

COVERAGE MONITORING NETWORK

National Coverage Training Report

Nairobi, Kenya

24TH-28TH August, 2015



Funded by:



Acknowledgement:

The national coverage training was successful through the support of the following;

- Ministry of Health (MoH) for taking lead in the process. Special appreciation to Head of Nutrition for gracing the workshop and Lucy Gathigi for supporting the process.
- UNICEF for financial support during the training session
- Coverage Monitoring Network (CMN) for facilitating training through their representatives Lovely Amin and Melaku Dessie. They also catered for financial costs of facilitators
- Action Against Hunger (ACF) for taking lead in planning process (liaising between national stakeholders and CMN).
- Lastly, all participants from various organizations who dedicated their time toward the training.

Summary:

The national coverage training was a follow up of national coverage workshop held in September, 2014 in Nairobi. The coverage training was proposed based on NITWG¹ ToR² to build capacity of stakeholders from MoH³, implementing partners and development agencies operating at national levels on different coverage methodologies for IMAM⁴. A core team of NITWG including MoH, Action Against Hunger and UNICEF⁵ did set priorities to engage CMN to support the national coverage training. The CMN⁶ offers trainings and workshops on the various coverage methods, as well as guidance on how to overcome the barriers identified. Furthermore, the CMN provides many online resources and toolkits to assist in the implementation of coverage assessments.

A total of 26 participants drawn from different stakeholders including MoH, UN agencies and implementing partners were selected for the training by MoH see **annex 1**. CMN agreed to facilitate the training which was held on 24th to 28th August, 2015 in Nairobi, Kenya. Before the training, the CMN sent a pre-questionnaire to assess prior knowledge and experience among the participants with regards to coverage methodologies. This was also instrumental in supporting contextualizing of coverage training modules based on needs identified. Participants also were engaged in drafting the way forward based on national coverage guidelines and implementation of action plan. Among other actions proposed by participants include improvement in performance and impact of IMAM program (26%); enhance capacity of counties and organization staffs to plan and conduct coverage assessments (24%), to use knowledge and skills gained to conduct coverage assessments representing (16%) respectively. Towards the end of the training, participants were provided the following; coverage companion documents and supervision tools, standardised data collection and analysis tools for quantitative and qualitative data, document templates, reports and action plans and training packages for each of the coverage competencies including schedules, presentations and exercises. Participants were also presented with certificates after the qualification of the five day training.

¹ National Information Technical Working Group

² Terms of Reference

³ Ministry of health

⁴ Integrated Management of Acute Malnutrition

⁵ United nation children's education fund

⁶ Coverage monitoring network

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1. Objectives of the national level training

1.1 Primary objective

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

1.2 Specific objective

1. To remind participants why to measure and implement activities to improve coverage
2. To provide participants with an overview of the theory, practice and training techniques for the key coverage competencies
3. To support national partners to plan for future coverage activities

1.3 The main training expectations for participants

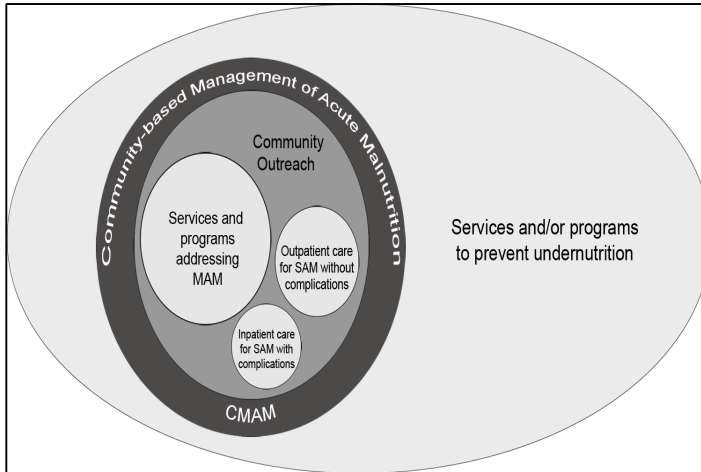
- How to plan and conduct the core elements of coverage assessments
- How to use their findings and results
- How to train their teams on the different coverage competencies
- When to conduct coverage assessments and which ones are most appropriate to use

2. Key highlights from national coverage training

2.1 Principles of Integrated Management of Acute Malnutrition (IMAM)

- Maximum access and coverage
- Timeliness/Early Presentation
- Compliance to Treatment
- Care for as long as needed
- Appropriate medical & nutrition care

Figure 1: Core components of IMAM programmes



2.2 Coverage assessment of CMAM programmes

The participants were explained briefly on various coverage assessments methods, in which context they are applicable and how to choose or make decision most appropriate method see below **Figure 2**.

Coverage assessments methods:

- SAM Bottleneck analysis
- SQUEAC
- SLEAC
- Community assessment
- Barrier follow up
- “Light” SQUEAC

The participants were also taken through defined steps on coverage assessments includes;

1. Sampling framework
2. Sample size
3. Coverage estimators
4. Questionnaires
5. Barriers to access

Core elements of coverage assessments:

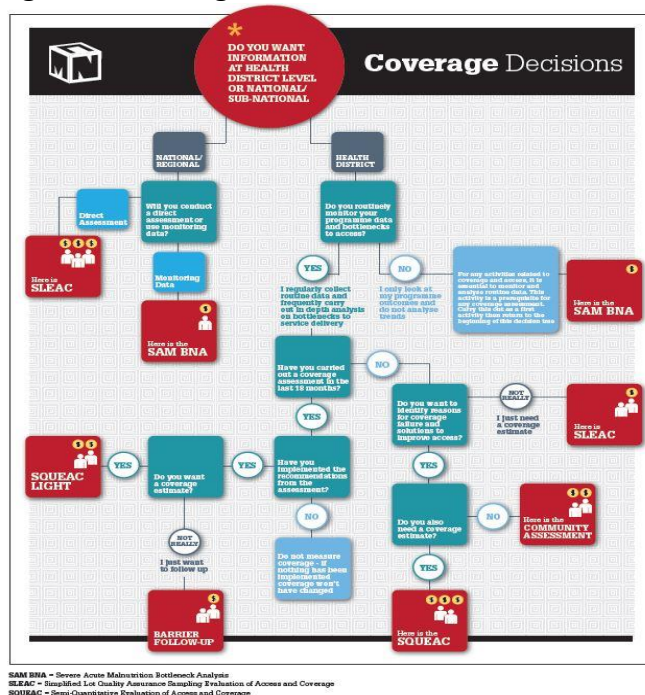
The below all six core elements involve in SQUEAC assessment but elements can be undertaken individually to measure coverage and barriers to access depending on the information actors need.

