

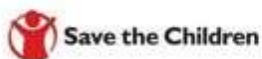
NATIONAL LEVEL COVERAGE ASSESSMENT TRAINING FOR GOVERNMENT & NGO STAFF, ETHIOPIA

DATE: NOVEMBER 30TH TO DECEMBER 4TH 2015.

VENUE: ADAMA, DALLOL HOTEL



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ACKNOWLEDGEMENT

- Thanks to Disaster Risk Management Food Security Sector (DRMFSS), Federal Ministry of Health (FMoH) and special thanks to UNICEF/ENCU Ethiopia for organizing the training.
- Thanks to Coverage Monitoring Network (CMN) for facilitating this training
- Lastly, thanks to all participants from various Government and organizations who dedicated their time by attending & actively participating in this training

INTRODUCTION AND BACKGROUND

Ethiopia, located in the northeastern part of Africa, also known as the Horn of Africa, lies between 3 and 15 degrees north latitude and 33 and 48 degrees east longitude. The total area of the country is around 1.1 million square kilometers. As of 2007, Ethiopia's population has been growing at a rate of 2.6 percent per annum (CSA, 2007). At this rate the total population will number 88.4 million by 2015. The majority of the population (84 percent) lives in rural areas. This rapid population growth exacerbates critical gaps in basic health services, and in food and nutrition security (MOH, 2008).

Ethiopia has developed a five-year development plan, the Growth and Transformation Plan (GTP), for the period 2010/11 to 2014/15. Key objectives of the GTP are ensuring high economic growth and achieving the Millennium Development Goals (MDG). Within the framework of the GTP, five-year sectoral development programmes have been outlined (MOFED, 2010b). Vital to the attainment of this plan are the systems and structures to reach communities and households.

Community based service delivery platforms have been made available in both the health and agriculture sectors to ensure decentralized and democratized public services. The Health Extension Programme (HEP) deploys two health extension workers per health post, who together reach a population of roughly 5,000. The Agricultural Extension Programme has a similar community level structure called the Agriculture Extension Programme. To strengthen and accelerate social and behavioral changes and the overall wellbeing of the population, a community level development army has been established using a "one-to-five network," wherein out of every six households one person takes a leading role, functioning as a key link with both health and agriculture extension workers. Five such leaders comprise a development team. Each development team looks after 25 to 30 households. This arrangement is contributing to Ethiopia's sprint toward the achievement of MDGs (MOH, 2011). Despite the availability of community based service delivery, the community level development army role on malnutrition screening and referral using MUAC needs to be institutionalized in the Health Development Army systems.

The Federal Ministry of Health (FMoH) has developed a protocol for the Management of Severe Acute Malnutrition in March 2007. The document is updated of existing guideline for the management of severe malnutrition written by professor Michel Golden & Dr. Yvonne Grellety (endorsed by the ministry of health in May 2004), which has a slight difference on the admission criteria of (MUAC < 11.0 cm) from the International Standard admission criteria of (MUAC < 11.5 cm).

The major impetus for the implementation of CMAM was the publication in March 2007 of the WHO/WFP/SCN/UNICEF Joint Statement on CMAM, which recognized that *"large numbers of children with severe acute malnutrition can be treated in their communities without being admitted to a health facility or a therapeutic*

feeding centre". The CMAM approach offers advantages over the traditional treatment of SAM in the hospital by providing safe and nutritious ready to use therapeutic food administered by caretakers at home to promote early recovery and prevent life-threatening medical complications. CMAM involves active participation of the community to diagnose moderately and severely malnourished children at a very early stage using the simplified WHO criteria by measuring middle upper arm circumference (MUAC) and assessing oedema. The CMAM approach also focuses on sustainability through integration into the existing health infrastructure system.

While the WHO/WFP/SCN/UNICEF Joint Statement on CMAM recognises that *"large numbers of children with severe acute malnutrition can be treated in their communities without being admitted to a health facility or a therapeutic feeding centre"*, the efficacy and effectiveness in treatment of acutely malnourished children through CMAM remain unacceptably low in most countries.

The CMN (Coverage Monitoring Network) is **an inter-agency initiative** established in July 2012 with the support from the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and USAID's Office of Foreign Disaster Assistance (OFDA) in order to **improve nutrition programmes** through the promotion of quality coverage assessment tools, capacity building and information sharing.

The CMN offers **trainings and workshops** on the various coverage assessment methods, as well as **guidance on how to overcome the barriers** identified. The CMN offers free technical support in the design, planning, implementation and analysis of coverage assessments of community management of acute malnutrition (CMAM) programs. Since its creation in 2012, the CMN Project has supported more than 50 organizations to design, plan and implement coverage assessments. During the first year of CMN Phase II, activities focused largely on providing support to programs in 9 priority countries with the planning and delivery of semi-quantitative evaluation of access and coverage (SQUEAC) surveys and community assessments. The first year of the project saw the team supporting organizations and focal points in each country to develop and start to implement national action plans to scale up coverage assessments. To support national scale up, during year one the CMN team launched a major review of coverage methods, developed simplified training materials for coverage and community assessments. These and more materials are available on the [Coverage Monitoring Network website](#).

One of the main activities of the second phase of the project (which started in 2014) is to provide technical support in the design, implementation and analysis of coverage assessments and the formulation of community mobilization action plans.

PURPOSE / OBJECTIVES OF THE TRAINING

PURPOSE

The purpose of the National Coverage Assessment training in Ethiopia was to build the capacity of government and nutrition cluster partners **with the skills and provide tools to implement and train others on the six core competencies of coverage assessments**. With the skills they learned during the workshop, the partners would therefore be able to go on to implement coverage assessments in their own CMAM programs and cascade their knowledge to other staff in their organisations.

