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EXTERNAL EVALUATION

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Sustainable CMAM implementation in Northern Nigeria

Funded by ECHO

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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.

Acronyms:

CMAM	Community Management of Acute Malnutrition
CIFF	Children's Investment Fund Foundation
DFID	Department of International Development
ECHO	European Commission Directorate-General for Humanitarian Aid
GAM	Global Acute Malnutrition
HF	Health Facility
HMIS	Health Management Information Systems
IYCF	Infant and Young Child Feeding
LGA	Local Government Area (similar to district)
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PRRINN	Partnership for Reviving Immunization in Northern Nigeria
RUTF	Ready to Use therapeutic Food
SAM	Severe Acute Malnutrition
SPHCDA	State Primary Health Care Development Agency
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
TA	Technical Adviser
UNICEF	United Nations Children Fund
WaSH	Water, Sanitation and Hygiene promotion
WINNN	Working to Improve Nutrition in Northern Nigeria (DFID prog)
WHO	World Health Organization

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I wish also to thank the ACF staff at HQ level in New York and ACF staff in the UK for their support in planning and organising the evaluation, the various briefings and for clarifying data and records as necessary.

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Executive Summary:

Nigeria, although the 12th largest producer/exporter of petroleum worldwide and an annual GDP of 1,502 USD in 2011[1] it still remains one of the countries with high levels if inequality and poverty. Approximately 68% of the population lives below the poverty line of 1.25USD. Life expectancy remains low at 52 years at birth and infant and young child mortality have significantly risen in the last number of years. Currently malnutrition rates countrywide are estimated at; wasting 10.2%, underweight 24.2% and stunting 34.8% [2] while levels are considerably higher in the North East where the ACF ECHO funded programme is with wasting at 11.5%, underweight 34.6% and stunting at 52.5%, far higher than the national average.

ACF became operational in Nigeria in 2010 with an office in Abuja and programming in Yobe and Jigawa States initially with ECHO funding and later DFID funding (Sept 2011). From the beginning the main focus has been in capacity building of health staff at state, LGA and health facility level on the management of severe acute malnutrition (SAM). However, the focus was broadened in Oct 2010 to include a WaSH and IYCF component.

A previous evaluation highlighted the need for ACF to take a more hands off approach, support the MoH at state and LGA to put systems in place to manage and analyse nutrition data, together with developing the stock management system. Other recommendations included the improvement in programme outcomes specifically cure, defaulter and death rates, and with a need to substantially support capacity building within the stabilisation centres. Some activities are specific to the three focus LGA's in Yobe State while other activities also support the remaining 6 LGA's in Yobe State and LGA's in Jigawa state.

There has been significant ongoing progress in the three focus LGA's. The number of OTP sites currently supported has increased to 36 sites (increase of 15 sites) with two main objectives for the management of SAM; 1) increase coverage and 2) improved services, reduces overcrowding and improves programme outcomes. Other interventions included targeting both health facilities and communities with WaSH and IYCF support.

Improving programme outcomes has been challenging although trends are now moving in the right direction. Currently Cure rates are 63.8%, Default 27.4% and Death rate1.2% below Sphere Minimum Standards, an improvement from cure rate of 51% the previous year. However, there are still weaknesses in accuracy of primary data recording and reporting, together with errors in discharge criteria. Death rates are likely to be under estimated with the lack of tracking absentees and defaulters. This area needs to be further strengthened. A SQUEAC survey in Damaturu in 2012 indicated "point coverage" at 50.4%, above Sphere Minimum Standards. Previous coverage surveys in Fune and Potiskum were significantly lower. Capacity building in data management and stock management by the LGA and state staff has hugely improved. RUTF stock-outs have been limited, in part due to the supply of RUTF through the ECHO funded ACF programme as necessary. However availability of routine medications by the MoH is a major limitation.

The management of SAM with complications in the SC's (stabilisation centres) has increased from two centres to three and numbers of admission has significantly increased with outcomes

[1] 2013 The World Bank Group
[2] Nigeria 2011 MICS

substantially improved. Lack of ownership was a particular issue in the start however, this appears to have been resolved overall –the lack of access to the field during this evaluation has been a considerable limitation to better understanding the ongoing changes to management of the SC's .

A core component of CMAM (community management of acute malnutrition) is a strong community component working with CV's (community volunteers) in sensitising and mobilising the community, screening children and tracking absentees and defaulters. Considerable work has been undertaken in this area with the development of locally appropriate tools and training on "Adult learning Cycles", moving from a "talking at" model to a participatory style model using a variety of means to distil information. Currently the weakness is in measuring the impact of this training and style. There is a need to develop an M&E tool to capture behavioural change. Anecdotal evidence suggests there has been considerable change in the training being conducted at all levels and this has positively impacted on behavioural change potentially.

Similarly activities are ongoing in IYCF training with health workers and CV's. Core IYCF groups have been formed within a number of targeted health centres with the establishment of mother support groups. Apart from recording the actual training and forming of groups there is a need to develop an M&E tool to capture change within these mother support groups and their neighbours. The planned KAP survey for June 2013 should be a vessel to capture some of this information. There is a need to utilise the M&E Specialist in Abuja currently focused on other programmes to assist in developing these tools.

The WaSH component is a combination of hardware and software interventions. The hardware is targeting HF's with improved access to water and sanitation services. The software is comprised of training in hygiene promotion focusing on health workers and CV's. Delays in implementation in phase 2 required a no cost extension. The large hardware components in phase 3 are currently ongoing. The CLTS component is at an early stage of development and needs to stay within the standard model. An M&E checklist has been developed for visits to the HF's but data needs to be compiled, analysed and reported on periodically. Anecdotal evidence suggests that there is a need to continue to strengthen collaboration between WaSH and nutrition, the community component.

It is difficult to ascertain the amount of support given to the other LGA's within Yobe and Jigawa States in CMAM capacity building. Key staff turnover and major recruitment gaps have significantly negatively impacted on progress (CMAM specialist position vacant for 9 months). Initial support to the SNO and others was undertaken however further planned activities were not able to be achieved due to lack of staff and security issues. OTP beneficiary data is not currently available in the phase 3 funding period; however it is questionable if indeed these should be considered direct beneficiaries. There is a need to substantially review this component of the programme.

Insecurity has increased over the last two phases of the ECHO funded programme substantially impacting on day to day activities and programme results particularly in Yobe State. Periodically the ACF expatriate staff was required to relocate due to the escalation of threats to expatriates and ultimately leading to permanent relocation and a shift to remote control and remote management model of management. This has been an ongoing process, taking some lessons learned from Somalia and refining tools to the Nigeria context. Staff turnover, gaps in senior management and lack of access to key policy documents has made the process more difficult. Programme monitoring and data information is particularly more challenging with tools less developed compared to

logistics/finance tools and systems. Nevertheless the movement to remote management should be considered an opportunity to continue to capacity build national staff and localise many of the senior coordination and management positions.

Overall Objective of the Evaluation:

- Evaluate the results of the programme (Results 1,2 &3) in terms of coverage, coherence, effectiveness and sustainability focusing on the below questions
  - Evaluate progress from previous evaluation recommendations (Aug. 2011)
  - Assess how ACF has adapted programming monitoring and implementation to change in security situation in the past 12 months
  - Provide recommendations for ACF's future strategy taking into consideration likely continuation of current situation

Programme Results (Phase 2 and Phase 3)

- Adequate nutritional treatment of SAM children is provided in Yobe and Jigawa States
- Adequate water and sanitation infrastructure integrated in health facilities and training in hygiene promotion to health workers to support delivery of quality CMAM services in Yobe state
- IYCF activities integrated into specific health facilities and catchment areas with CMAM services in Yobe State

Highlights /Recommendations from <u>Previous External Evaluation</u> (Aug 2011):

- Support the MoH in the expansion of OTP services to other sites within the current LGA's to increase/improve coverage
- Develop strategies to support and address chronic malnutrition with specific considerations in IYCF (infant and Young child feeding) practices, lack of access to food seasonally and WASH highlighted in ACF study conducted in the area in 2011
- Continue to capacity build MoH staff with more "hands off approach" including ongoing joint trainings and joint M&E activities (MoH and ACF)
- Community component- improve integration of services (OTP and community), develop simple tracking system to track CV (community volunteer) services and plan periodic meetings through current HC system to support CV's
- State Level – support the development of the supply management system for RUTF from state to LGA and HC and support the ongoing development of the MoH M&E system for collecting, analysing and reporting on nutrition
- Support the MoH to improve OTP outcomes especially high rates of absentees and defaulters
- Support the improvement in the management of SAM with complications in SC's

Methodology of the Evaluation:

The following methodology was used in the external evaluation of the ECHO funded ACF Nigeria CMAM Integration Programme:

Interview/briefing with the following ACF Key Staff (HQ and Abuja level):

- Skype/phone briefings with key ACF staff at HQ (Desk Officer, Senior Nutrition Adviser, Nutrition Adviser for Nigeria Country Programme, and the Water, Sanitation and Hygiene Adviser.
- Briefings with ACF key staff in Nigeria (Acting Head of Mission, Logistics Coordinator and HR Assistant)
- Interview with key staff in ACF nutrition programme including Nutrition Technical Coordinator and ACF CMAM Specialist
- Skype interview with ACF Communication Specialist based in DRC

Interview with key ACF Programme Staff:

- Interview with ACF Yobe Senior Nutrition Officer and acting nutrition programme manager in Abuja
- Interview with M&E TA (technical adviser) – new role for the WINNN programme
- Phone interview with ACF Damaturu Head of Base
- Phone/Skype interview with ACF WASH Programme Manager
- Phone interviews with the following: ACF IYCF TA, LGA officer, and ACF State TA

Interview with key stakeholders at national level:

- Federal Ministry of Health – Deputy Director/Head of Nutrition Division
- UNICEF Nutrition Specialist -Abuja
- DFID Health Specialist – Abuja
- Interview with Save the Children Fund and Valid International

Phone interviews with key stakeholders at State and LGA level:

- Phone interview with the Director of the State Primary Health Care Development Agency (SPHCDA)- interview limited as connection poor
- Phone interview with LGA nutrition focal persons for Fune , Damaturu and Potiskum

Review primary & secondary data:

- Review of programme data including individual beneficiary cards
- Review of programme statistics, monthly reports, field visit reports etc
- Review of secondary data including project proposals, project interim and final reports, ACF Yobe Reports of studies conducted and other relevant documents including DHS reports (see reference list)

(See annex 1 for evaluation timeframe and names of individuals met)

Limitations to the Evaluation:

Due to current security constraints in Northern Nigeria it was not possible to physically visit the programme site hence there are considerable limitations to this external evaluation. Some key ACF

Yobe staff was available for discussions in Abuja and many interviews were conducted over the phone/Skype with varying degrees of success. However it was not possible to visit some of the many OTP and SC sites to physically see how the work is being done, meet with MoH key health staff, beneficiaries and the community to capture their views on the programme. Taking into consideration these weaknesses this evaluation has been somewhat incomplete.

