

COVERAGE MONITORING NETWORK

2015

COVERAGE ASSESSMENT

» SEMI-QUANTITATIVE EVALUATION OF ACCESS & COVERAGE



Assessment Conducted: March 18th to April 1st 2015



**Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)
Community based Management of Acute Malnutrition (CMAM) Programme,
International Rescue Committee (IRC), Hagadera Refugee Camp, Dadaab, Kenya**

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ACKNOWLEDGEMENTS & ABBREVIATION

ACKNOWLEDGEMENTS

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Lastly, but not the least we would like to thank Coverage Monitoring Network's (CMN's) funders, ECHO and USAID for funding the CMN project. The CMN project made it possible to conduct this coverage assessment and to train some health and nutrition professionals that implement CMAM programme in Dadaab refugee complex in Kenya.

ABBREVIATIONS

CI	Credible Interval
CMAM	Community based Management of Acute Malnutrition
CMN	Coverage Monitoring Network
CHC	Community Health Committee
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
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
SFP	Supplementary Feeding Programme
UNHCR	United Nation High Commission for

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 camp has five main refugee camps i.e. Hagadera, Dagahaley, Ifo, Ifo2 and Kambioos, which cover a total area of approximately 50 sq. km within an 18 km radius of Dadaab Town. To accommodate the influx and reduce congestion, two more sites Ifo extension and Kambioos were allocated, bringing the number of camps to five. At the time of the assessment a total of 353,219 (UNHCR progress data base March 2015) refugees are residing in Dadaab in five different camp sites.

In Dadaab camp with leadership of UNHCR various national and international NGOs provide basic services to refugees includes community base management of acute malnutrition (CMAM) services. UNHCR invited the Coverage Monitoring Network (CMN) to conduct assessment to their CMAM programme in Hagadera camp and to train and build the capacity of nutritional professional of their partner organisation on the Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)¹ methodology.

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).

Main Results

Stage -1

❖ The CMAM programme performance (quantitative):

The routine OTP and SFP data showed that from January to December 2014, acute malnourished of SAM and MAM children that were admitted in 4 health facilities of them 96% in OTP and 98% in SFP were successfully treated and cured. The data that was used during the assessment to investigate the OTP & SFP service qualities were consistent and helped for comprehensive analysis, however data for all essential indicators were not readily available.

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

This community assessment revealed vital information, including on the contextual factors for accessing and use the CMAM service. The availability of RUTF and RUSF and free of charge CMAM service at decentralized health posts have been identified as most distinctive enablers for the community to access to CMAM services. Presence and support of the different stakeholders (WFP, UNHCR and ACF) operational and technical support to IRC and the team in the CMAM programme is another key element of the programme. However, the assessment identified some barriers that need to address such as refusal to admit in CMAM programme and mothers competing priorities that need to review and address to improve access and coverage.

Stage - 2

❖ Hypothesis testing and results

After collecting and analysing the qualitative and quantitative data in stage one, the following hypotheses were generated and tested in stage two. "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 18 blocks from three selected section and compared with the 90% coverage rate that is set for camp setting as a minimum coverage².

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.

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

The survey data revealed that for OTP the blocks with 'high admissions' and 'low admission' both have high coverage. On the other hand for SFP coverage was found low in both high and low admission blocks. The programme needs to use those data to analyse if coverage are homogenous in targeted blocks, if not, why not.

Stage - 3

❖ Coverage Estimation (results from wide area survey)

In stage three survey data allowed to perform the final coverage estimation, after the 'Wide Area Survey'. The 'point' coverage rate for OTP is estimated at **66.6%** (CI 55.0% -76.4%), P value= 0.6185, for SFP the point coverage rate at **62.0%** (CI 54.0% - 69.2%) P value = 0.6732 using Bayesian SQUEAC software. The single coverage for OTP estimated at **72.7%** rate with Credible Interval of (CI 63.3% - 80.3%), and P value= 0.7121. For SFP single coverage at **71.2%** rate with Credible Interval of (CI 65.7% - 76.1%), and P value= 0.4497 using Bayesian SQUEAC software. The programme coverage did not meet the SPHERE standard that set for camp settings, $\geq 90\%$. However, this result is in line with the coverage survey carried out in 2010. The survey also identified some key barriers, see below. To improve the coverage the programme need to address the barriers which hinder in achieving the expected coverage for the camp setting. See the recommendation and detail Joint Action Plan in Section 5.

Main Barriers identified:

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

- Caretakers are busy and have a lot of competing household tasks and priorities. Despite the husbands' support to women caregivers accessing the health facility, neither husband nor other family members take care of children at home if mother goes to the health facility to access the CMAM services.
- Logistic delays of transportation of the RUTF and RUSF from IRC's main warehouse to health posts can cause insufficient supply and long waiting times.
- Inadequate counselling of caregivers at health facilities- the caretakers received the RUTF and RUSF without proper counselling on correct adherence of RUTF and RUSF. As a result, the sharing and selling of the RUTF and RUSF is common practise in the camp.
- Double registration of beneficiaries in multiple OTP/SFP sites to receive extra supply of RUTF and RUSF were cited as common problems in CMAM services in Hagadera camp.
- To overcome some of the barriers and to improve access and use of the CMAM services by the communities in the Hagadera refugee camp, the following six essential recommendations were made:

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

1. Strengthen community mobilization activities for a CMAM programme by ensuring adequate integration and prioritization of nutrition into existing CHP , and capitalizing on the extensive community based network, such as MTMSGs, CHC , block leaders
2. Provide all partner staff responsible for CMAM-related activities with community mobilization and social and behaviour change communication training in line with their duties. It includes community figures, groups and CHWs
3. Engage strategically with CHC and block leaders to monitor programme barriers and address them
4. Introduce a system to minimize double registration and selling and sharing of RUTF/SF by involving the refugee leaders and CHC
5. Strengthen the refugee leaders and figures involvement in supporting the community mobilization for CMAM programme
6. Improve monitoring and evaluation of CMAM programme by collection and analysing OTP and SFP data on a regular basis, supervising and supporting community activities to improve access & coverage of the programme.

CONTENTS

ACKNOWLEDGEMENTS & ABBREVIATIONS	2
EXECUTIVE SUMMARY	3
1. INTRODUCTION	6
1.1 DADAAB REFUGEE CAMP	6
1.2 HAGADERA CAMP	6
1.3 ACUTE MALNUTRITION IN HAGADERA	7
1.4 CMAM PROGRAMME IN HAGADERA	7
2. OBJECTIVES	8
2.1 SPECIFIC OBJECTIVES	8
2.2 EXPECTED OUTPUTS	8
2.3 DURATION OF THE ASSESSMENT	8
2.4 PARTICIPANTS	8
3. INVESTIGATION PROCESS	9
3.1 STAGE 1	9
3.1.1 ROUTINE PROGRAMME DATA ANALYSIS	9
3.1.2 QUALITATIVE DATA COLLECTION AND FINDINGS	15
3.1.2.1 LOCAL UNDERSTANDING OF CHILDHOOD ILLNESS AND MALNUTRITION	15
3.1.2.2 TREATMENT OF ACUTE MALNUTRITION AND OTHER ILLNESS	15
3.1.2.3 FACTORS INFLUENCING ACCESS TO CMAM SERVICES	15
3.1.2.4 COMMUNITY STRUCTURES, LEADERSHIP AND GROUPS	16
3.1.2.5 COMMUNICATION CHANNELS	16
3.1.2.6 COMMUNITY MOBILIZATION STRATEGY	16
3.2 STAGE 2 SMALL AREA SURVEY	17
3.2.1 FINDINGS OF SMALL AREA SURVEYS	17
3.3 STAGE 3 WIDE AREA SURVEY	19
3.3.1 SUMMARY OF BARRIERS AND BOOSTERS	19
3.3.2 FORMING THE PRIOR	20
3.3.3 ESTIMATION OF SAMPLE SIZE AND SAMPLING FRAME	21
3.3.4 FINDINGS OF WIDE AREA SURVEY	21
3.3.5 COVERAGE ESTIMATION	22
3.3.6 BARRIER TO THIS PROJECT	24
4. DISCUSSION	26
5. JOINT ACTION PLAN	28
6. ANNEXES	30
ANNEX 1: SCHEDULE OF SQUEAC TRAINING AND ASSESSMENT	30
ANNEX 2: LIST OF PARTICIPANTS	32
ANNEX 3: SQUEAC SURVEY QUESTIONNAIRE	33
ANNEX 4: SQUEAC SURVEY QUESTIONNAIRES, SSI	34

1. INTRODUCTION

1.1 DADAAB REFUGEE CAMP IN KENYA

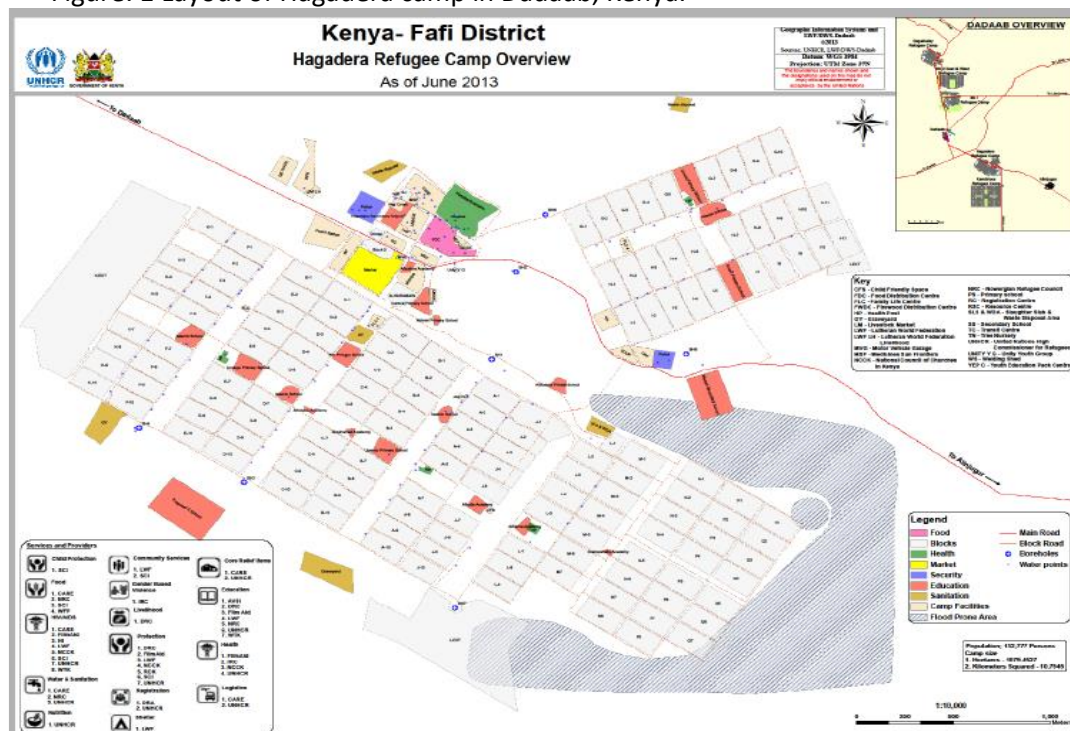
The Dadaab refugee camp is located approximately 500 km from Nairobi and 80 kilometers from the Kenya- Somalia border. It is situated in the Garissa District in North Eastern Kenya, which has a fragile ecological system. The region surrounding Dadaab is semi-arid desert with sparse vegetation and no surface water. Before the establishment of the refugee camps, the area was used as rangeland by nomadic livestock owners.

