Photo: Megan Christensen, Concern Worldwide US

EVALUATION

LAHIYA YARA CHILD SURVIVAL PROJECT
TAHOUA DISTRICT, NIGER

December, 2014

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Marydean Purves, Independent Consultant

LAHIYA YARA CHILD SURVIVAL PROJECT FINAL EVALUATION REPORT

STRENGTHENING COMMUNITY HEALTH SYSTEMS IN TAHOUA DISTRICT, NIGER

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ACKNOWLEDGEMENTS

The evaluator would like to thank the national staff of the Lahiya Yara Child Survival Project, in particular the Tahoua field staff – nurse supervisors, animators, and management. These dedicated workers are deeply invested in the important work of building a better health and nutrition scenario for Niger's future generations. They are led and supported by an exceptional Technical Advisor, who brings a superior level of expertise and rigor to her work, and sets a high standard of achievement for her colleagues.

Special thanks go to the other members of the field interview teams, including COGES and MOH/DHT personnel. They did their best to capture the authentic impressions of the project target populations, and adapted quickly to a rhythm of work previously unfamiliar to them.

The evaluator sends out a tribute to the Mother Leaders, both those conducting iCCM and BCC actions. These remarkable women have set a new standard for women's identification as care providers and leaders in their communities. Sincere wishes for continued growth and success.

ACRONYMS

BCC	Behavior Change Communication
CG	Care Group
CHA	Community Health Agent
CHN	Child Health and Nutrition
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
CMO	Chief Medical Officer
COGES	*Comité de Gestion*/Health Management Committee
COSAN	*Comité de Santé*/Health Committee
CS	Child Survival Project
CSHGP	Child Survival and Health Grants Program
DHT	District Health Team (*Equipe Cadre de District*)
DIP	Detailed Implementation Plan
FE	Final Evaluation
HC	Health Center (in French *Centre de Santé Intégré*)
HMIS	Health Management Information System
HP	Health Post (*Case de Santé*)
iCCM	Integrated Community Case Management
IPC	Interpersonal Communication
IMCI	Integrated Management of Childhood Illness
IYCF	Infant and Young Child Feeding
KPC	Knowledge, Practice, and Coverage
Lahiya Yara	Hausa for "Children's Health"
LLITN	Long-Lasting Insecticide Treated Nets
LYCSP	*Lahiya Yara* Child Survival Project
M&E	Monitoring and Evaluation
ML	Mother Leader
MoH	Ministry of Health
MTE	Midterm Evaluation
NGO	Nongovernmental Organization
NS	Nurse-Supervisor (Concern staff)
OJT	On-the-Job Training
OR	Operations Research
ORS	Oral Rehydration Salts
PMIT	Performance Monitoring Indicator Table
RDT	Rapid Diagnostic Test
R-HFA	Rapid Health Facility Assessment
RDPH	Regional Director of Public Health
SMART	Standardized Monitoring and Assessment of Relief and Transition

Care Group Mother Leaders with their children. Bambeye Commune, Tahoua District, Niger
Photo by J.Weiss, Concern

Key Findings:

- The project met targets for 15 of 23 outcome indicators in the areas of quality improvement, and essential family health knowledge or practices.
- 48 Care Groups were established, with 507 Mother Leaders conducting BCC initiatives on a regular basis.
- Under iCCM program, 56 Mother Leaders consulted and treated 5,189 children under five years over a period of thirteen months.
- 315 health committee members were trained and supported in their role as community liaisons for health center management and accountability.
- Malnutrition rates dropped at the MTE in 2012 to below target levels, (35%/29%), and then climbed again to 34%, only a few points below the revised baseline of 37%.

Lahiya Yara Child Survival Project Final Evaluation Report: Executive Summary

This project was funded by the U.S. Agency for International Development through the Child Survival and Health Grants Program.

December 2014

Evaluation, Purpose, and Evaluation Questions

The purpose of the Final Evaluation (FE) was to provide an opportunity for all project stakeholders to take stock of accomplishments to date and to listen to the beneficiaries at all levels, including mothers and caregivers, other community members and opinion leaders, health workers, health system administrators, local partners, other organizations, and donors. Three key questions were addressed in the final evaluation:

1. To what extent were the Strategic Objectives (SOs) achieved and what was the suitability (to local context) and effectiveness of key interventions?
2. Overall, what were the main contextual and/or implementation challenges faced by the project and how were they addressed?
3. What was the extent of collaboration with the Ministry of Health (MoH), UNICEF, and other United States Government (USG)-funded partners at the national, provincial, and district levels?

Findings will contribute evidence relevant to the Child Survival and Health Grants Program (CSHGP) learning themes and integrated community case management (iCCM) learning components for cross-project learning. The Lahiya Yara Child Survival Project (LYCSP) is the fourth and final generation of Child Survival grants in Niger, and as such may provide the final overview of how the CSHGP mechanism has been used to develop and improve the operational and policy environment for child health of the Ministry of Health in Niger.

The FE references four cross cutting learning themes to better understand how CSHGP programs have contributed to improved MNCH outcomes and what could be improved. The four themes are: 1.) Community engagement; 2.) Service delivery, equity, and continuous quality improvement; 3.) Scale-up and sustainability; and 4.) Learning and adaptation.

The FE report may be used as a source of evidence for diverse audiences to help inform decisions about future program designs and policies, in particular as regards efficacious models of iCCM, the nature of partnership between the MoH and non-government organizations (NGOs) and how health policy adoption can be managed. These audiences might include:

- In-country partners at national, regional, and local levels (e.g., MOH and other relevant ministries, district health team, local organizations, communities in project areas);
- USAID (CSHGP, Global Health Bureau, USAID Missions), and other CSHGP grantees;
- The international global health community

Project Background

The LYCSP is the last of four CSHGP initiatives that have operated in Niger since 1994, each in different regions, all with general objectives related to nutrition, diarrheal disease, malaria, immunization, and breastfeeding. Projects learned from one another over time. The 2004 Helen Keller International Diffa child survival project was advised to use the Positive Deviance Hearth Approach rather than mothers' support groups. The 2007 Relief International Konni child survival project had 'modified Care Groups' but no CCM. Concern is the first to develop the iCCM model in a child survival project.

Niger has been a recipient of continuous CSHGP support due largely to its status as one of the poorest countries in the world, with extremely low human development indicators. Niger figures among the countries with an acute intensity of deprivation as measured by the multi-dimensional poverty index (MPI)[1]. According to this index, 89% of the population lives with a 67.7% intensity of deprivation in education, health, and living standards. In the most recent UNICEF *State of the World's Children* report Niger ranks 10th in the world for child deaths (91/1000). Under-five and infant mortality rates are 114 and 63 per 1,000 live births, respectively.

According to the MoH's health information system, malaria, malnutrition, pneumonia and diarrheal disease account for 95% of child mortality in the Tahoua Region with the same four conditions responsible for 80% of under-five illness. In keeping with the country's selected Millennium Development Goals, this project's overall goal was to achieve sustained reduction in childhood mortality in the Tahoua Region. In Tahoua Region, like much of Niger only 53% of the population lives within 5 kilometers (km) of a health center.

Project activities fell into two main categories: strengthening the health care system at the facility level and investing in intensive community-level activities to promote sustained behavior change and iCCM of malaria, pneumonia and diarrhea. The project also intended to develop community engagement and ownership as a means to embed improved practices and stewardship for health care. The technical interventions focused on nutrition, which includes infant and young child feeding (IYCF) and community-based management of acute malnutrition (CMAM - 30% level of effort); prevention and treatment of malaria (30%); control of diarrheal diseases (20%); and pneumonia case management (20%). The Operations Research (OR) activity tested the effectiveness of the iCCM model that trains Care Group Mother Leaders (ML) on case management of sick children with simple malaria/fever, pneumonia, and diarrhea.

Evaluation Questions, Design, Methods, and Limitations

The final evaluation of LYSCP was implemented in three phases: Preparation Phase (June-August 2014), In-Country Data Collection Phase (September 3-22, 2014), and Report Writing Phase (September 23-November 15, 2014). During the Preparation Phase, Concern LYCSP staff conducted a final Knowledge, Practices, and Coverage (KPC) survey to capture changes since the baseline survey, as well as a Rapid Health Facilities Assessment (R-HFA) exercise in project-associated health facilities. The OR component also undertook a survey to measure progress to date. Findings from these surveys ideally would have provided information to guide the development of the qualitative tools, and for triangulation, analysis, and verification. Document review took place throughout all phases of the exercise. The FE format followed the participatory approach of the mid-term evaluation conducted in 2012, and focused only on Tahoua District, for the Phase II actions.

During the fieldwork phase, qualitative data (focus group discussions, key informant interviews) were collected in communities and health facilities over the course of 10 days, alternating one inquiry day with a data consolidation/analysis day to process the information. Collective discussions on some of the more salient findings were with the team members. The evaluation team conducted a preliminary de-briefing for the District and Regional MoH representatives in Tahoua. A final de-brief and report-

[1] Oxford Policy and Human Development Initiative. www.ophi.org.uk

out as per USAID FE requirements, was held in Niamey.

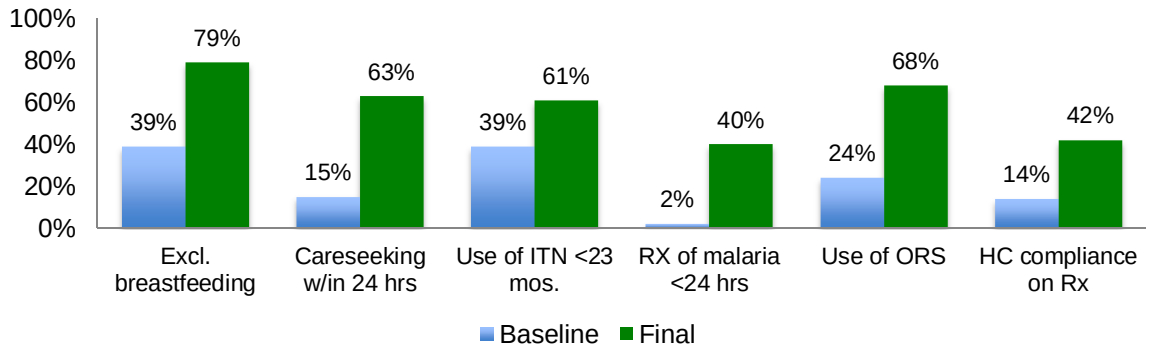
Limitations included tardy delivery of key data for advance consultation, miscalculation regarding the experience levels and language preferences of the inquiry teams, and travel restrictions for the expatriate team members due to security concerns. During the fieldwork, a cholera outbreak was signaled in the commune of Kalfou, and the site was dropped from the schedule.

Findings and Conclusions

The most outstanding achievements of the project include:

- The project met targets for 15 of 23 outcome indicators in the areas of quality of care, and essential family health knowledge or practices.
- 48 Care Groups were established, with 507 Mother Leaders actively conducting BCC initiatives
- Under the OR iCCM program, 56 Mother Leaders consulted and treated 5189 children under five years over a period of thirteen months.
- Care-seeking behaviors improved significantly, as caregivers brought their sick child to a health facility or ML instead of a traditional healer or other informal provider; and the rate of care seeking within 24 hours for all illnesses combined quadrupled.
- Three quality of care indicators for health facilities, while not meeting the targets, showed significant gains.
- 315 health committee members were trained and supported in their role as community liaisons for health center management and accountability.
- Malnutrition rates dropped at the MTE in 2012 to below target levels (35%/29%), and then climbed again to 34%, only a few points below the revised baseline of 37%.

Figure 1: Selected KPC Results



Some challenges remain:

- The project had very effective training and coaching methods, however there is no operational tracking system to collect and analyze health personnel coaching results;
- Quality of care principles have not been shared in detail with district health team;
- Drug supply chain management is still problematic, but Concern may mitigate some constraints, despite the issues with MoH cost recovery mechanism;
- Malnutrition has not been reduced, but given the larger context of the problem, the Child Survival instrument itself may have limited more effective approaches;
- Some practices need more attention, such as hand washing and recognition of danger signs;
- Advocacy for the adoption of a policy on iCCM delivered by MLs had not been initiated

Key Recommendations

***For Concern**:*

- Capture and correct the gaps in some of the performance-based indicators at the health facilities by first consolidating monitoring data from the coaching visits, evaluating them, and designing solutions;
- Develop a realistic plan to work with the DHT for assumption of the drug supply chain management;
- Study the USAID Sahel resilience programming, as well as Feed the Future initiatives for integration models of livelihood strategies with nutrition actions;
- Review/update Doer/Non-Doer exercises to revise and reinforce non-performing Key Family Practices;
- Pursue the intention to divide CG members into 'specialty groups' to avoid over-burden;
- Promote the self-esteem and social recognition benefits gained by women's involvement.
- Devise a policy adoption strategy for the iCCM/ML approach and implement it.

For the Ministry of Health Regional and District Partners:

- Take the lead in smoothing the transfer to the replacement NGO partner of LYCSP-directed processes and practices in Kalfou Commune;
- Take the lead in re-vitalizing the use of FRONTLINE data collection system by hosting a refresher training for field users, assigning coaching/mentoring responsibilities to the DHT Information System manager, and other measures as needed;
- Demonstrate greater leadership in the assumption of responsibilities for drug supply chain management, supervision chains, and advising and supporting COGES units;
- Build a component in the Action Plan for instituting quality of care mentoring and measurement processes within the DHT;
- Demonstrate greater understanding of the cycle of malnutrition and the fundamental causes, then undertake advocacy actions with all partners for integrated programming;
- Regional and District authorities should fully participate in, and advocate strongly for the development of a policy paper and process for the adoption of the iCCM/ML approach.

For International Partners and Future Donors:

- The upcoming expansion of Niger's USAID Health Unit allows an opportunity to do a desk review of Child Survival projects in Niger and glean key lessons learned for future health programming;
- USAID find an opportunity to do a post-project field visit to become acquainted with the successes, challenges and opportunities faced by NGO partners;
- UNICEF, as funder of on-going activities, should become thoroughly acquainted with the Care Group and Mother Leader model and parameters so as not to 'dilute' key elements that are fundamental to its success (e.g., ratio of villages,<>animators, ratio of MLs <>HHs).

