COVERAGE MONITORING NETWORK

LESSONS LEARNED WORKSHOP REPORT - ETHIOPIA

3RD-4TH MARCH 2016

VENUE: FRIENDSHIP INTERNATIONAL HOTEL, ADDIS ABABA

COVERAGE MONITORING NETWORK

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1. Context

The Coverage Monitoring Network (CMN) is an inter-agency program implemented by ACF-UK and its partners Concern Worldwide, Helen Keller International and International Medical Corps. The first phase of the CMN was launched in July 2012 for an implementation period of 18 months, with the support of the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and USAID's Office of Foreign Disaster Assistance (OFDA). The project aimed to improve nutrition programs through the promotion of quality coverage assessment tools, capacity building and information sharing in 9 priority countries in Africa and Asia (including South Sudan, Kenya, Ethiopia, Niger, Burkina Faso, Mali, Chad, DRC and Pakistan).

Following the success of the first phase of the CMN project, the CMN entered its second phase in June 2014. During the second phase, the CMN continued to provide technical support to nutrition programmes but introduced four significant changes to the way it operates:

1. **Enhanced quality engagement**. Closer and more sustained engagement with programs and partners is considered key to successfully influence programmatic and organizational dynamics.
2. **Development of consolidated, simplified and standardized tools**.
3. Enhanced support for **clearer and actionable recommendations** for boosting coverage.
4. Provision of additional support and guidance to **address key barriers to access**.

The objectives and results of CMN Phase II are:

General Objective.

Contribute to a reduction in malnutrition-related mortality and morbidity

Specific Objective.

Improved capacity of selected nutrition programs to develop and implement actions to increase access and coverage:

Result 1. Improved integration of coverage assessment tools by nutrition programs

Result 2. Increased availability of actionable recommendations for improving coverage of nutrition programs

Result 3. Increased availability and utilization of lessons learned, best practices and information to improving program coverage

