COMPOSTELA VALLEY, THE PHILIPPINES
SEPTEMBER, 2013
Lovely Amin
ACKNOWLEDGEMENTS

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The assessment team would like to thank UNICEF Philippines, for providing the local funding for this assessment and the global funders, ECHO and USAID for funding the CMN project. Without these funding it would not have been possible to conduct this coverage assessment and train some national health and nutritional professional of Philippines on SQUEAC methodology.
EXECUTIVE SUMMARY

Introduction
The Philippines is one of the countries with the largest island groups in the world with 7,107 islands, lying off the southwest coast of the Asian mainland between Taiwan and Borneo. It is bounded in the west by the South China Sea, in the east by the Pacific Ocean, in the south by the Sulu and Celebes Seas, and in the north by the Bashi Channel. The country has three major islands; Luzon, Visayas, and Mindanao, divided into 17 administrative regions.

Mindanao is the second largest islands of the Philippines and is located in the south of the country. It has a total population of 21.6 million. Mindanao is consists of five regions which includes the Autonomous Region in Muslim Mindanao (ARMM). In ARMM region, Muslim makes up the 90% of the total population. The island Mindanao has been suffering from arm conflict therefore humanitarian assistance in the Philippines has mainly focused on the consequence of the arm conflicts. In addition, the island also prone to natural disasters, in December 2012 it was hard hit the cyclone Bopha. After the cyclone, as post emergency response for treating acute malnutrition, Integrated Management of Acute Malnutrition (IMAM) programme approach has been implemented by Local Government Unit, supported by ACF in Compostela Valley.

Methodology
A two stage investigation model of Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) methodology was used. This model includes: i) Analysis of the qualitative and quantitative data; ii) Generation and testing of the hypothesis of coverage rates by conducting a Small Area Survey and estimate the programme coverage classification.

Main Results

Stage -1

- The OTP admissions
The programme admission data of January 2013 to August 2013 showed that only 19 SAM cases aged between 6-59 months were admitted in the two municipalities, Monkayo and Montevista, of Compostela Valley, 70% of these were successfully treated and cured. In the SFP from May to August 94 MAM children were admitted. During this period all children exited from the SFP were discharged cured.

- The defaulters cases
The defaulter rate was found to be higher (30%) than the expected SPHERE minimum standard (<15%). The main reason for the defaulters was recorded as caretakers migrated to another area. Considering the very low admission in OTP, the defaulter rates need to be interpreted carefully.

1 http://en.wikipedia.org/wiki/Philippines#cite_note-census1-6
Community participation to this programme:
The findings of the community assessment determined that almost all of the community members are aware of the IMAM programme and their participation in this programme was found positive.

Screening at barangays
In the Philippines, all children 0-59 months are under the regular growth monitoring scheme. In addition, the Operation Timbang\(^4\) ensures that the growth of all children 0 - 71 months are monitored bi-annually. Hence no separate community level screening takes place for the IMAM programme. During the growth monitoring any child identified as malnourished by MUAC or WHO growth standard 2006, where there is an IMAM programme, is being referred to the OTP or SFP as appropriate.

Stage – 2

Hypothesis testing
The hypothesis that was generated after stage 1 data collection and analysis was tested in stage 2. The hypothesis was ‘Health centers with high admissions have high coverage and Health centers with low admissions have low coverage’. The survey results determined that the hypothesis was not ‘confirmed’.

Estimated Coverage classification (results from small area survey)
The final coverage classification estimation was done after the ‘Small Area Survey’. No SAM case was found in the surveyed area, therefore, no coverage classification has been obtained for OTP. For the SFP, the ‘point’ coverage classification is estimated at <50%. This SFP coverage estimation lies below the SPHERE standard for rural area, >50%.

Main Barriers:
The main barriers found in the assessment are: inaccessibility to health services due to long distance, difficult terrains, and competing workload (economic work versus attending the health centre); no incentives to the health team, and insufficient supplies and equipment to carry out IMAM activities efficiently by the health centre etc.

Key Recommendations:
• Identify hard to reach areas for health services, advocate to the Local Government Unit (LGU) the establishment of ‘health post’ for those areas.
• Strengthen the IYCF practices within the communities. Linking vulnerable families with the livelihood programme.
• Conduct refresher course for health centre staff and review the IMAM protocol by all implementing partners.
• Improve hygiene practices; improve provision of water and sanitation facilities.
• Ensure coordination among NGOs and all nutrition teams receive the same incentives for their work.

\(^4\) OPT (Operation Timbang) – “timbang” means weighing; a regular growth monitoring program conducted by the Department of Health
### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACF</td>
<td>Action Contre la Faim / Action Against Hunger</td>
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<tr>
<td>ARMM</td>
<td>Autonomous Region of Muslim Mindanao</td>
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<td>BHW</td>
<td>Barangay Health Worker&lt;sup&gt;5&lt;/sup&gt;</td>
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<tr>
<td>BNS</td>
<td>Barangay Nutrition Scholar&lt;sup&gt;6&lt;/sup&gt;</td>
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<tr>
<td>CMAM</td>
<td>Community based Management of Acute Malnutrition</td>
</tr>
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<td>CMN</td>
<td>Coverage Monitoring Network</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>GAM</td>
<td>Global Acute Malnutrition</td>
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<td>IMAM</td>
<td>Integrated Management of Acute Malnutrition</td>
</tr>
<tr>
<td>INGO</td>
<td>International Non-Government Organisation</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interviews</td>
</tr>
<tr>
<td>LoS</td>
<td>Length of Stay</td>
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<td>MAM</td>
<td>Moderate Acute Malnutrition</td>
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<td>MNAO</td>
<td>Municipal Nutrition Action Officer</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
</tr>
<tr>
<td>NNGO</td>
<td>National Non-Government Organisation</td>
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<tr>
<td>OTP</td>
<td>Outpatient Therapeutic Programme</td>
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<tr>
<td>PGN</td>
<td>Promotion of Good Nutrition</td>
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<tr>
<td>PNAO</td>
<td>Provincial Nutrition Action Officer</td>
</tr>
<tr>
<td>PNC</td>
<td>Provincial Nutrition Committee</td>
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<tr>
<td>RUTF</td>
<td>Ready to Use Therapeutic Food</td>
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<tr>
<td>SAM</td>
<td>Severe Acute Malnutrition</td>
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<tr>
<td>SC</td>
<td>Stabilisation Centre</td>
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<tr>
<td>SSI</td>
<td>Semi Structured Interview</td>
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<tr>
<td>SQUEAC</td>
<td>Semi Quantitative Evaluation of Access and Coverage</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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</table>

<sup>5</sup> Civilian Volunteer, Village Health Workers

<sup>6</sup> Civilian Volunteer, Village Nutrition Workers
1. INTRODUCTION

1.1 COUNTRY CONTEXT

The Philippines is one of the countries with the largest island groups in the world with 7,107 islands, lying off the southwest coast of the Asian mainland between Taiwan and Borneo. It is bounded in the west by the South China Sea, in the east by the Pacific Ocean, in the south by the Sulu and Celebes Seas, and in the north by the Bashi Channel. It has a total land area of 300,000 km² and a coastline of 34,000 km, the longest in the world.

The country has three major islands – Luzon, Visayas, and Mindanao, divided into 17 administrative regions. The country has a population of more than 98 million people, the Philippines is the seventh most populated Asian country and the 12th most populated country in the world. An additional 12 million Filipinos are living overseas as migrant workers.

The island Mindanao has been suffering from armed conflict between the government and the separatist groups for more than four decades. Therefore, humanitarian assistance in the Philippines has mainly been focused on the consequence of the armed conflicts. In addition, the country also prone to natural disasters, almost every year there cyclone, typhoon and floods cause catastrophic.

1.2 CONTEXT OF MINDANAO

Mindanao is the second largest of the Philippines’ 7107 islands and is located in the south of the country. It has a total population of 21.6 million as of August 2007. Mindanao consists of regions IX, X, XI, XII, XIII and Autonomous Region in Muslim Mindanao (ARMM), which are further divided into 26 provinces, 422 municipalities and 33 cities. In the ARMM region, Muslim makes up 90% of the total population. Despite an abundance of natural resources, ARMM and Region XII of Central Mindanao are also known as among the poorest in the country which can partly be attributed to political instability including armed conflicts in the region.

In Mindanao, over 36 percent of the population lives below the poverty line according to the United Nations Development Programme (UNDP) report. Many people in central Mindanao do not have access to adequate healthcare, water and sanitation facilities and nutritious food causing widespread malnutrition. In addition to political instability, natural disaster such as droughts, typhoons, floods, poor productivity, under-investment in rural infrastructure, unequal land and income distribution, high

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7 General information about Philippines, http://park.org/Philippines/government/geninfo.htm
8 http://en.wikipedia.org/wiki/Philippines#cite_note-census1-6
9 http://en.wikipedia.org/wiki/Philippines#cite_note-13
12 ACF country briefing paper, 2013
population growth and the low quality of social services lie at the root of rural poverty and poor nutrition status in Central Mindanao\textsuperscript{13}.

A number of stakeholders are working in Mindanao towards improving nutritional status of the population. These include the Department of Health (DoH), the National Nutrition Council (NNC) an agency under the DoH, Local Government Units (LGU), UNICEF and WFP, NNGOs, i.e. MERN, the Assisi Foundation and PIE for Life and INGOs like Save the children, Merlin, MSF, The German Doctors and ACF to name few.

In the Mindanao, ACF has been responding to different emergencies, both complex emergencies in the conflict affected area and during natural disaster, since 2000. ACF responds to emergencies with lifesaving interventions and implements programme for post emergency recovery as well for the longer term development. All of ACF’s interventions are coordinated with the local government units, NGOs and INGOs partners, UN agencies, Clusters and other stakeholders to ensure coordinated and effective sustainable response to any situation.

**Integrated Management of Acute Malnutrition (IMAM)**

Integrated Management of Acute Malnutrition (IMAM) was adopted from a set of international standard guidelines replacing the use of less effective methods of diagnosing and treating acute malnutrition cases. IMAM is a community based approach; this approach brings the treatment to the people rather than bringing the people to the treatment facility. Through these guidelines, the Barangay Health Workers (BHW) and Barangay Nutrition Scholars (BNS) can treat acute malnutrition including carrying out the screening at the community and evacuation camp, identify and refer the acute malnourished cases for treatment in the outpatient programmes (OTP), supplementary feeding programme (SFP) or stabilisation centre (SC) as appropriate. The IMAM approach in the Philippines is guided by the draft Philippines IMAM guidelines, developed mainly by DoH, NNC, Philippines Paediatric Society, UNICEF, WHO and Nutrition Cluster Partners of Philippines, etc. November 2011.