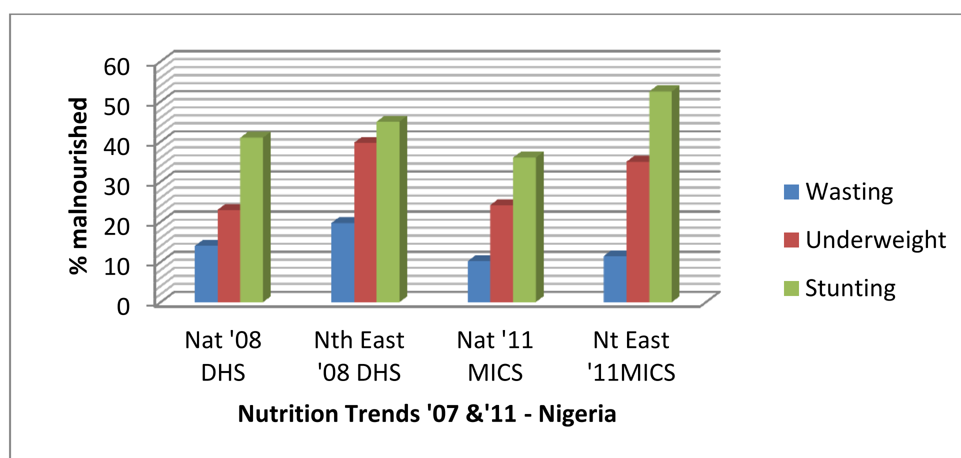
Background:

The Federal Republic of Nigeria, situated in West Africa with an estimated population of around 170 million is the most populous nation in Africa and contains around 1/6th of the total African population. Nigeria is ranked at 153 out of 187 in the HDI[3]. Life expectancy is 52.3 years (at birth).

Nigeria has the second largest economy in Africa with substantial untapped mineral resources and is the 12th largest producer of petroleum worldwide. Although gaining wealth and increasing GDP there is considerable inequality within the country leading to high levels of poverty with 68% of the population below the income poverty line of US$1.25 a day. National budgets spend on essential services such as health and education are low which has led to deterioration on the overall health of the population between 2007 and 2011.

Under-five mortality has increased from 138/1000 live births to 158/1000 live births[4]. Likewise nutritional indicators have altered little over the last number of years with national levels of underweight currently at 24%, wasting at 10% and stunting at 34% (MIC's 2011). However, rates of malnutrition are significantly higher in the North East and North West of the country. Rates of underweight, wasting and stunting are recorded at 34.6%. 11.5% and 52.5% respectively in the North East (2011 MICS).Malnutrition remains an extremely serious issue in Nigeria.

Graph1: Nutrition trends in Nigeria -2007 & 2011



Nutrition in Nigeria – Overall Context:

Nutrition in Nigeria has been seriously neglected over the years. This is validated by the extraordinary high levels of both acute and chronic malnutrition particularly in the North. In an attempt to address this and by invitation from UNICEF and the Federal MoH, Valid International

[3] UNDP Human Development Report 2013
[4] Nigeria DHS 2007 & Nigeria MICS 2011

piloted the management of SAM through the CMAM approach in one state in 2009. The success of this pilot has led to the scale up of CMAM services in a number of states in the North predominately by UNICEF through the PHC structure with the basic model of supporting five OTP sites per LGA (local government area). Other stakeholders including ACF, MSF and SCF have also supported the scale-up of CMAM activities with a similar approach but generally more OTP sites per LGA. In 2009 a total of 69,000 children were treated for acute malnutrition and this has increased to 261,000 by the end of 2012[5]. Currently only around 10% of LGA health facilities have some access to CMAM services which indicate the needs are enormous.

At federal, state and LGA level there has been some attempts to support nutrition with the recruitment of state nutritionists and nutrition focal persons within the LGA's. The health workers within the HF's (health facilities) are responsible for the day to day management of SAM. However state budgets for nutrition activities are lacking. The funding of RUTF was initially being supported by UNICEF with the understanding that with time this cost would be taken on at state level however, to date only one state has allocated some funds for the purchase of RUTF.

Food and Nutrition policies, guidelines for the management of SAM (only OTP) are being developed although the process is slow. The national nutrition/food policy is currently being reviewed with support from DFID. Nigeria has signed up to the SUN (Scaling Up Nutrition) Movement. A National Nutrition Summit was held in Abuja in February 2012. A number of key persons within Nigeria have been identified as champions for nutrition including the Minister for Agriculture. ACF has facilitated one of the nutrition champions to attend a SUN/1000-day event in Washington in June 2013 representing civil society.

The main stakeholder in nutrition in terms of donors is currently DFID with a large programme funded in the North. UNICEF receives considerable funding also for nutrition from many donors including ECHO while a number of INGO's are also receiving funding from ECHO for nutrition interventions. Furthermore, the EU is planning to take a stronger focus on nutrition, the World Bank has an initiative to "save 1 million lives" by 2015 and also is involved in costing a plan for addressing nutrition while the Children's Investment Fund Foundation (CIFF) is currently in the process of funding CMAM activities through UNICEF and INGO's (ACF and SCF) in Nigeria. There is also some funding allocated by CIDA for micro-nutrient initiatives and by USAID in MCH activities. It appears that in the last six months there is a "huge shift" in the interest in nutrition within Nigeria[6].

ACF in Nigeria:

ACF established a base in Abuja in Nigeria in May 2010. The initial fact finding assessments including key stakeholder meetings and dialogue particularly with the Ministry of Health and UNICEF indicated that the greatest unmet needs were in Northern Nigeria. Specific gaps were identified in Yobe and Jigawa States. ACF established a base in Damaturu in Yobe State. With ECHO funding the MoH staff capacity building programme to support the management of SAM was established. This support was targeted at state and LGA staff initially in two LGA's (Fune and Damaturu). Ten OTP sites were established in Fune at the end of February 2011 and seven sites established in Damaturu in June 2011. However, many beneficiaries were being admitted from Potiskum LGA where a high

[5] Verbal communication with UNICEF
[6] Verbal communications with DFID

population resides therefore following requests it was decided it was necessary to support services for the management of SAM also in this LGA in five OTP sites. Stabilization Centres were also established in the two main hospitals in Damaturu and Damagum.

ECHO funded Phase 2 and 3 – Nutrition, IYCF and WASH:

This evaluation is focused on two funding periods from October 2011 to June 2012 (9 month funding period) and the current programme July 2012 to June 2013 (12 month period) internal budget codes A1B and A1C. The core component of the ECHO funded proposal is the "support to the management of acute malnutrition" (Result 1) through capacity building of the MoH staff at state and LGA levels in Yobe and Jigawa States plus supply of RUTF, milk products and some drugs. This is reflected in the budget spend also with 70-80% of the budget on "goods and services to beneficiaries" allocated to the support of CMAM services. The WaSH component is the next largest component in terms of funding with support to IYCF attributed to the least funding at around 15% and 8% respectively (results 2&3). The budget over the two year period amounted to Euro 2.6million.

Support to Management of SAM– different approaches:

Support to the management of acute malnutrition varies substantially in different geographical areas in the ECHO funded phase 2 and 3. In Yobe state with ECHO funding ACF is currently actively supporting CMAM integration in three LGA's (Damaturu, Fune and Potiskum). ACF has recruited local staff to conduct training, mentoring and supervision visits in collaboration with the MoH staff at state, LGA and HF levels. Daily activities are carried out to support the improvement in services. ACF is also actively supporting community mobilization, CV (community volunteer) training, WaSH and IYCF activities with some of these communities and health facilities.

The remaining LGA's in Yobe State receive some technical support at LGA level which theoretically should support improvement in CMAM services. In particular the Yobe SNO receives considerable training and mentoring. There are donations of goods in particular CV training material. There are numerous planning meetings at state level on the scale-up/roll-out of CMAM services. However, no day to day hands on activities are conducted by ACF. UNICEF is the main player supporting the MoH in capacity building of health workers in OTP services in these six LGA's. The activities planned through the recruitment of an ACF CMAM Specialist included:

- Design capacity assessment tool and conduct capacity assessment in collaboration with the State to identify needs to strengthen CMAM services
- Collaborate together with UNICEF and the MoH at State level to plan and develop training as needs identified
- In collaboration with the State develop supply management system
- Conduct joint supervision visits to field sites and LGA's with State and LGA staff

In terms of CMAM support to Jigawa State again this is somewhat similar to the ACF support being given to the six LGA's above, technical support to strengthen CMAM services at a State and LGA level but not at health facility/health centre level in Phase 2 of the funding period. However, OTP services have commenced in April/May 2012 mainly supported with funding from the DFID WINNN (working to improve nutrition in Northern Nigeria) programme with the establishment of support by ACF to 5 OTP sites in three LGA's (total of 15 OTP sites). The ECHO funding is to continue to support some capacity building in particular refresher training for CV's and donation of material for CV training including kits to the Jigawa MoH. However, under the current ECHO funded proposal for phase 3

there was a plan to support the establishment of a further 10 OTP sites in the 3LGA's dependent on "commitment by government in ensuring condition for service delivery"

Findings in OTP Outcomes:

Admission trends – Phase 2 & 3 – all sites

Expected beneficiary numbers in the three main LGA's in Yobe State were 9000 children 6-59months with SAM in phase 2 and a further 9000 in phase 3. These are the "actual beneficiaries" directly supported by ACF with a combination of trainings, mentoring and joint supervisions. As seen from table 1 below in phase 2 the admissions were slightly higher that planned (106%) while in Phase 3 this component has already achieved its planned admission figures although there is a three month funding period still unfinished.

Table 1: Planned and actual admissions to CMAM programme

Admissions	Target	Actual	Target	Actual	Target	Actual	Planned Target	Actual Total
Locations	**Yobe State (3 LGAs)**		**Yobe State (6LGA's)**		**Jigawa State**			
Phase 2 (funding)	9000	9538	9000	10,938	?2000	3,555	20,000	**24,029**
Phase 3 (funding)	9000	9105*	9000	No data	9000	7643*	28,000	**16,748***

*Admission data only available to end March 2013 (3 months unavailable data)

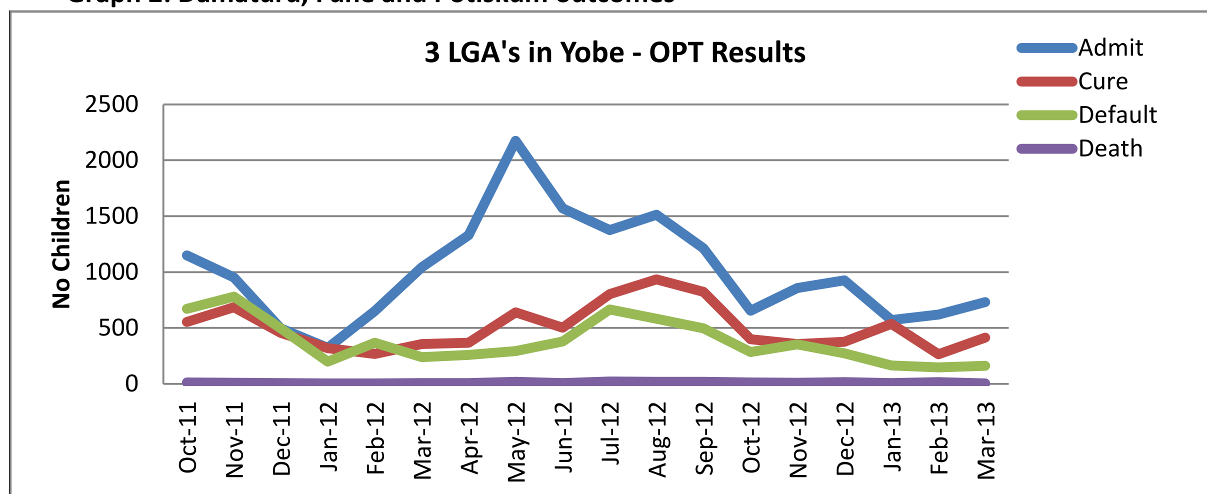
In the remainder of the Yobe LGA's there is admission data for the initial funded period which indicates again the actual admissions were substantially higher than the planned admissions (122%). There is no data available on admissions for the current funded period. In Jigawa State OTP services were only commenced at the end of Phase 2 funding period and admissions are on target.

