



FINAL EVALUATION OF GOAL ETHIOPIA'S EMERGENCY RESPONSE FOR DROUGHT-AFFECTED AND DISPLACED COMMUNITIES IN ETHIOPIA – SOMALI PROGRAM

FINAL REPORT

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ACRONYMS

AWD	Acute watery Diarrhea
CMAM	Community -based Management of Acute Malnutrition
DPPC	Disaster Preparedness and Prevention Commission
EPI	Expanded Program For Immunization
FGD	Focus Group Discussion
HEW	Health Extension Worker
HH	Household
HW	Health Worker
HMIS	Health Management Information System
IDP	Internally Displaced person/People
IYCF	Infant and Young Child Feeding
KII	Key informant Interview
MEAL	Monitoring Evaluation Accountability and Learning
MHNT	Mobile Health and Nutrition Team
OECD	Office Of Economic Cooperation for Development
OFDA	Office of US Foreign Disaster Assistance
OTP	Out-patient Therapeutic Feeding
PLW	Pregnant and lactating women
PPS	Probability Proportionate to Size
SAM	Severe Acute Malnutrition
SC	Stabilization Center
SNNP	South Nations Nationalities and Peoples
SPSS	Statistical Package for Social Sciences
TSFP	Targeted Supplementary Feeding program

EXECUTIVE SUMMARY

GOAL has been operational in Dollo Zone, Somali Region since May 2017, when GOAL began implementing a large-scale emergency response program to address high levels of acute malnutrition among children under five and pregnant and lactating women, and to improve access to water, sanitation and hygiene. GOAL is currently operational in seven Woredas (districts) in Dollo Zone, implementing a community-based management of acute malnutrition program, targeting more than ninety health facilities across the seven districts. The overall goal of the OFDA project was to reduce morbidity and mortality and improve wellbeing among drought-affected and displaced communities in Ethiopia. GOAL has commissioned CLIMAX Consulting Service PLC to conduct an end-line evaluation in order to examine the project progress towards its objectives; and draw lessons and recommendations based on OECD and OFDA evaluation criteria on the relevance, effectiveness, efficiency, sustainability, impacts and coverage of the project.

A participatory and mixed methods evaluation approach was used in line with the evaluation objectives and the need to assess progress & contribution of the project against OECD criterion, objectives & outcome of the project was utilized. The study population was drawn from three sampled districts/woredas namely; Warder, Bohk and Geladi Woredas of Dollo Zone of Somali regional states of Ethiopia. For the quantitative survey, 384 HH's with children under two years of age were sampled to collect relevant quantitative data using structured interviewer administered HH questionnaire. Qualitative data was collected from 20 key informant interviews and eight focus group discussions (four men and women community members benefitted from the project support). CMAM program database available at project field and regional coordination offices were reviewed and used to construct main project performance indicators. Data generated from the review exercise of project documents were used to triangulate and substantiate the findings from the primary data sources. SPSS version 20 was used to conduct descriptive analysis of the quantitative data and generated selected project indicators. Qualitative data was analyzed using thematic approach employing ongoing content analysis of the transcripts. Finally, different data sources were triangulated and presented under each evaluation questions and sub-thematic areas.

FINDINGS

Relevance

This final evaluation found that the CMAM intervention modalities designed & implemented in the project were appropriate and relevant taking the livelihood styles of the population. The intervention delivery modalities of the CMAM (a combination of static, outreach and mobile health & nutrition service delivery modalities) is appropriate for the lifestyle of pastoralist community & IDP's/returnees in the presence of multiple system level constraints. The evaluation findings confirmed that the project CMAM intervention modalities equivalently balanced both the demand and supply side interventions to bring effective synergy in the course of reducing the level of nutrition related morbidity and mortality in the targeted districts. Moreover, the OFDA supported CMAM program strongly backs and relevant to key government initiatives in the pastoralist regions such as the pastoralist health extension program and the FMOH five-years equity plan of action which are importantly aimed to expand a combination of service delivery outlets for pastoralist population (static, outreach and mobile service delivery channels).

Effectiveness

SC, OTP and TSFP: The project met & remarkably surpassed the OTP and TSFP targets. Specifically, the achievement made in the TSFP is by far above the project target. Moreover, the performance of SC and OTP against the recent Sphere standard (2018) is within the minimum acceptable standard. However, there is inter-district variation on specific indicator against the Sphere standard; in relative terms Dera Tole and Geladi had higher length of stay in the SC program (>10 days). Similarly, Warder district had higher length of stay in the OTP (>60 days). Moreover, the SC achievements made in the SC was below the project targets; only 70% of the targets achieved.

Mobile health and nutrition activities: The project is effective and met the target set on the establishment of three MHNTs in the three selected districts. The newly established MHNT's reached 9405 people through different nutrition and health services. As confirmed in this evaluation, the supported MHNTs remarkably improved access to health and nutrition services for hard to reach and remote pastoralist areas that don't have any access to basic health & nutrition services.

Strengthening of health workers capacity: 156 health workers (including health extension workers) received CMAM trainings by OFDA supported CMAM program across the seven districts. The project effectiveness in increasing the number of CMAM trained staffs was effectiveness as evidenced in this evaluation.

IYCF and Hygiene Promotion: Regarding IYCF and hygiene related SBCC activities, the project designed multiple mechanisms to delivered key IYCF and hygiene promotion activities for both IDPs and host community members in the implementation districts. During the implementation period of the project, sixty rounds of health education sessions on IYCF were convened and reached 67,273 affected people (M=5408 and F=61865). Similarly, 287 hygiene promotion campaigns conducted across the seven districts where 2449 people reached through the campaigns. Moreover, 6,743 people were also received hygiene promotion activities through OTP/SC, TSFP & IYCF-E. Data from the HH quantitative survey found that 68% of infants below 6 months of age breastfed exclusively. This finding exceeds by 18.6% from the finding of a survey report conducted 2019 for a similar emergency nutrition project that implemented (1st March 2018 – 31st March 2019) in the intervention zone by GOAL. The proportion of children who full fill minimum dietary diversity practices was also very low in the surveyed households; only 12% of children 6-12 months of age received foods from more than four or more food groups based on the 24-hrs recall period. However, this result exceeds by 10.1% when compared with a similar project implemented in the intervention area.

Factors contributed to the performance of the CMAM program; Intensive community mobilization and screening activities; effective use of multi-level coordination platforms as well as streamlined coordination & logistic system & adequate allocation of resources (specifically human power and finance) were the major factors that contributed to the good performance of the program. On the other hand insufficient service delivery modalities, lack of adequate number of MHNTs, issues interruption of supplies and shortage and high turnover of government staffs were among the impeding factors that negatively affected the performance of the project.

Impact

The OFDA CMAM program provided comprehensive system level support to capacitate local government health system to better manage CMAM activities. Most importantly, the on-job training, full fledge CMAM training based on the recent national SAM management protocol and continuous technical support to staffs working in all the supported SC & OTP sites were satisfactorily increased the number of skilled CMAM staffs across the project implementation districts. The support provided on MHNT in the three woredas had also positive contribution and impact in strengthening the local system. Furthermore the support provided in the TSFP activities had a huge positive contribution & impacted to reduce SAM cases in the project targeted areas. The OFDA project significantly improved the community mobilization, screening, coordination and logistic related activities in the TSFP program which subsequently improved the performance of the OTP program in the supported sites as well as potentially reduce the number of SAM cases. Additionally, this evaluation indicated that the emergency CMAM program highly contributed in averting significant number of mortality and morbidity of under five children and other vulnerable segment of the community members.

Efficiency

At the outset, the OFDA CMAM program identified and considered different multi-level coordination mechanisms and platforms to efficient delivery of the outputs across the project implementation districts. The OFDA CMAM program had strong coordination with the different regional and zonal level cluster meetings, which is considered as vital for efficient delivery of outputs. The evaluation also found that large majority of planned activities was accomplished timely across the seven-project implementation districts. CMAM related supplies were distributed on time with efficient and streamlined transportation system from region to Kebele level. However, there were delay and interruption of supplies in the three supported MHNTs, which slightly affected the timely provision of the CMAM services for some segment of the target areas.

Resource allocation and utilization was also satisfactory as reported in this evaluation. The allocated budget and the number of deployed staffs for the project were adequate to implement the major planned activities within the project implementation period. The OFDA supported CMAM project was also remarkably flexible and responsive to competing & emerging needs of the government. The regional coordination and project field offices were alert to any change in the external environment and take timely adaptation to implement the planned activities smoothly.

Sustainability

Overall, the OFDA project implemented through the existing government structure at all administrative level with streamlined joint coordination, supportive supervision and monitoring mechanisms. The project utilized all the established government structure and system to implement the CMAM interventions as part of sustainability strategy. System level supports were also an important strategy used to ensure the sustainability of interventions and outcomes. Multiple implementation structures such as the HEP, volunteer community health workers, cluster level coordination platforms, government logistic & Health Management Information System (HMIS) were used to implement the project activities. However, there is still poor capacity

on the side of government with respect to human resource, operational budget and logistic system to effectively & independently run CMAM program in the absence of external supports.

Coverage

Effective coordination system and full utilization of the government system and administration structure brought a positive effect on the geographical coverage of the project. The smooth coordination and implementation of activities in coordination with community volunteers and health post staffs should be positively factored in this evaluation on the geographical coverage of the program. Nevertheless, the geographical size of the implementation districts and distance between the woreda town and health facilities were an important factor that affected the geographical coverage of project. In particular, long distance coupled with absence of adequate number of MHNTs in Geladi, Bohk and Dera Tole districts was reported as impeding factor on the geographical coverage of the project. In addition, significant proportion of Kebeles & sub-kebeles in the project implementation districts are currently without health posts, which is also potentially affected the geographical coverage of the CMAM program.

Recommendation

- Increase the number of mobile health and nutrition team (MHNT) in the future will help to enhance program coverage and access to service for the community. Considering further integration, coordination and support with the government & partner supported mobile health & nutrition teams is important to improve access to CMAM services in the affected communities.
- Further capacity building trainings and continuous mentoring activities are needed across the project areas to further improve the capacity of the local health system and quality of the CMAM services rendered in existing health facilities.
- More WASH related supports are required across the project districts in order to improve access to WASH services, behavior and practices. The WASH supports are important to further improve the nutritional status of under five children and other vulnerable community groups.
- The TSFP supports across the project implementation areas brought positive change on the level of SAM cases as found in this evaluation. Therefore, intensive supports to the TSFP implementation are required in particular in areas where there is integration of TSFP with the health system.
- IYCF promotion activities such as optimal complementary feeding & exclusive breastfeeding need to be strengthened in similar projects in the future to improve the IYCF behavior & practices.
- As confirmed in this evaluation, the government institutions and capacity of the health system are not strong enough to continue CMAM program independently. Therefore, further external supports should be continued in all the intervention areas to contain the current humanitarian situation as well as to manage CMAM program effectively.
- The linkage of emergency nutrition response with early recovery activities proved very successful. Therefore, similar project should try to ensure the linkage in order to make the outcome sustainable as well as contribute in creating resilient system. Livelihood & development programs including different protection related interventions are highly required in the future in particular for IDP's. Advocacy activities and coordination with partners will also help to link the CMAM program with long-term development projects.

I. BACKGROUND

I.1. Project Description

For the past number of years, Ethiopia has been facing large-scale humanitarian crises as a result of drought and conflict. Almost three million people have been internally displaced in the last two years, and in 2019 more than eight million people require multi-sectoral humanitarian assistance. Protracted drought in Somali Region since 2017 has resulted in high levels of acute malnutrition and significantly reduced access to water. GOAL is an international NGO that has been working in Ethiopia since 1984. In collaboration with government and local community as a partner, GOAL implements nutrition, health, WASH, protection, shelter, livelihoods, economic development and food security programs – through integrated emergency response, recovery and development programs.

GOAL had a long history of implementing OFDA-funded projects mainly focusing on nutrition and WASH since 2005. GOAL Ethiopia is currently implementing the project Emergency Response for Drought-Affected and Displaced Communities funded by OFDA since April 2019 in four regions (Oromia, Somali, SNNPR and Benishangul Gumuz) with integrated sectoral approaches (Nutrition, WASH, Shelter, and Protection). The project was implemented over a 12-month period and built on previous interventions funded by both OFDA and other institutional donors. GOAL has been operational in Dollo Zone, Somali Region since May 2017, when GOAL began implementing a large-scale emergency response program to address the high levels of acute malnutrition among children under five and pregnant and lactating women, and to improve access to water, sanitation and hygiene. Dollo Zone was one of the worst affected districts in Somali, and nationally, as a result of the 2017 drought which resulted in widespread herd loss, significantly elevated levels of malnutrition, reduced access to water for human and animal consumption, large-scale water-related disease outbreaks, loss of livelihoods, and more than 100,000 internally displaced people across the Zone. With OFDA funding, GOAL is currently operational in seven Woredas (districts) in Dollo Zone, implementing a community-based management of acute malnutrition program, targeting more than ninety health facilities across the seven districts. The nutrition program is complemented by WASH activities that seek to support positive nutrition outcomes at household level for children and women recovering from acute malnutrition and improving hygiene in drought induced IDP camps. Activities consist of:

- Establishment and strengthening of out-patient and in-patient therapeutic treatment facilities
- Screening and referrals of children under five and pregnant and lactating women
- Treatment of severe and moderate acute malnutrition through out-patient, in-patient and targeted supplementary feeding programs
- Promotion of best infant and young child feeding practices through counseling and education
- Training and capacity building of government health workers
- Logistical support
- Mobile health and nutrition teams (primary healthcare consultations, nutrition activities, reproductive healthcare, immunization etc.) in remote pastoral areas and IDP camps
- Hygiene promotion and campaigns
- Distribution of WASH non-food items for households with children enrolled on GOAL's out-patient therapeutic treatment program.

