COVERAGE MONITORING NETWORK

ACTION PLAN REVIEW

Learnings from the CMN's support of coverage assessments and context-specific action plans during Phase II

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SUMMARY

Between 2012 and 2016, the Coverage Monitoring Network (CMN) supported NGOs and UN agencies with the planning and implementation of coverage assessments in CMAM programmes using SQUEAC and SLEAC methodologies. The project has been implemented by a partnership of NGOs including Action Against Hunger (lead agency), Concern Worldwide, International Medical Corps and Helen Keller International and funded by ECHO and OFDA.

From May 2014, when the CMN entered into its second phase of funding, the partners continued to provide donor funded coverage assessment support at no cost to programmes, focusing on nine priority countries (Burkina Faso, Niger, Mali, Chad, Democratic Republic of Congo, Kenya, South Sudan, Ethiopia and Pakistan)[1]. During this phase the CMN placed a new focus on improving the coverage of these programmes by supporting the design and implementation of context-specific action plans.

This report consolidates the learnings from the design and implementation of the action plans in the 45 CMAM programmes which the CMN team supported across the 9 priority countries. It includes a global analysis of the design and implementation of the action plans in addition to a summary of the perceptions of the programme managers who implemented the action plans on the ground. It also discusses the measured impact of the action plans on the treatment coverage of the CMAM services where it was possible to conduct follow-up assessments.

Summary of results:

- The CMN team supported 53 coverage assessments across the nine priority countries – Mali accounted for the largest number with 14 assessments. Between two and seven assessments took place in the other countries.
- 13 of the assessments took place in programmes supported by Action Against Hunger. The remainder were split between 18 international NGOs and two UN agencies (UNHCR and WFP).
- It was possible to track the progress of 35 of the 45 action plans developed with the support of the CMN technical staff. It was not possible to track action plan implementation in all programmes for various reasons (three main reasons: action plans finalised close to end of project so CMN team unable to oversee implementation, loss of contact with programmes and programmes unable to implement activities due to staff changes or resource limitations).
- The action plans included between seven and 60 activities; 22 included between 10 and 19 activities. All action plans included community engagement and quality of care activities.
- In terms of implementation, 60% of the 35 programmes that implemented action plans completed 50% or more of the activities. 11 programmes completed more than 70% of the proposed activities.
- 94% of programmes carried out community engagement activities – compared to between 60 to 69% of other categories of other types of activities (Quality of care, coordination and monitoring & evaluation activities).
- The influence of six determining factors (context, financing, continuity, human resources, motivation for improvement and partnerships and coordination) on the capacity of programmes to implement activities was reviewed for 35 action plans. Key results include:

[1] The priority countries were selected based on a criteria which included SAM burden, SAM cases treated, presence of CMN implementing agencies, number of coverage assessments carried out previously and membership of the Scaling Up Nutrition Movement.

    - **Context**: 52.5% and 62.5% of programmes respectively were implemented in unstable political and unstable security settings. 35% of programmes were implemented in emergency settings.
    - **Financing:** 45% of the programmes either had budget available or had flexibility in existing budget lines to cover the cost of activities.
    - **Continuity:** 85% of programmes were able to continue to implement activities uninterrupted throughout the action plan implementation period.
    - **Human resources:** 70% of implementing agencies suffered from staff changes following the initial coverage assessment.
    - **Motivation for improvement:** For 60% of implementing agencies, there was an external drive for improvement; while 68% of programmes identified an internal drive for improvement.
    - **Partnerships and coordination:** Action plans were developed with multiple stakeholders; notably 84% with local health district personnel and 67% with community members.
- Follow up coverage assessments were conducted in 12 districts at least 12 months after the implementation of the baseline assessments in order to measure the impact of action plan implementation on coverage. In two of the districts it was not possible to estimate coverage. In the remaining ten districts:
    - In two, coverage increased by more than 10%.
    - In five, coverage increased by less than 10%.
    - In three, coverage decreased (by between 1.4% to 10.3%)

Key learnings:

Uptake of coverage monitoring at national, regional and district level:

- Large scale coverage assessments (at national or regional level), can lead to increased demand for coverage assessments at programme level and to coordinated efforts to address barriers to access at national level (eg Mali).
- Donor recognition of benefits of coverage monitoring is key for sustained coverage monitoring and improvement.
- Some CMAM programme implementers view "one-off" coverage assessments as the only way in which to monitor the coverage of their programmes. However coverage monitoring can be integrated into the routine monitoring of programmes through a mixture of on-the-ground assessments and regular data monitoring.
- Some implementers maintain the belief that coverage monitoring is a highly specialised set of methodologies which can only be delivered by experts.
- On-the-ground trainings are the most effective way to train programme staff on how to conduct coverage assessments. However, for programme managers who have been trained in the methodologies previously, carefully managed remote support can be an effective way for them to practice the implementation of coverage assessments.
- Capacity building approaches for coverage monitoring need to be country-specific. Approaches to monitoring coverage at a country level should be modified according to the context.

Action plan design:

- If more district level stakeholders are involved in the elaboration of an action plan, there is a greater potential for full implementation of the action plan.

- A larger number of activities in an action plan is an indication that a programme requires many areas of improvement. Based on experiences during CMN Phase II, this does not result in overburdening of programme teams but it makes staff more aware of the need to make improvements.
- The completion of activities to boost community engagement was more successful and more popular than anticipated during CMN Phase II indicating that programmes were willing to make improvements in this vital area with minimal external support.

Contexts of programmes which implement action plans:

- Continuity of programmes is key – if the funding for a programme will end soon, it is unlikely that an action plan will be implemented. However recommendations can be incorporated into new project designs, to improve the quality of programming.
- Unstable security settings and high staff turnover can lead to delays in action plan implementation. Well-managed handovers can mitigate this challenge, and a commitment should be made to include results of coverage assessments as a key source of information regarding the programme.
- Bureaucratic restrictions are a key inhibiting factor in the implementation of multi-stakeholder action plans – therefore ministry of health staff must be part of the action plan formulation process from the start.
- During CMN Phase II, some programmes supported made progress to improve programme performance in spite of a lack of pressure from external sources such as donors and ministries of health. This demonstrates that improvements to coverage can be achieved through an internal motivation to improve.

Resources needed for action plan implementation:

- Action plans are not necessarily resource heavy: 60% of action plans supported by the CMN completed more than 50% of their activities – however only 32.5% of programmes reported having available finances to implement the activities in the action plans.
- Programmes generally need around 12-18 months to implement an action plan in full.
- The burden on teams of action plan implementation can be lessened if managers allow the integration of activities into the existing job descriptions of their team.

Perceptions of programme managers:

- Activities involving different community actors such as opinion leaders and mothers were perceived by programme staff to be most effective.
- Activities to influence community behaviour and to promote community engagement can be completed relatively quickly. However they need to be sustained overtime in order to incite lasting change and to improve coverage.

Impact of action plans and programme changes on coverage of CMAM services:

- Community engagement is an essential part of positive change in coverage and should be at the heart of all programming.
- Effective coordination between partners can result in a sharing of workloads leading to strong programme performance and impactful community engagement activities.
- Significant increases to coverage were only seen when significant changes were made to the CMAM model including changes to the service delivery model (community based health workers delivering treatment for SAM in communities instead of facility based treatment).

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Glossary

ACF	Action Against Hunger
ACTED	Agency for Technical Cooperation and Development
CMAM	Community based Management of Acute Malnutrition
CMN	Coverage Monitoring Network
COOPI	Cooperazione Internazionale
ECHO	European Commission's Humanitarian aid and Civil Protection department
HKI	Helen Keller International
iCCM	Integrated Community Case Management
IMC	International Medical Corps
LGA	Local Government Authority
MAM	Moderate Acute Malnutrition
MUAC	Middle-upper arm circumference
NGO	Non-governmental organisation
OFDA	Office of US Foreign Disaster Assistance
OTP	Outpatient Therapeutic Treatment
SAM	Severe Acute Malnutrition
SLEAC	Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage
SQUEAC	Semi-quantitative evaluation of access and coverage
TSFP	Therapeutic Supplementary Feeding Programme
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHZ	Weight for height Z-score

Priority country abbreviations

BF	Burkina Faso
CD	Democratic Republic of Congo
ET	Ethiopia
KE	Kenya
ML	Mali
NI	Niger
PK	Pakistan
TC	Chad
SS	South Sudan

1. Introduction

In May 2014, at the outset of the Phase II of the Coverage Monitoring Network (CMN), the project team set out to understand what impact context-specific action plans (designed based on the findings of preceding coverage assessments) would have on the coverage of CMAM programmes.

