

# SEMI-QUANTITATIVE EVALUATION OF ACCESS AND COVERAGE (SQUEAC) IFO 2 CAMP, DADAAB REFUGEE CAMP, KENYA

## FINAL REPORT

11<sup>TH</sup>- 29<sup>TH</sup> MAY 2015



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COVERAGE MONITORING NETWORK



## **ACKNOWLEDGEMENTS & ABBREVIATIONS**

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- IFO 2 Community members in Dadaab refugee camp for their useful information and time accorded during the assessment.

### **ABBREVIATIONS**

|        |                                                     |
|--------|-----------------------------------------------------|
| BCC    | Behavior Change Communication                       |
| BSFP   | Blanket Supplementary Feeding Program               |
| CHC    | Community Health Committee                          |
| CHW    | Community Health Worker                             |
| CMN    | Coverage Monitoring Network                         |
| CU     | Community Unit                                      |
| ECHO   | European Commission Humanitarian Aid                |
| FGDs   | Focus Group Discussions                             |
| GFD    | General Food Distribution                           |
| IMAM   | Integrated Management of Acute Malnutrition         |
| JAP    | Joint Action Plan                                   |
| KRCS   | Kenya Red Cross Society                             |
| ALOS   | Average Length of Stay                              |
| MAM    | Moderate Acute Malnutrition                         |
| MIYCN  | Maternal Infant and Young Child Nutrition           |
| MTMSG  | Mother to Mother Support Group                      |
| MUAC   | Mid upper arm circumference                         |
| OTP    | Outpatient therapeutic program                      |
| RUSF   | Ready to use Supplementary food                     |
| RUTF   | Ready to use therapeutic food                       |
| SAM    | Severe acute malnutrition                           |
| SAS    | Small Area Survey                                   |
| SFP    | supplementary feeding Program                       |
| SQUEAC | Semi-Quantitative evaluation of access and coverage |
| UNHCR  | United Nations High Commission for Refugees         |
| UNICEF | United Nations Children Fund                        |
| WAS    | Wide Area Survey                                    |
| WFH    | Weight for Height                                   |
| WFP    | World Food Program                                  |

## EXECUTIVE SUMMARY

The KRCS was established in 1965 through an Act of Parliament, and is the largest humanitarian organization in Kenya, with branches (64) and volunteers (about 70,000) across the country. In recent years, KRCS, with support from the IFRC, has mounted relief operations in response to large-scale disasters in the country including floods, droughts, terror attacks and forced population movements mainly resulting from conflicts. KRCS was involved in camp management till the first wave of Somali refugees arrived in Kenya back in 1991.

Over the last 4 years, KRCS has been involved in Dadaab Refugee operations in IFO 2 camp. Through its nutrition program focusing on High Impact Nutrition Intervention (HINI) whose indicators encompass IMAM, MIYCN, deworming, micronutrient supplementation, proper hygiene including emphasis on hand washing integrated with its WASH Programs so as to improve nutrition outcomes through scaled-up WASH interventions, KRCS supported by ECHO, UNHCR, WFP and UNICEF has been able to stabilize the nutrition status of vulnerable groups (children under the age of 5 years and pregnant and lactating women, as well as special cases (HIV/AIDS and TB Patients) as reflected in the 2013 and 2014 nutrition surveys.

KRCS, in collaboration with WFP and UNHCR carried out its first ever SQUEAC assessment in IFO 2 Camp-Dadaab Refugee Camp, between the 11<sup>th</sup> to 29<sup>th</sup> May 2015. The assessment exercise also acted as follow up of Staffs earlier trained on SQUEAC methodology by CMN Consultants Lovely Amin and Melaku Dessie in March 2015 while receiving remote technical support from them.

The entire assessment employed the three stages of SQUEAC Methodology involving (i) analysis of routine program data and qualitative data analysis, (ii) develop and test the hypothesis by a Small Area Survey; and (iii) conduct a 'Wide Area Survey' to estimate the Programme coverage rates of Out-patient Therapeutic Programme (OTP) and Supplementary Feeding Programme (SFP).

Hypothesis on areas of low and high coverage was confirmed only for OTP areas with High admission and for SFP areas with low admissions.

Following the 'Wide Area Survey' in stage three, the single coverage rate for SFP using Bayesian calculations is estimated at **77.5%** with a Credible Interval of (CI 72.1% - 82.2%), and P value= 0.0819 with reasonable overlap between 'prior' and 'likelihood'. The SFP coverage **did not meet the SPHERE standard** that set for camp settings, which is  $\geq 90\%$ .

For OTP, the Point coverage Bayesian calculations resulted in a high conflict between the prior and the likelihood. Therefore, **it was not possible to calculate the final coverage estimate for the OTP programme**, and this report does not inform a final coverage value for that programme. Calculations are available in the report's narrative (Stage 3) and additional explanation on the methodology is provided.

**Some of the identified barriers included:**

1. Competing priorities/lack of time by caregivers
2. RUSF misconception,
3. Rejection at the facilities after referral by CHWs
4. Sale of RUTF and lack of awareness by some caregivers on IMAM programs.

**Key Recommendations (for detail please see JAP)**

1. Train Community leaders on IMAM (Section/block leaders and Sheikhs) and Strengthen their roles in mobilizing the community for screening, case finding and referral, defaulter tracing and addressing selling RUTF/RUSF.
2. Provide all partners staff responsible for IMAM-related activities with community mobilization and social and behavior change communication training in line with their duties. It includes community figures, groups and CHWs
3. Ensure CMAM sites are open and functional in the afternoons to improve access by those beneficiaries who show up in the afternoon.
4. Do a refresher training to all CHWs on community mobilization for IMAM ( case finding and referral , home visit follow-up, sensitization )
5. Strengthen health education at health posts on RUTF and RUSF utilization.
6. Provide daily SFP service for newly identified cases even during non-SFP cycles.

# CONTENTS

|                                                                  |           |
|------------------------------------------------------------------|-----------|
| <b>ACKNOWLEDGEMENTS AND ABBREVIATION.....</b>                    | <b>2</b>  |
| <b>EXECUTIVE SUMMARY .....</b>                                   | <b>3</b>  |
| <b>1. INTRODUCTION.....</b>                                      | <b>6</b>  |
| 1.1 DADAAB REFUGEE CAMP.....                                     | 6         |
| 1.2 IFO 2CAMP.....                                               | 6         |
| 1.3 IMAM PROGRAMME IN IFO 2.....                                 | 7         |
| <b>2. OBJECTIVES.....</b>                                        | <b>8</b>  |
| 2.1 JUSTIFICATION.....                                           | 8         |
| 2.2. OBJECTIVES OF THE ASSESSMENT .....                          | 8         |
| 2.3 SPECIFIC OBJECTIVES .....                                    | 8         |
| 2.4 EXPECTED OUTPUTS .....                                       | 9         |
| 2.3 DURATION OF THE ASSESSMENT.....                              | 9         |
| 2.4 PARTICIPANTS .....                                           | 9         |
| <b>3. INVESTIGATION PROCESS.....</b>                             | <b>9</b>  |
| 3.1 STAGE 1 .....                                                | 10        |
| 3.1.1 ROUTINE PROGRAMME DATA ANALYSIS .....                      | 11        |
| QUALITATIVE DATA COLLECTION AND FINDINGS .....                   | 17        |
| 3.1.2.1 COMMUNITY STRUCTURES, LEADERSHIP AND GROUPS .....        | 17        |
| 3.1.2.2 COMMUNICATION CHANNELS .....                             | 17        |
| LOCAL UNDERSTANDING OF CHILDHOOD ILLNESSES AND MALNUTRITION..... | 17        |
| FACTORS INFLUENCING ACCESS TO CMAM SERVICES.....                 | 18        |
| COMMUNITY MOBILIZATION .....                                     | 18        |
| 3.2 STAGE 2 SMALL AREA SURVEY.....                               | 20        |
| 3.2.1 FINDINGS OF SMALL AREA SURVEYS .....                       | 21        |
| <b>3.3 STAGE 3 WIDE AREA SURVEY.....</b>                         | <b>21</b> |
| 3.3.1 SUMMARY OF BARRIERS AND BOOSTERS .....                     | 21        |
| 3.3.2 FORMING THE PRIOR .....                                    | 22        |
| 3.3.3 ESTIMATION OF SAMPLE SIZE AND SAMPLING FRAME.....          | 23        |
| 3.3.4. FINDINGS OF WIDE AREA SURVEY.....                         | 24        |
| 3.3.5 COVERAGE ESTIMATION.....                                   | 25        |
| 3.3.6 BARRIER TO ACCESS IMAM SERVICES.....                       | 27        |
| <b>4. DISCUSSION .....</b>                                       | <b>28</b> |
| <b>5. COMMUNITY MOBILIZATION COMPONENTS IN KRCS.....</b>         | <b>30</b> |
| <b>6. JOINT ACTION PLAN.....</b>                                 | <b>32</b> |
| <b>6. ANNEXES.....</b>                                           | <b>34</b> |
| ANNEX 1: SCHEDULE OF SQUEAC TRAINING AND ASSESSMENT .....        | 34        |
| ANNEX 2: LIST OF PARTICIPANTS .....                              | 36        |
| ANNEX 3: SQUEAC SURVEY QUESTIONNAIRE.....                        | 37        |
| ANNEX 4: SQUEAC SURVEY QUESTIONNAIRES, SSI .....                 | 38        |

# 1. INTRODUCTION

## 1.1 DADAAB REFUGEE CAMP IN KENYA

Dadaab is a semi-arid town in Garissa County, Kenya. It is the site of a large UNHCR base, the Dadaab Refugee camp hosting approximately 350,000 people in five camps as of May 2015. Dadaab is located approximately 80 kilometers from the Kenya-Somalia border and 500km from Nairobi and was created in 1991.

The camps cover a total area of 50 square kilometers and are within an 18 km radius of Dadaab town. As of May 2015, the base is the fourth largest population center in the country, and its five camps collectively constitute the world's largest refugee settlement<sup>1</sup>. Refugees living at the camp face numerous threats to their health, including diarrhea, pulmonary issues, and fever. Malnutrition is also a constant problem.

Dadaab hosts people that have fled various conflicts in the larger Eastern Africa region. Most have come as a consequence of the civil war in southern Somalia, including both Somalis and members of Somalia's various ethnic minority groups such as the Bantu. Most of the latter have migrated from the southern Jubba Valley and the Gedo region, while the remainder has arrived from Kismayo, Mogadishu and Bardera. Dadaab represents one of the largest and most protracted refugee situations in the world. Most Somali refugees cannot return to Somalia for fear of the ongoing violence and persecutions.

## 1.2 IFO 2 CAMP

IFO 2 camp was established in 2011 during the famine in the horn of Africa and is the fourth oldest and it is home to an estimated household of 11,003 with a population of 51,617 refugees comprising of 25,097 females and 26,520 males as at May 2015<sup>2</sup> mainly from the Lower and Middle Juba of Somalia. It is estimated that 98.7% of the population is composed of the Somali community. The camp also hosts minority South Sudanese, Burundians, Rwandese and Ethiopian communities. The camp is divided into two sub camps: IFO 2 East and IFO 2 West. Refugees in IFO 2 are mainly dependent on WFP for food and are mainly engaged in limited livelihood projects as it is one of the new camps without a defined existing market place/site.

The camp has three health posts and one level 5 Hospital<sup>3</sup>. The KRCS offers various health interventions within IFO 2. These include clinical management of patients, nutrition, reproductive health, HIV/TB programs, and mental health services and, community health program. The level five Hospital is the main referral hospital for the whole of Dadaab refugee camps where majority of the specialist's consultants conduct operations and provide specialized care to the refugees. See IFO 2 map below.