The Lahiya Yara Child Survival Project in Tahoua Region, Niger is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The Lahiya Yara Child Survival Project is managed by Concern Worldwide under Cooperative Agreement No. GHA-A-00-09-00006. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information about the LYCSP, visit: www.concernusa.org

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The Purpose Of The Final Evaluation was to provide an opportunity for all project stakeholders to take stock of accomplishments to date and to listen to the beneficiaries at all levels, including mothers and caregivers, other community members and opinion leaders, health workers, health system administrators, local partners, other organizations, and donors. Results and outcomes are herein documented, and findings will contribute evidence relevant to the Child Survival and Health Grants Program (CSHGP) learning themes and integrated community case management (iCCM) learning components to facilitate cross-project learning. The *Lahiya Yara* Child Survival Project (LYCSP) is the fourth and final generation of Child Survival grants in Niger, beginning in 1994 with CARE International, each operating in a different region but with the same premise of support to the health system and complementary community-based programming. This final project may provide some insight as to how the CSHGP mechanism has been used to develop and improve the operational and policy environment of the Ministry of Health in Niger. The final evaluation (FE) references four cross cutting Learning Themes[2] in order to better understand how CSHGP programs have contributed to improved maternal newborn and child health outcomes and what could be improved. The four themes are: 1.) community engagement; 2.) service delivery, equity and continuous quality improvement; 3.) scale-up and sustainability; and 4.) learning and adaptation. The FE report may be used as a source of evidence for diverse audiences to help inform decisions about future program designs and policies, in particular as regards efficacious models of iCCM, the nature of partnership between the Ministry of Health (MOH) and non-governmental organizations (NGOs), and how policy adoption can be designed. These audiences might include:

- In-country partners at national, regional, and local levels (e.g., MOH and other relevant ministries, district health team, local organizations, communities in project areas);
- USAID (CSHGP, Global Health Bureau, USAID Missions), and other CSHGP grantees;
- The international global health community.

USAID CSHGP approved the FE Scope of Work (SOW) and the external evaluator, who was hired with project funds. The evaluator was granted access to all requested documents and personnel. The draft and final reports were submitted simultaneously to USAID CSHGP and to the grantee.

Three Principal Evaluation Questions were formulated, with detailed sub-questions.

1. *To what extent were the Strategic Objectives (SOs) achieved and what was the suitability (to local context) and effectiveness of key interventions?*

Specific questions speak to the effectiveness of project approaches (training, capacity building, innovations in supervision, innovations in behavior change communication) to improve performance of key practitioners (health services personnel, community-based volunteer entities) as a means to deliver results and achieve the indicators. Other questions examined the extent to which the child health and nutrition policy environment has improved due to elements in the project's program, and how it might lead the way toward sustainability and scaling-up.

2. *Overall, what were the major contextual and/or implementation challenges faced by the project and how were they addressed?*

[2] These themes were finalized in July 2014 by USAID, grantees, and EnCompass. CSHGP recipients were instructed to include them in their FE frameworks.

This question examined key lessons learned around implementing a child survival project within a chronic emergency context, as well as any specific challenges associated with the implementation of the operations research (OR).

3. *What was the extent of collaboration with the MOH, UNICEF, and other USG-funded partners at the national, provincial, and district levels?*

This question addresses fundamental elements that help to determine the probability for project achievements to be absorbed into general programming and likelihood of scale-up.

PROJECT BACKGROUND

Project Design: As noted earlier, the LYCSP is the last of four CSHGP initiatives that have operated in Niger since 1994 in different regions, all with general objectives related to nutrition, diarrheal disease, malaria, immunization, and breastfeeding. Projects learned from one another over time. The 2004 Helen Keller International Diffa Child Survival (CS) project was advised to use the Positive Deviance Hearth Approach rather than mothers' support groups. The 2007 Relief International Konni CS project had 'modified Care Groups' but no Community Case Management (CCM). Concern is the first to develop the integrated CCM (iCCM) model in a CS project.

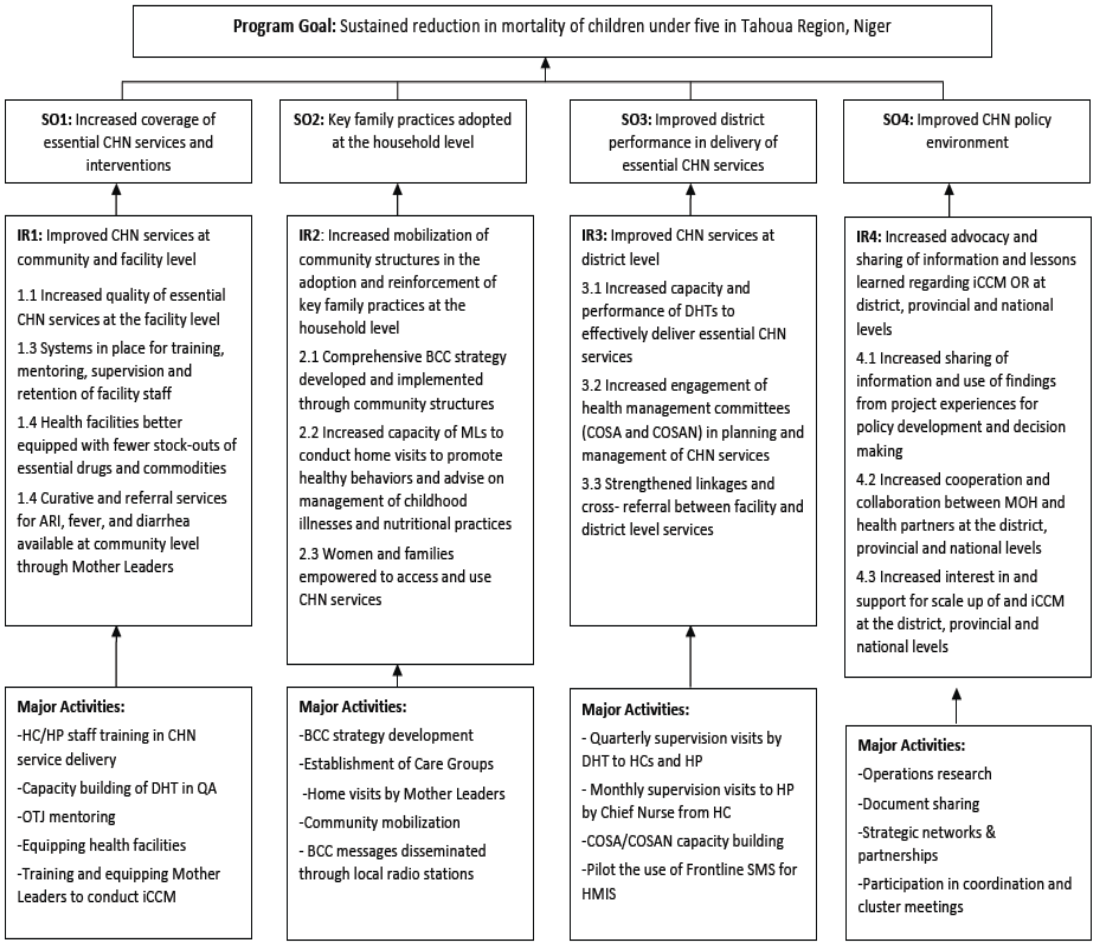
Niger has been a recipient of continuous CSHGP support due largely to its status as one of the poorest countries in the world, with extreme human development indicators. In the larger context, Niger figures among the countries with an acute intensity of deprivation as measured by the multi-dimensional poverty index (MPI) According to this index, 89% live with a 67.7% intensity of deprivation in education, health, and living standards. Poverty is known to be a leading contributor to poor health status, justifying the rationale for integrated programming. In the most recent UNICEF *State of the World's Children* report, Niger ranks 10th in the world for child deaths (91/1000). Under-five and infant mortality rates are 114 and 63 per 1,000 live births, respectively. According to the MOH's health information system, malaria, malnutrition, pneumonia and diarrheal disease account for 95% of child mortality in the Tahoua Region with the same four conditions responsible for 80% of under-five illness.

In keeping with the country's selected Millennium Development Goals, this project's overall goal was to achieve sustained reduction in childhood mortality in the Tahoua Region. The project was grounded in the original priorities of Niger's National Health Plan 2005 – 2010, and the five-year Regional and District Health Plans (2008 – 2012). The critical challenges for health service delivery in Niger and in Tahoua District have revolved around access and quality of services.

In Tahoua Region, like much of Niger, physical access to health services is very low –only 53% of the population lives within 5 kilometers of a health center (the WHO minimum standard). Although the government has invested heavily in establishing health posts (HP) at the community level, these facilities offered a reduced range of services compared to health centers, and the Community Health Agents (CHA) who staff them are less qualified than the health center nurses. As a result, coverage of basic health services in the catchment area was inadequate at the initiation of the project. Project activities followed two main categories: strengthening the health care system at the facility level and investing in intensive community-level activities to promote sustained behavior change and iCCM of malaria, pneumonia and diarrhea. This is in line with the MoH adopted policy on community case management (iCCM), although at the time of project start-up iCCM through MLs with a low level of education level was new and yet untested in Niger. The project also intended to develop community engagement and ownership as a means to embed improved practices and stewardship for health care. The MOH strategy on Community Health adopted in November 2012 provided a framework for the role of community entities, and the project adhered to this. Finally, the LYCSP strategy was in line with USAID/Niger

Mission priorities[3]. The activities, objectives, and expected results are illustrated in the Results Framework below.

Figure 2. Results Framework



The operations research activity tested the effectiveness of an iCCM model that trains Care Group Mother Leaders (*Maman Lumieres*) to screen for and treat common childhood illnesses while strengthening the health system to support this community-based strategy. The OR included 1.) Formative research to determine the feasibility of low literate and illiterate MLs to implement iCCM at the household level; and 2.) Evaluative research to assess the quality of iCCM services provided by the Mother Leaders. The OR Report documents the results of the OR, however, there are many intersects between OR actions and general project results, which are described in this report.

The final target population estimates were derived from the 2012 national census multiplied by annual growth rate for Tahoua District (4.2%) for an end of 2014 estimate. The project was implemented in two phases. In Phase 1, the LYCSP supported a total of 48 health facilities, which included 5 HCs in Illéla District, and 19 HCs and 24 HPs in Tahoua District. Community level activities in Phase 1 were implemented in one commune of Tahoua District (Bambeye). In Phase 2, the LYCSP

[3] http://www.usaid.gov/niger/health

handed over the Illela health facilities to another partner (*Médecins du Monde*), focused its support to 25 rural HCs in Tahoua District, and expanded support to 53 HPs in Tahoua District. Community level activities in Phase 2 were expanded to two additional communes (Tebaram and Takanamatt). The smaller population figures in Phase 2 reflect the withdrawal from Illela district and 2 urban heath centers in Tahoua District.

Table 1. Target Population

Beneficiaries	Phase 1 (Years 1-3; Tahoua and Illela districts)	Phase 2 (Years 4-5; Tahoua district)
Total Population	500,410	451,510
Infants aged 0 – 11 Months	21,518	21,672
Children aged <5 Years	101,083	102,041
Women of Reproductive Age (15–49 years)	115,095	97,526
Total Beneficiaries	216,178	199,567
Community Health Workers or Volunteers (CHWs), Disaggregated by Sex	270 Mother Leaders (all female)	507 Mother Leaders (all female)
Target Health Facilities	24 Health Centers 24 Health Posts	25 Health Centers 53 Health Posts
Community-Based Structures: Health Committees or *Comite de Sante* (COSAN) and Health Management Committees or *Comite de Gestion* (COGES)	24 COGES / 48 COSAN	25 COGES / 77 COSAN

Project Activities were designed to address significant disparities not in only service design and delivery, but also in health care seeking practices at the community and household level. Actions to strengthen the health care system at the facility level included1.) a series of trainings for nurses at Health Centers (HC) and Community Health Agents (CHAs) at Health Posts (HP), principally on community management of acute malnutrition (CMAM) and integrated management of childhood illness (IMCI); 2.) follow-up mentoring by the project's cadre of Nurse Supervisors (NS) at HCs and HPs; and 3.) establishing a core group of 100 Mother Leaders (MLs) with the skills, supplies, and support needed to conduct iCCM for diarrhea, pneumonia, and malaria diagnosis and treatment at the household level. Actions to promote the adoption of key family practices at the household level included intensive social and behavior change training, and mobilization. The project used the Care Group (CG) model to train MLs in BCC and community mobilization, using a phased approach to cover all communities and assure that messaging was embedded in communities before adding more locations and/or new key practice messages. Prior to the project, many of the health care providers at the HC and HP level had not been adequately trained in the IMCI and CMAM protocols. This ensemble of actions would close gaps in both knowledge and practice among health service delivery agents, other caretakers, and community members in general. These gaps included:

- Low levels of knowledge among caretakers concerning simple, life-saving actions contribute to high rates of child morbidity and mortality;
- Weak links between the health facilities and the communities they serve, resulting in poor coverage and poor treatment outcomes;
- Insufficient and inefficient operational systems as well as weak planning and management capacity within the District Health Team (DHT);
- Lack of access to health facilities for some villages due to geographic location, thus necessitating an intermediary model such as a pilot iCCM at the household level.

A potential stumbling block that could impede achieving the project objectives was the lack of basic infrastructure, equipment, material provisions, and even personnel, all of which are fundamental to assure a minimal operating environment. The project used cost-share funds to provide a secure supply of essential medications and materials for quality child health services, provided financial resources to engage additional personnel inside the DHT, financed transportation means and some facility upgrading measures at health facilities. To reach male audiences and increase their involvement, the project intended to work with traditional healers, male CHAs at the health posts and male project team members.

