Endline Evaluation

Emergency WASH, Nutrition and Protection Assistance Project to Conflict Affected People in Borno State, North East Nigeria

September 2019

International Medical Corps- Nigeria

1.1 List of Acronyms

BSFP	Blanket Supplementary Feeding Program
CG	Care Group
CMAM	Community-based Management of Acute Malnutrition
ENA	Emergency Nutrition Assessment
OFDA	Office of Foreign Disaster Assistance
IDP	Internally Displaced Persons
FGD	Focus Group Discussion
GAM	Global Acute Malnutrition
IMC	International Medical Corps
IYCF	Infant and Young Child Feeding
IPC	Integrated Phase Classification
LGA	Local Government Areas
NFI	Non Food Item
MMC	Maiduguri Metropolitan Council

1.2 List of figures

Figure 1: Children Assessed by LGA (0-23months) 10
Figure 2: Frequency of five critical handwashing times mentioned by respondents 12
Figure 3: Generic IYCF Household Survey Questionnaire 20
Figure 4: WASH household questionnaire 20

1.3 List of Tables

Table 1: Distribution of communities by LGA 3
Table 2: WASH Sample Size 7
Table 3: IYCF Sample Size.... 8
Table 4: Children between ages 0- 23 months assessed 10
Table 5: Foods and liquids infants 0-5 months were fed with breast milk 10
Table 6: Percentages of times at least any of the 7 food groups were consumed by children 6-23months 11
Table 7: Number of beneficiaries assessed at WASH household level....11
Table 8: Litre of water used by respondent household.... 12
Table 9: Indicators – WASH 12
Table 10: Indicators – Protection 13
Table 11: Indicators – Nutrition 13

Table 12: IYCF household survey locations.....19
Table 13: WASH household survey locations.....19
Table 14: Qualities data collection types of respondents and locations.....20

1.4 Executive Summary

International Medical Corps (IMC), with funding from USAID/OFDA, implemented the 'Emergency WASH, Nutrition and Protection Assistance Project to Conflict Affected People in Borno State, North East Nigeria' in four (4) local Government Areas (LGAs) of Borno State. The project was implemented to ensure that conflict affected people had access to water, sanitation and hygiene (WASH) promotion services; to increase protection for women and girls; to provide critical response services for survivors of GBV; and to prevent and reduce morbidity/mortality resulting from Acute Malnutrition among children (0-59 months) through the provision of Community-based Management of Acute Malnutrition (CMAM) and Infant and Young Child Feeding (IYCF) in Damboa, Maiduguri, Jere, and Konduga LGAs, Borno State.

The endline evaluation was conducted to evaluate the project's implementation and to measure its impact on the targeted beneficiaries by assessing the project's achievement on its outputs and outcomes. The results of the endline evaluation are vital in determining the success of the intervention in achieving the project objectives.

The endline evaluation was designed as a "before-and-after" mixed methodology study to assess the extent that the project contributed to achieving its proposed results, contribute to improving the lives of the project beneficiaries and evaluate lessons learned for future programming. The mixed methods approach involved the use of both qualitative and quantitative tools. In all, 2,112 households (1,440 IYCF and 672 WASH) were targeted for interviews. Eight (8) Focus Group Discussions (FGD) were conducted with lactating women in eight (8) communities where IYCF program was implemented to further understand the variations and practices on breastfeeding of infants. An additional 25 sessions of Key Informant Interviews (KII) were conducted with community leaders (n = 14) and IMC staff (n = 11); the IMC staff included: Program Director, Program Coordinators from nutrition, WASH and GBV and Program Officers based in both the Maiduguri and Damboa field offices.

1.5 Introduction

In August 2019, Matma Plus Consult Nigeria (MPC NG) was contracted by International Medical Corps to conduct an endline evaluation of a project funded by the Office of United States Foreign Disaster Assistance (OFDA). This report presents the findings of the final evaluation. The report is divided into four sections. Section 1 gives an overview of the OFDA funded project, an update on the emergency situation in North East Nigeria, and the objectives of the evaluation. The methodology employed in conducting the evaluation is presented in section 2, whilst section 3 covers the findings of the evaluation. The findings are presented in line with the DAC criteria for evaluation, which is based on the conception that an evaluation is an assessment "to determine the relevance and fulfilment of objectives, developmental efficiency, effectiveness, impact and sustainability". The conclusions and recommendations of the evaluation are presented in the section 4.

1.6 Background

1.6.1 Overview of the IMC OFDA funded project

The conflict in North East Nigeria has now entered its tenth year with over 1.8 million people displaced and facing large-scale humanitarian needs. In addition, the loss of livelihood and destruction to infrastructure have further threatened the survival among this vulnerable population. Humanitarian assistance is needed to support the WASH, Health, Protection, Food Security and Nutrition needs of 6.1 million people to guarantee their survival, basic human rights and dignity. Prior to the conflict, up to 80% of the population relied on crop and animal production as their primary source of livelihood. Now, these people depend on food assistance programs to meet their minimum daily food needs. The high level of food insecurity is directly linked to the burden of acute malnutrition. The four LGAs proposed in this project account for 40% of the total SAM burden projected for Borno in 2018 (Damboa (7,620), Jere (24,590), Konduga (9,451), and Maiduguri (41,725).

