BCC strategy).

Relevance/Appropriateness: The project designs are based on understanding of the local contexts gained from the previous phase of the project and aligned and contribute to the national policies and

strategies of nutrition. Training methods, use of LM to support CHW and supporting IGA for MSG were all considered relevant in terms of local practice and culture. Some IGA of FSG such as assorted items and fish selling may better consider local cultural relevance. Several needs assessments were conducted before the implementation of activities The assessment results informed needs, current knowledge, experiences, skills and gaps which were useful for taking into account beneficiary needs in the project implementation. Several considerations were needed in terms of timing and contents for increased usefulness of the assessments. Main purpose of Barrier Analysis was to help the design of behaviour communication strategy, but it has not been accomplished.

Coherence: The project was designed through consultation process with key stakeholders (key ministries, UN, NGOs, etc) and regular updates of the project have been shared at coordination meetings at district and national levels. Delay of Service Agreement Contract caused the project starting without formal inception to stakeholders, which posed challenges among Action Against Hunger staff and partners during the implementation. There has been no other FSL project in Western area, but integration of this project with other Action Against Hunger program existed in the target area to certain degree. However, there has been very limited integration with WASH. The project was implemented with well integrated and synergetic linkages between health/nutrition, food security and advocacy. Challenges remained in the actual activities of health/nutrition team and food security team which were vertically managed. Subject knowledge of other sector among field staff was still limited.

Coverage: The current targeting of Western area was considered appropriate in terms of food and nutrition security needs. In the previous project, only 26 PHUs were supported. In consideration of the recommendations from the previous project, the number of PHUs was increased to 32. The current target of 32 PHU may not be the most vulnerable among all the other PHU in the 2 districts. According to SQUEAC survey, IMAM coverage was estimated to be 51.2%, below the SPHERE standard. Despite existence of several areas within the districts where number of affected children may be higher than others, the project approach has been providing similar levels of support for PHUs in high burden and low burden areas. Current number of MSG members was still a small part of the total numbers of pregnant and lactating women in the target area and most vulnerable mothers or pregnant women in many cases may not be participating in MSG. Due to the training for CHW and LM, referrals of SAM children were practiced with improved accurately. MSG Member selection differed across the groups. MSG members were with or without inclusion of teen-ager pregnant women. Husbands were rarely member of MSG. Out of 462 MSG, 115 (25%) received IGA support and the selection was mainly based on the vulnerability ranking based on group-based assessment. The selection criteria and methods of LM and MSG members were well understood by local stakeholders. On the other hand, the selection criteria and method of IGA target groups were not uniformly understood.

Efficiency: Resources were generally properly allocated with minor over or under spending. All target health facilities (32 OTPs and 2 IPFs) were provided with adequate equipment and materials. Exception was equipment not distributed according to caseload which differed significantly between the two IPF. Cash transfer was more effective and efficient than in-kind provision considering the availability and access to materials at nearby markets. Use of service provider was with verification methodology, transparent and effective. The project activities were delayed due to several reasons such as the new CHW policy of MoHS and mudslide and procurement procedures. The current management set-up was efficient in ensuring intensive monitoring and supervision of IMAM, community mobilization and IGA separately. The position of Nutrition Security Expert was considered important and effective in ensuring the linkages of health/nutrition and food security.

Individual support for IGA could be more efficient than group based support. However, given the project purpose which was nutrition security, group approach was considered more effective as it helped ensure collaboration among group members. Consideration of food security factor and

inclusion a vice-leader in MSG member selection would contribute to better IGA performance. IMAM training approaches used were very participatory hence enhanced learning among the participants. Selection of participants and duration of IGA training could be improved for better training outcomes. DO NO HARM principle for nutrition-sensitivity should be applied to restrict some types of IGA while flexibility should be maintained in terms of the IGA type selection to help promote ownership and encourage participation of group members in IGA activities. A list of approved IGA types to be supported by Action Against Hunger could be developed and shared with the groups prior to the capacity assessment.

Effectiveness: Most of the project activities were implemented according to plan and the intended outputs were achieved. Effectiveness of FSG for nutrition and food security have been less obvious than MSG. Effective linkage between CHW and LM was established and supported for 1) referrals, 2) defaulter tracing and 3) follow up after discharge. Advocacy work contributed to enabling environment of nutrition security through mainstreaming of multi-sectorial approach in some of the major program documents such as FNSIP and ICADEP and budget tracking. Some challenges still remained for a few areas such as IMAM coverage, improvement of some IYCF practices and advocacy. The project faced several external factors which affected the implementation negatively; which included, prolonged election process, land slide, inflation, RUTF stock-out, high turnover of health workers , new CHW policy of MoHS and delayed incentives provision for CHW , delay of Service Level Agreement approval , poor access to land in Western urban district. The project team responded to the challenges with effective and focused training, on-the-job coaching and communication facilitated between PHU and DHMT.

The project applies very solid M&E systems including regular monitoring by Action Against Hunger staff and joint monitoring. Resource coordination between Action Against Hunger and DHMT has been well organized over the project related matter as well as ad-hoc campaigns. At national level coordination, Action Against Hunger take part in several technical coordination mechanism and Nutrition Security Expert was seconded (40%) to DFN-MoHS to update the national MSG database and in compilation and review of district feedback in the national IMAM database. Several difficulties were experienced in monitoring, supervision and coordination. Those include 1) difficulty in scheduling joint supervision, 2) limited number of staff available to conduct effective monitoring, 3) participation of DHMT was represented by district nutritionists with very little involvement of other members, 4) poor coordination between health/nutrition and food security for monitoring, 5) Poor utilization of complaint boxes. Focused on a few specific tasks which add value to DFN-MoHS, preferably fulltime, the secondment would have been more effective. Partnership agreement with FANSI-S has not been completed due to capacity of the agency.

Sustainability: The project was very much based on long-term context with gradual shift from direct to indirect support over several years over phase1 and 2. With the capacity building focus maintained throughout the project, health workers, CHW, LM and DHMT has increased their skills and knowledge to continue their respective services and management. As compared to a good likelihood of sustaining MSG activities, sustainability of IMAM services are negatively affected by relatively poor supporting environment such as unstable health human resource and RUTF supply and CHW incentives. For harmonized framework, although institutional sustainability was almost ensured, financial sustainability is questionable. Overall, project beneficiaries and stakeholders have a common perception that they still need support for some more years at least otherwise quality of the services cannot be ensured.