The Dadaab Refugee Complex was established in 1991/92 to cater to the influx of refugees from Somalia who were fleeing from civil war. The complex has three refugee camps i.e. Ifo, Hagadera and Dagahaley that were established in 1991/2. These cover a total area of approximately 50sq. km within an 18 km radius of Dadaab Town. To accommodate the influx and reduce congestion, two more camps; Ifo extension and Kambioos were established, bringing the number of camps to five. At the time of the assessment a total of total 353,219 (UNHCR progress data base March 2015) refugees are residing in Dadaab in five different camp sites.

1.2 HAGADERA CAMP

Hagadera was established in 1992 and is the third oldest and largest camp in the Dadaab refugee complex. The camp has one of the biggest markets in the region and a dynamic economy. Hagadera camp have estimated household of 26,690 with population of 106,926, of which 53,876 female, 53,050 male in the last verification exercise³. This camp remains highly congested. Most refugees and asylum seekers who arrived to Hagadera in the last few years are staying with relatives but some 20,000 have settled outside the designated camp area called 'Hagadera Outskirts'. In order to decongest Hagadera inhabitants, relocation exercises in 2011, 2012 and 2014 have moved around 2,000 families of about 10,000 individuals to Kambioos camp. See Hagadera map below.

Figure: 1 Layout of Hagadera camp in Dadaab, Kenya.

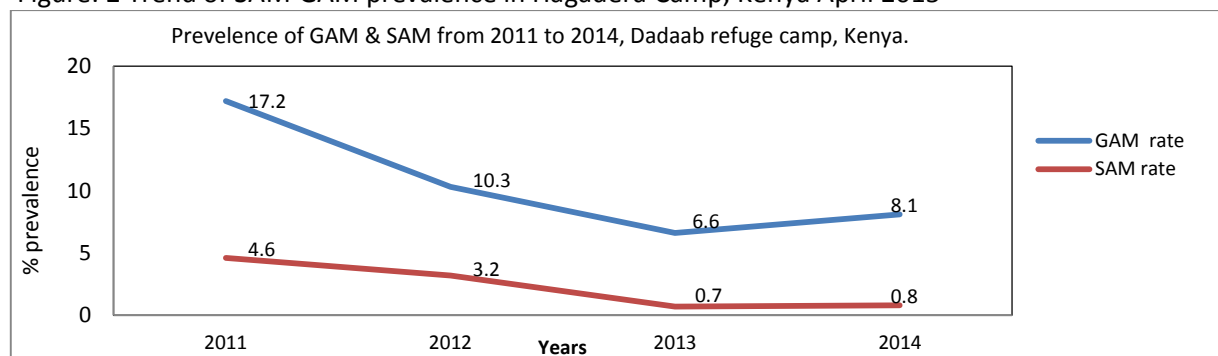


³ UNHCR, Hagadera Camp Profile, DADAAB REFUGEE CAMPS, KENYA, 01/03/2015

1.3 ACUTE MALNUTRITION IN HAGADERA CAMP

A number of nutritional surveys have been conducted in Hagadera camp using the Standardized Monitoring of Relief and Transitions (SMART) methodology to monitor 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 Hagadera camp was 8.1% (95% CI: 6.1-10.7) and the severe acute malnutrition (SAM) prevalence (WHZ<-3 and/or oedema) was 0.8% (95% CI: 0.4-1.8). Using Mid Upper Arm Circumference (MUAC), the GAM rate was 2.9% (95% CI: 1.7-4.9) and SAM rate was 0.3% (95% CI: 0.1-1.3)⁴, WHO 2006. This result is little higher compare with the results of 2013. However, according to WHO classification, the GAM prevalence rate is within the acceptable threshold of (5-9%).

Figure: 2 Trend of SAM GAM prevalence in Hagadera Camp, Kenya April 2015



1.4 THE HEALTH AND NUTRITION PROGRAMME IN HAGADERA

In partnership with UNHCR, approximately, 15 different national and international NGOs providing various services to the refugees in Hagadera 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 cares are provided through four health facilities for entire camp. The ratio is over 28,000 individuals per each health facility and therefore below the standard of 10,000 individuals. There is also one hospital in Hagadera, serving an average of 454 patients per day. Through the health facilities IRC provide nutrition care for the population including treatment for SAM and MAM cases though four health centres.

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 ensure a daily intake of 2,100 kilocalories per person per day, which is the global standard.

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

2. OBJECTIVES OF TRAINING & ASSESSMENT

To understand the coverage of CMAM programme and to train and build capacity of some nutrition professionals UNHCR & WFP requested CMN to support them with SQUEAC assessment in Hagadera camp one of the five refugee camp in Dadaab. Furthermore, it is hoped to enable UNHCR, WFP and their partner organisations (IRC, MSF, Kenya Red Cross, ACF, Islamic Relief) in Dadaab refugee camp in developing skills to conduct SQUEAC assessments in their programme independently, or with minimum remote support.

The training carried out in Dadaab UNHCR base and the SQUEAC assessment was conducted in Hagadera refugee camp. The camp has 17 sections and 140 blocks and SQUEAC assessment included sampling all sections despite insecurity and limited access by the CMN consultants, and International staff. The SQUEAC training included various issues such as how to improve collection and utilisation of the routine programme's monitoring data hence to improve the service quality; information gathering from various key stakeholders of the targeted community to ascertain their participation and perception on the CMAM programme; and using the data collected to estimate overall SFP and OTP programme coverage for Hagadera 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 Hagadera camp.

2.1 SPECIFIC OBJECTIVES

1. TO Enhance capacity of nutrition/health staff of UNHCR, WFP and their nutrition programme implementing partners on SQUEAC methodology.
2. To estimate coverage of SFP and OTP in the target areas of Hagadera camp.
3. Identify factors affecting access to and uptake of the CMAM services in Hagadera camp.
4. 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.
5. 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 OUTPUTS

1. Train selected health/nutrition staff on SQUEAC methodology
2. Develop a Joint Action Plan and strategy for community mobilization for CMAM programme
3. Produce a final coverage survey report of SQUEAC assessment and community mobilisation for Hagadera camp.

2.3 DURATION OF THE TRAINING AND THE ASSESSMENT

March 18th to April 2nd 2015, (Annex 1).

2.4 PARTICIPANTS

A total of 19 participants from seven different organisations attended the training and assessment of coverage survey on SQUEAC methodology (Annex, 2).

3. INVESTIGATION PROCESS

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 Hagadera 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:** Conducted 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.

3.1 STAGE 1

3.1.1 ROUTINE PROGRAMME MONITORING DATA & CONTEXTUAL DATA

Data collection:

In stage one, quantitative and qualitative data was collected and analysed from all the four health facilities that providing services to refugees in Hagadera camp. For the quantitative part, routine programme monitoring data for both OTP and SFP was provided by UNHCR team. However data for all essential indicators was not available, therefore, some data was collected from admission cards and OTP & SFP register book from the health facilities.

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:

Admission data	Programme performance indicators
- 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)

Admissions data

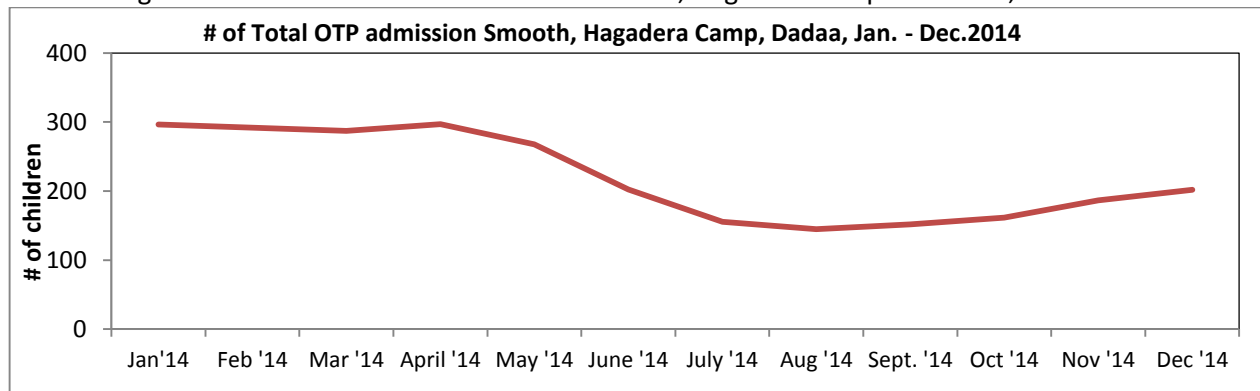
In Hagadera, the IRC Nutrition (CMAM) programme has admitted in total to OTP 2,672 SAM cases and in SFP 4533 MAM cases between 6-59 months of age from January 2014 to December 2014 in four health facilities.