As such, between May 2014 and March 2016, the CMN's field teams supported more than 50 CMAM programmes across nine countries (Burkina Faso, Niger, Mali, Chad, Democratic Republic of Congo, Kenya, South Sudan, Ethiopia and Pakistan) with the implementation of coverage assessments. The findings and results of these coverage assessments resulted in the elaboration of multi-stakeholder, context-specific action plans to tackle the main barriers faced by caregivers in taking their children to health facilities to receive treatment for severe and moderate acute malnutrition.

At the end of Phase II the impact of the action plans on levels of coverage was hard to measure. Partly because the CMN had limited control over the implementation of the action plans themselves and so were unable to oversee the implementation of the activities directly. And partly because few of the supported programmes were able to conduct follow-up coverage assessments to estimate new coverage estimates which would indicate the extent to which action plans increase (or decrease) treatment coverage.

However this report serves to consolidate vital learnings from the action plan implementation process across the CMN priority countries. During the final weeks of the project, a meta-analysis of all of the action plans was conducted to analyse different aspects relating to the design and content of action plans and to the relative extent of action plan completion. The results of the meta-analysis are presented in this report. The report also compiles and summarises some of the experiences of programme managers in implementing action plans, evidence of the impact of action plan implementation on coverage and observations of the CMN field teams during their interactions with teams across the CMN countries.

2. Context

The Coverage Monitoring Network (CMN) is an inter-agency project led by Action Against Hunger and including International Medical Corps, Concern Worldwide and Helen Keller International. The project was launched in 2012 with support from ECHO and USAID/OFDA.

Through the course of Phase II of the project (2014-2016), the CMN's field team has supported CMAM programmes across nine priority countries to develop context specific action plans to improve programme coverage. The action plans have been developed with particular emphasis on the improvement of community engagement in the health districts and have been based on the findings of the coverage assessments that have taken place.

The CMN field teams (including regional coverage advisors and community mobilisation advisors) have provided technical support for the assessments and the development of the action plans and have followed up with the programme staff to record their challenges and successes in the process of activity implementation.

3. Methodology

All learnings presented in this summary were collected on an ongoing basis since the onset of CMN Phase II. They were summarised in the "wrap-up" reports prepared by CMN staff in collaboration with programme focal points in country. They were further synthesized into an Excel spreadsheet, which allowed for a quick sorting and filtering of data. Considering the quantitative nature of this synthesis, a further extraction of qualitative elements from the wrap-up reports took place in order to add the necessary depth and insight to the findings.

The **first thematic section** focusing on the overview of provided technical support covers all **53 programmes** supported in 9 priority countries. Considering that 8 programmes, namely Gambella (ET), Kakuma (KE), Baringo (KE), Aweil Centre (SS), Kita[2] (ML), Djibo (BF), Dori (BF) and Dadu[3] (PK), did not (or not yet) produce context-specific action plans following a coverage assessment, only **45 programmes** were included in the analysis for the **second thematic section.** The **third thematic section** lost yet another two programmes, namely Gourcy (BF) and Moussoro (TD), which did not finalise their coverage assessment reports at the time of this analysis and thus could not be considered. Out of these, 5 programmes, Kirotshe[4] (CD), Tenenkou (ML), Tanout (NI), Kohat and Dadu (PK) could not be studied due to the lack of available data but they were integrated into the categories for which the data was available.

4. Structure

The results of the meta-analysis are structured as follows:

Section 1 is based on a meta-analysis of 53 CMAM programmes supported during CMN Phase II. It is organised in three thematic sections, namely:

1. **Overview of technical support provided** detailing **where** and **when** programmes were supported by the CMN, **who** were supporting agencies and **what** type of support was provided;
2. **Summary of learnings from the development of context-specific action plans** outlining major **actors** participating in the elaboration of recommendations and corrective actions as well as the **volume** of proposed activities needed to improve the quality of CMAM programming;
3. **Summary of learnings from the implementation of context-specific action plans** illustrating a variety of **factors** having a considerable impact on the implementation process and/or successive expectations of coverage increase.

The third thematic section comprises of three subsections:

a. **Analysis of determining factors** when programmes were **not able to implement** their action plans;
b. **Analysis of progress** in case of programmes which were able to (fully or partially) implement action plans;
c. **Analysis of determining factors** and their **interactions** in the implementation of action plans. For the purpose of this summary the following categories were considered: **context**, in which action plans were implemented; availability of **financing** and/or **human resources**, the sense of **continuity**, **motivation for improvement**, **partnerships and coordination**

[2] Coverage assessment support for C-project.
[3] Coverage assessment support for C-project.
[4] Supported by COOPI.

5. Meta-analysis of action plans

5.1 Section 1: Overview of CMN Phase II technical support

5.1.1 Summary

- Between May 2014 and March 2016 the CMN supported coverage assessments in **51 health districts in nine priority countries**.
- **32 of these involved direct**, **on-the-ground support** by at least one CMN field team member or consultant contracted by the CMN. The remainder were conducted by agencies supporting the implementation of CMAM programmes with the remote support[5] from the CMN team.
- **45 assessments** were conducted using the **SQUEAC methodology** and **4** were conducted using the **SLEAC methodology** (covering a minimum of 2 health districts). In **2 health districts,** the coverage assessment using the SLEAC methodology was followed by an in-depth community assessment.
- **7 SQUEAC assessments** evaluated both **SAM and MAM treatment coverage** while the rest focused on SAM treatment coverage only.
- **6 SQUEAC assessments** did not proceed to Stage 3 and so do not have a coverage estimate.

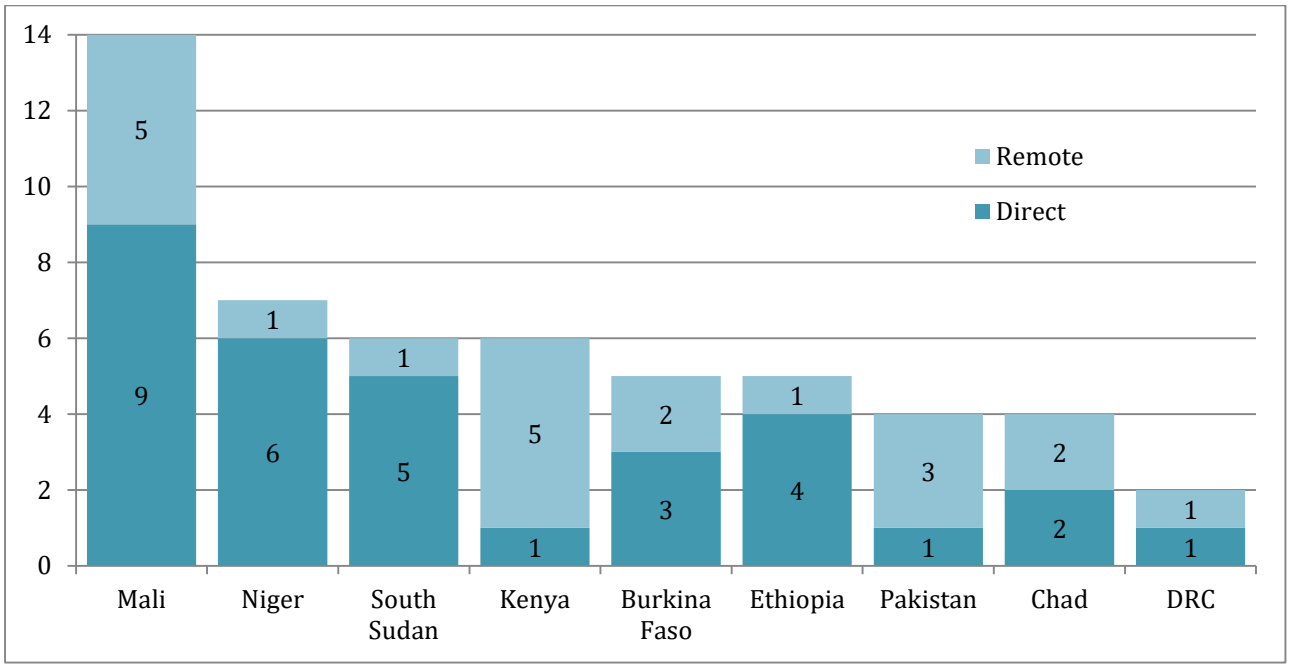
5.1.2 Where did coverage assessments take place?

CMN Phase II provided technical support for 53 programmes in 9 priority countries. As shown in Chart 1 below, Mali accounted for the largest number of assessments (n=14) supported by the CMN. This reflects the interest and motivation of organisations in Mali to implement coverage assessments as part of their project cycle.

The demand for the technical support in the remaining priority countries was fairly equal, oscillating between 2 for DRC and 7 for Niger. Niger's demand was still relatively high due the profound interest of a major donor (ECHO) to motivate the improvement of nutrition programming in country. As will be shown in successive sections, almost all implementing agencies in Niger (n=6) confirmed the presence of the external drive for improvement coming from the donor. This not only enabled the organisation of numerous coverage assessments but also created a favourable environment for the implementation of action plans.

