This report is commissioned by Action Against Hunger | ACF International. The comments contained herein reflect the opinions of the Evaluator only.
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He would also like to thank the translators, as well as the drivers, health workers and families who provided valuable information.

Figure 1. Focus Group Discussion with women in the village of Mohad Khan Samoo, Thatta district
Executive Summary

The main objective of this report is to evaluate the PEFSA II and MONSOON projects. These projects were implemented in 9 UCs in the Thatta district and 4 UCs in the Badin district in the Sindh Province between September 2011 and June 2012. The PEFSA II project was an alliance of 6 NGOs: OXFAM, ACF, Save the Children, IRC, ACTED and CARE; working principally in two sectors: FSL and Nutrition. The MONSOON project, also financed by ECHO, had a similar approach and started in December 2011.

At the same time, ACF has been working on nutrition programs in some UCs in the Dadu district. Continuing with UNICEF leadership, ACF will take charge of nutrition CMAM in the entirety of the Dadu, TMK, and Badin districts.

Both a qualitative and quantitative approach has been taken with regards to this evaluation, through the program target indicators seeking to determine its relevance, coverage, effectiveness and efficiency and to document best practices and lessons learned.

Overall it is considered that the needs were well defined, and a good detailed assessment has been observed. However the impact of some socio-cultural factors was not taken into account, which had an important impact in the awareness of the population. A lack of an exit plan in the design of the program was also observed.

The Project is found to be in line with national plans and nutrition policies. In addition, ACF is well known within the nutrition cluster at national and regional level. ACF still need to strengthen their knowledge with regards to Community / Lady Health workers (LHW) inside the national protocol since there was no formalized partnership with the LHW. Due the amount of trainings provided some time should have been spent in planning and preparing the training guide.

The Proposal recognized the need to ensure the project’s sustainability and expected that it would be achieved through partnerships and capacity-building. However some important partnerships were not possible and the OTPs were implemented in isolation, especially for outreach activities, and had a limited integration within the health system as a whole.

The need to target rural areas was appropriate. The problem was the distribution of different UCs among the NGOs working in nutrition. In addition FSL activities were distributed according to the needs assessed by FAO, meaning that ACF nutrition and FSL teams were working in different UCs. Sensitization coverage remained low among health workers (20% achieved, view impact) and LHW (80%), furthermore, these trainings had no real impact. However trainings on CMAM for beneficiaries in terms of attendance exceed the objectives.

It is difficult to assess the coverage rate for CMAM without a coverage survey/assessment. When the partnership with PPHI was not developed, OTPs moved from a static perspective in BHUs to a mobile perspective. This has clearly affected sustainability and integration within health structures but has improved coverage.

The program has a good impact in the number of admissions for SFP and PLW though OTP was greatly delayed and SC only opened in June 2012 and failed to raise awareness. The duration of the project is too short to expect significant changes in the prevalence of malnutrition. Though CMAM worked well and beneficiaries attended, activities concerning the integration of local Health Structures have not been achieved. SAM children attending OTPs are considered the most effective activities of the project by ACF staff.
In terms of the employment of resources, especially financial resources, it is difficult for us to give an in depth answer in this evaluation. Only an audit can give justified and evidenced opinions. Nevertheless it is important to note that there is a rigorous budget follow up that ensures expenses are regular and well established respecting ACFs procedures, comparing cost, and assuring quality.

The Project addressed gender as a woman’s issue rather than addressing the differential social roles of men and women. Given the dominance of the patriarchal system and the role of men in decision making, little attention to their specific needs may create misunderstandings and resistance, and ultimately limit impact if they feel excluded from the activities. The Project should encourage training for male and female community volunteers alike.

Based on the results obtained, the main recommendations to be considered are:

- **Increase integration into the health system.**
- **Improve integration with FSL.**
- **Promote CNV** to work independently with monthly refresher trainings and meetings, and implement a monitoring system for CNV.
- **Mobile CMAM** works very well but consumes a lot of resources. They should be combined with OTPs in Health Facilities to promote integration and sustainability. Need to think about different approaches to reach MAM and PLW.
- **Create an emergency stock** for OTP maintained at all times.
- **All trainings** need monitoring and feedback, and a training guide should be prepared with help from HQ.
- Every practice should have a **consensus** and be shared by the other NGOs working in the same area to facilitate integration.
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5. **ANNEXES (INCLUDED IN SEPARATE PDF FILE)** ......................................... 33
ACF  on Against Hunger
BHU  Basic Health Unit
CDR  Crude Death Rate
CNV  Community Nutrition Volunteer
DHS  Demographic and Health Surveys
DoH  Department of Health
ECHO  European Commission for Humanitarian Aid and Civil Protection
EDO  Executive District Office
ENA  Emergency Nutrition Assessment
FAO  Food and Agriculture Organization
FNRI  Food and Nutrition Research Institute
FS   Food Security
GAM  Global Acute Malnutrition
HH   Households
IDP  Internally displaced person
INGO International Non-governmental Organizations
IRC  International Rescue Committee
IYCF Infant and Young Child Feeding
LHW  Lady Health Workers
MAM  Moderate Acute Malnutrition
MUAC Mid Upper Arm Circumference
NGOs Non-governmental Organization
NNS  National Nutrition Survey
OTP  Outpatient Therapeutic Program
PLW  Pregnant and Lactating Woman
PPHI People Primary Health Initiative
RR   Risk Ratio
RHC  Rural Health Centre
SAM  Severe Acute Malnutrition
SC   Stabilization Centre
SMART Standardized Monitoring and Assessment of Relief and Transitions
SQUEAC Semi-Quantitative Evaluation of Access and Coverage
UC   Union Council
UN   United Nations
UNFPA United Nations Population Fund
UNICEF United Nations Children’s Fund
WASH Water, Sanitation and Hygiene
WHO  World Health Organization
WFP  World Food Program
WSB  Wheat Soy Blend

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1. Background

1.1. Target Area

Over the course of the 2010 monsoon season, Pakistan experienced the worst floods in its history. At the end of July, heavy rains triggered floods in several parts of Pakistan, resulting in loss of life, widespread displacement and damage. The floods have affected 84 districts out of a total of 121 districts in Pakistan, and more than 20 million people (one-tenth of Pakistan's population). The floods killed more than 1,700 men, women and children, and nearly 1.9 million homes have been damaged or destroyed. The UN has identified over 6 million people affected in Sindh Province.

Compounding the problem is that even before the monsoon floods Pakistan suffered from widespread hunger, with an estimated 82.6 million people, a little less than half the population, estimated to be food insecure.

Unfortunately, in August-September 2011 many districts in Southern Sindh were hit again by heavy rains and flooding with a devastating effect on the livelihood of the people. The district government and NGOs organized an emergency response through various interventions to support affected communities. By mid November 2011 the water had largely withdrawn from the affected areas and it was in that context that these programs were implemented in the Thatta and Badin districts.

