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External Evaluation

ACF Community based Management of Acute Malnutrition Integration Programme in Yobe State, Nigeria

Funded by ECHO

Mary Corbett, August 2011

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

Acronyms:

CMAM	Community Management of Acute Malnutrition
DFID	Department of International Development
ECHO	European Commission Directorate-General for Humanitarian Aid
GAM	Global Acute Malnutrition
HMIS	Health Management Information Systems
IYCF	Infant and Young Child Feeding
LGA	Local Government Area (similar to district)
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
UNICEF	United Nations Children Fund
WHO	World Health Organization

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Executive Summary:

ACF became operational in Nigeria in May 2010. The establishment of a base and registration within Nigeria has taken a number of months. Meetings were held with key stakeholders at central and regional level. Northern Nigeria and in particular Yobe State was identified as an area where there are substantial needs in terms of high levels of malnutrition and poor health indicators. With ECHO funding operations commenced in October 2010. A base was established in Damaturu, staff was recruited and meetings were held with key stakeholders at state and LGA level. Fune and Damaturu LGAs were identified initially for the integration of CMAM activities within the MoH structure and the ministry of local government structure. Advocacy and sensitization on CMAM activities was conducted with various groups including the LGA chairmen and the traditional religious leaders.

Capacity building was a substantial component of the programme. Health and nutrition staff was trained on outpatient therapeutic care (OTP) from all levels: state to LGA and health facility level. This was followed on with on-job training, mentoring and supervision. Outpatient activities were first established in Fune LGA at the end of February 2011 in ten health facilities and in June in Damaturu LGA in seven OTP sites. Staff in the health centres have been well trained and are well capable of managing OTP services in general. There has been strong buy-in of the activities by staff within the health centres. The smaller sites are functioning better as less over-crowding and more time for the carers and beneficiaries. It is necessary for ACF at this stage to reduce support to most of these health centres so as to prevent it from being labelled an ACF intervention. Identify weaknesses and address these and discontinue hands on activities.

A total of around 6000 beneficiaries were admitted into the OTP over the period from February to end of August 2011. Initially outcomes for the Fune OTP sites were acceptable with cure rates of around 70% and defaulter rates of 30%. However, over the last two months defaulters have increased substantially. There were many factors identified including service disruption during the elections, overcrowding in some sites where admissions are extremely high leading to long waiting time and poor services. Overcrowding has been reduced in one site with the opening of OTP sites in Potiskum LGA close by. There is also a need to strengthen the system for tracing absentees and defaulters within the context of Nigeria – realizing that the approach is around sustainability. Increasing coverage by adding more OTP sites should improve OTP services by addressing overcrowding and this should substantially reduce defaulters and absenteeism.

Some health staff at the two hospitals was trained on the inpatient management of SAM however SC (Stabilization Centre) services have really not been established. There are a number of reasons for this, there seems to be a lack of buy-in from the staff particularly in the paediatric wards and also from the dieticians at the specialist hospital. The staff appear to feel this is an ACF intervention and there should be financial gain for the activities. From ACF's perspective there has been little focus on supporting this component of the programme. All the focus has been on the OTP services. MSF in the past supported SC nutrition activities in these hospitals and gave incentives and this may be one of the reasons why the SC

activity is lacking ownership. There is a need for all stakeholders to reengage and come up with some solutions.

At state central level capacity building of CMAM activities particularly in terms of managing and analysing data has lagged behind. ACF has recruited a CMAM expert for this purpose; the previous expert unfortunately did not achieve any of these activities for various reasons – including lack of access during the election period.

Training on information management has been conducted in mid August with staff from all five LGAs (including UNICEF supported LGA's) and following on from this capacity building of the various staff is planned. M&E staff was also included in the training which is important as this nutrition data needs to be incorporated within the HMIS eventually. A motor bike and desktop computer were donated to the nutrition focal person at LGA level to assist in monitoring and analysing data. ACF nutrition staff and the CMAM expert need to support the capacity building of these staff so that all nutrition statistics go directly from the health facility to LGA and then the State nutritionist.

The other main component is the development of a system for the management of RUTF from state to LGA and health facility. ACF is in the process of ensuring adequate storage facilities exist in each health facility. This has been delayed due to ACF logistics constraints. Once this is in place then each centre needs to order supplies on a regular basis depending on needs and supplies need to be transported through the regular LGA to health centre process. Presently ACF is doing most of the transportation on an ad hoc basis. A system needs to be developed to address the whole process.

A clear MoU was established between all the stakeholders at the start of the programme which has been extremely useful. In the near future it is hoped that the MoH at state level will have a budget for the purchase of the RUTF supplies which will be dispatched then to the LGA's. This will ensure sustainability. The LGA's are also responsible for free drugs for SAM patients though availability of the routine drugs has not been regular to date. The LGA is also responsible for transportation of the RUTF from the LGA to each health centre. It is important that ACF continues to advocate for the LGA's to adhere to the MoU and their responsibilities. It is possible to transport the RUTR with other regular supplies such as when routine vaccines are transported to each facility- normally monthly.

Future activities should consider the following: continue to expand OTP services to other health centres within the current LGA's and therefore increase/improve coverage, develop strategies around addressing chronic malnutrition with a particular focus on areas identified during recent survey which include extremely poor IYCF practices, lack of access to food at certain periods in the year and poor water and sanitation. It is important to focus on a number of key areas and not over expand. These activities should be planned in collaboration with the relevant ministries. The potential DFID programme funding may incorporate some of these activities.

Criteria	Rating (1 Low, 5 high)	Rationale
Impact	**4**	Prior to intervention lack of awareness on identification of SAM and no treatment available – 6000 SAM cases admitted over 6 month period to the MoH services
Sustainability	**4**	High level of sustainability as strong by-in from the MoH staff and acceptance of increased workload
Coherence	**4**	Strong as using national guidelines and working through MoH structures
Coverage	**3**	Reasonably good considering intervention only started recently. However high defaulters has reduced point coverage
Relevance/Appropriateness	**4**	Extremely relevant as addressing high levels of SAM
Effectiveness	**3**	Initial delays at set-up meant less admissions to OTP that initially planned for, however strong capacity building and buy-in. Need to strengthen the community component to address high rates of defaulters
Efficiency	**4**	Some delays in procurement due to logistic limitations with HR gaps. However, due to capacity building of MoH staff overall cost of intervention substantially lower as the MoH staff carried out activities as part of their daily activities. 6,000 admissions to OTP services is amazing

Overall Objective of the Evaluation:

- To evaluate the results of the programme (Results 1 & 2) addressing relevance, coverage, coherence, efficiency, effectiveness and sustainability on how results achieved
- Evaluate assessment and project design process of Result 3 for achieving integrated approach to tackling underlying causes of Acute Malnutrition
- Provide overall recommendations for future strategy that will improve quality of interventions and reinforce integration aspect with MoH/LGA's and within different sectors

Objective of the Nigeria ACF CMAM Integration Programme:

Overall Objective: <u>Sustainable</u> detection and quality treatment of Severe Acute Malnutrition within the PHC services

Result 1:

- Adequate nutrition treatment of SAM children in Yobe State

Result 2:

- Quality of CMAM performance monitoring in health facilities and SMART surveys improved in Northern Nigeria

Result 3:

- Better understanding and knowledge of causes of acute malnutrition obtained for developing a multi –sectoral approach to address underlying causes

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 Staff:

- Briefings with ACF key staff (Head of Mission, Admin Coordinator)
- Interview with key staff in ACF nutrition programme including Nutrition Technical Coordinator, ACF Acting Nutrition Programme Manager, ACF CMAM Specialist and the nutrition and community programme officers
- Interview with other key ACF personnel- food and livelihood consultant conducting the study on identifying the "underlying causes of malnutrition" and ACF's ELA Advisor supporting the SQUEAC investigation.

Interview with other key stakeholders:

- UNICEF at Regional Level in Nigeria – Plan to meet UNICEF at national level but meeting cancelled due to insecurity incident
- DFID at Kano – Regional level
- Skype interview with ECHO representative in Dakar
- Interview with PRRINN Senior Programme Officer

At State and LGA level

- Interview with State nutritionist and LGA nutrition focal persons for Fune and Damaturu
- Interview with the Director and Deputy Director of the State Primary Health Care Development Agency (SPHCDA)
- Interview with the Fune LGA PHC Coordinator
- Interview with Dieticians within Damaturu Specialist Hospital

Review Visits:

- Visited the hospitals in Damaturu and Damagum- Visit the paediatric wards and interview key health staff (in-charge and acting in charge of paediatric ward), Met with Damagum hospital administrator
- Visited eight OTP sites in a variety of locations (urban, rural and different types of health centres)
- Attended ACF training on capacity building on data management with MoH staff

Focus group discussions

- Focus group discussions with carers of beneficiaries in OTP facilities
- Focus group discussion with community health workers (CHWs)

Direct observation:

- Direct observation of the working of a sample the OTP and SC sites including documentation recording and stores
- Observation of different components – anthropometric measurement taking, appetite test being conducted, beneficiary medical examination, recording data, conducting health education

Review primary & secondary data:

- Review of programme data including registration books and individual beneficiary cards
- Review of programme statistics, monthly reports, field visits etc
- Review of secondary data including Project proposal, project interim report, 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)

Country Background:

The Federal Republic of Nigeria is situated in West Africa bordering Benin to the West, Niger to the North, Chad and Cameroon to the East and the Atlantic Ocean coastline in the south. Nigeria is the most populous country in Africa with an estimated population of 155 million in 2010, the 7th largest country population worldwide.