Programme Outcomes for the three priority LGA's:

Admission trends:

The focus of this section will be on the three LGA's where ACF is actively supporting capacity building to the MoH at State/LGA level. As the programme has not reached a two year period as yet with a substantial number of operational OTP sites it was not possible to compare trends over a two year period therefore Graph 2 below looks at trends over the period from Oct 2011 to March 2013. As can been seen there is a substantial dip in admissions in the November/ January period in 2011-2012 compared to a similar period in 2012-2013. There is a huge spike in admissions in the period April/June 2012 with a steady decrease in admissions from June to October 2012. These trends are linked to events over this period as outlined in the event calendar below (table 2).

Graph 2: Damaturu, Fune and Potiskum outcomes



The main harvest period is October/November and this is automatically linked with the reduction in admissions as food is more widely available at household (HH) and community level. However, there was some reported insecurity and also OTP services were not conducted for a one week period in November 2011 linked to EID festivities. Admissions continued to decline in December and January due mainly to services not available over the Christmas period and a national strike in January for a three week period affected some OTP services. The major spike in admissions is linked a combination of increased community mobilization/awareness campaigns on CMAM (Feb/March 2012) and also the opening of 15 new OTP sites in May/June. There is a substantial drop in admissions from August to October although this is still considered the "hunger gap". This may be linked to a combination of continued intermittent insecurity together with the establishment of "remote management" as well as the earlier spike in admissions is May/June.

Table 2: Calendar of events

Nov '11	Nov '11	Dec '11	Jan '12	Feb-March '12	May-June '12	July '12	Sept '12	Oct-Nov '12
Serious insecurity incidents in Damaturu	EID celebration – double ration (no admissions for 1 week)	2 weeks-No OTP services-holiday period & insecurity	National strike (3 weeks) affected some OTP's & trainings	Substantial increase in community sensitization & mobilization	15 new OTP sites opened Insecurity Temporary remote management	Some insecurity incidents	Remote management	Harvest

Discharges, Defaulters and Deaths – OTP services:

At the end of Phase 1 of the ECHO funding the evaluation only focused on Fune LGA as then other sites were only newly established. At that time defaulter rates were slightly higher that recovered rates at 48.9% compared to 47.7%. Death and non recovered rates were low at 1.1% and 2.3% respectively. It was felt that one of the major areas to focus on was the reduction on absentee and defaulter rates with the strengthening of the community component in particular. However, it was also necessary to improve OTP services including the staff interface and overcrowding at OTP days leading to long waiting times as identified in the Fune SQUEAC survey conducted in July/Aug 2011.
The programme has struggled to improve these outcomes. As shown in table 3 below outcomes have improved somewhat but they are still below the Sphere Minimum Standards. Overall outcome trends are moving in the right direction. Furthermore, since early 2013 the programme outcomes have further improved (see table 3 below). There is no need for complacency though as the percentage of non-respondents has increased overall. There will be more detail in training/capacity

building and the community component below. However, given that the MoH is responsible for the management of SAM rather than ACF then it is more challenging to achieve the Sphere Minimum Standards. ACF has no control over the day to day running of services with only a monitoring /mentoring supportive role.

Table 3: OTP Programme Outcomes

Phase 2 (average) **Oct 2011- June 2012**	**Phase 3 (average)** **July 2012 -current**	**Jan 2013 to current**	**Sphere Minimum Standards**
Admissions – 9,538 SAM cases Cure 52.6% Default 45.9% Death 1.5%	Admissions – 9,105 SAM cases Cure rate 57.3% Defaulter rate 36% Death Rate 1.3% Non Respond 5.4%	Cure rate 63.8% Defaulter 27.4% Death Rate 1.2% Non Respond 7.6%	Cure rate >75% Default rate <15% Death rate <10%

Death rates have continued to remain extremely low, within the Sphere Minimum Standards. However, though the numbers of absentees and defaulters are decreasing they still remain high. Given that these beneficiaries are generally not traced it is not possible to know what their outcome really is. It is possible that some of these, in particular if early defaulters could possibly be deaths.

Over the last two years many attempts have been made to improve services with refresher training on SAM treatment, training on staff interface with beneficiaries and increasing the number of OTP days in some sites which as particularly busy.

Records from beneficiary cards:

A random selection of beneficiary cards was reviewed from Fune LGA to understand how the process was functioning and how well the cards were being completed. Out of 100 cards reviewed some parts of the cards were completed well while other parts were not. Overall name, address, age and the general medical checkup were filled out completely. Admission criteria was well adhered to with all admissions of 11.5cms or below

Table 4: Results from beneficiary cards

- Admit criteria ok (≤ 11.5cms)
- Discharge – mainly on 12.5cm x 1 occasion
- Generally no routing meds given (15%)
- Vaccination recorded in 30% of cards
- Temp recorded in 35% cards
- Mode of referral recorded in 30%

In general discharge criteria was on the beneficiary reaching a MUAC of 12.5cms on one occasion rather than 3 consecutive occasions (2 weeks), which means in theory they had not reached the proper discharge criteria. The temperature was recorded only on 30% of the beneficiary cards and few beneficiaries received their routine admission medications (15%). Information on vaccination coverage was only filled in on around 30% of beneficiary cards and finally only 30% of beneficiary cards indicated by what mode the beneficiary had arrived at the OTP centre such as self referral or CV referral. When cards are filled in well this is an important source of information on which components of the programme are working well and which components require more support.

Coverage:

At the end of the first ECHO funded phase a SQUEAC survey in Fune LGA in August 2011showed a low coverage (point coverage 33%) due to a combination of reasons; 1) low geographical coverage of OTP sites in some parts of the LGA, lack of awareness by the community of the availability of CMAM services and poor interface between HF staff and beneficiaries and carers. It was recommended that there was a need to increase coverage by adding more OTP sites, strengthen the community component in the three LGA's and conduct more training with health staff.

Access to CMAM services increased in early 2012 with the establishment of 15 new OTP sites. Substantial work was done on strengthening the community component and ongoing staff training. At present it is not possible to know if coverage has indeed improved. A SQUEAC survey conducted in Damaturu almost a year later shows acceptable point coverage at 50.4% slightly above the SPHERE Minimum Standards. Repeat SQURAC surveys are required to verify if coverage levels are being achieved. In Potiskum LGA, stage 3 of the SQUEAC survey was not completed in Aug 2012 due to insecurity, however results from stage 1&2 indicate coverage is likely to be below 50%, therefore coverage is possibly low. A coverage study is currently being completed in Fune LGA,

Table 5: Results from SQUEAC Surveys x

SQUEAK Survey – Fune July/Aug 2011 **- Point coverage 33%**
SQUEAK Survey Damaturu May/June 2012 – **Point coverage 50.4%**
SQUEAK survey Potiskum Aug 2012 **(stage three not undertaken due to insecurity, report incomplete)**
SQUEAK Survey Fune **(ongoing)**

Data Management, Joint Supervision and RUTF Supply:

In the initial programme ACF was hands-on supporting staff at HF level compile the weekly and monthly data on the OTP beneficiaries. ACF was also actively involved in the supply management of the RUTF from ordering supplies to transporting the RUTF from the state central level warehouse to LGA and HF on an ad hoc basis with little planning from the HF. It was recommended that it was essential that the State and LGA took over the responsibility of both these activities.

ACF in collaboration with the MoH placed much effort into supporting the establishment of a system for data management. Trainings were conducted with the state nutritionist and LGA NFP's together with health workers in the HF. At LGA and state level computers, cameras and modems were donated and computer trainings were conducted with the state nutritionist and the LGA NFP. On job mentoring and support was also given.

In general the ACF CMAM team was actively visiting the OTP sites on a weekly basis in the first funding phase (Oct 2010- Sept 2011), supporting the OTP days and actively participating. It was felt that there was a need stand back more, leave the HF staff do the work and mentor/teach as required. It was also necessary that the NFP at LGA level and others should be more actively involved in monitoring and joint supervision of the OTP services to understand how the service was functioning and ultimately increase ownership.

Findings:

There has been a vast improvement in the MoH responsibility to the management of data and RUTF supplies. In general, data is collected monthly and taken to the LGA by a member of the HF staff when attending the monthly coordination meeting. This data is then compiled by the NFP at the LGA

and emailed to the State Nutrition Officer (SNO). ACF staff supports the system as required with mentoring and trainings. However, there are still many inconsistencies in the data collection as seen with the ACF data base where the numbers of beneficiaries in the programme at the end of the month and the start of the following month don't always tally. There are potential errors at different levels; at the HF the health worker may not have accurate monthly statistics compiled, at LGA level the data may be inputted incorrectly. There are some bugs in the ACF evolution database that require attention. There are still weaknesses in the system which needs to be further strengthened.

Similarly the in-charge at the HF is responsible for ordering the RUTF on a monthly basis and this is not released until the monthly report is received at the LGA. From discussions with the ACF senior nutrition officer in Yobe it appears that Fune and Potiskum transport around 90% of the RUTF themselves while Damaturu is less organised receiving around 50% of the RUTF through their own system. In terms of the availability of RUTF, overall this has been surprisingly good. Stocks were low for one short period (May-June 2012) which meant giving reduced rations. However, overall supply has been constant and has not affected the programme significantly. The ECHO funded RUTF available to ACF has also positively assisted in the reduction of stock-outs.

Joint supervision is being conducted by relevant persons at LGA/state level together with ACF since January 2012. However, it is not clear how frequent these joint support visits are (monthly, Ad hoc). In recent times the check list within the draft OTP guidelines is being utilised. ACF and the MoH individually fill out these checklists and then in agreement compile a joint checklist. Results from these joint supervision visits are being compiled since the start of 2013 and it will be possible to look at trends and decide where weaknesses need to be addressed.

