Final Report of
Terminal Evaluation of Emergency Nutrition Intervention Program in Shashego and Hulbareg woredas of the SNNPR, Ethiopia

Submitted To:
Save the Children UK
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22 June 2012
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Acknowledgements
The evaluation team appreciates all the community beneficiaries, the woreda, Zonal and regional partners for their participation in the discussions and interviews carried out. The participation and support of the facilitators, the Program Manager (Minassie Bekele) and SCUK Addis Office staff (Samson Taffesse) has also been very helpful in guiding and tracking this evaluation. The evaluation team would also like to thank them for providing the team with all the necessary documents and for their continued follow up and feed back.

Cover page picture
On-site premix preparation by local people

ACRONYMS

ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
CMAM	Community Management of Acute Malnutrition
CSA	Charities and Societies Agency (CSA)
DAC	Development Assistance Committee
EWR	Early Warning and Response
FENCU	Federal Emergency Nutrition Coordination Unit
ENIP	Emergency Nutrition Intervention Program
FDA	Food Distribution Agent
FGD	Focus Group Discussion
KII	Key Informant Interview
HEW	Health Extension Worker
HO	Head Office
HRF	Humanitarian Relief Fund
HRD	Humanitarian Requirement Document
MAM	Moderate Acute Malnutrition
MUAC	Mid-Under Arm Circumference
NGOs	Non-Governmental Organizations
OCHA	Office for Coordination of Humanitarian Affairs
OTP	Outpatient Therapeutic Program
OVC	Orphans and Vulnerable Children
OVG	Other Vulnerable Groups
PLW	Pregnant and Lactating Women
PLWHA	People Living With HIV/AIDS
RHB	Regional Health Bureau
RDPPB	Regional Disaster Prevention and Preparedness Commission
OECD	Organization for Economic Cooperation and Development
SC	Stabilization Centre
SCUK	Save the Children United Kingdom
SAM	Severe Acute Malnutrition
TSFP/SFP	Targeted/ Supplementary Feeding Program
UNICEF	United Nation Children's Fund
VCHW	Voluntary Community Health Workers
WrHO	Woreda Health Office

1. EXECUTIVE SUMMARY

Based on the nutrition cluster/FENCU recommendation and SCUKs brief assessment, SCUK implemented Emergency Nutrition Intervention Program (ENIP) using the Community Based Management of Acute Malnutrition (CMAM) approach in two woredas of the SNNPR, Shashego (Hadyia zone and Hulbareg (Siltie zone). The program included four basic components, Management of severe acute malnutrition (SAM) and moderate acute malnutrition (MAM), Community mobilization and improving coverage and access through quality assurance.

The program was implemented from August 1st. 2011 to March 31st. 2012 including a no-cost-extension period. The present evaluation was commissioned at the end of the NCE period to assess the relevance/appropriateness, effectiveness/impact, efficiency, coverage, coherence and coordination and connectedness/sustainability of the program to serve as a learning document for future similar programs. The evaluation was carried out from April to May 2012. The evaluation employed mainly qualitative methods, community Focus Group Discussion (FGD), Key informant interview (KII) and document reviews. The analysis and results presented were finally derived using triangulation of results from these three and observations of the consultant.

The findings of the evaluation indicated that the program was undoubtedly relevant and appropriate for most attributes. The activities included were contributing significantly to the Ethiopian Federal Ministry of Health's (FMOH) vision for increased coverage of health services. The program has also been relevant to the beneficiary community, sectoral offices as well as the Woreda and Zonal administration enhancing their objectives at various levels and contributing to avert an escalation of malnutrition among the most vulnerable groups, children under-five and pregnant and lactating women (PLWs).

Reasonably sufficient **needs assessment** was carried out prior to implementation by the existing national and regional early warning and response systems and by SCUK. **The community mobilization** component was encouraging with the community made highly aware of the programs and its approaches which ultimately contributed to improved treatment seeking behaviour of mothers and care takers and contributed to increased coverage of the SAM and MAM treatment program. The level of **participation** by the community at various levels was encouraging to include the use, and training provided, Volunteer Community Health Workers (VCHW) as well as the communities involvement in case identification and referral activities of the health system.

The other limitations of the program are related to supplies and resources transfer. The lack of coordination between Shashego WrHO and the project in terms of procurement of medical supplies, which later resulted in rejection of the supplies by the WrHO, has been the most outstanding weak point that has been found by this evaluation. The WrHO complains that the procurement did not follow legal procedures as it did not ensure their full participation and consent despite the Project Manager's claim that consent had been obtained and the woredas recived the copy of the proposal and agreements signed with UNOCHA before the program started.

This evaluation recommends that SCUK should in the future assess the procurement requirement of woredas and obtain sufficient consent from the relevant authorities before engaging itself in procurement of any of the supplies stipulated in the proposal document.

Furthermore, at the end of the grant period, in contrast to the rules of Ethiopian Charities and Societies Agency (CSA), the program woredas claimed that the properties brought into the area for project implementation should be left to them and did not allow the transport of items back to SCUK office. The evaluation concluded that separate MOU (specifying the roles, responsibilities and rights of both parties) with woreda partners would have avoided problems like this one and recommends similar action for the future.

With regard to **effectiveness,** the program generally performed outstandingly mainly with the treatment of SAM, community mobilization and quality assurance components of the program.

With regard to effectiveness of activities related to the **management of SAM**, most objectives have successfully been achieved. The SAM management activities performed well above the plan, timely and adequate. The frequency and number of **SAM management** trainings held was outstanding and were highly appreciated by all partners. The number of beneficiaries screened and treated was very high and supplies provided to health posts and health centers were appropriate ensuring sufficient capacities to the health infrastructure at least for some years to come. The OTP and SC admission and treatment activities were successfully carried out with many on-the-job coaching sessions which contributed to capacity building and boosted confidence on health centre and the woreda health staff.

The contribution made to effective **community mobilization** was also adequate with the number of community based CHVW and FDAs trained above the plan, and well instituted referral systems in place and sufficient nutrition education and awareness raising sessions held. This is reflected in the performance of the OTP component which was very high, i.e. very few defaulters, absent death and high cure rates.

The **effectiveness of management of MAM** was constrained by the delayed implementation. An **overall delay in the implementation of TSFP** response has been the greatest challenge of the program with the start of the implementation compromising timeliness, the main reason being delay in signing of MOU and release of resources from partners. As a result of the late appeal (July 2012), the lengthy recruitment process, delayed signing of MOU, especially by the regional partners, and the food release process has affected the timeliness of the implementation of the TSFP, and poor coordination with woreda partners resulted in missing peak hunger period in the target woredas. The evaluation recommends better coordination efforts at all levels and with all partners including SCUK to improve the quality of the TSFP response.

The **efficiency** of budget utilization was high with 97% of the allotted grant used during the life of the project. Cost-efficiency was also reasonable with about USD$ 153 spent per child treated for children with SAM and MAM. In comparison to literature estimates of about USD$ 220[1] for similar interventions, the cost per child was also reasonable, and therefore, cost-efficiency has been high.

With regard to proxy **coverage**, both the OTP and TSFP did well during the **time range** when these program components were implemented. However, with the TSFP, the coverage appears low when considering the whole of the intervention period. The coverage had also limitations when considering addressing the different vulnerable groups. Only under-five children but not, elderly disabled were

[1] *Directions in Human Development: Scaling Up Nutrition; What will it cost. World Bank 2010.*

included in the program. Though the WFP resources are targeted for the under-five children and PLWs, resources that were procured by SCUK could have included these other vulnerable groups.

The level of coherence of program with governmental policies, strategies and approaches was reasonable. However, **coordination** with government partners had considerable limitations, as stipulated from the different disagreements between woreda partners and the project.

2. INTRODUCTION AND BACKGROUND

Save the Children UK (SCUK) has been operational in Ethiopia since 1973 and the organisation has developed into one of the largest international NGOs in the country. Currently, SCUK operates a programme that involves humanitarian relief, development and the relationship between them. Specifically, programmes focus on Emergency, Hunger Reduction, Health/HIV-AIDS and Education as thematic areas. In order to promote the fulfilment of children's rights, SCUK works to ensure quality programming on the ground forms the basis upon which to advocate for changes in policy and practice by key duty-bearers at Regional, national and global levels. In order to achieve this, SCUK Ethiopia Country Programme is organised into four main departments: Policy and Programmes Department (PPD), Programme Operations, Finance and Grants, and Human Resources and Administration.

2.1 Evolution of the crisis and the humanitarian response

Following above normal Meher rain in 2010 Shashego and Hulbareg woredas in SNNPR were affected by flood which damaged a large proportion of the "meher" crop. Following this crisis there was a two month delay of the Belg rains which in terms of intensity was also below normal. During the first half of 2011, the food security situation deteriorated in the south and *belg* dependent areas of the country. The poor performance of short-cycle crops and deterioration of livestock body conditions and production contributed to rising malnutrition in some *La Niña* affected areas including SNNPR. On the other hand, flooding posed a threat during the second half of 2011 with National Meteorological Agency's (NMA) forecast of normal to above normal *kiremt* rains.