Nigeria gained independence in 1960 from Britain and became a Federal state in 1963. However, over the following thirty or so years there has been serious political instability with many coups and counter coups. In 1967 Eastern Nigeria declared itself independent as the Republic of Biafra however, a civil war erupted between the Northern and Western part of Nigeria and the East which lasted thirty months with untold death and destruction. It is estimated that 1 to 3 million people died during this time from war, disease and hunger. In 1999 democracy was reinstated in Nigeria with free and fair elections

though somewhat flawed. Much progress has been made since then and elections have just taken place in April 2011 with the former president being re-elected.

Nigeria comprises of 36 states and one Federal Capital Territory. Each state is subdivided to LGA's (local government areas), with a total of 774 LGA's countrywide. Abuja is the capital with a relatively small population compared with other cities countrywide (Lagos has an estimated population of 8 million). There is high urbanization in Nigeria with approximately 49% of the total population living in towns and cities.

Nigeria is split almost equally between the Muslin and Christian Religion with a small minority practicing traditional religions. There are three main ethnic groups Hausa/Fulani, Yoruba and Igbo.

Economy:

Nigeria is the second largest economy in Africa (after South Africa) and is now classed as a middle income country. It has massive natural resources mainly untapped apart from petroleum. Nigeria is the 12th largest producer of petroleum worldwide exporting substantial petroleum to the US. It has been ranked as 37th worldwide in terms of GDP (2007). With strengthening democracy and government stability it has huge opportunities to achieve substantial progress.

However, with the increasing wealth in Nigeria there is also extreme poverty. It is estimated that 64%[1] of the total population is below the poverty line of 1.25USD per day. This disparity impacts on literacy levels, access to health services, access to safe water and sanitation as well as food and nutrition security.

Demographic and health indicators Nigeria:

Although Nigeria appears to be gaining economic growth it is lagging behind in terms of poverty reduction. There is a need to improve infrastructure particularly in terms of health services, access to safe drinking water and access to education. Life expectancy is still only 48 years[2].

Overall Nigeria with its sizable population has the third highest absolute numbers of children with stunting with 41% of children under-five stunted, 23% underweight and 14% wasted. Immunization coverage nationally is poor with only 41% of under-fives vaccinated against measles (UNICEF 2009). However, this is even lower in rural isolated areas. Infant and young child care practices are also poor with only 16% of infants being exclusively breastfed at 6months[3].

ACF in Nigeria:

ACF became operational in Nigeria in May 2010 with the opening of a country office in Abuja. The initial process involved registration and a fact finding period identifying needs and geographical area of focus.

[1] UNICEF Nigeria Statistics (1994-2008)
[2] Nutrition at a Glance- Nigeria, World Bank 2010
[3] UNICEF 2009 Statistics

Together with secondary country data and discussions with key stakeholders it was decided to focus on the Sahel Region of Northern Nigeria where health and nutrition indicators are the poorest[4]. Under-five mortality and rates of acute & chronic malnutrition are substantially higher in the north of the country compared to the national average and also those of the Southern States. There is some concern with some of the 2008 DHS data however most of the overall results are similar to the UNICEF statistics.

Recognizing the high burden of both acute and chronic malnutrition within Northern Nigeria ACF strategically decided in collaboration with UNICEF and the Nigerian MoH to support the integration of the management of acute malnutrition within the existing health services.

ACF also had a key role at central level in supporting nutrition with supporting the finalization of the national nutrition guidelines for the management of SAM (Severe Acute Malnutrition) as one of the core activities. ACF has also been active in other fora at central level. This work included supporting the national bureau of statistics on analyzing nutrition survey data. With funding from ECHO ACF became operational in Yobe State in Northern Nigeria

Nutrition in Nigeria:

Food and nutrition security has not been a high priority in Nigeria over the years. A national committee on Food and Nutrition was established in 1990. However, it has been moved between different ministries and seems not to have had any serious influence. A nutrition and food policy was developed in 2001 and a Plan of Action in 2004 (see annex 2 for list of reference documents). Although these documents clearly state roles of different sectors and overall targets of reducing malnutrition over the following years little has been achieved.

In 2005 the food security and malnutrition crisis in the region, in particular in Niger spilled over to Northern Nigeria with a limited emergency response by MSF. However, at this period Nigeria was not overly accepting that there was a malnutrition issue within Nigeria.

Although the 2008 DHS nutrition results may have recorded somewhat high GAM and SAM results in some of the northern states overall it is clear that there are serious issues in relation to both acute and chronic malnutrition in these states as well as access to quality health services, immunization coverage and other underlying factors impacting on nutrition. Results from the UNICEF 2007 MICS (Multiple Indicator Cluster survey) also indicate extremely high levels of acute and chronic malnutrition in particular in the North West of Nigeria. Table 1 below shows that there are substantially higher levels of malnutrition in rural populations compared to the urban under-five population. However, in the North Western states it is considerably higher than the national average for both rural and urban populations. Preliminary results from nutrition surveys conducted in some states in Northern Nigeria in July and December 2010 by UNICEF and the MoH have also indicated very high levels of acute and chronic malnutrition (results not official as yet.

[4] 2008 Nigeria Demographic and Health Survey

Table 1: Nigeria MICS Nutrition results (WHO/CDC/NCHS- Preliminary Report 2007

	W/A % Below -2SD Underweight	W/A % Below -3SD Severe underweight	H/A % Below -2SD Stunting	H/A Below -3SD Severe stunting	W/H % Below -2 SD Wasting	W/H % Below -3SD Severe Wasting
Rural	28.5	10.0	38.5	22.0	11.3	3.6
Urban	19.0	5.1	26.2	14.4	9.8	2.4
North West Nigeria	41.2	17.1	56.6	38.0	15.5	5.4

Progress in addressing Acute Malnutrition:

At the end of 2008 interest in terms of addressing acute malnutrition was beginning to come into play in Nigeria. Valid International in collaboration with UNICEF and the MoH initially piloted CMAM in Kebbi State in April 2009. The model was to focus on OTP services in health centres targeting 5 health centres in 3 different LGA's per state. Services for the management of acute malnutrition were developed in 15 OTP s (health centres) within the state. A further pilot was conducted in Gombe State again targeting 5 health centres in each of 3 LGA's.

This lead to the development of a strategy where there were clear roles and responsibilities for the main stakeholders and the process of introducing CMAM services within states and LGA's. The roles and responsibilities are as follows:

UNICEF: Support process of setting up OTP services including recruitment of community volunteers, training and initial supply of the RUTF

Supply some equipment such as weighing scales, data tools

Government/MoH: Supply of basic routine drugs, some equipment, OTP services within the health facilities and the supply of qualified health staff

Include supply of RUTF within the health budget - place on essential drug list!

The Model for introducing OTP services followed the model Valid International piloted which included:

Step 1: Advocacy

- Start with advocacy with different stakeholders at different levels
- State and local government agreement on the need to have CMAM services within the health system

Step 2: Sensitization

- Community mobilization at different levels – initially at LGA level with authorities and LGA PHC coordinator, nutrition focal person, etc

- With Religious leaders and other relevant stakeholders
- Community leaders at ward, village and settlement level

Step 3: Identify and train community volunteers

- Recruit two community volunteers from each community (ideally 1 male and 1 female)
- Train volunteers on identification of malnutrition, screening with MUAC and referral

Step 4: Training health staff

- Train health staff at state and health centre level (sites that have been identified for OTP) on the outpatient management of acute malnutrition (4-5 day training)

Establishment of sites:

- In the first week the trainers do the admissions and routine work in the OTP site and in the second week to health staff from each centre conducts the services with supervision and technical support from the training team.

Follow up:

- Regular follow-up visits (monthly) to the OTP sites to support staff especially in relation to activities and data collection for a three month period

At that stage there were no further pilots planned. It was decided that the CMAM services should be integrated within existing health services within the PHC system. This meant there were no specific incentives for health workers to treat acute malnutrition in the health facilities. The OTP services should be integrated within ongoing PHC services such as immunization services, in some places within HIV services and linked with ongoing WASH activities (water and sanitation). Nutrition data should be incorporated within the routine HMIS.

From July 2010 scale-up of integration of CMAM services has expanded considerably in the North East of Nigeria and to a slightly lesser extent in the North West. There is a further scale up planned by UNICEF for the remainder of this year with a further scale-up planned for Yobe and Jigawa States in October 2011. Further scale-up by UNICEF is planned for Kano and Borno in November and Bauchi and Adamawa in December 2011.

- July 2010 – Jugawa State – 3LGA's with 16 OTP sites (State asked for services)
- Oct 2010 – Borno and Yobe State (Borno 4LGA's -16 OTPs and Yobe 3 LGA's and 15 OTP's)
- 2011 – A further 3 states have established OTP services – Bauchi, Kano and Adamawa

Save the Children (SCF) commenced support to CMAM activities in September 2010 in 2 LGA's in Katsina state supporting the establishment of 14 OTP sites.

