



2013

COVERAGE ASSESSMENT

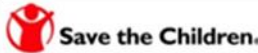
» SEMI-QUANTITATIVE EVALUATION OF ACCESS & COVERAGE

COVERAGE MONITORING NETWORK

MERTI SUB-COUNTY, KENYA

NOV-DEC, 2013

ACF AND MINISTRY OF HEALTH





ACKNOWLEDGEMENTS

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- *UNICEF* for the financial support.
- Merti community specifically who were directly involved in the assessment; local authorities, parents who allowed the team collect data using different methods and Village guides for facilitating data collection (during wide area survey).
- ACF staff for logistics support and data collection



ACRONYMS

ACF - Action Against Hunger
ASAL-Arid and Semi-Arid area
CHW -Community Health worker
CHEW-Community Health Extension Worker
CHVs- Community Health Volunteers
CUs-Community Units
CSB -Corn Soy Blend
DNO - District Nutrition Officer
EPI-Expanded Immunization
FFA -Food for Asset
GFD -General Food Distribution
H/W- Health worker
HEDU-Health Education
HH- Household
HRIO-Health records officer
IMAM -Integrated Management of Acute Malnutrition
MOH- ministry of health
MUAC -Mid upper arm circumference
LQAS- Lot Quality Assurance Sampling
OJT -On job Training
OTP- Outpatient feeding program
RDQ-Rapid data quality
RUTF - Ready to use therapeutic food
RTI-Respiratory Tract infections
SAM - Severe acute malnutrition
SFP- supplementary feeding Program
SQUEAC- Semi-Quantitative evaluation of access and coverage
THP - Traditional health practitioner
URTI-Upper respiratory Infection
WFH-Weight for Height



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EXECUTIVE SUMMARY

ACF International in collaboration with MOH conducted an OTP program coverage assessment in Merti Sub County to investigate the coverage levels on 30th November to 2nd December 2013. This was the second coverage assessment to be carried out in Merti Sub County since the inception of Nutrition, WASH and FSL programs by ACF in May 2012. The assessment was done to determine boosters and barriers, establish OTP program coverage, and highlight significant recommendations that could improve service provision to beneficiaries and program coverage as a whole. It was also done as a follow up of the recommendations from the previous SQUEAC and persons trained on the methodology in November 2012. The entire coverage assessment involved establishment of barriers and boosters for high and low awareness through analysis of program data in Stage 1. There was development of hypothesis and testing using the small area survey in Stage 2; with program awareness being below 50% for villages without the programs and above 80% for villages with a health facility or outreach activities. In Stage 3 there was development of the Prior and conducting the wide area survey and a **period coverage estimate of 53.8% (40.1%-66.7%)** was realized.

Table 1: Program coverage Barriers and recommendations

Barrier	Recommendations
Sharing of RUTF	Community sensitization on the content in the package and dangers of excessive use by an individual. Advocacy plan be in place for the county
Distance	More outreach sites be established by MoH and agency supported outreach sites
Stigma and cultural beliefs	Sensitization through HEDU in outreach sites and facilities on the benefit of modern treatment
Understaffing	Increase the number of MoH staff to offer nutrition and EPI(at least 2 staff per facility)
Poor documentation	Capacity enhancement through OJT by DHMT and partners to the few facilities facing the challenge and GAP assessment