The overall goal of the OFDA project is to reduce morbidity and mortality and improve wellbeing among drought-affected and displaced communities in Ethiopia. As part of the project strategy, the outcomes of the project are measured through the following indicators, as well as continuous output level indicators:

- Proportion of infants 0-5 months of age who are fed exclusively with breast milk
- Proportion of children 6-23 months of age who receive foods from 4 or more food groups

- Number of people receiving behavior change interventions to improve infant and young child feeding practices
- Number of health care staff trained in the prevention and management of acute malnutrition
- Number of supported sites managing acute malnutrition
- Number of people admitted, rates of recovery, default, death, relapse, and average length of stay for people admitted to Management of Acute Malnutrition sites

1.2. Purpose, Objective and Scope of the Evaluation

The main purpose of this evaluation is to examine the nutrition program outcomes in Somali Region, assess the contribution of GOAL's performance and activities in achieving the desired outcomes, and evaluate the effectiveness of the nutrition program. The general objective of the evaluation task is to undertake summative evaluation of the project's progress towards its objectives; and draw lessons and recommendations based on OECD and OFDA evaluation criteria on the relevance, effectiveness, efficiency, sustainability impacts and coverage of the project.

1.3. Context of the project implementation area

At present food security continues to be of concern due to flooding, protracted impacts of past poor seasons, conflict and insecurity, desert locusts, and poor macroeconomic factors, despite the favorable 2019 Kiremt and Deyr seasons. Access to food from livestock has declined and at the same time, the price of food is atypically high. As a result, much of the eastern part of the country including the Somali region expected to be in Crisis (IPC Phase 3) or Stressed (IPC Phase 2) from February to September¹ 2020. Despite average national production, staple food prices across much of the country are atypically increasing, including in central and western surplus-producing areas. Staple food prices anticipated continuing increasing as the lean season approaches and the election period begins. Conflict expected to disrupt the movement of food from surplus producing areas to deficit areas. As labor rates not expected to keep pace with price increases, household purchasing power expected to further deteriorate.

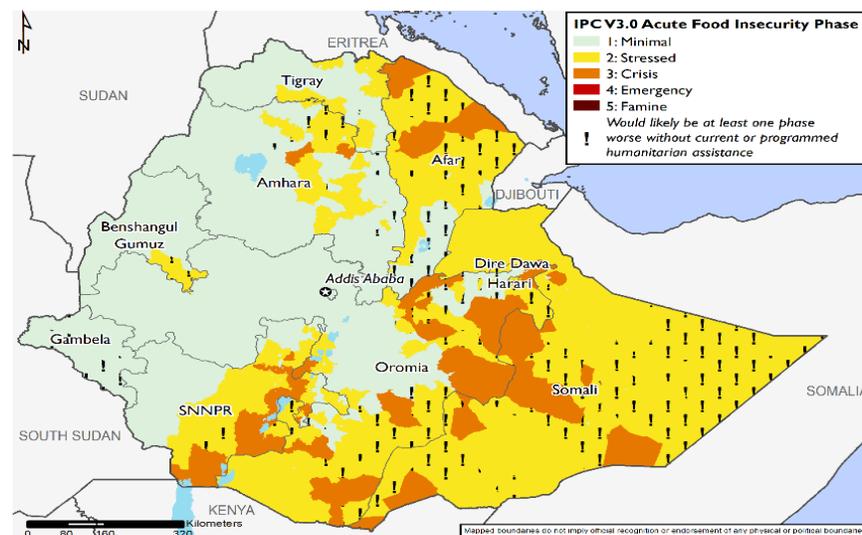


Figure 1: Current food security outcomes, February 2020 (Source: FEWS NET)

The eastern and south-eastern lowlands of Ethiopia because of delayed and sub-optimal 2019 Gu/Genna (spring) rains (mid-February-May) is drought affected. This below-average rain was resulted in significant crop loss, increased food prices, and poor livestock body conditions and milk availability, which reduced poor households' access to food.² Crop planting was delayed or missed, while pasture and water sources

¹ FEWS NET, Ethiopia food security outlook, February 2020

² Emergency preparedness and response plan in quest of the 2019 Gu rainfall failure and floods in Somali region, 2019

were not replenished. Many poor households have depleted their food stocks earlier than normal and recovery of livestock assets has stalled. The effects of the drought are being felt in most of Somali and pastoralist areas of Oromia and Afar regions. Reports of deteriorating food and nutritional security, water shortages and worsening livestock body conditions and livestock deaths were increased, while concerns were rising over pipeline breaks in emergency supplies and interruption of life-saving operations due to funding shortfalls. At the outset of 2019, Ethiopia faced multiple humanitarian crises, predominantly because of drought and conflict. Millions of Ethiopians have yet to recover from three consecutive years of severe drought since 2015. In 2019 around nine million people required humanitarian assistance, among those some two million people were in the Somali Region, and there were nearly three million internally displaced persons (IDPs). The entire southern belt of Somali region had been the center of drought response throughout 2018, including Dollo Zone.³ According to the Mid-Year Review of the 2019 Humanitarian Response Plan, about 8.22 million people in Ethiopia were in need of food assistance. And 3.1 million in need of agriculture and livestock support, 3.32 million in need of shelter and NFIs, nearly 7 million women and children in need of life-saving nutrition assistance, 3.1 million facing major protection concerns, and more than 7 million people in need of water, sanitation and hygiene support. The majority of moderate, major and severe needs are found in Somali, Oromiya, and SNNP regions.⁴

Massive internal displacement due to conflict and drought also dominantly occurred in the country; specifically in the Somali region, Oromia and SNNPR. The Government of Ethiopia's strategic plan to address internal displacement that commenced in April 2019 completed its first phase in June 2019. The Government has reported that 94 per cent of IDPs returned to their places of origin⁴. Returnees remain in dire need of lifesaving and recovery assistance as most have not been able to fully resume their normal lives, have returned to destroyed homes, have no livelihoods, and lack of access to basic services. Returnees, many of whom are closer to places of return but have not returned to their original homes, report being fearful of retaliation, living in insecure environments, and lacking access to basic services such as water and shelter.

Ethiopia has suffered two of the worst drought waves in decades; these have resulted in severe food and nutrition insecurity across the country, with Somali region among the most affected. In the region, the failure of two consecutive rainy seasons recorded between 2015 and 2016 and flash flooding left thousands of people displaced. Somali Region has yet to recover from the severe drought that affected the Region in 2017 which left more than three million people in need of emergency food aid, and resulted in herd losses of up 90% in some parts of the region, and high levels of malnutrition. The region is predominantly pastoral, with communities relying on animals for both food securities at household level, and incomes. Hundreds of thousands of people migrated across the region in search of food, water and pasture, which led to the creation of IDP camps. The effects of the drought were so severe that it may take up to seven years to build up animal herds. During 2017 the Somali region alone shared 26% of total SAM admissions in the country, a radical increase from 5% in normal years. In 2018 the humanitarian response shifted to the needs of conflict-induced IDPs and IDP returnees, resulting in extreme vulnerability for the climate-induced IDPs and IDP returnees. While many of the displaced are living in informal settlements and collective centers, an undetermined number of IDPs and IDP returnees are living in host communities.

In 2019 an estimated 500,000 IDP reside in Somali region due both to conflict and the effect of protracted droughts and remain highly vulnerable and in need of full response and recovery package. According to Somali Hotspot Classification Matrix (Dec 2018), nearly 88 out of 93 woredas in the region was classified as hotspot I (severely affected districts). Moreover, according to the 2019 HRP report, on average 500 AWD cases per day were reported in Somali region. Inter-communal unrest had also affected humanitarian access in Somali region, including Dollo zone where there was a temporary halt of food aid.

³ GOAL Ethiopia, Emergency Response for Drought-Affected and Displaced Communities in Ethiopia, March 2019

⁴ OFDA Semi-annual Report- Narrative April-September, 2019

Dollo Zone of the Somali region was one of the severely hit by 2016/2017 drought where its effect protracted to this year. Somali region remains the worst affected by recurrent droughts in the past years. In Jan 2019-Feb 2019, 27% of total SAM admissions of Ethiopia were reported from Somali Region⁵. In May 2018 FEWSNET carried out an assessment of the food security, nutrition, and mortality situation in Dollo Zone among residents and IDPs. Among those surveyed, rates of malnutrition were found to be particularly high among pregnant and lactating women: 12% of Dollo resident PLW and 17% of IDP PLW were found to be acutely malnourished. The situation was classified as 'Serious' among Dollo residents and 'Critical' among IDPs. Moreover, only 0.4% and 0.3% of sampled children 6-23 months from the resident and the IDPs respectively had minimum diet diversity.⁶

While, on the other hand poor health care system is the characteristic of the whole region, worst in the Dollo zone of the Somali region. The health system in the Somali region is generally weak and at sub-standard level against all the key pillars of the health system. In particular, the provision of Community-Based Management of Acute Malnutrition (CMAM) is impeded by multiple factors including lack of adequate number of trained staffs, low coverage of CMAM programs, absence of appropriate service delivery modalities for hard to reach remote & IDP communities. Moreover, weak logistic and coordination system, NGO staffing restraints, poorly skilled staff and surge staff that lack experience in CMAM program, which resulted in weak CMAM service provision in the region hindering factors.

2. EVALUATION DESIGN MATRIX

Table I presents the evaluation matrix used in this evaluation and provided a structured framework at all stage of the evaluation process. It presented and unpacked the main evaluation parameter along with questions and specifies the most appropriate methods, tools and data sources necessary to answer each evaluation criteria.

TABLE I: EVALUATION DESIGN MATRIX

Parameters	Evaluation questions	Sources of data & method of data collection	Data Analysis Method
Relevance	Were the various CMAM intervention modalities (at health facility, outreach and mobile sites) sufficiently appropriate and relevant for the pastoral context?	Sources: <ul style="list-style-type: none"> ✓ Project field officer / Program staff ✓ Woreda Health Office ✓ Woreda DRR office ✓ Health facility staffs ✓ HEW ✓ MHNT representatives ✓ Project related documents, strategy and policies Methods: <ul style="list-style-type: none"> ✓ Key Informant Interview (KIIs) ✓ Desk Review 	Thematic analysis based on themes and sub questions corresponding to evaluation question
Effectiveness	<ul style="list-style-type: none"> - What are the main reasons that contributed to the performance indicator results of the CMAM program? - Were the monitoring mechanisms effective in providing timely data to inform programing decisions? 	Sources: <ul style="list-style-type: none"> ✓ Project field officer / Program staff ✓ Woreda Health Office ✓ Woreda DRR office ✓ Health facility staffs ✓ HEW ✓ MHNT representatives 	Thematic analysis based on themes and sub questions corresponding to each evaluation question. & Descriptive/Analytical analysis of monitoring data and HH

⁵ UNICEF Emergency Nutrition Response in Ethiopia, as of 15 April 2019

⁶ OFDA Final Report - Narrative - Mar 2018-Mar 2019

DRAFT REPORT OF FINAL EVALUATION OF GOAL ETHIOPIA'S EMERGENCY RESPONSE FOR DROUGHT-AFFECTED AND DISPLACED COMMUNITIES IN ETHIOPIA-SOMALI PROGRAM

		<ul style="list-style-type: none"> ✓ Project related documents, strategy and policies ✓ Benefited HH's with children under two years ✓ Selected community members <p>Methods:</p> <ul style="list-style-type: none"> ✓ Key Informant Interview (KIIs) ✓ FGD's ✓ Desk Review and secondary data ✓ Health facility surveys ✓ HH quantitative survey 	survey data, and statistical test.
Efficiency	<ul style="list-style-type: none"> - What evidence is available that efficiencies were sought in program design? - Were adequate human and financial resources applied to delivering project outcomes? 	<p>Sources:</p> <ul style="list-style-type: none"> ✓ Project field officer / Program staff ✓ Woreda Health Office ✓ Woreda DRR office ✓ Health facility staffs ✓ HEW ✓ MHNT representatives <p>Methods:</p> <ul style="list-style-type: none"> ✓ Key Informant Interview (KIIs) ✓ Desk Review and secondary data 	Thematic analysis based on themes and sub questions corresponding to each evaluation question
Impacts	<ul style="list-style-type: none"> - To what extent did GOAL's intervention strengthen the capacity of the Government health system to manage CMAM without the support of external actors? - Are unplanned positive or negative impacts because of this project? - To what degree did the targeted supplementary feeding activities contribute to reducing the level of severe acute malnutrition? 	<p>Sources:</p> <ul style="list-style-type: none"> ✓ Project field officer / Program staff ✓ Woreda Health Office ✓ Woreda DRR office ✓ Health facility staffs ✓ HEW ✓ MHNT representatives <p>Methods:</p> <ul style="list-style-type: none"> ✓ Key Informant Interview (KIIs) 	Thematic analysis based on themes and sub questions corresponding to each evaluation question.
Sustainability	To what extent did the program utilize established institutions / mechanisms to ensure sustainability at the end of the project?	<p>Sources:</p> <ul style="list-style-type: none"> ✓ Project field officer / Program staff ✓ Woreda Health Office ✓ Woreda DRR office ✓ Health facility staffs ✓ HEW ✓ MHNT representatives <p>Methods:</p> <ul style="list-style-type: none"> ✓ Key Informant Interview (KIIs) 	Thematic analysis based on themes and sub questions corresponding to each evaluation question.
Coverage	What are the main factors affecting GOAL's geographical coverage?	<p>Sources:</p> <ul style="list-style-type: none"> ✓ Project field officer / Program staff ✓ Woreda Health Office ✓ Woreda DRR office ✓ Health facility staffs ✓ HEW ✓ MHNT representatives <p>Methods:</p> <ul style="list-style-type: none"> Key Informant Interview (KIIs) 	Thematic analysis based on themes and sub questions corresponding to each evaluation question.