**IMAM PROGRAMME IN COMPOSTELA VALLEY**

Typhoon Bopha, locally known as Pablo, hit the Philippines in December 2012 affecting 9 out of 13 regions of the country. In Davao region, the provinces of Compostela Valley and Davao Oriental were hit hard, damaging the livelihoods fully or partially, of more than 678,000 people and 518,000 people respectively\textsuperscript{14}. The Compostela Valley and Davao Oriental are among the poorest provinces in the country with poor nutritional and health indicators. Taking into consideration the poor nutritional status of the province prior to the typhoon, the nutrition cluster called for a post typhoon emergency response for nutrition. The nutrition programme was implemented using IMAM approach along with IYCF-E (Infant and Young Child Feeding in Emergency) and Care Practices.

\textsuperscript{13} AusAID, Philippines Country Profile; Available at: http://www.ausaid.gov.au/country/country.cfm?CountryID=31

\textsuperscript{14} Pablo rips through Mindanao, ABS-CBNnews.com http://www.abs-cbnnews.com/nation/regions/12/04/12/
Following the call for an emergency nutrition programme, three INGOs, ACF-International, Save the Children and Merlin developed a consortium programme proposal for the Integrated Management of Acute Malnutrition (IMAM) targeting five municipalities that were badly affected by typhoon Bopha. The intervention was planned for nine months, initially as an emergency response from January to April 2013, which was funded by UNICEF. Then for the early recovery phase, the same programme continued from May to October 2013, by all three organisations but on a smaller scale for Compostela Valley. In this phase, the targeted municipalities were reduced to two for Compostela Valley while in Davao Oriental they continued with all three municipalities. For the early recovery phase funding was secured from ECHO. The Supplementary Feeding Programme (SFP) was managed by the local government unit which was funded by WFP.

The acute malnutrition cases that present with medical complications were referred to Compostela Valley Provincial Hospital (CVPH) Montevista, a district, level hospital with 25 beds. In this hospital, one doctor and ten nurses were trained for in-patient care services for complicated malnourished cases. Also fifteen other hospital staff (dieticians, midwives, nursing aides) was oriented about malnutrition, IMAM and inpatient care services.

From January to August 2013, there were 7 SAM cases referred with medical complications to CVPH and were successfully treated and referred back to their respective OTP sites. The most common medical complications were recorded as pneumonia and loss of appetite.

After 8 months of active support and assistants from the consortium to LGUs, the IMAM programme is now being slowly handed-over to the LGU. Before fully handing over the programme, the implementing agencies, (consortium, local government and nutrition cluster) would like to assess the programme coverage. This was to find out the impact this intervention has made to the nutrition situation of the targeted municipalities, therefore the coverage assessment was carried out. The result of the coverage assessment will be utilised to improve the programme, just in time while the local government is preparing its annual Health and Nutrition budget for 2014. The three INGOs will support the local government in establishing a sustainable and efficient Health and Nutrition programme as part of their exit strategies.

The coverage assessment was conducted in two municipalities, Monkayo and Montevista of Compostela Valley (Figure 1) using the SQUEAC methodology. The main objective of the SQUEAC methodology is to improve the routine monitoring activities, and identify the potential barriers to access services. The findings intend to facilitate optimum coverage of the programme. The coverage assessment was funded jointly by the Coverage Monitoring Network (CMN) and UNICEF, Philippines.
A team of health and nutrition professionals of ACF, the Local Government Unit, of the Compostela Valley were trained in the SQUEAC methodology. The aim was to assess the programme coverage while building the local capacity and to continue with the coverage monitoring assessment in the region in the coming months and years.

The coverage assessment and training on the coverage assessment methodology was commissioned to the Coverage Monitoring Network (CMN). The CMN project is a joint initiative by ACF, Save the Children, International Medical Corps, Concern Worldwide, Helen Keller International and Valid International. The programme is funded by ECHO and USAID. This project aims to increase and improve coverage monitoring of the CMAM/IMAM programme globally and build capacities of national and international nutrition professionals; in particular across the West, Central, East & Southern African countries where the CMAM approach is used to treat acute malnutrition. It also aims to identify, analyse and share lessons learned to improve the CMAM policy and practice across the areas with a high prevalence of acute malnutrition. The project is mainly focus on building skills in Semi Qualitative Evaluation of Access and Coverage (SQUEAC) methodology.

Figure: 1. The Map of Davao Region
2. PURPOSE OF THE ASSESSMENT

There are two main purposes of this assessment; one was to determine the programme coverage of Compostela Valley IMAM programme; two was to provide training and build skills of key nutrition staff of the ACF and the nutrition staff Local Government Unit of Compostela Valley, Mindanao, the Philippines on SQUEAC methodology. The assessment also focused on how to strengthen quality and utilisation of the programme’s routine monitoring data as well as how to improve the programme coverage.

2.1 Specific Objectives
1. To determine the coverage train the ACF staff and the LGU staff, to conduct the coverage survey using the SQUEAC methodology.
2. Assess the data quality whilst in the field and during data entry and analysis during SQUEAC survey implementation in the Compostela Valley.
3. Identify factors affecting access to IMAM services in the Compostela Valley and find possible solutions to these barriers using data gathered from those cases found with acute malnutrition and not admitted in the programme at the time of the survey.
4. Determine the IMAM programme coverage in the Compostela Valley.
5. Develop specific recommendations in collaboration with ACF and LGU to improve acceptance and programme coverage in the programme areas.

2.2 EXPECTED OUTPUT
- Implementation of coverage assessment in Compostela Valley
- Train team on SQUEAC methodology
- Produce final coverage survey report for the Compostela Valley IMAM programme.

2.3 DURATION OF THE ASSESSMENT & THE TRAINING
   September 5th to September 18th 2013 (Annex 1)

2.4 PARTICIPANTS
A total of 20 staff were trained for the SQUEAC method, from which, 11 were from ACF Compostela Valley, 9 from LGUs, that includes municipalities and provincial nutrition team (Annex 2)
3. METHODOLOGY

The Integrated Management of Acute Malnutrition (IMAM) programme in Compostela Valley, Davao province was an emergency as well as an early recovery programme after the typhoon Bopha. To assess service quality and coverage of the programme, the Semi-Quantitative Evaluation of Access and Coverage methodology was used. The SQUEAC methodology was developed to provide an efficient and accurate method of identifying existing barriers to access services, opportunities that can be exploited and assessing coverage in an emergency as well as non-emergency context. This approach places a relatively low demand on logistical, financial and human resources but provides detailed information. To estimate coverage, some Barangays were sampled, finding malnourished cases and if they were in programme, the coverage classification was estimated and the principle factors preventing higher coverage in targeted areas were identified. SQUEAC coverage assessment generally uses three stages of investigation model. For this assessment a two stage SQUEAC investigation model was used due to short term recovery programme and the small geographical area of intervention. This two stage model includes;

- **Stage 1**, gathering and analysing qualitative (contextual data) and quantitative (programme routine data) data.
- **Stage 2**, conducting a ‘Small area survey’ in the communities with the highest and lowest admissions in the OTPs & SFPs/Barangay Health Centre and compare results with SPHERE minimum standard

3.1 STAGE 1

**Quantitative and qualitative data analysis to understand barriers/boosters to coverage**

In stage one, existing routine programme data which have been collected and compiled from March 2013 to August 2013 for OTP and SFP were gathered and analysed. In addition to the routine programme data, qualitative data were collected by the teams from the IMAM programme area of two municipalities, Monkayo and Montevista of Compostela Valley. The data (both qualitative and quantitative) were collected using various methods and sources.

The qualitative data collection aimed at understanding the perception of the target population on the programme and the programme implementers. A generic questionnaire was developed and utilised to guide the data collection from communities about their knowledge on malnutrition, perceptions of the IMAM programme, their participation in the programme, health and care seeking behaviours and common practices of treating malnutrition etc. (Annex 3). The data collectors were then trained on how to

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15 Mark Myatt, Daniel Jones, Ephrem Enmu, Saul Guerrero, Lionella Fieschi. SQUEAC & SLEAC: Low resource methods for evaluating access and coverage in selective feeding programs.

16 The Sphere Project Humanitarian Charter and Minimum Standards in Disaster Response, 2004
conduct the interviews and how to facilitate focus group discussions (FGDs). The methods used were FGDs and Key Informant Interviews (KII), see the below table for details. Open ended generic questionnaires were used for FGDs and KII.

The information was collected using the following methods and sources:

<table>
<thead>
<tr>
<th>Methods</th>
<th>Sources</th>
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<tbody>
<tr>
<td>Key Informants Interview (KII)</td>
<td>Barangay Captains, Women leaders, IP leaders, Traditional Healers</td>
</tr>
<tr>
<td>Focus Group Discussions (FGDs)</td>
<td>Caretakers of OTP and SFP children, OTP staff (BNS, BWH and Midwives)</td>
</tr>
<tr>
<td>Semi Structured Interview (SSI)</td>
<td>Mothers of children with SAM who are ‘not in Programme’</td>
</tr>
<tr>
<td>Seasonal Calendar (Fit to Context and Seasonality)</td>
<td>Community and the assessment team</td>
</tr>
</tbody>
</table>

Information was gathered and triangulated until the questions had been answered. Based on the findings from routine data and information gathered from communities, the barriers and boosters were identified and questions were generated for further investigation.

**Boosters and Barriers (Mind Map)**

From Compostela Valley, IMAM programme information that was gathered from different sources through various methods was plotted on the ‘Mindmap’ which is a graphical way of storing and organising data and ideas around a central theme, the coverage. At the same time information was simultaneously transferred to the X-Mind programme (Annex 4). This information was used to summarise the findings of the SQUEAC assessment and, was drawn and modified as the assessment proceeded. Information from the Mindmap was grouped as barriers or boosters, and then each element was weighed and scored that determining the coverage. The scoring was done by the assessment team based on the weight of each element. The scale used rating from 1-7 to score ‘barriers’ and ‘boosters’ (Figure 2). The team scored each booster and barrier separately as it was expected that the scoring would differ among groups. However in this
case the scoring did not differ to a great extent. The final scoring for each booster and barrier was agreed and assigned using the average scores. These average scores for each category were added to “build up” from zero (i.e. lowest possible coverage) and to “knock down” from 100% (i.e. highest possible coverage). Using the averages from these estimates the upper and lower expected values of coverage were then estimated (Table-1).