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

OTP Admissions and Seasonal Trend & Childhood Illness

The graph below shows the OTP admission trends of Hagadera 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, Hagadera Camp in Dadaab; March 2015

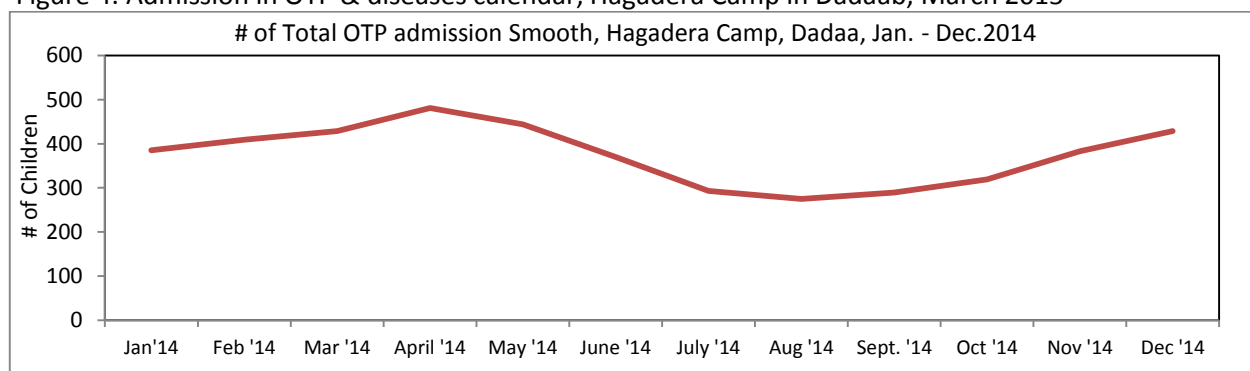


Acute Watery Diarrhoea (AWD)			AWD						AWD		
Pneumonia			Pneumonia						Pneumonia		
Skin Diseases						Skin diseases					
Respiratory Infection			Respiratory infections						respiratory infections		
Dry Spell-(Jilal)			Short Rain-(Deyr)			Dry spell (Xagaay)			Long rains-(Gu)		
Jan	Feb	Mar	April	May	June	Jul	Aug	Sept	Oct.	Nov.	Dec.

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 April then gradually slowed down and increased again in November continue till February. The SFP admissions seemingly went up after peak of seasonal illness, the below graph shows the trend.

Figure 4: Admission in OTP & diseases calendar, Hagadera Camp in Dadaab; March 2015

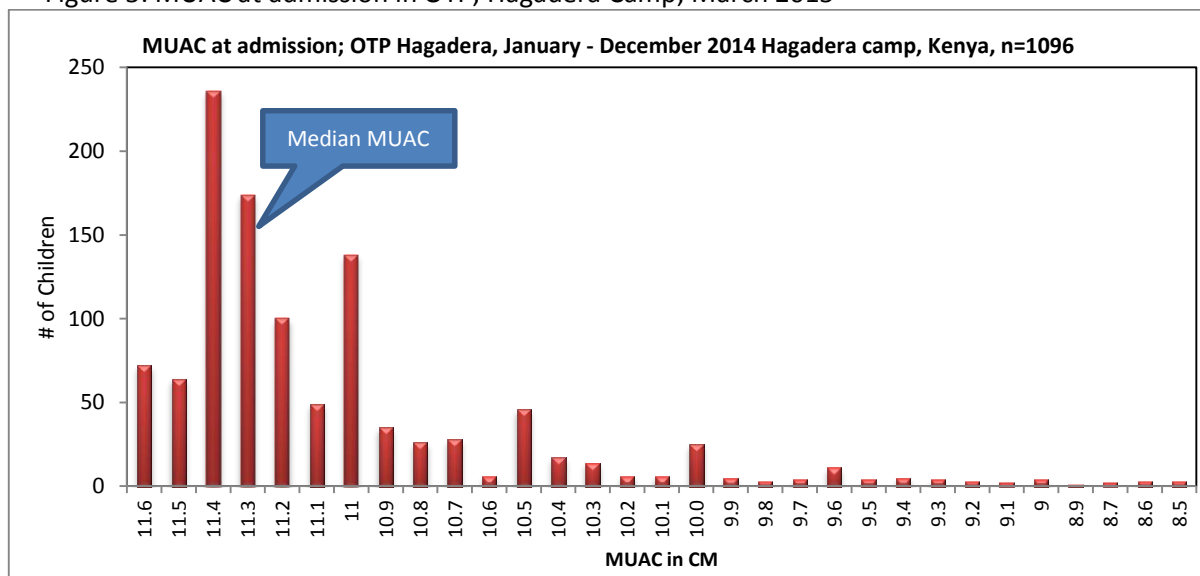


Acute Watery Diarrhoea			AWD						AWD		
Pneumonia			Pneumonia						Pneumonia		
Skin Diseases						Skin diseases					
Respiratory Infection			Respiratory infections						respiratory infections		
Dry Spell-(Jilal)			Short Rain-(Deyr)			Dry spell (Xagaay)			Long rains-(Gu)		
Jan	Feb	Mar	April	May	June	Jul	Aug	Sept	Oct.	Nov.	Dec.

MUAC at the time of admission in OTP

The admission MUAC allows the programme team to understand the timeliness of care seeking behaviours of communities as well as the pro-activeness of the volunteers & communities on early screening and referring of cases to CMAM programme. The data on admission MUAC was available for 1096 children, the median MUAC at admission from the programme data was calculated to 11.3cm. This shows early case findings and positive health care seeking behaviour from the community for malnutrition care services. The highest admission (21%) was recorded on MUAC of 11.4cm, which to the cut-off points. This number may bring some concerns on the accuracy of measuring MUAC. There were also some admissions on MUAC of 11.5cm and 11.6cm, which above the admission criteria for MUAC due to use of weight for height Z-scores admission criteria along with MUAC (see figure below).

Figure 5: MUAC at admission in OTP, Hagadera Camp; March 2015



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 71% in OTP & 74% in SFP admitted in the programme are children age between 6 to 24 months, with highest percent between 6-12 months. This shows a great need to focus on infant and young child feeding (IYCF) practice interventions in operational area.

Figure 6: Admission Hagadera camp OTP March 2015

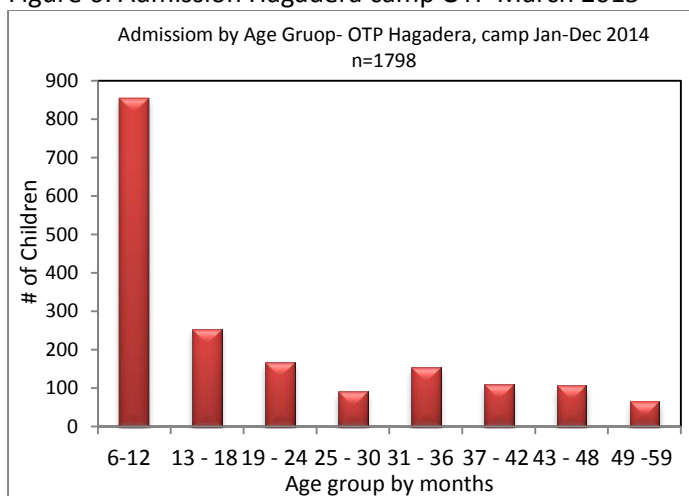
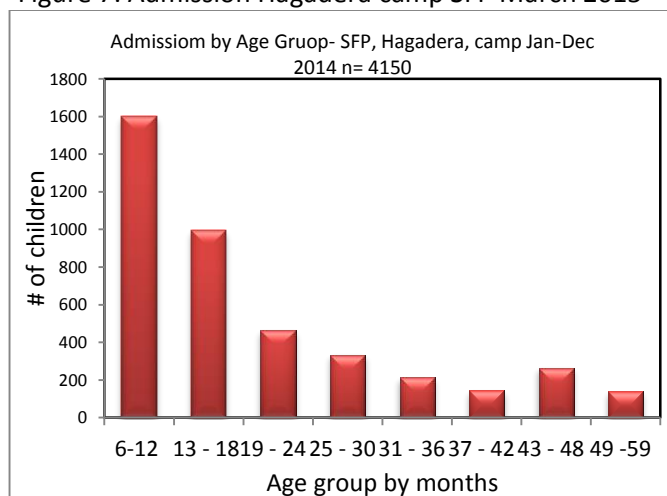


Figure 7: Admission Hagadera camp SFP March 2015

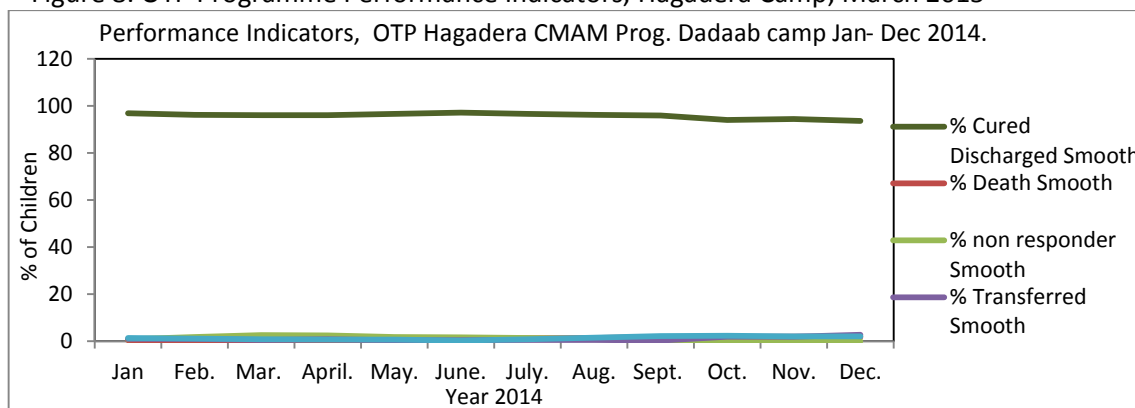


Programme performance indicators for OTP and SFP

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.