[5] Remote support generally involved the support of the CMN team in the weeks prior to the start of the assessment, technical support during the assessment and report reviewing after the assessment.

Chart 1: Locations of CMN-supported coverage assessments during Phase II



With six coverage assessments in South Sudan, the country secured the third spot on the list owing to a large number of short-term emergency programmes. This increased their needs for direct support for three reasons – first, in some cases short term programmes are required to complete at least one coverage assessment within the project timeline, second there is high staff turnover in these contexts so the staff trained during preceding assessments move on and third, staff already have a high number of activities to complete and don't believe they have the capacity to do 'additional' activities such as assessments. These three factors decreased partners' capacity to conduct these assessments and increased their need for direct, on-the-job trainings from CMN.

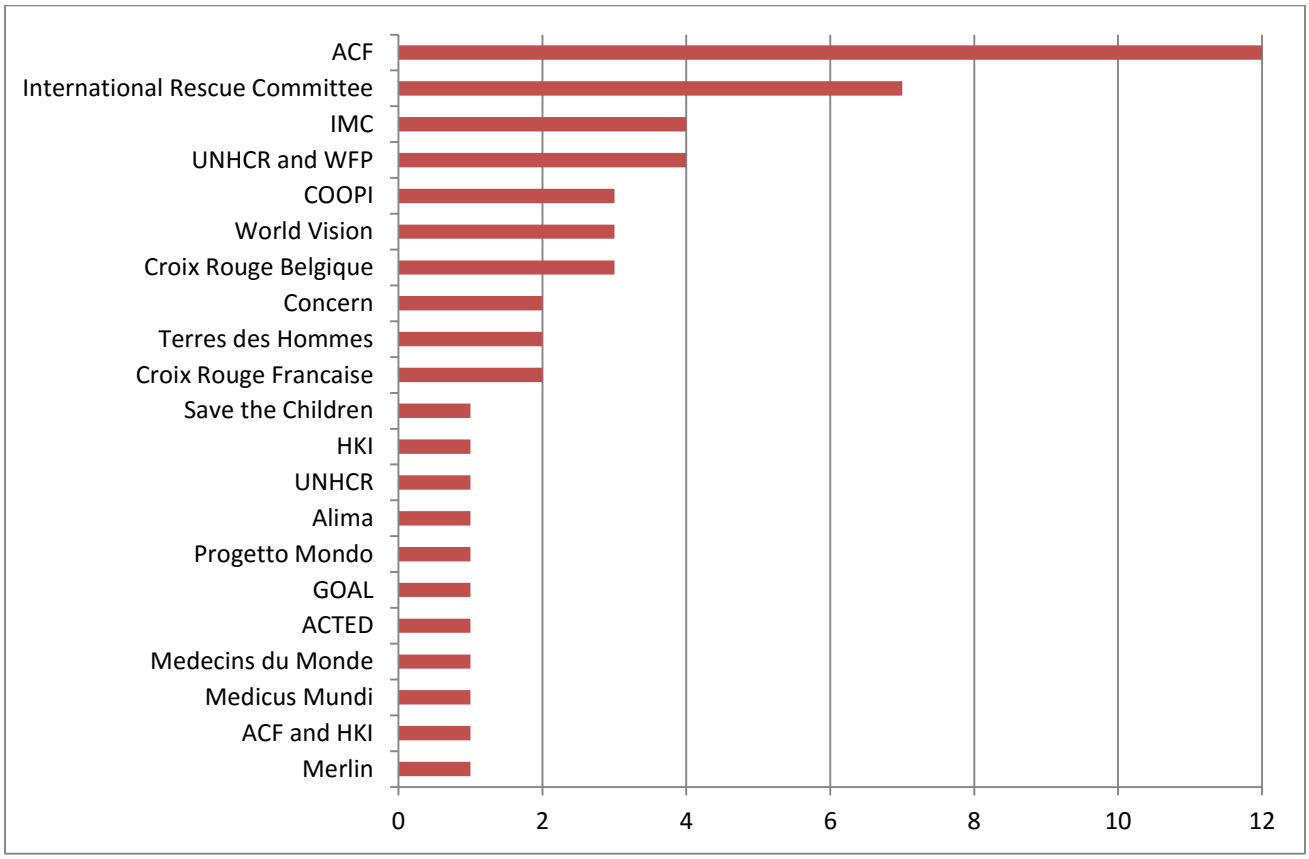
Kenya, finding itself on the other side of the spectrum with 1 direct support and 5 remotely supported coverage assessments, built on its relatively good knowledge of the SQUEAC methodology with one on-the-job training in a camp in Dadaab leading to multiple coverage assessments in other camps with minimal help from CMN.

The demand in DRC, Chad, Ethiopia and Pakistan was generally hesitant owing to the lack of decisive buy-in of country partners, including health authorities, donors or implementing agencies. This was found to be due to competing priorities e.g. the drought in Ethiopia, staff writing funding proposals; redirecting attention and resources away from coverage assessments.

5.1.3 Which organisations were supported?

Chart 2 provides an insight into the utilisation of CMN services by different implementing agencies. While a total of 22 different organisations benefited from CMN's technical support during the planning, delivery and follow up of coverage assessments, Action Against Hunger (ACF) came to the top of the list with a total of 13 supported coverage assessments in all priority countries. This reflects ACF's strong internal motivation for improvement, which translated into a requirement for all nutrition programmes to carry out regular coverage assessments (more information available in "ACF Coverage Review").

Chart 2: Number of assessments supported per organisation



Other implementing agencies, such as International Rescue Committee or International Medical Corps demonstrated consistently their buy-in, rooted in the appreciation of coverage methodologies and preceding positive experience, by requesting the support of the CMN in seven and four of their programmes respectively.

The demand for CMN's technical support demonstrated that technical capacity to conduct coverage assessments remains quite limited. While on-the-job trainings which the CMN provided have proven to be an effective way to instilling technical capacity and knowledge in capable individuals, staff turnover and limited staff time due to competing activities continued to prompt many programmes to seek support from CMN.

Furthermore, based on discussions during the national level workshops in the priority countries, donors and NGOs still feel that coverage assessments should be conducted by external bodies or trained consultants. There remains a general perception that coverage assessment methodologies are very technical and that the results of coverage assessments would not be credible if conducted by programme staff. This was reflected by the high demand for the CMN's on-the-ground support during Phase II (particularly in South Sudan and Mali).

The CMN team aimed to dispel this perception during national workshops and trainings. It also built and reinforced the capacity of programmes to monitor and evaluate programme coverage by coaching key programme staff and developing and sharing simplified, standardised guidance for coverage assessments.

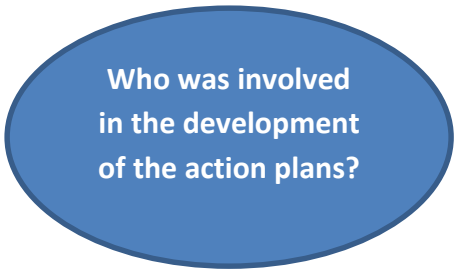
5.1.4 Key learnings from uptake of coverage monitoring at national, regional and district level

- Large scale coverage assessments (at national or regional level), can lead to increased demand for coverage assessments at programme level and to coordinated efforts to address barriers to access at national level (eg Mali).
- Donor recognition of benefits of coverage monitoring is key for sustained coverage monitoring and improvement.
- Some CMAM programme implementers view one-off coverage assessments as the only way in which to monitor the coverage of their programmes. However coverage monitoring can be integrated into the routine monitoring of programmes through a mixture of on-the-ground assessments and regular data monitoring.
- Some implementers maintain the false belief that coverage monitoring is a highly specialised set of methodologies which can only be delivered by experts.
- On-the-ground trainings are the most effective way to train programme staff on how to conduct coverage assessments. However, for programme managers who have been trained in the methodologies previously, carefully managed remote support can be an effective way for them to practice the implementation of coverage assessments.
- Capacity building approaches for coverage monitoring need to be country-specific. Approaches to monitoring coverage at a country level should be modified according to the context.

5.2 Section 2: Learnings from the development of context-specific action plans

CMN Phase II support extended to 53 programmes but resulted in only **45** traceable **context-specific action plans.** The action plans for the remaining 8 programmes were either not developed as coverage assessments served as baselines for a separate project (Kita ML and Dadu PK), the support provided was limited to a qualitative research (Kakuma KE and Aweil Centre SS) or recommendations proposed in a coverage assessment report were not transformed into an operational action plan for the whole district but only for 15 priority health facilities (Djibo BF and Dori BF). In two cases, Gambella ET and Baringo KE, coverage assessment reports were not shared with the CMN in time to be included in this analysis.