Impact: The project related survey and records indicated improved FCS among the IGA beneficiaries, positive change of some IYCF and maternal nutrition practices among MSG members and improved access to quality OTP/IPF services. Although the project contributed to addressing some of the causes of malnutrition, the positive changes were still at limited coverage and have not yet been

translated into change of nutritional status during the project duration. As compared to health seeking, breastfeeding and pregnancy care which indicated some improvement among MSG members, challenges still remains in complementary feeding practices. Actual behaviour change requires addressing other barriers and requires more time.

The nutrition and livelihood activities had impact on the households of MSG members represented by improved FCS. Also, many mothers reported they have already received some profit from IGA. The mothers felt sense of empowerment as the money can be spent by themselves. Other perceived benefits of the income were improved health of mothers and better breast milk due to more foods for lactating mother. IGA has given passion among the members for their activities. At the same time, however, IGA could also give negative impact on nutrition such as distracting MSG members' interest towards business activities and creating time constraints for mothers. Although FSG scale remained small and communities were not aware of their performance, some testimonies indicated FSG contribution to activities related to nutrition and food security. FGD members also reported IGA helped the household economy. However, some groups did not perform well. In order to maintain common interest in IGA of the project, good training and preparation is needed.

Largest contribution of the project for SUN and SUNI-CSP was Budget Tracking Analysis as it impacted on the awareness about the gap between the commitment and actual budget allocation. Revision of FNSIP was also appreciated as the important impact in the policy context for food and nutrition security in Sierra Leone. Other outputs of advocacy works include evidence generation (case studies), advocacy for CMBS, community sensitization using materials with harmonized messages, capacity building of SUNI-CSP members through participation in international workshop.

6. Lessons Learnt and Good Practices

There are several lessons learned from the evaluation which highlight strengths or weaknesses in preparation, design, and implementation that affect performance, outcome, and impact

Continuous capacity support for accessible and quality OTP/IPF service increase the confidence of caregivers in the program: The health system in Sierra Leone is particularly weak and it has been further stretched by the EVD Outbreak. The weak health systems are characterised by insufficient human resources capacity, high turn-over of health staff and unstable supply of medicine and RUTF. Under the circumstances, patients loose confidence in heath facility. The project support for capacity building, equipment and RUTF supply improved treatment outcomes in targeted PHUs as observed by the improved cure rate and reduced death rate. This in turn contributed to regaining of the confidence among patients in health facilities.

Prevention focus needs Behaviour Change Communication (BCC) strategy with clear target audience and population-based M&E strategy: It is in accordance with MoHS policy as well as donor interest that the project has increased focus on prevention from treatment. A growing body of evidence suggests that interventions developed with an explicit theoretical foundation are more effective than those lacking a theoretical base. Therefore, Behaviour Change Communication strategies based on understanding of determinants of target behaviours and underlying theory of change is an essential preparation for designing the prevention interventions. The BCC strategy should target audiences at multiple levels using multiple communication channels and include monitoring and evaluation plans with indicators to measure behaviour outcomes preferably at population level. The current project used several communication channels (MSG, FSG, Community Health Clubs, media) mainly focused on IYCF, hygiene, pregnancy care and maternal nutrition practices. However, the evaluation could not find any comprehensive BCC strategy developed by the

project. Since BA was carried out as foundation work, the recommendations and outputs of BA would have been reflected into the current communication designs.

Systematic evaluation of the capacity linked with IMAM is necessary for exit strategy: IMAM component of the project design was done based on assessment of the service delivery capacity of DHMT. Capacity building support was provided to fill the gaps identified. However, there is little documentation of assessment results, actions taken and challenge remained at DHMT level capacity. The project support is coming close to the point of handing over to MoHS and the importance of exit strategy is highlighted in this evaluation. Discussions were made at the Lessons Learnt Workshop to explore potential support needs at district and national level Conduction and regular updates of the systematic and comprehensive assessment of DHMT capacity would have informed the exit strategy and focuses of capacity support needs.

Rigorous design of impact assessment is needed for operation research of multi-sector approach: The project included innovative interventions for community-based multi-sector approach, namely IGA using MSG/FSG. Behind the pilot interventions, there are several implicit hypotheses of how the interventions impact on nutrition security. Those hypotheses include 1) IGA increases functionality and sustainability of MSG activities, 2) IGA empowers MSG members, 3) IGA enhances household food security and foods intake. Baseline and enline surveys were conducted to measure those impacts. However, data collected in those surveys do not cover all the required information to test the hypotheses (ex. Data for empowerment, data showing functionality of MSG, etc). Furthermore, limitations of the survey designs such as the absence of control and insufficient power to detect difference reduce the usefulness of the assessment. Therefore, designing the rigorous impact assessment design in conjunction with intervention planning would provide effective and useful outcomes.

The following Good Practices that has been proven to work well in the project and can be recommended as a model to be e utilized by Action Against Hunger in future programming:

Supporting effective linkage between CHW and LM for community mobilization structures helps improving health seeking behaviours. EVD also affected negatively health seeking behaviours. Although CHW is agent for community mobilization officially authorised by MoHS, they can often be seen as “outsiders” by mothers and pregnant women. On the other hand, LM is a volunteer but most of mother and pregnant women feel easier to talk to them. Though training of collaboration and complementarily between CHW and LM, they can effectively mobilize community. The improved health seeking behaviours are represented by willingness of caregivers referred from the community to attend OTP services, reduction in stigmatization of malnourished cases; caregivers willingness to visit the facilities.

MSG with adequate technical and financial support for income generation enhances the potential for functionality of their activities: MSG is a group consisting of 10 pregnant, lactating women and/or mothers of children under-two years of age. It is a forum spear headed by a lead mother where members gather for evidence based information dissemination and provision of appropriate support for parents and caregivers. One challenge of MSG was difficulty in maintaining motivation among members as the activities are not diversified. The IGA support for MSG has given passion among the members for their activities.