Figure 2. Pakistan Province map and Sindh District map

Pakistan is a federation of four provinces and other autonomous regions. The Sindh province accounts for more than 55 million inhabitants. Since the 18th amendment of the constitution in 2011, the Ministry of Health was abolished and all health responsibilities were transferred to provincial Health Departments, which have since been the main implementers of public sector health programs. However a good part of the healthcare is administered mainly in the private sector. Within the Sindh province there are 23 districts and one district health office coordinates health care, centralizing it in a District hospital.

Each district is divided into several Talukas (9 for the Thatta District that accounts for 1,150,000 inhabitants and 5 for Badin with a similar population but geographically is half its
size). Normally a Taluka counts for a Rural Health Centre ruled by the government through the District Health department. Each Taluka is divided into 2, 3 or 4 Unit Councils which are the smallest administrative division and count for 1 Basic Health Unit. The management of Basic Health Units was subcontracted to the semi-private initiative PPHI by the government for a period of 3 years.

A UC can be subdivided into Dehs which account for several villages (7-10). Usually a General/Civil dispensary can be found in every Deh at village level and are controlled by either the government or the PPHI. Another governmental health initiative is the National Programme for Family Planning & Primary Health Care (LHW Programme). It is the world’s largest community based primary health care programme delivering services through 96,000 LHWs in their own communities to address unmet health needs of rural populations and slum dwellers. Coverage however remains imbalanced, and some areas need more personnel, a topic that will be explored later in this paper.

It is in this context that ACF has been working for various years, and this report aims to evaluate the implementation of two nutrition programs in two districts of Sindh province.

The Thatta district is especially prone to seasonal floods that, in combination with underlying root causes of chronic food insecurity, push local communities below poverty thresholds. On June 6th 2010, Cyclone Phet hit the coastal area between Karachi and Keti Bunder and caused a landfall at Mirpur Sakro in the Thatta district. The cyclone caused torrential rainfall, significant destruction by sea swell and high winds in Thatta, Hyderabad and neighboring areas. On the 26th of August, two dykes protecting land in the Thatta district from the Indus River broke in two locations. One of these breaches heavily flooded the 3 Talukas of the east bank of the Indus River (Sujawal, Jati, Mirpur Bathoro, see map in coverage section), and the other one heavily flooded the Thatta Taluka on the west bank of the river including Thatta town. In 2011 heavy rains fell till the end of September, again with grave impacts on populations.

The Badin District is located to the east of Thatta. Based on NDMA reports, over 1,000,000 people in the Badin District in 5 Talukas and 46 UCs have been severely affected. A total of 984,805 acres of agricultural land, mainly cotton (100%), rice (85%) and sugarcane (43%), have been destroyed. Secondary data from FAO bring the number of villages affected by the recent floods to 1,890 (graph 1) and the number of informal IDP camps to over 266.

Chronic food insecurity was exacerbated due to the extreme weather conditions that hit the districts back to back, destroying livelihoods, weakening coping mechanism and creating a humanitarian emergency in an area where there was already an underlying crisis. At present, the situation in the worst-affected parts of the Thatta and Badin districts remains prevalent. The Agriculture and Food Security Early Recovery Working Group estimates that only after four planting seasons, small farmers will be able to come close to a pre-flood situation. Now, the poorest households are almost entirely dependent on casual labour for food and income.

1.2. Projects and Main objectives

ACF’s humanitarian assistance in Pakistan started in 1979. ACF was already working in WASH and FSL programs in the Sindh Province before the 2010 floods. Following the declaration of a flood emergency by the government on 9th September almost after one month of floods, ACF conducted an Integrated Rapid Assessment (WASH, FSL and NUT) in union councils in the Dubi, Golarchi, Kario, Ganhwar, Trai and Khorwah in Badin districts. ACF used knowledge and interaction with beneficiaries of existing projects to gain an accurate understanding of the situation in Thatta district UC’s.

Before the end of 2010, ACF was working in 5 UCs on Integrated Nutrition Programs financed by OCHA and CIDA. Following this, the PEFSA project financed by ECHO was implemented in 2011 with 6 International partners (SC and AF working in nutrition) and was followed by PEFSA
II from June 2011 to May 2012. A further project financed by ECHO, the MONSOON project, was implemented between December 2011 and June 2012. The program was a continuation of the previous ERF program.

The main objective of this report is to evaluate the PEFSA II and MONSOON projects. These projects were implemented in 9 UCs of the Thatta district and 4 UCs in the Badin district. A 5th UC in the Badin district was scheduled but due to security reasons was not carried out.

Table 1. PEFSA II objectives and beneficiaries

<table>
<thead>
<tr>
<th>Objective</th>
<th>Number of beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase purchasing power and income</td>
<td>7,000HH 49,000 beneficiaries</td>
</tr>
<tr>
<td>2. Identification and treatment of acute malnutrition</td>
<td>6,500 individuals</td>
</tr>
<tr>
<td>3. Improved coherence, knowledge and information on FS and Nutrition</td>
<td>No direct beneficiaries but largest impact</td>
</tr>
</tbody>
</table>

Objective 1 was targeted mainly by FSL team, Nutrition teams implemented the second, and Objective 3 was shared between FSL and Nutrition.

Table 2. MONSON Objectives and beneficiaries

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conditional Cash grants</td>
<td>most vulnerable</td>
</tr>
<tr>
<td>2. Cash for work</td>
<td>vulnerables</td>
</tr>
<tr>
<td>3. CMAM program</td>
<td>SAM, MAM and PLW</td>
</tr>
</tbody>
</table>

Nutrition teams were, again, responsible for activities under the scope of Objective 3

1.3. Development of the projects

PEFSA II

PEFSA II was an alliance of 6 NGOS: OXFAM, ACF, Save the Children, IRC, ACTED and CARE. These organisations worked mainly in two sectors; FSL and Nutrition.

FSL: ACF implemented an approach to empower the most vulnerable HH. In an effort to give more households a chance to benefit from the project, and also in order to avoid community conflicts, ACH and target communities agree that a household will be considered for one Food Security and Livelihood support modality that bests suits its needs in accordance with the beneficiary selection criteria. Therefore in absence of double counting ACF planned to reach 7700 households (or 51,100 individuals).

Nutrition: CMAM admission activities started with at least a 2 months delay due to; problems in the delivery of UNICEF and WFP supplies, signing partnerships with the government which
took longer than expected, challenges with PPHI and the floods in September. Based on the admission trends of the CMAM programme in December and the new national GAM and SAM prevalence, the target to be achieved at the end of the project was changed to 3,720 beneficiaries, a reduction of 57%.

**MOONSON**

In the Thatta district the nutritional activities undertaken were a continuity of the CMAM program that was run by ACF’s ERF/OCHA funded program and ceased in mid November 2011. In the Badin district the 5 UC nutritional activities were newly implemented.

In addition to the treatment of children and PLW in CMAM, program trainings to build local capacities were dispensed to health workers. Lady Health Workers were newly trained on CMAM and anthropometric measurements, and Community Nutrition Volunteers (CNVs) were trained on identification and referral.