5.2.1 Which actors participated in the development of the action plans?



- The assessment investigation team: **98%**
- Other staff from the NGO: **49%**
- Health District and/or other MoH representatives: **84%**
- Community members: **67%**
- Collaborating NGOs: **44%**
- Community restitutions after the assessment **47%**

A new approach for the development of action plans during CMN II encouraged the participation of a variety of stakeholders in the process in order to ensure their involvement in later stages and, consequently, to ensure the success of the implementation process. Almost all action plans (98%) were developed by **SQUEAC investigation team members** whose learning during the investigation translated into the skeleton of operational recommendations. Representatives of a **local health system** (i.e. usually representatives of a respective health district) participated in the elaboration of 84% of action plans. **Community members**, including local community-based organisation or networks, were invited to

participate in 67% of cases, while **community restitutions**[6] were organised in 47% of health districts. Considering that the participation of community members in the development of action plans and/or sharing SQUEAC results with community members was a new addition, which was not implemented during CMN I, results are very promising and contributed to a favourable enabling environment for the implementation of action plans (Cf. 5.3.4 Section F: Partnerships & Coordination). In terms of the participation of **non-nutrition staff** from the same implementing agency in the development of action plans (e.g. livelihoods & food security, WASH, monitoring & evaluation, etc.), these were involved in 49% cases. The **staff of partner implementing agencies** was involved in only 44% of action plans, however they may not have always been present in the health district.

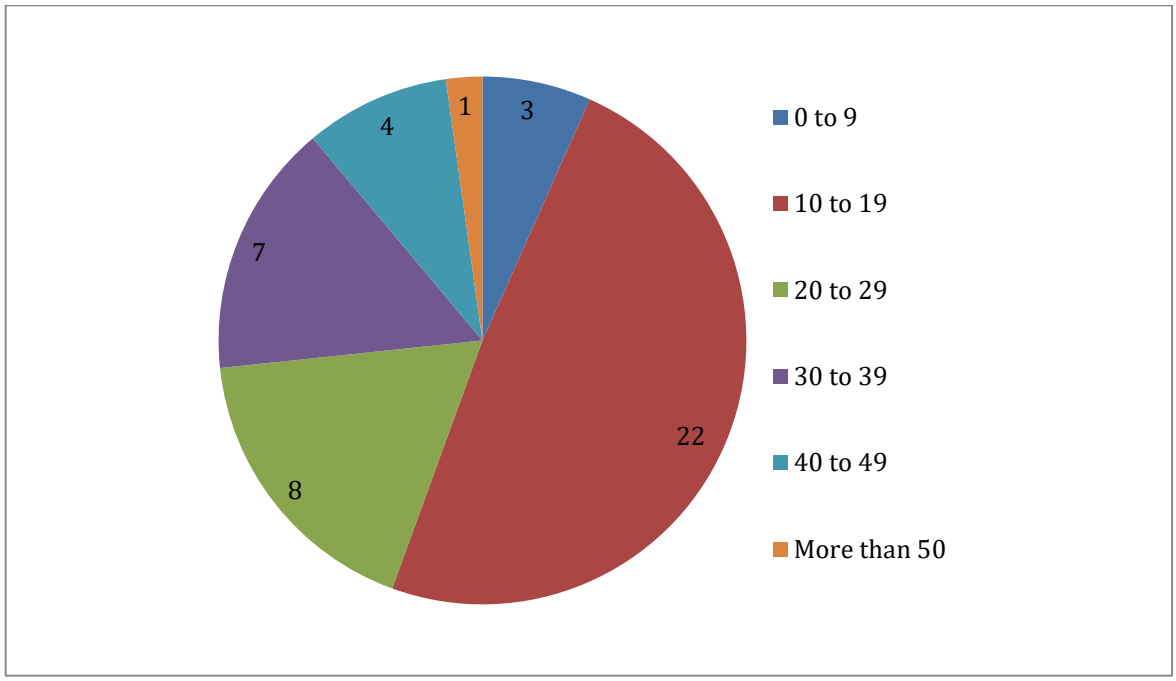
A cross-analysis against the progress of the implementation of action plans showed that a greater variety of stakeholders in the development of action plans can increase their implementation potential. When all categories of stakeholders were involved, 80% programmes reached the implementation rate of 60% or more. 50% of action plans developed in collaboration with community members reached over 50% implementation rate, most of them reaching 70% and more. The same is true for community restitutions, which not only inform community members about the results of the investigation but also allow them to engage with the programme in the following stages. In case of participation of a collaborating NGO, 75% programmes reached the implementation rate above 50%.

5.2.2 Action plan design

In terms of the total number of activities included in the action plan, around half of the action plans included 10 – 19 proposed corrective measures. 20% comprised 20 – 29 activities and only 25% of action plans went beyond the benchmark of 30 activities (see Chart 3). Interestingly enough, more activities in the action plan do not necessarily mean less progress. Action plans with a higher number of activities have equal (or sometimes higher) chances of the implementation success as implementing agencies are more aware of the necessity to improve the programming. On the other hand, action plans with a minimum activities (0-9) demonstrated a below 50% implementation rate.

[6] A community restitution is an exercise or a series of exercises during which the results of a coverage assessment are shared with community representatives with an aim to collect their feedback and possibly assure their engagement in the programme at later stages.

Chart 3: Number of activities per action plan



In terms of the content of action plans, the CMN technical teams supported the programmes to include a variety of activities to address barriers relating to supply such as service delivery and demand such as community engagement.

Based on the experiences from Phase I of the CMN, it was noted that programmes tended to favour not thinking "outside the box" when monitoring their programmes such as focusing on traditional indicators including number of admissions, discharges, defaulters, deaths and training of health staff and community volunteers. Therefore with the support of the CMN during Phase II, they were able to conduct in-depth assessments of community engagement activities and design action plans to address gaps to scale up coverage. As shown later in this report (Section 6), activities to improve community engagement were deemed to have the most impact on coverage by the programmes.

5.2.3 Key learnings from action plan design

- If more district level stakeholders are involved in the elaboration of an action plan, there is a greater potential for full implementation of the action plan.
- A larger number of activities in an action plan is an indication that a programme requires many areas of improvement. Based on experiences during CMN Phase II, this does not result in overburdening of programme teams but it makes staff more aware of the need to make improvements.
- The completion of activities to boost community engagement was more successful and more popular than anticipated during CMN Phase II indicating that programmes were willing to make improvements in this vital area with minimal external support.

5.3 Section 3: Learnings from the implementation of context-specific action plans

The analyses in this section centralise learnings from the implementation of context-specific action plans during CMN Phase II. As previously stated, while 45 action plans were developed, only **43** were included in this review as two programmes, namely Gourcy (BF) and Moussoro (TD) have not yet started with the

implementation process and thus it was not possible to assess the interplay of factors having impact on the implementation of their action plans. **3 programmes**, which were not able to implement their action plans at all, were analysed separately under subsection 5.3.1. The remaining **40 programmes** were included in the analyses under subsections 5.3.2 and 5.3.3.

5.3.1 Determining factors for programmes not able to implement their action plans

Despite the fact that action plans were duly developed, three programmes, namely Mangalmé (TD), Tominian (ML) and Kolokani (ML), were not able to implement them at all. The first two programmes closed their activities immediately after the initial coverage assessment as the NGOs supporting the programmes came to the end of their funding cycle and thus did not have an opportunity to follow up on the implementation process. Although a programme in Mangalmé was fully handed over to local health authorities, there was little evidence that the health authorities could absorb the implementation of an elaborate action plan. In fact, results of a regional SLEAC assessment in September 2015 in Manglame showed a decrease in coverage of some 20% over the course of 11 months. A programme in Kolokani (ML), on the other side, was neither discontinued nor transferred but an implementing agency did not show enough interest in community engagement activities suggested in the plan.