Nutrition Budget Tracking can contribute to government’s accountability and commitments for financing for nutrition: 2016 Nutrition Budget Tracking and analysis study were done and the final report was shared with the DFN-MoHS and with five other ministries. Also, the findings were presented by REACH in Nutrition/FSL donors meeting and also by CSOs in SUN global gathering. Although the findings indicated slight reduction of the government spending for nutrition in 2016 as

compared to 2015, it helped raising awareness among the key stakeholders by showing the gap between the commitments and actual spending for nutrition.

7. Recommendations

The following recommendations are made, based on the Findings and the Conclusions of the evaluation. They are listed in order of priority and should be addressed in the immediate to near future.

Short-term recommendations:

1) Promote integration of health/nutrition and food security within Action Against Hunger teams through joint training, monitoring and review workshop. Currently, health/nutrition and food security interventions are managed separately. There are several cross cutting issues which increase or reduce synergy of the two sectors. It is, therefore, advisable that the two teams make efforts to maximize the synergy by conducting 1) joint training to share common understanding of the two sectors, 2) joint monitoring to review the household level synergy, and 3) joint workshop to review the process of selecting beneficiaries and training participants (high priority).

2) Respective HoD and expert, in consultation with HQ, revise the design and tools of baseline and end-line surveys. Since the current KAP and FSL survey design and tools do not sufficiently include data to answer some of the key research questions of interest; Does IGA help MSG members to 1) be empowered (decision making at household)? 2) increase their participation in activities? 3) increase expenditure for nutrition sensitive purposes (food for child and mothers, etc)? It should be ensured that the survey results can provide information to answer them (high priority).

3) Health/Nutrition HoD, Expert and the team assess training and capacity support needs of IMAM at DHMT. It is important that the next phase project shifts the focus from direct support at PHU level to indirect support through DHMT, which can benefit all the PHU with OTP in the two districts. In addition to joint monitoring and review meeting which have been the primary support for DHMT so far, additional training and capacity support should be conducted with focus on risk management such as forecasting caseload to adapt to RUTF shortage and prioritizing high-risk PHU for focused monitoring (high priority).

4) Action Against Hunger-SL teams, in consultation with HQ and potentially with support of external consultant or positioning of a dedicated person at mission level to focus on BC, develop BCC strategy using BA recommendations. The BA recommendations provided Designing Behaviour Change (DBC) framework which have not been integrated into the existing communication activities (high priority).

5) Action Against Hunger and DHMT review caseload of IPF and apply necessary resource re-allocation between the two facilities. Caseload at one IPF is very low while the other IPF has very high caseload. It is advisable, therefore, review the caseload with potential factors to the difference and come up with solutions which include re-allocation of the equipment/supply or identification of a new IPF Alternatively, it could be considered to add another IPF to replace the one with low caseload (medium priority)..

6) Respective HoD and expert review indicators of LFA based on feasibility, relevance: Some of the current indicators do not relevant (not matching with activities or not feasible). They should be reviewed for appropriate revisions (medium priority). Also, it is advisable that M&E plan is developed at proposal stage with details on indicator definitions.

Medium-term recommendations

7) Action Against Hunger Health and Nutrition team discuss and design non-material incentive for MSG. Currently, with poor diversification of MSG activities, it is challenge for members to maintain motivation to continue the activities. Potential non-material incentive scheme includes awards, competition and certificates (high priority).

8) Exit strategy is further detailed and elaborated by Action Against Hunger-SL mission in consultation with key stakeholders including DHMT, MoHS and MAFFS on the roles and responsibility to be performed by respective stakeholder to maintain the activities and services after the withdrawal of the project support. The preliminary discussion was made at the Lessons Learnt Workshop, of which results have not been in sufficient detail and depth (high priority).

9) TOR of the secondment to DFN-MoHS is reviewed by Health and Nutrition HoD, in consultation with MoHS as well as HQ; Ideally, the position should be full-time and less number of specific tasks.

10) Action Against Hunger food security HoD and the team develop a list of IGA based on market analysis with consideration of DO NO HARM principle for nutrition-sensitivity. The list should be used by participating groups to opt for their activity. This also helps promote ownership and encourage participation of group members in IGA activities (medium priority).

11) Health and Nutrition HoD, expert in consultation with DHMT and MoHS, review IMAM protocol for response procedures in case of RUTF shortage. Action Against Hunger HSS methodology is providing orientation for it. At the time of evaluation, several OTP sites reject patients without consultation and admission. The shortage often extents for several weeks (medium priority).

12) Increase the level of working with CSOs partners to strengthen their capacity for increase impact and sustainability of advocacy strides made.

Long-term recommendations

13) Consider integration of WASH through WASH support for selected PHU.

Annex I: Evaluation Criteria Rating Table

Criteria	Rating (1 low, 5 high)					Rationale
	1	2	3	4	5	
Design						Needs were assessed but without gender analysis. More efforts were made than before to take into account gender in the project design as illustrated by Father Support Group (FSG). There were several indicators that Action Against Hunger staff found difficult to report against. The exit strategy discussion was still not matured and need to be further detailed. The project applied very solid M&E systems. Apart from men's participation, some other recommendations were not considered in the project. Barrier Analysis conducted but the results were not integrated into the project BCC strategy.
Relevance/ Appropriateness						The project designs were based on understanding of the local context and aligned and contribute to the national policies and strategies of nutrition. Training methods were all considered relevant in local practice and culture. Several needs assessments conducted before the implementation and the assessment results informed needs, current knowledge, experiences, skills and gaps which were useful for taking into account the beneficiary needs in the project implementation. Several considerations needed in terms of timing and contents for increased usefulness of the assessments.
Coherence						The project was designed through consultation process with key stakeholders and regular updates were shared at the coordination meetings. Delay of Service Agreement Contract caused the project starting without formal inception to stakeholders. Integration of this project with other Action Against Hunger program existed in the target area. However, there has been very limited integration with WASH projects. The project was implemented with well integrated and synergetic linkages between health/nutrition, food security and advocacy. Some challenges still remained in actual integration of the activities of the health/nutrition team and food security team.
Coverage						IMAM coverage was estimated to be 51.2%, below the SPHERE standard. The current targeting of Western area was considered appropriate. But the targeted 32 PHUs may not be the most vulnerable ones among all the others. Mother Support Group (MSG) members was still a small part of the total women and most vulnerable women in many cases may not be participating in MSG. 25% of MSG received Income Generation Activities (IGA) supports and the selection was mainly based on vulnerability. Referrals of SAM children were practiced with improved accurately. MSG members were with or without inclusion of teen-ager pregnant women while husbands were rarely member of MSG. The selection criteria and methods of LM and MSG members were well understood by local stakeholders. On the other hand, the selection criteria and method of IGA target groups was not uniformly understood.
Efficiency						Resources were generally properly allocated with minor over or under spendings. All target health facilities were provided with adequate equipment and materials. Exception was equipment not distributed according to caseload which differed significantly between the two IPF. Cash transfer was more effective and efficient than in-kind provision. Use of service provider was effective. The project activities were delayed due to several reasons such as the new CHW policy of MoHS, mudslide and procurement procedures. The current management set-up was efficient and the position of Nutrition Security Expert was considered important. Group based IGA support was considered more effective. Consideration of food security factor and inclusion a vice-leader in MSG member selection would contribute to better IGA performance. IMAM training approaches used were very participatory hence enhanced learning among the participants. Selection of participants and duration of IGA training could be improved for better training outcomes. Identification of IGA types could be improved to maximize nutrition-sensitivity while maintaining interest of members.