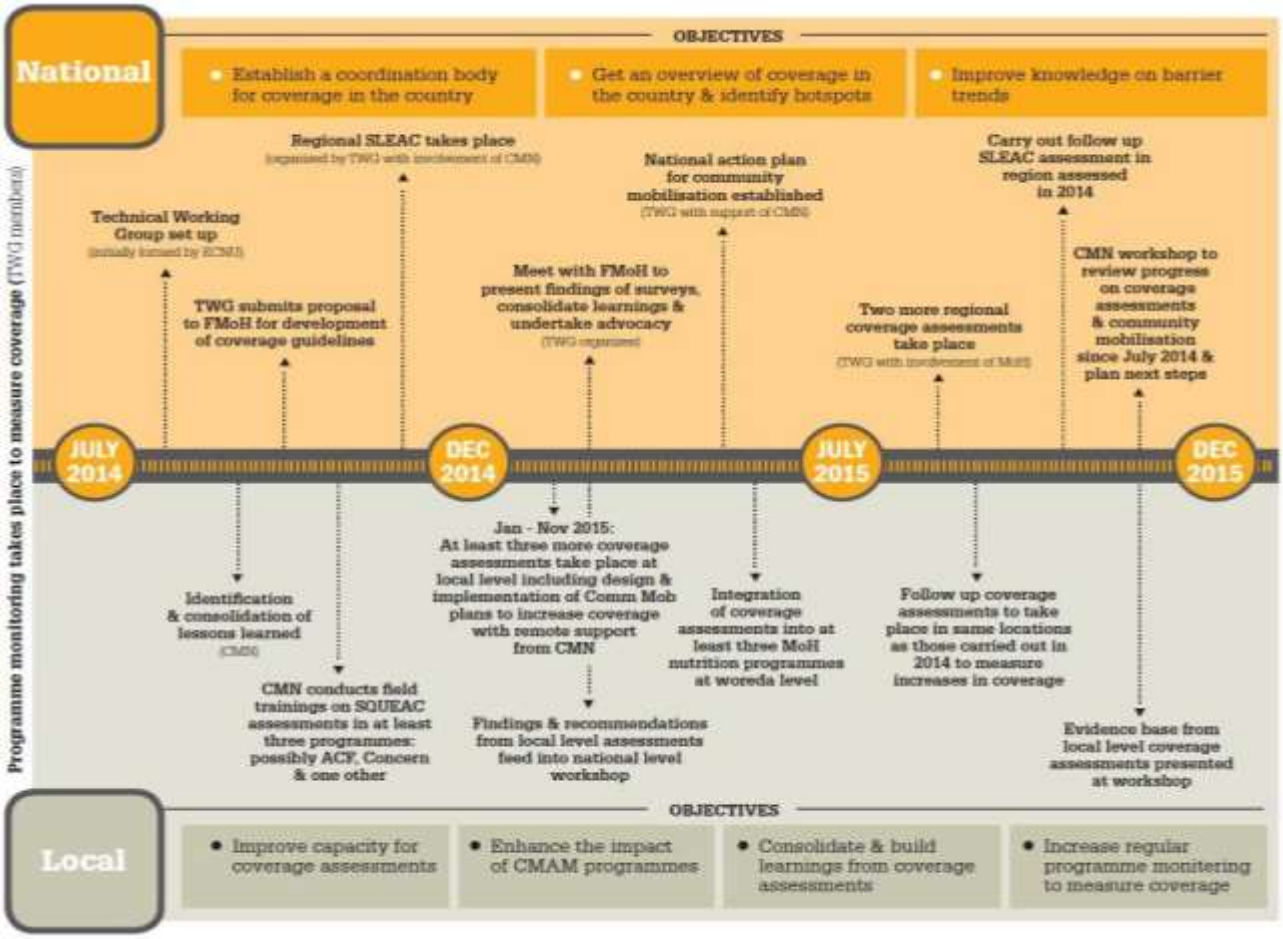
2. Introduction

Ethiopia is one of the CMN's priority countries for 2014/15. On 1-2 July 2014, a workshop was held in Addis Ababa with the ENCU (Emergency Nutrition Coordination Unit) and members of the nutrition cluster in the country. The workshop was organized by the ENCU Coordinator and facilitated by the CMN. The main objective of the workshop was to develop a country-specific action plan for scaling-up coverage assessments in Ethiopia for the forthcoming years.

A total of 37 participants took part in the workshop, including 4 CMN representatives, 2 representatives from the DRMFSS and 6 Regional ECNUs from the Ethiopian Government and representatives from 22 different donor and implementing agencies.

During the workshop, participants were asked to think about and make note of where the priorities and gaps lie in relation to national and regional coverage assessments and local coverage assessments. They then added their notes to five thematic areas: Objectives, Timeline, Resources (financial), Capacity and Leadership.

Based on these notes from participants an action plan was developed taking in to consideration all five thematic areas:



The CMN project will be drawing to a close at the end of March 2016. As such, with support of the ENCU and NDRMC, the CMN organised a two-day "lessons learned" workshop on March 3 – 4, 2016 in Addis Ababa.

3. Workshop objectives and agenda

3.1 Workshop ToR and objectives

In conjunction with the ENCU, the CMN developed a Terms of Reference (TOR) for the workshop and shared this with participants. The full ToR is available in Annex 1 of this report. The objectives of the workshop were set out as follows:

Principle objective: To improve access to and uptake of SAM and MAM treatment programs in Ethiopia

Specific objectives:

- To share the findings and recommendations coming from coverage assessments in Ethiopia over recent years.
- To share and document examples of how the evidence and data generated by recent coverage assessments (including SQUEAC assessments and CBSC-CE) are being used by programs,
- To share and document activities being undertaken in different contexts to overcome barriers to access and to identify best practices in key contexts.
- To discuss and agree the next steps needed to improve programming in order to improve access and uptake of services to treat SAM and MAM.

