Nutrition Coverage survey

Report of the Semi-Quantitative Evaluation of Access & Coverage survey (SQUEAC) of the emergency nutrition project in Galckayo Puntland state of Somalia

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This report documents the findings of the March 2012 SQUEAC survey carried out by World Vision in Puntland in partnership with the Ministry of Health. World Vision East Africa Health and Nutrition Learning Centre provided infield technical assistance for the survey. The project is funded by CIDA and is designed to assist food insecure populations.

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**Foreword**

Severe acute malnutrition (SAM) affects about 13 million children under five years worldwide and is associated with 1-2 million preventable deaths annually. Over the last few years a new model for the Management of SAM has been used, referred to as Community Management of Acute Malnutrition (CMAM). This approach enables care to be brought closer to the family through decentralized treatment services, ideally placed at existing health facilities. It has been shown to be highly effective and is now being widely adopted by various ministries of health as part of routine health services.

In addition to achieving low levels of mortality, the success of this approach is its improved engagement and access to communities, leading to the achievement of high levels of coverage.

It is therefore essential to measure coverage to see whether a programme is functioning optimally and reaching the maximum number of malnourished children in need. Even for a programme that is achieving good clinical outcomes (high cure rates and low death rates); impact is diminished if it only achieves low levels of coverage. Some programme reviews have demonstrated acceptable performance outcomes but low coverage meaning many malnourished children are being missed.

One of the most important elements behind the success of CMAM programmes for the treatment of severe acute malnutrition has been their ability to achieve high levels of coverage. Current practice in the conduct of national CMAM programme coverage is the use of, SQUEAC and SLEAC methods which provides accurate and reliable estimates of programme coverage as well as information on the primary reasons for non-attendance.
**Acronyms**

CMAM - Community-based Management of Acute Malnutrition

MOH - Ministry of Health

RUTF - Ready-to-Use Therapeutic Food

OTP - Outpatient Therapeutic Programme

SAM - Severe Acute Malnutrition

SLEAC - Simplified lot quality assurance sampling

SQUEAC - Semi-Quantitative Evaluation of Access and Coverage

UNICEF - United Nation's Children Fund
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Acknowledgment

The SQUEAC team would like to thank the World Vision team in Galckayo, Ministry of Health, communities and volunteers for their commitment to ensuring the successful completion of the survey.

CIDA for providing the overall project funding, PMWDO (Puntland Minority Women Development Organization based in Galckayo) for project implementation support

The survey was a joint effort and partnerships of various groups.

Overall coordination and planning

- World Vision Puntland area team management

Data entry and analysis

- Cyprian Ouma, Nutrition team, Galckayo

Training, Data analysis and Reporting

- Cyprian ouma

Logistics, Mapping and geographic information systems

- SQUEAC survey team

Transport facilitation was conducted by world vision
1. Executive summary

Current internationally accepted standards for coverage of CMAM programmes from SPHERE are 50% for rural areas, 70% for urban contexts and 90% for camp settings. In the recent past, measurement of coverage has been mainly through two-stage cluster sampled surveys either as part of a nutrition assessment. SQUEAC, which stands for Semi-Quantitative Evaluation of Access and Coverage, is a new low resource method designed specifically to address this limitation and is used regularly for monitoring, planning and importantly, timely improvement to programme quality, both for agency and Ministry of Health (MoH) led programmes.

SQUEAC is an investigation into existing barriers to service access:

- A mixture of quantitative and qualitative data, collecting and analyzing diverse data to identify what facilitates or blocks access and coverage
- Employs specific statistical analysis to provide an overall coverage estimate and show areas of poor coverage
- A rapid and low resource tool useful for regular programme monitoring and evaluation
- Action-oriented and practical, highlighting specific interventions (where needed) to increase Coverage

SQUEAC investigations are then undertaken in one or more of the succeeding and one or more of the failing CMAM delivery Units so that factors influencing program success and failure can be identified and used to CMAM programme redesign.

A Semi-Quantitative Evaluation of Access & Coverage (SQUEAC) was carried out in Galckayo DISTRICT. The SQUEAC design was defined to provide an estimate of district wide coverage and to investigate key barriers/boosters to the programme quality and coverage.

Nutrition project coverage in Galckayo was found currently to be 42.2% with many new arrivals of severely malnourished children coming from south central. Coverage over time referred to us period cover was 83%. Point coverage fails to meet the SPHERE standard estimate of more than 50% for rural areas but the period coverage is impressive given the mixed rural /IDP pattern of settlement in the project context. Out of the 177 current cases of severely malnourished found in the project area at the time of this survey. Only 77 were accessing the project sites for services.

These means that 100 severely malnourished children found during the survey were not getting any treatment for severe acute malnutrition. They were referred during the survey for rehabilitation to the various nutrition sites.

Increasing geographic coverage of CMAM availability to reduce the distance barrier and tracking of new arrivals from south central Somalia coupled with strengthened awareness about CMAM services availability are strong factors that could enhance coverage.
2. Background and Context

Somalia is situated in eastern Africa. It occupies part of the Horn of Africa, and fronts on the Gulf of Aden and the Indian Ocean. Bordering the country are Djibouti in the northwest, Ethiopia in the west, and Kenya in the southwest.

Agriculture is the most important sector with livestock accounting for about 40% of the GDP and about 65% of export earnings. Nomads and semi nomads, who are dependent upon livestock for their livelihood, make up a large portion of the population.

Galckayo is a district in the Southern Region of Puntland. The capital is Garowe.
Introduction

Due to the renewed conflict between the Al-Shabaab and TFG and allied forces throughout South-Central Somalia, IDP populations have continued to grow. Joint TFG and Ethiopian forces have moved in south and east into Bakool and Gedo regions in South Central provoking displacement towards Garowe and Mudug respectively. An Al-Shabaab offensive in Mogadishu has forced the few remaining inhabitants to flee.

Seeking security and access to basic services, many have fled to clan and family relations in parts of Puntland. Currently Puntland has an estimated 125,000 IDPs, Regions such as Nugaal and Mudug have seen their numbers of IDPs swell in the past few months. These new arrivals have placed tremendous strain on weak government institutions. Already food insecure host communities have begun to resent the new arrivals as they compete for limited social services and communal facilities.

Though the government of Puntland has made tremendous strides towards ensuring internal security and providing basic public services, its weak economic base ensures that its capacity to deal with the current crisis is limited. On top of that Puntland Authority focus had shifted towards a fight against piracy that had jeopardized Aid and other business in the area. Key sectors such as health remain under-funded with only 2.6% of Government of Puntland budget dedicated to support this ministry.

The increased influx of IDPs coupled with increased food insecurity has led to alarming rates of malnutrition. Areas of the highest malnutrition are also areas known to host high numbers of IDPs. An August 2010 OCHA assessment report noted IDPs in main urban centers as well as those in rural areas indicate high rates of malnutrition.

Project description

Community-based Management of Acute Malnutrition (CMAM) has been integrated into routine health services. The approach has focused on capacity strengthening of stakeholders (health workers, leaders, etc.) on CMAM at different levels i.e. district, health facility and community. Activities are done in 4 CMAM sites weekly. The main objective of the project is to ensure sustainable access of CMAM services for severely acutely malnourished children 6-59 months in Galckayo district.