QUANTITATIVE DATA MONITORING AND DATA ANALYSIS
QUALITATIVE DATA COLLECTION / COMMUNITY ASSESSMENT
LQAS
BAYES THEORY
GEOGRAPHIC SAMPLING
REPORT WRITING AND ACTION PLAN SETTING

2.3 Coverage assessment decision tree

The participants were taken through the coverage assessment decision tree which provides a snap shot on different coverage assessment methods and their linkages, frequency and when its advocated to use the method as illustrated in figure 2. It also came to participant attention that coverage assessments should be conducted based on seasonality to be able to evaluate the particular barriers and boosters of IMAM programme. The recommendation was for stakeholders to conduct coverage assessment during the lean or dry seasons as it's at this time we expect to have high caseloads of children at risk or detected to be acute malnourished (suffering from both severe and moderate acute malnutrition) and the need to document on approaches to influence effectiveness of service delivery and improve coverage.

Figure 2: Coverage decision tree



2.4 Quantitative data collection and analysis

Routine programme data should be monitored and analysed on an ongoing basis in all CMAM programmes. The findings of quantitative data analysis should be the trigger for further investigation. Analysis should identify areas of low and high coverage as well as reasons for coverage failure using routine program data.

The participants were given a dataset to work and analyse on the following indicators:

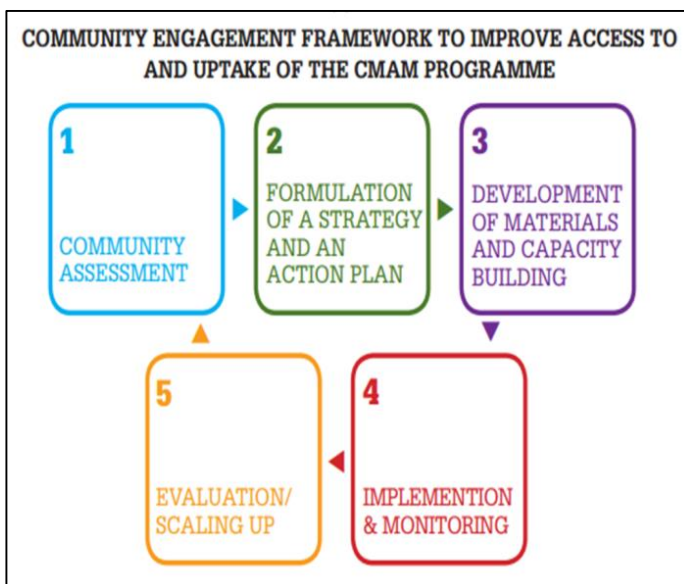
- Admissions (over time and by location)
- Programme Exit data
- MUAC at admission
- Length of Stay
- Defaulters
- Time of default
- Location of default
- Mapping

2.5 Qualitative data collection, community assessments and community engagement

Community actors:

- Country/County level: decision makers at MOH, NGO/CBO, government sector offices, media professionals
- Health facility :public and private health care providers, support staff, outreach workers
- Community: gatekeepers and highly respected leaders; community leaders, women leaders, community health volunteers, community groups and associations leaders and volunteers
- Beneficiary: Caretakers of children with acute malnutrition

Figure 3: Community engagement to improve access and uptake of IMAM programme



Impact of community engagement

Increased coverage and access to information and services

Maximized the service uptake, minimizing defaulters, and ultimately reducing deaths

More likelihood of, and sustainability for, behavior change

Increased ownership, support and responsibility
More cost-effective programming

Better response to community needs and concerns. More culturally-appropriate strategies, messages and service

Community participating at different stages of community engagement framework for IMAM/CMAM programme

Step 1: community assessment:

Involve community members in the data collection, interpretation and analysis of their own concerns

Step 2: Formulation of strategy and an action plan

Facilitate community involvement in setting priorities and developing an action plan by using appropriate exercises

Step 3: development of materials and capacity building

Invite community members to suggest messages and materials and involve them in selection of community workers and volunteers

Step 4: implementation and monitoring

Mobilize community actors to help with the implementation of activities and creating a broad sense of ownership