3. METHODOLOGY

3.1. Evaluation Approaches

During this evaluation a participatory and mixed methods evaluation approaches were utilized. The methods were aligned with the evaluation objectives and the need to assess progress & contribution of the project against OECD criterion, objectives & outcome of the project.

3.2. Geographical Areas and Target Population

From the total seven project implementation districts; three districts were selected purposively considering some criteria like geographical distance (near, far and at the middle of both), population size, case load and Woredas with and without mobile health service to avoid bias. The study population was drawn from the three districts/woredas namely; Warder, Bohk and Geladi Woredas of Dollo Zone of Somali regional states of Ethiopia. HH with children under two years of age, health facility representatives, health extension workers, MHNT representatives, Health & DPPC office representatives, field office program officers, regional manager and national level technical and MEAL team staffs were included in this final evaluation.

3.3. Sample Size and Sampling Techniques

For the quantitative data collection, 384 HH's with children under two years of age were sampled to collect relevant quantitative data using structured interviewer administered HH questionnaire. The total calculated sample size was allocated to each selected districts based on PPS techniques. A two-stage sampling method was used to select study households. Two kebeles from each district (a total of six Kebeles's) were selected using distance as the main criteria. In the first step, two sample categories was created; one category included the list of Kebeles located within 5 kms radius from the Woreda town and the second group with list of Kebeles located at a distance above 5kms radius. Then, from each sample category one Kebele was selected randomly using lottery method. After selection of the Kebele, the sample size allocated for the district was further distributed to the two selected Kebeles based on PPS techniques. Households who fulfilled the sampling criteria (mainly presence of under two years of children) were selected using 'Improved EPI method' techniques. Table 3 below shows the selected districts, Kebeles and allocated sample size for the HH survey.

TABLE 2: SAMPLED DISTRICTS AND KEBELES WITH ALLOCATED SAMPLE SIZE, FEBRUARY 2020.

Name of the Woreda	Selected Kebele	Population size	Allocated sample size
Warder	Walwal	3,000	39
	Kurtunde	6,700	49
Bohk	Kawan	8,200	100
	Jirale	5,700	69
Geladi	Baltag	4,238	67
	Durawayale	3,794	60
Total	6 Kebeles	28,932	384

3.4. Methods of Data Collection

Qualitative data was collected using key informant interviews & focus group discussions conducted with project beneficiaries and representatives of relevant sector offices. The quantitative data was collected through structured interviewer administered quantitative questionnaire. In addition, CMAM program database available at project field office and regional level were reviewed and analyzed to construct relevant project performance indicators. For the quantitative HH survey, a structured interviewer administered questionnaire was developed and used in a way to answer the evaluation questions as well

as in order to construct key project performance indicators. Key informant and focus group discussions guides were also developed and employed in alignment with the major evaluation questions (please see annexed tools). A total of 20 key informant interviews and 8 focus group discussions (four men and women project beneficiaries where 8-12 participants were included in one homogenous group) were conducted during this evaluation. The following table lists the number and type of key informant interviews conducted during the evaluation period.

Table 3: List of key informants

Office/Representative	Number
National and Regional key Project Staffs	4
Woreda Health Office	3
Woreda DRRM and Agriculture office	2
Project staffs at field level	3
HEW's	4
Health facility representatives	3
MHNT	2
Total	20

Additionally, the evaluation team reviewed all project related documents and findings from the document review were analyzed and triangulated to substantiate the findings from the primary data sources.

3.5. Field Management and Data Quality Assurance

A total 12 professionals were assigned for the field data collection; 10 enumerators & two qualitative researchers responsible to collect HH quantitative data and conduct KII/FGDs respectively. Adequate training was provided to the field data collection team at Warder town in the presence of GOAL program officer and assistant regional manager in addition to staffs from the woreda and zonal health offices. Moreover, the evaluation team employed the following data quality assurance measures at various stages of the data collection process to ensure the quality of the data.



3.6. Data Entry, Cleaning, Analysis and Reporting

Data entry template was developed on SPSS version 20 software and two highly experienced data encoders were assigned to manage the data entry. Prior to the actual data analysis exercise, standard data cleaning procedures were employed using SPSS version 20 software. Preliminary analysis such as Skewedness', kurtosis and etc. tests were also conducted to assess whether or the entire data in the form of SPSS dataset is free from outliers and when necessary appropriate statistical measurements were taken to correct such kind of data. The second phase of the data analysis involved, major statistical data analysis

process to calculate percentages and averages including tabulate by sample stratifies and cross tabulation. Qualitative data analysis involved thematic coding of the transcribed and translated in depth interviews and focus group discussions. The analysis of the qualitative data involved thematic approach by using ongoing content analysis of the transcripts. The project database was used to examine and analyze the key performance indicators of the CMAM program. Finally, findings generated from the different data sources was triangulated and presented under each evaluation thematic and sub-thematic areas.

4. FINDINGS

4.1. RELEVANCE

Evaluation Question 1: Were the various CMAM intervention modalities (at health facility, outreach and mobile sites) sufficiently appropriate and relevant for the pastoral context?

CMAM intervention modalities: This final evaluation found that the CMAM intervention modalities designed & implemented in project were appropriate and relevant taking the livelihood styles of the population. As estimated by the different key informants, more than 90% of the population in Dollo zone have pastoralist livelihood; as estimated less than ten percent of the populations in the Dollo zone have settled type of livelihood. The rural pastoralist populations living in the seven project intervention districts were highly prone to recurrent drought with very limited access to basic services such as health & nutrition services. The limited access to health and nutrition service including CMAM services is mainly resulted from lack of adequate alternative service delivery modalities that fit to the lifestyle of the mobile pastoralist community members. In the absence of alternative service delivery modalities such as mobile health & nutrition team and strong outreach service delivery approaches, conventional static type of CMAM service delivery modality was not working well previously in the affected districts as reported in the key informant interviews. Additionally, the health system has very low capacity in terms of health infrastructure, human power, supplies, availing alternative service delivery modalities and so on to effectively respond to emergency nutrition situations like that occurred in the zone in 2016/2017 & protracted its impact since then.

Therefore, in the presence of multiple system level constraints, the service delivery modalities of the CMAM program used in this project (a combination of static, outreach and mobile health & nutrition service delivery modalities) is appropriate to the pastoralist community & IDP's/returnees of Dollo zone. The interventions importantly worth appropriate in the presence of limited availability of government & partner supported alternative service delivery modalities such as mobile health & nutrition team (MHNT) for the pastoralist community of the three districts (Boh, Geladi and Dera tole districts). In addition, as witnessed by the different key informants and focus group discussants, the support provided by the project on community mobilization, screening and referral in coordination with the health system was also suitable for the local context.

Overall strategy and approach of the CMAM program: The evaluation findings confirmed that the project CMAM intervention modalities equivalently balanced both the demand and supply side interventions to bring effective synergy in the course of reducing the level of nutrition related morbidity and mortality in the targeted districts. On the demand side, the OFDA project designed multiple interventions to disseminate key messages to improve the behavior & practice of the affected community on IYCF and WASH, which is the right component to reinforce other CMAM related interventions. While on the supply side, the OFDA CMAM program focused on multiple system strengthening supports and capacity-building interventions to make the system capable to respond to nutrition emergencies across the spectrum of the CMAM program components.

“The project various CMAM intervention modalities were sufficiently appropriate and relevant to our community; that were provided in three different levels... supports to SC, OTP and MHNT. It was not only enough to provide capacity building support to the existing health facilities; there was a critical need of introducing MHNT as part of responding the nutrition emergency in this woreda.” (Key informants, government sector office, Bohk Woreda)

Relevance to the local context: the project implementation districts targeted in this evaluation were severely affected by prolonged drought occurred since 2017 as reported by key informants and beneficiary focus group discussants. The drought resulted in loss of large proportion of livestock (such as camel, goat) in the seven CMAM project implementation districts.

“Since 2016/2017 there was occurrence of severe drought in all districts of Dollo Zone and the impact of the drought reached peak level in the middle of 2017. As a result, significant death of livestock’s was recorded due to shortage of water and livestock pasture/grazing land.” (Key informant from Warder Woreda)

Data generated from the document review also indicated that above 90% of livestock of the affected community were lost due to the impact of the 2016/2017 drought. As witnessed in the focus group discussions with men and women community members in the three districts, the loss of livestock directly affected the food security of the community; apparently, largest proportion of the rural pastoralist people relies on animal source food such as consumption of milk. Because of severe food shortage in the project-targeted districts, there was sharp rise of malnutrition across the seven districts. In particular, under five children and PLW community members were the primary affected population group. The drought impact subsequently resulted in large number of drought induced IDP’s across the seven districts; but the share of IDP’s differ from district to district. Meanwhile, occurrence of AWD across the districts found in Dollo zone was an important aggravating factors amid drought induced humanitarian crises. Even if no official records found in this evaluation, significant number of deaths was reported from AWD which was further paced the widespread occurrence of malnutrition among children and other vulnerable community members. Even though there was sign of recovery at the beginning of this project (April 2019) from the impact of the severe drought & AWD occurrence, there was a critical need of humanitarian assistance including emergency nutrition responses to prevent further nutrition related deterioration among vulnerable community members. While in the contrary, there was no adequate integrated livelihood development program undergoing in the affected community at the inception stage of this project as part of the recovery plan to prevent further nutrition deterioration.

“There was also an incidence of AWD cases in many districts of the zone which exacerbated the humanitarian situation in particular further resulted to the sharp rise of malnutrition among under five children and PLW.”

“Widespread occurrence of WD in the zone was also a critical emergency incidence that further worsened the situation and resulted in increased morbidity and mortality due to malnutrition and other related complications in the affected community” (Key informant from Geladi Woreda)

On the other hand, IYCF related behavior and practices were very poor in the districts. So long, pre-lacteal feeding such as providing water or water with sugar for newborns before initiating breastfeeding is an accepted norm across the community members. Giving camel or goat milk before the baby rich six months is also a common practice as found in the focus group discussions and key informant interviews. People had limited awareness on the health and nutrition importance of exclusive breastfeeding.

On the service provider side, the performance of the government health system was very weak and had inadequate capacity to provide CMAM related services for all affected people in the host community and IDP’s. Existing OTP sites were limited in number and constrained specifically with lack of trained staffs

and supplies. The same was true with SC sites; there were few numbers of health centers as well as the existing SC units have had poor capacity in terms of the necessary SC materials, trained staffs and medical supplies to effectively shoulder the large number of malnutrition cases occurred in all districts. Certainly, there was lack of adequate and trained staffs across health facilities due to long standing turnover of HEW's and health workers across the project implementation districts as witnessed by the key informants participated in this evaluation. Moreover, the political instability occurred in the region in 2018 further escalated the turnover of health workers & later critically affected the poor performing health system of Dollo zone. Overall, the health system and relevant sector government offices at all level in the OFDA supported districts had/have very limited capacity to effectively coordinate and deliver quality CMAM services for the affected community as found in this final evaluation, which highly make the project interventions relevant. With the presence of all the above factors across the project implementation districts, the interventions & modalities both at the community and system level were satisfactorily appropriate for the local context.

“Concerning the governmental capacity, we have only one Ambulance in the woreda; so that it was very difficult to distribute OTP supplies without the external project support; even some health posts are 120km far from the woreda.” (Key informants from the relevant government sector office, Galadi woreda)

Relevance to the government policy & strategy: In recognition of the needs of the Somali region, the Federal Ministry of Health has been providing health system strengthening support to the region. The Ministry of Health has developed a five-year equity plan of action to address geographic inequity, providing budget subsidies and deployment of additional health professionals to the regions. However, the support is irregular and insufficient in particular during the time of nutrition emergencies as revealed in the qualitative findings. As indicated in the government policy and strategy, one or two service delivery modalities is not adequate to ensure access to health & nutrition services for pastoralist communities such as the rural pastoralist population of Dollo zone. The government policy and strategy strongly suggest designing and introducing a combination of static, outreach and mobile health nutrition service delivery outlets for the pastoralist population. Therefore, the OFDA supported CMAM program strongly backs and relevant to the recent government initiatives as stipulated in the pastoralist health extension program and the current five-years equity plan of action to expand a combination of service delivery outlets for the pastoralist communities.