The nutrition activities consist of support for Outpatient Therapeutic Programs, Stabilization Centers and community outreach for mobilization. These services are provided at the community level with their full participation and easy accessibility. Supplementary Feeding Programs are coordinated with other agencies on the ground for children that are found to be moderately malnourished.

The entry and exit criteria are described below:

<table>
<thead>
<tr>
<th><strong>OTP entry criteria:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 6 – 59 months: Z score &lt;-3 SD / &lt;69% median weight for height (W/H) or MUAC &lt;11.5cm/115mm, no medical complications and with APPETITE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>OTP Discharge criteria:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 85%* W/H for two consecutive weeks &gt;-3 sd</td>
</tr>
<tr>
<td>MUAC &gt;11.5cm no edema for two weeks</td>
</tr>
</tbody>
</table>
Methods

Purpose of the study

1. To train staff on the SQUEAC method for evaluating access and coverage of the CMAM nutrition project
2. Conduct an investigation and evaluation of the programme impact by identifying boosters and barriers to programme access and coverage.

Study design and Methodology

SQUEAC STAGE 1: The Prior building

The Prior is the expression of beliefs about coverage based on qualitative data (or quantitative data transformed into qualitative data) provided by the Mind Map exercise. The distribution of prior coverage estimate is determined through a beta distribution of the belief of or perceived possible coverage estimates. The Prior mode is determined by adding the sum of the total “positive point’s i.e. boosters to coverage” to the bottom 20% and by subtracting the total “negative point’s i.e. barriers to coverage and access” from the top 80%. The mode is calculated as the mid-point between the “built-up” and “built-down” results.

Analysis of routine programme data and other relevant available data and collection of qualitative information from target communities, beneficiaries, volunteers and health staff to explain and better inform the programme data. Both quantitative and qualitative data were then processed through a mind mapping exercise resulting in the determination of the prior estimate of programme coverage.

SQUEAC Stage 2: Likelihood

The prior estimate of programme coverage is then further refined by determining the likelihood through conducting a wide area survey using a simple stratified severe acute malnutrition across the catchment areas of the clinics being investigated. Using an active and adaptive case-finding methodology informed and defined by the information gathered during prior building, cases of severe acute malnutrition children are identified and categorized as either being in or out of the programme. A simple questionnaire is administered to those out of the programme so as to gain information on various barriers to access to the programme.
Training

World Vision Somalia-(Nutrition Manager-Puntland) facilitated and arranged for all meetings and site visits. The lead researcher was responsible for facilitating the design of study tools, training of the survey team composed of 16 data interviewers from Galckayo and compiling the study report. Monitoring was done by Ministry of Health of Puntland Government. Two representatives from MOH were involved at all levels during the survey including training.

Participants Training outcomes

How do you rate the training overall?

- Excellent
- Good
- Average
- Poor
- Very poor

The training met my expectations.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree
Class participation and interaction were encouraged.

- Strongly Agree: 55%
- Agree: 27%
- Neutral: 18%
- Disagree: 8%
- Strongly Disagree: 9%

The quality of instruction was good.

- Strongly Agree: 91%
- Agree: 9%
- Neutral: 9%
- Disagree: 0%
- Strongly Disagree: 0%

Adequate time was provided for questions and discussion.

- Strongly Agree: 42%
- Agree: 50%
- Neutral: 8%
- Disagree: 0%
- Strongly Disagree: 0%

The trainer met the training objectives.

- Strongly Agree: 64%
- Agree: 27%
- Neutral: 9%
- Disagree: 0%
- Strongly Disagree: 0%

The materials distributed were pertinent and useful.

- Strongly Agree: 55%
- Agree: 36%
- Neutral: 9%
- Disagree: 0%
- Strongly Disagree: 0%

The content was organized and easy to follow.

- Strongly Agree: 55%
- Agree: 45%
- Neutral: 0%
- Disagree: 0%
- Strongly Disagree: 0%

I will be able to apply the knowledge learned.

- Strongly Agree: 36%
- Agree: 64%
- Neutral: 0%
- Disagree: 0%
- Strongly Disagree: 0%

The training objectives for each topic were identified and followed.

- Strongly Agree: 37%
- Agree: 36%
- Neutral: 27%
- Disagree: 0%
- Strongly Disagree: 0%
Materials (Equipment, suppliers, personnel)

The materials used in this study comprised of the questionnaire and anthropometric equipment. The questionnaire was developed by the study team. The MUAC tapes were provided by the ministry of health.

Approvals

Approval to conduct the survey was received from the Ministry of Health, Government of Puntland.

Data analyses

All the data was entered in Microsoft access database. The data was then transferred to the window based EPI info programme for detailed analysis to generate frequencies and into the Bayesian SQUEAC calculator for conjugate analysis.

Survey limitations

- Bits of language barriers among participants—however this barrier was mitigated by back and forth translations and extensive use of illustrations
- Uncertain Security situation in Galckayo which limited some form of free movement around the project area especially for international staffs
Programme routine data analysis and qualitative data collection

These stage involved analysis of routine programme data and collection of qualitative data.

Mapping of project catchment areas

2.1 CMAM Admissions

Programme Admissions over Time, Galckayo
2.2 Admissions by OTP site, Galckayo district,

The analysis identified some difference between the various health facilities. The investigation concluded this to be the result of the location of some sites in IDP camps and others in rural areas.

**Standard programme trends**

Programme trends indicated a similar pattern except in Garsoor. There were good rates of cured children in Buulo Mareer, Buulo Mustaq and Roox and a below sphere performance in Garsoor where the rates of cure were lower than the expected 75% with an equally high rate of non response and defaulting among the admitted children.
In all the four OTP sites in Galckayo, the cured line is higher than the defaulter and death lines and is not crossing with the death and defaulter lines. If the percentage of defaulters is higher than the percentage of those cured among the exits this is a cause for concern. The close links between the defaulter and non recovery lines might point to a case of ‘hidden deaths’ among these two groups of exits that has not been captured in the programme records.

The figure indicates similar trends for almost all health facilities with an increase in January to March and then a decrease during the harvest and initiation periods.

**Performance rates, Galckayo district, 2011-2012**

To determine the effectiveness of the CMAM program, standard program monitoring data was analyzed and compared against SPHERE Standards for Therapeutic Feeding programs in rural areas. The analysis focused on three key indicators: default, cured and death rates.
2.3 Functional indicators analysis and review

All the functional indicators of the project were Positive and met all the minimum thresholds for SPHERE standards (Default < 15%, Cured > 75%, Deaths < 5%)

However individual site analysis indicated that programme outcomes were not meeting Sphere standards in Garsoor OTP site where cure rate was 70% with high defaulting and non recovery rates of 15%

Rate of Defaulting < 15% ✓

The overall projects defaulting rate was 7% and Within SPHERE minimum standards. Defaulting was found to be affected by mother’s workload, distance and migration in search of pasture.

Rate of recovery > 80% ✓

84% of the children who exited the CTC were cured and Within SPHERE minimum standards.

Rate of Deaths < 5% ✓

The CMAM programme has recorded no death.

Admission trends and response to context ✓

Admissions in the OTP program were analyzed. Admissions were plotted against time to determine whether they reflected seasonal changes, the context and whether they revealed an increasing, decreasing, or flat trend.
In order to get a broader picture of program performance against context, a seasonal calendar was developed (including agricultural labor, disease, and food availability). Admissions and defaulters were then compared to the seasonal calendar to determine whether the program was responding to seasonal changes and context-specific factors. The analysis concluded those periods of disease, hunger and heightened seasonal food insecurity coincided with increase in admissions.

