



Islamic Relief
Worldwide



COVERAGE MONITORING NETWORK



**SEMI QUANTITATIVE EVALUATION OF ACCESS AND COVERAGE
(SQUEAC), OF COMMUNITY BASED MANAGEMENT OF ACUTE
MALNUTRITION (CMAM), PROGRAM OF IFO N REFUGEE CAMP,
DADAAB, KENYA**

FINAL REPORT

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ACRONYMS

CBVs	Community Based Volunteers
CHWs	Community Health workers
CHCs	Community health committee
CMN	Coverage Monitoring Network
CNW	Community nutrition worker
H/W	Health worker
IMAM	Integrated Management of Acute Malnutrition
ALOS	Average length of stay
MIYCN	Maternal Infant and Young Child Nutrition
MAM	Moderate Acute Malnutrition
MIYCN	Maternal Infant and Young Child Nutrition
MOH	Ministry of health
MTMSG	Mother-To-Mother Support Group
MUAC	Mid upper arm circumference
NDMA	National Drought Management Authority
OJT	On job Training
OTP	Outpatient Therapeutic Program
RUSF	Ready to Use Supplementary Food
RUTF	Ready to use Therapeutic food
SAM	Severe acute malnutrition
SCHMT	Sub County Health Management Team
SFP	Supplementary Feeding Program
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
SMP	Safe Motherhood Programme
URTI	Upper Respiratory Tract Infection
WASH	Water Sanitation and Hygiene

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EXECUTIVE SUMMARY

Dadaab refugee camp comprises of 5 camps namely, Hagadera, Dagahaley, IFO, IFO- 2 west and Kambios camp. Dagahaley, Hagadera and IFO are the oldest camps as well as the largest. Currently, Islamic relief implementsts health and Nutirtion activities and management of schools in IFO camp.

Previously coverage was based on the HIS data reported on monthly basis, hence the coverage reported was over 100% which was not a true representaion of the camp coverage. To establish the actual coverage of the CMAM program SQUEAC assesment was undertaken in IFO camp. The objective of the assesment was to identify contextual barriers and boosters of the program, understand community knowleldge and current practises in relation to malnutrition.

The assesment was conducted in three stages, the first stage was collection and analysis of secondary data, the second stage involved hypothesis generation and conducting a small area survey to test the hypothesis. The third stage entailed, actual survey data collection where in sampled blocks the teams moved from house to house taking MUAC measurement of all children age 6 to 59 months. Mothers who had malnourished children who were not in any CMAM program were intervieweed so as to identify some of the barriers preventing them from accesing the programs.

Summary of the results

Qualitative and quantittative data collected during the first stage revealed that performace indicators for both OTP and SFP are within the SPHERE standards. The data also exhibited that the highest admissions for both SFP and OTP are between the age 6-12 months. Interviews with the mother revelead that complemenatry feeding is still an issue that needs to be addressed in the camp. Highest admission are during the rainy season this is mainly caused by the increased acute diarrhea cases . Focus group discussions with other key groups showed that the community is aware of malnutrition and they recognise it as a health problem in the community. There was general understanding of the signs and causes of malnutrition among the community. Some of the causes they sited were, diseases, lack of adeuqate food, lack of alternatives liveihoods and poor hygiene. The community also lacked clear understanding of the therapeutic feeds they received from the health posts, sharing and selling of plumpy sup and plumpy nut was noted as one of the livelihood strategies utilised by mothers hence impacting negatively on the outcome of the programs.

Results in stage two confirmed that areas with low admissions have low coverage. However areas with high admissions does not signify thay the areas have high coverage. The Single coverage for IFO camp for the OTP Program is 81.4% (CI 72.0% - 87.9%) P value = 0.3324, while the SFP Single coverage is 68.8% (62.5% - 74.5%), P value = 0.2551.

The assessment revealed that some of the barriers to accessing the CMAM program are as follows;

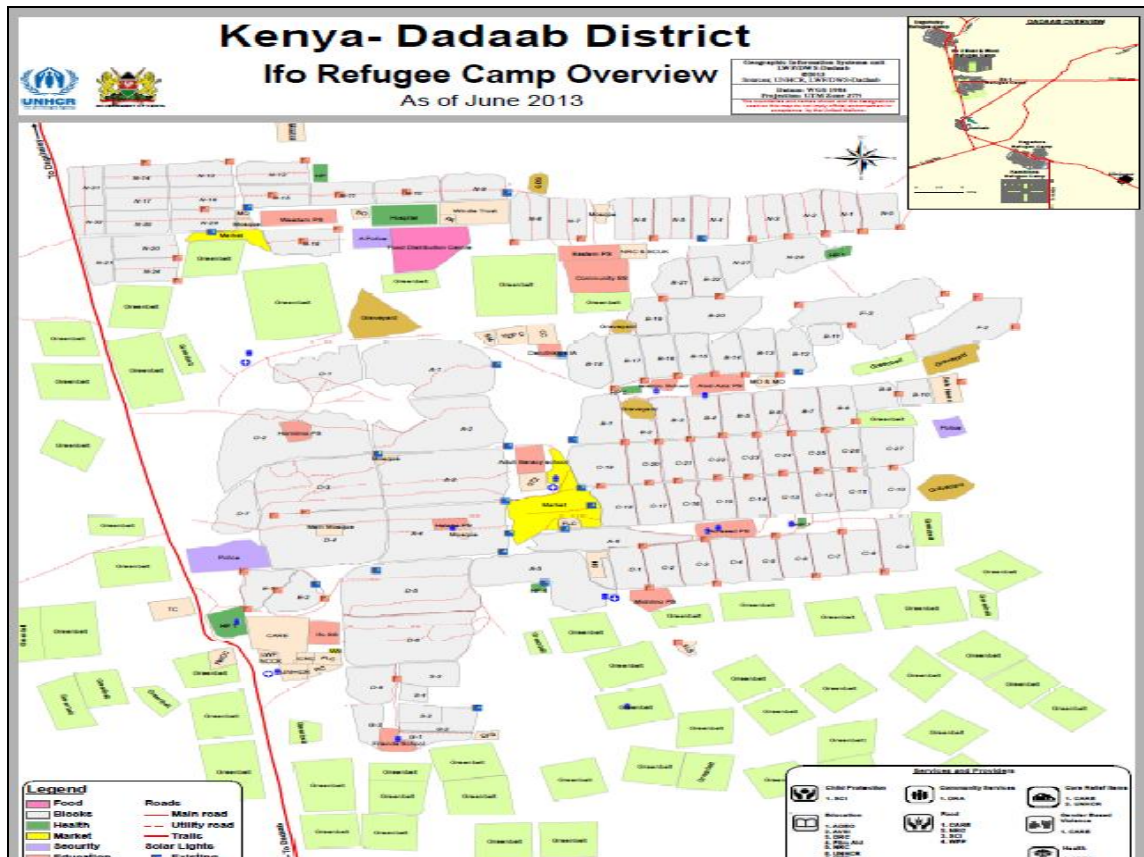
- Competing priorities for the mothers at household level
- Lack of referral documents from the Community health workers
- Lack of confidence in the program and its products
- Fear of rejection by the nutrition workers
- Double registration
- Children relapsed after discharge
- Poor referral system from Stabilisation centre(SC)

1. INTRODUCTION

1.1 Demographics and background information

At the time of the SQUEAC assessment the total population in IFO refugee camp was 84,784, the population of children 6-59 months 12,556 (UNHCR progress database March 2015).

Figure 1; Map of Ifo refugee camp;

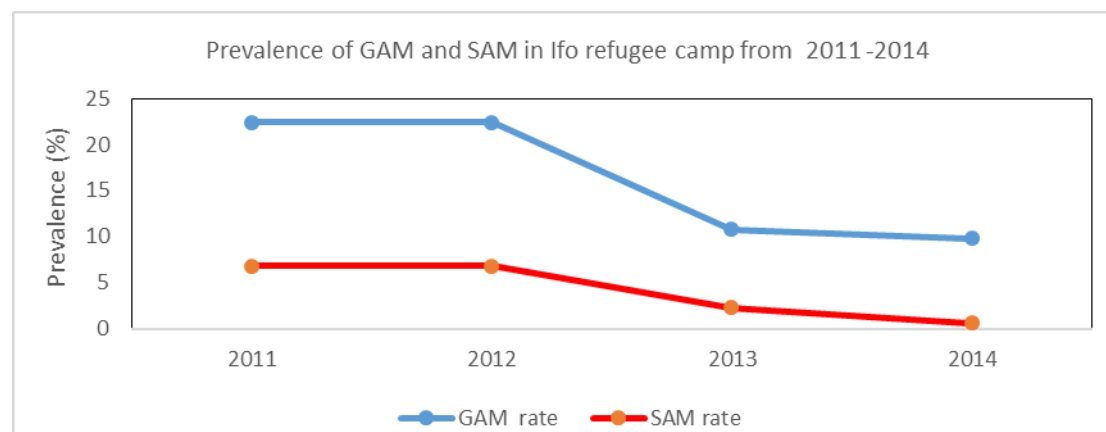


Source: UNHCR progress database March 2015

1.2 Nutrition situation in IFO N refugee camp

Standardised monitoring of relief and transitions (SMART) survey results of 2014 show that the prevalence of global acute malnutrition rate among children 6-59 months is 9.8 % (6.9-13.7 % 95 CI) and severe acute malnutrition is 0.6 % (0.2-1.6% 95 CI) this was an improvement when compared to 2013 results when the GAM rates were 12.3 % (8.4 - 17.6 95% C.I) while the SAM rates were 2.3 %(1.0 - 5.1 95% C.I). Although the SAM rates reduced, there was no significant statistical difference from the 2013 results. The situation is categorized as serious according to the WHO 2006 classification of malnutrition, see figure 2 below.

Figure 2: Trends of GAM and SAM in IFO refugee camp 2011 to 2014



1.3 Overview of Health and Nutrition program

The health and nutrition programmes in IFO refugee camp are implemented by Islamic Relief Kenya (IRK) with support from UNHCR and WFP. The other partners working in Ifo at the time of the assessment are; CARE food distribution partner and WASH services , Danish refugee council (DRC) –livelihoods, Save the children UK –child protection, IRK also provides education in the camp.

There are six health posts and one main Hospital with a stabilization centre, the OTP and SFP services are provided in five health posts; health post 1, 5, 7, N0 and N12. The CMAM programme is conducted by at least 10 incentive staff and supervised by a nutrition nurse and the nutritionist.

1.4 Objective of the coverage assessment

To determine the coverage of CMAM program in IFO and to identify community mobilization activities in the camp, focusing their impact on the CMAM program.

1.4.1 Specific objectives:

- To estimate the actual coverage of SFP and OTP programs.
- To identify community mobilization activities carried out in the camp and their effect on CMAM programs.
- To understand the community perception on malnutrition
- To determine the factors affecting uptake of CMAM services.
- To develop joint plan of action, to be implemented in collaboration of UNHCR, WFP and IRK

1.5 Duration of assessment

The assessment was conducted jointly with Malezi Bora, this is expected to be replicated in the coming years. The assessment was undertaken from 11th - 28th May 2015. The second and third stage was integrated with the bi-annual national activity Malezi bora campaign (Swahili word dubbed good nurturing) focusing on improving maternal and

young child health. The activities conducted during the campaign include vitamin A supplementation, deworming and mass MUAC screening of all children 6-59 months at the household level.

1.6 Participants

Having integrated SQUEAC with malezi bora a larger number of staff were required for the data collection for the assessment to be comprehensively covered. A total of 28 outreach workers from IRK were trained and involved in data collection, one staff from ACF was also engaged in the training and assessment.