3.2 Agenda

Key highlights of the agenda of the two day lessons-learned workshop (full agenda available in Annex 2):

- Presentation of country profile: including mapping of coverage assessments, overview of trends in programme data and community profile
- Presentation of CMAM Coverage and caseload in Oromiya Region
- Transforming coverage results into action: experiences, challenges and best practices Introduction to the topic
- Presentation of activities to overcome barriers to access by three organisations in Ethiopia (Concern, IMC and Concern)
- Group work to discuss and identify national priorities regarding access and coverage of CMAM programmes
- Overview of materials and tools developed by the CMN during CMN Phase 2.
- Which method to use when?
- Remaining Questions and Way Forward

4. Outputs of the workshop:

4.1 Workshop Opening

An opening remark was given by the National Disaster Risk Management Commission (NDRMC) head emphasizing the importance of coverage assessments and the commitment by the ENCU/TWG to draft the National Coverage Assessment guideline and to conduct wide area coverage assessments in the country. The NDRMC/ENCU committed to take the lead on the activities following the workshop and to engage the TWG on the guideline development process.

4.2 CMAM update – Oromiya Region

The Regional ENCU representative from Oromiya region presented program data from the region and mapped CMAM coverage in the region. Following the El Nino drought the regional ENCU plans to expand OTP services to all Health Posts and Stabilization Centres (SC) at Kebele level in all hotspot woredas.

4.3 Ethiopia country profile

The CMN presented a country profile with an updated mapping of coverage assessments and trends in program data. By early 2011, CMAM had already extended to all Regions in the country, reaching 504 Woredas out of a total of over 750. In late 2011, **8,100 OTPs and 473 stabilization centers (SC)** were offering CMAM services in 622 Woredas. This impressive roll-out of CMAM was possible due to the guiding role of the state, and to the change in vision whereby CMAM was not regarded exclusively as an emergency intervention, but rather as a sustainable component of an integrated national approach to health provision. As a result of this effort, by early 2014 the country had over 12,000 OTP sites, which meant that **three out of four health posts in the country delivered CMAM services**, as well as 62% of health centres[1].

Between 2010 and 2015, 11 SQUEAC assessments were conducted in eight different locations in Ethiopia with direct and remote support from the CMN. Seven of these incorporated the full extent of the respective Woredas. One SQUEAC was conducted in Dollo Ado Camp in the Woreda of the same name, close to the border with Kenya. So far, no SLEAC assessments have taken place, and there has been no other attempt to estimate coverage for wider areas, despite the extended geographical coverage of CMAM programs in the country.

The general results of the SQUEAC assessments, specifically the final coverage estimate, **have been retroactively calculated using the Single Coverage Method**. It's important to note that this does not invalidate the original coverage estimates. It makes it possible to compare the results of each SQUEAC result with each other and across time. Out of the eleven SQUEAC assessments conducted, 9 have assessed the coverage of SAM programs and two have done so for MAM programs (in Bati and Dollo Odo). In both cases, the assessment for MAM happened simultaneously to SAM.

In all Woredas assessed during SQUEAC surveys, coverage was classified with a three-stage classification system. This changes according to the location type of the program. In rural areas, coverage is classified as low if it is below 20%, coverage is classified as moderate if it is between 20% and 50% and it is classified as high if it is above 50%. This classification applies to rural areas only. The **SQUEACs done in a refugee camp (in Dollo**

[1] UNICEF, Briefing Note, *Community Management of Acute Malnutrition (CMAM)*, July 2014.

Odo) are compared against another classification threshold. Low coverage is considered as being below 40%, moderate is 40-90%, and high coverage is above 90%.

Meanwhile, Cure rate is a strong indicator of a program's performance. There is no doubt that a program that admits several children but only successfully treats a few successfully is not an efficient one. Yet, cure rate tells little about a program's final effectiveness if it is not compared to the coverage rate. This is the powerful descriptive power of the Met Need.

CMAM programs that have excellent cure rates (which is the case of all Woredas assessed through SQUEACs as well as the overall cure rate for Ethiopia) can also have very low coverage rates. This will immediately bring down the whole effectiveness of the program. Consequently, coverage rates can clearly influence a program's success. Comparing both indicators (and obtaining the Met Need) is thus useful to understanding the real reach of a given intervention.

An average Met need of 45% was achieved in camp settings and 44.6% was achieved in rural settings. This illustrates the important effect of coverage rates on the overall efficiency of a program. Extraordinary cure rates actually a small impact on Met Need if coverage rates are not equally high.