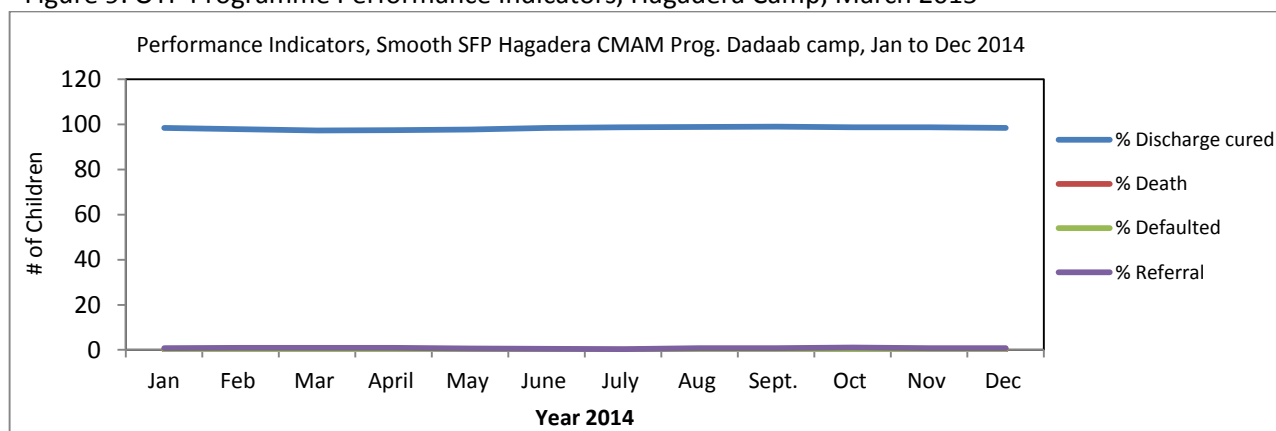
From April to December 2014, children that exited from the programme after receiving the treatment were from OTP 2485. Of them 96% children have been successfully treated and discharged cured. In the same period there are 19 deaths (0.97%) were recorded in OTP. See figure below 8.

Figure 8: OTP Programme Performance Indicators, Hagadera Camp; March 2015



During the same period (Jan. to Dec. 2014), children that exited after receiving the treatment from SFP were 5373. Of them 98% have been successfully treated and discharged cured from SFP. In the same period there no death was recorded in SFP. The remaining two percent either defaulted or referred. See figure below 9.

Figure 9: OTP Programme Performance Indicators, Hagadera Camp; March 2015



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 Hagadera camp, OTP was 7 weeks and SFP was 8 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.

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

Figure 10: Length of Stay in OTP Hagadera Mar. 2015

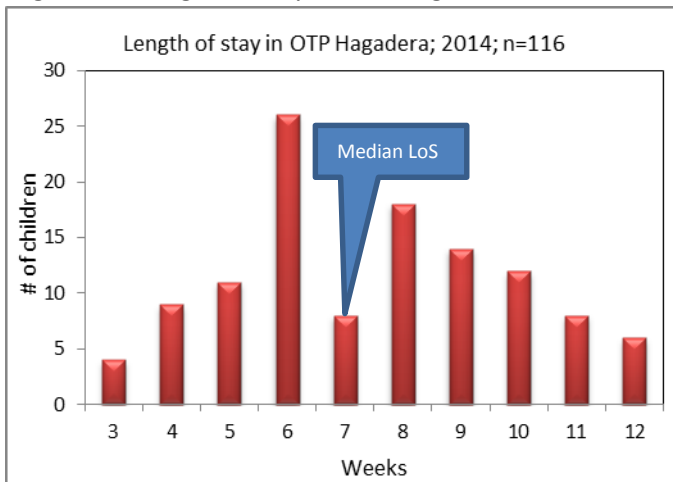
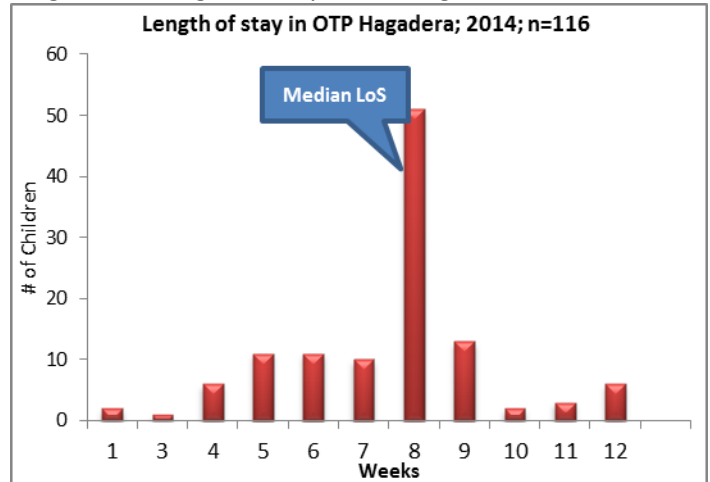


Figure 11: Length of Stay in SFP Hagadera Mar. 2015



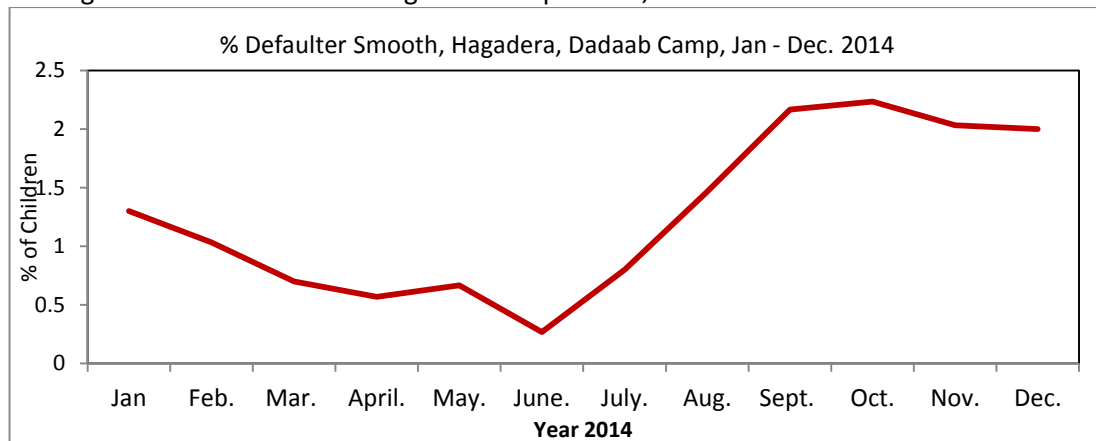
Data on defaulters:

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 2485 children were exited after receiving treatment. Of them 1.0% 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 in Hagadera. During the EPI campaign community volunteers were busy and not able to follow the defaulter children at home therefore increased rate of defaulter. However, according to the SPHERE standard (<15%) the OTP defaulter rate is within the acceptable level, figure: 12.

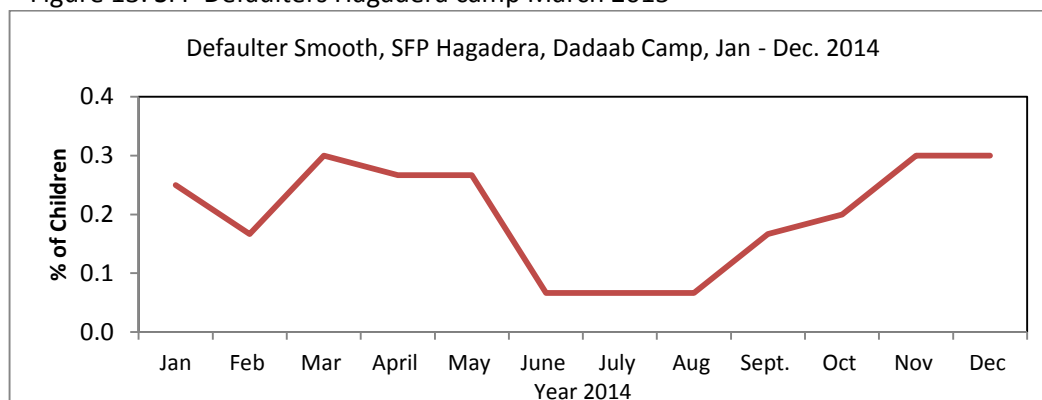
Figure 12: OTP Defaulters Hagadera camp March, 2015



Analysis of SFP defaulters' data

During same period (January to December 2014) from SFP 5373 children were exited after receiving treatment. Of them 0.2% children defaulted. The figure below shows that the defaulter rate went up in March and April and again November & December, this period coincided with EPI campaign in Hagadera camp. However the defaulter rate is minimal (0.2%) and within the acceptable range, SPHERE standard (<15%), figure: below 13.

Figure 13: SFP Defaulters Hagadera camp March 2015



The database and record keeping in Health Facilities, in Hagadera 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 all four health facility sites. The OTPs the admission cards and the registers have been examined by the assessment team. The team checked 239 cards between OTP & SFP, found more than 75 percent card was filled fully and information matched between cards and register. Therefore record keeping of this programme need to improve further with regular supervision and continuous training.

3.1.2 QUALITATIVE DATA⁷

For the qualitative part of the assessment eight blocks and all four health facilities from Hagadera camp were systematically visited and key programme stakeholders were interviewed and consulted to better understand how community perceives this programme and how to improve the access and services of CMAM programme in Hagadera camp. Below are the summary of the key findings:

3.1.2.1 LOCAL UNDERSTANDING OF CHILDHOOD ILLNESS AND MALNUTRITION

Most of the community members were fairly familiar with different signs and symptoms of malnutrition, such as weakness, irritability of a child, loosened skin, wasting/thinness, loss of appetite and brown hair. However, men and block leaders were found less aware about malnutrition. The perceived causes of malnutrition cited by most of the community members are inadequate food for children and early cessation of breastfeeding. Most of them also reported that sorghum that is commonly given, as part of general food ration is not consumed by children as well by the adult.

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) and also provide milk for sick children, while receive treatment from CMAM programme.

3.1.2.3 FACTORS INFLUENCING ACCESS TO CMAM SERVICES

The availability of RUTF and RUSF and free of charge CMAM service within close proximity at health posts were distinct enablers for the caretakers to access and use CMAM services in Hagadera camp. Providing OTP and TSFP services through four health facilities improved access to the service. All health facilities are approximately within 10 minutes walking distance from most sections and blocks of the camp. Presence and support of the different stakeholders (WFP, UNHCR, ACF, and IRC) and community leaders was also mentioned as enabler for provision of good CMAM services and the caretakers' access to it. Moreover, integration of nutrition into primary health care programme at health facility and community level was among boosters for the caretakers to access CMAM service. CHWs conduct community mobilization for CMAM as part of community based health programme.

On the other hand, inadequate counselling of caregivers at health facilities was cited as top barriers for the programme. The caretakers received the RUTF and RUSF without proper counselling on why they need it and how to use it. As a result, the sharing and selling of the RUTF and RUSF is the major challenge in the camp. Double registration of beneficiaries at multiple health facilities and bring somebody's child with SAM or MAM for registration to get the RUTF and RUSF were cited as common problem in CMAM services in Hagadera camp.