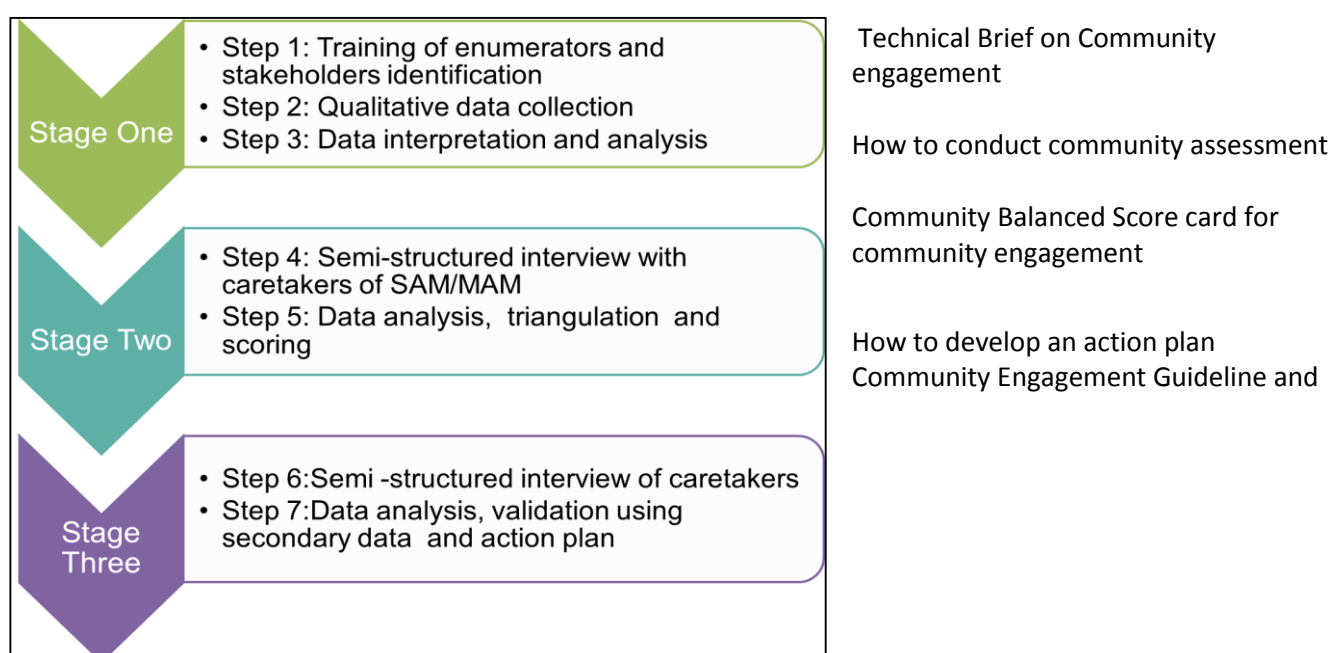
Step 5: evaluation/scaling up

Involve community members in the evaluation of the program against parameters they set themselves

Community assessment for IMAM/CMAM objectives

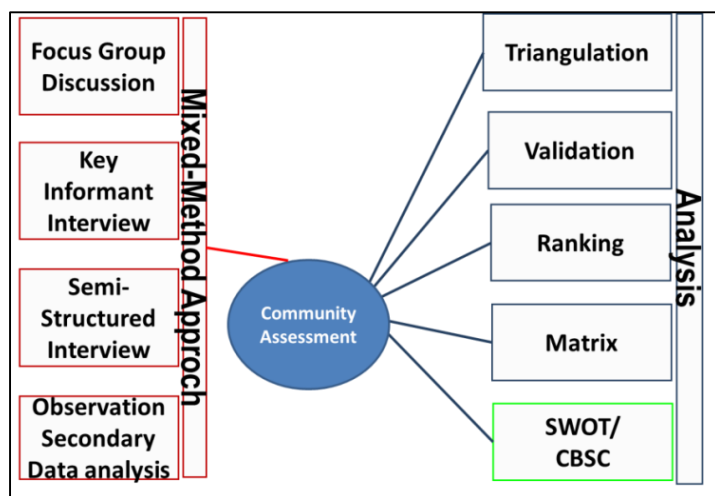
- Understand community Knowledge, attitude and perception on malnutrition and CMAM services
- Understand community systems and structures
- Identify factors that influence caretakers decision to access and use CMAM services
- SWOT analysis for current community engagement strategy
- Design a community engagement strategy that fits with and builds on local resources to improve access and coverage.

Figure 4: Step by step community assessment methods



Summary statements on community assessment and engagement

Figure 5: community assessment various methods and data analysis



High coverage and good outcome can be achieved in a community when its leaders, members, actors and caretakers are fully engaged in mobilizing and sensitizing the community, implementing good quality of services, and increasing access to CMAM services.

Integrate community assessment into exist assessments: SQUEAC, SMART etc.

Strengthen community engagement in the NFSL programming to improve access and coverage services

2.6 Stage 2 (Small area survey)

Survey Data collection tools

The participants were taken through data collection tools, theory and simulation activities to get gain some practical experience. During the stage 2 (Small area survey) exercises, hypothesis was developed to tested using the secondary data from an OTP.

In SQUEAC stage 2, Hypotheses about coverage usually focuses areas where the combined data suggest that coverage is likely to be satisfactory and areas where the combined data suggest that coverage is likely to be unsatisfactory.

In simulation exercise, participants were asked to administer the questionnaires with information on imaginary SAM or MAM cases; both in-program and not in-program and recovering cases were recorded.

Semi structured questionnaires were administered for caregiver if their children are in program or not in program. These questionnaires shed light on barriers and boosters to access and program uptake faced by caregivers.

Survey data was compiled, analyzed and hypothesis was tested using LQSA methods see examples:

Number of Children meeting case definition (SAM/MAM) = 12

$$d = \left\lfloor n * \frac{p}{100} \right\rfloor = 12 * \frac{50}{100} = 6$$

2.7 Stage 3 (Likelihood survey)

The likelihood survey is designed to provide evidence to modify prior belief about coverage, using beta-binomial conjugate analysis. It uses a two-stage sampling procedure:

Setting 'Prior' and selection of survey sample size:

The participants were trained on use of Bayesian SQUEAC to set 'prior mode' of coverage (the prediction about likely programme coverage rate) with explanation of Prior 'Mode', Alpha & Beta prior, acceptable precision and how to consider different level of uncertainty level ($\pm 20\%$ & $\pm 25\%$).

Sample size:

The participants were trained on how to calculate sample size manually see equation below; as well as using the Bayesian SQUEAC. The sample size required for a likelihood survey depends on the prior and the precision required for the posterior estimate, Sample sizes for likelihood surveys are usually calculated to achieve a precision of $\pm 10\%$. To accommodate require sample size for the survey (bigger or smaller) the precision can be reduced or increased but it is not advisable to increase precision higher than $\pm 13\%$.

$$n_{\text{Likelihood}} = \left\lceil \frac{\text{mode} \times (1 - \text{mode})}{(\text{precision} \div 1.96)^2} - (\alpha_{\text{Prior}} + \beta_{\text{Prior}} - 2) \right\rceil$$

Minimum number of villages to be selected to find require number of cases (sample size):

First stage sampling method: This is a sampling method that is used to select the villages to be sampled.