4.4 Transforming findings from coverage assessments into action plans

Members of the Nutrition cluster were invited to present their own experiences of transforming coverage assessment results into action plans. The following organisations presented:

- International Medical Corps
- Action Against Hunger
- Concern Worldwide

Following this, four key questions were discussed during group discussions on the challenges to implementing activities to overcome barriers to access. The participants responded to through group work sessions as follows:

- **Issues to consider when creating action plan:**
    - Team formation (including senior management and finance)
    - Setting of feasible activities
    - Understanding of the community structure
    - Participative with partners and integrating with health office plan
- **What factors affect implementation of the action plan?**
    - Budget constraints (inadequate budget allocation for community mobilization and engagement).
    - Lack of skilled manpower (at health post level and a supervisors for M&E activities)
    - Staff turnover
    - Lack of commitment among stakeholders (especially when there is no clear responsibility for shared activities)
    - Lack of follow up and revisions of action plan
    - Ambitious action plan (unachievable) considering time and resource (HR, Logistic, finance)

- **What factors should be considered during the development of Action Plan?**
    - Should be SMART
    - Resources (Internal & External)
    - Capacity
    - Feasibility
    - Monitoring and Evaluation mechanism
    - Participative
- **What changes or improvement should be carried out?**
    - All stakeholder should agree on the resource sharing and commitment
    - Capacity building for the staffs
    - Well documented handover notes during staff turnover
    - Review of action plan periodically
    - Avoid ambitious action plan

4.5 Barriers to access and solutions to overcome them

Participants also engaged in group discussions (in four regional groups) to identify barriers and activities to overcome them in specific regions. The responses were as follows:

4.5.1 Oromiya Region

Main barriers

- Geographical location of services
- Traditional beliefs and health seeking behavior
- Poor service quality
- Lack of awareness about the services
- Inadequate supervision and follow up

Solutions to overcome barriers

- Improving infrastructure or considering Community Based Nutrition (CBN)
- Awareness creation at grass root level
- Developing a systematic monitoring and supportive supervision mechanism

Best solution to overcome barriers to increasing access to service delivery:

- Intensive awareness creation/sensitization at grass root level including enhancing basic training delivery

4.5.2 Tigray Region

Main barriers

- Distance
- Shortage of supply
- Lack of staff commitment
- Staff turnover
- Transportation

Solution to overcome barriers

- Support transporting of supplies with PSNP rations
- Awareness creation at all level
- Conducting thorough discussions between staff and management teams
- Capacity building (training more staff) due to high turnover of staff

Best solutions to overcome barriers to increase access to service delivery:

- Support of transporting of supplies with PSNP ration
- Awareness creation to community at all level

4.5.3 SNNPR Region

Main barrier

- Discriminations or discrepancy of the family/ misconception about malnutrition
- Inadequate monitoring & technical support to HEW by Woreda HO.
- Inadequate/ poor capacity of HEW
- Work load of HEW
- Lack of incentive
- Poor OTP service delivery in kebele HP
- Distance/ Geographical barrier
- Poor work environment
- High turnover of HEW

Possible solutions on identified key barriers

- Community awareness of malnutrition
- Involve comm. leaders & figures in supporting comm. mobilization for CMAM program.
- Strengthen technical support of HEW & supportive monitoring of OTP sites.
- Refreshment/ on job training
- Incentives - on duty overtime payments
- Provision of regular quality OTP service at HP including supply of basic medicines.
- Improve work environment
- Upgrading /motivation schemes.

Best solution to overcome barriers increase access to service delivery is

- Availabilities of different supportive structures like 1: 30 HAD, 1: 5 CDA

4.5.4 CMN solutions database

The CMN also presented briefly the solutions database that it has developed. This is available to view on their website here: http://www.coverage-monitoring.org/2016/01/19/introducing-solutions-to-barriers-a-clever-way-to-visualise-results/ . This database has been developed based on all of the programmes supported by the CMN during 2014/15 and can act as a source of ideas for activities to overcome different barriers.

