



2015

COVERAGE ASSESSMENT

» SEMI-QUANTITATIVE EVALUATION OF ACCESS & COVERAGE

Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)
Community based Management of Acute Malnutrition (CMAM) Programme,
International Rescue Committee (IRC)
Kambioos Refugee Camp Dadaab, Kenya
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**Authors: Dorothy Gazarwa (UNHCR), Joshua Rutto (IRC), Amina Mohammed (IRC),
Lovely Amin (CMN) and Dessie Melaku (CMN)**



ACKNOWLEDGEMENTS & ABBREVIATION

ACKNOWLEDGEMENTS

Our appreciation goes to UNHCR, WFP and IRC for organising and leading the execution of this assessment.

We would also like to acknowledge the survey participants; community leaders, care givers of children aged 0-59 months, Traditional healers, Tradition birth attendants and IRC staff who participated in this assessment.

Lastly, we also recognise Coverage Monitoring Network's (CMN's) for their efficient remote support provided during and prior the assessment of the CMAM programme in Kambioos refugee camp.

ABBREVIATIONS

CHC	Community Health Committee
CI	Credible Interval
CMAM	Community based Management of Acute Malnutrition
CMN	Coverage Monitoring Network
ECHO	European Commission Humanitarian Aid and Civil Protection
FGD	Focus Group Discussion
IRC	International Rescue Committee
KII	Key Informant Interview
LoS	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 Care
RUTF	Ready to Use Therapeutic Food
RUSF	Ready to Use Supplementary Food
SAM	Severe Acute Malnutrition
SSI	Semi Structure Interview
SQUEAC	Semi Quantitative Evaluation of Access and Coverage
TBA	Traditional Birth Attendant

EXECUTIVE SUMMARY

The Dadaab refugee camp is located approximately 500 km from Nairobi and 80 kilometers from the Kenya- Somalia border. The camp was established in 1991/92 to cater to the influx of refugees from Somalia fleeing from civil war. The Dadaab complex is made up of five separate camps i.e. Ifo, Kambioos and Dagahaley, Ifo2 and Hagadera, which cover a total area of approximately 50 sq. km within an 18 km radius of Dadaab Town. At the time of the assessment a total 353,219 (UNHCR progress data base March 2015) refugees are residing in Dadaab in five different camp sites. In Kambioos where the assessment took place, the population was about 20,000 persons of concern.

In Dadaab camp with leadership of UNHCR various national and international NGOs provide basic services to refugees including community base management of acute malnutrition (CMAM) services. UNHCR invited the Coverage Monitoring Network (CMN) to train and provide remote support for an assessment of the CMAM programme implemented by IRC in Kambioos camp using the Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)¹ methodology.

Nutrition service provision is from one health post with outpatient therapeutic programme, supplementary and blanket feeding programmes. Kambioos is a relatively newer camp with an agro-pastoralist community that came to Dadaab during the 2011 drought in Somalia. Means of livelihood are limited and the population is mostly dependent on food aid.

The assessment used a three stage SQUEAC methodology i) collect and analyse the qualitative and quantitative data; 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 Targeted Supplementary Feeding Programme (TSFP). However due to the small size of the camp, wide area survey covered all the blocks that had been excluded in the small area survey.

Main Results

Stage -1

❖ The CMAM programme performance (quantitative):

Routine data from OTP and SFP was collected from registers in the field and cross-checked with data in the UNHCR HIS from January to December 2014. The UNHCR HIS performance indicators 2014, show that the cure rate was 94.9% and 93.5% for OTP and SFP, respectively. This data was also used in the assessment to establish the quality of OTP and SFP service provision in the health-post in Kambioos.

❖ Communities' participations and access to CMAM services (qualitative):

This community assessment entailed interviews with caretakers of children, community leaders, religious leaders and traditional healers. Additionally, a balance score card from CMN was administered to caretakers, community leaders, CHWs, Community health programme and nutrition officers. The information collected was used to establish the quality of the community based programme and the community perspective on the CMAM programme. The community assessment revealed that availability of free services, supply of therapeutic products, health education at the health posts, use of easy to understand posters at the health posts, support of CMAM services by community leaders, good outreach activities and good treatment outcomes were some of the boosters that can continue to be enhanced.

¹ Mark Myatt, Daniel Jones, Ephrem Emru, Saul Guerrero, Lionella Fieschi. SQUEAC & SLEAC: Low resource methods for evaluating access and coverage in Selective feeding programmes.

However, competing priorities for caretakers, especially, in cases where both caretakers leave children alone when they go to work, rejected cases at the point of admission that later deteriorate, poor logistical arrangements for the first day of distribution, inadequate individual counselling should be resolved. One of the biggest challenges is relapse of children that had been cured (27%) as such counselling infant feeding during and on discharge is very crucial to prevent readmission or ensure for self-referral where needed. The referral system from Hagadera SC to Kambioos OTP needs to also be improved as some discharges reportedly had no referral documents and had not been admitted in the OTP. Deterioration of children while in the SFP needs to be addressed by closer supervision, regular home visits. Children that are deteriorating and correct inappropriate use of treatment products and improve child care practices at household level.

Stage - 2

❖ Hypothesis testing and results

Hypotheses in stage two were generated basing partially on the qualitative and quantitative information collected in Stage 1. "Blocks with high admissions have high coverage and blocks with low admissions have low coverage." To test this hypothesis, a small survey was conducted in 6 sections from a total of 36 blocks in Kambioos camp and compared with the 90% coverage threshold that is set for camp setting as a minimum coverage rate ².

The survey data revealed that for OTP the blocks with 'high admissions' and 'low admission' both have low coverage. On the other hand for SFP coverage was found low in high admission and high in low admission blocks. The programme needs to use this data to analyse if coverage varies in different blocks.

Stage - 3

❖ Coverage Estimation (results from wide area survey)

Following the 'Wide Area Survey' in stage three the 'Point coverage' and 'Single coverage' rates were estimated using Bayesian calculator for both SFP and OTP. The Single coverage is reported in this section. For point coverage see report's narrative (stage 3).

The single coverage rate for SFP using Bayesian calculations is estimated at **79.6%** with a Credible Interval of (CI 71.7% - 85.6%), and P value=0.575 with reasonable overlap between 'prior' and 'likelihood'. The SFP coverage **did not meet the SPHERE standard** that set for camp settings, which is ≥90%.

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

Main Barriers identified:

The main barriers identified were for not accessing and up taking of CMAM service were:

1. Competing priorities (too much work in the household, mothers go to work in Hagadera leaving children to look after younger children)
2. Distance to health post for beneficiaries in section 6, 5 and also inpatient services are far in Hagadera.
3. Long queue, overcrowding, inadequate nutrition staff
4. Lack of individual counselling (rejected MUAC referrals, admissions, discharges, misinterpretation of quick recovery)

² The Sphere Project, Humanitarian Charter and Minimum Standards in Humanitarian Response, 2011 Edition

5. Sharing and selling of RUTF and RUSF

❖ **Key Recommendations (for detail please see JAP in section 5)**

1. Strengthen community mobilization activities for a CMAM programme by training of key staff members, involvement of traditional leaders and MMSG leaders in CHP activities.
2. Conduct individual counselling on admission, during the programme and on discharge. Preventive actions such as appropriate infant feeding practices need to be discussed before discharge of the beneficiary.
3. Engage CHC and block leaders and MMSGs to monitor programme barriers and address them
4. Improve monitoring and evaluation of CMAM programme
5. Follow up of discharges from SC in Hagadera by allocating a specific CHW to ensure the discharged case has a referral slip and is admitted in the OTP
6. Integrate MIYCN in CHP activities to strengthen the preventive activities of acute malnutrition. See the recommendation and detail Joint Action Plan in Section 5.

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1. INTRODUCTION

1.1 DADAAB REFUGEE CAMP IN KENYA

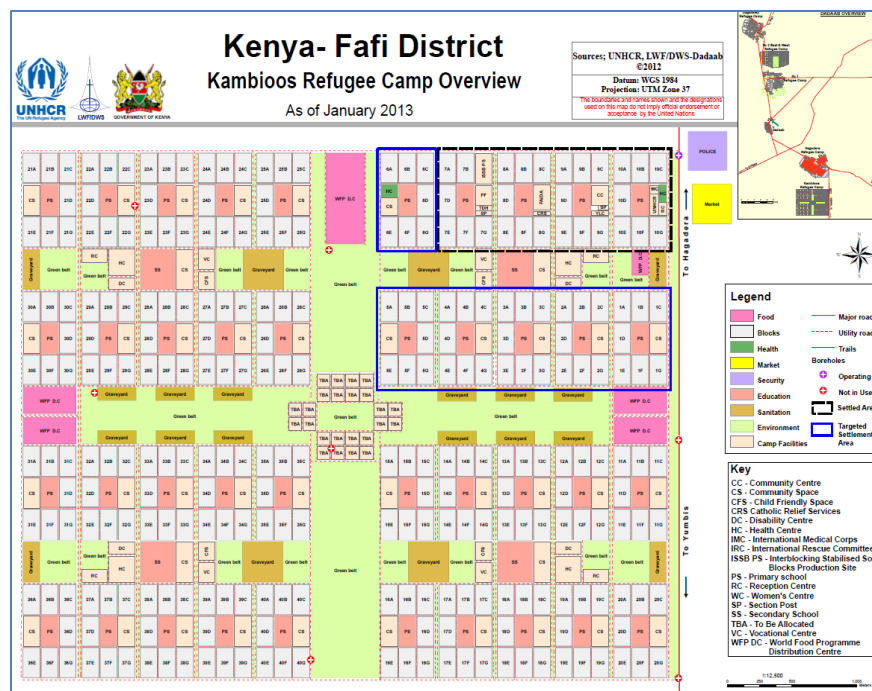
The Dadaab refugee camp is located approximately 500 km from Nairobi and 80 kilometers from the Kenya-Somalia border. The camp was established in 1991/92 to cater to the influx of refugees from Somalia fleeing from civil war. The Dadaab complex is made up of five separate camps i.e. Ifo, Kambioos and Dagahaley, Ifo2 and Hagadera, which cover a total area of approximately 50 sq. km within an 18 km radius of Dadaab Town. At the time of the assessment a total 353,219 (UNHCR progress data base March 2015) refugees are residing in Dadaab in five different camp sites. In Kambioos where the assessment took place, the population was about 20,000 persons of concern

In Dadaab camp with leadership of UNHCR various national and international NGOs provide basic services to refugees including community base management of acute malnutrition (CMAM) services. UNHCR invited the Coverage Monitoring Network (CMN) to train and provide remote support for an assessment of the CMAM programme implemented by IRC in Kambioos camp using the Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)³ methodology.