The participants were taken through and exercise on how to select the number of villages using the set variables and defined calculation method, see below:

This formula requires other variables, ***average village population, percentage of the population age between 6-59 months and SAM/MAM prevalence.***

✓ Estimating prevalence for unknown variables

It is always better to use a low SAM prevalence estimate rather than a high SAM prevalence for sample size calculation. A value midway between the point estimate and the lower 95% confidence limit for SAM prevalence from a recent SMART survey could be used. For example, if the SAM prevalence is estimates as 1.2% (95% CI = 0.6% – 2.6%) during the lean season, then a suitable estimate for an assessment conducted post-harvest would be:

Prevalence = $1.2 - \frac{1.2-0.6}{2} = 0.9\%$, therefore using 0.9% would be a suitable prevalence rate for calculating the sampling size.

A minimum number of villages to be sampled to achieve the sample size using the following formula:

$$n_{\text{villages}} = \left\lceil \frac{n}{\text{average village population}_{\text{all ages}} \times \frac{\text{percentage of population}_{6-59 \text{ months}}}{100} \times \frac{\text{SAM prevalence}}{100}} \right\rceil$$

Sampling framework:

The participants were trained on two methods on village sampling once minimum numbers of villages are calculated

1. Centric systematic area sampling (CSAS):

A map was used for practice that was divided into **quadrats**. Villages to be sampled are selected by their proximity to the center of each quadrat see figure: 6.

2. Systematic stratified spatial sampling: All villages in catchment area are stratified and selected systematically from a complete list.

The CSAS method is the gold-standard for village sampling. However, in most cases, a current map including all villages very rarely available. Therefore in absence of map the systematic stratified spatial sampling method can be used see below figure: 7.

The key to quality sampling is to assure that all villages that exist in the catchment area are present on the list. Organizing the list alphabetically and stratifying by health zone will assure that representivity is homogenous across the catchment zone without the need for mapping.

Figure 6: Quadrant Sampling:

Target sample size. A target sample size (n) of 41 cases was calculated using a $Beta(29, 13)$ prior and a desired precision of $\pm 10\%$:

$$n = \left\lceil \frac{0.7 \times (1 - 0.7)}{(0.1 \div 1.96)^2} - (29 + 13 - 2) \right\rceil = 41$$

Number of villages to be sampled. The following information was used to calculate the number of villages to be sampled:

Target sample size : 41

Average village population (all ages) : 600

Prevalence of SAM : 1%

Percentage of children aged between 6 and 59 months : 20%

Using this information, the minimum number of villages to be sampled was calculated to be:

$$n_{\text{villages}} = \left\lceil \frac{41}{600 \times \frac{20}{100} \times \frac{1}{100}} \right\rceil = 35$$

When area sampling is used (see Figure 58 and Figure 59) then the villages to be sampled are distributed evenly between the areas. For example, if a CSAS/quadrat sample with eight quadrats, such as that shown in Figure 58, is used and at least 35 villages are to be sampled then:

$$\left\lceil \frac{35}{8} \right\rceil = \lceil 4.38 \rceil = 5$$

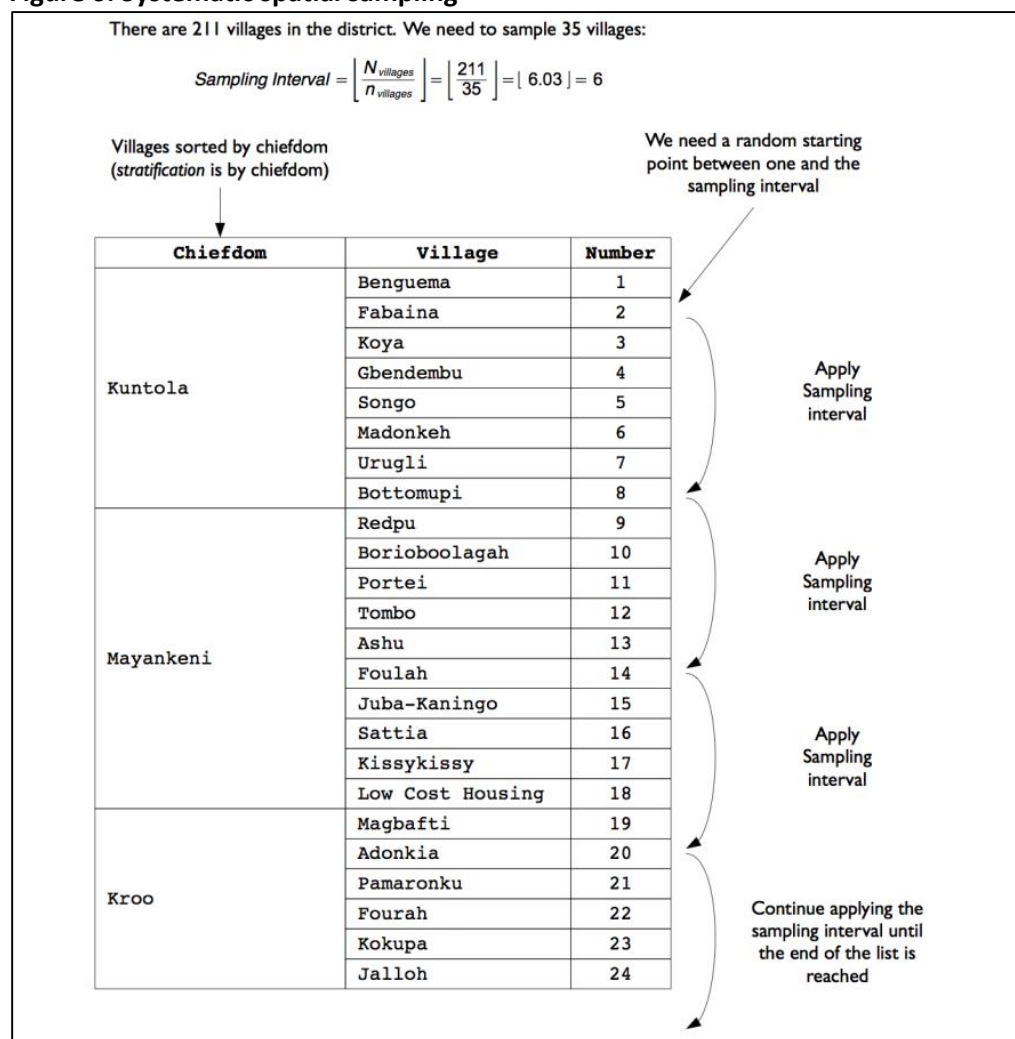
villages will need to be sampled from each quadrat.