With the support of OFDA in 2019, International Medical Corps implemented a project to provide WASH, nutrition, and GBV services to vulnerable IDPs and host populations in and outside IDP camps in 4 LGAs of Borno State. In terms of nutrition, prior to the project, IMC was already implementing CMAM alongside the emergency food assistance program in Damboa, Maiduguri and Jere in partnership with World Food Program (WFP). The project with OFDA in 2019 expanded on this program and was integrated into the emergency food assistance activities as a multi-pronged strategy to secure a sustained reduction in incidence, morbidity and mortality due to acute malnutrition. This guaranteed a continuum of care for households (HH) and ensured access to food commodities to reduce vulnerability to acute malnutrition, and the availability of treatment services to prevent mortality and long-term complications. IMC also worked in close coordination with the State Ministry of Health and the nutrition sector to operate 26 Outpatient Therapeutic centres in Damboa, Maiduguri, Jere and Konduga Local Government Areas (LGAs) targeting 22,939 children with Severe Acute Malnutrition (SAM). One Stabilization Centre was supported in Damboa to provide treatment for SAM among children under 5 years of age. The Care Group Model was a hallmark of IMC's Social and Behavioural Change Communication strategy to promote IYCF-iE. IMC also leveraged its BSFP and strengthened referrals to provide linkages for treatment of Moderate Acute Malnutrition.

As reported in the 2018 Humanitarian Response Plan (HRP), approximately 28% of IDPs do not have access to adequate safe water for cooking, drinking and other domestic use. To address gaps in access to safe water, IMC conducted water trucking in Damboa, while in Maiduguri, water systems were maintained and rehabilitated and equipped with solar systems as alternative power sources. Water monitors were trained and supervised to conduct community based water quality management across all the sites to ensure safe water access. IMC provided water testing materials and HH water treatment chemicals. Community participation and ownership in the governance of water and sanitation infrastructure was a priority of the WASH intervention to ensure sustainability and maintenance of the WASH facilities. Sanitation (latrine and shower) coverage in the areas covered by the project were below the Sphere standards. As a result, IMC prioritized latrine desludging and repair to keep the latrines usable. IMC also procured laundry and bathing soap to distribute for hygiene promotion and reusable sanitary pads for women and girls in the target IDP camps for Menstrual Hygiene Management.

As of 2018, approximately 2.4 million people are in need of GBV response services in Borno, Adamawa and Yobe States (HRP 2018). Prolonged uncertainty and shrinking resources have also led to new vulnerabilities, including exposure to sexual exploitation and abuse (SEA), survival sex, and opportunistic violence perpetrated by community members as IDPs live in crowded conditions without appropriate safeguards. In this context, GBV incidents remain significantly under reported, underscoring the need for active community sensitization and improving access to GBV response services. IMC is one of the few partners recognized by the GBV subsector in providing comprehensive GBV response services in Northeast Nigeria. To date, with the support of OFDA and other donors, IMC has established 21 Women Friendly Spaces (Damboa 3, Maiduguri 15, and Dikwa 3) to provide access to GBV response services. With the support of OFDA in 2019, IMC supported 3 WFS in Damboa, 5 WFS and one health facility GBV service centre in Maiduguri for GBV survivors and vulnerable women/girls to receive GBV case management and psychosocial support. IMC is developing a complementary project with WFP that will strengthen the livelihood component of the PSS intervention.

1.6.2 Overview of the emergency situation in North East Nigeria

With a population of approximately 197 million, Nigeria accounts for about 47% of West Africa's population, and has one of the largest populations of youth in the world. A federation that consists of 36 states, Nigeria is a multi-ethnic and culturally diverse society. With an abundance of resources, it is Africa's biggest exporter of oil, and has the largest natural gas reserves on the continent.

The nine years of insurgency and armed attacks carried out by Boko Haram (BH), also known as Jama'atuAhlis Sunna Lidda Awatial-Jihad, on civilians since 2009 in the North-East Nigeria has affected over 15 million people. More than 20,000 people have been killed and over 4,000 women and girls abducted since the conflict began ten years ago[1]. An estimated 7.7 million people in the three most affected states of Borno, Adamawa and Yobe now depend on humanitarian assistance for their survival.

In 2016 and 2017, in close cooperation with the Government of Nigeria, the humanitarian community provided life-saving assistance and helped stabilize living conditions for millions of people. In 2017, the response was scaled up and as of October 2018, humanitarian partners had reached 5.6 million people. Some major successes were achieved, including a decrease in the number of food insecure people from 5.1 million to 3.9 million, the rapid containment of the cholera outbreak through the innovative use of an oral cholera vaccine, and improved agricultural production through assistance to 1.3 million farmers. These results can be attributed to strong coordination, extensive engagement and generous funding. The Government of Nigeria succeeded in stabilizing several regions in mid-2017 that enabled the humanitarian community to provide much-needed life-saving assistance[2].

As reported in UNCHR's Displacement Tracking Matrix (DTM) in May 29 2019, the estimated number of IDPs in conflict affected northeastern Nigerian states of Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe States was 1,980,036 people, or 392,019 households. The figure represents a nominal increase of 31,687 (less than 2%) compared to the DTM assessment conducted in January 2019. The most-affected state is Borno state, which continues to host the highest number of IDPs, with 1,467,908 IDPs residing in the state as per Round 27 of the DTM. The total number of IDPs observed in Round 27 represented a 2 per cent increase (32,091 IDPs) from the 1,435,817 IDPs that were recorded in Borno during Round 26 assessment. The increase the IDP population between Round 26 and Round 27 can be contributed to the increase in insecurity over the period. In addition, the figure is an underestimate of the total IDPs in Borno state due to the lack of data from LGAs which remain inaccessible due to the security situation, including Kala/Balge, Kukawa and Guzamala.