Principal objective:

To provide participants with the knowledge and tools to roll out coverage assessment methodologies in their own organisations

Sub-objectives:

1. To provide participants with an overview of the theory, practice and training techniques for the key coverage competencies (which together constitute a SQUEAC assessment)
2. To train partners in SQUEAC and related techniques in coverage surveys
3. To support national partners to plan for future coverage activities
4. To promote participants' interest in measurement and implementation activities that improve coverage in CMAM programmes

Participant's needs and expectation on Coverage assessment training:

Before the training, the CMN administered pre-questionnaire send by email to assess prior knowledge and experience among the participants with regards to coverage methodologies. Accordingly, the participant number and the findings of the questionnaire as follows:

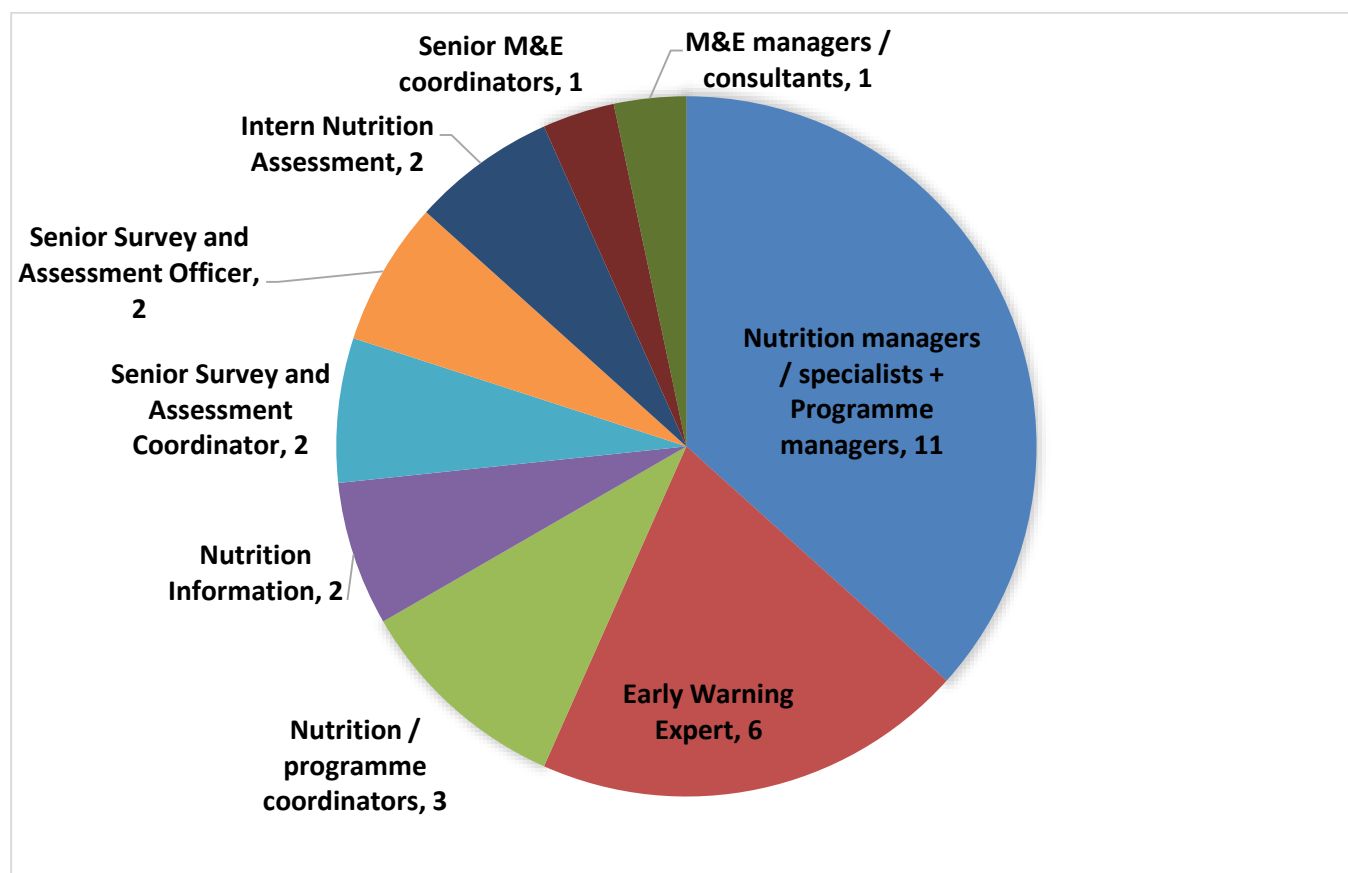


Fig 1. Trainee's category

A total of 30 participants of which 18 from various government departments, 9 people from NGOs and 3 people from UNICEF were addressed the pre-questionnaire.