4.2. EFFECTIVENESS

Evaluation question 2: What are the main reasons that contributed to the performance indicator results of the CMAM program? Were the monitoring mechanisms effective in providing timely data to inform programing decisions?

Performance of SC, OTP and TSFP: 2557 (1158 and 1399 male & female OTP admission respectively) under five children were enrolled in the 86 supported OTP sites across the seven project implementation districts. As displayed under Figure 1, there was an overall increasing trend of OTP admission in particular in last three months of the project life compared with the first three months of the project implementation period. Similarly, 152 SAM cases admitted in the 16 supported SC sites across the seven districts from April to December 2019. The SC admission trend is similar with that of the OTP admission trend described above; there was an increasing trend when comparing the number of admissions between the first and last three months of the project life.

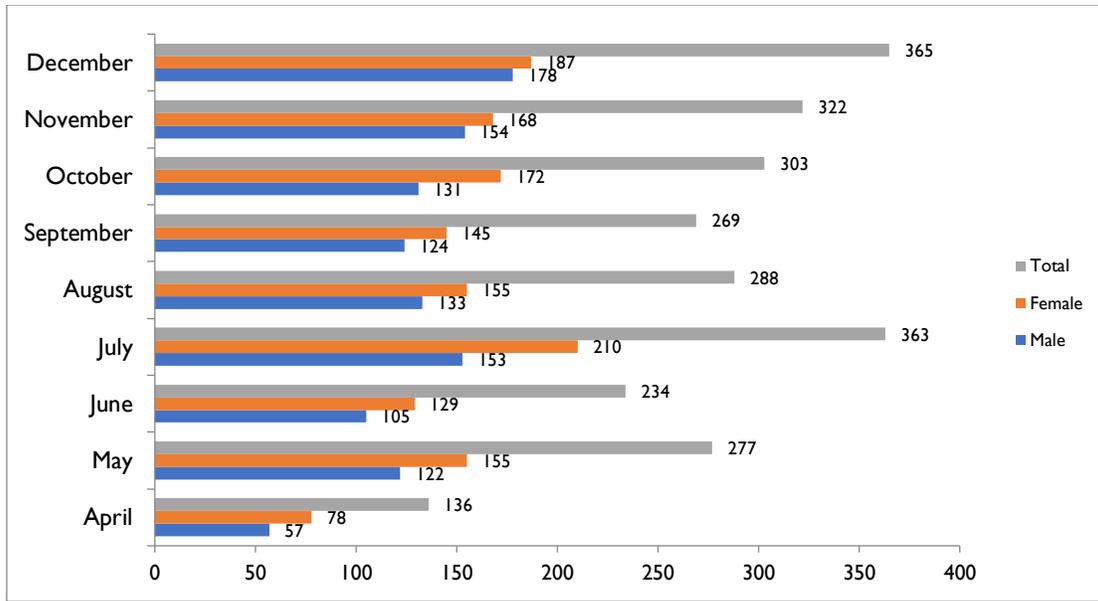


Figure 2: OTP admission trend (April-December 2019), Dollo zone, Somali region, March 2020.

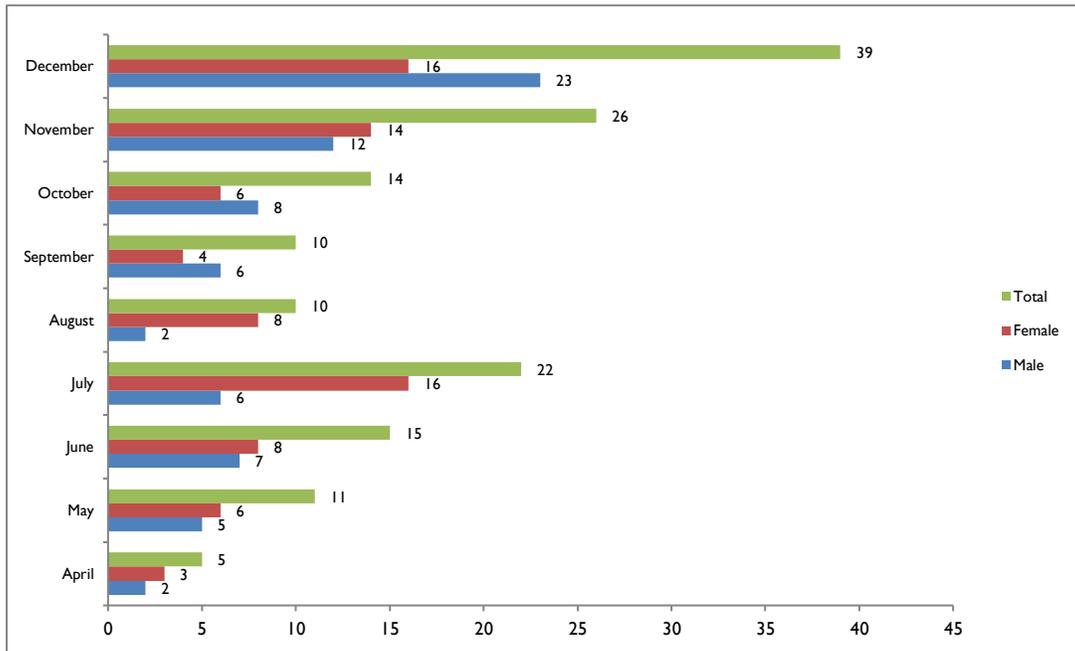


Figure 3: SC admission trend (April-December 2019), Dollo zone, Somali region, March 2020

Moreover, since October 2019 until the end of the project (for the last three months of the project life), 9789 and 8274 under five children and PLW admitted in the TSF program through the OFDA project supports. Table 4 below further shows the project targets and achievements of OTP, SC and TSFP in Dollo Zone of Somali region. In this regard, the project fully met & remarkably surpassed the OTP and TSFP targets set by the project. Specifically, the achievement made in the TSFP is by far above the project target. However, the SC achievement was below the expected level; 70% of the targets achieved at the end of the project.

TABLE 4: TARGETS AND ACHIEVEMENTS OF OTP, SC AND TSFP, MARCH 2020

Indicator	Target			Achievement		
	Total	Male	Female	Total	Male	Female
Number of children treated severe acute malnutrition in OTP	2187	1072	1115	2557	1158	1399
Number of children treated severe acute malnutrition in SC	216	106	110	152	71	81
Number of MAM children (6-59 months) treated through Targeted Supplementary feeding program	6326	3095	3226	9789	4575	5214
Number of MAM PLWs treated through Targeted Supplementary feeding program	3563		3653			8274

Review of OTP, SC and TSFP records in the sampled health facilities confirmed that the admission and discharge criteria of <5 children and PLW was fully adhered with the national CMAM protocol. Moreover, the performance of SC and OTP against the recent Sphere standard (2018) is within the minimum acceptable standard. However, there is inter-district variation on specific indicator against the Sphere standard; in relative terms Dera Tole and Geladi had higher length of stay in the SC program (>10 days). Similarly, Warder district had higher length of stay in the OTP (>60 days).

TABLE 5: PERFORMANCE OF SC AND OTP AGAINST SPHERE STANDARDS, MARCH 2020

SC		OTP	
Sphere standards	Performance	Sphere standards	Performance
Recovery rate >75%	89.6%	Recovery rate >75%	97.1%
Mortality rate <10%	2.9%	Mortality rate <10%	0.0%
Default rate <15%	2.2%	Default rate <15%	2.7%
Length of Stay <10 days	8.4	Length of Stay <60 days	50.5

Infant and young child feeding & Hygiene/WASH/ promotion activities: The project designed multiple mechanisms to delivered key IYCF and hygiene promotion activities for both IDPs and host community members in the implementation districts. During the implementation period of the project, sixty rounds of health education sessions on IYCF were convened and reached 67,273 affected people (M=5408 and F=61865). Similarly, 287 hygiene promotion campaigns conducted across the seven districts where 2449 people reached through the campaigns. Moreover, 6,743 people were also received hygiene promotion activities through OTP/SC, TSFP & IYCF-E.

Data from the HH quantitative survey and qualitative findings were triangulated to examine the possible effect of IYCF and hygiene promotion activities on IYCF and hygiene related practices of the community in the three evaluation districts. Out of the 384 HH's with children below two years of age, about 106(27%) of the households had access to drinking water from improved sources. The existence of safe water storage practices was measured by direct observation during a HH visit. The type of storage used in about 88.7% of the households who had access to drinking water from improved sources was safe – meaning it was of a type that limits the risk of further contamination (e.g., sealed/covered container with a spigot or narrow-necked jerry can) and clean. The quantitative HH survey also found that above 88% of the surveyed households often wash their hands with water and soap/ash at three of the five critical times, which is a satisfactory result in terms of hand washing practices of the community at critical times.

Regarding IYCF practices in the evaluation districts, the HH survey result shows that only 68% of the infants below 6 months of age had exclusive breastfeeding practice. This finding exceeds by 18.6% from the finding of a survey report conducted 2019 for a similar emergency nutrition project that implemented (1st March 2018 – 31st March 2019⁷) in the intervention zone by GOAL. The proportion of children who full fill minimum dietary diversity practices was also very low in the surveyed households; only 12% of children 6-12 months of age received foods from more than four or more food groups based on the 24-hrs recall period. However, this result was exceeds by 10.1% when compared with a similar project implemented in the intervention area⁸.

TABLE 6: HH SURVEY RESULTS ON IYCF AND WASH PRACTICES, MARCH 2020

Key IYCF and WASH indicators	%
Proportion of infants 0-5 months of age who are fed exclusively with breast milk (n=122)	83(68%)
Proportion of children 6-23 months of age who receive foods from 4 or more food groups(n=262)	30(12%)
Number of people receiving behavior change interventions to improve infant and young child feeding practices	67,587
% of people targeted by the hygiene promotion program who know at least three (3) of the five (5) critical times to wash hands	88.3%
% of households targeted by the hygiene promotion program who store their drinking water safely in clean containers	88.7%

Qualitative data gathered through focus group discussions and key informant interviews further support the above HH survey results. The qualitative findings indicated that recommended IYCF behavior and practices of the affected community is quite low across the evaluation districts, which indicate the effectiveness of the IYCF related activities unsatisfactory on the behavior and practices of the community. In fact, majority of focus group discussants and key informants agreed that there are positive changes on IYCF related awareness and knowledge in the communities. Key messages delivered through multiple channels at least widened access to IYCF and WASH related information for the community. However, recommended IYCF related practices in the community is still a challenge and need a long-term investment to bring desired behavior change & practices in the affected communities. For example, the qualitative findings revealed that, pre-lacteal feeding (such as giving water for newborn before initiating breast feedings within 1hr after birth) and giving water or other fluids before the child gets six months of age are still dominantly practiced by the affected community members across all the evaluation districts. Thus, the project effectiveness seems insufficient to bring positive change on IYCF & hygiene related behavior and practices. However supports provided to the SC sites on catering services to caregivers (the OFDA project provided food supplies and covered salary of cooks in the SC sites) was an important integral IYCF components to promote caregivers' coping capacity as well as essential in promoting IYCF messages in SC's. Moreover, provision of key WASH & IYCF messages through health posts and health centers as well as in any community level CMAM related gatherings was effective approach used in the project to bring the intended behavioral changes and practices. Community volunteers were also oriented to disseminate key messages of IYCF & hygiene promotion, which was an effective approach taking the context of the area and the mobile life style of the community. Besides, as part of NFI (non-food items) interventions, the project provided soaps and Jerry cans for targeted community members such as people

⁷ GOAL: 720FDA18GR00013 Final Report 1st March 2018 – 31st March 2019: "Emergency Nutrition and WASH Response for Drought-Affected Communities of Somali Region": "the proportion of infants 0-5 months of age who are fed exclusively with breast milk was 49.4% and the proportion of children 6-23 months of age who receive foods from 4 or more food groups was 1.9%, according to this source.

⁸ *ibid*

admitted in the OTP and SC programs, but the supports provided in this regard was inadequate as reported in the key informants and focus group discussions.

Mobile health and nutrition activities: The OFDA project supported to introduce new MHNT's in Geladi, Bohk and Dera Tole districts of Dollo Zone. As indicated in the project database, 9405 people received health and nutrition services from the three supported MHNTs as indicated in the following table.

TABLE 7: PEOPLE RECEIVED SERVICES FROM THE THREE MHNTS BY AGE AND SEX, MARCH 2020

Type	Achievement
Male Under Five Children total consultation	517
Female Under Five Children total consultation	629
Male Adult Consultation	1217
Female Adult Consultation	1810
Total number of People Health Education received during MHNT service	5232
Total	9405

Qualitative findings of the evaluation indicated that the service provided through the supported MHNTs improved access to health and nutrition services for the affected community across the three districts; each of these three supported MHNTs were providing services for five Kebeles with no access to health facility. The three districts initially either did not have government supported MHNT or the number of available MHNT was inadequate in number to reach the needy people. Thus, the support provided on MHNT was effective in improving access to CMAM services for the community in the three districts.