2. METHODOLOGY

SQUEAC methodology was used to conduct the coverage assessment, this involved analysis of both quantitative and qualitative data to establish performance of key IMAM indicators. The investigative process involved three stages, namely:

1. **Stage 1:** collection and analysis of routine program data, both qualitative and quantitative. Data collected in this stage provided an insight of the IMAM program performance as well as barriers and boosters. Areas with high and low coverage were also identified in this stage.
2. **Stage 2:** formulation and testing of hypothesis by conducting a small area survey- confirms the location of areas of high and low coverage and the reasons for coverage failure identified in Stage 1 small-area surveys.
3. **Stage 3:** Wide area survey to determine the OTP and SFP coverage estimate using the Bayesian SQUEAC. In this stage actual survey data was collected to estimate program coverage, questionnaires were also administered to identify more barriers and boosters for the program

3. RESULTS

3.1 STAGE 1: QUANTITATIVE AND QUALITATIVE DATA

3.1.1 Findings- Review of Secondary data (Quantitative)

The data available for analysis was collected from the HIS and OTP and SFP register in the health posts for the period covering January to December 2014. The analysis of these data provided a view of the 2014 performance of the CMAM program in IFO. Data collected included admissions by age, blocks, number of cured cases, admission by MUAC, number of defaulter, average length of stay.

The 2014 OTP and SFP Qualitative and Quantitative data was collected from all the five health posts in IFO refugee camps . The data was validated using HIS data base by UNHCR team . All the essential data was shared with the CMN team for the purpose of remote support before the start of the assessment.

This routine data as in the table below was further analysed using the SQUEAC methodology to assess the accuracy in relation to programme coverage , determine the hypothesis to be tested in the small area survey.

Table 1: 2014 Routine programme data collected in IFO refugee camp

Data	Programme performance indicators
OTP & SFP Admissions & Exit data	- Cured, Defaulters, Death, Non-respondents ,transferred cases and age at admission
Length of Stay (LoS), MUAC	- Average Length of Stay (ALoS) - MUAC status at admission
Defaulter information	- Defaulters' trend and seasonal calendar (<i>Disease occurrence patterns</i>) - Defaulter's nutritional status at the time of defaulting - Number of weeks spent in OTP and SFP before defaulting, and

3.1.2 OTP and SFP Admission data

The total number of admissions of children 6-59 months is 2711 in the OTP and 5892 in SFP from January to December 2014. The trends of admissions for OTP and SFP was analyzed against the main four seasons experienced throughout the year in Dadaab namely ; short and long rains , dry spell and windy seasons and also the trends of disease occurrence patterns in the camps. The OTP and SFP admission trends are linked to the different seasons and disease patterns as illustrated in figure 3 and 4 below.

As observed over the years, increase in admissions in the OTP and SFP is usually noted starting December through March when there is high incidence of acute watery diarrhea (AWD) and respiratory infection among children less than five years old and other age group. The onset of increase admissions starts in November /December during the long rains and reaches the peak during the dry spell in January up to March. July through to September characterized by the dry spell season usually has the lowest admissions in both programmes, skin diseases which the common illness has no direct impact on the malnutrition rates in the camps.

Figure 3: Total OTP admissions based on the Seasonal calendar and Child hood illnesses in IFO N refugee camp

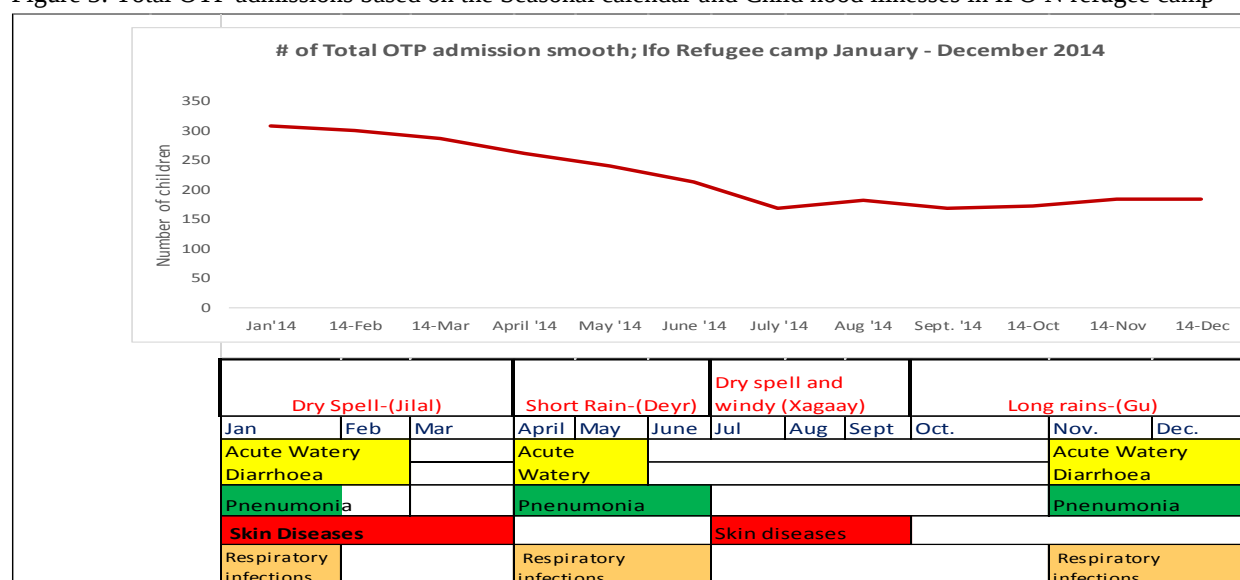
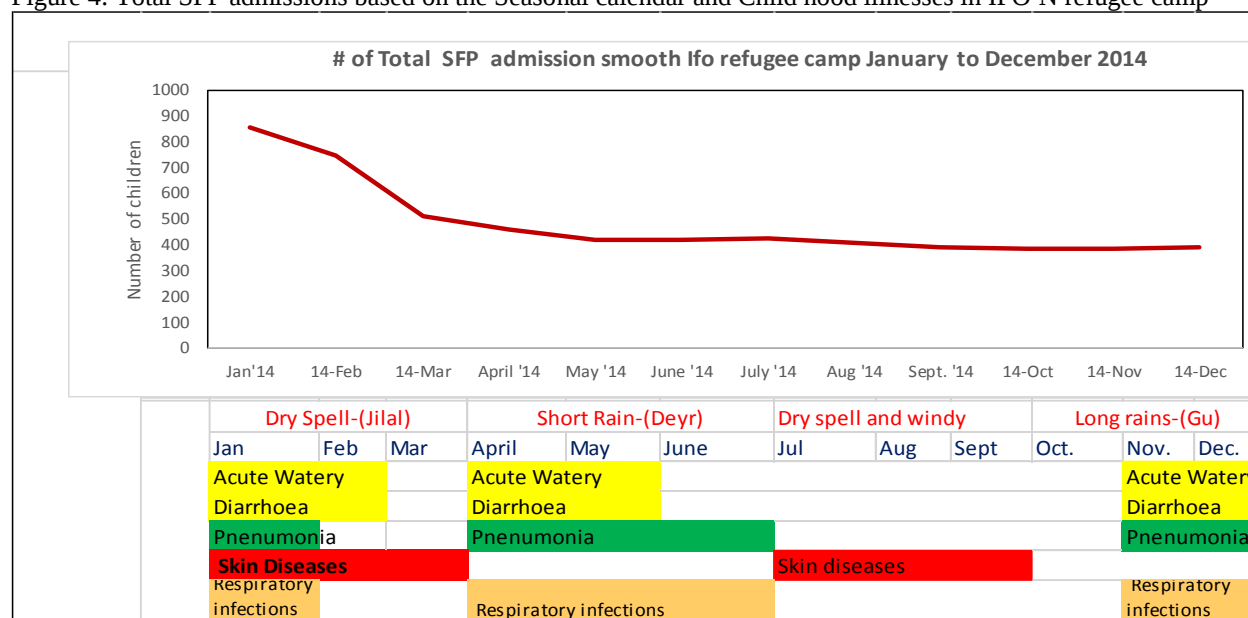


Figure 4: Total SFP admissions based on the Seasonal calendar and Child hood illnesses in IFO N refugee camp



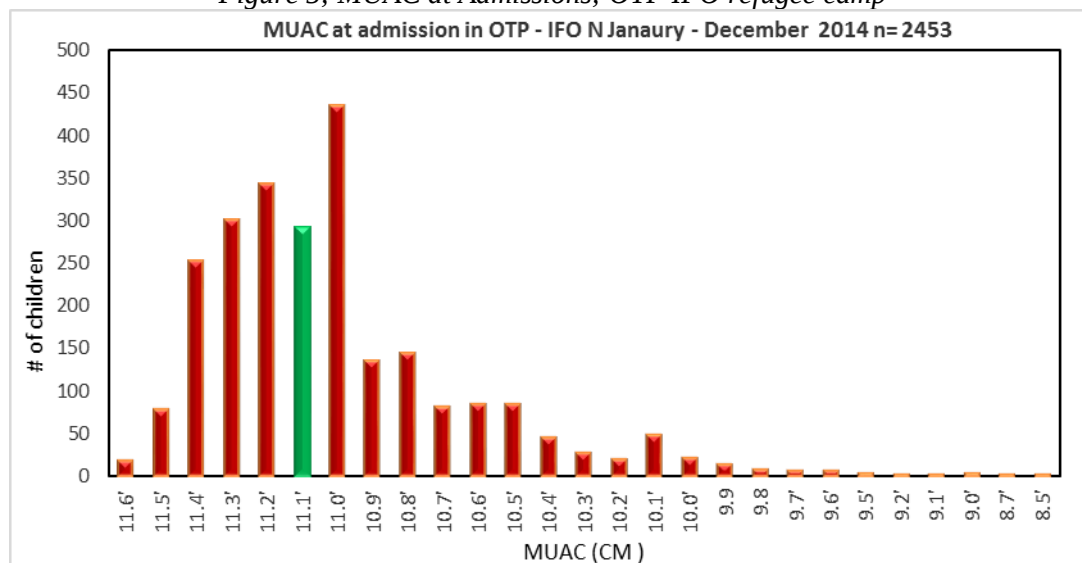
3.1.3 OTP Admissions by MUAC

Weight for Height z-score and MUAC criteria are used independently during the admission of malnourished children in to the CMAM programme in Dadaab (IMAM guidelines 2009). MUAC as an independent admission criteria is used as community active case finding tool by the CHWS on a daily basis to screen and refer children who are found to be severely and moderately malnourished.

The analysis of the admissions by MUAC in the programmes help understand the timeliness of screening and referrals of malnourished children hence used to measure the effectiveness of outreach programmes working within the camp. A total number of 2453 admissions data was available for analysis during SQUEAC, median MUAC 11.1cm was established showing active & early case finding is done in IFO refugee camp.

The highest number of admission was recorded at the MUAC measurement of 11.0cm representing 17% of the total admission, 11% of the cases were identified when their MUAC was >10.5 cm showing that some cases are identified very late.

Figure 5; MUAC at Admissions; OTP IFO refugee camp



3.1.4 Age at Admissions

Admission by age group into the CMAM programme indicate the age group that is mostly at risk of acute malnutrition. Findings show that the most at risk children are aged 6-24 months, with SFP and OTP admissions being high in this age category, 75.4% of children aged 6-24months are admitted in OTP and 58.7% in SFP. The highest percentages when compared across all the age group categories was noted among children 6-12 moths with 43.8% in OTP and 24.4% in SFP. This shows that there is a gap in IYCF practices especially exclusive breastfeeding and complementary feeding focus in improving the IYCF practices in the camp is urgently required.