4.6 Analysis of CMAM using Bottleneck Analysis Tool

As part of broader discussions on improving access and coverage to CMAM services, the attendees were asked to reflect on relevant priorities for focus and further work. The analysis was conducted in four groups in line with the 4 main determinants of CMAM services: Enabling environment, Supply, Demand and Quality. For each of the determinants, the four groups reflected on themes and sub-themes identified during a global analysis of CMAM that was conducted to develop the SAM 2.0 agenda (more details available in the presentation:
https://www.dropbox.com/s/k9apggx52va9ldh/1.%20National%20Coverage%20Priorities.pptx?dl=0).
The results of the discussions were presented to the other groups (and added to if necessary) and captured in the tables in the following pages:

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
ENABLING ENVIRONMENT	Political Commitment	There is limited evidence-based understanding how to position SAM as a national priority	No	✓ NNS, NNP, SAM ,MAM GL , PHEM GL,CMAM,CHD ,	Strengthen the national programs in the ground, M & E
		There are no national level wasting reduction or SAM treatment coverage targets at country level which would mirror WHA commitments	NO	✓ HSTP (2016-2020), NNP, reduction of stunting from current 40%	Implementation of activities w/c is on HSTP, SEKOTA commitment
		The leadership and coordination to influence national policy on SAM needs to be reinforced	PARTIALLY RELEVANT	✓ National command post, MANTF, SAG	Strengthen all existing nutrition coordination bodies at all levels MANTEF
	Financing	The inclusion of SAM treatment in national health budgets is inadequate and/or inconsistent	YES	✓ Most SAM programs are donor dependant, Gov.t started showing commitment	Government has to allocate budget step by step for SAM programmes
	Management	The use of data/evidence for strategic and tactical decision making on SAM scale-up is limited	YES	✓ OTP /SC sites are scaled-up	Improving the reporting system /shifting to electronic reporting, improve timeliness of the reporting, research and case studies should be done
	Coordination	The lack of clear guidance and division of labour that	NO	✓ There is a national MAM and SAM guidelines, there is also TOR for	To adhere on the guidelines and TOR, strengthen government lead close monitoring and

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
		undermine the ability to address SAM and MAM across the continuum of care in emergency and non-emergency contexts		division of labour in both emergency and non-emergency context	evaluation and coordination at all levels,
		There are limited joint initiatives between nutrition and health actors/stakeholders to support the integration of SAM into health	NO	✓ There is a joint command post at federal level and there is a NHTF at regional level	Needs to be strengthen

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
SUPPLY	Commodities	The procurement and supply of RUTF occurs outside of regular health supply chain and is unpredictable and unsustainable	Yes, It is the problem of Ethiopia as it is mostly procured off shore	✓ Started producing locally to fill the gaps ✓ Giving order in advance for purchasing from abroad ✓ Some communities started preparing similar RUTF from existing resources to fill gaps	➢ Scaling up the local production ➢ Prepare contingency planning on scenario based session ➢ Intensive awareness on how to prepare balanced diet food locally ➢ Preparation of manual on how to do balanced diet.

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
		Exploring alternative RUTF formulations at country level is made challenging by the lack of expertise in evaluating opportunities (e.g. recipes) and challenges (e.g. production)	Yes	✓ Currently with very limited technology and experts, the country is producing alternative RUTF	➢ Import quality checking machine ➢ Capacity building for expertise
		The understanding of key issues, challenges and barriers to inpatient treatment remains limited	Yes	✓ Adhere to existing national level protocol for SAM treatment	Provide training on protocols
	HR	The support from health authorities, paediatricians and other senior health stakeholders in-country for SAM integration into health policy and practice (including health training curricula) is limited	Yes	✓ Some universities, colleges and training institutes provide training	➢ Include in national educational curriculum ➢ Intensive training
		There are inadequate numbers of health workers in place that are adequately prepared and/or trained to deliver SAM treatment	Yes	✓ Within the limited staffs, at various levels of health facilities is providing treatment of SAM case	➢ Accelerated training of health staffs