Unfortunately the partnership with PPHI could not been implemented and CMAM programs was not placed on BHU. Instead a program of mobile OTP was established in the 14 UCs. In each UC one team was in charge of delivering the CMAM project. The team’s structures change slightly through 2012 and between programs but can be seen in the following flow chart.

![Flow Chart](image)

Usually some casual workers were employed to help with screening, to do the medical check-up, and distribute RUTF sachets in numbers of 5 per OTP site.

At the same time ACF has been working on nutrition programs in some UCs of the Dadu district, and continuing with UNICEF leadership, ACF will take care of nutrition CMAM in all of the Dadu, TMK, and Badin districts. Thatta will be mainly taken care of by MERLIN and Shikapur by Save the Children. The PPHI will take over some UCs in these districts but different UNCs from those where the iNGOs will be working.
2. Methodology

2.1. Objectives of the evaluation

This final evaluation, covering the period June 2011 - June 2012, aims to assess the overall impact and sustainability of the two Projects founded by ECHO: PEFSA II and MONSOON, corresponding to the budgetary lines A1F and A1D. It also seeks to determine its relevance, coverage, effectiveness and efficiency and to document best practices and lessons learned. The results are to be used to inform all ACF headquarter (HQ) offices, field level and other organisations, of the progress achieved, in order to guide decision making about future programming, and to contribute to the knowledge in a region with a high SAM and MAM prevalence. The latest national survey indicates a Global Acute Malnutrition (GAM) rate of 17.5% and a Severe Acute Malnutrition rate of 6.6% for children under five years, in the Sindh province.

ACF-UK, which serves as the focal point for monitoring and evaluation (M&E) in ACF-International, has overall responsibility for managing the Project evaluation. The evaluation has been carried out by an independent international consultant, with expertise in evaluation, epidemiology and public health, and experience in nutrition and CMAM programs in developing countries. The Consultant had no prior involvement with the Project.

An evaluation matrix was developed to provide a framework to guide data collection, fieldwork and analysis (see annex 6). The matrix will link evaluation criteria to key hypotheses, indicators, data collections methods and information sources.

2.2. Preparatory Work

ACF made a large number of documents available at the beginning of the preparatory work, which was also carried out by the staff in Islamabad and New York. The evaluation therefore started with the review of relevant documents, including proposals, logframe, progress reports, narrative and financial reports, training resources, materials, and correspondence. Further data was provided by ACF staff in Thatta, including admissions data-base, census of the villages covered by the program, admissions formularies etc.

2.3. Selection of Sites and Respondents

A first attempt to select the sites to be visited, to agree the field work schedule and to define the interviews was made in Islamabad. A final schedule was proposed once in the field. It was considered that visiting 6 out of 13 Unit Councils is a sufficiently large sample size to gain an overall overview of the Project, and meet sufficient stakeholders and beneficiaries.
In each UC two villages were visited. In each selected village, separated male and female focus group discussion (FDG) and key informants interviews were conducted, as well as direct observations of established camps and village status.

Before leaving Pakistan, the Consultant presented the preliminary findings to ACF-Pakistan and ECHO was invited. After this presentation the Consultant submitted the first draft report to ACF-UK, ACF-USA and ACF-Pakistan. The comments received were used in preparing the final report.

2.4. Data Collection Instruments

To answer the evaluation’s questions, the Consultant used key informant interviews, group discussions, direct observation, secondary data extracted from the Project documents and triangulation. Data collection instruments consisted primarily of open-ended questions to guide the interviews (see annexes 5&6).

2.5. Data Analysis and Reporting

Data analysis was carried out daily in conjunction with data collection. The interview notes were collated and analysed to identify key emerging themes, focusing on issues that were mentioned frequently and/or consistently, and/or received particular emphasis. The analysis was confirmed triangulating information from Project staff, beneficiaries and relevant stakeholders.

2.6. Limitations

The Consultant did not encounter major constraints in terms of access to selected sites. All travel worked to plan with logistical support. The Consultant greatly appreciated the willingness of ACF staff members to communicate with him regularly throughout the mission period.

Nevertheless some constraints required additional efforts form everyone.

- This evaluation happened whilst ACF’s Thatta base was moving to TMK base. Coordination was difficult in terms of assuring transport, drivers and logistical support.

- Demonstration and strikes on the road happened twice, once preventing access to 1 UC and again delaying the road trip on another occasion: resulting in no time to visit all the desired villages on that day.

- Meeting with UNICEF and WFP in Karachi was not possible due to visits from UNCEF regional advisors. These individuals were contacted via telephone.

- ECHO was not finally contacted in Islamabad and they could not attend the presentation of preliminary results.

- PPHI was welcoming but refused to talk about any subject related to nutrition since, according to them, this should be a strictly internal debate within Pakistan.

The Consultant found the beneficiaries receptive to the interviews. However, local populations do not allow male strangers to meet women and are reluctant to give permission
to conduct interviews with them. That is why FGD was the most selected approach when talking with female beneficiaries. In the village of Rahib Amro they did not allow us to enter the village and meet with the women, therefore only interviews and FGD with males were conducted.

Often beneficiaries did not know the Project to the extent envisaged, and time was spent explaining the mandate of ACF. But almost everyone was welcoming and willing to share opinions.
3. Findings and discussion

3.1. Relevance and appropriateness

Relevance is concerned with evaluating whether the Project is in line with local needs and priorities. The core elements needed to answer this question were: Project design (including assessment of needs), priority-setting, and level of participation of partners and beneficiaries. Appropriateness was evaluated as the degree of correspondence between the needs identified and the type of strategies and activities selected.

3.1.1 Needs Assessment and priority settings

ACF was familiar with the area thanks to other nutrition, FSL and WASH programs in the region and have had some experience developing CMAM programs in Sindh since 2010. These two new projects intended to continue some of the activities already started after the 2010 floods as well as increasing ACF presence in other Thatta’s UC and Badin District. Several assessments and/or baseline surveys were done by ACF and the members of the PEFSA alliance.

The context analysis was very comprehensive and based on different sources of information including: PEFSA partners’ assessments, post distribution/harvest reports and baseline surveys, OCHA reports, preliminary result of the Flood Recovery Assessment, UNHCR Village profiling, ACF/UNICEF Flood Affected Nutrition Survey (FANS), PDMA data and information gathered by partners’ staff through informal discussions with key informants and affected populations. All this pointed out the following problems:

Malnutrition prevalence: In the national survey of 2001-02, the prevalence of Global Acute Malnutrition (GAM) rate was 13%, while the national prevalence of severe acute malnutrition (SAM) was 3%. An integrated assessment after the 2010 floods showed GAM to be at 19.6% & SAM to be at 2.4%. The ACF SMART survey carried out by the end of 2011 in Thatta showed GAM to be at 12% and SAM to be at 2%. The latest national survey indicates in the Sindh province a GAM rate of 17.5% and SAM rate of 6.6%.

We think that malnutrition was a chronic problem in Pakistan and Sindh much before the floods, which drew the attention of the international community.