Figure 6; OTP Admissions by Age group

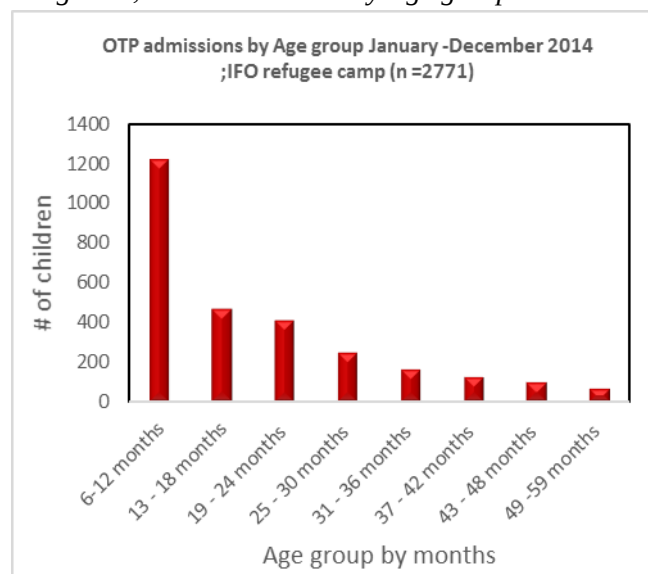
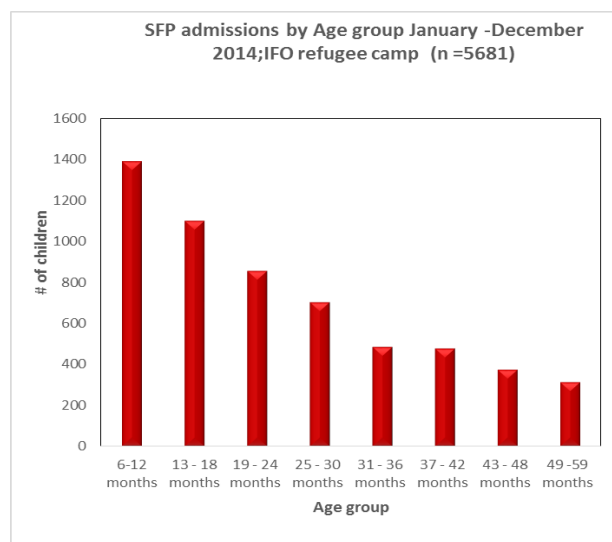


Figure 7; SFP Admissions by Age group



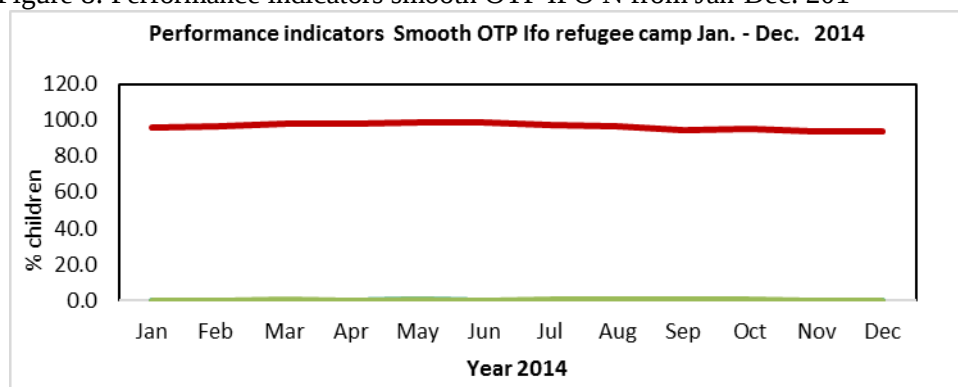
3.1.5 Programme performance indicators for OTP and SFP

Program performance in the CMAM programme is calculated based on the total number of exits within a certain reporting period. The indicators monitored in the programme include the status of the children at the time of discharge such as the discharged cured, defaulter, death. Other indicators include transfers to other CMAM programmes, referrals and non-respondents. The three performance indicators such as discharged cured, defaulter and deaths are measured and compared against the standard SPHERE minimum standards

OTP programme performance indicators

The overall recovery rate (% of children discharged cured) was at 96% the SPHERE minimum standards, the defaulter rate at 0.2% which was below the cut off of > 15%. No deaths were reported in the programme throughout the year.

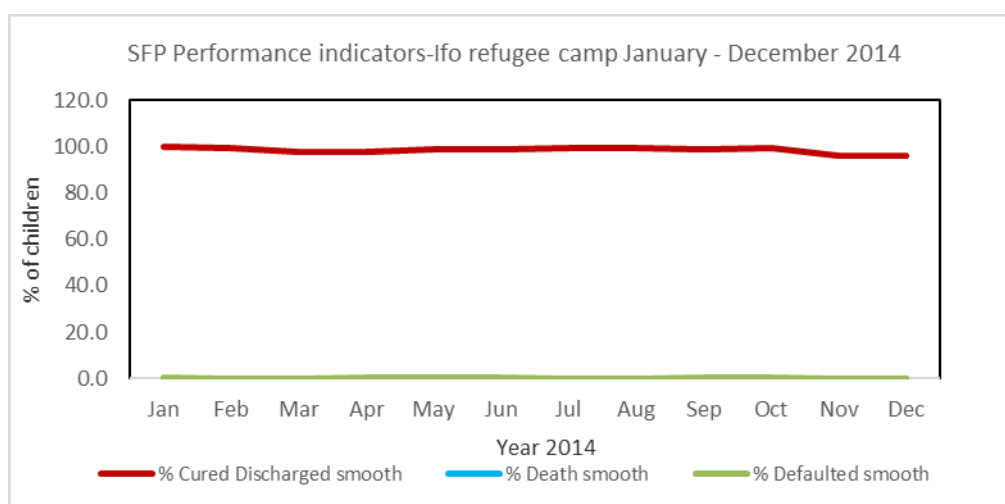
Figure 8: Performance indicators smooth OTP IFO N from Jan-Dec. 201



SFP programme performance indicators

The overall recovery rate for SFP from January was 98% which is above the minimum SPEHERE standards

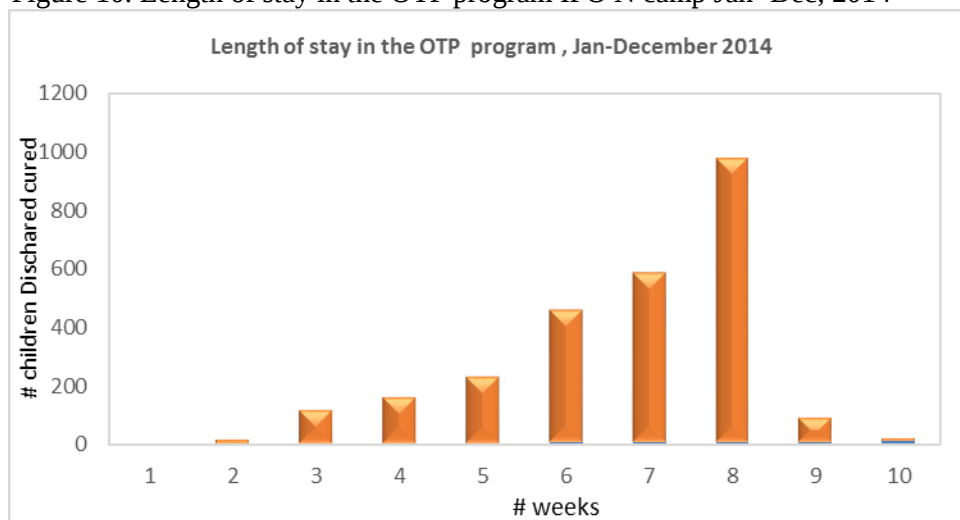
Figure 9: SFP Performance indicators in IFO N from Jan-Dec. 20



3.1.6 Length of stay (LOS)

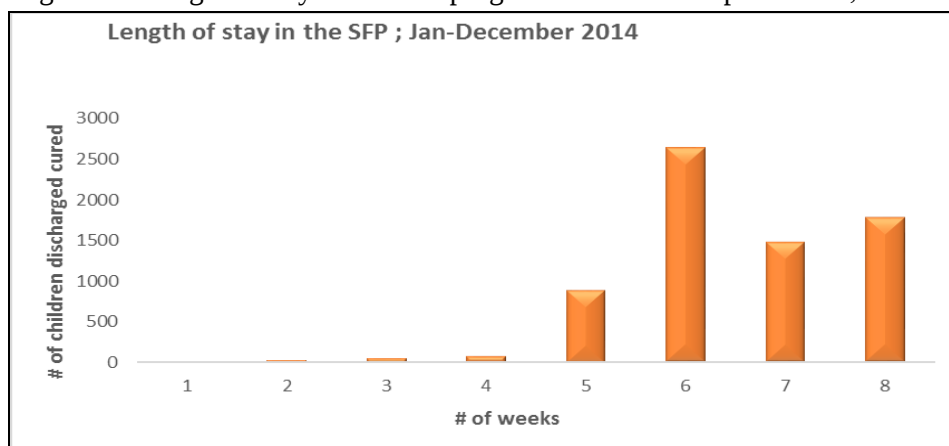
The expected length of stay for children in the OTP programme is 8 weeks and SFP is 12 weeks (IMAM guidelines 2009), from the data analysis in IFO, majority of the children are discharged cured from the OTP as from 5- 8 weeks.

Figure 10: Length of stay in the OTP program IFO N camp Jan- Dec, 2014



In the SFP programme most children are discharged from the program between 6-8 weeks. The highest percentage being discharged at 6 weeks

Figure 11: Length of stay in the SFP programme IFO N camp Jan- Dec, 2014



3.2. QUALITATIVE DATA

Qualitative data was collected through structured interviews, Focus group discussions and Key informant interviews. Some of the key responders who provided these information included, camp leaders, mothers with children below five years who are admitted in SFP or OTP, mothers with children who are not admitted in either of the CMAM programs, Fathers of children below five years, Mother to mother support groups, TBAs, Community health workers, community health committees and outreach workers.

Table 2: Data sources and methods used to collect the data

Source	Method of data collection
Mothers of under-fives, fathers of under-fives, mother to mother support groups	Focus group discussions
Community health committee, block leaders, camp chairman, chairlady	Formal discussions
Nutrition workers, mothers of children in SFP and OTP, Community health committee	Semi-structured Interviews
CHW, Nutrition workers and health workers	Key informant interviews

3.2.1 Local understanding of Malnutrition and child hood illnesses

All the community members interviewed were aware about the signs and symptoms of malnutrition. The common term used to describe it is ‘Nafaqadaro’, the common symptoms mentioned included wasting, lack of appetite, oedema and protruding stomach (oedema), brittle brownish hair and skin color changes. They also mentioned that malnourished children appear to have a pale pallor and are often inactive.

The perceived causes of malnutrition in the camps as mentioned by all the community members were, insufficient food, lack of food diversity, inadequate livelihood activities hence limited resources and money to purchase food. Poor hygiene, poor infant feeding practices, (poor breastfeeding and complementary feeding were mentioned to have a high impact on the children 0-23 months).

3.2.2 Treatment of Acute Malnutrition and other child hood illnesses

Most of the key informants interviewed (CHC, sheikhs, and block leaders) and the focused group discussions mentioned that they first seek health care and treatment of the acutely malnourished children at the Islamic relief health post and at the main hospital.