1.0 INTRODUCTION

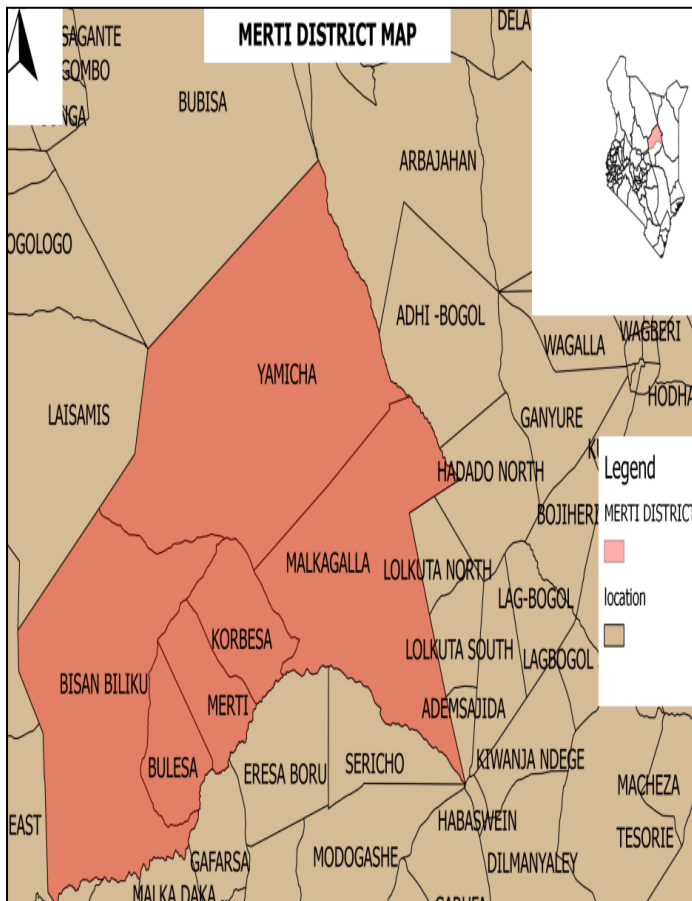


Figure 1: Map of Merti Sub County

1.1 BACKGROUND INFORMATION

Isiolo County has three Sub Counties with Merti being one of them. The Sub County has an area of 12612KM² and is 100% ASAL¹ inhabited by pastoralists with little farming along the Ewaso Nyiro River. It has a catchment population of 21, 878².

ACF-USA has been working in the area since September 2012 supporting 7 health facilities and 7 integrated outreach sites with a main goal of scaling up HINI packages. Integrated efforts between ACF and MoH in Merti Sub County have been geared towards the community for the past one year through strengthening the health and nutrition and intervention systems using HINI packages.

1.2 JUSTIFICATION OF THE COVERAGE ASSESSMENT

This is the second coverage assessment to be carried out in Merti Sub County since the inception of IMAM activities in June 2006 by Save the Children. A baseline coverage assessment was conducted in November 2012, realizing a posterior OTP coverage estimate of 46.0% (32.0%-60.7%). Some recommendations to overcome barriers were put in place in order to enhance program coverage in Merti Sub County. The basis for this year's coverage assessment was carried out to establish the boosters and barriers to access to program and also as a follow up of the recommendations from the previous coverage assessment.

¹ Arid and Semi-Arid Lands, Draft National ASAL Policy, 2004

² 2009 National Population Census



1.3 OBJECTIVES OF THE ASSESSMENT

The following were the specific objectives of assessment;

- To determine OTP program coverage and establish the head line coverage estimate
- To determine and show barriers and boosters for the OTP coverage
- Review recommendations from previous assessment and the impact of the interventions on improving program access and coverage
- Provide recommendations and possible solutions improve coverage and nutrition outcomes
- To capacity build MoH and program staff on the coverage methodology

2.0 METHODOLOGY

The SQUEAC investigation process involved three stage techniques namely;

Stage 1: Identification of Areas of Low and High Coverage

Quantitative data:

This involved collection and analysis of the relevant routine data from the OTP sites to identify areas with low and high coverage. The collected data included OTP admissions, OTP exits on monthly basis, defaulters by village of residence, disease calendar, crops and livestock produce weather patterns and labour demand calendars.

Qualitative data:

This involved collection of data through use of various tools to include Informal Group Discussions, Semi and Simple structured interviews. The information from both quantitative and qualitative data was used in formulation of a set of hypothesis about program coverage.

Stage 2: Verification of hypothesis through a small study

Stage 3: Developing a Prior.

This stage involved undertaking a Wide area survey and use of Bayesian technique to find the program coverage estimate.



3.0 RESULTS

3.1 STAGE 1: IDENTIFICATION OF AREAS OF LOW AND HIGH COVERAGE

3.1.1 Qualitative Data

This involved analysis of OTP data covered the period between November 2012 and October 2013 and included admissions and exits by month, MUAC at admissions. Both admissions and exits were plotted against the seasonal calendar to identify any possible pattern and reasons behind it. Data collection using different methods and sources were used then triangulated to redundancy.

Table 2: Method used to collect qualitative data and sources

Method used	Summary of Sources interviewed
In-depth interviews	Sheikhs, Traditional Health Practitioners, Caregivers of children in OTP
Simple Interviews	Youth, Program staff and Chiefs
Informal Group Interviews	Caregivers of children in OTP and Village elders
Semi-Structured Interviews	School teachers, CHWs and Health facility staff (Nurses)

Table 3: Barriers affecting coverage

Program barriers	Source
Sale of RUTF	Caregivers, Facility staff, CHW, Community members
Sharing of RUTF	Facility in charge, CHW, Caregivers, program staff
Distance	Caregivers, CHW,
Migration	CHW, Community members,
Poor linkage to GFD, FFA	Community, caregivers, program staff, facility in charge
Lack of commitment by caregivers	Facility staff,
Stigma and cultural practices	Caregivers, community members, facility in charge
Competing activities	Caregivers, village elders, program staff,
Community in understanding malnutrition	Village elders,
Health seeking behavior where the care giver gets node from the family head (husband)	Caregivers, community members, Nurse
Understaffing	Facility in charge, CHW, HRIO