The multi-agency nutrition assessment results also indicated Shashgo as woreda with chronic food insecurity; and malnutrition problem was critically increased due to the delay of the belg rain in Shashogo and HHulbareg. As a result, the affected communities failed to meet and sustain their needs and livelihoods. The assessment therefore recommended immediate interventions in food and water, among others, to avert heavy loss of lives and livelihoods. The findings of the multi-agency assessment and monitoring results indicated that in SNNPR there were a total of 252,236 affected populations that required 9,234 MT of food aid. Based on the appeal by the nutrition cluster, SCUK carried out a reconnaissance visit to the area to discuss the situation with zonal and woreda partners and collect some background information.

The findings of the mission were as follows:

Poor Meher 2010 production:

Shashego and Hulbareg fall among the flood-prone areas of SNNPR. Normally, flooding occurs at the end of July beginning of August. According to local EW informants, the 2010 "meher" rain was above normal and the two Woredas were affected by floods which damaged a large proportion of the "meher" crop. In addition, the newly tested maize variety supplied by Ethiopian Seed Authority totally failed due to unknown reasons.

Poor Belg 2011 production:

The reported two month delay in the Belg rain coupled with a below-normal precipitation has seriously affected the Belg production and pasture. As a result out of the planned 5384 hectares

only 3336 hectares (62%) were covered by crops. The poor Belg rain has resulted in severe pasture shortage. The condition of the cattle was poor with most looking highly emaciated. As a consequence there is reported lack of milk and butter. Especially the butter is considered an important source of cash. Moreover, the poor "belg" rains has affected land preparation and planting of long cycle meher crops, such as maize and sorghum, especially in the lowlands (NMA, June 2011).

The situation was made worse by increased food prices. Cereal prices were at relatively low levels until January 2011 and increased sharply starting from February. Prices of maize rose markedly between 60 and 117 percent in both surplus and deficit markets from February to May 2011. Prices of wheat and mixed teff followed the same trend. Food inflation has increased by 32.2 percent in April 2011 compared to the same period in 2010.

3. Impact on vulnerable groups:

The agricultural and livestock production loss coupled with sharp increase on the food price has already had a toll on the health and nutritional status of children under five years as shown from the increase in TFP admission starting from March 2011. Additional vulnerable groups that were likely to be affected included pregnant and lactating women and other vulnerable groups including people PLWHA, elders and orphaned children. The food crisis in the two Woredas has resulted already in a great number of men and youth migrating to neighbouring regions for casual labour.

The overall situation is expected to remain *serious* until October. The *'Belg'* harvest failure has already deprived the population of the necessary food stock to satisfy the requirements during the rainy season and this adds to the emaciated condition of the livestock and to the high market prices of staple foods. Even in normal production years the level of food availability is considerably reduced during the rainy season in these two Woredas. For example, about 90% of the population in Shashego lives in "meher-dependent mixed cereal growing mid-land" with hunger period extending from Jun-Oct. Seasonality therefore is also considered to contribute to food scarcity in these communities increasing the vulnerability of the Meher-dependent population and consequently contribution to an imminent crisis.

Due to the prevailing and forecasted synergistic and negative agro-climatic and market phenomenon, the two Woredas were further exposed to considerable level of food shortage, which as a consequence might overburden the capacity of the health system to provide for the required additional health and nutrition services.

To prevent the anticipated increase in rates of malnutrition among children and other vulnerable groups and the consequent impact in child morbidity and mortality, SCUK, proposed to reinforce the response capacities of the two Woredas through strengthening of the health and nutrition services. SCUK Ethiopia program received HRF grant and implemented the emergency nutrition intervention project in Shashego and Hulbareg woredas of the SNNPR from August 2011 until December 31st, 2012. With the grant period ending at the end of March Save the Children UK announce to engage a consultant to evaluate this Emergency Nutrition Intervention Project. The present report is the result of the participatory evaluation exercise which was carried out from April to May 2011.

2.2 Objectives the ENIP

The goal of ENIP was to contribute to reduction of morbidity and mortality related to malnutrition in the 2 Woredas of SNNP Region by ensuring adequate standards in the health and nutrition response.

The specific objectives of the ENIP were:

- To strengthen TFU service *coverage* and *quality* in all Health Centers
- To strengthen OTP service *coverage* and *quality* in all Health Centers and Health Posts
- To provide Supplementary Feeding to all discharged TFP cases (all woredas) and to MAM cases
- To improve community mobilization and use of TFP/SFP and related health-services

2.3 Program components of the ENIP

The project had **four inter-linked components**:

1. Management of Severe Acute Malnutrition (SAM): Strengthening of Therapeutic Feeding Program (TFP) *quality* at health centre and health post levels
2. Management of Moderate Acute Malnutrition (MAM): Strengthening of Supplementary Feeding Program (SFP) *coverage* and *quality*
3. Community-Mobilization: Mobilization, active case finding, referral and follow-up of SAM/MAM cases For Component 3 (Community Mobilization), activities include
4. Quality Assurance: Logistic support, timely and quality reporting and joint support supervision with key stakeholders (RHB, WrHO, DRMFSS and development partners)

3. PURPOSE AND METHODOLOGY OF THE EVALUATION

3.1 Purpose of the evaluation

The overall purpose of the terminal evaluation is to assess the effectiveness, efficiency, and impact of the Emergency Nutrition Intervention project in Shashego and HHulbareg woredas of the SNNPR.

SCUK considers this as an important exercise that contributes to institutional learning. It is therefore envisaged that findings from this project terminal evaluation will produce important insights and lessons that Save the Children UK will draw from and use to inform and improve future programming, design and implementation of such interventions in future.

The evaluation is based on the OECD/DAC criteria and used the project log frame, Sphere Standards and national protocols and as benchmarks for analysis. Further description of the evaluation criteria are provided below.

3.2 Evaluation approach and methods

The methodology was designed to answer specific questions related to the Emergency Nutrition Intervention Project in Shashego woreda (Hadyia Zone) and Ulbarge woreda (Silte zone) of SNNPR. The main evaluation criteria were relevance/appropriateness, coherence, effectiveness, efficiency, connectedness/sustainability and impact of the project. In order to achieve the evaluation objectives, the study assessed all factors influencing the performance of

the Emergency Nutrition Intervention Project in Shashego and Ulbarge woreda including the programmatic approach, implementation strategies and institutional setup/arrangements while implementing the program.

For the purposes of this evaluation, the consultant employed a qualitative evaluation (through PRA methods such as KII and FGD) collecting primary and secondary data using pre-designed guides and plans. The data collected was triangulated in order to provide answers to questions specified in the TOR.

For the purpose of this study the Consultant firstly disaggregated the above six general review criteria to specific review questions relevant to each of the project components. The evaluation questions constituted a set of indicators which will cover each program components that serve the review process and the review questions were made operational by turning them into evaluation instruments.

Secondly, the study team attempted to find the answers to these questions on the basis of reliable information from different sources including, focus group discussion, direct observation and key informants interviews.

The third step was the analytical process. The analytical part of the evaluation transformed detail information into conclusions at a more aggregate level, and finally made use of these to draw the overall conclusion at the highest level, linked to the six major evaluation criterion in question.

3.3 Data collection methods and data sources

Sources of data were programme monitoring data (*secondary data*) complemented by information collected from key informants, stakeholders and beneficiaries themselves (*primary data*).

Focus Group Discussion(FGD)

Focus Group Discussions were held with beneficiaries in selected Kebeles. FGDs were held with Supplementary Feeding Program (SFP) and Outpatient Treatment Program (OTP) beneficiaries in the two different kebeles of Achiraye Fuge (HHulbareg woreda) and Sheyembie Kebele (Shashego woreda). A pre-prepared FGD guide was used to lead the FGD process with one facilitator and one note taker at a time.

Key Informant Interviews (KII)

Interviews using a guiding open- and close-ended questionnaire were conducted with representatives from RHB, RENCU and RDPPB at regional level. At woreda level WrHO, EWR and at zonal level zonal early warning representatives were interviewed. For the detail see Annex 2.

Document Review

Program documents including proposals, reports, monitoring data records, agreements and correspondences were obtained and reviewed to reinforce the facts and conclusions in this report.

4. MAJOR FINDINGS

4.1 RELEVANCE/APPROPRIATENESS

According to ANLAP[2] relevance is concerned with assessing whether the project is in line with local needs and priorities (as well as donor policy). Appropriateness is the tailoring of humanitarian activities to local needs, increasing ownership, accountability and cost-effectiveness accordingly.

The **needs assessment** carried out prior to the intervention was reasonably sufficient. The multi-agency assessment reported that the two woredas need nutritional support to save the lives of children based on the forecast in escalation of malnutrition. Furthermore, SCUK conducted a brief assessment of its own to verify the situation.

The **CMAM approach** employed by the program was in alignment with focus of the MOH which prioritized increasing coverage at community level; including decentralization of services to community. The strategy is utilization and involvement of health extension workers (HEWs), other community health agents and kebele /village level actors, in the planning and management of services. The CMAM program of SCUK has been relevant contributing significantly to the decentralization by working closely with the HEWs, VCHWs and all the health partners including those at woreda, zone and regional levels.

According to the KII and FGD data, the emergency nutrition response has undoubtedly been **relevant** to the beneficiary community, sectoral offices as well as the Woreda and Zonal administration. All the FGD beneficiaries and the sectoral partners expressed their view that the program was relevant. As per the evidence from the screening, admission and treatment data and capacity building initiatives from the program, the overall goal or outcome of the project i.e. reducing morbidity and mortality related to malnutrition among under-five children has been reasonably achieved according to this evaluation. Women's and men's **coping capacities were rather supported**, than undermined, as the decision for support was based on regionally and nationally verified multi-stakeholder assessments that proved that the community has exhausted it's coping capacities.