ACF CMAM Integration Programme:

The ACF supported CMAM integration commenced in Yobe State, Northern Nigeria at the start of October 2010 with ECHO funding. During October ACF senior management staff met with key stakeholders in Yobe State and had introduction meetings on supporting the integration of CMAM with state authorities including the state nutritionist. Other meetings were held with key personnel within Damaturu and Fune LGA's (LGA Chairman and PHC coordinators). Overall the meetings were very positive and ACF was welcomed to assist in the management of acute malnutrition[5].

Two LGA's were identified for the integration of CMAM – Damaturu and Fune. MoU's were developed with clear roles and responsibilities for each stakeholder. (State MoH and State local government, LGA authorities in Damaturu and Fune and ACF). ACF programme staff was recruited and commenced work in January 2011. The programme commenced in earnest in February 2011 with sensitization on the CMAM approach, training of health workers on both outpatient and stabilization centre treatment of acute malnutrition. Training was also conducted with community volunteers and the first of the OTP services were established in six health centres in Fune LGA.

The main component of the programme was to achieve sustainable CMAM implementation in health facilities in LGA's in Yobe State, and secondly conduct a study to understand underlying causes of malnutrition. In achieving sustainable CMAM services the MoU clearly outlines the roles and responsibilities of each stakeholder (see annex 3).

Understanding the Nigerian Health System:

The Nigerian government operates a three-tier political system incorporating Federal, State and Local Government Areas (districts). Policy is developed at national level mainly and adapted totally or partially at lower levels depending on conditions. Similarly within the health ministry it is a three tier system with the LGA's mainly responsible for PHC, while the State is responsible for secondary health care services within the main hospitals and the federal MoH is responsible for tertiary health care at specialist hospitals. The FMOH is responsible for coordination and policy formation. There is also the National Primary health Care Directorate Agency (NPHCDA) which is responsible for coordination and policy within the PHC system. The primary health care system is the main vehicle for supplying a health care system in Nigeria. However, over the years it has been realized that the health of the population has been declining as indicated by core health indicators. Structural and systemic weaknesses within the health care system in delivery of health services have been identified as key[6].

At the end of 2010 Yobe State passed legislation to implement a State Primary Health Care Development Agency (SPHCDA) with the main focus to improve coordination and quality of PHC services within the state. However, though the agency has been established and there is energetic and active staff, at

[5] ACF October field visit report

[6] The Gunduma Story, Emerging health system architecture to reform a disintegrated system in Jigawa State of Nigeria, Partnership for Reviving Routing Immunization in Northern Nigeria; Maternal Newborn and Child Health initiative, June 2010 (PRRINN- MNCH)

present it is in transition without a budget and therefore little power. It is hoped that by the start of 2012 there will be a budget allocated to this agency. Meetings with the SPHDA director and deputy director indicated that there was strong support for the integration of CMAM services within the PHC system. There were already positive outcomes including the increase in uptake of other services, in particular immunization and ANC/PNC services.

Treatment of Acute Malnutrition- integration process

Capacity Building:

Health Staff:

A substantial component of the CMAM integration programme consists of capacity building of MoH health staff within the hospitals and health centres on the identification and management of acute malnutrition. Key staff at state level (state nutritionist) and LGA level (PHC coordinator and nutrition focal person) were also part of the training. The initial training was on management of SAM as outpatients within the health centre structures (MCH clinics, PHC clinics and health posts). This was a five day training consisting of a combination of theoretical and practical teaching using training material developed from the national nutrition guidelines. It was targeted at the "in-charge" within the health centres and other trained health workers. By the end of August a total of 127 health workers were trained on OTP services in three LGA's which amounted to 85% of planned training. In addition to this 12 (8%) health workers were trained in the management of SAM with complications within inpatient facilities in Damaturu and Damagum hospitals. See table below for overview of training time schedule. Initial training was conducted in Fune LGA in February 2011 with training in June for Damaturu LGA.

The average improvement in knowledge post test was 26% (ACF Activity Progress Report July 2011). Following on from the training ACF nutrition programme staff conducted weekly monitoring and mentoring of staff from the OTP sites.

Although nurses and midwives were targeted for the OTP training in the health facilities where they were available, in some health facilities the only qualified health staff are community health extension workers (CHEWs). There are two categories of CHEWs; senior CHEW's receive three year training and junior CHEWs receive two year training. Therefore in some sites CHEW's were also trained.

Table 2: Training conducted by ACF and MoH

ACF & State training	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
OTP Training (150 target for OTP & SC)	34				35	28	30	127
SC training	6				6			12
OTP Refresher						22		22
CV Fune	352	149					No info	501
Refresher -Fune					31	327	No info	
CV Damaturu		149			135		No info	284 (67 female: 23%)
CV Refresher - Damaturu					31	47	No Info	
SQUEAC							3 ACF (3 SCF)	
Training on monitoring & data management							17	

Staffing levels vary substantially in health facilities. In the more urban areas there are more senior qualified staff and higher levels of staffing. There are a variety of different types of health facilities from MCH clinics, PHC centres and health posts and each has different staffing requirements. However, there is recognition that there are substantial gaps within staffing levels throughout the Yobe state. The situation has been exacerbated due to a moratorium on staff recruitment presently in place. A study has just been completed in Yobe state on staffing levels within all health facilities and looking at gaps/needs and how to address this issue.

The feedback from health staff and other senior MoH staff was that the training was well perceived. The health workers were appreciative of the overall content with the mix of theoretical and practical content of the training. Some health workers thought it would have been useful to have more practical experience however the on job training and mentoring was extremely useful.

On visiting the health centres, in general procedures were being well adhered to. The beneficiary cards were properly filled in on admission and at subsequent visits. MUAC measurements and weighing of children was being conducted mainly by community volunteers and TBA's that come to the clinics on OTP days. The volunteers also received on job training.

The ACF nutrition team consists of a programme manager and four nutrition officers and three community officers. This team has expanded over the months with the increase in activities. In general,

the nutrition officers conducted weekly mentoring and on-job training in the different health facilities while the community officers were responsible for the community component. However, at times the community officers were also pulled into the curative component particularly on days when the OTP sites had a very high caseload.

In the case of the training of health staff in the two hospitals on the management of SAM with complications this was done for nurses in both Damagum and Damaturu hospitals (discussed in more detail below).

Conclusions:

Overall the training and capacity building on the outpatient management of SAM has been very successful. The combination of formal and on job training has ensured that the health staff is well capable of identification and management of the treatment of SAM using the national guidelines and protocols.

However, at this stage there is a need for ACF to take a more hands off approach. Although some of the sites have been functioning for six months ACF is still routinely visiting on a weekly basis and instead of mentoring are doing a substantial amount of the work (hands-on) particularly some components such as filling in the registration books and compiling the weekly and monthly statistics.

There is a "routine monitoring tool" within the national guidelines. This tool should be used on a monthly basis during "joint supervision" visits by ACF and the MoH. This would be a clear record of how each health centre is functioning in terms of OTP services. Weaknesses should be identified and these could be addressed in future monitoring/capacity building visits. It also ensures that there is a proper record of these visits.

It is also important that all the health staff in each facility is trained in the management of SAM, so that it becomes a routine part of the everyday activity in the health facility. Initially the focus was on training the more qualified staff such as nurses and midwives while in reality in some sites it is the less qualified staff such as CHEW's that are doing the work while in particular the midwives focus on services for the pregnant and lactating women.

At state level (central level) it would be useful to develop the capacity of staff to become trainers. Although some senior state health staff received TOT from UNICEF in 2009 it would be important l to train others within the health system that could be released at times to conduct training. Initially this could be joint ACF/MOH training and later MoH training. It was suggested that staff from the school of nursing and the school of health technology could be considered for this training.

Recommendations:

- Continue with MoH staff training, ensuring that all staff in each health centre has been trained in the management of SAM in the community
- Plan joint supervision visits with the MoH and conduct these visits regularly

- Fill in the supervision checklist (Annex 13 in national Guidelines) and tailor future visits to the needs identified
- Take a more hands off approach. There is no need to visit each site on a weekly visit. It leads to an ownership issue. The nutrition intervention will be considered an ACF intervention. It will weaken the integration concept. Identify sites where OTP services are functioning well and visit more infrequently
- Develop the capacity of health staff from the state to conduct the CMAM training.

Capacity building: Community Component

The community component of the OTP services is fundamental for the success of the CMAM intervention. It is necessary to address this in a number of ways. Initially there is a sensitization required. This is to ensure that there is awareness of the programme and of the need to treat acute malnutrition within the community.

The initial sensitization started towards the end of 2010 when ACF senior staff met with the authorities at State level to introduce the CMAM concept and together identify the LGA's where ACF would support the MoH in the CMAM service integration process. Following on from this the PHC coordinators and nutrition focal persons together with others identified health centres where services would be introduced. The main criteria for selection of LGA's and health centres were the interest and buy-in of the authorities and health centre staff.