Also the flood struck just before the harvesting of key crops, including cotton, rice, maize, vegetables and sugarcane and on the onset of the Rabi (winter) wheat planting season. In Sindh 7.2 million people were affected and in terms of overall production there was a loss of 94.000 large animals, 82.0000 sheep and goats and around 7 million poultry.

Table 3. Malnutrition prevalence in Thatta according to ACF’s SMART survey December 2011

<table>
<thead>
<tr>
<th></th>
<th>WHO (n) = 522 (C.I. 95%)</th>
<th>NCHS 1977 (n) = 523 (C.I. 95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevalence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of GAM</td>
<td>12.3 % (9.1-16.3)</td>
<td>11.1 % (7.9-15.3)</td>
</tr>
<tr>
<td>of MAM</td>
<td>10.4 % (8.7-12.4)</td>
<td>10.8 % (7.1-14.6)</td>
</tr>
<tr>
<td>of SAM</td>
<td>1.9 % (1.1-3.1)</td>
<td>0.2 % (0.1-1.4)</td>
</tr>
</tbody>
</table>
PEFSA II partners have gained a good understanding of the situation on the ground and the needs to be covered at district and UC level. Field level coordination with local authorities, other national and international NGOs, and UN Agencies was empowered through different clusters to prevent duplications and gaps in the coverage of needs. Unfortunately the provincial nutrition cluster and UNICEF, who were responsible for distributing UC among INGOS, did not have good information of the affected area after the floods or about prioritizing the most affected UCs which resulted in a complicated intervention map (see geographical coverage).

The Thatta and Badin districts are especially prone to seasonal floods which in combination with underlying root causes of chronic food insecurity push local communities below poverty thresholds. Chronic food insecurity was exacerbated due to the extreme weather conditions that hit the Thatta district back to back, destroying livelihoods, weakening coping mechanism and creating a humanitarian emergency in an area where there was already an underlying crisis. At present, the situation in the worst-affected parts of the Thatta district remains critical, WASH needs remain significant, food insecurity is higher than ever before and nutritional indicators signal an alarming situation.

Recent casual analysis is being conducted by a FSL team regarding the causes of malnutrition in Pakistan. It can safely be assumed that poor care practices, food consumption, health and a lack of access to safe drinking water and sanitation/hygiene facilities are all contributing factors.

The needs were therefore well defined and a good detailed assessment has been observed. However the impact of some socio-cultural factors were not taken into account (e.g. patriarchal culture, intra-household inequality, high fertility rate, highly population density), and the nutrition approach was mainly emergency focused while nutrition seems to be inherent in the region. This had an important impact on the awareness of the population and rapid-socio cultural assessment, to address this point, would have helped to prevent other problems found. A lack of an exit plan in the design of the program was also noted.

### 3.1.2 Level of Participation of Stakeholders

The local government structures acknowledge that ACF consulted them prior to the submission of the project and were working together since the early implementation stages, with the exception of the organisational structures of community-based volunteers and their linkages to the health system, including roles and responsibilities. Potential resources and synergies with the existing Lady Health Workers and PPHI were overlooked which lead to delays and problems. Sometimes local political issues affect proceedings, and for that reason the proposal was slightly generic. Rather than reflecting the local situation and capacity, the coordinator of the LHW said that there was no contact with him and to implement capacities and collaboration, papers should have been signed. The PPHI was also informed about the project and scope of ACF’s plan, but subsequently refused to participate in any sense. The Nutrition Cluster was informed and the directions from UNICEF as to which NGOs goes where, were followed. However, the project was delayed again as a result of signing partnerships.

Beneficiaries also state that they were contacted and participated in the selection of interventions.
3.1.2 Project objectives and results

Given the scale and dynamics of the malnutrition situation in the country, the overall goal of the Project is highly relevant. The Project’s purpose and main objectives are shown in the following table.

In general, the choice of activities was focused on CMAM (result 2), whilst efforts for raising awareness and reducing causes of malnutrition were less coordinated and failed.

**Table 4. Activities proposed to meet the objectives related to nutrition**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely identification and treatment of acute malnutrition</td>
<td>Training of local health staff on CMAM</td>
</tr>
<tr>
<td></td>
<td>Health structures hosting CMAM are equipped and supported</td>
</tr>
<tr>
<td></td>
<td>Regular supervision together with the health authorities</td>
</tr>
<tr>
<td></td>
<td>Support the District Health Departments in mobilizing supplies</td>
</tr>
<tr>
<td></td>
<td>Training of Community Nutrition Volunteers (CNVs)</td>
</tr>
<tr>
<td></td>
<td>Nutrition screening and referral in the community</td>
</tr>
<tr>
<td></td>
<td>OTP and SFP Sites are Established and Integrated Within the Existing Health Structures</td>
</tr>
<tr>
<td></td>
<td>Awareness raising</td>
</tr>
<tr>
<td>Improved knowledge of food security and nutrition</td>
<td>Mainstreaming of cross cutting issues throughout the alliance</td>
</tr>
<tr>
<td></td>
<td>Development and sharing of best practice and lesson learned</td>
</tr>
</tbody>
</table>

3.2. Coherence

In general all interventions must be integrated with the national policy, and this program was.

3.2.1 Coherence with national policy, ACF country strategy and humanitarian actors

The Project was found to be in line with national plans and nutrition policies. National protocol has been followed and was referenced in:
ACF still need to strengthen their knowledge regarding Community / Lady Health workers (LHW) inside the national protocol since there was no formalized partnership with the LHW.

At national level, there is a protocol for CMAM and it has been followed. In addition, ACF is well known within the nutrition cluster at national and regional level.

Given the amount of trainings provided some time should have been spent in preparation, especially in planning and preparing the training guide.

There has been a good level of dialogue and communication between the ECHO donors and project staff, both through grant-specific and more general meetings.

The NGO coordination at both national and regional level has also been described as good by the leadership of UNICEF. MERLIN and Save the Children are aware of the situation of our OTPs. The newly established SC in Thatta is being used by MERLIN.

Small details in the protocol should be pointed out:

1) **Multi Micronutrient tablets** and powder are being dispensed (the first to children, the second to mothers). They are provided by UNICEF but no clear protocol is established. ACF is giving these micronutrient tablets in PLW and SFP programs, and also as blanket distribution in Badin. Other NGOs are implementing different protocols. I have not assessed the composition of this tablets but supplementary Plumpy should be enough to cover MAM cases. Other approaches should be considered for distribution of MM tablets, for example: use this supplementation for at risk children (MUAC 125-135mm) who arrive at OTPs. Any practice should have a consensus and be shared by the other NGOs working in nutrition in the region to facilitate integration.

2) **Treatment of PLW** seems quite different amongst NGOs. Some do not distribute WSB and vegetable oil and others only give Folate supplement. Though ACF is following the national CMAM protocols it would be wise to have a common protocol to avoid mistrust among beneficiaries. There is evidence that vegetable oil is often sold out at the door of the OTP to buy other necessities, but again women re-buy it later at their local village for an increased amount. Better sensitisation of these products will enhance rational usage and prevent selling out.