In terms of its **significance to avert an escalating malnutrition levels** associated with transient food insecurity, the SNNPR ENIP has clearly contributed to the over all goal of reduction of morbidity and mortality related to malnutrition in the two woredas of the SNNP through the SAM and MAM treatment components of the program. Mortality among children admitted to the OTP/SC and TSFP has been almost nil (0%). According to beneficiaries from FDG participants and TFU nurses and HEWs there had been no malnutrition related child death during the implementation of the program. Improved nutrition and health were reported by these participants as the main benefits of the program.

The community was well **informed** of the program. The FGD beneficiaries described that they are well aware of the program and they have been informed before and during the intervention by different community entities. Kebele leaders, women representatives, community volunteers

[2] *Evaluating Humanitarian Action using OECD/DAC criteria: An ANLAP guide for humanitarian Agencies. London. March 2006*

and health workers provided them with information about the program. The beneficiaries further described that they were always been informed of the *dates and places* of the services ahead of the implementation of the screening and the TSFP.

The community **participated** in the program through community volunteers and FDAs that served as channels between governmental and non-governmental bodies with duties of alleviation of malnutrition in the area. The FGD participants described also of direct participation in the program. They have been informing neighbors and close relatives on the need to present their children to the screening and to the health facilities when they are diagnosed as malnourished. They also recognize signs of malnutrition in children as swelling of the face and legs, thin body, child crying frequently and big abdomen and advice each other to visit health facilities whenever they encounter children with such signs. All the FGD discussants unanimously indicated that ***the community is aware why the program beneficiaries were admitted*** in the program.

With regard to the **local capacity,** in terms of knowledge and staffing to implement the ENIP, the evaluation noted that there was a due lack of both in the target areas before the implementation of the program. The initiative to complement the local capacity has been of critical importance. To address the capacity gap SCUK ENIP has implemented health workers training as one of the main component.

Regarding the **program approach** of the TSFP, in the non-EOS/TSF woreda of HHulbareg, SCUK used its own emergency staff (SFP nurses and measurers /registrars) with the local FDAs that were available in all kebeles. In the CHD woreda of Shashego, SCUK provided community mobilization and screening support and distributed supplementary food to deserving beneficiaries that were not included CHD program run by the DPP. This was in accordance with the tripartite agreement memorandum signed between SCUK, DPPD and UNWFP. This has led to increased coverage, with very minimal defaulting, and highly improved access to the services.

The KII with DPP and the FGD participants appreciated that the **food distribution sites** were close enough for the large majority of beneficiaries maximizing access to the services, except a single kebele that was relatively located far. Even for this kebele beneficiaries were able to return to their homes within the same day.

Timeliness

There was no the slightest doubt as to the relevance of the food distribution support by SCUK as the beneficiary FGD and most KII with regional partners indicated. However, **t**he **relevance of the TSFP** was somewhat compromised because the period of peak food shortage corresponded with the months of May through August (according to DPPB) and April through August (according to FGD beneficiaries) while the actual distribution took place during October through March. This flaw is by and large attributable to the overall coordination system where the HRD appeal was released in July 2011 followed by hotspot declaration in September 2011. Despite these, SCUK submitted the proposal promptly on 15th. July 2011, according to the CAD document, and the proposal approval process was also swift with agreement signed by UNOCHA on August 12, 2011 for a grant period of 01 August 2011

through 31st. December 2011. The project was further extended through NCE to March 31st. 2012.

In relation to timeliness the regional DPPB key informant stated:

> *"The TSFP response was not timely. There was a delay in the actual start up of the project and the implementation of the TSFP. It was started late in the 2nd week of October in HHulbareg and in November in Shashogo. The situation was relatively better after September but the malnutrition situation was severe b/n May and August as a result of the delay of Belg rain in the 2 woredas.."*

Beneficiaries' remarks also were in partial conformation with the above indicating the TSFP implementation period was not at the peak hunger period, however, still it was useful as the hunger lingered thereafter.

> *"Although the food shortage was not serious in November, there was a hunger gap; and still it was timely."* [Shashego beneficiary]

> *"The food shortage problem at the start of the program was not more serious as it was b/n April and August. There was food shortage problem [any how]. Thus, it was timely."* [Hulbareg beneficiary]

As per the analysis made by this evaluation, the reasons for the overall delay in the food distribution were rather a result of coordination gaps including late HRD appeal (July 2011) left little time for donors and implementers to respond at the peak hunger period, delayed MOU signing with regional DPPB, delayed screening, with out which WFP cannot release the food resources to the CHD woreda, and consequent delay in food release. According to the documents reviewed by the evaluation and the interviews with the KII informants, MOU with the regional partners was finalized on October 10, 2011 (2.5 months after grant approval). Although the signature with the RHB was finalized promptly, the signatures of the DPPB were delayed considerably. On October 11, 2011 SCUK requested WFP to release for food resources. At this time, WFP responded that the warehouse is closed until a new agreement will be signed between UNOCHA and WFP. Despite the closure, WFP agreed to make a special arrangement to avail the food resources and managed to release the resources for HHulbareg on October 15, 2011 (1 month later). However, resources for Shashego could not be released before December 2011 as the woreda has to carry out screening since it was a CHD woreda. The reason for the additional delay of about 1 month in Shashego was the time taken to align the beginning of the distribution with the Woreda Food Security food distribution to prevent beneficiary disappointment that would arise as a result of distributing to minority groups (OTP discharges and newly identified cases) compared to the large majority of beneficiaries mainly managed by the woreda food security. Although in consultation with woreda partners, the decision was made by the PM, who misunderstood the dire need for timeliness. A close follow up of PMs is recommended for the future and the need to adhere to the DIPs and inform SCUK in case of needs for such changes to be made. The distribution in HHulbareg, however, was more prompt since the food was received on October 15, 2011.

In conclusion the food distribution was not as timely as it could have been. Timeliness factors were more related to late HRD appeal at national level, delayed MOU signing by regional partners, lengthy staff recruitment, delayed food release from WFP, and misunderstanding of the PM on the urgency and low follow up from head office. However, SCUK should also strategize its lengthy response procedures to maximize the quality and timeliness of its response programs.

With regard to **human resources** SCUK gave a pre-deployment training to the staff and their technical and organizational capacity were much appreciated by all partners.

With regard to staff capacity the Hadyia zone health department informant remarked:

"SCUK's technical staffs are capable and highly motivated. The program is effectively implemented at SC and OTP sites i.e. Management of the SAM is incorporated into the regular program at health facilities. The training helped health workers to discharge their duties efficiently."

The **food resources** provided were culturally and physically appropriate. Children liked the RUTF very much that they crave for it. The pre-mix approach of SCUK has been very much appreciated as appropriate by all regional partners and beneficiaries as it avoided the chance of selling of the resources for other priorities.

The regional TSFP focal person expressed his appreciation as follows:

"Mixing CSB with oil before distributing to beneficiary is effective in tackling food sharing and selling problem, in this case SCUK can be appreciated and acknowledged."

CSB and Plumpy Nut was appropriately obtained and was of the **appropriate quality** and standard. However, the quality of edible **oil distributed to the Hulbareg beneficiaries was not of the standard required**, according to regional partners as well as according to the observation of this evaluation. The edible oil provided was a regular from the Ethiopian market which was not fortified with the micronutrient vitamin A. This was due to budget allocation errors made by SCUK, wrongly assuming that WFP will not provide oil to non-EOS/TSFP woredas, such as HHulbareg. SCUK could not finally procure timely fortified oil from external markets and had to procure regular products available locally. Such flaws, though not uncommon in such complex humanitarian response endeavors, SCUK should update its information on resources with partners before embarking on finalizing proposal documents and WFP should also provide a clear and continued guidance to NGO partners on the existing modalities.

Medical supplies were well accounted for in the proposal document. However, at the end of the project there was a disagreement with Shashego woreda health office in the purchase process, though the proposal document has been shared early. The woreda health office was unhappy by the process of procurement and was hesitant to endorse the supplies until the last day of the grant period. It seems that the woreda health partners wanted to be part of the

procurement process. SCUK staff's opinion was that the normal purchasing procedure has been adhered to. SCUK has obtained permit from the appropriate national agency to procure the supplies and used its formal bidding system. SCUK also provided the necessary purchase documents and invited the woreda health office to investigate the situation, to include their coming to Addis and do their own investigation by discussing with the supplier itself. Until the end of survey period of the present evaluation, however, the woreda did not officially endorse the supply of these medicines. Though this inconsistency mainly outweighs to the woreda health office, SCUK also has the responsibility of engaging each entity to a level as much as they are willing to be involved. Though in most circumstances this level of involvement was unusual, such a slight variations in different target woredas had to be recognized and adjustment should be done accordingly.

There were also problems in relation to furniture and equipment during **handover** phase of the program according to the latest information from the head office and the program staff. According to the Charities and Societies Agency's (CSA) new law, all material inputs to projects implemented by NGOs had to be passed to CSA but not to woreda partners. However, at the end of SNNPR the woreda partners, apparently misunderstood the law and disagreed to release all the equipment and the furniture used for the implementation of the project. The situation has been informed in writing to the CSA and is still being followed up by SCUK logistics section.