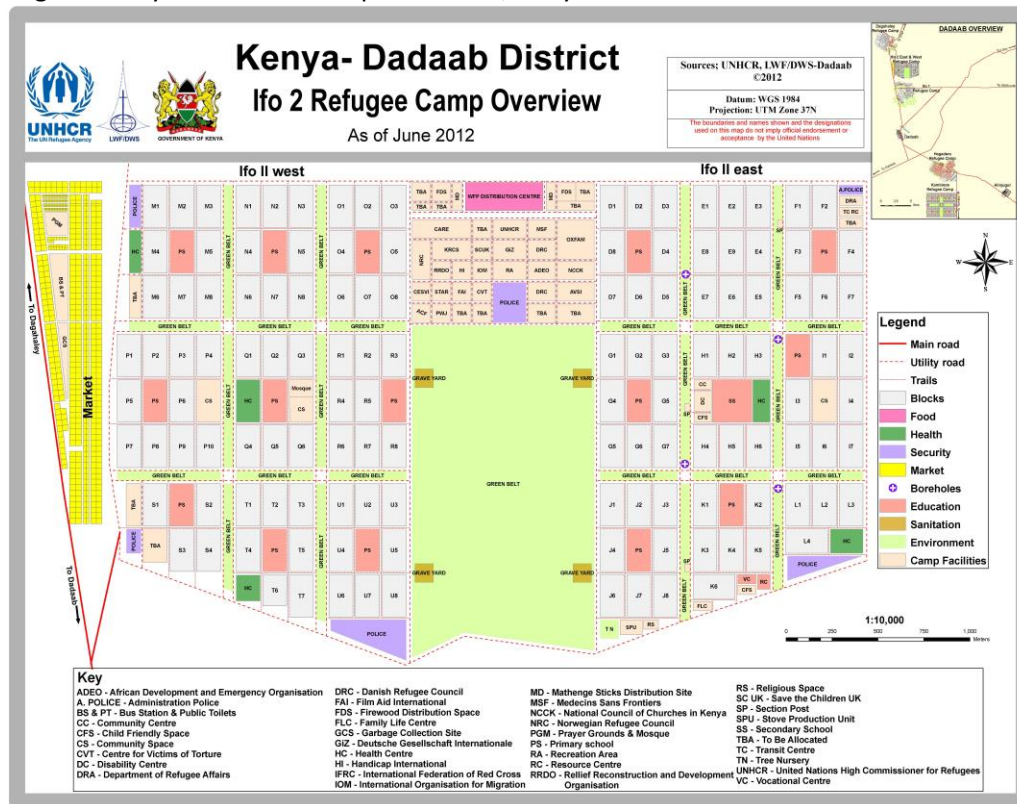
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<sup>1</sup> <https://en.wikipedia.org/wiki/Dadaab>

<sup>2</sup> UNHCR Dadaab Population Statistics May 2015

<sup>3</sup> The Hospital is equipped with and staffed to provide comprehensive medical services including initial evaluation, stabilization and diagnostics capabilities. It has an Emergency unit functional 24-hours daily, theatre, psychiatric and pediatrics units, SC, Maternity and NBU but lacks ICU. The Hospital is the main referral hospital for the whole of Dadaab refugee camps.

Figure: 1 Layout of IFO 2 camp in Dadaab, Kenya.



### 1.3 IMAM PROGRAM IN IFO 2 CAMP

KRCS has been implementing IMAM program in IFO 2 since October 2011. The community health program conducts all the outreach activities such as active case finding of malnourished children through daily screening using MUAC at the household level, referrals of the cases found to be malnourished, defaulter tracing immunization coverage, health education, mass campaigns such as polio and measles at the community level.

The nutrition program has two key programs: IMAM and Maternal, Infant, and Young Child nutrition (MIYCN). The MIYCN components includes Behavior change communication (BCC) strategies aimed at promoting optimal infant and young child feeding practices exclusive breastfeeding , optimal complementary feeding through cooking demonstration in the mother to mother support groups, community engagement through community dialogues and family bazaars.

IMAM on the other hand is a curative program aimed at rehabilitating malnourished children. The program has four key components; SFP, OTP, SC and community mobilization. KRCS has been providing inpatient treatment services for the SAM cases with medical complications and outpatient for severe acute malnutrition (SAM) without complication and moderate acute malnutrition (MAM) SAM cases with medical complications are treated as inpatients in the stabilization center located in the level five hospitals. KRCS has a clear referral mechanism between the components. The IMAM program is implemented following the national MoH guidelines.

## 2. OBJECTIVES OF TRAINING AND ASSESSMENT

### 2.1 Justification

No SQUEAC assessment has been previously conducted since the inception of the camp in 2011. The lack of a coverage assessment, coupled with implementation of IMAM in the area over the past four years deemed it important to establish barriers and boosters to program coverage

### 2.2 Objectives of the assessment

The main objective of the training and assessment was to equip KRCS staff with capacity to be able to conduct SQUEAC assessment in IFO 2 with remote support from CMN. The training was to further enable KRCS staff incorporate SQUEAC into the routine Malezi Bora<sup>4</sup> MUAC assessments. The training and assessment were carried out in IFO 2, Dadaab Refugee Camp

The SQUEAC training included how to improve collection and utilization of the routine program's monitoring data hence to improve the service quality, qualitative data collection techniques, qualitative data analysis and generation of barriers and boosters. The training further included quantitative data collection and analysis and how to set up the prior. Finally, the SQUEAC team developed a Joint Action Plan (JAP) on community mobilization activities to improve the access and coverage of this IMAM program for IFO 2 camp.

### 2.3 Specific objectives

1. Build the capacity of KRCS nutrition and health staff in SQUEAC methodology.
2. To estimate point /Single coverage of SFP and OTP in IFO 2.
3. Identify factors affecting access to and uptake of the IMAM services IFO 2.
4. To design a comprehensive community mobilization strategy to improve access to IMAM services.
5. Develop specific recommendations and Joint Action Plan improve acceptance and coverage of the program

---

<sup>4</sup> Malezi Bora (Swahili for Good Nurturing) was adopted in 2007 by Kenya's Ministry of Public Health and Sanitation in partnership with UNICEF. The initiative works to address the declining child survival indicators in Kenya through countrywide mobilization for increased utilization of routine child survival services targeting children under- five, expectant women and breast feeding mothers in Kenya, thus propelling Kenya towards achieving the Millennium Development Goals.

## 2.4 Expected outcomes

1. Train selected health/nutrition staff on SQUEAC methodology
2. Develop a Joint Action Plan and strategy on how to implement the plan
3. Produce a final coverage survey report for IFO 2 SQUEAC assessment and community mobilization.

## 2.5 Duration of the training and assessment

The training and assessment took 19 days from 11<sup>th</sup> May to 29<sup>th</sup> May 2015.

## 2.6 Participants

WFP and KRCS facilitated the training of 37 participants both national and refugee in the assessment. The assessment was integrated with the first cycle of the Malezi Bora campaign for 2015. 15 participants conducted stage 1 and the rest participated in the small and wide area survey alongside Malezi Bora campaign that included vitamin A supplementation, mass MUAC screening of children 6-59 months and deworming of children 2 -15 years .

### 3. INVESTIGATION PROCESS/METHODOLOGY

The KRCS health and nutrition team in IFO 2 was trained on Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) methodology in order to build their skills as well as to conduct the coverage assessment in IMAM program in IFO 2. The SQUEAC investigation methodology included:

**Stage 1:** Analysis of qualitative (contextual data) and quantitative (routine program monitoring data) data, compared with SPHERE minimum standard and identification of program *boosters and barriers*.

**Stage 2:** Conducted a 'Small area survey' and testing of the hypothesis; if areas with the highest OTP/ SFP admissions had high coverage and areas with the lowest OTP/SFP admissions had low coverage.

**Stage 3:** Conducted a 'Wide area survey' to estimate program coverage rate and compared it with SPHERE minimum standard. Later formulate recommendations and develop a JAP to improve access to IMAM services and increase program coverage.

#### 3.1 STAGE 1:

In stage 1, quantitative and qualitative data was collected and analyzed from all the three SFP and OTP sites. For the quantitative part, routine program monitoring data was collected from patient registers and reports from the three SFP /OTP health posts.

##### 3.1.1 ROUTINE PROGRAMME MONITORING DATA

###### **Routine program monitoring data**

SQUEAC utilizes routine program monitoring data that are accessible and directly related to quality of service in the program. The data can be used to assess three things: i) the accuracy and appropriateness of the data related to the coverage and program performance, ii) whether or not a program is responding well to the demands of its context, and iii) whether there are specific areas within the program's target area expected to have either relatively low or high coverage. The program performance indicators were compared to international minimum standard (SPHERE) related to the context of the implementation area. The aim was to assess the program's capacity to respond to changes in demand for its services. The following data was collected and analyzed:

| <b><i>Admission data</i></b>                                                                                                                                                     | <b><i>Programme performance indicators</i></b>                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>- Admissions trend for OTP &amp; SFP and seasonal calendar</li><li>- MUAC status at admission for OTP</li><li>- Age at admission</li></ul> | <ul style="list-style-type: none"><li>- Cured, Defaulters, Death, Non responders and Transferred cases – OTP &amp; SFP</li><li>- Defaulters' trend and seasonal calendar (labour period and migration etc.)</li><li>- Defaulter's nutritional status at the time of defaulting</li><li>- Number of weeks spent in OTP before defaulting</li><li>- Length of Stay (LoS)</li></ul> |

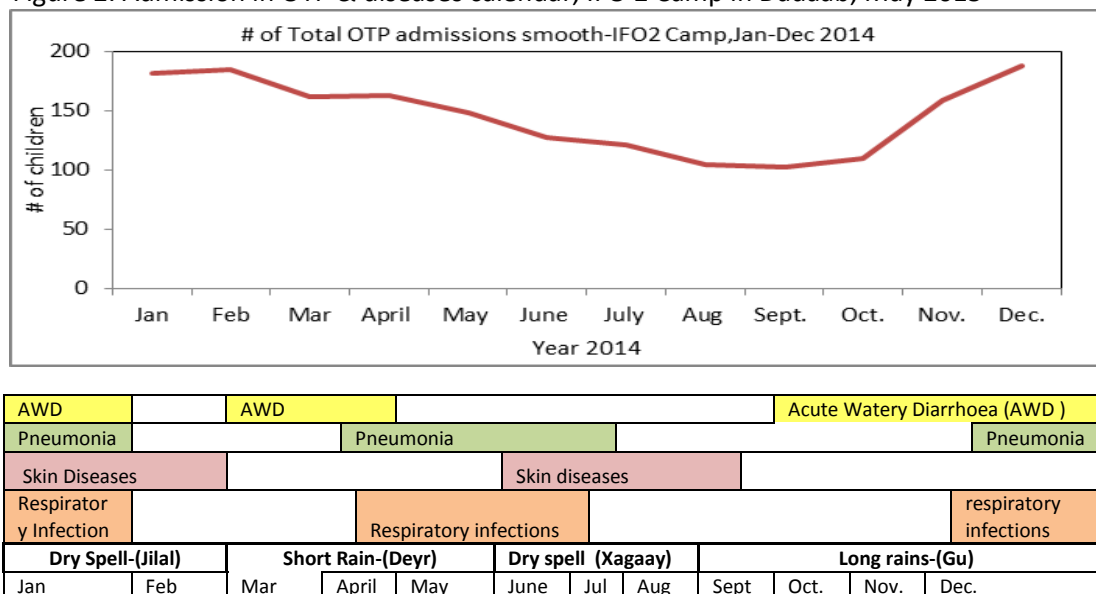
## Admissions Data

KRCS nutrition program had admitted in total of 3636 SFP and 1790 OTP children between 6-59 months of age from January 2014 to December 2014 in three SFP/ OTP sites. Of the 3726 and 1552 children for SFP and OTP respectively were discharged as cured. This gave a cure rate of 96.2% and 91% for SFP and OTP respectively. Compared to SPHERE standards, KRCS achieved a cure rate of above the SPHERE standards for both the programs.

### OTP admission, seasonal trends and childhood illnesses

There was a peak in admission in the month of December 2014 for both SFP and OTP. However, the peak season for childhood illnesses especially Diarrhoea was from November to February comparing with the other months of the year, when admissions were considerably high. The disease calendar was identified by both the assessment teams and the community. There was also a reduction in the ration provided by WFP. For the rest of the year, the admissions were fairly stable. Figure 2 below shows that there is a relation between peak seasons of childhood illness with the admission trend in OTP.