PREVIOUS EXPERIENCE OF COVERAGE ASSESSMENTS

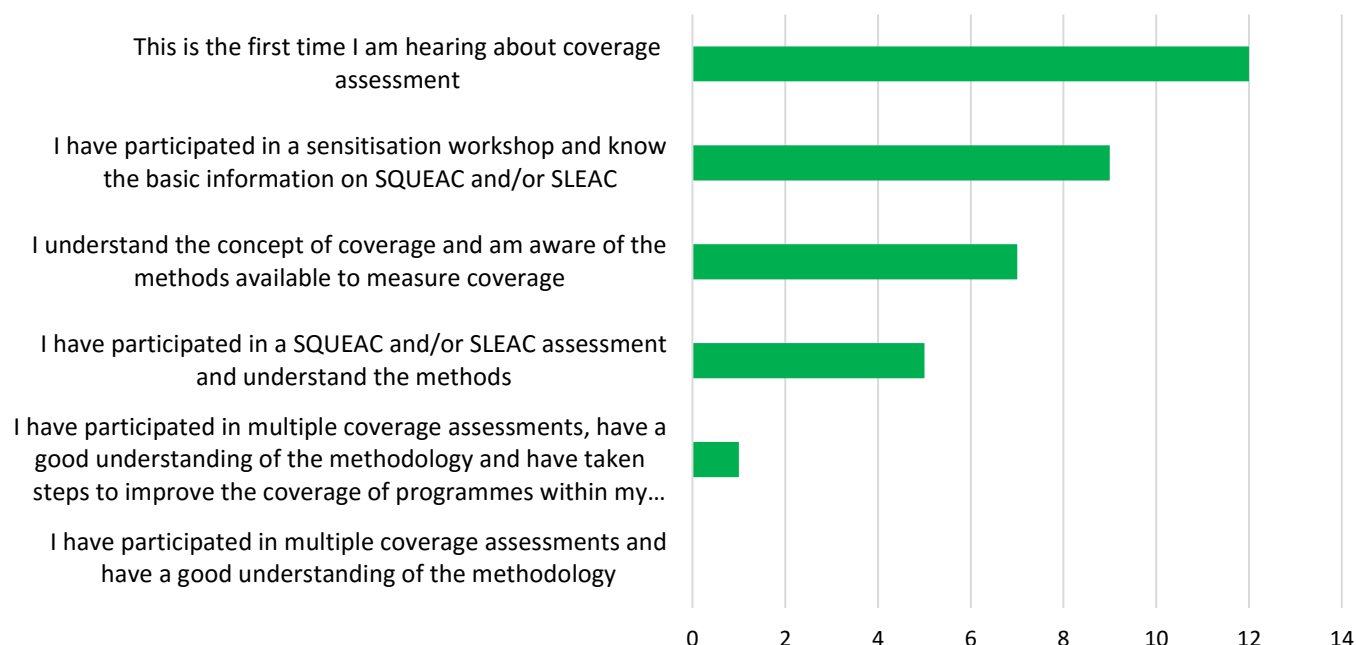


Fig 2. Trainee's previous experience of coverage assessments

ACTIONS TO TAKE FOLLOWING TRAINING

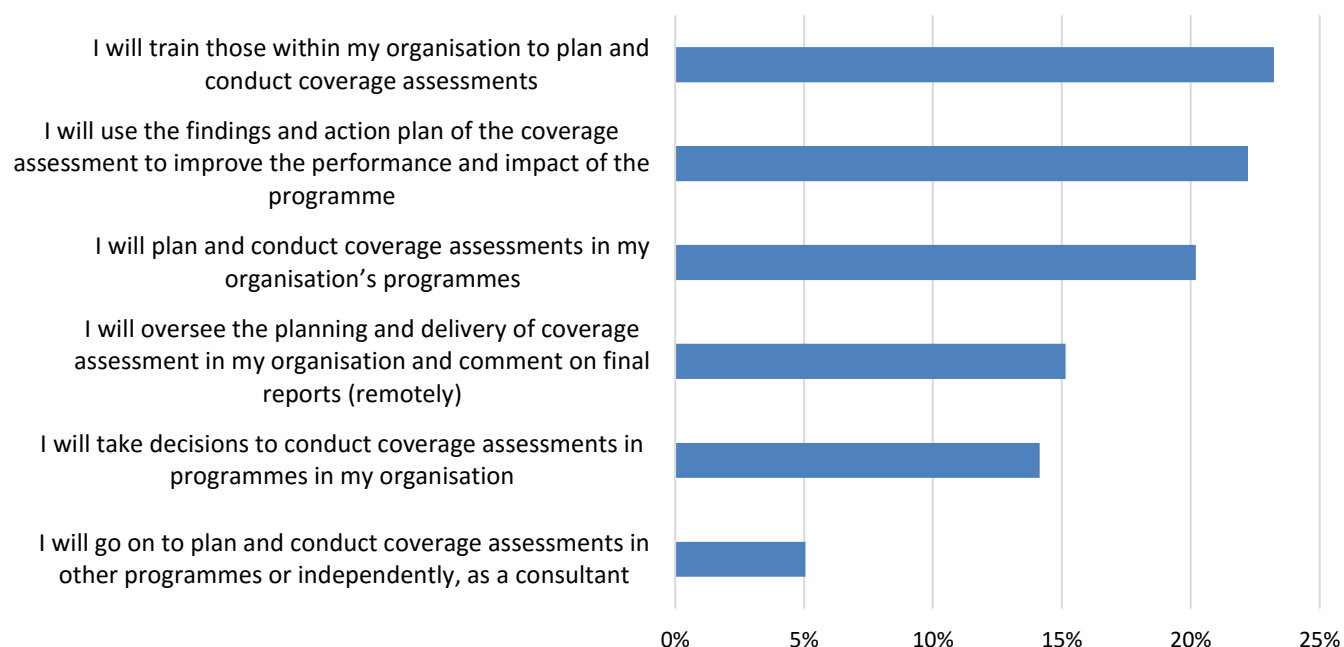


Fig 3. Trainee's action to take following training

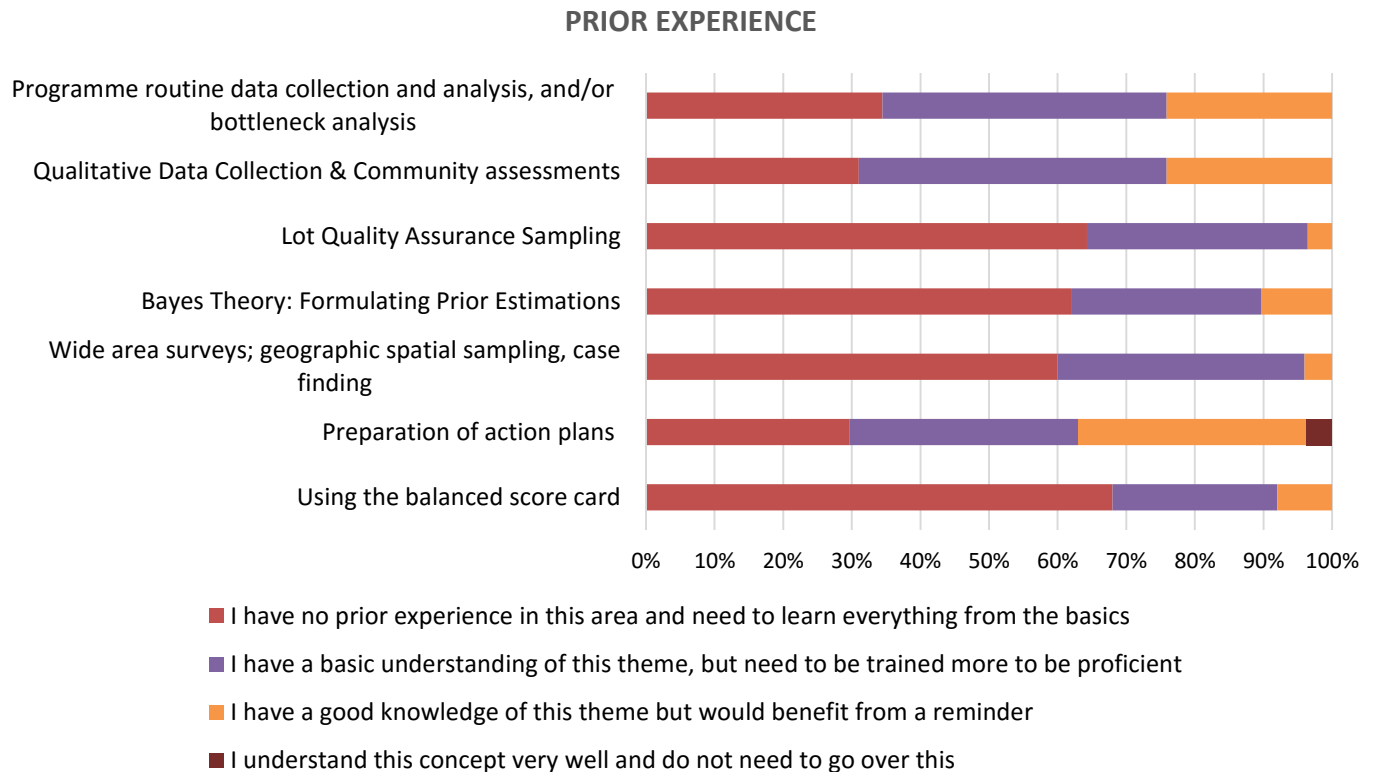


Fig 4. Trainee's Prior experiences

Most of the trainees are from various government department which not have any prior experience on coverage assessments mainly on Lot Quality Assurance Sampling (LQAS), Bayes Theory on formulating prior estimation, Wide area survey; geographical spatial sampling and case finding as well as using the balanced score card (CBSC).

The results of the questionnaires helped the trainers to adapt the coverage training modules based on identified needs. As part of facilitating the capacity building process, at the end of the training CMN shared a flash disk with all training materials used during the training, which trainees could access without Internet connection.

Participants were provided all the necessary documents, presentation and assessment tools, reports, joint action plan and training packages for each of the coverage competencies. Additionally, participants were present with certificates after satisfactory post-test score and the qualification of the five days training. The training was done in Adama, Dallol Hotel from November 30th to December 4th 2015, (see annex 1 for the agenda).

TRAINING ORGANIZATION

The training was organized in close coordination with Emergency Nutrition Coordination Unit (ENCU) and UNICEF.

ATTENDANCE RECORD

A total of 24 (20 Male & 4 Female) trainees or 80% of the 30 trainees attended from 6 INGO/NGO, 3 UNICEF as well as 15 participants from various the government department offices working in Nutrition Program in Ethiopia. All

the training participants attended the training for all the duration of the training. (See attached **Annex 2** the name of the participants)

PRE AND POST TEST RESULTS OF THE TRAINEES

In order to evaluate the training effectiveness as well as the knowledge gained by the participants, pre and post-tests were conducted. The average score of the pre-test was 63.1%. However, the average score of the post-test was 88.6%. Overall, scores increased by an average of 25.6% over the course of the training (see **table 1 below**)

Very few of the trainees were unable to answer the following topics during the post-test:

- Qualitative data collection and Analysis Stages
- Prior Coverage estimation/formulation
- Sampling calculation during stage three

Table: 1 Pre & Post-Test Results, Ethiopia, National Level Coverage Training, December, 2015