5.3.2 Progress in cases of programmes which were able to (fully or partially) implement action plans

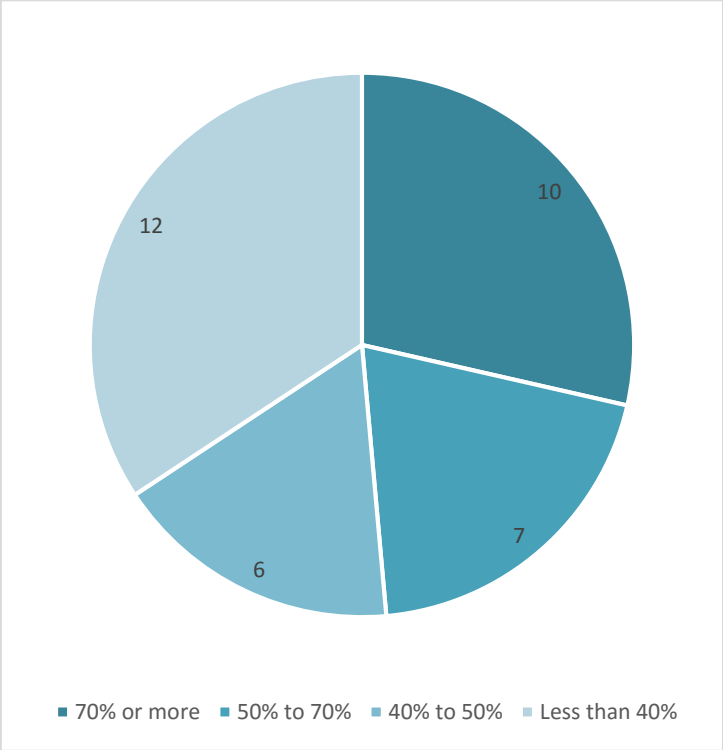
The implementation of all **40 action plans** developed during CMN Phase II was regularly monitored by CMN field teams. The level of provided support was agreed after the completion of coverage assessment reports and varied from programme to programme. Whenever possible, regular monitoring calls were scheduled to track the progress of the implementation process and to support programmes with any technical challenges. In addition, programmes were requested to submit updated action plans on a three to six-month basis, allowing CMN field teams to study their progress in a greater detail.

However, this active follow-up was hampered by a loss of contact with programme teams in 5 locations, namely Kirotshe[7] (CD), Tenenkou (ML), Tanout (NI), Kohat and Dadu (PK). For this reason, CMN could not monitor the programmes' progress on the implementation of developed action plans and, consequently, collect relevant valuable data. Nonetheless, gathering from exchanges with secondary or tertiary contact persons, the implementation of action plans was under way, even though not necessarily completed. Owing to the unavailability of the progress data, these 5 programmes were not integrated in the analyses under section 5.3.3 but were, to the extent possible, integrated in the analyses under section 5.3.4.

Therefore, in terms of the progress of the action plan implementation, **60%** of 35 closely monitored action plans have reached an implementation rate above 50%. Only one programme, namely ACF's programme in Mao and Mondo health districts in Chad, reached an implementation rate of 100%, **11 programmes** completed **more than 70%** of proposed activities and only **4 programmes**, all located in Mali, stayed **below the 30%** benchmark.

[7] Supported by COOPI.

Chart 4: Proportion of activities completed

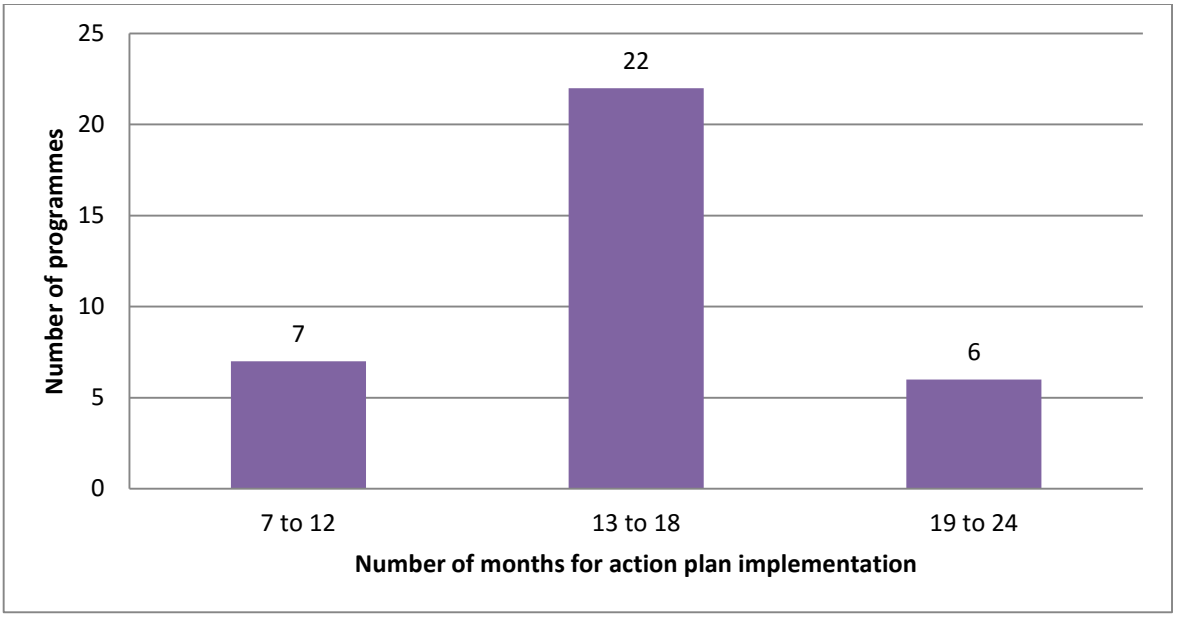


Overall, **55%** of activities set out in action plans have been completed.

The progress of the action plan implementation needs to be set against the time which programmes had available to complete proposed activities. In fact, **11 of the best performing programmes**[8] had between **9 to 19 months** to implement their action plans; 7 of them having more than 12 months. Only 7 out of 35 programmes had 12 months or less for the completion of activities and their progress appears not to have been significantly limited by this short timeframe, with at least 60% of activities completed. Nevertheless, the data shows those programmes that have a longer timeframe for activity implementation were more successful in doing so.

[8] I.e. programmes, which completed more than 70% of proposed activities.

Chart 5: Months elapsed between the completion of the coverage assessment and the end of CMN project



5.3.3 Structure of action plans and implementation preferences

Each action plan would normally cover 4 major types of activities: quality of care, community engagement, coordination and monitoring & evaluation. All aimed to improve access to care and therefore coverage. **94%** of programmes carried out **community engagement activities**, despite the fact that their implementation implied getting out of programmes' comfort zone and sharing the weight of programmes' success or failure with external stakeholders. The implementation rate for community engagement activities is particularly impressive because implementing agencies generally resisted the proposition of such activities due to time and budgetary constraints and a lack of expertise on the operationalisation of the activities. Quality of care, coordination and monitoring & evaluation activities were implemented roughly equally, with 60 to 69% of programmes implementing activities.

A cross-analysis against the progress of the action plan implementation showed that programmes which achieved the implementation rate of 70% or higher, implemented all four types of activities proportionally, suggesting they are likely to be in the best position to attain a coverage increase.

5.3.4 Determining factors and their interactions in the implementation of action plans

The extent of action plan implementation was not solely determined by the time factor. More often than not, other circumstances came into play and affected the manner or the speed of the implementation process. The analyses under this section look at data from **40 programmes** detailing the influence of **context, financing, continuity, human resources, motivation for improvement, partnerships and coordination** on a programme's capacity to successfully implement all corrective measures.

A. Context

The implementation of action plans was to a certain extent dictated by the setting of CMAM programmes, which were predominantly (and naturally) located in challenging locations. While only 35% of action plans were implemented in emergency settings (Ethiopia, Kenya, Mali), 52.5% of them were marked by unstable political situations and 62.5% by the unstable security environment, often liable to create unnecessary halts in the implementation or difficulties to warrant the sense of continuity for all relevant stakeholders. While these did not obstruct the implementation of action plans as such, they did contribute to delays and consequently decreased the extent to which action plans were implemented (See section 5.3.2). Almost three quarters of action plans were implemented in food insecure settings, which more often than not generated competing priorities for relevant stakeholders and might have contributed to temporal disengagement in the action plan implementation.

Table 1: What were the contexts of the programmes?

Unstable political situation	Unstable security	Food insecure	Emergency setting
52.5%	62.5%	72.5%	35%

B. Financing

The implementation of action plans on the basis of learnings and recommendations from coverage assessments was very much determined by the availability of financial resources to fund proposed activities. Only **32.5%** of implementing agencies (Kenya, Pakistan and South Sudan) confirmed the **availability of finances** to cover the costs of activities needed to improve programme's coverage while only **12.5%** of them stated that their **budget lines** were **flexible** enough to allow for some budget readjustments. None of the latter were linked to a major donor. In most cases, implementing agencies faced bureaucratic restrictions inside or outside their structures, which did not allow all elements of the proposed action plan to be absorbed (Cf. Section 5.3.2).

In one case in Burkina Faso, the implementing agency used SQUEAC recommendations in a new project proposal and thus secured funding for all activities in the next project cycle. However, the implementation of the action plan was naturally delayed and further readjustments could have been useful to ensure relevant budget allocations by the Ministry of Health.

In some programmes, donors were reluctant to fund community engagement activities. For example in Boloso-Sore (Et) and IFO 2 and IFO N (KE), following initial assessments, community engagement activities were included in the proposal for next phase of the programme however the donors decided not to fund these activities.

