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COVERAGE MONITORING NETWORK

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# STATE OF SAM COVERAGE

## AN OVERVIEW FROM 2013 & 2014

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## Acknowledgements

This document was produced by Jose Luis Alvarez Moran, Sophie Woodhead and Saul Guerrero. The authors would also like to thank Sabine Appleby and Kaiser Esquillo for their meaningful contributions.

**Proposed Citation:** Coverage Monitoring Network (2015) State of SAM Coverage: An Overview from 2013 & 2014 (London, August 2015)

This document has been produced with the financial assistance of the European Commission. The views expressed herein should not be taken, in any way, to reflect the official opinion of the European Commission.

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# INTRODUCTION

Programme coverage is one of the most useful and reliable indicators to measure the performance of Community Based Management of Acute Malnutrition (CMAM) programmes. There are many indicators (e.g. cure rates, average length of stay, average weight gain) to measure effectiveness, but only treatment coverage provides a reliable measure of impact, by measuring the proportion of needs met by an intervention. The recent development of comprehensive and innovative coverage monitoring tools (including SQUEAC and SLEAC) by Valid International/Food and Nutrition Technical Assistance (FANTA) has provided the means by which to measure programme coverage practically and easily.

The importance of coverage has been recognised in the Lancet<sup>1</sup> and by the SUN movement. Treatment has significantly increased from approximately 1,000,000 in 2009 to 2,900,000 in 2012<sup>2</sup>. To better understand the challenges to service delivery, The State of SAM Coverage<sup>3</sup> was released in 2012. Since then there have been no global updates. The 2012 report estimated that 7 to 13 per cent of the SAM caseload was being treated.

It is still difficult to calculate a global number, due to the limited use of direct estimations at national level and the unavailability of nutrition information. This report will therefore focus on direct estimates at subnational level collected by the Coverage Monitoring Network (CMN). This paper does not attempt to provide global data or an in-depth view of the coverage situation around the world. Given the lack of access to the former, this document explores, in a synthesised format, available direct coverage estimations.

The majority of the data is derived from assessments using the Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) or Simplified LOAS Evaluation of Access and Coverage (SLEAC) methods. This data is compiled by the CMN in to a global database.

Different indicators can be used to evaluate coverage. The following sections focus on treatment coverage which reflects the accessibility and use of therapeutic programs. Geographical coverage is also useful to measure availability of services; however this data was not available.

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<sup>1</sup> The struggle for universal health coverage. The Lancet, Volume 380, Issue 9845, 859

<sup>2</sup> UNICEF. nutridash 2013: Global report on the pilot year. New York: UNICEF, 2014.

<sup>3</sup> The State of Global SAM Management Coverage 2012 (New York & London, August 2012)



# AVAILABILITY OF COVERAGE INFORMATION

Data from 24 countries is available for the years 2013 and 2014. In 2013, 22 out of 24 countries were able to report coverage estimates. Central African Republic and Côte d'Ivoire were lacking data in 2013. In 2014, only 14 countries out of 24 were able to provide estimates. A total of 130 programs were assessed and are included in this report, but they are not evenly spread among the 26 countries as can be seen in Figure 1 below.