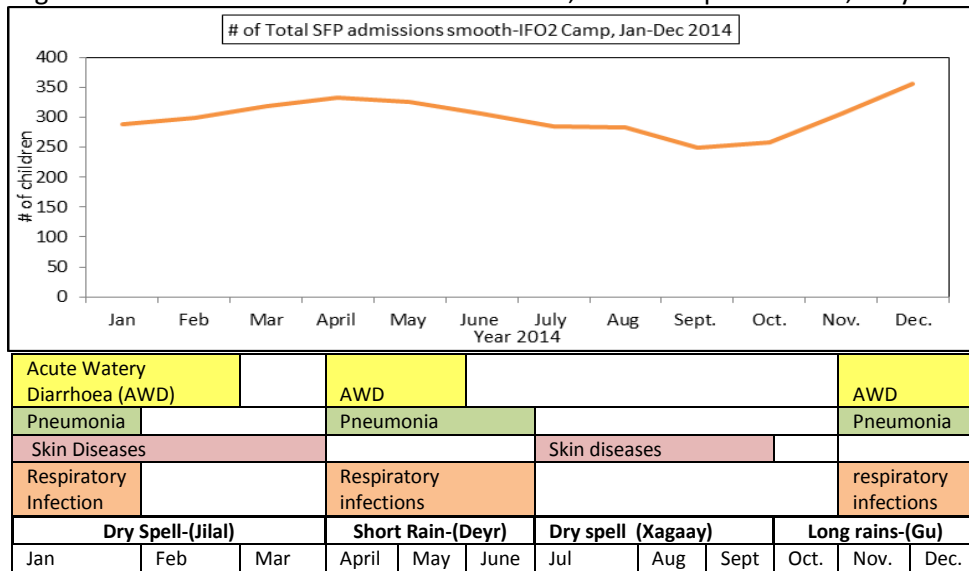
Figure 2: Admission in OTP & diseases calendar, IFO 2 Camp in Dadaab; May 2015



### SFP Admissions, Seasonal Trend & Childhood Illness

The admission trends for SFP show a similar trend like for OTP with the peak season for admission and childhood illnesses from November reaching its peak in December. Important to note however, is that during the short rains period the SFP admissions also increased due to increased cases of Acute Watery Diarrhoea and respiratory infections as observed by the assessment team.

Figure 3: Admission in SFP & diseases calendar, IFO 2 Camp in Dadaab; May 2015



### **MUAC at the time of admission**

The admission MUAC allows the program team to understand the timeliness of care seeking behaviors of communities as well as the pro-activeness of the communities on early screening and referring of cases to the IMAM program. The median MUAC at admission from the program data was 11.3cm for OTP and 12.1 for SFP. This shows a positive health care seeking behavior from the community as malnutrition cases are identified timely. However 17.6% of the children were admitted with a MUAC of below 11 cm. There were also 18.9% of children admitted with a MUAC above 11.4 which was against the admission criteria. It was assumed that these children were admitted through weigh for height.

Figure 4: MUAC at admission in SFP, IFO 2 Camp; May 2015

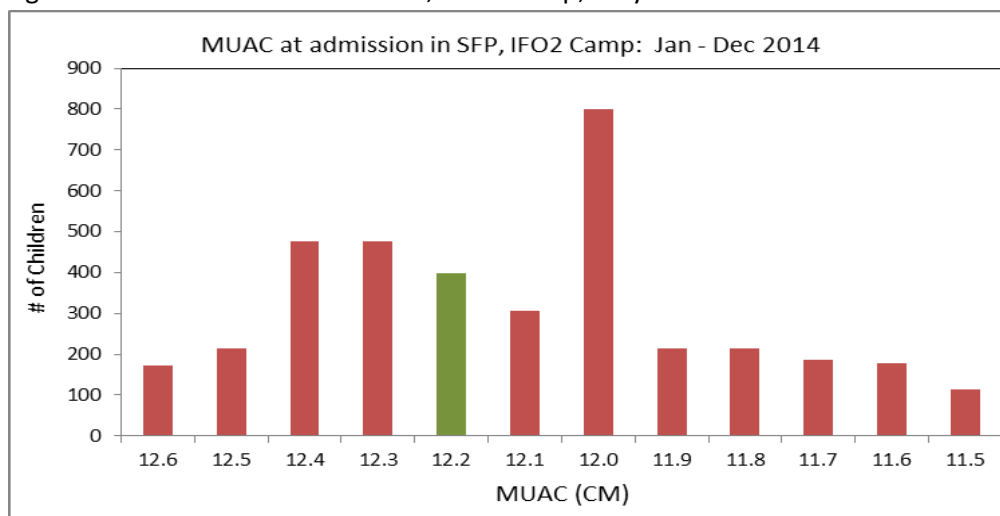
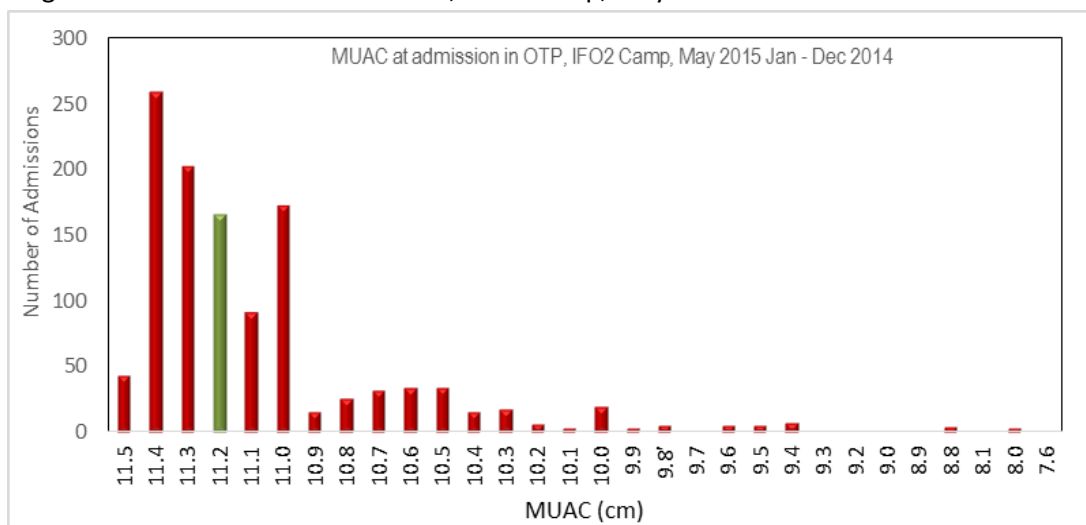


Figure 5: MUAC at admission in OTP, IFO 2 Camp; May 2015



### Age at admission

Age at admission allows the program team to identify the age group that is at higher risk of malnutrition for further investigation on the causes. This information can be used to better address the causes of malnutrition in the community. Majority of the children admitted in the program are children less than the age of two years with the median age group of admission being 6 to 12 months for OTP and 13 to 18 months for SFP. This highlights the need to focus and address infant and young child feeding practices and the current nutrition interventions in IFO 2.

Figure 6: SFP admission by age group

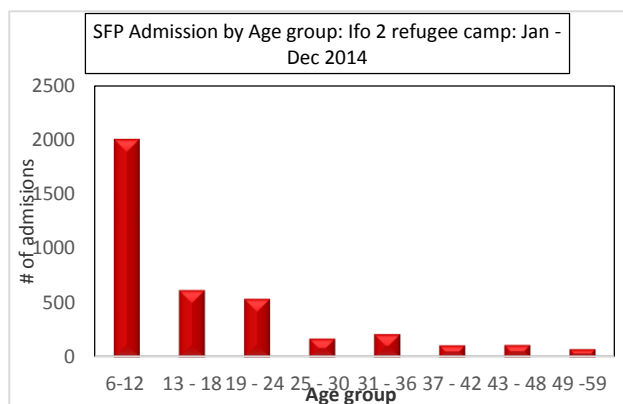
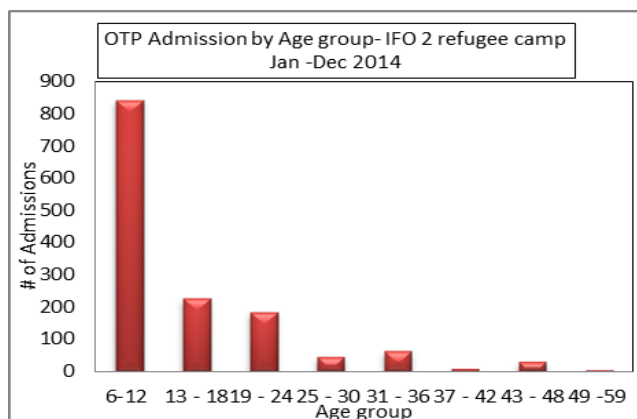


Figure 7: OTP admission by age group



## Program performance indicators

### Program exits

The program performance indicators are the indicators that measure the program effectiveness in achieving SPHERE standards. They are the percentage of children who exited from the program, compared to their status at time of exit (discharged cured, defaulter, and death etc.). For this assessment, percentages were used to ascertain the effectiveness of the program and compared with the SPHERE minimum standards. From January 2014 to December 2014, 1705 OTP and 3875 SFP children exited the nutrition program. 96.2% of the OTP discharged and 91% of the SFP discharged were exited as cured. No death was reported in SFP and OTP.

Figure 8: OTP Programme Performance Indicators, IFO 2 Camp; May 2015

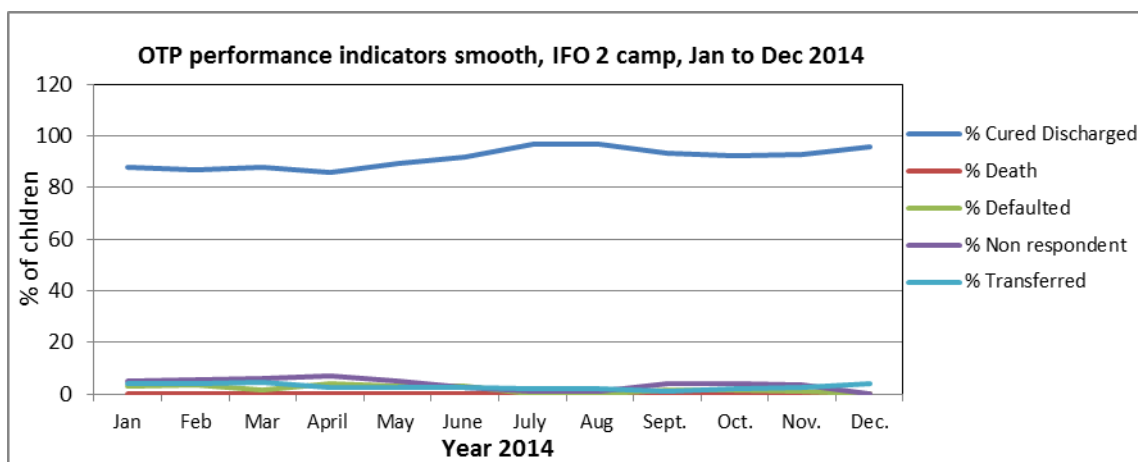
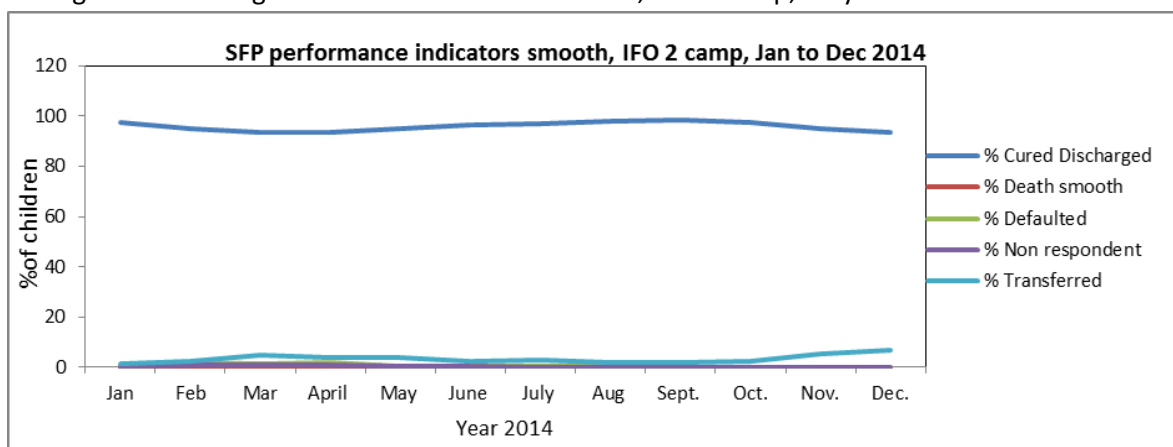


Figure 9: SFP Programme Performance Indicators, IFO 2 Camp; May 2015



### **Length of Stay (LoS)**

Length of Stay in OTP is also an important performance indicator to assess the quality of care a child is receiving during treatment at the facility, at home and the effectiveness of the IMAM program. The average acceptable length of stay in OTP is between 45-60 days according to the IMAM. The median length of stay for children admitted in IFO 2 nutrition program is nine (9) weeks which is slightly higher than the expected length of stay. There is a significant number of children (417 children) discharged after the 9<sup>th</sup> week. This also reflects poor utilization of therapeutic commodities /dilution of rations at home through sharing with Non-OTP beneficiaries.