The technical package and implementation process outlined in the revised (8/2010) Detailed Implementation Plan (DIP) was straightforward in design and clear in procedural mechanisms, using standard methodologies such as formative research, cascade training, supportive supervision, and a scaled approach to project expansion. The technical interventions focused on nutrition, which includes infant and young child feeding (IYCF) and CMAM (30% level of effort); prevention and treatment of malaria (30%); control of diarrheal diseases (20%); and pneumonia case management (20%). Project processes for conducting formative behavior research were exceptionally well executed, as well as the attention to on-going training and refresher courses for health workers. In addition, the project constantly emphasized the importance of consultation and participation by the health system and the community alike. Over the course of the project, operational adjustments were made in response to the changing security situation, nutrition emergencies, and the policy/practice environment within the MOH. The emergent challenges are discussed in the Findings section.

Key Partners and Collaborators: The table below summarizes partnerships and the quality of the relationships. The MoH at the regional and district level described Concern as being their closest and strongest partner. Community level partnerships are singled out as exceptionally well developed.

Table 2. Key Partners/Collaborators

Partner	Role in Project	Focal Point	Frequency of meeting	Current Status of Engagement (most recent activity)
Ministry of Health				
Maternal and Child Health Dept. - National	Advisory	Direction of Maternal and Child Health; Direction of Nutrition; National Malaria Control Program	Nutrition Technical Meetings (GTN) (1-2 times a month); Roll Back Malaria Meetings (RBM) (1-2 times a semester)	DSME-little engagement (discussions on CCM at the end of 2012); DN-engaged (last GTN meeting in August) NMCP: moderately engaged (Last RBM held in August)
Regional Directorate of Health	Advisory	Dr. Adamou Amadou	2-4 times a year and as needed	Moderately engaged (Collobaration on regional IYCF training in Aug and for recent cholera epidemic)
District Health Department	Implementer	Dr Oumarou Batoure	Monthly and as needed	Very Engaged – bi-weekly meetings
Local community entities				
COGES/COSAN	Implementor	Abdourahamane Ahamadou, President Association of Tahoua Health Committees	As needed for activities at centralized level and monthly during project activities and visits at the HC level	Very engaged (Training of COGES members July 2014)
International agencies/NGOs				
UNICEF	Advisory; in-kind contribution	Dr Hamadou Boureima	GTN meetings and frequent email contact	Engaged (beginning of Sept to finalize nutrition proposal)

Collaboration with USAID Mission: During the life of the project, there was no bilateral Mission in Niger, and USAID operated through a field office housed within the U.S. Embassy in Niamey. During Year 4, the Concern Country Director represented the LYSCP through attendance at in-country meetings for USG partners. Concern Niger also participates in USAID Mission partners' meetings, sends project reports, and invites USAID to participate in major activities. During the life of the project, no opportunity presented itself for a USAID representative to visit. However the US Ambassador and the OFDA representative visited the project at different times.

Other relevant programs operating in the project catchment area are summarized in the table below. In particular, Movement for Peace has acknowledged and encouraged the synergies between their programs and those of LYCSP. World Vision will incorporate the Kalfou commune programs previously delivered by Concern.

Table 3. Other Relevant Programs

Organization	Programming	Geographic Zone	Duration
World Vision	– Multisectoral Area Development Program (includes health and WASH) – Moderate Malnutrition (via WFP support)	Urban Communes of Tahoua and Kalfou health zone Kalfou Commune (expanded from health zone to commune in 2014)	2008 and 2012 – present (zone 1 and 2)
Movement for Peace (MPDL)	– Reproductive and Sexual Health – training, equipment, supervision, outreach activities, Husbands' schools – WASH-training, equipment	3 health zones (1 each in Bambeye, Affala and Barmou Communes)	2007-present
UNFPA	– Reproductive Health-training and birthing kits – Family Planning-contraceptives, CBD program	District of Tahoua (direct to MOH)	Ongoing for RH and FP products and clinical services, CBD began in 2014
UNICEF	– Nutrition –drugs and RUTF – IMCI-training, drugs – EPI vaccination days, training	District of Tahoua (direct to MOH in addition to support through Concern)	Ongoing

EVALUATION METHODS AND LIMITATIONS

The final evaluation of LYSCP was implemented in three phases: Preparation Phase (June-August 2014), In-Country Data Collection Phase (September 3-22, 2014), and Report Writing Phase (September 23-November 15, 2014). Document review took place throughout all phases of the exercise.

Preparation Phase: During this phase, Concern LYCSP staff conducted a final Knowledge, Practices, and Coverage (KPC) survey to capture changes since the baseline survey. The sample size was 600 children, used the Standardized Monitoring and Assessment of Relief and Transition (SMART) survey instrument, and was analyzed with EPIInfo. For full details and content, please consult the Endline Evaluation Report in Annex 3. A Rapid Health Facilities Assessment (R-HFA) exercise was conducted in 25 health centers and 46 health posts. This exercise used an adapted WHO instrument, and was also analyzed with EPI Info.

The OR component also undertook a survey to measure progress to date. Data was collected using various methodologies. Observations of sick child consultations with MLs and, for comparison purposes, CHAs at Health Posts were used to evaluate the first research question. A total of 135 consultations with 20 ML and 8 CHA were observed, an average of 5 per ML and 4.5 per CHA. A total of 199 cases of illness were seen. For the second and third research questions a household survey was conducted with parents of children 0-23 months of age that had been ill in the two weeks preceding the survey. This was compared with information from a similar household survey conducted in 2011 before the introduction of iCCM. A total of 199 and 220 parents of sick children were interviewed in 2011 and 2014 respectively. Data were also collected from the routine information system tracking supervision visits and drug supply. Detailed information on the Operations Research component will be submitted as a supplement to this project evaluation in January 2015.

During the preparation phase, the evaluator complied a Progression Table to track findings and proposed adjustments across annual reports, mid-term evaluation, and work plans. This was an internal tool.

The in-country data collection phase in September 2014 followed the participatory approach of the midterm evaluation (MTE) conducted in 2012. Nine team members were selected from the project staff pool, the District Health staff pool, and community representatives. The Concern Worldwide US Health Advisor also participated the fieldwork, while the Concern Niger Health Advisor oversaw the quantitative survey work. (Annex 10 provides a full list of team members.)

The evaluation methodology combined quantitative and qualitative tools to produce information for triangulation, analysis, and verification. Methods included Key Informant Interviews (KII), Focus Group Discussions (FGD), Exit Interviews (EI), and checklists for verification. Qualitative data (FGDs, KIIs) was collected in communities and health facilities over the course of 10 days, alternating one inquiry day with a data consolidation/analysis day to process the information. 22 FGDs were conducted with an average of 10 persons per group, 54 individual interviews were conducted, and 40 exit interviews collected, among other information collection activities. On the days for data consolidation, all participants reviewed their notes and organized pertinent information into wall charts with specific headings that corresponded to the themes noted above (effectiveness, probability for sustaining, capacity-building, and ownership). The notes were identified by location and source of information. Collective discussions on some of the more salient findings were held each day with the team members. The evaluation team conducted a preliminary de-briefing for the District and Regional MoH representatives in Tahoua. For the final de-brief and report-out as per USAID FE requirements, the national level representatives from the Ministry of Health were unable to attend due to conflicting agendas. (See Annexes 6, 7, and 8 for more detailed information, related to evaluation methodologies and instruments.)

The Report writing phase took place throughout the month of October into November 2014. The final revised data sets came in at this time. All recorded field interviews were transcribed, translated, and organized into tables where appropriate. There were frequent consultations between the evaluator and Concern staff to review the accuracy of facts and data interpretation. Two draft versions were exchanged prior to the final submission.

Limitations: Data that was to be provided to the consultant in advance of arriving in country (KPC and R-HFA results, Rapid Catch Table, final OR report, among others) was only provided near the end of the field visit or afterwards, requiring revisions to tables and narrative. Thus, the qualitative question guides could not be designed to inquire in a more in-depth way about the results from the KPC. The amount of time available to 'train' and orient the field team for the qualitative inquiries was limited to one day.

The qualitative tools were overly complex in their question format, and were subsequently revised and simplified for the second and third day of fieldwork. The consultant had arranged for the guides to be

translated into the local language of Hausa, however while the entire team spoke Hausa as their mother tongue, they stated they were not adept at reading it. The guides were redacted in French, and the members were left to 'free' translate. Some exercises were conducted among the group to test the verbal translation of some questions; however there remained a strong chance that each person would articulate a slightly different version of each question.

Timing of the baseline and final surveys reportedly account for some of the fluctuations of the malnutrition metric over time, as well as stock-outs at supplementary feeding programs for moderately malnourished kids in the program area in the months preceding the final survey. According to project management, the high levels of food insecurity in the project zone as well as the cyclical increases and decreases in acute malnutrition during the lean season and after the harvest shows the difficulty in using a highly sensitive indicator like current weight as a measure of progress. As occurred during the MTE, the expatriate team members were only able to accompany the nationals on two of the three field days in Tahoua region due to security restrictions, which prevented overnight stays in the village areas. During the course of the fieldwork, a cholera outbreak was signaled in the commune of Kalfou, and the site was dropped from the schedule. For more details on methodologies and limitations, please consult Annex 6.

Data Quality and Use: The evaluator found different sets of demographic and operational data for the project. Project management explained that this is consistent with policy to adjust targets as per country statistical updates. Population group figures were established with the DIP (8/2010), changed at MTE (9/2012), and adjusted again in the FE SOW (7/2014).

Targets for the training and activating of MLs under the OR were revised downward at MTE from 100 to 48 and again revised to 60 in 2013. By FE, the total number of MLs trained and being supervised to conduct iCCM at the time of the FE was 56. These target adjustments were in response to the MoH literacy requirements and in some cases due to the size of a given community.

A number of indicators contained multiple criteria, which complicated some calculations. Some baseline indicators (in particular the malnutrition data point) were re-calculated, following the discovery in the errors in their initial calculation at mid-term, and again at the time of the final KPC survey. Details of this re-analysis are provided in the Project Data Form (Annex 12).

The end line KPC survey was conducted in July 2014. Due to an error in the sample size calculations methodology, insufficient data was collected and a decision was made by project management to return to the field and collect additional data in September 2014 (for additional details please reference the end line KPC report in Annex 3).

Following recommendations in the MTE, Concern began monitoring KPC indicators through the bi-annual SMART surveys. Although the SMART survey data is not 100% comparable with the baseline and end line values due to denominators from different age groups and the way the questions were asked, the SMART survey data provides a general benchmark of progress over time towards targets, and can serve to signal consistency in progress or erratic performance.

At the R-HFA baseline, only health centers were included while at endline the health posts were also surveyed, which explains why there is no reference data point for HPs in some cases. All potential project HCs were surveyed at baseline and all HCs in Phase II of the project were included at endline, which reportedly accounts for the difference in denominators.

Databases designed post-MTE that were to consolidate information on trainings, supervision/coaching, equipment, and materials, etc. were not finalized or populated with data at the time of the FE, limiting the ability to rapidly consolidate and make some evidence-based conclusions.

Lastly, there was no evidence that data generated by the District Health Management Information System (HMIS) was used to verify project achievements, nor did the evaluator find documentation to

indicate that the project has access to disease prevalence data collected by the District Health system. The project collects data that records compliance on health services procedures at each facility through the supportive supervision/coaching activity, however this information is paper-based and not yet consolidated into a database, and elements of the information are included in reports or exchanged with the DHT during meetings, but not in the form of a systems tool. Nonetheless, in the judgment of the evaluator, these limitations had minimal effect on the validity of the data, as the Concern staff worked diligently with the evaluator throughout the analysis and interpretation process to review, complete, and correct information as needed.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

MAJOR ACHIEVEMENTS

1. Of 23 outcome indicators with end line targets, the majority met the targets. 5 out of 9 quality improvement indicators measured in line with the R-HFA targets, while 10 out of 14 essential family health knowledge or practice indicators measured in line with the KPC targets or above.
2. The number of children 0-23 months regularly sleeping under a treated mosquito net nearly doubled over the life of the project.
3. 48 Care Groups were established, with 507 Mother Leaders actively conducting BCC initiatives on a regular basis.
4. Under the OR iCCM program, 57 Mother Leaders consulted and treated 5,189 children under five years over a period of thirteen months.
5. Care-seeking behaviors improved significantly, as caregivers brought their sick child to a health facility or ML instead of a traditional healer or other informal provider; and the rate of care seeking within 24 hours for all illnesses combined quadrupled.
6. Three quality improvement indicators, while not meeting the targets, showed significant gains.
7. Over 150 health center and health post personnel improved their skills and performance on IMCI and CMAM protocols after receiving training and capacity building services under LYSCP.
8. Almost half of the health facilities (10/24) improved their rates of appropriate treatment -for fever, breathing problems or diarrhea.
9. Health Centers with outreach sites (health posts) now conduct at least one outreach session per month reinforcing both the clinical links and the community trust in the health service delivery mechanism.
10. 315 health committee members (COGES/COSAN) were trained and supported in their role as community liaisons for health center management and accountability.

FINDINGS

Findings are organized in the Summary Table series by strategic objective. Given the inter-related nature of the actions, the FE chose to include all outcomes. Targets are from the revised Performance Monitoring Indicator Table (PMIT) in Annex 13. The reasoning behind the revisions to these targets are in **Data Quality and Use.** Baseline data is from the 2/2010 KPC and R-HFA surveys. If the SMART indicators were included, a noticeable fluctuation appears in the progression of indicators over time,

gaining and then losing ground, to recover again in some cases. The narrative addresses the key questions in the SOW as well as the EnCompass learning themes where relevant.

1. To what extent were the SOs achieved and what was the suitability (to local context) and effectiveness of key interventions?