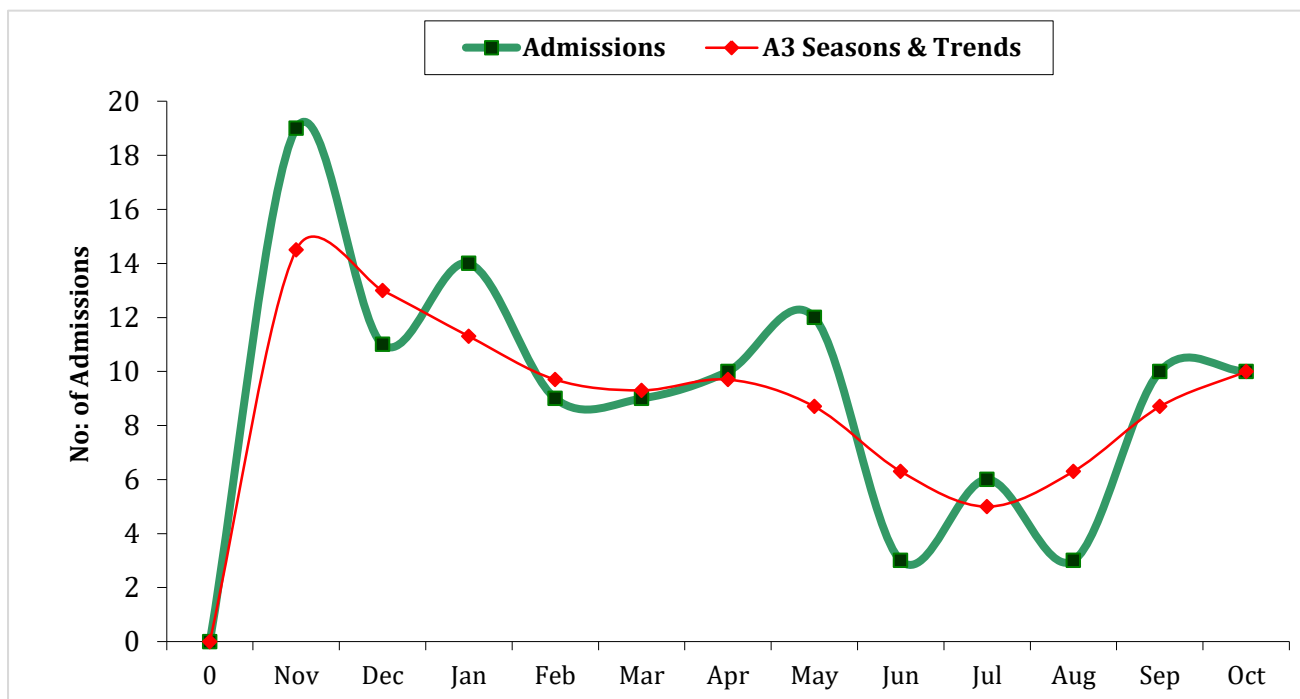
Table 4: Boosters influencing access and coverage

Coverage boosters	Source
Awareness on nutrition program	Teacher, school going children, caregivers,
Outreach activities	Facility in charge, CHW, Program staff, caregivers
Regular active case finding	CHW, Community members, DNO
Capacity building through OJT, Health education	Facility in charges, CHW, records officer
Strong supply chain	Facility in charge, CHW,
Early admission	MoH register, facility staff
Incentives to CHWs	CHW, Facility staff
Use of ration cards with to return dates	Care givers, CHWs, nurse



3.1.2 Quantitative Data

3.1.2.1 Monthly Admissions



Event	Nov' 12	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct' 13
Weather	Rains(Short rains)			Sunny			Rains	Dry spell and windy				
Diseases	Malaria and Diarrhea				Malaria, RTI and diarrhea							
Food availability/milk	Plenty of Milk/food		No food-Dry spell(Bona)				Food availability with low prices	No food (high prices)				

Figure 2: Monthly admissions against Seasonal Calendar

There was a high new admission in November during which there was the national nurses' strike, because of unmanaged infections which deteriorated the nutritional status of the children. During this time, the admissions and management of the cases was being done by the CHWs. There was a decline in December after end of strike. Admissions are high during the wet season when infections are also on the increase. May recorded high admissions immediately after the onset of long rains with many cases of diarrhea reported. From June to August there was decline in admissions due to availability of food and also migration to areas with pasture. August to September recorded incline in admission attributed to the dry spell.



3.1.2.2 Admissions by MUAC

There were few MUAC admissions since most admissions in the Sub County were based on Weight for Height (WFH) criteria. Most MUAC admissions were at 11.4-11.3cm category, which is also the median position. This indicates early treatment seeking before deterioration resulting into Short length of stay in program hence minimal defaulting. This is attributed to active case finding by facility and outreach site CHWs and program staff. Also community members sought treatment at the health facilities first before visiting the Traditional health practitioners (THPs) as realized during the interviews with different key informants.