SFP LoS was also noted to be 14 weeks which was above the IMAM guideline acceptable average of 3 months. 624 children were discharge from week 20 while 10 children stayed for 24 weeks in the program. This reflected badly on the adherence to the discharge criteria.

Figure 10: Length of stay in OTP IFO 2 May 2015

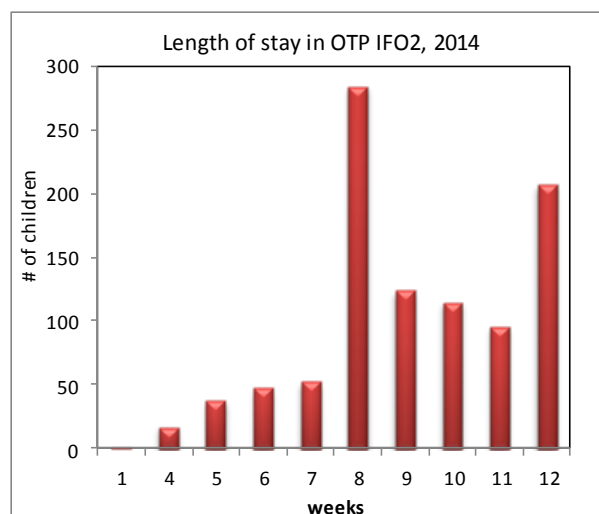
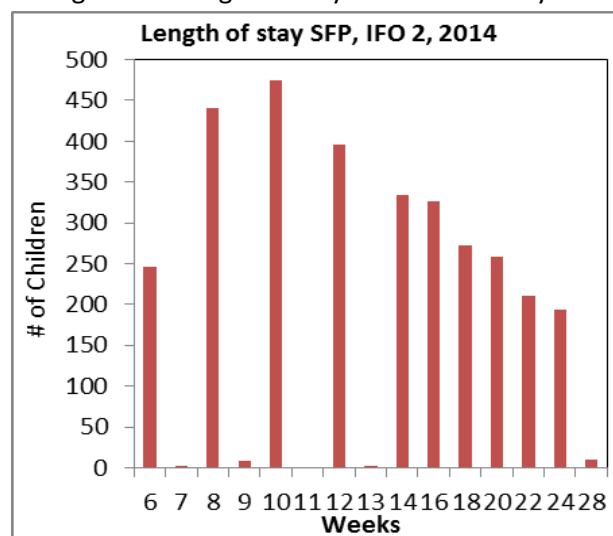


Figure 11: Length of stay in SFP IFO 2 May 2015



### **Data on Defaulters**

The IMAM guideline defines a defaulter as a children who is absent from follow up for three consecutive visits. The defaulter data were examined as follows:

#### **Nutritional Status at the time of Defaulting**

Monitoring of the nutritional status of children at the time of defaulting helps to inform the program on how to address issues related to defaulting. Data collected from the three sites showed that showed that 14.5% (n=27) and 59.3% (n=54) of children defaulted from OTP and SFP respectively when they were still malnourished (MUAC < 11.5cm for OTP and < 12.5cm for SFP). Defaulter rate for SFP was significantly high although within the acceptable SPHERE standards, and follow up for such cases have to be intensified and thorough. The average Median MUAC at defaulting was recorded at 11.7cm for OTP and 12.4 for SFP.

Figure 12: MUAC status at default, OTP

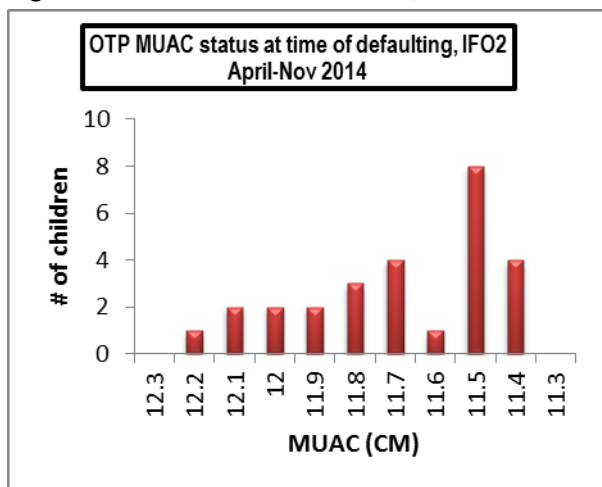
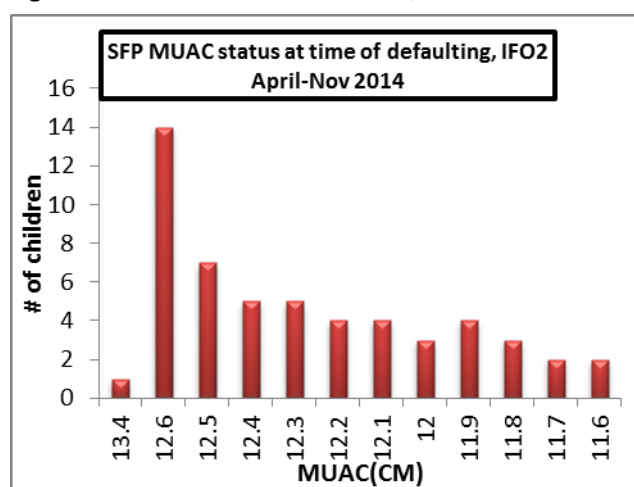


Figure 13: MUAC status at default, SFP



### Time of defaulting from OTP and SFP

It is paramount to monitor the length of stay in the program before defaulting. This information directly reflects on the quality of services the beneficiaries are getting from the facility. However for IFO 2 it could not necessarily show the quality of care but rather associated with voluntary repatriation. Children defaulted as early as week 1 in the program. Interviews from the staff showed that defaulters were children who had gone back to Somalia. For majority of SFP defaulters, it was associated with preference for RUTF to RUSF.

Figure 14: Length of Stay for OTP defaulters

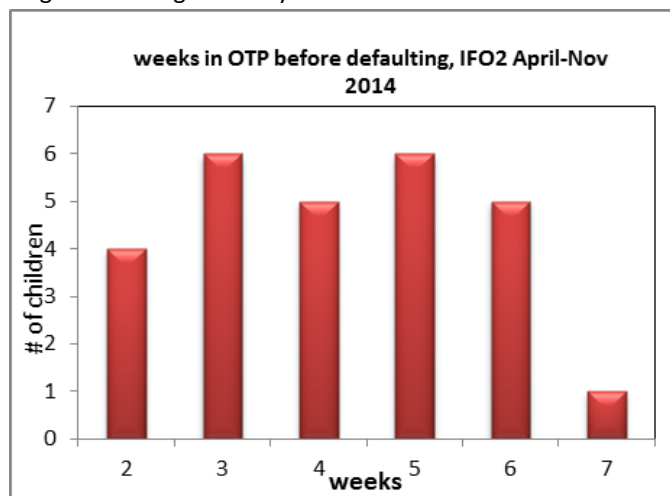
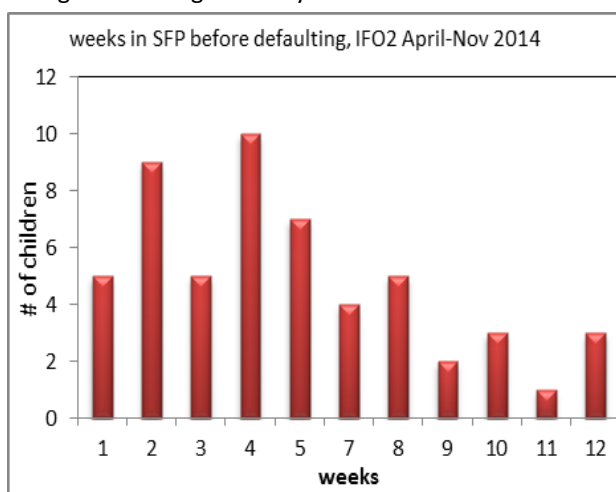


Figure 15: Length of Stay for SFP defaulters



### 3.1.2 QUALITATIVE DATA

For qualitative data, FGDs and key informant interviews were conducted. The groups that were interviewed included the mother to mother support group women, mothers of under-fives, fathers of under-fives, community health workers, facility healthcare workers, block leaders, food security, camp chairman, camp chairlady, and religious leaders. Below are the summary of the key findings:

#### 3.1.2.1 COMMUNITY STRUCTURES, LEADERSHIP AND GROUPS

The camp chairman and chairlady the block leaders, and religious leaders, are gatekeepers of the communities IFO 2. The camp chairman and chairlady are elected by the community member and serves as a link between the community and the agencies. The religious leaders (a sheikh or Imam, and pastor for minority groups), lead the worship mosque and church. The Sheikhs are very influential in uptake of healthcare services in IFO 2. The block leaders help to refer beneficiaries to the IMAM program.

Through the community health program, the camp has been divided into three community units (CUs). Each CU has a community health committee and a number of community health workers. The CHC supports health service delivery and function as a bridge between health facilities and communities. There is a clear integration of services between IMAM and CUs.

#### 3.1.2.2 COMMUNICATION CHANNELS

The use of megaphones and campaigns are key communication methods used in IFO 2. The mosque and the church also serve as communication channels although they are not very effective as they reach a minimal audience. Informal methods used at food distribution sites were cited during FGDs as an effective communication channels.

#### 3.1.2.3 LOCAL UNDERSTANDING OF CHILDHOOD MALNUTRITION

Most community informants were able to understand and describe malnutrition, and could differentiate it from other childhood illnesses. They were also familiar with different signs of malnutrition, Edema ,Wasting (Loss of weight),Skinny ,Lack of appetite ,Browning of hair ,Pale eyes/ pallor, Sunken eyes, delayed milestones, Crying all the time / irritability, Loose skin/ child looks aged

The perceived causes of malnutrition cited by community members were lack of balanced diet,, Lack of adequate food, Poor hygiene, Diarrhea and vomiting, Mixed feeding before 6 months, Diseases, Change of weather conditions, Evil eye/witchcraft/ curses, Smelling herbs, , Lack of staple food , Ignorance/ Lack of information.

Despite the community having knowledge of malnutrition, its perceived causes and where to seek assistance in case a child is malnourished, they did not know the admission criteria to OTP and SFP.

Traditional healing practices, home remedies and religious interventions were cited as ways that the community uses sometimes to address malnutrition alongside available IMAM services.

#### 3.1.2.4 FACTORS INFLUENCING ACCESS TO IMAM SERVICES

Several factors were cited as boosters to accessing IMAM services. These included active case finding by community health workers, involvement of CHC, mother to mother support groups and MIYCN counselors in the IMAM program. Training was also cited as a booster especially in building the capacity of the incentive staff to conduct IMAM activities. Good defaulter tracing by the CHWs, community acceptance of malnutrition, availability of ambulance services and freedom in decision making on seeking healthcare services also came up as boosters to the program.

Moreover, this assessment showed a range of barriers to IMAM services. Distance especially by the blocks far from health post, SFP and OTP not operational in the afternoon, delayed payments of incentive staff, inadequate awareness of malnutrition by some community members, lack of respect from some incentive staff and some beneficiaries, discrimination of the minority groups at the health post, rejection at the health post after referral by CHWs and not targeting above five year children were the major barriers cited.

#### 3.1.2.5 COMMUNITY MOBILIZATION

The community health program within IFO 2 is guided by the community health strategy approach. The Community Health Strategy's is an approach to empower households and communities in the delivery of Kenya Essential Package for Health at the community level. The overall goal of the community health strategy geared towards creating a demand for health seeking behavior and services within a community. The community's role in health is enhanced by strengthening their knowledge, skill and participation. In addition, this goal is accomplished by establishing sustainable level 1 service aimed at promoting dignified livelihoods across all the stages of the life cycle, and there is decentralization of services, as well as enhanced accountability and responsibility among all concerned partners.

Within IFO 2 camp, service delivery at level 1 has been established, with a work force of 75 Community Health Workers who ensure the promotion of health across all stages of the life cycle. The community's participation is enhanced through household dialogues, community dialogue days, community health action days, health education forums and training sessions. A total of 3 functional community units (group of households who have access to the same resources, face the same challenges and seek services from a particular health post) have been set up having 63 Community Health Committee members (CHC). The CHC provide leadership and governance at the community units. Within the CHC membership there is representation from religious leaders, community leaders, women, youth and people living with disability.