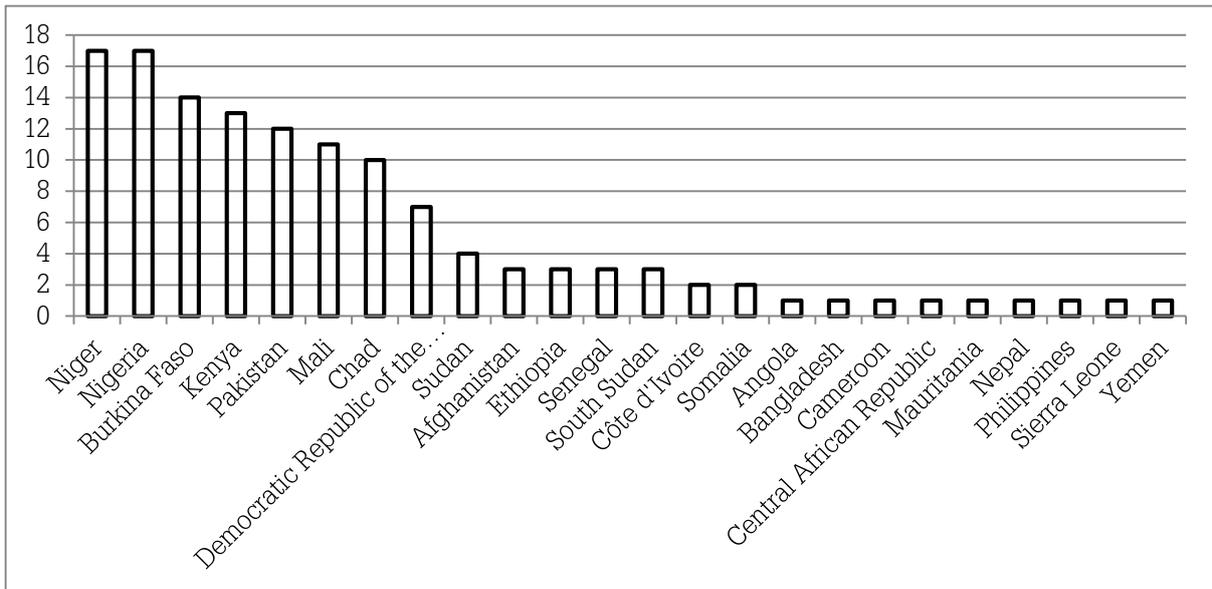


Figure 1. Amount of Assessments by Country, 2013 & 2014



Amount of Assessments by Country



Figure 2. Map of Assessments by Country, 2013 & 2014



# COVERAGE DATA BY LOCATION SETTING

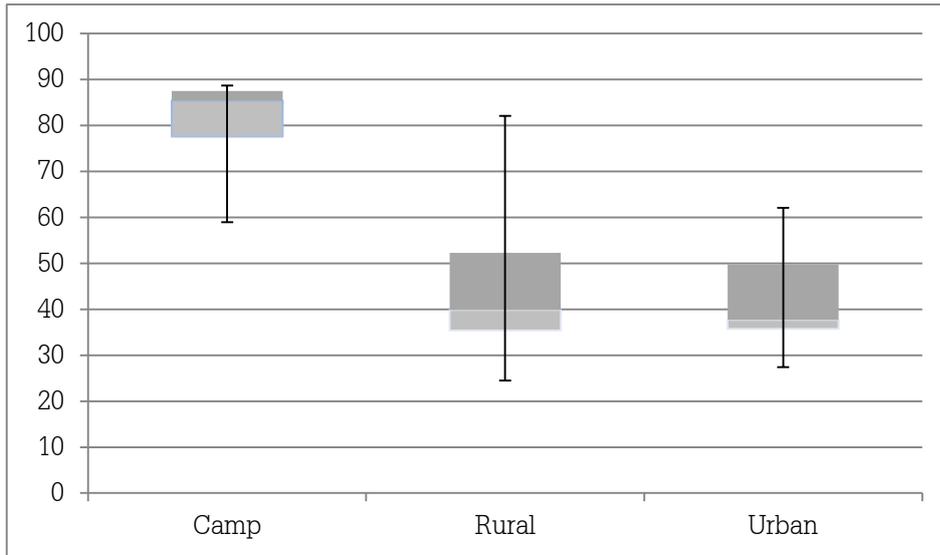
It is important to look at the coverage estimates in relation to their location setting. The SPHERE standards<sup>4</sup> recognise a difference in minimum standards for coverage in rural, urban and camp settings. Program data was therefore also categorized as rural, urban and camps. 4 out of 26 countries (Ethiopia, Pakistan, Somalia and Sudan) reported coverage from camps in 2013 while 7 countries reported coverage from urban locations from 2013-2014. There was no reported coverage from camps in 2014. The following table summarizes the coverage findings in each country.