**Table: 1 Boosters & Barriers, ACF Compostela Valley, September 2013**

<table>
<thead>
<tr>
<th>Boosters</th>
<th>Values</th>
<th>Values</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>Good coordination between LGU and stakeholders</td>
<td>7 6</td>
<td>Inaccessibility, Distance, Workload/Lack of Income</td>
<td></td>
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<tr>
<td>Community awareness on IMAM program</td>
<td>6 5</td>
<td>Lack of support from local Government Units, Equipment/Supplies funds for malnutrition programs</td>
<td></td>
</tr>
<tr>
<td>Orientation of Community leaders, day care workers, school nutrition coordinator ad IMAM program</td>
<td>6 4</td>
<td>Poor attitude of Health workers towards clients</td>
<td></td>
</tr>
<tr>
<td>Adequate training on IMAM</td>
<td>6 6.5</td>
<td>Poor care practices, Poor food diversification/utilization, poor hygiene and sanitation practices</td>
<td></td>
</tr>
<tr>
<td>Adequate Supplies and equipment</td>
<td>6 5.5</td>
<td>Poor community mobilization</td>
<td></td>
</tr>
<tr>
<td>Positive attitude of Health workers towards IMAM</td>
<td>6 4</td>
<td>Poor community participation</td>
<td></td>
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<tr>
<td>Active community leaders</td>
<td>6.5 4.5</td>
<td>Unequal provision of incentives to the BNS by some Nutrition Partner</td>
<td></td>
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<tr>
<td>Acceptance of IMAM programme by community members</td>
<td>7 5</td>
<td>Both admission and discharge criteria not fully understood</td>
<td></td>
</tr>
<tr>
<td>Conducting nutritional Screening</td>
<td>6.5</td>
<td></td>
<td></td>
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<tr>
<td>Competency of OTP and SFP Personnel</td>
<td>6.5</td>
<td></td>
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<tr>
<td>Functional Referral system</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good supervision of IMAM by ACF (OTP) and PLGU (SFP)</td>
<td>7</td>
<td></td>
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<tr>
<td>Reactivation and reorganisation of the Barangay Nutrition Committees (BNC)</td>
<td>5.5</td>
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<tr>
<td>Little stigma on Malnutrition</td>
<td>4.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Added to Minimum Coverage (0%)</td>
<td>86.5 40.5</td>
<td>Subtracted from Maximum Coverage (100%)</td>
<td></td>
</tr>
<tr>
<td>0+86.5 = 86.5</td>
<td>100-40.5 = 59.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>86.5+59.5/2 = 73%</td>
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</tbody>
</table>
**Seasonal calendar**

In stage one, a seasonal calendar was developed in order to get a broader picture of the programme performance against the local context of the targeted area for IMAM programme. The seasonal calendar included agricultural labour, disease, hunger gaps, and meteorological changes. Generally, admission and defaulter trends are then compared to the seasonal calendar to determine, whether the programme was responding to seasonal changes and context-specific factors.

For Compostela Valley IMAM programme, a calendar was developed with the SQUEAC assessment team and mothers/caretakers of OTP/SFP children (figure 3), compared, and then a final calendar was developed. For this SQUEAC, the seasonal calendar was compared with the OTP admission only. This programme was short lived and only had few defaulters, therefore, a logical comparison is not possible to make with the defaulter trends. In addition, this programme was running from January to September 2013, therefore a year-long comparison is also not possible to make.

![Figure: 3 Seasonal Calendar, Compostela Valley, Sept. 2013](image)

3.2. **STAGE 2 ‘SMALL AREA SURVEY’**

The programme routine data and contextual data analysis (stage one) generated this question: “Does the areas with high admissions also have high coverage, and areas with low admissions consequently have low coverage?”

**Hypothesis formation**

Following the above question, a hypothesis was generated. Barangay health centres with high admission in OTPs and SFPs, have high coverage rates while Barangay health centres with low admissions at OTPs and SFPs have low coverage rates.
To test the hypothesis, eight barangays out of the 16 implementation sites were systematically selected and surveyed to see whether areas with high admissions indeed have high coverage and areas with low admissions indeed have low coverage. Four barangay health centres were selected with the highest number of admissions and four barangay health centres were selected with the lowest number admissions were recorded from January to August 2013.

For this assessment it was decided to analyse both SFP and OTP data as the OTP admission in this programme was very low. Therefore in this small area survey both SAM and MAM cases were actively searched for.

In stage two, to estimate the coverage classification in total eleven barangays were surveyed. The survey was conducted in two days by the eight teams. Sample size was not necessary to calculate in advance for this survey. The survey sample size was the number of SAM and MAM children found by the surveyors in the sampled barangays in two days. Based on coverage threshold for rural area noted in SPHERE minimum standard, 50% coverage was defined as adequate coverage.

Questionnaires were developed to record the cases (SAM & MAM), including both current cases and recovering cases (Annex 5a). The data were collected using active, adaptive and door to door case-finding methods (Figure 4).

Figure 4: Measuring with MUAC, Small area survey

**ACTIVE:** The method actively searched for cases rather than just expecting cases to be found in a sample.

**ADAPTIVE/DOOR TO DOOR CASE FINDINGS:** The method was used based from the information gathered during the case-finding as the search progressed.

In this survey, together with adaptive methods, a door to door case finding method was utilized, especially to find the MAM cases. There were 1334 children age 6 to 59 months in eleven barangays measured. It was anticipated that almost all children in the eleven barangays will be measured within two days for the small area survey.
**Case Definition**

The admission criteria for SAM and MAM of the Philippines IMAM programme included children age between 6 and 59 months with at least one of the following criteria:

**For SAM to be admitted to OTP:**
1. A Mid Upper Arm Circumference (MUAC) of <11.5 cm and/or
2. Bilateral pitting oedema and/or
3. WHZ Score <-3

**For MAM to be admitted to SFP:**
1. A Mid Upper Arm Circumference (MUAC) of <12.5 cm and/or
2. WHZ Score <-2

The case definition used for Compostela Valley coverage survey was “a child matching one of the admission criteria (MUAC) of the OTP or SFP”. Thus, in this SQUEAC survey, a case is defined as a child with a MUAC of <11.5 cm and/or presence of bilateral pitting oedema for SAM; and a MUAC of <12.5 cm for MAM.

**Local terms for malnutrition in Compostela Valley**

For the SQUEAC assessment, local terms were used for case finding. Marasmus is known as “Niwang” or “Payat” and Nutritional oedema is known as “Hupong” or “Manas”. However, for the MAM case finding, a door to door survey was conducted, measured almost all children of sample areas age 6 to 59 months.

**Semi Structured Interview (SSI)**

Semi structured interviews were used as part of the small area surveys for the mothers/caretakers of malnourished children (both SAM and MAM) who were not attending the programme. A list of questions or ideas was developed and used in interviewing the main stakeholder (mothers/caregivers) of the programme (Annex 5b).
4. RESULTS

4.1 STAGE 1 PROGRAMME ROUTINE DATA & CONTEXTUAL DATA

Data collection:
Using the SQUEAC assessment guidelines, quantitative data were collected from routine programme data and qualitative data from the key informants of the eight targeted Barangays and health centres.

4.1.1 Programme Routine data analysis (from card & register books)

For this assessment data for both OTP and SFP were collected and analyzed. The data used for OTP programme are the routine data from January until August 2013; while the SFP programme routine data from May to August 2013 (SFP started late). Since the routine OTP data showed low admission despite active casefinding, there’s insufficient data to be analysed for the program indicators like cure rate, defaulter and death rates etc. during the SQUEAC. Therefore, the available data were reported by percentage and in actual number as appropriate.

Admission data
- Admissions trend and seasonal calendar
- Admissions by MUAC (MUAC status)
- Admission by age of children
- Admission by different Barangays

Programme performance indicators
- Cured rates
- Defaulter rates
- Death rates
- Non responded and transferred cases

Figure: 5 Programme Routine data analysis

SQUEAC assessment utilises programme's routine monitoring data (Figure: 5) that are accessible and directly related to programme quality and coverage to assess three things: i) the accuracy and appropriateness of the data related to the coverage & 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. This data are first analysed in isolation for comparison with the changing and seasonal context of the targeted area. This is to assess the programme’s capacity to respond to changes demanding for its services. However, since Compostela Valley emergency response and early recovery programme was short lived
emergency response and early recovery programme, therefore, very limited scope for comparison. Nonetheless, the routine data was compared to international standard indicators (SPHERE) related to the context of the implementation area.

Admissions data

**OTP and SFP admissions and cured discharged.**

The Compostela Valley IMAM programme has admitted 19 SAM cases to the OTP from January to August 2013. Of those, 70% SAM cases were successfully cured and discharged. The programme also admitted 94 MAM cases to the SFP from May to August 2013. Of those admitted, 100% were discharged cured.

**OTP admission and seasonal trends**

The assessment team in consultation with the community identified the seasons and the peak of childhood diseases occurrences. For this assessment, a yearlong comparison was not possible to make the duration of the emergency and recovery programme was short. However, according to the seasonal calendar below, acute respiratory tract infection (ARIs) are found to be linked with the rainy season, which starts in March and continues until April and start again in August at the end of the dry season. According to the eight months data, the peak season for malnutrition seems to start from the month of August which is correlated to ARI and the hunger gap. The figure below (Figure 6), indicates that the programme admissions to some extent follow the seasonal disease pattern and seasonal variation.

Figure: 6 Pattern of Admission and seasonal Calendar, Compostela Valley, Sept 2013
**SFP admission trends**
The programme routine data available for SFP were only from May to August 2013; therefore no comparison was possible with seasonal calendar. Following the data, it seems that at the beginning just after the disaster (typhoon), admission is high which by August reduced to very few cases (only 1 case) figure below: 7. This reflects the “after effect” of the emergency where case admission is expected to be high at the start and gradually decrease as the emergency phase moves to recovery mode. This trend also indicates that the programme has found the cases, admitted and treated it successfully.