**Table 1: Functionality of CUs within IFO 2 Camp as at May, 2015**

| <b>Variable</b>                                                       | <b>Status</b>                                                                            |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| Existence of trained Community Health Extension Workers per CU        | One CHEW per CU                                                                          |
| Existence of trained Community Health Committee members               | Community Unit H – 26<br>Community Unit T – 17<br>Community Unit Q – 17                  |
| No. of Community Health Committee monthly meetings held for each unit | 1 ( minutes are available)                                                               |
| Availability of an updated Chalkboard (MOH 516)                       | All CUs have an updated MOH 516                                                          |
| Existence of trained CHWs                                             | 75 ( 58 CHWs, 15 Team leaders and 2 supervisors)                                         |
| Use of appropriate CHS stationery                                     | All CHWs have access to the household register, service delivery logbook, weekly summary |
| CHW Review Meetings                                                   | weekly meetings held and appropriate feedback provided                                   |
| Reporting Rate                                                        | 100 % ( Daily, Weekly, Monthly and Quarterly)                                            |

Community mobilization is usually carried out by the CHWs and CHC members. Various channels are usually used to mobilize the community and create awareness these include, household sessions, use of public address systems, announcements in the mosques and church and health education sessions at the facility.

The screening of children for acute malnutrition is done at health post and communities. Trained CHWs screen children and refer them to the health post for further screening. CHWs conduct active case finding, follow up and defaulter tracing. The nutrition incentives compile a list of defaulters and share with the CHWs on a weekly basis who then go to the community to look for the children.

At the community level, there are MTMSGs who meet fortnightly to discuss about MIYCN.

At the health facility level, KRCS has 34 nutrition incentives, 18 at health post H, and 8 each stationed at Q and T. The nutrition incentives perform different roles at the health post level. These activities include health education, growth monitoring and registration of new beneficiaries and follow up of old OTP and SFP beneficiaries. Each health post has the support of a nutrition officer who gives the technical support to the incentive staff.

## 3.2 STAGE 2: SMALL AREA SURVEY

In the second stage, qualitative and quantitative data gathered and analyzed was used to generate hypothesis. The assumptions and/or questions that were generated needed further investigation to validate the findings of stage one. Therefore one question was generated from the program admission data, “Do the blocks with high admissions have high OTP and SFP coverage and blocks with low admissions consequently have low coverage”?

### **Hypothesis formation**

From the above question, a hypothesis was generated that stated high admission blocks had high coverage and low admission blocks had low coverage.

Based on the above assumption, 8 blocks had high & 8 blocks that had low SFP and OTP admissions was selected.

The high admission blocks are, I1, I3, L4, M8, N5, Q6, R3 and R3 for OTP and E3, H6, I3, I4, L2, L4, M8 and Q3 for SFP.

The low coverage blocks, are D2, F6, G2, G3, J5, L1, P2 AND S3 for OTP and N7, P4, S1, T1, T6, U3, U4, and U 6 for SFP.

Therefore in order to test the hypothesis, those blocks were surveyed.

Data was collected from those blocks in one day for both SFP and OTP. In this survey, sample size was not necessary.

The survey sample size was the number of SAM and MAM children found by the surveyors in the selected blocks.

Based on coverage threshold for camps noted in SPHERE minimum standard,  $\geq 90\%$  coverage was defined as minimum coverage rate.

Pre designed questionnaires were used to record the cases (SAM & MAM), including both current cases and recovering cases (Annex- 3). A ‘semi structure’ interview was carried out using separate questionnaire for the mothers/caretakers of malnourished child that were not attending the program to find out and record the reasons for ‘not attending the program’ (Annex- 4).

In this survey, a door to door case finding method was utilized to find active cases of SAM and MAM as well as recovering cases for both SAM and MAM. Therefore almost all children age 6 to 59 months were measured in surveyed blocks.

### **Case Definition**

The admission criteria for SAM and MAM of IFO 2 IMAM program included children age between 6 to 59 months with at least one of the following criteria.

#### **OTP admission criteria:**

1. A Mid Upper Arm Circumference (MUAC) of  $<11.5$  cm and/or
2. Bilateral pitting edema (grade+ and grade++) with no medical complication
3. WFH  $<-3SD$

#### **SFP admission criteria:**

A Mid Upper Arm Circumference (MUAC) of  $<12.5$  cm to  $\geq 11.5$  cm

### 3.2.2 STAGE 2: SMALL AREA SURVEY FINDINGS

Table 2: Active cases found during Small Area survey

|                           | Total cases found | Total cases in program | Total cases not in program | Coverage by simple equation |
|---------------------------|-------------------|------------------------|----------------------------|-----------------------------|
| OTP High admission blocks | 18                | 17                     | 1                          | 94.4%                       |
| OTP low admission blocks  | 8                 | 8                      | 0                          | 100%                        |
| SFP high admission blocks | 17                | 9                      | 8                          | 52.9%                       |
| SFP low admission blocks  | 39                | 23                     | 16                         | 59%                         |

|                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b><u>OTP High coverage decision rule</u></b></p> <p>In high admission blocks 18 cases were detected. Out of 18, 17 cases were in program which gave coverage of 94.4%. According to SPHERE standard this was high coverage and therefore the hypothesis was confirmed. Blocks with high SAM admission means a high coverage.</p> | <p><b><u>OTP low coverage decision rule</u></b></p> <p>In low admission blocks 8 cases were detected. All the 8 cases were in program which gave coverage of 100%. According to SPHERE standard this was high coverage and therefore the hypothesis was not confirmed. Blocks with low SAM admission do not necessarily mean a low coverage.</p> |
| <p><b><u>Decision rule for SFP High admission blocks</u></b></p> <p>In SFP high admission blocks, 17 cases were found and 9 were in program. This gave coverage of 52.9%. This was below the SPHERE standards in the camps of &gt;90%. Therefore this part of the hypothesis was not confirmed.</p>                                  | <p><b><u>Decision rule for SFP low admission blocks</u></b></p> <p>In low SFP admission blocks, 39 cases were found and 23 were in program. This gave coverage of 59%. This was below the SPHERE standard of &gt;90% and therefore this part of the hypothesis were confirmed.</p>                                                               |

### 3.3 STAGE 3: WIDE AREA SURVEY

In Stage three the surveyors, try to get all information from stage one and two to understand the possible coverage rate for the program that undergoing the assessment. To predict the program coverage rate, estimation or scores from boosters and barriers and the survey result from stage two are generally consulted.

#### 3.3.1 SUMMARY OF BOOSTERS AND BARRIERS

The lists of comprehensive boosters and barriers were derived from well triangulated evidence in stage 1 and stage 2 by the assessment team. The scoring of boosters and barriers was done by the assessment team based on the weight of each element. The scale used rating from 0 to 9 to score for both 'barriers' and 'boosters'. 6 assessment teams scored each booster and barrier separately as it was expected that the scoring would differ among the team. However in this case the scoring did differ in some extent. The final scoring for each booster and barrier was agreed and assigned by using the average score. These average score for each category were added to "build up" the coverage score. The scores of Boosters are added to zero (i.e. lowest possible coverage) and the scorers of barriers are "subtracted" from 100% i.e. highest possible coverage.

Using the averages scores from boosters and barriers the expected coverage values with upper and lower expected values of coverage for both SFP and OTP were then set separately to test.

Table 3: SUMMARY OF BOOSTERS AND BARRIERS

| Barrier                                                                                                                                         | Score                  | score        | Booster                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|--------------|------------------------------------------------------------------------------|
| Long Distance from CMAM service point                                                                                                           |                        | 7            | Active case finding by community mobilization team                           |
| Long queues at service center                                                                                                                   | 5                      | 5            | Decision making by mothers with regard to seeking treatment for malnutrition |
| CMAM services not offered in the afternoon                                                                                                      | 4.5                    | 8            | Free CMAM services                                                           |
| Inadequate awareness on CMAM services                                                                                                           | 5.8                    | 5            | Good defaulter tracing                                                       |
| Delayed payment to CHWs                                                                                                                         | 5.5                    | 7            | Community not ashamed of malnutrition                                        |
| Lack of respect by Health workers to the beneficiaries                                                                                          | 2                      | 4.5          | Availability of ambulance                                                    |
| Discrimination of beneficiaries by the Health workers and guards especially from the minority groups such as Sudanese, Rwandese and Burundians. | 2                      | 5            | Supportive community leadership                                              |
| Rejection                                                                                                                                       | 3.5                    | 6            | Active MTMSGs                                                                |
| Misconception                                                                                                                                   | 6.5                    |              |                                                                              |
| Not targeting >5 years                                                                                                                          | 4.3                    |              |                                                                              |
| Lack of time                                                                                                                                    | 5                      |              |                                                                              |
| Total score                                                                                                                                     | 47.1                   | 47.5         |                                                                              |
| Subtracted from the maximum coverage (100%)                                                                                                     | 100-47.1=52.9%         | 0+47.5=47.5% | Added to the minimum coverage (0%)                                           |
| Estimated coverage                                                                                                                              | 52.9+47.5=100.4/2=50.2 |              |                                                                              |

### 3.3.2 Formulation of Prior<sup>5</sup>

The teams used findings from stage 1 and 2 data to set the 'prior' for both OTP and SFP, for the final stage of the coverage survey. The team assumed that the program coverage is likely to be around 75% for OTP and 65% for SFP. Therefore the 'mode' was set at 75% for OTP, with speculation of lowest possible coverage 50% and highest possible coverage 95%, and 65% for SFP, with speculation of lowest of 45% and highest possible coverage of 85%. The SFP prior was then described using the probability, alpha prior = 20.6 and Beta prior = 11.5, and the OTP prior was described using the probability, alpha=19.5 and beta= 7.1 using Bayesian-SQUEAC software. The precision for OTP was set at ±10% while that of SFP was set at ±7%, the software then automatically calculated, 44 SAM cases and 115 MAM cases were to be found regardless of whether they were in the program or not in the program.

<sup>5</sup> PRIOR is a statistical representation of our belief in Programme coverage

Figure 16: OTP prior for IFO 2

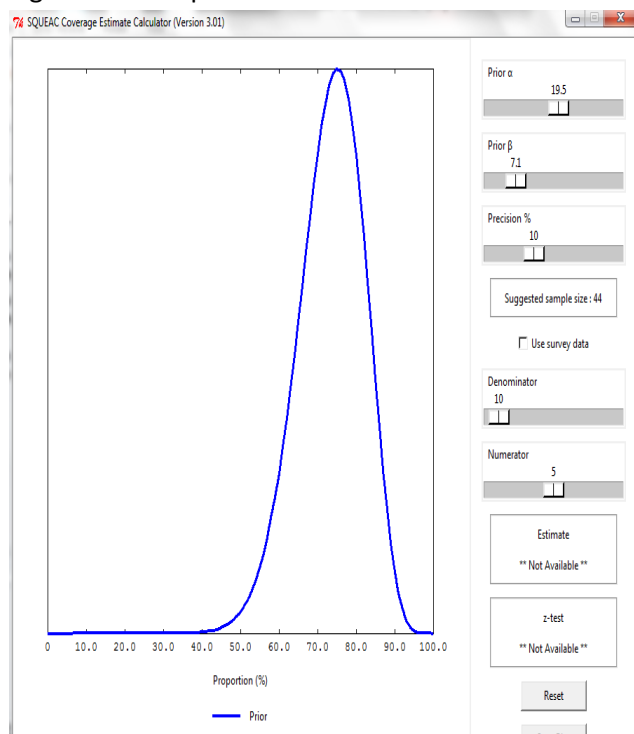
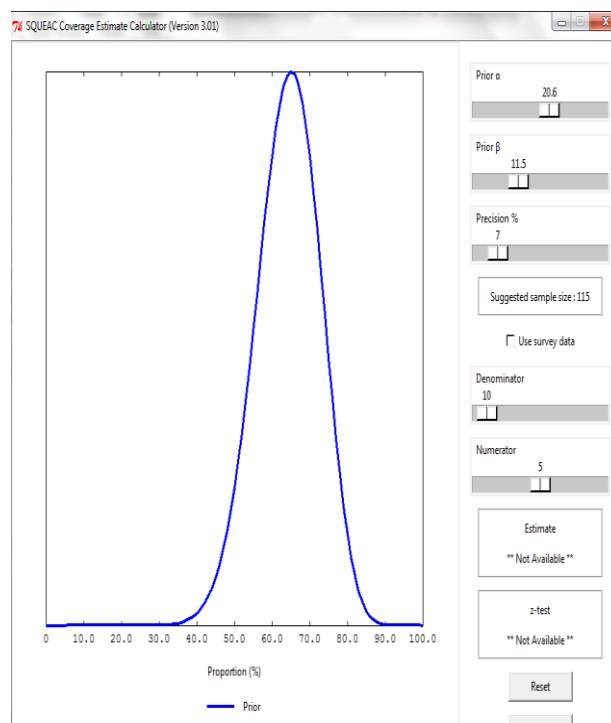


Figure 17: SFP prior for IFO 2 camp



### 3.3.3 Estimation of sample size and sampling frame

The Wide-Area Survey sampling covered the entire program catchment areas by adopting a spatial sampling method. A two-stage sampling procedure was employed to estimate the sample size and sampling frame. Sample size requirements were calculated, using simulation with the Bayesian-SQUEAC calculator by setting the 'Prior'. To provide a coverage estimate with a 95% Credible Interval (CI) and in a set precision, therefore the Bayesian SQUEAC calculated minimum sample size,  $n = 44$  SAM  $n = 115$  MAM current cases, either in program or not in program for OTP and SFP coverage.