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
		routinely			
		The potential contribution of community health workers to SAM treatment is not maximised	Yes	✓ Enhance the capacity of WDA ✓ Enhancing Community conversation while CBN was done	➢ Sensitizing VCHW to increase CBN
	Geographic Access	There is an inadequate number and distribution of functioning health service delivery points (e.g. fixed and community) providing SAM treatment	Partially relevant	✓ SAM treatment is given in the existing health facilities. ✓ In case of emergency FTC is used as treatment centres ✓ Using tents provide treatment during emergency	➢ Enhance the existing health facilities. ➢ Construct additional health facility in reasonably distances
		The ability of national health actors to adequately evaluate and structure SAM treatment scale-up is limited by basic information about the health system (e.g. # of HFs; resources; days per week)	Yes	✓ HEW deliver reports regularly	➢ Use Woreda net , LAN and automated data transferring technology ➢ Nutrition information management system is being set up by MoH with support of UNICEF ➢ Mobile data information management system

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
DEMAND	Community Mobilization	Community mobilization initiatives remain limited, and when they do exist, they do not generally support health seeking behaviour on SAM	Partially relevant	- Sensitization and awareness creation (HEWs) - Active participation of community leaders	- Strengthening the on going sensitization
		There is a limited understanding of how best to empower communities to demand SAM management services, and caregivers to diagnose, prioritise and seek treatment for SAM	Partially relevant	- Sensitization and community awareness creation Utilization of currently existing structure	- Strengthening the on going sensitization - Conduct CA in order to understand the community level of understanding
	UTILISATION	Referral pathways to SAM/MAM treatment do not currently result in consistent detection and admission of cases - Distance after referral - Inadequate detection of MAM	Partially relevant	- Utilization of currently existing structure - Home to home visit with active participation of HDA's - Monthly and quarterly mass screening - Transportation availability for TSFP	- Strengthening the existing mass screening by provision of refreshment and on job training for HEWs, HDA's - Strengthening awareness creation for the community - Improve reporting on referrals (eg narrative in the monthly reports) - Improved coordination between health posts / facilities / partners
		The opportunity cost (including		- Supporting the transport and	- Reinforcing Joint

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
		transport, loss of income, official and unofficial fees, etc.) associated with SAM/MAM treatment can be too expensive	Partially relevant	other expenses in collaboration with other partners	Supportive Supervision (minimises cost) - Reducing waiting time / improving facilities for mothers and children at health posts
		The availability, quality, and consistency of SAM treatment services is irregular affecting staff –user interface and compliance with treatment regime - Absenteeism of health workers affecting supplies due to non-reporting-related to security - Lack of knowledge on management of SAM	Partially relevant	- Follow up by Woreda office - Refreshment and on job training - Bi annual review - Updating the existing National CMAM guidelines	- Provision of on job training - Conduct regular JSS - Conduct regular performance management evaluation of staff

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
QUALITY	Effective Coverage	The protocols and guidelines for SAM treatment are not applied systematically, limiting their ability to adapt to patients' needs	Yes-The problem is utilization of the guideline and The cut of point for	- Training on the protocols and guidelines - On job supervision and mentoring - Translating the protocols in to	- This should be part of the performance evaluation for the health facility staffs who engaged on CMAM

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
			admission is less than 11 cm-due to resource implication	local languages - We have national CMAM guideline-2007 - National Nutrition policy - WHO	management - Quality spot checks of OTP cards - The guideline should be reviewed and updated based on needs (Such as MMN)
		SAM treatment services do not meet minimum standards of care in terms of WASH, ECD and psycho-social support and broader promotion components	Yes this is the priority for Ethiopia-The SAM treatment is not integrated with other programs	- Some sectors like agriculture-PSNP integrated the nutrition component in their strategies - Health promotion and education at health facility - The national nutrition program policy focuses on mainstreaming nutrition in other sectors (Nutrition sensitive program)	- Ensure woreda level integration between different sectors-for example organizing joint training on WASH,ECD and CMAM management - Improving availability of IEC materials at health facility level - Refresher and basic training on minimum standards - Assigning of a focal point for promotion (integrated) activity at the health facility level…. - Organize radio programs and campaign on different sectors - Setting up of referral pathway between the

Determinant	Themes	Sub-themes	IS THIS PRIORITY RELEVANT TO ETHIOPIA?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
					CMAM program and Psychosocial, WASH and education and other relevant programs