Another main reason for not accessing and using a CMAM service was caretakers' competing tasks and priorities. This includes the women caretakers are busy and have a lot of competing household tasks. Despite the husbands being supportive to women caregivers going to health facilities, neither husband nor other family members take care of children at home if mother goes to the health facility to access the CMAM services. Lack of adequate logistic arrangements sometime delay of transportation of the RUTF and RUSF from main IRC's warehouse to health posts can cause insufficient supply and long waiting.

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

3.1.2.4 COMMUNITY STRUCTURES, LEADERSHIP AND GROUPS

Hagadera refugee camp is structured in 17 sections and 140 blocks with two elected leaders (one male, one female) representing each block and each section (26 section leaders, 260 block leaders). 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. Similarly, pastor is a top religious leader for minority Christian in Hagadera camp.

Hagadera 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 Hagadera, each block has its own CHC (12 members) and serves as bridge between the refugees and health facilities and partners. The selected representatives from block-CHC make main CHC, which consists of around 22 members. IRC with UNHCR also established and supports 352 MTMSGs made up of pregnant and lactating women (PLW) who meet weekly with lead mothers in discussion about infant and young child feeding practices. Furthermore, IRC recruited and trained 143 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.

3.1.2.5 COMMUNICATION CHANNELS

The refugee leaders meeting with partners, and subsequently dissemination of information to the refugees is among effective communication channels in the camp. The men and women attend the community meeting and the section and block leaders and partners convey important messages and refugees discuss to address community concerns. During prayer time at the mosque, the sheik passes on important information and identified as effective channel in the camp. The partners also used public address system to disseminate information and reported as it reached the audience effectively in Hagadera refugee camp.

3.1.2.6 COMMUNITY MOBILIZATION STRATEGY

The community mobilization for CMAM programme is integrated into Community-Based Health Programme (CHP), which is staffed by 143 CHWs, approximately one 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 Hagadera refugee camp. CHWs conduct the active case finding at household level and refer to health posts. This contributes to active case finding and referral of children with acute malnutrition. Furthermore, UNHCR with IRC and partners conducted mass MUAC screenings every six months to identify children with SAM/MAM as part of a 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. Four CHWs supervisors under the supervision of one CHP coordinator coordinate and support 143 CHWs in Hagadera camp. The supervision and coordination of CHP is fairly good. However, the ratio of CHW supervisor to CHWs (35) is too many to manage by one person.

3.2 STAGE 2: SMALL AREA SURVEY

In second stage of SQUEAC assessment, utilises the data (qualitative and quantitative) that was gathered and analysed in stage one. The assumption and/or question that generate sometime needs further investigation to better understand and to validate the findings of stage one. In Hagadera camp, the SQUEAC assessment has generated one question from the stage one data: “Does the health facility with high admissions have high coverage and health facilities with low admissions consequently have low coverage” for OTP & SFP?

Hypothesis formation

Trailing the question above, a hypothesis was generated: “OTP/health facility with high admission has high coverage rate while OTP/health facility with low admissions has low coverage rate”. Based on the coverage threshold for camp setting noted in SPHERE minimum standard, $\geq 90\%$ coverage was defined as minimum coverage rate.

Sample size & case findings:

The sample size was not necessary to calculate in advance for small area survey. The survey sample size was the number of SAM children found in the surveyors in the selected villages by one day; as in this stage programme coverage is not calculating rather testing a hypothesis.

Consulting the OTP & SFP programme routine data, Section I & Section K were found with the highest admissions respectively, while Section D was found with lowest admission for both SFP and OTP. Therefore to test the hypothesis, six blocks from each three selected section, in total 18 blocks was 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 percentage of children under the age of five years admitted to the OTP & SFP. However, 17 blocks were surveyed by 9 teams in one day to find SAM and MAM cases, whether they are in the programme or not in the 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 villages around two health facilities. Pre-designed questionnaires were used to record both SAM & MAM cases, including current cases and recovering cases (Annex 3). A semi structured interview was carried out using separate questionnaires 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 4).

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 ≥ 11.5 cm, 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 ≥ 11.5 cm and /or
2. Weight for height <-2 Z-scores

3.2.2 STAGE 2 'SMALL AREA SURVEY FINDINGS'

Active SAM cases found

In twelve surveyed blocks for 'Small Area Survey' in total 5 SAM cases were detected, of which all five were found to be in programme (Table: 1).

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

Status by OTP admission	Total SAM case found	In prog.	Not in prog.
HIGH ADMISSIONS-Section I	1	1	0
LOW ADMISSION-SECTION D	4	4	0

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=1

$$d = \left\lfloor n * \frac{p}{100} \right\rfloor = 1 * \frac{90}{100} = 1$$

→ 1 child enrolled, so, hypothesis 1 is confirmed, blocks with 'high admission' may have high coverage rate

- Hypothesis 2: In blocks around the 'low admission' HF have 'low coverage'
- Number of Children meeting case definition= 4

$$d = 4 * \frac{90}{100} = 4$$

→ 4 children enrolled so hypothesis 2 is not confirmed (<4 cases need to be in prog. to qualify as low coverage), therefore, blocks with 'low admission' not necessary mean have low coverage rate.

Active MAM cases found

The survey detected twenty five MAM cases, of which 20 cases were found to be in programme and 5 were not in programme see table: 2.

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

STATUS BY SFP ADMISSION	TOTAL MAM CASE FOUND	IN PROG.	NOT IN PROG.
HIGH ADMISSION S SECTION K	13	11	2
LOW ADMISSION SECTION D	12	9	3

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 = 13

$$d = \left\lfloor n * \frac{p}{100} \right\rfloor = 13 * \frac{90}{100} = 12$$

→ 11 children enrolled (<12), so hypothesis 1 is not confirmed, therefore, blocks with high admission 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 = 12

$$d = 12 * \frac{90}{100} = 11$$

→ 9 children enrolled (<11), so hypothesis 2 is confirmed, blocks with low admission could mean 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.

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'. Eight assessment teams scored each booster and barrier separately as it was expected that the scoring would differ among the team. However, in this case the scoring did differ in some extent. The final scoring for each booster and barrier was agreed and assigned by using the average score. These average score for each category were added to "build up" the coverage score. The scores of Boosters are "added" to zero (i.e. lowest possible coverage) and the scorers of barriers are "subtracted" from 100% i.e. highest possible coverage (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, Hagadera, Dadaab Camp, Kenya, March 2015

Boosters	Values	Values	Barriers
CMAM services are free and available within close proximity	9	6	Inadequate counselling of caretakers at health facilities
Adequate involvement of various community members in CMAM programmes (Leaders, husbands, stakeholders, MTMSGs)	8	6	Inadequate Human resource and capacities to provide services
Adequate health and nutrition education at health posts and through MTMSG	7	5	Inadequate community mobilization for CMAM activities
Active community mobilization such as referrals, defaulter tracing, screening by CHWs and Nutrition staff in some area	7	5	Caregiver's competing tasks and priorities
Availability of well-structured community mobilization work plan	7	4	Double registration of beneficiaries
Integration of CMAM programmes with other services	6	3	Inadequate medicines supply and delay of RUFT/RUSF/SF delivery to health posts
Presence of qualified national staff who provide technical supporter to refugee workers	5	3	Inadequate involvement of MTMSGs in the CMAM programme
		3	Insecurity & Discrimination
		1	Long distance to health posts from some area
		1	Language barrier (beneficiaries other than Somalia)
Added to Minimum Coverage (0%)	49 + 0 = 49	100 - 39 = 61	Subtracted from Maximum Coverage (100%)
	49+61= 110/2=55%		

3.3.2 FORMING THE PRIOR⁸

The 'Prior' or 'Mode' for wide area survey is generally 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 express it as a probability density. Based on the findings from stage one and two for the Dadaab 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 70% and SFP 65%

Prior for OTP

Using Bayesian-SQUEAC software the 'mode' was set for OTP at 70% with speculation of lowest possible coverage 40% and highest possible coverage at 90%, building with $\pm 10\%$ precision. The prior was then described using the probability, alpha prior =20.4 and beta prior =9.3. The software then automatically calculate sample size, 48 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 65% with speculation of lowest possible coverage 40% and highest possible coverage 90%. Viewing the higher prevalence rate of MAM the precision was reduced to $\pm 7\%$ to accommodate higher case load that was expected to be found in the survey. The prior is then described using the probability, alpha prior =20.6 and beta prior =11.4. The software then automatically calculated the sample size, for SFP 115 MAM cases need to be found weather they are in the programme or not in the programme (Figure: 15).

Figure: 14 Prior for OTP Coverage, Hagadera,

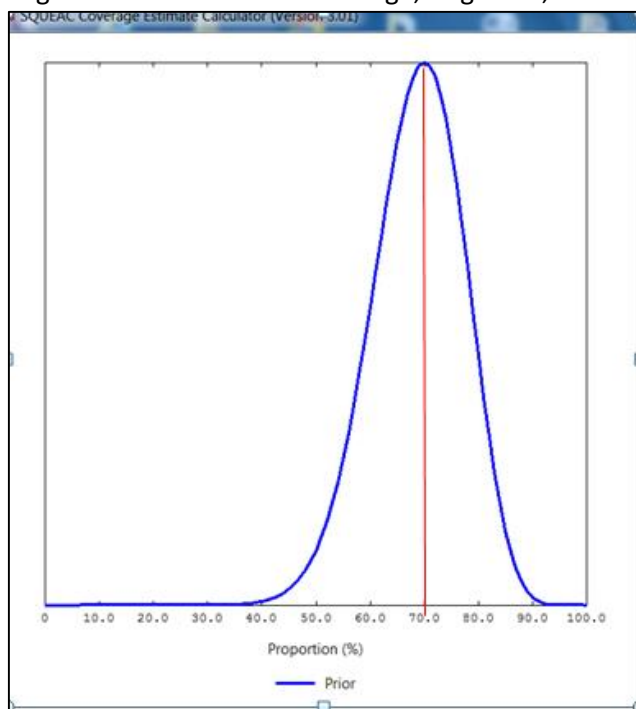
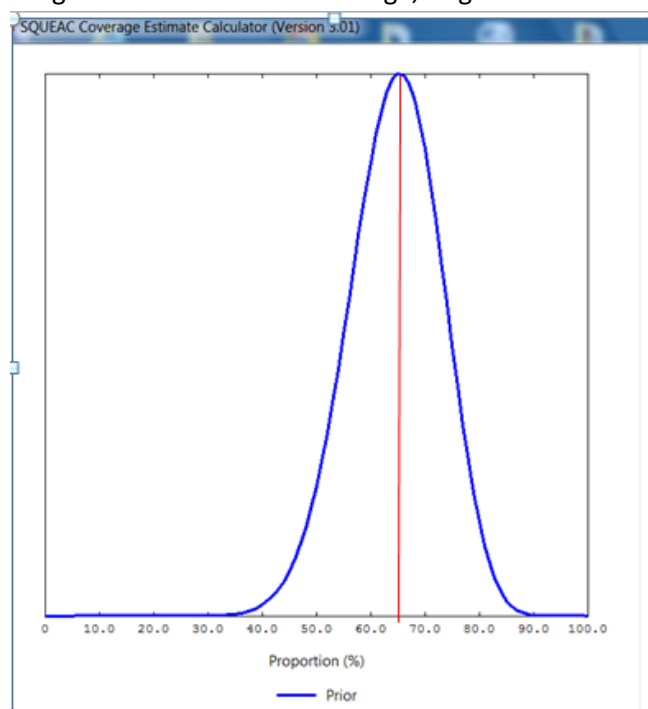