The ACF evolution MS Excel spreadsheet has some flaws and inconsistencies and is cumbersome if not trained in its use. Some cells are unprotected which leads to formulas changing and leading to inaccuracies in data compiled. This has affected the availability of accurate data. It was not possible to access the MoH excel spreadsheet so it is not clear if this spreadsheet also had flaws.

Conclusions:

Overall there have been huge improvements in the OTP component of the programme. It appears there is much stronger buy-in from the ministry at state and LGA level[7]. The OTP services have meant that the community is attending the HF's more regularly and availing of other services, in particular immunization services. The more hands off approach by ACF have led to the state and LGA taking on the responsibilities of data and supplies management. Although presently imperfect, this is the most appropriate approach for sustainability and particularly in the current insecure context.

There has been considerable ongoing work to improve programme outcomes from strengthening the community component (see section below), to joint supervision monitoring visits to the HF's. However, programme indicators are still below the Sphere Minimum Standards but appear to be going in the right direction. There is further work required to strengthen systems, in particular on addressing defaulter and absentee rates.

Human resources (in more detail below) have substantially exacerbated the situation. This is both in terms of delays/difficulties for ACF in recruitment of key staff, ACF programme staff being based at Damaturu rather than LGA , the state embargo on the recruitment of health staff and rotation of health staff between health facilities. The recruitment embargo has led to many vacancies within the health system unfilled and some volunteers that have undergone training and increased skills but remain as volunteers. This significantly impacts on staff morale.

[7] Telephone conversations with the three LGA NFP's and the State PHC Director

Furthermore, there have been other external factors that have also seriously impacted on the programme outcomes. In particular intermittent insecurity has affected the programme significantly. It has impacted on access to services by beneficiaries and health facility staff. There has been some population movements reported. For the ACF local staff it has meant no access to the field on occasions and longer travel time due to checkpoints on the roads and therefore less time in the health facilities. At one particular period with serious insecurity in Damaturu even the MoH staff at state level was unable to get to their offices in Damaturu town for a considerable period of time. Periodic withdrawal of ACF international staff from Jan 2012 and complete withdrawal from September 2012 has also impacted on the programme (see remote management section below).

Recommendations:

- Continue to support the ongoing capacity building component in the current OTP sites in the three LGA's improving programme outcomes (defaulters and absentees)
- Continue to support the improvement of the supply management and data management system including further training for the NFP's on computer skills
- Award certificates to those that attended the Adult Learning Circle Training
- Advocate for more support from the Abuja ACF M&E Specialist to assist in the development of appropriate M&E tools

Human Resources:

Human Resource issues have considerably impacted on the Nutrition programme both for ACF and the MoH. There are ongoing attempts to address some of these constraints. In terms of the MoH there are two major factors:

- Recruitment embargo
- Rotation of staff

The rotation of staff between health facilities occurs periodically and this appears to be part of the MoH system. Health workers are rotated from remote areas to more urban areas and the reverse. This impacts negatively in particular when the staff trained in OTP services is moved and the new staff have not the required skills and training. Secondly, there has been a recruitment embargo in Yobe state for a considerable time. This means vacancies have not been filled, staff that has trained up with higher qualifications is not receiving the appropriate salaries and furthermore some volunteers have received training but continue to be volunteers. These hugely impacts negatively on staff morale and work ethic.

Within the ACF team there has been many gaps in key staff at Abuja and Yobe level. Some positions have been particularly difficult to recruit and staff have resigned from contracts and left early. There was a gap of around three months in the recruitment of the Nutrition Coordinator in 2012, and a seven month gap in filling the CMAM specialist. Similarly there have been gaps at Abuja level with a gap in the Log Coordinator position of around three months and recruitment gaps with the country representative position. The remote management of the programme in terms of the senior key ACF expatriate staff in Yobe State from September 2012 has also caused difficulties for programme staff at all levels. Currently there is no nutrition programme manager in Damaturu.

In recent times ACF nutrition field staff, including the LGA officer and community officers have been allocated specific LGA's for continuity in terms of work and follow-up activities. However, currently these staffs are based at the ACF Damaturu office with travel to the field on a daily base or as

required. This is time consuming and in the current environment with security issues there is even further delays.

Findings:
Attempts to support the recruitment process at MoH level include a component of funding from the ECHO budget to initially fund a number of key positions within the health facilities to assist in reducing the work load in relation to OTP services. Considerable time was required initially to finalise a MOU between ACF and the state MoH. The budget was expected to cover newly recruited staff for a short period (couple months) and then the State would take over the costs. However, due to the recruitment embargo it has not been possible to utilise this funding.

In terms of key ACF Staff at programme level it is essential to recruit national staff with the relevant qualifications and experience to fill posts in the field, in particular the "programme manager" position and also the" CMAM Specialist" position. There is currently no nutrition programme manager and the senior nutrition officer is covering this position to some extent. However, this person is also covering one of the LGA officer positions currently vacant. This affects programming and report writing among other issues.

Each LGA has an ACF officer and two community officers but they are currently located in the ACF base. In discussion with some of the team it is felt that it would be more beneficial to have these persons located at LGA level similar to the WINNN model. It would positively benefit on the programme however, the modalities of how this would work need to de developed.

Within ACF at central (Abuja) level again it is necessary to look at increasing local HR capacity and indigenising some of the current positions. Maybe this requires experienced expatriate staff shadowing their counterparts until capacity has been build up. This would be particularly relevant where individuals should ideally spend a considerable portion of their time supporting the programme at field level. Currently ACF is looking at how best to capture the HR needs. New proposed structures are being developed and some ongoing recruitment is in place.

Conclusions:
Ideally it would appear to be more logical if under agreement of the LGA authorities the nutrition programme staff were allocated office space at the LGA and worked from there on a daily basis. It would have a number of benefits from the improvement in team dynamics as there would be day to day contact with LGA staff, less travel time and therefore more efficiency in terms of time and cost. The modalities of how this would work need to de developed.

Recommendations:
- Continue to develop ACF structure in the context of remote management and recruitment difficulties
- Continue to develop and capacity build national staff
- Consider relocation ACF programme staff to LGA offices
- Continue to train OTP new HF staff to incorporate issues relating to staff rotation and OTP ownership by all staff at HF
- Consider working with the MoH to develop a curriculum on the management of acute malnutrition to incorporate into new training for nurses and other cadres of health staff

Community component:

A strong community component is imperative for the success of CMAM services. In the initial phase active recruitment of CV's (community volunteers) and training was conducted in collaboration with the LGA and health centre staff. Recruitment was through the village leaders and other community leaders. In the initial phase there was a considerable imbalance in gender representation with significantly more male CV's - Fune only 11% female and 23% in Damaturu.

A rapid socio cultural assessment was conducted during March/May 2011 to understand the dynamics within the community in Fune and Damaturu LGA's and how best to sensitize and mobilise the community. Within this relatively conservative Muslim community access to women is limited. However, traditional healers, women political leaders, hair dressers and others have access to women together with health workers. The community component has evolved in line with these findings.

Community component - Findings:

Considerable work has been undertaken to strengthen the community component. Initially the ACF team worked together and rotated between LGA's and health centres. However, in March 2012 a new strategy to target high defaulter rates was put in place. Two ACF Community Officers (CO's) were assigned to each LGA's on a permanent basis. The CO's were tasked to visit the OTP sites on the day following services to arrange beneficiary cards and identify absentees in particular to pass on to the CV's so that the absentees are tracked and encouraged to return for continued treatment of SAM. A proper filing system was developed at the HF to categorise beneficiary cards in terms of the following: In Program, Absentee, Defaulter, Cured and Non-Recovered.

To improve tools and training skills an ACF Communication Specialist was recruited from Feb/May 2012 and again July/Sept to support the programme in developing communication tools on key messages in CMAM such as identification of malnutrition, treatment process, keeping healthy etc. A second component included training key ACF and health/state staff on "adult learning skills" using numerous different approaches including theatre, demonstrations, colour cards, card games. During the second specialist visit the main focus was to conduct TOT with health staff for by-in of the community component as ultimately the health workers are responsible for CV cascade training. Unfortunately due to insecurity the training was transferred to Jigawa State however staff from both states were trained there.

Over the last 18 months a considerable amount of CV trainings and refresher trainings have been conducted. Almost 2000 CV's and other key stakeholders have received training/ sensitization. There has been ongoing monitoring and mentoring on OTP days in particular. A system was developed to track which children were being referred by the different CV's to ensure CV's were active and referrals were accurate. CV's recruited for the WaSH component of the programme have also received training.

Currently the ACF community officers have been allocated to specific LGA's however, they travel on a daily basis from the ACF base in Damaturu. For some of the OTP sites and villages the distances are great. Increased insecurity has impacted negatively on travel time with increased check-points and security clearance prior to travel. This means at times teams are on the ground for limited periods. It was suggested that it would be better if the ACF team were located at the LGA rather than the ACF base similar to the WINNN programme. This would have many positives including building a better working relation with LGA staff due to the day to day interface and better access to the programme/community.

Monthly CV meetings were established to improve contact and communication with the CV's. A travel allowance was also important as an incentive for the CV's to remain active. Lack of financial gain has been voiced as a reason for CV's not being active. The programme is currently identifying those that are active and will work with these CV's. Other incentives such as tee-shirts, caps and bags have been supplied to the CV's together with the training/mobilization kits.

The nutrition CV's and WaSH CV's is currently receiving similar training and therefore can conduct nutrition and WaSH messaging. There is some collaboration between the two CV's but it was felt this need to be substantially stronger with regular planning and collaboration.

Conclusions:

Due to lack of access to the programme site during this evaluation it has been difficult to get a sense on exactly what progress has been achieved in this area. The combination of monthly reports, interviews with some key staff and some discussions (Skype and phone) has helped to draw some conclusions. Overall the development of the CV training material and the introduction of the "adult learning approach" had significantly improved skills within health staff at LGA, State and health facility level, together with ACF staff. ACF and LGA NFP's voiced this during phone interviews. In discussion with the Communication Specialist there had been a "visible improvement in training skills". The CV kits have been appreciated by the LGA focal persons in particular. Lack of access to the CV's means it is not possible to get their views. Both CMAM and WaSH CV's have received similar training which is positive. However, in discussions it was felt that there was a need for better planning and collaboration with these teams in the future.

There is a need to ensure pre and post training tests are conducted and this data is reported on and compiled. It might be worthwhile compiling a three monthly report on the community activity component – assessing impact of activities and highlighting issues. This component seems to be shadowed in the overall monthly technical report although an important component of the overall success of the programme.

There is a need for a more rigorous system for monitoring the impact of the current community activities on behavioural change. A planned KAP in June 2013 will focus on WaSH however; it may be possible to add some questions on nutrition & caring practices. Results from this would assist in measuring the impact of the substantial work on community sensitisation and mobilization. There is a need to develop a tool for capturing behavioural change periodically within the beneficiaries at the HF and also within the community. This could be a short questionnaire conducted by the team possibly on a three monthly interval. Assistance from the M&E Specialist in Abuja and the M&E technical Adviser in Damaturu would be worthwhile in developing these tools.