Table 1. Direct Estimates of Coverage of SAM Treatment 2013-2014

| Country                          | 2013                        |   | 2014                        |   | Setting     |
|----------------------------------|-----------------------------|---|-----------------------------|---|-------------|
|                                  | Count of Programme coverage | Range of direct estimates of SAM program coverage (%) | Count of Programme coverage | Range of direct estimates of SAM program coverage (%) |             |
| Afghanistan                      | 2                           | 36  | 1                           | 25  | Urban/Rural |
| Angola                           | 1                           |   |                             |   | Rural       |
| Bangladesh                       | 1                           | 61  |                             |   | Rural       |
| Burkina Faso                     | 5                           | 26-46   | 9                           | 35-62   | Rural       |
| Cameroon                         | 1                           | 35  |                             |   | Urban       |
| Central African Republic         |                             |   | 1                           | 38  | Urban       |
| Chad                             | 7                           | 20-44   | 3                           | 28-46   | Rural       |
| Côte d'Ivoire                    |                             |   | 2                           | 39  | Rural       |
| Democratic Republic of the Congo | 5                           | 14-51   | 2                           | 41-51   | Rural       |
| Ethiopia                         | 2                           | 89-91   | 1                           | 42  | Camp/Rural  |
| Kenya                            | 12                          | 22-67   | 1                           | 33  | Urban/Rural |
| Mali                             | 3                           | 25-86   | 8                           | 11-46   | Rural       |
| Mauritania                       | 1                           | 35  |                             |   | Rural       |
| Nepal                            | 1                           | 41  |                             |   | Rural       |
| Niger                            | 13                          | 20-61   | 4                           | 20-53   | Urban/Rural |
| Nigeria                          | 4                           | 14-50   | 13                          | 14-88   | Rural/Urban |
| Pakistan                         | 10                          | 37-87   | 2                           | 55-57   | Camp/Rural  |
| Philippines                      | 1                           | 33  |                             |   | Rural       |
| Senegal                          | 2                           | 12-41   | 1                           | 41  | Rural       |
| Sierra Leone                     | 1                           | 62  |                             |   | Urban       |
| Somalia                          | 2                           | 82-85   |                             |   | Camp        |
| South Sudan                      | 2                           | 24-51   | 1                           | 47  | Rural       |
| Sudan                            | 4                           | 43-75   |                             |   | Rural/Camp  |
| Yemen                            | 1                           | 62  |                             |   | Rural       |

Source: based on SQUEAC data compiled by the Coverage Monitoring Network (CMN).

<sup>4</sup> Spherehandbook.org, (2015). The Sphere Handbook | Management of acute malnutrition and micronutrient deficiencies standard 2: Severe acute malnutrition. [online]



While not much difference can be seen between Rural and Urban settings, Camp settings do indeed have higher coverage rates. The range of coverage estimates is most evident in the rural setting.

Figure 3. Coverage Data by Location Setting

## COVERAGE DATA BY POPULATION TYPE

Populations were classified as “Pastoralist”, “Sedentary”, and “Sedentary and Pastoralist”. From 2013-2014, 3 countries (Kenya, Mali and South Sudan) reported coverage from Pastoralist population while 11 out of 26 countries reported coverage from Sedentary and Pastoralist population. 10 of these 11 countries reported coverage from both Sedentary and Sedentary and Pastoralist population.