1.2 KAMBIOOS CAMP

Kambioos camp was established in 2011 following the influx due to famine in Somalia. The camp is well planned, has one health post that comprises an OTP, SFP and outpatient health service provision. Nutrition rehabilitation services for children with severe acute malnutrition with complications are accessed in Hagadera camp. Kambioos camp has an estimated population of 20,000 individuals and per UNHCR ProGress database. See Kambioos map below.

Figure 1: Lay out of Kambioos camp in Dadaab, Kenya

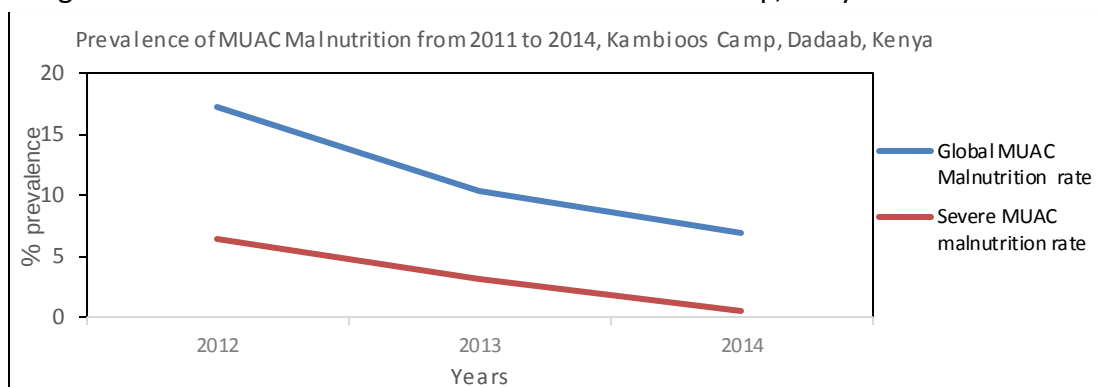


³ Mark Myatt, Daniel Jones, Ephrem Emru, Saul Guerrero, Lionella Fieschi. SQUEAC & SLEAC: Low resource methods for evaluating access and coverage in Selective feeding programmes.

1.3 MUAC MALNUTRITION IN KAMBIOOS CAMP

A number of nutritional surveys have been conducted in Kambioos camp using the Standardized Monitoring of Relief and Transitions (SMART) methodology to assess the nutritional status of children age between 6-59 months (see figure 2). The last survey conducted was in August & September 2014 showed that the prevalence of Global Acute Malnutrition (GAM) (WHZ<-2) for Kambioos camp was 6.9% (95% CI: 5.1-9.3) and the severe acute malnutrition (SAM) prevalence (WHZ<-3 and/or oedema) was 0.6% (95% CI: 0.2-1.6). Using Mid Upper Arm Circumference (MUAC), the global malnutrition was 4.1% (95% CI: 2.8-6.1) and SAM rate was 0.6% (95% CI: 0.2-1.6)⁴, WHO 2006.

Figure 2: Trend of MUAC malnutrition in Kambioos Camp, Kenya



1.4 THE HEALTH AND NUTRITION PROGRAMME IN KAMBIOOS

In partnership with UNHCR, approximately, different national and international NGOs provide humanitarian assistance to the refugees in Kambioos camp. The services mainly included health, food security and nutrition, water and sanitation, education, shelter and environment, community empowerment and self-reliance.

The basic health and nutrition care is provided through one health post. The ratio is almost 20,000 individuals for the one existing health-post and therefore below the standard of 10,000 individuals per health facility.

WFP through NRC distributes food rations twice a month. There is one food distribution point, where refugees collect food and non-food items through a biometric check system. These food rations are calculated to provide a daily provision of 2,100 kilocalories per person per day, which is the global standard.

⁴ UNHCR NUTRITION SURVEYS, DADAAB, Final report- October 2014

2. OBJECTIVES ASSESSMENT

A SQUEAC training was conducted in Kambioos to ensure quality data collection and utilisation of the routine programme's monitoring data to improve the service quality; information was gathered from various key stakeholders of the targeted community to ascertain their participation and perception on the CMAM programme; the data collected to estimate of overall SFP and OTP programme coverage for Kambioos camp. Finally, the SQUEAC team developed a Joint Action Plan (JAP) on community/camp mobilisation activities to improve the access and coverage of this CMAM programme for Kambioos camp.

2.1 SPECIFIC OBJECTIVE

1. To estimate coverage of SFP and OTP in the target areas of Kambioos camp.
2. Identify factors affecting access to and uptake of the CMAM services in Kambioos camp.
3. To understand the context and communities targeted by the CMAM programme in order to design a comprehensive community mobilization strategy to improve access to CMAM services.
4. Develop specific recommendations and Joint Action Plan in collaboration with assessment team and programme implementing agencies to improve acceptance and coverage of the programme.

2.2 EXPECTED DURATION OF THE TRAINING AND THE ASSESSMENT

May 25th to June 17th

2.3 PARTICIPANTS

A total of 10 participants (5 teams) from IRC were trained on data collection tools for SQUEAC methodology.

3. INVESTIGATION PROCESS

2.4 OUTPUT

1. Develop a Joint Action Plan and strategy for community mobilization for CMAM programme
2. Produce a final coverage survey report of SQUEAC assessment for Kambioos camp.

The Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) methodology was used to train the team and to conduct the coverage assessment in CMAM programme in Kambioos camp. The SQUEAC investigation methodology includes:

- Stage 1:** Analysis of qualitative (contextual data) and quantitative (routine programme monitoring data) data, compared with SPHERE minimum standard.⁵ Identify programme *boosters and barriers*.
- Stage 2:** Conduct a 'Small area survey' test hypothesis; if areas with the highest OTP admissions have high coverage and areas with the lowest OTP admissions have low coverage.
- Stage 3:** Conduct a 'Wide area survey' to estimate programme coverage rate and compare with SPHERE minimum standard. Make recommendations and develop a JAP to improve access to services and increase coverage.

2.1 STAGE 1

2.1.1 ROUTINE PROGRAMME MONITORING DATA & CONTEXTUAL DATA

Data collection:

In stage one, quantitative and qualitative data was collected and analysed for the one health post that is used to provide health and nutrition services to refugees in Kambioos camp. For the quantitative part, routine programme monitoring data for both OTP and SFP was provided by IRC and UNHCR team. This data was collected from the registers and cross-checked with UNHCR HIS data.

Routine programme monitoring data

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

<i>Admission data</i>	<i>Programme performance indicators</i>
- Admissions trend for OTP & SFP and seasonal calendar - MUAC status at admission for OTP - Age at admission	- Cured, Defaulters, Death, Non responders and Transferred cases – OTP & SFP - Defaulters' trend and seasonal calendar (labour period and migration etc.) - Defaulter's nutritional status at the time of defaulting - Number of weeks spent in OTP before defaulting - Length of Stay (LoS)

⁵ The Sphere Project Humanitarian Charter and Minimum Standards in Disaster Response, 2004

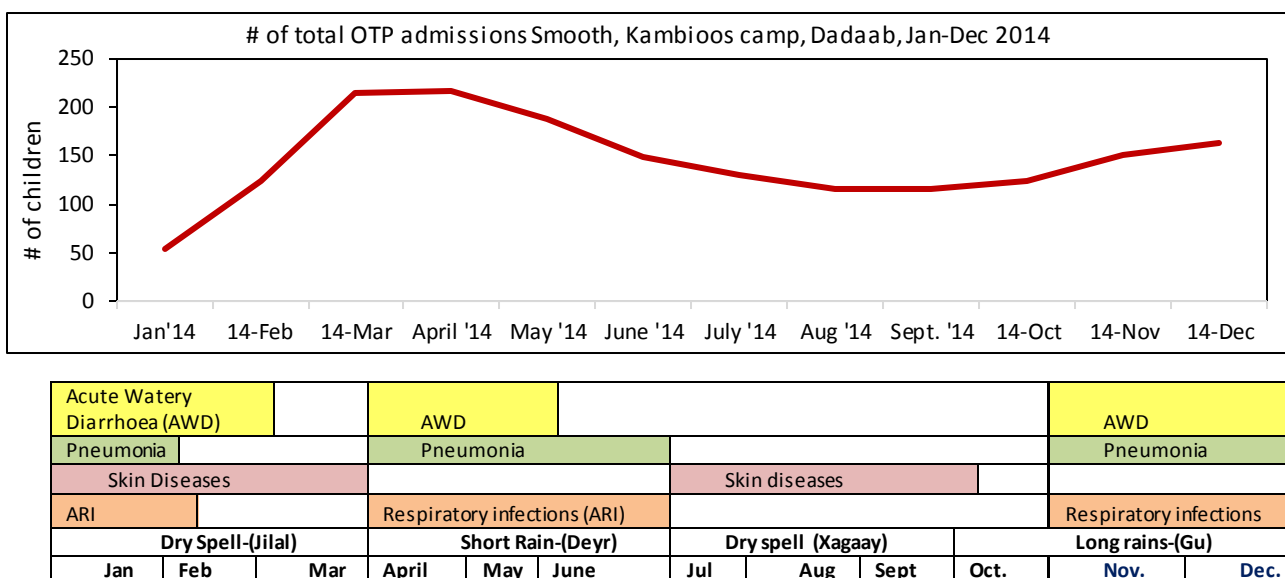
Admissions data

In Kambioos, the IRC Nutrition (CMAM) programme has admitted 779 cases in OTP and 1188 cases in SFP of children aged 6-59 months from January 2014 to December 2014.

OTP Admissions and Seasonal Trend & Childhood Illness

The graph below shows the OTP admission trends of Kambioos refugee camp in comparison with the seasonal calendar. There was a peak in admission in the month of April 2014 then gradually slowed down from June. The assessment team in consultation with the community identified seasonal peak of childhood diseases and seasonal affects. The peak season for childhood illnesses seems November to January comparing with the other months of the year, when admissions were considerably high. Figure 3 below shows that there is a relation between peak seasons of childhood illness with the admission trend in OTP.