If a CSAS/quadrat sample with 19 quadrats, such as that shown in Figure 58, is used and at least 35 villages are to be sampled then:

$$\left\lceil \frac{35}{19} \right\rceil = \lceil 1.84 \rceil = 2$$

villages will need to be sampled from each quadrat.

Figure 6: Systematic spatial sampling



A within-community sampling method (case findings):

The participants were explained that there are two methods are usually employed for case findings:

- I. Active and adaptive case-find method or
- II. House-to-house census sampling method, depending on the context.

Case finding in villages and communities

- ✓ Active and adaptive case finding recommended for rural settings
- ✓ Door to door sampling recommended for urban locations and MAM assessments

The participants were given a survey data set to analyse the data and estimate, identify barriers.

How to estimate Single coverage:

This estimator replaces the previously used **Point** and **Period Coverage Estimators**. The calculation includes SAM / MAM cases and recovering cases that **are** in the programme and SAM / MAM cases not in the programme **AND** recovering cases that **are not** in the programme. It is a new estimator, uses data for both current cases and recovering cases. It is improved estimator as this formula includes Recovery cases that not in program. In previous estimator this data was missing. Therefore it consider most accurate and updated

estimator. In CMN we encourage **ONLY** use 'Single coverage estimation' using the following formula to estimate recovery cases that could be out from program:

$$R_{out} \approx \frac{1}{k} \times [R_{in} \times \left(\frac{C_{in} + C_{out} + 1}{C_{in} + 1} \right) - R_{in}]$$

$$R_{out} \approx \frac{1}{3} \times \left[21 \times \left(\frac{14 + 23 + 1}{14 + 1} \right) - 21 \right] - 11$$

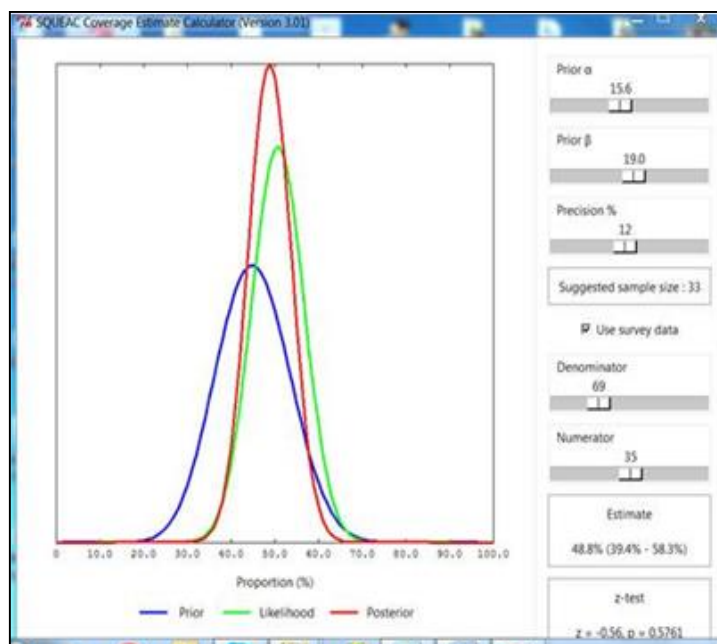
$$Recovery\ case_{out} \approx \frac{1}{k} \times [Recovery\ case_{in} \times \left(\frac{Active\ cases_{in} + Active\ case_{out} + 1}{C_{in} + 1} \right) - Recovery_{in}]$$

Single Coverage = $\frac{\text{\# of current cases} + \text{\# of recovery cases that attending the programme}}{\text{of current cases} + \text{recovery cases that attending the progarmme} + \text{\# of current cases and recovering cases that NOT attending the programme}}$
--

Example: calculation for single out coverage for OTP in South Sudan

Table: 6 Single coverage estimation for OTP, Aweil South, South Sudan, March 2015

Description of SAM survey data	Number	Equation
K = a correction factor	3	
C _{in} = Current SAM cases in the programme	14	
C _{out} = Current SAM cases not in the programme	23	$R_{out} \approx \frac{1}{k} \times [R_{in} \times \left(\frac{C_{in} + C_{out} + 1}{C_{in} + 1} \right) - R_{in}]$
R _{in} = Recovering SAM cases in the program	21	
R _{out} = Recovering SAM cases not in the programme	11	$R_{out} \approx \frac{1}{3} \times \left[21 \times \left(\frac{14 + 23 + 1}{14 + 1} \right) - 21 \right] - 11$



To calculate the 'Single coverage' for OTP below equation was used.

Denominator 69 (14+23+21+11, current SAM in prog.+current SAM cases not in prog. + recovering cases + recovering cases not in prog)

Numerator 35 (14 + 21 current SAM cases in programme + recovering cases)