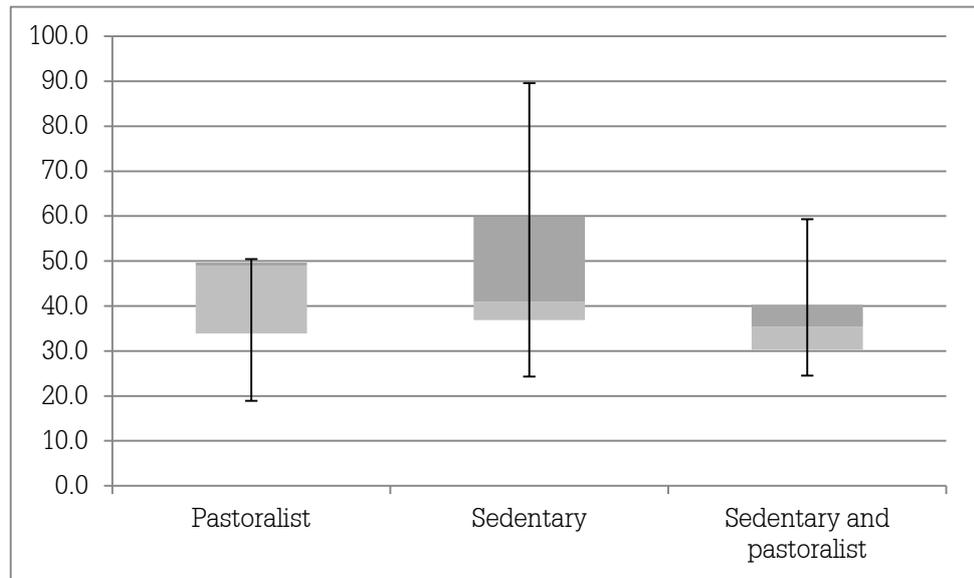
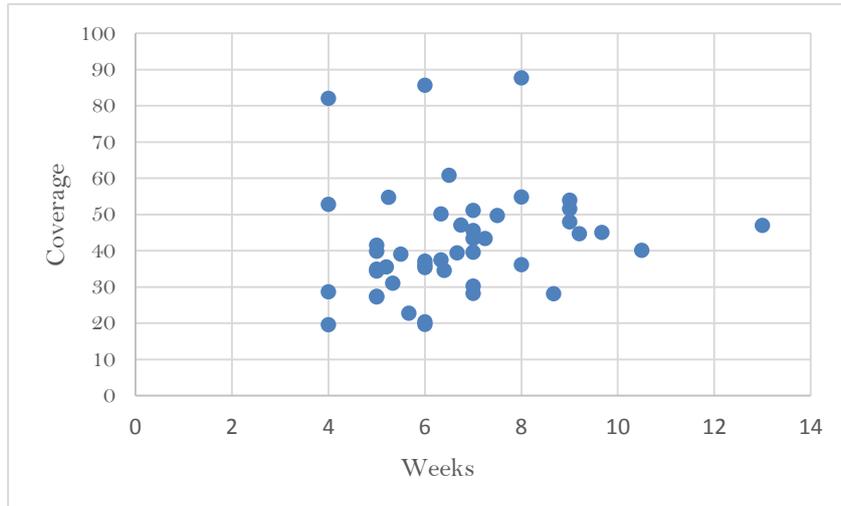


Figure 4. Coverage Data by Population Type

As the graph indicates, there is no marked difference in coverage rates by population type. This being said, it is clear that sedentary populations have a higher variability in coverage estimates.



## COVERAGE VS. LENGTH OF STAY



The median length of stay per discharged case is collected in coverage assessments. From all of the programmes assessed, the average length of stay was 7 weeks but Programs mean length of stay ranged from 4 to 14 weeks. As can be seen by Figure 5, no clear relationship can be identified by length of stay and programme coverage.