[1] ACAPS Thematic Report 2017 Nigeria; Protection in the Northeast

[2] https://reliefweb.int/report/nigeria/nigeria-humanitarian-response-plan-january-december-2018

Table 1: Distribution of communities by LGA

LGA	Number of communities	Percentage
Damboa	18	64%
MMC	3	11%
Jere	6	21%
Konduga	1	4%

1.6.3 Purpose and scope of the evaluation

The endline evaluation was conducted to assess the project performance and analyse the key criteria of evaluation in emergency contexts such as effectiveness, relevance, coverage, and expected/unexpected effects on targeted communities. In addition, this assessment also provides recommendations of priority areas of need and direction for future programming in the areas of WASH, GBV and Nutrition for the IDPs and host communities in Maiduguri and Damboa in Borno State. The evaluation included both quantitative and qualitative approaches such as WASH and IYCF household surveys inform practical and sustainable recommendations based on the survey findings.
The scope of the evaluation was as follows:

1. Project Timeframe: July 1, 2018 – June 30, 2019
2. Geographical Coverage: Maiduguri Metropolitan Council (MMC), Konduga, Jere and Damboa in Borno State, Nigeria
3. Target groups: primary and secondary beneficiaries as well as broader stakeholders
4. Human Resources: A consultant, supported by IMC M&E staff, conducted the evaluation. The consultant and the IMC M&E Coordinator worked as a team to support each other in developing methodologies, tools and approaches of the evaluation. The team worked to organize and conduct Key Informant Interview (KII) with relevant stakeholders, training for enumerators, data collection/validation, data analysis and interpretation and finalization of report.

The overall objectives of the evaluation were to:'

1. Evaluate the project in terms of effectiveness, relevance, efficiency, coverage and impact, with a strong focus on assessing the results against the project's outcome and project goals;
2. Generate key lessons and identify promising practices in humanitarian work for learning purposes;
3. Undertake a comparative assessment on the progress achieved in delivering the program results and to identify key successes, gaps, and constraints that need to be addressed.
4. Document good practices and generate evidence-based lessons learned and actionable recommendations to strengthen the strategies of ongoing and future programs.

2. Methodology

The evaluation was designed as a "before and after" mixed methods study to compare the situation of the beneficiaries before and after the project. The mixed methods approach involved the use of both qualitative and quantitative methods. The quantitative methodology was used to quantify achievements against the targets as per the project's indicators while a qualitative methodology was employed to develop a deeper understanding of the relevance of the project interventions. The methodology also included the collection and review of secondary data.

2.1 Qualitative data collection

Qualitative data was collected through focus group discussions (FGD) and key informant interviews. The FGDs were held with pregnant and lactating mothers in communities. The focus groups were designed to assess the

developments and changes in the perception of participants in the project's intervention areas, and as a holistic and participatory approach whereby participants assessed project activities, outcomes and impacts. It also provided insight into some of the barriers affecting nutrition and hygiene practices amongst the projects' beneficiaries.

Selected by IMC project staff, community leaders served as the key informants and were interviewed using a key informant interview (KII) guide. The guide for each group of respondents focused on the roles they played in the project. The questions included critical reflection that allowed respondents to mediate on both project success and challenges and to capture new knowledge and actions for future projects.

In total, 8 FGDs and 25 KII were conducted as part of the evaluation. During the focus groups and KIIs, inquires focused first on what worked well within the project and what beneficiaries would like to see more of. These elements were translated into a Strengths and Opportunities, Weaknesses and Threats (SWOT) Analysis which will inform and enhance the sustainability and development of future phases of the project.

2.2 Quantitative data collection

The quantitative data was collected using a WASH household questionnaire and IYCF generic household questionnaire. The tool was administered using an electronic mobile phone platform (Kobo Tool Box). The mobile application was chosen to ensure the quality of the data collected, improve data integrity, reduce human error during data entry, and ensure data security.

WASH household beneficiaries and IYCF households with children 0-23 months were selected for the household surveys. The respondents for the household questionnaire were the head of household or any representative of the household above the age of 17, and caregiver/mother of children between the ages of 0-23 months for IYCF.

The household questionnaire was used to collect information on the key project results at the outcome level and contained questions pertaining to the WASH and nutrition sector. This included information on the socio demographic characteristics of the respondents.

2.3 Sample size determination

The sample size adopted the same methodology for both WASH and IYCF household survey as was used at baseline. The sample sizes are outlined below:

For WASH, 672 households were included in the sampling unit. The sampling size was sufficient and representative enough to allow reasonable levels of certainty that findings are representative of target population in the two LGAs.

Table 2: WASH Sample size

No of Households:	N	51598	(Number of households in the project area covered by the survey).
Error risk parameter:	Z	1.96	1.96 For 95% confidence interval.
95%CI :	D	3.8%	+/-3.8 % systematic random sampling
Percentage	P	50%	Prevalence rate
Actual number of samples needed:	N		$n= \quad z2\ p(1-p)$

			d2
No. of HH targeted:	N	672	Target number of households to interview.

During the enumeration, a sample size was assigned to the communities proportionally and then a systematic random sample was used to select the households in each unit.

For IYCF, the sample size of two OFDA indicators, exclusive breastfeeding under 6 months and minimum dietary diversity, was calculated based on the prevalence rates from a survey conducted by Save the Children[3] (point 1). The target for the OFDA project (point 2) was based on the CARE guidelines on IYCF surveys.[4] Using the prevalence rates of point 1 and 2, the sample size for each indicator was calculated separately. The highest sample size between the two indicators was used for the survey. Using the point estimates for prevalence both OFDA indicators the sample size below: The following other variables were used to calculate the sample size.