“There was government supported mobile health team in 2017 in the district and unfortunately unable to continue the service in 2018/2019 & transferred to another place due to shortage of government operational budget. The introduction of the MHNT was an important step in bridging the poor capacity of government to run mobile health team in this district. Moreover, it was an effective strategy to improve access to nutrition services for mobile pastoralist and hard to reach areas with no alternative service delivery outlets.” (KII Bohk Woreda health office)

“The project introduced mobile health team in the woreda which contributed a lot in reducing nutrition related morbidity and mortality in the five targeted Kebeles. The MHNT programme also integrated and prioritized the delivery of key messages of IYCF and WASH to improve the awareness of the community.” (KII Geladi project field office)

Strengthening of health workers capacity: as part of improving the quality of CMAM services and building the local capacity, the project supported different rounds of CMAM trainings for health workers and health extension workers across the seven districts. In this regard, 156 health workers and health extension workers received CMAM trainings by OFDA supported CMAM program across the seven districts. The capacity building CMAM training provided by the project in the seven districts effectively improved the number of CMAM trained staffs in the health posts and health centres, according to government office and health facility representatives participated in the key informant interviews. As witnessed in the interviews, there is overall shortage of health workers in Dollo zone; specifically, shortage of skilled and experienced CMAM trained staffs is uniform across districts found in Dollo zone. The shortage of CMAM trained staffs were further constrained due to the 2018 political instability occurred across the region, which forced significant number of health workers forced to leave their jobs. Overall, the CMAM capacity building training was effective in improving both the number of trained health workers as well as increased the number of OTP/SC sites; thus, eventually contributed in improving access to CMAM services for the community.

“Available CMAM trained staffs in the two SC sites were very low in number as well as had skill gap to confidently handle the admitted cases. Because of the skill gap & shortage of CMAM trained staffs in the two SC sites, transfer/referral cases to the hospital was high in number. The shortage of staffs was exacerbated since August 2018 incident (political instability) given that large number of health workers left and went to other places. Nowadays, the number of trained staffs is improved in number, though continued challenged by high turnover.”

Key factors contributed to the performance of the project:

- Major facilitators

Community mobilization and screening related supports: The support provided to the TSFP program to conduct intensive community mobilization and screening activities for the last three months of the project life was an important driver to improve the performance of the OTP and SC service provision. As found in this evaluation, the number of screening in the TSFP was very low before the support of the project, which specifically affected the OTP performance across the districts. However, after the project support the performance of the TSFP significantly improved; which is one of the factors behind an increased trend of OTP admission within the last three months of the project life.

Streamlined coordination and logistic supports: use of multi-level coordination platforms to implement the project activities identified as main factors for the effective implementation of the planed project activities. The coordination platforms were important to receive timely feedbacks, avoided potential duplications, made easy to implement SBCC and screening related activities at community level and helped to institute effective supply system during the project implementation period. While, the logistic system and supports provided by the project was one of the strong sides of the CMAM program as revealed in this evaluation. The OFDA project supported the transportation & distribution of CMAM related commodities across the supported districts in coordination with health & DPPC offices as well as partners, which was vital to the performance of the program.

Human resource and budget: in all visited project field office and regional level coordination offices, staffs working on the OFDA supported project considered as adequate that help to deliver the planned activities on time, which is an important driver behind the overall performance of the CMAM programme. The same is true with the allocated budget; based on the findings of the evaluation the allocated budget for the project was quite adequate; shortage of budget was not reported as impeding factors to implement the planned activities.

- Key impeding factors

Insufficient service delivery modalities: across the visited districts large majority of Kebeles do not have access to health facilities; there are districts where about half of the Kebeles have no access to health post. Even though the project supports on MHNT brought positive results in terms of improving access to nutrition services to the affected community, the number and coverage of the supported MHNTs was insufficient. Thus, lack of adequate number of MHNT was one of an impending factor that limited the ability of the project in reaching remote and hard to reach pastoralist areas adequately.

Livelihood of the affected community & inter-clan conflicts: the lifestyle of the community was one of the challenges encountered during the implementation of the CMAM program. Sometimes, regular provision of nutrition and WASH related messages to the community was difficult and interrupted occasionally; because majority of the affected population are pastoralist and do not settle for long period of time on one specific village. Occasional occurrence of inter-clan conflict was also an additional challenge

that had some negative effect on the performance of the project; there were reported instances where health posts were closed for long period due to presence of inter-clan conflicts.

Occurrence of seasonal diarrhea: occurrence of seasonal diarrhea around November and December 2019 was one of the alternative reasons for increased number of admission cases in the last three months of the project period, which affected the performance of the CMAM programme.

Supply interruption & joint supportive supervision: Problem related to the provision of MHNT & SC medical kits received from partners was another challenge that affected the performance of service provision through the supported MHNTs. As reported in the key informant interviews, sometimes the provided medical kits either incomplete or lacks important medical items such as S-kit (stabilization center kit). Engagement of government staffs on other priorities to some extent affected the smooth implementation of joint supportive supervision activities on timely bases. Occasionally there was delay on timely transportation and delivery of supplies due to several reasons.

Shortage and high turnover of government staffs: Given that the project performance highly depends on the government system, high staff turnover in the government system was an important challenge encountered during the project implementation period. Trained health workers frequently leave their jobs from the supported health facilities, which further exacerbate the existing shortage of health workers. As reported by project's field office staffs, sometimes the OFDA project staffs assigned in the health posts to provide CMAM related services for the community because of the critical shortage of health workers and health extension workers.

Poor awareness and practices: Even though there are improvement on the promotion and improvement of IYCF and WASH related behavior and practices of the affected community, there is unsatisfactory level of community awareness and practices as revealed from the qualitative and quantitative findings of this evaluation. De-prioritizing of WASH interventions in the three evaluation districts during the project implementation period was also additional explanation reported in the qualitative findings that affected the performance of the project in terms of improving WASH related behaviors.

Effectiveness of monitoring mechanism: The monitoring mechanism instituted from region to the field office level, which created smooth path to provide timely data for important program decision. Regular review meetings and joint supportive supervision with key government sector offices also created opportunity to receive feedbacks and take timely action. In addition, day to day follow up across the health posts and health centers as well as joint implementation of activities at the community level with the government staffs played positive role for the good performance of the project monitoring system. The OFDA project staffs also provide technical supports and close follow up on the CMAM related documentations and reporting which is important for timely delivery of data for decision making. The support provided by the project also contributed for improving the quality of CMAM related data; reduced CMAM related data inconsistency at all level.

4.3. IMPACTS

Evaluation question 3: To what extent did GOAL's intervention strengthen the capacity of the Government health system to manage CMAM without the support of external actors? Are unplanned positive or negative impacts because of this project? To what degree did the targeted supplementary feeding activities contribute to reducing the level of severe acute malnutrition?

Possible impact on the capacity of government health system: The OFDA CMAM program provided comprehensive system level support to capacitate local government health system to better manage CMAM activities. Most importantly, the on-job training, full fledge CMAM training based on the recent national SAM management protocol and continuous technical support to staffs working in all the

supported SC & OTP sites were satisfactorily increased the number of skilled CMAM staffs across the project implementation districts which increased the pace of institutionalization of CMAM program. The training provided by the project coupled with the continuous technical supports during the project implementation period also improved the CMAM program data recording and reporting practices as witnessed in this evaluation. Additionally, different material supports provided to some selected health centers as part of strengthening and expanding the services was also an important system level supports which resulted in improved access to CMAM services for the affected community members.

“The first significant change made due to the project was all “Geladine” woreda health workers were trained on CMAM program. In the second place food and nutrition supply for the community was provided in all health facilities with significant logistic support by the project. The third was material supply for health institutes like mattress, ventilation AC and others supplies were crucial to strengthen and expand SC sites. TSFP service was also strengthened to provide routinely service for the community.” (Key informant, Geladi woreda health office)

The support provided on MHNT in the three woredas had also positive contribution and impact in strengthening the local system; often the local government health system has multiple constraints including shortage of budget to introduce mobile health and nutrition team as explained by relevant key informants from the woreda health offices. Thus, the health system was incapable of improving access to alternative CMAM service delivery modalities across the targeted districts before the implementation of the OFDA supported project. As observed in this evaluation, the newly established MHNT teams across the three districts to some extent also had positive trickledown effect in improving access to other health care services to the community (other than CMAM services) as described in the focus group discussions and key informant interviews. Furthermore, community level supports such as community mobilization, screening and facilitation of coordination between health posts, community volunteers & the affected community members across the seven project districts tangibly reinforced the capacity of the system to identify adequately active cases and timely provision of CMAM services.

As revealed in this final evaluation, the project laid some system level foundation to better management CMAM program across the visited project districts. However, the support provided by the OFDA project has less impact in terms of building strong health care system that make the government system capable of managing CMAM program independently. Even though the project tried to strengthen the local system, still the system is deficient to adequately take over and provide the service without the support of external entities. The fact that, the health system in Dollo zone have been suffering from different system level constraints which are not adequately mitigated by short term emergency response. Moreover, the coordination and logistic capacity of the woreda level government offices and health centers had still minimal capacity taking the geographic size of the districts and recurrence occurrence of nutrition crises. Additionally, woreda level health and DPP offices have very few numbers of vehicles and staffs, which is further compounded by high staff attrition rate to deliver timely and adequate nutrition related responses to the affected population.

“As a government, we can't continue to provide CMAM services with similar intensity. For example, we have only one Ambulance; how are we going to distribute the supplies for 18 health posts and 3 health centers? What about shortage of human resource? For these reasons it is difficult for the government to provide the service without external support.”(Key informant, Geladi health office)

Contribution of TSFP supports in reducing SAM cases: The evaluation confirmed that the support provided in the TSFP activities had a huge positive contribution & impacted to reduce SAM cases in the project targeted areas. The OFDA project significantly improved the community mobilization and screening activities provided in the TSFP program which increased the number of cases admitted in the OTP program in the supported sites. This achievement in the TSFP program contributed for timely screening and admission of cases in the OTP program. For example in all of the visited district (Bohk,

Warder and Geladi Weredas), the project supported the implementation of both blanket (reported in Bohk Woreda) & targeted SFP interventions in coordination with the relevant government sector offices and partners that elapsed for three consecutive months. As a result of massive community mobilization and screening activities since October 2019 in the TSF program, the number of admitted cases in the OTP dramatically showed incremental trend (please see figure 1 above under effectiveness section of this report). Indeed, the occurrence of seasonal diarrhea across the three districts also reported as an alternative explanation for the increased trend of OTP admission. In addition, the support provided in the TSFP to have smooth coordination & timely communication between sector offices as well as logistic support provided for distribution of food items significantly contributed in decreasing the number of monthly SAM admission cases in the subsequent months. Nevertheless, the support provided to the TSFP activities elapsed only for the last three months of the project life, which made difficult in this evaluation to broadly see the contribution of the supports provided to TSFP in reducing SAM cases. In particular, because of delays in the implementation processes of the TSFP supports relatively missed the initial peak period.

“The supports provided by the project on TSFP were very critical in reducing the number of SAM cases. In particular the supports were vital in the presence of weak government capacity and system to implement effective TSFP. Yet, occurrence of seasonal diarrhea in the district in November and December was also another alternative reason for increased monthly admission in the OTP.” (Key informant, GOAL project field office representative)

Impact on averting malnutrition related mortality and morbidity: As the qualitative findings of this evaluation indicated, the emergency CMAM program highly contributed in averting significant number of mortality and morbidity of under five children and other vulnerable segment of the community members. For example, as explained by the different key informants across the visited evaluation districts the number of referral and admission of SAM cases across SC sites and in the existing non-supported hospitals significantly showed a decreasing trend, (good example from the non-supported facility is the MSF supported hospital in Warder woreda). As found in this evaluation, improved access to CMAM services across the supported districts and early identification of cases in the community were the dominantly reported reasons for the decreased in-patient admission cases which highlight the impact of the project in averting complications and deaths among the targeted children. The impact of the project in saving the life of under five children and other vulnerable community groups such as IDP's and PLW recognized positively in this evaluation. However, given the present humanitarian conditions of households across the visited districts, further humanitarian assistances and external support in need, if not there would be a likely deterioration of the already achieved positive improvements with regard to the current nutritional status of the affected community.

“The HH's already lost their livestock and nothing remained on their hand to recover from the situation. While on the other hand, no adequate livelihood and development program is underway currently for drought induced IDP's/returnees in this district which make the situation worrisome in terms of nutrition related morbidity and mortality in the near future.” (Key informant, woreda level DPPC office)

4.4. EFFICIENCY

Evaluation question 4: What evidence is available that efficiencies were sought in program design? Were adequate human and financial resources applied to delivering project outcomes?

Coordination and timeliness: At the outset, the OFDA CMAM program identified and considered different multi-level coordination mechanisms and platforms to efficient delivery of the outputs across the project implementation districts. GOAL have been on the ground before the beginning of this project which made the current CMAM program to easily identify and use local resources and coordination

opportunities during the project implementation period. The OFDA CMAM program had strong coordination with the different regional and zonal level cluster meetings, which considered as vital for efficient delivery of outputs. At zonal level, there were nutritional cluster meetings took place every two weeks; there is a WASH cluster and humanitarian coordination meeting on monthly bases. At regional level, there were also humanitarian, WASH cluster and command post coordination meetings. Often, GOAL regional coordination office was at the forefront in the coordination meeting, which eventually helped to resolve challenges ahead of time as well as more importantly avoided duplications across the project implementation districts. Moreover, the need assessment conducted, and anticipated risks and assumptions identified at the design stage of the project helped to plan different implementation mechanisms where no significant deviation appeared regarding the risks & assumptions during the project implementation period. Therefore, the assumptions were realistic considering the local context in the course of the project implementation, which positively affected the efficiency of the project.