Effectiveness						Most of the project activities were implemented according to plan and the intended outputs were achieved. Effective linkage between CHW and LM was established and supported. Some challenges still remained in IMAM coverage, improvement of some IYCF practices and advocacy works. The project faced several negative external factors but the project team responded to them with effective and focused trainings, on-the-job coaching and communication. The project applied very solid M&E systems and resource coordination has been well organized. At national level coordination, Action Against Hunger took part in several technical coordination mechanisms and Nutrition Security Expert was seconded to DFN-MoHS. Several difficulties were experienced in monitoring and partnership agreement with FANSI-S which was completed due to capacity of the agency.
Sustainability and Likelihood of Impact						The project was very much based on the long-term context. Through capacity building focuses, health workers, CHW, LM and DHMT have increased their skills and knowledge to continue their respective services and management. As compared to a good likelihood of sustaining MSG activities, sustainability of IMAM services is negatively affected by relatively poor supporting environment. Financial sustainability of Harmonized Framework is questionable. Likely positive impact of IGA included 1) increased FCS among the beneficiaries, 2) perceived sense of empowerment, improved health and better breast milk among mothers, 3) increased passion among the MSG members for their activities. IGA could also give some negative impacts. Other impacts included positive change of some IYCF and maternal nutrition practices among MSG members and improved access to quality OTP/IPF services. Challenges still remained in complementary feeding practices. Those likely impacts were not yet translated into change of nutritional status. Some testimonies indicated FSG's contribution to activities related to nutrition and food security. Largest contribution of the project for SUN and SUNI-CSP was Budget Tracking Analysis

Guidance for rating the evaluation criteria:

Rating	**Definition**
1. Unsatisfactory	Performance was **consistently below expectations** in most areas of enquiry related to the evaluation criteria. **Overall performance** in relation to the evaluation criteria **is not satisfactory** due to serious gaps in some of the areas. Significant improvement is needed. Recommendations to improve performance are outlined in the evaluation report and Action Against Hunger will monitor progress in these areas.
2. Improvement needed	Performance **did not consistently meet expectations in some areas of enquiry**– performance failed to meet expectations in one or more essential areas of enquiry. Some improvements are needed in one or more of these. Recommendations to improve performance are outlined in the evaluation report and Action Against Hunger will monitor progress in these key areas.
3. On average meets expectations	On average, performance **met expectations** in all essential areas of enquiry and the overall **quality of work was acceptable**. Eventual recommendations over potential areas for improvement are outlined in the evaluation report.
4. Meets expectations	**Performance consistently met expectations** in all essential areas of enquiry, and the overall **quality of work was fairly good**. The most critical expectations were met.
5. Exceptional	**Performance consistently met expectations** due to **high quality of work** performed **in all essential areas of enquiry**, resulting in an **overall quality** of work that was **remarkable**.

Annex II: Good practice

Title of Good Practice
Mother Support Group improving Household Diets by Small Scale Business
Innovative features and key characteristics
MSG in Waterloo was established in 2015 and has been conducting activities such as bi-monthly nutrition group meetings to discuss nutrition issues using counselling cards. With the project IGA support for training and seed money for capital, the group started fish selling in 2016 in order to improve their income and dietary diversification, hence improving their nutritional status. LM manages the income collected from members to maintain the capital, re-investment and profit distribution among members. The profit money helps the members practice what they learnt from the nutrition talk sessions such as purchase of foods or soap or spend for medical care
Background to the Good Practice
Based on the need to consider both affordability and accessibility to food stuffs in order to improve dietary diversity for preventing malnutrition, the group previously worked on backyard gardens for household consumption and income generation. The project supported seeds for it. However, due to insufficient land available for gardening in the urban dwelling setting, it was challenge for them to work on gardening. Supported by Action Against Hunger on IGA training on technical topics and business management skills, 'on job' trainings and conditional cash transfer to establish sustainable income generating activities, they started small business of fish processing / preservation. Before the transfer, the Lead Mothers of the MSGs signed a memorandum of understanding (MoU) with Action Against Hunger and the Ministry of Agriculture, Forestry and Food Security (MAFFS) to ensure that they were clear about their roles and responsibilities and those of Action Against Hunger regarding the utilization of the money to help them to establish IGAs for addressing the underlying causes of malnutrition.
Further explanation of the chosen good practice
The group continue to meet on nutrition discussion twice a month while extra meeting were also held weekly to run the small business. They used a part of the capital to purchase processing equipment and the remaining was used to buy raw fish from fish market which was distributed to members who sell it individually. The sales are all collected by the leader who replenish to the capital first and then distribute the surplus to members. The profit can be 100,000 or even more per person per week. The money was used for foods, VLSA share, household's items, medical cost and school fees. Most of the member asked their husbands' permission to use the money but nobody had complaint by husbands. In terms of benefit of the income for nutrition, some of the answers are lactating mother can eat more foods which help more breast milk, and pregnant women and mothers have good health as they learnt good foods and now actually can eat them)•
Practical/Specific recommendations for roll out
Group members can be expanded if the current capital money increase to a sufficient level...The practice can be replicated to other groups if essential training and capital support are available. Apart from Action Against Hunger support, access to capital could be obtained from other potential sources such as formal or informal finance, government social protection scheme, and private sector engagement.
How could the Good Practice be developed further?
Impact assessment should be conducted to validate the impact. Exchange visits between different MSG will enhance capacity of different MSG *Evidence-based advocacy to promote*