At the end of the exercise, the **key priorities** for each determinant were agreed by participants:

4.6.1 Enabling Environment

- ✓ Develop a national guideline
- ✓ Initiate discussions on setting a national target for achieving met need in CMAM programmes (Treatment coverage combined with cure rate rather than geographic coverage and reaching target caseload)
- ✓ Revitalize the proposed regional SLEAC coverage assessment

4.6.2 Supply

- ✓ Standardize the quality of the RUTF product to minimize cost and reduce lead time for import from abroad as these might avoid the supply pipeline breakage.
- ✓ Scaling up of RUTF production locally
- ✓ Develop recipe manual that is comparable with RUTF/RUSF from locally available ingredients.

4.6.3 Demand

- ✓ HDA (1:30) and CDA (1:5) groups should be trained on MUAC screening & referral rather than finding opportunistic cases as well as sensitization on CMAM

4.6.4 Quality

- ✓ Include coverage indicators in monitoring & evaluation tools as well as performance indicators (cure rate, Death & Defaulter)
- ✓ Strength the referral system from community to health facility and vice versa
- ✓ Improve quality of screening

4.7 Way forward and next steps

- ✓ Reactivate the TWG or establish sub TWG from MANTF members in order to continue the process of developing national coverage assessment guidelines
- ✓ Conduct large area assessment (SLEAC) to better understand treatment coverage.
- ✓ Capacity building (Mapping, conducting assessment & training)
- ✓ Information exchange (publishing of coverage assessment report on NDRMC monthly bulletin.
- ✓ Publishing of all coverage assessment reports conducted in Ethiopia in CMN website to be discussed with concerned officials.
- ✓ Share information on Coverage Assessment finding during regular MANTF meeting.

Annex 1: Terms of reference of the Ethiopia Coverage Lessons learned workshop

Introduction:

The Coverage Monitoring Network (CMN) is an inter-agency project lead by Action Against Hunger and including International Medical Corps, Concern Worldwide and Helen Keller International. The project was launched in 2012 with the support of ECHO and OFDA.
The project aims to increase and improve the coverage of CMAM programmes through the promotion of quality coverage assessment tools and the sharing of lessons and good practices in 9 priority countries in Africa and Asia (including South Sudan, Kenya, Ethiopia, Niger, Burkina Faso, Mali, Chad, DRC and Pakistan).

Following the success of the first phase of the CMN project, the CMN entered its second phase in June 2014. During the second phase, the CMN field teams continued to provide direct and remote technical support to CMAM programmes with the planning and delivery of coverage assessment methodologies. The CMN field teams also helped programmes to develop context specific action plans to improve community mobilisation in their programmes. Since June 2014, the CMN team supported the CMAM programmes they had supported to implement the action plans in their programmes and have worked with programmes to consolidate best practices and lessons from their experiences.

The CMN has supported directly and remotely four organisations to conduct coverage assessments in Ethiopia since the start of Phase 2 of the project and some more in the two years previously. The reports for these surveys along with the reports from all previous coverage assessments are not published due on this page: http://www.coverage-monitoring.org/country/Ethiopia/ due to pending National Coverage Assessment guideline development and endorsement by the government.

The CMN project will be drawing to a close at the end of February 2016. The CMN would like to organise a two-day "lessons learned" workshop in Addis Ababa to consolidate available tools and experiences from coverage assessments in Ethiopia and to further the steps made to improve the access and reach of CMAM programmes.

Objectives:
Principle objective:
To improve access to and uptake of SAM and MAM treatment programmes in Ethiopia
Specific objectives:

- To share the findings and recommendations coming from coverage assessments in Ethiopia over recent years.
- To share and document examples of how the evidence and data generated by recent coverage assessments (including SQUEAC assessments and Community Assessment) are being used by programmes
- To share and document activities being undertaken in different contexts to overcome barriers to access and to identify best practices in key contexts.
- To discuss and agree the next steps needed to improve programming in order to improve access and uptake of services to treat SAM and MAM.

Participants:
Members of the Emergency Nutrition Coordination Unit (ENCU) Group as Well as MoH and DRMFSS

Format of workshop:
The workshop will take place over two days.
The CMN will be responsible for facilitating and documenting discussions. Different partners will be responsible for leading discussions and preparing presentations and experiences. The workshop will consist of presentations and working sessions.