The strategy to permanently allocate two CO's to each LGA improves accountability and continuity. However, due to increased insecurity and travel from ACF Damaturu base it may be more appropriate to have CO's based at LGA. There is a need to look at the modalities of how this would work.

Insecurity and the introduction of remote management plus gaps in key programme staff have negatively impacted in access and availability of monthly reports and other relevant documentation. From July 2012 monthly reports have been sporadic and the information extremely limited.

Recommendations:

- Consider developing a tool to regularly monitor behavioural change in the community and at health facility in collaboration with the ACF Abuja and Damaturu personnel

- Consider three monthly questionnaires and reports on the community component of the programme to analyse progress
- Consider relocating ACF CO's to the LGA site
- Ensure planned KAP survey captures some components of the community mobilization/sensitization programme
- Ensure WaSH and CMAM programme CV's work more closely together to increase impact

Stabilization Centre Management:

The management of severe acute malnutrition with medical complications +/- severe oedema is normally managed in the inpatient facility – stabilization centre (SC) as these children are at high risk of mortality. To date no guidelines are developed in Nigeria to support staff in this treatment process. Some draft guidelines have been developed but it is not clear of the ownership of these, although in discussions with UNICEF, there are indications that work is ongoing to finalise these. Currently there are 81 SC's throughout the country and three of these are within the ACF programme area (the currently supported LGA's). However, with no guidelines in place responsibility for the supply of the specialized milk products (F75 and F100) is a challenge. ACF supplies these products in the SC's in Yobe State.

In the initial evaluation there were two SC's operational but with many constraints. There was a lack of buy-in by staff at the hospitals and also a lack of physical capacity as the SC was within the paediatric ward which was generally extremely busy with other sick children. ACF had not specifically prioritized the support to these SC's and therefore the progress in achieving standards was slow.

Findings:

Currently there are three SC sites one in each of the main hospitals within each LGA supported by ECHO funding. A member of the ACF team was given the responsibility for supporting capacity building within these SC's (SC officer). Meetings were held in Oct/Nov 2011 on planning and ways forward to improve space capacity and staffing capacity within the SC's. The need for training on data management was recognized as an issue.

Admission trends can be seen in the graph below. In early 2012 admissions were extremely low but this has been attributed to high levels of insecurity in the period (ACF monthly reports), admissions picked up in March with the opening of a SC in Potiskum. Admissions remained reasonably constant until August (no data available), a peak again in October and a gradual decrease to the end of the year with the harvest coming in. Numbers of deaths were high in March and this was reportedly due to lack of suction and oxygen equipment in Damaturu Hospital (equipment ordered) and late admissions of very sick children in Potiskum. Mortality reduced over the remainder of the year. Overall a total of 623 children were admitted to the three SC's over the 15 month period.

Programme results overall have been acceptable with the combined cure and transfer rate at 75.3%, defaulter rate of 13.4% and death rate of 11.3%. There were times over the Jan/June period when some of the SC's recorded higher death rates and this was monitored closely to understand whether this was linked to the condition of the patients on arrival to the SC or the treatment/care in the SC.

However, the lack of regular ACF nutrition programme monthly reports from July 2012 makes it difficult to determine how this component of the programme has evolved.

Graph 3: Outcomes from the SC's in Yobe State

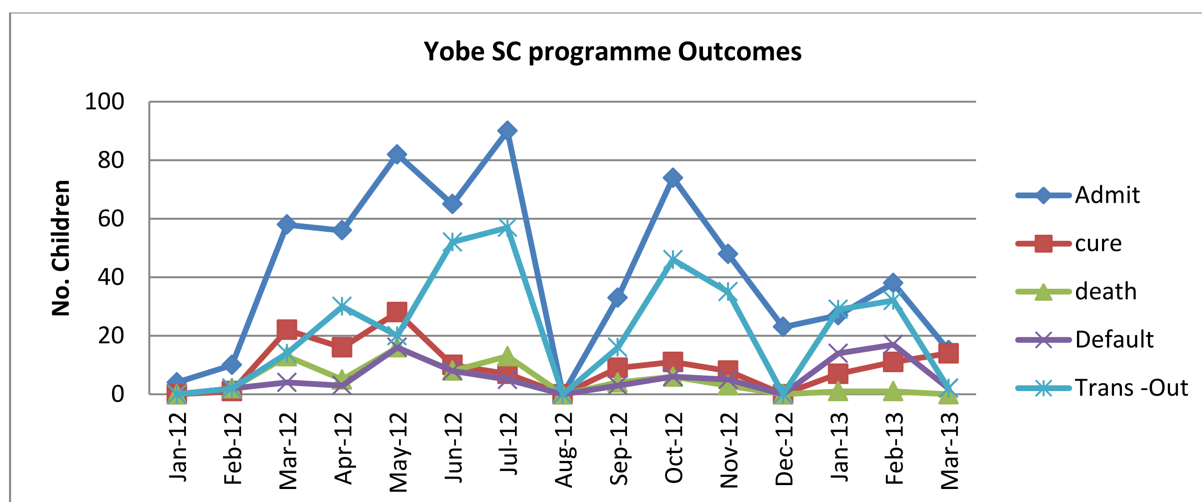


Table 6: SC Overall Outcome Results (Jan 2012-Mar 2013)

Cure + Transfer	Default	Death
75.3%	13.4%	11.3%

In discussions with the ACF SC Officer the feeling was that the programme is functioning much better and there is greater buy-in. There are regular refresher trainings and staff attends the monthly LGA coordination meetings together with the other OTP staff from the health facilities (OTP sites). Equipment including water flasks has been supplied for use overnight to ensure children have access to the specialized milk. There were issues with the use of IV fluids particularly when paediatric IV sets are not available to control the volume of fluid being given. Similar issues were raised in terms of blood transfusions. It has also been suggested that the transfer in and out mechanisms from the SC to the OTP still remain weak and require further follow-up. There are some discrepancies in the data reporting with admissions and discharges not tallying up accurately which suggest more support are needed in this area.

Conclusions:

The review of this component is particularly weak as the evaluator was physically not able to visit the sites and speak with the MoH staff and beneficiaries means the evaluation is very incomplete. However, from the previous evaluation it appears that substantial strides have been made in terms of buy-in by the hospital staff, the increased numbers of beneficiaries admitted to the SC and overall the outcomes are acceptable and within Sphere Minimum Standards. There is probably a need to continue to support capacity building and possibly this role in the future should be taken on by the individual ACF LGA officers.

Recommendations:

- Continue capacity building support to the SC's and consider including this responsibility under the ACF LGA Officer's role of responsibilities.

CMAM Support to other LGA's in Yobe and Jigawa States:

In the initial Phase of the ECHO funded programme a component of capacity building support to the MoH at state and LGA level was part of the overall intervention. The main objectives were to strengthen the nutrition data monitoring systems and support the development of a supply chain system for the supply of RUTF within the whole state. Training was conducted in Aug 2011 at state level on data monitoring and reporting with 17 participants.

A joint monitoring visit was conducted in two LGA's in Dec 2011 in collaboration with the state nutritionist and deputy to identify weaknesses, develop trainings depending on needs and develop/strengthen the supply chain management especially of the RUTF. During this visit CV motivation kits were distributed to the LGA authorities in two LGA's. Following on from the visit a draft state implementation plan was developed. This planned support was for all the nine LGA's in Yobe state which mainly included PC training for the NFP's, training on supply management systems at different levels within the health system, CMAM guideline trainings for health workers. Six of the nine LGA's are supported by UNICEF in terms of general OTP activities and training.

One of the main outputs measured in this component is the number of children admitted to the six UNICEF supported OTP sites. Data was available on these admissions in the second phase but no data is available in the current phase.

Findings:

In phase 1 and the start of phase 2 of funding April 2011 to Jan 2012 some progress was made with the recruitment of two CMAM specialists. The initial CMAM specialist resigned within 3 months with little impact as access was an issue initially. Following a gap of 6 weeks the second specialist was recruited however resigned after a six month period. Following this there was a huge gap of seven months until the post was recruited again. Furthermore, the context had altered significantly in this period. The security situation had deteriorated considerably and access was a serious issue. In reality activities in general have not taken place from Jan 2012 apart from one refresher training conducted in Jigawa for both states (Jigawa and Yobe) towards the end of 2012.

From the CMAM specialist handover notes[8] there appears to be some issues in regard to clarity of the ACF CMAM Specialist role. There are overlaps in activities being conducted by ACF and UNICEF in particular with training. The report also intimated that in reality it was challenging to take on this role as it required substantial travel, accommodation and logistics together with a language barrier were serious considerations. The current CMAM Specialist was recruited in Sept 2012 when security

[8] Handover Notes from CMAM Specialist, January 2012

had deteriorated in Yobe State and therefore deployment was not possible. The specialist is not based in Abuja contributing to support and improve CMAM quality in Jigawa State.

Although the support role in capacity building in these 6 LGA's is considerably less than the ACF focus LGA's however the OTP beneficiaries are considered and counted in a similar manner. There is a need for clarity in counting of beneficiaries. There is a risk of double counting if UNICEF is counting the beneficiaries in these six LGA's predominately supported by UNICEF and at the same time ACF is also reporting on these beneficiaries.

Conclusions:

There is a need to re-visit this role completely as in general activities have not taken place over a substantial period of phase 2 funding and all of phase 3 due to recruitment and access issues. Furthermore, it is questionable that this role is suitable to an expatriate with little knowledge of the area, context and language. Furthermore, with the current security constraints and remote management in place this further exacerbated the situation. There is a need for clarity in the roles of the state, ACF and UNICEF to prevent duplication and conflict.

In terms of recording the OTP beneficiaries it seems a bit disingenuous to consider them direct beneficiaries given the amount of support given to capacity building of OTP services in these six UNICEF supported LGA's. It is probably more accurate to consider these OTP beneficiaries in these LGA's "indirect beneficiaries" rater than direct beneficiaries. It also potentially leads to double counting of beneficiaries by ACF and UNICEF.

Recommendations:

- There is a need to reconsider this role seriously and the current working environment. Link with the WINNN programme and address gaps with ECHO funding.
- Given recruitment issues the relevant positions need to be indigenized
- Consider OTP beneficiaries in the six LGA's as "indirect beneficiaries" to prevent double counting and in view of the limited support being given
- Develop clear lines of responsibility between State MoH, UNICEF and ACF

Infant and Young Child Feeding Practices component:

Phase 2 and 3 of the ECHO funded programme has incorporated a component to address infant and young child feeding (IYCF) practices with the ultimate goal to improve care and feeding practices and support the reduction in both acute and chronic malnutrition ultimately. This component had a combination of activities including planning meetings with state and LGA authorities, training of health workers in health facilities (15), training of influential women and men in the community on IYCF and the development of 20 mother support groups in phase 2. Similar activities were planned for phase 3 funding.