The mothers of children under five years and the fathers said they also seek help from the religious leaders by visiting the sheikhs for Quran reading and prayers for chronic cases such as epilepsy, cerebral paralysis. In the key informant interviews with the sheikhs, they also mentioned that the offer prayers and encourage them to seek healthcare at the health posts

3.2.3 Home remedies for common illnesses

The following remedies were outlined by the community members who emphasized that they seek health care first at the health facilities and once in a while use the following to treat certain conditions

Table 3: Home remedies used for common illnesses

Home remedy	Condition treated
Tahlil (Holy water and Lemon mixed with oil, mal –mal	Persistent fevers in children
Haba-sodow (solution made from the back of medicinal plant	Applied on the chest and the back when a child has pneumonia
Haldith-traditional herbs added to fluids and administered to young children	Given to children to stop diarrhea
Lemon and honey solution	Treating common colds

3.2.4 Community Structures and leadership

Camp leadership consists of camp chairman and chairlady, section leaders, block leaders and minority leaders. Key decisions are made by camp chairman and information is disseminated to the community through other leaders. There also exist other community groups within the camp that are vital in supporting health and nutrition services, this includes WASH groups, safe motherhood program and mother to mother support groups

3.2.5 Communication channels

Information is mainly disseminated through community leaders such as block leaders. Health information was mainly disseminated through CHWs and public address system. These two methods were noted to be the most effective. Key important messages were also passed through Sheikhs in mosques.

Table 4: Channels of communication

Channel of communication	Source
CHW	MTMSG, Mothers, Block leaders, CHC, Fathers, TBA
Chairman and Chairlady, block leaders	Fathers
CHC section leaders	CHW, Fathers, mothers
Radio	MTMSG, M<5, F<5, CHW, CHC, Block leaders
Public address system	MTMSG, F<5, , M<5, CHW, block leaders
Public places, water points, funerals	M<5, Block leaders,, Sheikh
From the Mosques- Announcements	Block leaders, F<5, Sheikh,
through Mother groups	CHW
through father groups	CHW
Through public barazas/meetings conducted by ;leaders in the camp	CHC, Block leaders
Nutrition incentives	CHC

3.2.6 Documentation

Beneficiary information is recorded in the HIS registers that are provided by UNHCR. The CMAM and other health program data is provided on a weekly basis to UNHCR through the health information system (HIS) by IRK. The program performance data for SQUEAC was aggregated from the HIS master database while other data such as admission by age category, MUAC at admission, and length of stay from the health posts based registers.

Registers in all health posts were reviewed with an aim of checking completeness, accuracy, and reliability of the data collected at the health post. The review looked at data captured in the last one year. In SFP 171 cases in IMAM registers were selected randomly, out of these cases 165 (96%) cases had all information recorded in the register from time of admission to discharge. Information that was missing included anthropometric measurements during discharge and discharge criteria/reasons for discharge. In addition, 132 (77%) cases had the correct information while 39 (23%) cases had wrong information.

Registers in OTP were also noted to be incomplete, out 177 cases checked for the previous year 169 (95%) had been fully filed, 144 (81%) cases had been correctly filled while 35 (19 %) had not been correctly filled.

Some of the incorrect information included;

- Wrong Z-score at admission and discharge this was a concern as it contributes to beneficiaries that do not meet the criteria to be in the programs, as well as early discharge

- Inconsistent anthropometric measurements; some cases were noted to have irregular weight gains on each consecutive visits, for example a weight gain of more than 2kg in two weeks. This could have been due to errors while taking anthropometric measurements
- Wrong treatment; cases of children being admitted in the wrong program was noted where children meeting criteria for OTP(not exits from OTP) were admitted in SFP program an indication that criteria was not being observed cases
- ALOS Wrong calculation of average length of stay; ALOS was not correctly calculated for some discharged clients, while for some it was completely missing in the registers.
- Early discharge: children discharged before meeting discharge criteria for two consecutive visits
- Lack of clear indication for exit; cases exited are not accurately defined

3.2.7 Barriers and Boosters of CMAM program

During the first stage, some of the barriers and boosters mentioned during the interviews were as follows;

3.2.7.1 Barriers to Accessing CMAM program

Service facility: In IFO the service facilities were in poor conditions. Health workers, community health workers, Community health committee and mothers of under-fives noted this as one of the challenges affecting access of the CMAM services. The SFP sites did not have adequate space to accommodate the number of beneficiaries seeking services during the SFP cycles.

Long queues: this was mentioned by the mothers, block leaders and Community health workers. Long queues could be caused by lack of adequate waiting space or inadequate staffing at health posts

Double registration: some cases were noted to be registered twice, by two different caregivers. Nutrition workers indicated this is common in the camp as mothers are looking for alternatives source of livelihoods. The extra sachets of Plumpy sup and Plumpy nut are sold to the market. This has affected the commodity utilization since numbers are escalated.

Lack of referral documents and other supporting documents: mothers screened at block level are expected to take their child to the health post, but due to lack of referral documents most mothers feel that they would not be well received if they lack any official documentation, as a result they don't present their children to the health post. This also revealed a gap from the CHWs, its expected that follow up on identified cases be done promptly for early treatment.

Misconception of the OTP and SFP commodities; interviews with mothers and CHW revealed that the community does not perceive RUSF and RUTF as therapeutic feeds, sharing at household level is still rampant despite health education and awareness given by the health workers. In addition, some mothers indicated that consumption of Plumpy sup causes diarrhea, hence were hesitant to attend the SFP and to use the product. Focused and intensified health education is required to demystify these beliefs.

Late admission of MAM cases; In IFO N camp the SFP cycles runs between the period 7th-12th and 21st -26th of every month. During this period new admissions are registered and given their RUSF since the distribution is ongoing. After the cycle screening takes place but admissions have to be done during the SFP cycle, hence MAM cases are forced to wait, therefore some cases never show up at health post later on. Mothers prefer immediate action/admission.

Delay of transportation of RUSF and RUTF: This is caused by logistics arrangements in place as it was centralized at the beginning of the year. The IRK management should submit their transport request on time to ensure that there are no delays.

Lack of understanding on the ration quantity of RUTF/RUSF: mothers have very little information on the dosages of the therapeutic commodities.

Remuneration of the community workers: Community health workers and nutrition outreach workers were demoralized with the current salaries

Competing priorities for the mothers; this prevents them from bringing the malnourished child to the health post

Stigma: malnutrition is associated with poverty, poor hygiene, mothers with malnourished children tend to feel ashamed

High defaulter rates: the number of defaulters were noted to be high in the previous year especially in June and September, some of the reasons mentioned include, competing priorities for the mothers, inter-camp movements, conflict between parents, and mothers getting sick.

3.2.7.2 Boosters of CMAM program

Integration of CMAM program with the health system: there is a synchronization of services between the health and nutrition department

Engagement of mother to mother support groups and safe motherhood mothers

Community ownership of the program: the community is well aware of the program, there is also immense participation from the leaders, and health committees

Accelerated nutrition program activities: such as malezi bora, polio campaign informs the community on current nutrition programs and forms a good platform to pass important nutrition messages to the community

Health seeking behaviour of the community: the community seeks health services at the hospital before initiating other remedies

Community awareness of the nutrition program

Established referral system: from the community to the health posts through community outreach workers

Health education at the health post is carried out by the nutrition workers

Proximity of the health post: they are located centrally in the blocks thus increasing accessibility

3.3 STAGE 2: SMALL AREA SURVEY

It involves triangulating the data collected in stage one and utilizing the data so as to generate hypothesis. Two hypothesis were generated from the data collected in stage one, these were;

Hypothesis 1. Blocks with high SFP/OTP admissions have high coverage

Hypothesis 2. Blocks with low SFP/OTP admissions have low coverage.

A small survey was conducted to test and verify the formulated hypothesis. Sections with high SFP and OTP admissions were selected, as well as those with low SFP and OTP admissions. From these Sections, a total of 19 blocks were selected randomly. It is in these blocks that data was collected to test the two hypotheses.

Having combined SQUEAC and malezi bora, the team visited all households in the identified blocks for case finding. All children 6- 59 months were measured and based on their MUAC they were categorized as either in the program, not in program or recovering cases. Questionnaires were administered to caregivers of those children found to be malnourished and not in the program so as to identify some of the barriers to accessing CMAM services

3.3.1 Hypothesis testing and verification

The following formula was used to confirm the hypothesis; $d = \lceil n \cdot p / 100 \rceil$

n=sample size

p = 90% - SPHERE Standards threshold for refugee camps

d=decision rule

Testing Hypothesis 1. Blocks with high admissions have high coverage

Table 5: MAM and SAM cases in the blocks with high admissions

SAM findings		MAM Findings	
Block	B22	Blocks	B12
SAM in program	2	MAM in program	5
Not in program	1	Not in program	2
No. of cases	3	No. of cases	7
Decision rule	2.7 (3)	Decision rule	6.3 (6)

To establish the coverage for SFP and OTP the above formula is applied

$d = \lceil n \cdot p / 100 \rceil$

SAM:

$d = 3 \cdot 90 / 100 = 2.7 = 3$

For the hypothesis to be true the SAM cases in program have to be 3. In this case the total SAM cases in program in block B22 are 2 thus the Hypothesis is not true- blocks with high OTP admissions may not have high coverage.

SFP:

$d = 7 \cdot 90 / 100 = 6.3 (6)$

In SFP block B12 from the small area survey the total cases in program was 5 and decision rule was calculated at 6. Since the number of cases in the program is less than the decision rule the hypothesis is not true- blocks with high SFP admissions may not have high coverage.

Testing Hypothesis 2. Blocks with low SFP and OTP admissions have low coverage.

Blocks selected to test the hypothesis had low admissions for OTP and SFP. The summarized data is as below;

Table 6: MAM and SAM cases in the blocks with low admissions

SAM findings		MAM Findings	
Block N11	N11	Block	C14
SAM in program	1	MAM in program	3
Not in program	3	Not in program	3
No. of cases	4	No. of cases	6
Decision rule	3.6 (4)	Decision rule	5.4 (5)

SAM:

$$d = 4 * 90 / 100 = (3.6) = 4$$

Since the SAM cases i.e. 1 case in program is less than the decision rule (4), then the hypothesis is confirmed to be true. Low admission means low coverage

SFP:

$$d = 6 * 90 / 100 = (5.4) = 5$$

Since the MAM cases in program is less than the decision rule of 5 - therefore the hypothesis is confirmed to be true

It was concluded that blocks with high admissions may not have high coverage this could be due to inadequate community mobilisation activities within this specific blocks. On the other hand, blocks with low admission have low coverage, some of the reasons leading to low coverage was lack referral card, poor screening leading to fear of rejection, this were mentioned by mothers as one of the major challenge to accessing CMAM program

3.4 STAGE 3: WIDE AREA SURVEY

Data collected in stage one and two is used to estimate the prior, which is the most likely coverage for both programs. To establish the prior first step was to weighing barriers and boosters and second stage involved getting the SFP and OTP estimated coverage from the small area survey and barriers and boosters.

3.4.1 Weighing of barriers and booster

All barriers were given scores as follows;

Table 7: weighted barriers and boosters for OTP and SFP programs

Barriers	Score	Score	Boosters
Delay in the delivery of nutrition commodities at the health posts experienced at the beginning of the SFP and OTP Cycles	4	8	Health education
Poor nutrition structures in all the health posts and no waiting shed for the beneficiaries	7	6	established referral system between the community and the health post
Long queues and congestion at the health posts	7	6	Integration of the CMAM program within the health system
Inadequate livelihoods and food security in the community		7	Qualified health and nutrition staff in the health facilities
Inadequate health education and misconception about nutrition products	5	7	Engagement of the community leadership (leaders, CHC, SMP)in IMAM
Poor infant feeding and young child feeding (IYCF) practices		5	Proximity of the nutrition sites to the blocks
Poor hygiene situation at the block level		5	Community awareness of the nutrition programs
Long distance from the blocks to the health post and frequent movements across camps (N31, N32,N33, N30), takes 25-30 Mins (/E1/D4/G5) 45 mins (C1/C18/C19 =30)	3	3	Mother to mother support groups engagement
Inadequate capacity building for nutrition staff	6	6	Accelerated nutrition and health programs such as malezi bora and polio campaigns
Inadequate qualified nutrition staff and community health workers	3	6	The community's health seeking behaviours ; Hospital preference to alternative source of health care
Unavailability of OTP/SFP referral cards and other IMAM IEC materials in the health posts	4		
Poor active case finding at the community level	5		
No admissions of moderately malnourished children in the non SFP cycle.	3		
Shortages of drugs at the health posts especially towards the end of the week	5		
Stigma surrounding children with acute malnutrition	3		
Competing activities among the caregivers leaving no time to take their children to the health post for treatment and follow up	6		
Total weighted score Barriers	61	59	

Weighted mean = $(100-61) + 0+59= 98/2= 49\%$

The coverage estimation using the barriers and boosters= 49%

From the small area survey the coverage was estimated to be 54.7 for SFP and for 74.2 % OTP. This estimate were averaged with the coverage from the barriers and the boosters for both programs to identify most likely coverage. The coverage value was arrived at 62% for OTP and 52% for SFP. The team noted this values to be low for both programs hence adjusted the coverage values to arrive at an estimated prior of 75% for OTP and 60% for SFP.