Annex III: List of persons interviewed

No.	Date	Organization / Office	Name	Title	Methods
1	4-Jun-18	Action Against Hunger - West Office	Alessandro Dalle Carbonare,	Food Security and Livelihoods HoD	KII
2			Mumin Kallon	Dupty HoD - Health and Nutrition	KII
3			Aruna	Advocacy Expert	KII
4	5-Jun-18	Action Against Hunger - East Office	Fatima Azizova	Field Coordinator East Freetown	KII
5			Claire Kimurahebwe	Nutrition Security Expert	KII
6			Emmanuel D. Kemoh	Food Security and Livelihoods Project Manager	KII
7			Andrew Manah Kargbo	Head of Project (Food Security and Livelihood)	GI
8			Admay Gebeh Mustapha	Field Monitor	
9			Hassan Jaei Juana	Capacity Building Nutritionist	GI
10			Alicious Ndanema	Community Mobilizer	
11	6-Jun-18	Waterloo CHC (OTP)	Memunatu Favour Hassan	MCH aid	KII
12		Waterloo CHC	Martha Conteh	CHW	KII
13		Waterloo	Yamma Samunka	MSG Lead Mother	FGD, Obseva tion
14			Elizabeth Bangura	MSG members (IGA - Fish)	
15			Yeaby Kargbo		
16			Abigiel Samura		
17			Aminata Kargbo		
18			Mariatu Kamara		
19			Adiline Bendu		
20			Mamusu Kargbo		
21		Hastings CHC (OTP)	Musus Mansaray	OTP in charge	KII, FGD
22		Hastings CHC	Victoria Deen	CHW	GI
23		Hastings CHC	Laura Chine Decker	LM	
24		Hastings	Abioselu D. Iqaru	MSG Lead Mother	FGD
25			Edith Columbia	MSG members	
26			Menneh Turay		
27			Mary Gbankoy		
28			Lovette Jones		
29			Kadietu S. Kemare		
30			P. Ynamu,		
31			Honneh K, Murrie Tunay		
32			Meshella Sawyen		
33		Action Against Hunger - East Office	Francess Boima	Nutrition Project Manager	KII
34	7-Jun-18	King Harman Road Hospital (OTP)	Iye Maciatu Kamara	State Enrolled Community Health Nurse (SECHN)	GI
35			Minta Jalloh	MCN	
36		King Harman	Ginate Johnson	CHW	KII

		Road Hospital			
37		King Harman Road Hospital	Olivie George	FMC member	KII
38		King Harman Road	Mariama Kargbo	MSG Lead Mother	FGD
39			Abibabe Teray	MSG members	
40			Isatu Sankoh		
41			Mamunatu Simah		
42			Faturata Yamara		
43			Kadiya Kangbo		
44			Aminata Kamara		
45			Mumunatu Sanuya		
46		Western Area	Isafa Courel	Nutritionist	GI
47		DHMT (Western Rural)	Sylvia Yajah	Nutritionist	
48	8-Jun-18	Grafton CHC	Isatu M. Kanu	State Enrolled Community Health Nurse (SECHN)	KII
49		Grafton CHC	Jamestina Panda Younge	Community Health Officer (CHO)	KII
50		Grafton CHC	John Kamara	CHW	Kii
51		Grafton	Susan Sylvia Dyke	MSG Lead Mother	FGD
52			Famumata Kabbia	MSG members	
53			Hawanatu Bangura		
54			Metty Kamara		
55			Victoria P. Dyke		
56			Adama Sesay,		
57			Kadiatu Mansaray		
58		DHMT (Western Urban)	Kadie Yata Kanteh	Nutritionists	KII
59		Blessed Mokaba CHC (OTP)	Isatu Kamara	State Enrolled Community Health Nurse (SECHN)	KII
60		Blessed Mokaba CHC	Abu Bakarr Sesay	CHW	KII
61		Blessed Mokaba	Botteh Sangan	MSG Lead Mother	FGD
62			Alimatu Conteh	MSG members	
63			Sia Bangura		
64			Lucy Fanta John		
65			Finnah Canteh		
66			Marie Kamaru		
67			Salematu Kamara		
68			Sally Kabbia		
69	9-Jun-18	Malama CHP (OTP)	Timuni Akinwumi	OTP in charge	KII, FGD
70		Malama CHP	Amadu Kargbo	CHW	GI, Obsv
71		Malama CHP	Sia Momoh	FMC member	
72		Malama	Abibatu Turay	MSG Lead Mother	FGD
73			Adama Sesay	MSG members	
74			Fudia bangua		
75			Mary Bangua		
76			Mabiuty Mustapha		
77			Isatu A. Kamara		