![Figure: 7 SFP Admission, Compostela Valley, Sept 2013](image)

**Admission to OTP by age group**
From the admission data, January to August 2013, it was found that over 53% of children who were admitted to OTPs aged between 6 to 24 months. The number of admissions is very low, therefore, interpretation of this pattern is limited, (Figure: 8).

![Figure: 8 Admission and age group, Compostela Valley](image)
**MUAC at the time of admission in OTP**

The admission MUAC is an important indicator which allows the programme team understand the timeliness of care seeking behaviours of the communities as well as the pro-activeness of the health centre staff on early screening and prompt referral of cases to the IMAM programme.

Of the cases that were admitted to OTPs, about 74% were admitted with <-3 Z-scores, their MUACs were measuring ≥115mm (figure below: 9). No oedema cases were identified during the eight months of the intervention. It therefore indicates that there was early case finding by the health centres and the communities were also seeking early treatment. There were very few admissions in OTPs, therefore the median MUAC is not practical to be calculated.

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**Figure: 9 Admission based on MUAC, Compostela Valley, Sept. 2013**
**OTP programme performance indicators**

The programme performance indicators are the proportion of exits from the programme (number of exit cured, defaulter, and death etc.). Percentages were used to assess the performance of the programme from March to September 2013, compared with the SPHERE minimum standards.

The chart below is showing the performance of the Compostela Valley IMAM programme compared with the SPHERE standards (Figure 10).

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Comval</th>
<th>SPHERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cured</td>
<td>70%</td>
<td>&gt;75%</td>
</tr>
<tr>
<td>Defaulter</td>
<td>30%</td>
<td>&lt;15%</td>
</tr>
<tr>
<td>Death</td>
<td>0%</td>
<td>&lt;10%</td>
</tr>
<tr>
<td>Non respondent</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Transferred</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

OTP performance data from the Compostela Valley IMAM programme determined that some performance indicators lie below the SPHERE standard. For example the cure rate is lower (70%) than the SPHERE minimum standard (>75%). On the other hand the defaulter rate is higher (30%) than SPHERE minimum standard (<15%). There was no death or the non-responders that were occurred and recorded during the intervention period. However, given that this programme has very few admissions and exits, this data specially the defaulter data needs to be carefully interpreted (Figure: 10).

Figure: 10 Programme Performance Indicators, Compostela Valley, Sept, 2013
**Defaulters’ information**

Defaulters are classified as uncured cases that have discontinued the OTP treatment. The numbers of defaulters were examined to determine if it is worryingly high and if it follows the seasonal context over time. For the Compostela Valley programme, there were only 4 cases defaulted, 3 cases from Monkayo and 1 case from the Montevista OTP (figure below 12). When compared with the percentage of exited cases, 30% have defaulted. However, this percentage needs to be carefully interpreted as the number of admissions and exits are very few, therefore, percentage can inflate even with only few defaulters. Still, due to the short length of programme and few defaulter cases, no comparison was made between defaulter and seasonal calendar such as the variation and seasonal activities.

**Reasons for defaulter**

Four cases defaulted from the Compostela Valley IMAM programme. The reasons for defaulting were cases were migration, long distance and refusal to continue with the treatment (Figure: 11).

![Reasons for defaulting, Compostela Valley, Sept 2013](image)

**The database and OTP & SFP record keeping:**

The OTP data provided by the team allowed the analysis of multiple indicators of the IMAM programme. There were no inconsistencies found in the data provided for different indicators. As part of field data collection, admission cards and OTP registers in some selected OTPs have also been examined by the assessment team and some information was compared with the compiled database provided by the programme team. While conducting these checks in the OTPs, some inconsistencies were found and noted. Out of all OTP cards checked by the team, 92% of the cards were found to be filled correctly by the local health staff and are consistent with OTP registers. The remaining cards (8%) were found to be inconsistent, either not filled properly or not updated regularly. For SFP, 53% of information was found recorded correctly. The remaining records were found incorrect or incomplete.
due to:  a) no record or absent or defaulted cases, b) no regular updates on child’s condition and, c) some confusion on RUSF supplies and records.

4.1.2. QUALITATIVE DATA COLLECTION

Qualitative data were collected from the eight barangays of the two municipalities, four barangays from Monkayo and four from Montevista of Compostela Valley. The aim of collecting qualitative data is to allow further detailed development of the coverage hypotheses and an in-depth analysis of the existing information and routine programme data described in the previous section. This data also provide vital information concerning the underlying causes of low or high programme coverage, including key barriers and accessibility of the services. The data were then segregated and scored using the BBQ (Boosters, Barriers and Questions) approach. The BBQ were recorded separately and analysed: the Boosters, the Barriers and the issues that need more investigation were listed as questions.

There were no great variations or difference in knowledge and attitudes towards the IMAM programme found in areas far away from OTP service centre and areas near to OTP service centres, when compared.

Findings from the qualitative assessment (key stakeholder interview)

The sources:

1. Barangays Captains
   Twelve Barangay captains from different barangays were individually interviewed, 86% of them were aware about the programme. The other 14% claimed to not know anything about the programme.

2. Women leaders
   Ten women leaders from the eight Barangays were interviewed, almost all of them claimed to have knowledge about the IMAM programme.

3. Indigenous People’s Leader (IP Leader)
   Six leaders from the indigenous communities were interviewed and more than 83% of the leaders seem to know the programme.

4. OTP staff (BNS, BHWs, Midwives)
   In total, 92 barangay health staff that have been working with OTP and SFP activities have attended the focus group discussions and were interviewed as appropriate.

   These health and nutrition teams are not only working for IMAM programme, they also have other roles. They are employed by the local government to work in the barangay health centres.
They are involved in other health care services in their communities such as growth monitoring, immunization campaigns, ante natal and post natal care etc. During the discussion, some of the staff were found not knowing the OTP’s admission and discharge criteria fully.

5. **OTP mothers/caregivers**
   Twelve mothers of children who were admitted in the OTPs during the programme period were interviewed. Most mothers said their children were in the programme 12 to 20 weeks before discharged cured. Majority of them got information about the IMAM programme from the Barangay Nutrition Scholars (BNS). Most caregivers seem have correct knowledge on the causes of malnutrition of their children.

6. **Traditional Healers**
   Eleven traditional healers were interviewed from the eight selected barangays (in some barangay there are more than one traditional healers) of IMAM intervention area of Compostela Valley. More than 60% healers were found to know about the IMAM programme. The interview also revealed that 50% of traditional healers treat children who have malnutrition. Their treatment is mainly focus on body parts massage and providing herbal based medicines. They said after not able to cure them within a week or two, SAM children are referred to the IMAM programme.
**The main findings from various sources:**

<table>
<thead>
<tr>
<th>Issues</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge of the programme</strong></td>
<td>The results of FGDs and individual interview with various community members determined that all most all of the community members are aware about the IMAM programme and their knowledge is good on programme and malnutrition. However, few key informants reported that they were not formally introduced to IMAM programme by any agencies. Therefore their involvement in the programme was less than expected.</td>
</tr>
<tr>
<td><strong>Knowledge about malnutrition:</strong></td>
<td>The question on knowledge of malnutrition included the causes and general signs of malnutrition. Almost all community members seemed to know the basic signs of malnutrition. Regarding the causes of malnutrition, most were able to cite some of the correct causes such as disease, lack of nutritious food, poor practice of Infant and Young Child Feeding (IYCF) etc. Majority of the community recognise malnutrition as a poor health condition. Therefore, when a child presents with wasting, the caregiver brings the child to a health facility. However they often think that their child is unwell rather than malnourished.</td>
</tr>
<tr>
<td><strong>OTP staff training on IMAM protocol</strong></td>
<td>The Barangay health centre staff who are responsible for OTP activities were trained on IMAM protocols. During the assessment it is also found that less than 50% of the interviewed OTP/SFP staff was not able to cite the OTP admission and discharge criteria correctly.</td>
</tr>
<tr>
<td><strong>Screening and referrals</strong></td>
<td>In the Philippines, all children 0-71 months are under the regular growth monitoring by various growth monitoring schemes in order to determine malnutrition prevalence. Under Operation Timbang(^\text{17}), growth of all children 0-71 months are being monitored bi-annually. Under the Growth Monitoring and Promotion (GMP) all children less than 2 years of age and those who are underweight are being monitored every month, while those 2 years and above and with normal weight are monitored quarterly. During the growth monitoring any children identify as malnourished by MUAC or WHO growth standard 2006, are referred to OTP or SFP as appropriate. Therefore no separate barangay/community level screening takes place to identify malnourished cases.</td>
</tr>
<tr>
<td><strong>In tolerance of RUTF/RUSF</strong></td>
<td>The health centre staff mentioned that some children do not like the taste of RUTF/RUSF. Some even vomit after taking the RUTF, therefore, some mothers/caretakers refuse to continue the treatment, even when occasionally they were counselled on the use of and unexpected experience with RUTF.</td>
</tr>
</tbody>
</table>

\(^{17}\) OPT (Operation Timbang) – a regular growth monitoring program conducted by the Department of Health
In the Philippines, it is required by the government to form the Barangay Nutrition Committees (BNC) in all barangays (villages). The BNC is composed of the Barangay Captain, the Kagawad/Councillor for Health, the Sangguniang Kabataan (SK=Youth leaders) chairman, the Rural Health Midwife, the Barangay Nutrition Scholars and the Barangay Health Workers. The main tasks of the BNC are to formulate the Barangay Nutrition Action Plans and to coordinate in the implementation and monitoring of the barangay nutrition activities. However, in some municipalities the BNCs are not that active as the others. Just like in Compostela Valley, there were some BNCs that were not very active. With this, ACF International assisted these BNCs to be reactivated. During the SQUEAC assessment all BNCs in Compostela Valley were already active.

### Incentives to BNS and staff work load

The SFP is being managed by the Provincial Nutrition Committee in agreement with a UN agency. The incentives provided for the BNS working for the SFP are not uniform. BNS under ACF programme do not receive incentives while their counterparts from the barangays outside of ACF programme receive it. This is attributed to the avoidance of funding duplication from the same donor in the same intervention areas. While ACF utilize the fund for capacity development, some UN agency provides incentives to BNS this creates conflicts.