Total number of participants:		24		
Participants name/CODE	Pre-test result	Pre-test result %	Post-test result	Post-test result %
MON	54	60.0%	72	80.0%
Afera	57	63.3%	90	100.0%
912133	45	50.0%	78	86.7%
4a	60	66.7%	75	83.3%
95	66	73.3%	84	93.3%
D	51	56.7%	78	86.7%
ZM	48	53.3%	72	80.0%
S	63	70.0%	81	90.0%
AB	54	60.0%	75	83.3%
ASZ	72	80.0%	90	100.0%
KD	66	73.3%	84	93.3%
TK	57	63.3%	81	90.0%
Mihiret	66	73.3%	84	93.3%
08	45	50.0%	81	90.0%
EY	66	73.3%	81	90.0%
Jb	45	50.0%	78	86.7%
	54	60.0%	78	86.7%
	63	70.0%	81	90.0%
AAE	72	80.0%	90	100.0%
M2	48	53.3%	72	80.0%
TTW	54	60.0%	75	83.3%
Birbir	60	66.7%	81	90.0%
0541	51	56.7%	72	80.0%
N	45	50.0%	81	90.0%
Total	56.8	63.1%	79.8	88.6%
Increase in knowledge 25.6%				

EVALUATION OF THE TRAINING

In order to measure the efficacy and effectiveness of the training various monitoring and evaluation methods were applied during and at the end of the training.

At the end of each day's training, participants were asked to complete daily evaluation forms, and an end of workshop evaluation was done. Each day, participants gave an overall rating for each session (scale: 1 = insufficient to 5= excellent), overall comments, and picked the most valuable learning session (see Figure 1 below).

The majority (95 %) of participants mentioned that they gained new knowledge and skills during the training and that the training was useful. All participants voted that they were either "satisfied" or "extremely satisfied" with the training overall and more than 95% of the participants agreed that they will be able to train others or do the work on what they have learned in the training (see Figure 6 below).

Additionally, 75% of the training participants mentioned that the training is extremely effective, while 80% of the trainees were extremely satisfied with the overall session formats and presentation style. However, majority of the trainees they commented on the shortness of the training duration.

Meantime, more than 85% of the trainees mentioned that the overall information and materials provided to their work was extremely relevant. While less than 15% of the trainees mentioned that they satisfied with the information and materials provided. However, they suggest that if they could receive the handout before the training days it will help them to read and ask more questions during the training time.

Almost 95% of participants of the training would recommend the training to others and above 80% of the trainee mentioned they are confident to apply the learning in their own roles. Of this, 85% of the trainee mentioned that they would apply the learning to their work.

All the participants (100%) attended the training for the full five-days. Except, one trainee is left at the end of the training sessions due to emergency family issue.

The majority (80%) of the participants said that the environment and setup of the training was extremely sufficient.

All participants were extremely satisfied with the training and thanked the trainers for improving their knowledge on coverage assessments and understanding the importance of the coverage assessment for the program quality.