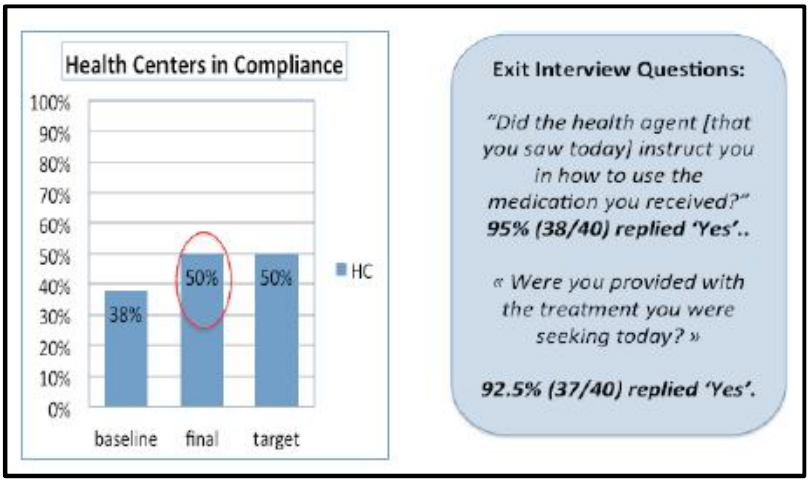
Table 4a. Summary Table of Inputs, Activities, Outputs and Outcomes for SO 1: *Increased coverage of essential child health and nutrition services and interventions*

Inputs	Activities	Outputs	Outcomes – baseline to final
Logistical and financial support.	Material support: - Distribution of basic, equipment, supplies, and medicines. Materials development: - CCM training and support materials Logistical support: - Outreach activities - Support for emergency evacuation.	Reproduction/dissemination - of IMCI registers, data collection forms, training manuals. - CCM training materials and tools developed. Supportive supervision: - Minimum monthly OJT, and mentoring visits for 31 HC and 52 HP. - HCs with outreach sites conduct at least 1 outreach session per site per month. - Monthly supervision of ML from August 2013.	*Increased number of health facilities where treatment is routinely appropriate for clinical encounters …* from (14%) to (42%); but did not meet target (50%). *Increased number of HCs with nationally-mandated guidelines for care of …* from (24%) to (68%). HC target not reached (88%), but HP target significantly surpassed. *Increased number of health facilities with first-line medications for child health …* from (17%) to (84%) at the HCs only and for HPs the endline was (17%)-no baseline *Increased number of health facilities with all essential supplies in place to support child health* from (28%) to (44%) at HCs. HC target not reached-(50%). At HPs, the endline (30%) surpassed target (17%)-no baseline. *Increased number of health facilites where caretakers could correctly describe how to administer what was prescribed* from (28%) to (50%). *5189 sick children 2-59 months seen by MLs with 1301 treated for malaria after a positive test, 1149 treated with ORS and zinc for diarrhea, and 2163 received cotrimoxazole for acute respiratory infection.*
Technical support through program staff.	Training/MoH staff: - IMCI, c-IMCI, and national CMAM policy and protocols. - Supportive supervision, OJT, and mentoring Training and supervision: - MLs to conduct CCM	IMCI: 50 HC staff CCM trainers: 25 DHT, HC and HP staff CCM training: 57 MLs IMCI-c or CCM: 108 HP staff CMAM: 84 HC staff CCM supervision: 23 HP staff 57 ML trained in CCM.	
Basic supplies, medical equipment, medicines.	OJT support: - commodity logistics and drug supply management	CCM medicines distribution: Zinc, ORS packets, amoxicillin, RDTs, gloves, malaria treatment, cotrimoxazole, paracetamol. Equipment distribution: - Infant scales, adult scales, measuring boards, thermometers, otoscopes, stethoscopes, blood pressure cuffs, laryngoscopes, hand-washing posts, exam and delivery tables, hospital beds, autoclaves, hygiene and santitation kits (wheelbarrows, shovels, rakes, brooms, trash cans, cleaning supplies, soap). - 2 vehicles for use as ambulances, 7 donkey carts for evacuation. - Committees set up to manage evacuation.	

Coverage and quality of care improved, despite some gaps. The key indicators for coverage and quality of care show across-the-board improvements, and remarkable gains, despite missing some targets by a few points. Improved quality of care is evident in the treatment outcomes as captured in the

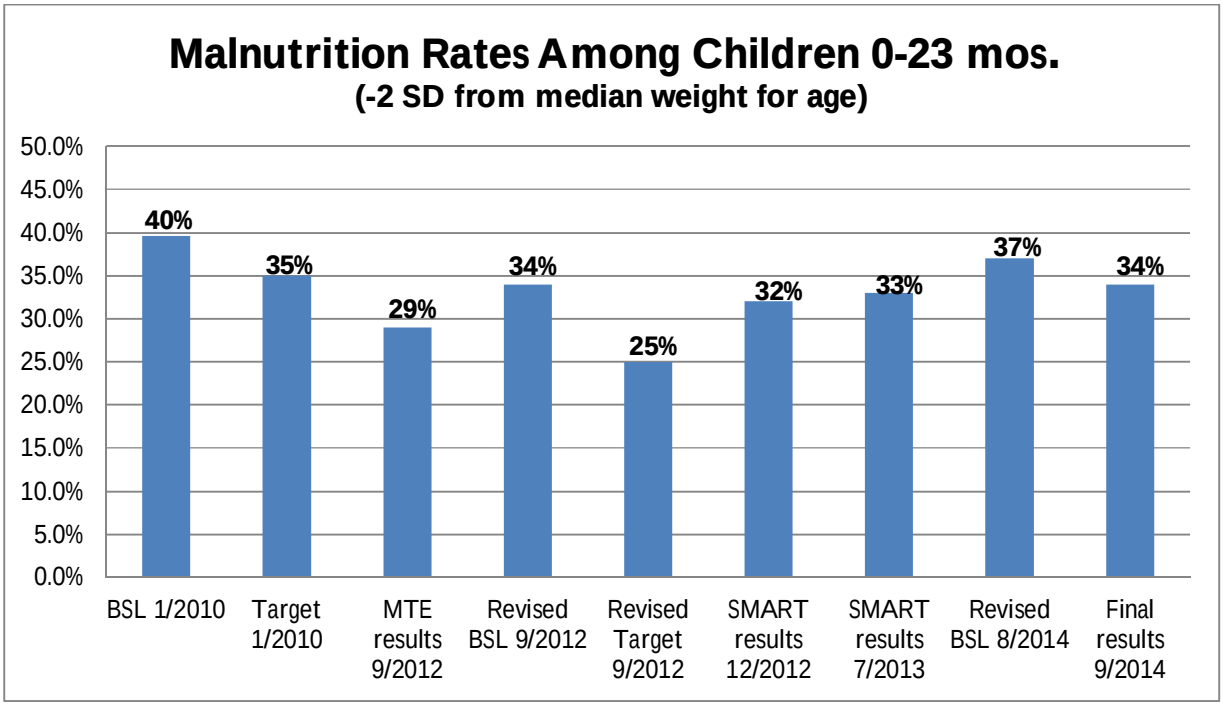
KPC. Correct management of fever episodes went from 2% to 40%, although the target was 50%. Effective malaria treatment depends on early care seeking and proper administration of available medication. Both of these criteria must be met in order to meet the objective. Use of zinc in diarrhea cases went from 15% to 42%. Beneficiaries testify to the improved quality of care in FGDs and KIIs. Participants overwhelmingly expressed patient satisfaction and greater confidence in the formal health care services overall, and especially for the iCCM activities conducted by MLs. Exit interviews at health facilities confirmed that the majority of respondents a), received the treatment they came for and b), received instructions on how to use the medication they received. The PMIT results confirmed this, with on average 72% of the caretakers interviewed in HC able to correctly describe the administration of all the medicines (antibiotic, antimalarial, ORS or zinc) prescribed.

Figure 3. Caretaker whose child was prescribed an antibiotic or antimalarial or ORS or zinc can correctly describe how to administer what was prescribed (Health Centers)



Progress to reduce malnutrition was erratic, and ultimately did not meet the target. Malnutrition rates dropped at the MTE in 2012 to below original DIP target levels (35%/29%), and then climbed again to 34%, only a few points below the baseline of 37%. It be noted the LYCSP did not engage in direct treatment for malnutrition. NS train health personnel in the identification of malnutrition as part of the IMCI protocols, while treatment is covered under another Concern program, which has its own network of volunteers and field staff. Despite the lack of progress on reducing malnutrition, the Chief Medical Officer (CMO) of the DHT, the District Nutrition Focal Point, and the Regional Director of Public Health (RDPH) all indicated that in their opinion, the nutrition *treatment* program had the most impact of all the Concern interventions, not distinguishing between projects. While this doesn't diminish the value of the treatment actions, it does suggest a gap in understanding how these interventions operate, which could impinge on the ability of the MOH to assume eventual fiscal and operational responsibility.

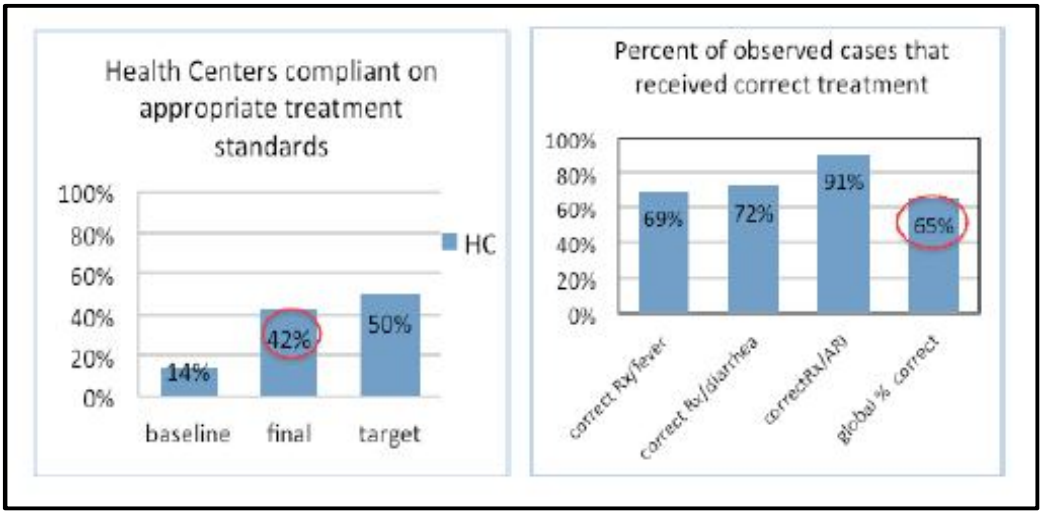
Figure 4. Timeline of Malnutrition: LYCSP 2010-2014



The target of 35% was set in the DIP in 2010. The MTE results were considerably below the target (29%), and subsequently a new target was set (25%). At the same time, the baseline data was corrected (34%). By December 2012, the effects of a worsening nutrition situation were revealed in the SMART survey, and this trend stubbornly continued throughout the life of the project.

One function that is fundamental to quality care – 'routinely appropriate treatment', tripled in application, despite not reaching the target of 50% of all health centers.

Figure 5. Health facilities where treatment is routinely appropriate for clinical encounters in which at least one of the presenting problems was fever, breathing problems, or diarrhea



Effective training and coaching methodologies are in use by project staff. As noted above, the two functions -'routinely appropriate treatment' and 'prescription and instructions for use of medications' - increased by 28 and 22 points respectively. This can be attributed in large part to the intensive coaching and supervision activities by project staff (note Indicator 21 and number of visits to each facility in the Summary Table 5a.). The changes are echoed in statements among health care providers who report they have increased their knowledge and improved confidence in their ability to diagnose and treat. Individual interviews with over 40 facility-based health personnel and correlated with 14 training verifications testified to a net perceived improvement in the capacity to diagnose, treat, refer, and even supervise MLs or other community volunteers.

> *"The most important thing [I learned] is the procedure for IMCI. Previously, our approach was all over the place; now the process is clear."*
>
> -- Head Nurse. Training Verification
>
> *"I learned how to do IMCI from the Head Nurse, who learned it from the LYSCP staff. This has greatly improved my knowledge."*
>
> --Nurse, Afala HC. KII

This also translated into a desire to have more training and support, a testimony to their motivation to continually improve. There appear to be 'knock-on' effects in the referral system as well. Both health personnel and community caregivers report issuing fewer referrals due to their ability to address the presenting problems on site (individual interviews and exit interviews). The LYSCP did not directly deliver clinical training, but financed the MOH trainings. The project reported in the Year 4 Annual Report that no surveys have been conducted to measure learning from training events. However, the non-representative training verification during the FE did confirm that most MOH trainings do conduct pre and posttests, so this might suggest that trainings are designed for efficacy, having learned these Adult Education techniques from their NGO counterparts.

The DIP intended that "…*Both the DHT and the project's Facilities Support Team (e.g., NS) will conduct the follow-up mentoring as well as scheduled on-the-job training sessions. To ensure better supervision, a series of trainings in supportive supervision techniques will be offered to all supervisors."* It was not clear if 'supervisors' here meant project staff or DHT. Ultimately, the training and coaching methodologies were for project NS to use when conducting quality mentoring with the DHT staff, and not as a tool to model supportive supervision for DHT take-up in their system. The results of the regular visits are recorded manually into each individual NS work dossier. The stated main purpose of this dossier is to provide internal records among the NS team in the event that one must cover the sites of a colleague – and not primarily to provide the project and/or the DHT with a means for systematic overview of the evolution of performance at the health facilities. The monthly recordings are not digitized, and there was no evidence of a regular collective review of the data to identify trends, tendencies, etc. across all NS dossiers and sites. Notwithstanding, project management stated that the dossiers undergo periodic review, which is through participatory ranking on quality aspects done by the NS, the health facility staff, and the COGES. The evaluator did not see a documented framework for this process. NS do register the outcomes of each site visit in a notebook at the health facility however there is no confirmation that the content of these notebooks are transmitted to the DHT. That being said, as part of the exit strategy, information from the coaching guides is now being shared during meetings with the DHT. Project management also indicated that it was not the intention of the project to offer to integrate the coaching process into the district health systems, due to the DHT human resource limitations.

It was acknowledged by all levels of project staff that joint supervision/coaching visits with the DHT were the exception rather than the rule, due to severe under-staffing within the MoH. The CHA have not had an official supervisory role in the MOH structure, however this is evolving with the new

community health strategy. According to project management, CHA have only begun ML supervision activities in the last 3 months of the project, following training (Some iCCM sites are still supervised by HCs as there is no HP close by). These supervision visits use a different set of tools designed just for the iCCM by MLs. It shares some common elements with the coaching tool such as record review, interviews with mothers, observations. The evaluator did not see these instruments.