In Compostela Valley IMAM programme, WFP promised to provide incentives to BNS that are involved with SFP programme. WFP’s incentive scheme did not include the barangays that has been supported by ACF. This discouraged the BNS of ACF supported IMAM programme as ACF had no plan to provide incentives. This situation occurred due to lack of communication between partners in planning stage of the programme. Some of the barangay staff also mentioned IMAM is extra work and it is unfair if some of the staff will receive incentive while others will not.

On the other hand they also acknowledged that this work given them new knowledge and opportunities to treat children with acute malnutrition in their communities. Therefore they appreciated this new approach to treating malnutrition.

### Staff attitude towards beneficiaries

Staff attitudes towards beneficiaries are, at times, unfriendly and unprofessional. The ACF team and the programme beneficiaries claimed to have observed it. They also mentioned this issue may contribute to an increase in defaulter and refusal rates.

### Poor Care Practices

Poor hygiene and sanitation practices, poor infant and young child feeding, poor food diversification/utilization as main causes of malnutrition were mentioned by all community members who were interviewed by the assessment team. This is due to inadequate knowledge of care practice by the greater community and ineffective health and nutrition education by the health facilities.
4.2 STAGE 2 ‘SMALL AREA SURVEY’

A small area survey was carried out to test the hypothesis that was generated in stage one as well as to estimate the programme coverage classification of Compostela Valley IMAM programme.

**Hypothesis**

The hypothesis tested was: OTPs with high admission rates have high coverage and OTPs with low admission rates have low coverage. To test this, 8 Barangays out of 16 were selected systematically and surveyed to see whether areas with high admissions indeed have high coverage and areas with low admission indeed have low coverage. Barangays with overall high admissions are New Dalaguete and New Cebulan in Montevista and Babag and Salvacion in Monkayo. Barangays with overall low admissions are Banglasan and Banagbanag in Montevista and Inambatan and Macopa in Monkayo. High and low admissions were defined by the number children under the age of five years in the area vs. the percentage of children under the age of five years admitted to the OTPs with SAM. A coverage threshold of 50% for rural area (based on SPHERE standards) was defined as adequate coverage. See table below:

### Table: 2 Barangays with high and low Admission

<table>
<thead>
<tr>
<th>Municipals</th>
<th>Barangays with <strong>high</strong> admission</th>
<th>% of U 5 children admitted</th>
<th>Barangays with <strong>low/no</strong> admission</th>
<th>% of U 5 children admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OTP</td>
<td>SFP</td>
<td>OTP</td>
<td>SFP</td>
</tr>
<tr>
<td>Montevista</td>
<td>New Dalaguete</td>
<td>2.19</td>
<td>Banglasan</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>New Cebulan</td>
<td>1.16</td>
<td>Banagbanag</td>
<td>0</td>
</tr>
<tr>
<td>Monkayo</td>
<td>Babag</td>
<td>1.54</td>
<td>Inambatan</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Salvacion</td>
<td>1.47</td>
<td>Macopa</td>
<td>0</td>
</tr>
</tbody>
</table>

4.2.1 Findings of Small Area Survey

**Results of the Hypothesis test**

<table>
<thead>
<tr>
<th>Decision rule Barangays with High coverage</th>
<th>Decision rule Barangays with Low coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In four barangays with high OTP admission, NO SAM case was found during the assessment. Four children with MAM were found. Among the 4 MAM cases only 1 case was found admitted in programme.</td>
<td>In barangays with low admission, NO SAM case was found during the assessment. Two children found with MAM, among the 2 MAM cases 1 case was found admitted in programme.</td>
</tr>
<tr>
<td>Out of 4 MAM children, 2 children need to be ‘in the programme’ in order to confirm the hypothesis of high coverage which is defined as at least 50% coverage.</td>
<td>Out of the 2 MAM children, 0 child needs to be “in the program” to confirm the hypothesis of low coverage which is defined as less than 50% coverage rates.</td>
</tr>
</tbody>
</table>
Cases (MAM) found in different Barangays

For small area survey, 11 out of 16 barangays were surveyed using the door to door survey method measuring almost all eligible children (6-59 months old) using MUAC. For small area survey, survey sample size was the actual number of SAM and MAM children found by the surveyors. By using MUAC and signs of nutritional oedema, no SAM case was found but 6 MAM cases were found from the 11 barangays using MUAC measurement.

Among these 6 MAM cases, 2 cases were found to be attending the SFP programme and 4 were not attending at the time of the survey (Table-3). These cases were found only in 4 barangays; the rest of the 7 barangays did not have any SAM or MAM cases at the time of the survey.

Table: 3 Compostela Valley SQUEAC, small area survey results, Sept. 2013

<table>
<thead>
<tr>
<th>Municipals</th>
<th>Barangays</th>
<th>MAM Cases found</th>
<th>MAM Cases in programme</th>
<th>MAM Cases not in programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montevista</td>
<td>New Dalaguete</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>New Cebulan</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Banglasan</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Bangbanga</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Lebanon</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>New Calape</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Monkayo</td>
<td>Babag</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Salvacion</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Macopa</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Naboc</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Inambatan</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
4.2.2 **Coverage Estimation**

To estimate the programme coverage classification rate data from the ‘Small Area Survey’ was used.

*Coverage estimation*

- There was no SAM case identified in small area survey therefore no coverage classification can be obtained for OTP.
- Six MAM cases were identified in the small area survey and only two cases were found to be enrolled in the programme. Therefore the coverage classification for SFP was estimated to <50%.
- Comparing with the SPHERE minimum standards for coverage (>50%) for rural areas, coverage classification for this programme lies below expected standard.

4.2.3 **BARRIERS TO THIS PROJECT IDENTIFIED DURING THE SMALL AREA SURVEY**

*Mother/caretakers knowledge on the programme*

According to the findings of the ‘small area survey’ for Compostela Valley, 4 out of 6 MAM cases were found not attending the programme.

When mothers/caretakers of these 4 MAM cases were asked if they know about the nutritional status of their children, 75% of the mothers/caretakers said that they know about it and only 25% mother/caretaker said she doesn’t know. On the other hand 100% mothers said that they are aware of the programme that can treat their children. See Table 6 below:

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes - # (%)</th>
<th>No - # (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your child malnourished</td>
<td>3 (75%)</td>
<td>1 (25%)</td>
</tr>
<tr>
<td>Do you know programme that can help your child</td>
<td>4 (100%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>
Reasons that made mothers/caretaker ‘not to attend’ the programme:
Out of the 4 mothers/caretakers of MAM cases that were ‘not in programme’, 1 was found not to be aware of the condition of her child. Three mothers/caretakers cited other reasons for not taking their children to the health facilities (see Figure 12). The graph below displays the reasons why mothers of MAM children don’t bring the children in the programme.

Figure: 12. Reasons given by the mothers for not having their children admitted in the programme

<table>
<thead>
<tr>
<th>Reason</th>
<th># of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not aware child became malnourished (early stage)</td>
<td>2</td>
</tr>
<tr>
<td>Migrated from another area waiting to be introduced to BHW</td>
<td>1</td>
</tr>
<tr>
<td>Child got sick recently and very early stage of malnutrition</td>
<td>3</td>
</tr>
</tbody>
</table>

4.2.3.1 THE MAIN BARRIERS AFFECTING THE PROGRAMME

Findings from the overall assessment determined various negative aspects which became main hindrances or barriers to the IMAM programme, contributing to poor coverage and coverage failure. Following are some important barriers that have been identified during the assessment:

1. Inaccessibility to health facilities:
   Findings from the contextual data and small area survey show that distance from the community to health facilities are long and terrains in some barangays are difficult. Therefore, some mothers/caretakers are not motivated to take their children to attend health facilities regularly, especially at the early stage of malnutrition (MAM stage).

2. Busy career /high opportunity costs (poor income sources):
   Competing agenda sometime determine the priority such as work to generate income versus attending the IMAM programme for child’s treatment. The family sometimes needs to choose between the 2 priorities. Going to work could be prioritized rather than attending the health center especially when child is recovering or if they are in their very early stage of malnutrition.

3. Weak community mobilization
   Few communities, particularly the IP community, are aware of the programme. It was due to short programme period and distance in some barangays.
4. Unequal incentives given to the BNS:
WFP announced to provide incentive to some of the BNS in Compostela Valley, caused disappointment to other BNS who are not part of WFP’s intervention area in Compostela Valley. Apparently, this issue seems demotivated some of the BNS’s of ACF supported IMAM programmes.

5. Unsuitable Treatment Interface
The communities’ care seeking behavior was found to be poor. Their practice of hygiene and sanitation also found to be insufficient. Poor Infant and young child feeding practice and poor food diversification and utilization were recognized to play major roles in the development of poor nutritional status among children.

6. Inadequate training of Barangay health team
Some of the barangay health teams were found not fully understanding the IMAM programme’s admission and discharge criteria. This was due to rapid/crash course training for the emergency programme and fast turn-over of local health staff who did not get the opportunity to be trained on IMAM protocol.
5. DISCUSSION

5.1 PROGRAMME ROUTINE DATA FROM OTP/SFP CARDS & REGISTERS

Programme routine data were collected from the OTP cards and registers from January 2013 to August 2013. Data on SFP were also collected from SFP registers (no SFP cards available). Issues that are highlighted below were discussed during the programme data gathering and data analysis.

**OTP and SFP data:**

**Admission data**
The OTP and SFP data recorded 19 SAM and 94 MAM cases admitted in the 16 barangay health facilities from January to August 2013. The programme was expected to be admitting and treating more acute malnutrition cases than the actual number of admissions during the emergency and recovery period after typhoon Bopha. Due to the low programme admissions, multi-indicator analysis is limited. However, all the admission data were found to be consistent and accurate.

**Performance indicators:**

**Defaulter Information**
From January to August 2013, 30% of SAM children who were admitted were found defaulted from the OTP. Thirty per-cent defaulter rate is very high when compared to SPHERE standards. But, it should be kept in mind that only few cases (19) were admitted to the OTP during the 8 months programme period, therefore, even a few number of defaulter can inflate the rate. Hence, the percentage of defaulter for this programme needs to be interpreted carefully.