78			Sia R. Cante		
79		Malama	:Isatu SEsay	MSG Lead Mother	FGD, Obsv.
80			Aminata Gbao	MSG members (IGA - Assorted Items)	
81			Ngabi Squire		
82			Mammi Gbondo,		
83			Janet Sam		
84			Mariama Gbao		
85			Marian Koroma		
86			Fatmata Kamara		
87	11-Jun-18	Signal Hill MCHP (OTP)	Isato John	OTP in charge	KII
88		Signal Hill MCHP	Alie Bantama	CHW	KII
89		Signal Hill	Kadiatu M. Sesay	MSG Lead Mother	FGD
90			Aminata Kargbo	MSG members	
91			Isatu Bah		
92			Rugiatu Sesay		
93			Hannah Stevens		
94			Memuna Sesay		
95			Aminata Koroma		
96			Janet N. Gahuja		
97			Fatumata Kamara		
98		Looking Town MCHP (OTP)	Sallay Tamba	PHU-in-charge	GI
99			Manama Krgbo	OTP in charge	
100		Looking Town MCHP	Mbalu Mansaray	CHW	KII
101		Looking Town	Lansana Samura	Lead Father (FSG - Takula)	KII
102	12-Jun-18	Ola During Hospital (IPF)	Nancy Njavomso	Nutritionist	KII
103		Ola During Hospital (OTP)	Freserica Powers	SECHN (OTP-In-charge),	GI
104			Messie Kannel	SECHN (OTP-in-charge, assistant),	
105			Francess Gnekpa	SECHN (OTP-in-charge assistant)	
106		Ola During Hospital	Lamin M. Kamara	CHW	KII
107		Ola During	Isatu Ayub	MSG Lead Mother	FGD
108			Fatumata Koromo	MSG members	
109			Fatima Ayub		
110			Sallay Koromo		
111			Sento Bangura		
112			Hawanatu Kamara		
113			Fatmata Sesey		
114		Jenner Wright CHC (OTP)	Fatmata A. Turay	SECHN, OTP-in-charge	KII
115		Jenner Wright	Joseph B. Kamara	FSG Lead Father	FGD
116			Alhaji Mohamed Fofanah	FSG members	
117			Joseph Kamara		
118		Leicester	Tombo Canpbell	Lead mother -MSG with IGA (vegetable)	KII, Obsev.
119	13-Jun-18	34 Military Hospital (IPF)	Lt Col Gatrude Mansaray	Sister	KII

120			Lt. Faila Johnny	Sr. in charge	KII
121		34 Military Hospital (OTP)	Mamie Koroma	OTP in charge	GI
122			Esther Kai (EPI)	EPI	
123			Gertrude A.K. Mansaray	Sr. in-charge	
124		34 Military Hospital	Cecilia Mamie	CHW	GI
125			Sai Grace Koroma	CHW	
126			Sama Conteh	CHW	
127		Thompson Bay CHP (OTP)	Hannah Kanneh	MCH-aid	KII
128		Thompson Bay CHP	Kandeh Kamara	CHW	KII
129		Thompson Bay CHP	Alhassan Conteh	FMC member	KII
130		Thompson Bay	Sally Goba	MSG Lead Mother	FGD
131			Aminata Fofonar	MSG members	
132			Haja Kabbah		
133			Yeli Kargbo		
134			Fatmata Kamara		
135			Mariama Bah		
136			Aminata Kamara		
137			Fatmata Bangura		
138			Jeneba Kamara		
139			Hugiatu Samura		
140			Samadu Kamara		
141			Afeda Koroma		
142			Bunta Bane		
143			Fatmata Kamara		
144			Aminata Kamara		
145	14-Jun-18	DHMT - Western Urban	Aminata Nunie	DHS-1, DHMT members	GI
146			Sahr Gtandeh	Principal CHO, DHMT members	
147		SUN - Secretariat	Mohamed B.K. Foh	SUN National Coordinator	KII
148		SUNI-CSP	Mohamad B. Jalloh	SUNI-CSP coordinator (CEO, FOCUS1000)	KII
149		District Agriculture Office	Fatama Lamrana Bangura	Sr. M&E Officer, Acting District Agriculture Officer	GI
150			Alfred Tambi	M&E officer	
151	18-Jun-18	DHMT - Western Rual	Stephan Koroma	District Social Mobilization, DHMT members	KII
152		Food and Nutrition Department - MoHS	Aminata Shamit Koroma	Director	KII
153	21-Jun-18	Planning, Evaluation, Monitoring and Statistic Division (PEMSD), MAFFS	Mohamed Ajuba Sheriff	Deputy Director	KII

Annex IV: List of documents reviewed

Action Against Hunger's Evaluation Policy and Guideline
Project Proposal and Amendments
Sierra Leone National Nutrition Survey 2014
GoSL Basic Package of Essential Health Care Services 2015
Population and Housing 2015
Essential Medicines List
ACF WASH Nutrition manual
ACF SL Country Strategy
Anemia Strategy 2017
NHSS Strategis Plan 2010-2015
SL National Strategy Ebola Recovery 2015-2017
SL CHW Policy 2016-2020
SL Micronutriient Survey 2013
SL Anemia Strategy 2017
SL SARA 2017
FMC strategy 2017
Action Against Hunger: Aligning Health and Nutrition Strategy
Project Interim Reports
Project Baseline survey reports
Project Barrier Analysis report 2017
Project Semi Quantitative Evaluation of Access and Coverage (SQUEAC) report 2017
Mother to mother support groups: a guidance document, 2016
Sierra Leone Livelihood Zoning Report 2016
Comprehensive Food Security and Vulnerability Analysis (CFSVA) 2015
Sierra Leone National Nutrition Survey report 2017
Irish Aid Project Final External Evaluation 2015
ACF Gender Policy and Toolkit
Action Against Hunger Agro-ecology position paper 2017
Action Against Hunger Our Expertise Food Security and Livelihoods
Tracking Government Expenditure on Nutrition in Sierra Leone 2017
Support, Protect and Promote Breastfeeding: Parliamentarians Workshop (Final Report)
Civil Society Statement: To integrate nutrition in Sierra Leone's ICADEP
Final draft of Inclusive Comprehensive Agriculture Development Plan (ICADEP)
Food and Nutrition Security Implementation Plan 2013-2017
Nutrition Sensitivity Analysis of ICADEP
Policy and Plan Overview – Sierra Leone (Done by REACH)
Nutrition Security in Sierra Leone – Case Studies (1st year and 2nd year)
Mama Salone Newsletters (Volumes 7 to 10)

Annex V: Inception Report

Version dated: 6 June 2018

Inception Report for Independent Final Evaluation

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

Koichiro Watanabe

1. Evaluation Background

The health status of Sierra Leoneans is still amongst the poorest in the world. As of 2015, Sierra Leone ranks fifth for under-five mortality rate (119 deaths/1000 live births), and the worst for maternal mortality (1,360 deaths/100,000 live births)[3]. Overall, from 2010 to 2014, stunting and wasting rates improved. Stunting among children under-five decreased from 34.1% to 28.8%. During the same period, wasting among children under-five decreased from 6.9% to 4.7% The 2017 findings indicate a plateau and no significant improvement from 2014 results; stunting at 31% and wasting 5.1%. 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 has been improving but still stood at 62% in 2017. There also remain disparities in nutrition with respect to complementary feeding. With respect to feeding for infants and children - In 2017, only 44% and 30% of children in Sierra Leone received adequate number and diversity of feeding respectively. Additional efforts were needed to build on this progress towards scaling up nutrition and to reach the N4G targets by 2020.

