ACF INTERNATIONAL

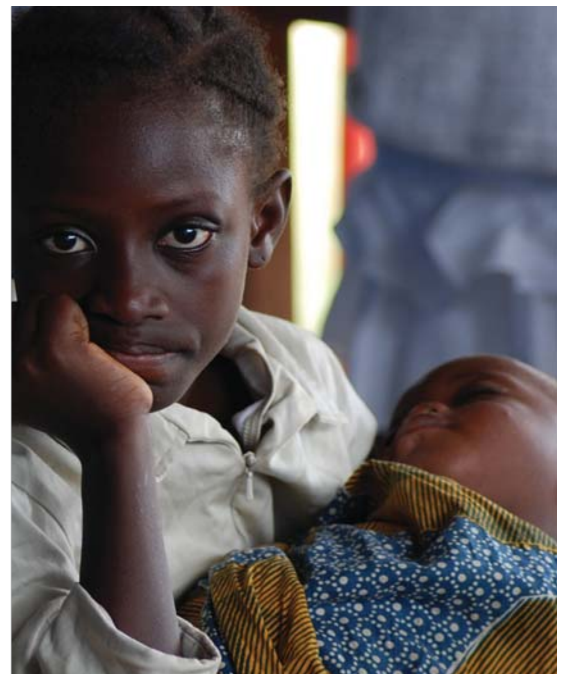
Irish Aid
An Roinn Gnóthaí Eachtracha agus Trádála
Department of Foreign Affairs and Trade

afd AGENCE FRANÇAISE DE DÉVELOPPEMENT

EXTERNAL EVALUATION

AUGUST 2014

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



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

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

Contents

Contents 1
Acronyms 2
Executive Summary 3
Background Information 6
  Context 6
  Programme area and scale-up 7
  Programme approach 8
  Scope of Evaluation 8
Methodology 10
Findings and Discussion 12
  Treatment of severe acute malnutrition 12
  Community health workers 16
  Mother-to-mother groups 18
  Programme data 19
  District level 21
  National level 21
DAC-based Rating Table 24
Best practice 27
Conclusions and Recommendations 28
Annex 1: Rates of global, moderate and severe acute malnutrition by district 34
Annex 2 List of ACF supported OTPs and SCs and their location 35
Annex 3 Outputs to be evaluated 0
Annex 4 Evaluation matrix 5
Annex 5 Stakeholder Analysis 6
Annex 6 Recommendations from 'Developing State Capacity to Prevent Malnutrition in Sierra Leone', Focus 1000 (Feb 2014) 7
Annex 7 References 8

Acronyms

ACF	Action Contre La Faim
CBN	Capacity Building Nurse
CHW	Community Health Workers
CMAM	Community-based Management of Acute Malnutrition
CMO	Community Mobilisation Officer
DAC	Development Assistance Committee
DHMT	District Health Management Team
DLO	District Logistics Officer
DMO	District Medical Officer
FGD	Focus Group Discussion
FND	MoHS Food and Nutrition Directorate
HSS	Health Systems Strengthening
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitudes and Practice
MoHS	Ministry of Health and Sanitation
MUAC	Mid-upper arm circumference
NGO	Non-Governmental Organisation
NPPU	National Pharmaceutical Procurement Unit
OTP	Outpatient Therapeutic Programme
PHU	Peripheral Health Unit
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SC	Stabilisation Centre
SFP	Supplementary Feeding Programme
SLEAC	Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage
SMART	Standardized Monitoring and Assessment in Relief and Transition
SQUEAC	Semi-quantitative Evaluation of Access and Coverage
UNICEF	United Nations Children’s Fund
WFP	World Food Programme

Executive Summary

This evaluation comes mid-way through the current phase of the nutrition programme in Freetown which started in July 2012, although support to health facilities began in December 2012, and is due to finish in August 2015. From the start of the programme, ACF has supported 14 Peripheral Health Units (PHUs) (at the beginning ACF supported 15, but one was handed over to GOAL and was replaced by another one, while another OTP closed and only community activities were continued) to deliver an out-patient therapeutic programme (OTP) but has not been able to support the 20 PHUS planned in the proposal as the Food and Nutrition Directorate (FND) of the Ministry of Health and Sanitation (MoHS) has stipulated that ACF should await endorsement of the revised community-based management of acute malnutrition (CMAM) protocol before scaling up with the final six. At the outset, a Stabilisation Centre (SC) was supported in one referral hospital but due to an overwhelming caseload and inaccessibility for those living in the western part of the city; another SC was established in a military hospital.

As well as supporting the treatment of acute malnutrition at facility level, ACF has been supporting a network of community screeners, now termed community health workers (CHWS), to screen and refer cases of acute malnutrition and follow up defaulters. In addition, with the aim of preventing malnutrition, ACF has established mother-to-mother support groups, a group of 10 pregnant or lactating women led by a Lead Mother, who work through a series of topics, before cascading the approach to form new groups using the strongest women from the previous group as new Lead Mothers. ACF has also been involved with the inclusion of nutrition into the pre-service training curricula of some health staff and, since January 2014, has recruited an advocacy officer to develop an advocacy strategy and support policy efforts at national level. The outputs of the programmes covered by the Terms of Reference of this evaluation are highlighted in Annex 3.

Many of the PHUs supported by ACF were already doing CMAM activities to some extent prior to this programme. When ACF started, it conducted a classroom training for four staff per PHU followed by on-the-job training. ACF has four Capacity Building Nurses who do this. At the time of the evaluation mission, the four CBNs were still visiting each OTP once per week (OTPs function one day per week) and as such it can be said that on-the-job training has continued since the beginning. While this may have contributed to good performance, it has led to a dependency on ACF staff and is also an inefficient use of human resources. ACF could have reduced the level of input much sooner to more sporadic visits revolving around the needs of any particular PHU. That said, the PHU staff are capable and willing so despite the dependency on ACF, the chance of the treatment of SAM being sustained at facility level without ACF is good.

Similarly, in the two Stabilisation Centres the staff are capable and willing and it is reasonable to conclude that treatment can continue without ACF presence. The first SC at Ola During is located at a referral hospital and as such, the caseload is often higher than the capacity. In the military hospital the caseload is much smaller. Here, the SC is adjacent to a paediatric ward where most children are reported to be from military families. There are also discrepancies between military and civilian families with Free Healthcare drugs because although both are entitled to these drugs, the evaluation found that military families were prioritised. These families are also entitled to food for caregivers, whereas civilian families are not. Civilian families have also been required to pay for laboratory tests although this has seemingly been resolved according to ACF staff. This has resulted

in some cases leaving the hospital but ACF is trying to resolve it with the World Food Programme (WFP), the MoHS and the Ministry of Defence (which is responsible for the hospital).

At the time of the evaluation, it was not possible to know whether the CMAM programme has had an impact on levels of malnutrition but the results of the latest national SMART survey, available in September, should give some indication. Whilst most performance indicators are within SPHERE Standards, the defaulter rate is not but, according to programme staff, this is because at Ola During, malnourished cases on the paediatric ward are admitted to the OTP, but when they leave the ward they default from the OTP. When Ola During defaulters are taken out of the calculation, it falls within SPHERE standards. The number of children who are admitted to OTP from the SCs falls far short of the number of children who are cured from SC, which requires further investigation.

The community health workers (CHWS), who are volunteers, work one hour per week in the community although some do attend the OTP session. At the beginning the CHWs were supposed to do quarterly screening with monthly reports but after some time it was apparent that the CHWs were screening all children on a monthly basis. Because of a high workload, in March 2014 the routine was changed to split the target area into three and screen one area per month. This means that a household will only get screened quarterly which creates a risk of having a negative impact on early detection and coverage (ACF is awaiting a national coverage assessment to give more of an indication on coverage). Because of the distortions caused by a long history of varied NGO engagement with community volunteers, expectations now mean that the current CHW cohort cannot be classed as sustainable however the MoHS has brought in a CHW policy with a training manual and taskforce to harmonise practice. Although it will take time to turn the tide towards a culture where CHWs feel owned by the government, the manner in which NGOs interact with them from now onwards can contribute to this.

A certain amount of importance is being placed on mother support groups since they are seen as a primary tool to prevent malnutrition. There have been problems with these groups with mothers coming at the beginning but dropping out when they realise they don't receive anything. Despite this, in a group observed during the evaluation period, the Lead Mother was an energetic lady and the participating mothers were able to repeat back key messages, however, there was little room for discussion. As identified by Denney *et al* (2014), throughout Sierra Leone the theory of change behind these groups has not been clearly defined and some assumptions have been made that may or may not be true. There is a need to test these assumptions and provide a robust evidence base on the effectiveness and impact of these groups.

At national level, ACF has achieved a useful position and is supporting the FND on several policy issues. This gives ACF as platform from which to advocate for critical issues concerning the programme. There are two key issues that constrain the programme most, RUTF stock-outs and staff turnover. ACF is collecting relevant data around the stock-outs to use to advocate for change and it is also exploring ways to overcome the staff turnover issue, inclusion of nutrition into pre-service training for medical staff being one. The comparative advantage of ACF is that it can draw on evidence and experiences from the grassroots and feed them upstream to advocate for change using its position at national level.

- **Recommendation 1: Given the intention for the activities to endure beyond the short-term, ACF should adopt a less 'humanitarian' approach – it has started to do elements of this, but needs to do more**
- **Recommendation 2: Treatment of acute malnutrition at facility level has a chance of sustainability but scale-up should be less HR intensive**
- **Recommendation 3: Peer-to-peer learning works but don't 'overdo it - use nutrition champions strategically**
- **Recommendation 4: Give 34 Stabilisation Centre a time by which to work but explore other options whilst keeping in line with MoHS (national and district) preferences**
- **Recommendation 5: Better understand the outcome of Stabilisation Centre discharges**
- **Recommendation 6: Better understand the reasons for defaulting**
- **Recommendation 7: Ensure early detection and treatment of malnutrition and childhood illnesses:**
    a) **Assess the impact of quarterly screening on early detection and coverage**
    b) **Better understand the barriers for accessing healthcare**
    c) **Strengthen further collaboration with other nutrition and health NGOs**

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

- **Recommendation 9: Understand and strengthen the effectiveness of mother-to-mother support groups:**
    a) **Articulate the theory of change associated with mother-to-mother groups and test the assumptions made in that theory**
    b) **Better understand the impact on the groups have on participating mothers,**
    c) **Continue to strengthen the ownership and linkage of the groups with indigenous networks such as the MoHS at national district and PHU level, Ministry of Agriculture, local organisations, the community, religious institutions**
- **Recommendation 10: Conduct an internal exercise to articulate and define ACF's competencies and limitations at community level and explore options to address gaps**
- **Recommendation 11: The advocacy officer should stay in post to solidify this position and maximise the chance of succeeding on critical advocacy points**
- **Recommendation 12: Continue to focus on health systems strengthening**
    a) **Conduct a Health Systems Strengthening Assessment for Freetown**
    b) **Continue to gather evidence relating to stock-outs and the functionality of the logistics system and convey it upstream to advocate for change**
    c) **Explore sustainable solutions to overcome staff turnover**
    d) **The forthcoming surveillance officer should improve the database to make manipulation easier to facilitate analysis, whilst maintaining simplicity to enable integration with HMIS in the future**
- **Recommendation 13: Facilitate the FND to effectively plan and execute the inclusion of nutrition in the pre-service syllabus for medical staff in collaboration with partners**