Table 3:IYCF Sample size

Indicator	Estimated prevalence, point 1	Estimated prevalence, point 2	Number of persons to select per group
Exclusive breastfeeding under 6 months	19%	30%	360
Minimum dietary diversity	13%	40%	63
Precision	95%		
Power	80		
Design effect	1.5		
Number of clusters	30		
Total sample size (360x4)	1440 (The sample size for exclusive breastfeeding which has the larger sample from the calculation is then multiplied by 4 to account for the 4 age groups		
Number of children per cluster	48		

2.4 Sampling criteria

[3] Save the Children, Nutrition and mortality survey report, Borno state, August 2018

4 Infant and young child feeding practices. Collecting and Using Data: A Step-by-Step Guide. Care USA, Jan 2010.

For the IYCF survey, since the focus is on children between the ages of 0-23 months, the primary caregiver (mothers) in the household were asked questions on child feeding and food intake patterns. This method used a multi-stage sampling technique, which involved two stages:

Stage One: With a list of the areas and population, a random selection of 30 clusters. The total population of study was divided into small distinct units. At this stage, the primary unit of the selection was the community/village. The clusters were randomly selected from communities/ villages using according to their population proportion.

Stage Two**:** To determine how many children 0-23 months of age were selected per cluster. With a sample size of 1,440, data was collected from 30 clusters, having 48 children per cluster. For each cluster, the team arrived at the first household, and identified a least one child 0-23 months of age for the survey. The team continued with the surrounding households, identifying children 0-23 months until the cluster limit was reached.

2.5 Consent process and ethical consideration

Consent of all respondents was sought before interviews. The consent process involved explaining the nature of the evaluation, confidentiality issues, the time the interview will take place and the risk involved. Where children were too young to provide consent, consent was provided from their respective guardians.

The information collected from the respondents was handled confidentially and the views of any individual respondent cannot be traced to him/her. The training of the data collectors covered topics on research ethics with different target groups, and how to interview and ensuring confidentiality.

2.6 Recruitment and training of local data collectors

Local data collectors from the LGAs were recruited to support the collection of the data, especially the household data. The recruited data collectors were trained in the sampling methodology, how to use the mobile app and on the data collection tools. The training also covered research ethic and conducting research with breast feeding mothers. In all we recruited and trained 20 data collectors in MMC, Jere and Konduga and 10 in Damboa.

2.7 Data analysis and report writing

An electronic mobile app (Kobo Collect) was used for the collection of the quantitative data. The use of the electronic mobile app helped to limit data collection errors.

Quantitative data was analysed with MS Excel and SPSS. Descriptive statistics were used to describe the basic features of the data collected. Summary results about the data collected is presented in charts and tables with a narration below.

The analysis also focused on comparing the evaluation results with that of the baseline. The report was presented according to the format provided in the ToR.

3.1 Findings

3.1.1 Nutrition

Figure 1: Children Assessed by LGA (0-23months)

Sex	No	Yes	Total
Female	139 (94.56%)	8 (5.44%)	147
Male	157(94.58%)	9 (5.42%)	166
Total	296(94.6%)	17 (5.4%)	313

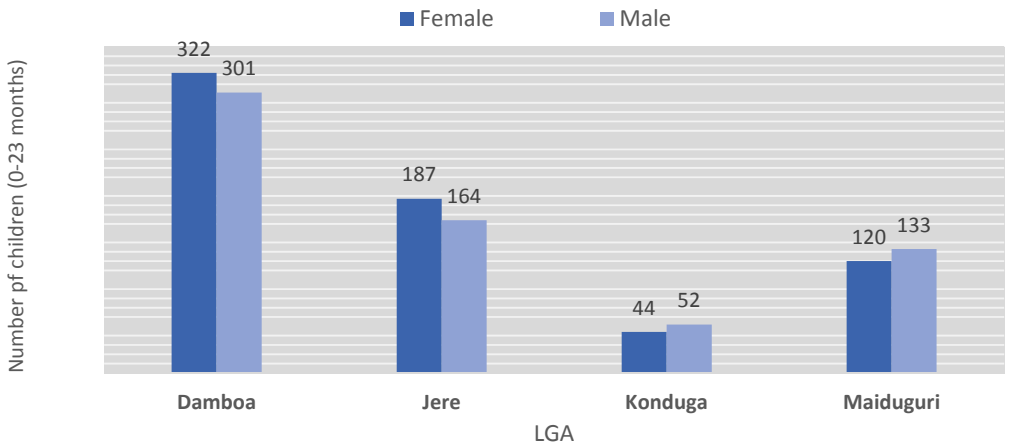


Table 4: Children between ages 0- 23 months assessed

Age in months	Male	Female	Total %
0-5	166	147	24.9
6-11	190	180	29.4
12-17	182	185	29.2
18-23	87	122	16.6
Total	625	634	100

In total 1440, children were assessed, including 1259 children aged between 0-23 months. The rest of the children (181) were aged between 24-36 months and were not included in the analysis and presentation of these findings.

Table 5: Foods and liquids infants 0-5 months were fed with breast milk

	Age Group in Months			
Foods/Liquids	0-1	2-3	4-5	Total
ORS	10(20%)	19(37%)	22(43%)	51(13.0%)
Plain water	39(29%)	52(39%)	43(32%)	134(34.2%)
Infant formula	23(38%)	189 (30%)	20(33%)	61(15.6%)
Milk	11(20%)	20(37%)	23(43%)	54(13.8%)
Juice or juice drinks	1 (5%)	6(30%)	13(65%)	20(5.1%)
Other water-based liquids	7(21%)	11 (33%)	15(45%)	33(8.4%)
Sour milk or yogurt	4(22%)	8(44%)	6(33%)	18(4.6%)
Thin porridge	5(24%)	10(48%)	6(29%)	21(5.4%)

Proportion of children 6-23 months of age who receive foods from four or more food groups, by sex (MDD)
41.9% of the children between 6-23 months of age assessed were fed solids and semi solids from at least from four food groups. A breakdown of the ages could be found in figure 4. Percentages of food feed to children 6-23 month is in the table below.