4.2 EFFECTIVENESS /IMPACT

Effectiveness measures the extent to which an activity achieves its purpose, or whether this can be expected to happen on the basis of the outputs. Assessment of effectiveness examines whether intermediate objectives have been achieved and fed into outcomes.

The evaluation analyzed and measured the extent to which the program achieved the desired goals, targets and change, including the short and long term impact of the interventions both by comparing against the program log frame and against the sphere minimum standards. To assess the effectiveness of the SNNPR ENIP, the evaluation mainly used the program documents, program data, program reports and KII and FGD interview results.

Community mobilization

Community mobilization aims to raise awareness of CMAM services, promote understanding of its methods and lay the foundation for community ownership in the future. Community mobilization is an ongoing, and many of the community interactions take place early in the program but should be continuously reinforced throughout the implementation phase to be effective.

As part of the **community mobilization** activities SCUK carried out a **launching workshop** to increase awareness levels among partners. During the start-up, woreda and zonal level discussions were held on project start-up issues to include sectoral integration, sharing of responsibility during implementation, TSF site targeting and support requirements from respective government offices. Moreover, the field team had a thorough discussion with Woreda health and DPP officials on the establishment of SFP, OTP and SC sites. Furthermore,

continuous and ongoing discussion sessions were held with woreda, zonal and regional partners during the implementation of the project.

During the life of the present CMAM project, a total of 702(135% achievement) and 696(99% achievement) **VCHWs** received **basic and refresher trainings**, respectively, and were equipped for effective community mobilisation and screening skills at community level. Furthermore a total of 156(100%) food distributors received two trainings on food distribution management and hygiene related issues.

Moreover, all the **beneficiaries** of SFP and OTP were given **health education** in OTP and SFP sites by FDAs, community volunteers, project staff and health extension workers. About a total of 7171 beneficiaries have been reached through the community health and nutrition education. Health and nutrition education was among the CMAM activities that contributed to change of behaviour in the communities as acknowledged by the beneficiaries and the key informants from WrHO.

Table 1: Achievement of community mobilization activities

	Target	Achivement	
Community Mobilization for effective implementation of OTP/SC/TSFP	Number	Number	*%*
Community Volunteers Training	520	702	*135%*
Food Mixers/Distributors Training	156	156	*100%*
Total	676	858	*127%*
Community Volunteers Training	702	696	*99%*
Food Mixers/Distributors Training	156	156	*100%*
Total	858	851	*99%*
Health and Nutrition Education	9514	7171	*75%*
Refresher Training	676	396	*59%*

The health and nutrition activities carried out by SC UK were an important achievement in assisting communities' well-being in the with likely short and long- term impacts. The potential to maintain and develop such an approach with trained volunteers working within communities, where the needs are so great, could have a great impact for future management of similar interventions.

Management of Severe Acute Malnutrition (SAM)

Outpatient care is aimed at providing home-based treatment and rehabilitation for severely malnourished children 6-59 months who have an appetite and no medical complications. CMAM programs achieve this objective through timely detection, referral and early treatment before the health condition becomes severe or before the onset of a complication.

In the SNNPr ENIP, outpatient care was provided to the majority of children with SAM, those without medical complications and who have appetite. Outpatient care has also been provided to children after referral from inpatient care to continue treatment and nutritional rehabilitation.

The admission criteria were based on The Protocol for the management of children with severe acute malnutrition, FMoH. March 2000. Addis Ababa, Ethiopia.

Beneficiary admission and discharge criteria for TFU/OTP

TFU admission criteria	**TFU transfer to OTP**
MUAC<11 cm (length >65 cm) And: - Failed appetite test - Bilateral pitting oedema Grade 3 - Marasmus Kwashiorkor - Medical complications Infants less than 6 months	After Transition Phase if return of appetite and reduction of oedema

OTP admission criteria	**OTP discharge**
MUAC<11 cm (length >65 cm) Presence of bilateral pitting oedema Grade 1 or Grade 2 And: - Passes appetite test - Alert with no medical complications	Target weight gain reached (as indicated in SAM protocol) No oedema for 14 days Note: all discharged children will be given supplementary food for 2 months

Program performance indicators for Therapeutic Feeding Program were:

- Mortality rate <5% (FMoH March 2007)
- Recovery rate >75%
- Defaulter rate <15%
- Mean weight gain >4g/kg/day
- Coverage >50% in rural settings (SPHERE)
- Length of stay <6 weeks (OTP)
- Length of stay 4-7 days on average (TFU)
- Hospital referrals <10% (TFU)

SCUK supported a total of 55 OTP sites in Health Posts and 3 SC sites in Health Centers distributed in the 55 Kebeles of the two woredas. Based on the recommendation of the woreda, zone health department & Regional Health Bureau, all OTP sites received full technical and logistical support from SCUK to ensure good coverage and accessibility to the government's rollout of OTP/SC. As part of this support, SCUK contributed to the successful implementation of the OTP/SC decentralized management through complementing the activities of the woreda health. The main components of OTP in which SCUK was involved were screening, capacity building (basic and refresher training to health workers and VCHW) on the management of SAM with and without complications and on-the-job coaching of HEWs.

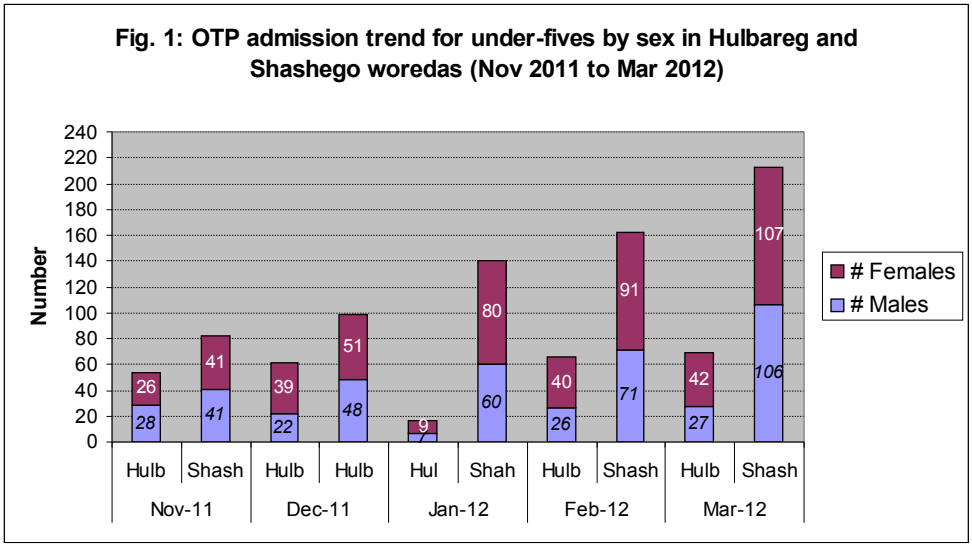
Screening and Admission to OTP and SC

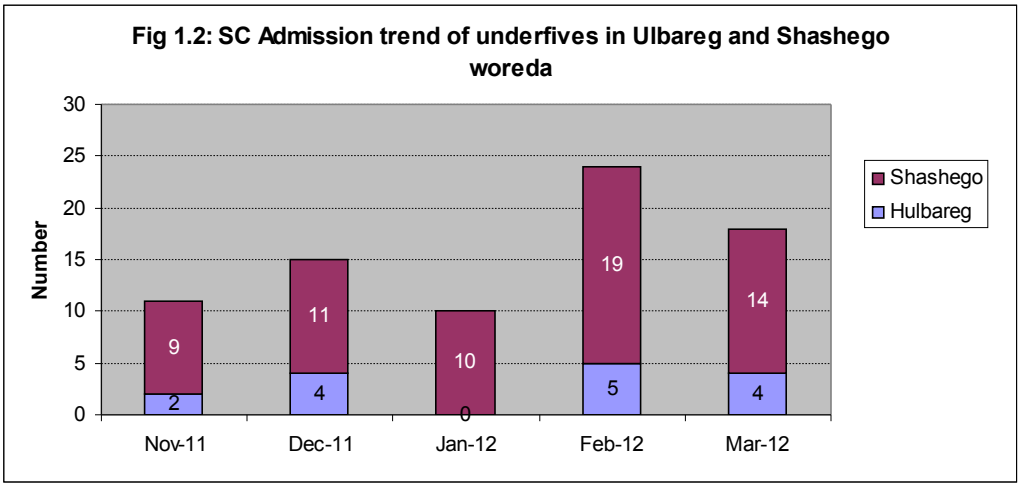
SCUK staff was involved in screening activities supporting the woreda health structure. A total number of 12843 under-five children and 6226 PLW were screened (Table 1) from October to March 2012.

Table 2: under five children and PLW screened in HHulbareg and Shashego Woredas

Months	Number of <5yrs		Pregnant mothers	Lactating mothers
	M	F		
October 2011	196	248	60	73
November 2011	698	950	506	480
December 2011	1204	1420	640	798
January 2012	1402	1485	766	772
February 2012	1859	1798	740	948
March 2012	825	758	245	198
	6184	**6659**	**2957**	**3269**

A total of 962 children were admitted and treated for SAM without complications, about 90% achievement whereas the total number of children with SAM with complications admitted and treated at SCs was 78(130% achievement).