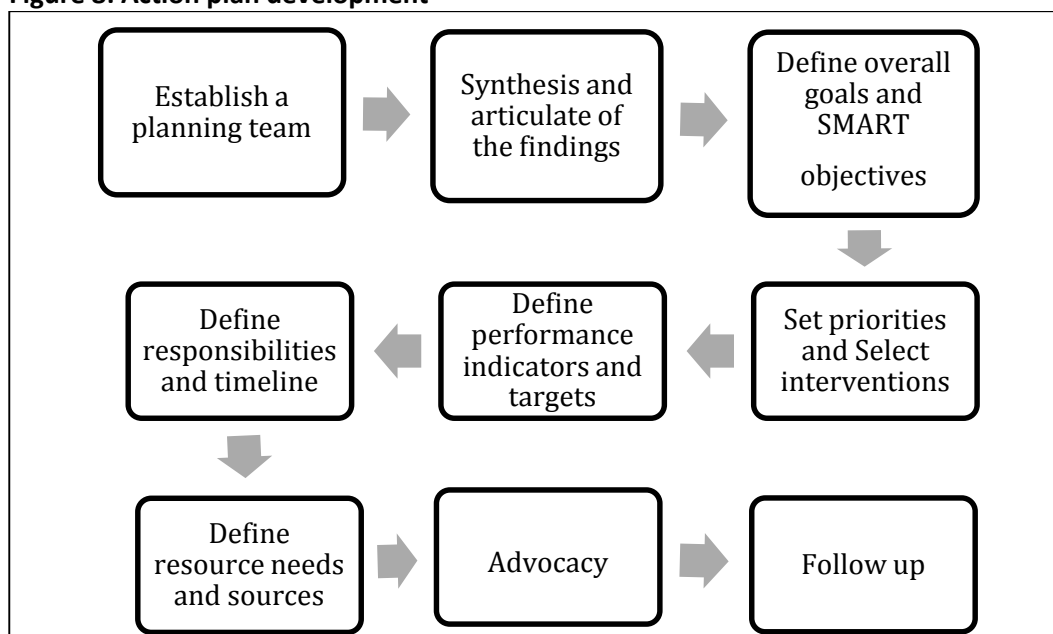
Alpha and Beta values (α 15.6 β 19.0) and precision ±12% from the pre-set 'Prior'

The Bayesian-Software estimated 'Single' coverage at **48.8%** (CI 39.4% - 58.3%), and P value= 0.5761

Technical references are available in the below link: <http://www.ennonline.net/fex/49>

2.8 Action plan development

Figure 8: Action plan development



- Planning for action plan should be participatory process
- Involve main actors: MOH, assessment team, donor
- Involve community members including women, various ethnic groups

Major reason to synthesize and articulate of the findings

- Addressing main barriers and enhancing boosters
- Analysis gaps in community engagement and services delivery
- Compare the performance against standard and generic strategies
- Build community engagement program on community structures, systems and resources, and opportunities
- Consider less resource intensive activities or can be implemented within existing project budget

Joint Action plan for development

1	Strategy /Activities	Performance indicator	Target	Priority/When	Responsible (Focal Person or Agency)	Applicable Internal Resources	External Resources Needed
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For detail training package link: [Coverage Monitoring Network - Homepage](#)

3. Way Forward

Outcome	Outputs	Activities	Time lines	Responsible person
Increased funding and commitment to support coverage assessment	Have a coverage advocacy plan in place	Advocacy plan	By 25 th September, 2015	NITWG task force
National Coverage assessment guidelines	Coverage documents (Strategy & Guidelines) validated and shared	-Develop coverage guidelines and strategy	Process Ongoing- Expected completion time- February, 2015	NITWG task force (ACF, MoH, UNICEF, WVI)
Lessons learnt, stakeholder feedback	No. of advocacy (sensitizations/orientations) meetings/forums held	-Hold advocacy forums	quarterly	NITWG
Capacity of coverage taskforce	Enrich NITWG ToR with new revised set of coverage taskforce/set activities	-Revise coverage task force TOR	24 th September	NITWG
Multi-sector linkage	Strengthened the link with other working groups i.e. ENAC, Advocacy, WESCOORD, KFSSG etc.	-Linkage with other working groups, have NITWG representation	24 th September	NITWG
National nutrition Action Plan	Coverage assessments to be imbedded in the nutrition sector annual plan	-Development of annual work plans -Develop a community engagement plan	June 2016	NITWG
Stakeholder capacity	Improved technical capacity on National and County staff.	-1 trainings yearly on coverage assessment -Technical support during coverage assessments	August 2016 Engagement with CMN	NITWG Task force (ACF, WVI, UNICEF and MoH)

4. Pre and Post Test Result of the Participants

A total of 25 participants have taken part pre and post-test. The average score of participants in pre-test is 8.9 and post-test 12 out of 15. The pre-test results ranging from 6 to 12 and post-test is 7-14. In the post-test, 24 out of 25 participants scored ≥ 10 compare to only 9 scored same in pre-test

Score	# of participants scored in Pre-test	# of participants scored in Post test
6	1	0
7	4	1
8	6	0
9	4	0
10	5	2
11	4	3
12	1	9
13	0	7
14	0	3
15	0	0

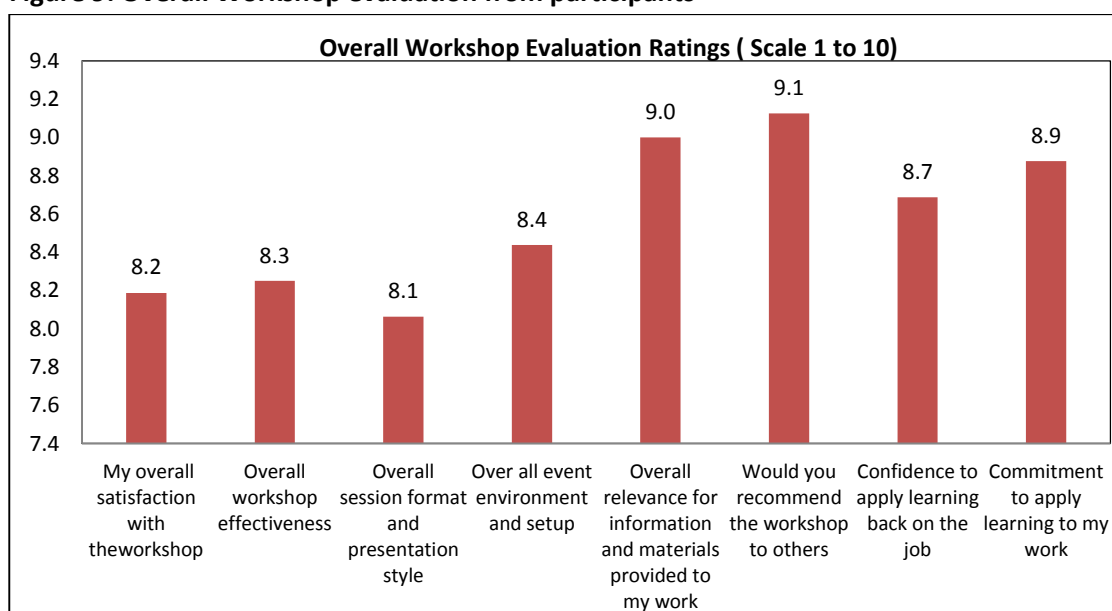
4.1 Training Evaluation

Participants were asked to complete five daily evaluations, and an end of workshop evaluation. 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.