**OTP and SFP Record Keeping**
The OTP and SFP registers and cards were also been examined by the team and some information was compared with the compiled database. Most of the OTP cards (92%) and registers were found to be filled out correctly and consistently. On the other hand, nearly half of the SFP records were found to be incomplete. The reasons of poor record keeping for SFP could be due to: poor training of health centre staff, poor understanding of the use of the data/records by the health centre staff, and poor monitoring and supervision by the technical team. To maintain good programme qualities, it is important that record/data are kept accurate, adequate and well-analysed.

5.2 PROGRAMME CONTEXTUAL DATA FROM THE COMMUNITIES

The data collected from the community key stakeholders were complemented by the data gathered from the OTP and SFP and findings from small area survey. The information gathered through the contextual data and important key issues are highlighted below.
Inadequate training on IMAM protocol to Barangay health team

From the analysis of contextual data, some of the barangay health teams were found to do not fully understand the IMAM programme’s admission and discharge criteria. The ACF team reported that this was due to rapid training for the emergency response programme and fast turn-over of local health staff who have no chance of being trained on IMAM. The barangay health center will continue with the IMAM services with support from UNICEF after ACF’s end it’s support by September 2013. To ensure the correct usage of the IMAM protocol, the local government will conduct refresher training for the barangay health centers’ staff.

Barangay Health centre staff and IMAM services

In Compostela Valley IMAM programme, the BNS are the key staff to provide IMAM services in the health centres. Health centres are being supported by ACF for the OTP/ITP while WFP supports them for the SFP. Both ACF and WFP were funded by the same donor, but for different programmes. WFP provides incentives for the BNS working only for the SFP supported by WFP. BNS under ACF program do not receive the incentives while their counterparts from the barangays outside of ACF programme receive it from WFP. This is attributed to the avoidance of funding duplication from the same donor in the same intervention areas. The BNS that are working in ACF areas become disillusioned hence affected their performance. This issue has been brought to the attention of the provincial nutrition committee during the report presentation of the coverage assessment. The Provincial Nutrition Action Officer (PNAO) mentioned to take actions on this matter.

New health post for far away Barangays and for Puroks of larger barangays

Hard to reach areas and terrains difficult to cross are among the issues that come across several times in contextual data. These were mainly affecting the people, especially the IP, from accessing health services. These factors were also observed by the assessment team during the coverage assessment. The issue of hard to reach areas is not only affecting the IMAM programme, but also affecting the other health services in those communities. This issue has been raised to the local government during the coverage survey briefing meeting. The PNAO will look into this issue and propose to establish new health post for the hard to reach puroks in the area.

Poor IYCF & care-practice

Through the contextual data and discussions with the community key informants, it was found that one of the leading causes of acute malnutrition among children is possibly the poor care practices. Poor care practice includes poor IYCF practices, poor dietary diversities and poor caring of children when having illness. The OTP admission data also showed that more than half of the children are between the ages of 6 to 24 months. This may indicate weak IYCF practices in the targeted communities. These findings are in line with the findings of Philippines Food and Nutrition Research Institute, 2010. The survey showed low exclusive breastfeeding rate in the region at 60%, while the continued breastfeeding up to 2 years is even lower than the national average (20.7% vs. 28.9%). For sustainable intervention and preventing children from becoming malnourished the health team needs to actively address these issues in various health interventions including the OTP and SFP interventions at the health centers.
5.3 SMALL AREA SURVEY

The small area survey data revealed that there were no SAM cases identified in the 11 surveyed barangays using door to door case finding methodology. The surveyors found only 6 MAM cases in the eleven barangays, and two third (66%) of them were found not attending the programme. This figure looks high for a programme which has a very efficient screening strategy. However, almost all MAM cases that were identified by small area survey were found to be still in their early stage of moderate acute malnutrition, which explains why they were not picked up by the programme. The progression of MAM sometimes is very slow, not easily noticed by an open eye, therefore the delays in identification. On a positive note, the survey found that all mothers/caretakers of MAM children who were ‘not in the programme’ were aware of the IMAM programme.

Overall, the communities in Compostela Valley were found well informed about malnutrition and the IMAM programme which can treat the cases of acute malnutrition. This is probably due to integration of IMAM services to barangay health centres’ routine health programs.
6. CONCLUSION

The health centre of LGU has been implementing IMAM programme in Compostela Valley with the support of ACF since the aftermath of typhoon Bopha that hit Mindanao including the Compostela Valley. The IMAM programme routine data showed that the programme has admitted and has successfully treated SAM and MAM cases. The performance indicators (cure, death, non-responders and defaulters) some are found to be lower and some are within the corresponding SPHERE standards. In a positive note, no death has been occurred in OTP or SFP during the 8 months intervention period.

Communities’ knowledge of the programme and active participation was found to be encouraging. Reactivation and functionality of the Barangay Nutrition Committees with the inclusion of IMAM services in Barangay health services is a prime example.

The issue of intolerance of RUTF (Eezeepaste) and RUSF need to be further investigated to understand the cause of intolerance. Also proper guidance and education on the use of RUTF/RUSF need to be strengthened by the barangays’ health team with support from technical partners (ACF, WFP, Save the Children etc).

The survey data of the Small Area survey suggests that there are no SAM cases in 11 surveyed barangays. However the coverage for SFP was found less than 50%, the SPHERE minimum standard set for rural areas. The LGUs need to ensure that SAM and MAM cases are continuously detected and treated in their early stage to prevent children from developing into the severe form of malnutrition as well as to improve the programme coverage.
7. RECOMMENDATIONS & ACTION PLAN

The SQUEAC exercise identified barriers that prevent access to the services of the IMAM programme and hindrance to programme coverage. To address these barriers, the assessment team invited the provincial nutrition team, the PNAO, PNC, and MNAO of Monkayo to participate in the recommendation and action planning session. From the discussion, it was understood that as ACF is slowly pulling out its support from the IMAM programme, the LGUs are getting ready to take it over. In order to remove some of the barriers, the local government unit responded positively and came up with some practical suggested solutions.

It was also recommended by the PNAO to share the ACF’s monitoring and evaluation tools with the Provincial nutrition team and to train the personnel of LGU on IMAM programme data management. See below recommendations based on the barriers identified:

7.1 SPECIFIC RECOMMENDATION

<table>
<thead>
<tr>
<th>Issues/Barriers</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccessibility to health centers</td>
<td>Identify and cluster the far and hard to reach areas.</td>
</tr>
<tr>
<td>- Long distance to health facilities</td>
<td>Establish Health and Nutrition posts for the hard to reach areas.</td>
</tr>
<tr>
<td>- Workload of caretakers /Lack of income</td>
<td>Increase Health human resource specifically BNS, BHWs</td>
</tr>
<tr>
<td>- Establish Health and Nutrition posts for the hard to reach areas</td>
<td></td>
</tr>
<tr>
<td>Lack of support from Local Government</td>
<td>The PNAO assured to look in to this issue as well as assured the group to include IMAM programme budget in the provincial Annual Investment Plan (AIP).</td>
</tr>
<tr>
<td>- Short supplies of equipment</td>
<td></td>
</tr>
<tr>
<td>- Poor funds for Malnutrition programmes</td>
<td></td>
</tr>
<tr>
<td>Poor attitude of Health workers towards clients/beneficiaries</td>
<td>The LGU will look into this issue. They will encourage the barangay health staff to provide better services to include fostering of volunteerism in communities.</td>
</tr>
<tr>
<td>Poor Care Practices</td>
<td><strong>Hygiene and Sanitation</strong></td>
</tr>
<tr>
<td>- Poor hygiene and sanitation practices</td>
<td>Coordinate with Municipal Environment and Natural Resources Office (MENRO), Republic Act 9003 (Solid Waste Management) to ensure improve hygiene and sanitation services to communities.</td>
</tr>
<tr>
<td>- Poor infant and young child feeding</td>
<td>Ensure that the Community-Led Total Sanitation (CLTS) approach is being practiced in all barangays.</td>
</tr>
<tr>
<td>- Poor food diversification/utilization</td>
<td><strong>IYCF/ PGN</strong></td>
</tr>
<tr>
<td></td>
<td>Training for BNS, BHWs and Midwife to ensure that proper message are given to the mothers/caretakers regarding IYCF and behavior change communication.</td>
</tr>
<tr>
<td></td>
<td>Whenever appropriate, to make the vulnerable families with malnourished children link with the community Livelihood</td>
</tr>
<tr>
<td>Issue</td>
<td>Proposed Solution</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Weak Community mobilization and participation, especially in IP communities</td>
<td>Focus on IP communities for better understanding of programme and improved participation. Establish linkage with National Council for Indigenous People (NCIP).</td>
</tr>
<tr>
<td>Unequal provision of incentives to the BNS in the 5 Municipalities</td>
<td>The PNAO assured to review of MOA between WFP and Compostela Valley Provincial Government to ensure that all BNS receive equal incentives.</td>
</tr>
<tr>
<td>Both admission and discharge criteria not fully understood</td>
<td>IMAM Refresher Course for Barangay Nutrition Scholars (BNS) will commence before the year ends to ensure improved knowledge and practices in this area.</td>
</tr>
</tbody>
</table>
7.2 ACTION PLAN

Following on the agreed recommendations, some key actions were planned and agreed upon by the LGU and ACF to take the recommendations forward. See the action plan below:

<table>
<thead>
<tr>
<th>Issues to be addressed</th>
<th>Recommendations</th>
<th>Time frame</th>
<th>Responsible person</th>
<th>Resource needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccessibility to health centers</td>
<td>Identify and cluster the far and hard to reach areas.</td>
<td>Start from 4th Quarter of 2013 until 2016</td>
<td>Municipal Nutrition Action Officer (MNAO)/Barangay Nutrition Action Office (BNAO)</td>
<td>Budget for LHB meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss in Local Health Board (LHB) meeting in Sept. 23 &amp; 24, 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish Health and Nutrition posts for the hard to reach areas.</td>
<td>By 2014 to 2016</td>
<td>Municipal Nutrition Action Office (MNAO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Budget Annual Investment Plan (AIP) Office of Congress</td>
<td></td>
</tr>
<tr>
<td>Increase Health human resource specifically BNS, BHWs</td>
<td>2014-2016</td>
<td>Barangay Nutrition Action Office (BNAO)</td>
<td>Budget Barangay Nutrition Scholar (BNS) &amp; Barangay Health Workers (BHWs)</td>
<td></td>
</tr>
<tr>
<td>Establish linkages with local and international partners</td>
<td>Last Quarter of 2013-2016</td>
<td>MNAO</td>
<td>Budget for Meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Municipal Health Office (MHO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provincial Health Office (PHO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of Support from Local Government Short supplies of equipment Poor funds for Malnutrition programmes</td>
<td>The PNAO assured to look into this issue as well as assured to include IMAM programme budget in the Annual Investment Plan (AIP).</td>
<td>Sept. 17-20, 2013</td>
<td>MNAO Municipal Planning and Development Office (MPDO)</td>
<td>Budget for Meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Attitude of Health workers towards clients/ beneficiaries</td>
<td>Last Quarter of 2013 to 2016</td>
<td>Provincial Nutrition Action Officer (PNAO) &amp; Barangay Nutrition Council (BNC)</td>
<td>Budget for Training of Trainers (TOT) &amp; Barangay health team.</td>
<td></td>
</tr>
<tr>
<td>Issues to be addressed</td>
<td>Recommendations</td>
<td>Time frame</td>
<td>Responsible person</td>
<td>Resource needed</td>
</tr>
<tr>
<td>------------------------</td>
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<td>------------</td>
<td>--------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Poor Care Practices</td>
<td>Hygiene and Sanitation Coordinate with Municipal Environment and Natural Resources Office (MENRO), Republic Act 9003 (Solid Waste Management) to ensure improve hygiene and sanitation services to communities. Ensure community Lead Total Sanitation (CLTS) approach has been used.</td>
<td>Last Quarter of 2013</td>
<td>Municipal Environment and Natural Resources Office (MENRO), Municipal Health Office (MHO), Rural Sanitation Inspector (RSI)</td>
<td>Budget for Meetings</td>
</tr>
<tr>
<td>Poor hygiene and sanitation practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor infant and young child feeding</td>
<td>IYCF/ PGN Training for BNS, BHWs and Midwife to ensure proper message are given to the mothers/caretakers regarding IYCF and behavior change communication.</td>
<td>Last Quarter of 2013 (October-November)</td>
<td>National Nutrition Council (NNC), Provincial Nutrition Council (PNC)</td>
<td>Budget for Training (PhP 600,000)</td>
</tr>
<tr>
<td>Poor food diversification/ utilization</td>
<td>Wherever appropriate, to link the vulnerable families with malnourished children with community Livelihood Programme.</td>
<td>Last Quarter of 2013-2016</td>
<td>Barangay Nutrition team Municipal Agriculture Office (MAGRO)</td>
<td>Budget for Meetings</td>
</tr>
<tr>
<td>Unequal provision of incentives to the BNS in the 5 Municipalities</td>
<td>The PNAO assured to review of MOA between WFP and Compostela Valley Province to ensure all BNS receive the incentives.</td>
<td>Sept.2013</td>
<td>National Council for Indigenous People (NCIP)</td>
<td>Budget for Meetings</td>
</tr>
<tr>
<td>Both Admission and Discharge criteria not fully understood</td>
<td>IMAM Refresher Course for Barangay Nutrition Scholar (BNS) will commence before the year ends to ensure improve knowledge and practices in this area.</td>
<td>Sept.2013</td>
<td>Provincial Nutrition Council (PNC) &amp; ACF Staff</td>
<td>Budget for training</td>
</tr>
</tbody>
</table>
## 8. ANNEXES

### ANNEX: 1

**Schedule for SQUEAC Training & Assessment, Sept 5-19 2013 Compostela Valley, Philippines**

<table>
<thead>
<tr>
<th>Date</th>
<th>Day</th>
<th>Time</th>
<th>Activity</th>
<th>Venue</th>
<th>Facilitator</th>
</tr>
</thead>
</table>
| 5 Sept.    | Day 1(Thu)| 8:30-17:00 | *Class room training*  
Opening Session  
Introductions  
Schedules  
Overview of the SQUEAC methodology  
Assessment team’s perception about the programme | Nabunturan | Lovely /Ellie/Sally |
| 6 Sept.    | Day 2 (Fri)| 8:30-17:00 | Classroom training  
Starts up with mindmap  
Develop/adopt guide for FGD, KII and SSI  
Distribute task to the assessment team  
Distribution of ID, vest, pins | Nabunturan | Lovely /Ellie/Sally |
| 7 Sept.    | Day 3 (Sat)| 8:30-17:00 | *Field Exercise; Collection of some Contextual data from the field:*  
Barangay’s leaders  
IP leaders/Elders  
Women’s leader  
Traditional healer | Municipality of Monkayo or Montevista | Team |
| 8 Sept     | Day 4 (Sun)|            | Day off                                                                 | Tagum City                  | Team |
| 9 Sept.    | Day 5 (Mon)| 8:30-17:00 | *Classroom training*  
Contextual data analysis (Field visit data  
Identification of potential barriers and boosters of coverage  
Selection area with high and low admission  
Going through the methodology and Questionnaires  
Revised the Tasks | Nabunturan | Team |
| 10 Sep     | Day 6 (Tues)| 8:30-17:00 | *Classroom training*  
Information collection from OTP & SC | OTP                         | Team |
|            |            |            | PM  
Data analysis findings  
Back to Tagum (ACF Car) | Nabunturan | Team |
| 11 Sept.   | Day 7 (Wed)| 8:30-17:00 | Classroom  
Contextual data analysis  
Planning for ‘Small area survey’ | Nabunturan | Team |
<p>| 12 &amp; 13th  | Day 8 &amp; 9  | 8:30-17:00 | <em>Conducting Small area Survey by active case findings</em> | Field                      | Team |</p>
<table>
<thead>
<tr>
<th>Day</th>
<th>Activity Description</th>
<th>Location</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>14th</td>
<td>8:30-17:00 Classroom Data analysis of Small area survey Estimations of coverage</td>
<td>Nabunturan</td>
<td>Team</td>
</tr>
<tr>
<td>15th</td>
<td>Day Off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16th</td>
<td>8:30-17:00 Field work Conducting Wide Area Survey</td>
<td>Field</td>
<td>Team</td>
</tr>
<tr>
<td>17th</td>
<td>8:30-17:00 AM/PM Data compilation of wide area survey Recommendation Action plan</td>
<td>Nabunturan</td>
<td>Team</td>
</tr>
<tr>
<td>18th</td>
<td>8:30-17:00 AM PM Presentation of preliminary results to the team Open Plan</td>
<td>Nabunturan</td>
<td>Lovely/Ellie/Sally</td>
</tr>
<tr>
<td>19th</td>
<td>AM PM Lovely’s Departure For Manila (ticket and car c/o log)</td>
<td>Manila</td>
<td>Lovely (Ellie will stay for Davao Oriental)</td>
</tr>
<tr>
<td>20th</td>
<td>AM PM Lovely’s Debriefing/Presentation of Preliminary Report in Manila Office. Lovely’s Departure for Dublin</td>
<td>Manila</td>
<td>Lovely</td>
</tr>
</tbody>
</table>
## Annex: 2

### List of people trained for SQUEAC, COMPOSTELA VALLEY, 2013

<table>
<thead>
<tr>
<th>Participants</th>
<th>Position</th>
<th>Agency</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Anilyn Musong</td>
<td>BNS Compostela</td>
<td>Compostela LGU</td>
<td></td>
</tr>
<tr>
<td>2 Medelyn Torlao</td>
<td>BNS Compostela</td>
<td>Compostela LGU</td>
<td></td>
</tr>
<tr>
<td>3 Juanita Villocino</td>
<td>BNS Compostela</td>
<td>Compostela LGU</td>
<td></td>
</tr>
<tr>
<td>4 Esmerna S. Maitem</td>
<td>BNS Olaycon</td>
<td>Compostela LGU</td>
<td></td>
</tr>
<tr>
<td>5 Kristine Angeli O. Gimongala</td>
<td>Project Coordinator</td>
<td>Prov’l Nut Office</td>
<td><a href="mailto:Kristineangeli.og@gmail.com">Kristineangeli.og@gmail.com</a></td>
</tr>
<tr>
<td>6 Maurecia Sugano</td>
<td>BNS Monkayo</td>
<td>Monkayo LGU</td>
<td></td>
</tr>
<tr>
<td>7 Nena Mirafuentes</td>
<td>Prov’l Nutrition Coordinator</td>
<td>Prov’l Nut Office</td>
<td></td>
</tr>
<tr>
<td>8 Georgel Ta-ala</td>
<td>Nut Asst. New Bataan</td>
<td>New Bataan LGU</td>
<td></td>
</tr>
<tr>
<td>9 Rosalia Bataclan, MD</td>
<td>SQUEAC Head of Program</td>
<td>ACF</td>
<td><a href="mailto:hopnut-ph-tm@acffilipinas.org">hopnut-ph-tm@acffilipinas.org</a></td>
</tr>
<tr>
<td>10 Ray Anthony Banglos</td>
<td>SQUEAC Supervisor</td>
<td>ACF</td>
<td><a href="mailto:rbanglos@hotmail.com">rbanglos@hotmail.com</a></td>
</tr>
<tr>
<td>11 Pete John Biscarra</td>
<td>Nut Supervisor</td>
<td>ACF</td>
<td><a href="mailto:bpetejohn@yahoo.com">bpetejohn@yahoo.com</a></td>
</tr>
<tr>
<td>12 Suzette Tubelleja</td>
<td>Nut Supervisor</td>
<td>ACF</td>
<td><a href="mailto:stubelleja@yahoo.com">stubelleja@yahoo.com</a></td>
</tr>
<tr>
<td>13 Angeles Caparoso</td>
<td>BNS Monkayo</td>
<td>ACF</td>
<td></td>
</tr>
<tr>
<td>14 Doniza Tocmo</td>
<td>BNS Monkayo</td>
<td>ACF</td>
<td></td>
</tr>
<tr>
<td>15 Pearl Catingub</td>
<td>Surveyor</td>
<td>ACF</td>
<td><a href="mailto:joypmc988@gmail.com">joypmc988@gmail.com</a></td>
</tr>
<tr>
<td>16 Salze Casilac</td>
<td>Surveyor</td>
<td>ACF</td>
<td></td>
</tr>
<tr>
<td>17 Charis Theresa Albao</td>
<td>Surveyor</td>
<td>ACF</td>
<td></td>
</tr>
<tr>
<td>18 Nashrudin Modin</td>
<td>Consortium Deputy Coordinator</td>
<td>ACF</td>
<td></td>
</tr>
<tr>
<td>19 Lailanie Joy Sero</td>
<td>ACF M and E for the consortium</td>
<td>ACF</td>
<td><a href="mailto:conssup-ph-tm@acffilipinas.org">conssup-ph-tm@acffilipinas.org</a></td>
</tr>
<tr>
<td>20 Mary Grace Mantilla</td>
<td>BNS Mt. Diwata</td>
<td>Monkayo LGU</td>
<td></td>
</tr>
</tbody>
</table>
Annex: 3

SQUEAC Assessment Interviewing the community, ACF IMAM Programme, Compostela Valley, Philippines, Sept 2013

Guiding questions KIIs & FGDs, with community Key Informants: (Knowledge and appreciation of the programme)

1. **Questionnaire: For Traditional Healer**  
   (KII, one from each village)
   1. Do you know the programme called OTP?  
   2. If yes, who informed you?  
   3. What do you know about malnutrition?  
   4. Is there any case of malnutrition in your community?  
   5. Do they come to you for treatment/help?  
   6. If they do how do you treat them?