Figure 5: Daily Training evaluation from participants

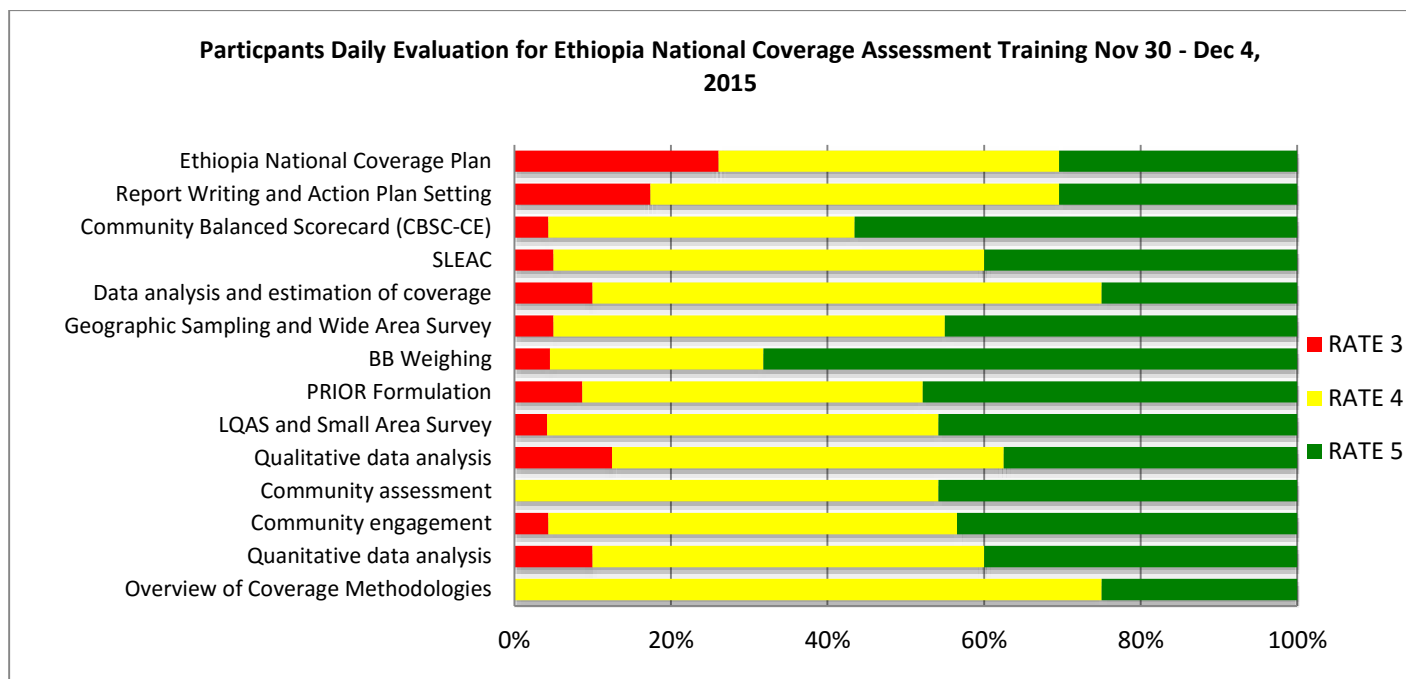
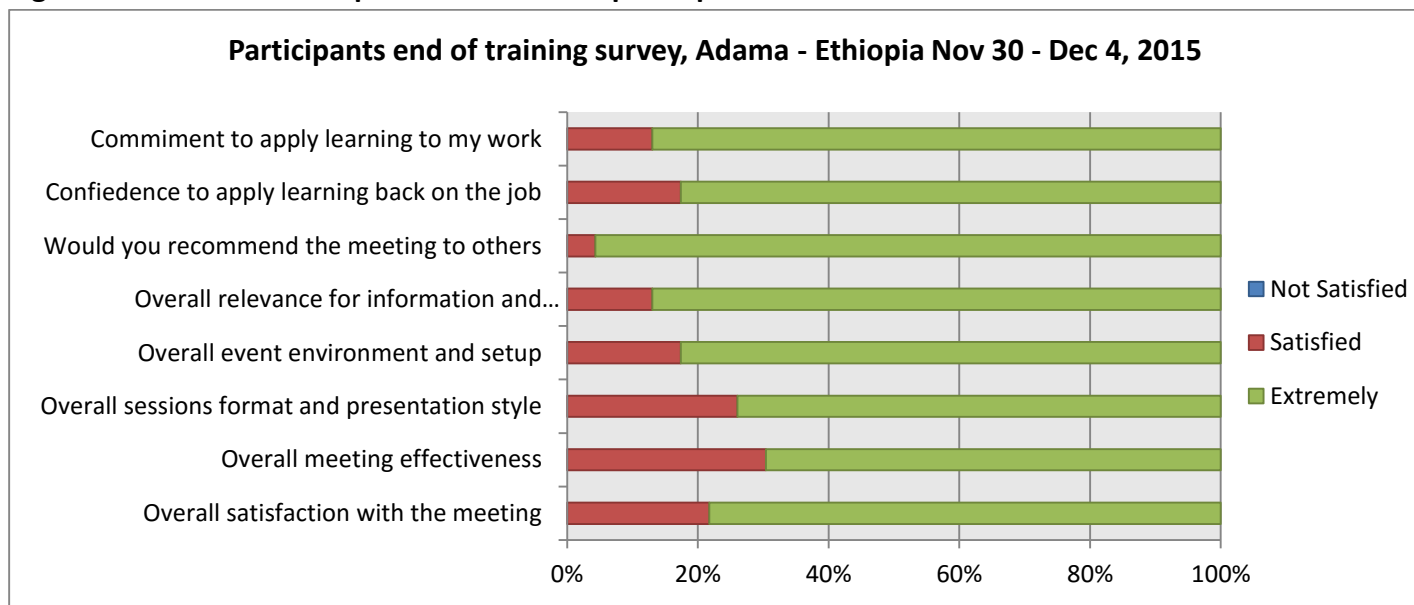


Figure: 6 Overall Workshop evaluations from participants



SUGGESTION/ RECOMMENDATION FROM THE TRAINEES

At the end of the training evaluation, followings are the suggestions and recommendations were made by the participants:

- Increase the training days from five days to seven days to accommodate field practices for participants who do not have prior experience or knowledge on Coverage Assessment.
- More practice at field level.
- To have more training on S3M, NCA, Mind Map

- Establish a global online CMN forum for information sharing and technical support
- Enrich the training presentation with lesson-learned experiences.
- Incorporate more statistical justification on sample representativeness, testing hypothesis, Stage one and Stage two.

National Plan for Coverage assessment & way forward:

At the end of the training the participants were asked to develop a national strategy on coverage assessment. There are three key areas that the strategy was focused, i.e.

- I. National plan for coordinated coverage activities,
- II. Official buy-in by government and donors of coverage methodologies
- III. Information sharing and learning process

	Strategy /Activities	Lead Process	Output	Timeline
I	National Plan for Coordinated Coverage Activities	DRMFSS/ENCU, MoH with the existing platform	SQUEAC/SLEAC - Established National Technical Working Group - National Coverage assessment guideline development. - Community Engagement guideline development - Identify funding partner	1 year full (2016)
II	Official buy-in by government and donors of Coverage Methodologies	DRMFSS/MoH/ENCU Chaired by DRMFSS Co-Chaired by MoH through TWG for National Coverage	- Strengthening National Coverage TWG. - Preparation of National Coverage Guideline - Planning of Coverage Surveys (Regional /National) - Sharing of Survey Results	Before 3 rd phase of CMN project (2016)
III	Information Sharing and Learning Process	FMoH, DRMFSS/ENCU in coordination with UNICEF & NGOs	- Development of guideline for Coverage Survey endorsed by FMoH. - Establish centralized database. - Monthly update & maintenance of Data Base - Coverage Survey information sharing & dissemination forum - Standard Report writing format	Anytime after March 2016 Monthly update

ANNEX 1: TRAINING AGENDA

Day 1:
- Introductions - Overview of agenda - Coverage methodologies - Quantitative data analysis
Day 2:
- Community assessments and qualitative data collection and analysis
Day 3:
- Lot Quality Assurance Sampling (LQAS) - Prior formulation (Bayes Theory)
Day 4:
- Geographic sampling and wide area surveys - SLEAC assessments
Day 5:
- Balanced Scorecard - Action Plan - Report writing and action plan setting