Galckayo local calendar of events

<table>
<thead>
<tr>
<th>Months</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
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<tr>
<td>Malaria</td>
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<tr>
<td>ARI</td>
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<tr>
<td>Other disease</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hunger season</td>
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</tr>
</tbody>
</table>

Galckayo Admissions trends

Defaulting/Absence for B/mareer, B/Mustaqbal And garsoor Branch Five

Defaulters: reasons given for defaulting include poverty and distance from their homes to the clinic. Other respondents believe that malnutrition as a disease is complicated and treating it is very difficult prefer religious interventions and prayers over the use of ready to use therapeutic foods

Time constraints due to women workload and long waiting times at the OTP sites were also reported as a cause for default.
2.4 Distance

The lack of enough decentralization of services was seen as a major barrier. Even for those who can afford to pay, the roads lack public service vehicles. These coupled with long queues complicated the beneficiary’s compliance with the services.

Some defaulters were found to come from homes near the OTP sites but cited a number of reasons for default. These included sickness of caretaker, husband refusal and the suspicion that plumpy nut may be a disease causing and religiously not appropriate food.

2.5 Qualitative Data Mind-maps by computer

A simplified mind map approach generated by xmind software was used to organize, review, discuss and analyze the results gathered from the prior estimation phase. The information was grouped according to the key determinants of coverage that included discussions with community lay people, leaders, programme staff, beneficiaries and outreach workers. The findings were divided into those with positive effects on coverage — boosters represented by a green tick and those with negative effects — barriers represented by a red cross mark as shown below:
### 2.6 SQUEAC qualitative investigation

Barriers and boosters to programme coverage

<table>
<thead>
<tr>
<th>Boosters</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding of malnutrition</td>
<td>The communities understanding of malnutrition is a person with wasted muscles and severely emaciated, who is not able to sit. There are some children who are given some plumpy nut but mothers are always busy for work to get daily food for the other children who are not in the program. Common health problems mentioned include frequent diarrhea and fever. Other common symptoms include fever, loss of appetite, and much crying in infants. ✓</td>
</tr>
<tr>
<td>Health seeking behavior</td>
<td>Children are kept at home, and treat traditionally, unless child condition deteriorates. In serious cases we run to the hospital for lifesaving help, though there is no hospital in our area. Our nearest health centers are Galckayo Medical Center and MSF-Holland. ✓</td>
</tr>
<tr>
<td>Awareness of CMAM service</td>
<td>Awareness of the OTP program was ok and the Perception of CMAM was good with a number of beneficiaries seeing it as an excellent programme ✓</td>
</tr>
<tr>
<td>Long serving OTP staff</td>
<td>Health staffs have been involved on CMAM about 3 years. They have had trainings. They still need training on other aspects like monitoring and evaluation, and project cycle management.</td>
</tr>
<tr>
<td>Motivated volunteers</td>
<td>Most volunteers have been for 2 years. The main activities include community mobilization, and preparing appropriate place for the mobile OTP team. The mobilization activities involve telling mothers to bring to the OTP site any child who is thin, or having oedema on face or lower limbs. They also inform mothers of plumpy nut key messages. They are aware of their roles and have regular communication with the health staffs ✓</td>
</tr>
<tr>
<td>Opinion of the service</td>
<td>The OTP service was reported to be well organized and children received complete treatment until cured ✓</td>
</tr>
<tr>
<td>Communication</td>
<td>Volunteer and staff meetings take place on a weekly basis. Training on community mobilization and active case finding. ✓</td>
</tr>
</tbody>
</table>

### Barriers

<table>
<thead>
<tr>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and understanding of CMAM</td>
</tr>
<tr>
<td>Local ways of treating sick children included the following therapies</td>
</tr>
<tr>
<td>- diarrhea and vomiting by removing teeth in infants, constipation by putting finger at the anus,</td>
</tr>
<tr>
<td>- hepatitis by burning on abdomen while hydrocephalus by burning on the head.</td>
</tr>
<tr>
<td>Issue</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>2.1 Spatial coverage of Admissions</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
3. Areas of High and Low Coverage

A hypothesis was developed to determine the likely level of coverage in the area and was done prior to the small area surveys. Information on the spatial mapping was used to develop the hypothesis about coverage.

Coverage is low in areas where most IDPS settle on arrival from south central Somalia. Coverage is low in facilities with long waiting times.

Based on these, two areas were selected to test the hypothesis:

- Horumar branch 1 village in Bulo Mareer: The admissions mapping exercise showed few admissions coming from this area.
- Baadweyn village in Roos: The trend analysis showed that the facility had a low number of admissions and the high defaulting. Barriers were therefore investigated.

4. Wide Area Survey

These involved confirming areas of high or low coverage and the reasons. Four teams were formed for the small area surveys. Both identified locations were sampled in one day. One team of 3 people went to each of the catchment areas of the 4 OTP sites. The case definition used was for both marasmus and kwashiorkor cases - terms used included: children who are not eating, have lost weight, are being weaned or swollen (kwashiorkor) with use of photos, as well as for children in the programme but no longer with severe acute malnutrition (recovering cases). A Combined active & adaptive case finding methodology and house to house screening were used to serve both the rural and IDP contexts.

The findings indicated that long waiting times at the health facilities due to health talks and volunteer and staff motivation and to some extent distance were the major factors that were affecting coverage.

4.1 Developing a Prior

The information was synthesized into boosters and barriers to coverage. Each factor was ranked and weighted using points from 1 to 5. All positive factors were added to the minimum possible coverage (20%) while all the negative factors were subtracted from the highest possible coverage of 80%.

<table>
<thead>
<tr>
<th>Boosters</th>
<th>Weight</th>
<th>Barriers</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and understanding</td>
<td>2</td>
<td>Standard and perception of service</td>
<td>4</td>
</tr>
<tr>
<td>Motivated volunteers</td>
<td>3</td>
<td>Insecurity</td>
<td>5</td>
</tr>
<tr>
<td>High OTP awareness</td>
<td>4</td>
<td>Long distance</td>
<td>5</td>
</tr>
<tr>
<td>Huge involvement of leaders</td>
<td>2</td>
<td>Rejection problem</td>
<td>5</td>
</tr>
<tr>
<td>Positive perception of programme</td>
<td>3</td>
<td>Knowledge and understanding of programme</td>
<td>2</td>
</tr>
<tr>
<td>Total-Barriers to coverage</td>
<td>14</td>
<td>Total -Boosters to coverage</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>alpha</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>beta</td>
<td></td>
</tr>
</tbody>
</table>
A distribution of prior belief was developed the beta distribution. Using Bayes software, a distribution of prior belief was then plotted using the previously identified mode as well as the perceived belief in all other coverage proportions (i.e. between 0 and 80%).

**Range and mode of prior coverage estimates**

Coverage = \((20\% + \text{sum of positive aspects of OTP}) - (80\% - \text{sum of negative aspects})\)

= \((34-59)\%\) hence midpoint of 46.5%

**4.3 Determining Distribution of Prior Coverage Estimate**

The distribution of prior coverage estimate was determined through a beta distribution of the belief of or perceived possible coverage estimates. An average was calculated and used as the median for a trial distribution curve (Prior) plotted using The Bayes SQUEAC Calculator.