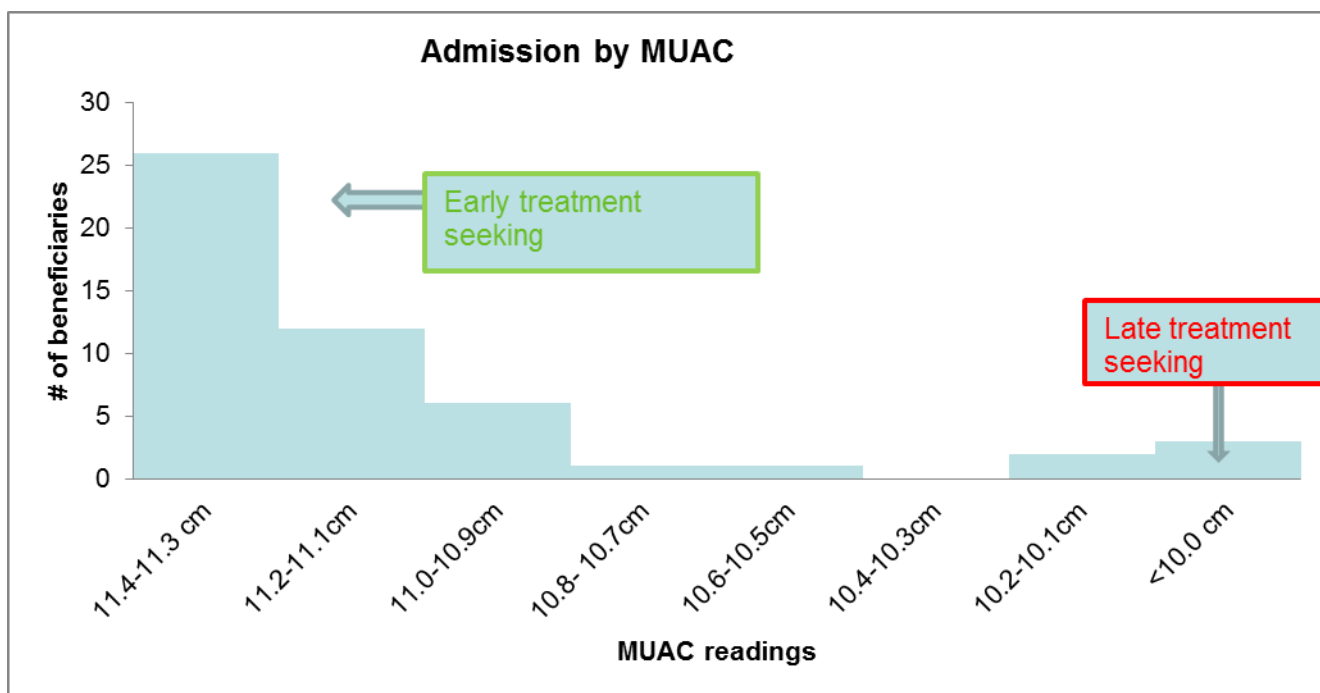


Figure 3: Admissions by MUAC

Important to note is that there were few cases of late admission, as indicated by low MUAC admissions, and only managed to get to the health facility when the child had complications. This is because children were either screened and referred but did not go to the health facility.

3.1.2.3 Documentation

As an integral programmatic component, documentation and reporting are fundamental in process monitoring. During data extraction, inadequately filled OTP registers were evident in some of the facilities. The OJT sessions are consistent in all health facilities, with the sessions being conducted bi-monthly. However, there was notable absence of health facility staffs due to shortage in the Sub County. The facility based CHWs are mostly charged with filling the registers with the other health providers giving minimal or no assistance other than the OJT sessions conducted by ACF staff.

This unduly filled OTP registers in a number of health facilities is a clear indication that IMAM procedures are not adhered to. The probable reason for this is inadequate staff to conduct all OTP procedures.



3.1.2.4 Program Exits

The program exits which include cured cases, death, defaulters and non-response were analysed to obtain a standard program indicator graph (Figure 4). The analysis of program exits is important in assessing program performance based on SPHERE standards of death rate (<10%), recovery rate (>75%), and default rate (<15%). **Cure rate in November and December was below SPHERE threshold due to the absence of Nurses at the facility due to the national strike.** Non response rate was noted to be high during months of February and October due to the Dry spell and food unavailability leading to sharing of RUTF as a coping mechanism. Death in January was as a result of underlying causes while the child was undergoing treatment attributed to late treatment seeking as informed through interviews.