	Small area coverage	Coverage from barriers and boosters	Average	Estimated prior %
SAM	74.2	49	$(74.2+49)/2= 62$	75
MAM	54.7	49	$(54.7+49)/2= 52$	60

3.4.2 Setting the Priors

OTP: the precision was set at 9%, while the alpha prior and beta prior was set at 24.2 and 8.4, figure 12.

SFP: The prior was set at 60% with a precision of 6%, alpha value of - 20.1 and beta value of 13.7, figure 13

Figure 12: OTP prior coverage, IFO N camp

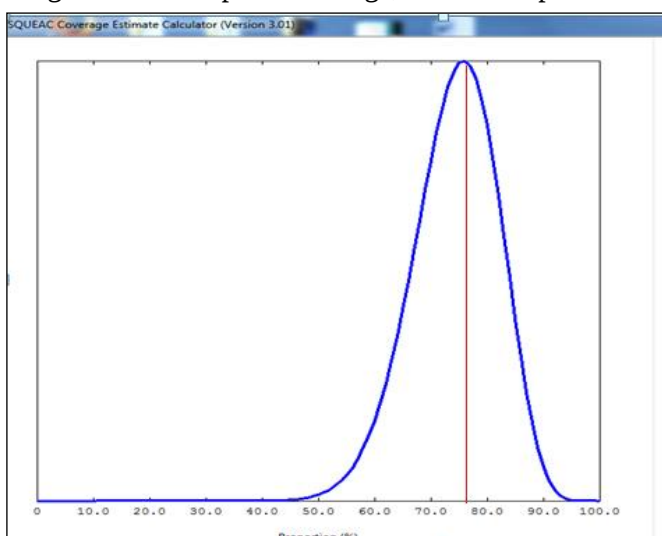
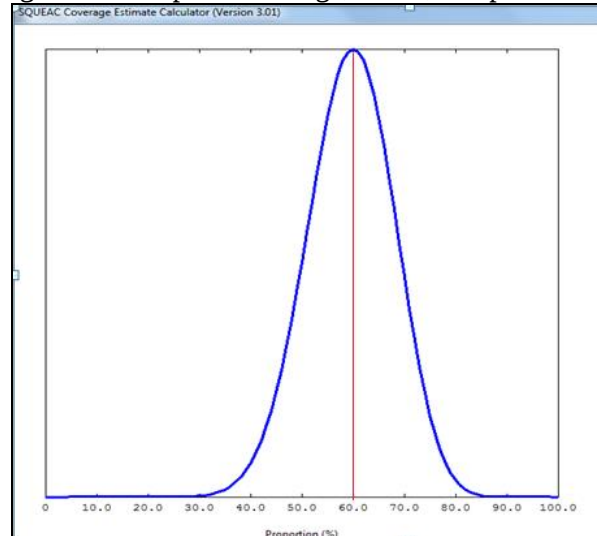


Figure13: SFP prior coverage, IFON, camp



3.4.3 Selection of sample size

This was done in two stages; the first stage involved using the priors to select the sample sizes as indicated in the graphs above. The Bayesian calculated the SFP sample size to be 155 while the OTP was arrived at 51.

The second stage involved determining the number of blocks to be covered in the assessment for both OTP and SFP. To determine the number of blocks (villages) the following formula was employed

$$\text{Blocks} = \frac{n}{\text{Average Block population} * \% \text{ of population 6-59m} / 100 * \text{prevalence of SAM/MAM} / 100}$$

Where: n = sample size for either SAM or MAM

Number of blocks to be sampled for OTP and SFP = 41

The blocks were then selected using the spatial method, this ensured adequate representation. In this method, population per block was factored as well as the location of the blocks. Door to door case finding method was used where the teams moved from house to house to identify cases.

3.4.4 OTP wide area survey findings

A total of 52 cases were found, of which 43 were noted to be already in the program while 9 were noted to be not in the program. It was also noted that 14 of the blocks (34%) did not have any SAM cases. This is summarized below;

Table 8: OTP wide area survey results

Case definition	Number of cases
SAM cases NOT in program ($MUAC \leq 11.4$ /Oedema	9
SAM cases IN OTP ($MUAC \leq 11.4$ /Oedema	43
OTP RECOVERING cases ($MUAC \geq 11.5$ CM/NO OEDEMA	10
Total SAM cases(total in program+ not in program)	52

3.4.5 SFP Wide area Survey Findings

A total of 181 cases were found, 56 were noted to be not in program while 125 were found to be in program.

Table 9: SFP wide area survey results

Case definition	Number of cases
MAM cases NOT in program ($MUAC \leq 12.4$ cm	56
MAM cases IN program ($MUAC \leq 12.4$ cm	125
MAM cases in SFP but RECOVERING ($MUAC \geq 12.5$ CM	12
Total SAM cases(total in program+ not in program)	181

3.4.6 Point Coverage Estimation

Point coverage for both SFP and OTP was calculated using the Bayesian SQUEAC software. For OTP the point coverage was estimated to be at 80.1% with a credible interval of (CI 70.0 - 87.3%), p value 0.4494, figure 14.

In SFP point coverage was estimated at 67.7% with a credible interval of (CI 61.2%-73.7%), p-value 0.3619, figure, 15.

Figure 14: graph showing OTP point coverage

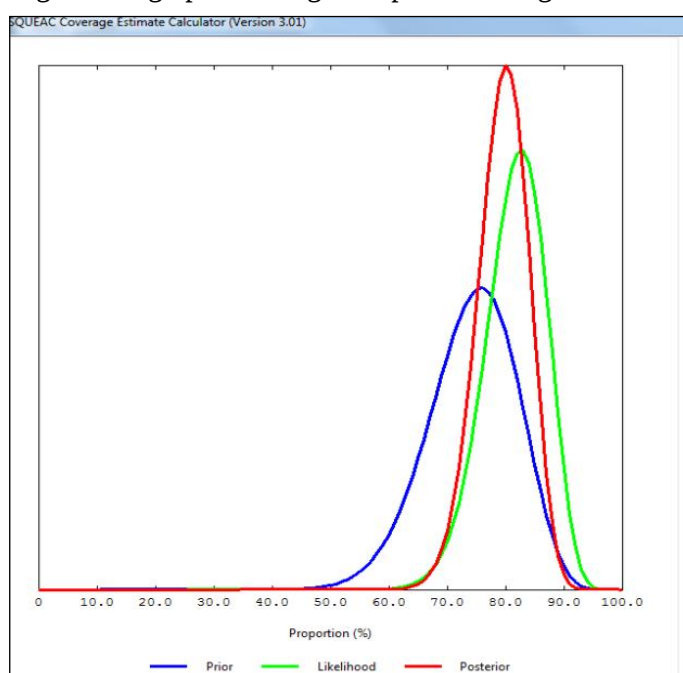
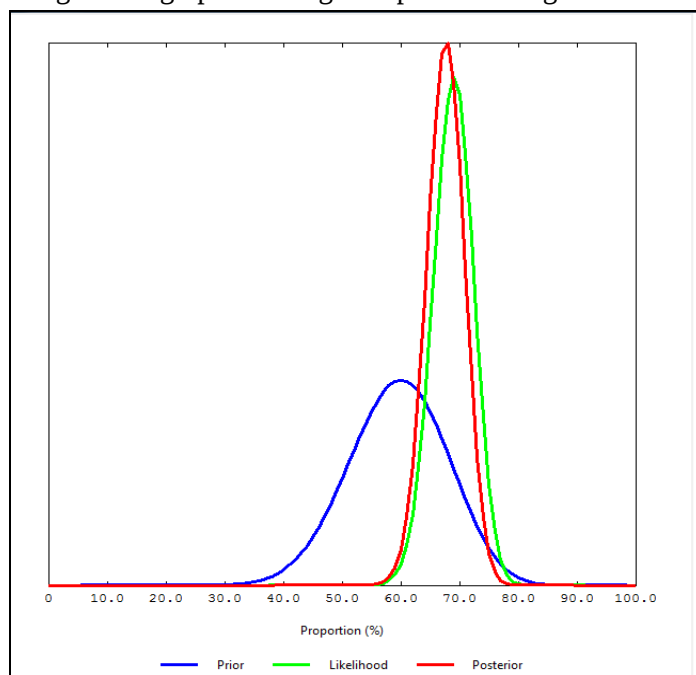


Figure 15: graph showing SFP point coverage



3.4.7 Single coverage

First step was to determine the recovering cases that were not in the program, this was calculated using the following formula;

Table 10: determining the recovering cases who are not in the program

Description of OTP survey data	OTP data	Equation
K = a correction factor	3	$R_{out} \approx \frac{1}{k} \times [R_{in} \times \left(\frac{C_{in} + C_{out} + 1}{C_{in} + 1} \right) - R_{in}]$ $R_{out} = \frac{1}{3} \times [10 \times \left(\frac{43+9+1}{43+1} \right) - 10]$ $R_{out} = 1 \text{ case}$
C _{in} = Current SAM cases in the programme	43	
C _{out} = Current SAM cases not in the programme	9	
R _{in} = Recovering SAM cases in the program	10	
R _{out} = Recovering SAM cases not in the programme	1	
Description of SFP survey data	SFP data	equation
K = a correction factor	3	$R_{out} \approx \frac{1}{k} \times [R_{in} \times \left(\frac{C_{in} + C_{out} + 1}{C_{in} + 1} \right) - R_{in}]$ $R_{out} = \frac{1}{3} \times [12 \times \left(\frac{125+56+1}{125+1} \right) - 12]$ $= \frac{1}{3} \times [12 \times (1.44) - 12]$ $\frac{1}{3} \times 5.28 = 1.76$ $\text{Recovering and not in program} = 2 \text{ cases}$
C _{in} = Current MAM cases in the programme	125	
C _{out} = Current MAM cases not in the programme	56	
R _{in} = Recovering MAM cases in the program	12	
R _{out} = Recovering MAM cases not in the programme	2	

For OTP denominator of 63 (43+ 9+ 10 +1) current SAM in program + current SAM cases not in program + recovering cases + recovering cases not in the program) and numerator of 53(43+ 10, current SAM cases in programme + recovering cases) were keyed in the Bayesian at a precision of 9%. The single OTP coverage was estimated to be at **81.4%** with a credible interval of (CI 72.2%- 88%).

The same was replicated for SFP, where the denominator was 195 (125+ 56+ 12+2, current MAM in program + current MAM cases not in program + recovering cases + recovering cases not in program) and numerator of 137 (125 + 12; current MAM cases in programme + recovering cases) this figures were used to determine the coverage using the Bayesian SQUEAC software. The alpha and Beta values for the priors were used the coverage was arrived at **68.8%** (CI 62.6- 74.5%).