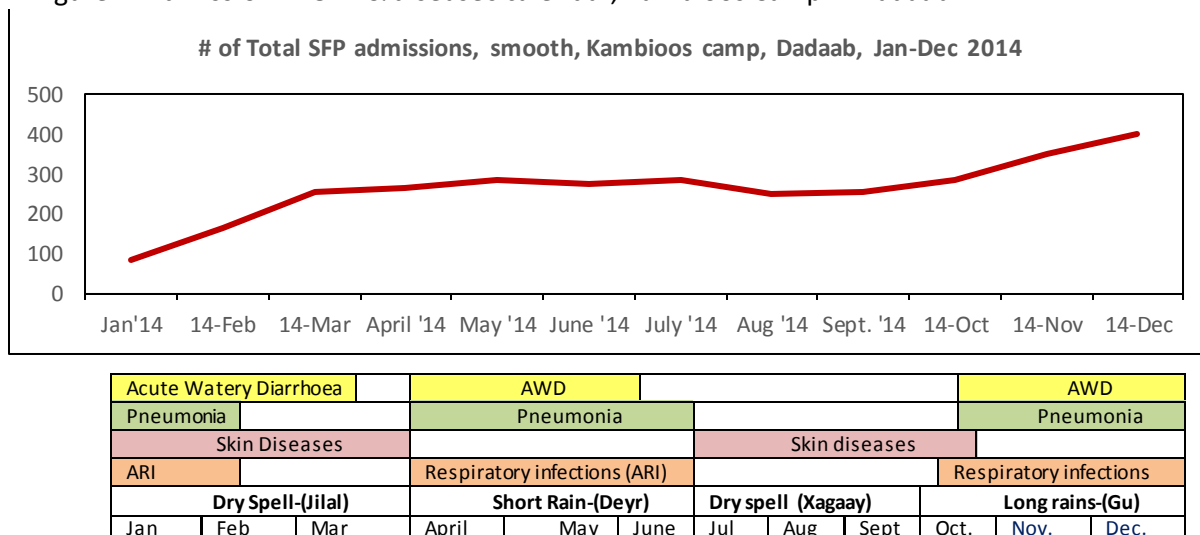
Figure 3: Admission in OTP & diseases calendar, Kambioos Camp in Dadaab



SFP Admissions and Seasonal Trend & Childhood Illness

The assessment team in consultation with the community identified seasonal peak of childhood diseases and seasonal affects. Similar to OTP admission the peak in admission shows in the month of March then gradually slowed down and increased again in November continue till December. The SFP admissions seem went up after peak of seasonal illness, the below graph shows the trend.

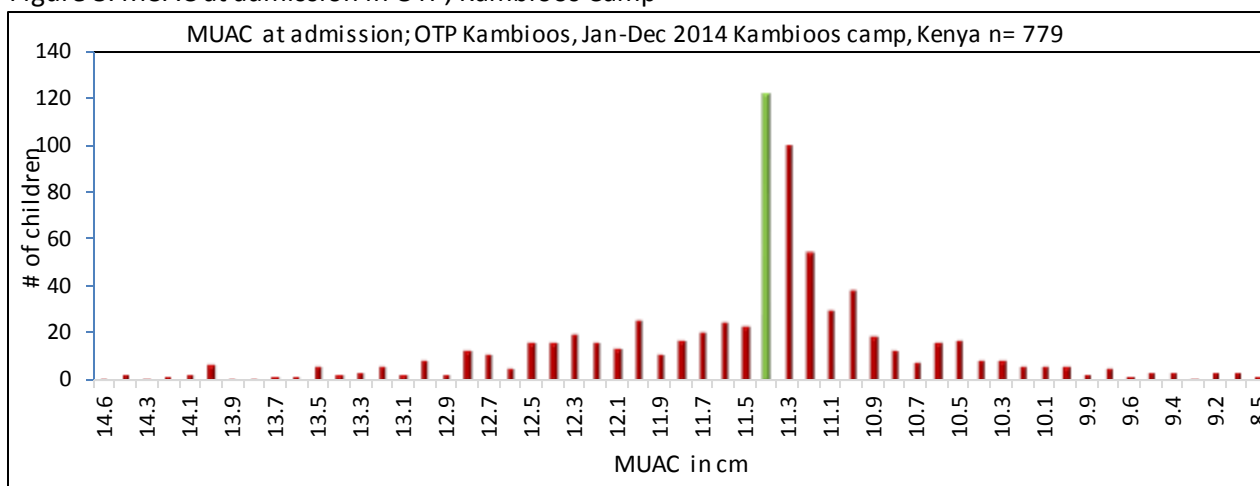
Figure 4: Admission in OTP & diseases calendar, Kambioos Camp in Dadaab



MUAC at the time of admission in OTP

The MUAC admission allows the programme team to understand the timeliness of care seeking behaviours of communities as well as the pro-activeness of the community volunteers & communities on early screening and referring of cases to CMAM programme. The data on admission MUAC was available for 779 children, the median MUAC at admission from the programme data was calculated to 11.4cm. This shows early case findings and positive health care seeking behaviour from the community for malnourished cases. The highest admission (16%) was recorded on MUAC of 11.4cm, which is the upper cut off point for MUAC admission. In the refugee camps, both MUAC and weight for height criteria are used for admission consequently, 37% of the admissions reflected below are above the MUAC cut off point of 11.4 cm. This number reflects the fact that MUAC and weight for height z-scores admit different children and both criteria should continue to be used. (see figure below).

Figure 5: MUAC at admission in OTP, Kambioos Camp



Age at admission

Age at admission allows the programme team to identify the age group that is at higher risk of malnutrition for further investigation on the underline causes. This information can be used to better address the causes of malnutrition in the community. Figure six & seven shows that majority of the children 88.2% in OTP & 82.9% in SFP admitted in the programme are children age between 6 to 24 months, with highest percent between 6-12 months (58.5% in OTP & 48.6% in SFP). This shows a great need to focus on infant and young child feeding (IYCF) practice interventions in area.

Figure 6: Admission Kambioos camp OTP

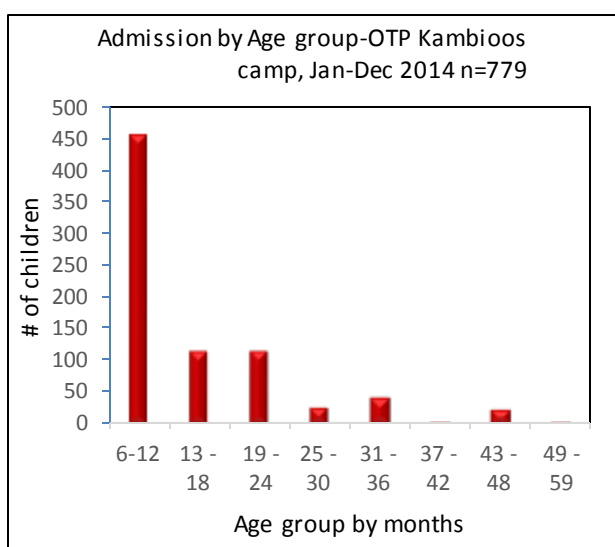
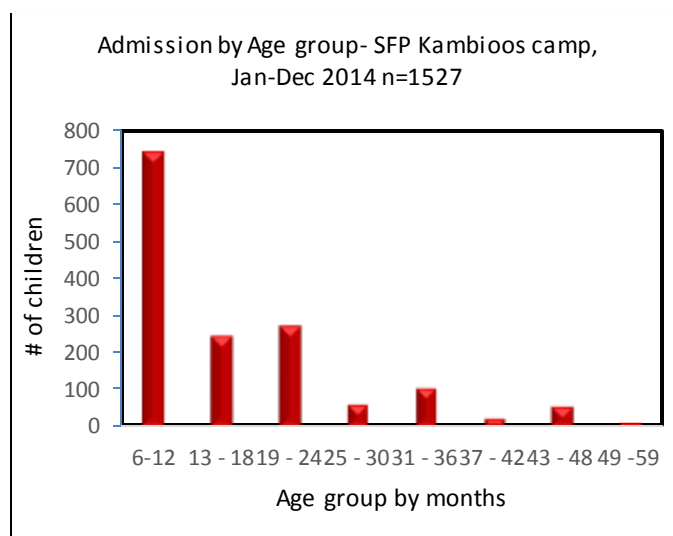


Figure 7: Admission Kambioos camp SFP

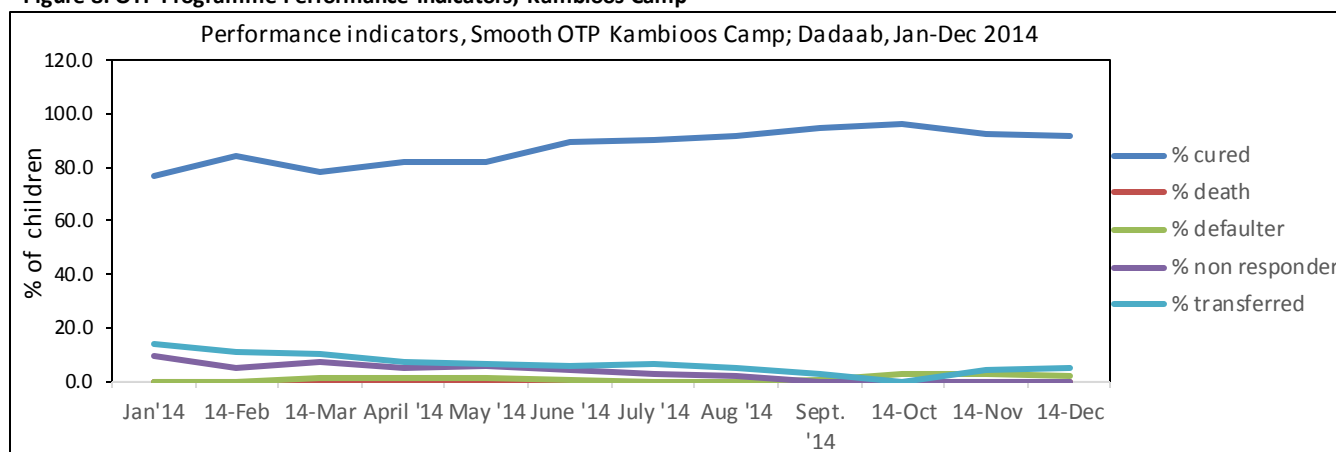


Programme performance indicators for OTP and SFP

The programme performance indicators are the number of children who exited from OTP, compared to their status at time of exit (discharged cured, defaulter, and death etc.). Percentages were used to ascertain the effectiveness of the programme and compared with the SPHERE minimum standards.