Basic and refresher training for SAM management

In order to strengthen the provision of treatment and case management in SAM through institutionalizing the services within the existing health services, SCUK supported a series of trainings. The project supported, strengthened and integrated OTP and SC activities within health facilities; and built the capacity of health workers and HEWs. To this end, the project has developed different training package for various groups of project participants, including the community volunteer, health professionals and health extension workers. Training on management of SAM was provided to 113 health staff including 101 HEWs, 6 HEW supervisors and WrHO staffs. Refresher training on the management of SAM was also provided to a total of 164 health workers consisting of 89 HEWs, 23 HEW supervisors, 12 WrHO staff, 8 Zonal Health Department and hospital staffs and 32 health center nurses. The achievement in implementation of activities stated in the program proposal was satisfactory. Under the SAM management component, a total of 337 partners (HEWs, Nurses, WrHO staff and others) have received basic and refresher trainings as well as on-the-job trainings. The achievement in basic and refresher trainings was 34% higher compared to the planned. According to the project manager, the additional number of partners trained was based on the request from the woreda health offices. A total of 447 on-the-job coaching sessions were held to strengthen SAM management at the health post and SC in the health centers. In general, the achievement of the capacity building support was satisfactory with achievement of between a 65% and 100%+ in terms of quantitative coverage.

Table 3: Achievement of SAM management activities

Indicators	Target	Achievement	
		Aug-11 to Mar-12	Accomplishment
I. Management of SAM			
OTP site rehabilitation, admission & treatment of SAM			
OTP Site establishment/rehabilitation	52	55	*106%*
SC Site establishment/ rehabilitation	3	3	*100%*
Admission & Treatment in OTP	1007	962	*96%*
Admission & Treatment in SC (6%	60	78	130%

of SAM)			
Training on Management of SAM			
HEWs	104	101	*97%*
HEW Supervisors	0	6	*+100%*
WrHO (Nurses & Others)	6	6	*100%*
Total Trainees	**110**	**113**	*103%*
Refresher Training of SAM with out complication for HEWs, Supervisors, WrHO Staffs at the end of the project			
HEWs	104	89	*86%*
HEW Supervisors	13	13	*100%*
WrHO (Nurses & Others)	6	6	*100%*
Total Trainees	**123**	**108**	*88%*
Health Centers Nurses	15	32	*213%*
HEW Supervisors	0	12	*+100%*
WrHO (Nurses & Others)	3	6	*+100%*
ZHO and Hospital staff	0	8	*+100%*
Total Trainees	**18**	**58**	*322%*
Training on Mgt of SAM with Complications for H/Cs staff at the end of the project			
Health Centers (Nurses)	0	32	*213%*
HEW Supervisors	0	12	*100%*
WrHO (Nurses & Others)	0	6	*100%*
ZHO and Hospital	0	8	*100%*
Total Trainees	**0**	**58**	*322%*
On the job training to HEWs	676	441	*65%*

Using the **performance** criteria set in the proposal document (Sphere and FMoH criteria) and the log frame, the performance of the OTP program was satisfactory. The performance of the OTP in HHulbareg and Shashego woredas was 96.9% and 97.8%, respectively, which is much higher than the sphere performance criteria of >75%. Defaulter rate was 3.1% and 2.2% for HHulbareg and Shashego, respectively, much lower than the Sphere minimum of 15%. Mortality rate in the OTP program was 0% which is acceptable compared to the FMoH minimum criteria of 5%.

Table 4: Performance OTP in the two intervention woredas

Target group	**Woreda**	**Cure rate (%)**	**Defaulter rate (%)**	**Mortality rate (%)**
OTP <5 children	HHulbareg	96.9	3.1	0.0
	Shashego	97.8	2.2	0.0
		98.4	***1.6***	***0.0***
		>75% (Sphere)	15% (Sphere)	<5% (FMoH)

Strengthening the referral system

The **referral system** in the two woredas was improved and well-functioning due to the change brought by the contribution of the basic, refresher training jointly provided by the RHB and woreda partners and on-the-job coaching provided to HEWs and HEW supervisors, and by the on-the-job coaching provided by SCUK OTP nurses.

According to the three KII TFU nurses in Shashego and HHulbareg, on the contribution of SCUK to strengthening of the referral system:

> *"The referral system is effectively linked b/n the SC and the OTPs in the woreda. The referral linkage is strong with TSFP as well. At village level community volunteers screen and refer to OTP .Consequently screening is done at OTP by HEWs and severe cases with poor appetite are referred to SC. SC cases on discharge are admitted into OTP."*

> *"The linkage b/n SC and OTP as well as with SFP is effective".*

> *"The referral linkages b/n SC and the OTPs strongly established. B/n OTP and SFP is also strong. Severely acute malnourished children with complication or poor appetite are referred to SC and those who discharged from SC are admitted into OTP program."*

Ensuring timely and adequate provision of supply and equipment

SCUK supported the woreda health office to ensure ***timely and adequate supply of resources*** and improve the standard of SAM management services in the two woredas. Over 4600 cartons of plumpy-nut and other materials were transported to 60 Health facilities based on the needs assessment carried out by SCUK. Routine drugs were supplied for both woredas some of which were purchased while the remaining was received from zone health department.

According to Shashego WrHO KII participant:

> *"The Woreda Health office is responsible for the implementation of the program while SCUK provided technical and logistic suppoort - delivers plumpy nut to outreach OTP sites. SCUK also supported WrHO by delivering vaccines and cold chain equipment to Health Posts."*

Strengthening timeliness and quality of reporting

OTP data collection, collation and reporting were improved due to the support provided. The field staff supported these activities by compiling the information and sending to SCUK head office who reports monthly to the FENCU. This helped the MANTF to closely follow the implementation of the programs and monitor and track malnutrition situation in the two woredas also contributing to performance of the national early warning system.

Supplementary Feeding Program

Supplementary feeding programs (SFPs) manage and treat MAM in children 6-59 months and other vulnerable groups. A commonly known supplementary feeding approach in food-insecure environments or emergencies is targeted supplementary feeding, where a

supplementary food ration, normally a fortified-blended food, is targeted to individuals with MAM in specific vulnerable groups, such as malnourished pregnant women and lactating women with infants under six months.

In the SCUK ENIP setup, Targeted Supplementary Feeding Programs (TSFP) provides pre-mixed take-home rations and routine basic treatment for children with moderate acute malnutrition without complications. The objectives of supplementary food programs for the moderately malnourished in general are:

- To prevent further deterioration in the nutritional status of moderately malnourished children.
- To improve the nutritional status of moderately malnourished children and pregnant and lactating women.
- To reduce relapse of malnutrition.

Beneficiary admission and discharge criteria for TSFP

SFP admission criteria	**SFP discharge criteria**
- Children with MUAC between 11 and 11.9 (length >65 cm) - PLW with MUAC <21 cm - Children discharged from OTP (admitted for 2 months)	- WFH ≥85% of the median for 2 consecutive weights (ENI Guidelines 2004) - Weight gain of 15%-20% PLW when they reach 6 months post delivery or MUAC ≥23cm

Program performance indicators for Supplementary Feeding Program (

- Mortality <3%
- Recovery rate >75%
- Defaulter rate <15%
- Coverage >50% for rural settings

***Refs**: TSFP standard performance indicators included as required by the Ethiopian Emergency Nutrition Intervention Guidelines ENCU-EWD/DPPC, 2004, Management of SAM FMoH March 2007, Valid CTC Field Manual 2006 and SPHERE 2004*

The implementation of TSFP was carried out through the coordination of four entities, including SCUK, the *Woreda* Health Office, the *Woreda* DPPA and the community using Food Distribution Agents. However, in HHulbareg woreda, which is neither EOS/TSFP nor CHD woreda, the actual food distribution was managed by SCUK staff members with the involvement all woreda partners. A total of 16 **distribution sites** (7 in HHulbareg, 9 in Shashego) were used to distribute the food resources. 7 distribution sites in HHulbareg were established while in Shashego woreda the distribution sites previously established by the woreda DPP office were used. The targeted supplementary feeding programs were linked to the local health structure and the standard protocols were followed to identify health problems and children were referred to appropriate centers based on the screening results.

As per the national standard guidelines (*Nutrition Intervention Guidelines ENCU-EWD/DPPC, 2004*), the amount of targeted supplementary food that should be provided per child per month was 8.33kg CSB/Famix and 0.9 L of oil. For Shashego woreda all the food resources were provided by WFP whereas for HHulbareg oil was bought by SCUK and supplied to the beneficiaries.

An **MOU** was required to be signed between SNNPR Early Warning & Food Security Work Process (EWFSP), UNWFP and Save the Children UK Regarding the Integrated implementation of Targeted Supplementary Feeding (TSF) as part of the Extended Outreach Services (EOS) for Child Survival Initiatives (CSI) in Shashego Woreda of Hadyia Zone of SNNPR. The MOU was Model-1, where SCUK is expected to fill the gap by providing SF to OTP discharged children and newly identified cases and PLWs, while the FSCDPO maintains the three-monthly distribution to the remaining beneficiaries. Furthermore, SCUK undertook ongoing screening at OTP sites for 6-59 months old children with moderate acute malnutrition and pregnant and lactating women with a child less than 6 months using the criteria stated.