ANNEX 2: PARTICPANTS List, Ethiopia

No	First Name	Last Name	Position	Organisation	Email Address
1	Gezahegn	Shimelis	Senior Nutrition Survey Officer	CONCERN	gezahegn.shimelis@concern.net
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6	Abubaker	Abdu	Senior MEEL officer	IMC	aabdu@internationalmedicalcorps.org
7	Mahamoud	Mahamed	Nutrition Specialist	RENCU-Somali	m.jiroon@gmail.com
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9	Yoseph	Kanaa	Nutrition Specialist	RENCU-Oromia	josykoo@yahoo.com
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15	Banchiliyew	Getahun	Nutrition Officer	UNICEF Oromia Office	bgetahun@unicef.org
16	Kiyeon	YOON	Nutrition M&E Officer	UNICEF Country Office	kyyoon@unicef.org
17	Mathewos	Tamiru	Information analyst	ENCU/DRMFSS	mtamiru@unicef.org
18	Tareke	Aga	Sr.Expert and Nutrition focal person for ENCU	DRMFSS	agatareke0@gmail.com
19	Almaz	Girmay	Early Warning Expert	DRMFSS	almaz_girmay85@yahoo.com
20	Abay	Sefene	Intern (nutrition assessment and woreda risk profile.	DRMFSS	yamsemayawi@gmail.com
21	Zinash	Tesfahun	Intern (nutrition assessment and woreda risk profile.	DRMFSS	Zenashtesfahun91@gmail.com
22	Abdi	Ahmed	Public Health Emergency Officer	EHNRI	abdiseid04@yahoo.com
23	Taye	Wondimu		Oromia RHB	
24	Negash			Tigray DPPC	

ANNEX 3: ASSESSMENTS OF PARTICIPANTS' PRIOR KNOWLEDGE ON COVERAGE ASSESSMENT

The training will take place over five days. Each day will focus on different themes of coverage assessments. Please complete the table below (checking one box per row) to indicate your prior level of knowledge. Add additional topics that you would like the trainers to focus on:

DAY	TOPIC	PRIOR KNOWLEDGE				List specific topics which you need extra training on within each theme
		I have no prior experience in this area and need to learn everything from the basics	I have a basic understanding of this theme, but need to be trained more to be proficient	I have a good knowledge of this theme but would benefit from a reminder	I understand this concept very well and do not need to go over this	
1	Programme routine data collection and analysis, and/or bottleneck analysis	☐	☐	☐	☐	
2	Qualitative Data Collection & Community assessments	☐	☐	☐	☐	
3	Lot Quality Assurance Sampling	☐	☐	☐	☐	
4	Bayes Theory: Formulating Prior Estimations	☐	☐	☐	☐	
5	Wide area surveys; geographic spatial sampling, case finding	☐	☐	☐	☐	
6	Preparation of action plans	☐	☐	☐	☐	
7	Using the balanced score card	☐	☐	☐	☐	

ANNEX 4: A SAMPLE JOINT ACTION PLAN DEVELOPMENT BY PARTNERS

Table x: Concern and Bati-Woreda Health Office draft Joint Plan of Action on Community Mobilization, Oct 2014-June 2015, Bati Woreda

	Strategy/Activities	Barriers	Performance indicator	Target	Responsible	Time	Budget	Status
1	Sensitization							
1.1	Orient Woreda executive members on malnutrition and CMAM	-Lack of awareness about the CMAM services	# of executive members trained	40	DHO with Concern support	Oct 2014	35,000.00	
1.2	Orient Kebele executives members on malnutrition and CMAM		# of Kebele executive members trained	196	DHO and HC	Nov 2014	60,000.00	
1.3	Orient religious (Imam, Olama), traditional leaders (Abagari, Dubrati, Iddir leader) and traditional healers on CMAM and malnutrition	-Misconception about the cause of malnutrition	# of community figures oriented on CMAM and malnutrition	168	HEWs and kebele chair man	April 2015	90,810.00	
1.4	Provide TOT on community mobilization for CMAM program to TFP focal persons from HC and HEWs from HP	-Preference of alternative treatment	# TFP focal persons and HEWs trained	44	DHO with concern support	Dec 2014	46,200.00	
1.5	Provide a day training to the leaders of 1:30 HDAs network on CMAM and malnutrition by TOT from HC/HP		# 1:30 leader trained	576	HEWs and TFP focal persons	Feb 2015	265,500.00	
1.6	Orient the leaders of 1:5 HDAs network on CMAM and malnutrition through 1:30 HDAs leaders	-Poor sensitization about malnutrition & CMAM	# of 1:5 HDAs leaders oriented	3,456	HEWs	Feb-April 2015	172,800.00	

	Strategy/Activities	Barriers	Performance indicator	Target	Responsible	Time	Budget	Remark / Status
2	Ongoing sensitization							
2.1	Initiate 1:5 HDAs members to discuss about malnutrition and CMAM services	-Lack of awareness about the CMAM services	# of HDAs members reached	21,615	HDAs leaders HEWs, DHO	April-June 2015	50,000.00	
2.2	Reach the community members to aware about malnutrition and CMAM service at Friday Prayer time by Imam		# community reached to aware about CMAM	20,000	Imam and HEWs	April-June 2015	100,000.00	
2.3	Orient Kebele council members on CMAM service and malnutrition	-Misconception about the cause of malnutrition -Preference alternative treatment	# Kebele council members	2800	Kebele house speaker & HEWs	April-June 2015	12,000.00	