Table 6: Percentages of times at least any of the 7 food groups were consumed by children 6-23months

	Age in months			
Food Score	6-11	12-17	18-23	Total
0	22%	8%	4%	13%
1	21%	14%	5%	15%
2	12%	16%	15%	14%
3	13%	15%	25%	16%
4	11%	20%	17%	16%
5	9%	8%	12%	9%
6	4%	7%	12%	7%
7	8%	12%	10%	10%

3.1.2 Water, Sanitation and Hygiene

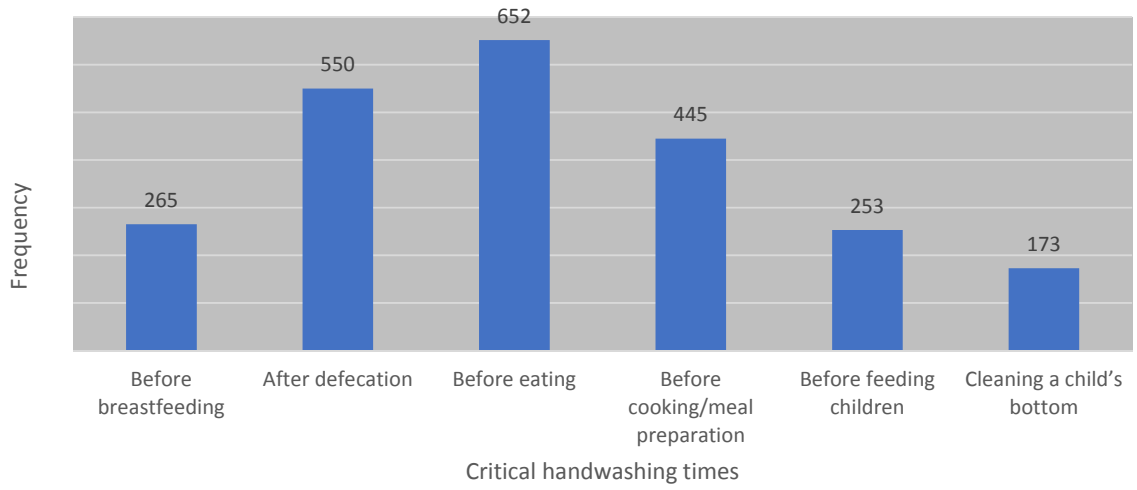
Overall 85% of the respondents assessed were female, while 15% of them were male. The average household size across the camps assessed between Damboa and Maiduguri was 6 (5 Damboa, 7 Maiduguri). The population of the households assessed according to their age groups is found in the table below:

Table 7: Number of beneficiaries assessed at WASH household level

Age Group	Total Number of people	Percentage
Male less than 5yrs	636	16.4%
Female less than 5yrs	530	13.6%
Male between 5-18yrs	711	18.3%
Female between 5-18yrs	630	16.2%
Male above18yrs	629	16.2%
Female above18yrs	748	19.3%

Hand Washing Practices
Across the two LGA's 90.5% of the respondents could mention at least 3 critical handwashing times. 9.5% could only mention between 1 to 2 of the five critical handwashing times. A breakdown of the frequency of the handwashing times mentioned by respondents is included the figure below.

Figure 2: Frequency of five critical handwashing times mentioned by respondents



Drinking Water Storage

From observation across the two LGAs, 81% (544) of the respondents' stored their drinking water in clean containers after fetching from the source. The common container used in storing this drinking water is either a used paint bucket or Jerry can.

Drinking water storage in a clean and protected container?	No	Yes
	127 (19%)	545 (81%)

Functional handwashing facility within the defecation site

90 percent of the respondents have a local kettle within their tents, however on closer observation for functional handwashing facilities within the communal latrines, less than 50 percent of them (41. 2%) are functional within the camps assessed.

Litre of water and Source of water for household use

The average number of litres of water per person per household is approximately 20 litres per person across the households assessed in the two LGA's. About 96.7% (656) of the household assessed fetch water for household use from an improved water source.

Table 8: Litre of water used by respondent household

Litre	Number of respondent	Percentage Respondent
0-14	233	34.67%
15-29	329	48.96%
30-44	82	12.20%
45-59	21	3.13%
60-74	4	0.60%
75-90	3	0.45%
Total	**672**	**100.0%**

The delivery of outputs is central to the achievement of project results. The evaluation analysed the extent to which the project outputs and outcome indicators for each sector was achieved as shown in table 9, 10, and 11.

Table 9: Indicators – Nutrition

Outputs – Nutrition	Target	Baseline	Endline	% of target met
IYCF				
Proportion of infants 0-5 months of age who are fed exclusively with breast milk, by sex	15%	7.1%	5.4%	36%
Proportion of children 6-23 months of age who receive foods from 4 or more food groups, by sex	40%	46.4%	41.90%	100.75%
Number of people receiving behavior change interventions to improve infant and young child feeding practices	9259	30898	12988	140%
CMAM				
Number of health care staff trained in the prevention and management of acute malnutrition, by sex	150	0	153	102%
Number of supported sites managing acute malnutrition, Type of Facility (OTP, SFP, SC	27	27	27	100%
Number of people screened for malnutrition by community outreach workers, by sex; age : children ≤5, PLWs (10-14, 15-19, 20-49, 50+)	60000	0	133,701	223%

Table 10: Indicators – WASH

Outputs – WASH	Target	Baseline	Endline	% of target met
	Environmental Health			
Number of people receiving improved service quality from solid waste management, drainage, or vector control activities (without double Counting) by sex	51598	0	59720	116%
Average number of community cleanup/debris removal activities conducted per community targeted by the environmental health program, N/A	240	0	200	83%
Average number of communal solid waste disposal sites created and in use per community targeted by the environmental health program, N/A	150	0	165	110%
Hygiene				
Number of people receiving direct hygiene promotion (excluding mass media campaigns and without double-counting) by sex	50050	0	55935	112%
Percent of people targeted by the hygiene promotion program who know at least three (3) of the five (5) critical times to wash hands by sex	90%	78.7%	90.5%	101%
Percent of households targeted by the hygiene promotion program who store their drinking water safely in clean containers, N/A	65%	51%	81.1%	125%
Sanitation				