3.2.2 Involvement of the community

This aspect seems good in every stage: needs assessment, program design and implementation. Village leaders were informed prior to the beginning of CMAM and participated in helping with identification of CNVs.

Unfortunately most contacts were developed through ACF program staff. A number of local partners should have been identified before and during the Project so that they can continue to promote activities once ACF is gone.

In Pakistan cash incentives are common to engage local and government partners in programs. ACF is using giving incentives to the nutrition focal point in Thatta and the
paediatrician in the hospital so they support the SC. Also 1 CNV per UCs received a monthly salary (on a base 500-700 PKR per day) to serve as coordinator, and others were employed as casual workers to help with crowd management during OTPS. However this incentive was not carried out with the LHW and their coordinator, probably being the reason why LHW never participated in the program though they received the trainings. It must be said that LHW are not actually in place everywhere, not necessarily paid on time by the government and that the extent of LHWs’ activities are not well understood, monitored, reported. ACF could work with Moh, DoH, EDO to promote this national LHW program, strengthen it, and add a small CMAM component (screening and referral) in LHWs’ work plan.

Other NGOs are using incentives with LHW. MERLIN spends 1000 PKR for every LHW per month and Save the Children is giving 100 PKR for every child sent and admitted to the program.

Though incentives work, the consultant feels that they create bad habits that will be difficult to eradicate. ACF should recognize that it cannot deliver a program without incentives, and should therefore play a coordinating role with other agencies to try to mainstream efforts. People in the communities understand the concept of voluntarism and qualified persons are willing to subscribe for the sake of the community. Governmental officials and LHW must understand that these activities should be part of their duty and not a punctual extra-work load. Other incentives could also be appropriate: bags with logos, regular refresher training and exchange activities, and access promotion within the local structure etc. And a common position must be adopted among the different NGOs working in the area: mainly MERLIN and Save the Children. In addition CNVs understand the concept of volunteerism and are willing to participate without salaries or incentives.

It should be particularly noted that despite the difficulties encountered, good relations appear to have been generally maintained, and most partners continue to view ACF positively, especially in providing the necessary support for training.

3.3. Sustainability

In this project sustainability must be appreciated at several levels and we must ask ourselves what is left beyond the project support and what exit plans were put in place to see if the intervention will be maintained and endure in the long-term.

The proposal recognized the need to ensure the Project’s sustainability and expected it would be achieved through partnerships and capacity-building but do not specify these. Issues of exit strategies were not considered when the Project started.

3.3.1 Partnerships

Different partnerships were created:

- PEFSA II was, from the beginning, an alliance amongst 6 INGOs. Nutrition activities were coordinated through the provincial cluster. The PEFSA alliance will continue with a new project: PEFSA III

- A partnership was developed with the Executive District Office for Health in Thatta to create the Stabilization Centre in the hospital. ACF keep a good relation with them and now
that ACF has moved to TMK it should not be lost. The Stabilization Centre is working independently but needs supervision until MERLIN takes care of it, ideally in September.

It was not possible to implement two important partnerships:

- **PPHI.** The proposal was to establish an OTP in BHU but PPHI made their opinions clear and did not agree to develop such partnership. At that point ACF decided to implement a mobile OTP.

- **LHW,** due to lack of incentives. LHW were trained but did not participate consequently. MERLIN gives incentives (1,000 PKR / month) and SC per child referred an admitted to the program. It will be difficult to have partnership with no economical incentives but it should be tried as mentioned before

At this level, it is clear from the site visits that the work done was intended to be short-term and that the local organisations were mainly to provide a certain number of volunteers to be trained.

### 3.3.1 Capacity buildings

The Project concentrated primarily on the technical training of volunteers. LHW were trained but did not participate. A small amount of Health Workers were trained (only 20% of planned, see impact) given that the BHU level was closed to us. Some trainings were done at RHC but they seem not to have worked, doctors still call RUTF “chocolate” and expect ACF to come back to distribute the RUTF. Nurses do not know how to use MUAC which are kept together under key and nutrition admissions are not followed and almost non existent.

On the other hand, capacity building at the Stabilization Centre in Thatta worked well. Unfortunately SC opened its doors at the moment when the program was finishing because it took months to sign the agreement with local government structures and it was not used for ACF’s referrals. The majority of admissions there come from MERLIN which does not follow the protocol for sending severe cases to the SC. A training session should have been done at MERLIN before leaving. Nevertheless this partnership worked well but it took much longer to be implemented than planned and many incentives were needed to every level.

Capacity building at village level through CNVs appears to not have so successful, especially in terms of the understanding of malnutrition related issues, increase of knowledge base, and use of their skills in the best possible way.

The provision of refresher trainings to CNVs should have been the rule and it was done in only 20% of them. Community volunteers often had uncertainties during home visits and/or follow-up and the consultant allowed them to raise their questions and issues of concern.

At beneficiary level the program had very good social acceptance, and at least the 5 key messages (hand wash, breastfeeding, food security and diversification, child nutrition and personal hygiene) seem to have gone through the whole community. Nevertheless these messages are felt as not enough from beneficiaries and stakeholders.

### 3.3.3 Integration into the health system
The OTPs were implemented in isolation, especially for outreach activities and had limited integration within the health system as a whole. At BHU level collaboration with PPHI did not work and when the program was finished, the mobile OTPS ran by ACF stopped their activities. On the other hand, staff from BHU units welcome CMAM activities and are willing to allow ACF space and even Human Resources. Problems with PPHI seem more political and at provincial level.

At district level the SC was a good example of how cooperation can be achieved. Rooms were given to ACF in the district hospital and ACF prepared them to be used. Doctors, nurses and assistants were employed by the District Health Department with ACF resources but this way we ensured that salaries were in the same order as the rest of the hospital staff. Protocol was shared with the paediatrics department and paediatrician visits admissions are on duty if needed. The nutrition focal point is carrying out supervision, monitoring systems have been endorsed, and contacts to ask for their own supplies have been made with UNICEF and WFP.

3.3.4 Exit Plan

Planning an exit strategy to close the Project was not addressed. As a result, ACF has not made it clear to all the stakeholders that it was closing the project and the information was communicated on an informal basis. Supplies of RUTF were given to RHC so they can continue with CMAM activities and UNICEF has signed an exit plan (see bibliography) to provide more RUTF when it finishes. However this is not working.

CNVs have stopped their activities so no one is doing screening or referring cases to RHC, they do not even know which RHC they have to use. In addition mothers refuse to travel such big distances from their home. In RHC supplies are mostly untouched, and they have not contacted UNICEF or WFP, nor vice versa. This should be pointed out in the provincial cluster.

Only the activities of the SC are maintained as described, but most cases arrive from UCs where MERLIN is operating.

The 9 UCs where ACF was working have been redistributed. There was discussion with MERLIN and EDO, but these always depended on financing. Finally 5 UCs were directed to MERLIN, and they will start ideally in September and 4 UCs to EDO through RHC, but they have no clear plan.