At the community level, introduction meetings were conducted with senior community leaders both political and traditional and CMAM activities were introduced. The traditional leaders were particularly important in relaying the information through the different levels, from LGA, ward, village and settlements. At the smallest unit –the settlement each community was asked to identify two community volunteers for the CMAM interventions. It was recommended that there should be a gender balance with 50% male and 50% female. However in Fune only 11% of the volunteers were female. The identification of CV's for Damaturu had a better gender balance with 23% of those identified and trained females from the community. However there is still a strong gender imbalance.

The training was conducted at health centre level. It was a one day training on identification of malnutrition using MUAC and the other signs particularly oedema. Later refresher training was again conducted with the CV's to ensure that criteria were understood and the correct children were being referred with acute malnutrition using the MUAC for screening.

During the initial community mobilization a rapid socio-cultural assessment was also conducted to obtain an understanding of dynamics within the community. This included looking at the structures that exist within the community and also identify health attitude and health seeking behaviours within the community.

An interesting outcome from the study was a realization that malnutrition is not normally recognized as a disease by the community that can be treated in the health centre[7]. Therefore these children are normally taken to traditional healers or have Quran prayers/messages to heal the children. There are many perceived reasons for malnutrition including poverty, hunger, witchcraft, evil spirits, adultery of mother during breastfeeding, continued breastfeeding when pregnant with another child. There is no actual local word for malnutrition. Due to this ACF decided to develop a facts sheet with basic terminology plus symptoms to identify acute malnutrition so that all staff and CV's used the same terminology and to reduce confusion and conflicting messaging.

The number of admissions to the health centres in Fune increased quickly after the start up of the OTP services at end of February 2011 (see section below). This indicates that there was good community sensitization from the start. On interviewing the carers of beneficiaries attending the OTP services, the mothers knew of the service from different sources. Some had been identifies by the CV's while others had heard of the service from neighbours or other members of their families. Some mothers were attending the health centre for other reasons and realized that mothers were attending with children with SAM. The admission figures in Damaturu in some of the sites are low and this suggests there is a need to understand why this is the case and if it is linked to community awareness/mobilization then there is a need to do further awareness., training and capacity building with the community and the community volunteers.

There is a realization also that due to the gender imbalance there is a need to target women groups specifically. This will be particularly important for the next phase of the programme when there will be a focus on addressing some of the underlying causes linked to malnutrition.

At present there is no system in place to know which CV's are working well. There is a need to put a simple system in place so that if children are referred one can know which CV has referred this child. There are two main reasons this information is needed. One can identify CV's that are referring incorrectly and conduct refresher training if needed and also identify the CV's that are active. It is thought the attrition rate from CV's is high.

Within the ACF nutrition team at times the curative component seemed to take more precedence with the community officers involved in supporting the OTP activities in some of the very busy sites. Also logistics were more focused around the OTP activities. Although the community officers supported the curative services the nutrition offices have not been active in supporting the community component.

Conclusions:

In general there has been substantial work done in community sensitization on CMAM services. This has been shown during the recent coverage investigation conducted in Fune. The result of this indicates"*point coverage" of 33% and "period coverage" of 52%.* Given that the services are only in existence for less than 6 months and only cover around 30% of the health centres this is quite

[7] ACF Community Mobilization assessment Report, Damaturu and Fune LGA's, Yobe State March/May 2011

impressive. Although there was a serious gender imbalance in the identification and training of CV's it is not a wasted opportunity. As men are the decision makers at HH level and women must get permission to visit the health centre it is useful that men have received training on the CMAM services. However, there is now a need to correct this imbalance by targeting women in different fora and other key stakeholders in the community.

Different women's groups have been identified for training on identification and referral for acute malnutrition. These include TBA's, female tailors and local hairdressers as they have access to groups of women. Traditional healers will also be targeted in the future. There are also suggestions of mass media campaigns such as dramas on the local radio and other messaging and the development of banners and pamphlets.

In the present intervention there is a need to put a tracking system in place to identify which CV's are active and also identify training needs. Due to the lack of incentives it is difficult to expect the CV's to be extremely active. ACF is in the process of giving each volunteer a volunteer kit as a form of incentive.

In relation to motivation of the CV's and giving any type of incentives- either regular or occasional, this is a difficult issue. At present UNICEF supported LGA's organize a monthly meeting with the CV's and give a travel cost payment as an incentive to work between 500-1000 Nigerian Naira per month (around 50 -70 US cents)). There is recognition that there is a high attrition rate among the CV's. Ideally UNICEF is hoping that ongoing negations with the government at LGA level may lead to some regular financial support from the LGA budget.

There is a need for the ACF nutrition team to work better together in identifying programme needs and planning activities with equal weighting for the needs identified. This is particularly relevant at present where the defaulter and absentee rates have increased substantially. The team needs to work closely together to identify what the main issues are in contributing to the high defaulters and how to address this.

Recommendations:

- If possible develop a simple system for tracking CV's so that it can be recorded which CV's are active and also identify training needs- this will not be easy in a sustainable way
- Continue to develop strategies and target women and other key persons (traditional healers) within the community for sensitization of CMAM services and identification and referral of malnourished children
- Consider periodic meetings with groups of CV's and possibly give small financial incentive to cover transport costs – again this is difficult in relation to sustainability
- ACF team need to work more closely as a team planning activities together and sharing resources.

Capacity building at State level:

An ACF expert was recruited at the start of April 2011 to support capacity building at state level. The specific outputs of this piece of work included;

- Strengthening nutrition support system between health centre, LGA, State and FMOH
- Defining an orientation programme with a specific focus on CMAM and IYCF in conjunction with the SPHCM Board.
- Improve stock management system in collaboration with MoH
- Other activities as required

Due to a number of factors there was little progress in this area. The April elections meant the CMAM expert was unable to move from Abuja to Yobe State during this period. Then when the expert arrived in Yobe little progress was made as she was unable to actively link up with the local authorities due to the work load of the various persons and other constraints. This expert finished her contract in early June and was replaced by mid July. Over that two month period little was accomplished. However the replacement has commenced activities in July.

The initial focus has been on strengthening nutrition data management including data analysis. In mid August three-day training was conducted with a total of seventeen participants from five LGA's. Personnel within the LGA's in Yobe state where UNICEF has supported integration of CMAM were also included in the training. The training included the nutrition focal persons and the M&E officers from each LGA. Seven senior staff from state level was also part of the training including the State nutritionist, IMCI focal person and MCH focal person. Training was modified to the needs identified.

To assist in routine monitoring of CMAM activities, data collection and analysis, the nutrition focal persons have received donations of a desktop computer and also a motor bike. However, to ensure data goes through the proper channels ACF nutrition team needs to take a more hands off approach ensuring that health staff at the health centres compile the weekly and monthly statistics and transfer this data through the normal data collection system to the LGA nutrition focal persons.

The other area of fundamental importance is the management of the RUTF. Presently it comes from UNICEF regional office to the state warehouse and then it is distributed to the LGA's and from the LGA to individual health centres. There is no regular system of ordering according to needs and having a buffer stock available at health centre level. ACF is active in the whole ordering and transportation system at present.

Conclusions:

Unfortunately this component has lagged behind for a combination of reasons as stated above. However, it is a fundamental component for long term sustainability of CMAM services within the health care system.

The capacity of staff at LGA and state level to manage the weekly and monthly statistics is essential for ownership and understanding of the CMAM activities, strengths and weaknesses and. The training has been extremely valuable (during this evaluation I visited the training). There was strong engagement with all the participants. However, there is a need to continue mentoring for a period of time to ensure the data is being managed and analysed well. It was important to include the M&E officers as they are the key resource persons for the HMIS (health management information systems) and ultimately the nutrition data/statistics need to be incorporated within this system also for sustainability.

In terms of the RUTF management there are two fundamental issues. Firstly, in the MoU there is an expectation that in the near future the MoH will allocate a budget for the supply of RUTF. This is an issue UNICEF is currently advocating for. Secondly, at state level a large order is made to UNICEF but not necessarily calculated on estimated needs. Then once at state level there is no clear procedures on supply of RUTF to LGA and health centre. There is a need to develop a clear system. During this evaluation one of the LGA's supported by UNICEF had run out of RUTF for a month and at state level this information had not been reported therefore they were unaware that CMAM services were not functioning. In one of the sites visited during this review there was insufficient RUTF for the beneficiaries on the OTP day therefore it was necessary to bring a supply from the state warehouse on that particular day.

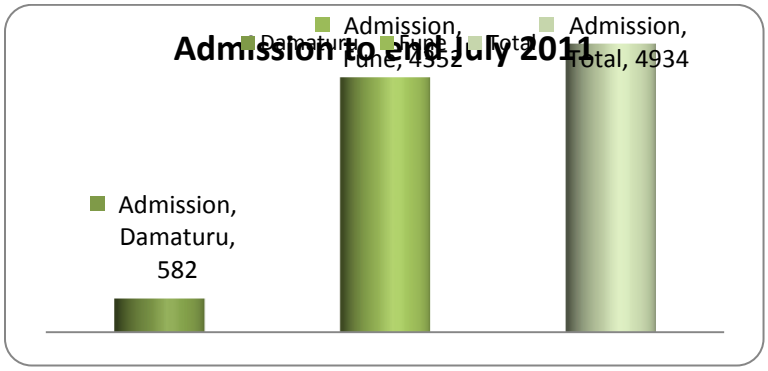
Recommendations:

- There is a need to actively work with staff at LGA and State level to increase skills on data management and analysis. The ACF nutrition officers should support this activity
- There is a need to focus on developing a system for the ongoing management of RUTF throughout the whole system – from state to LGA to health facility. Order and supply of RUTF need to be routinely done according to predicted needs with a buffer stock at health centres. Supply of RUTF needs to be done when other supplies are routinely occurring such as when vaccinations are being supplied.
- In collaboration with the ACF nutrition team and MoH health staff develop a training module for incorporation IYCF information within the CMAM services considering that many of the carers are either semi-literate or illiterate.