Number of people directly utilizing improved sanitation services provided with OFDA funding by sex	51598	0	56216	109%
Percent of latrines/defecation sites in the target population with hand washing facilities that are functional and in use by type (households, public)	25%	21%	41.2%	165%
Number of people per safe bathing facility completed in target population, N/A	60	0	68	113%
Percent of excreta disposal facilities built or rehabilitated in health facilities that are clean and functional, N/A	100%	0%	0	0%
Water Supply				
Number of people directly utilizing improved water services provided with OFDA funding, by sex	51598		65,670	127%
Average liters/person/day collected from all sources for drinking, cooking, and hygiene, N/A	15	28	20	133%
Percent of households targeted by WASH program that are collecting all water for drinking, cooking, and hygiene from improved water sources, N/A	95%	87%	97.6%	102%.
Percent of households whose drinking water supplies have a free residual chlorine (FRC) > 0.2 mg/L	80%	87%	92%	115%
Percent of water points developed, repaired, or rehabilitated with 0 fecal coliforms per 100 ml sample, N/A	80%	70%	100%	125%
Percent of water user committees created and/or trained by the WASH program that are active for at least three (3) months after training, by sex	80%	0%	100%	125%
NFI				
Total number of people receiving WASH NFIs assistance through all modalities (without double-counting)	30000	0	12252	41%
Percent of households reporting satisfaction with the contents of the WASH NFIs received through direct distribution (i.e. kits) or vouchers	80%	0%	89%	111%
Percent of households reporting satisfaction with the quantity of WASH NFIs received through direct distribution	80%	0%	96%	120%

Table 11: Indicators – Protection

Outputs – Protection	Target	Baseline	Endline	% of target met
Prevention and response to Gender Based Violence				
Number of individuals accessing GBV response services, by sex; age: <5, 5-9, 10-14, 15-19, 20-49, 50+	1780	822	681	38%

Number of dollars allocated for GBV programming, USD amount	410,135	0	331,934	81%
Number of individuals accessing GBV risk mitigation activities, by sex; age: <5, 5-9, 10-14, 15-19, 20-49, 50+	4450	4575	85669	1925%
Percentage of rape survivors who report within 72 hours of incidents and are referred for appropriate clinical care	100%	100%	80%	80%
Number of vulnerable women and girls participating in PSS and empowerment activities in WFS, by age: <5, 5-9, 10-14, 15-19, 20-49, 50+	1440	3404	1940	135%

This section elaborates on the findings that came from this evaluation. The findings are presented based on the five OECD/DAC evaluation criteria, which include relevance, effectiveness, efficiency, impact and sustainability. The OECD DAC criteria assesses the extent to which objectives of an intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies.[5]

3.2.1 Relevance

The evaluation team concludes that the USAID/OFDA project connected all the three (3) strategic objectives of the Nigeria 2018 Humanitarian Response Plan (HRP). For example, Strategic Objective 3 of the USAID/OFDA project aimed to increase protection for women and girls and provide critical response services for survivors of GBV. This was in line with the Strategic Objective 1 of the HRP 2018 which aimed at providing lifesaving activities and alleviating suffering through integrated and coordinated humanitarian response focusing on the most vulnerable people.

To a greater extent, the USAID/OFDA project was also aligned with the priority humanitarian concerns of Nigeria. The project addressed the urgent needs of vulnerable people by implementing interventions focused on promoting the protection, nutrition and WASH/NFIs among the most vulnerable populations. The populations included children, pregnant women, lactating mothers and boys and men in Borno State. At the completion of the project interventions, 228,342 beneficiaries were supported with WASH, nutrition, and protection services. This included, 65,670 beneficiaries supported with improved access to water, safe excreta disposal infrastructure and access to solid waste management systems, 248,752 people reached with GBV prevention and response services, and 133,701 people reached by nutrition support, including the admission of 6,484 children aged 6-59 months to CMAM and screening of 107,294 people for acute malnutrition. The implementation of a multi-sectorial project contributed to ensuring that beneficiaries received lifesaving and integrated support that contributed to alleviating their suffering.

Findings from KIIs revealed that water shortages, malnutrition especially among young children, and rampant cases of sexual and gender based violence (SGBV) were among some of the most serious challenges before the project was implemented. Internally displaced persons (IDP) camps in particular were reported to have a high incidence of rape cases, denial of resources and other domestic violence when compared to host communities.

The project contributed to addressing these challenges through WASH, nutrition and GBV services. These services included, but were not limited to: water supply, sanitation, hygiene promotion and solid waste management services through the installation and renovation of WASH infrastructure, community mobilization, sensitization activities, and distribution of non-food items (i.e. hygiene kits and waste bins); screening of children and referral for management of Severe Acute Malnutrition in OTPs, referral to in-patient care for severely malnourished children with medical complications, sensitization on exclusive breastfeeding for children of 0-5 months, health

[5] http://www.oecd.org/development/evaluation/dcdndep/36596604.pdf

care promotion and referral for services of children and lactating mothers; and sensitization against Gender Based Violence, knowledge and skill acquisition for GBV survivors, and distribution of relief materials.

3.2.2 Effectiveness

The evaluation demonstrated that there was a strong and effective M&E system in place, which generated quality and timely data to inform decision making. As part of the M&E system, a baseline was conducted for the GBV, WASH and Nutrition sectors. The M&E system was supported by accountability mechanisms for affected person that allowed beneficiaries and staff to give feedback on IMC's activities. There was however need for improvement regarding how the information generated by the M&E systems and the accountability mechanism was used in decision-making.