3.4. Coverage

Project coverage can be appreciated at several levels: geographical coverage, as % of beneficiaries covered, regularity of care provided etc…

3.4.1 Selection of geographical area and target group

The need to target rural areas was appropriate. The problem was the distribution of different UC among the NGOs working in nutrition. No plan was clearly defined by UNICEF and NGOs started to work in those UCs that seemed more affected in the left band of the Indus. Unfortunately some other partners were already working there and they had to relocate. See maps.
Figure 3. Thatta UCs according to whom is running OTPs

Figure 4. Badin UCs according to whom is running OTPs
In addition FSL activities were distributed according to the needs assessed by FAO, meaning that ACF nutrition and FSL teams were working in different UC. Among the 9 UCS where CMAM was implemented in Thatta, only 2 ACF FSL were present, in 3 UCs some FSL activities were run by other partners and in the rest none.

A better distribution of the areas should have been assessed. This will help with logistics, integration with FSL activities and facilitate communication with the local government. Ideally we should try to work with the idea that only one organization operates in one district in future programs.

3.4.2 Training Coverage

Sensitization coverage remained low among health workers (20% achieved, view impact) and LHW (80%), moreover when these trainings had not a real impact.

For CNV it seems that the number of people trained was ok, though refreshers are considered necessary to some CNV and not often carried out. Some CNV do not have MUAC bands and just send the children to the supervisor CNV of the UC, who will do MUAC and send the child to ACF’s screeners and mobiliser.

The amount of beneficiaries going to training and sessions has exceeded the objectives. Unfortunately, what seems to be happening is that as long the program goes on, more beneficiaries come to the session (or come twice) but more sessions are not given. Around 20 beneficiaries were coming at the beginning, now it is over 40, often accompanied by children. We think that in these crowded groups the messages are not being received.

Other FSL partners such as OXFAM demand more trainings and sessions not only in the 5 key messages, to really raise awareness.

3.4.3 Beneficiaries
It is difficult to assess the coverage rate for CMAM without a coverage survey/assessment. When the partnership with PPHI was not developed, OTPs move from a static perspective in BHUs to a mobile perspective. This has clearly affected sustainability and integration within health structures but has improved coverage. OTPs move within a UCs from Dehs to Dehs: when it was felt that SAM cases were reached they move to a new Dehs. Beneficiaries were coming from as far as 5-10km; if not attempts to move OTP to those far away villages were made. This also facilitated following defaulters. Indeed the defaulters rate is very low (3%, see impact).

Unfortunately there was no time for the mobile OTPs to cover all the villages in UCs within the program time (since it started with 2 months delay) and some Dehs were not covered. Admissions from those areas seem to be scarce.

Community mobilization had some problems while being implemented as mentioned but considering OTPs are so close to beneficiaries mothers have found time to come. Reasons for not attending from the beneficiary’s point of view were:

- Mothers and other persons in charge of children too busy: working in the field or taking care of big families. This could affect to 15% of mothers
- Long time waiting in the OTPs to received RUTF. Mothers spend the whole day there
- Supply out breaks that force mothers to come back empty handed

Distance don’t seem to be a major problem but mothers says that if OTPs move and install themselves in BHU they will not go, since it is too far away.

Stock breaks happen due to 2 reasons. First supplies from UNICEF and WFP have not been continuous. For the last three months ACF has been using stock bought in Dubai. It would be wise to create a permanent emergency stock. Secondly, space in the cars is limited when doing mobiles OTPs. If beneficiaries are more numerous than expected there is not enough RUTF for every one. It could be a good idea to leave small stocks in the schools where OTPs are implemented.

Of course SAM is better covered than MAM and thanks to the mobile approach is more accessible. The mobile approach is working well, which can be seen by the fact that over the period of a month, when some OTPs went statics, defaulter’s rate went up from 3% to 10% immediately.

Unfortunately there was no SC during the time of the mobile OTPs and sever cases were sent to RHC or district hospital where the national protocol was not implemented.

3.4.4 Integration FSL and Nut

As mentioned, malnourished cases found by all the members of the PEFSAN alliance while implementing FSL activities should have been referred to CMAM. Unfortunately UCs where FLS and nutrition worked were not the same and only some INGOS did this. OXFAM referred them when the OTP was close in a neighbouring UC. ACF did the same. Unfortunately there is no monitoring of such referrals among programs. In addition UNICEF considered that MUAC measures from FSL staff were not reliable and in most cases they were not done.

Integration should have also been done when selecting beneficiaries for grants and Cash for Work activities. In addition to vulnerability criteria, malnutrition in HH should have put it in FSL program. Nutrition criteria most often used were: Women having 2 children < 24 months
and pregnant women having a child <24 months. Recently discharged (< 3 months) from CMAM was also a criteria. FSL activities started earlier than CMAM. 34% of ACF’s FSL beneficiaries had nutrition criteria but only 1.4% came from CMAM. In this sense integration has not worked well. It is also difficult since CMAM only register the name of the child while FSL contact the head of the HH.

On the other hand, ACF asked for the list of CMAM beneficiaries from MERLIN and IMC when working in UCs where these NGOs were implementing CMAM. Unfortunately they never received the list. In UC where there was no partner doing CMAM, nutrition criteria was not used.

3.5. Impact

Impact is assessed through different data to show the effects of intervention in treating malnutrition, improving food and nutrition practice in households, improving the screening network, and improving the quality of health delivery. The duration of the Project is too short to expect significant changes in malnutrition prevalence

3.5.1 Identification and treatment of acute malnutrition

Admission of SAM cases only started in December, two months later that expected, mainly due to lack of supplies from UNICEF and signing partnerships with local government. There were no admissions in the SC since it wasn’t opened until June 2012. Due to this fact the number of beneficiaries changed from 6500 to 3720 in PEFSA II. However in the last months admissions were much more numerous than expected, crowding the OTP sites. Admissions were similar in Monsoon and PEFSA II (see figure 5). The drop in January and February can be partially explained by opening doors in December (lots of people coming in the 1st month of the program thus reducing admissions in 2nd month) and partially because screening was reduced once OTPs started since ACF staff had to help with the distribution of RUTF. The drop in number of admission during the last months is due to stopping the programs halfway through the month. Please note that MONSOON covered more people than PEFSA II.

Figure 5. Monthly admissions in both programs
Since the main objectives were reduced because SAM treatment specifically started later, based on the last objectives, goals were much more than attainable for SFP and PLW.

**Table 5.** Goals and achievement for number of admissions in different modalities. PEFSA II

<table>
<thead>
<tr>
<th>Goal</th>
<th>Goal Achievement</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>180</td>
<td>0</td>
</tr>
<tr>
<td>OTP</td>
<td>1250</td>
<td>77</td>
</tr>
<tr>
<td>SFP</td>
<td>1410</td>
<td>&gt;100</td>
</tr>
<tr>
<td>PLW</td>
<td>880</td>
<td>&gt;100</td>
</tr>
</tbody>
</table>

**Table 6.** Goals and achievement for number of admissions in different modalities. MONSSOON

<table>
<thead>
<tr>
<th>Goal</th>
<th>Goal Achievement</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OTP</td>
<td>1180</td>
<td>124</td>
</tr>
<tr>
<td>SFP</td>
<td>2160</td>
<td>150</td>
</tr>
<tr>
<td>PLW</td>
<td>1900</td>
<td>78</td>
</tr>
</tbody>
</table>

Exits from the program are shown in the next figure. This data is to be believed correct since most defaulters are tracked by the community mobilizers and low figures are expected with mobile OTPs. SPHERE recommendations were widely reached. In MONSSOON these rates were very similar (graphic not shown).
Due to the high number of admissions in 2012 when families lived more than 5km away they were given RUTF for 2 weeks if SAM and for 4 weeks if MAM. This could have compromised quality since the protocol specifies 1 visit per week and 1 visit per 2 weeks respectively, but crowd management was a big problem.