Findings:

A joint plan for IYCF training of health workers and formation of support groups was developed in collaboration with the SNO and NFP's which focused on forming a "core team" at health facility

level. An IYCF consultant was hired and two health workers from each HF (health facilities) were trained in IYCF counselling, a total of 28 health workers. Cascade training by the health workers followed on from the initial training at HF level with the core group which included two TBA's, one influential man and a PLW with support from the ACF CO. By the end of June 2012 30 IYCF mother support groups were formed (2 from each HF). Each mother support group has ten members mainly a combination of TBA's and PLW's. The women in the mother support group receive one day training on IYCF. Each of these women target four women in their neighbourhood for training/transferring information. Regular meetings are held at the HF where the support group mothers and other mothers attend. In the July 2012 monthly report it was noted that the mother support groups and other PLW attended the HF for sensitization/awareness sessions. The sessions were held in small groups and it was noted that it was better to focus on a number of key messages (3) to prevent confusion. It was also felt there was a need for further IYCF training for some of the members of the support groups. In phase 3 of the programme the IYCF training was ongoing during this evaluation.

Due to the lack of programme monthly reports from July 2012 until December 2012 it is difficult to know what has happened over this period in terms of the progress within the mother support group activities. This is due to a combination of issues but mainly due to gaps in HR with a vacancy in the Nut Co position for a three month period and the change to remote management in September 2012 therefore no nutrition manager at programme level. Currently this position is vacant. However, the position has been nationalised and currently recruitment is ongoing.

Conclusions:

Considerable work has been ongoing in addressing IYCF practices. The model of developing a core group of IYCF champions was decided in collaboration with state and LGA staff. Cascade training by this group to mother support groups has expanded the knowledge within these communities on good practices for feeding and caring for young children. However, at this stage it is imperative to develop a tool to measure the impact of this training. A planned KAP in June needs to incorporate some information on behavioral change. It may be worth conducting the KAP in health facilities where the IYCF has been in place over a year and compare with sites where there has been no training on IYCF or recent training to ascertain possible behavioral change. It is probably necessary to conduct periodic questionnaires with the beneficiaries and community to measure change. Engage with the relevant ACF M&E Specialist and TA for support in developing tools

Recommendations:

- Incorporate questions on IYCF in the planned KAP and consider geographically covering areas where IYCF is being implemented and compare with areas where IYCF training has not been conducted
- Develop a tool for regular monitoring behavioral change (possibly 3 monthly questionnaire with a number of beneficiaries in some HF's) in collaboration with the M&E Specialist and TA
- Possibly produce a three monthly report in collaboration with the community component of the programme to ensure information is being recorded.

Water, Sanitation and Hygiene Promotion (WaSH):

Results from the study conducted by ACF in mid 2011 on the "underlying causes of malnutrition" in Yobe State, indicated that improvements in WaSH was considered key in addressing malnutrition. In considering these results the ECHO funded Phase 2 and 3 project proposals included a WaSH component. A substantial component involved a total of 15 health facilities becoming "Model WASH Health Facilities" adhering to SPHERE standards for quality and quantity standards.

In Phase 2 the various activities included a feasibility study for health facilities, planning and developing activities in collaboration with LGA and State authorities. Addressing water supply and sanitation in the health facilities was one of the core activities which included a combination of: conducting eight geophysics studies, the rehabilitation of broken down boreholes (2) and construction of new solar boreholes (6). Other activities included the installation of 6 latrine stances and training of WaSH committees. Training was planned for (75) Health workers and (450) community volunteers in improved hygiene practices to reduce disease and illness. It was expected that this would also positively impact on malnourished children attending the OTP sites in rehabilitated health facilities where hygiene promotion activities were being conducted. A "micro" KAP was completed in May/June 2012. Other activities included the development of committees in the health WaSH model health facilities and the construction of a number of shelters for waiting beneficiaries at the OTP sites.

In Phase 3 of the ECHO funded programme the activities are similar with higher numbers of health workers and CV's trained on hygiene promotion. An added activity was the introduction of CLTS (community led total sanitation) to a number of HH's within communities within a health facility catchment area and improvement in access to safe water within these communities.

Findings:

The WaSH component of the programme commenced in Phase 2 of the ECHO funding (A1B). This component was slow starting as although the programme was agreed in principle in early October 2011 the contract was not signed until the end of November when funds were released. Therefore two months of a nine month programme had already lapsed without funding. Recruitment of key staff for the programme started at the beginning of 2012 which included the programme manager, deputy manager and technical officers but this was also a slow process. Tendering for the geophysics studies and borehole drilling was a tedious process taking 3-4 months to complete. This meant there was a need for a no cost extension to finalise the main component of the work.

However, it has been extremely difficult to validate exactly what has been completed as documentation has been poor combined with the lack of access to the field. There was an absence of monthly combined programme reports from July 2012 until October 2012 when the WaSH team started compiling their own reports. Furthermore as activities planned during phase 2 did not happen in that timeframe, they were completed during a no cost extension these activities are not recorded in the ACF APR Oct 2011-June 2012 (activity progress report). It is possible they should have been recorded in the follow on APR (phase 3) with a note to explain they had been completed during a no cost extension. The only mention of a delay in the activities and not achieving all objectives is mentioned in one short paragraph in the October 2012 WaSH monthly report, with a

summary of activities in an annex to the report which was not readily available. Water quality testing was completed in the five newly constructed boreholes in November 2012 with satisfactory results.

In discussions with the WaSH PM, Logs Co and WaSH technical adviser together with email correspondence over the period and an excel spreadsheet found by the Log Co it transpires that a total of 5 out of 8 boreholes with solar pumps were constructed. The remaining three were not constructed as the water level was too deep for the equipment available to the contractor. These are planned to be constructed in the current phase. A further 2 boreholes were rehabilitated and solar pumps installed and one new underground reservoir. Three new latrines were constructed and 13 barrel incinerators installed. A total of 710 community volunteers and a total for 125 health workers were trained on key hygiene messages. Committees were established in the health facilities to take on responsibility for the maintenance and use of the resources.

In phase 3 there are similar delays in the programme with the major activities taking place currently therefore it is not possible to evaluate Phase 3 for the major activities. However training of CV's, health workers and ongoing mentoring has been in progress as indicated by the monthly reports and the APR.

The CLTS sensitization process started in October 2012 in Fune LGA and also in two villages with a number of village heads explaining the CLTS concepts and the need to address open defecation for the health and wellbeing of the communities. Step-down training on CLTS was conducted in November with LGA partners who will lead the triggering process within the communities/villages in all three LGA's. The CLTS process has been slow due to many constraints including access to the community/villages due to security issues and lack of availability of the LGA trained facilitators. Visits to some of the villages identified for the CLTS have witnessed the spontaneous construction of pit latrines by a small number of HH individuals which is encouraging. On discussions with the PM there was a plan to support some HH with material goods to assist in the construction of latrines however this is in contradiction to the ethos of the CLTS approach whereby the community needs to buy-in to the importance of a defecation free environment and support the process themselves. On discussions with the ACF HQ WaSH Adviser there are plans to rectify this.

A checklist has been developed for use during visits to the health facilities. This is extremely useful for monitoring progress. However, there is a need to compile and analyse this information over time and observe trends. Similarly on a monthly basis records are being compiled on diarrhoeal cases attending HF, again this needs to be compiled and analysed for trends.

Conclusions:

Overall substantial work has been achieved in this sector although there have been substantive delays in some components of the programme especially in the hardware component in phase 2 leading to a no cost extension. There have been similar delays in phase 3 however it is expected that major hardware works will be completed by the end of the funding period.

Lack of systematic data collection and reporting has challenged the evaluator in understanding the process, achievements of the programme and constraints/weaknesses. High turnover and gaps in

key staff have added to the limitations. The lack of a technical coordinator at national level is possibly a further weakness which may be alleviated if DFID funding for WaSH is available for Yobe and Jigawa States.

The training and mentoring component has been ongoing. A checklist has been developed for use during HF monitoring/supervision visits which is valuable. However, there is a need to compile and analyse this data regularly and report on trends. Similar to the community component in the nutrition programme results from the trainings is not being captured in terms of possible behavioral change. Anecdotal evidence suggests there is a need to integrate the WaSH and nutrition CV team better and work more closely together including developing plans and utilizing resources more efficiently.

The CLTS component of the programme is progressing slowly. However it is important that the programme does not deviate from the standard model/approach by giving incentives to the community. These needs to be a community led and owned process for success.

Recommendations:

- Develop and refine M&E tools to capture behavioral change where possible and establish a system for ongoing monitoring, analysing and reporting on primary data collection
- Continue to integrate WaSH and nutrition CV's to strengthen their role in the community
- Report on hardware components in the health facilities (are they working etc)

Remote Management

Over the last two ECHO funded periods from Oct 2011 there has been substantial change in the working context with increased unpredictable insecurity in Nigeria and specifically in Northern Nigeria. The first evacuation of expatriate staff occurred in November 2011 and the deteriorating security situation led to the temporary relocation of ACF expatriate staff from early 2012 and then the complete withdrawal from Yobe State in September 2012. This complete withdrawal signaled a formal change to a remote management (RM) modality for programme implementation.

The RM component of the programme was itself assessed as part of this evaluation from a remote location (UK). Telephone interviews with ACF staff based in the field and in Abuja was supported by a document and data review specifically looking at the evolution of the RM systems in place. As far as possible, inferences made from the document and data review were triangulated with the information obtained through interviews and vice versa.

Constraints to this methodology were as follows;

- Inconsistent quality of internet, land line and mobile phone connections during interviews
- Staff turnover resulted in limited organisational memory

The issue of staff turnover was a primary weakness which was noted by ACF staff at all levels and had a significant impact on the implementation of RM through the consequent leadership gap. The RM tools which were under development over the 12 month prior to the evacuation were not in place at the time of evacuation.

Remote Management policy / guideline environment:

The RM modality is supported by a key document from ECHO[9] and internal policies[10], guidelines[11] and tools developed by ACF. The ECHO instruction note was published in February 2013 was not available at the time of withdrawal, however the document sets forth criteria against which the remotely managed programme should be assessed for appropriateness and the ACF ECHO funded programme under evaluation satisfies those criteria.

The policy document for RM (2011) was developed by ACF France but was not a policy document which had been distributed or ratified by ACF more widely. The policy document sets out criteria to distinguish between 2 modalities; Remote Control and Remote Management. The major differences between the two modalities lie in the expectation of the term of the withdrawal (short and medium term respectively) and in the extent of the delegation of decision making to field level. Based on those criteria the ACF ECHO programme is in a state of Remote Management as opposed to Remote Control although the delegation of decision making to the field level is still in evolution.

Remote Approach Guidelines developed by ACF International offers generic guidance in the development of a remote approach which is loosely tied to operational conditions based on a Classification Matrix Risk Management Policy (2011) and on the previously mentioned policy document of ACF France. In addition a 'Security Rules' excel spreadsheet has been developed for Abuja and the field sites with specific actions to be undertaken according to the prevailing security risks. As part of future RM development it should be considered whether the security rules could be tied to the evolution of a RM modus operandi more explicitly.