2. **Questionnaire: For Traditional Birth Attendant/Midwives**  
   (KII, one from each Village)
   1. Do you know programme called OTP?  
   2. What do you know about malnutrition?  
   3. Do you know the causes of malnutrition?  
   4. Is there any case of malnutrition in your community?  
   5. Did you refer any children to this programme/CHV?  
   6. If yes, how many did you refer?

3. **Questionnaire: For village Chief**  
   (KII, one from each Village)
   1. Do you know the programme, OTP? If yes, who inform you?  
   2. What is your role in the programme?  
   3. Is there any child in the programme from your village?  
   4. What are the causes of malnutrition in your village?  
   5. In your village any malnourished children that refuse to go to the programme?  
   6. If they did refuse, what was your role?  
   7. Is there stigma for malnutrition in your community?  
   8. Did you refer any cases to the programme?  
   9. How do you collaborate with the community volunteers?

4. **Questionnaire: CHV (FGDs- group of 6 to 15 CHVs)**

How IMAM works:
   1. What is your role to this programme?  
   2. What are the Admission criteria for OTP?  
   3. Who are the beneficiaries of the prog?
4. Do you have enough material/supplies for the work?
5. When is the last time you did the screening
6. Are there many cases of malnutrition in your village?
7. What are the causes of Malnutrition in your communities?
8. How do you collaborate with the health centres?
9. Do you get feedback on your work/report from the HC?
10. Are there any children who refuse to go to OTP?
11. If yes, what do you do with those cases?

**What is your appreciation of the programme?**
1. Benefit you have seen from the programme
2. Problem you face by involving to this programme
3. Does the OTP programme cause workload for you?
4. Any suggestion to improve the programme?

Dev. a Seasonal calendar with them, if time allows

5. **Questionnaire: OTP/SC Staff, (FGDs, 4 to 10 staff)**

1. What is your role to this programme?
2. What are the Admission criteria for OTP?
3. Who are the beneficiaries of the prog?
4. Do you have enough material/supplies for the work?
5. Do you do sensitisation with community?
6. Are there many cases of malnutrition in your OTP?
7. What are the main causes of Malnutrition?
8. Do you get feedback on your work/report from the manager?
9. Are there any children who refused to go to OTP?
10. If yes, what do you do with those cases?

**What is your appreciation of the programme?**
1. Benefit you have seen from the programme
2. Problem you face to implement this programme?
3. Does the OTP programme cause workload for you?
4. Any suggestion to improve the programme/your work?

Dev. a Seasonal calendar with them

6. **Questionnaires OTP/SC mothers, (FGDs, 12 to 15 mothers/caretakers)**

1. How long your child in the programme?
2. How do you know about this programme?:
3. Do you know why your child in the OTP/SC?
4. What was the cause of the condition of your child?
5. Did your child admitted before in OTP/SC (this one)
6. Any of your other children admitted to OTP/SC before?
7. Is this programme helping your child to get better?
8. Will you refer other child in this prog, if you find them with malnutrition (generally use local term)

Dev. a Seasonal calendar with them
Annex: 4

X-MIND, COVERAGE ASSESSMNET, COMPOSTELA VALLEY, SEPT. 2013

Workload

Additional Workload

Incentives

KII

OTP Mothers

Knowledge on OTP
4 out of 4 Mothers said YES-100 %

Knowledge about Malnutrition

CAUSES OF MALNUTRITION
Inadequate supply of Food
No Regular Economic Income
Poor Appetite

DEFINITION
Underweight

Treatment for Malnutrition
Benefits of the Program
Encourage from the staff
Follow up through Home visit
Accommodating
SFP Mothers
Knowledge on SFP
6 out of 6 mothers said YES-100%
Knowledge about malnutrition
CAUSES
Inadequate Supply of Food
Financial Problem (either lack/delay)
Lack of Care practices of caregivers
Poor knowledge on food variation
Shortage of food supply
Intake vs Expenditure activity
Ineffective breastfeeding
DEFINITION
Poor acceptance to RUTF/RUSF
Traditional healers
Knowledge on OTP
8 out 11 traditional healers said that they have an idea about IMAM
Knowledge about malnutrition
Knowledgeable about malnutrition
a. Lack of foods
b. lack of vitamins
c. Thin children, those with very low weight
d. stunted height
Do they treat malnutrition?
8 out of 11 said that they treat malnutrition through massage, herbal oils and herbal plants
Barangay Captain
Knowledge on OTP/SFP
a. ACF during courtesy visit and/or orientation
b. BNS
Knowledge about Malnutrition
Lack of food
Poor care practices/Knowledge deficit
Disease
Not feeding on time
poverty
Family size
Benefits form the program
a. Trainings (additional skills and knowledge)
b. Children treated and rehabilitated
c. Their feeding activity was supposed to have the same effect but the program proved to be more effective in rehabilitating the child
Perception on IMAM
Something NEW
Role
Underweight
Services they got from SFP
Supply
Plumpy sup (every 2 weeks)
Staff attitude
Supportive
Active monitoring
Dedication
Who refer them to the programme
BNS
BHW
IP Leader
SFP Mother
Duration of stay in the program
2-4 months
Problem faced during the program
Information dissemination
Education
Encouraging caregivers
Create ordinances
Coordination
Meeting/Assembly
Support to planned activity
Campaign/Advocacy
Women’s leader
Knowledge about OTP/SFP
9 out of 9 mothers said yes
Knowledge about malnutrition
Lack of knowledge
Poor care practices
calamity
No income source
Inadequate food intake
Lack of vitamins
Lazy parents
Lack of supply
Knowledge deficit on IYCF
Role in the Program
Encourage mothers
Teach care practices
Facilitate feeding sessions
Information dissemination
Coordination
Working together with BHW
Educate mothers
Assist the health staff in Outreach program
Referral
Coordinating with Barangay Council about OTP Program
Trainings
OTP Staff ✓✓
BNS, BHW and RHMs

Screening

Longer Waiting Time ✓✓
Distance of the mothers houses to the Barangay Health Station

Supervision

ACF ✓
Regular supervision
Focus oriented
Adequate Supervision

MNC and MNAO

Inadequate Supervision ×

Absence of MNAO ×
In Municipality of Monkayo

Not Motivated MNAO ×
In Municipality of Montevista

Provision of Supply and Measuring Equipment ✓
All barangays were provided with weighing scales RUTF and OTP Supplies provided to all BHS

FGD

OTP Staff ✓✓

Role in the program ✓✓

Information dissemination
Data recording
Monitoring/Taking of anthropometric measurements
Identification of cases of malnutrition
Distributing of RUTF/RUSF

IYCF Promotion
Home visits/Follow up

Knowledge on Malnutrition ✓
Poverty
Poor care practices
Inadequate nutritious food intake
Big family size
Illness
Lack of food diversification

Benefits on the program ✓
Rehabilitated malnourished children
Lessens malnourished cases
Knowledgeable on anthropometric measurements
care givers knowledgeable on IYCF and
Anthropometric measurements

Problems faced in implementation ×
Incentives is not enough
Passive participation of caregivers
Intolerance to RUTF/RUSF
Annex: 5a

QUESTIONNAIRE SMALL AREA SURVEY, COMPOSTELA VALLEY, SEPT. 2013

<table>
<thead>
<tr>
<th>#</th>
<th>Child’s Name</th>
<th>Mother’s Name</th>
<th>Barangay</th>
<th>MUAC</th>
<th>Oedema</th>
<th>MAM in the prog.</th>
<th>MAM NOT in the prog.</th>
<th>SFP recovering Cases in prog.</th>
<th>SEX</th>
<th>Age (Months)</th>
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Annex- 5b

Questionnaire for the guardians of the children (cases) NOT in the programme

Small/Wide area survey- Compostela Valley, Sept 2013

Name of Child: ____________________________ OTP sites: ________________________________
Section: __________________________ Subsection/Road: ________________________________

1. DO YOU THINK THAT YOUR CHILD IS MALNOURISHED?
   YES [ ] NO [ ]

2. DO YOU KNOW A PROGRAM WHICH CAN HELP MALNOURISHED CHILDREN?
   YES [ ] NO [ ] (No stop!)
   If yes, what is the name of the program? ______________________________

3. WHY DIDN'T BRING YOUR CHILD IN FOR CONSULTATION TO THIS PROGRAM?
   • Too far (What distance to be travelled with foot? ______ how many hours? ______)
   • I do not have time/too occupied
   • To specify the activity which occupies the guardian in this period_______
   • The mother is sick
   • The mother cannot travel with more than one child
   • The mother is ashamed to go the program (no good cloths etc.)
   • Problems of safety
   • The quantity of services too poor to justify to go
   • The child was rejected before.
   • The child of other people was rejected
   • My husband has refused
   • The guardians do not believe that the program can help the child (or prefers the traditional medicine, etc.)
   • Other reasons: ____________________________________________________________

4. Was the CHILD ALREADY ADMITTED IN THE PROGRAM before?
   YES [ ] NO [ ] (No stop!)
   • If yes, why isn’t s/he registered any more at present?
   • Defaulted, when? ............... Why? .................
   • Cured and discharged from the program (When?______________________)
   • Discharged but not cured (When? ________________)
   • Others: _________________________________________________________________
   (Thank the guardian)