3.5.3 Improved coherence, knowledge about food security and nutrition

ACF training has had an impact on the capacity of community volunteers to prepare themselves in malnutrition support but this impact has been limited. As mentioned CNVs are not continuing any activity once ACF has left and more refresher trainings seem to have been lacking. Community workers, especially females, felt that the level of detail provided empowered them to act on and refer cases.

The Project impact on referrals shows mixed results.

Table 7 Goals and achievement for trainings and screening in PEFSA II

<table>
<thead>
<tr>
<th>Goal</th>
<th>Achievement</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Staff who received training</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td>Health Staff who received training Sessions at CMAM site</td>
<td>1000</td>
<td>200</td>
</tr>
<tr>
<td>Participant in sessions</td>
<td>13,200</td>
<td>361</td>
</tr>
<tr>
<td>&lt;5 screened</td>
<td>8400</td>
<td>338</td>
</tr>
</tbody>
</table>
During the discussions, it became apparent that the primary concern of communities was to improve food security, and not nutrition training and/or education per se. Most of the respondents, including community volunteers, highlighted the need to support livelihoods as well.

The Project lacked direction: PM and national coordinators often changed and nutrition delegate had to manage big teams (14 teams of 5 people), making staff confused about their roles in CMAM activities, which led to difficulties in reporting and monitoring. The activities were often implemented in parallel, rather than in a convergent manner. Duplication of activities between the two projects was also noted; especially those related to community sensitizations in villages were FSL was also working.

3.5.4 Negative Impact

Some aspects have already been mentioned. Paying some of the CNV creates a bad understanding about volunteers and is introducing the idea that volunteers can get a paid position if they are improving their skills or access casual workers positions. Casual workers are necessary on special occasions but not as a regular basis to reinforce ACF’s staff; more qualified workers should be found for a regular position.

Moving out of BHU has improved our results (for example according to SPHERE standards) and District Health Officers are very satisfied with our programs but these results are mainly ACF’s, and local government should see them as so. Improving health must be the results of a common effort and not just one sided, since ACF will never reach all malnourished children without the government intervention.

3.6. Effectiveness

The following figure show which activities have been effectively implemented. Note that those concerning Health Structures have not been achieved, though CMAM worked well and beneficiaries were attained. SAM children attending OTPs are considered the most effective activities of the project by ACF staff.

Figure 6 Activities fulfilled during the program
3.6.1 ACF dealing with unforeseen challenges in the program

ACF was able to respond to many unforeseen challenges that happened during the implementation of the program which jeopardized many activities, but thanks to efforts at every level, beneficiaries of the CMAM activities were satisfied. The biggest challenge was to deal with the refusal from PPHI to work in BHU, a very intelligent approach with mobile OTPs was implemented.

The lack of supplies from UNICEF and WFP was solved by the logistics department through buying 570 boxes of RUTF from Dubai.

A topic on emergency information and preparedness will also be added to the training staff in the field receive.

3.6.2 Monitoring activities

Monitoring is implemented but some aspects can be improved. For CMAM admissions the Nutrition Information System from UNICEF is used. The software is well designed but there are some problems with importing and merging tools that will facilitate deeper analysis with other statistical software. The biggest problem is that MUAC is not codified (or just as \(<115\text{mm \&} <125\) and since MUAC is the only admission criteria in the protocol it would be very useful to evaluate aspects such as severity of children admitted. Having a detail MUAC at the admission in the data base will no be more costly than the way it is done nowadays.

CNVs monitoring suffers many weakness. It is difficult to follow track of the children when referred by CNVs since they go to several steps (from CNVs, to supervisor, from this to ACF's
community workers and finally to OTPs). CNVs should refer children and PLW directly to OTPs after checking MUAC. A good way to monitor them will be to provide referral cards (one from each colour for OTP, SFP and PLW to help organise crowds in CMAM) to beneficiaries sent to CMAM and at the same time CNVs register how many beneficiaries they have sent. Later, with the collected cards, it is simple to know which % of those referred finally arrive to OTP and which % is finally admitted. That way the need of refreshment about MUAC measures to the CNVs can be determine if they are not done properly. Trainings of CNVs were often implemented by ACFs staff to big groups (>70), more detailed trainings were done to selected supervisors that later replicate training to the rest. The quality of this has not been assessed but is doubtful.

Gaining weight is also monitored but the information provided is hardly used. Home visits should be scheduled to those not gaining weight similar to the process for defaulters.

3.7. Efficiency

In terms of the employment of resources, especially financial resources, it is difficult for us to give an in depth answer in this evaluation. Only an audit can give justified and evidenced opinions. Nevertheless it is important to note that there is a rigorous budget follow up that ensures expenses are regular and well established respecting ACFs procedures, comparing cost, and assuring quality

There can be some improvement in various aspects:

- Trainings: LHW should only be trained if a partnership is signed to use them in screening. Same is applied for the Health workers trained; most of them were not involved in CMAM services.

- Optimize sessions. Many people have to wait at OTP sites. Session can be implemented here for selected groups, not just one big session for mothers. Fathers often accompany children and there are no specific sessions for them.

- Optimize CMAM: financial resources could have been optimized, especially those related to human resources. One nurse per 2 UCs was clearly insufficient for the large number of admissions. ACF’s screeners and community mobilizers were often employed for distribution of supplies and measuring weight or MUAC at OTP site.

- Optimize evaluation: since the program is replicated with other INGOs, SMART surveys can be done together and since in Pakistan there is a high degree of education locals who can be trained to satisfy the needs of different organisation for SMART and coverage surveys. External consultants coming from abroad double or triple the cost of surveys.

Costs outside the budget of the Project (casual workers, paid volunteers or last minute incentives) should be avoided and incentives used only when it has been planned. Do not forget to plan cost for exit plan to ensure sustainability.

A certain amount of resource should be employed to prepare an emergency capacity. This includes: create an emergency stock of RUTF, consider buying vehicles instead of renting, especially if a long standing presence is previewed and keep a list of local key informant from different programs (WASH, NUT and FSL) and
3.8. Cross-cutting issues

3.8.1. Gender equality and sensitivity to gender issues

The Project addressed gender as a woman’s issue rather than being about the differential social roles of men and women. Given the dominance of the patriarchal system and the role of men in decision making, little attention to their specific needs may create misunderstandings and resistance and ultimately limit impact if they feel excluded from the activities.