An advantage of the guideline document lies in the identification of generic mitigation methods to be considered for separate components of the programme (logistics, finance etc.). The guidance for programme implementation (Section G: programmes) is more generic than for other more specific components.

Specific tools for RM were made available to staff shortly following the evacuation of expatriate staff in September 2012 and since that time have been under development. These are further discussed below.

In summary policy and guideline documents exist which will support the strengthening of tools for remote management but need to be disseminated to all levels and may be an indication for the requirement for better networking and tool sharing within ACF at the international level.

Remote Management Tools:

A package of RM tools was supplied for review and contained the following documents;

- Security rules Abuja 2013
- Security rules Damaturu Feb 2013
- Security rules Dutse 2013
- Authorised signatures form 240413

[9] Instruction note for ECHO staff on Remote Management: Ref. Ares (2013) 168580 – 08/02/2013
[10] ACF policy paper on remote approach (2011): ACF France
[11] ACF remote approach programming: guidelines for implementing a remote approach(2011): ACF International

- Remote management capvisaccept240413
- Remote management finance 240413
- Remote management logistics 240413
- Remote management overview PowerPoint 240413
- Remote management programmes 240413
- Remote management programmes2 240413
- Remote management training policy 240413
- Remote management weekly timeline

It should be noted that the coding (240413) does not appear to be the date of file creation as the files were supplied for review prior to this date. A secondary package of RM tools was supplied from which the documents above had largely developed.

The security rules documents are appropriately highly specific for the operational region. The previously mentioned more generic remote approach guidance document is appropriately more generic. For future RM approaches ACF international should consider the development of a compromise document which ties the RM tools package to the security document such that it is generic enough for wider dissemination but detailed enough to provide guidance in the stepwise evolution of 'Remote Control' and 'Remote Management' as the security situation deteriorates.

The tools for logistics and finance are contextually appropriate. In discussion with field staff it was indicated that there was greater oversight and the requirements for RM had led to an increase in paperwork, however this was not perceived to be burdensome and had come together with a greater sense of responsibility. A potential obstacle for a RM modality is that the checks and balances required lead to a sense of mistrust. It is a positive finding from this review that there was no sense of mistrust conveyed by field staff. The tight financial controls in place are appropriate for this stage in the evolution of the RM approach and are consistent with policy and guidance documents which require as a prerequisite that there is no transfer of risk to the national staff remaining in the field.

While there was no mistrust, discussions did suggest a sense of being two teams; field based and Abuja based. The RM tools do indicate the need for 'regular' face to face meetings and set other standards for telephone / Skype discussions and reporting although the implementation of these varied. The face to face meetings during the current period of RM were perceived by field staff to be somewhere between regular and ad hoc, it would likely be beneficial to increase the regularity of face to face visits and set a specific range of time in which these meetings are required (e.g. minimum 1 month / maximum 2 months).

The impact of the change to RM is hard to evaluate. In the case of logistics there had been staff turnover during the life of the programme which had impacted reporting and by inference programming likely suffered, however the appointment of the current logistician improved the standard operating procedures (SOP) for logistics. Comparing the improved SOP with the change to RM there was perceived to be no negative impact; a review of the data within the context of the RM review did not reveal any contradiction to this view.

A PowerPoint presentation indicated the desire of field staff to have some restrictions eased in order to improve the efficiency of operations in the field. It would be appropriate at this stage of RM

evolution for Abuja and field based staff to conduct a joint assessment of procedures and the prevailing security situation in order to ensure the tools remain contextually appropriate. Such joint reviews while in the RM modality should occur at least every 3-6 months.

Tools for programming are less prescriptive than for finance and logistics. The programmes2 document disaggregates guidance and includes ‘technical works’, hygiene promotion, surveys, water quality and quality control in very generic terms within a framework of assessment problem solving and reporting. The programmes [1] document is a little more prescriptive but biases nutrition. Greater clarity in these documents may be achieved by separating the assessment / problem solving / reporting component into a single generic document which may be utilised by any programme while providing more prescriptive approaches in data management for each programme component in a separate document.

An additional tool in use to complement the RM package was the use of vehicle tracking. The use of vehicle tracking appears to be entirely appropriate to context and in discussions with field staff were seen as a security measure rather than any misperception of a lack of trust.

Data Management:

The assessment of data management in this review biases nutrition programming. In the packages provided for review the data for the nutrition programme was more complete that for the WaSH component. The data provided for WaSH primarily covered the period January to July 2012.

As far as can be seen the situational narrative reports and the database progress reports were appropriate and provided an excel format which allowed the progress to be measured against measurable goals. Discussions with field staff suggest that the WaSH component of programming has “always been in remote control”. Evaluation of the programme per se is covered earlier in this report however in terms of RM, the gap identified by field staff was the inability to make decisions at field level. The remote technical support provided resulted in some (unspecified) instances of technical decisions being made which would likely have been different if the supporting technician had been able to see the situation in the field first hand. Further investigation aside, the RM approach would suggest that an assessment of the technical capacity of the WaSH field staff should be conducted (perhaps at a remote location) and upon satisfactory completion decision making should be delegated to field level in Nigeria as far as reasonably possible.

Strong data management is a crucial component of a RM approach. For the purpose of this report data is divided into 3 categories;

- Primary data: Generated from the programme at field level as the source data from which other data forms are derived. (e.g. OTP cards)
- Secondary data: Generated from the primary data which for example might include the register of admissions and discharges and monthly reporting sheets
- Tertiary data: Generated from secondary data and entered into a database

Analysis of secondary and tertiary data requires as a first step the verification of the accuracy of the primary data (or at least an assessment of the errors involved). The sources of secondary data need to be verified as far as possible while the database for the entry of tertiary data needs to be robust.

Two programmatic issues which lie outside of the scope of this review require mentioning in the context of the RM approach. Interviews with field staff suggest that;

1. There is a rotation of MoH staff in the clinics and
2. That there has been significant staff turnover within ACF

In the first instance the rotation of staff undermines the capacity building approach of the programme and an ultimate exit strategy which would leave competent practitioners in place. The impact on RM is through the generation of poor primary data from untrained or inexperienced health workers. This requires stricter controls on the verification of primary and secondary data by ACF field staff. The RM approach has been impacted by the turnover of ACF staff, evidenced through discussion with ACF staff at all levels indicating leadership gaps and through data review indicating gaps and errors (which at the time of writing are being addressed retrospectively). Discussion with senior ACF staff indicates that the issue of staff turnover has been well appreciated. The appointment of new staff (e.g. the 'flying logistician') and the desire to nationalise positions are consistent with the proper evolution of the RM approach and the ultimate exit strategy from a RM modality through a competent, direct management, national staff base.

The document on programmes [1] as part of the RM package focuses on the verification of secondary data using tools such as scanning, videoing for data collection and the use of Drop box® or emailing for data transmission. Training in the verification of primary data has been given to field staff. Further use of the same technologies could be expanded to include verification of primary data and the procedures for this written into the programmes RM document. Photography is already used for verifying food stores in logistics and could also be used for the photography of primary data such as OTP cards which can be uploaded and transmitted for remote review. This provides 2 opportunities;

1. The provision of continued capacity building for field staff in identifying errors in practice through feedback from technical experts remotely
2. A source of information which can be used to estimate errors between primary and tertiary data

The ACF M&E expert indicates a process of retrospective data cleaning being undertaken. Ensuring the data is properly cleaned would (unreasonably) require the verification of all previous primary data. It would be more efficient to sample a number of OTP cards along with the applicable monthly report and database entry to estimate the errors. The sampling size for prospective verification should be considered carefully to balance verification with workload. For statistical purposes a sample of 30 cards from each site each month would be preferable although this would likely be unreasonable in terms of the workload generated (for the field and Abuja) and the capacity of internet bandwidth. A random sampling of sites using approximately 15 cards from each site at intervals of 3 months would likely satisfy capacity building for ACF staff in recognising errors in primary data and provide reasonable estimates over time of errors between primary and tertiary data.

The MS Excel database provided for the monitoring of the nutrition programme is contextually appropriate. The database provides some level of data verification through checking columns but this applies only to the admissions side of the database. The entry of data appears to be done

differently in different locations which appears to arise from some confusion over 'new' and 'total' admissions. When the data columns are crosschecked vertically and horizontally some errors are evident. To put the errors in tertiary data into context the errors on admissions was approximately 8.5% while the error in the calculation of discharges was approximately 4.4% or CMAM beneficiary numbers. As a point of note there was a large discrepancy between transfers in and transfers out.

The cells of the database correctly contain some data entry fields and some calculated fields. On examination the calculated fields contained the correct formulae but were unprotected against inappropriate data entry. This resulted in data being entered into fields which should be calculated. In addition to locking the cells for calculated data verification columns should be created in the same fashion for the discharges as for the admissions.

Data management for the nutrition programme is done by the CMAM technical expert and the M&E expert. In discussions with field staff the responsibility for the onward transmission of data to headquarters was perceived to be a joint responsibility while senior staff indicated in later discussion that it is a clearly defined responsibility of the M&E expert. It is conceded that there is a possibility of a misunderstanding of the question during the interview process; however it is worth ensuring that the lines of responsibility are clearly understood.

A suggestion by field staff for using a system of reporting by mobile phone to improve the efficiency of reporting for government staff is a potential tool for future development at the national scale, it is however inappropriate to the current context and is not recommended. The system of reporting by SMS bypasses the verification of primary and secondary data prior to reporting which is a requirement for the capacity building approach within the RM context. It is also a system heavily dependent on large data systems at national level which would require an overhaul of the Health Management Information System and deployment of the required technology. All of this is beyond the scope of the current programme.

Summary:

While planning scenarios and detailed security plans had been developed for the programme area, at the time of the evacuation of staff and change to the RM modality in late 2012, the tools for RM were not in place. A tying of the development of remote control (RC) and remote management strategies to the security plans would enhance the dissemination of tools to the field in a stepwise fashion as a security situation deteriorates and would be a recommendation for future programmes where the requirement for RC and RM are reasonably predictable.

Policies and guidelines supporting RC/RM do not appear to have been well disseminated throughout the ACF organisation suggesting that better networking within ACF would be beneficial to future programming and ensuring that lessons of previous RC/RM approaches are learned and incorporated into future tools. At the time of the evacuation the policy and guidance documents (including that of ECHO) were not available in the field, however the RM modality in use in Nigeria conforms to the requirements and standards set out in those documents.

The tools in use appear contextually appropriate and remain under evolution at the time of writing. The relaxation of some logistic and financial constraints should be considered by a joint assessment conducted by field and Abuja level staff. Lessons learned from the assessment and subsequent relaxation of restrictions should also be documented for the purposes of future tools and guidance

which is tied to the security plan. The tools for programming are less prescriptive than for logistics and finance and would benefit from being made more prescriptive.