**To estimate number of village to be sampled the following data was used:**

- i) The total population living in IFO 2 = 52 290
- ii) Percentage of population age less than five years old (18%, according to HIS progress report) and
- iii) Based on 2014 SMART survey using the MUAC the prevalence of SAM was 1.3% and prevalence of MAM 5.0% among children 6-59 months
- iv) To determine the minimum number of blocks to sample, using the formula 44 blocks were calculated to be sampled using spatial selection method to find both SAM and MAM cases in IFO 2.

### **Spatial Representation**

In order to achieve spatial representation, a list of all blocks in IFO 2 was developed. Blocks from each section were selected based on the population size. Blocks with a higher population were given priority.

To find SAM and MAM cases and recovering cases of SAM and MAM, a door to door case finds method was used, which was same as 'Small Area Survey' method. This method allowed for the inclusion of all, or nearly all, current MAM and SAM cases in all sampled blocks. Cases that were 'not in the IMAM program (SFP/OTP)' were referred to the nearest SFP/OTP care, as appropriate.

### **3.3.4 Findings of Wide Area Survey**

#### **Cases found in different communities**

The wide area survey team found 150 MAM and 65 SAM cases from 46 selected blocks that were surveyed using MUAC measurement and checking for bilateral pitting edema.

For MAM coverage assessment, out of 150 MAM cases out of 111 cases were found to be in program while 39 cases found are 'not in program'. For the 65 SAM, 60 cases were found to be in program.

Table 4: WAS SAM RESULTS

|     | Total cases | SAM in program | SAM not in program | Recovery cases | Male | Female |
|-----|-------------|----------------|--------------------|----------------|------|--------|
| OTP | 65          | 60             | 5                  | 44             | 55   | 54     |
| SFP | 150         | 111            | 39                 | 68             | 102  | 116    |

### **3.3.5 COVERAGE ESTIMATION**

#### **Point coverage of OTP & SFP:**

To estimate the program coverage rate data from the 'Wide Area Survey' and the pre-set Bayesian-SQUEAC prior was used. For this survey, point & Single coverage were estimated, but only the single coverage estimated was reported (see the executive summary).

#### **OTP coverage estimation**

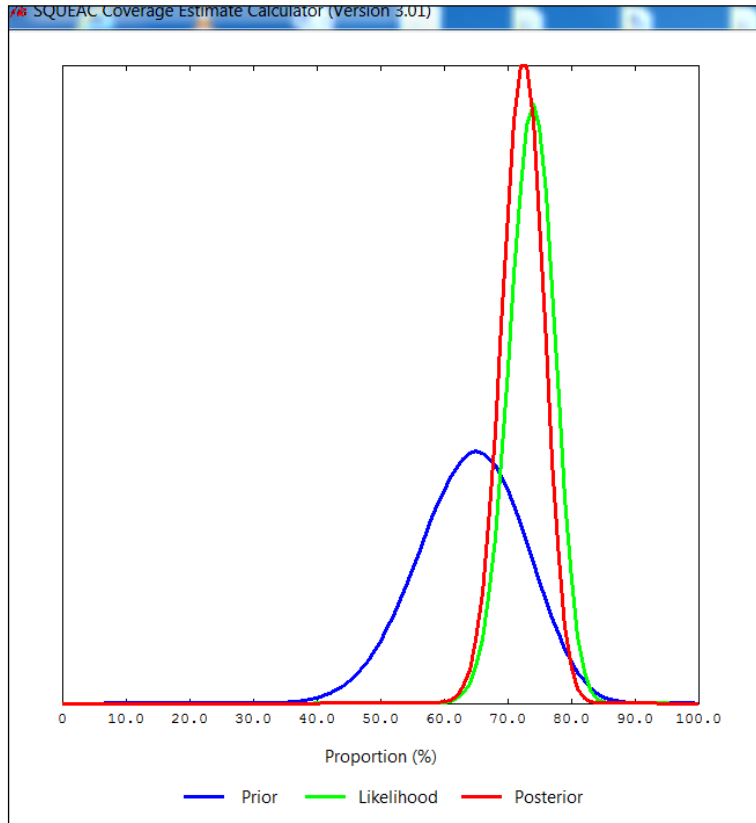
Bayesian calculations require a certain extent of coherence between the prior estimation and the results found in the Wide Area Survey. For the OTP services, the results of Bayesian calculations showed that there was great conflict between the prior and the likelihood, which can be seen by a very low 'p' value (<0.05) and very little overlap between the curves (see Figure 19 below).

Because of this large contrast between the elements of the calculation (prior and likelihood), **a coverage estimate for the OTP cannot be provided.**

### **SFP coverage estimation**

To calculate the 'Point coverage' for SFP as denominator (150) and numerator (11) was inserted to Bayesian-SQUEAC calculator while same Alpha and Beta values ( $\alpha$  20.6  $\beta$  11.5) and precision 7% have been used from the pre-set 'Prior'. The 'Point' coverage is estimated at 72.5% rate with Credible Interval (CI 65.6- 78.5%) P value = 0.3191, see graph

Figure 18: SFP 'point' coverage Estimation



### **Single Coverage for OTP & SFP:**

To calculate the 'Single coverage' for OTP & SFP below equation was used to calculate recovery cases that cannot be identified in the survey.

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

### **Single Coverage OTP**

For OTP single coverage estimation Bayesian calculator was not able to use. However, single coverage was estimated using the simple equation at 94.5%, see below.

## Single Coverage

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

$$\frac{60+44}{65+45} \times 100 = 94.5\%$$

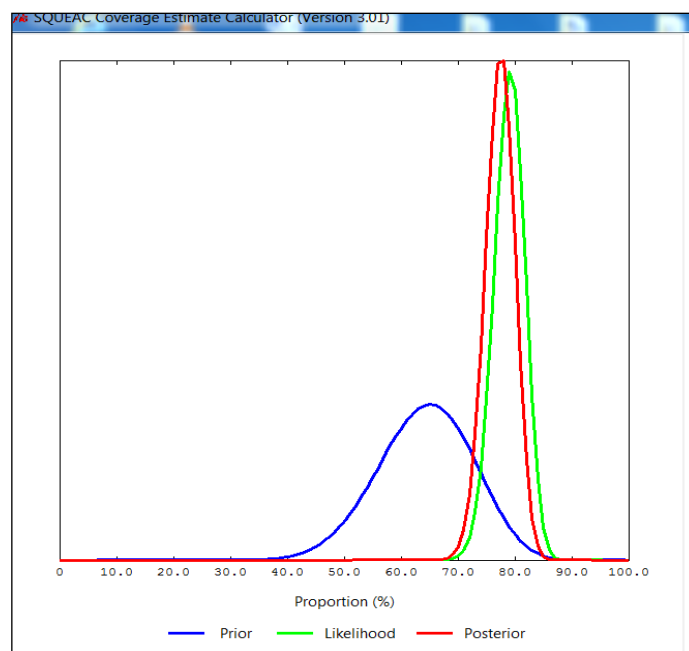
Table 5: Summary of point and Single coverage estimations

| Description                                                                                                                                                                                                           | Survey data                               | Point coverage    | Single coverage |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------|-----------------|
| <b>OTP</b><br>K = a correction factor<br>Cin= Current SAM cases in the program<br>Cout=Current SAM cases not the program<br>Rin= Recovering SAM cases in the program<br>Rout= Recovering SAM cases not in the program | Cin= 60<br>Cout=5<br>Rin= 44<br>Rout= 1   | 92.3 <sup>6</sup> | 94.5%           |
| <b>SFP</b><br>Cin = Current MAM cases in the program<br>Cout =Current MAM cases not the program<br>Rin = Recovering MAM cases in the program<br>Rout= Recovering MAM cases not in the program                         | Cin= 111<br>Cout=39<br>Rin= 68<br>Rout= 8 | 72.5%             | 77.5%           |

## SFP SINGLE COVERAGE ESTIMATION

For SFP single coverage estimation as denominator 226(111+ 39+ 68+8, current MAM in program + current MAM cases not in program + recovering cases + recovering cases not in program) and numerator 179 (111 + 68 current MAM cases in program + recovering cases), was inserted to Bayesian SQUEAC calculator while same and precision have been used from the pre-set 'Prior'. The Bayesian Software estimated 'single' coverage at **77.5%** rate with Credible Interval of (CI 72.1% - 82.2%), and P value= 0.0819, there is reasonable overlap between 'prior' and 'likelihood'.

Figure 19: SFP Single Coverage Estimation



<sup>6</sup> For OTP, the coverage was calculated using simple equation and was found to be **92.3%**. Bayesian calculator was not used to calculate the OTP coverage because the prior was set very low hence the resulting P value too low thus there was conflict between the prior, posterior and the likelihood.

The z- test revealed that there is a reasonable overlap between the ‘prior’, the ‘posterior’ and the likelihood in SFP single coverage estimation (figure: 19).

### 3.3.6 BARRIERS TO ACCESS IMAM SERVICES

Wide area survey interviewed the mothers/caretakers of MAM and SAM cases who were found ‘not attending the program. The interview included if they know the condition of their children and if they know the program that can treat acute malnutrition cases.

For SAM cases more than 85% mothers/caretakers claimed to know the status of their children. Only one mother (5%) said that she did not know the program that can treat her child with SAM.

Table 6: Summary of results for Barriers to access IMAM services

| Questions (MAM cases)                             | Yes (#/%)  | No (#/%)   |
|---------------------------------------------------|------------|------------|
| Is your child malnourished                        | 28 (71.7%) | 11 (28.2%) |
| Do you know a program that can help your child    | 32 (84.2%) | 6 (15.7%)  |
| Was your child previously admitted in the program | 21 (53.8%) | 19 (48.7)  |
| Questions (SAM cases)                             | Yes (#/%)  | No (#/%)   |
| Is your child malnourished                        | 1 (20%)    | 4 (80%)    |
| Do you know a program that can help your child    | 4 (80)     | 1 (20)     |
| Was your child previously admitted in the program | 2 (40%)    | 3 (60%)    |

Figure 20: Reasons for not being in SFP-IFO 2

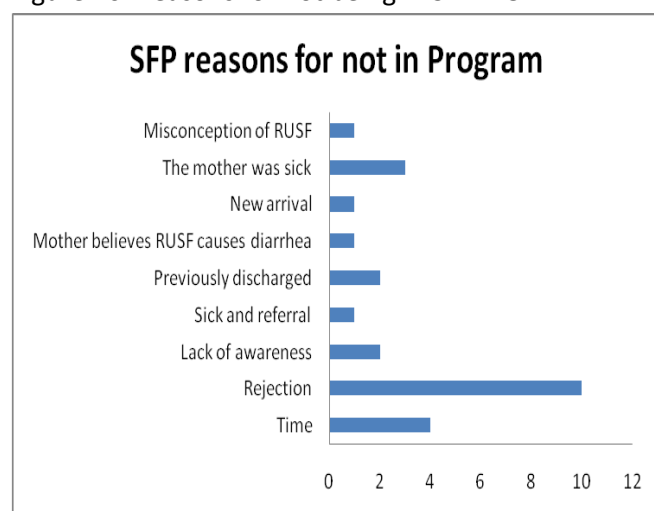
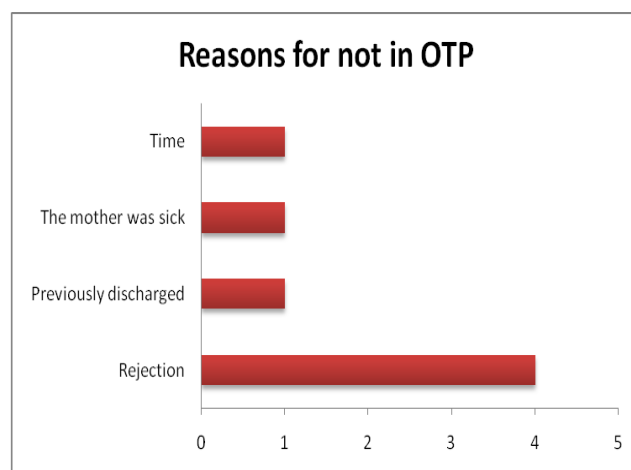


Figure 21: Reasons for not being in OTP-IFO 2



## 4. DISCUSSION

During the SQUEAC assessment, teams collected both primary and secondary qualitative and quantitative data. The data was further analyzed to better understand the program. The main aim of this assessment was to understand the program effectiveness and access. In terms of accessibility, the assessment focused on understanding the barriers and boosters to accessing IMAM program. This assessment also aimed to improve the quality of services as well as access and coverage of the program by developing and implementing a Joint Action Plan (JAP).