**4.4 Sampling Methodology**

**Minimum Sample Size**

To estimate the minimum number of cases (children) needed in the area Survey \((n)\), the following formula is used:

\[
n = \text{mode} \times (1 - \text{mode}) - (\alpha + \beta - 2) \times \left(\frac{\text{precision}}{1.96}\right)^2
\]

However given the nature of the context that comprises more of IDPS populations in a small catchment area. A decision was reached to sample all children under five in the project area who fell in the case definition criteria

**Minimum number of villages**

Given the nature of settlement in the project area comprising majorly of internally displaced persons, all villages were sampled in each OTP catchment area and all efforts were made to find all the malnourished children in the area.

**4.5 Spatial Representation**

Villages were selected covering the catchment areas of the facilities delivering CMAM services. Within-community sampling method: a combined active & adaptive case-finding & mass screening approach was used to ensure selected communities were sampled exhaustively.
Wide Area Surveys

Point Coverage per catchment area

<table>
<thead>
<tr>
<th>OTP site</th>
<th>Severe cases</th>
<th>Severe cases covered by programmes</th>
<th>Percent coverage</th>
<th>settlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulo Mareer</td>
<td>63</td>
<td>20</td>
<td>31.7%</td>
<td>IDP</td>
</tr>
<tr>
<td>Bulo Mustaaq</td>
<td>82</td>
<td>41</td>
<td>50%</td>
<td>IDP</td>
</tr>
<tr>
<td>Roox</td>
<td>16</td>
<td>9</td>
<td>56.2%</td>
<td>Rural</td>
</tr>
<tr>
<td>Garsoor branch 5</td>
<td>13</td>
<td>6</td>
<td>46%</td>
<td>rural</td>
</tr>
</tbody>
</table>

Point coverage was not uniform in all the 4 OTP sites. The worst coverage was in Buulo Marer where only 20 of the 63 children identified with severe acute malnutrition had been reached. Of the IDP camps, Buulo Mustaaq had 50% coverage of the current cases of malnourished children.

Reasons for those not in programmes in OTP catchment area

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness of mother</td>
<td>10%</td>
</tr>
<tr>
<td>New arrivals from South Somalia</td>
<td>40%</td>
</tr>
<tr>
<td>Long distance</td>
<td>30%</td>
</tr>
<tr>
<td>Long waiting times</td>
<td>2%</td>
</tr>
<tr>
<td>Husband refused</td>
<td>1%</td>
</tr>
<tr>
<td>Caretaker not aware</td>
<td>3%</td>
</tr>
<tr>
<td>Relapse</td>
<td>9%</td>
</tr>
<tr>
<td>Mothers workload</td>
<td>5%</td>
</tr>
</tbody>
</table>

Most of the children who were not in the programme at the time of this survey were reported to be new arrivals from south central Somalia (40%) They were cases that were mostly found in Buulo Mustaaq IDP camps. Distance was cited as a major barrier to accessing CMAM services. Of note is that a number of children i.e. 9% were cases of relapse pointing to the need of having a safety net programme like supplementary feeding to provide a buffer to the discharged children.

Gender and age pyramid of children

An almost equal number of boys and girls were sampled in the wide area survey with no significant imbalance noted.
5. **Overall Coverage Estimation**

Conjugate analysis was used in this stage to provide an estimate of overall programme coverage. Both point and period coverage are presented in this section. However, focus is set on period coverage as it provides a more accurate picture of the actual coverage of SAM cases at the time the investigation was conducted.

<table>
<thead>
<tr>
<th>Box 1: Definitions of terms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Point coverage</strong>&lt;br&gt;Is defined as the proportion of current cases found who are in the programme. Point coverage therefore focuses on current cases. It does not include those who are in the OTP but are now recovering.</td>
</tr>
<tr>
<td><strong>Period coverage</strong>&lt;br&gt;Is defined as the proportion of children found who are in the programme. Period coverage takes into account recovering cases in the programme who no longer correspond to the admission criteria (MUAC &lt;11.0 cms and/or bilateral oedema).</td>
</tr>
<tr>
<td>Definitions for numerator and denominator for point coverage&lt;br&gt;• Numerator: current cases in the program&lt;br&gt;• Denominator: current cases (including current severe cases covered by the program)</td>
</tr>
<tr>
<td>Definitions for numerator and denominator for period coverage&lt;br&gt;• Numerator: SAM cases in programme + Cases in programme but recovering&lt;br&gt;• Denominator: Total SAM cases found + Cases in programme but recovering</td>
</tr>
</tbody>
</table>

5.1 **Point Coverage**

Point coverage provides a snapshot of programme performance and places strong emphasis on the coverage and timeliness of case-finding and recruitment. To calculate point coverage, the numerator and the denominator were selected from the results for the wide area survey with a denominator of 100 children and numerator of 77 children.

Based on the existing prior and wide area survey (likelihood) **point coverage** was estimated by the formula below.

\[
\text{Point coverage: Severe Acute Malnutrition cases in programme divided by total Severe Acute Malnutrition cases X100}
\]

The results produced a coverage result of 42.2% (35.7% - 48.8%)

5.2 **Period Coverage**
Period coverage includes recovering cases; case that should be in the programme because they have not yet met the discharge criteria. Selected data used as numerator was 495 children and denominator was 595 Children. These comprised of 100 children with severe acute malnutrition but not admitted in the project, 77 were covered by the project currently and 318 were fund to be recovering in the project

Diagnostic plot for period Coverage was not produced for use in the analysis due to the large sample size. The classical (frequentist) estimator was used based on the following formula:

\[
\text{Period coverage} = \frac{\text{SAM cases in programme} + \text{Cases in programme but recovering}}{\text{Total SAM cases found} + \text{Cases in programme but recovering}} \times 100\%
\]

Using \(x = 495\) and \(n = 595\), the coverage was: 83.2% (79.9% - 86.1%)

6. **Recommended Programme reform and improvement areas identified by stakeholders**

- More training to Nutrition Volunteers and enhancement of their motivation
- Include CMAM as part of the comprehensive integrated outreaches that are run by the MOH
- More volunteers to cover areas that are large and have few community based outreach staff
- Proper tracking and registration of new arrivals from south central Somalia
- Conducting review meetings to analyze and feedback on the progress of CMAM at facility level.
- Decentralization by opening more OTP sites close to communities and increasing the number of staff so that they can attend to numerous health issues raised by the beneficiaries.
- Increasing awareness in the community to encourage more admissions
APPENDIXES

SQUEAC INVESTIGATION

Qualitative work – Topics for discussion

1. **COMMUNITY - LAY PEOPLE**

The discussion should flow naturally and leads/interesting points should be followed/explored as they come up. The question list should not be rigidly adhered to. This is just a guide as to the kind of topics which are important and the type of questions which could be asked. The direction the discussion takes will depend on what is said by the participants. It is always important to probe and ask follow up questions.

**UNDERSTANDING OF MALNUTRITION**

1. What are the common health problems that children experience here?
2. Which are the most frequent? Rank.
3. Are any more frequent at certain times of the year? When? Why?
   
   *If malnutrition mentioned ask:*

   4. What symptoms do these children have?
   5. What terms do you commonly use to describe this condition?
   6. Which children get this condition? Why?