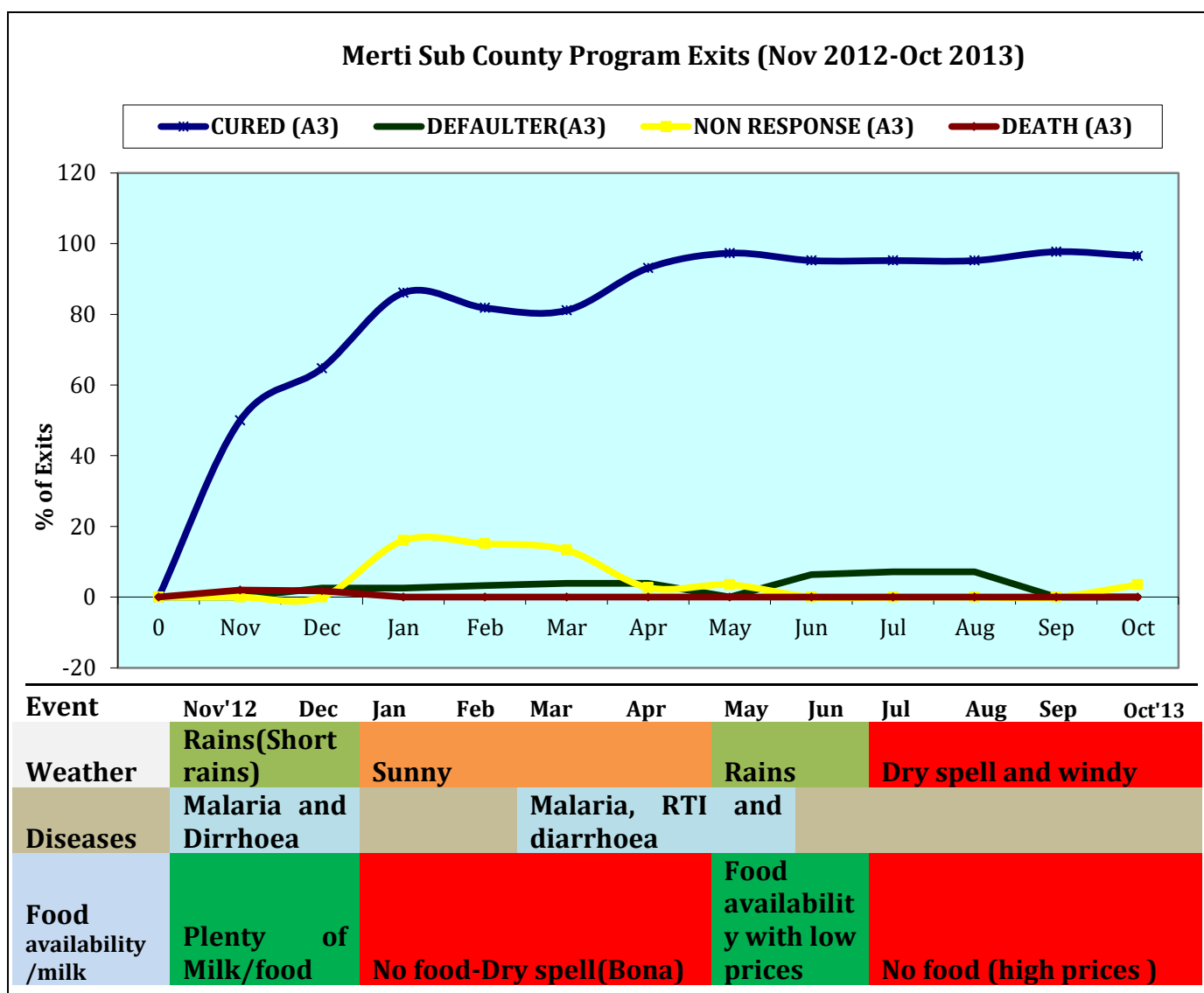


Figure 4: Standard performance indicators against the seasonal calendar



Defaulting time

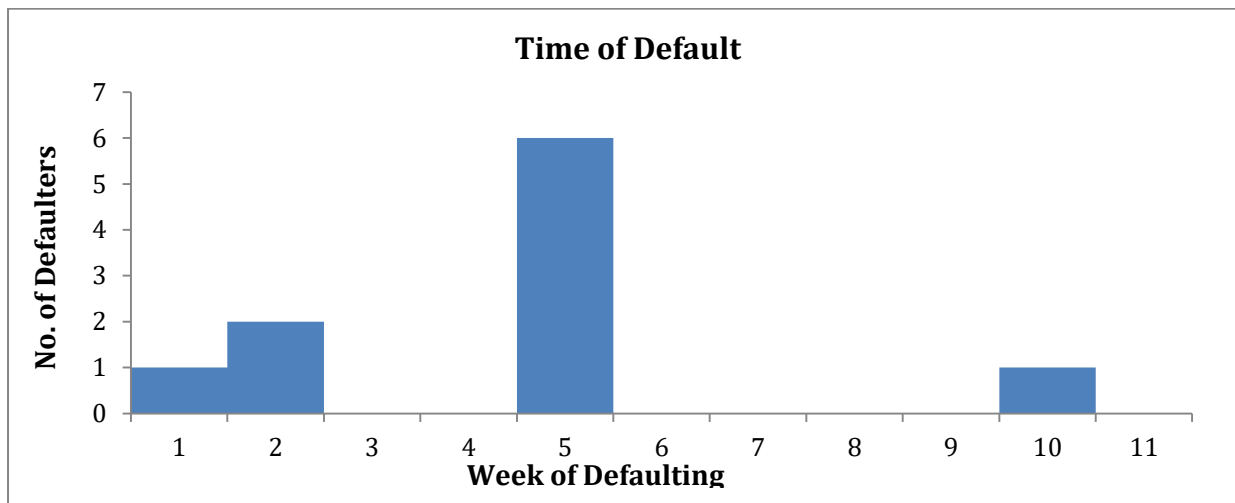


Figure 5: Time of default in Merti Sub County

The high defaulter rate in July was attributed to seasonal migration whereby children below five years move together with their caregivers in search of water and pasture. Other caregivers may not be willing to walk under the scorching sun to the health facility. It was noted that most defaulters were experienced in week five. Only 10% of the defaulters exited before week five thus the program was doing well in retaining clients.