Table 3: Achievement of SAM management activities

Management of MAM								
	Planned		**Achieved**			**Accomplishment (%)**		
Total TSFP Beneficiaries	**Ulb**	**Sha**	**Ulb**	**Sha**	**Total**	**Ulb**	**Sha**	**U+S**
< 6 to 59 months old children	338	0	266	0	266	79	-	79
OTP discharged children	330	568	345	665	1010	105	117	111
Pregnant & Lactating women	533	919	466	186	652	87	20	54
Total	1201	1487	1077	851	1928	72	69	81

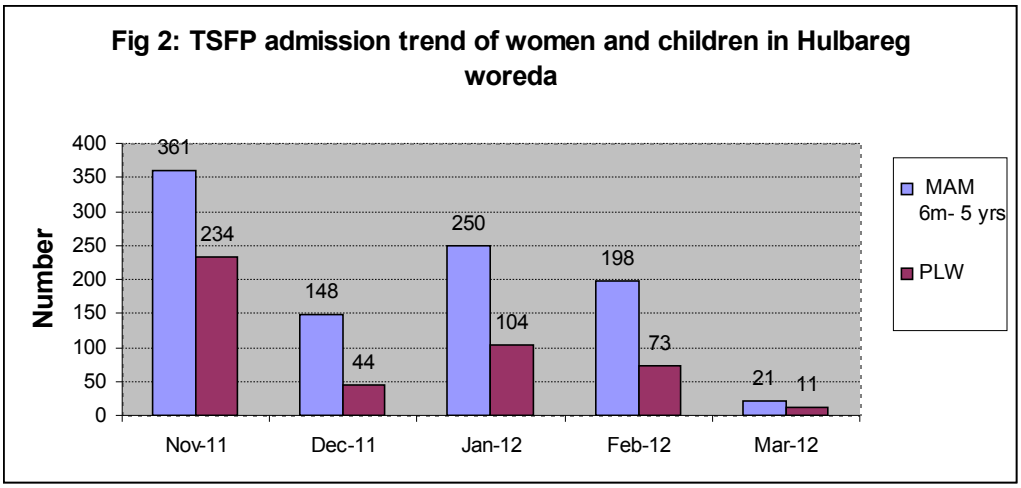
With regard achievement in TSFP admission, a total of 1928 beneficiaries were admitted (72% overall achievement) and over 95% of the food resources were distributed to the beneficiaries.

Table 5: Food resources distributed

TSFP Food (in MT)	**Received**	**Distributed**	
CSB /Famix	111.66	109.46	*98%*
Edible Oil	12.01	11.21	*93%*
			96%

A total of 1928 beneficiaries (266 6-59 months children, 1010 OTP discharged children and 652 PLWs) have been covered by the program for the treatment of MAM. 72% of the beneficiaries were reached compared to the targeted number of beneficiaries. The reason for this was mainly the *delay in food resources which limited the frequency of the food distribution and poor coordination with woreda food security, especially for Shashego woreda*. Save the Children UK started the SFP three months after the grant starting period, in the 2nd week of

October in HHulbareg and in November 2011, in Shashego and managed to carry out only 4 distributions in Shashego whereas 10 distribution sessions were held in Hulbareg.



The performance of the TSFP in HHulbareg was acceptable using the Sphere minimum criteria. The recovery rate, defaulter rate and mortality rate were 98.4%, 1.6% and 0% respectively. Performance for Shashego cannot be computed as the TSFP was carried out only for two months, which did not allow sufficient time for recovery data to be obtained. However, it can be concluded that the performance of the TSFP in Shashego woreda was not satisfactory based on the TSFP data and information from partners.

This evaluation concluded that the TSFP component in both woredas was moderately constrained by the delay in dispatch of food resources which requires improvement in coordination between the CHD screening and distribution program and complementary programs such as that of SCUK.

4.3 EFFICIENCY

Efficiency measures how economically inputs (usually financial, human, technical and material resources) were converted to outputs. This evaluation used crude proxy indicators to address the efficiency aspects of the program.

Budget utilization

Table 6 below presents ***e***xpenditure summary for SNNPR (August 01 2011 to March 31, 2012). The total grant here refers to the overall cost both in-kind and cash contributions made by different organizations (WFP and UNICEF) that were shown in the proposal document.

This excludes the cost of supplies such as clean delivery kits and drugs provided by UNICEF. The total cash grant refers to the cash allotted to SCUK, from HRF, for the emergency nutrition program in SNNPR for the six months which was USD 359,824.00. With the in-kind contributions from UNICEF and WFP the total grant estimated/planned was USD 651,317.00 and the total actual program expenditure to date was estimated at USD 348,352, assuming that all the committed cost will be spent. This was about 97% budget utilization, which is appropriate. The highest expenditure (30.1%) was for relief items, followed by transport and storage (25.2%) and staff costs (19.3%). Compared to planned expenditure, the maximum variance was for staff costs (-4.4%) followed by relief items (+2.9%), which was highly reasonable. Therefore, this evaluation concluded that efficiency of budget utilization was excellent.

Table 6: Expenditure summary for SNNPR ENIP (August 01 2011 to March 31, 2012).

HRF Budget lines	Planned	Expended	Expenditure (%)	Difference (%)
Expatriate Staff salary including benefit	5334	5200	97	-3
Local Staff Salary including benefits	79703	61928	88	-12
Operational program cost	22620	27515	110	10
Relief items	97980	107961	98	-2
Transport and storage costs	96656	87619	99	-1
Accountability	24820	26461	96	-4
Administrative Cost	32711	31668	97	-3
Total	***359,824***	***348,352***	***97.8***	***-2.1***

Cost-efficiency

The cost of the SNNPR-ENIP could not be disaggregated by program component since the expenditures were not provided or accounted for the various components. As a result the evaluation attempted to calculate and analyse cost efficiency for total number of MAM and SAM children treated by the program. Therefore, the total cost of the program calculated as cost-per child treated was compared with the benchmark figure[3]. Furthermore, training costs were not included in the benchmark cost.

To assess the cost-efficiency, this evaluation estimated the total cost of the program from MAM prevention and treatment cost and SAM treatment cost provided in the reference. Accordingly the total cost estimated to prevent and treat MAM and treat SAM in was estimated at USD$ 220. The total cost of the SNNPR-ENIP was USD$ 346,352. The cost of treatment per child in the program was USD$ 153 per child, which is about 30% lower compared to the cost estimate provided. Since the cost of the SNNPR-ENIP includes costs of training, the cost-efficiency of this program could be considered very high.

[3] *Directions in Human Development: Scaling Up Nutrition; What will it cost. World Bank. 2010*

Table 7: Estimation of cost-efficiency of the SNNPR ENIP

Program component	**Treated**
Number of children treated in SNNPR-ENIP	
OTP	1928
TSFP	266
SC	63
Total children treated	2257
Benchmarks[1]	
SAM cost[2]	USD$ 200/episode
MAM treatment benchmark for treatment and prevention[2]	USD$ 40-80/child per year
Total estimated SAM and MAM treatment cost for 6 months (taking lower range for MAM)	USD$ 220
SNNPR-ENIP cost efficiency	
Total program cost	346352
Cost per child treated	153
Percent difference	-30

[2] *Does not include training costs*

4.4 ESTIMATED COVERAGE

Coverage is the need to reach major population groups facing life-threatening suffering wherever they are (providing them with assistance and protection proportionate to their need and devoid of extraneous political agendas) according to OECD/DAC. Coverage concerns whether all those in need have been considered. An efficiently managed intervention that meets an important specific need is not enough if it excludes the bulk of the affected population. However methodologically sound coverage surveys are resource and time consuming and should be based on surveys.

As a result the evaluation employed an indirect method using the formula shown below. For the purpose, population data (from proposal document), census 2007 (for estimation of proportion of under-five children), DHS 2011 (for estimation of prevalence of SAM and MAM) have been used.

The indirect method employs the following formula:

$$\text{Coverage (\%)} = \frac{\text{No of children attending the program}}{\text{Estimated Prevalence of malnutrition} \times \text{Estimated Population of the target area}}$$

In the log frame, coverage has been incorporated in results statements and indicators relating to the numbers and groups of the affected people targeted. The results statement in the log frame clearly spelt the particular groups and number of women and children to be covered.

Computation of the likely target number of under-five children using the above data yielded on average about 76% lower caseload with overestimation of OTP discharged cases and underestimation of the others. As a result the proxy coverage for both SAM and MAM cases was over more than 100%. If one relies on the methods, the results indicate that the coverage of both TSFP and OTP were satisfactory.

Table 8: Estimation of beneficiaries for calculation of proxy coverage of under-five SAM and MAM cases (from independent data)

	Shashego		Hulbareg		Total		
	Proposal	Estimated	Proposal	Estimated	Proposal	Estimated	% difference
<5 SAM	0	0	338	244	338	244	72
<5 MAM	0	0	2243	848	2243	848	38
OTP discharged	568	337	533	1044	1101	1381	125
Total MAM	568	337	2776	1892	3344	2229	67

Table 9: Estimation of proxy coverage of under-five SAM and MAM cases from independent data

		Shashego	**Hulbareg**	**Total**
Population	Tot rural popn. (Woreda info)	150104	87132	237236
	Percent <5 (16.5%, census 2007)	24767	14377	39144
Estimated SAM and MAM caseload based on DHS 2011, SNNPR rates	SAM (1.7% DHS 2011, SNNPR)	421	244	665
	OTP discharge (80% of SAM)	337	196	532
	MAM caseload (5.9% DHS 2011, SNNPR)	1461	848	2309
	New MAM cases (20% of MAM)	292	170	462
	Total MAM caseload (OTP discharge + MAM)	1798	1044	2842
Estimated target caseload	Total MAM target (OTP discharged + new cases)/ Shashego/	629	*	629
	Total MAM target (MAM cases + OTP discharged) / Hulbareg/	*	1044	1044
	Total SAM target	*	244	244
Achieved SAM and MAM number	Total MAM achieved /Shashego and Hulbareg/	665	1323	1988
	Total SAM achievement /Hulbareg/	*	266	266
Proxy SAM and MAM coverage	MAM coverage (%)	**106**	**127**	**116**
	Coverage SAM (%)	*	**109**	**109**

** Not targeted for Shashego woreda*

In previous chapters, the TSFP, especially in Shashego, woreda was concluded to be not as high as it could have been. The evaluation believes that the high estimated TSFP coverage observed, despite the low effectiveness, emanates from the fact that the estimation of coverage here takes into consideration only the coverage when the TSFP was implemented. Therefore,

from this exercise it can only be concluded that when considering only the time range when the TSFP was implemented the coverage has been very high.