### ***DATA ANALYSIS OF PROGRAM PERFORMANCE INDICATORS:***

The Secondary data (routine Programme monitoring data) from the OTP and SFP registers was collected two weeks prior to the start of the assessment. Data on admissions by age, admissions by MUAC status, admissions by blocks, discharge by MUAC status, length of stay for cured and defaulters and defaulter per block was collected from the registers for the period January 2014 to December 2014.

Analysis of secondary data showed that both SFP and OTP program performance were meeting all the SPHERE minimum standards adequately. The discharged cured rate was recorded as 99% and 94% for SFP and OTP respectively, which was above >75% set by the SPHERE standards. Death rate remained 0% for both SFP and OTP while defaulter rate was 0.66% and 2% for SFP and OTP respectively. Non response rate was low at 0.32% for SFP and 3.88% for OTP. The OTP non respondents were children admitted to the program with other underlying medical conditions like Celebropalsy. These children never met the discharge criteria and were therefore being re-admitted.

### ***QUALITATIVE DATA ANALYSIS:***

Qualitative data analysis showed that a number of factors acted as boosters to the program. These included active case finding by community health workers and mother to mother support groups and staff trainings. Good defaulter tracing by the CHWs, community acceptance of malnutrition, availability of ambulance services and freedom in decision making on seeking healthcare services also came up as boosters to the program.

On the other hand this assessment showed a range of barriers to IMAM services. Distance especially from the blocks far from health post, SFP and OTP not operational in the afternoon, delayed payments of incentive staff, inadequate awareness of malnutrition by some community members, lack of respect from some incentive staff and some

beneficiaries, discrimination of the minority groups at the health post, rejection at the health post after referral by CHWs and not targeting above five year children were the major barriers cited.

### ***STAGE TWO & STAGE THREE:***

The stage two assessments focused on areas that recorded higher and lower admission based on program admission data. A small area survey was conducted on those areas. The survey results confirmed that areas with high admissions for OTP had high coverage but this part of the hypothesis was not confirmed in areas with high SFP admissions

SFP coverage was low in areas with low admission while in areas with low SAM admission had a high coverage thus the hypothesis was not confirmed thus OTP blocks with low SAM admissions do not necessarily mean a low coverage. However the same results showed that areas with low coverage did not necessarily mean they had a low coverage.

### ***LIMITATION:***

The major challenge faced during the assessment was insecurity. This limited the active involvement of partner staff in the blocks due to security policies.

### ***LESSONS LEARNT***

- Respect for health workers and respect for community members while carrying out community activities is essential for uptake of IMAM services.
- The community/ beneficiaries have different levels of knowledge and understanding of IMAM services.
- Skin diseases and hygiene is a concern and something should be done. KRCS To inform its WASH department on the situation at the community level
- Despite all the blocks being covered during Malezi Bora, it was noted that the coverage was slightly low compared to previous Malezi Bora exercises since we had 8 teams and couldn't get time to conduct Mop-up aimed at targeting children who were not captured during the exercise. Teams to be increased in future.
- It was evident that combining Malezi Bora exercise with SQUEAC assessment reduced the costs considerably for doing the activities separately as agencies saved on vehicle hiring costs, daily allowances/incentives to the teams and on engagement of staffs who have other competing responsibilities.
- Most children are being taken care of by older children instead of parents.
- Staffs participating in the SQUEAC learned on how to analyzing data.

## 4 COMMUNITY MOBILIZATION COMPONENTS IN KRCS

The community balanced score card and interviews were administered to the KRCS CHP health and nutrition team to identify the existing of community mobilization structure and resources in IFO 2. The findings were as follows;

### ***Community Assessment:***

The last assessment was conducted in 2011, during the inception stage of KRCS programs in Dadaab. The assessment conducted during the emergency period was to identify health and nutrition needs in the community. The assessment was comprehensive and involved all the stakeholders.

There after no major assessment has been done, however quarterly mass screening is conducted across the camp. The MUAC screening focuses on identifying cases but not the actual analysis of the program barriers and booster. KRCS has regular meeting with the CHWs and CHC, these meetings are held on monthly basis and they provide a good platform for the health and nutrition workers to discuss performance of the health and nutrition programs. In this forum health and nutrition indicators are discuss and action plan developed. In addition, quarterly assessments are conducted to evaluate the programs.

### ***Community mobilization strategy:***

KRCS has been functioning under the ministry of health community health strategy. The community mobilization structure consists of community health program officer, the CHWs and the CHCs. Some of the community mobilization activities include active case fining by CHWs, health education, a stable referral system and active involvement of community. KRCS has also been working closely with MOH more especially during campaigns and training, there has been proper integration of IMAM activities into the existing community based health activities. There also exist a well-coordinated communication strategy; KRCS uses multiple channels to pass the information to the community. This include using the community leaders and CHWs, local radio stations, mega phones and use of key groups in the community such as, men champion groups, mother to mother support groups, safe motherhood groups and community health committees. The integration with the health unit has also enabled information on IMAM to be communicated through health workers. The organization also works closely with film aid which is responsible for information dissemination in the camps.

### ***Capacity Building and creating material:***

The organization has been relying and using the ministry of health tools. In addition they have been working in liaison with ACF to produce MIYCN tools. The tools are tested at community level before they are adopted. One of

the key challenges in development of IEC materials is the suitability and acceptability of some of the materials. In IFO- 2 the community consists of the Gambelas, Burundians, Rwandese, Congolese and Somali, and generating materials that are acceptable in these communities have been a challenge due to the diverse cultures.

Capacity building of staff is one of the core activities of KRCS; most of the staff had undergone trainings on IMAM which encompasses community mobilization.

***Implementing and monitoring of community Mobilization:***

Community mobilization has been integrated and adopted as one of the key nutrition activities within the organization. Community mobilization and nutrition work plans are generated separately, however there is good integration with other departments such as WASH, SGBV, and health. This ensures proper implementation of the activities.

Monitoring and evaluation plan is in existence. Specific indicators are tracked on a monthly basis and if they are not performing as per the standard action is planned for. The health and nutrition coordinator has been integral in coordinating the activities, regular visits to the outreach teams are conducted on a monthly basis. Meetings are held to discuss on program performance indicators and action plans developed jointly.

The monitoring tools in place are those developed by MOH. Reports are submitted on a daily, weekly and monthly manner. To ensure there is data quality and accuracy, KRCS has trained the outreach workers on use of reporting tools and good reporting.

## 6. JOINT PLAN OF ACTION

The SQUEAC Assessment team in IFO 2 made some recommendations to improve quality of current IMAM Programme by analyzing Programme Barriers and Boosters to access of IMAM services by the community members thus developing an action plan as a clear guide for their implementation and achievement.

Table 8: KRCS, WFP and UNHCR Joint Plan on Community Mobilization for IMAM, June –Dec 2015

|          | Strategy /Activities                                                                                                                                                                                                                                           | Performance indicator                                                               | Target                         | Priority/When April-Dec 2015 | Responsible (Focal Person or Agency ) |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------|------------------------------|---------------------------------------|
| <b>I</b> | <b>Community Mobilization</b>                                                                                                                                                                                                                                  |                                                                                     |                                |                              |                                       |
| <b>1</b> | <b>Community participation</b>                                                                                                                                                                                                                                 |                                                                                     |                                |                              |                                       |
| 1.1      | Train Community leaders on IMAM program (Section/block leaders and Sheikhs) and Strengthen their roles in mobilizing the community for screening , case finding and referral, defaulter tracing and addressing selling RUTF/SF                                 | # of leaders actively involved and supported                                        | 17                             | June-Dec                     | KRCS                                  |
| 1.2      | Extend nutrition activities especially SFP and OTP distributions to the afternoons to cater for those beneficiaries who were engaged in other competing activities such as GFD. (This is pegged to security advisory to permit staff to work in the afternoon) | # of distribution days and hours conducted in the afternoon                         | 5 distributions days per cycle | June-Dec                     | KRCS                                  |
| <b>2</b> | <b>Outreach activities</b>                                                                                                                                                                                                                                     |                                                                                     |                                |                              |                                       |
| 2.1      | Do a refresher training to all CHWs on community mobilization for IMAM ( case finding and referral , home visit follow-up, sensitization )                                                                                                                     | # CHWs trained and actively do community mobilization                               | 78                             | June-Dec                     | KRCS,UNHCR                            |
| 2.2      | Community sensitization on use of RUTF and RUSF via trained leaders and sheikhs                                                                                                                                                                                | # outreach sessions on nutrition product utilization per quarter at the block level | 2                              | June-Dec                     | KRCS,UNHCR                            |
| 2.3      | Initiate an advocacy component on the appropriate use of RUSF and sensitize the community on the                                                                                                                                                               | # outreach sessions on nutrition product                                            | 2                              | June-Dec                     | KRCS,WFP                              |

|           |                                                                                                                                                       |                                                     |               |                                     |                                              |
|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------|-------------------------------------|----------------------------------------------|
|           | RUSF Misconceptions                                                                                                                                   | utilization per quarter                             |               |                                     |                                              |
| <b>3</b>  | <b>Technical support, M and E</b>                                                                                                                     |                                                     |               |                                     |                                              |
| 3.1       | Standardize CHW's registration book to make sure MUAC data is captured                                                                                | % CHWS received revised registration book           | 78            | June                                | KRCS                                         |
|           | <b>Strategy /Activities</b>                                                                                                                           | <b>Performance indicator</b>                        | <b>Target</b> | <b>Priority/When April-Dec 2015</b> | <b>Responsible (Focal Person or Agency )</b> |
| 3.2       | Analysis of CHWs report and data from registration book and use findings to improve community mobilization                                            | % of CHWs received feedback monthly                 | 75%           | June-Dec                            | KRCS                                         |
| 3.3       | Strengthen joint UNHCR and WFP technical support and monitoring to KRCS                                                                               | # joint supervision                                 | 2             | June -Dec                           | UNHCR, WFP                                   |
| 3.4       | Strengthen supervision and technical support to CHWs by nutrition and health workers                                                                  | % CHWs supervised by month                          | 75%           | June -Dec                           | KRCS                                         |
| 3.5       | Conduct quarterly performance review of this JPA implementation                                                                                       | # performance review meeting held                   | 2             | Sept and Dec                        | KRCS, UNHCR, WFP and ACF                     |
| <b>II</b> | <b>SFP and OTP Services</b>                                                                                                                           |                                                     |               |                                     |                                              |
| <b>1</b>  | Strengthen capacity for health workers especially on documentation and reporting.                                                                     | # staff trained                                     | 34            | June-Dec                            | KRCS                                         |
| 2         | Provide counseling to caretakers on IMAM service and malnutrition at least during admission and discharge of cases, and problem cases at health posts | % caretakers received counseling                    | 75%           | June -Dec                           | KRCS                                         |
| 3         | Strengthen health education at health posts on RUTF and RUSF utilization.                                                                             | # sessions conducted /month<br># caretakers reached | 4<br>800      | June-Dec                            | KRCS                                         |
| 4         | Provide daily OTP and SFP service for newly identified cases                                                                                          | # health posts provided SFP provide                 | 34            | June-Dec                            | KRCS , WFP and UNHCR                         |