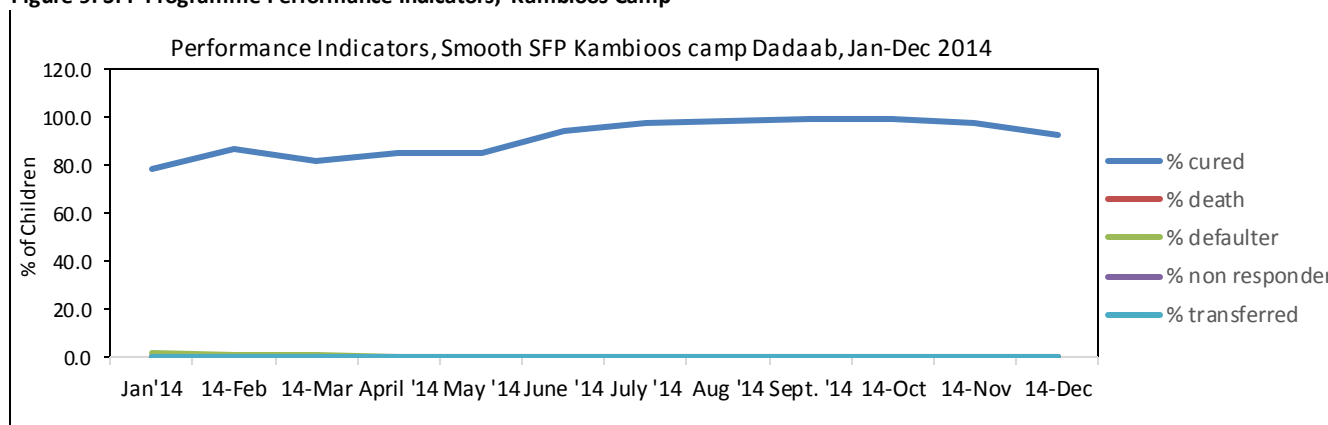
From January to December 2014, children that exited from the programme after receiving the treatment were from OTP 830. Of them 94.9% children have been successfully treated and discharged cured. In the same period there are 15 non responders (1.8%) were recorded in OTP. No deaths were found. See figure below 8.

Figure 8: OTP Programme Performance Indicators, Kambioos Camp



During the same period (Jan. to Dec. 2014), children that exited after receiving the treatment from SFP were 1260. Of them 93.5% had been discharged cured from SFP. In the same period there no death was recorded in SFP. The remaining were mostly transfers (6.2%) who deteriorate to OTP and non-responders (2 cases). Cases of children deteriorating in the SFP need to be identified and followed up at household level. See figure below 9.

Figure 9: SFP Programme Performance Indicators, Kambioos Camp



Length of Stay (LoS)

Length of Stay in OTPs is an important performance indicator to assess the quality of care a child is receiving during treatment at the facility and at home. The average acceptable length of stay in OTP is 8 weeks and in SFP 12 weeks according to the national IMAM guidelines of Kenya⁶. The median length of stay for children admitted in nutrition programme in Kambioos camp, OTP was 8 weeks and SFP was 6 weeks which are within the expected length of stay (figure 10 & 11). However, all children got discharged within 12 weeks which is maximum LoS according to the Kenya national IMAM guidelines. The SFP in Kambioos camp appears to be very effective however the issue of deteriorating cases needs to be improved.

⁶ National Guideline for Integrated Management of Acute Malnutrition, version 1, June 2009

Figure 10: Length of stay in OTP Kambioos

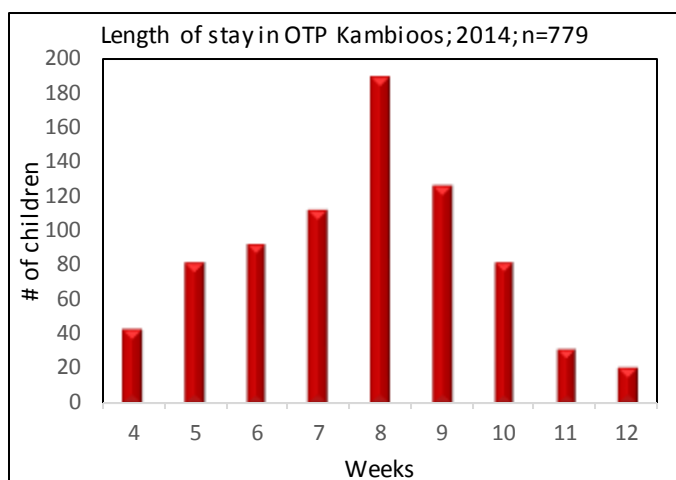
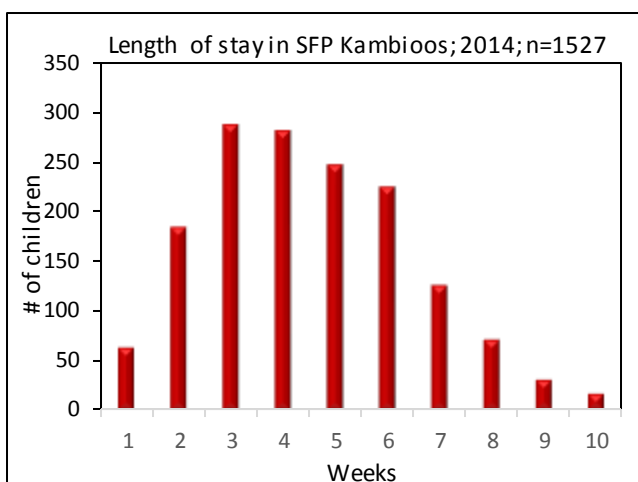


Figure 11: Length of stay in SFP Kambioos



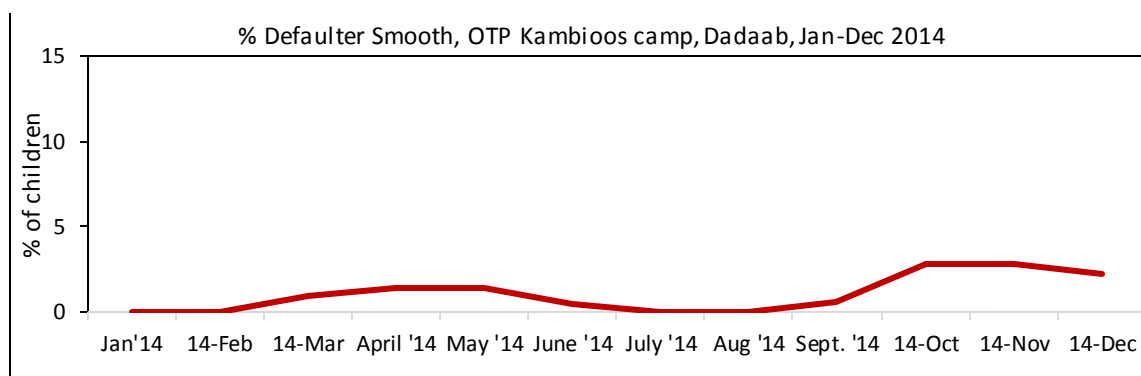
Data on defaulters:

According to the Kenya IMAM guidelines a defaulter is classified as a child who is absent for treatment for three consecutive visits.

Analysis of OTP defaulters' data

During the period of January to December 2014, from OTP 830 children were exited after receiving treatment. Of them 0.7% children from OTP have been defaulted. The figure below shows that the defaulter rate for OTP went up from August to December 2014, this period coincided with EPI campaign, malezibora campaign and religious holidays towards the end of the year in Kambioos. During this period community volunteers were busy and not able to follow the defaulter children at home, and towards the end of the year most of the staff are on holidays resulting in reduced supervision of outreach team therefore increased rate of defaulter. However, according to the SPHERE standard (<15%) the OTP defaulter rate (0.7%) is within the acceptable level, figure: 12.

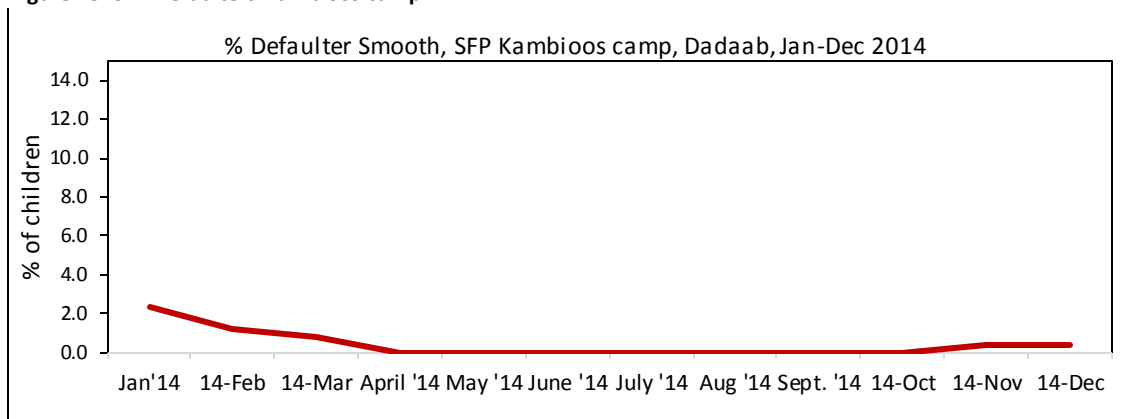
Figure 12: OTP Defaulters Kambioos camp



Analysis of SFP defaulters' data

Similarly, during same period (January to December 2014) from SFP 1260 children were exited after receiving treatment. Of them 0.2% children defaulted. The figure below showing that the defaulter rate went up from August to this period coincided with campaigns and end of the year holidays and increased number of admissions in Kambioos camp. However the defaulter rate is minimal (0.2%) and within the acceptable range, SPHERE standard (<15%), figure: below 13.

Figure 13: SFP Defaulters Kambioos camp



The database and record keeping in Health Facilities, in Kambioos camp

The CMAM programme monitoring data provided by the UNHCR/IRC team were useful and allowed the analysis of some important indicators of the CMAM programme that are essential for SQUEAC assessment and to understand the service qualities of the programme. The data were found consistent and available for some of the important indicators of the OTP & SFP programme.

During the assessment some sample data were collected to better understand the programme service quality. Also for quality assurance of programme data, the treatment cards and registers were cross checked in the only health facility. The OTP and SFP cards examined were found more than 75 percent card was filled fully and information matched between cards and register. Most of the referral information was not available. Therefore record keeping of this programme need to improve further with regular supervision and continuous training.