The plots for the overall **OTP and SFP** program coverage shows a considerable **overlap** between the prior and the likelihood (prior and likelihood do not conflict) an indication of reliability in setting the prior. The **posterior** is **narrower** than the **prior** showing that the **likelihood survey** has **reduced uncertainty** on the coverage. This indicates the credibility of the survey results, see figure below 16 & 17.

Figure 16: graph showing OTP single coverage

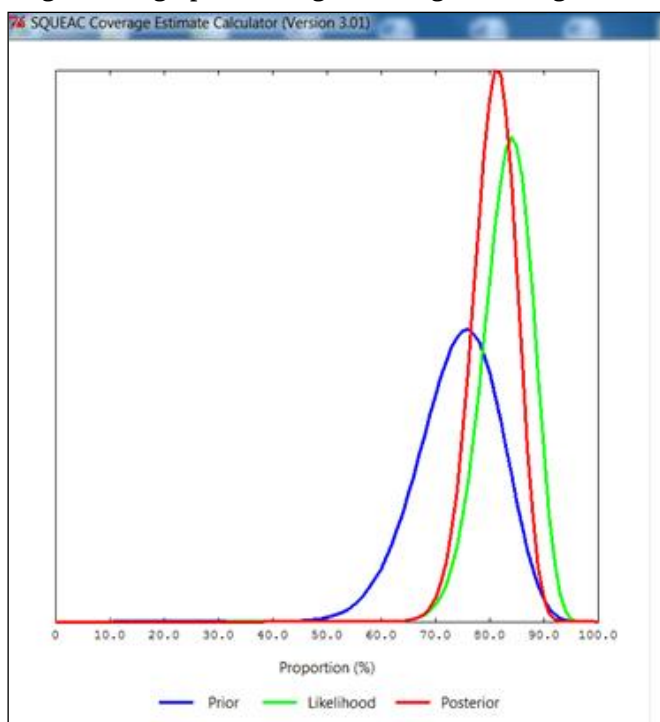
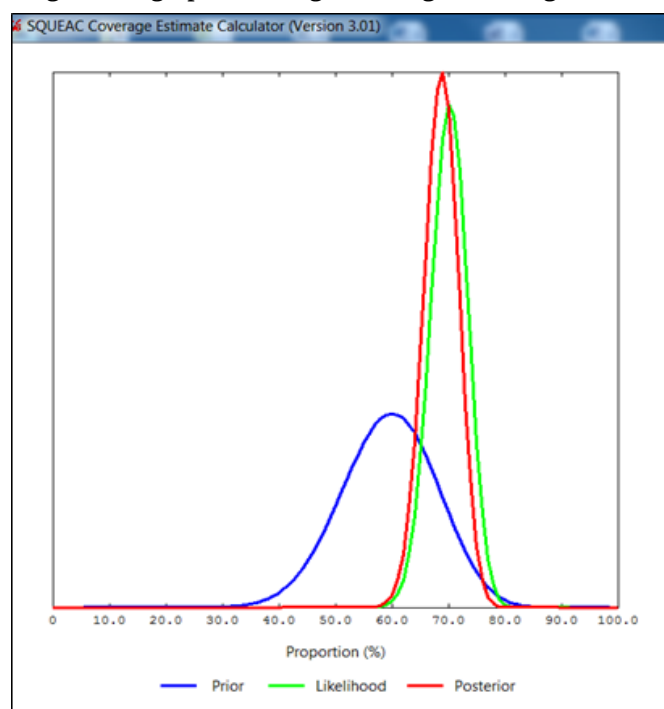


Figure 17: graph showing SFP single coverage



3.4.8 Reasons for not bringing the children to the programs

Of all the mothers who had malnourished children who were not in the program, 73% had adequate knowledge on signs of malnutrition hence were aware that their children were malnourished, while 27% were not aware. Mothers who were aware sighted wasting and weakness as one of the common signs of malnutrition, sickness was sighted as one of the causes of malnutrition.

Table 10: Mothers aware that their children are malnourished

	yes	no
% of mothers aware that children are malnourished	73%	27%
% of mothers aware of the CMAM program	67%	33%

During the Small and the wide area survey questionnaires were administered to caregivers of children who were found to be malnourished and not in any Programme, (Appendix 4). Some of the barriers mentioned are as below Graph 18 & 19.

Figure 18: Graph showing reasons for not bring children to the health post among OTP mothers

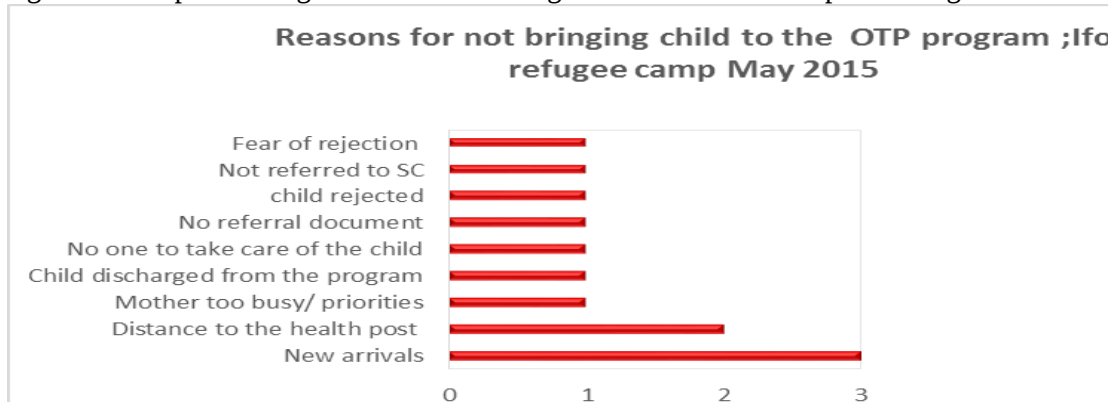
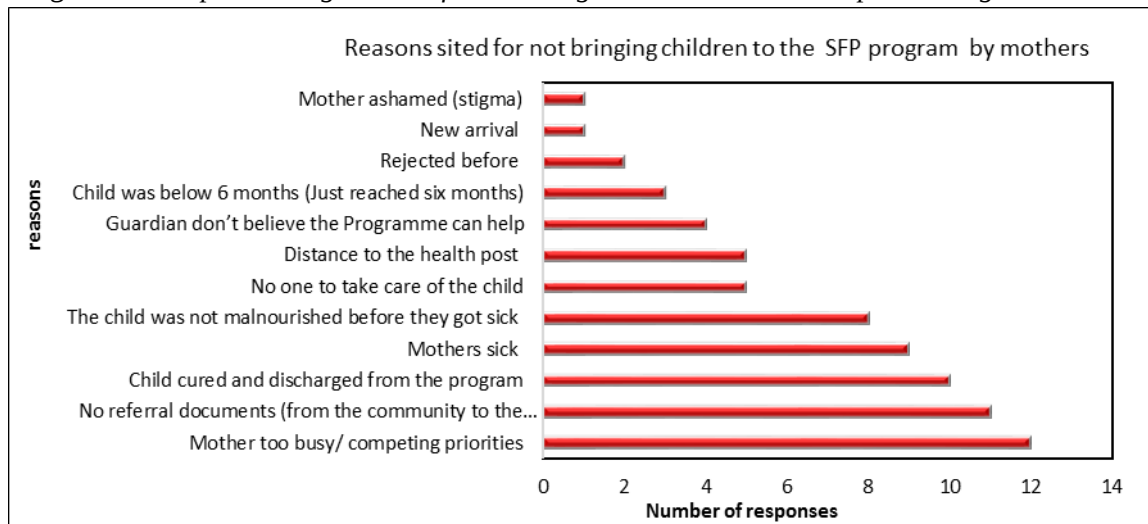


Figure 19: Graph showing reasons for not bring children to the health post among SFP



- **Competing priorities at household level and no one to take care of the child:** This was one of the most mentioned barriers by the mothers. Household chores and lack of alternate person to take care of other children prevented them from taking the malnourished child to the health facility.
- **Fear of rejection:** This was cited as one of the reason by SFP and OTP mothers. Mothers referred from the community level are rejected at the health post due to child not fitting the criteria an indication of inaccurate MUAC measurements at community level. This also implies that information on why they are being rejected is not adequately disseminated to the mothers.
- **Lack of referral documents from the Community health workers:** on a daily basis, CHWS conduct MUAC screening in the blocks alongside other outreach activities, children found to be malnourished are referred to the health post but no referral document is given to the mothers to take to the health post. Mothers lacked confidence to go to the health post indicating they would be chased away from the health post.
- **Mothers too sick to take children to the health post:** Mothers who were sick could not take their children to the health post. This is a clear indication that fathers need to be brought on board at community level so that they can support women.
- **Lack of confidence in the program and products;** a few mothers demonstrated to lack confidence in the programs. This was due to misconceptions about the nutrition commodities among the mothers.
- **Children cured from the program:** Some mothers had their children admitted in the program before and discharged as cured. The children had relapsed but the mothers had not returned back to the health post.
- **Distance:** some health posts were too far from their blocks making accessibility a challenge
- **Poor referral from SC:** This was noted as one of the commonest reasons for not bringing children to the health post. There was no adequate follow up to ensure SAM cases from stabilization centre are admitted in OTP program.

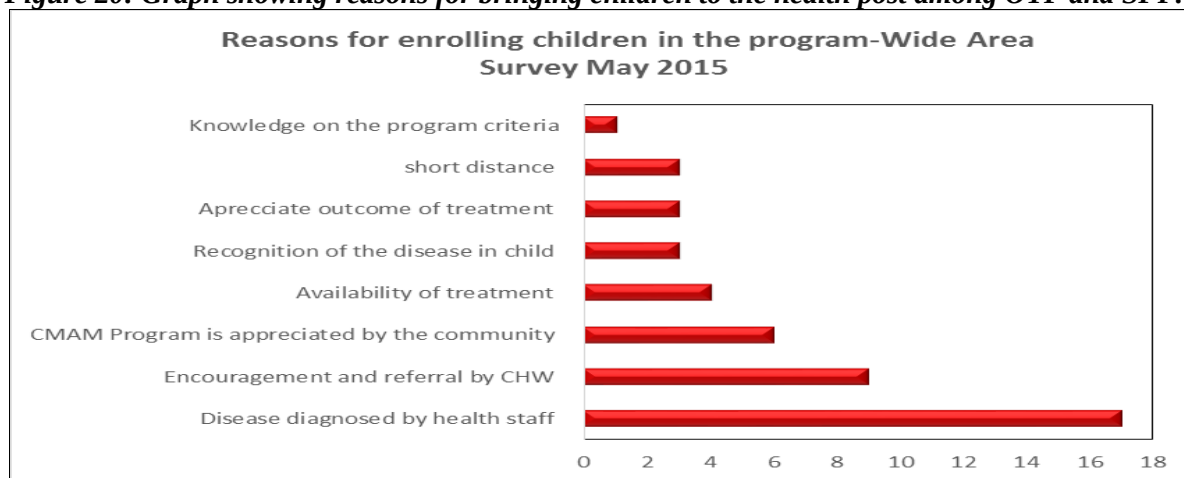
- **New arrivals:** new arrivals were not aware of the programs at the health posts there is need for community sensitisation as well as extensive community screening.

3.4.9 Boosters from the Wide area survey

A pilot of questionnaire to find out more boosters to the CMAM programme was administered on the second day of the wide area survey. A sample of 40 - SAM and MAM cases who were in the programme were interviewed.

Most of the caregivers appreciated with the screening and diagnosis of malnutrition at the various health posts they visited and encouragement by the CHW's, and the overall outcome of the treatment in the CMAM programmes, availability of treatment proximity to the health was also mentioned. Other boosters are shown in the figure below:

Figure 20: Graph showing reasons for bringing children to the health post among OTP and SFP.