Achievements in performance can be attributed to the training and coaching methodology to a large degree, but it should also be noted that the project supply of human resources, medications, equipment, and consumables were essential contributions to overall quality improvement. FGDs and KIIs predictably praised LYCSP for the material and financial assistance, requesting that it continue and that more be done in the same vein. Community members believe there are more health personnel on staff, easing a bit the burden of work, despite still being insufficient for the needs, and not mitigating the continual turnover. It may be that they count the MLs as part of the health team, which would attest to their credibility as care providers.

> *"[The project] subsidizes eight MOH nurses to eight sites with only one nurse. Actually where MLs are working there should be a huge change [in care seeking], because where before clients were going 80% to the HC and 20% to the HP now they are going 90% to the ML in those sites [with MLs]. For some of the sites this is a big change… they tell us that. The HCs now have the time to focus, they do have time to supervise MLs and are able to organize their work in the HC."*
>
> -- LYCSP Technical Advisor, individual interview

Despite good management, drug supply chain integration is still problematic. According to the exit strategy, the project reported it has integrated the project-financed and managed drug supply for iCCM activities into the DHT and health facility supply chain management system, with drugs for iCCM now being managed by the health facility and health post. The majority of drugs for iCCM however, are still being supplied by Concern through non-USAID funding sources, and Concern continues to assure the inventory management at the district level depot, which includes the ready to use therapeutic food and drug supply for CMAM, provided by UNICEF to Concern for other projects. Concern will not continue to employ a full time staff person, but will still assign oversight tasks to NS. The iCCM drugs are now being given to the DHT and Concern will support the planning and logistics for distribution. LYCSP financed a one-day training conducted by the DHT for *'percepteurs',* or drug inventory clerks, as well as providing overall 'on-the-job' training and support. These efforts appear to have concentrated on the mechanics of rational drug management, and less on the cost recovery procedures and governance. Drug supply management at the health facility level is a key intersect activity between the institution and the community, as the clerk is officially responsible *not* to the health facility manager but to the COGES for accounting on drug supply and purchases. Although currently iCCM drugs are not part of the cost recovery mechanism, they are reimbursed from the national level, and so eventually show up in the accounting system.

> *"Often the problem is out of their [COGES] hands. Even though in the text of the legislation it is forbidden for the HC personnel to be involved in the cost recovery fund mechanism often there is a strong involvement by the HC personnel. This makes that often COGES members don't have much power vis-a-vis the chief health officer…Even though we have had trainings on how to manage drugs, and receipts, and even though we have had COGES trainings there are insufficiencies even at the level of COGES, often related to good governance."*
>
> --LYCSP Deputy Health Program Manager

The issue is beyond the range of LYCSP, however cost recovery processes, and revolving fund management are a significant challenge for the health facilities, as acknowledged by both the DHT and LYCSP project staff. Both parties report that upwards of 50% of health facility drug supply accounts are not solvent, taking bank loans on a regular basis to cover the purchase of supplies. Even the RDPH acknowledged that two policies are at cross-purposes – free medications to children under five and

pregnant women, and fee-for-drugs/services. The largest consumer groups for medications are children under five and pregnant women, thus almost assuring a running deficit in the cost recovery fund mechanism. Niger has historically struggled with the cost recovery mechanism, which was declared a 'failure' in 1999 and re-vitalized with modest success through different programs funded by the European Development Fund and the International Labor Organization.[4] Concern will continue to face this challenge in future projects.

iCCM instruction, supervision, and reporting systems are of good quality and at a promising level of development. The iCCM package is the product of rigorous research, testing, and modification to needs. It includes a training manual, data collection tools for the ML, supervision and data collection tools for the supervisors, and visual aids. As noted earlier, the MTE revised the number of MLs to be trained and fielded from 100 to 48 and then again to 60 in 2013. 21 literate ML have been active since their training in June 2013. The remaining MLs were to be trained in Nov/Dec 2013, however this did not occur until June 2014, when 36 completed training and have only begun practice. In a display of capacity-building and peer-to-peer support, MLs from Bambeye Commune participated in the training of new MLs in Tebaram. The foundation of the ML program (instruction, supervision, reporting) has produced remarkable results, to be discussed later. This is especially notable given the low literacy levels of the women, and some skepticism with which the concept was initially greeted. In fact, progress on building a cadre of MLs was less robust than planned, due to some delays in approval by the MoH, and the introduction of national level policies instituted in late 2012[5], which specified literacy requirements for community health volunteers, requiring re-negotiation and redesign of some materials by project staff.

As part of the project Sustainability Plan to build the capacity of ML with more advanced skills to train and mentor new MLs during Year 5 and beyond, MLs from Bambeye Commune participated in the training of new MLs in Tebaram. The supervision policies and procedures for MLs were designed conjointly with the DHT. Potential supervision mechanisms for this level of health care worker have become part of a national level discussion, given the adoption of the Community Health Strategy which recognizes community volunteers below the HP level and the COSAN as elements of the health system. At the local level, preliminary discussions were held with communal leaders in Bambeye and Tebaram. As noted earlier, CHAs at the HP in Bambeye and Tebaram have recently been trained in supervision for iCCM. Supervision for BCC actions has not yet been integrated. Work on this aspect and community level support will continue locally and nationally under new funding sources and in collaboration with other NGO partners and the MOH. Preliminary OR results show some of the challenges ahead:

> *"Health worker opinions are divided between those who feel the addition [of supervision] is too much to handle given their already heavy work load whole, while others feel it is just a matter of planning in order to be able to integrate the supervision activities into the monthly program [of] supervision for the health posts and outreach activities. Some of the differences are likely due to the numbers of ML in each health zone as certain zones have significantly more ML villages and MLs than others. To reduce the workload, supervision activities have been handed over in the majority of cases to the CHA and the health center staff has moved to the role of supervisor of supervisors".*
>
> --Summary of Operations Research Preliminary Evaluative Results. 10/2014.

The project introduced innovative data reporting systems used by the CGs and MLs. The CG tools were designed for a low or non-literate cohort, and include simple line drawings, which are rendered in cue card form, on banner cloth, and repeated in a register book. A tally system using colored beads inserted into pockets on the banners underpins the data reporting. CGs are able to record their

[4] Assessment of Niger's national cost recovery policy implementation in the primary health care sector. F.D. Diop, 1996. Partners for Health Care Reform.

[5] *National Strategy for Integrated Community Health in Niger.* Ministry of Health. Validated 11/2012.

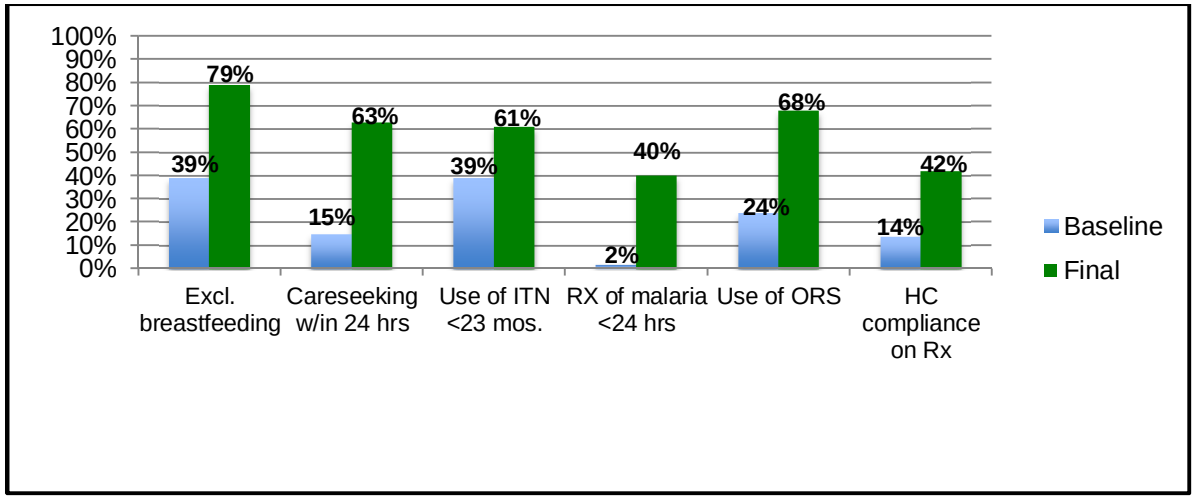
meeting activities, with a high degree of accuracy. For the MLs, there is a supervision form and data collection form for the supervisors and a set of algorithm cards, individual case management forms, stock management forms and a register. The data from MLs is passed up the health information chain via their supervisors (Health Center Nurses or Community Health Agents/CHA). As noted above, there may be challenges in reporting timeliness and accuracy once it leaves the hands of the MLs. At the time of the FE, the project was revising its own ML consultations database to improve general management of the activity. Currently, ML data (disease incidence, consultations, treatment) is consolidated and integrated by HC and HP staff into their general activities report, which they send on to the DHT. Meanwhile, the BCC information collected by the CGs remains within the project sphere. The National HMIS is under revision to include this kind of community level data, but there were conflicting reports about whether the DHT is familiar enough with the CG BCC tools (banners/beads, registers) to be able to advocate for the system. (Individual interviews, LYSCP staff).

Table 4b. Inputs, Activities, Outputs and Outcomes for SO 2: *Key family practices adopted at the household level.*

Inputs	Activities	Outputs	Outcome
Logistical support.	- Distribution of soap and ITNs at household level. - WASH materiels for schools and communities.	Monthly household visits and small group discussions by MLs. Support for ML through regular visits and sessions to reinforce capacity to conduct BCC activities.	*Increased percentage of children age 0-23 months who slept under a* LLITN from 39% to 61%, including 97% of those living in households with a LLITN. *Improvements in care-seeking behaviors for sick children:* For all illnesses combined, improvement from *74% to 84%* of care-seeking caregivers who sought care for a sick child. Of this, 93% brought their sick child to a health facility or ML (as opposed to a traditional healer or other informal provider, up from 72%. Care seeking within 24 hours for all illnesses combined also increased from *15% to 63%.* *Increased percentage of children age 0-59 months* with a febrile episode who were treated with an effective antimalarial drug within 24 hours of onset of fever from *2% to 40%.* *Increased percentage of children age 0-59 months with diarrhea who received ORS and/or recommended home fluids* from 24% to 68%. *Increased percentage of children age 0-23 months who were put to the breast within one hour of delivery and received no pre-lacteal feeds* from 21% to 57%. *Increased percentage of children age 6-23 months fed according to minimum appropriate feeding practices* from 6% to 30%. More than a third of caretakers (35%) *were reached with health messages through radio and interpersonal communication.* 34% received at least *one home visit/month by a health agent or volunteer, including ML or COSAN member* – 69% in ML/CG villages vs 26% in other villages. 40% in ML/CG villages *participated in small group session vs. 14% in other villages*. 45% of respondants knew at least two danger signs for seeking care immediately.
Financial support for BCC material development and activities.	- Formative research/ BCC materials development. - Production and diffusion of radio messages.	3-4 radio messages/3 times/day/5 local radio stations covering Tahoua and five rural communes. Soap and ITNs distributed. Handwashing posts distributed to schools in ML villages. Hygiene and santitation kits (wheelbarrows, shovels, rakes, brooms, masks, trash cans) distributed to ML villages.	
Technical support through program staff.	<u>Technical Support:</u> - Care Groups established and supported. - Care Group household visits.	-48 Care Groups established with 507 Mother Leaders. -Doer/Non-Doer survey conducted on # key family health practices. -Set of 23 counseling cards developed and disseminated.	

Key family practices are being adopted at the household level: SO 2 showed the most consistent and overall achievement. In general, the uptake of improved practices suggests that the success of the non-iCCM MLs can be traced to the quality of training, supervision, and support they receive from the project. All MLs interviewed during the FE were categorical about the changes they have helped to bring about in their communities. Of fourteen key household practices, ten met or exceeded the targets, with an average of 25 points improvement over baseline figures. Breastfeeding practices, including immediate and exclusive feeding, went from 21%/39% respectively at baseline, to 57%/79% at the final. Complementary feeding practices for children 6-23 months increased from 6% to 30%. Care seeking for suspicious breathing also increased from 51% to 82%.[6] Care seeking behaviors overall, from seeking out qualified care to timely care within 24 hours of manifestation, increased significantly.

Figure 6. Selected Key Family Practices at the Household Level



One key practice of giving more liquids to children with diarrhea failed to reach the target, and fell below the original baseline (target: 95%, baseline: 32%, final 20%). This was the case as well at mid-term. At both survey intervals, project management explained that the surveys did not take place during peak hot season as at the baseline. Nevertheless, project management acknowledged the need to intensify messaging for this key practice. Recognition of danger signs by caretakers to stimulate care seeking (45%) did not achieve the ambitious target (85%). Project management attributes this in part to the fact that only 40 villages out of 127 project communities had community-based interpersonal communication (IPC) activities which emphasize the danger signs. Preliminary results from the OR research identify a weakness among the 21 MLs (45%) in looking for danger signs, so the trend to neglect this message is across both means of interaction with beneficiaries (iCCM and IPC). Hand washing with soap also did not achieve the target and fell by one point from the baseline. 33% of the target population received at least one home visit from a health agent or volunteer. As noted earlier, 56 MLs are actually conducting iCCM as of June 2014, while the majority of the MLs do only health education and home visits.