Regarding the timeliness of the project, the evaluation found that large majority of planned activities conducted timely across the seven-project implementation districts. CMAM related supplies distributed on time in the health facility level with efficient and streamlined transportation system from region to Kebele level.

“We can say the project was efficient in terms of timely delivery of outputs and materials. Particularly when supplies arrive at woreda level we often start to distribute on time.”

Moreover, the support provided on community mobilization, screening and other capacity building supports has also resulted in timely admission of children for treatment. However, there were delay and interruption of supplies in the three supported MHNTs, which slightly affected the timely provision of the CMAM service for some segment of the target area as reported in the key informant interviews. Moreover, delay in the recruitment process of new MHNT staff also reported as a factor to timely implementation of MHNT activities, though not dominantly reported in this evaluation. In addition, as found from the document review the plan on TSFP distribution starting from April 2019 was not carried out as planned due to different challenges encountered on the side of the TSFP partner (WFP).

Resource allocation and utilization: as per the findings from key informant interviews with the project staffs and representatives from the relevant government sector offices, the allocated budget for the project was adequate to implement the major planned activities during the project implementation period. The staffing of the CMAM program was also adequate in number to deliver the planned activities timely and to the standard which contributed to the achievements of the CMAM program outcomes. Moreover, the project resources were spent on designed activities and in conformity with the approved budget lines as reported in the key informant interviews. Qualitative and desk review findings also found that there are no better proven alternative implementation arrangements and strategies than the one used in this project in the Somali region that ensure further reduction of the project costs. *(NB. Further analysis of budget utilization and efficiency of human resource will be done once we received the relevant data from the national/regional team)*

Adaptation and responsiveness: the OFDA supported CMAM project was remarkably flexible and responsive to respond timely to competing & emerging needs of the government on CMAM program. The regional coordination and project field offices were alert to any change in the external environment and take timely adaptation to implement smoothly the planned activities. For example, during the occurrence of inter-clan conflicts, the team in consultation with the woreda health office makes the necessary re-planning to design ways to bridge the gap. The other adaption made in this project was on the TSFP activities due to a temporary supply break and lack of funding for operational costs. Hence, the organization able to secure co-funding for the TSFP distributions and subsequently implemented within the last three months of the project life without funding from the WFP.

4.5. SUSTAINABILITY

Evaluation question 5: To what extent did the program utilize established institutions/ mechanisms to ensure sustainability at the end of the project?

Overall, the OFDA project implemented through the existing government structure at all administrative level with streamlined joint coordination, supportive supervision and monitoring mechanisms. The project utilized all the established government structure and system to implement the CMAM interventions as part of sustainability strategy. System level supports were also an important strategy used to ensure the sustainability of interventions and outcomes. The project planned and implemented its activities in close coordination with the government system. Multiple implementation structures such as the HEP, community health workers, cluster level coordination platforms, government logistic & Health Management Information System (HMIS) and so on used to implement the project activities. For example, the supported MHNT in Bohk, Geladi and Dera Tole districts managed & implemented with the same modalities with the government supported mobile health team, which would make smooth for the regional health bureau to sustain the intervention in the future.

Even though the project utilized the government structure and system to implement the CMAM interventions, there is still poor capacity on the side of government with respect to human resource, lack of operational budget and logistic system and so on to effectively run CMAM program across the project implementation districts. In general, the health system in the supported zone further need intensive multipronged and long-term investments to make it resilient to shocks and effective management of CMAM programs without the support of external entities.

“Overall, the current health system including the human resource, infrastructure, logistic, coordination and other dimensions of capacity are not strong enough to sustain the CMAM program. As observed across the health institutions, human resource is spread thin & compounded by high staff turnover which make the sustainability of achievements unlikely.” (Key informant, government stakeholder)

4.6. COVERAGE

Evaluation question 6: What are the main factors affecting GOAL's geographical coverage?

Effective coordination system and full utilization of the government system and administration structure brought a positive effect on the geographical coverage of the project. The smooth coordination and implementation of activities in coordination with community volunteers and health post staffs an area where that positively factored in this evaluation in particular on the geographical coverage of screening and community mobilization activities.

Nevertheless, the geographical size of the implementation districts and distance between the woreda town and health facilities were an important factor that affected the geographical coverage of project. In particular, geographical size of the project and long distance in the absence of adequate number of MHNT in the Geladi, Bohk and Dera Tole reported as impeding factor on the geographical coverage of the project. Similarly, significant proportion of Kebeles & sub-kebeles are currently without health posts, which indirectly affected the geographical coverage of the CMAM program.

“We have almost 50 “kebeles” in our “woreda” but half of them were without health post mean that the project had no actual coverage in these Kebeles. Besides, there is only one MHNT which only cover 5/6 kebeles.” (Key informant, Geladi Woreda, government sector office)

Availability of inadequate number of government mobile health team or absence of mobile health team in a particular district was the major criteria used to support MHNT. Although, mobile health and nutrition teams designed and decided based on the joint decision made by the program staffs and zonal & woreda health offices staffs, the criteria used to select districts for MHNT as well as lack of adequate resource to establish adequate number of MHNT were affected the geographic coverage of the CMAM program. Presence of inadequate number of MHNT or absence of MHNT in a given district was the major criteria considered in the selection process of districts for MHNT related project interventions. MHNTs have been running by the support of the OFDA project in Boh, Geladi and Dera Tole Woredas. In Warder district there was no OFDA supported MHNT due to the presence of government led mobile health team and it was assumed as duplication of effort to introduce new Mobile health team. But as revealed in this evaluation Warder district has a critical need of MHNT as explained by key informant from the woreda health office. Nonetheless, the available government mobile health team is not enough to cover adequate geographical areas; there are significant number of Kebeles without health facilities as well as there is very long physical distance between sub-kebeles and health facilities.

Frequent closure of government OTP sites (health posts) due to different reasons such as commitment or turnover of staffs & inter-clan conflicts in some districts during the project implementation period also affected the geographical coverage of the project.

5. CONCLUSION, LESSONS LEARNED AND RECOMMENDATION

5.1. CONCLUSION

This evaluation confirmed that the CMAM program implementation modalities are highly relevant to the implementation areas and the affected pastoralist community members. A combination of supports to deliver interventions throughout-reach, static and mobile health & nutrition team appropriately reinforced to provide the CMAM services for the affected community with mobile lifestyle. The CMAM program implementation modalities also well backed by policy and strategy, such as Equity plan of Action (2016-2020) and pastoralist's health extension program, which strongly entails to introduce a combination of service delivery modalities for the pastoralists people.

The CMAM program was effective as evidenced by its ability to treat all the anticipated number of both SAM and MAM cases across the project implementation districts. The effectiveness of the project was reasonable. The project admitted and treated many SAM and MAM children, which consequences to halted escalation of malnutrition and mortality among the affected population. The out puts on SAM & MAM management, capacity building activities, community level supports, and IYCF & WASH promotion activities effectively delivered during the project implementation period. The CMAM program performance effectively meets the Sphere standard but there is variation by across the project implementation districts.

Regarding the impact of the project, system level supports and capacity-building interventions such as health workers training on CMAM and technical supports resulted in improvement of the local system and capacity to manage better the CMAM program. The contribution of the CMAM program towards building local capacities in terms of skills, materials and systems was substantial. Capacity building efforts were successful in training of health professionals, expanding OTP & SC sites and strengthening the CMAM Monitoring and Evaluation system. Although the intervention of the project brought improved government capacity, this evaluation concludes that managing CMAM program & provision of the service with the same intensity by government capacity alone will not be possible.

The strong coordination mechanisms, adaptation and flexibility of the project to change in the external environment helped to implement the project quite efficiently. Joint decision making with relevant sector

government offices & partners as well as active involvement of the project on different cluster level coordination meetings helped to resolve challenges ahead and avoided possible duplications. The project fully used the government system, structures and local level opportunities to implement the project interventions, which is a considerable strategy to ensure the sustainability of the interventions and outcomes. However, the evaluation concludes that, the government capacity in all parameters found spread thin across the project implementation areas and therefore, existing institutions are still not in a good position to manage effectively the CMAM program in the future.

Multiple factors positively or negatively affected the geographic coverage of the CMAM program. Overall, government staff commitment and turnover, presence of health facilities, number of available MHNT, distance, inter-clan conflicts, effective coordination system and the large geographic size of the supported districts factors behind the geographical coverage of the CMAM program.

5.2. LESSONS AND PROMISING PRACTICES

- Introducing appropriate service delivery modalities specifically a combination of static, outreach and mobile CMAM interventions modalities much improved access to nutrition & health services across the affected pastoralist population. However, the number of available government mobile health team and the number of supported MHNT were disproportional taking the scope of the problem and the geographical size of the implementation districts.
- Strong multi-level coordination mechanisms and streamlined logistic system was the strong side of this emergency response project, which is highly contributed for the effective and efficient implementation of the planned interventions.
- The project support in the TSFP on community mobilization, screening activities and logistic supports had remarkable positive results to early identify cases as well as to reduce the number of SAM cases later.
- Promotion of key WASH and IYCF related messages to the community was important & assumed to reinforce other CMAM related interventions. In addition the promotion activities will potentially contribute to sustainable behavioral change in affected communities.
- Given that the project performance highly depends on the government system, high staff turnover, shortage of trained staffs and weak capacity in the government system were an important challenge encountered during the project implementation period. In this regard, provision of repeated rounds of training, organizing refreshment trainings and close follow up were some of the adaptation made by the project to minimize the impact on the performance of the project.
- The fact that the health systems and human resources are spread thin in all target areas of the zone, sustaining CMAM related results and activities is challenging across the project implementation districts.

5.3. RECOMMENDATION

- Increase the number of mobile health and nutrition team (MHNT) in the future will help to enhance program coverage and access to service for the community. Considering further integration, coordination and support with the government & partner supported mobile health & nutrition teams is important to improve access to CMAM services in the affected communities.
- The pastoralist health extension program and five year equity plan of action (2016-2020) strongly recommends introducing a combination of service delivery modalities for pastoralist community. Therefore, depending on the life style of the pastoralist and agro-pastoralist community it is critical to further scale up mobile, outreach and static service delivery systems in the project implementation zone.
- Further capacity building trainings and continuous mentoring activities are needed across the project areas to further improve the capacity of the local health system and quality of the CMAM services rendered in existing health facilities.
- More WASH related supports are required across the project districts in order to improve access to WASH services, behavior and practices. With regard to WASH infrastructures, detail feasibility study should be undertaken on the need and type of source development in the project areas in order to alleviate the community problems associated with WASH service delivery. Likewise, to bring behavior change on hygiene and promotion issues, intensive behavior changes communication and social mobilization activities needed to be strengthened in similar projects in the future by engaging Health Extension Workers, health workers and community volunteers etc. The WASH supports are important to further improve the nutritional status of under five children and other vulnerable community groups.
- The TSFP supports across the project implementation areas brought positive change on the level of SAM cases as found in this evaluation. Therefore, intensive supports to the TSFP implementation are required in particular in areas where there is integration of TSFP with the health system.
- IYCF promotion activities such as optimal complementary feeding & exclusive breastfeeding need to be strengthened in similar projects in the future to improve the IYCF behavior & practices.
- As confirmed in this evaluation, the government institutions and capacity of the health system are not strong enough to continue CMAM program independently. Therefore, further external supports should be continued in all the intervention areas to contain the current humanitarian situation as well as to manage CMAM program effectively.
- The linkage of emergency nutrition response with early recovery activities proved very successful. Therefore, similar project should try to ensure the linkage in order to make the outcome sustainable as well as contribute in creating resilient system. Livelihood & development programs including different protection related interventions are highly required in the future in particular for IDP's. Advocacy activities and coordination with partners will also help to link the CMAM program with long-term development projects.