4. DISCUSSION

Knowledge and perception on Malnutrition

The first stage of the assessment revealed that community is well conversant with the causes and signs of malnutrition. The health facility is considered as the first option when seeking health and nutrition care, however caregivers indicated that they resolve to alternative remedies such as sheikhs' prayers, traditional medicines like malmal, hadith, especially when a child's condition does not improve after being taken to the hospital. Stigma was sighted as one of the setbacks to taking malnourished children to the health post, mothers' associate malnutrition with poor hygiene and poverty, and this was sighted as one of the barriers. There is need to sensitize key groups about malnutrition in the community to curb the stigma within the community

Integration and Community engagement

There is a well-established referral system in IFO camp. The CHWs are engaged in home visits where they screen children and refer them to the health posts, however community mobilisation was noted to be inadequate since most community members indicated that community health workers are not consistent with their visits at block level, in addition a lot of focus is usually put on immunization and very little on screening and counselling contributing to low coverage especially in the SFP programme. Incorrect screening at community level reduced the confidence of the community towards the CMAM program and created fear of rejection among the caregivers such that they don't go to the health when their children meet the admission criteria, the caregivers also reported that information on why the child was rejected was not provided on site thus reducing the mothers' confidence in the program.

One of the major boosters for the CMAM program was the continuous engagement of key groups in the community, these include the mother to mother support groups, community health committee (CHCs) and the safe mother hood program (SMP). These groups had been trained on CMAM and are useful in conveying relevant information to the mothers including health education and follow up. The camp leaders were aware of the current programs but had not been trained on CMAM. The nutrition department works closely with the health and outreach department. Routine growth monitoring is conducted on a daily basis for all children seeking medical attention at the health posts, children who are identified to be malnourished are referred nutrition programmes for treatment and follow up for management. This integration has ensured sick children coming to the health post for treatment are identified.

Utilisation of therapeutic products

There is misconception on the utilization of RUTF and RUSF. Mothers indicated that the products are good however in some instance they cause diarrhea. The mothers showed their discontent in the quantities of RUSF they receive, they viewed it as inadequate and as a result most mothers discharged from OTP did not see the need for attending the SFP as the amounts were fewer compared to the RUTF. This was noted as one of the contributing factors to low coverage for SFP.

Sharing of therapeutic feeds at household level remains a challenge in IFO camp, despite the nutrition educated on the utilisation. The assessment also revealed that selling of RUTF and RUSF is common among women who are looking for alternative sources of food to diversify their children's diet and source of income. One packet of Plumpynut is sold 30kshs while a Plumpysup at 20kshs. Selling of these products is seen as one of the main setbacks for the programme as it affects indicators such as the coverage, recovery rates and also the average weight gain of the children in the programmes. Intensive campaigns through radio talks, involvement of community leaders and health workers is required to promote proper usage of the products.

Infant and young child feeding Practices

The community is well conversed with IYCF practices, however poor feeding practices remains a challenge among children 0-23 months. Most mothers do not breastfeed exclusively up to six months. Some of the reasons mentioned include lack of adequate milk and lack confidence that the child is getting enough milk. Some of the food introduced before the six months includes, milk (goat, camel or packet milk), water, and a solution of water and sugar. After six months most children consume Corn soy blend (CSB++) which is provided at the general food distribution, other foods given to children include, tea, pancakes and potatoes. From the secondary data, highest admission was noted to be between ages 6- 12 months, this indicates a gap on the feeding practices for children at this age.

Inadequate space in Health posts

It was observed that the nutrition structures are in a dilapidated state. There were no waiting sheds for the beneficiaries. Community indicated the small waiting areas lead to congestion at the health posts, increasing the opportunity cost for the mothers, mothers indicated to have left their other children and household chores unattended to bring their children to the hospital.

Coverage

OTP was noted to have coverage of 81.4% while SFP was noted have coverage of 68.8%. The coverage of both programs are below the recommended 90% for refugee set up (SPHERE standard). Some of the contributing factors include poor mobilisation at community level, lack of adequate follow up and health information from the community health workers on the program admission requirement thus leading to fear of rejection, high defaulter rates, distance, and competing priorities for the mothers, stigma and lack of referral documents. During the second and third stage of the assessment, it was observed that mothers who had malnourished children and had not taken them to the health posts was mainly because they had been discharged before and their children had relapsed after sometime, mothers were either too occupied with other household chores to take their children back to the facility. This revealed that there was not close follow up from the CHWs after children have been discharged especially from SFP program.

Double registration especially in SFP was also noted as a challenge, interviews with health and community health workers revealed mothers exchange malnourished children for the purposes of getting extra sachets to sell. As a result Islamic relief introduced measures to mitigate this, where each mother had to produce a UNHCR proof sheet which contains household information before any child can be admitted into the program. Mothers saw this as a challenge since some genuine cases might miss admission due to lack of this important document.

The assessment noted that breaking of the SFP cycle impacts negatively on the coverage of the program. The SFP distribution takes place between the 7-12th (first cycle) and 21-26th (second cycle) of every month. When the distribution is not ongoing community mobilisation activities are usually ongoing. Any new cases for admission encountered during this period have to wait until the next cycle so that they can be enrolled into the programme. This waiting period lowers the chances of the mother coming to the health post, consequently leading to low admission and coverage

COMMUNITY MOBILISATION STRATEGY

Community Assessment; Most aspects on community assessment were not applicable to IRK given the nutrition programmes have been in existence for the last ten years, IRK took over the health programmes from 2013 from GIZ. IRK however uses information from routine nutrition data collection and assessments carried out at the camp to improve on various aspects of community mobilization for the existing CMAM programme for instance the routine HIS information and annual nutrition survey information.

Capacity Building and Creating Materials and Messages

Capacity building is part of IRK undertakings to enhance the CMAM programmes but most of the time limited funding and resources pose a major challenge to IRK hence gaps in capacity building of the relevant teams.

Notably, religious leaders have been left out of the whole process hence need for IRK to consider including the leaders in their community mobilization strategy given their major influence on the well-being of the community. In regard to Creating **materials and messages**, IRK relies more on the already existing IEC materials that are developed collectively by all the relevant stakeholders in addition to the already pre-existing one. No budget line for development of new materials is in place for IRK

Implementing and Monitoring of Community Mobilization Activities

Due to limited resources, implementation of community mobilization is done as part of the health and nutrition component and not separately since there is no budget in place specifically for such activities. These activities are added to the workload of the health workers as part of their routine workload. Most activities under this component are done to improve the CMAM programme because the programmes are already in place.

There lacked a monitoring and evaluation plan, hence specific indicators on Community mobilization indicators were not monitored. SPHERE standards indicators were used to track the performance of the CMAM program. WFP and UNHCR conducts routine monitoring of the programs on a monthly basis, this is done jointly with Islamic relief Nutrition staff.

Outreach workers report on a weekly and monthly basis, however there needs improvement to ensure data is more complete, accurate and reliable.

Feedback is adequately shared with the outreach workers on a regular basis, interviews with the community health workers demonstrated they do not to have key information on the general performance of the CMAM programme, for instance the GAM rates and SFP/OTP performance indicators. For better improvement of service delivery to the community the assessment recognised the need to share such information with the CHWs and CHCs.

RECOMMENDATIONS

Below are some of the recommendations emerging from the assessment

- Islamic relief to intensify health education at community and hospital level, especially on RUSF and RUTF utilisation.
- Continuous Sharing of feedback with the CHCs' and CHWs' on overall CMAM program performance
- Delay of RUSF and RUTF due to transport challenges was mentioned as a common challenge by both the community and health workers, IRK to organize transport on time
- Strengthening of MIYCN activities in IFO camp
- Community health workers to intensify case finding at block level
- WFP and IRK to explore how SFP products can be made available during non- SFP cycles
- Improve on integration with other departments such as WASH
- More engagement of key leaders in the community in the CMAM program such as Sheikhs
- IRK to provide referral cards to the CHWs
- An assessment of all structures to be done
- IRK to develop a monitoring plan and a work plan for the CMAM program

Limitation:

One of the challenges encountered during the assessment was the unstable security situation in the camp which limited movement of national staff during the data collection process.

5. JOINT PLAN OF ACTION

The SQUEAC assessment in IFO N refugee camp made some recommendations to improve the service qualities of current CMAM programme, increases access in services and continue to keep high coverage rate. To implement the recommendations below Joint Action Plan (JAP) has been developed in association with UNHCR, WFP, Islamic Relief and other relevant partners.

Gaps identified	Action	Applicable Internal Resources	External Resources Needed	Priority /When	Responsible Focal Person or Agency
Barriers to CMAM programme					
Delay in the delivery of nutrition commodities at the health posts experienced at the beginning of the SFP cycle and Monday for the OT	IRK to ensure that the OTP/SFP commodities are requested and transported to the health post on time	Logistics /Nutrition departments	UNHCR track	Immediately and to be maintained	IRK/CARE
Poor nutrition structures in all the health posts and no waiting shed for the beneficiaries	An assessment of all structures to be done.		Funding	December 2015	UNHCR/IRK
Inadequate health education and misconception about nutrition products	Sensitization of the community on nutrition products through leaders, CHWs and nutrition staff. IRK to explore other avenues of disseminating this information such as radio talks. UNHCR /WFP and IRK to incorporate nutrition messages on Nutrition products during nutrition campaigns		Radio talks	End of October	UNHCR/IRK and WFP
Poor infant feeding and young child feeding (IYCF) practices	Strengthen MIYCN activities at the facility and community through family bazaars ,community dialogues ,health education and cooking demonstrations	MIYCN counsellors/Nutritionists/RH and SMP		Continuous	IRK/UNHCR/
Poor hygiene situation at the block level	Integration of nutrition and WASH to address all hygiene issue at the blocks	Hygiene promoters and CHW's	Technical support	Continuous	CARE /IRK /UNHCR
Inadequate capacity building for nutrition staff	Refresher training on IMAM /IYCN for nutrition staff	OJT/CMES		December 2015	
Inadequate qualified nutrition staff and community health workers	IRK to fast track the hiring of the nutrition staff (Nutritionist and Nutrition nurses)	IRK		End of July	IRK /UNHCR
Unavailability of OTP/SFP referral cards and other IMAM IEC materials in the health posts	IRK to print OTP/SFP referral and admission cards.	IRK	N/A	End of July 2015	IRK
Poor active case finding at the community level	CHWs to intensify community mobilization activities at community level.	CHP/Health and Nutrition departments	Monitoring of the CHWS activities	Continuous	IRK
No admissions of moderately malnourished children in the non SFP cycle.	WFP to give provision for continuous admissions and IRK to ensure availability SFP staff at the health post to cater for the new admissions.			Every non SFP cycle	IRK/WFP
Component 1: Community Assessment					