Background Information

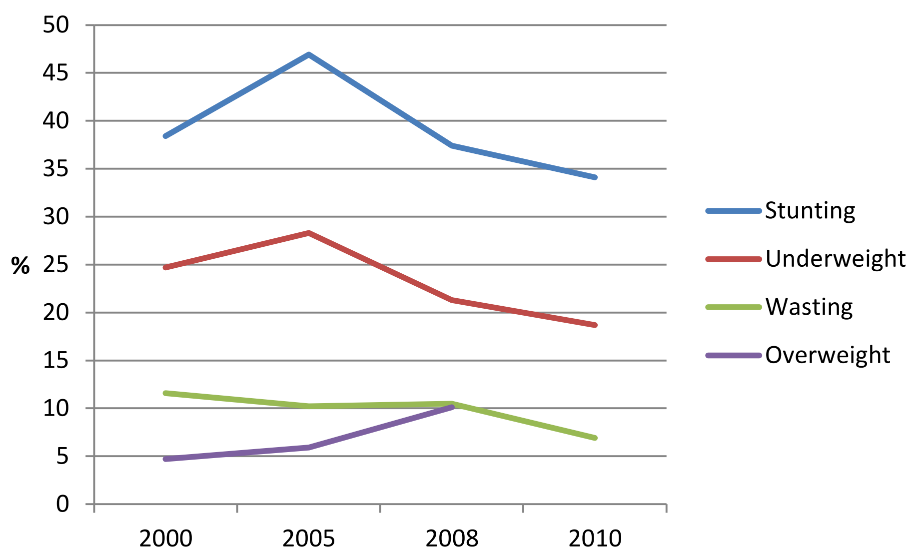
Context

The Ministry of Health and Sanitation (MoHS) has several different initiatives that contribute to the prevention of malnutrition and treatment of acute malnutrition. In April 2010 Sierra Leone launched "Free Health Care Medical Insurance", a system of free healthcare for pregnant and breast-feeding women and children under five to improve health care for women and children. The Community-based Management of Acute Malnutrition (CMAM) programme started as a pilot project in 2007 but this was incorporated into the Free Healthcare Initiative in 2011 with the national protocol for CMAM being developed in 2009 and revised in 2011. A further revision, named the Integrated Management of Acute Malnutrition (IMAM), was finalised in May 2014 but at the time of the evaluation mission it still hadn't been endorsed by the government. CMAM is being implemented in all districts in the country and the government plan is to have at least 50% coverage of PHUs in each district. Some districts have reached this and some have not hence there is a plan to imminently scale-up to reach this target.

The country also has a history of community volunteers that dates back to before the war and community health workers (Blue Flag Volunteers, Community Based Distributors, Community Based Providers, Pump Attendants, Traditional Birth Attendants and Community Vaccinators) are seen as vital to the health system, being responsible for a wide variety of tasks. In 2012 the MoHS launched a CHW policy and strategy designed to harmonise the volunteer system. Mother groups have also been in place for some time, functioning to a greater or lesser degree.

Health indicators in Sierra Leone remain worrisome. According to UNICEF's State of the World's Children report (2014) Sierra Leone has the highest under 5 mortality rate globally (182 per 1,000 live births) and an infant mortality rate of 117 per 1,000 live births. The adjusted maternal mortality ratio is 890. Nutritional indicators show the exclusive breastfeeding rate is 32% while Figure 1 shows improvements in the rates of stunting and wasting between 2000 and 2010, but an increase in the rate of overweight.

Figure 1 Rates of stunting, underweight, wasting and overweight in children under 5 years, 2000-2010



Source: Nutrition Landscape Information System Sierra Leone, WHO and The Nutritional Situation of Sierra Leone, Nutrition Survey Using SMART Methods, 2010, UNICEF

The 2010 Standardized Monitoring and Assessment in Relief and Transition (SMART) survey indicated that some districts of Sierra Leone still had higher levels of acute malnutrition (Annex 1). Furthermore a Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage (SLEAC) and Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) national survey in 2011 found coverage of CMAM to be low in a considerable number of districts.

Against this backdrop the Food and Nutrition Directorate (FND) of the MoHS turned to implementing partners in search of greater support for CMAM and asked ACF to assist in Western urban areas. Already supporting CMAM activities in Moyamba district, ACF began a second nutrition programme in Western urban and rural areas in July 2012, although support to health facilities began in December 2012, with funding from Irish Aid and l'Agence Francaise de Developpement.[1] The current phase of funding is until August 2015.

Programme area and scale-up

During discussions with the FND at the outset, ACF discussed supporting CMAM in Western rural areas as well as Western urban areas but apparently a local non-governmental organisation (NGO) was planning to operate there, although the extent to which activities have been implemented remains uncertain. The FND expressed a preference for ACF to work in Western urban areas to fill the gap where GOAL is not working. There are 64 Peripheral Health Units (PHUs) in this area, 19 of which are supported by GOAL. In accordance with the FND's wishes, ACF began supporting 15 OTPs and 1 Stabilisation Centre at Ola During. Shortly after commencing, the OTP at Iscon was handed over to GOAL and replaced by another PHU at Adbangs as this was deemed more practical, while Rina OTP was closed and only continued with community activities. The programme proposal states that ACF would support 20 OTPs in total but there has been a delay in scaling up the remaining six

[1] Two OTPs are in rural areas

since the Food and Nutrition Directorate has stipulated that they prefer to wait until the endorsement of the new IMAM protocol which has been delayed due to other commitments such as contact point training, national nutrition survey and more recently the Ebola outbreak.

Ola During SC is part of a referral hospital and as such the caseload coming from the hospital was putting a strain the capacity of the SC. It is also located in the eastern part of the city, far from the OTPs situated in the western part of Freetown. ACF consulted the FND about opening a second SC, who recommended that it should be located at 34 hospital, a military hospital. While ACF acknowledged the risky connotations associated with a military establishment, investigations showed that the capacity of other facilities in the area was lacking. Hence a second SC was opened at 34 hospital in March 2014.

At the time of the evaluation mission 14 out-patient therapeutic programmes (OTPs) and 2 Stabilisation Centres (SCs) were being supported by ACF. The list of OTPs and a map showing their location can be found in Annex 2.

Programme approach

At each OTP site ACF supports three elements:

- treatment of severe acute malnutrition (SAM) in the facility
- detection and referral of SAM cases and tracing of defaulters by community health workers
- mother-to-mother support groups

In both OTPs and the SCs, cases are treated by the trained staff at the facility while in the community, detection, referral and tracing is done by trained community health workers. There are 10 mothers groups per PHU and each group has 1 Lead Mother and 10-15 members who are pregnant or lactating women.

At field level, ACF has 4 Capacity Building Nurses (CBNs) and 5 Community Mobilisation Officers (CMOs). The CBNs support the facilities while the CMOs support activities in the community. ACF also supports the District Health Management Team (DHMT). There are 4 District Nutritionists (1 overall manager, 1 for rural, 1 for urban and 1 assistant) while other key people at District level include the District Logistics Officer, the District Medical Officer and the District Surveillance Officer. Within the MoHS at national level, nutrition is housed in the Food and Nutrition Directorate and ACF has been collaborating with the FND for some considerable time. In January 2014, ACF employed an advocacy officer to support develop an advocacy strategy for ACF which then culminated in supporting the FND more on policy issues.

Scope of Evaluation

Coming mid-way through the programme the objectives of the evaluation were to:

1. **Assess the impact, sustainability, coverage, coherence, relevance/appropriateness, effectiveness and efficiency of the project implemented in Western Area Urban district, Sierra Leone, from 2013 up to mid 2014**
2. **Give operational and strategic recommendations for the last phase of the project (e.g. provide insight on exit strategy).**

The recommendations given in objective 2 were based on the findings from evidence gathered to fulfil objective 1.

Not all of the programme activities were part of the Terms of Reference. Annex 3 indicates which outputs were evaluated (selected outputs are shaded).

Methodology

The methodology for this evaluation adheres to the guidance set out in the Terms of Reference and ACF's Evaluation Policy and Guideline.

Evaluation Matrix

Key evaluation questions from taken from the Terms of Reference which formed the basis of the evaluation matrix (Annex 4). Small additions were made following the initial de-brief with the ACF Nutrition Programme Manager. These evaluation questions were categorised under the Development Assistance Committee (DAC) evaluation criteria.

Data collection

The main instruments for assembling data and stakeholder views were:

- **Document/literature review**. A number of different reports, strategies and policy documents relating to different elements of ACFs authored by ACF and other actors were assessed. This evaluation also drew on an evaluation of ACF's other nutrition programme in Sierra Leone, located in Moyamba district, which was conducted in December 2013.

- **Review of secondary data**. This included a collection of programme data as well as survey data conducted by other actors.

- **Key informant and stakeholder interviews** were the main form of primary data collection. The range of interview targets, both at national and district level, was indicated in the stakeholder analysis (Annex 5). All interviews were treated as confidential and were systematically written up by the evaluator which facilitated triangulation of different interviewee recollections and perspectives.

- **Field visits**. Field visits were used to gather more interviews and conduct focus group discussions. A mother-to-mother support group was also observed. Both Stabilisation Centres and 4 out of the 14 PHUs were selected. The table below shows the sites visited. The sites were chosen in consultation with the ACF nutrition staff, based on particular characteristics that may influence performance or how well they were performing. Interviews were held with facility staff and caretakers of beneficiaries.

Table 1 Facilities visited during the evaluation mission

Type of facility	Location	Reason for selection
Stabilisation Centre	Ola During	SC
	34 Military	SC
PHU	Ola During	Highest caseload and located in referral hospital
	Malama	Less well performing
	Looking Town	Accessibility issues
	Hill Station	Well performing

- **Focus group discussions (FGDs).** The field work included FGDs with community health workers, lead mothers, participants of mother to mother groups and members of the community.

Evaluation process, feedback and validation

The evaluation mission was from 19th July to 5th August. There were two public holidays during the evaluation period which meant that no interviews could be held that day and a SMART survey was also being carried out at the time of the evaluation mission therefore two interviews with Food and Nutrition Directorate staff were conducted by telephone.

An informal debrief was held with the Field Coordinator and the Health and Nutrition Programme Manager on departure from East Freetown field office and a debrief was held before departure with the Country Director and the Health and Nutrition Head of Department. A debrief was also held at ACF Headquarters in Paris.

Findings and Discussion

Treatment of severe acute malnutrition

CMAM was not new for many of the PHUs since the FND/UNICEF National CMAM programme had been operating in many sites prior to ACF's involvement. An assessment carried out by ACF at the start of the programme determined which sites were already implementing CMAM and to what extent, as well as the quantity and condition of equipment, challenges such as stock-outs and any community activities that were running. Many PHUs were implementing CMAM to some extent albeit with significant constraints such as stock-outs of RUTF and treatment errors. Following this, ACF trained 4 staff per PHU which invariably meant that all the staff in a PHU were trained. Following classroom training, ACF used the concept of 'on-the-job' training whereby an ACF staff member is present on OTP day (OTP functions on a designated day once per week) and trains the PHU staff. However, to date ACF staff still continue to attend the OTP day every week, with reports that they are sometimes involved in treatment. Arguably then, on-the-job training has continued since the start of the programme, well over a year and a half. However, ACF had intended to scale-up to the full 20 OTPs before now and would probably have reduced their presence in the 14 OTPs to focus on this.

In a programme that aims to support the MoHS in service delivery there is a continuum regarding the approach a NGO can take. At one end, the NGO can train the staff and then be hands-off which can promote ownership but may compromise quality. ACF is positioned towards the other end of the spectrum since the input is quite intensive in order to ensure quality but it may be disadvantageous with regard to ownership by the facility staff. In an integrated approach, it is idealistic to expect perfection from the PHU staff but certainly there should be standards that have to be met. From May 2013, the cure rate has been consistently above Sphere Standards which should have started to trigger questions whether attending the OTPs every week was still appropriate. Reducing the presence of ACF staff does not have to be a blunt tool either, rather it should be more nuanced around the need of each PHU. ACF staff may not attend for one or more weeks, but when supervision does happen, a significant slide in performance may prompt reinstalling support in a tailored way. In interviews, PHU staff reported that they were happy with the level of ACF presence but it is likely that this indicates a certain degree of dependence; if ACF is there it makes life more comfortable for them. Despite this though, the PHU staff seemed confident with managing the treatment of SAM and when asked if they could continue on their own, all of them responded positively. From observations during the evaluation it is highly likely that this is true. In Western Area (urban) the rationale for having one specific day for OTP was to avoid beneficiaries attending several OTPs, given there are several PHUs near each other. It may be pertinent though to reorganise the schedule so that it is more integrated into daily activities at the PHU; instead of having a separate day for OTP, any child coming to the PHU can be screened for SAM and treated there and then. This would help improve the link with health too. ACF measures the capacity of the PHU staff using a Knowledge Assessment Tool that examines the staff capabilities around the following aspects:

- Detection of acute malnutrition
- Nutrition and medical protocol
- Documentation

- Stock management
- Nutrition and health education/sensitisation
- Hygiene practice and promotion

Table 2 shows the results of 4 Knowledge Assessments. Having done these 4, ACF felt there wasn't an increasing improvement following the training, so peer-to-peer coaching was introduced in April 2014 although it was initially planned for earlier than this.