4.2 Overall Evaluation

At the end of the workshop, participants rated their satisfaction (scale 1=not satisfied; 10= extremely satisfied) pertaining to eight key aspects of the workshop. Additionally, they listed future learning requests and recommendations to the workshop organizers. 26 participants completed end of workshop evaluations, which includes 100% partner's participants.

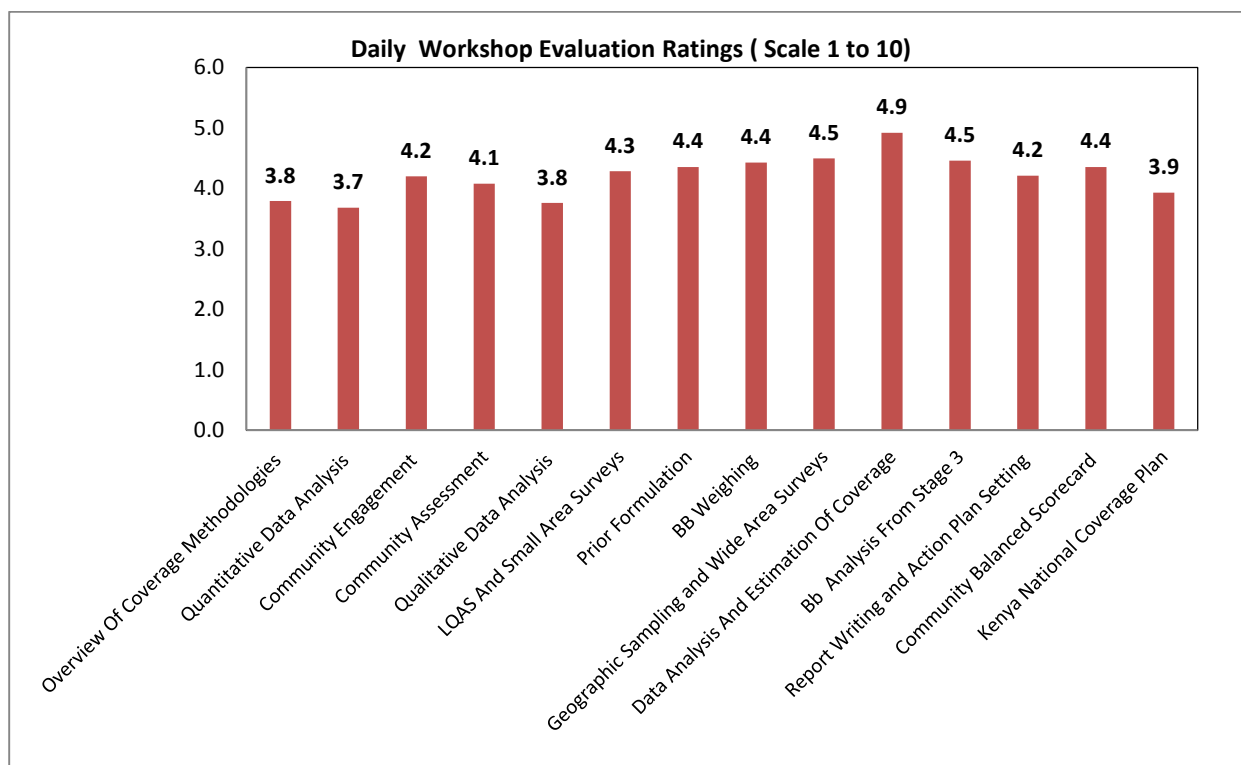
Figure 9: Overall Workshop evaluation from participants



4.3 Daily Evaluation

On average 18 participants completed daily evaluations. The following sessions received an average rating ranging from 3.65 to 4.9 (scale: 1 = insufficient to 5= excellent).

Figure: 10 Daily Workshop evaluations from participants



Annexes

The participants were drawn from the Ministry of Health, UN agencies and Non-governmental organizations implementing nutrition programs in Kenya.

Annex 1: List of participants who attended the national level coverage training

	Name	Organization	Position	Location	Email Address
1	Catherine Macharia	GAIN	Senior M&E Specialist	Nairobi	cmacharia@gainhealth.org
2	Lilian Kasina	IRC	Monitoring & Evaluation Manager	Nairobi	Lilian.Kasina@rescue.org
3	Viddah Owino	IRC	Nutrition Manager	Nairobi	Viddah.Owino@rescue.org
4	Edward Kutondo	UNICEF	Nutrition M&E officer	Nairobi	ekutondo@unicef.org
5	Louise Mwirigi	UNICEF	Nutrition M&E officer	Nairobi	lmwirigi@unicef.org
6	Nahashon Kipruto	ACF	surveillance DPM	Nairobi	Fsnsasst.ke@acf-international.org
7	Stanley Macharia	ACF	Surveillance officer	Nairobi and field support	Fsns.ke@acf-international.org
8	Kevin Mutegi	ACF	surveillance PM	Nairobi	Fsns.ke@acf-international.org
9	Caroline Chiedo	IMC	Deputy Nutrition PM	Nairobi	cchiedo@internationalmedicalcorpors.org
10	Jacob Oduor	Islamic Relief	Nutrition Coordinator	Mandera County	jacob.oduor@islamic-relief.or.ke
11	Kelvin Musau	Islamic Relief	Nutrition Coordinator	Wajir County	kelvin.musau@islamic-relief.or.ke
12	Dennis Mramba	Islamic Relief	Senior M&E Officer	Nairobi	dennis.mramba@islamic-relief.or.ke
13	Felicity Munene	Concern Worldwide	Assistant programme manager	Nairobi	felicitymunene@gmail.com
14	Siti Halati	WFP	Nutrition Programme officer	Uganda	siti.halati@wfp.org
15	Jackline Gatimu	WFP	Nutrition programme officer	Nairobi	jackline.gatimu@wfp.org
16	Lydia Ndung'u	WVI	Programme officer	Nairobi	lydia_Ndungu@wvi.org
17	Simon Gacheru	WVI	M&E programme officer	Turkana County	simon_gacheru@wvi.org
18	Charles Mumbi	WVI	Project manager	Nairobi	charles_mumbi@wvi.org
19	James Kamau	KRCS	Regional Nutrition Officer	Rift valley region	kamau.james@redcross.or.ke
20	Lucy Sembei	KRCS	Regional Nutrition Officer	Eastern region	sembei.lucy@redcross.or.ke
21	Luisalba Ngoma	KRCS	Project Officer	Dadaab	ngoma.luisalba@redcross.or.ke
22	Rosemary Nyaga	Feed the children	M&E Manager	Nairobi	rosemary@feedthechildren.co.ke
23	Lucy Gathigi	MoH	M&E programme officer	Nairobi	lucy.gathigi@gmail.com
24	Grace Gichohi	MoH	Emergency Nutrition Prog. Manager	Nairobi	grace.gichohi@yahoo.com
25	Eric Muthiani	SCUK	Nutrition Coordinator	Mandera County	eric.muthiani@savethechildren.org
26	Angela Kithua	SCUK	Nutrition Coordinator	Wajir County	angela.kithua@savethechildren.org