Average Length of Stay

Calculation of the *median* duration of the length of stay (Figure 6) indicated most patients stayed in the program up to 8 weeks (an average length of stay). This translated into few defaulting cases and good program outcome. The few cases of long length of stay were attributed to late treatment seeking as indicated by MUAC admissions (Figure 3) and sharing of RUTF.

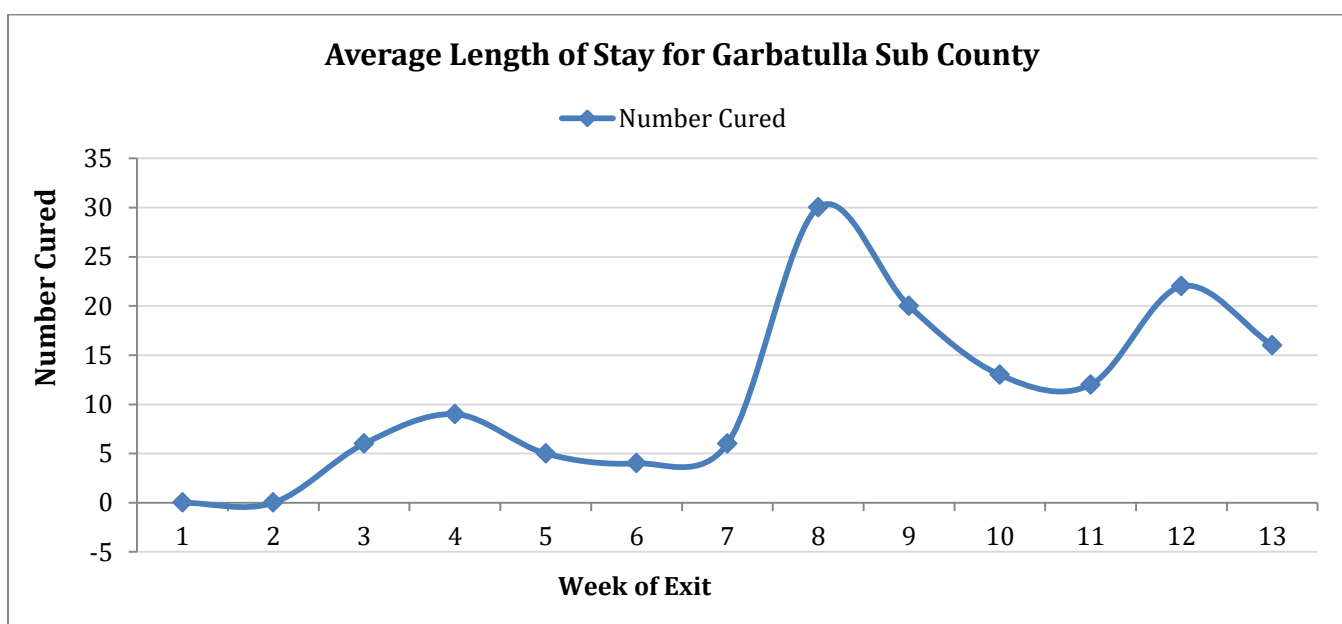


Figure 6: Average Length of Stay



3.2 STAGE 2: FORMULATION AND VERIFICATION OF HYPOTHESIS

The objective of this stage was to confirm areas of high and low coverage based on data collected from stage 1. Many respondents would recognize and associate RUTF and MUAC tapes with the health facility during Stage one analysis. They were quick to point out that RUTF was food for children who are ‘thin’ and sick. However, in some villages there were some respondents who either associated RUTF with health facilities but didn’t know its main purpose or saw it as ‘chocolate’ sold in shops or didn’t know that it was given freely in the health facilities.

The hypothesis, *awareness is low in villages far from OTP sites and high in near villages* was formulated from the results with awareness being defined as, “A caregiver’s ability to identify the MUAC tape and RUTF, what they were used for and also knowledge of an existing program offering nutrition services in their area”.

Villages without service delivery points near (outreach/ health facility) were deemed to be of low awareness hence coverage. More than 5 kilometers was termed as far by the respondents due to vastness, while near villages with access to integrated health services were perceived as high awareness sites. Simple random sampling where all villages **without** service delivery points were listed down then randomly picked. The same methodology was applied on selection of the villages **with** service delivery point to get areas to be visited. One village, *Olaolote* without health facility/ outreach site was visited. One village, *Awarsitu*, covered by an outreach site was also visited.