## 7. ANNEXES

Annex: 1 Schedule: **SQUEAC Training & Assessment, IFO 2 Camp, Dadaab May 11<sup>th</sup> to May 29<sup>th</sup> 2015.**

| Time                                 | Activity                                                                                                                                                                                                                                                                                                                               | Facilitators |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| Day 1 Monday May 11 <sup>th</sup>    | <b>Classroom Training</b> <ul style="list-style-type: none"> <li>• Opening session</li> <li>• Introduction</li> <li>• Schedules</li> <li>• Overview of the SQUEAC Methodology</li> <li>• Overview of the qualitative data collection objectives, methods</li> <li>• Group work identify Programmes boosters and barriers</li> </ul>    | Albert/Sarah |
| Day 2 Tuesday May 12 <sup>th</sup>   | <b>Classroom Training</b> <ul style="list-style-type: none"> <li>• Overview of FGD,KII,SSI methods</li> <li>• Review of the questionnaire</li> <li>• Distribution of tasks to the assessment teams</li> <li>• Developing Seasonal Calendar</li> <li>• Analysis of Programme data</li> </ul>                                            | Albert/Sarah |
| Day 3 Wednesday May 13 <sup>th</sup> | <b>Field Data collection</b><br>Collection of some contextual data from the camp: <ul style="list-style-type: none"> <li>• Local leaders</li> <li>• TBAs</li> <li>• Traditional healer</li> <li>• Health extension workers, community volunteers</li> <li>• Stakeholders (health, agriculture, education and social office)</li> </ul> | SQUEAC Team  |
| Day 4 Thursday May 14 <sup>th</sup>  | <b>Classroom Training</b> <ul style="list-style-type: none"> <li>• Contextual Data analysis(Field Data)</li> <li>• Identification of potential barriers and boosters of coverage</li> <li>• Selection of OTP sites for data collection</li> <li>• Going through Data collection format</li> </ul>                                      | Albert/Sarah |
| Day 5 Friday May 15 <sup>th</sup>    | <b>Field Data collection</b>                                                                                                                                                                                                                                                                                                           | SQUEAC       |

|                                       |                                                                                                                                                                                                                                                                                                |              |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
|                                       | <ul style="list-style-type: none"> <li>Information collection from OTP/SFP and SC</li> <li>FGD with OTP/SFP mothers</li> <li>FGD with health center staffs</li> <li>Developing seasonal Calendar with OTP Mothers</li> </ul>                                                                   | Team         |
| Day 6 Saturday May 16 <sup>th</sup>   | <b>Classroom Training</b> <ul style="list-style-type: none"> <li>Analysis of field data OTP/SFP</li> <li>Preparation for Small Area Survey</li> <li>Selection of areas with High and Low admissions</li> <li>Going through the Methodology and Questionnaires for Small Area Survey</li> </ul> | Albert/Sarah |
| Day 7 Sunday May 17 <sup>th</sup>     | Day off                                                                                                                                                                                                                                                                                        |              |
| Day 8 Monday May 18 <sup>th</sup>     | <b>Classroom Training</b><br>Class room training for Malezi bora team on the data collection tool and MUAC Screening                                                                                                                                                                           | Albert/Sarah |
| Day 9 Tuesday May 19 <sup>th</sup>    | <b>Field Data collection</b><br>Small Area Survey                                                                                                                                                                                                                                              | SQUEAC Team  |
| Day 10 Wednesday May 20 <sup>th</sup> | <b>Classroom Training</b> <ul style="list-style-type: none"> <li>Data analysis of Small Area Survey</li> <li>Data Analysis (Qualitative)</li> <li>OTP and SFP Data Analysis</li> <li>Bayesian SQUEAC</li> <li>Calculation of samples and villages for Wide Area Survey</li> </ul>              | Albert/Sarah |
| Day 11 Thursday May 21 <sup>st</sup>  | <b>Field Data collection</b><br>Conducting Wide Area Survey                                                                                                                                                                                                                                    | SQUEAC Team  |
| Day 12 Friday May 22 <sup>nd</sup>    | <b>Field Data collection</b><br>Conducting Wide Area Survey                                                                                                                                                                                                                                    | SQUEAC Team  |
| Day 13 Saturday May 23 <sup>rd</sup>  | <b>Malezi Bora Screening</b>                                                                                                                                                                                                                                                                   | SQUEAC Team  |
| Day 14 Sunday May 24 <sup>th</sup>    | <b>Malezi Bora Screening</b>                                                                                                                                                                                                                                                                   | SQUEAC Team  |
| Day 15 Monday May 25 <sup>th</sup>    | <b>Malezi Bora Screening</b>                                                                                                                                                                                                                                                                   | SQUEAC Team  |
| Day 16 Tuesday May 26 <sup>th</sup>   | <b>Classroom Training</b> <ul style="list-style-type: none"> <li>Data Compilation/Analysis of Wide Area Survey</li> <li>Estimation of Coverage</li> <li>Recommendation</li> <li>Development of Joint Action Plan (JAP)</li> </ul>                                                              | Albert/Sarah |
| Day 17 Wednesday May 27 <sup>th</sup> | <b>Community Mobilization Questionnaire</b> <ul style="list-style-type: none"> <li>KRCS Medical team leader/Nutrition coordinator /CHP coordinator</li> </ul>                                                                                                                                  | SQUEAC Team  |
| Day 18 Thursday May 28 <sup>th</sup>  | Report Compilation                                                                                                                                                                                                                                                                             | Albert/Sarah |
| Day 19 Friday May 29 <sup>th</sup>    | Sharing of Results/Findings                                                                                                                                                                                                                                                                    | Albert/Sarah |

Annex: 2 List of Participant, SQUEAC Training & Assessment- IFO 2 Camp Dadaab May 11<sup>th</sup> to May 29<sup>th</sup> 2015.

| NAMES                      | AGENCY | DESIGNATION                       | EMAIL ADDRESS                                                                        |
|----------------------------|--------|-----------------------------------|--------------------------------------------------------------------------------------|
| JUDITH OGUGU               | KRCS   | Nutrition Officer                 | <a href="mailto:ogugu.judith@redcross.or.ke">ogugu.judith@redcross.or.ke</a>         |
| ASHA AYAN                  | KRCS   | Nutrition Officer                 | <a href="mailto:ashaayanadan@gmail.com">ashaayanadan@gmail.com</a>                   |
| FUGICHA ARERO              | KRCS   | Nutrition Officer                 | <a href="mailto:fugichaarero@yahoo.com">fugichaarero@yahoo.com</a>                   |
| SARAH OTERI                | KRCS   | Nutrition Coordinator             | <a href="mailto:oteri.sarah@yahoo.com">oteri.sarah@yahoo.com</a>                     |
| MARTHA KAGUARA             | KRCS   | RH CO-ORDINATOR                   | <a href="mailto:kaguara.martha@redcross.or.ke">kaguara.martha@redcross.or.ke</a>     |
| ALBERT MWAMBONU            | WFP    | Nutritionist/Monitoring Assistant | <a href="mailto:albert.mwambonu@wfp.org">albert.mwambonu@wfp.org</a>                 |
| CHRISTINE SIMIYU           | KRCS   | HOSPITAL MATRON                   | <a href="mailto:simiyu.christine@redcross.or.ke">simiyu.christine@redcross.or.ke</a> |
| BRENDA JHUTHI              | KRCS   | COMMUNITY H. CO-ORDINATOR         | <a href="mailto:jhuthi.brenda@redcross.or.ke">jhuthi.brenda@redcross.or.ke</a>       |
| HASSAN ADEN OSMAN          | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| MOHAMMED ADOW<br>ABDULLAHI | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| SIYAD MOHAMMED NOOR        | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| HASSAN SHARIF              | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| WELI SHUKRI ALI            | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| SAID KHALIF OSMAN          | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| ALI ABDI AHMED             | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| BARE IBRAHIM MOHAMMED      | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| MOHAMMED SBTOW<br>ABDILLE  | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| HASSAN ADAN ALI            | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| IBRAHIM MOHAMED ADEN       | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| ABDULLAHI NOOR DIRIYE      | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| OMAR ALI HAJI              | KRCS   | MIYCN COUNSELOR                   |                                                                                      |
| MOHAMMED SHALE MAYOW       | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| ADEN ABDULLAHI ALI         | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| SAMAN BISHAR ISSACK        | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| IBRAHIM HUSSEIN ADAN       | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| MOHAMMEDNOOR RASHID        | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| ADAN ISMAIL ISSAQ          | KRCS   | INCENTIVE STAFF                   |                                                                                      |
| ABDI MOHAMMED ADAN         | KRCS   | INCENTIVE STAFF                   |                                                                                      |

|                        |      |                 |  |
|------------------------|------|-----------------|--|
| Weli Shukri Ali        | KRCS | INCENTIVE STAFF |  |
| Mohamed Adow Abdullahi | KRCS | INCENTIVE STAFF |  |
| Siyad Mohamed Noor     | KRCS | INCENTIVE STAFF |  |
| Hassan Shariff         | KRCS | INCENTIVE STAFF |  |
| Hassan Aden Osman      | KRCS | INCENTIVE STAFF |  |

ANNEX: 3 Survey data collection form 'Small/Wide area survey', IFO 2 Camp, Dadaab May 11<sup>th</sup> to May 29<sup>th</sup> 2015

SQUEAC: Small/Wide Area Survey SAM/MAM, IFO 2, Dadaab, March -2015

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Team\_\_\_\_ Team  
members\_\_\_\_\_

| #  | Child's Name | Mother's Name | Boma | Age (Month) | SEX |   | MUAC | SAM in the prog. | SAM not in the prog. | OTP recovering Cases in prog. |
|----|--------------|---------------|------|-------------|-----|---|------|------------------|----------------------|-------------------------------|
|    |              |               |      |             | M   | F |      |                  |                      |                               |
| 1  |              |               |      |             |     |   |      |                  |                      |                               |
| 2  |              |               |      |             |     |   |      |                  |                      |                               |
| 3  |              |               |      |             |     |   |      |                  |                      |                               |
| 4  |              |               |      |             |     |   |      |                  |                      |                               |
| 5  |              |               |      |             |     |   |      |                  |                      |                               |
| 6  |              |               |      |             |     |   |      |                  |                      |                               |
| 7  |              |               |      |             |     |   |      |                  |                      |                               |
| 8  |              |               |      |             |     |   |      |                  |                      |                               |
| 9  |              |               |      |             |     |   |      |                  |                      |                               |
| 10 |              |               |      |             |     |   |      |                  |                      |                               |

ANNEX: 4 Small/ Wide area survey Questionnaire for the guardians of the children (Active SAM and MAM cases)  
NOT in the programme

Name of Child: \_\_\_\_\_ Payam: \_\_\_\_\_

Village: \_\_\_\_\_ OTP site: \_\_\_\_\_ Date: \_\_\_\_\_

1. DO YOU THINK THAT YOUR CHILD IS MALNOURISHED?

YES ☐ NO ☐

2. DO YOU KNOW A PROGRAM WHICH CAN HELP MALNOURISHED CHILDREN?

YES ☐ NO ☐ If answer is NO stop

If yes, what is the name of the programme? \_\_\_\_\_

3. WHY DIDN'T BRING YOUR CHILD IN FOR CONSULTATION TO THIS PROGRAMME?

- Too far (What distance to be travelled with foot? .....how many hours? .....)
- I do not have time/too occupied
- To specify the activity which occupies the guardian in this period \_\_\_\_\_
- The mother is sick
- The mother cannot travel with more than one child
- The mother is ashamed to go the program (no good cloths etc...)
- Problems of safety
- The quantity of services too poor to justify to go
- The child was rejected before.
- The child of other people was rejected
- My husband has refused
- The guardians do not believe that the program can help the child (or prefers the traditional medicine, etc.)
- Other reasons: \_\_\_\_\_

4. Was the CHILD ALREADY ADMITTED IN the PROGRAMME before?

YES ☐ NO ☐

If answer is NO stop, if answer is yes continue,

- Why isn't s/he registered any more at present?
  - Defaulted, when? ..... Why? .....
  - Cured and discharged from the programme (When? .....)
  - Discharged but not cured (When? .....)
  - Others: \_\_\_\_\_
5. If you decide to use OTP/SC service, where and when you want to use of CMAM service?
6. Who decide or influence you take or NOT to take a child to a health facility?

7. How do you deal with a child who sick? Where you first seek a solution for a sick child? (**Probe:** home remedies with herbs used and which herbs are used, are the traditional treatment sought and administrated before children are taken to a health facility? Change of trend on the use of these methods, OTP )

8. Do you (women caregivers) breastfeed their babies under six months of age? At what age do mother start to give additional liquids to infants? What about complementary soft foods? How many times per day does a mother feed a 12 month-old infant? What is the child fed?

(Thank the guardian)