2.1.2 QUALITATIVE DATA⁷

During the qualitative phase of the assessment, 6 blocks and one health post from Kambioos camp were systematically assessed including key stakeholders were interviews to better understand how community perceive this programme and how to improve the access and services of CMAM programme in Kambioos camp. Below are the summary of the key findings:

3.1.2.1 LOCAL UNDERSTATING OF CHILDHOOD ILLNESS AND MALNUTRITION

Most of the community members were relatively familiar with different signs and symptoms of malnutrition, such as weakness, wasting/thinness, oedema and loss of appetite. However, traditional healers found less aware about malnutrition. The perceived causes of malnutrition cited by most of the community members were diarrhoea, prolonged illness, inadequate food for children, poor hygiene and poor breastfeeding practices.

3.1.2.2 TREATMENT OF ACUTE MALNUTRITION AND OTHER ILLNESS

Most of the community informants mentioned that they used a CMAM service to treat acute malnutrition. However, significant community members indicated they also sought alternative solution from Sheik (prayer), private clinics, pharmacies, traditional healers and use of home remedies such as 'malmal', 'hildid' and covering of child with goats hide after slaughtering a goat. Burning of heads and removal of false teeth were also practiced by traditional healers to treat illnesses.

⁷ For more information, please refer To Community Assessment Report, CMAM prog, Kambioos camp, Dadaab refugee camp, Kenya, March, 2015.

3.1.2.3 FACTORS INFLUENCING ACCESS TO CMAM SERVICES

Free and uninterrupted CMAM service provision, community sensitisation about admission criteria, health education by block leaders, active case finding for referrals, defaulter tracing, positive treatment outcome and welcoming staff at the health post were some of the enablers for use of CMAM services in Kambioos camp. Involvement of the community leaders such as block leaders and TBAs in the nutrition programme is also evident as they were informed and pass on messages in the community on malnutrition and encourage use of the health facilities. Generally, CHWs conduct community mobilization for CMAM as part of community based health programme.

Barriers experienced by the community in accessing services were a high work burden on mothers as many of them work in Hagadera camp, lack of individual counselling especially for rejected MUAC referrals, on admission, on discharges, misinterpretation of quick recovery (in some instances children who stayed longer in the programme were perceived to be favoured over those that were cured and discharged earlier), in-patient service delivery could only be accessed in Hagadera. Few staff at the health post overcrowding and long queues were also barriers to use of services.

Delays in transportation of the RUFT and RUSF from main IRC's warehouse to health posts and not admitting MAM children during non SFP weeks (no provision of stock during non SFP weeks) also resulted in delays in service provision.

3.1.2.4 COMMUNITY STRUCTURES, LEADERSHIP AND GROUPS

Kambioos refugee camp is structured in 6 sections and 36 blocks with two elected leaders (one male, one female) representing each block and each section. The camp population has also elected an overall chairman and chairlady. These leaders are responsible for the safety and security of the refugees, providing advice and managing disputes. The clan leaders are also influential persons in the camp and preserve the customs and cultural norms of the refugee. Sheik is top religious leader and is highly respected by the community.

Kambioos refugee camp has various committees, which are established and supported the UN agencies and partners, such as Food committee, WASH committee and Community Health Committee (CHC). In Kambioos, each block has its own CHC (12 members) and serves as bridge between the refugees and health facilities and partners. They generally follow up admissions, ambulance services and provide needed support to CHWs. The selected representatives from block-CHC make main CHC. IRC with support from UNHCR and other donors also established and supports MTMSGs made up of pregnant and lactating women (PLW) who meet weekly with lead mothers in discussions about infant and young child feeding practices. Furthermore, IRC recruited and trained community health workers (CHWs) for the community-based health and nutrition programme in the camp. The CHWs are responsible health and nutrition promotion, disease surveillance, case finding and referral for nutrition, immunization and safe motherhood services. A linkage between CHCs, CHWs and MMSGs needs to be made to improve message delivery on infant and young child feeding practices.

3.1.2.5 COMMUNICATION CHANNELS

The main means of communicating messages was use of public address system followed by the community leadership & CHWs, radio and posters. The refugee leaders routinely meet with partners, bring up concerns and issues that are going well from the community then disseminate subsequent information to the refugees. This has so far been the most effective communication channel since there is feedback from the community. During prayer time at the mosque, the sheikh also passes on important information. This is also an effective channel in the camp.

3.1.2.6 COMMUNITY MOBILIZATION STRATEGY

The community mobilization for CMAM programme integrated into Community-Based Health Programme (CHP), which staffed by 28 CHWs, approximately a CHW per block that leads to 100-140 households per CHW. The screening of children for acute malnutrition is done at health facilities and community –level in the Kambioos refugee camp. CHWs conduct the active case finding at household level and referral to health posts. This contributed to active case finding and referral of children with acute malnutrition. Furthermore, UNHCR with IRC and partners conduct door to door mass MUAC screenings every six months to identify children with SAM/MAM as part nationwide initiative called 'Malezi bora'.

CHWs conduct 10-15 home visits every morning and trace absentees and defaulters while they visit homes to screen pregnant mothers, and children under one and five years old for immunization and any illness. The supervision and coordination of the CHWs is by one Outreach Officer and one supervisor. However, the ratio of CHW supervisor to CHWs (28) is too many to manage by one person.

3.2 STAGE 2: SMALL AREA SURVEY

During the second stage of SQUEAC assessment, qualitative and quantitative information collected and analysed in stage one was utilised. The assumption and/or question that generate sometime needs further investigation to better understand and to validate the findings of stage one. In Kambioos camp SQUEAC assessment, the assumption /or question generated was: "Does the block with high admissions have high coverage and blocks with low admissions consequently have low coverage" for OTP & SFP?

Hypothesis formation

Trailing the question above, a hypothesis was generated: "blocks with high admissions for OTP/SFP have high coverage and blocks with low admissions consequently have low coverage"". Based on coverage threshold for camp setting noted in SPHERE minimum standard, $\geq 90\%$ coverage was defined as minimum coverage rate.

Sample size & case findings:

Sample size calculation for small areas survey was not necessary. The survey sample size was the number of SAM children found by the surveyors in the selected blocks; at this stage programme coverage is not calculated rather a hypothesis is tested.

Using routine OTP & SFP programme data, blocks 6A and 6B had the highest OTP admissions while blocks 10G and 8G had the lowest OTP admissions. Blocks 6C (highest SFP admissions) and block 10E (no SFP admission) were selected to test the hypothesis. In total 6 blocks were selected for 'Small area survey'. High and low admissions were defined by number of children under the age of five years in the area vs. the percent's of children under the age of five years admitted to the OTP & SFP. Six teams then surveyed the 6 blocks to find SAM and MAM cases, whether they are in programme or not in programme and the recovering SAM and MAM cases.

The data was collected using door to door case-finding methods to find current 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 six blocks. Pre designed questionnaires were used to record the cases both SAM & MAM, including both current cases and recovering cases (Annex 1). A 'semi structure' interview was carried out using separate questionnaire for the mothers/caregivers of malnourished children (SAM & MAM) that were not attending the programme to find out and record the reasons for 'not attending the programme' (Annex 2).

Pre designed questionnaires were used to record the cases (SAM & MAM), including both current cases and recovering cases (Annex 1). A 'semi structure' interview was carried out using separate questionnaire for the mothers/caretakers of malnourished child that were not attending the programme to find out and record the reasons for 'not attending the programme' (Annex 2).

Case Definition

- Children 6-59 months;
- For SAM, MUAC <11.5, and/or Bilateral pitting oedema and recovering OTP cases with MUAC >11.4
- For MAM, MUAC <12.5 cm to ≥11.5cm, and recovering SFP case with MUAC >12.4

❖ OTP admission criteria:

1. A Mid Upper Arm Circumference (MUAC) of <11.5 cm and/or
2. Weight for height <-3 Z-scores
3. Bilateral pitting oedema with no medical complication

❖ SFP admission criteria:

1. A Mid Upper Arm Circumference (MUAC) of <12.5 cm to ≥11.5cm and /or
2. Weight for height <-2 Z-scores

3.2.2 STAGE 2 'SMALL AREA SURVEY FINDINGS'

Active SAM cases found

In six surveyed blocks for 'Small Area Survey' in total 12 SAM cases were detected, seven of which were found to be in programme (Table: 1).

Table: 1 Active SAM cases found 'Small Area Survey' Kambioos

Status by OTP admission	Total SAM case found	In prog.	Not in prog.
HIGH ADMISSIONS HC (Block 6A & 6B)	6	4	2
LOW ADMISSION HC (BLOCKS 10G & 8G)	3	1	2
OTHER ADMISSIONS (BLOCKS 10E & 6C)	3	2	1

Decision rule for OTP coverage

- Coverage threshold for camp: 90%
- Hypothesis 1: In blocks around the 'high admissions' HF have high coverage
- Number of Children meeting case definition=6

$$d = \left\lceil n * \frac{p}{100} \right\rceil = 6 * \frac{90}{100} = 5.4$$

→ 4 children are enrolled, so, hypothesis 1 is not confirmed, blocks with 'high admission' may not necessarily have high coverage rate

- Hypothesis 2: In blocks around the 'low admission' HF have 'low coverage'
- Number of Children meeting case definition=3

$$d = 3 * \frac{90}{100} = 3$$

→ 1 child is enrolled so hypothesis 2 is confirmed (<3 cases need to be in prog. to qualify as low coverage), therefore, hypothesis 2 is confirmed that blocks with 'low admission' may have low coverage rate.

Active MAM cases found

Twenty-seven MAM cases were found during the small area survey of which 21 were in programme and 6 were not in programme table: 2.

Table: 2 Active MAM cases found 'Small Area Survey' Kambioos

STATUS BY SFP ADMISSION	TOTAL MAM CASE FOUND	IN PROG.	NOT IN PROG.
HIGH ADMISSION S HF (BLOCK 6C)	5	4	1
LOW ADMISSION HF (BLOCK 10E)	6	6	0
OTHER ADMISSIONS (6A,6B,10G,8G)	16	11	5

Decision rule for SFP coverage

- Coverage threshold for camp: 90%
- Hypothesis 1: In blocks around the 'high admission' HF have high coverage
- Number of Children meeting case definition = 5

$$d = \left\lceil n * \frac{p}{100} \right\rceil = 5 * \frac{90}{100} = 5$$

→ 4 children enrolled (<5), so hypothesis 1 is not confirmed, therefore, blocks with high admission do not necessarily means have high coverage rate.