Figure 5. Programme Coverage by Length of Stay in Weeks

## COVERAGE VS. CURE AND DEFAULT RATES

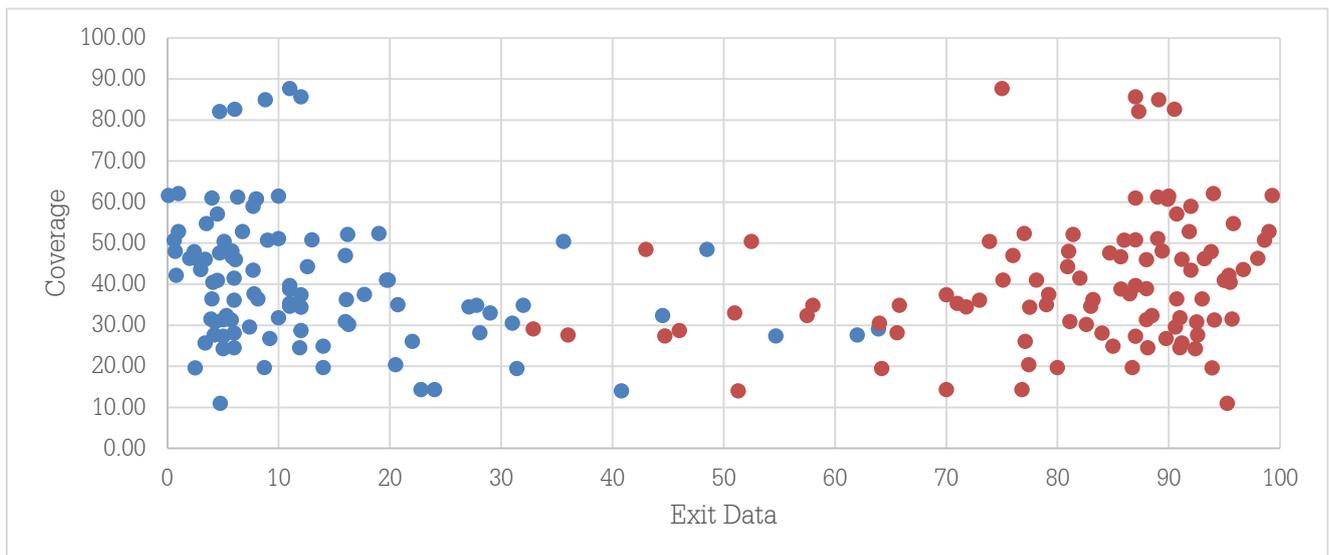


Figure 6. Programme Coverage by Cure and Default Rates

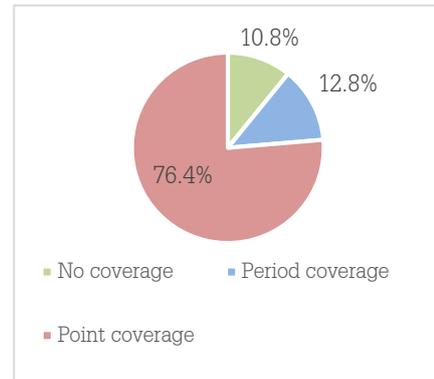
A correlation can be seen between poor programme outcomes and programme coverage. The lower the cure rate and the higher the default rate, the lower the programme coverage. This correlation, albeit weak, confirms the relationship between effectiveness and coverage.



# STATISTICAL CHARACTERISTICS OF THE SURVEYS IMPLEMENTED:

## Type of indicator, Precision and Sample Size

Coverage assessments can report coverage rates as Period Coverage or Point Coverage. In the graph below it can be seen that most of them is Point coverage and that there is a small amount that cannot calculate a coverage rate.