Substantiated formative research behavior change strategy and activities for BCC message development. The LYCSP took extra care to conduct formative research as a means to develop the

[6] Project management extended a cautionary note regarding some of the KPC results. For details please consult the PMIT in the annexes.

most appropriate strategy and activities for BCC and other performance-based interventions. A Doer/Non-Doer Survey provided the basis for the selected key behaviors to promote. A thorough review of existing BCC materials was conducted to gauge the need for new materials.[7] New materials were developed, tested, revised, and tested again. A special report, *Perceptions of the Quality of Care at the Community Level* [8] was produced in 2012, which added to the overall body of formative research. The project leveraged modest but diverse access to radio broadcasts[9], producing and broadcasting radio spots on the key messages. A little more than one-third (35%) of the target population heard a radio message, which is consistent with official access statistics (assuming a fixed radio, as per DHS question format). No tracking systems were in place to assure that broadcasts did go out, or to do rapid recall inquiries during IPC activities. Two campaign-style events proved to be extremely successful (International Hand Washing Day and International Malaria Prevention Day), using local drama and songs, which really appealed to the cultural love of folk entertainment. KPC data was not disaggregated by sex, thus this source does not provide information as to the gender breakdown of the results. Furthermore, despite multiple references in the MTE to the need for greater involvement of men* there is no evidence that a deliberated strategy was designed to specifically target men with BCC messages. However, there is other non-scientific information to infer that both sexes have been reached, at least through radio broadcasts, via standard radio or cell phone service. There are approximately 5.4 million cell phones in use in Niger, with almost half located in rural areas, and the majority reportedly used by men. Media surveys confirm that most phones have FM radio,[10] so it may be assumed that men are hearing the messages broadcast on their local stations. FGDs with men also reveal that they are attentive to project key messages, with references in particular to the hygiene activities and the improved sanitation conditions in their homes and communities. Women report that men are now more supportive for them when seeking care; 'authorizing' care, finding and paying for transport, and prescriptions.

> *"We listen to radio Teberam, [Barmou], which tells about exclusive breastfeeding, hand washing, and going to the health center when ill."*
>
> --FGD with fathers, Maifaria village
>
> *"With the radio messages, we have heard about good practices for health."*
>
> --Mayor, Health Center, Toro
>
> *"We plan to continue using good practices."*
>
> --FGD with fathers, Tebaram
>
> *"All my first 3 children suffered from malnutrition, but this last one is doing well, because I required the mother get nutrition consultation."*
>
> -- FGD with fathers, Adoua village

Care Groups have demonstrated functionality, receptivity, and a manageable service model. The Care Group model has evolved continuously since its inception in 2011. 48 Care Groups with 507 (from 270 in 2013) MLs are fully active, equipped with visual aids to do home visits and small

[7] The lack of formative research was assessed as a weakness in two preceding CS projects in Niger.
[8] Issaka Salifou, Concern, June 2011.
[9] DHS 2012 data reports 49% radio ownership, with 30% of women and 33% of men listening at least once/week to the radio. Anecdotally, the project M & E Officer asserted that men listen to radio via a mobile phone, independent of a fixed radio.
[*] The DIP stated that men would be reached through male traditional healers, male CHAs, and male staff members. The majority of the field staff are female (nurse supervisors and animators).
[10] www.cellularnews.com. Nov.2012, Nov.2013. Accessed Sept.2014.

group discussions. Interviews with MLs revealed they are extremely well informed about the project and the actions – often more so than MoH health agents. According to project reports, BCC data collection tools, registers, and community boards for CGs to monitor household information are in place and operational. The Care Groups hold weekly meetings, and attendance might vary - from 40% to 98%. In general, each ML attends at least two of the monthly meetings. The average number of household visits per month overall is a bit more than 8000, an average of 16 per ML. CGs host on average 1200 small group education sessions per month, with 2 to 3 sessions per month per ML. One in three (34%), beneficiaries from all communities (including those without a CG) reportedly received at least one home visit in the month before the KPC survey, most often from a ML. As noted in the summary table, when selecting just communities with CGs the percentage increases to 69% receiving at least one home visit in the proceding month compared to 26% for those communities without CG.

Eight project field staff supervise the CGs on a monthly basis, observing a combination of CG meetings, small group sessions, and/or home visits conducted by the members. Retention is very high. The few MLs who have left service have done so mainly because of re-location with their husband (often for employment reasons), divorce, or death. MLs are being incorporated as co-trainers in the creation of new CGs. There is a lingering perception among some that the MLs were selected by Concern, and are working for Concern. To dispel this and to address the sustainability of the system, discussions have been initiated with commune authorities to explore ways to support, recognize, and compensate MLs for their work. The MLs performing iCCM appear to have solid credentials as first resort caregivers, and as noted earlier, the preliminary OR research reports that 88% of sick children were taken to MLs for their first contact with care. The engagement of women as health actors has had a noticeable (although untracked) impact on the perception of women's status and role in the community. There were numerous references in the FGDs and the KIIs to this effect. Men as well as women remarked on the enhanced self-image and sense of self-worth among MLs. This was noticed as well among women beneficiaries. They remarked that their homes are now tidier, more hygienic and they have a sense of pride in what they have learned.

Table 4c. Inputs, Activities, Outputs and Outcomes for SO 3: *Improved district performance in the delivery of essential child health and nutrition services.*

Inputs	Activities	Outputs	Outcome
Logistical support	Logistical and financial support for monthly supervision visits to HPs by Chief Nurses from HCs. - Quarterly supervision visits to HC by DHT. - Support for national vaccination and international health days.	- Quarterly supervision visits performed by DHT to 38 HCs throughout the life of the project. - Monthly supervision visits performed by Chief Nurses to 52 HPs throughout the life of the project. - Annual vaccination and international health days supported.	*Increased number of health facilities with essential infrastructure* from 11/29 HCs (38%) to 20/25 HCs (80%). *Increased number of health facilities that maintain up-to-date records of sick children under the age of five and have a report in the last three months with evidence of data use* from 3 of 29 HC (10%) to 17 of 25 (68%); 21 of 46 HPs (46%) – no baseline. *Health facilities that received external supervision at least once in the last three months increased from* 21/29 (72%) to 22/25 88% (HC); 45/46 92% (HP) - no baseline. *Health facilities with proof of nationally mandated guidelines for care of children* – 24% to 68% (HC); 89% (HP) – no baseline. *Increased number of HCs with a trained and active body for community participation:* 43% of health facilities demonstrated increased functionality of the COSAN and COGES. At least one COGES meeting with meeting notes in the last two months, at least one COSAN meeting in the last three months, and participation in at least one community health activity in the last three months.
Material and financial support for essential infrastructure.	Construction or repair of essential HC infrastructure.	- Solar power systems, latrines, incinerators installed at selected HCs. - 8 motorcycles purchased and distributed to target HC.	
Technical support from program staff	-Training for COGES and COSAN on roles and responsibilities - Pilot the use of Frontline SMS.	Frontline SMS system in place in Tahoua district to communicate weekly reports on reportable diseases as a pilot for large scale use for routine HIS data collection. 315 COGES/COSAN members trained on roles and responsibilities.	

Performance and capacity are improving at the district level. Evidence of capacity building with the DHT by the project to strengthen the overall health system is inferred and anecdotal, as neither the stated inputs nor the measurable indicators directly correspond to the FE questions on management and governance. The MTE noted in 9/2012: "*Capacity-building of the DHT in the first phase of LYCSP has focused more on technical rather than managerial capacity*…"., and this appears to still be the case. The rate of quarterly supervision visits by the DHT to the HCs was already quite high (72%) at baseline, moving to 88% at end line. Real progress was seen in the rate of supervision from the HC and the HP, at 92%. This may be attributable to a.) transport means provided by the project, and/or b.) project-subsidized personnel who had more time to do the supervision. Project staff in the form of nurse supervisors, as noted earlier, did sustained rounds of supportive supervision and coaching, however they were only occasionally accompanied by anyone from the DHT (due largely to lack of time among the very small team).

The quality of supportive supervision was one of the focus issues for the following years. As noted earlier, the coaching/mentoring program was not intended for integration into the district system, so it is difficult to gauge if the quality of supportive supervision by the DHT has been enhanced by these tools or by the routine. Notwithstanding, information that is collected during these visits is passed along to the DHT, and reportedly studied for application. Assisting the MoH to diagnose problems and match appropriate solutions was identified in the MTE as an area that needed work. Project management reported in the MTE recommendations update (9/2014) that training and capacity building for the DHT has not been achieved, due in part to disagreement on methodology. Project management reported that on average, of five problems discussed with the DHT, one might be solved in a timely and effective manner. Deficiencies in human resources management are a continual drag on the operational capacity of the district. Project staff observed: *"At the health facilities they have the clinical capacities but don't apply them systematically and there are tasks which are left to unqualified agents, who are not allowed to be trained. There are also difficulties in supervising community activities (HP and MLs). Not all the staff has the necessary skills. The total responsibility falls on the DHT to do more tasks with few people."*

The district level is responsible for enforcing key administrative practices at the point of service that are part of the essential process of organizing care, and which are critical to *"ensure that inputs (personnel, drugs, technology) are appropriately used to attain […] desired outcomes".*[11] Accurate record keeping and consistent reference to norms and standards are two elements of a well-organized system of care. At health centers, indicators for accurate record keeping and evidence of nationally mandated guidelines for reference made significant gains but fell short of their targets by almost 10 points. The NS reported that one of the areas they must routinely reinforce and correct at the health facilities is accurate compliance with protocols. If the norms and standards are not available on site for consultation, the result is inadequate compliance.

Planning and budgeting operations appear to have evolved satisfactorily under the constant coaching of LYSCP management staff. The DHT produces an Annual Action Plan (AAP), in consultation with all NGO partners, and they have a dedicated budget manager now. Nevertheless, the CMO/DHT stated that within the budget and action plan, a good portion of it must be assumed by non-state actors for some time to come. Project staff observed sincere willingness within the MoH to appropriate operational models and to continue these activities but also a very strong sentiment that another project will come along [to take over the management and financing. [12]

[11] USAID Applying Science to Strengthen and Improve Systems Project. 2014. Quality Improvement. Technical Reference Material. Published by the Maternal and Child Health Integrated Program for USAID.

[12] Citations in this section are from: *Individual interview, Deputy Health Program Manager; checklist "Evaluation of MoH organizational management capacity" by Concern staff*].

With the intention to strengthen the Health Information System (HIS), LYCSP continued work to pilot the use of the Frontline SMS service for data reporting from the service delivery sites to the district level.[13] Reportedly, the national MoH has embraced the concept of '*MoHealth*' and other regions in Niger are already operational. Progress over the life of the project has been inconsistent, with benchmarks for uptake moved from year to year. At the time of the FE, Frontline SMS going operational in Tahoua was on 'stand by'. The project developed the application, designed, and installed the data entry program and Internet at the district, purchased the cell phones, installed the application on the phones and trained agents to use it. It then subsidized Internet and phone credit for three months. Cell phone usage is common even in rural Niger, and Concern beneficiaries are experienced in using cell phone technology for cash transfers, which suggests that there is familiarity with the technology. The bottleneck appears to be of a human nature rather than technology-based. Within LYSCP, the activity was reportedly championed or sidelined depending on the perceived priorities of the ex-pat Health and Nutrition Coordinator on staff at the time. At the District, development and implementation of the program was highly dependent on the IT specialist, a mid-level staff member who was re-assigned to another district just weeks before the system was to go on line. End-users (community health agents) reportedly felt that the training they received was too short, too complicated, and did not have supportive assistance to coach them along the way (LYCSP nurse supervisors did not participate in the Frontline training). The Chief Medical Officer (CMO) of the DHT stated that *"Frontline is Concern's initiative; it is dependent on the Internet which is not reliable in Niger".* (Individual Interview, Dr. Batoure, DHT). This observation suggests a lack of understanding and involvement in the development of the system. The RDPH later was surprised to learn that the initiative exists in the district, and dismayed that it is not yet operational (Individual Interview, Dr. Amadou, RDPH).

Finally, each year project annual reports underline the challenges on information sharing and coordination between the MoH and LYSCP. Progress appears to have improved by the FE although both parties feel there is room for improvement (individual interviews, Checklists *'Concern evaluates MoH/MoH evaluates Concern'*-Annexes 7, 8).

Significantly increased engagement and capacity building at the community level. As noted earlier, the MoH has an official Community Health Strategy (Nov.2012), which outlines the roles and responsibilities of non-clinical actors on how to collaborate with the formal health system. The strategy serves as the official directive for civil society and international partners in the development of such bodies as the COGES/COSAN, and volunteer units. LYCSP's CG and ML initiatives are right in line with the intentions of the strategy, and based on the information collected during FGDs and KIIs, they have had a watershed impact on the landscape of accessible primary care at the community level. Training and supportive supervision by LYSCP for 315 COGES members has instilled credibility and authority in what was often just a figurehead body. During coaching visits, the NS routinely identify actions that can be conducted by the COGES/COSAN for the benefit of the health facility. Three-quarters (72%) of COGES and almost half (49%) of COSAN bodies meet regularly and have the meeting records to prove it. Over half (57%) of active COSAN bodies report helping to organize the large-scale campaign events cited earlier. Village and commune administrators in individual interviews routinely cited the indispensible support of the COGES for the health centers – assuring hygienic conditions, building fences, etc. Still, 25% of the health facilities have no qualifiably functional COGES/COSAN. No one cited the COGES involvement in drug supply purchases, which according to the strategy, is one of their main roles and is the foundation for transparency and community accountability. Project staff and COGES

[13] The Detailed Implementation Plan (8/2010) states: "One of the activities of the previous health project (Pro-SantE) was the successful implementation of Frontline SMS (texting) in 12 health centers for reporting HIMS data and for ordering drugs when there was a stock out. The project team plans to expand this technology to an additional 10 HC and 10 HP. The technology is cost-effective and it is anticipated that the DHT will incorporate this cost into their annual operating budget".

members did indicate that this can be a problematic area, as noted in the section on drug supply chain management. Another expressed concern was the COGES member profile. Officially, village administrators (chiefs) cannot sit on the COGES, however there are reports that quite a few are active members. To this end, the Mayor of Bambeye issued a circulaire in his region re-stating the criteria to be a member. The CMO stated that he sees the COGES as the logical body to assume eventual supervision of the MLs – a notion that is not supported by LYSCP as the COGES are not health personnel. This suggests the DHT has some misconceptions by the about the activities conducted by MLs, given that they MLs are actually conducting wha could be termed clinical work. program. COGES supervision of iCCM it is not appropriate, but it may be for the creation and functioning of the CG and the BCC activities. LYCSP is working with the communes to have these actitivites taken over by the MOH and communal authorities. It also emerged that the CMO has not had the opportunity to see the MLs in action.