Table 2 Data (%) from 4 Knowledge Assessments carried out at 14 OTPs

	Mar-13	Aug-13	Oct-13	Jan-14	**Average of 4 assessments (%)**
Regent	57.5	59.5	59.0	51.5	**56.9**
Military	54.2	61.5	61.0	71.0	**61.9**
Wilberforce	48.5	52.0	50.5	69.0	**55.0**
HajaNeneh	53.5	54.0	54.0	73.0	**58.6**
Leicester	33.5	47.0	48.5	54.0	**45.8**
Looking Town	44.5	70.5	70.5	84.0	**67.4**
HillStation	55.0	62.5	63.8	72.5	**63.4**
Ola During	66.8	74.5	75.0	82.3	**74.7**
Sunshine	34.5	40.5	40.5	45.5	**40.3**
Signal Hill	55.5	50.0	49.5	71.0	**56.5**
Murray Town	59.0	61.5	61.5	59.5	**60.4**
Lumley	51.5	56.0	56.0	66.5	**57.5**
Malama	58.5	63.5	63.5	50.5	**59.0**
Adbangs	58.5	63.5	41.8	85.0	**62.2**
Average	**52.2**	**58.3**	**56.8**	**66.8**	

Every month stronger PHU staff are taken to train weaker ones on a particular topic that has been identified. This is perceived by ACF to have been well-received by those involved and to have been effective although no further knowledge assessments have been done subsequently to support this. Interviews with PHU staff during the evaluation showed that those who have participated thought it was a good approach and learning from colleagues complemented the training received by ACF. No-one thought one approach was better than the other. ACF continues to conduct peer-to-peer learning once a month although it is starting to lean towards a regimented exercise that is routine and as such there is a risk it will lose its appeal or effect. Those staff that are selected as coaches to train the other staff get an allowance therefore appeal may become more financially related rather than work-related. However, an evaluation in Moyamba in December 2013 cited the peer-to-peer coaching visits as best practice "*The initiative was very effective at improving OTP performance, was low cost and motivated those who were recognised for their exemplary performance. They reported with pride about the experience and felt that their recommendations were well received at the facility that they visited. It also allows for greater ownership of the programme as well as strengthens professional networks between peers".* Peer-to-peer coaching is therefore clearly a useful tool that, when used in a relevant, useful and appropriate way, can be effective.

In general the OTPs visited were well run, the staff were treating children as per the protocol and the cards were filled out. All of them had clean water and staff washed the mother's and child's hands before doing the appetite test. Some of the PHU staff did have quite an abrupt manner towards caregivers which can be off-putting, although discussions with caregivers showed that they were satisfied with the programme. ACF staff should not just focus on technical quality but must consider non-technical aspects too, such as staff behaviour.

One PHU staff said they still had trouble filling out the reports but were assisted by ACF staff from time to time. In the current protocol, discharges from OTP are meant to be followed up in a supplementary feeding programme (SFP), however in all the locations the SFP food had run out. It also appears that the actual caseload often exceeds the allocated caseload, and therefore amount of available food, predicted by the World Food Programme (WFP), although OTP discharges have priority. In the revised protocol, OTP cases will be discharged when the mid-upper arm circumference (MUAC) is above 12.5 cm and therefore won't be disadvantaged if there is a stock-out of SFP food.

A Nutrition Causal Analysis conducted by ACF in 2010 found that acute malnutrition was significantly related to current and previous disease and the seriousness of disease. Given this, it is critical that there is a strong link between nutrition and health programming. PHU staff reported that children that present at the PHU outside of the OTP are also screened for acute malnutrition, although one reported that she will look for wasting or oedema and only take anthropometric measurements for those children where it is visible. There is clearly a need to mainstream OTP into daily PHU activities more. Generally though, CMAM is perceived by health staff to be in line with other PHU activities.

There are two challenges that the OTPs face that were cited in every interview: staff turnover and stock-outs of RUTF and sometimes routine drugs, particularly amoxicillin. The routine drugs are part of the Free Healthcare drugs that are distributed by UNICEF in collaboration with the DHMT. The PHU also has a minimum threshold of RUTF and if stocks reach this it should trigger an order by the PHU. Interviews revealed that PHU staff are relatively weak on this procedure with ACF often stepping in. Districts also sometimes have difficulty in transporting the RUTF to PHUs and will call on ACF to assist.

When there is a new person in the OTP, ACF will train that person through the weekly visits and given the level of staff turnover this was cited in interviews as a reason for ACF staff to continue being present. Staff turnover will continue to be a problem and it's not unique to Sierra Leone, therefore more sustainable solutions need to be sought. The PHU staff and the District Nutritionist report they all have performance-based contracts which include CMAM. These can be explored to see if there are ways for training and supervision to become more systematically done by PHU or District level staff. Since PHUs fall under the Primary Health Care Directorate, stronger collaboration with this can ensure they see CMAM service delivery as part of routine health activities. There are also Master Trainers in place who are a combination of government staff and staff from implementing partners who will be used for the national scale-up of CMAM and ACF is also working on including CMAM into the training curricula of pre-service training of medical staff (not medical doctors). The topics of logistics and staff turnover are discussed more in the National Level section of this report. As well as weekly visits, ACF has done joint monitoring with GOAL and the DHMT. PHU staff also report that the District Nutritionist visits of her own accord. This is meant to be

monthly and while it does not happen that frequently, all the PHUs stated that they have received a visit from the District Nutritionist, without ACF, in the last 6 months.

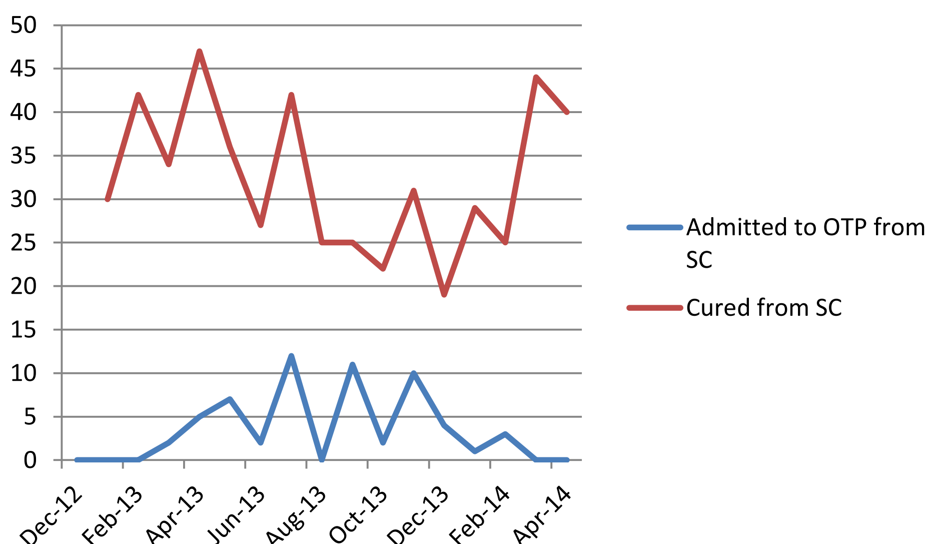
Ola During Stabilisation Centre has 13 beds and at the time of the visit had 12 cases. Treatment of SAM has taken place there since before the war although had been disrupted for periods. According to the SC staff, 98% of cases are referred to the SC from the hospital and on discharge the cases are referred to their nearest OTP. The caregivers are provided food by WFP. The main challenge they face is stock-outs of RUTF and therapeutic milk.

Being in a military hospital, 34 Stabilisation Centre is managed by the Ministry of Defence. The capacity of the Stabilisation Centre is 6 beds and it is adjacent to the paediatric ward. Military families are entitled to receive food for caregivers whereas civilian families are not and according to the SC staff, most cases on the paediatric ward are from military families whereas in the SC they are civilian families. Two cases have defaulted because of a lack of caretaker food and the staff reported that one child died because the family could not afford the drugs, although further questioning revealed that the child also had tuberculosis which went undetected (X-rays were re-examined and the results came back after the child had passed away) . ACF is trying to resolve this issue with the DHMT and WFP. As with Ola During SC, 34 SC often runs out of RUTF, therapeutic milk and Free Healthcare Drugs. According to evaluation interviews, Free Healthcare drugs are prioritised for military families although both military and civilian families are entitled to these drugs. Civilian families also have also been required to pay for lab-tests while military families have not, although this has seemingly been resolved according to ACF staff. This discrepancy between civilian and military families has created discontent amongst caregivers of children at the SC. ACF is aware of this and trying to seek a resolution in collaboration with the District Health Management Team and the FND.

The staff at both SCs are enthusiastic and have a certain level of ownership and at 34 SC the location has been rehabilitated by ACF. A further problem that is common to both SCs is a lack of trained Doctors however, the FND has a plan to train medical Doctors once the revised protocol has been endorsed but since there is no funding for this, have asked ACF to support the training of medical Doctors for Freetown. ACF has also done peer-to-peer training between the two SCs and staff from both locations were positive about this approach.

Programme data shows that there is a gap between those cases that are discharged cured from SC and those that arrive to OTP, as demonstrated in Figure 2.

Figure 2 Cases discharged cured from the Stabilisation Centres compared with the number of cases admitted to all the OTPs in Western Area (ACF supported and non-ACF supported) from the SCs



Between January 2013 and April 2014, 518 cases were discharged cured from the SCs in the district and 59 arrived for follow-up at an OTP in the district, but according to ACF staff this may be due to the way admissions from SC are reported in OTP. Given the SCs support the whole district, GOAL should also be involved in efforts to understand and rectify this.

Community health workers

At the start of the programme, members of the community were selected by community stakeholders often including the sister-in charge at the PHU, to screen for malnutrition in the community, refer any cases to the PHU for treatment and trace any defaulters. They are meant to work one hour a week and they have a target area within which to work and a target number of households to visit. At the beginning the CHWs were supposed to do quarterly screening with monthly reports but after some time it was apparent that the CHWs were screening all children on a monthly basis. Because of a high workload, in March 2014 the routine was changed to split the target area into three and screen one area per month. In FGDs, community health workers reported that they were now able to cover all the households. However, with this move to quarterly screening there is now a risk that early detection of cases will be reduced. If a child slips into malnutrition shortly after a CHW has visited that area, it could be 2 months before they are detected, although district data shows that SC admissions are 17% of the total admissions which is close to the global average of 20% (UNICEF 2007).

As mentioned above the detection of illness is crucial too. CHWs say they are screening for cases of illness and referring them, but they are less emphatic about this than screening for malnutrition. Furthermore, the quarterly screening also raises a question over whether there is early detection of illness too. ACF is trying to have a stronger link with health actors who are also using community health workers, for example it has ensured there is one CHW database used by all the NGOs in the urban consortium to avoid duplication; such efforts are vital. ACF has also tried to link CHWs with PHU staff although some CHWs already attend the PHU on OTP day. There are instances where

CHWs are appreciated by PHU staff with CHWs participating in PHU activities. In one interview, CHWs said that wearing identification tags has helped gain them respect. However, there is sometimes a negative sentiment by PHU staff towards CHWs, who think they are not effective and only want incentives. Trying to promote government ownership of the volunteers by involving the DHMT may help to address this. The evaluation found that although there are staff responsible for community activities in the DHMT, community nutrition activities are perceived by these staff as something that falls under the District Nutritionist and therefore there is little ownership by them.