Figure 15 Prior for SFP coverage, Hagadera



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

3.3.3 Estimation of sample size and sampling frame

The Wide-Area Survey sampling covered the entire Hagadera camp by adopting a spatial sampling method. 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:

- i) The proportion of the population living in the survey blocks=765
- ii) percentage of population age less than five years old (16%, according to UNHCR progress report) and
- iii) Based on 2014 Nutrition survey⁹ the MUAC prevalence of SAM was 0.3% and prevalence of MAM was 2.9% among children 6-59 months
- iv) Using the formula it has calculated that the minimum number of blocks to sample was 58 to find 48 SAM and 115 MAM cases. The blocks were then selected using spatial selection method, covering all sections in Hagadera camp to find both SAM and MAM cases.

Spatial Representation

In order to achieve spatial representation, Hagadera camp map was used of select blocks and health facilities. Sampling frame was choose from all most all sections, in total 60 blocks was selected for the survey, ensuring spatial coverage of case finding from every section. Blocks closest to the centre of section were selected as a sampling area for the survey. Name of the blocks for each section was listed separately, with population figure.

Case Finding Methods

To find SAM and MAM cases and recovering cases of SAM and MAM cases a door to 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 two 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 42 SAM cases were found of them 27 was found in programme and 15 cases not in programme (table-4). No SAM cases found in 26 blocks out of 53 blocks that was sampled.

Table: 4 Wide Area Survey, SAM cases and recovering cases, Hagadera SQUEAC, Dadaab, March 2015

Section	Total SAM cases found	SAM cases in prog.	SAM cases not in prog.	Recovering Cases in OTP
A	4	3	1	6
B	6	3	3	8
C	2	2	0	1
E	3	2	1	0
F	5	5	0	1
G	8	6	2	1
H	1	1	0	3
J	3	1	2	4
K	3	2	1	4
L	6	2	4	0
M	1	0	1	1
TOTAL	42	27	15	29

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

MAM Cases found in different Blocks

Out of 121 MAM cases 74 cases were found to be in programme while 47 cases found are 'not in programme' and no MAM case was found in 5 blocks out 58 blocks that was surveyed (table 5).

Table: 5 Wide Area Survey, MAM cases and recovering MAM cases, Hagadera SQUEAC, Dadaab, March 2015

Section	Total MAM cases found	MAM cases in prog.	MAM cases not in prog.	Recovering Cases in SFP
A	10	3	7	6
B	14	7	7	11
C	4	3	1	3
D	9	8	1	7
E	17	14	3	17
F	8	4	4	12
G	11	5	6	3
H	17	11	6	8
J	5	1	4	8
K	8	8	0	14
L	6	4	2	5
M	3	1	2	7
N	9	5	4	2
Total	121	74	47	103

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:

For OTP as denominator (42) and numerator (27) was inserted to Bayesian-SQUEAC software while same Alpha and Beta values (α 20.4 β 9.3) and precision 10% have been used from the pre-set 'Prior'. The 'Point' coverage is estimated at **66.6%** rate with Credible Interval (CI 55.0% - 76.4%), P value = 0.6185.

For SFP Point coverage estimation as denominator (121)) and numerator (74) was inserted to Bayesian-SQUEAC software while same Alpha and Beta values (α 20.4 β 11.4) and precision 7% have been used from the pre-set 'Prior'. The 'Point' coverage is estimated at **62.0%** rate with Credible Interval (CI 54.0% - 69.2%) P value = 0.6732. 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 Hagadera, Mar. '15

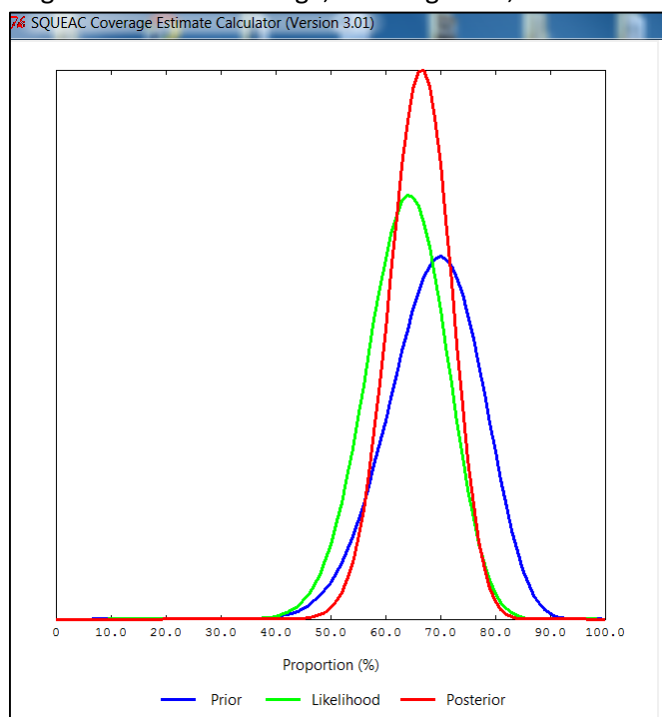
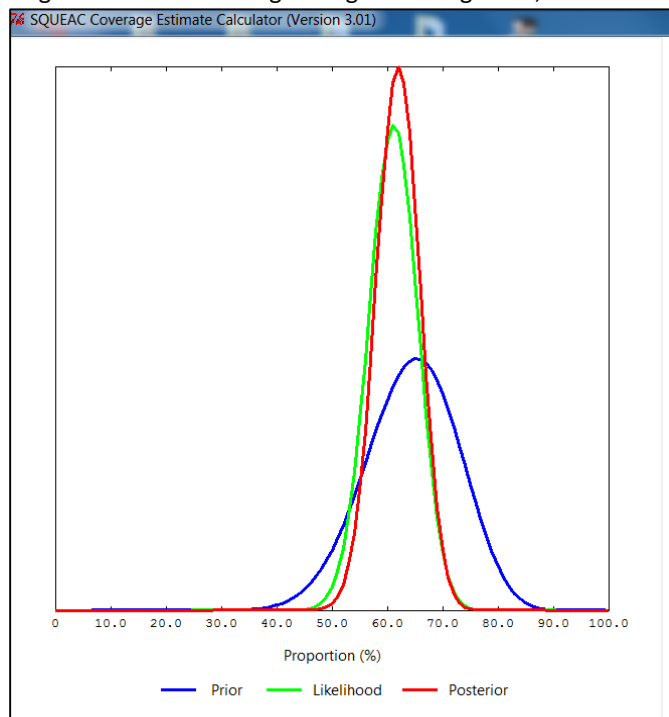


Figure: 17 Point coverage SFP greater Hagadera, Mar. '15



Single Coverage for OTP & SFP:

To calculate the 'Single coverage' for OTP & SFP below equation was used. For OTP single coverage estimation as denominator 76 (27+ 15+ 29 +5, current SAM in prog + current SAM cases not in prog. + recovering cases + recovering cases not in prog.) and numerator 56 (27 + 29 current SAM cases in programme + recovering cases) was inserted to Bayesian SQUEAC calculator while same Alpha and Beta values (α 20.4 β 9.3) and precision $\pm 10\%$ have been used from the pre-set 'Prior'. The Bayesian-Software estimated 'Single' coverage at **72.7%** rate with Credible Interval of (CI 63.3% - 80.3%), and P value= 0.7121.

For SFP single coverage estimation as denominator 246 (74+ 47+ 103+22, current MAM in prog + current MAM cases not in prog. + recovering cases + recovering cases not in prog.) and numerator 177 (74 + 103 current MAM cases in programme + recovering cases) was inserted to Bayesian SQUEAC calculator while same Alpha and Beta values (α 20.6 β 11.4) and precision $\pm 7\%$ have been used from the pre-set 'Prior'. The Bayesian-Software estimated 'Single' coverage at **71.2%** rate with Credible Interval of (CI 65.7% - 76.1%), and P value= 0.4497. The z- test revealed that there is a reasonable overlap between the 'prior', the 'posterior' and the likelihood for both OTP and SFP single coverage estimation (figure: 18 & 19).