Databases for programme monitoring prior to the evacuation are goal oriented, appropriate and supported by narrative reports; for the WaSH component of programming it was not possible to assess the quality of data prior to and after the switch to RM.

The focus of the RM tools for nutrition is in the verification of secondary data by transmission of documents to Abuja level for review. This could be extended to include primary data collection and transfer which would allow a mechanism for remotely supervising staff and continuing the capacity building of ACF staff while also providing a source to estimate errors generated between primary and tertiary data collection and entry.

The database for nutrition is appropriate to context although should be made more robust through protecting cells containing formulae for calculated values and by including a verification column for discharges as well as admissions. In any case the discrepancies in beneficiary numbers produced by the errors in data entry in the database are low to moderate at 4.4 – 8.5% for discharges and admissions respectively.

The RM approach has likely been significantly impacted by gaps in leadership which is being addressed and is part of an on-going process which includes the nationalising of positions where possible. This will likely contribute significantly to an exit strategy from the remote management modality.

Recommendations for Remote Management:

- Lessons learned from RM approaches and the subsequent policies/guidelines/tools be disseminated more widely for future programming where RC/RM modalities are reasonably predictable
- RM tools should be tied to security rules documents to create a stepwise implementation of RC/RM tools
- RM tools for programming should be more prescriptive and include processes for the verification of primary data
- Modification of the current nutrition database to protect cells with calculated values and improve the current level of verification of data entered
- Estimate errors retrospectively by sampling associated primary, secondary and tertiary data to provide an estimate of errors rather than attempting a retrospective cleaning of all data
- Estimate errors prospectively by random sampling of OTP cards from a sample of sites on a quarterly basis
- Ensure face to face meetings between field staff and Abuja level staff occur on at least a 1-2 monthly basis while the RM modality continues
- Conduct a joint assessment to evaluate the current security conditions with a view to relaxing restrictions on finance and logistics as appropriate as reflected in the delegation of decision making capacity to the field
- Narrative reports from the field should make reference to data in order to make the findings more objective

Looking back – Recommendations from 2011 Evaluation:

In general as discussed throughout the report there have been substantial achievements and improvements over the last two funding phases (21 month period). Overall the MoH has taken on far more ownership of CMAM services. Joint supervision is being done, the MoH is collecting and analysing the monthly nutrition statistics and managing the supply and stock management of the RUTF. SC services have improved considerably and are now within Sphere Standards. OTP outcomes have improved but there is still support required to achieve Sphere standards. The community sensitization and IYCF components have been strengthened. IYCF and WaSH have been introduced in phase 2 and have expanded. ACF has taken a stronger capacity building approach with a more hands-off focus.

There is still considerable work to be done. There is a need to develop better M&E tools to capture behavioural change. The MoH still requires support in improving OTP outcomes by continuing to support the community component and staff training on management of CMAM and data management. The MoH also needs to commit to funding some of the nutrition activities and improving staffing levels in the HF's.

Relevance:

This ongoing capacity building programme on the management of SAM through the integration of services within the MoH structure remains extremely relevant given that acute malnutrition remains a substantial issue in Northern Nigeria with limited federal and State capacity. Programme results are improving but require a considerable amount of further support to achieve Sphere Minimum Standards.

Coverage:

Programme coverage has substantially improved with the further opening of OTP sites in mid 2012. A coverage survey conducted in Damaturu in May/June 2012 indicated "point coverage" of 50.4% slightly above the Sphere Minimum Standards and significantly better that a previous study completed in Fune LGA estimated at only 33%. A repeat coverage study in Fune is being conducted at present.

Coherence:

With the increased focus on nutrition within Nigeria and the recognition of the challenges to addressing acute and chronic malnutrition with its enormous caseload and impact on mortality and morbidity the current interventions fit well within the MoH strategies and policies

Effectiveness:

In general the programme objectives have been achieved in terms of OTP admissions however there is a need to continue to strive to improve programme outcomes and impact (cure, defaulter and death rates). WaSH and community component need to capture behavioral change if possible.

Sustainability:

Substantial capacity building with MoH staff has increased capacity in resource management and data collection although requires more support. Ongoing staff training and CV training continues to build capacity which will lead to an exit strategy in time.

Cross-cutting issues:

Impact on the environment is being addressed through the WaSH components with the supply of incinerators and repair of sanitation facilities. Gender balance is identified and there are ongoing efforts to ensure women are empowered and accessible to services.

Annex 1: Best practice:

Best Practice: ACF Communication Specialist	The introduction of the Communication Specialist to the programme in early 2012 helped to develop the community component in particular which was weak. The focus was to support the trainers conduct more interactive training adapting the adult learning style. ACF and health staff was trained on the many more interactive ways to conduct training/learning. Some of the training was recorded (video) and reviewed later with feedback (individual and group)
Innovative Features & key Characteristics	The Adult Learning Style was developed using a variety of different methods for distilling information in an interactive approach such as drama, board games and role play. ACF staff and health staff at different levels were involved in the TOT (state, LGA and HF). This was to ensure ownership by the MoH especially staff at health facility (HF) level. Cascade training to the CV's was conducted by health staff with support from ACF staff. This ensures sustainability and ownership of the community component at HF level.
Practical/Specific Recommendations for Roll-Out	Continue to support training of health workers within the HF's and the CV cascade training. Develop M&E tool to measure impact of the training especially behavioral change. Adapt training to results of impact
Best Practice: Development of CV Kits	It was recognized that there was a lack of locally appropriate tools to support the CV's in conducting nutrition awareness and OTP service sensitization campaigns. In collaboration with the MoH at the different levels and recognizing that many of the CV's and community are illiterate or semi-literate the materials were developed in this context.
Innovative features & Key Characteristics	Most of the material is in pictorial form with the people dressed in locally appropriate clothing. A number of topics have been covered including; identification of malnutrition in the community, what the process is for CMAM at health facility (treatment including how to use the RUTF), hygiene promotion. The material has been translated to the main local language. The material has been printed and widely distributed to HF and CV's. The CV's receive the material as part of the CV Kit.
Practical /Specific recommendations for Roll-Out	There is a need to develop M&E tools to ensure the ToT at different levels is achieving impact – impacting on behavioral change. Lessons learned from the M&E need to be incorporated into further development of tools and training. Consider recording training intermittently and reviewing to ensure standards are maintained

Annex 2: DAC –Based Rating for Programme Evaluation

Criteria	Ratings (1 low-5 high)	Rationale
Impact	4	Substantial positive impact from the considerable capacity building at community, health facility, LGA and State level of awareness and management of SAM, WaSH and IYCF components
Sustainability	4	High level of sustainability as MoH is basically running and monitoring the CMAM services with some support from ACF. Currently no financial resources from State for commodities which is a weakness
Coherence	4	Well developed intervention, fits within the Nigerian nutrition policies and strategies. Capacity building existing services and all activities integrated within existing systems
Relevance/ Appropriateness	4	Highly appropriate in the context of Northern Nigeria where acute malnutrition is a serious issue together with poor WaSH and IYCF practices
Effectiveness	3	Although programme outcomes have improved there is need for further improvement to meet Sphere Minimum Standards
Efficiency	3	High numbers of beneficiaries (direct and indirect) have access to services. HR recruitment has been difficult, with substantial gaps in senior positions. Insecurity has led to remote management with moves to nationalize many senior positions in the future. No cost extension in phase 2 for WaSH component. Overall major activities have been achieved.

Annex 3: Meetings and discussions:

Date	Description of activities/meetings
Friday 12th April	Skype briefing with Charmaine Brett, ACF Desk Officer
Sat 13th April	Skype briefing with Cecile Basquin – Nut HQ Adviser
Wed 17th April	Travel to Abuja _arrive 1600 & introduction to team Met briefly with Rebeckah Piotrowski (acting CD)
Thurs 18th April	Meet with Tesfastion Woldetsadik, ACF Nut Co, programme briefing & and plan meeting schedules Briefing from Rebecca Piotrowski – ACF acting CD Collect document and review material
Friday 19th April	Continue to review documents Interview with David – ACF Yobe Senior Nutrition Officer
Sat 20th April	Review documents Skype interview - Armelle Sacher (ACF Communication Specialist)
Sun 21st April	Review documents Interview with Tamanna Ferdous – ACF CMAM Specialist
Mon 22nd April	Interview with Teresa Banda – Valid International Interview with Dr Chris Oma Isokpunwa – Deputy Director/Head, Nutrition Division, Federal MoH Interview with Karina Lopez -SCF Technical Adviser
Tues 23rd April	Phone interview Abdullahi (ACF State Technical Adviser Skype interview – Maureen Gallagher, ACF Senior Nut. Adviser Phone interview – Bwakat – ACF WASH PM Phone interview - Nwahari Endurance, ACF IYCF TA & previous SC officer Meeting with Dr Omatola (UNICEF Nutrition Specialist)
Wed 24th April	Meeting with Temba (ACF M&E Specialist) Meeting with Adamu (ACF Yobe M&E TA) Meeting with Ammar(ACF Log Co) Phone interview with Fati Mustapha- Damaturu NFP Discussions with Tesefa – Nut Co
Thursday 25th April	Phone interview with Danladi – ACF Potiskum LGA TA Phone interview with Asabe Danda- Fune NFP Phone interview with Hawa Ibrahim – Potiskum NFP Meeting with ACF Abuja HR assistant- Damilola
Fri 26th April	DFID meeting – Sajil Liagat Phone interview with Dr Hauwa, State MoH Phone interview with Ibrahim –ACF head of Base Yobe Mini debrief with Rebeckah (ACF acting CD)
Saturday 27th April	Work on statics, review documents, compile info
Sunday 28th April	Work on statics, review documents, compile info Skype conversation with Paul Binns
Mon 29th April	Compile data and continue discussions with Nut Co
Tues 30th April	Debrief with ACF Abuja team – draft findings and recommendations – clarify issues as necessary
Wed 1st May	Continue to compile data Skype interview with Nick Radin – WASH Adviser HQ
Thurs 2nd May	Follow-up phone interview with Ibrahim -ACF Head of Base Flight out of Abuja (night flight)

Annex 4: Reference Documents

- ECHO proposals, interim and final reports
- ACF monthly Nutrition Programme Reports and weekly sit-reps
- ACF Remote Approach Programming – guidelines for implementing a Remote Approach
- Instruction note for ECHO staff on Remote Management
- ACF Nigeria ECHO Programme, PM end for mission report 31/10/2012
- Final Report – community Specialist – Feb/May 2012
- WaSH monthly reports – Oct 2012-Feb 2013
- SQUEAK Fune and Damaturu survey Reports
- Mini-KAP survey report May/June 2012
- Handover note – CMAM Specialist – Jan 2012
- CMAM community awareness training for community volunteers – "CV CMAM Awareness Kit
- Jigawa Field Visit Report by CMAM Specialist – Oct 2012
- CMAM Specialist and MoH state level Joint supportive visit Report – Dec 2011
- Nigeria CMAM guidelines _ Final
- ACF monthly evolution Excel spreadsheets and Activity Progress Reports