Table 4d. Inputs, Activities, Outputs and Outcomes for SO 4: *Improved child health and nutrition policy environment.*

Inputs	Activities	Outputs	Outcome
Human resources invested in participation in coordination and technical meetings.	Participation in [DHT] annual review process. Facilitation of regional coordination meetings for health sector partners in Tahoua. Participation in national technical working groups. Attendance at health cluster meetings.	Participation in 9 district and regional semi-annual review meetings. 6 coordination meetings for health sector partners in Tahoua region hosted by Concern in its role as NGO partner coordinator. Regular attendance by Concern senior management at health cluster meetings at national level and nutrition cluster meetings at national and regional levels.	*Increased interest in and stronger support for CCM:* The National Malaria Control Program (NMCP) considers *Lahiya Yara's* CCM activities as part of the program to pilot and explore household management of malaria. MOH looking at ML data collection tools during revision of community level data collection for HMIS.

Modest contribution to the policy environment and evidence-based decision making.
Concern as an organization is very active and engaged with all the players in the health services arena, as noted in the outputs above. The NMCP has officially included Concern in its list of partners with specific reference to piloting iCCM of malaria by MLs. Given that NMCP originally expressed resistance to the idea of non-literate community-based providers (using RDT), this is a notable achievement. The MTE in 2012 stated: " *It will be important for the success of the iCCM component to engage the MoH at the national level.[..]. The initiative to train MLs to carry out iCCM at the household level and the OR associated with it could have a significant impact on MoH policy in the future, but it will be necessary to identify some "champions"* ***within*** *the MoH, organize visits to the project for them, and keep them apprised of the results of the OR."* Project management reports that the MoH is studying the ML data collection tools to include in future HMIS models. Selected tools and materials have also been shared with other partners (World Vision) and the CORE Group globally. At the District level, the DHT/BCC Coordinator stated that the AAP contains the ML activities, and the AAP is endorsed by the RDPH. However, neither the CMO nor the RDPH has seen the MLs in action, and despite visits to the District by national level MoH officials, the opportunity for LYSCP to organize a visit did not materialize. When questioned directly about the DHT's intentions to 'champion' the possibility of scaling up/replication of iCCM by MLs, the CMO responded: *"Hypothetically yes, but there are no concrete plans. We are waiting to see the evaluation and results."* He continually referred to it as a 'partner initiative'. The DHT/BCC Coordinator said: "*This is my concern for MLs…without CONCERN there… the DHT does not have the means or capacity to do it. To do follow-up, to give them the materials, drugs, etc. what mechanism can we put in place?"* Later, he explained

about an information initiative he undertook to try to build greater awareness about the ML program, which he hoped would lead to more of a sense of ownership. See discussions below.

Promotion of information sharing and learning is standard. Concern is clearly a leader in coordinating meetings at the District level that provided opportunities for information exchange and learning – as per the outputs in the Summary Table. The organization is also a regular presence at the regional and national level on nutrition issues. The LYSCP project sent the (previous) District Medical officer Washington DC to present the DIP. The project also sponsored DHT members for a workshop on Nutrition in Emergencies in Niamey in November 2010, and sent the former CMO/DHT to a Child Survival Program Workshop in Rwanda, in July 2011. No further formal learning opportunities were recorded. Concern was very attentive to maintaining a regime of regular meetings with the DHT. Project staff reported that the weekly meetings had fallen off, but by the time of the FE they had resumed. As noted above, the DHT/BCC Coordinator stated that he had prepared two model information bulletins for circulation to promote the activities of MLs: "*I thought this would demonstrate not just CONCERN's role, but the real work of MLs. Because in some areas of the district, the people can't believe that there are illiterate women doing the work of MLs (iCCM) – they can't believe that these women can diagnose malaria, signs of malnutrition, diarrhea, and do treatment. So at each meeting, I would tell about this, and no one believed me at first."* He claims to have approached LYSCP to produce and distribute this, but according to him, it was not taken up. A check with the LYSCP Communications Strategies Officer and the Deputy Health Program Manager revealed that they were not aware of this initiative, which may have been prior to their employment with the project.

The project databases for information management and use are not fully operational, and access to data is unwieldy. This limits the impact that analysis from triangulated data can have for reporting and decision-making. When this is not happening within the project, it is not being shared with the partner.

2. Overall, what were the major contextual and/or implementation challenges faced by the project and how were they faced?

The contextual and implementation challenges date back to some early design weaknesses that interfered with the rhythm of implementation, firstly in the realm of information management including monitoring, data collection, and use of data for decision-making. The OR targets were scaled back as the implementation was hindered by a variety of factors largely beyond the project's control, such as a nutrition crisis in 2010, a change in criteria for community health actors, and only moderate engagement by the MoH in the earlier years. An implementation process that lost steam was the FRONTLINE SMS technology for reporting HIMS data. By the time of the FE, this initiative was in the words of the project focal point on 'stand-by' due to lack of MoH uptake, despite all elements having been put in place, evidence of success from a previous project, and clear interest from the national level. Furthermore, the plan to upgrade the project-specific drug supply chain management system and hand over the management to the District has not happened. Finally, the evaluator felt that formal documentation provided was somewhat slim on the details, such as a plan for male involvement, iCCM drug supply chain management handover, re-engagement for FRONTLINE, operational processes with DHT, etc., and project management acknowledged that some key discussions, processes, and decisions did not have a clear paper trail. Clarifications on numerous issues came only lately and in the form of e-mails.

In response to early design weaknesses, The MTE examined the resultant adverse effects, and the project undertook corrective steps. Regarding the FRONTLINE technology, project management has confirmed that work on full handover and integration will continue under a new funding source. Other challenges were identified in the MTE and the Year 4 Annual Report. The FE requested LYCSP to update progress on the MTE Recommendations and the Year Five Work Plan/Exit and Sustainability Plan, both of which addressed persistent challenges over the life of the project. These documents are in

the annexes. Following is a snapshot of lingering challenges and how the project is engaged in their resolution, all of which have been discussed throughout this report:

1) *Reducing the rate of malnutrition is a complex undertaking.* Two years into the project, LYSCP had surpassed the target indicator (35%/29%) at MTE, but within three months, the rates of malnutrition climbed and never came down again. For all of the countries in the Sahel, the 'everyday emergency' persists. It is often influenced by factors outside the scope of a Child Survival project.
2) *No full handover of drug supply chain management*. Despite still being managed by Concern, the project has significantly improved the rational use and management of iCCM drugs at the facilities level, and will pursue the handover of the stand-alone depot and transport of supplies, which is independent of the DHT.
3) *Inconsistent engagement and leadership for HIS Frontline operationalization.* Plans to renew interest and encourage the MoH to operationalize Frontline are part of Concern's agenda in the next iteration of programming. However, if not for this arrangement, the future of Frontline might be in doubt.
4) *Improving engagement of CMO/DHT.* This was the case for more than half the life of project, and was a factor largely out of Concern's control. By Year 4, a new CMO was in place, and is demonstrating active engagement and leadership.
5) *An uncertain security environment.* International staff presence and support to national staff was severely hindered by this. National staff identified the constant turnover among Concern ex-pat staff and long periods of vacant posts as a very significant constraint. Largely out of Concern's control, it appears to be an on-going hindrance.
6) *Insufficient human resources*. The MoH is handicapped both at the service delivery level and at the district management level by a severe lack of personnel. LYSCP palliated this by subsidizing additional MoH nurses assigned to the most over-burdened health centers during the life of the project. This was a necessary step to reinforce the learning and uptake curve of the project actions.

Supervision challenges for the iCCM Mother Leaders. Despite being a groundbreaking addition to the health care services available to the population, the ML corps has added a layer of supervision tasks to the already over-burdened health workers. While the health center staff were able to conduct the visits, less than half of the ML were supervised within the agreed upon time frame of less than one month (approximately 30 days), between supervision visits. In July 2014, 7 CHAs were trained in supervision, bringing the total number of supervisors to 13 and by the end of August 2014, 56 iCCM/ML in 19 villages received a supervision visit. Maintaining this rhythm depends on Concern providing material and financial inputs at this time.

Tardy advocacy and policy promotion for iCCM/ML adoption. Delays in getting early MoH buy-in on the OR methodology led to late implementation, which then affected the selection, training and deployment cycles of the iCCM MLs. The numbers of MLs in practice by the end of the project were less than expected, and subsequently the body of data with which to assess the work is quite small. The late consolidation of evidence from ML activities has in turn delayed planned advocacy initiatives with the regional/ national MoH, right up to the end of the project. Concern has initiated plans for a presentation at the national level (to be hosted by DHT) before the end of the year. This post-project activity is possible due to new funding sources, which will allow for continued work on ICCM.

3. What was the extent of collaboration with the MOH, UNICEF, and other USG-funded partners at the national, regional, and district levels?

Partnerships are value-added for achieving project objectives. The MoH considers Concern its strongest and most engaged partner. Both the CMO/DHT and the RDPH stated this without prompting in their interviews. One of the elements, which appears to contribute to this strong alliance is the regularity of consultation between the two bodies.

> *"Concern is the largest, closest partner for DHT in the Dept. of Tahoua. Take a visit to CSIs to see what a difference has been made; changes that are fundamental and not to be undone. This year the DHT hopes to assume the responsibilities on its own after the close of some elements, [because] Concern has helped to position the DHT to take over…"*
>
> --Dr. Oumarou Batoure, Chief Medical Officer, Tahoua District Health Team.
>
> *"I find the partnership with Concern is excellent. In all honesty, in the short time I have worked with them…I have worked in MoH for more than 15 years, at the regional level in operations. And I have the habit to tell Concern that I really appreciate the sense of integrated programming that we are doing together."*
>
> --Dr. Amadou Adamou, RDPH/Tahoua District.

Tangible evidence of this sense of joint mission is in the development of the AAP, the notes on file of meetings, and the sharing of staff on occasion to host meetings. Challenges still exist to further the sense of collaboration and collective impact. Neither official professed to having read many of the LYSCP basic documents such as the DIP, the MTE Evaluation, or the Annual Reports (despite having copies).

Because Concern has other development actions in the Tahoua District, they have also forged close working relationships with Government of Niger administration officials. This is evidenced by the level of awareness of all Concern actions by village chiefs, town mayors, and commune leaders. Awareness-raising activities by LYSCP have led to the inclusion of health planning actions in the municipal 'micro-plans' – a demonstration of scaling up in a broader context. In the commune of Bambeye, these efforts have contributed to a collaboration, which has been formalized through a tri-partite written agreement between MoH, Government of Niger administration officials, and Concern.

Collaboration with UNICEF has been advisory and in-kind in the form of drugs and RUTF, IMCI training and drugs, and EPI actions. At the national level, Concern has been an active participant in Health Cluster senior management meetings at and nutrition cluster meetings at national and regional levels. Concern has kept UNICEF abreast of LYSCP activities and progress, and this has ultimately resulted in a new funding opportunity for Concern to continue actions initiated under LYSCP.

Some key program elements integrated and institutionalized into the formal health system. Strictly speaking, the Care Groups, iCCM/MLs, and/or the coaching/ supervision model have yet to be formally introduced and absorbed into the health system. There is general enthusiasm all around and a strong desire within the rank and file to see the adoption of iCCM/MLs as standard practice. The process of designing and experimenting new health processes/protocols can be long, and requires a deliberated strategy. LYSCP's operations research program is a first step in that direction, however it lacks a clear roadmap on how to translate evidence into policy. Budget models have not been developed. Operational issues such as supervision, drug supply, and compensation require more investigation in order to provide evidence-based winning arguments to craft legislation – which is how protocols and policy are adopted. Concern's intentions to present the findings of OR to national bodies will not be enough.

CONCLUSIONS

SO 1: Increased Coverage of Essential CHN Services and Interventions

The Lahiya Yara Child Survival project succeeded in expanding the scope and scale of health care service providers to a considerable degree. *Scope* is illustrated by the improved performance among existing health care personnel, as well as adding to their skills set. Infrastructure limitations that previously impeded progress have been mitigated by project inputs of basic equipment, transport, electricity, and hygiene systems, for as long as they may last without MoH investment. *Scale* has been enhanced by adding a layer of quality care closer to the household in the form of Mother Leaders practicing integrated community case management, supported by Care Groups doing awareness and education, and COGES/COSAN units assuming some stewardship for the non-clinical systems and processes that underpin iCCM. However, sustaining these gains in *scope and scale* may be impaired because the necessary accompanying adaptations and changes in the MoH institution have not kept up (see SO 3 and 4). The DHT's ability to manage the key principles of quality improvement (formerly known as quality assurance) is inferred rather than directly attributed. Without the extension of Concern's activities through another donor, replication of the intense coaching and supervision model by the MoH is not likely, due in large part to the lack of human resources. Concern will continue the quasi-parallel drug supply system for the iCCM activities because the problem-riddled cost recovery mechanism cannot underwrite it.

The reduction of malnutrition in Niger continues to escape the influence of interventions by NGOs, UNICEF, the World Food Programme, etc. In fact, development policies in the entire Sahel region have been under scrutiny as the 'everyday emergency' cycle evades resolution. A July 2012 study commissioned by Save the Children and World Vision explored root causes, and described how singular nutrition components in programs such as LYSCP are unable to bring about significant change.[14] Further work on the "resilience deficit" took the form of a USAID Sahel Region workshop in March 2014, during which strategies were outlined to address neglected structural factors.[15] Concern's larger country portfolio includes opportunities for integrated programming that might have been better exploited for progress in reducing malnutrition.