Hypothesis 2: in blocks around the low admission 'HF have low coverage'

Number of Children meeting case definition = 6

$$d = 6 * \frac{90}{100} = 6$$

→ 6 children enrolled (=6), so hypothesis 2 is not confirmed, blocks with low admission do not necessarily mean that they have low coverage rate.

3.3 STAGE 3 'WIDE AREA SURVEY'

In Stage three the surveyors actively look for acute malnourished cases from the selected sampling frame to see if they are in programme or not in programme. In this stage, a Bayesian-Software was used to predict the prior for likely coverage value, and to calculate a minimum sample size (active SAM/MAM cases should be found in the survey). Ultimately, the survey data uses to estimate the programme coverage value. However the camp had only 36 blocks thus all the remaining 30 blocks were surveyed during WAS.

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 1 to 10 to score for both 'barriers' and 'boosters'. Six assessment teams scored each booster and barrier separately as it was expected that the scoring would differ among the team. 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 (see Table: 3).

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 Boosters & Barriers, Kambioos Camp

Boosters	Values	Values	Barriers
Beneficiaries are well received at facilities	6	6	Distance to health for beneficiaries in section 6, 5 and 8(to Hagadera for inpatient).
Free services	7	3	Inadequate quality CMAM services (Poor Staff attitude and delay in RUTF and RUSF on first day of distribution)
Good outreach activities(sharing of information, active case finding, referrals, household visits and defaulter tracing)	6	5	Long queue , overcrowding, inadequate nutrition staff
Health education at the health post (plus use of clear IEC materials)	5	6	Competing priorities (too much work in the household, mothers go to work in Hagadera leaving children to look after younger children)
Community appreciates good treatment outcome	5	2	Sharing and selling of RUTF and RUSF
Short distance to health facility (Sections 7,8 and 9)	4	3	No stabilization centre in Kambioos
Proper hygiene at health facility	4	5	Lack of individual counselling (rejected MUAC referrals, admissions, discharges, misinterpretation of quick recovery
Adequate refugee staff	3	2	Insecurity.
Good community leaders support (acceptance of CMAM)	4		
Good motivation of staff (recent salary increase, supervision by qualified staff)	3		
Adequate supplies of RUTF and RUSF at health post.	6		
Added to Minimum Coverage (0%)	60.5 + 0 = 60.5	100- 32 = 68	Subtracted from Maximum Coverage (100%)
	60.5+68= 128.5/2=64%		

3.3.2 FORMING THE PRIOR⁸

The 'Prior' or 'Mode' for wide area survey was set using the prior information from stage one and two SQUEAC investigation to make an informed assumption about the most likely coverage value for the programme and then expressed as a probability density. Based on the findings from stage one and two for the Kambioos SQUEAC coverage assessment, the assessment team decided to calculate the sample size for the 'Wide Area Survey', (3rd Stage), assuming that the programme coverage for OTP going to be 80% and SFP 75%.

⁸ PRIOR is a statistical representation of our belief in programme coverage

Prior for OTP

Using Bayesian-SQUEAC software the 'mode' was set for OTP at 80% with speculation highest possible coverage above 90%, building with $\pm 9\%$ precision. The prior was then described using the probability, alpha prior =26.0 and beta prior =7.0. The software then automatically calculate sample size, 40 SAM cases to be found in survey regardless weather they are in the programme or not in the programme, (Figure: 14) .

Prior for SFP

Using Bayesian-SQUEAC software for SFP the 'mode' was set at 75% with speculation of lowest possible coverage 40% and highest possible coverage 90%. Viewing the higher prevalence rate of MAM the precision was reduced to $\pm 9\%$ to accommodate higher case load that was expected to be found in the survey. The prior is then described using the probability, alpha prior =19.0 and beta prior =7.0. The software then automatically calculated the sample size, for SFP 57 MAM cases need to be found whether they are in the programme or not in the programme (Figure: 15).

Figure: 14 Prior for OTP coverage, Kambioos

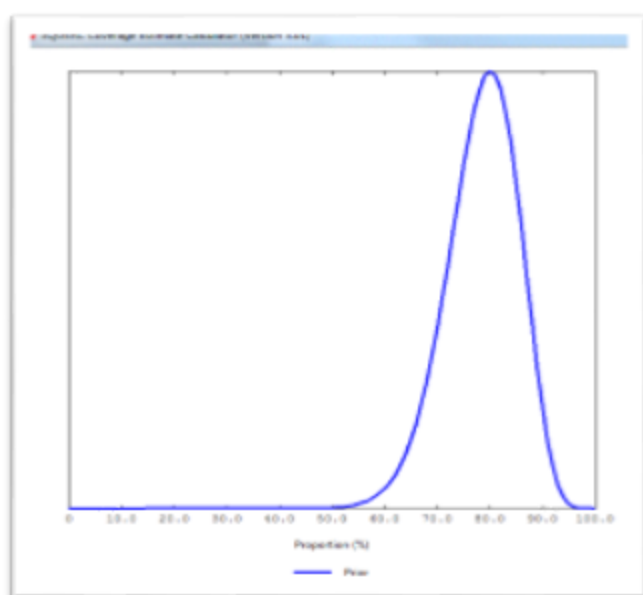
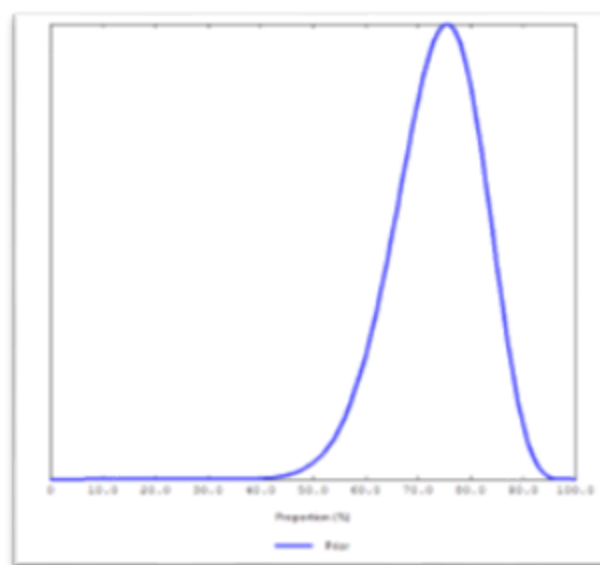


Figure 15 Prior for SFP coverage, Kambioos



3.3.3 Estimation of sample size and sampling frame

The Wide-Area Survey sampling covered the entire Kambioos camp. A two-stage sampling procedure was employed to estimate the sample size and selecting the sampling frame. Sample size was calculated, using simulation of the Bayesian-SQUEAC software by setting the 'Prior' coverage value. To estimate the sampling frame below information was used to estimate that number of blocks to be sampled. However due to the small size of the camp, all the blocks not included in the SAS were assessed during the wide area survey :

- i) The proportion of the population living in the survey blocks=576
- ii) percentage of population age less than five years old (16.8%, according to UNHCR progress report) and
- iii) Based on 2014 Nutrition survey⁹ the MUAC prevalence of SAM was 0.6% and prevalence of MAM was 3.5% among children 6-59 months

⁹ UNHCR NUTRITION SURVEYS, DADAAB, August-September 2014 Preliminary report- October 2014

- iv) Using the formula the minimum number of blocks to sample was 48 to find 40 SAM and 17 blocks to find 57 MAM cases. All the remaining 30 blocks were then covered to find both SAM and MAM cases.

Case Finding Methods

To find SAM and MAM cases and recovering cases of SAM and MAM cases a door to door method was used, which was same as used in 'Small Area Survey' (section. 3.2). This method allowed for the inclusion of all, or nearly all, current MAM and SAM cases in all sampled blocks. As anticipated that almost all suspected MAM and SAM children in surveyed blocks has been measured within five days by 10 teams. Cases that were found 'not in CMAM programme (SFP/OTP)' were referred to the nearest SFP or OTP centre, as appropriate.

3.3.4. Findings of Wide Area Survey

SAM Cases found in different Blocks

In wide area survey 45 SAM cases were found of them 41 were found in programme and 4 cases were not in programme (table-4). No SAM cases were found in 3 blocks out of 30 blocks assessed in the wide area survey.

Table: 4 Wide Area Survey, SAM cases and recovering cases, Kambioos SQUEAC, Dadaab, June 2015

Section	Total SAM cases found	SAM cases in prog.	SAM cases not in prog.	Recovering Cases in OTP
5	0	0	0	1
6	7	7	0	7
7	7	6	1	4
8	5	5	0	7
9	19	16	3	10
10	7	7	0	4
TOTAL	45	41	4	33

MAM Cases found in different Blocks

Out of 87 MAM cases 108 cases were found to be in programme while 21 cases found are 'not in programme' and no MAM case was found in 1 block out 30 blocks that was surveyed (condensed into sections in table 5).

Table: 5 Wide Area Survey, MAM cases and recovering MAM cases, Kambioos SQUEAC, Dadaab, June 2015

Section	Total MAM cases found	MAM cases in prog.	MAM cases not in prog.	Recovering Cases in SFP
5	4	4	0	7
6	15	15	0	6
7	13	6	7	6
8	25	19	6	12
9	39	34	5	18
10	12	9	3	27
Total	108	87	21	76

3.3.5 COVERAGE ESTIMATION

To estimate the programme coverage rate data from the 'Wide Area Survey' and the pre-set Bayesian-SQUEAC prior was used. For this survey 'point' and 'single' coverage rate was estimated and reported. To calculate the 'Point coverage' for OTP with 95% Credible Interval (CI) Bayesian-SQUEAC software was used while same Alpha and Beta values and precision have been used from the pre-set 'Prior'.

Point coverage of OTP & SFP:

During the point coverage estimation for OTP a denominator (45) and numerator (41) were inserted to Bayesian-SQUEAC software while same Alpha and Beta values (α 26.0 β 7.0) and precision 9% have been used from the pre-set 'Prior'. The 'Point' coverage is estimated at **86.8%** rate with Credible Interval (CI 77.3%-92.5%), P value = **0.185**.

For SFP Point coverage estimation the denominator (108) and numerator (87) was entered to Bayesian-SQUEAC software while same Alpha and Beta values (α 19.5 β 7.0) and precision 7% have been used from the pre-set 'Prior'. The 'Point' coverage is estimated at **79.6%** rate with Credible Interval (CI 71.7% - 85.6%) P value = **0.575**. The z-test revealed that there are reasonable overlaps between the 'prior' the 'posterior' and the 'likelihood' on graphs of Bayesian SQUEAC for both OTP & SFP coverage estimation (figure, 16 & 17).