Limited use of the communication channels; the mostly identified were the key community figures that deal directly with health leaving the religious leaders and FAC out.	Improve on the communication channels in order to reach the wider community	Staffing /existing community structures	n/a		IRK
	Improve the analysis of community assessment data and dissemination to key community members and other stakeholders	CHP/nutrition staff	Reporting tools		UNHCR /IRK
Inadequate involvement of the religious leaders and traditional healers into the community mobilization strategy	Map out the key Sheikhs and in the camp and orient them on malnutrition and CMAM	Staffing / existing community structures	n/a	End of July	IRK Nutritionist and CHP coordinators
Component 2:Formulating community mobilization strategy					
There is nutrition specific community mobilization work plan in place, the one available is part of the nutrition programme	Develop a joint community motivation work plan within the organization	Staffing (M& E officer	n/a	End of October (3 months)	IRK /MTL
Limited resources allocated for community mobilization activities in the camp.	Advocate for donor funding and MOH support by including the needs of the CHP programmes in to the overall health and nutrition budget	Advocacy team and fundraising	Additional Funding for CM activities	December 2015	UNHCR IRK
Component 3.Capacity building and Creating Materials					
Inadequate trainings and capacity building of the community outreach workers.	Develop a work plan to capacity build the outreach worker through trainings /CME'S /OJTS and mentorship programme by the MOH	CHP /Nutrition staff can conduct CMES and OJTS with minimal costs	Funding for training of the nutrition staff and CHWS	CMES and OJT – end of October Funding - December 2015	
Inadequate orientation of the community leaders on CMAM and community mobilization ; <i>the leaders requested for a training</i>	Orient the newly elected community leaders on CMAM and the community mobilization strategy	CHP /Nutrition staff	Material form MOH		UNHCR /WFP/IRK
Component 4.Implementing and Monitoring					
Inadequate /limited supervision of the community mobilization /outreach activities					UNHCR/WFP and IRK
Integration of CMAM with other sectors such as WASH is not adequate at the camp level such that there is no synchronized of conducting activities and messaging during campaigns and disease outbreaks	Improve coordination and integration of WASH in the community mobilization by UNHCR/IRK /CARE	Staffing	Coordination support from UNHCR	Continuous	UNHCR –(Health and WASH unit) IRK –MTL and CHP coordinator CARE
Component 5.Evaluating and Reinforcing or Maintaining					
Lack of a detailed M&E plan for community mobilization for CMAM programme	Develop a M\$ E plan for CMAM programme	n/a	n/a	October 2015	IRK

6. ANNEXES

Appendix 1: FOCUS GROUP DISCUSSION /KEY INFORMANT INTERVIEW GUIDE- IFO SQUEAC: STAGE ONE

Name of organization: _____ Camp: _____ Block: _____

Team: _____ Date: _____ Health Facility: _____

INTRODUCTION TO PARTICIPANTS: In this assessment, we aim to collect and analyse information on childhood acute malnutrition and available treatment services in order to understand the obstacles which the community might be facing and design solutions to address these obstacles.

Do you agree to participate? (A) Yes; (B) No. Thank you for participating in this assessment

SECTION I: COMMUNITY LEVEL DATA COLLECTION

I. GUIDE I: BLOCK LEADER, IMAM/ SHEIK, TRADITIONAL HEALER, TBA, MEN & WOMEN GROUP etc.

MALNUTRITION

1. What are common childhood illness in your community? (**Probe:** in which period & which illness are most severe)
2. Is malnutrition common (use local terms) in your community? (**Probe:** what are perceived signs and associated causes? Can they differentiate acute malnutrition from general illness?)
3. Where do you first seek a solution for a sick child? (**Probe:** home remedies with herbs, the traditional healers, a treatments sought before children are taken to a health facility, change of trend on the use of these methods)

SFP/OTP AND FACTORS AFFECTING ACCESS TO THE SERVICES

4. If CMAM service is mentioned in Q3, who informed you about the CMAM?
5. Are you happy to use the CMAM service? What are your challenges to use the OTP/SFP/SC services, how far and time required traveling to that?
6. Who is responsible for taking a child to a health facility? Does a mother make a decision herself or does she needs her husband's/family's approval?
7. Are there families who hide malnourished children in your family? Why? Do your community ashamed of malnutrition?
8. Have you heard or know of children who are in the program, but left/ stopped coming? What are the reasons? What can encourage the family to return of these children to program?

COMMUNICATION CHANNELS AND COMMUNITY GROUPS

9. How relevant information is commonly disseminated in your community? Which are the good channels to disseminate timely information to large communities? What are your sources of health and nutrition information?
10. How are decisions made in your community? How are they communicated to all community members?
11. Are there active committees/associations which act on community behalf? Are there community-based volunteers and outreach workers? In which areas are they active?

COMMUNITY MOBILIZATION ACTIVITIES

12. What was the last time that you saw a volunteer measuring children with MUAC in your community? Do you know how a child is referred to CMAM site? Do they provide health & nutrition education?
13. Do the community volunteers/workers visit a family with malnourished child?
14. Do your community leaders support to a community mobilization for CMAM? (**Probe:** case finding, referral, sensitization, transporting RUTF, support to volunteers' works)
15. In your opinion, who are the most appropriate groups and volunteer networks to carry out outreach activities for CMAM? (**Probe:** religious leaders, traditional healers, paid volunteers, CHWs, TBAs, etc.)

IYCFP

16. Do infants under six months of age feed exclusively breast milk? (**Probe:** colostrum given)? At what age do mothers start to give additional liquids to infants? How many times per day does a mother feed a 12 month-old infant? What is the child fed? (**Probe:** food taboo, any change in dietary intake during pregnancy, when a child is sick)

Community Recommendations

17. What are the recommendations to improve the community mobilization for CMAM program? (**Probe:** case finding, defaulter tracing, sensitization, increase service use by the community?)

II. GUIDE II : COMMUNITY HEALTH WORKERS AND NUTRITION ASSISTANTS

Malnutrition and OTP/SFP services

1. Where do the communities first seek a solution for a sick child? Why
2. In your opinion, what would make the CMAM service easier, more comfortable and familiar to use by your community? (Probe: existing challenges and positive factors, recommendations)

Outreach worker/volunteer

3. How long you worked as volunteer? What are your primary activities and frequency? (**Probe** : working hrs/week or month, unpaid volunteer commitment, motivation, challenges, reporting.)
4. Do you get support from UNHCR/WFP, partners and/or community? (Probe: training, materials and use, workload etc.)
5. Have you encountered caregivers who refused to take a child to the OTP/health facility after referral? If yes, what were their reasons? What have you done with those cases?

Communication channels

6. How do you disseminate health and nutrition message to the community? Why preferred these channels?
7. What are the common methods of disseminating information to the community? (**Probe:** communication methods, perceived relative effectiveness)

Community actors and volunteers

8. Who are existing community groups, associations and network of volunteers exist in the communities? How can they be used for community outreach activities for CMAM? (**Probe:** their initiatives, target populations & coverage, and the community mobilization approach they use)
9. In your opinion, who are the most appropriate groups and volunteer networks to carry out community mobilization activities for CMAM? (**Probe:** religious leaders, traditional healers, mother groups, father groups, grandmother groups, paid volunteers, CHWs, TBAs, etc.)

Recommendation

10. What are the recommendations to improve the community mobilization for CMAM program? (**Probe:** case finding, defaulter tracing, sensitization, increase service use by the community)

SECTION I: HEALTH FACILITY LEVEL DATA COLLECTION

III. FGD/KII GUIDE: CARETAKERS OF CHILDREN IN OTP/SFP PROGRAM

MALNUTRITION AND CMAM SERVICES

1. What are common childhood illness in your community? (**Probe:** in which period & which illness are most severe)
2. Is malnutrition common (use local terms) in your community? (**Probe:** what are perceived signs and associated causes? Can they differentiate acute malnutrition from general illness?)
3. How did you hear about the CMAM service? Why did you come to the health facility?
4. Are you happy with use the service? What are your challenges to follow up the service? How long does it take you to come here?
5. How long has your child been in the OTP /SC or SFP program? Has your child changed since he/she was admitted?
6. What are your recommendations to make the CMAM service easier and more comfortable to use? (**Probe:** when and where to use the service)
7. Was your child admit before in the SFP/OTP/SC? Any of your other children admitted to SFP/OTP/SC before?
8. Have you referred any other children for treatment? Will you refer another child to this program if you think they are sick of malnutrition (use local term) (**Probe:** peer referral, stigma)

TRADITIONAL MEDICINE

9. Have you used any other means of treatment for your child illness before coming to the health facility? If yes, what and where you used? Why did you choose to come to health facility? If woman, what was your husband's reaction? How did you arrange for other children's care?

Community MOBILIZATION ACTIVITIES

10. Did the volunteer or health worker visit at your home? If yes, how they support you? (**Probe:** case follow-up, screening, sensitization)

IV. FGD/KII GUIDE: OTP/SC/SFP WORKERS, HEALTH WORKERS CMAM services

1. What kind of treatment for children with acute malnutrition available in this health facility? (**Probe:** SAM/MAM admission and discharge criteria? Is there a protocol? Is the staff use the protocol?)
2. What are the challenges to deliver OTP/SC or SFP service? (**Probe:** staffing, supply, motivation)
3. Do you get technical support and feedback from your supervisor? (**Probe:** training? when? do they have necessary materials to deliver the services?)
4. In your opinion, what are your recommendations to improve the CMAM services?

Community MOBILIZATION ACTIVITIES

5. What are existing community mobilization activities already underway to promote CMAM service use? Who is doing that work? What works best? What is not working and why? (Probe; SWOT, team structure, reporting, how you collaborate with community-based volunteers?)

6. Who are existing network of volunteers could be used for community mobilization activities for CMAM? **(Probe:** initiatives, target populations, coverage)
7. In your opinion, who are the most appropriate community figures and groups to carry out community mobilization activities for CMAM? **(Probe:** religious leaders, traditional healers, mother groups, father groups, youth groups, paid volunteers, CHWs, TBAs, etc.)

IV. OBSERVATION CHECKLIST FOR NUTRITION UNIT/HEALTH FACILITY

1	Community mobilization	Yes	No	DK	Remark
1.1	Does a health facility/partner has written a community mobilization strategy?				
1.2	Is there assigned focal person to coordinate community mobilization activities?				
1.3	Is there coordination mechanism exist?				
1.4	If yes to 1.3, do community members attend the meeting?				
1.5	Is there a minutes of the coordination meeting and follow up?				
1.6	Do outreach workers/volunteers report weekly/monthly?				
1.7	Is there analysis of outreach worker report and feedback system in place?				
2	Staffing and infrastructure	Yes	No	DK	Remark
2.1	Is all scheduled nutrition staff present today?				
2.2	Is there functional a toilet that is available for clients to use?				
2.3	Does the health facility has potable water available today?				
2.4	Does the health facility has waiting area /shaded for caregivers and children?				
3	Supplementary feeding program/SFP	Yes	No	DK	Remark
3.1	Do you have an SFP/MAM treatment program? If No, skip to Section 4				
3.2	Does a protocol exist?				
3.3	Are there clear criteria for referral to SFP?				
3.4	Are there clear referral mechanism between SFP to OTP /SC and OTP/SC to SFP?				
3.5	Is there a mechanism in place to search for defaulters?				
4	Therapeutic Feeding Program/OTP/SC	Yes	No	DK	Remark
4.1	Do you have an OTP service? If No, skip to section 5				
4.2	Does a protocol exist?				
4.3	Are there clear criteria for referral to OTP				
4.4	Are there clear referral mechanism between SFP to OTP /SC, OTP/SC to SFP, OTP to SC?				
4.5	Is there a mechanism in place to search for defaulters?				
5	Triage	Yes	No	DK	Remark
5.1	Is pre-screening used to screen child for acute malnutrition using MUAC tape?				
5.2	Does an entrance to registration and consultation occur in a controlled manner?				
6	Take random 30 SFP/ 30 OTP cards and check who referred a child to health facility	COW/ CNV	Self- referral	Health worker	Other

Appendix 2: Survey questionnaire: IFO SQUEAC, Dadaab Camp, Kenya: May 2015

SQUEAC: Small/Wide Area Survey SAM/MAM, IFO N, Dadaab Camp, May -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										

Appendix: 3 Small/ Wide area survey Questionnaire for the guardians of the children (Active SAM and MAM cases) NOT in the program, IFO , Dadaab camp, Kenya, May 2015

Name of Child _____ Section: _____
OTP: _____ Block: _____ 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 program? _____

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

- 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 PROGRAM 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 program (When?)
- Discharged but not cured (When?)
- Others: _____

5. If you decide to use OTP/SC/SFP 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)