There has been a long history of community volunteers in Sierra Leone and NGOs have engaged with them in a fairly substantial way. Until recently, NGOs differed in what they gave to volunteers, whether it was in-kind incentives or monetary incentives and the amounts differed too. In an effort to harmonise practice, the government developed a community health worker policy and strategy. Volunteers participate in a standard training after which they can be called Community Health Workers. Under the new policy, incentives are standardised in terms of what NGOs can and cannot give. Most of the CHWs working with the nutrition programme have participated in the CHW training, done in April 2014, and the remaining few will be trained soon. It's too early to see the impact of this training on activities.

Whilst this is an important step in achieving government ownership of CHWs, CHWs have been distorted by NGOs and the different practices for so long, that a sifting process that takes some time may need to happen to achieve a more sustainable process. It is clear that the current CHWs very much see themselves as owned by ACF and part of ACF, and there is little doubt that if ACF should leave they would not continue. Although ACF CMOs interact with the CHWs a fair bit, given the current unsustainable nature of CHWs, the question over whether this leads to dependency and lack of ownership is irrelevant at the present time. However, once the CHW policy becomes more embedded in daily practice, CHWs may begin to realise that they are more part of a government system and ACF should reflect this in their interaction and collaboration with the CHWs. Forging stronger relationships with staff responsible for community activities in the DHMT and brokering relationships between the community staff and nutrition staff at the DHMT, and beyond to the FND, will also be valuable. However, the fact that NGOs will still be giving incentives, as currently the MoHS does not have the capacity to do so, will not help efforts to promote CHWs seeing themselves as part of the government system.

Given the sustainability issues around CHWs, there is also a need to improve community awareness on malnutrition and self-referrals to maximise the referrals coming from the community themselves. This will be achieved through community dialogue and awareness raising which is based on fostering relationships with the community, having a two-way dialogue and gaining the respect and trust of the community.

GOAL are experiencing a huge turnover of CHWs as those who are not happy with the standard CHW package are leaving and being replaced by ones with potentially lower expectations. ACF may well see the same thing. Experience from other countries does show that volunteers do not work for many years and inevitably there is a point at which a volunteer seeks alternative work, most likely paid. Of the 73 CHWs trained at the start of the programme, by the mid-term point 51 active ones were left, so ACF has just trained some new ones (22) to replace those who have left.

Mother-to-mother groups

Although there is a history of mothers groups in Sierra Leone, they do not seem to have been active in ACF's target areas in Freetown. As with volunteers, Lead Mothers were selected by the community and participating mothers were chosen by the Lead Mother. These are women who are pregnant or breastfeeding. The groups meet twice a month and work through standard training materials that are used by all stakeholders involved in infant and young child feeding (IYCF). Once the training course has been completed, the stronger member of the group become Lead Mothers, new participants recruited and the process is cascaded.

The mothers group observed during the evaluation mission was certainly energetic with the Lead Mother teaching the mothers who then demonstrated what they had learnt. However, there was no space for mothers to discuss issues they face or ask questions. Lead Mothers in other areas have seemed equally strong. It is likely that for this first round some of the strongest women have been chosen to be Lead Mothers and hence they may be characters who are less inclined towards discussion and more inclined towards didactic teaching. Once the groups are cascaded Lead Mothers who are less perceived as community leaders, but who have more participatory skills, may come to the fore but this is something that ACF can promote. In every FGD, Lead Mothers and mothers who are part of the group state that participating mothers have changed their behaviour at home, particularly around hygiene, although they seem slightly more reticent to claim that breastfeeding behaviour has changed. Since it is too soon for the end line Knowledge, Attitudes and Practice (KAP) survey, this cannot be substantiated and there has been little interim investigation by ACF to analyse preliminary effects. The focus seems to have been on Lead Mothers so far, rather than participating mothers and the changes they are making. It does seem that there are some teenage mothers who participate in the groups although the exact number could not be determined. According to ACF staff, it is difficult to mix teenage mothers with older mothers and teenage mothers are reticent to participate as they feel ashamed. ACF would like to trial separate groups of teenage mothers and older mothers at some stage.

Almost all Lead Mothers reported that during the initial meeting, participating mothers were keen to join but numbers dropped off as they thought the Lead Mothers were receiving payment from ACF and not sharing it with them. The Lead Mothers have tried to explain but it may just be something that needs to be weathered and in time, the mothers will realise it's not the case. It is another example, where ACF's interaction is important though. Since the mothers groups are new, while there is some distortion from them seeing other NGO activities in the community, there isn't the history with them directly. Although currently the Lead Mothers are leaning towards seeing themselves as part of ACF, there are some strong characters amongst the Lead Mothers and these groups are something that the FND is keen on promoting and developing. For these reasons, ACF should ensure their interaction with the groups doesn't distil any ownership but in fact, does the opposite. ACF should have a clear understanding of the networks and dynamics within the community that will support these groups and find ways of promoting this. It is also important for ACF to advocate for the involvement of the FND and the DHMT in the support of these groups, which is limited at present. The current Lead Mothers have been trained as CHWs which will direct them away from their involvement with the groups, but given the cascade approach and the turnover of Lead Mothers this should not be too detrimental.

ACF has acknowledged the importance of linking Mothers groups with other structures and through the gardens which are part of the food security component, are hoping that this will link them to the Ministry of Agriculture. ACF is also exploring ways of strengthening the link between the mothers groups and the PHU although in the PHUs visited there is a monthly meeting between PHUs, Lead Mothers and CHWs to share experiences.

As described in a report by Denney *et al* (2014) mother-to-mother support groups are relied upon by both the Government and development partners as one of primary structures for preventing malnutrition at the local level yet the theory of change associated with these groups has not been well-articulated and certain assumptions have been made that may or may not be true. This is extremely applicable to ACF's programme too and the recommendations made in the report (Denney *et al* 2014), should be taken on board by ACF (Annex 6). In discussions with mothers present at the health facilities, most had not heard of mother-to-mother support groups which suggest coverage may be an issue, although these groups are still relatively new and the first round of the cascade is just happening. ACF staff acknowledge that radio discussions and programmes will help raise awareness of the groups.

Programme data

Figure 3 below shows the number of admissions between Jan 2013 and April 2014 broken down into those cases admitted to Ola During OTP and cases admitted to the other 13 OTPs. Cases admitted to Ola During make up 26% of the total admissions over this time period. This is because Ola During OTP is located at a referral hospital from which many cases are referred. 1,113 cases were admitted between January 2013 and April 2014, 291 of which were admitted to Ola During OTP. Apart from Ola During, the caseload of the OTP visited during the evaluation mission was quite small, 4 in Malama, 7 in Looking Town and 4 in Hill Station.

Figure 3 Cases admitted to Ola During OTP and the other 13 OTPs between Jan 2013 and April 2014.

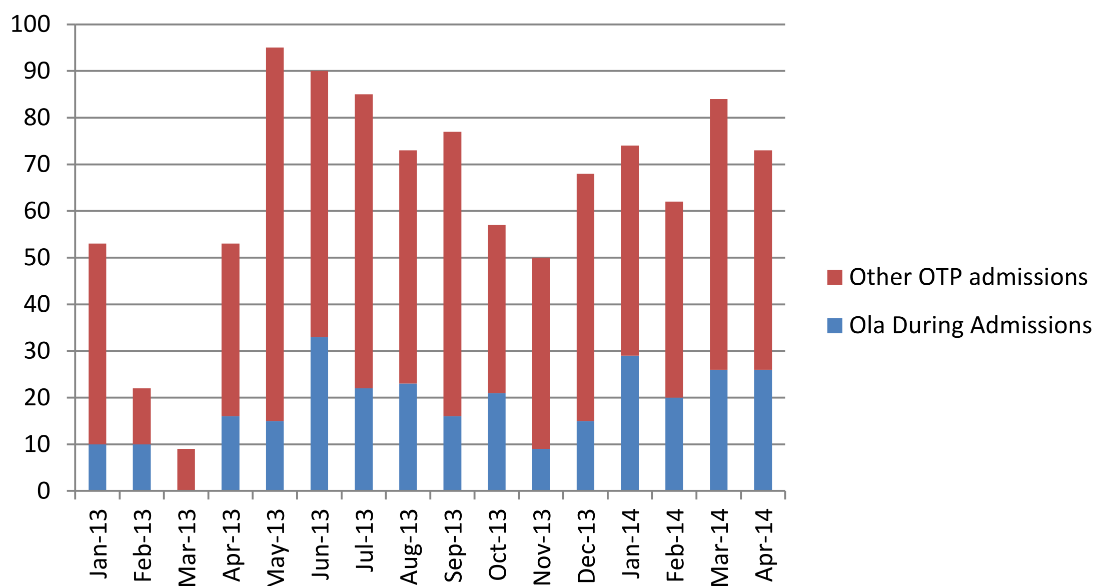


Table 3 shows the performance data from the programme

Table 3 Programme performance data

	OTP	SC	OTP (without Ola During)
Cured	78%	85%	
Defaulter	21%	5%	13%
Death	1%	8%	
Non recovered	0%	0%	
Others		2%	

While the cure rate, death rate and non-recovered rate all meet Sphere Standards, the OTP defaulter rate does not. According to ACF staff, most defaulters come from Ola During OTP because if there is a malnourished child on the paediatric ward, they will be admitted into the OTP but stay on the ward. When they are discharged from hospital then they do not return to the OTP. If the defaulters from Ola During are taken out of the defaulter calculation, the defaulter rate is 13%, within Sphere Standards. In other PHUs, the reasons for defaulters most likely stock-outs of RUTF however ACF has not carried out any defaulter monitoring to gain a definitive understanding. ACF has collected data on the level of stock-outs.

As the programme is using the MoHS report templates, there is no data on length of stay or weight gain. There has also not been a coverage survey done since ACF is awaiting a national coverage assessment to be carried out in 2015. GOAL has done a coverage survey for their Freetown programme and the 'point' coverage rate was estimated at 62.1 % (CI 49.6.0- 73.3%), below the SPHERE standard for urban area, 70%. It is difficult to determine whether this figure could be extrapolated to ACF supported areas. While the approach is similar, with the elements of treatment of SAM, community volunteers and mothers groups, there are differences. GOAL took quite a hands off approach at the beginning until a joint monitoring visit highlighted some failing OTPs. ACF perceive GOAL's community approach to be stronger which may also have a bearing and the fact that screening is now quarterly may add to this. The ACF programme proposal estimated treating 4200 children based on OTP and SC admissions for 31 months, a SAM of 1.1% in Freetown, covering 28% of health facilities in Freetown and a CMAM coverage of 40%. Currently, ACF is covering 22% of health facilities in Freetown and have admitted 1,113 cases in 16 months. In reality, the coverage of ACF's programme is unknown. Given ACF's experience with the Coverage Monitoring Network, it may be pertinent to undertake some preliminary analysis on coverage and barriers to treatment ahead of the national SMART survey, although this should be done in consultation with the MoHS.

The impact of the programme is also unknown. It is arguable that the treatment of SAM cases won't lead to any significant changes in prevalence data as generated by a SMART survey. [2] This is because prevalence data is a snapshot in time and in Freetown it is a longer-term context and the caseload is quite small. The prevalence of acute malnutrition is more likely to be affected by prevention activities. Understanding the impact of treatment will come more from data on coverage and analysis in the community. It is also difficult to make a 'best guess' with regard to impact.

[2] A national SMART survey was being carried out at the time of the evaluation mission, which will be directly comparable with the one done in 2010.