Figure: 16 Point coverage, OTP Kambioos, Jun. '15

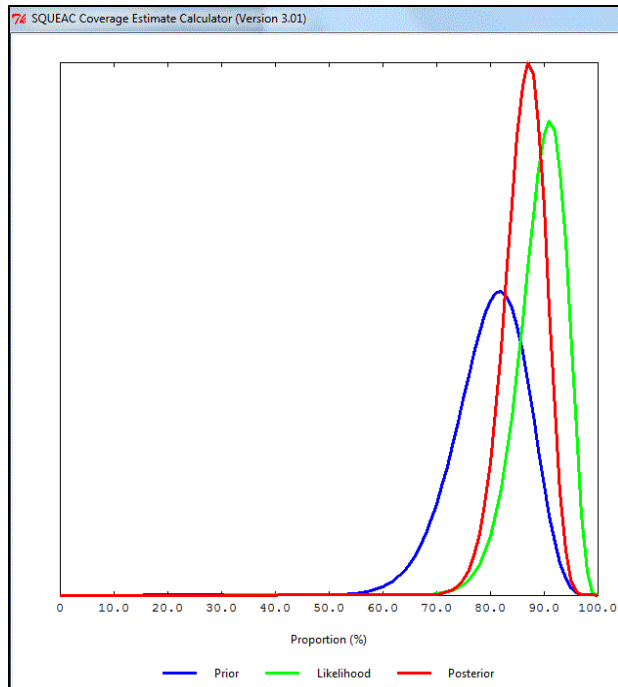
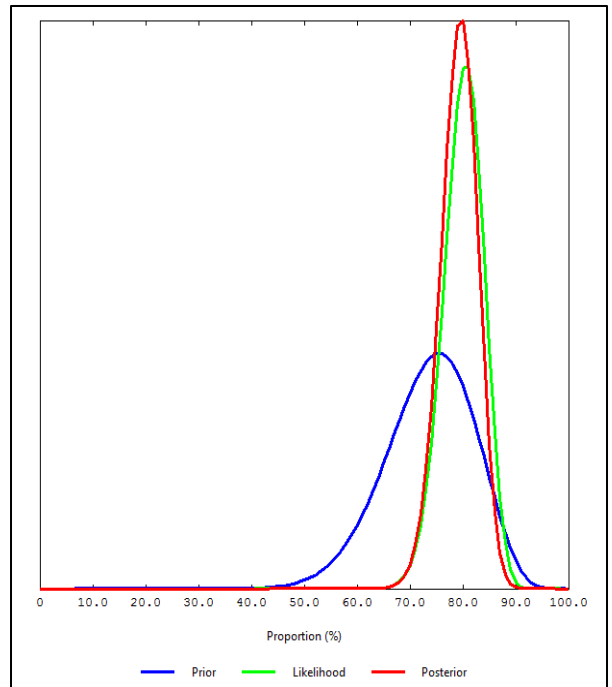


Figure: 17 Point coverage SFP greater Kambioos, Jun. '15



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 93.6%, see below.

Single Coverage

$$= \frac{\text{\# of current cases} + \text{\# of recovery cases that attending the programme}}{\text{of current cases} + \text{recovery cases that attending the programme}} + \text{of current cases and recovering cases than}$$

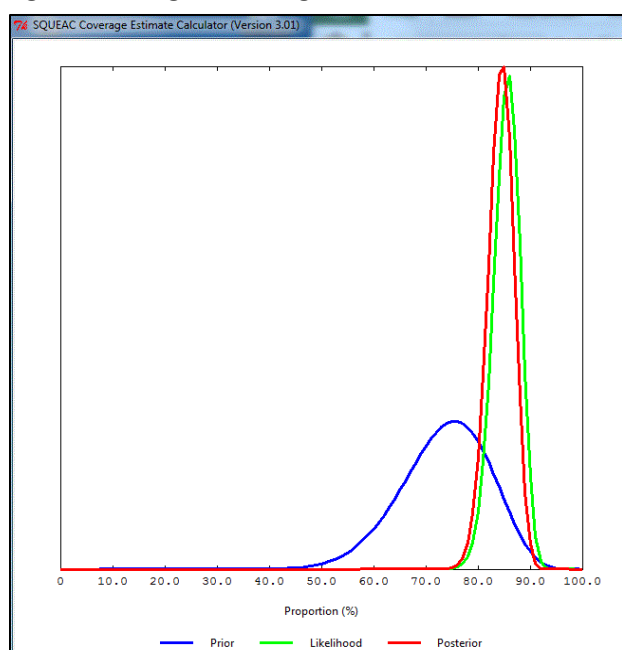
$$\frac{41+33}{45+34} \times 100 = 93.6\%. \text{ The OTP single coverage estimated using simple equation at rate 93.6\%}$$

Table: 6 Single coverage estimation for OTP & SFP, Kambioos Camp, June 2015

Description of SAM survey data		Equation
K = a correction factor	3	$R_{out} \approx \frac{1}{k} \times [R_{in} \times \left(\frac{C_{in} + C_{out} + 1}{C_{in} + 1} \right) - R_{in}]$ OTP data $R_{out} \approx \frac{1}{3} \times \left[33 \times \left(\frac{41 + 4 + 1}{41 + 1} \right) - 33 \right] - 1$
C _{in} = Current SAM cases in the programme	41	
C _{out} = Current SAM cases not in the programme	4	
R _{in} = Recovering SAM cases in the program	33	
R _{out} = Recovering SAM cases not in the programme	1	
Description of MAM Survey data		Equation SFP data
K = a correction factor	3	$R_{out} \approx \frac{1}{3} \times \left[76 \times \left(\frac{87 + 21 + 1}{87 + 1} \right) - 76 \right] - 6$
C _{in} = Current SAM cases in the programme	87	
C _{out} = Current SAM cases not in the programme	21	
R _{in} = Recovering SAM cases in the programme	76	
R _{out} = Recovering SAM cases not in the programme	6	

SFP SINGLE COVERAGE ESTIMATION

Figure: 18 Single Coverage SFP, Kambioos, June.'15



For SFP single coverage estimation as denominator 190 (87+ 21+ 76+6, current MAM in prog + current MAM cases not in prog. +recovering cases + recovering cases not in prog) and numerator 163 (87 + 76 current MAM cases in programme + recovering cases) was inserted to Bayesian SQUEAC calculator while same Alpha and Beta values (α 19.5 β 7.0) and precision $\pm 9\%$ have been used from the pre-set 'Prior'. The Bayesian-Software estimated 'Single' coverage at 84.6% rate with Credible Interval of (CI 79.4% - 88.8%), and P value= 0.185.

The z- test revealed that there is a reasonable overlap between the 'prior', the 'posterior' and the likelihood for both SFP single coverage estimation (figure: 18).

3.3.6 BARRIERS TO ACCESS IDENTIFIED BY WIDE AREA SURVEY

In the wide area survey interviews, mothers/caretakers of MAM and SAM cases whose children were found to be malnourished but not attending the nutrition programme.

Reasons given by mothers/caretaker of SAM cases for 'not to attend' the programme:

Among the caretakers of children with SAM, 77.8% mothers/caretakers reportedly knew the nutrition status of their children. One of the mothers (11.1%) was not aware that there was a programme that could treat her child. See Table 7 below:

Table: 7 Caretakers knowledge of the status of their 'SAM' children and prog. Kambioos, Jun. 2015

Question (SAM cases)	Yes (# & %)	No (# & %)
Is your child malnourished?	7(77.8%)	2(22.2%)
Do you know programme that can help your child	8(88.9%)	1 (11.1%)
Did your child previously attend the programme	3(35.7%)	5(62.5%)

Barrier's for SFP coverage:

For MAM cases only 48.1% mothers/caretakers claimed to know the status of their children. When asked do you know the programme that can treat your child 18.5% of the mother/caregivers said that they did not know the programme that can treat children with MAM while at least 2 out of every five children had previously been in the programme (Table: 8).

Table: 8 Caretakers knowledge of the status of their 'MAM' children and prog. Kambioos, Jun. 2015

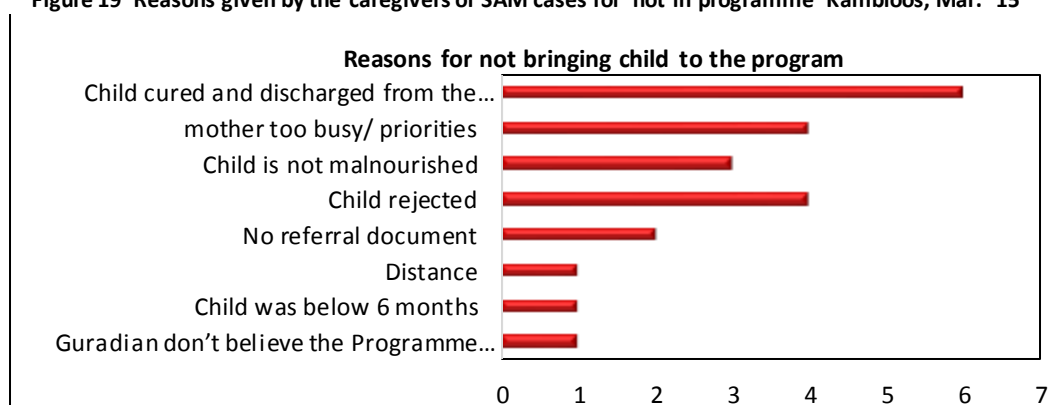
Question (SAM cases)	Yes (# & %)	No (# & %)
Is your child malnourished?	14(48.1%)	13(51.9%)
Do you know programme that can help your child	22(81.5%)	5 (18.5%)
Was your child previously attended the programme.	7(43.8%)	9(56.2%)

Reasons given by mothers/caretaker of SAM and MAM cases for 'not to attend' the programme:

Mothers/care takers of SAM:

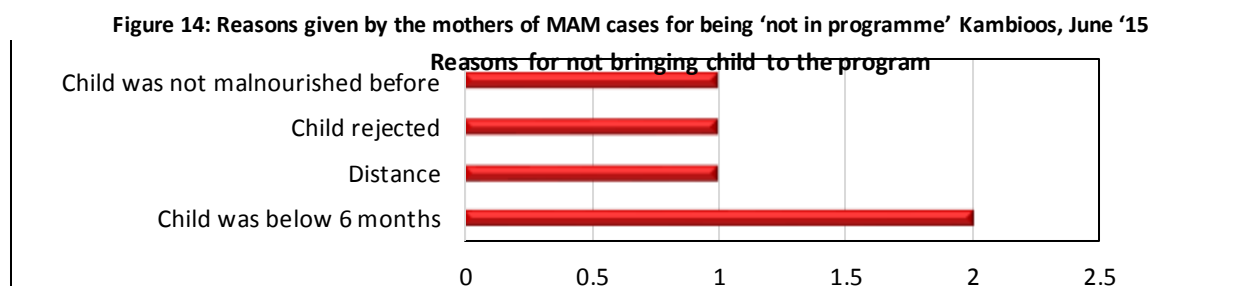
Out of the 22 mothers/caregivers of SAM cases that were 'not in programme' among those 6 children had relapsed after discharge, 4 mothers mentioned their workloads and another 4 competing priorities. Three caretakers had had their children rejected from admission in the programme while two children from the SC in hagera did not have referral documents. Distance, belief that child was still under six months and lack of trust in the ability of the nutrition programme to cure malnutrition were the reasons why children were not in the programme(Figure 19).