**HEALTH SEEKING BEHAVIOUR**

7. What do you do when your child has this (insert name of most common illnesses) problem?
   a. Probe fully for different illnesses

8. What factors determine which treatment / approach you use for a particular illness?
   Probe on:
   a. Cost, Access, Father permission, Habit/familiarity

   *If clinic/hospital mentioned:*

   9. Which? How far is it? Why do you go there?
   10. Are there any alternative/anything else you might do/anyone you might ask for advice nearer home?

   *If malnutrition not already mentioned ask/show pictures:*

   11. Have you seen children like this (those who have lost weight/become very thin or whose feet/legs/hands have started to swell)?
   12. When do you see this condition? Are there children who have this problem now?
   13. What do you call this condition?
   14. Which children get this condition? Why?
   15. What do you do when your children get this condition? Why?

**AWARENESS OF CMAM SERVICE**

16. Do you know of a place where this condition can be treated?
17. How did you hear about it?
a. Who told you? When? What do you know about it?

18. What are children given for this condition?

If people think the RUTF is a food ask:

   a. What sort of food is it?
   b. What do you call it?
   c. Who can eat it?
   d. What foods do you give your children to make them health/strong?

19. Do you know children receiving this treatment?

PERCEPTIONS OF CMAM

20. What do you think / what are people saying about this service?

If people say it is good ask:

   a. What is good about it?

21. Have you noticed a change in the children who are being treated?

22. What improvements would you like to see to the service?

If people say it isn’t good ask:

   a. What is wrong with it?

23. What do people not like about the service?

24. How can we change it? What suggestions do you have?

AWARENESS OF CHW/VOLUNTEER (CASE FINDER) AND HIS/HER ACTIVITIES

25. How are children identified for treatment?

   a. What tool is used?
   b. Have you seen anyone doing this in your community?

   If people know the volunteer/have seen the MUAC ask:

   c. When was the last time you saw the volunteer measuring children? How often does he do it?
   d. How are children referred to the health centre?

   If not, show the MUAC tape and repeat questions if necessary:

COVERAGE QUESTION

26. Do you know children who have this condition but who are not going to the health centre for treatment? Why?

27. Do you know of any children who have stopped going for treatment?

   a. Why is this? What would encourage them to return?

28. Do you know of children who have been to the clinic and have not been given the treatment?

   If yes,

   a. Why not? What were they told? How did they feel?

BARRIERS

29. What factors might prevent children from being able to access treatment? Why? How can we overcome these obstacles?

30. What messages/suggestions would you like us to pass to the people running the CMAM service?

Key community figures (local village/religious leaders)

Open questions about the situation in the village / the health of the children etc. can always be asked of the leaders at the start before focusing on the issues of interest.

➢ Understanding of malnutrition
Health seeking behaviour

**KNOWLEDGE AND UNDERSTANDING OF IMAM**

1. Are you aware of any nutrition service at your local clinic?
2. Who told you about it?
3. When did you hear about it?
4. What do you know about it?
   a. Target children? (ensure both marasmic and kwashiorkor types are identified)
   b. Admission criteria?
   c. Treatment given?
   d. OTP day?
   e. Identification of children?

**ROLE / AWARENESS RAISING**

5. Have you been involved in telling others about the service? How? When?

**PERCEPTIONS OF IMAM**

6. What are people saying about IMAM?
   a. Do you think most people are aware of it?
   b. What do they understand about it?
7. What do you think of the service?
   a. What do other key community figures think of it?

**BARRIERS/COVERAGE QUESTION**

8. Do you know any children currently receiving treatment in the village?
   a. What can you tell me about them?
9. Are you aware of any children who need treatment but are unable to access services?
   a. What stops them coming? (distance/family/beliefs/other)
   b. How could we reach these children/encourage them to attend?
10. Do you know any children who have defaulted/stopped coming?
    a. Why is that? How can we encourage them to return for treatment?

**STIGMA**

11. Is there a stigma attached to malnutrition in your village? Are there parents who might hide their malnourished children? Why?

**COMMUNICATIONS**

12. Do you know anyone in the village who identifies children for this service?
    a. When did you last see them? When were they last active?
    b. What do they do? (frequency and organisation of activities = passive or active)
13. Have you had any feedback from the volunteer/clinic staff/MoH officials about the service?
14. Do you know what the results are (number of children cured)?

**IMPROVEMENTS**

15. How can we improve the service?
16. Do you have any messages for those who run the service?
2. TRADITIONAL HEALER / OTHER HEALER

TREATMENT AND PERCEPTION OF MALNUTRITION

Start the discussion by asking:

1. What types of illnesses do you treat? Most common? How many patients do you see a week?
2. How do you treat this illness? What do you do if the treatment is not effective?

If not mentioned show picture of malnourished children and ask:

3. Do you see children like this in the village? Do you treat this illness? How do you treat this illness? How often do you see it and when? What are the causes of this illness? How effective is the treatment?
4. Are you aware of any other treatment for this condition?

Continue with similar questions asked of key community figures starting with awareness of the service

KNOWLEDGE AND UNDERSTANDING OF IMAM

1. Are you aware of any nutrition service at your local clinic?
2. Who told you about it?
3. When did you hear about it?
4. What do you know about it?
   a. Target children? (ensure both marasmic and kwashiorkor types are identified)
   b. Admission criteria?
   c. Treatment given?
   d. OTP day?
   e. Identification of children?

3. CARERS OF BENEFICIARIES
   Individual case history

HISTORY OF THE ILLNESS

1. When did you first notice that your child was unwell?
   a. What was wrong with them? What symptoms did they have?
   b. What was the cause of the problem (probe for illness / food availability)?

HEALTH SEEKING BEHAVIOUR

2. What did you do when your child became ill?
3. Did anyone tell you to go to the health centre (information source)?
4. How long was it before you went to the health centre?

INFORMATION SOURCE FOR THE OTP

5. How did you first hear about the service?
   a. Who told you?
   b. Have you heard about it from any other source since?
   c. Who is telling people about it in your settlement?
6. What did you hear about it?
7. What made you come?

AWARENESS OF/CONTACT WITH CHW/VOLUNTEER (CASE FINDER)

8. Did your child have his/her arm measured at home (MUAC)?
   a. By whom? How was it done? What did he/she tell you about it?
When was the last time your child was measured at home?

**UNDERSTANDING OF THE SERVICE**

9. What did the clinic staff tell you about your child’s condition?
10. What were you told about the treatment? (Check understanding of procedures, approximate length of treatment, what to do if you need to travel, sharing of RUTF etc.?)
11. What do the staff call the treatment? What do you call the treatment?

**STANDARD OF SERVICE**

12. How long do you usually wait before the nurse sees you?
13. How much time do you spend with the nurse?
   a. How do the staff treat you?
   b. Have you ever been scolded? Why?
14. Have you always received the correct supply of treatment sachets?
   a. Have there been any shortages on any week?
   b. Have you ever not received the full amount / or received something else instead?

**OPINION OF THE SERVICE**

15. What do you think of the service?
   a. What are the strengths/weaknesses?
   b. Difference in the health of your child?
   c. What could be improved?

**ABSENCE/DEFAULTING**

16. How easy is it for you to come every week?
   a. What makes it difficult / stops you from coming sometimes?
17. Do you know of any children who have stopped coming?
   a. Why is that?
   b. How can we encourage these children to return and continue the treatment?