Certainly the programme is curing cases of malnutrition but the caseload is quite small and coverage is unknown. In terms of preventing malnutrition, there is also no data on the impact of the mothers groups since ACF has done a baseline KAP and it is too early for the end-line KAP and there is no interim data. An interview with ACF staff highlighted that within ACF globally there is a need to strengthen monitoring and evaluation data with regard to behaviour change activities.

District level

The District Nutritionist (the overall manager) has been in post 13 years and has a good understanding of nutrition issues and protocols and has a strong sense of ownership. ACF's collaboration with the District is predominantly with the Nutrition department; there is little interaction with the District Surveillance Officer, the District Social Mobilization officer, the CHW supervisor or the District Logistics Officer.

There seems to be a good relationship between ACF and the District Nutritionist and she sees ACF playing an important role when it comes to transporting RUTF when required and by putting pressure on PHU staff to submit their reports on time. Reportedly, 80% of PHU report on time although this is facilitated by the fact they are obliged to attend a meeting at district level that coincides with the time the report is due. The responsibility of reporting stays with the District Nutritionist rather than involving the District Surveillance Officer. The District Nutritionist is responsible for disseminating the report upstream to the FND but also to implementing partners as well. Implementing partners do not have their own databases which not only promotes ownership but helps to standardise data and minimise data errors.

National level

Since starting in January 2014 the ACF advocacy officer has been able to foster good relationships with the FND to the point where she is now being asked to assist with policies and documents of a substantial nature. Prior to this the team was involved in advocacy, especially when Sierra Leone joined the SUN, but before 2014 there wasn't a dedicated position. The role is perceived by the FND as extremely useful and important to them, although ACF should guard against the FND becoming too dependent. Nonetheless, it puts ACF in an excellent position to advocate for change and stakeholders at national level certainly see ACF has one of the strongest NGOs in nutrition, with only Helen Keller perhaps being of similar standing. This gives ACF a comparative advantage at national level, and the fact they are also operational at field level and can feed lessons and experiences from the grassroots upstream, provides an important alternative voice to some of the UN agencies.

As mentioned above stock-outs of RUTF and staff turnover are two critical challenges for the programme. In 2013 UNICEF and the MoHS carried out a case verification exercise and according to their results found that approximately 50% was being misused. As a result, the way the caseload was calculated was reformulated but this had the effect of creating further stock-outs, perhaps because misuse was still happening or because the formula was inappropriate. ACF has though, collected evidence on RUTF supply in their PHUs. A caseload verification in July 2013 found 96% of cases were correct and data on the extent of RUTF stock-outs in each PHU have been collected since the start of the programme. Gathering evidence in this way is essential in being able to robustly communicate experiences upstream, provide an alternative voice and advocate for change. At the time of the evaluation, the DHMT was trying to get a meeting with UNICEF to discuss case

verification and caseload calculation. Advocacy can be even more effective if ACF can support the DHMT to lead the discussion. UNICEF continues to view stock-outs as a problem of misuse and RUTF usage in the country as difficult to control however it is a central issue for them and acknowledge the shortage of RUTF as a constraint to effective treatment. It is relying on certain measures to curb this practice such as verification of cases, better discharge of defaulters, following up cases at community level, using mothers groups to monitor children and encouraging local authorities to fine anyone found to be misusing RUTF.

UNICEF is responsible for ordering and stocking RUTF at national level and until recently was responsible for distributing it to districts. In April 2014 distribution was allegedly handed over the National Pharmaceutical Procurement Unit (NPPU) but since it was not possible to gain an interview with the NPPU it has been difficult to determine the exact logistical architecture in place at the moment. Reportedly, NPPU were responsible for the last distribution and UNICEF is currently observing how well this has gone and the functionality of the NPPU. The District Logistics Officer is still on a UNICEF contract although he is waiting to hear when he will be transferred over to NPPU. UNICEF will remain responsible for procurement. There is a local production of RUTF, through project Peanut Butter, but since this cannot meet demand, RUTF is also imported. ACF can continue to push the importance of local production and the need for procuring suitable amounts to reduce the risk of breaks in supply.

While ACF can gather evidence on the functionality of the logistics system, share it with key stakeholders and advocate for change, beyond this there is little scope for input unless they could manoeuvre themselves into a position to build the capacity of the NPPU through training and mentoring. Although since this should be done for the health logistical system as a whole, rather than just the nutrition part, realistically it would be more effectively done by an organisation with much greater logistical capacity and expertise, than ACF.

Pre-service training curricula for health staff (not medical doctors) is also an area where ACF is unsure whether it has the expertise. A training manual and training for certain medical staff was carried out in 2013 but then the process stalled and what had been learnt has not been implemented due to poor planning by the FND. The FND has turned to ACF for support and ACF is currently focusing on providing anthropometric tools, putting together training materials and printing. ACF can have a role in this given their technical expertise but it needs clear planning to include all the necessary elements and to have a realistic action plan and timeframe. The FND is keen that it should be led by the MoHS, which is correct, and ACF can support in driving the process forward, there is after all a clear need for it given the level of staff turnover and the requirement for input by Doctors at hospitals and stabilisation centres and the importance of the link between health and nutrition. However, ACF has wisely acknowledged that it is not in a position to do all aspects though and should collaborate with partners who can assist. Other national stakeholders agree that ACF cannot do this alone and the outcome would be enhanced in terms of quality and timeliness if it's a collaborative effort.

In May 2014 ACF carried out a Health Systems Strengthening (HSS) assessment in Moyamba district. Since the 6 functioning building blocks are the bedrock for a successful CMAM programme, an assessment such as this is crucial for understanding how the health system works and devising a plan to address weaknesses and gaps. A HSS should therefore be carried out for Freetown district that

should focus on how the systems function at the district level and how they interact with systems at national level. ACF has started to acknowledge that HSS requires developing relationships beyond the MoHS nutrition department which is a deviation from ‘normal practice’ but nonetheless important. ACF is planning on recruiting a surveillance officer who can sit in the MoHS and can build the capacity of the Surveillance Officer in the FND. The Surveillance Officer seems genuinely keen and enthusiastic to learn and there is certainly a need to strengthen the reporting system further, particularly to allow easy manipulation to facilitate better analysis of data, whilst maintaining simplicity to facilitate integration with HMIS further down the line.

Coordination between NGOs appears to have improved during the evaluation period. ACF now seems to have a reasonably good collaboration with GOAL, as illustrated in the joint supervision visits for example, whereas at the beginning of the programme there was more distance between the two organisations. At national level, the introduction of the Scaling Up Nutrition coordination network has led to the development of the Civil Society Platform as well as a general SUN coordination meeting, although the latter is reportedly less participatory than the nutrition technical coordination meetings held by the FND. There are also other challenges compromising coordination through the SUN, such as lack of leadership and clear vision. The Civil Society Platform is only attended by civil society organisations and not UN agencies or donors, so unless dialogue happens in the SUN coordination meeting there is no other fora for it to occur. Agencies seem quite good at ensuring there is no overlap but less good at achieving multisectoral intervention in one geographical area which is reflective of the lack of a desire from donors for this. Nutrition, WASH, food security and health interventions all in the same communities would amount to a stronger effort to tackle malnutrition.

ACF is well-respected by other stakeholders and is seen as having a strong voice and a high profile. While this is important for achieving change, Sierra Leone is not a humanitarian context and therefore activities should be done with sensitivity, which ACF has acknowledged to some extent. Stakeholders at national level also agree that ACF is good at sharing information and communicating its activities. ACF is also seen as technically competent but an FND staff member reported that they look to ACF as a technical resource at facility level but not community level. Sierra Leone is a context where preventative activities will become more prominent, given the relatively low levels of wasting and the higher levels of stunting. Given its history as a humanitarian organisation, ACF needs to ask itself what balance to strike between prevention and treatment. It is not that the treatment of acute malnutrition should be disregarded since there is still a need to be addressed, but rather to what extent can ACF effectively implement preventative activities or should it look to other actors for this. Whether ACF continues with the current level of preventative activities or choose to scale-up, the same principle applies, it needs to be done in such a way that promotes community and MoHS ownership and involvement and is effective, with a robust monitoring and evaluation system that can show this.

DAC-based Rating Table

Criteria	Rating (1 low, 5 high)					Rationale
	1	2	3	4	5	
Impact			X			The impact of the programme is also unknown. It is arguable that the treatment of SAM cases won't lead to any significant changes in prevalence data as generated by a SMART survey. [3] This is because prevalence data is a snapshot in time and in Freetown it is a longer-term context and the caseload is quite small. The prevalence of acute malnutrition is more likely to be affected by prevention activities. Understanding the impact of treatment will come more from data on coverage and analysis in the community. It is also difficult to make a 'best guess' with regard to impact. Certainly the programme is curing cases of malnutrition but the caseload is quite small and coverage is unknown. Furthermore, there is a question over whether quarterly screening will affect early detection which can influence impact. In Sierra Leone it is more likely that malnutrition rates will decrease through preventative approaches and there is still much more scope for these to be strengthened. There is also no data on the impact of the mothers groups since ACF has done a baseline KAP and it is too early for the end-line KAP and there is no interim data. An interview with ACF staff highlighted that within ACF globally there is a need to strengthen monitoring and evaluation data with regard to behaviour change activities. Capacity building efforts have been limited to trainings of PHU staff, CHWs and Lead Mothers. PHU staff are in a position to conduct OTP sessions on their own (once ACF reduce support) with good results. The sustainability of CHWs and mothers groups is more questionable, compromising impact.
Sustainability			X			This rating takes into account 3 elements: service delivery, the activities of the CHWs and the activities of the mothers group. The treatment of acute malnutrition at facility level is reasonably sustainable (as long as supplies as available), although there is currently a slight dependence on ACF the staff are capable and willing. The CHWs associated with the programme are not sustainable and should ACF cease activities so will they. This isn't necessarily ACF's fault

[3] A national SMART survey was being carried out at the time of the evaluation mission, which will be directly comparable with the one done in 2010.

						since the long history of NGO engagement with CHWs has created unrealistic expectations from CHWs. In the future, if the government CHW policy really takes hold, then this could be rated higher but it a long-term process. The sustainability of mothers groups falls somewhere in the middle. There isn't the history of such groups in ACF target areas and there is a considerable amount of importance placed on these groups by the FND and other stakeholders. Yet the distortions caused by NGO community engagement puts their sustainability as risk.
Coherence				X		The different elements of the programme are coherent since the preventative activities are in the same areas as treatment and ACF is trying to strengthen linkages between the two. Collaboration between different actors working in the target area has improved and there is some degree of a multisectoral approach – PHU staff a reportedly screening for malnutrition when a sick child comes to the facility and ACF has started a food security component. More can be done in terms of having a strong and integrated nutrition, health, WASH and food security approach in the same communities.
Coverage				X		This is also unknown although ACF is waiting for a national coverage assessment scheduled for next year. A SQUEAC survey in GOAL's target areas found a point coverage of 60%, although this is below the Sphere Standard for urban areas (70%). Since ACF's programme is not dissimilar to GOAL it is likely that the coverage in ACF's target areas is the same or more. Quarterly screening may have a negative effect on coverage though.
Relevance/appropriateness					X	The MoHS has a plan for 50% of PHUs to implement CMAM in all district therefore ACF's approach is in line with this. Not only are they supporting the treatment of acute malnutrition but they are supporting the health system to do it. Community-based activities such as mothers groups are growing in prominence and importance in Sierra Leone and ACF's involvement with activities such as these is in line with the context and the need.
Effectiveness				X		The treatment of SAM is meeting Sphere Standards for all discharge indicators except defaulter rate, yet if Ola During OTP is excluded (for reasons explained in the narrative) the defaulter rate does meet Sphere Standards. The effectiveness of mothers groups is unknown and needs to be determined especially as more importance is being placed on them. Evidence on how they are working and if they are effective needs to inform decision-making.
Efficiency		X				Even with the delay in scaling-up to 20OTPs, the

						programme uses a relatively high number of staff. They have been attending OTP days at each PHU each week and visit the two SCs every week. This is a very inefficient use of human resources. The same quality in the facilities could have been achieved with fewer staff and the same is true at community level. Having a more hands-off approach much sooner would have lessened the dependence on ACF and allowed time for other activities such as community-based participatory discussions or strengthening links between different stakeholders.