This project is the continuation of the project Action Against Hunger implemented from September 2013 to October 2015 in Western Area. The areas of interventions were chosen along with representatives of the Ministry of Health and Sanitation (MoHS) and the Ministry of Agriculture Forestry and Food Security (MAFFS). The specific objective of the project is to reinforce institutional capacity for quality treatment of acute malnutrition, improve preventive strategies and to raise national awareness on nutritional security in the communities. The aim of the project is to strengthen the capacities of the MoHS at local and national level to ensure quality implementation of the Integrated Management of Acute Malnutrition (IMAM) protocol following its national revision in 2014.

As per phase I, this project proposal is part of a larger regional intervention in West Africa, co financed by Agence Française de Développement - French Development Agency (AFD) which 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 in West Africa.

Through this intervention Action Against Hunger aims to improve the nutritional status of children under-five and Pregnant Women and Lactating Mothers (PWLM) by intervening to strengthen the health system, at community and health facility level, and by implementing preventive approaches tackling the direct causes of undernutrition.

[3] WHO Global Health Observatory (GHO) data

Whilst this intervention represents the second phase of a project co-funded by Irish Aid, implemented in the period 2013-2015 in Western Area, which has proven to be effective in improving the nutritional knowledge and status of the targeted communities, it also takes in consideration the recommendations highlighted in the external evaluation conducted in September 2015, and the needs expressed by stakeholders and the communities.

The specific objectives of the project are:

1. Improving the nutritional status of children under-five and Pregnant Women and Lactating Mothers (PLW) through the integration of nutrition in a strengthened health system and in preventive approaches to the direct causes of undernutrition;
2. Mobilizing contributing sectors to address the underlying causes of under nutrition in a holistic, integrated and sustainable way;
3. Enabling political, social and sectorial environment is created for the scaling-up of the fight against acute malnutrition based on the experiences of Action Against Hunger and civil society in Sierra Leone

Under the specific objective-1, technical supports were provided to Directorate of Food and Nutrition (DFN) within MoHS at national and district level and the health staff in Peripheral Health Unit (PHUs) and Hospitals in the implementation of the IMAM protocol. District Health Management Team (DHMT) was also supported for strengthened coordination. Community Health Workers (CHWs) were trained and provided with the tools to conduct community activities while Mother Support Groups (MSGs) were trained and supported to promote IYCF practices and monitoring nutritional status of the children. Community health clubs and fathers' groups were also supported with specific behaviour change approaches. SQUEAC, KAP surveys and Barrier Analysis were conducted to assess IMAM coverage and understand deeper the reasons for undernutrition. Cooking demonstrations were organized at PHU level targeting pregnant women and mothers of children under two. Ad hoc secondment of an international nutrition expert was provided to the DFN. The DFN was directly involved in joint supervision visits at the implementation sites.

Under the specific objective-2, technical support was provided on the inclusion of nutrition indicators in national surveys and analyses. At community level, community groups (Mother Support Groups and Father Support Groups) were supported to prevent malnutrition through vegetable production and to improve their livelihoods through income generating activities (IGAs). Village Savings and Loan Association (VSLA) groups were also established and provided with equipment and training. Photo-based counselling cards are planned to be developed.

Under the specific objective-3, advocacy works were conducted at national level for better integration of nutrition in the strengthened health systems through supports for media campaigns, the endorsement of the Code of Marketing for Breast milk Substitutes (CMBS), budget tracking, production of case stories, analysis of policy documents. Civil society's role is facilitated in national policy influencing processes, conducted awareness raising activities and high level events with the local civil society.

2. Scope and Purpose of Evaluation

This evaluation is conducted as an exercise of accountability towards the donor and the beneficiaries. It is also expected to contribute to better understand the strengths and

weaknesses of the intervention, drawing lessons learnt and making operational and strategic recommendations that can be used to improve the implementation of a potential next phase or similar interventions in the future. While the most immediate user of the evaluation will be Action Against Hunger (Head quarters, SL Country Teams) and Irish Aid, indirect users are wide-ranging including Action Against Hunger's International Network, relevant ministries and government in Sierra Leone, donors, partner organizations, UN agencies, Global Clusters and NGOs

The overall purpose of the evaluation is to assess the overall performance of the project and to determine if the intervention has reached its intended outputs and objectives. In particular, it will assess to what extent (and the reasons why) the project's outputs have contributed to the improvements in the nutritional security of children and mothers in Western Areas.

The specific objectives of the evaluation are:

- To assess whether the design of the project is based on beneficiaries needs (sex and age disaggregated), recommendations from previous projects and studies, has a sustainability strategy and allows for Results-Based Monitoring
- To assess whether the project is relevant and appropriate given the local context, culture and needs of the population
- To assess whether the project is aligned with other interventions by Action Against Hunger and with interventions by other actors and to what extent the different technical sectors were integrated in this project
- To assess whether the project was able to reach the most vulnerable groups
- How efficient was the use of resources in achieving the project objectives?
- To assess to what extent the project objectives were achieved and what was the quality of the achievements?
- To assess the sustainability of the project interventions
- To assess the impact of the project

The evaluation focuses on the entire project funded by Irish Aid and AFD for the entire project period (1/6/2017 - 31/5/2018[4]). It covers all geographical areas and all selected target groups of beneficiaries; in the Western Urban and Western Rural districts of Western region, Sierra Leone, these were 5,532 target beneficiaries (government health workers, CHWs, Lead mothers and Mothers Support Groups (MSG) and Father Support Groups (FSG). The indirect beneficiaries were 1,517,194 persons, including children under five years, pregnant and lactating women and the communities. It also looks at different levels of the intervention (community level, district level, and national level) and at the links between those levels and cover. It examines the implementation of all activities and the degree of achievement of all outputs and objectives and include a gender analysis, explores the differences in vulnerabilities between men, women, boys and girls, how the project addressed these gender equalities and how a new project can improve on this. Furthermore, the evaluation shall assess any potential negative consequences of the project on the gender equality situation.