**COVERAGE QUESTION**

18. Do you know of other children who have the same problem but who are not attending the clinic?
   a. If yes, why not?

**Group discussion with carers**

**INFORMATION SOURCE FOR THE OTP**

1. How did you first hear about the service?
   a. Who told you?
   b. Have you heard about it from any other source since?
   c. Who is telling people about it in your settlement?
2. What did you hear about it?
3. What made you come?

**AWARENESS OF/CONTACT WITH CHW/VOLUNTEER (CASE FINDER)**

4. Did your child have his/her arm measured at home (MUAC)?
   a. By whom? How was it done? What did he/she tell you about it?
   b. When was the last time your child was measured at home?

**STANDARD OF SERVICE**

5. How long has your child been receiving treatment?
6. Difference in child’s condition?
7. Have you had any difficulties in following the treatment/attending every week? (Probe for: distance, waiting time, welcome, etc.)
8. Have you missed a week? Why?
9. Have you always received the correct supply of treatment sachets?
   a. Have there been any shortages on any week?
   b. Have you ever not received the full amount / or received something else instead?

**OPINION OF THE SERVICE**

10. What do you think of the service?
    a. What are the strengths/weaknesses?
    b. What could be improved?

**DISTANCE**

11. How far is it from your home to the clinic?
    a. How do you get here? Walk/transport?
    b. How long does it take?
    c. Determine the farthest distance travelled within the group
12. Do you have any other reason to come to this clinic/this place?

**COVERAGE QUESTION/DEFAULTING**

13. Do you know of any children who have stopped coming?
    a. Why is that?
    b. How can we encourage these children to return and continue the treatment?
14. Do you know of other children who have the same problem but who are not attending the clinic?
    a. If yes, why not?
    b. What would encourage them to come?

**CASE REFERRAL**

15. Have you told anyone else to bring their child to the clinic?
    a. Why/why not?

**PERCEPTION OF IMAM**

16. What are people saying about the service in your settlement?
17. Are the other mothers aware of the service?

**STIGMA**

19. Is there a stigma attached to malnutrition in your village? Are there parents who hide their children? For what reason?
   If stigma exists:
20. How does the stigma affect you personally? In what way?

**FEEDBACK**

18. Have you any messages you want us to give to the people running the service?
4. VOLUNTEERS

ROLE

1. How long have you been a volunteer?
2. What are your main activities?
3. How often do you do these activities?
4. What area do you cover for case finding?
   a. How long does it take you?
5. How do you decide which children to measure?
6. What tools do you have to help you?
7. Tell me about the last case you identified? When was that? What was the problem?

EXPLANATION GIVEN TO MOTHERS

8. What do you tell the mother when you identify a case?
9. What do you say about the new treatment?
10. How do you refer to the treatment?
   a. What do the mothers call it?

REFERRAL AND FOLLOW UP

11. Do you give the mother a referral slip/paper when you refer the child to the clinic?
   a. Why/why not?
   b. How do you know if the child actually went to the clinic?
12. Are you aware of any children who have stopped coming?
   a. Why is that? How can we encourage them to return?
13. Are you ever asked to visit a case that is not improving / has been absent? Tell me about the last one you visited.

REJECTION

14. Have you referred any children who have been turned away and not given treatment?
   a. For what reason? How many were rejected last month?
   b. Did you receive an explanation from the nurse as to why?
   c. How did the mother react?
   d. What was your reaction?
15. Are you aware of any other children who went spontaneously to the health centre and were turned away and not given treatment? Probe: a-d as above.

COVERAGE QUESTION

16. Do any mothers refuse to go to the clinic? Why? How can we encourage them to bring their children?

COMMUNICATIONS

17. When was your last contact with clinic staff?
18. Are there regular monthly / 3 monthly meetings with health centre staff? Are IMAM issues discussed?
19. Do you have a monthly written/verbal report to make on your activities (number of children identified, number referred, home visits etc.)
20. How do you usually communicate with the nurse at the health centre (for example when a home visit is needed)
21. Have you received any feedback from clinic staff
   a. Number cured?
   b. Number of defaulters? Reason?
22. Have you talked with village / religious leaders or other people about IMAM since it started? When was your last contact? Topic of discussion?
23. Have you had any further contact with children you have referred?
   a. Do you know how many were cured?
   b. Do you know if any defaulted? Why?
24. What have mothers said to you about CMAM?
   a. What are people saying/thinking about CMAM?

**OPINION OF THE OTP**

25. What is your opinion of the OTP? Why?
26. What is the opinion of the community?

**MOTIVATION**

27. Appreciation of your work by the community?
28. Appreciation of your work by programme staff?
29. Do you enjoy your role? Why/why not?
30. Challenges/difficulties?

**IMPROVEMENTS**

31. What would help you in your job as a volunteer?
32. How do you think IMAM could be improved?
33. Any messages for those running the service?

5. **OTP STAFF**

**CMAM INVOLVEMENT AND CHALLENGES**

1. How long have you been working on IMAM?
   a. How many staff are involved/trained on IMAM?
2. When were you trained on CMAM?
   a. Have you had refresher training?
   b. Is there any additional training you feel you need?
3. What difficulties, if any, do you have on the OTP day?
   a. High number of patients
   b. Time
   c. Completing paperwork accurately and keeping up to date

**CALENDAR**

4. What are the main childhood diseases you see in the clinic?
   a. Which is the most common? Rank.
   b. What time of year do they occur?
5. What do you think are the causes of malnutrition here?

**REFERRAL**

6. How do children usually come to the clinic for IMAM?
   a. Referred by volunteer
   b. Heard about it from other beneficiary
   c. Heard about it from other person in the village
   d. Heard about it at the clinic
   e. Heard via the radio/town crier etc.
   f. Other source
   g. Rank in order

**REFERRAL AND FOLLOW UP**

7. Do children who are referred by the volunteer come with a referral slip/paper?
   a. What do you do with the referral slips?
8. Is there a system to check that the child referred by the volunteer has actually presented at the clinic? System to confirm the number of referrals per volunteer?
9. How do you refer patients to the stabilisation centre? Paper slip?
   a. How do you know if they have arrived at the SC?
   b. Do you know what happens to them?
   c. When patients are referred back do they come with any paperwork?

**REJECTION**

10. How many healthy children have you rejected who do not correspond to the admission criteria?
    a. How many every week?
    b. Explanation given? What do you actually say/what words do you use?
    c. Why do you think these mothers come with healthy children?
    d. How do mothers react?
11. Have you had any wrong referrals from the volunteer?
    a. How many? What was the problem? Did you report back to the volunteer?

**DEFAULTING**

12. How many children are absent for more than 1 week during the course of treatment?
    a. Why do you think this is?
13. How many children default?
    a. Why do you think this is?
14. Is there a system to follow up on defaulters? How does it work? How could we encourage children to return for treatment?
15. What barriers prevent mothers from bringing their children to the OTP?

**COVERAGE QUESTION**

16. Are you aware of any children with this condition who don’t come to the CS? Why is that?

**COMMUNICATIONS**

17. Are there regular monthly/3 monthly meetings with volunteers? Are CMAM issues discussed? How often do you see the volunteers? Last time?
18. When was the last time you saw someone from the district office? Frequency of contact?
19. Support from the district?