Best practice

Title of Best Practice	Health Systems Strengthening
Innovating features and key characteristics	Health Systems Strengthening is the bedrock of an approach that integrates CMAM into the national health system. It involves going beyond the typical relationships in a number of different areas. ACF is addressing the 6 building blocks of HSS in a thoughtful, flexible and nuanced way while recognises the organisation's strengths and limitations. In logistics, ACF has limited input but can collect evidence on the situation and advocate for change. On human resources, ACF has more involvement by working on the pre-service training curricula while in health information systems, ACF is planning to bring in a surveillance expert to build capacity. In governance, the ACF advocacy has achieved a fruitful relationship with the FND that should result in successes. In service delivery ACF has supported facility staff so that now it can arguably be called sustainable. It is only finance where ACF has had little involvement but this is a wise decision since others, such as Save The Children, are working on this.
Practical/specific recommendations for roll out	A Health Systems Assessment was done in Moyamba and it would be useful to repeat the exercise in Freetown. ACF at regional level are putting together a lessons learned document from all the HSS exercises that ACF has done in the region so it is worth waiting for that before undertaking the exercise. An assessment should produce an action plan which will help to shape activities going forward to ensure they are effective and to highlight where collaboration with other stakeholders need to be commenced or develop further.

Conclusions and Recommendations

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

ACF has started to recognise that Sierra Leone is a context where an approach that it quite hands-on with a structured set of outputs that are achieved in fairly a regimented manner is less appropriate than a more supportive, participatory, nuanced and flexible approach. This way of working needs to be crystallised into the ACF working culture and employed from community level up to national level. Adopting such an approach does not mean losing technical quality but it may mean that results take longer to achieve in order to maintain relationships and promote buy-in, which admittedly can be challenging in a short-term funding environment. Nonetheless, at all levels ACF staff should engage in dialogue that is two-way and discusses needs and solutions and puts community and MoHS leadership and engagement systematically at the fore.

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

The health facility staff do show that they are capable and willing to conduct OTP and SCs on their own but they are constrained by their dependence on ACF staff who still continue to be consistently present. Given this capability and willingness, there is a good chance that the treatment of acute malnutrition will be sustained (if there are supplies) but ACF could have reduced their input much sooner which is a lesson that can be taken forward during further scale-up. A period of on-the-job training can be defined which should only last a few weeks after which ACF presence can be reduced with follow-up visits to conduct supervision and address any arising issues.

- **<u>Recommendation 3</u>: Peer-to-peer learning works but don't 'overdo it - use nutrition champions strategically**

Both this evaluation and the evaluation in Moyamba have shown that peer-to-peer learning is welcomed by those involved and has a positive effect. Cross-learning can be used in a number of different ways, not just for facility staff, but for mothers groups and community volunteers too. Strong voices from field level are effective as nutrition champions at district or national level. However, as per recommendation 1, this approach should not become overused, stale and ineffective but should be based on need and be as fresh and dynamic as possible to be effective. Peer-to-peer learning is on the cusp of becoming another routine exercise which would lose impact.

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

ACF is working towards resolving the problems of caretaker food at 34 Stabilisation Centre but there is also the problem of the difference between the treatment of military and civilian families in terms of what they are entitled to and who has priority for free drugs. 34 SC certainly has many advantages in that the building is suitable, the staff are enthusiastic and engaged and there are medical doctors, but during the visit for this evaluation there was clearly discontent amongst staff and the caregivers and if this is not resolved it will affect outcomes. Efforts to address these

problems should continue but ACF should bear in mind that if they are unsuccessful alternatives may have to be sought. Given that it is important to adhere to FND preferences, ACF may have to influence FND opinion but providing evidence to support ACF's argument should assist with this. It is important to bear in mind though, that since a number of different stakeholders are involved, such as MoHS and Ministry of Defence, this could be an intensive exercise in terms of human resources and yet the caseload in question is quite small. As far as possible ACF should encourage other actors, such as government and UN agencies, to take responsibility to resolve the issues, especially since the location was chosen by the MoHS.

- **Recommendation 5: Better understand the outcome of Stabilisation Centre discharges**

As shown in Figure 2 there is a gap between the number of children that are discharged from SC and those that are admitted to OTP from SC. ACF should investigate what is happening to discharges from SC and if they are not being admitted to OTP, steps should be taken to address this issue.

- **Recommendation 6: Better understand the reasons for defaulting**

This evaluation has made assumptions around the reasons cases default from Ola During OTP and the other OTPs based on informant interviews, since ACF has not carried out any defaulter monitoring. To support these assumptions, more robust investigations should be conducted and the results used to inform corrective actions.

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

Outcomes are improved when cases are detected and treated early. Whilst the proportion of complicated cases is 17% of the total admissions, below the global average, quarterly screening raises the question over whether early detection is comprehensive. Given the context, it is essential to not only detect and treat cases of acute malnutrition but also childhood illness too. ACF should conduct an exercise to assess the impact of quarterly screening on early detection and coverage but should also engage in community dialogue to understand the barriers for accessing healthcare. Given ACF's experience with the Coverage Monitoring Network, it may be pertinent to undertake some preliminary analysis on coverage and barriers to treatment ahead of the national SMART survey, although this should be done in consultation with the MoHS. This can be done in collaboration with any other health actors active in the target area, since effective collaboration with such organisations is also crucial. PHU staff report that they are screening children that are coming to the facility, but this can be reinforced by clear messages coming from health actors, particularly those involved with IMCI. For example, in any training on health, CMAM should be referred to. It may also be pertinent to reorganise the schedule so that it is more integrated into daily activities at the PHU; instead of having a separate day for OTP, any child coming to the PHU can be screened for SAM and treated there and then. This would help improve the link with health too.

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

While this recommendation is closely related to Recommendation 1, it's important to have this as a stand-alone recommendation due to the government CHW policy, taskforce and manual and particularly the distorted nature of CHWs by the history of NGO intervention. ACF is adhering to the new policy and strategy which is important and acknowledges the challenges associated with the CHW network.

CHWs in Sierra Leone see themselves as attached to a NGO and there have been large differences in practice by NGOs. The government is trying to rectify this through the new CHW policy and strategy and while these are embryonic steps, ACF can continue to help to steer the entrenched culture towards the ideal of CHWs seeing themselves as government CHWs and should continue to collaborate strongly with the WASH consortium (a group of NGOs working on WASH activities in Freetown). ACF wrote and presented the CHW policy addendum to tailor the policy for the urban setting and ensured that nutrition was part of the manual and training. Changing culture can be done subtly such as through the language ACF uses, for example not calling them ACF CHWs, promoting government strategy and not ACF strategy, as well as more explicitly by strengthening links with the PHU, promoting supervision by the PHU and the DHMT, promoting government involvement in training, as well as exploring any other measures that can promote ownership and sustainability (like the identification tags).

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

Sierra Leone is a context where prevention activities are vital in addressing levels of malnutrition and as such more prominence is being placed on them, with mother-to-mother support groups being a primary tool in such efforts. Whilst ACF has started such groups and baseline and end line KAP surveys will help understanding their effectiveness to some degree, the understanding and evidence around these groups needs to be of a much higher quantity and quality.

As stated in Denney *et al* (2014) the theory of change relating to these groups has not been articulated. It has been assumed that there is a demand for the groups, members will participate and learn, Lead Mothers will exchange information in an effective way, the behaviour of the participating mothers will change and that the cascade process will work. Currently, there is no evidence that any of these assumptions are true. ACF therefore needs to define the theory of change, test the assumptions made and revise the results accordingly.

It is clear that there is a need for better data on the impact of these structures on the member mothers. Interim research should help to provide this data. However, given the importance placed on the mother-to-mother groups in Sierra Leone, it would have a more far-reaching impact if efforts to define and test a theory of change, and come up with robust data were a national effort, involving

all stakeholders engaged with these groups. Given ACF's position within the nutrition community, it has a role to play in enabling this to happen.

Currently the effectiveness and sustainability of the mother-to-mother groups are at risk from distortions caused by the long history of NGO community intervention. The effectiveness and sustainability of the groups will be increased by local ownership and engagement. ACF has already started to link mothers group with PHUs and agricultural actors through its food security interventions and CHWs, Lead Mothers and PHUs meet monthly to share experiences, but this can be strengthened, particularly if the Primary Health care Directorate, which oversees the PHUs, and MAFF can be enabled to encourage this link. Again, the manner in which ACF conducts itself when doing this will be influential. Furthermore, understanding the community networks and dynamics that surround these groups will assist in promoting the indigenous ownership and engagement of the mother-to-mother groups.

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

Many of the recommendations in this evaluation involve community-based activities that require a set of skills and approaches which ACF is not used to. As mentioned elsewhere this does not mean that treatment of acute malnutrition in facilities should reduce, since this would result in the loss of lives, rather that preventative and community measures can be built. ACF has achieved an excellent reputation as a humanitarian organisation and it is interesting that the FND sees ACF as technically competent as facility level treatment but less so at preventative interventions. That said, it is not impossible for ACF to move towards a more developmental approach but it does require an internal dialogue within the organisation to examine how well ACF can achieve this, whether they should and who else may be better placed. If it is deemed that a third party would be more appropriate to implement some of the required efforts, careful planning will help define a successful collaboration. Clearly, such an exercise is not a task for the Country Office alone but should involve both ACF at regional and global level. This will provide a solid foundation for ACF moving forward that will facilitate planning and execution of activities.

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

While the advocacy activities were not included in the ToR for this evaluation, they do have a direct bearing on the outputs that were included in this ToR, therefore the evaluator deems it reasonable to make this recommendation. The advocacy officer has put ACF in a pivotal position at national level thus creating an excellent opportunity through which to evoke change. It is understood that the contract of the advocacy officer is due to end before the end of 2014 yet not only is advocacy often built on relationships, rightly or wrongly, but it is a long-term effort. Given this role is new for ACF in Sierra Leone, this position needs to be solidified so that some of the issues which ACF is advocating for have a greater chance of success. It may be appropriate for hand-over to a national staff member at some stage but this needs to occur over a sensible time-period, once ACF's position has been solidified. There are also opportunities for greater capacity building of the FND in national level which can be explored.

- **Recommendation 12: Continue to focus on health systems strengthening**

e) **Conduct a Health Systems Strengthening Assessment for Freetown**
f) **Continue to gather evidence relating to stock-outs and the functionality of the logistics system and convey it upstream to advocate for change**
g) **Explore sustainable solutions to overcome staff turnover**
h) **The forthcoming surveillance officer should improve the database to make manipulation easier to facilitate analysis, whilst maintaining simplicity to enable integration with HMIS in the future**

Since a strong health system is the bedrock for the successful treatment of acute malnutrition through the national health system, conducting a HSS assessment in Freetown would enhance understanding and help to shape efforts. This should clearly be done in collaboration with GOAL as well as the MoHS and it is important that this focuses on the community, facility, district and national level.

The issue of stock-outs was cited in the majority of interviews as a challenge and as such ACFs existing efforts to address this issue are relevant and appropriate. ACF should continue to collect evidence relating to the reality of what is happening and use its position at national level to advocate for change. As described elsewhere, ACF's comparative advantage is that it can draw on its experiences and lessons through having a field presence as well as using its strong role within the nutrition community, to provide an alternative voice. Advocacy can be even more effective if MoHS staff from facility or district level can lead the discussion. Although ACF is limited in terms of the direct input it can have in changing the logistics system, it can hold those who are responsible to account.

Staff turnover is another issue that deeply affects service delivery. The current situation of ACF training new staff is not sustainable and ACF should encourage dialogue within the CMAM community to explore more sustainable solutions. This should include greater participation from the DHMT, or peers, but it could also explore using academic institutions. Having regular training sessions, for example induction trainings, may also be effective. It would also be helpful to draw on experiences from other countries since this is not an issue unique to Sierra Leone.