Table 5: Outcome for Hypothesis testing in both near and far villages

Village	State	Perceived Distance to SDP in Minutes	N	Aware of IMAM Program	Not Aware of IMAM Program
Olaolote	Not covered	Far	14	3	11
Awarsitu	Covered	Near	14	14	0
Total			28	17	11

The following formula was used to confirm the hypothesis against the 50% sphere standard for coverage for rural areas.

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

Where **d**=decision rule, **n**=total number found, **p** = 50% - SPHERE Standards Threshold

Awareness in *Olaolote*; **d= [14*50/100]**

$$d=7$$

Since 11 is greater than d=7 threshold in *Olaolote*, the hypothesis stands positive for areas without service delivery points near have low awareness while those near service delivery points have high awareness. Lack of a health facility or an outreach site and the long distance to the nearest health service delivery were the main reasons for low awareness in *Olaolote*.



3.3 STAGE 3: WIDE AREA SURVEY

3.3.1 Developing the Prior

3.3.1.1 Weighted Boosters and Barriers

Qualitative and quantitative data were used in determination of prior through the use of weighted boosters and barriers as well as a histogram. All the qualitative data was logically categorized as either a booster (positives) or a barrier (negatives) to the program. The prior mode was established as an average of positives ('build-ups' from 0%) and negatives ('knock-downs' from 100%) through triangulation by source and method as shown in the table below.

Table 6: Using Program boosters and barriers to calculate the prior mode

Program barriers	Score	Score	Coverage boosters
Sale of RUTF	-3	+4	Awareness on nutrition program
Sharing of RUTF	-4	+3	Outreach activities
Distance	-4	+4	Regular active case finding
Migration	-1	+3	Capacity building through OJT, Health education
Poor linkage to GFD, FFA	-2	+4	Strong supply chain
Lack of commitment by caregivers	-1	+4	Early admission
Stigma and cultural practices	-4	+3	Incentives to CHWs
Competing activities	-3	+2	Use of ration cards with to return dates
Community in understanding malnutrition	-3		
Health seeking behavior where the care giver gets node from the family head (husband)	-2		
Understaffing	-4		
Sum	-33	27	Sum
Upper value anchor	100%	0%	Lower value anchor
Total	67%	27%	Total

Prior mode was the Mean = $\frac{27+67}{2} = 47\%$

Concept map

The prior mode was developed by a physical count of the positive links (11) added to Minimum coverage (0%), while negative links (10) were subtracted from the maximum coverage (100%). Then the mean was calculated;

$$\text{Mean} = \frac{11+90}{2} = 51\%$$

3.3.1.3 Histogram

The third prior mode was determined using data; 48% as the peak. Having been derived from the collected data and also in relation to the previous assessment this was more reliable. The minimum and the maximum values were believed to be at 20% and 60% respectively.

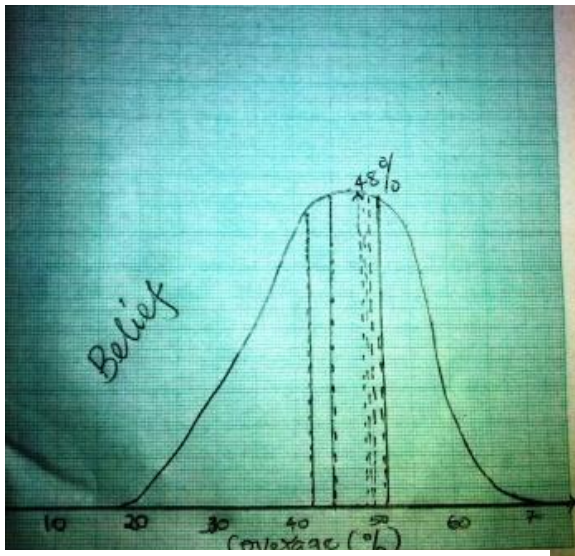


Figure 7: Histogram showing prior belief

The Prior Mode derived from the three totals was;

$$\text{Prior mode} = \frac{47+51+48}{3} = 48.0\%$$

Using the *Bayes SQUEAC Coverage Estimate Calculator* (version 2.02)³, the final prior was plotted by adjusting the prior α and prior β until the mode was obtained with uncertainty of ± 20 . The alpha and beta values were **α prior 18.2 and β prior 19.4** as shown in figure below.