**OPINION OF THE SERVICE**

20. Does the OTP give good results?
21. Has the condition of the children improved?

**WORK LOAD**

22. Does the OTP give you more work?
23. What changes have you had to make to your routine activities?

**IMPROVEMENTS**

25. What messages do you want us to pass to the people organising IMAM?
7. FIELD AGENT (if NGO)

ROLE AND ACTIVITIES

1. Tell me about the activities you did last week?
   a. One off activities?
   b. How much time do you devote to nutrition activities?
2. How many volunteers do you supervise?
   a. Last contact? For what reason?
   b. How many have recently had training/refresher training?
   c. How is case finding carried out and how often?
   e. How motivated are the volunteers? Complaints? Replacement of non active volunteers?
   f. What tools are provided to volunteers? MUAC tape?

COMMUNICATIONS

3. How do you communicate with health centre staff?
   a. Last contact? For what reason?
   b. Relations with health centre staff?
   c. What information is shared? In what format?
4. Last contact with your supervisor?
   a. For what reason? Report?

FOLLOW UP / HOME VISITS

5. Who follows up defaulters? How?
   a. Last defaulter traced? Reason for defaulting? Did the child return to treatment?
6. Who follows up children not responding to treatment? How?
   a. Last case? Reason?
7. Is feedback given after home, if so to whom?

OPINION OF OTP

9. What do you think of the OTP? Why? Has your opinion changed?
10. Challenges / problems / suggestions for improving the service?
11. Messages for those running the OTP service?

8. PROGRAMME STAFF

ROLE AND ACTIVITIES

1. When was your last field visit and what was the outcome/what did you find out?
2. How much time do you devote to nutrition activities?

COMMUNICATIONS

3. Relations with health centre staff? Last contact? For what reason?
4. Relations with district MoH staff? Last contact? For what reason?

OVERVIEW OF THE SERVICE

1. Strengths / weaknesses?
2. Challenges / problems / changes? Improvements / recommendations?
3. What factors influence the coverage for the service? In a positive way / in a negative way?

**BARRIERS**

4. What barriers to access exist? Why? How can we overcome them?

**ADDITIONAL QUESTIONS (adapt according to the audience)**

**Terminology:**

- Check what terms are used to describe the different types of malnutrition.

**Key people:**

- In your village who are the people who are in close contact with children under 5 and can point out their houses (because they are involved in care or preventive/other activities).

**Calendars:**

- Ask the community to help you develop seasonal calendars for:
  - The hunger gap
  - Agricultural labour (periods of intense activity)
  - Child illness (ARI, malaria, fever, diarrhoea etc.)
### List of teams and areas of survey

<table>
<thead>
<tr>
<th>Teams</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mowlid Abukar Abkey</td>
<td>Fuad Hashi</td>
</tr>
<tr>
<td>2. Ubah Abdirahman Ali</td>
<td>Roox</td>
</tr>
<tr>
<td>3. Abdirashid Mohamed Guled</td>
<td></td>
</tr>
<tr>
<td>1. Sadam Garad Abdi</td>
<td>Saadig Abdikhar</td>
</tr>
<tr>
<td>2. Hawo Abdi Mohamed</td>
<td>Buulo Marer</td>
</tr>
<tr>
<td>3. Abdi Hashi Dhagalab</td>
<td></td>
</tr>
<tr>
<td>1. Amino Said Abdullahi</td>
<td>Ahmed Haji Ali</td>
</tr>
<tr>
<td>2. Asho Abdirisaq Ali</td>
<td>Buulo Mustaqbal</td>
</tr>
<tr>
<td>3. Kheyre Hassan Salad</td>
<td></td>
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<td>1. Hamdi Abdulkadir Mohamed</td>
<td>Fysal Mohamed</td>
</tr>
<tr>
<td>2. Ahmed Abdi Hashi</td>
<td>Garsor Branch Five</td>
</tr>
<tr>
<td>3. Sucdi Abdikheyr Mohamed</td>
<td></td>
</tr>
</tbody>
</table>

### Survey action plan

<table>
<thead>
<tr>
<th>Days</th>
<th>Action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday</td>
<td>Interviewing local community leaders, religious leaders, traditional healers, volunteers and mothers</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Continue interview, and look OTP cards</td>
</tr>
<tr>
<td>Thursday</td>
<td>Active case finding</td>
</tr>
<tr>
<td>Friday</td>
<td>Active case finding</td>
</tr>
</tbody>
</table>
The Director General of Health
Services, Ministry of Health,
Puntland-Somalia

Dear Sir,

Re: Terms of Reference for coverage survey in Galckayo

I would like to officially inform you that World Vision intends to conduct Nutrition Coverage survey in Galckayo in the area where we have been operating. The project is coming to an end and therefore need to evaluate our performance in order to improve service to the community. Kindly, see the attached details.

Thank you.

Michael Abaasiku
Nutrition Manager

Cc. Regional Health Officer-
Mudug
Introduction
World Vision is committed to improve the well-being of children, families and communities, takes on a holistic approach to protection that has multisectoral dimensions working to create an overall protective environment for children especially in vulnerable communities. World Vision intends to conduct Nutrition Coverage survey in Galckayo District in the villages where it has been implementing nutrition program.

Objectives

1. To estimate the coverage and access of the nutrition project in Galckayo

Method

SQUEAC method will be used and tools with a special focus on participatory methods in undertaking the exercise. Qualitative and quantitative methods will be utilized for data collection which will include (but will not be limited to) the following:

- Literature review/examination of relevant records.
- Anthropometric measurements
- In-depth interviews.
- Stakeholders’ analysis.
- Focus Group Discussions (FGDs).

Team composition

The World Vision Somalia-Puntland will recruit a team of competent data collectors who will support the data collection under the close supervision.

Consultant

Cyprian Ouma, a technical staff from World Vision Regional Office with demonstrated experience in coverage surveys, good data analysis skills, ability and experience in working with communities including research and report writing skills will be the lead researcher.

Roles and Responsibilities

World Vision Somalia-(Nutrition Manager-Puntland) will facilitate and arrange for all meetings and site visits. The lead researcher will be responsible for facilitating the design of study tools, training and compiling the study report. Monitoring will be done by Ministry of Health of Puntland Government. Two representatives from MOH will be involved at all levels during the survey including training. (Preferably the Nutrition Focal Person at MOH headquarters and the one at Regional office in Galkayo will participate).
Facilitation while in the field for data collection

World Vision Somalia will cater for the Consultant/lead Researcher and facilitation for the research assistants. In addition, we will cater for the field travels and the travel to and from Garowe.

Deliverables
- Draft Tools for the survey
- Filled questionnaires
- Draft report
- Final report

Ethical Considerations
The survey procedure is not invasive to the respondents and/or community. It is conducted in the best interest of the community. Relevant Government and political authorities will be notified. Informed consent will be sought from individual respondents, after explaining to them the purpose of the study. Respondents will be assured that the information obtained from them will be treated with confidentiality.

Duration and timetable
Training of data collectors, data collection, analysis and reporting writing is planned to last 17 working days. The proposed time for the coverage survey is from 21st March to 10th April 2012.