The project made significant improvement in mitigating the harmful effects of violence and displacement on the IDPs and host communities. This was achieved through improvement in their safety and protection and improved access to WASH infrastructure and nutrition services. The improvement in access to water was significant with 94% of the beneficiaries having potable water within 500 meters from their homes.

3.2.3 Efficiency

In both the design and implementation of the project, IMC took steps to ensure that the project was efficient. The project design allowed IMC to train and work with selected community members as volunteers in all the sectors. The use of the volunteers enabled IMC to increase community mobilization the reach of the project.

From its inception, communities were involved in the planning of the project interventions. Lawans and Bulamas, which are the primary community leaders were engaged series of meetings. Community volunteers were engaged in each beneficiary community during the implementation of the project.

Communities were given opportunities to provide feedback, which informed IMC of beneficiary satisfaction. The feedback mechanism was appropriate, however, IMC could still improve by having a dedicated person employed to be in communities to increase its capacity to field and address feedback.

Spaces were identified within the communities for establishment of women-friendly spaces. In the General Hospital in Damboa, a meeting point was established within the hospital building, and shades were also used during distribution of materials to promote the safety and dignity of beneficiaries accessing IMC's services.

3.2.4 Impact

The impact of the OFDA project was measured by reviewing and reflecting on the project performance and achievements per indicator. Analysis of the respective achievements together with beneficiary narrations and perspectives obtained from FGDs were used to draw conclusions on the project impact. It is important to note that some of the targets set were based on existing secondary literature obtained by IMC from other humanitarian agencies, and therefore some caution has been exercised in the interpretation of achievements of targets.

The project made significant improvements in mitigating the harmful effects of violence and displacement on the IDPs and host communities. This was achieved through improvement in their safety, access to WASH infrastructure and nutrition services. There was an improvement in water, sanitation and hygiene indicators at the endline (average baseline of 53.5% compared to an average endline of 66.1%). This achievement was driven largely by the improvement in the storage of water in clean containers and improved water sources.

Women in communities where the project was implemented felt confident and began to report sexual and domestic violence, although some cases of sexual assault and rape were reported after seventy-two hours.

Key changes identified in the lives of beneficiaries included the increased awareness of women rights and mitigation of exposure to GBV risk through women's empowerment. The project's achievements included reduced level of sexual and domestic violence, increased youth support in the mitigation of violence against women and

adolescent girls, communities where husbands assist their wives with household's chores, and sustained GBV activities after the project interventions.

3.2.5 Sustainability

Involvement of community volunteers assisted in the community ownership of the project. At present , community volunteers and community leaders, who benefitted from the training conducted by IMC, are engaged in community mobilization and sensitization and awareness creation of community members on various aspects of the project. Respondents reported that that through the knowledge gained from IMC, they were able to strengthen their cooperation among each other. Their weakness however remains poverty, which does not allow them to carry out activities requiring more substantial financial resources.

3.2.6 Effectiveness of Monitoring Mechanisms in Providing Timely Data to Inform Programming Decisions

IMC used different forms of monitoring mechanisms to track project implementation. They included routine data collection on service delivery for nutrition, protection and WASH sectors; surveys conducted during implementation, indicator tracking sheets designed across sectors, customised data collection tools developed for respective sector indicators and routine field monitoring tools. A baseline was also conducted for the nutrition (IYCF) and WASH sector.

The M&E Officers under the leadership of the M&E Coordinator were largely responsible for collecting routine monitoring data in collaboration with program staff. The M&E team developed monitoring tools in collaboration with the program staff, and recruited and trained data collectors to support the data collection when it involved surveys and a large number of beneficiaries. The collected data was analysed based on the indicator definitions and the results shared with the sector leads. Some of the monitoring data collection processes for the project included Post Distribution Monitoring (PDM) for every round of distribution; a WASH household survey, water quality tests, monthly protection monitoring, safety audits, a SQUAEC Survey and mass MAUC screening. Nutrition service statistics was also collected monthly from all CMAM treatment sites. The beneficiaries were involved in collecting the required information to feed into these monitoring systems. For example, IMC trained Camp Management officials and community volunteers on how to monitor the services delivered by the service providers.

Mobile technology was employed to ensure that the monitoring information was available in a timely manner. For all surveys conducted, IMC used mobile phones and the mobile app "kobo collect" for data collection. With this method, there was reduced need for data entry and cleaning . There was an integrated M&E system, which allowed each sector to collect their monitoring data to track project outputs and other results.

4. RECOMMENDATIONS AND CONCLUSION

The exclusive breastfeeding rate among children 0-5 months was recorded at 5.4%, a decline from the baseline value which was at 7.1%, while the proportion of children 6-23 months of age who receive foods from four or more food groups was recorded at 41.5%. The low rate of exclusive breastfeeding in the project intervention area requires a barrier analysis to identify key factors that prevent mothers from exclusively breastfeeding their babies. Furthermore, most caregivers include water in their definition of exclusive breastfeeding out of fear that the infant will die or delay in growth. IYCF messages should put an immediate and increased focus on EBF through sensitization sessions and support through home visits and emphasis on the proper knowledge of exclusive breastfeeding.

For WASH, more than half of the respondents (90.5%) were reported to have knowledge of at least three of the five critical hand-washing moments, although is difficult to know if they practice these handwashing times. Less than of 50 percent of the respondents mentioned handwashing before breastfeeding (39%), before feeding children (38%) and changing a diaper (26%). This suggests that there is still need to intensify hygiene messages on handwashing particularly before feeding and changing a baby's diaper. This will help break the circle between

waterborne diseases and acute and chronic malnutrition. Availability of water was found to be sufficient in quantity with 20l/person/day, above the Sphere indicator of 15l/p/d.