Annex I: Socio-demographic characteristics of respondents participated in the HH survey

TABLE: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF HH RESPONDENTS

Variables	N(%)
Sex of respondents	
Female	336(87.5)
Male	48(12.5)
Educational Level	
Ever attend school	98(25.5)
Never attend school	286(74.5)
Among ever attended, level of education completed	
Primary education(1-4)	53(54.1)
Primary education (5-8)	45(45.9)
Marital status	
Single	4(1.0)
Married	380(99.0)
Mean age of respondents	
Female respondents(n=336)	31.5(±6.8)
Male respondents(n=48)	44.9(±6.7)
Both sexes	33.2(±8.1)
Household size and size of under five children	
Average household size (Mean, Standard Deviation/±)	7.8(±2.9)
Average ≤5 people in the household(Mean, Standard Deviation/±)	2.2(±0.9)
Households with ≤5 people in the household	373(97.1)

ANNEX I: HH SURVEY DATA COLLECTION TOOLS

QUANTITATIVE HH SURVEY QUESTIONNAIRE

Introduction and Consent

My name is _____ from Climax Consulting PLC and working on behalf of Goal-Ethiopia to collect data for a final evaluation of an emergency project implemented in the past 12 months in seven woredas of Dollo Zone of Somali regional state. The objective is to evaluate the project's progress towards its objectives; and draw lessons and recommendations by conducting an independent, external evaluation on the relevance, effectiveness, efficiency, sustainability and impacts of the project

As I explained earlier, Goal Ethiopia would like to evaluate the project's progress towards its objectives; and draw lessons and recommendations. We would like to talk with the person in your family who is the primary care givers of the index child below five years of age. The information we collect during this interview will be entirely confidential and will not ask for the names of none interviewed. Also, when the results of all of the interviews are combined, we will not identify specific individuals with any of the information collected. The information you provide will help Goal- Ethiopia to learn about the project plan versus accomplishment of the project supported by sufficient evidences, financial utilization, and structural/implementation arrangement/setup for project delivery. The project benefits your community as a whole and there will not be any financial or other benefits that you will receive as a result of your participation. Furthermore, there are no known risks associated with your participation in this evaluation. As participation in this survey is voluntary, please let us know your decision whether you want to take part in this evaluation as an informant or not.

(Please circle the category that describes the decision made by the respondent).

Consent granted _____

Consent refused _____

Date of Interview: _____

Code of the Interviewer: _____

HOUSEHOLD SURVEY QUESTIONNAIRE FOR THE FINAL EVALUATION OF A PROJECT CALLED "EMERGENCY RESPONSE FOR DROUGHT-AFFECTED & DISPLACED COMMUNITIES IN SOMALI REGION" WHICH IS FUNDED BY OFDA SINCE APRIL 2019.

SECTION 1: IDENTIFICATION

NO.	QUESTION	CODING CATAGORIES
101	Woreda/district	Warder 01 Bohk 02 Geladi 03
102	Kebele	XXX 01 XXX 02
103	Code of Interviewer	
104	Date of Interviewer	
105	Respondent Code	

SECTION 2: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

NO.	QUESTION	CODING CATAGORIES	SKIP
201	Sex of the respondent	Female 1 Male 2	
202	Respondents position in the household?	Wife of HH head 1 Husband of HH head 2 Son/Daughter of the HH Head 3 Other (specify)..... 88	
203	How old are you? (In completed years)	
204	Did you ever attend school?	Yes 1 NO 2	If No. go to Q 206
205	If yes, what was the highest level of education that you completed?	Primary Education (1-4) 1 Primary Education (5-8) 2 Secondary Education(9-12) 3 College/University 4	
206	Current marital status of the respondent	Single 1 Married 2 Living together/conceptual 3 Divorced 4 Widowed/Widower 5	
207	Religion of the respondent	Muslim 1 Orthodox 2 Protestant 3 Catholic 4 Traditional 5 Other (specify)..... 88	
208	How many people live permanently in this household? (Write the number)	
209	How many under five children are there in the household?(Write the number)	

SECTION 3: WATER SUPPLY AND HYGIENE PROMOTION

NO.	QUESTION	CODING CATAGORIES	SKIP
301	What is (currently) the main source of drinking water for your family?	Piped Water Into Dwelling 1 Piped Water From A Neighbor 2 Piped Water Into Yard/Plot 3	

NO.	QUESTION	CODING CATAGORIES	SKIP
		Public Tap/Standpipe 4	
		Protected Spring with on-spot tap 5	
		Protected Dug Well with hand pump 6	
		Water From Protected Spring 7	
		Unprotected Dug Well 8	
		Water From Unprotected Spring 9	
		Rainwater 10	
		Tanker Truck 11	
		Cart with Small Tank 12	
		Surface water (river/dam/lake/ponds/stream/canal/Irrigation Channel) 13	
		Bottled water 14	
		Other(specify) 98	
302	If the respondents answer is any of the options from 1-7(improved sources), ask the following Do you get water from your main source throughout the year? (Note to enumerator: Throughout the year = no interruption for 365 days)	Yes 1 No 2	
303	Observe and record how safely and clean drinking water is stored in the household. Note to the enumerator: The existence of safe water storage practices is measured by direct observation during a HH visit. The observation will determine whether the container is both (a) safe – meaning it is of a type that limits the risk of further contamination (e.g., sealed/covered container with a spigot or narrow-necked jerry can); and (b) clean.	Safe and clean 1 Not safe and clean ... 2	

304	When do you usually WASH your hands with soap/ash and water? (MORE THAN ONE ANSWER IS POSSIBLE DO NOT READ THE ANSWERS)	After defecation	1	
		Before eating	2	
		After cleaning a child bottom/Washing a pad/potty	3	
		After cleaning latrine	4	
		Before food preparation	5	
		Before feeding a child	6	
		Other(specify)	88	

SECTION FOUR: INFANT AND YOUNG CHILD FEEDING RELATED

No	Question	Answer code	Skip/Go to
401	Sex of the child	Male.... 1 Female ...2	
402	Age of the index child in months	0-5 months.... 1 6-23 months ... 2	2→Q 404

403	If your response for Q402 is 1 (child is 0-5 month), did you feed your child [NAME] breast milk exclusively? <i>(that is, give only breast milk and no other liquids or foods)?</i>	Yes ... 01 No ... 02	
404	Did you ever breastfeed [NAME]?	Yes ... 01 No ... 02	
405	Are you still breastfeeding [NAME]?	Yes 01 No 02	Yes → Q 406
406	If no, at what age did you stop breastfeeding [NAME]?	Month <input type="text"/> Don't remember 99	
407	How soon after birth did you put [NAME] to the breast for the first time? IF LESS THAN 1 HOUR, WRITE '00' IN HOURS. IF LESS THAN 24 HOURS, NOTE IN HOURS; OTHERWISE, NOTE IN DAYS.	HOURS <input type="text"/> DAYS <input type="text"/> Don't know/Don't remember 99	
408	Did anyone or yourself feed [NAME] IMMEDIATELY anything ELSE besides breast milk after the birth?	Yes 01 No 02 Don't know 99	No → Q 409 Don't know → Q 410
409	What was put in [NAME'S] mouth IMMEDIATELY after birth? Probe to ask everything that was given to the child, even if someone else gave it to the child MULTIPLE ANSWERS ALLOWED	Honey.... 01 Fruit juice ... 02 Plain water... 03 Sugar/glucose water ... 04 Tea.... 05 Milk (other than breast milk)..... 06 Infant formula 07 Raw butter ... 08 Ersho.... 09 Abish water... 10 Water with rue, thyme, other herbal extract... 11 Other (specify)_____ 88 Do not remember.... 99	

**NB. THIS SECTION IS ONLY FOR HH WITH CHILDREN IN THE AGE GROUP 6-23 MONTHS
THE FOLLOWING QUESTIONS ARE BASED ON PREVIOUS DAY RECALL, i.e., YESTERDAY DURING THE DAY AND THE NIGHT.**

410	How many times did you breastfeed [NAME] yesterday, in day time and night time?	<input type="text"/> NA 99	NA → Q 412
411	How many times did you breastfeed [NAME] yesterday, during the daylight hour?	<input type="text"/> NA 99	
412	Did the child [NAME] drink any milk , fluids, semi-solid and solid foods other than breast milk?	Yes 01 No 02	No → end the

			interview
413	Other than breast milk, how many times did [NAME] drink other milk (goat's milk, cow's milk, buttermilk, formula or yogurt yesterday, during the day and night? (Note: Do not include number of times the child was breastfed in this question. This variable is only to capture milk or milk products other than breast milk.)	<input type="text"/> NA 99	
414	How many times did [NAME] eat solid, semi-solid or soft foods other than liquids yesterday, during the day and night? Soft and Semi-solid foods such as gruel, porridge, mashed potato, ripe banana, other mashed family foods etc. Solid foods such as Injerea, Fir fir, bread, wheat etc. MEALS include both MEALS and SNACKS (other than trivial or very small amounts)	<input type="text"/> NA 99	
415	Of the cooked foods that you fed the child yesterday, could you tell us about how many <i>meals</i> you offered the child to eat yesterday? Please think of the total amount of food the child was given.	<input type="text"/> NA 99	
416	Yesterday (during the day or the night) did you give any of the following liquids to the child?		
01	Breast milk	Yes 01 No 02	
02	Water	Yes 01 No 02	
03	Baby formula milk	Yes 01 No 02	
04	Any other kind of milk (cow/goat milk, etc)	Yes 01 No 02	
05	Fruit juice (made at home)	Yes 01 No 02	
06	Fruit juice or sodas (purchased, packaged)	Yes 01 No 02	
07	Water-based liquids, teas, sugar water, coffee	Yes 01 No 02	
08	Other (ask respondent if child drunk anything not on this list) specify: _____	Yes 01 No 02	
417	Did your child eat (or drink) any of the following Solid foods yesterday (during the day or night)?		
01	Any porridge	Yes 01 No 02	
02	Any gruel	Yes 01 No 02	
03	Any commercially fortified food (Cerifam, Fafa, Farmixt milk, Favena, Berta, Mother's Choice) <i>Add name of most common food that iron fortified. Country specific.</i>	Yes 01 No 02	
04	Bread, pasta, rice, noodles, biscuits, cookies, or any other foods made from oats, maze, barley, wheat, sorghum, millet or other grain	Yes 01 No 02	
05	Injera or kita	Yes 01 No 02	
06	Any white potatoes, white yams, Bulla, Kocho, Kasava or any other food made from roots	Yes 01 No 02	
07	Any pumpkin, carrot, squash or sweet potato that are yellow or orange inside	Yes 01 No 02	
08	Dark green leafy vegetables (example: Kale, spinach or Amaranth leaves)	Yes 01 No 02	
09	Any other vegetables (starchy vegetables: plantain)	Yes 01 No 02	
10	Any liver, kidney, heart or organ meats	Yes 01	

		No 02	
11	Any meat? (which does not include any organ meats, dry meat, any chicken ducks or other birds)	Yes 01 No 02	
12	Any dry meat?	Yes 01 No 02	
13	Any chicken ducks or other birds	Yes 01 No 02	
14	Any eggs	Yes 01 No 02	
15	Any fresh or dried fish or shell fish	Yes 01 No 02	
16	Any food made from beans, peas, lentil or pulses	Yes 01 No 02	
17	Any nuts or seeds such as peanuts, sesame, sunflower seeds	Yes 01 No 02	
18	Any milk product like cheese, yogurt	Yes 01 No 02	
19	Any food made from oil, fat or butter	Yes 01 No 02	
20	Any Ready to use therapeutic foods (like plumpy nuts, F100)	Yes 01 No 02	
21	Candies or chocolates, cakes	Yes 01 No 02	
22	Any other solid or semi-solid food (ASK RESPONDENT IF CHILD ATE ANYTHING NOT ON THIS LIST)SPECIFY: _____	Yes 01 No 02	
23	Any iron-containing tablet, syrup or sprinkles	Yes 01 No 02	

ANNEX II: QUALITATIVE DATA COLLECTION TOOLS (KII Guide)

KEY INFORMANT INTERVIEW GUIDE FOR PROJECT STAFF AT FIELD AND NATIONAL LEVEL, WOREDA HEALTH OFFICE & DRR AND AGRICULTURE OFFICE REPRESENTATIVES

INTRODUCTION AND CONSENT

Hello, my name is _____ and I am here on behalf of Climax Consulting Service PLC, GOAL Ethiopia and the regional health bureau to collect data for a final evaluation of a project called “Emergency Response for Drought-Affected & Displaced Communities in Somali Region” which is funded by OFDA since April 2019. The project has been implemented in the past 12 months in seven Woredas of Dollo Zone of Somali regional state.

This interview is intended to collect information that will inform GOAL Ethiopia and Donors on the contribution of the project performance and activities in achieving the desired outcomes, and evaluate the effectiveness of the nutrition program. The result of the evaluation will also examine lessons and best practices that will potentially give inputs to design future similar interventions.

As participation in this interview is voluntary, please let us know your decision whether you want to take part in this evaluation as an informant or not. Please be informed that we will be using voice recorders to record the discussion; but this is only for this evaluation purpose to make sure that we don't forget the most important points you share during the discussion and will not be shared to anyone outside of the evaluation team. We would like to thank you for your time and willingness to participate in this discussion and please be informed that all the information you provide will be confidential and will not be shared to anyone else except the evaluation team. Your name, or any other identifying information, will not be used in a final report or in any other document available to the public. Your participation is voluntary, and you are not obliged to answer any questions you do not want to. The discussion will take about 45 minutes to complete.

Are you willing to take part in the study? (Circle)

1. Yes 2. No

I read the aforementioned information and procedures to each evaluation participants.

I asked if the evaluation participants have any questions and tried to address all of them to the best of my capacity. Each person is willing to take part in the evaluation.

Do you have any question before we start our discussion?