SO 2: Key family Practices Adopted at the Household Level

The project has had transformational effect on care seeking behaviors and some hygiene practices at the household level. This has been achieved through a strategy of multiple messaging through health personnel, home visits, group sessions, and project radio broadcasts. The role of Care Groups cannot be under-estimated, through whom the landscape of their community's health care needs and use of services has clearly changed for the better. Due largely to their efforts, beneficiaries appear to have bridged the critical transition from knowledge to practice through attitudinal recognition of the value proposition of some of the new behaviors. At the same time, it is too early to determine if the CGs will be able to maintain the threshold of time and effort necessary to assure that the practices are embedded for the long term. Ambiguities within both the community and the MoH about how to sustain the approach must be cleared up. The life span of Care Group effectiveness will depend on external support in the form of materials and supplies, supervision and refresher training, and possibly some form of parastatal engagement with the MoH. Finally, the parameters that define what a 'care group' is must be

[14] ENDING THE EVERYDAY EMERGENCY: resilience and children in the Sahel, July 2012. Groundswell International, commissioned by Save the Children and World Vision International.
[15] A good point of departure is to design a framework for measurement. Consult the USAID FSIN TWG on RMhttp://www.fsincop.net/topics/resilience-measurement/en/

respected, as the tendency is there to enlarge member numbers or inflate the number of households overseen by a ML. These deviations have proven to put operations at risk in other country examples.[16]

The project might have made better use of mass media and folk media for message dissemination. Radio message reception could have been even better had the project done continuous formative research in the form of rapid recall surveys, or sentinel listening sites to monitor broadcasts and listening. The original DIP had programmed the use of drama, which in preliterate cultures uses the oral tradition to great effect. The subsequent work plans made no further reference to this, apart from the highly successful theatre troupes that were engaged for the one-off campaign events. This was a lost opportunity for the project.

The FE inquiries revealed that the project has had an unprecedented affect on the sense of self for women participants, from the MLs, the CG members, to the individual women beneficiaries. Their identities are shifting, as they begin to see themselves in a new context of change agent and social innovator. The local society is beginning to acknowledge this as well, and as intentional involvement grows, a sea change in women's status in the region may be in the making. The route may lead towards empowerment in other realms as well. The opportunities to build on this phenomenon are numerous. However, the key factor is that the women are delivering *results*. Other initiatives must ensure that women can do the same, while striving toward the greater goal of self-agency (and not just service to the community).

SO 3: Improved District Performance in Delivery of Essential CHN Services

The project defined improved district performance in part by the increase in supervision visits from the DHT downward. This was already relatively high initially so the incremental increase is only a modest achievement. The essential system functions that underpin sustained improved performance at the facility level still require significant input and oversight from external players, as demonstrated by the unattained targets for records-keeping, availability of protocols, and the erratic compliance with protocols over the life of the project. Although the project's coaching guide contains many of the essential gauges to develop measures and methods for measurement of quality of care (USAID TRM) there is no evidence that the project helped the DHT to evolve its own understanding of quality of care. The DHT has benefited from project support on development of service delivery but has not been enabled to absorb new mechanisms such as the coaching model, the iCCM approach, the drug chain supply management, and the Frontline data system. A missing piece seems to be no deliberate capacity building for health systems management and physician/health personnel practice management. The less-than-optimal data-sharing processes may be hindering both parties. More comprehensive data and data management by the DHT will go a long way to influencing decision-making at the RDPH on issues that enable or impede progress. Finally, there is a tacit assumption by the DHT and the RDPH that these kinds of initiatives will be the domain of partners for some time to come.

The project's actions to reinforce competencies of the COGES/COSAN units of the community health system, is a valuable achievement with excellent growth potential. For a minimal investment (two 'training/orientations' over the life of the project), the project capacitated and built greater credibility to a corps of community stewards who are informed about local health issues, and demonstrate strong commitment to improving conditions at both the household and facility level. This potential may be in jeopardy if more attention is not given to their authority as an accountability body for the health facilities. Furthermore, it appears that the DHT has more or less relinquished responsibility for materials and support to external players.

[16] Care Group Criteria, Talking Paper. Edited by Tom Davis, World Relief & Food for the Hunger.

SO 4: Improved Child Health and Nutrition Policy Environment

The project fell short of achieving this objective on a number of fronts, and it can be traced back to the DIP and the activities for the objective. The activities as designed do not provide a roadmap for action in the policy arena. The indicator that would have pushed the project to develop a directed strategy for this objective was eliminated at MTE. The reasoning behind this was that there was not enough time or data to develop a policy position. The remaining indicator to measure achievement is void of real impact. Document sharing, networking, and participation in coordination meetings are all expected standard operating procedure for such a project. LYCSP implemented all of these, but failed to produce the expected results. The policy improvement objective appears to rest entirely on the results of the operations research, which were only produced at the very end of the project, and thus unavailable for early advocacy. The OR model itself does not define how to translate the evidence into a policy product, how to undertake dissemination of the evidence and recommendations, craft language for legislative and financial circles, answer questions of applicability, rally 'champions', and walk the policy through the system. Were it not for additional funding to continue the program, even the overdue presentation of OR results likely might not be made, which was not accomplished during the life of the project.

In conclusion, the Lahiya Yara Child Survival Project has rendered communities capable of becoming authentically engaged on the issues of health, health care and services, prevention and treatment options available to them. The project has succeeded, in the words of the DIP, in bringing "…*health education, disease prevention interventions, malnutrition screening and case management of the sick child as* ***close to the family*** *as possible".* The project also succeeded in improving the overall quality of care and service environment, albeit with little evidence of really embedding new approaches and models of care within the MoH. However, results to date are so promising that a new donor will finance further actions. The critical questions of sustainability and ownership may be suspended for a time.

RECOMMENDATIONS

The recommendations are designed to be as practical and applicable as possible. All stakeholders stand to benefit if they participate in the adjustments. Keep in mind that that recommendations focus on necessary improvements, adjustments, etc., and do not diminish the important achievements of the project.

Table 5. Recommendations

Finding	Conclusion	Recommendation	Action	Lead
SO 1: Increased coverage of essential CHN services and interventions				
Improved coverage and quality of care at health facilities and via start-up iCCM activities. Effective training & coaching methods, however… no operational tracking system to collect and analyze coaching results.	This is due largely to LYCSP inputs> training, products, personnel, and less to enabling the DHT internal systems. Quality improvement principles not shared in detail with DHT. Transfer/replication in DHT not likely under current	– First priority is to maintain achieved standards of care. – Reinforce community level iCCM, support culture of change. – Actualize DHT stated intentions to assume more ownership. – Determine if the LYSCP coaching approach is suitable for the DHT then pursue adoption if so.	– Close the gap on some of the performance-based indicators – assess first, discuss wit DHT, apply enhanced coaching. – Convert/adapt coaching and supervision guides for use by DHT. – Develop mentoring program HC>HP; ML >ML to stimulate on-going support. Develop a blueprint for gradual assumption of actions by DHT: conditions to be met, timeline, resource	Task force DHT and Concern.

	scenario. Currently no means to chart capacity-building over time, i.e. trends, tendencies, emerging problems across facilities.		search. – Digitalize coaching files, build user-friendly database.	
Drug supply chain mgt still problematic.	DSCM current procedure unlikely to change in the near future, due to issues with MoH cost recovery mechanism.	– Study the CR history/problems; become informed on case-by-case facility/COGES situation. – DHT must be encouraged to take the lead.	– DHT: demonstrate greater leadership in the assumption of responsibilities for drug supply chain management, supervision chains, and advising and supporting COGES units; - Concern: Develop a plan for DSCM handover: DHT personnel rather than Concern. Integrate stocks into DHT depot. Support COGES role in DSM.	DHT, COGES, Concern and local commune admin.
LYSCP surpassed the malnutrition target (35%/29%) at MTE, but within three months, malnutrition climbed and never came down again.	For all of the countries in the Sahel, the 'everyday emergency' persists. It is often influenced by factors outside the scope of a Child Survival project.	Study and adopt resilience programming that integrates livelihood strategies with FNS. DHT: - Demonstrate greater understanding of the cycle of malnutrition and the fundamental causes.	Concern: - Working sessions with UNICEF and USAID. - Revise current activity model. DHT: Undertake advocacy actions with all partners for integrated programming.	Concern, MoH, UNICEF.
SO 2: Key family practices adopted at the household level				
Most of the KFP adopted and in use.	Multiple and intense messaging strategy is effective. Some KFP need more attention.	Review/update DOER-NON-DOER exercise to revise, reinforce non-performing KFPs.	Design a modified Formative Research exercise. Animators implement in the course of their work.	Concern
CGs performing at high rate of productivity.	CG model is effective and highly valued. Some deviations in structure may have adverse effects. Ambiguities about how CGs should be 'governed' and supported may hinder future development.	– Continue current level of support and development. – Review and adhere to basic criteria for CGs. – Pursue the intention to divide CG members into 'specialty groups' to avoid over-burden. – Explore potential 'ownership' models.	– As new CGs are formed, reinforce the parameters and criteria for effective CGs. – Refresher sessions for animators on constitution of CGs. – Develop task descriptions for 'specialist' areas. – Engage the COGES in discussions on CG mgt. and support.	Concern COGES
Radio message reach matched reported listening patterns, but may have missed mobile phone-as radio potential.	Mass and folk media messaging potential was under-planned and under-used.	Make better use of the popular media channels (radio, drama, songs) to transmit KFP messages.	– Study up on the use of entertainment education. – Devise a deliberate MFM strategy that includes monitoring, sentinel listening /observing, community engagement	Consultant? Concern CSO

One-off theatre events had tremendous success.			(schools?).	
Enhanced self-image among women participants due to service role and results.	The project has provided a route to empowerment which appears to be acceptable in the cultural context.	Promote the self-esteem and social recognition benefits gained by women's involvement.	– Conduct a discreet study to examine this in more depth. – Distil LL and transfer some elements for behavior change among men. – Explore additive initiatives that provide a means for women to respond to community needs.	TA-Consultant? Concern
SO 3: Improved district performance in delivery of essential CHN services				
LYCSP inputs and indicators did not correspond to mgt. and governance measurement.	Inconclusive evidence that LYCSP has tangibly improved DHT performance. Ownership of project outputs is not evident.	– Revise the type of assistance to provide to DHT in their capacity as overseer of quality improvement and service delivery. – Change the 'partner dynamic' to diminish complacency in MoH/DHT/RDPH regarding stewardship and ownership.	DHT: – Build a component in the Action Plan for instituting quality of care mentoring and measurement processes of the DHT Concern: – Re-engage the DHT to jointly study their administration, management and governance responsibilities. – Develop a plan to address weaknesses. – Identify professional expertise to mentor.	Concern TA - Consultant?
DHT problem-solving ability rated mediocre.	Anecdotal information that DHT administrative mgt still needs considerable work. Tacit assumption that the NGO partner will resolve issues.			
Key admin practices at HC and HP levels improved.	Despite not reaching targets, general trend is good, but needs constant attention.	Make greater effort to involve DHT in the results of coaching and supervision exercises.	– Consultations with DHT on recurring performance problems. – Joint refresher sessions btx NS and health personnel. –	Concern
Frontline data transmission system is not operational.	Poor management of the activity over the life of project. Bottleneck is human, rather than technology.	Concern: Engage at the level of RDPH to get Frontline system on the 'to-do' agenda, and gain real buy-in. DHT: Take the lead in re-vitalizing the use of FRONTLINE data collection system.	Concern with DHT: Working sessions to better i.d. resistance. Re-train health personnel, include project NS. Explore SMS payment options. DHT: Host refresher training for field users, assigning coaching/mentoring responsibilities to the DHT Information System manager, and other measures as needed.	RDPH DHT Concern
Project databases for information management and	Limits the impact that analysis from triangulated data can	Develop an information management and use model that is responsive to needs	– Hasten the process underway to digitalize data entry and	Concern

use are not fully operational, and access to data is unwieldy.	have for reporting and decision-making. When this is not happening within the project, it is not being shared with the partner.	and indicative for changes, program growth.	triangulation. – Working sessions to design the operational route for data sharing.	
COGES/COSAN have improved performance in some task areas, and are recognized as stakeholders in community health systems.	COGES/COSAN are an important element to build and maintain community engagement in healthcare, but without more deliberate support may lose influence and credibility.	– Reinforce the role and authority of the COGES/ COSAN to DHT. – Examine how the COGES/COSAN models can yield more and better results. – Re-dynamize those COGES/COSAN that are quasi-functional.	– More and better trainings, working sessions with COGES/COSAN. – Identify the specific role of DHT in oversight and governance issues to assist COGES in tasks. – Mount a short-term campaign to promote membership to COGES/COSAN.	Concern, DHT, COGES Leadership.
SO 4: Improved child health and nutrition policy environment				
The objective was not attained.	– Project activities do not correspond to expected results. – Outputs are standard requirements of a project of this type.	– Define what policy the project really wants to champion. – Devise a policy adoption strategy and implement it. – Package the OR results according to guidelines for policy advocacy. – Tease out the unique qualities of MLs and justify the success of iCCM based on this.	Concern: – Research health policy development. – Study the HKI zinc protocol policy adoption (2006) for ideas. – Open a dedicated activity and budget line for this. – Finalize the OR results. RDPH/DHT: - Fully participate in, and advocate strongly for the development of a policy paper and process for the adoption of the iCCM/ML approach.	TA- consultant? Concern Health Advisor
OR results were not ready in time to use for advocacy during life of project.	- The OR model does not have a plan how to translate the evidence into a policy product. - The OR model does not in itself prove that iCCM is effective due to the unique ML model, over other volunteer models.			
		UNICEF, as funder of on-going activities, should become thoroughly acquainted with the CG and ML model and parameters so as not to 'dilute' key elements that are fundamental to its success (e.g., ratio of villages,<>animators, ratio of MLs <>HHs).	Study foundational documents on the concept of Care Groups. Visit CGs and MLs in action. Hold FGDs with Concern CADs to discuss parameters and constraints.	UNICEF
		The upcoming expansion of Niger's USAID Health Unit is opportunity to do a desk review of Child Survival projects in Niger and glean lessons learned for future programming.	USAID find an opportunity to do a post-project field visit to become acquainted with the challenges and opportunities faced by NGO partners.	USAID