Besides women and children, older people, OVCs, and disabled members may suffer specific disadvantages in coping with a disaster and may face physical, cultural and social barriers in accessing the services and support to which they are entitled. In terms of reaching these most obvious vulnerable groups (OVCs, elderly and disabled people) the project did little. The focus has been on women and children mainly. The reason is, of course, obvious. The policy of WFP and the MOU in terms of targets for the food resources allows only children and PLW. However, participants of the community FGD, expressed their dissatisfaction with exclusion of a number of disabled, elderly and OVCs in the program. As a result theses groups were not targeted in the proposal document. However, it is the impression of this evaluation that SCUK should endeavor either to allot separate resources or create link with other organizations targeting those vulnerable groups that could not be targeted by the ENIP.

Therefore, with regard to coverage of OTP and TSFP target groups, coverage was considered satisfactory. However, the emergency response failed short of covering the remaining prominent target groups. The recommendation for the future is that SCUK to include a reasonable number of OVCs, elderly, PLWHA and disabled members as they are among those severely affected by similar crisis.

4.5 COHERENCE & COORDINATION

In order to achieve its objective, Save the Children UK worked in cooperation with woreda government line departments' sector offices, kebele administrations and community volunteers, regional bureaus, and other NGOs as well as UN agencies. There has also been continued commitment from the community, concerned most government partners and NGOs throughout program cycle.

In Ethiopia, to promote a coordinated response, the humanitarian community has established several mechanisms, including a cluster approach and a Humanitarian Response Fund (HRF) system. The community maintains close cooperation with various Government-led coordination forums, including the Multi-Agency Coordination Forum and the Disaster Risk Management Technical Working Group and its subsidiary bodies. Needs are identified through assessment process in a twice per year frequency. Annual humanitarian requirements for food assistance and health and nutrition are presented in the Humanitarian Requirements Document. Conducting standard assessments are not mandatory since it is resource and time intensive. Decision is made based on hotspot categorization which is based on admission and early warning data which allows priority 1 woredas to be considered for implementation. In summary coherence with national policies and donor policies and community needs is ensured by the instituted structure and mechanism which enables that responses are initiated only when needed and at locations where they are most needed.

Coordination at the level of the organization is reasonably good, although low participation of the operations department has been reported which would have improved further the effectiveness and timeliness of the response. Most units within the organization including nutrition, emergency coordination and grants departments all had had a role at relevant stages

of the project cycle. However, the HR department needs to hasten recruitment procedures, which should be managed different from the regular employment procedures. The delay in recruitment procedures has been mentioned as limitations that affected the effectiveness of ENIPs in SCUK.

The coordination in the TSFP component with woreda level partners especially in Shashego seemed to face difficulties. As a result the food distribution in Shashego was not sufficiently carried out. According the KII with the head office staff, this was mainly related to the Model of agreement which limited the role of SCUK in the food distribution by envisaging on that NGOs should provide food resources to OTP discharged children and newly identified cases. The food distribution by the NGOs in this case is carried out biweekly or monthly whereas the frequency by the woreda food security is only at three month intervals.

Although the Model has the advantage of enhancing more ownership by the woreda food security, due to the poorly developed logistics and manpower status, timeliness and quality of the TSFP is usually compromised. In such circumstances, the evaluation recommends that SCUK to opt for the alternative model which allows higher involvement (food distribution mainly managed by the NGO) to ensure all children in need are reached timely and lives saved and morbidity reduced.

Therefore, the goals and objectives of the emergency nutrition intervention were perfectly in line with government policies and approaches and that of SCUK policy which is targeted at improving the future of children.

However, for the purpose of coordination SCUK should determine jointly with the woreda food security whether the woreda has sufficient capacity before deciding on the model of agreement.

4.6 CONNECTEDNESS / SUSTAINABILITY

In complex emergencies where there is limited development activity, or in natural disasters where primary stakeholders are semi-permanently caught in the relief phase, sustainability may be difficult to achieve. Emergency intervention programs are usually meant to address urgent one-off needs rather than long term development aspects. In relation to this the criteria of sustainability in ENIP programs appear less relevant and the focus is more on connectedness (ANLAP 2006). Connectedness refers to the need to ensure that activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account. This evaluation is mainly based on OECD/DAC criteria and adhered to this definition. The evaluation attempted to analyze whether the ENIP attempted to take the longer term context while implementation and whether the key linkages between the relief and recovery phases have been established (including the soundness of exit strategy with timelines, allocation of responsibility and handover to government departments, and adequate availability of funding post-response).

With regard to **connectedness** in terms of the ENIP's contribution to enhance ownership and empowerment, the ENIP has contributed significantly to capacity building of the woredas

through the training and on-the-job coaching component of the project. A considerable number of frontline health workers (VCHWs and HEWs) and staff dealing with management of health services have been repeatedly and intensively trained through the ENIP. Details on the success of this component have been described in the effectiveness section.

Almost all KII participants indicated their gratification with the quality and number of trainings provided to the health workers and consider that it would contribute towards self sufficiency of their respective woredas in emergency nutrition response and CMAM approaches.

Government commitment with regard to the ENIP has been satisfactorily achieved, though in Shashego woreda, there were some limitations as discussed in the appropriateness section. The woreda partners are well aware of the program and know their respective responsibilities with regard to the ENIP. The level of government commitment that has been developed to a reasonable standard is also partly due to interactions with the emergency nutrition and health programs carried out in collaboration with these regional partners. Such partnership is believed to have an advocacy dimension since continuous dialogue is a common place in such approaches. This is also taken as a contribution that would ultimately capacitate the regional health system to overtake the responsibilities after the closeout of the program.

The KII participant from regional health bureau stated the roles and responsibilities of the two parties as follows:

> *"The government partner's offices are responsible for the implementation of the project and the role of SCUK is mainly a technical and logistic support, has a facilitation role where the project requires support at all levels. SCUK delivers the essential items timely by transporting them from Zone to woreda and to outreach sites. We are responsible to facilitate the timely project document approval and to create enabling working environment for SCUK to implement its project activities."*

The Regional Early warning and response unit remarked:

> *"WFP provides food to SCUK for the two targeted woredas. SCUK transports the food from Nazreth and delivers to outreach posts. DPPD is closely following up or monitoring whether food distribution is being carried out timely and beneficiary verification."*

The woreda health office representatives:

> *"Screening is made by HEWs in partnership with SCUK. We are responsible to monitor the distribution of food +oil. We are also actively involved in community mobilization in partnership with SCUK."*

> *"The Woreda Health office is responsible for the implementation of the program while SCUK provided technical and logistic support - delivers plumpy nut to outreach OTP sites. SCUK also support our office by delivering vaccines, cold chain equipment to Health Posts."*

As per the KII, all local partners capacity has been developed to a reasonable standard partly due to interactions with the emergency nutrition and health programs carried out in

collaboration. Such partnership is believed to have a capacity dimension since continuous dialogue has been the most common strategy which capacitated facilitated the regional health system to overtake the responsibilities in the long term. Moreover, the contribution of the ENIP program in terms of building the capacity of the health facilities with the necessary **equipment and materials** has a role to play in ensuring the continuation of quality inpatient care after exit of the support. All required inpatient materials and equipment were provided by the project were provided to all the three clinics. Mattresses, bed sheets and blankets, cooking utensils including electric stoves have been provided to the clinics. These are long lasting items that will help to carry out the stabilization care for some years to come.

Treatment seeking behavior of care takers for their malnourished children has also been improved significantly. Mothers are aware of the signs of malnutrition in children and are ware of the need to take children to the health post where they can be referred to health centers if the condition of the child is indicative of the need.

Exit strategy

The exit criteria were clearly set at the out set of the ENIP, as shown in the proposal document. Decline in admission of cases and improvement of the two woredas to non-hotspot 1 status were the two main criteria. OTP admission in Shashego was sharply increasing while in HHulbareg admission remained stable. Though temporarily, the two woredas were not considered as priority hotspot 1. However, lately Shashego was reclassified as HS 1 while HHulbareg remained as non-hot spot woreda. After a through analysis of the situation, SCUK reached a consensus that the intervention in shashego should continue. However due to the SNNPR being non-traditional program area for SCUK and absence of SNNPR in the 2012 plan of SCUK, the ENIP had to be transferred to SC USA, whose programs in SNNPR are sturdier. All available information were rightly transferred to SC USA, while an exit workshop has been organized and appropriate measures taken to implement a smooth handover process.