Name of Interviewer/Facilitator			
Date of Interview			
Start time	hh/mm	End Time	hh/mm
Signature			

Socio Demographic Background

Region/ Zone		Woreda	
		Kebele	
Age			
Sex			
Name of Organization represented			

Position/Responsibility of interviewee			
Telephone number of interviewee			

Relevance	<ul style="list-style-type: none"> ▪ In general, what was the situation in this area at the inception stage of this emergency response project? What triggering factors were there for the design of this project? Probe for; <ul style="list-style-type: none"> - Humanitarian context in general (e.g. drought effect, HH food security status, malnutrition related morbidity & mortality etc) - Capacity of government institutions (specifically the health system & facilities) ▪ How would you assess the relevance of the project? Probe relevance of the project in terms of : <ul style="list-style-type: none"> - Malnutrition related morbidity and mortality - IYCF related behaviors of the community - Capacity gap in the health system - Being aligned to government emergency response policies, strategies and priorities ▪ How do you see the appropriateness of the project service delivery modalities vis-à-vis the livelihood styles of the pastoralist communities? Please describe any gaps observed on CMAM intervention modalities of the project used during the implementation period ▪ What do you think that the various CMAM intervention modalities (at health facility, outreach and mobile sites) sufficiently appropriate and relevant for the pastoral context?
Effectiveness	<ul style="list-style-type: none"> ▪ Please describe for us how the project were able to meet the targets and contribute to the set outcomes and outputs (provide evidence on drivers on): <ul style="list-style-type: none"> - Improving IYCF behavior and practices of the community - Management of Acute Malnutrition - WASH - Improving access to nutrition and health services for drought affected pastoralist communities and IDP's ▪ How do you see the effectiveness of the project comprehensive responses in reducing malnutrition related morbidity and mortality among children under five and pregnant and lactating women? <ul style="list-style-type: none"> - Treatment of severe & moderate acute malnutrition (e.g. site expansion, capacity building of health workers, TSFP etc) - IYCF behavior change interventions and community mobilization - Outreach and MHNT service delivery <p>If the above comprehensive approach is effective, please describe for us the major drivers of success and innovation that need to be scaled up? Also describe the major gaps and challenges</p> ▪ How do you see the performance of the monitoring and follow up mechanisms of the project with respect to improving the effectiveness of the project? Probe for; availing quality, adequate and timely data; use of data for improving performance & program decision making. Are there any best practices as well as gaps on the monitoring and follow up mechanism used during the project implementation period? <ul style="list-style-type: none"> - To what extend was learning and research captured by the Project? - Was learning being used to adapt programming and influence other projects, and/or national and/or local policy and practice? - Was the learning and research shared internally and externally?
Efficiency	<ul style="list-style-type: none"> ▪ How do you assess the efficiency of the project in terms of timely delivery of outputs, human resource use and other management and administrative issues? ▪ Do you think the project made appropriate and timely adaptations in response to changes in the external environment? How? What examples can you mention? ▪ What innovation introduced by the project do you think is cost effective and needs to be scaled up? (Probe for : project implementation strategy, monitoring mechanisms, collaboration with partners and synergy etc)

	<ul style="list-style-type: none"> ▪ Did any unplanned outputs arise from the activities so far? ▪ Which of the innovation (implementation strategy and interventions) introduced by the project do you think are cost effective and needs to be scale up? Which ones are costly & needs to be looked into?
Impact	<ul style="list-style-type: none"> ▪ In your opinion what are the significant changes made due to the implementation of this project? Probe for: the contribution of the project in strengthening the capacity of government to effectively deliver CMAM services without external support ▪ What are the likelihood effects of the project in reducing the level of severe acute malnutrition? ▪ What factors do you anticipate that affect the long term impact of the project? Are there any unplanned positive or negative effects (impact) of the project?
Sustainability	<ul style="list-style-type: none"> ▪ In your opinion, which project activities do you think could the government at all levels take over and implement without the project support? Why and how? Which ones cannot be sustained and need further support? Please provide evidence and justification. ▪ To what extent did the project utilize established institutions/mechanisms to ensure sustainability at the end of the project? ▪ What were the major factors which influence the sustainability of the project? ▪ In your opinion, what lessons learned could be used beyond the project area? What does this project do that others don't do?
Coverage	<ul style="list-style-type: none"> ▪ What is your opinion on the adequacy of the geographical coverage of this project? Do you think the project covered all the needy people? Please explain on the strength and limitation of the project in terms of geographical coverage. ▪ At the design stage of the project, what were the main factors considered for the geographical coverage of the project? ▪ What do you think is important to consider in the future with respect to project coverage? ▪ How do you explain the coverage of the project intervention in all sites, in terms of creating access and service provision; <ul style="list-style-type: none"> ❖ Community Outreach and Mobilization ❖ Periodic Screening for Acute Malnutrition ❖ Treatment of Moderate Acute Malnutrition – TSFP ❖ Treatment of Severe Acute Malnutrition – OTP and SC ❖ Mobile Health and Nutrition Teams and/or Outreach Services

KEY INFORMANT INTERVIEW GUIDE FOR HEALTH FACILITY REPRESENTATIVES, HEALTH EXTENSION WORKERS AND MHNT REPRESENTATIVES

INTRODUCTION AND CONSENT

Hello, my name is _____ and I am here on behalf of Climax Consulting Service PLC, GOAL Ethiopia and the regional health bureau to collect data for a final evaluation of a project called “Emergency Response for Drought-Affected & Displaced Communities in Somali Region” which is funded by OFDA since April 2019. The project has been implemented in the past 12 months in seven Woredas of Dollo Zone of Somali regional state.

This interview is intended to collect information that will inform GOAL Ethiopia and Donors on the contribution of the project performance and activities in achieving the desired outcomes, and evaluate the effectiveness of the nutrition program. The result of the evaluation will also examine lessons and best practices that will potentially give inputs to design future similar interventions.

As participation in this interview is voluntary, please let us know your decision whether you want to take part in this evaluation as an informant or not. Please be informed that we will be using voice recorders to record the discussion; but this is only for this evaluation purpose to make sure that we don't forget the most important points you share during the discussion and will not be shared to anyone outside of the evaluation team. We would like to thank you for your time and willingness to participate in this discussion and please be informed that all the information you provide will be confidential and will not be shared to anyone else except the evaluation team. Your name, or any other identifying information, will not be used in a final report or in any other document available to the public. Your participation is voluntary, and you are not obliged to answer any questions you do not want to. The discussion will take about 45 minutes to complete.

Are you willing to take part in the study? (Circle)

1. Yes 2. No

I read the aforementioned information and procedures to each evaluation participants.

I asked if the evaluation participants have any questions and tried to address all of them to the best of my capacity. Each person is willing to take part in the evaluation.

Do you have any question before we start our discussion?

Name of Interviewer/Facilitator			
Date of Interview			
Start time	hh/mm	End Time	hh/mm
Signature			

Socio Demographic Background

Region/ Zone		Woreda	
		Kebele	
Age			
Sex			
Name of Organization represented			
Position/Responsibility of interviewee			
Telephone number of interviewee			

<p>Relevance</p>	<ul style="list-style-type: none"> ▪ In general, what was the situation in this area at the inception stage of this emergency response project? What triggering factors were there for the design of this project? Probe for; <ul style="list-style-type: none"> - Humanitarian context in general (e.g. drought effect, HH food security status, malnutrition related morbidity & mortality etc) - Capacity of government institutions (specifically the health system & facilities) ▪ How would you assess the relevance of the project? Probe relevance of the project in terms of : <ul style="list-style-type: none"> - Malnutrition related morbidity and mortality - IYCF related behaviors of the community ▪ What do you think that the various CMAM intervention modalities (at health facility, outreach and mobile sites) sufficiently appropriate and relevant for the pastoral context?
<p>Effectiveness</p>	<ul style="list-style-type: none"> ▪ How do you see the effectiveness of the project comprehensive responses in reducing malnutrition related morbidity and mortality among children under five and pregnant and lactating women? <ul style="list-style-type: none"> - Treatment of severe & moderate acute malnutrition (e.g. site expansion, capacity building of health workers, TSFP etc) - IYCF behavior change interventions and community mobilization - Outreach and MHNT service delivery <p>If the above comprehensive approach is effective, please describe for us the major drivers of success and innovation that need to be scaled up? Also describe the major gaps and challenges</p> ▪ In what ways the capacity building training helped you to provide better CMAM services for the community? Please provide us some explanation and examples in terms of capacity improvement ▪ How do you see the performance of the monitoring and follow up mechanisms of the project with respect to improving the effectiveness of the project? Probe for; <ul style="list-style-type: none"> - Were there any supportive supervision and monitoring provided for you during the project implementation period? In what ways such supports helped you to perform better?
<p>Efficiency</p>	<ul style="list-style-type: none"> ▪ How do you assess the efficiency of the project in terms of timely delivery of outputs, human resource use and materials? ▪ Did any unplanned outputs arise from the activities so far? ▪ Which of the innovation (implementation strategy and interventions) introduced by the project do you think are cost effective and needs to be scale up? Which ones are costly & needs to be looked into?
<p>Impact</p>	<ul style="list-style-type: none"> ▪ In your opinion what are the significant changes made due to the implementation of this project? Probe for: the contribution of the project in strengthening the capacity of government to effectively deliver CMAM services without external support ▪ What are the likelihood effects of the project in reducing the level of severe acute malnutrition? ▪ What factors do you anticipate that affect the long term impact of the project? Are there any unplanned positive or negative effects (impact) of the project?
<p>Sustainability</p>	<ul style="list-style-type: none"> ▪ In your opinion, which project activities do you think could the government at all levels take over and implement without the project support? Why and how? Which ones cannot be sustained and need further support? Please provide evidence and justification. ▪ To what extent did the project utilize established institutions/mechanisms to ensure sustainability at the end of the project? ▪ What were the major factors which influence the sustainability of the project? ▪ In your opinion, what lessons learned could be used beyond the project area? What does this project do that others don't do?
<p>Coverage</p>	<ul style="list-style-type: none"> ▪ What is your opinion on the adequacy of the geographical coverage of this project? Do you think the project covered all the needy people? Please explain on the strength and limitation of the project in terms of geographical coverage.

- | | |
|--|--|
| | <ul style="list-style-type: none">▪ How do you explain the coverage of the project intervention in all sites, in terms of creating access and service provision;<ul style="list-style-type: none">❖ Community Outreach and Mobilization❖ Periodic Screening for Acute Malnutrition❖ Treatment of Moderate Acute Malnutrition – TSFP❖ Treatment of Severe Acute Malnutrition – OTP and SC❖ Mobile Health and Nutrition Teams and/or Outreach Services |
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ANNEX III: QUALITATIVE DATA COLLECTION TOOLS (FGD Guides)

FOCUS GROUP DISCUSSION GUIDES

General Instruction to the Interviewer

- Introduce yourself and explain the purpose of the final evaluation and how this interview will contribute to the success of the study.
- Ask for consent from the discussants and that participation is voluntary.
- Remember that it is not necessary to ask every question or to ask the questions in the exact order given. Sometimes, a topic will come up spontaneously and it is advisable to explore that topic even if it is being discussed in an order different from that of the discussion guide.
- As a discussion facilitator, you should be very familiar with the guide before starting the discussion so that topics that come spontaneously out of order can be followed and that you will know when it is necessary to use the “probe” sections extensively.

General information about the participant:

Participant	District	Kebele	Sex	Age	Education	Occupation
P1						
P2						
P3						
P4						
P5						
P6						
P7						
P8						

Begin the Discussion by Saying:

Today we will be discussing some issues related to the activities and results achieved through implementation of ***Emergency Response for Drought-Affected and Displaced Communities*** funded by OFDA since April 2019 to reduce morbidity and mortality and improve wellbeing among drought-affected and displaced communities in Somalie region.

The findings of the evaluation will inform Goal Ethiopia and its partners about the effects of the project on the target groups. It will also help to identify and document on success factors and challenges. We would like to thank you very much for your time and willingness to participate in this group discussion and please be informed that all the information you provide will be confidential and will not be shared to anyone else except the research team. There is no need to mention your name in the discussion.

Do you have any question before we start our discussion?

Can we start our discussion now?

Guiding Questions

- What was the situation in this area before the implementation of the emergency response project with respect to malnutrition morbidity and mortality, rainfall patterns (drought) and household food security in general?
- What kind of interventions do the project have been implementing in your community with regard to the following activities:
 - ✓ Management of Acute malnutrition among under five children
 - ✓ IYCF-education and promotion (improving the behavior and practice of the community)
 - ✓ Improving the nutrition and health services of pregnant and lactating women
 - ✓ Creating WASH behavior change activities for drought affected pastoralist communities
- How do you explain the participation and engagement of the community members/ beneficiaries in different project implementation activities?
- How do you explain the various CMAM intervention modalities (at health facility, outreach and mobile sites) are sufficiently appropriate and relevant for your community?
- How do you assess the effectiveness of the project emergency responses in reducing malnutrition related morbidity and mortality among children under five and pregnant and lactating women? Probe, in terms of;
 - Treatment of severe & moderate acute malnutrition (e.g. site expansion, TSFP etc)
 - IYCF behavior change interventions and community mobilization
 - Outreach and MHNT service delivery
- What changes have you seen after the intervention of the project on the knowledge and practice of community members on issues related to IYCF and pregnant and lactating women and malnutrition?
- Do you think the project covered all the needy people? Do you think that all children with SAM in your community are identified and get the appropriate service timely? Please explain on the strength and limitation of the project in terms of geographical coverage.
- How are going to support (contribute) in order to sustain the project activities?
- In your opinion, what are your general recommendations that the project should have been improved during the implementation period?
- Anything else that you would like to add