C. Continuity

The availability of financial envelopes for the implementation of CMAM programming also revealed itself through the continuity of support by implementing agencies. Apart from 3 programmes which closed soon after the coverage assessment (Cf. Analysis of determining factors in case of programmes not able to implement their action plans), 6[9] programmes were transferred to a health district or partner

[9] Bati (ET), Twic (SS), Kirotshe (CD), Bamako Commune 6 (ML), Bamako Commune 2 (ML), Thatta (PK).

implementing agencies within 12 months of the original coverage assessment. Thus, **85%** of the **programmes could continue their support** to designated health districts.

D. Human resources

An analysis of factors contributing to the success of the action plan implementation reveals a human resources category as one of the most prominent in terms of its capacities to encourage or halt the pursuit of action plan objectives. **70% of implementing agencies suffered from staff changes** during the 12 months after the initial coverage assessment, which generally induced an interruption of activities for a minimum of three months depending on the learning curve of newly designated staff. On a few occasions, programmes experienced double-layer staff changes where a turnover on a project manager position was accompanied by a turnover on a nutrition coordinator position and thus a sense of continuity was often difficult to restore. Effective hand-over procedures would mitigate the impact of staff-changes. However it wasn't possible to determine if these were in place in cases where staff changes did take place.

However, staff changes were not the only human resource factor influencing the implementation of action plans. While **50%** of programmes believed they had the **know-how available** among their ranks and **55%** considered their **staff dedicated**, only **17.5%** of them reported enough **time available** for the implementation of proposed activities. Most frequently cited reasons for "not having enough time" were competing priorities, weak team capacities (and thus considerable time losses to carry out activities) and/or the unavailability of designated staff (especially community mobilisers), who could carry out and monitor relevant tasks.

The "burden" from the implementation of additional responsibilities was less overwhelming only if the project manager allowed for a fusion of routine activities with coverage assessment recommendations and the weight of the action plan implementation was shared among different departments.

However, one of CMN technical team also noted that while it is important to include multiple stakeholders in the development of action plans, implementation of the action can be poor if roles and responsibilities are not defined adequately in the action plan as was observed in Sekota and Boloso-Sore in Ethiopia, in Hagadera in Kenya, and in Aweil West in South Sudan.

E. Motivation for improvement

The "motivation for improvement" category looked at the internal or external motivation of implementing agencies to improve the CMAM programming. The internal motivation was defined as an intra-organisational desire to perform well accompanied by relevant strategies and guidelines to ensure the high quality of implemented programmes. The external motivation referred to triggers outside of the organisation, such as impulses and incentives from the Ministry of Health or donors. While differences are not substantial, in Ethiopia, Kenya, Mali, Niger, Pakistan and South Sudan, **60%** of implementing agencies admitted there was an **external** reason to **strive for improvement** and **67.5%** believed that the **push came from within the organisation**. Even though one can observe the complementarity of both triggers in the above-mentioned countries, there are partners in other countries that were internally motivated to pursue initiatives to improve the quality of programming despite a lack of an external enabling environment. This demonstrates that an unfavourable external environment should not necessarily limit an implementer's own motivation for improvement. Agencies with the most evident quest for success were Action Against Hunger (ACF), International Medical Corps (IMC), International Rescue Committee (IRC) and COOPI.

F. Partnerships and coordination

Considering that the development of action plans during CMN Phase II was a truly collaborative process between various types of stakeholders, their implementation tested the continuous engagement of key stakeholders and their commitment to the improvement of service delivery. While only **17.5%** of programmes **intensified** their **collaboration with ministries of health** during the implementation of action plans, **60%** of them invested in the **reinforcement of their collaboration with community members**. This triggered a noteworthy **70%** increase of **active community participation** in CMAM programming. None of the programmes reported the lack of interest or community resistance – yet such resistance (at national, regional or district level) of local health systems was observed in **32.5%** of programmes. In addition, only 7.5% believed that intensified collaboration with MoH representatives led to their greater independence and increased capacity to manage CMAM programming on their own.

5.3.5 Key learnings from contexts of programmes which implement action plans

- Continuity of programmes is key – if the funding for a programme will end soon, it is unlikely that an action plan will be implemented. However recommendations can be incorporated into new project designs, to improve the quality of programming.
- Unstable security settings and high staff turnover can lead to delays in action plan implementation. Well-managed handovers can mitigate this challenge, and a commitment should be made to include results of coverage assessments as a key source of information regarding the programme.
- Bureaucratic restrictions are a key inhibiting factor in the implementation of multi-stakeholder action plans – therefore ministry of health staff must be part of the action plan formulation process from the start.
- During CMN Phase II, some programmes supported made progress to improve programme performance in spite of a lack of pressure from external sources such as donors and ministries of health. This demonstrates that improvements to coverage can be achieved through an internal motivation to improve.

5.3.6 Key learnings from resources needed for action plan implementation

- Action plans are not necessarily resource heavy: 60% of action plans supported by the CMN completed more than 50% of their activities – however only 32.5% of programmes reported having available finances to implement the activities in the action plans.
- Programmes generally need around 12-18 months to implement an action plan in full.
- The burden on teams of action plan implementation can be lessened if managers allow the integration of activities into the existing job descriptions of their team.

6. Feedback from programmes regarding the implementation of context-specific action plans

The CMN's field teams were each responsible for supporting programmes in specific countries. At the end of the CMN project, the relevant CMN staff member conducted a final interview with the key focal point in each of the programmes supported to gather their experiences in the action plan implementation process. This section summaries the feedback received from the interview questions.

6.1 What did programme managers believe worked well?

Community engagement activities received a generous positive feedback from implementing agencies, although the operationalisation of certain recommendations might not have been straightforward (Cf. what didn't work well?). They noted that involving a variety of stakeholders, including health authorities and community representatives, in the development of the action plan paved the way for a formal commitment of these parties to implement proposed corrective measures and to mobilise necessary resources to implement them (Cascades BF). It also created a healthier work environment and a feeling of trust among parties (Aweil West SS). In Djibo and Dori (BF) community consultations resulted in financial contributions by health centre management committees to support the implementation of action plans in their milieu.

Generally speaking, implementing agencies appreciated integrating nutrition activities into existing health initiatives or established community events/gatherings (Bosolo Sore ET). In the same manner, a harmonisation of mass screening and sensitisation events with a seasonal calendar reaped success (Hagadera KE.).

The community assessment allowed implementing agencies to better understand the coverage of community volunteer networks (Thatta PK) and to fill the identified gaps through the recruitment and training of more volunteers (Twic SS) or, preferably, through the reinforced engagement of community resource persons, such as community leaders (Akobo East SS), traditional healers (Mao and Mondo TD) or mothers of SAM children (East BF). In Panyijiar (SS), an increased participation of community leaders in the CMAM programme decision-making improved the performance and motivation of community volunteers and, consequently, encouraged the feeling of the community ownership towards the OTP/TSFP equipment and supplies in all areas.

Quality of care activities were equally appreciated by implementing agencies as they produced rather quick and visible results in service delivery. Most activities involved the reinforcement of health personnel capacities through training and supervision (Kirotshe CD) or the harmonisation of tools and processes (Aweil West, Twic SS, Bitkine TD).

6.2 What did programme manager think didn't work well?

While implementing agencies appreciated the added value of **community engagement activities**, their operationalisation was often challenging, heavily dependent on the availability of financial resources as well as dedicated experienced staff. The scope of initial sensitisation sessions and/or trainings of community members was thus limited and did not manage to trigger a district-wide community engagement (East BF, Dollo Ado ET). "No money" aspect also discouraged the active participation of community health volunteers, who expected to be paid for their "voluntary" work (Aweil West SS). In Cascades (BF), the post-SLEAC action plan was developed in February while annual action plans of local health authorities and other stakeholders were already being implemented. Additional activities were thus viewed as "off plan" and a resource mobilisation for their implementation was very difficult.

Still related to financing, programmes running in emergency mode (e.g. Kirotshe CD) on 12-month budgets often lacked time and stability to implement action plans in full. The unforeseeable future beyond current project and its financial capacity did not allow programmes to roll-out activities set within a comprehensive strategy but rather focus on most urgent, shorter term solutions.

The **coordination** among stakeholders also proved somewhat problematic for some implementing agencies. While some did not manage to clearly delineate responsibilities and to set-up communication mechanisms, which would allow for a better coordination for OTP (Hagadera KE), others struggled with coordination outside of OTP, more particularly with referrals towards TSFP and respective information sharing (Twic SS). Furthermore a failure to have quarterly action plan review meetings meant that action points were not followed up closely which impacted their ability of the teams to meet the set targets (KambioosKE)

6.3 Key lessons learnt (based on programme manager feedback)

The participation of various (internal and external) stakeholders in the development of the action plan translates into **shared efforts** for its implementation and enhances its chances to be successfully implemented (Maban SS, Mao and Mondo TD). This also implies the integration of CMAM programming into other, already existing community/health initiatives (Twic SS).