Activity plan

<table>
<thead>
<tr>
<th>Date</th>
<th>Tasks</th>
<th>Duration (days)</th>
<th>Responsible persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>20th-3-2012</td>
<td>Arrival of participants and lead researcher to Garowe</td>
<td>1</td>
<td>Nutrition Manager</td>
</tr>
<tr>
<td>21st, 22nd, 24th-3-2012</td>
<td>Training of data collectors</td>
<td>3</td>
<td>Consultant</td>
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<tr>
<td>22th-3-2012</td>
<td>Travel to back to Nairobi/Galckayo</td>
<td>1</td>
<td>Nutrition Manager</td>
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<tr>
<td>26th-29th-3-2012</td>
<td>Data collection exercise</td>
<td>4</td>
<td>Field Supervisors</td>
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<tr>
<td>1st-3rd-4-2012</td>
<td>Data compilation in Garowe</td>
<td>2</td>
<td>Nutrition Manager</td>
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</tbody>
</table>
Nutrition Coverage survey

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Duration</th>
<th>Team</th>
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</thead>
<tbody>
<tr>
<td>5th-10th-4-2012</td>
<td>Data analysis and report writing</td>
<td>5</td>
<td>Consultant</td>
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<tr>
<td>11th-4-2012</td>
<td>Dissemination of findings</td>
<td>1</td>
<td>Health and Nutrition</td>
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CMAM Coverage Survey Form

<table>
<thead>
<tr>
<th>Team =</th>
<th>OTP</th>
<th>Date surveyed =</th>
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<table>
<thead>
<tr>
<th>X</th>
<th>Y</th>
<th>Village 1</th>
<th>Village 2</th>
<th>Village 3</th>
<th>Village 4</th>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Name of child</th>
<th>Severe case (CASE / NOT IN PROGRAMME) Y / N</th>
<th>Severe case in OTP (COVERED / IN PROGRAMME) Y / N</th>
<th>Recovering case in OTP (IN PROGRAMME) Y/N</th>
<th>Comments</th>
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</table>
• Administer the “coverage failure” form for all severe cases that are not covered (i.e. not in OTP/TFC).
• All severe and moderate cases that are not covered should be issued a referral slip and given instruction about when and where to take their child.

**Coverage Failure Form**

Questions for caretakers of severe cases not in the programme

Survey Cluster: ____________________ Surveyed Village: ____________________

Full name of child: _____________________________________________

Do you think this child is malnourished? Yes |__| No |__|
If NO then STOP!

Do you know of a programme where this child could be treated?

Yes |__| No |__|
If NO then STOP!

Why is this child not being treated for malnutrition?

*Do not read these answers to the respondent. After each answer prompt by asking “Any other reason?” Tick the appropriate box for each answer given. More than one box may be ticked.*

<table>
<thead>
<tr>
<th>Child is in the supplementary feeding programme</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Lack of childcare / help with children (not willing to... detail why)</td>
<td></td>
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<tr>
<td>Mother / carer sick</td>
<td></td>
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<tr>
<td>Ashamed to go to the centre</td>
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<td>The programme is closed / not running any more</td>
<td></td>
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<td>I need to be referred and there is no-one to do this</td>
<td></td>
</tr>
<tr>
<td>Reason</td>
<td>Comment</td>
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<td>-----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Do not know where to go</td>
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<tr>
<td>Programme is too far away</td>
<td></td>
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<tr>
<td>That programme is for people in another camp / village</td>
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<td>It is too dangerous to travel</td>
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<td>My husband or family will not let me go</td>
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<td>Programme staff request money (detail: heard it, experienced it?)</td>
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<td>Programme staff are rude or difficult</td>
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<tr>
<td>Programme runs on the wrong days</td>
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<tr>
<td>Waiting times are too long</td>
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<tr>
<td>Child (or sibling) was rejected previously</td>
<td></td>
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<tr>
<td>Child (or sibling) was in OTP/TFC and discharged</td>
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<td>My child is undressed in the centre for weighing</td>
<td></td>
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<tr>
<td>Child (or sibling) was in programme and defaulted (reason?)</td>
<td></td>
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<td>Other children were rejected</td>
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<tr>
<td>Programme is not good (detail)</td>
<td></td>
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<tr>
<td>Programme staff in the centre is favouring only their own tribe</td>
<td></td>
</tr>
<tr>
<td>Programme staff in the centre don’t speak my language (different ib )</td>
<td></td>
</tr>
</tbody>
</table>

Record any other reasons given:

__________________________________________________________________
__________________________________________________________________

Now give the caretaker a referral slip and tell him where to go and when
CASE-FINDING PROCEDURE

Ask the leader to provide you with a guide/informant to show you houses with oedematous, thin and sick children and children in the program (Specifically, ask for HEW, CHW’s, TBAs and or a woman who knows all the mothers of U5s in the villages).

Ask the guide to take you to houses with oedematous, thin and sick children and children in the program.

Go to the first household identified by the guide or the leader.

When you arrive at an identified household, introduce yourselves, the program, and explain why you are there and what you will be doing. Then start assessing the child.

Is the child between 6-59 months of age? To confirm the age ask for vaccination card and calculate the age in months (if no card use calendar of events to calculate the age of the child)

No
Thank the career and ask the mother of this child if she knows of any children that might be oedematous, thin or sick, or in the program. Then move on.

Yes
Check Oedema, take MUAC
The child has bilateral oedema or MUAC < 11.5cm?
If yes, is he in the OTP programme?
If not, is he in the OTP programme? (not a case)

No (for cases not in the programme)
Fill the form then fill up the questionnaire for children who are not in the program and refer the child to the appropriate programme.

Yes
Fill the form
Thank the mother, and ask her if she knows of any children that might be oedematous, thin or sick, or in the program.
Then move on.
Remember

1) After you have assessed the children in the selected household, always ask the mother if she knows of any children that might be oedematous, thin or sick, or in the program. Then move on to the selected household.
2) Always ask if any child from the village is currently in hospital or at a health centre. If so, get the name of the child and mother and make sure you measure him / her in the health facility.
3) If a mother with oedematous, thin and sick child is away from the village, go where she is and measure the child.
4) If a mother with a child in a program is away from the village, take the name and age of the child, verify in the OTP register

SQUEAC

OVERALL EVALUATION OF PRESENTATION

1. Please take a moment to answer the following questions. Your comments are an important contribution as we design learning experiences to meet your professional needs.

What will you do differently in your practice/service setting as a result of this training?

What do you feel were the strengths of this presentation?

What do you feel were the weaknesses of this presentation?

How can we improve this presentation?
What **additional** training-development education do you require?

2. Please rate the following statements using a 1 through 5 scale where:
   - **1 = Disagree Strongly**
   - **5 = Agree Strongly**

   - [ ] I can **apply the information** in my practice/service setting.
   - [ ] The presentation met my professional **field needs**.
   - [ ] The trainer **actively involved** me in the learning process.

**Training Evaluation Form**

Please indicate your impressions of the items listed below.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The training met my expectations.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>2. I will be able to apply the knowledge learned.</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>3. The training objectives for each topic were identified and followed.</td>
<td>[ ]</td>
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<td>4. The content was organized and easy to follow.</td>
<td>[ ]</td>
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<tr>
<td>5. The materials distributed were pertinent and useful.</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>7. The quality of instruction was good.</td>
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<td>[ ]</td>
<td>[ ]</td>
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</tbody>
</table>
8. The trainer met the training objectives.

9. Class participation and interaction were encouraged.

10. Adequate time was provided for questions and discussion.

11. How do you rate the training overall?

   Excellent   Good   Average   Poor   Very poor
   ○          ○          ○          ○          ○

10. What aspects of the training could be improved?