Figure 19 Reasons given by the caregivers of SAM cases for 'not in programme' Kambioos, Mar. '15



Mothers/caregivers of MAM:

Out of the 5 mothers/caregivers of MAM cases that were 'not in programme' two of them reported that their children did not meet the age for admission, while the others mentioned rejection from being admitted before, child recently deteriorated as the child was not malnourished before and distance from the health post (see, Figure 20).



4. DISCUSSION

In this SQUEAC assessment, the team collected some primary and secondary data on both qualitative and quantitative and analysed them to better understand the programme and the dynamic associate with access and coverage. The main focus of this assessment was if performance of the programme is up to the standard, if the community easily access the programme? This assessment also aimed to improve the services qualities as well as access and coverage of the programme by developing and implementing a Joint Action Plan (JAP).

OTP DATA ANALYSIS:

Routine monitoring data was available for analysis. This was collected from the registers and also compared with data that was submitted to UNHCR in the Health Information system. Comparison of data on cards and that in the registers, length of To understand the service qualities, utilising programme data and its use them in regular programme monitoring will help in emphasising boosters and reducing barriers to improve the quality and outcome of the programme.

Kambioos programme performance data suggested that the programme was meeting all the SHPERE minimum standards adequately. The discharged rate for OTP and SFP for the year 2014 was 94.5% and 93.5% respectively which is >75% set by the SPHERE standards. The defaulter rate was less than 1% however reasons for routine increases in defaulting towards the end of the year need to be further assessed and controlled.

About half of the children admitted in the programme were aged 6-12 months. This clearly shows that infant feeding practices are a challenge in Kambioos camps and this programme needs to be strengthened to prevent these cases from becoming malnourished. Additionally, programmes that promote and support exclusive breastfeeding among children below the age of 6 months need to be expanded to other sectors to improve effectiveness of this programme.

QUALITATIVE DATA ANALYSIS:

Engagement of the community in programme evaluation is key in ensuring that any programme is effective. The community assessment revealed that availability of free services, supply of therapeutic products, health education at the health posts, use of easy to understand posters at the health posts, support of CMAM services by community leaders good outreach activities and good treatment outcomes were some of the boosters that can continue to be enhanced.

However, competing priorities for caretakers especially in cases where both caretakers leave children alone to go work, need community involvement to ensure children receive the care they need. Logistical arrangements for the first day of distribution should be resolved and individual counselling should be implemented especially for rejected cases, on discharge and for children that do not meet the age for admission but need nutrition support. The biggest percentage of children was not in the programme because they had relapsed (27%) and such counselling on discharge is very crucial for self-referral where needed. The referral system from Hagadera SC to Kambioos OTP needs to also be improved as some discharges reportedly had no referral documents and had not been admitted in the OTP. Deterioration of children while in the SFP needs to be improved possibly due to closer supervision of routine screening, home visits for children that are deteriorating to assess and correct inappropriate use of treatment products and improve child care practices at household level.

Although the primary source of accessing treatment for malnutrition was the clinic, use of traditional herbs was also practiced especially when caretakers felt that the child had stayed in the programme for long. Engagement of traditional healers by IRC in appropriate awareness raising is needed. Home visits by staff should also include follow up on use of traditional herbs concurrently with treatment and discouraged through dialoguing at household level and through involvement of community leaders.

The community was generally well informed about malnutrition and most knew where to access services. Community mobilisation although quite good, could still be improved by involving the traditional healers to support in adherence to treatment while MMSGs leaders/groups should also be linked to follow up of discharges, screening of children and also work with CHPs to prevent malnutrition, identification of cases and follow up of discharged cases that are cured.

STAGE TWO & STAGE THREE:

The stage two assessments focused on all the blocks in the camps in order to be representative. The findings of the 'small area survey' did not confirm that for OTP coverage was high in blocks with high & low admission. For SFP coverage was found low in blocks with high & not necessarily low in blocks with low admission. The reason for low coverage appears to be partially due to deterioration in discharge, while in the SFP and prior rejection of children due to age criteria and failure to meet admission criteria for some referrals.

The wide area survey data estimation of overall programme point coverage for both SFP was estimated at **79.6%** rate with Credible Interval (CI 71.7% - 85.6%) P value = 0.575 while that for the OTP was estimated at **86.8%** rate with Credible Interval (CI 77.3%-92.5%), P value = 0.185 which is below the SPHERE standards set at >90%, for camp settings.

OTP 'Single' coverage was estimated at **90.0%** rate with Credible Interval of (CI 83.0% - 94.3%), and P value= 0.041.

For SFP single coverage estimation at **84.6%** rate with Credible Interval of (CI 79.4% - 88.8%), and P value= 0.185. Overall showing that performance of the OTP programme was relatively good in Kambioos camp when assessed using single coverage estimation rather than point coverage estimation.

LIMITATIONS:

The major challenge of this assessment was not having free access to many of the locations due to security issues. This situation reduced the supervision during the field assessment.

5. JOINT PLAN OF ACTION

The SQUEAC assessment in Kambioos refugee camp made six consolidated 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 action plan has been developed in association with UNHCR, WFP, IRC and other relevant partners.

TABLE 9: UNHCR, WFP, IRC and ACF Joint Plan on Community Mobilization for CMAM, April –Dec 2015

	Strategy /Activities	Performance indicator	Target	Priority/When Jul-Mar 2015	Responsible (Focal Person or Agency)	Applicable Internal Resources	External Resources Needed
I	Community Mobilization						
1	Community participation						
1.1	Conduct community mobilisation training for Outreach coordinator, officers and supervisors	# trainings	1	Mar	UNHCR, WFP, IRC		
1.2	Develop a community mobilisation work plan including community mobilisation activities such as assessments of communication channels in use, identification gaps message development and selection of appropriate channels for communication such as use of posters or radio for messaging	Annual work plan developed	1	ASAP	IRC		
1.3	Train the traditional healers and MMSGs on CMAM and malnutrition and involve them in community mobilization. All community leaders should also be trained on IYCF practices.	# community figures and groups members trained and involved	150	Oct –Jan	IRC		
1.4	Involve Community health committee (CHC) to monitor the programme barriers and address them	# CHC meetings held to assess and address programme barriers	3	Dec- Mar	IRC		
1 . 5	Strengthen community leaders role in mobilizing the community for screening , case finding and referral, defaulter tracing, addressing selling RUTE/SF and	# block leaders actively involved and support	36	Jan-Mar	IRC		

	accountable to CHWs' work						
2	Outreach activities						
2.1	Pilot direct-observation and dialoguing with caretakers on use of RUTF/SF at household level for problematic cases by CHWs in blocks with highest density of acute malnutrition	% CHWs conduct direct observation in the selected blocks	80%	Jan -Mar	IRC, UNHCR , WFP		
2.2	Counselling of referrals at risk on children possibly not being admitted in the programme and need for follow up of nutrition status of child by care taker	% of referrals reporting counselling by CHW	100%	Nov-Mar	IRC		
2.3	Follow up of discharges from SC in hagadera by allocating a specific CHW to ensure the discharged case has a referral slip and is admitted in the OTP	% of SC discharges that report to the OTP on time	100%	Oct- Mar	IRC		
	Involve Nutrition staff in field monitoring support to capacity build the CHWs, CHCs and community leaders as they work	# staff involved in support activities at household level	50%	Sept 2015 – Mar 2016	IRC		
3	Technical support, M and E						
3.1	Develop and M&E plan for the outreach/ community mobilisation team for assessment of performance	Indicators for performance developed and performance documented	100%	Dec 2015	IRC		
3.2	Standardize CHW's registration book to make sure MUAC data is captured	% CHWS received revised registration book	100	July	IRC		
	Strategy /Activities	Performance indicator	Target	Priority/When April 2015-Mar 2016	Responsible (Focal Person or Agency)	Applicable Internal Resources	External Resources Needed
3.1	Analysis of CHWs report and data from registration book and use findings to improve community mobilization	% of CHWs received feedback monthly	75%	Oct-Mar 16	IRC		
3.2	Conduct joint quarterly performance review of this JPA implementation	# performance review meeting held	2	Dec '15, Mar '16	IRC, UNHCR, WFP		
II	SFP and OTP Services						
1	Train OTP and SFP workers on basic counselling in nutrition	# staff trained	10	Dec 2015			

	programme				IRC , UNHCR		
2	Provide counselling to caretakers on CMAM service and malnutrition at least during admission and discharge of cases, and cases that are not progressing and other cases that are not admitted when they do not meet criteria	% caretakers received counselling	75%	Dec 2015- Mar 2016	IRC		
3	Provide commodities for daily SFP service for newly identified cases during non SFP weeks.	% identified MAM cases that receive supplementary food during non SFP weeks	100%	April -Dec	IRC		
4	Intergrade MIYCN in the CHP programme to strengthen preventive activities	% Outreach workers trained on MIYCN	40%	Dec 2015	IRC, UNHCR		

6. ANNEXES

ANNEX: 1 Survey data collection form 'Small/Wide area survey' Kambioos Camp, Dadaab. Jun 2015

SQUEAC: Small/Wide Area Survey SAM/MAM, Kambioos, Dadaab, Jun -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: 2 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'ts/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)