Community outreach is the backbone of CMAM programming (Dollo Ado ET). True community ownership is the best CMAM programme booster (Twic SS). The involvement of community members, such as community volunteers (Twic SS) or mothers (East BF), creates an important link between treatment centres and the community and contributes to early case finding and defaulter tracing. Female outreach workers are especially important for an in-depth penetration in conservative communities (Thatta PK). However, depending on their positioning within the programme, they need to be monitored and held accountable for their activities (Thatta PK). The involvement and commitment of opinion leaders inspires behaviour change (BitkineTD). However, this process takes considerable time and the implementation of the action plan may not immediately result in a desired change, especially in emergency settings (Kirotshe CD).

What additional resources were used?

The implementing agencies admitted the necessity to pool additional financial, logistical, human and material resources to implement proposed corrective measures. Each agency prioritised a different activity; however most resources seem to be dedicated to additional training and sensitisation sessions and/or the development of printed sensitisation materials. In Akobo East (SS) the implementing agency widely resorted to using available community resources – which not only stimulated further community engagement but also saved some stress and funding of a single partner implementation.

What would have been needed / useful?

The budget. Whatever the location, the implementing agencies found an instant agreement on the greatest shortfall of the implementation process. While some also mentioned the need for greater coordination and more time to implement proposed activities, the prevailing majority of agencies agreed that a financial envelope aligned with an annual local health system budget would have improved the implementation rate – and more importantly would allow for a harmonisation of initiatives and respective spending.

In terms of materials, many implementing agencies stated that ready-to-use or low-effort-adaptable community engagement/IEC/BCC materials would have been very useful as many lacked capacities or relevant expertise to produce them in an efficient fashion (Kirotshe [CD], Ifo 2 [KE], Maban[SS]).

6.4 What activities did programme managers believe had the biggest impact on coverage?

The activities involving different categories of community actors, such as opinion leaders and mothers, in screening and sensitisation mechanisms were believed to be the most effective (Sekota [KE], East [BF], Bitkine [TD]). Not only have they filled in gaps in community volunteer networks but they also made use of their influence within the community. Such interplay and complementarity of various actors addressed identified barriers and consequently resulted in the increase of coverage.

6.5 Key learnings from perceptions of programme staff

- Activities involving different community actors such opinion leaders and mothers were perceived by programme staff to be most effective.
- Activities to influence community behaviour and to promote community engagement can be completed relatively quickly. However they need to be sustained overtime in order to incite lasting change and to improve coverage.

7. Impact of action plans and programme changes on coverage of CMAM services

7.1 Impact of CMN supported action plans on coverage during CMN Phase II

During the second phase of the CMN, twelve districts conducted two coverage assessments (a baseline and follow up assessment) allowing for a comparison of coverage and an identification of the impact of the action plan implementation. These were implemented in four countries, Mali (6), Niger (4), Burkina Faso (1) and South Sudan (1). Two of the districts did not conduct stage three in the follow up assessment so a comparison of the coverage estimates was not possible.

From the remaining ten districts, seven saw an increase in coverage ranging from 3.8% to 31.9% and three a decrease ranging from -1.4% to -10.3%. In all districts, at least 12 months elapsed between the baseline and follow up assessments. The results are summarised in Table 1.

It was hoped that more of the supported programmes would be able to conduct follow up assessments during Phase II. However many programmes were not in a position to do so due to a variety of reasons including programme closure, lack of resources and competing priorities.

Table 1: Summary of changes to treatment coverage between baseline and follow up coverage assessments during CMN Phase II

Country	Health District	Date of baseline Assessment	Coverage Estimate (%)	Date of follow up assessment	Coverage Estimate (%)	Key Comments	Report available ? (Y/N)
Burkina Faso	Est (3 health districts)	Nov-14	41.03	Dec-15	N/A	No stage 3 conducted in follow up	Y
Mali	Macina	Sep-14	34.4	Dec-15	38.2		Y
Mali	Markala	Oct-14	27.3	Dec-15	42.5	Com mob +*	Y
Mali	Mopti	Oct-14	42	Dec-15	46	Com mob ++*	N
Mali	Kita	Dec-14	38	Dec-15	69.9	C-project baseline and 6 months on in intervention area	N
Mali	Kalabancoro	Jan-15	40.2	Jan-16	48.6	Com mob +++*	Y
Mali	Kati	Jan-15	40.2	Jan-16	48.6	Com mob +++*	Y
Niger	Tanout	Jul-14	47.6	Nov-15	37.3		Y
Niger	Tillaberi	Nov-14	52.8	Dec-15	59.8		Y
Niger	Fillingue	Dec-14	29.9	Nov-15	28.5	Coverage classified as 'medium'	Y
Niger	Ouallam	Dec-14	29.9	Nov-15	28.5		Y
South Sudan	Akobo East	Dec -14	N/A	Jan -16	46.4	No stage 3 in initial assessment	N

*Action plans included the following community engagement activities: Com mob + = Integrated com mob activities in the action plan, Com mob ++ = Integrated com mob activities in the action plan and the recruitment of a com mob programme manager, Com mob +++ = Integrated com mob activities in the action plan, the recruitment of a com mob programme manager and the organisation of community consultations.

One programme (Kita in Mali) was part of a pilot study and did not actually implement an action plan between the baseline and follow up assessments. The aim of the pilot study was to include the treatment of SAM into integrated community case management of malaria, diarrhoea and pneumonia. In the intervention arm of the health district, treatment for SAM was made available as part of the iCCM package.

Meanwhile in the control arm, community health workers diagnosed SAM cases in villages and then referred them to local health centres to receive treatment (in line with the national CMAM protocol). The intervention arm saw a large increase in coverage (31.9%) between the baseline and follow up surveys.

In the other programmes, the coverage estimates from the baseline assessments, all conducted in rural settings, yielded coverage estimates which were below the Sphere minimum standards for (50% for rural settings) with the exception of Tillaberi in Niger where a coverage estimate of 53% was recorded. The remainder were all above 20% and so the programmes were considered to have "moderate" coverage.

As shown in Table 1, out of the 12 programmes which did conduct follow up assessments and therefore assessed the impact of action plan implementation on coverage (and excluding Kita), only one recorded a "significant" increase to coverage (more than 10%): Markala in Mali.

In Markala, the Terres des Hommes team implemented or partially implemented 12 out of 16 of the activities set out in the action plan originating from the baseline assessment. These included a mixture of community engagement activities and activities to address quality of care. One significant activity which was part of the action plan developed following the baseline assessment was that all community health workers were given MUAC tapes and referral forms (this took place in July 2015). This was reflected in the increase in admissions around this time. The change also took place in neighbouring Macina – however the coverage in Macina did not increase as significantly as in Markala (3.7% compared with 15.2%).

In the other supported programmes, changes to coverage were less significant. In Kati and Kalabancoro in Mali and Tillaberi, Fillingue and Ouallam in Niger, coverage increased or decreased marginally (by less than 10%) during the implementation period despite the programmes implementing between 24% and 46% of their activities. Coverage decreased in the Croix Rouge Francaise's programme in Tanout by around 10%. This was attributed to the fact that the majority of the action plan activities were not implemented due to a change of programme manager. This illustrates the risk of programmes reaching a smaller proportion of children in a health district by continuing with "business as usual" and not acting on the results of a coverage assessment.

Based on the results of the follow up assessments, it is therefore not possible to say that the implementation of context-specific action plans will necessarily lead to significant increases in coverage within a 12 month period.

The results show that moderate coverage can be achieved or sustained in the short to mid-term (9-12 months) by the supporting-NGO or district level health teams implementing some basic activities and actions such increased community sensitisations and screenings, more trained community health workers and/or regular meetings with key community members. However it is very hard to move from moderate to high coverage (20%-50% to more than 50%). It is possible for implementers to achieve this if they provide consistent and sustained investment in community engagement activities (e.g. in Tillaberi). This data shows that achieving much higher rates of coverage (60% or more) in rural contexts is only possible by making significant changes to the CMAM model (eg in Kita where the model of service delivery changed – more information above).

In none of the health districts supported by the CMN was it possible to adequately engage the community in all areas of programme planning, management and monitoring. While this was not an objective of the CMN, it is clear to the CMN team that this is a long term goal requiring years of community engagement activities. However while many cite a lack of resources as a reason to not do this, the perception by many

that community engagement is a very costly process is wrong. Community activities can be low cost and should not be based on the remuneration of community members.