From the analysis above, the evaluation concludes that while some indicators met or surpassed the targets, others need additional strategy and in order to increase low performance. There is a need to re-emphasize IMC's SBCC strategy focusing on the identified areas (EBF and handwashing before feeding a child) where knowledge and/or practices are poor.

The following recommendations have been put forward to help IMC improve its programming.

1. IMC should ensure that incentives for volunteers in the different sectors remain uniform. Giving different incentives to volunteers based on the sectors in which they work breeds dissatisfaction among the volunteers.
2. Use of community members in the identification of vulnerable groups in the community is key in efforts to reach the most vulnerable groups. However, the process should be monitored closely to avoid a situation in which community leaders and volunteers select only their favorites or their family members. The process can be further enhanced by developing a joint criterion for identifying the vulnerable groups within the community members.
3. Adopt and use Pico camera and projectors in the development and use of behavior change communication messages. This technology allows community members to develop videos on simple practices that can be used for documentary purposes at the community level.
4. IMC should consider prioritizing implementing multiple interventions in the same location. This will help increase the integrated nature of the project. In doing this, IMC should ensure that protection, which is a cross cutting theme, is implemented in all communities and also integrated across all sectors.
5. IMC should continue to build on the relationship it has with the government and INGO agencies working in the same states and sectors. This will promote complementarity.
6. Market surveys on the WASH components costs (bore holes and construction materials) should continue to be conducted prior to the review and awarding of WASH Infrastructure (latrine and borehole) contracts is to ensure efficiency.
7. IMC should consider developing a more clear criterion for setting targets for indicators in all projects and the criteria used in setting targets should be clearly documented. It is critical for the M&E team to collaborate with the sectors on the plans for the collection and use of monitoring data at the start of each project.
8. The use of an accountability to affected population (AAP) system is a great initiative that can be a source of information for improving program quality and ensuring that interventions respond to the needs of the beneficiaries. However, IMC should focus on re-assuring staff and community members that the information will not be used against them. The re-assurance process should include examples on how the information from the system has been used to improve implementation.
9. IMC should improve its vehicle management system to allow teams from different sectors to more effectively share vehicles when going to the same community for activities.

Table 12: IYCF household survey locations

LGA	Location	Latitude	longitude
Damboa	Aburi IDPs CAMP	11.16658327	12.75340205
Damboa	Afunuri	11.05536885	12.80584116
Damboa	Central IDP CAMP	11.16061951	12.75540793
Damboa	Gamsuri	11.05430624	12.81036532
Damboa	General Hospital Camp	11.16637686	12.76103872
Damboa	Hausari IDP Camp	11.16064369	12.75541152
Damboa	Lawanti	11.15795733	12.75450299
Damboa	Wavi	10.9992198	12.78240017
Jere	Dalori Quarters	11.77497338	13.21744945
Jere	Gate 4	11.80922885	13.1865696
Jere	Maimusari	11.83222145	13.18473129
Jere	Kashari	11.8550273	13.18271254
Jere	Maimusari	11.83220736	13.17986298
Jere	Mairi Kuwait	11.81925399	13.18913803
Jere	Mashamari	11.85563448	13.18375256
Jere	Shokari	11.85588444	13.18302502
Konduga	Gambori	11.842205	13.03543063
Maiduguri	Dalai lawanti	11.81044696	13.09590969
Maiduguri	DalaLawanti	11.81103279	13.09574421
Maiduguri	DalaLawanti	11.81106533	13.09569142
Maiduguri	DalaLawanti	11.8241633	13.09985413
Maiduguri	Layinbulama	11.8101666	13.09598787
Maiduguri	Laying makabarta	11.81011409	13.09603246
Maiduguri	Maisandari	11.81177416	13.09360891
Maiduguri	Maisandari 2	11.82121213	13.10159326

Table 13: WASH household survey locations

LGA	Location	Latitude	Longitude
Damboa	Aburi IDPCAMP	11.16682158	12.75415134
Maiduguri	Bakassi IDP Camp	11.79333837	13.11916746
Damboa	Central IDP CAMP	11.16234187	12.75624474
Damboa	General IDP Hospital	11.16715188	12.762577
Damboa	Vocational Training Center IDP camp	11.0521188	12.80867112
Damboa	Hausari IDP camp	11.14900242	12.75386813

Table 14: Qualitative data collection and types of respondents and locations

Type of qualitative session	Type of Respondent	Location of Respondent	Number of Respondents
Key Informant Interviews	GBV coordinator	IMC, Maiduguri	1
	GBV Officer	IMC, Damboa	1
	Case Management Officer	IMC, Damboa	1
	Case Management Officer	IMC, Maiduguri	1
	WASH Coordinator	IMC, Maiduguri	1
	WASH Officer	IMC, Damboa	1
	Nutrition Coordinator	IMC, Maiduguri	1
	Nutrition Officer	IMC, Damboa	1
	Stabilization Centre Doctor	IMC, Damboa	2
	Programme Coordinator	IMC, Maiduguri	1
	Lead Mothers	1 each in 8 host communities where FGDs were conducted	8
	Camp Chairmen	Bakassi camps	4
	Community Volunteers		2
Focus Group Discussions	Lactating Mothers	Dalori Quarters	10
		Gambori	10
		Maisandari II	10
		Shokari	10
		Damboa Central	10
		Wuvi	10
		Afonori	10
		Gumsuri	10

FINAL Generic IYCF Questionnaire.doc

Figure 3: Generic IYCF Household Survey Questionnaire

WASH Household Questionnaire.docx

Figure 4: WASH household questionnaire