As part of the exit strategy, linkages of households of malnourished children with existing food security programs were also stated in the program document which was not realized. According to the PM, the attempt to do so did not yield any results due to existing modality, which do not allow such flexibility. The food security program has its own approach and implementation modalities which do not link up with such emergency programs. It was a little ambitious of SCUK to plan such a link which can be done rather through advocacy at national/regional or nutrition cluster levels than at project and woreda level. Furthermore, the community FGD and KII with partners indicated that, SCUK should have continued with the ENIPs rather than transferring to other organizations, an indication of a level of trust that stakeholders have built with SCUK.

The evaluation, therefore, concluded that both the exit strategy and its implementation were valid and the continuation of the program was validated objectively. SCUK should in the future, assess as early as possible, for the need to continue or terminate ENR programs to avoid gaps created between successive grants.

FINDINGS AND RECOMMENDATIONS

Relevance and appropriateness

The ENIP was relevant to the community, sectoral

The needs assessment which is coordinated by the national coordination cluster and was complemented by SCUK brief verification visit was found to be sufficient. The community and all local partners were well aware of the program. Community participation was sufficient with VCHW, FDAs and community members did participate at various levels. The contribution of the ENIP towards building local capacities in terms of skills, materials and systems was considerable.

As a result of delays in processes (delay in HRD appeal, staff recruitment, MOU signing and food release) and coordination limitations (partnership and low commitment of local partners) there were considerable challenges with regard to timeliness of the TSFP, which missed the peak hunger period.

SCUK should improve recruitment delays, and build the capacity of the program managers in coordination and partnership capacities while all stakeholders need to identify bottlenecks for timeliness and commit themselves for better coordination.

The extent of partnership building and earning local partners (woreda, zonal and regional offices) commitment of woreda partners was not satisfactory. As a result there have been challenges with regard to transfer of resources and supplies. Accountability in ENIPs should be clearer within SCUK in order to provide quality support and follow up of field activities. The role of various relevant departments such as operations in ENIPs should clearly be spelt and their engagement ensured from beginning to the end of ENIPs.

Effectiveness /impact

Most objectives of the ENIP were successfully achieved. Some of the activities stipulated in the log frame / proposal document were only partially achieved or not accomplished. The impact of the ENIP was reasonable with many children being admitted and treated for SAM and MAM and escalation of malnutrition prevented and local capacities built through extensive trainings and on the job-coaching activities as well as provision of needed supplies for effective future implementation of ENIP. More follow up from head office, log frame-based

reporting, better use of DIPs and clear guidance to PMs are recommended to ensure that all stipulated activities are reasonably achieved.

Sufficient community mobilization activities were carried out with almost all VCHWs and FDAs trained on appropriate subjects and skills, familiarization workshop carried out,

Efficiency

Despite some activities remained unaccomplished, extent of budget utilization was high through subsequent adjustments made. The cost-efficiency as measured by the number of under five children treated for SAM and MAM has been good, compared to cost estimates in the literature.

In conclusion the food distribution was not as timely as it could have been. Timeliness factors were more related to late HRD appeal at national level, delayed MOU signing by regional partners, lengthy staff recruitment, delayed food release from WFP, and misunderstanding of the PM on the urgency and low follow up from head office. However, SCUK should also strategize its lengthy response procedures to maximize the quality and timeliness of its response programs.

Annex 1: Log frame of the SNNPR-ENIP

Project Summary		**Measurable Indicators**	**Source of verification**	**Risk and assumptions**
Goal	**To contribute to reduction of morbidity and mortality related to malnutrition.**			
Project objective 1	**To strengthen TFU service *coverage* and *quality* in all Health Centers**			
Result 1	Therapeutic Feeding Units (TFU) fully functional to provide quality treatment for severely malnourished children with complications	• Number of SAM cases with complications successfully treated • Sphere standards attained for the overall TFU response • Functional referral system between TFU and OTP • Adequate performance by health practitioners	• TFU *compiled* reports • Joint-support supervision score cards	• Health Centres are functional and with required human resources • Endorsement from RHB and WrHO
Activities for Result 1	• TFU refreshment training provided • Intensive on-the-job capacity building through the deployment of one TFU nurse in each facility • Timely and adequate provision of supply and equipment • Timely and quality reporting • Joint-support supervision	• Sphere performance standards attained for each established TFU • Routine medication and treatment provided to all children as per national protocol • Adequate TFU performance as per results from joint supervisions	• TFU facility records • TFU facility reports • Joint-supervision individual score cards • TFU beneficiary registration records	• Health Centres have minimum requirements to implement TFU • Availability of supply F100, F75 and routine medicines

Project Summary		Measurable Indicators	Source of verification	Risk and assumptions
Project objective 2	**To strengthen OTP service *coverage* and *quality* in all Health Centers and Health Posts**			
Result 2	Outpatient Treatment Program (OTP) fully functional in all HC and HP to provide quality treatment for severely malnourished children without complications	• Number of SAM cases without complications successfully treated • Sphere standards attained for the overall OTP response • Reliability and consistency of OTP service provision • Adequate performance by health practitioners HEWs	• OTP *compiled* reports • Joint-support supervision score cards	• Sufficient number of HEWs • Limited turn-over of HEWs • Endorsement from RHB and WrHO
Activities for Result 2	• OTP refreshment training • Intensive on-the-job capacity building through the deployment of three OTP nurses • Timely and adequate provision of supply and equipment • Timely and quality reporting • Joint-support supervision	• OTP established in each available HP with adequate supply and trained HEWs • Sphere performance standards attained for each targeted OTP • Routine medication and treatment provided to all children as per national protocol • Adequate OTP performance as per results from joint supervisions	• OTP facility records • OTP facility reports • Joint-supervision individual score cards • OTP beneficiary registration records	• Woreda have the minimum number of HEWs to implement OTP • Availability of RUTF and routine medicines
Project objective 3	**To provide Supplementary Feeding to all discharged TFP cases (all woredas) and to MAM cases**			

Project Summary		Measurable Indicators	Source of verification	Risk and assumptions
Result 3	Supplementary Feeding Programs fully functional in both woredas	• 100% of TFP discharged cases provided with Supplementary Food • Number of successfully treated MAM cases	• SFP compiled reports	• TSF properly addresses MAM cases in targeted woredas • Endorsement from RHB and WrHO
Activities for Result 3	• Training provided to food distributors and measurers • On-the-job capacity building through the deployment of two SFP nurses • Timely and adequate provision of supply and equipment • Timely and quality reporting • Joint-support supervision	• Sphere performance standards attained	• SFP records • SFP reports • SFP beneficiary registration records	• Availability of CSB and edible oil
Project objective 4	**To improve community mobilization and use of TFP/SFP and related health-services**			
Result 4.1	Community sensitized on TFP services and active case-finding, referral and follow-up conducted by community key resource people	• OTP coverage • Defaulter, unknown and non-response rates are not significant/abnormal	• OTP service coverage survey • OTP compiled reports	• Available community structures in Hullbareg • Endorsement from RHB and WrHO

Project Summary		Measurable Indicators	Source of verification	Risk and assumptions
Activities for Result 4.1	• Training of community-health volunteers on community mobilization, active case finding, referral and follow-up • Implementation of community mobilization events • Joint support-supervision	• Number of community health volunteers trained • Accuracy of referral (versus total number of 'potential' SAM/MAM cases referred from the community)	• Projects reports • Joint-supervision individual score cards	• Regular communication and reporting
Result 4.2	Key health and nutrition messages disseminated to caregivers to address priority behavioral gaps	• Changes in knowledge and attitudes among caregivers	• Participatory Impact Assessment of knowledge and attitude (prior and after intervention)	• Messages and behaviours are tailored to the context
Activities for Result 4.2	• Training of community health volunteers in Hullbareg • Health and Nutrition education using multiple contact points conducted in Shashego and Hullbareg	• Number of community health volunteers trained • Number of health and nutrition education sessions conducted	• Projects reports	• Regular communication and reporting

Annex 2: Participants of KII and FGD in the two woredas

Name	**Position & work place**
KII participants	
Ato Ezra Tefera	SNNPR ENCU, Nutrition Specialist
Dr. Mulugeta Wondossen	SNNPR RHB, Disease Prevention Head
Ato Wondimu Redi	EWR and Food Security Sector, TSFP Focal person
Ato Adane W/yes	EWR Expert, Shashego woreda EWR
Ato Tesfaye Eriste	Disease Prevention Head, Shashego WrHO
Ato Behredin Kedir	Disease Prevention Head, Hulbareg WrHO
W/o Fozia Neja	TFU/Sc Nurse, Hulbareg woreda, Kerate Health Center
Ato Berhanu Seyum	TFU/Sc Nurse & HEW Supervisor, Shashego woreda, Bonosha Health Center
W/o Shitaye Gichamo	HEW Sheyembye Kebele Health Post, Shashego woreda
Ato Minasse Bekele	Program Manager, SCUK, SNNPR ENIP project
Ato Samson Taffesse	Nutrition Technical Manager, SCUK
FGD participants	
!0 participants (7 women and 3 men)	Shashego woreda, Shyebye Kebele, Shashego woreda
10 participants (8 women and 2 men)	Hulbareg woreda, Fuge Achiraye kebele Kebele, Hulbareg woreda