Table: 6 Single coverage estimation for OTP & SFP, Hagadera Camp, March 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 $R_{out} \approx \frac{1}{3} \times \left[29 \times \left(\frac{27 + 15 + 1}{27 + 1} \right) - 29 \right] - 5$
C _{in} = Current SAM cases in the programme	27	
C _{out} = Current SAM cases not in the programme	15	
R _{in} = Recovering SAM cases in the program	29	
R _{out} = Recovering SAM cases not in the programme	5	
Description of MAM Survey data		Equation SFP data
K = a correction factor	3	$R_{out} \approx \frac{1}{3} \times \left[103 \times \left(\frac{74 + 47 + 1}{74 + 1} \right) - 103 \right] - 22$
C _{in} = Current SAM cases in the programme	74	
C _{out} = Current SAM cases not in the programme	47	
R _{in} = Recovering SAM cases in the programme	103	
R _{out} = Recovering SAM cases not in the programme	22	

Figure: 18 Single Coverage OTP Hagadera, Mar. '15

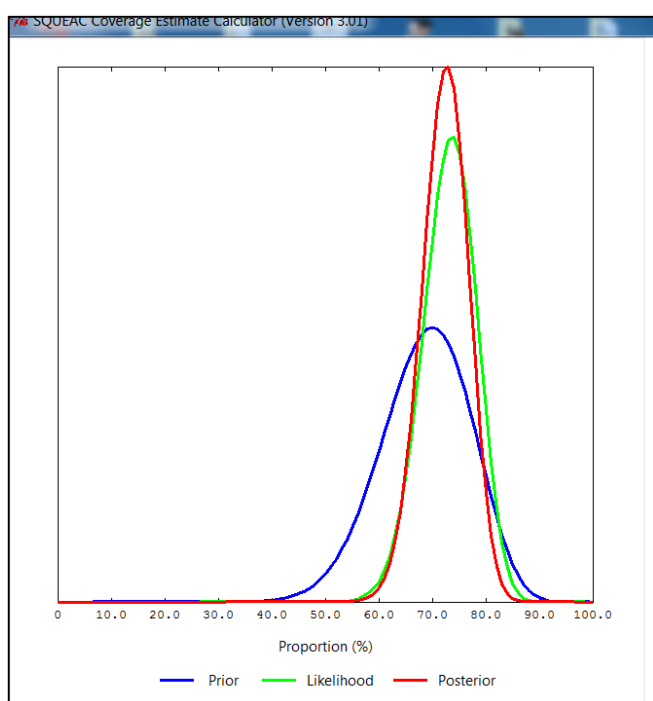
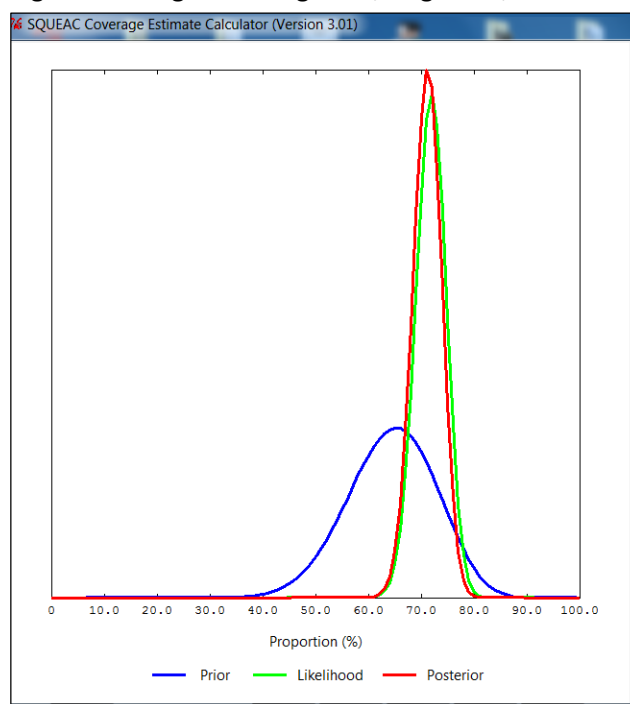


Figure: 19 Single Coverage SFP, Hagadera, Mar.'15



3.3.6 BARRIERS TO ACCESS IDENTIFIED BY WIDE AREA SURVEY

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

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

For SAM cases more than 69% mothers/caretakers claimed to know the status of their children. Only one mother (7.7%) said that she did not know the programme that can treat her child with SAM. See Table 7 below:

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

Question (SAM cases)	Yes (# & %)	No (# & %)
Is your child malnourished?	9(69.2%)	4(30.8%)
Do you know programme that can help your child	12(92.3%)	1 (7.7%)
Was your child previously attended the programme.	7(53.8%)	6(46.2%)

Barrier's for SFP coverage:

For MAM cases more than 75% mothers/caretakers claimed to know the status of their children. When asked do you know the programme that can treat your child 12% of the mother/caregivers said that they did not know the programme that can treat children with MAM while more than half of the children have been readmitted (table; 8).

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

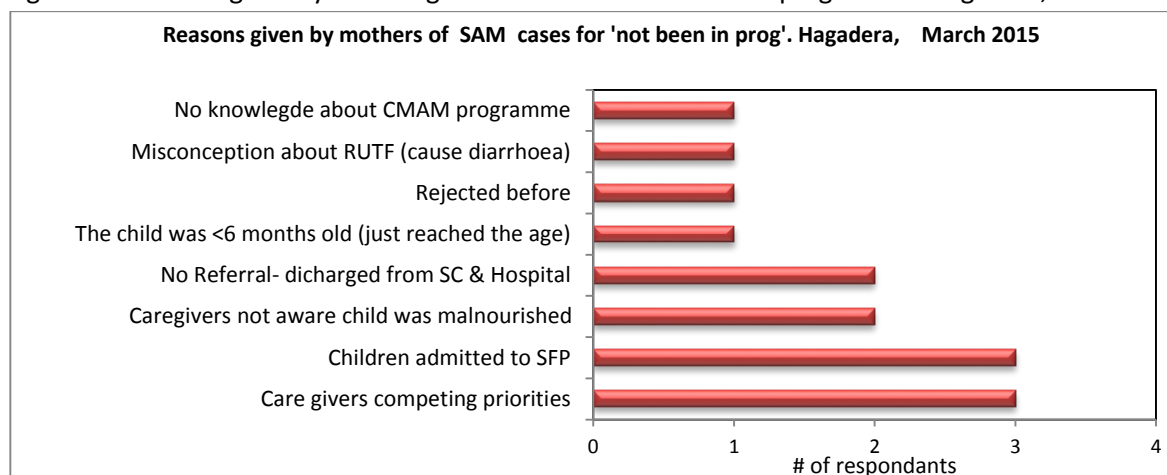
Question (MAM cases)	Yes (# & %)	No (# & %)
Is your child malnourished?	31 (75.5%)	10 (24.5%)
Do you know programme that can help your child	36 (88%)	5 (12%)
Was your child previously attended the programme.	18 (44%)	21(56%)

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

Mothers/care takers of SAM:

Out of the 15 mothers/caregivers of SAM cases that were 'not in programme' among those 3 mothers mentioned their workloads or competing priorities. Three children were admitted wrongly to the SFP. While others were mentioned various reasons for not attending the programme (see Figure 20).

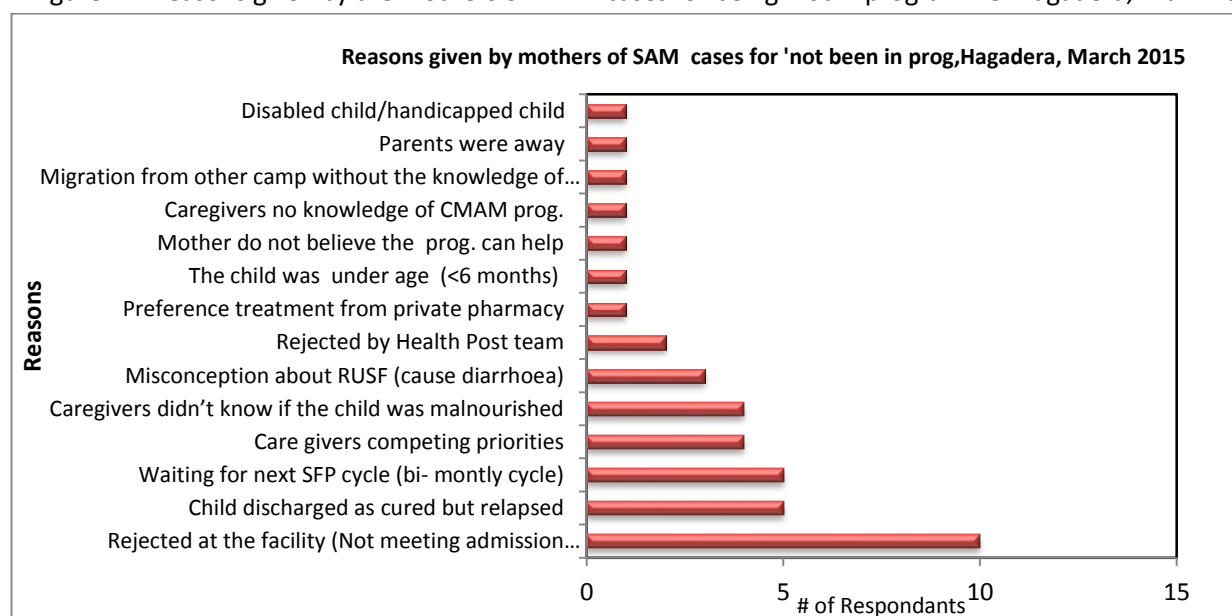
Figure: 20 Reasons given by the caregivers of SAM cases for 'not in programme' Hagadera, Mar. '15



Mothers/caregivers of MAM:

Out of the 47 mothers/caregivers of MAM cases that were 'not in programme' among those majority (about 21%) claimed that their children were rejected. While others were mentioning various reasons including waiting for next cycle of SFP admission etc. (see Figure 21).

Figure: 21 Reasons given by the mothers of MAM cases for being 'not in programme' Hagadera, Mar. '15



4. DISCUSSION

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

OTP DATA ANALYSIS:

The secondary data (routine programme monitoring data) that was provided by the team to analyse for the SQUEAC assessment was not readily available for all essential indicators as routine programme monitoring data. The programme team were not gathering the data from OTP cards and registers on a regular basis and utilising them as programme monitoring tools. However, some programme performance data are used for donor report such as programme 'exit' data. To understand the service qualities, utilising programme data and use them as regular programme monitoring tools can help to improve the quality and outcome of the programme.

Hagadera programme performance data suggested that the programme was meeting all the SHPERE minimum standards adequately. The discharged cured rate was recorded as 96% which is >75% set by the SPHERE standards. The defaulter rate is also low (1%), however, no further information on defaulter was recorded to understand why care givers are defaulting.. It is important to collect and monitor the programme defaulters' data to understand why caregivers default from the programme hence to take corrective measure.

QUALITATIVE DATA ANALYSIS:

This community assessment revealed vital information, including the contextual factors for accessing and using the CMAM service. The availability of RUTF and RUSF and free of charge CMAM service at decentralized health posts have been identified as the most distinctive enablers for the community to access to CMAM services. Presence and support of the different stakeholders (WFP, UNHCR and ACF) and technical and operational support to IRC and the team in the CMAM programme is another key element of the programme. Outreach activities for CMAM through CHWs as part of integrated community health programme is a good component of the programme and contributed to early case finding and referral, minimized defaulter, sensitization and consequently improve the refugee health seeking and access to treatment of acute malnutrition. However, the CHWs are already overworked. In order to reinforce the community mobilization for CMAM service, the UN agencies and IRC should explore other options for community mobilization strategies such as using section and block leaders, and refugees groups (MTMSGs, food committee, CHC etc.) who can engage and support the community mobilization for CMAM.