OTP Services:

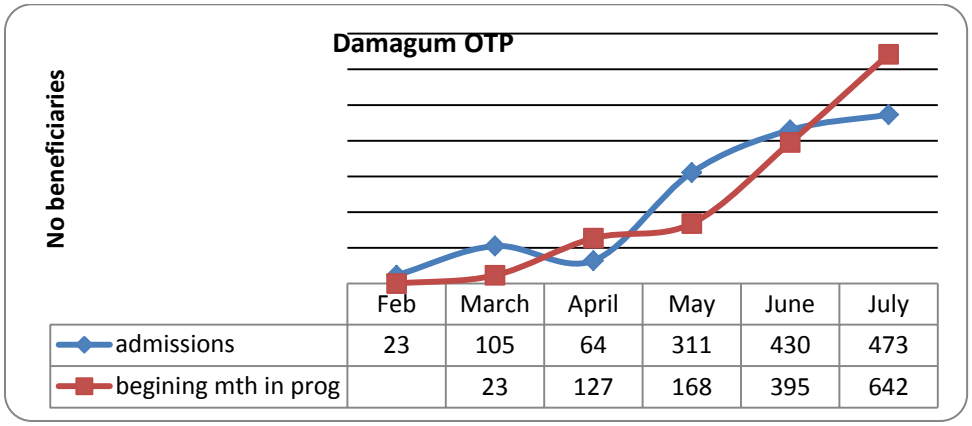
CMAM services started in Fune LGA at the end of February 2011. This followed on from the community sensitization and training of health workers in the identified health centres. Six sites opened in February and a further four in early March. All sites have weekly OTP services. In Damaturu the OTP activities only became operational in June 2011. There were a number of delays due initially to the national elections in April and then other MoH scheduled activities led to the training being postponed. Seven OTP sites opened, one in the specialist hospital and the remainder in health centres in Damaturu LGA.

Graph 1: OTP admissions in the in ACF supported CMAM integrated sites



A total of almost 5000 admissions have been registered over the five month period using MUAC of ≤11.5 as admission criteria or bilateral oedema. However, a total of just over 1,400 children were admitted into one health centre alone, Damagum. The numbers of admissions increased dramatically from May in Damagum with over 300 admissions alone in May, 430 in June and 473 in July (see graph 4 below). In April in all sites in Fune the admissions were low and this was possibly linked to the general election period. The hunger gap starts in May/June and lasts until the harvest starts to come in during September/October. There are seasonal outbreaks of disease during the rainy season, in particular malaria and often increases in diarrhoea also.

Graph 2: Trends of admissions and in the programme at start of each month in Damagum

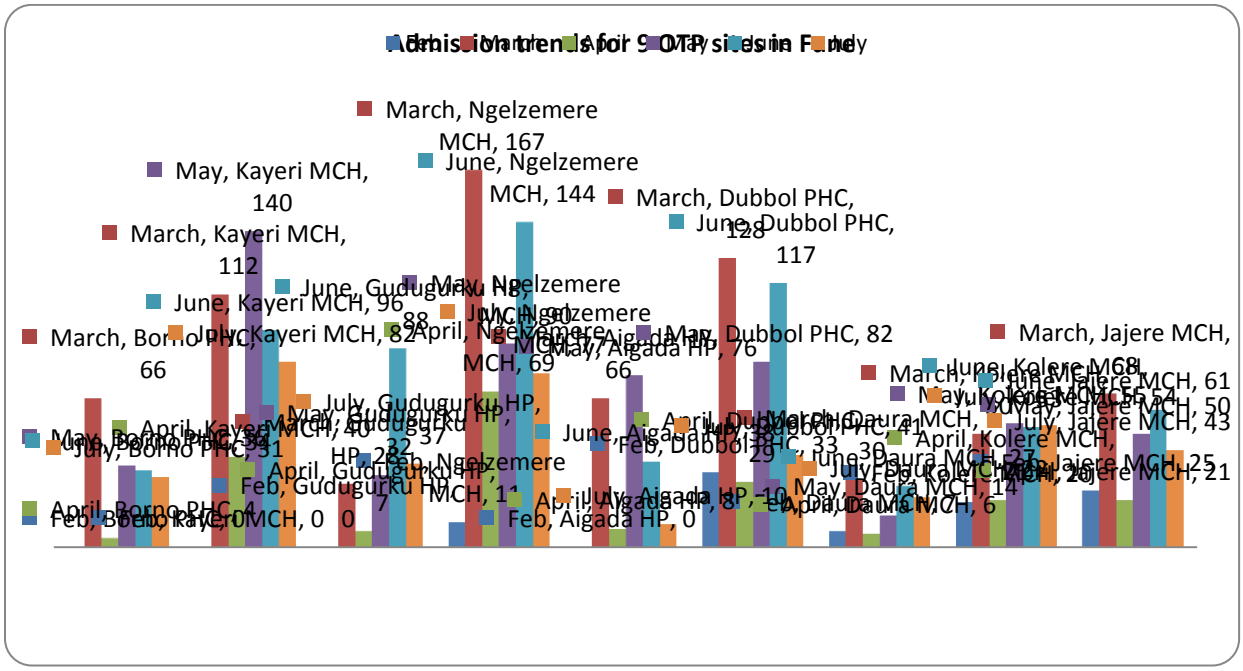


	Feb	March	April	May	June	July
admissions	23	105	64	311	430	473
begining mth in prog		23	127	168	395	642

One of the reasons for the extremely high numbers of admissions is its location in a reasonably large town on the main road. However, large numbers of admissions were also coming from the next LGA Potiskum which is a substantially larger town and also along the main road with transport available.

The graph below shows the admission trends in the other nine sites in Fune for the period from February 2011. Damagum above is not included as the numbers of admissions are substantially higher and this would skew information on the graph below for the other sites.

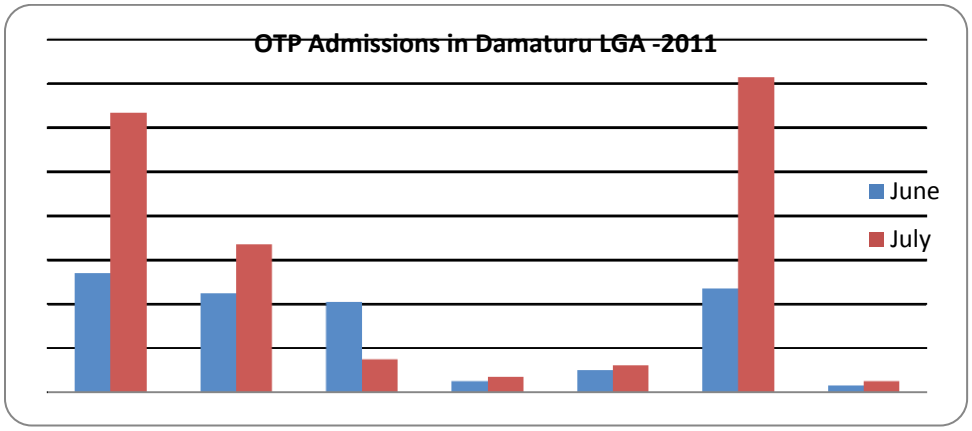
Graph 3: Admission trends in nine sites in Fune LGA (Damagum excluded)



There were concerns at the high numbers attending Damagum health centre even though there were high numbers of staff available in this health centre. This centre is the main MCH facility for Fune district and staff from other services was pulled in to support the nutrition services on the OTP days. Also ACF staff arrived early and remained late to assist in the process. ACF nutrition staff stayed overnight in Damagum after completing work as it was late by the time the services were finished and they also could go to other sites the following day that were close to Damagum but a long distance from the ACF base in Damaturu. However, if ACF had not taken such a hands-on approach the LGA authorities together with the health centre staff would probably have been forced to conduct OTP services in more than one day which may have ensured better services for the beneficiaries. There would have been less overcrowding and this may have led to less defaulting also.

The OTP sites in Damaturu are in a mixture of health centres from a dispensary, to a health post, a PHC centre and MCH centre and also there are OTP services in the dietetics department within the central specialized hospital. As can be seen the admission figures are extremely low in three of the sites. It is not clear from the ACF staff why this is the case. I was informed that in one area “there was no malnutrition”. This is unlikely to be the case. It is probably due to a combination of the lack of community mobilization and also possibly poor interface between staff and beneficiaries at some of the health centres. This was identified as an issue during the SQUEAK Study.