The Project should encourage training for community volunteers male and female together. This has worked in some UCs where 50% are men and 50% women, but there is surprisingly UCs where volunteers are 100% male. When asked about it, locals tend to explain that females are not allowed to travel outside the village; this should be no problem since each village can have its own CNVs. Everyone finally accepted the role of female volunteers so it feels that not enough efforts were made in some UCs.

Ideally in every town 1 male and 1 female CNVs should be considered since men are not allowed to touch women for MUAC but can facilitate acceptance in the HH.

If new projects move to static OTP in BHU or other dispensaries an important aspect should be considered. Travelling can be cheap for men using public transport but quite expensive for women that are only allowed in private vehicles.

3.8.2 Security of employees and stakeholders

The most important problems are strikes and demonstrations that cut roads with no notice. These strikes prevent OTPs from working 2 or 3 days per month. The consultant faced these problems on two occasions. ACF security staff are well informed and often know about the demonstration as they are happening and where are they moving. This information is shared instantaneity with the teams that modify routes or cancel activities and inform beneficiaries at local site to go back home.

The consultant has noticed that there is very little (almost inexistent) ACF visibility in the area. Two reasons are given for this; one is security, the other is because due to the short duration of the program it is not considered cost effective. People hardly recognise ACF or know about other ACF programs. According to beneficiaries, CNVs are the main reason to visit OTPs sites. Visibility helps to raise awareness and can be very cheap. If security prevents them from using it on cars, maybe other options can be looked into: bags, posters already used for sessions etc.
4. Recommendations

Based on the results obtained, the recommendations to be considered are:

- **Integration into the health system.** PPHI kept us separate from BHU and we moved to a mobile OTP system run entirely by ACF. Coming back to health structures even in keeping some mobility is a must, otherwise sustainability is highly reduced. ACF must continue efforts at Karachi and Islamabad level to un-block the situation with PPHI (share with other NGOs in Sindh but not in other areas of the country), in the meantime district health officers can be invited to supervise mobile OTPs, and statics site can be implemented at RHC and general dispensaries. ACF must also contact LHW coordinator (preferably after doing common cause with other NGOs to avoid cash incentives) and try to engage them in nutrition.

- **Integration with FSL.** Many good activities were described in the proposal but were not implemented due to lack of communication with other NGOs and bad timing between Nutrition and FSL activities. Cooperation should not mean only mutual staff trainings. Sharing results of the project (as well as this evaluation), talk about difficulties met and try to define concrete actions among partners will help to create a cadre with all different actors.

- **CNV** should be able to work independently with monthly refresher trainings and meetings. LHW should participate in these trainings when available, since they only covered approximately 50% of the village in the region. Community volunteers per village should be identified and should not have to travel from village to village to do screening, travel can be organized once a month or so to the health facility to attend CNVs coordination meeting and linkage with the health workers running the CMAM activities and the LHW that could be ideally the link between health facilities and CNVs A monitoring system as described should be implemented. Mobilization should be done door to door and not just gathering people in one place the day ACF is coming, mobilization is too static and should be more dynamic and independent. Also the coloured cards system and better anthropometric skills of the CNVs through trainings will reduce the crowd and only the most specific beneficiaries will reach the CMAM sites.

- **Mobile CMAM** works well but consumes a lot of resources. Some OTPs in Badin and TMK receive large numbers of admissions (an average of 70 beneficiaries visit CMAM sites every day) and have forced some changes: space visit of beneficiaries, community workers and screeners forced to stay in OTP sites, CNVs working at OTP sites, not enough space in vehicles for supplies, not measuring height etc... The relevance of CMAM approach is fully justified for SAM but is it for MAM and PLW? Is there no other way to address MAM? Also the government will not have enough resources to take care of OTP and SFP programs. Community Health Programs can be designed on Positive Deviance and Hearth Nutrition Models that will ease CMAM and in addition address underlying causes and raise awareness as well as canalise efforts towards reducing stunting.

- Create an **emergency stock** for OTP maintained at all times and plan, anticipate, and coordinate with logistics the needs for mobiles OTPs. There may even be the need to create local stocks at schools.

- **Coverage and SMART surveys** should be considered. SMART surveys will be a good opportunity to find out about malnutrition measured by MUAC and weight for height.

- A number of **local partners** should have been identified before and during the Project so that they can continue to promote activities once ACF is gone.

- Give **MUAC tapes** to everyone with knowledge and abilities to screen children and identify malnutrition.
• Several organisations are working in the same area: every practice (from using vegetable oil to giving incentives) should have a consensus and be shared by the other NGOs to facilitate integration.

• All trainings need monitoring and feedback. The quality of trainings will be frequently assessed and facilitated by the DPM and PMs. Those for health workers as well as those for FSL and other NGOs. Trainings should target health staff that will indeed play a role in CMAM activities themselves or in their monitoring/supervision. MoH should communicate in advance a list of participants to trainings, and the list should be then negotiated. Trainings were not always targeting the right staff. Trainings should be conducted right before the launching of activities, and refresher trainings during the course of programs (in addition to providing knowledge and skills, trainings are also opportunities for ACF to engage and motivate local health staff and to encourage them to commit to CMAM). Trainings of CNVs and LHWs should equip them with MUAC tapes. Cooperation among PEFSA alliance has only been made through trainings, keeping track of those trainings will help to create more exchanges. Number of beneficiaries attending trainings and sessions should be controlled. Sessions with 40 mothers and their children were not very manageable. Also materials for the sessions can be improved: posters should not contain a lot of text, and pictures are often clearer than photographs.

• A training guide should be prepared with help from HQ. To build the capacity of ACF’s staff in organizing trainings, develop training materials and community mobilization strategies, learning training techniques (work group, role play...) and tools to assess training impact, a Communication Expert should be employed and spend time with the teams on the field. It should be budgeted in future proposals.

• ACF teams on the field are expanding constantly to admit more beneficiaries. This is creating problems for team management and for staff in terms of knowing their responsibilities. It is preferable to have smaller teams and visit sites twice per week, with 1 supervisor controlling several teams and reporting to PM. Involve more local health staff, LHWs, and Community Volunteers will help to reduce demand for more ACF staff.

In general terms the interventions were planned from an emergency point of view. Nutrition is inherent to the region and we should move to a more developmental approach, integrating FSL and WASH activities to address the underlying causes of malnutrition that include: water access, diversification of income, care providers. Efforts for raising awareness and reducing causes of malnutrition should be more coordinated. Also, once crowds are reduced, messages will pass better to beneficiaries and ACF staff could benefit from Behaviour Change Approach trainings. FSL activities also can move from Grants and Cash for work to activities such as kitchens gardens, poultry, introducing sewing machines, producing soap etc.
5. Annexes (included in separate PDF file)

Annex 1. Terms of References
Annex 2. Chronogram
Annex 3. Selected UC and villages
Annex 4. Persons met
Annex 5. Qualitative data collection
Annex 6. Evaluation Matrix
Annex 7. DAC rating
Annex 8. Best Practices
Annex 9. Bibliography