Whilst nutrition surveillance activities fall outside the scope of this evaluation, through the evaluation process the need for the forthcoming ACF surveillance officer was apparent and the FND Surveillance Officer is very keen to have his capacity built. There is also a need to explore how the existing reporting system can be more robust and user-friendly, allowing easy manipulation of data to facilitate analysis whilst keeping in mind the longer-term goal of integrating the reporting system into the HMIS.

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

Given the problem of staff turnover and the requirement for input from doctors in the SCs, a syllabus that includes nutrition protocols and approaches is welcome. However, in the past the process has stalled due to a lack of planning. The FND wants to lead on this, which is appropriate, and ACF is adhering to this, but it can facilitate the development of a strategy with robust planning and division of tasks. ACF has acknowledged that it does not have the resources to do everything and can support the FND to collaborate with suitable partners. A proper understanding of the

context and needs is important for example what is currently being taught and how, what has happened to the training documents produced so far, what is the appetite to learn about nutrition (it is reported that nurses don't get credits for nutrition modules) and what is required to increase the knowledge of medical staff and change in-service practice. ACF is engaged in similar activities in other countries, drawing on experiences from other countries can promote cross-learning and can also help to mitigate against pitfalls.

Annex 1: Rates of global, moderate and severe acute malnutrition by district

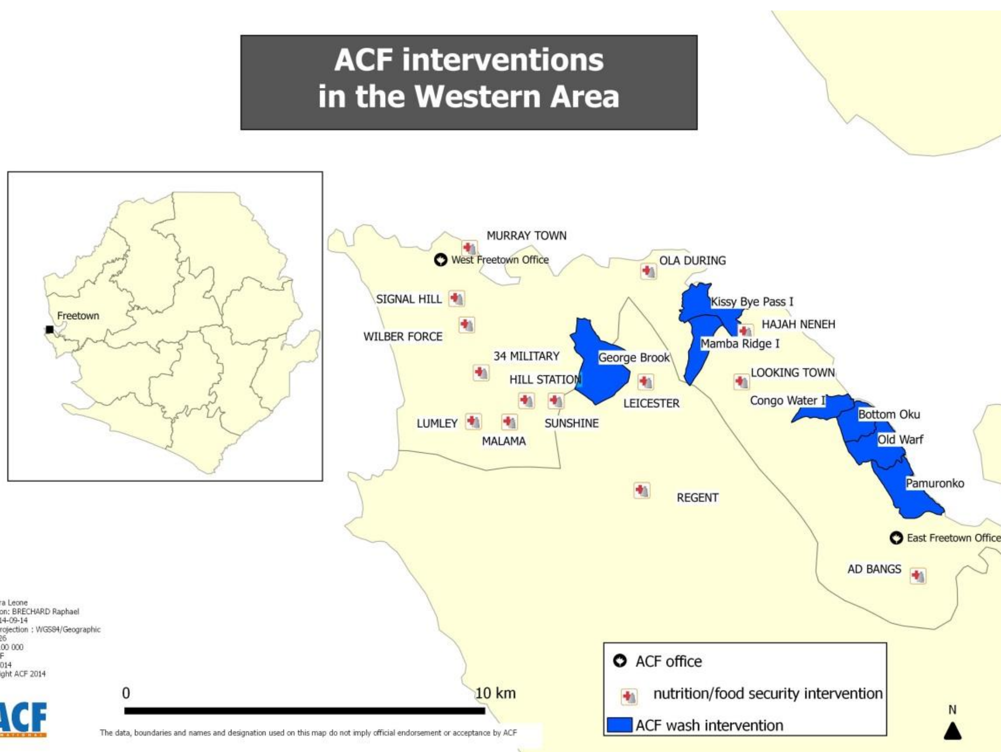
Districts/ Domain	Total N	Global Acute Malnutrition (WHZ <-2 and/or edema)	Moderate Acute Malnutrition (WHZ <-2 & >=-3, no edema)	Severe Acute Malnutrition (WHZ <-3 and/or edema)
Urban	566	8.8% (6.4-12.1)s	7.8% (5.3-11.2)	1.1% (0.5- 2.3)
Slum	667	9.6% (7.5-12.2)	7.3% (5.5- 9.8)	2.2% (1.4- 3.5)
Rural	691	6.8% (4.6- 9.9)	5.6% (4.0- 8.0)	1.2% (0.4- 3.3)
Kenema	760	8.9% (6.4-12.3)	6.8% (5.1- 9.1)	2.1% (1.2- 3.7)
Kailahun	750	5.5% (4.1- 7.2)	4.5% (3.2- 6.4)	0.9% (0.3- 3.1)
Kono	769	5.6% (4.0- 7.7)	5.2% (3.7- 7.2)	0.4% (0.1- 1.2)
Pujehun	897	7.8% (6.1- 9.9)	6.5% (4.9- 8.4)	1.3% (0.8- 2.3)
Bo	844	7.5% (5.6- 9.9)	6.6% (5.0- 8.7)	0.8% (0.4- 1.9)
Moyamba	927	8.1% (6.3-10.3)	7.2% (5.6- 9.2)	0.9% (0.5- 1.6)
Bonthe	913	7.7% (6.0- 9.8)	7.0% (5.5- 9.0)	0.7% (0.3- 1.4)
Kambia	955	7.9% (6.3- 9.8)	6.6% (5.2- 8.3)	1.3% (0.7- 2.3)
Port Loko	883	7.7% (5.8-10.2)	7.0% (5.2- 9.4)	0.7% (0.3- 1.7)
Koinadugu	873	3.2% (2.1- 4.9)	3.2% (2.1- 4.9)	0.0% (0.0- 0.0)
Tonkolili	948	3.5% (2.3- 5.2)	3.3% (2.2- 4.9)	0.2% (0.1- 0.9)
Bombali	876	5.4% (3.7- 7.8)	5.1% (3.4- 7.6)	0.2% (0.1- 1.0)

Note: results in brackets are 95% confidence intervals

Source: The Nutritional Situation of Sierra Leone, Nutrition Survey Using SMART Methods, 2010, UNICEF

Annex 2 List of ACF supported OTPs and SCs and their location

DAY	No	Name of OTP	Responsible CBN
MONDAY	1	Regent	Christiana
	2	34 Military	Anita
	3	Adbangs quarry	Denis
	4	Wilberforce	Christiana
TUESDAY	NONE		
WEDNESDAY	5	Hajaneneh	Anita
	6	Leicester	Sento
	7	Rina (only Com.activities)	
	8	Looking town	Denis
THURSDAY	9	Hill Station	Anita
	10	Ola During	Denis
	11	Sunshine	Sento
	12	Signal Hill	Christiana
FRIDAY	13	Murray Town	Christiana
	14	Malama	Sento
	15	Lumely	Anita
Stabilisation Centres		Ola During SC	Sento and Denis
		34 Military SC	Anita and Christiana



Annex 3 Outputs to be evaluated

OUTPUT AND INDICATORS	ACTIVITIES	RISK AND ASSUMPTIONS
Result 1: Institutional capacity building – technical and management – for treatment of acute malnutrition, as per national CMAM program, in Sierra Leone western area Freetown		Therapeutic food and Routine treatment for feeding centres are available at district level according to Monthly report and case load Community volunteers are identified and recognized by communities and health system; they are available for training High turnover of Health staff would limit the impact of on the job coaching Health staff are fully following the CMAM protocol DHMT members and partners are available
Outputs: 1.1 Initial assessment of decentralised services' needs for support	**Activities:** - Assessment of 20 PHU's and one SC to identify needs for support - Based on assessment, provide technical support in the form of on the job coaching (weekly) and formalized trainings to 20 PHU's and one SC in the Freetown urban area	
1.2 Practical training of 100 health staff and 100 community volunteers in OTP and SC (coverage of 20 PHUs) *<u>Indicator:</u> 80% of children are screened in the area of intervention*	- Train 100 community volunteers to support community mobilization efforts for active case finding (detection and referral) as well as community sensitizations per the national nutrition protocol - Provide tools to the community volunteers for detection and referral (Tally sheet, referral slip, MUAC[4]) and for sensitisation and awareness	
1.3 Decentralised services support for supervision of health staff *<u>Indicator:</u> SPHERE standards will be attained and will progress in the health centres supported (Cured rate > 75%, Defaulter rate <15% and death rate < 10%)*	- Provide tools to the community volunteers for detection and referral (Tally sheet, referral slip, MUAC) and for sensitisation and awareness - Provide tools and anthropometric material through DHMT to ensure proper management of acute malnutrition - Monthly joint supervision visits to PHU's, SC and communities with ACF, the DHMT and other NGO partners in Freetown	
1.4 Decentralised services support for management of acute malnutrition in the district *<u>Indicator:</u> Annual increase of CMAM coverage*	- Development of tools, in collaboration with MOHS, to improve data collection: report formats, data communication and compilation systems through health facilities - Support DHMT on launching of Nutrition Coordination meeting at district level following the SUN recommendation - Support the DHMT on the scaling up of CMAM activities through training and supportive supervision of new OTP - Work on capacity building and transfer of skills in order to plan an exit strategy, jointly with DHMT and MoHS, at the end of the project	

[4] Middle Upper Arm Circumference

Result 2: Government of Sierra Leone and major donors prioritize nutrition security in their strategies, frameworks, and financial commitments by 2015		National consensus is reached and examples are disseminated to partners Radio network covers the entire district
Outputs: 2.1 A national advocacy strategy is defined internally to enhance nutrition security in Sierra Leone *Indicator:* ▪ *Advocacy strategy is defined and baseline is completed* ▪ *Indicators to measure advocacy strategy impact are defined and agreed with Irish Aid*	**Activities:** - Literature review of the different policies, guideline and protocols link to nutrition security in Sierra Leone with emphasis on the FNIP - Internal meeting to define key messages and advocacy target - Meeting with different stakeholders working in nutrition and other sector linked to nutrition security in order to understand their position and share advocacy strategy - Develop the baseline in regard to the literature review and stakeholders meeting - Define advocacy strategy and action plan up to September 2015	
2.2 Develop advocacy activities and support MoHS in advocacy strategy development *Indicators:* ▪ *The MoHS Nutrition office defined a communication plan related to nutrition security in Sierra Leone*	- Conduct advocacy to influence the process of programmatic interventions across country in order to fight against nutrition insecurity (following the FNIP) - Capitalization of the results of programs and produce communication materials on our projects (documents capitalization, workshops, brochures, short videos) - Identify a local partner (journalist organisation; community radio…) to disseminate messages to the community and representatives of the civil society and nourish the debates on nutrition security - In collaboration with MoHS produce a documentary based on lessons learned to feed debates and promote nutrition security - Support MoHS on the definition of advocacy strategy and design of pedagogic material and implementation of activities during yearly events	
2.3 REACH/SUN initiative participation in SL and West Africa *Indicator: Technical support provided to different ministries enable them to integrate nutrition sensitive activities in their policies/strategies*	- Actively participate to the different meetings linked to nutrition security and specially Nutrition Technical committee and Nutrition Coordination meeting (at national and district level) - Capitalisation and dissemination of information internally and to partners - Central level support for development of technical documents and/or coordination (revision of CMAM protocol…)	

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Result 3: Improve at central level initial training for health staff and nutrition surveillance and propose innovative study related to nutrition security</td><td rowspan="4">MOU between ACF and MoHS is maintained and respected

DHMT members dedicate time for nutrition related activities

MoHS staff at central level dedicate time for nutrition related activities</td></tr>
<tr><td>Outputs:
3.1 The training material for university is developed