7.2 Changes in coverage in other programmes analysed by CMN team

The CMN team has also compiled case studies from other programmes where coverage assessments have taken place and where coverage has changed (positively or negatively) and where coverage has been recorded especially high. While context-specific action plans were not developed and implemented in these programmes, three case studies were able to make a number of observations and conclusions about how positive changes to coverage can be made:

LGA of Wammako and Binji, Nigeria (link to case study and link to the assessment report – Daniel Takea, IMC, participated in the assessment and prepared the case study): Since 2013, IMC have been supporting the implementation of CMAM programmes in the rural areas of Wammako and Binji in Sokoto in north-west Nigeria. In late 2014, a coverage assessment in the combined area found a coverage estimate of 87.7% (point coverage).

Key observations:

- Community engagement was a strong component from the start of the programme: programme staff engaged in discussions with community members and invited them to express their opinions and help solve problems encountered.
- Supporting and defining role of community groups: IMC encouraged the formulation of mothers care groups (10-15 individuals) who would meet regularly with community health volunteers for training, support and supervision.
- Good CMAM programme performance encouraged uptake of other services: Mothers were able to see visible improvements to health as a result of the CMAM programme which increased demand for other services (antenatal care and routine immunisation).

Dollo Ado refugee camp, Ethiopia (link to case study prepared by Daniel Takea, IMC): IMC has supported the implementation of CMAM services in Dollo Ado refugee camp in Ethiopia since July 2011. A SQUEAC assessment was conducted in September 2012 and a follow up assessment in August 2013. The first assessment identified a coverage estimate of 78.5% and the second assessment an estimate of 88.7%.

Key observations from period between assessments:

- Continuous screening using both MUAC and WHZ can ensure that virtually all SAM cases were found and referred on time.
- Screening was actively supported by groups of mothers, improving community participation and integration with the programme.
- Sensitisation and disseminating key messages on malnutrition and CMAM program took place via loud speakers and periodic campaigns

Fada N'Gourma, Burkina Faso (link to case study prepared by Lenka Blanarova, ACF, 2012 assessment and 2014 assessment): Since 2012, ACF has been supporting the implementation of CMAM services in Fada N'Gourma in Region d'Est in Burkina Faso. The first coverage assessment in the district in February 2012 yielded an estimate of 19.9%. An assessment in January 2014 resulted in an estimate of 48%. A subsequent SLEAC survey in November 2014 classified coverage as moderate (between 20 and 50%).

Key observations from period between first two assessments:

- New and improved CMAM protocol in Burkina Faso, allowed for the introduction of new approaches, such as engagement of traditional healers in screening/referral of SAM cases
- Change of a supporting partner with a narrowed focus on quality of care
- Availability of more NGO staff to train and support health centre personnel in the provision of CMAM services
- Better coordination among partners and outsourcing of CMAM components to other stakeholders (if beyond supporting partner's capacity)
- Engagement of community actors, namely community-based organisations
- Parallel NGO activities aiming at prevention of malnutrition and/or fighting its underlying causes

7.3 Key learnings from impact of action plans and programme changes on coverage of CMAM services

- Community engagement is an essential part of positive change in coverage and should be at the heart of all programming.
- Effective coordination between partners can result in a sharing of workloads leading to strong programme performance and impactful community engagement activities.
- Significant increases to coverage were only seen when significant changes were made to the CMAM model including changes to the service delivery model (community based health workers delivering treatment for SAM in communities instead of facility based treatment).

8. Discussion of findings

This report shows that the CMN successfully supported coverage assessments, provided remote support for assessment implementation and supported the development of context specific action plans in which the majority of activities were implemented. This report also demonstrates that there are some valuable lessons learned related to capacity building, action plan development and requirements for the successful implementation of activities to improve CMAM programmes, which should be considered for future implementation. Some key learnings to come out of the process are the need to operationalise community mobilization activities, improve referral between programs and review strategies for systematic monitoring and evaluation.

First, a key factor defining the uptake of coverage assessments across the 9 priority countries was the interest and motivation of implementing partners and the staff implementing CMAM programming. In Mali there was significant buy-in which led to a high number of assessments undertaken, at least a third of which were implemented with only remote CMN support. Second, this interest can be donor driven. In Niger ECHO created an environment in which the whole coverage improvement process was prioritised which successfully motivated, and financially supported, partners to engage with the process. Third, this motivation can also be created through organisational priority setting. ACF's organisational policy to engage with the coverage improvement cycle was likely an influencing factor in their implementing the highest number of assessments out of all NGO partners.

There are also factors which can limit the success of capacity building exercises. Despite South Sudan implementing a high number of assessments they also required a high level of direct support which was put down to high staff turnover resulting in a loss of capacity as staff move on when programme funding ends. This, combined with a high level of pressure on staff to implement programme activities in a short timeframe leaving little time for assessments, suggests a more effective strategy for capacity building in emergency environments is required (eg partners could start to include surveillance teams in their programmes). In fact based on the CMN's experiences of capacity building, it can be concluded that capacity building approaches for coverage monitoring should always be adapted to the context.

It was also noted that there is still a perception of that coverage monitoring activities can only be carried out by experts in the methodology. Following the work of the CMN to simplify methodologies and guidance, this is no longer the case. Furthermore, the CMN has worked hard to ensure that programme implementers recognise that coverage monitoring should not be limited to one-off, time and resource intensive assessments (such as SQUEAC and SLEAC assessments). While these are essential parts of the process, they can be complemented by routine monitoring activities and implemented only as and when coverage information is most important and useful.

With regards to action plan development, their success and critically their potential for implementation, was reported to be positively influenced by the involvement of multiple types of stakeholders in the development process. A wide range of stakeholders from members of the community to decision makers in the health system were shown to create context appropriate action plans and create a level of ownership, in some cases leading to community groups funding the implementation of specific coverage improvement activities. The number of activities included in an action plan didn't appear to have an effect on the likelihood of their implementation and in fact those that had more activities had at least an equal chance of being implemented. Lastly, enough time needs to be available for action plan implementation, with appropriately time-bound activities. Success should not be determined before these timelines have passed.

Feedback from implementing partners on action plans that were or were not implemented is some of the most valuable analysis in understanding the challenges they face in implementing programme strengthening activities. These insights enable the development of more appropriate support which will result in improvements in programmes quality. The main factor reported to be limiting the complete implementation of action plans was a lack of budget for activities. Donor flexibility on the refocusing of funds to these activities was a positive influence on implementation and should be encouraged in future funding rounds. Although the use of the action plans in the development of new funding proposals should be encouraged, the delay encountered in waiting for the proposal to be improved will unnecessarily slow the implementation of activities suggesting that a more responsive mechanism is required.

Programme staff reported that a lack of time to implement activities was another limiting factor as they did not have the time to implement activities on top of existing responsibilities. If programme managers allowed a fusion of these new activities into their existing role it increased the likelihood of their implementation, an approach which should be considered during the action plan development phase. An extension of this challenge is the short programme cycle for emergency programmes limiting the time available for activity implementation, monitoring and supervision and any outstanding activities included in the subsequent funding proposal. A third influencing factor is staff turnover which limited the continuity of the coverage improvement cycle and is a challenging limitation to address. Finally, the coordinated implementation of the action plan was compromised due to lack of joint monitoring and follow up.

The role of the community in ensuring successful action plan implementation must be highlighted. Despite initial resistance to the inclusion of community engagement activities in action plans, nearly all programmes implemented some community engagement activities which was shown to be a successful way to include the community in CMAM programming, making it truly community focused. The engagement of carers, traditional healers and opinion leaders to complement more traditional community nutrition volunteer networks were all activities that were successfully implemented across all of the nine priority countries.

The extent to which the activities implemented in the action plans led to an increase in coverage, which is the ultimate aim of the coverage improvement cycle, is difficult to determine. However out of 12 districts in which a follow-up assessment was carried out, 7 saw an increase in programme coverage. Interpreting these figures separately from their associated confidence intervals renders the analysis difficult. However, only one programme saw a considerable increase in programme coverage (more than 30%). This was in a health district where the intervention model itself changed from facility based treatment services to community based health workers delivering treatment. This information suggests that in a rural setting, in order to achieve coverage over 50%, the model itself must undergo significant structural modifications, which focus on context appropriate alternatives to increase access and uptake of services.

9. Conclusion

Based on the experiences of the programmes which have undertaken the action plans during the Phase II, the CMN has learnt that significant positive changes in coverage and quality service delivery are possible. Community engagement, systematic monitoring and evaluation are an essential part of this positive change and should be at the heart of all programming.

However, in order to achieve significant transformations in coverage, significant changes to the implementation of community engagement and CMAM as a whole are needed. Without these structural adaptations, it remains very hard for programmes to achieve coverage of over 50% in rural contexts.

The CMN (via the coverage assessments supported by ACF UK) will therefore continue to work with programmes to support assessments and build evidence on how to ensure that CMAM services are as effective as possible.