Graph 4: Admission trends in Damaturu



The health staffs fill in the beneficiary cards well. Appetite test is conducted on new beneficiaries. Routine medications are available at some centres periodically but not consistently. There are a number of sources through which drugs are received infrequently. Although the LGA's are responsible for drug supply ACF has donated supplies on occasion.

Outcomes from OTP admissions:

As the Damaturu LGA OTP services only commenced in June there is only two months data therefore it is not possible to look at outcomes and trends. Although trends on the OTP outcomes for Fune LGA are from March, in reality they will not be accurate for at least about two months when one would expect to see children being discharged cured. Initially the cure rates in April were around 70% with the defaulter rate at 30%. However, by July these statistics had reversed with close to 60% of the discharges as defaulters and just over 40% as cure. Mortality rates remained extremely low throughout the period, well below the Sphere Minimum Standards of <10%.

Graph 5: Fune OTP Outcomes

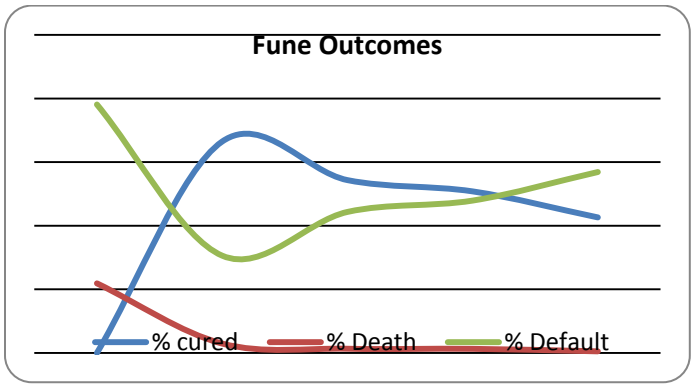


Table 3: Overall performance rates, Fune LGA, Feb-July 2011

Performance Rate	Number	**Percentage**
Recovered	1190	**47.7%**
Death	27	**1.1%**
Defaulter	1219	**48.9%**
Non-recovered	57	**2.3%**

(Table from ACF SQUEAC Report 2011)

The SQUEAC report has highlighted some of the issues linked to defaulting. Defaulting was looked at in terms of early defaulting (first or second visit) and late defaulting (fifth or more). The reasons for early and late defaulting can be significantly different. Distance and service being delivered can be reasons for early defaulting while for those defaulting late it may be due to the child being much improved and the carer feels the child is cured. Higher percentages of early defaulting happened in the bigger health facilities with high numbers of admissions therefore it may be linked to long waiting times and poor services as staff are stressed with the high volume of beneficiaries. Late defaulting occurred in some of the small sites such as Aigada and Gudugurka health posts. The elections in April also affected defaulter rates as some of the health facilities did not function regularly during this period as some staff returned home to vote. However, the SQUEAC report suggests that it was not the primary cause for the high defaulter rates. For more details on the issues related to defaulting please refer to the SQUEAC Report – August 2011.

CMAM ownership and increased workload:

During this evaluation around 50% of the OTP sites were visited. Overall the health staff and community volunteers were extremely positive with the CMAM activities. Although the workload had increased substantially staff were generally very positive to have the skills and resources to identify and treat acute malnutrition. It has other positive outcomes as the higher numbers of mothers and their children attending the health centre meant there was an increased uptake of other services especially immunization services. Staff felt it was their duty to treat children with malnutrition and part of their work activities.

In general the smaller sites seemed to be managed better. It appeared that the health staff was closer to the community and that there was better collaboration and cooperation. In sites where the numbers are high there is a need to increase the number of days where OTP activities are available and possibly cover different geographical areas on different days to prevent double registering (children attending on more than one day)

At state level there was very positive feedback of the CMAM integration. It was felt that in general it really was an integrated intervention and that already uptake of other services had improved. There was

a concern from one individual that ACF had remained too hands-on with a danger in ownership of the CMAM activities.

Conclusions:

A substantial amount has been achieved since the start up of the integration of CMAM activities. There is strong community awareness as this is a relatively new intervention and coverage and uptake of services is quite high. The health centre staff has been well trained and mentored over the last six months. Overall activities are well managed.

There is now a need to re-prioritize activities. It would be useful to first complete the routine monitoring form on each facility and then identify weaknesses and needs. On discussions with the ACF team over half of the sites were considered to be functioning very well and not requiring much assistance. If this is the case then there is no need to continue to support these sites on a weekly basis. Prioritise needs and support and also scale back support where not required.

ACF nutrition team should also not continue to actively engage in the day to day OTP activities as if this continues then the MoH staff will continue to take a hands-off approach in some sites. On visiting Ngelzerma site there were three health staff involved in the OTP activities while earlier in the day when the ACF nutrition team were there, there was only one MoH staff member supporting the OTP services. In the case where there is a high case load ACF may have potentially exacerbated the situation with the strong hands-on approach particularly in Damagum. With less assistance the in-charge of the health facility may have decided to operate OTP services on more than one day.

Three is a need for the ACF nutrition team to work more closely together to address the high defaulter rates. The system of tracking absentees and defaulters needs to be substantially improved. The SQUEAC study indicated that many of the defaulters live close to the health facilities therefore distance was not the main factor for all defaulters.

It may be useful to set an upper limit of the number of OTP beneficiaries that can be seen on a daily basis. This would be dependent on the facility and staffing levels. However, quality of services is important. . On discussions with MoH staff at state level there was agreement on this. At state level it was felt that if OTP services were available on a daily basis in the health facilities this would be the best solution. The other main way of reducing actual numbers would be to increase coverage by expanding services to other health centres in the LGA's. To reduce the caseload in the Damagum MCH ACF nutrition staff together with the Fune LGA nutrition focal person conducted training with health staff in Potiskum and supported the opening of OTP services in five health centres in Potiskum LGA at the end of August 2011 when this evaluation was being completed.

The numbers of beneficiaries in the OTP are lower that initially planned for in the ECHO proposal. However, one of the main reasons for this was the late start of operations especially in Damaturu due to other MoH planned activities and the elections. As this is an integrated intervention it is important to work within the constraints and limitations of the MoH for ultimate buy-in and sustainability. At state levels MoH staff was very complementary of the overall process.

By the end of August 2011 approximately 6,000 children have been admitted into OTP services diagnosed with SAM. These are huge figures given that admissions only commenced in late February 2011. It is estimated by the end of the programme in September that there should be around 7,000 admissions which will be around 75% of the target number of OTP beneficiaries admitted.

Joint supervision is part of the MoU. In Fune there have been some joint supervision visits however this does not appear to have happened in Damaturu as yet. This is important for ownership. On a monthly basis ACF together with the LGA MoH authorities need to conduct coordination meetings to discuss issues and plan activities together for the coming month.

In terms of routine medicines it is important that ACF does not start giving medications regularly as it may undermine the integration process as the supply of medicines is the responsibility of the LGA's It is necessary to continue to advocate for the different stakeholders to fulfill their obligations.

Recommendations:

- ACF nutrition team needs to refocus activities with a priority on improving programme outcomes – reducing absentees and defaulters. This needs to be a collaborative approach between the community activities and health services
- Monthly coordination meetings need to be established with the LGA MoH staff and joint supervision visits planned.
- Utilize the monitoring tool to record visits to the OTP sites and identify where there are gaps and training needs, equipment needs etc.
- Where sites have high case loads discuss options on reducing this as quality is affected when caseload is too great
- ACF nutrition team needs to take a more hands off approach, monitoring and mentoring and not actually doing
- Support the health centre staff to compile the weekly and monthly statistics, assist staff in the regular ordering of RUTF calculating order to needs.
- Advocate with the LGA's to supply routine medicines and be cautious in filling gaps in drug availability
- Ensure proper system is in place for ACF drug storage, dispatching drugs and recording

Stabilization Centres:

The treatment of SAM with complications is normally an inpatient service within a stabilization centre (SC). These children are particularly vulnerable as they are extremely ill and at high risk of death. The majority of SAM cases are treated in OTP services particularly if the services are available for a period and there is good community awareness and screening for SAM. This means that children are identified early and treated before they develop complications and become seriously ill. Within the ECHO proposal there was not a particular priority in establishing the SC's however the management of SAM with complications is part of the overall CMAM services.

The two hospitals at Damaturu and Damagum were identified as appropriate for the treatment of SAM with complications as there are paediatric wards and qualified health staff. Training was conducted with staff in both hospitals. Some equipment was given to the paediatric wards to support the activities linked to management of SAM with complications.

On visiting Damagum hospital meetings were held with the hospital administrator and also the nurse in charge of the paediatric ward. The nurse in charge at the paediatric ward informed us that in reality the SC was not functioning. The hospital had a 10 bed paediatric ward capacity. A notice was on the wall indication that there were "*ACF CMAM services in existence*". Four staff had been trained on CMAM (2 nurses from the paediatric ward, 1 from the maternity ward and one from outpatients). One of the paediatric nurses had withdrawn from partaking in SC services as there was no financial gain from this extra work load. At one stage there was an attempt to treat malnutrition using a combination of in and outpatient protocols. However this was stopped particularly as mothers were being given the F75 and F100 milk to make-up themselves or take home. One of the main issues seemed to be a lack of qualified staff. Also ACF had agreed to do some small rehabilitation work but this had not been completed.