<u>Indicators:</u>
▪ CMAM and IYCF practices is integrated in the curricula of health and nutrition training schools and university (for nurses, CHO, MCH-Aid and Nutritionist)
▪ Cross fertilising visits are organised between schools and health facilities to train the students on CMAM and IYCF</td><td>Activities:
- Participation in the development of training material (by attending the related workshop) in collaboration with MoHS and WHO
- Development of innovative material to support lecturers at university: CD-ROM
- Propose cross fertilizing visits for University and Health Facilities in order to improve practice and knowledge related to CMAM programmes and protocol</td></tr>
<tr><td>3.2 Define, develop and establish officially a nutrition surveillance system

<u>Indicator:</u> Nutrition program data is high quality and published systematically (evolution of admissions, quality programs, absenteeism rates etc.)</td><td>- Meet with MoHS (Nutrition Program) and identify weaknesses and gaps in the nutrition surveillance system
- Contribute to nutritional surveillance through the support of the district and health centres in the management and monitoring of community screening activities for reference of malnourished children
- Develop district reporting template for SAM management programme in order to harmonise data compilation
- Advocacy at national and local level for the recognition of the role of the community volunteers and community health workers in the nutrition surveillance system</td></tr>
<tr><td>3.3 A CoD survey is carried out for specific livelihood zones of Freetown and Moyamba

<u>Indicator:</u>
▪ The CoD is determined for the minimum of two livelihood zones in Freetown and two in Moyamba
▪ The Cost of Diet report is prepared in a timely manner and to high quality
▪ Results of the CoD are shared with MOHS and MAFFS at both national and district-level staff</td><td>- Initial discussions with MOHS, MAFFS, WFP, FAO and other stakeholders
- Carry out CoD survey in selected parts of Freetown and Moyamba town
- Present the findings to coordination meetings, relevant line ministries and other stakeholders and share the report</td></tr>
<tr><td>3.4 A Teenage mother care practices study is done in 2 districts and 6 city</td><td>- Undertake a short review of literature related to Teenaged Mothers and IYCF/</td><td></td></tr>
</table>

section in Sierra Leone <u>*Indicators:*</u> ▪ *The teenage mother care practices study report including findings and recommendations is shared with key stakeholders*	Care Practices in Sierra Leone and internationally to highlight the key areas - Train data collector with specific focus for teenager who will be part of data collector - Design and coordinate a field study in 2 districts and 6 City Sections with NGO and DHMT staff - To hold a stakeholder meeting to present and discuss key findings from the study - Write a report with analysis of the results with practical recommendations of ways to support teenaged mothers to improve their IYCF practices	
Result 4: Prevention of malnutrition through gardens for health and IYCF mother to mother support groups		ACF and DHMT are able to identify 20 PHU and 2 Stabilization centre to support Mother to mother support groups are identified Access to water can be difficult in some PHUs, ACF will propose options for supplying water (e.g., Establishing a roster to carry water). If not feasible, we will work with these PHUs only in the rain season. Household have space for vegetables garden or ACF will provide training in small space vegetable growing, e.g., in bags, disused car tyres, or buckets
Outputs: 4.1 Formation of at least 10 mother to mother support groups per PHU supported composed by 10 mothers each <u>*Indicator*</u>: 60% of mother improved their knowledge on IYCF	**Activities:** - Development of selection criteria for participants of M2M groups - Community led selection of 10 M2M lead women per PHU in the area of intervention - Development of IYCF and other necessary IEC materials suitable for those of all literacy levels - Training of the 200 lead women on IYCF and prevention of underlying causes of malnutrition - Training 1 PHU Nurse per community to monitor M2M groups to ensure full understanding of nutrition education initiatives as well as continuation of activities after ACF exit - Supportive supervision will be done by ACF staff during the group session done by the lead mother into their community	
4.2 22 urban garden displays or demonstration gardens are developed in collaboration with staff of the 20 PHUs and two stabilisation centre <u>*Indicator:*</u> *Over 80% of PHU staffs are able to effectively provide health education about the importance of dietary diversity*	- Determine interest from PHU staff and/or volunteers to have an urban garden display or demonstration garden at their PHU - Sign MOU with each PHU and stabilisation centre - Work with PHU and SC staff to develop gardens at a seasonally appropriate time	
4.3 At least 1300 persons are trained in vegetable gardening and cooking <u>*Indicator:*</u> *Over 50% of households*	- Develop or adapt training materials to be relevant to the Freetown context and for participants with limited or no literacy - Conduct training-of-trainers (TOT) ensure	

improve their dietary diversity (according to an adapted food consumption score) from improved nutrition knowledge and vegetable growing	a high quality of training - Conduct the Gardens for Health package of five training sessions for at least 20 M2M lead mothers and 5 Community Volunteers at 20 PHUs - Conduct the half-day training sessions at the stabilisation centre on a monthly basis for 25 months - Follow-up with carers living in city sections with an ACF-supported PHU	
4.4 At least 1300 households are provided with vegetable kits Indicator: *Over 50% of households are successfully growing vegetables in the growing season following training and provision of kits*	- Provide at least 300 vegetable kits to women from M2M groups and CV - Provide at least 1000 seed kits to carers from stabilisation centre - Conduct follow up post-distribution monitoring	
4.5 50 vegetable growers are trained and supported to sell vegetables for an income Indicator: *Over 80% of vegetable growers have developed sound business and work plans to improve their vegetable growing business*	- Conduct Gardens for Income training over five days - Based on applications and business plans, provide in-kind support to five vegetable growers - On-going coaching of the five vegetable growers who receive in-kind support	
		No disease epidemics over the project period Security situation remains stable Rainy season doesn't affect access to beneficiaries No Major Food Crises

Annex 4 Evaluation matrix

DAC criteria	Key questions
Impact	What impact has the programme made in the evaluation period in terms of a) treating acute malnutrition b) preventing malnutrition? What factors have contributed to this result? Does the project have a real long term impact through the on the job coaching of health staff and community volunteers? If not why? And what should be changed? Does the project have a real long term impact through the on the job coaching of the Mother Leader in charge of the group in the communities? If not why? And what should be changed? Measure the level of impact of the peer to peer methodology used by ACF to improve the level of service delivery in Health facilities.
Sustainability	How sustainable is the programme and its different elements? What factors have contributed to the sustainable elements and what are the gaps? What needs to change to improve less sustainable components? What are the challenges in community mobilisation and how can ACF ensure sustainability of those activities (mother support groups and community volunteers)? As a new National strategy is currently developed for Community Health Worker (CHW), how ACF could roll out the activities in order to ensure sustainability? What should be the step to undertake to ensure a proper exit strategy in link with the support of the DHMT for the treatment of malnutrition and at community level for the prevention and detection? How ACF can coordinate the exit strategy from OTPs supported since 2013 and the new support to 6 OTPs?
Coverage	What is the programme coverage? What are the barriers for those who do not access the programme? How does the programme address those barriers? How is the programme perceived by the community?
Coherence	What are the synergies between this programme and other similar efforts to integrate CMAM into health systems? How coherent is it with the FNAP, health system strengthening efforts, IMCI? What are the synergies between ACF activities and SUN? What is the comparative advantage of ACF at national level?
Relevance/appropriateness	How appropriate is the programme itself and the approach used by ACF? What are the implications for sustainability and scalability? How ACF and its activities are perceived by the community, by the health workers and by the authorities, including DHMT? What is the level of acceptance of the program at district level and at central level? What is the level of program ownership by local stakeholders: health facilities, DHMT staff, community health workers, community volunteers, beneficiaries at community level?
Effectiveness	How effectively does the programme prevent malnutrition and treat acute malnutrition? What factors contribute to the results seen in different locations? This program has several components including three outcomes (prevention through Mother groups; detection and prevention through active screening in the community with Community volunteers; treatment of acute malnutrition through the support of DHMT and health workers in health facilities). Evaluator should analyze the consistency of 3 outcomes and their contribution to the achievement of specific objectives.
Efficiency	Are costs as well as effectiveness of these activities appropriately monitored? What are the implications for their sustainability and scalability?

Annex 5 Stakeholder Analysis

Level	Organisation	Position
Regional level	ACF	West Africa Regional Representative
National level interviews	Irish Aid	Deputy HoM
	MoHS -FND	Director
	MoHS -FND	Deputy Director
	MoHS -FND	IYCF officer
	MoHS -FND	CMAM officer
	MoHS -FND	Surveillance officer
	MoHS -FND	Stabilisation Center officer
	UNICEF	Nutrition manager
	SUN secretariat	National coordinator SUN
	GOAL	Samuel Jigba
	ACF	Country Director
	ACF	Health and nutrition head of department
	ACF	Advocacy Expert
District level interviews	MoHS – DHMT	District Nutritionist
	MoHS – DHMT	District Logistics Officer
	MoHS – DHMT	District Surveillance Officer
	ACF	Field Coordinator
	ACF	Health and nutrition program manager
	ACF	Nutrition head of project
	ACF	Community team leader
District level FGDs	ACF	Capacity building nurses (4)
	ACF	Community mobilisation officers (5)
Facility level interviews	MoHS	Nurse in-charge 34 Stabilisation Centre
	MoHS	Nurse in-charge Ola During Stabilisation Centre
	MoHS	Olla During OTP – 2 nurses
	MoHS	Malama OTP – sister in-charge
	MoHS	Looking Town OTP –sister in-charge, 1 CHW
	MoHS	Hillstation OTP – sister-in-charge
Community FGDS	Ola During	6 mothers of beneficiaries, 5 CHWs, 7 Lead Mothers, 15 participating mothers
	Malama	3 community leaders, 8 Lead Mothers, 5 CHWs, 4 mothers of beneficiaries
	Looking Town	2 CHWs, 1 community leader, 6 Lead Mothers, 8 participating mothers Observed a mother-to-mother support group
	Hillstation	5 Lead Mothers, 3 CHWs

Annex 6 Recommendations from 'Developing State Capacity to Prevent Malnutrition in Sierra Leone', Focus 1000 (Feb 2014)

1. Consider shifting funding from one-off, spread out trainings for health workers towards more sustained trainings. Also, ensure that technical training is complemented by training in managerial, leadership and communication skills, where appropriate to the role
2. Carefully unpack the assumptions underpinning the successful implementation of cascade training models, Mother-to-Mother support groups and Farmer Field Schools; articulate the theories of change behind these interventions and examine if these are realistic and consistent across implementation sites
3. Support the Food and Nutrition Directorate in building political support for the National Food and Nutrition Security Implementation plan within other ministries – in particular the Ministry of Agriculture, Forestry and Food Security (MAFFS), the Ministry of Education, Science and Technology (MEST) and the Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA) – including by providing greater support to these more peripheral ministries
4. Ensure that programmes clearly align to government-set priorities in the nutrition sector. Where government priorities are not immediately clear, conversation should be brokered to clarify.
5. Engage government more systematically throughout programme planning, implementation and monitoring, and evaluation cycles. This should include regular meetings throughout programming stages, including at the outset; sharing drafts and relevant information; and jointly discussing evaluation outcomes to feed into programme refinement.
6. In keeping with commitments made by donors in the Accra Agenda for Action and the New Deal for Engagement in Fragile States, provide 3-5 year forward estimates of planned contributions to assist government in planning.
7. Ensure regular reporting(every 3-6 months), using government's standardised template to the Food and Nutrition Directorate (in addition to any reporting requirements to DACO).
8. Provide the SUN Secretariat and/or the Food and Nutrition Secretariat with a detailed map of all nutrition-related interventions currently being undertaken across the country. This should be updated on an annual basis.
9. Commit to regular participation in coordination meetings with staff of an appropriate level of seniority to meaningfully contribute to meetings, beyond updating on programme activities.
10. Create flexible contingency funds for unplanned requests from government that can be mobilised quickly on an *ad hoc* basis.
11. Diversify forms of capacity support beyond training and providing resources/materials. In particular, consider how support can build capacity in coordination and political support and shift incentives to enable improved prevention of malnutrition capacity. This may require longer-term and more iterative programming approaches that focus on relationship building, rather than on project-to-project cycles.

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ACF Yearly statistics 2013 and 2014

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Peer to Peer Best Practice