Annex 2: Agenda of the training

THEME	TIMING LINE	AGENDA-Day 1 (24 th August 2015)	PRESENTER(S)
INTRODUCTIONS	9.00-9.30	Introductions	CMN/MoH/ACF
	9.30-10.00	Expectation from the participants	All contribute
OVERVIEW OF AGENDA AND CMN	10.00-11.00	CMN overview and overview of training agenda	Lovely
Overview of coverage methodologies	11.15-12.00	Why measure coverage	Lovely
	12.00-1.00	coverage methodology to choose and outline of coverage assessment methods	Lovely
	2.00-2.30	SLEAC overview	Lovely
Quantitative data analysis	2.30-3.00	Quantitative data analysis and collection (+brief overview of BNA pilot)	Lovely
	3:00-3:30	Data analysis of sample data set	Team work
	3.45-4.30	Data analysis of sample data set	Team work
	4.30-5.00	Daily Evaluation	Team work

THEME	TIMINGS	AGENDA-Day 2 (25 th August 2015)	PRESENTER(S)
Recap	9.00-9.30	Recap-day 1	Team
Overview of community engagement Overview of community assessment for CMAM	9.30-10.15	Overview community engagement for CMAM program	Melaku
	10:15-11:00	Overview of community assessment for CMAM	Melaku
	11.15-12.30	Community assessment steps and implementation	Melaku
	12.30-1.00	Simulation on FGD/KII and BBQ	Team work
Qualitative data analysis	2.00-3.30	Qualitative data analysis	Melaku
	3.45-4.30	Data analysis- case study and group work	Team work
	4.30-5.00	Daily Evaluation	Team work

THEME	TIMINGS	AGENDA-Day 3 (26 th August, 2015)	PRESENTER(S)
Recap	9.00-9.30	Recap of Day two	Melaku
LQAS and Small surveys and studies	9.30-11.00	Hypothesis formulation, LQAS and small surveys and studies	Lovely
	11.15-1.00	Small area survey simulation	Team work
Prior formulation	2.00-3.30	Weighing of barriers and boosters	Melaku
	3.45-4.30	Setting prior	Lovely
	4.30-5.00	Daily Evaluation	Team

THEME	TIMINGS	AGENDA-Day 4(27 th August, 2015)	PRESENTER(S)
Recap	9.00-9.30	Recap of Day three	Team work
Geographic sampling	9.30-11.00	Preparing for wide area survey and case finding	Lovely
	11.15-1.00	Wide area survey simulation exercise	Team work

	2.00-3.30	Data analysis and estimation of coverage	Team work
SLEAC overview	3.45-4.30	BB analysis from stage 3	Melaku
	4.30-5.00	Daily Evaluation	Team work
THEME	TIMINGS	AGENDA-Day 5(28 th August, 2015)	PRESENTER(S)
Recap	9.00-9.30	Recap of Day four	CMN
Report writing and action plan setting	9.30-11.00	Action plan development	Melaku
	11.15-12.30	Balanced scorecard	Melaku
	12.30-1.00	Sharing of tools	Lovely and Melaku
Way forward	2.00-3.30	Setting national plans and coverage guidelines	Team
	3.45-4.30	Daily Evaluation	Team work
	4.30-5.00	Closure of the workshop	MOH

Annex 3: Questionnaire on capacity needs for coverage

What is your name?

Which organisation or department do you work for? What is your position? Explain briefly what your role involves.

Why are you interested in coverage?

What is your previous experience of coverage assessments?

☐	This is the first time I am hearing about coverage assessment
☐	I understand the concept of coverage and am aware of the methods available to measure coverage
☐	I have participated in a sensitisation workshop and know the basic information on SQUEAC and/or SLEAC
☐	I have participated in a SQUEAC and/or SLEAC assessment and understand the methods
☐	I have participated in multiple coverage assessments and have a good understanding of the methodology
☐	I have participated in multiple coverage assessments, have a good understanding of the methodology and have taken steps to improve the coverage of programmes within my organisation
Other:	

What actions will you take once you have completed this training? Please tick the action (or actions) you will take once you have been trained – tick / mark multiple boxes if necessary:

☐	I will take decisions to conduct coverage assessments in programmes in my organisation
☐	I will oversee the planning and delivery of coverage assessment in my organisation and comment on final reports (remotely)
☐	I will plan and conduct coverage assessments in my organisation's programmes
☐	I will go on to plan and conduct coverage assessments in other programmes or independently, as a consultant
☐	I will train those within my organisation to plan and conduct coverage assessments
☐	I will use the findings and action plan of the coverage assessment to improve the performance and impact of the programme
Additional actions:	

How do you plan to institutionalise the capacity you receive in this training within your organisation/team?

Annex: 4 Assessment 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	☐	☐	☐	☐	