3. Evaluation Methodologies

Overall design of the evaluation is to look at those who participated in the project and assess changes over time before and after the project without including any comparison with units

[4] Although the project has been extended to 31/7/2018 through a No Cost Extension, most of the project field activities have been already completed

(people, communities, etc.) that did not participate in the intervention. The evaluation approach follows Action Against Hunger Evaluation Policy and Guidelines and adheres to the Development Assistance Committee (DAC) criteria for evaluating its programmes and projects. In addition, Action Against Hunger applies “Design” criteria: Hence, the applied criteria are Relevance/Appropriateness, Coherence, Coverage, Efficiency, Effectiveness, Sustainability and Likelihood of Impact. The pre-designed evaluation questions included in TOR and the criteria guides key information to be gathered and data source / means of data collection which is summarized in the evaluation matrix (**annex**). For each of the main evaluation questions, several sub-questions are formulated to be asked to different data source to ensure triangulation. In particular, theory of change associated with the Mother Support Groups will be critically reviewed in order to frame appropriate questions to test the assumption. The IASC Gender marker scoring will be applied to the project design in the selection of beneficiaries and activities and is discussed in the findings for ‘Design’ and ‘Coverage’.

The external and independent consultant is recruited to conduct a final independent evaluation between 30 May 2018 and 12 July 2018. The assignment is for approximately 29 work days during that period including 21 days in Sierra Leone. Qualitative methodologies such as Key Informant Interviews (KII) and Focus Group Discussion (FGD) will be used for primary data collection for the evaluation. At the same time, secondary data analysis will be performed using available data such as project records and beneficiary database. All collected data are triangulated to ensure validity of conclusions. Qualitative information will be compared and as well as complementing quantitative analyses. Efforts will be made to ensure collecting sex and age disaggregated data when possible. Data tools are developed by the consultant for review and necessary revisions and modifications by Action Against Hunger Sierra Leone Team and Head Quarters (UK, France)

- **Desk review**: Review of project materials, including the project documents and proposals, progress reports, outputs of the project (such as publications, communication materials, case stories, etc.), results of any internal planning process and relevant materials from secondary sources which include government policy and strategy documents, ACF program policies, survey reports, related technical protocol and literatures.
- **Interview with ACF staff:** Key individuals of Action Against Hunger Sierra Leone mission and project staff (expatriate/national project staff), are interviewed to collect necessary information. Also, any additional project records and data are collected for review and analysis. Aside from the questions for evaluation grid, focus will also be put on the implementation process of project activities, role performed by different stakeholders, perceived challenges and constraints as well as appreciated strengths of the project.
- **Interview with project stakeholders at national and district levels:** A proposed list of key stakeholders and main questions to be asked will be shared with Action Against Hunger mission before departure to help making relevant appointments in time. Main stakeholders to be interviewed include UN agencies, NGOs, cluster leads, donors, government ministries and DHMT.
- **Interviews with project participants**: Field visit is organized to carry out 1) key Informant Interviews with local authorities, community leaders and other key project participants such as community health workers and 2) focus group discussion (FGD) with beneficiaries. The both will use interview guides prepared before the field visit.

Selection criteria and method of selection of FGD participants will be determined based on document review and discussion with ACF staff.

Focus group discussions (FGD): The focus group discussion approximately 6 - 12 persons guided by a facilitator, during which group members talk freely and spontaneously about a certain topic. A FGD is a qualitative method. Its purpose is to obtain in-depth information on concepts, perceptions and ideas of a group. A FGD aims to be more than a question-answer interaction. The idea is that group members discuss the topic among themselves, with guidance from the facilitator.

Key informant interview: A key informant interview (KII) is qualitative in-depth interview with people who have a specific area of expertise, a particular role or responsibility, and/or have an in-depth understanding of what is going on in the community. KII will be used mainly with health workers, volunteers and community leaders. However, it may also be used with other key informants when necessary.

- **Observation**: Project related activities such as OTP, SC, gardens, etc and facilities are observed.

Sampling: Given the timeframe for the evaluation and requirement of diverse information to be collected, it is not possible to exhaustively visit all programme areas; therefore, it is necessary to take a sampling of locations. It is proposed that a random sampling of around 12 (38%) of the PHUs in the programme will be conducted and one village will be randomly selected from the catchment area of the selected PHU. Type of facilities, distance, direction and the day for OTP will be considered in formulating day-to-day visit schedule. Interviews with health workers will be conducted at the PHU while mothers will be interviewed mainly at community. In addition, observation and focus group discussion will be conducted at several communities where MSG/FSG are engaging in vegetable production and/or income generation activities. It is estimated that approximately 3-4 stakeholders will be interviewed at each of the 2 district and at least 5 at national levels.

Data collection and analysis: Action Against Hunger and local staff will support appointment and arrangement of the interviews. A translator will accompany the consultant during the field visits, for translating Krio/English during interviews. and occasional translation when needed. All the interview notes are taken and kept as backup. The gathered data will be analyzed using EXCEL and summarized according to the evaluation grid to answers each of the evaluation questions. The rating will be carried out based on the summary table. Lessons learnt and good practices will be identified and described following the pre-specified format.

Stakeholder workshop: Preliminary findings will be shared for discussion at a half-day workshop to gather feedback on the findings and build consensus on recommendations.

4. Detailed Work Plan

The evaluation will be carried out in a total of 29 working days as shown in the table (**annex**)

5. Reporting Formats

The evaluation report follows the following format and be written in English. It will be not longer than 30 pages, 50 pages including annexes.

- Cover Page;
- Summary Table
- Table of Contents
- Executive Summary
- Background Information
- Methodology
- Findings
- Conclusions
- Lessons Learnt and Good Practices
- Recommendations
- Annexes (Good Practice, Evaluation Criteria Rating Table, list of documents for the desk review, list of persons interviewed, data collection instruments and evaluation TORs.)

It will be ensured that each contents of chapter follows ACF Evaluation Report Template as well as reporting requirements described in the TOR.

6. Limitations

At the time of document review, endline survey reports are not yet available for review. It is expected that the report will be available within 1-2 weeks. Due to limited time for preparation, some of the intended interviewees might not be available.