## SINGLE COVERAGE ESTIMATE

Currently two different estimators for coverage are used: point and period coverage. The first only includes current SAM cases whilst second includes current SAM cases and recovering cases. Depending on the context, one is preferably used; but it is not always easy to make this choice. That is why research has been conducted to create a unique estimator: the single coverage estimator.

$$\text{Singlecoverage} = \frac{C + R_{in}}{C_{in} + R_{in} + C_{out} + R_{out}}$$

$C_{in}$  = current SAM cases in the programme  
 $C_{out}$  = current SAM cases not in the programme  
 $R_{in}$  = recovering SAM cases in the programme  
 $R_{out}$  = recovering SAM cases not in the programme

As the single coverage estimator can be calculated from point and period coverage of previous coverage surveys, it will enable the coverage community to compare and analyse all the surveys done so far, thus ensuring continuity in the coverage assessments. Moreover, the use of the single coverage estimator does not affect the existing coverage assessments methods and tools.

Coverage methodologies indicate that precision for calculating coverage estimates should remain below 15%. Out of 130 assessments only 4 calculated the coverage estimates with a precision of 15 or more. The width of the coverage intervals (upper limit minus lower limit) of the estimates remain around 20% and in order to calculate those estimates a total of 11, 956 SAM cases were surveyed of which 4,088 were covered by CMAM programs.



# REASONS FOR NON-ATTENDANCE

During a SQUEAC or SLEAC investigation the caregivers whose children are not in the programme are asked for reasons why their child has not been able to access the service. This information provides highly valuable insight into the factors influencing attendance. For each coverage assessment, only the 5 top mentioned barriers were introduced in this analysis.

Results have not changed much since 2012, with awareness related issues dominating the reasons for non-attendance. Distance and Carer Busy are also important factors affecting many of the populations interviewed. This information highlights the fact that whilst there is the need to increase geographical coverage and catchment areas, this scale-up must be complemented by strengthened community sensitization and engagement activities.

## Addressing awareness through Community Engagement

### What is community engagement?

Several terms and definitions are used interchangeably throughout policy and programming to refer to community-focused approaches. A thorough review of this terminology was recently carried out which identifies the term community engagement as an overarching definition for “all interactions with the community”<sup>5</sup> encompassing sensitization, outreach and community participation in order to increase community participation, ownership, support and responsibility.

As such, the term community engagement is used to refer to any set of activities, which are established through a context-specific research resulting in greater uptake of CMAM services. It is important to highlight that community engagement refers to a comprehensive set of activities which do not simply look at one reference point between the health facility and the community, but a far broader set of individuals who make up the community. Without taking the community as a whole and engaging with multiple partners within that community, issues of uptake and

access will continue to exist. Community engagement is not a campaign, nor a series of campaigns. Nor is community engagement the same as social mobilization, advocacy, social marketing, participatory research or popular education. Although community engagement often makes use of these strategies, community engagement is not something done for the community but by the community.

The CMAM approach, despite its community-oriented intentions, remains standardized most of the time. Community engagement seeks to alter this.

### What is the process of community engagement?

As a rule of a thumb, community engagement activities need to be initiated and sustained during all stages of project management. With community engagement, the role of the implementing agency shifts from a more traditional service provider to that of a facilitator. In other words, an implementing agency, such as a health facility or NGO, should guide and mentor communities as they make their way through this step-by-step process.

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<sup>5</sup> Nell Gray, et al. Community Engagement: the ‘C’ at the heart of CMAM, CMAM Forum Technical Brief, August 2014.



Community involvement will thus create a strong sense of ownership of the program and contribute to resolving obstacles faced by target communities to access the services. To do so, it is extremely important to establish a reliable communication platform, which will allow for a continuous dialogue with communities and inspire their participation in the process. A village health committee, where communities can

voice their insights and identify new barriers as well as timely and jointly developed local solutions, is a good example of such structure.

The figure below provides concrete examples of community participation at different stages of Community Engagement Framework for CMAM programme.

**EXAMPLE OF COMMUNITY PARTICIPATION AT DIFFERENT STAGES OF COMMUNITY ENGAGEMENT FRAMEWORK FOR CMAM PROGRAMME**



Concrete guidance on the 5 stages of a Community Engagement Framework soon to be available on the [CMN website](#):