At the hospital in Damaturu the system was somewhat different. This is a specialized hospital therefore funded by the SMOH and managed by a board. The paediatric ward has substantial capacity however is also very busy. A meeting was held with the acting in charge of the paediatric ward. Some staff had been trained on SC activities and protocol but there was a need to train all staff so that all the activities would be completed by everyone. Staffing levels at night were identified as an issue. Some equipment had been given by ACF for the SC but not all equipment. There was a problem with where water could be prepared (boiled) and milk made-up. Patients were responsible for getting boiled water themselves from the main kitchen and on the day of this visit there was no water at the hospital. Some children from the paediatric ward were sent to the dietetic unit and were admitted to the OTP services where they received RUTF. This service was available during week days. Discussions with the head dietician indicated that some staff was unhappy within the dietetic unit and also the paediatric ward for the increase in workload in the management of SAM with complications as there was no financial gain or reward for this extra workload. In the past MSF had supported nutrition interventions and staff had received incentives for the extra workload.

In terms of the inpatient national guidelines, at present the WHO guidelines are being utilized as the national guidelines are mainly focused on outpatient management of SAM. However these are somewhat outdated. There is a plan by UNICEF to revise these guidelines in 2012 in collaboration with MoH and other stakeholders.

Conclusions:

There is clearly a major ownership issue in relation to the management of SAM with complications within the hospital setting. Each hospital is managed differently. Damagum is funded by the Fune LGA while in Damaturu hospital the funding is through the SMOH. There is a need for ACF to restart the process again with clear roles and responsibilities for the management of SAM with complications in the hospital setting but adapting to the individual contexts.

If there is an interest and willingness by the hospital management at a senior level to include these services within its paediatric wards then there is a need for buy-in by the paediatric ward staff. All staff then need to be trained on management of SAM with complications in the paediatric ward. Other staff such as the ward assistants could be trained on making up the milk feeds, recording activities on the multi-charts and other related activities.

ACF for their part need to place more focus on this area. One of the nutrition officers should be given specific responsibility to focus particularly in this area but not exclusively. Regular monitoring and on job mentoring is required to ensure quality services are in place

Recommendations:

- ACF must renegotiate with MoH at state level and senior hospital management on SC activities. There is a need for buy-in and ownership before services can be established
- In the event there is a willingness to have SC services than train/retrain all paediatric ward staff (nurses and ward assistants) on the management of SAM with medical complications
- Within the ACF nutrition team identify a focal person to follow-up with on-job training and mentoring of staff in the two paediatric wards
- Support staff on compiling weekly/monthly statistics
- ACF ensures that the necessary rehabilitation and equipment is given necessary for conducting SC services
- Hospital administration ensures that the necessary medicines are available free of charge for SAM patients.
- Support UNICEF/MoH in the revision of the guidelines on inpatient management of SAM

Role of ACF at FMOH level:

ACF has been an active key stakeholder at central level. From early on in ACF's presence in Nigeria ACF has been actively involved in the finalization of the national nutrition guidelines. ACF has also been actively involved in the different coordination meetings in conjunction with the other key nutrition stakeholders. ACF has also been supporting the MoH, UNICEF and the statistics department on analysing nutrition data which was collected during the SMART surveys in July and December 2010. Although ACF has only been in Nigeria over a year it is recognized as a strong nutrition player in terms of nutrition for Nigeria.

Evaluating the Assessment and Project Design Process on the Recent Study on understanding underlying causes of malnutrition:

Two consultants were recruited by ACF to conduct a study to identify and develop programmes to support the underlying causes of malnutrition in Yobe State. One of the consultants had a background on food security/livelihoods while the others focus was on the water and sanitation sector.

The initial plan was to use the existing livelihood zones and a household economy approach in six LGA's however this was later changed to the current LGA's where ACF is supporting (Fune and Damaturu).

During the study it was also decided to include Potiskum as this area was quite different. It is a small LGA with a high population (>200,000) and also with a high urban population. ACF was also planning to work in this LGA.

Wealth ranking was developed initially as this was important in terms of sampling and also to look at vulnerability. It was decided to also conduct sampling in all of the wards to get a better understanding of complexities and differences between and within different communities.

In terms of looking at sustainable livelihoods information on the following areas were compiled using questionnaires and focus group discussions:

- ✓ Natural resources- land, water, forestry
- ✓ Physical environment- roads
- ✓ Human capital – skills, education
- ✓ Social Capital – networking, access to credit/loans from family
- ✓ Financial – access to credit
- ✓ Political – wars, vulnerable groups, ethnic minorities

Questionnaires were initially planned to be completed by 360HH however this was eventually increased to 600HH. Areas of particular focus included: 1) care practices for infants and young children 2) food security 3) terms of trade 4) family diet 5) access to safe drinking water and sanitation facilities

Some of the preliminary findings included the following;

- Extremely poor infant and young child feeding practices – introduce complementary feeding early
- In terms of food insecurity – access to food is a bigger issue rather than availability of food
- In terms of cereals – millet is by far the most important crop
- Female HH have labour issues
- Diet is extremely limited- cereals and vegetables (baobab leaves, spinach) are the main food commodities with around 40% accessing pulses and some oil. Meat, milk, eggs and fruit are totally unavailable.
- There are a number of different livelihoods
    - Urban and peri-urban
    - Different areas grow cassava and rice
    - Fishing is important in some communities
- In terms of sanitation – in Potiskum most communities have access to latrines while this is not the case in Fune and Damaturu.

Conclusions:

This has been an extensive study and extremely valuable information has been collected on different livelihood zones and coping strategies. The wealth ranking will be useful for targeting resources to the most vulnerable in communities.

Some of the information particularly around IYCF practices will assist in developing interventions to complement the existing CMAM activities. The access to food and diet diversity appears to be important issues that could be addressed in certain communities.

Recommendations:

- The information compiled during this study will be valuable in developing the next phase in terms of longer term development programming in Yobe State and possibly other states in Northern Nigeria.

Strategy for the future:

The present intervention has been very successful in terms of highlighting the seriousness of malnutrition in Northern Nigeria. The integrated approach of CMAM services within the existing MoH health system has been extremely valuable in embedding the identification and management of SAM in a sustainable manner within the community and health structures. It would be important for ACF at this stage to pull back on some of the day to day activities in individual centres and focus more on capacity building in other areas – at LGA and state level on data management, RUTF management and resource management. This requires advocating for state and LGA resources to continue these activities. In terms of further CMAM activities it would be beneficial to extend services to other health centres in Fune and Damaturu LGA's to improve access, coverage and reduce overcrowding and possibly reduce defaulter rates. There is a need to further strengthen the community component, identifying active CV's and other important community persons to assist in identification of SAM and tracing defaulters and absentees. Utilize current ACF nutrition staff for all activities.

In terms of addressing the underlying causes of malnutrition a more long term approach is required. Apart from interventions such as training ACF staff and MoH health staff on IYCF counselling in collaboration with other stakeholders three is a need to expand this counselling into the community with appropriate approaches.

Food access has been identified as an issue, is it possible to pilot some sort of safety-nets interventions targeting mother's with young children. This may be a voucher system for specific foods such as pulses or a micro-nutrient supplement. Sometimes information alone is not sufficient for extremely vulnerable households. This may be linked as part of the potential DFID intervention.

Other areas of focus for health and nutrition education should include water and sanitation activities although it is important not to over burden communities with too many messages. Would it be possible to consider CLTS (community-led total sanitation) in target villages as clearly access to safe drinking water and sanitation are major risks to ill health and also malnutrition. There may be opportunities of funding through other donors.

Relevance:

The integrated CMAM intervention has been extremely relevant. Firstly acute malnutrition is a serious problem in Northern Nigeria and until recently it has mainly been ignored. Communities were unaware of malnutrition as a disease and health workers and community volunteers were unable to identify and treat acute malnutrition.

A substantial component of the programme is capacity building at different levels (State, LGA and health facility) to address the treatment of SAM through existing health services. Some of the results have been substantially achieved particularly in relation to training and capacity building.

Coverage:

This is a new intervention with activities only started in February 2011. The point coverage was estimated at 33% and period coverage at 52% (SQUEAC Study). The point coverage is low as there have been high defaulter rates in recent times. There is a need to address this. An increase in geographical coverage will also address the lower coverage though given the intervention is quite new the coverage overall is acceptable. The population is a mixture of urban and rural therefore coverage expectations will differ.

Coherence:

The programme activities had a direct link with the overall objective of the programme. Sustainable SAM identification and treatment was achieved with the strong advocacy, community mobilization and capacity building of health staff and community volunteers. The MoH at the different levels was the main stakeholder and there has been strong buy-in of the CMAM services at all levels.

Effectiveness:

Many of the components of the programme have been achieved particularly in terms of capacity building, training and on job mentoring. In terms of admissions to the OTP these are lower than expected mainly due to delays in becoming operational. Some of the factors related to this were outside ACF's control. The Nigerian elections in April slowed down activities and other MoH programme commitments also delayed the start of interventions in Damaturu LGA.