Agenda:
The proposed approximate agenda is as follows:

DAY 1		
TIME	**TOPIC**	**LEAD**
Morning	- Introductions and outline of agenda - Update on the progress of the national coverage guidelines - Presentation of country profile: including mapping of coverage assessments, overview of trends in programme data and community profile	- CMN - ENCU - ENCU Members & CMN
Afternoon	- Transforming coverage results into action: experiences, challenges and best practices. - Presentation of activities to overcome barriers to access in different contexts. - Group work to identify and document other best practices	- ENCU members and CMN
DAY 2		
TIME	**TOPIC**	**LEAD**
Morning	- Overview of materials and tools developed by the CMN during CMN Phase 2. - Group work to discuss and identify next steps to improve access and uptake of CMAM programmes	- CMN - ENCU partners and CMN
Afternoon	- Presentation of group work and further discussion and allocation of responsibilities	- CMN and partners

Date and venue of workshop:
The workshop will take place on Thursday 3rd and Friday 4th March 2016 between 9am and 5pm. Venue TBC.

Expected outputs:

- The consolidation of information, results, challenges and opportunities related to improving the coverage of SAM and MAM treatment programmes in Ethiopia in a country profile document – initiated by the CMN, completed by ENCU partners.
- Key points from discussions, conclusions and next steps documented in a short report.
- A road map of actions and next steps to improve access and uptake of SAM and MAM treatment.

Annex 2: Agenda of Coverage Lessons learned Workshop, Addis Ababa, Ethiopia

THURSDAY 3RD MARCH		
TOPIC	**TIME**	**LEAD**
Introductions and objectives of workshop	09.00 - 09.15	NDRMC/ENCU
Update on CMAM: Geographical coverage of services, challenges to scale up and implementation, update on strategy and Update on the finalisation of the national coverage guidelines	09.15 - 09.45	ENCU/NDRMC
Presentation of **country profile**: including mapping of coverage assessments, overview of trends in programme data and community profile	09.45 - 10.15	CMN / ENCU/NDRMC
Questions & Comments	10.15 - 10.30	Plenary
Break		
Transforming coverage results into action: experiences, challenges and best practices Introduction to the topic	11.00 - 11.10	CMN
Presentation by Concern	11.10 - 11.30	Concern
Presentation by IMC	11.30 - 11.50	IMC
Presentation by ACF	11.50 - 12.10	ACF
Group Discussion and presentation to the plenary	12.10 - 13.00	Groups and plenary
LunchBreak		
Presentation of activities to overcome barriers to access in different contexts. Introduction to the topic	14.00 - 14.20	CMN
Identification of best practices in Ethiopia context - group discussion	14.20 - 15.00	Partners
Group work to discuss how key barriers to access can be tackled	15.00 - 15.30	Plenary
Break		
Group Work Continued	15.45 - 16.00	Plenary
Presentation of Group Work + Q&A	16.00 - 17.00	Plenary

FRIDAY 4TH MARCH		
TOPIC	**Time**	**LEAD**
Recap of Day One	09.00 - 09.30	ENCU/NDRMC
BNA approach to scaling up access and coverage of CMAM services	09.30 - 09.45	CMN
Group work - discussion of possible solutions	09.45 - 10.30	Group Work
Break		
Presentation of Group Work + Q&A	11.00 - 12.00	Plenary
Overview of materials and tools developed during CMN Phase 2	12.00 - 13.00	CMN
LunchBreak		
Which method to use when?	14.00 - 15.00	CMN
Remaining Questions and Way Forward	15.00 - 15.30	ENCU/NDRMC
Break		
Group work to discuss and identify next steps (action plan with times and responsibilities) to improve access and uptake of CMAM programmes (4 groups - 4 themes)	15.45 - 16.45	Plenary
Close of workshop	16.45 - 17.00	CMN and ENCU/NDRMC

Annex 3: Coverage Lessons learned workshop – List of participants

First Name	Last Name	Position	Organisation	Email Address
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