On the other note, this assessment also revealed that the sharing and selling of RUTF and RUSF is a major problem in the camp. This includes cases that have been found previously fetching of RUTF /RUSF at multiple health posts by the same beneficiary and the double registration of children with SAM or MAM at a health post using different names and caretakers. Therefore, it necessary to address these barriers by encouraging the proper use of RUTF/RUSF and introducing a system to minimize double registration at health posts. The delay of delivery of RUTF/RUSF from main IRC warehouse to health posts also caused delay of CMAM service delivery and long waiting hours particularly every Monday. To be successful, the community mobilization to increase access and uptake of the CMAM services should be implemented in tandem with strategies to improve CMAM service quality at health facility level.

STAGE TWO & STAGE THREE:

The stage two assessment focused on areas that have higher and lower admission in OTP & SFPs assuming higher and lower coverage rate, respectively. The findings of the 'small area survey' confirmed that for OTP coverage are high in blocks with high & low admission. For SFP, coverage was found low in blocks with high & low admission. The reason for low coverage was cited by the team that some sections of the camp also serves the community from outskirts with no volunteers assigned for screening to find cases. However, to better understand the reason behind the low admission a regular data analysis and discussion with community are an essential step to further increase the programme coverage, including allocation of volunteers for 'outskirts'.

The wide area survey data estimation of overall programme coverage for both SFP and OTP revealed that the programme did not meet the standard that was set by SPHERE at >90%, for camp setting. However, this result is similar to the first SQUEAC survey conducted to Dadaab camp in 2010, in Hagadera OTP coverage was reported to be 70.5% compared to current point coverage rate at 66.6% (CI 55.0% -76.4%).

The programme identified some important barriers such as caretaker competing priorities and rejection from health centres etc. To address the barriers of this programme; detailed recommendations are provided in the joint plan of action for community mobilization and to improve the CMAM services, see section below; table 9.

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 works as well the team had limited time to complete the work and analyse the barriers to have better understanding of the reasons and dynamic associated with them.

5. JOINT PLAN OF ACTION

The SQUEAC assessment in Hagadera 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 Hagadera CMAM programme, Dadaab camp, Kenya, April –Dec 2015

	Strategy /Activities	Performance indicator	Target	Priority/When April-Dec 2015	Responsible (Focal Person or Agency)	Applicable Internal Resources	External Resources Needed
I	Community Mobilization						
1	Community participation						
1.1	Train the community figures (sheiks, pastor, TH and section and block leaders) and groups (CHC, MTMSGs) on CMAM and malnutrition and involve them in community mobilization	# community figures and groups members trained and involved	200	April –Dec	IRC, ACF		
1.2	Involve Community health committee (CHC) to monitor the programme barriers and address them	# CHC meetings held to assess and address programme barriers	3	July , Sept and Dec	IRC		
1.3	Strengthen community leaders role in mobilizing the community for screening , case finding and referral, defaulter tracing , addressing selling RUTF/SF and accountable to CHWs' work	# block leaders actively involved and support	140	April-Dec	IRC		
2	Outreach activities						
2.1	Train CHWs on community mobilization for CMAM (case finding and referral , home visit follow-up, sensitization)	# CHWs trained and actively do community mobilization	143	April-Dec	IRC, UNHCR		
2.2	Community sensitization on use of RUTF and RUSF via radio programme	# sessions on nutrition product utilization per quarter	3	April- Dec	IRC, UNHCR , WFP, ACF		
2.3	Community sensitization on CMAM and malnutrition through different community leaders and groups , and during key calendar events	# sensitization at scale conducted per year	10	April -Dec	IRC, UNHCR , WFP, ACF		
2.4	Community sensitization on CMAM and malnutrition at mosques via trained sheiks during Ramadan	# sessions conducted at mosques	50	July	IRC		
2.5	Pilot direct-observation of use of RUTF/SF at household level for problematic cases by CHWs	% CHWs conduct direct observation	50%	April –Dec	IRC, UNHCR , WFP, ACF		
3	Technical support, M and E						
3.1	Standardize CHW's registration book to make sure MUAC data is captured	% CHWS received revised registration book	100	May	IRC		

	Strategy /Activities	Performance indicator	Target	Priority/When April-Dec 2015	Responsible (Focal Person or Agency)	Applicable Internal Resources	External Resources Needed
3.2	Analysis of CHWs report and data from registration book and use findings to improve community mobilization	% of CHWs received feedback monthly	75%	April –Dec	IRC		
3.3	Strengthen joint UNHCR, WFP and ACF technical support and monitoring to IRC	# joint supervision	8	April -Dec	UNHCR, WFP and ACF		
3.4	Strengthen support supervision to CHWs by nutrition and health workers	% CHWs supervised per month	50%	April -Dec	IRC		
3.5	Conduct quarterly performance review of this JPA implementation	# performance review meeting held	3	June , Sept and Dec	IRC,UNHCR,WFP and ACF		
II	SFP and OTP Services						
1	Train OTP and SFP workers on basic counselling in nutrition programme	# staff trained	42	June and Oct	IRC, ACF , UNHCR		
2	Provide counselling to caretakers on CMAM service and malnutrition at least during admission and discharge of cases, and problem cases at health posts	% caretakers received counselling	75%	April -Dec	IRC		
3	Strengthen health education on use of RUTF and RUSF at health posts	# sessions conducted /month # caretakers reached	4 1, 540	April -Dec	IRC		
4	Employ systems to minimize double registration of beneficiaries at health posts	# health posts employ system	4	June	IRC, WFP and UNHCR		
5	Strengthen screening and case finding at triage place and all contacts points at health facility	# health posts introduced triage system	4	April -Dec	IRC		
6	Provide commodities for daily SFP service for newly identified cases during non SFP weeks.	# health posts provided SFP provide	4	June	WFP		

6. ANNEXES

Annex: 1 Schedule: SQUEAC Training & Assessment, Hagadera Camp, Dadaab March 18th to April 2nd 2015.

Time	Activity	Facilitator
Day 1 Tuesday Mar. 17 th	Arrive in Nairobi	
Day 2 Wednesday Mar. 18 th	Travel to Dadaab & Meeting UNHCR/WFP Team	
Day 3 Thursday Mar. 19 th	Class room training • Opening Session • Introduction • Schedules • Overview of the SQUEAC methodology • Overview of the qualitative data collection objectives, methods • Group work identify Programme's boosters and Barriers	Lovely/ Melaku
Day 4 Friday Mar. 20 th	Class room training • Overview FDG , KI and SSI methods • Review of the questionnaire • Distribution of task to the assessment team • Developing Seasonal Calendar • Analysis some programme data	Lovely/ Melaku
Day 5 Saturday, Mar. 21 st	Field data collection Collection of some Contextual Data from the villages: • Local leaders • TBAs • Traditional healer • Health extension workers, health development armies, Community Volunteers etc. • Collection data from stakeholders (health, agricultural, education and social office)	Team
Day 6 Sunday Mar. 22 nd	Day Off	
Day 7 Monday, Mar. 23 rd	Classroom training • Contextual data analysis (Field data) • Identification of potential barriers and boosters of coverage • Select OTP sites for data collection. • Going through data collection format	Lovely/ Melaku
Day 8 Tuesday, Mar. 24 th	Field data collection • Information collection from OTP & SC • FGD with OTP Mothers • Health Centre staff • Developing Seasonal Calendar with OTP mothers	Team

Day 9 Wednesday Mar. 25 th	Classroom training • Analysis of field data (OTP data) • preparation for Small area survey • Selection area with high and low admission • Going through the methodology and Questionnaires for small area survey	Lovely/ Melaku
Day 10 Thursday Mar. 26 th	Field data collection Small Area Survey	Team
Day 11 Friday Mar. 27 th	Classroom training • Data analysis of Small area survey • Data analysis (qualitative) • OTP & TSFP Data analysis • Bayesian SQUEAC • Calculation of samples and villages for 'wide area survey'	Lovely/ Melaku
Day 12 Saturday, Mar. 28 th	Field data collection Conducting Wide Area Survey	Team
Day 13 Sunday Mar. 29 th		
Day 14 Monday, Mar. 30 th	Field data collection Conducting Wide Area Survey	Team
Day 15 Tuesday Mar. 31 st	Classroom training • Data compilation of wide area survey • Estimations of coverage • Recommendation • Develop Joint Action Plan (JAP)	Lovely/ Melaku
Day 16 Wednesday April 1 st	travel back to Nairobi	
Day 17 Thursday April 2 nd	Debriefing and presentation of preliminary findings of SQUEAC to UNHCR & WFP.	Lovely/ Melaku
Day 18 th Friday April 3 rd	Travel back home	

Annex: 2 List of Participant, SQUEAC Training & Assessment, Hagadera Camp, Dadaab. March 2015

Name	Agency	Designation	Email address
Dorothy Gazarwa	UNHCR	Food and Nutrition officer	gazarwa@unhcr.org
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Dorcas L. Moraa	IRK	Nutrition nurse	njamudo@yahoo.com

ANNEX: 3 Survey data collection form 'Small/Wide area survey' Hagadera Camp, Dadaab. March 2015

SQUEAC: Small/Wide Area Survey SAM/MAM, Hagadera, Dadaab, March -2015										
Date: ____/____/____ Team ____ Team members _____										
#	Child's Name	Mother's Name	Boma	Age (Month)	SEX		MUAC	SAM in the prog.	SAM not in the prog.	OTP recovering Cases in prog.
					M	F				
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

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

Name of Child: _____ Payam: _____

Village: _____ OTP site: _____ Date: _____

1. DO YOU THINK THAT YOUR CHILD IS MALNOURISHED?

YES ☐

NO ☐

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

YES ☐

NO ☐

If answer is NO stop

If yes, what is the name of the programme? _____

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

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

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

YES ☐

NO ☐

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

- Why isn't s/he registered any more at present?
- Defaulted, when? Why?
- Cured and discharged from the programme (When?)
- Discharged but not cured (When?)
- Others: _____

5. If you decide to use OTP/SC service, where and when you want to use of CMAM service?

6. Who decide or influence you take or NOT to take a child to a health facility?

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

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

(Thank the guardian)