In terms of programme outcomes the defaulter rates have increased and therefore reducing the cure rates. This is as a result of many factors including the elections and high admissions to some health centres reducing quality of care and increasing waiting time. Some of these issues are being addressed although there is a need to strengthen the community component of tracing absentees and defaulters.

Efficiency:

Overall this has been an effective intervention with substantial capacity building and the admission of around 6000 children with severe acute malnutrition for treatment. The MoH has mainly paid for the day to day care of the beneficiaries within the existing health services. Furthermore, the strong capacity building ensures that the intervention will remain as part of ongoing health services into the future.

Sustainability:

In general this intervention has the potential to be sustainable into the future. There has been strong buy-in and ownership by the authorities at different levels (LGA chairmen, MOH at different levels and the community). Although the intervention has increased the workload of staff in the health centres in general there is no problem with this. The health staff feel it is part of their responsibility to treat children with SAM. Ultimately the challenge will be for the state and LGA authorities to put a budget in place to pay for the costs of the RUTF supplies and other recurrent costs.

Cross cutting issues:

Some of the cross cutting issues are being addressed. There is gender balance within the ACF staff. The main issue is gender balance at community volunteer level. Although the community were advised to choose a male and female volunteer this was not done and most of the volunteers especially in Fune are male. To counterbalance this female community groups are now being identified for training on identification and screening for SAM.

There has been strong participation at all levels between ACF and the main stakeholders, particularly the MoH. Regular meetings and combined trainings have been conducted where appropriate.

The empty RUTF packages are being collected at each OTP distribution day and these packages are being disposed safely. Overcrowding at some OTP sites is also being addressed by opening more sites.

Best practice:

Training on Nutrition data management	Training on management of nutrition date conducted with numerous key stakeholders to ensure data embedded within the HMIS system at district/state level
Kew stakeholders included those involved in nutrition directly and also key staff involved in general health data management and other key staff (MCH & PHC coordinators)	Initial training conducted with a number of staff including the LGA and state nutritionists, nutrition focal persons, M&E staff at different levels, MCH and PHC coordinators with clear focus on reasons for analysing and reporting on nutrition Follow up on-job practical training with key staff planned to ensure M&E being conducted well
Inclusion of many stakeholders in training Donate equipment as necessary	Both theoretical and practical training conducted with key staff Desk-top computers donated to key staff to ensure data collated and analysed well and within the MoH structure/systems

Annex 1: Schedule of evaluation of the ACF Nigeria integrated CMAM

Date: Aug 2011	Activity
Sun Aug 7th	Travel from Dublin to Abuja Briefing with ACF Country Director – Thierry Laurent-Badin Briefing with Saul Guerrero – ELA Advisor
Mon 8th Aug	Travel from Abuja to Damaturu Meet with ACF programme staff
Tues 9th Aug	Briefing from ACF Field Coordinator – Sarah Crawford Briefing with ACF Technical Coordinator – Maureen Gallaher Planning evaluation schedule
Wed 10th Aug	Interview with Endurance, ACF Nutrition Officer Visit Ngelzerma MCH- interview in charge- Solomi - Focus group discussion with mothers of OTP beneficiaries Visit Damakusasu health post - Interview with in-charge-Mohamed, - Focus group discussion with community volunteers
Thurs 11th Aug	Interview with ACF Nutrition Officer –Ahmed Interview with dieticians at Damaturu Hospital Interview with Nutrition focal person, Damaturu LGA
Fri 12th Aug	Visit Jajere and \kolere Health centres Interview the in-charge of the health centres Focal group discussions with carer groups and community volunteer groups
Sat 13th Aug	Review programme documentation Interview with the external FSL assessment team leader – Gordon Dudi
Sun 14th Aug	Review programme documentation Review nutrition national guidelines and training material
Mon 15th Aug	Visit Damagum health centre Interview with the Fune PHC coordinator Shaiben Musa Visit the SC in Damagum hospital. Interview with the hospital in charge Interview with the paediatric in-charge. Visit the SC
Tues 16th Aug	Visit the OTP at the Damaturu main hospital. Focus group discussion with mothers. Interview with the senior dietician Jumai Visit the paediatric ward and discuss the SC (stabilization centre) with staff. Visit malnourished children in the paediatric ward. Interview with State deputy PHC coordinator Dr Omar Chirom Visit ACF training conducted by Bele on Management of data (M&E) Interview with Fune Nutrition Focal person Madam Lali
Wed 17th Aug	Travel to Bauchi to meet UNICEF regional Nutrition manager (3.5hrs one way) Meeting with Oluniyi Oyedokun
Thurs 18th Aug	Interview ACF Nutrition Officer - Ruth Visit Daura Health centre. Interview in charge. Review statistics and beneficiary cards. See store room Focus group discussion with carers of OTP beneficiaries

	Interview with State nutritionist – Laraba Audu Interview with Damaturu PHC coordinator Interview with David (ACF senior nutrition officer) Review programme date
Fri 19th Aug	Visit community at Ngelzerma with Fatima (ACF community officer). Meet with village chief and other community members. Discussion on CMAM activities Review programme data
Sat 20th Aug	Review data and start to develop presentation for Damaturu ACF debrief
Sun 21st Aug	Review material and develop presentation Interview with Sarah Crawford (Acting ACF field coordinator) Interview with Beke (ACF Nutrition expert for CMAM integration)
Mon 22nd Aug	Meeting with Dr Hauwa – PHC Director Review data and compile
Tues 23rd Aug	CMAM integration review – debrief with all ACF nutrition programme staff
Wed 24th Aug	Travel to Kano (5hrs) Meeting with DFID – Susan Elden
Thurs 25th Aug	Travel from Kano to Abuja Continue to compile data
Fri 26th Aug	Meeting with UNICEF – Stanley Chitekewe (didn't happen due to security issue) Skype/phone discussion with ECHO regional representative – Jan Eijkenaar Debrief with ACF CD – Thierry Travel from Abuja to Frankfurt
Sat 27th Aug	Travel from Frankfurt to Dublin

Annex 2: Reference Documents

- Echo Proposal and Interim Report – Sustainable CMAM implementation in Northern Nigeria – Interim Report 30th June 2011
- MoU between ACF, Yobe State Ministry of health and Yobe State Ministry of Governments and individual Local Government Areas, December 2010
- Community Mobilization Assessment Report, Damaturu and Fune LGA's, Yobe State, Nigeria- March –May 2011
- ACF Nigeria Strategy – 2011 – 2015
- National Operation Guidelines, For Community Management of Acute Malnutrition, Federal Ministry of Health, Family Health Department, Nutrition Division, August 2010
- Management of Acute Malnutrition, Training Package 2, Nigeria October 2010, Training of Community Volunteers on CMAM
- National Policy on Food and Nutrition in Nigeria, 2001
- National Plan of Action on Food and Nutrition in Nigeria 2004
- Nigeria Demographic and Health Survey 2008, Preliminary Report – May 2009
- ACF Monthly programme reports
- ACF technical field visit reports
- ACF CMAM statistics
- ECHO Humanitarian Implementation Plan (HIP), Sahel Region of West Africa, 2011
- ACF Letter of Intention to ECHO- July 2011
- ECHO Monitoring Visit Report – ACF US in Yobe State- (visit end of March 2011)

Annex 3: Overview of MoU with key responsibilities for all stakeholders

ACF Responsibilities:

- Training and capacity building of health staff on CMAM respecting national protocols
- On job monitoring and joint supervision visits with LGA nutrition focal person, state nutritionist
- Supporting the OTP and SC with basic materials (anthropometric materials (weighting scales, MUAC tapes), stationary, benches, tables etc.)
- Support to MoH at central level on data management and reporting including supporting the HMIS
- Promoting linkages between state and LGA for sustainable management of RUTF supplies
- Community sensitization of CMAM, identification and training of CV's (community volunteers)
- Conduct rapid socio-cultural study and coverage survey
- Participation in coordination meetings

Yobe State MoH Responsibilities:

- Ensure that OTP & Sc services are available in hospitals and HC's and services are free of charge
- Provide appropriate staff for SC in the hospitals and HC's for OTP services respecting national protocols
- Ensure staff are available for hygiene purposes (cleaning)
- Participate in planning, training and supervision
- Compile monthly reports
- Identify and implement financial mechanisms (with ministry of planning) for long-term standard medicine and therapeutic food for LGA's implementing CMAM

LGA Responsibilities:

- Provide health staff for CMAM training and ensure implementation & integration of SC & OTP services respecting national nut protocol
- Provide necessary medical consultation in hosp for children referred to the SC free of charge
- Ensure provision of essential medicines to health facilities providing CMAM services ensuring that services are free for children with SAM
- Facilitate transportation between OTP and SC
- Participate in regular joint supervision and produce monthly reports for SMOH
- Immunise all children <5years receiving CMAM services
- Assist ACF in identifying CV's
- Promoting CV collaboration with medical staff in HC's
- Strengthen links between all stakeholders: CV's, LGA health staff and State level staff
- Ensure transport for RUTF

Yobe State Ministry of Local Government Responsibilities:

- Support ACF's approach to health centres in integrating CMAM to the state health system in identified LGAs
- Support LGA PHC department in provision of medicines for treatment of acute malnutrition and transport for goods
- Facilitate communication and coordination between MoU signatories