2.4	Reach the community to aware about CMAM service and malnutrition during monthly and quarterly mass screening	-Poor sensitization about malnutrition & CMAM	# caregivers reached to aware about CMAM	15,000	HEWs	April-June 2015	8,000.00	
2.5	Reach 1:5 Community development armies (CDAs) to aware about CMAM service and malnutrition		# CDAs member reached	3000	HEWs	April-June 2015	17,000.00	
2.6	Orient school director and teachers on CMAM and malnutrition to sensitize teachers- parents association members and 1:5 student peer support network		# Teachers oriented about CMAM services % school conducted quarterly	120 75%	HEWs, Kebele chairman, Teachers	April-June 2015	16,000.00	
2.7	Reach the community to aware about malnutrition and CMAM service by trained community figures		# community reached to aware CMAM and malnutrition	10,000	Community figures	April-June 2015	42,000.00	
2.8	Adapt counseling card on malnutrition and CMAM to 1:5 HDAs leaders		# counseling card produced	4000	Concern WW	June 2015	72,000.00	
2.9	Orient the community about malnutrition, CMAM and IYCFP at SFP distribution day		# community reached	4247	Concern, HEWs	Oct-Dec 2014	11,000.00	
3	Case finding and referral							
3.1	Strengthen current monthly and quarterly mass screening with active participations of HDAs	Non systematic	% HP conducted monthly and quarterly screening	100	DHO and concern support	April 2015	3,000.00	
3.2	Improve case referral between SFP and OTP program	Inadequate referral between SFP and OTP	% of discharged cases referred to SFP from OTP % of deteriorated cases referred to OTP from SFP	80 80	DHO Concern WW	Oct 2014	5,000.00	
	Strategy/Activities	Barriers	Performance indicator	Target	Responsible	Time	Budget	Remark / Status
4	Home visit follow up							
4.1	Strengthen home visit follow-up for defaulter and non-responded cases with HDAs participations and during HEWs home visit	Nonsystematic screening across health facility	26 HP conducted regular defaulter tracing and follow up visit	100%	DHO	Jan 2015		
5	Community participation and coordination							
5.1	Work with Kebele chairman to engage community members or /and PSNP participant to transport RUTF and supply from HC to HP rather than HEWs pay for transport from their pocket	-Inadequate supply (Non – RUTF) -Geographic barriers	52 HP received community support to transport supply	100%	DHO and Kebele chairman, HC head, HEWs	Dec 2014		

		-Inadequate health workers						
5.2	Mainstream CMAM program as agenda in the Health Management Meeting (HMM) at the health center level to address challenges and strengthen the CMAM services	Limited community participation in CMAM program	6 HC with active HMM address CMAM program 6 HMM meeting held per month per HC	100 12	DHO with concern technical support	Jan 2015		
5.3	Activate Health and Nutrition Taskforce meeting at district level to address CMAM program and malnutrition	Inactive coordination mechanism for CMAM and nutrition activities	8 HNT meeting held per month	12	DHO, HC	Dec 2014		
5.4	Establish community health committee at Health post to strengthen CMAM services as part of HEP package and address barriers		26 HP has active community health committee	28	HEW, Kebele chairman	March 2015		
5.5	Assign focal person community mobilization for CMAM program at the health center and district level from existing staffs		6 HC has active focal person for Community mobilization	7	HC and DHO	Feb 2015		
6	Technical support and Monitoring							
6.1	Provide regular technical support and monitoring to HEWs at HP and TFP nurses at HC level	Limited technical support to HEWs	6 HC and 26 HP visited quarterly by DHO /HC	100	DHO, HC	Feb, Apr, June 2015		
6.2	Strengthen monitoring and reporting system on CMAM program and performance review	Incomplete to nil report on community mobilization	26 HP correctly and completely report monthly	75	DHO. HC	March 2015		

ANNEX 5: A SAMPLE JOINT COMMUNITY BALANCED SCORE CARD FOR COMMUNITY ENGAGEMENT (CBSC-CE) DEVELOPMENT BY PARTNERS

TABLE X : Community Balanced Scorecard Result, Boloso Sore Woreda, June 2015

	Domain	Score	Scale	Out of 100%	Remark
1	Capacity and Service Perspectives				
	Community Assessment	8	12	66.7%	International Medical Corps uses and support the MOH's HDA structure for community engagement for CMAM. The 1:30 HDAs leaders through HEW are trained and equipped with IEC materials. Inadequate community figures involvement, case finding and referral through HDAs and technical support and monitoring of the program need to be improved.
	Strategy Formulation	10	16	62.5%	
	Capacity Building	9	12	75.0%	
	Creating materials	8	12	66.7%	
	Implementing	22	32	68.8%	
	Monitoring	16	28	57.1%	
	Evaluating	11	16	68.8%	
	Total score	84	128	65.6%	
2	Caretakers Perspective	23.3	40	58.3%	The caretakers reported there is limited activity of case finding and referral, home visit and community awareness on consequence of malnutrition
	Caretakers overall satisfaction	2.6	4	65.0%	
3	Community Perspective	34.4	52	66.2%	The community figures indicated that there is need to increase community awareness, regular follow up of cases and strong involvement of religious , idir and community leaders
	Community overall satisfaction	3.3	4	82.5%	
4	Staff Perspective	76	100	76.0%	Staff and HDAs recommended daily provision of RUTF to reduce selling , regular training to HDAs and need to assign focal person under International Medical Corps who can coordinate
	Staff overall satisfaction	3.6	4	90.0%	
	Grand total CBSC Score	218	320	68.1%	