³ The calculator can be freely downloaded from www.brixtonhealth.com

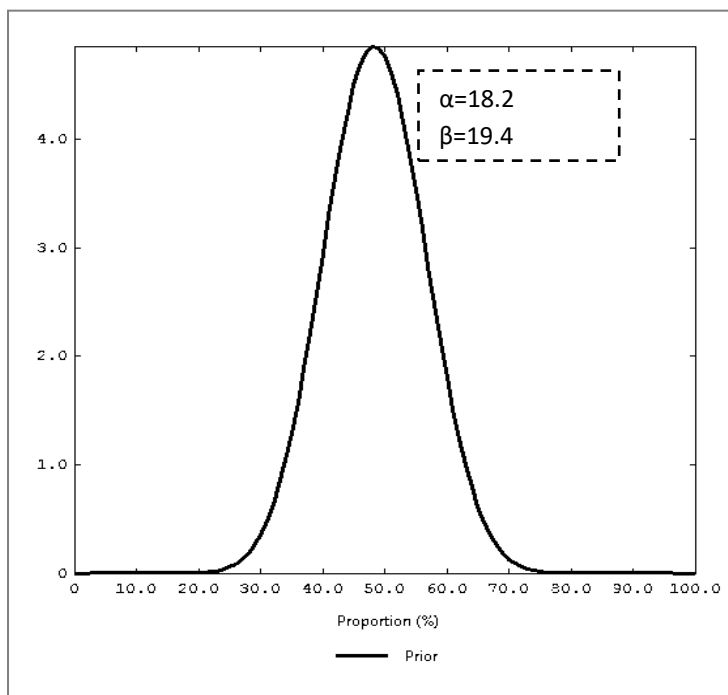


Figure 8: Showing the prior mode

3.3.2 Calculation of the sample size (SAM cases)

The formula below was used to calculate the sample size for the wide area survey;

$$= \frac{\text{mode}(1-\text{mode})}{(\text{precision} \div 1.96)^2} - (\alpha + \beta - 2)$$

n =minimum sample size, mode=48.0%, precision=10%, α =18.2, β =19.4

$$n = \frac{\text{mode} \cdot (1 - \text{mode})}{\left(\frac{\text{precision}}{1.96}\right)^2} - 18.2 + 19.4 - 2$$

$$n = \frac{0.48 \cdot (1 - 0.48)}{\left(\frac{10}{1.96}\right)^2} - 18.2 + 19.4 - 2 \quad n = 7 \text{ SAM cases}$$

3.3.3 Calculation of the Sample (Number of Villages)

The number of villages to be visited was determined using the formula below:

$$n \text{ villages} = \frac{n}{\text{average villages population} \times \frac{\% \text{population of } 6 - 59m}{100} \times \frac{\text{Prevalence}}{100\%}}$$

$$n \text{ villages} = \frac{7}{382 \times \frac{18.4}{100} \times \frac{0.5}{100\%}}$$

$n \text{ villages} = 20 \text{ villages}$

Average village population=382⁴

% population of <5 years=18.4%⁵

Prevalence of SAM=0.5%⁶

n =sample size (7)

⁴ Approximated from Kenya National Bureau of Statistics (KNBS) census 2009

⁵ Approximated from Kenya National Bureau of Statistics (KNBS) census 2009

⁶ Integrated SMART Survey for Merti Sub County, May 2013



3.4 Sampling for the Wide Area Survey

Since there was no reliable map, an updated list of villages in all the three divisions of Merti Sub County was obtained and subsequently selected by **Systematic Sampling**. Stage 1 and 2 of the coverage assessment took place when the rains had already started and most pastoralists had moved back to their respective villages according to the chiefs and local village elders. Therefore there was no population at the grazing zones during the scheduled time for the wide area survey.

3.5 Data collection

With the aid of the village guides active and adaptive case finding was done in the sampled villages to capture SAM cases for a period of three days. The tools used during data collection included a questionnaire for non-covered cases, tally sheet, and referral slips given to all non-covered cases for either OTP or SFP programs.

The findings of the wide area survey were analysed as shown in the table 6:

Table 7: Active case finding results

Days	All SAM cases (MUAC <115mm)	SAM in Program	SAM not in Program	Recovering cases in Program
Day 1	2	0	2	0
Day 2	3	2	1	1
Day 3	3	1	2	1
TOTAL	8	3	5	2

Based on MUAC admission trends obtained from routine program data which translated into short Length of Stay, cases of recovering children in the OTP program, as well as the coverage estimates from the previous coverage assessments, it was established that there was early admission of SAM cases into OTP program. The program had good case finding and recruitment of new cases in to the program by early admissions and good retention of cases evident by presence of recovering cases and late defaulting. Therefore, **period coverage** was deemed to be appropriate to explain OTP program findings

Using the *Bayes SQUEAC* Coverage Estimate Calculator (version 2.02), the coverage was estimated as shown in Figure 7. The coverage estimates have improved compared to last years' 46.0% (32.0%-60.7%) to **53.8% (40.1%-66.7%)**. The following reasons were attributed to improved coverage;

- Strong supply chain of RUTF. There was no supply breakdowns reported in the course of the year.
- There were Integrated outreach activities in hard to reach areas where IMAM program sensitization was done through Health education and malnutrition screening
- Two Community units were re-trained on Nutrition and Public Health Promotion by MoH which has improved program awareness and early recruitment of the cases
- Regular data audit by DHRIO⁷ which has improved data accuracy and consistency

⁷ District Health Records and Information Officer

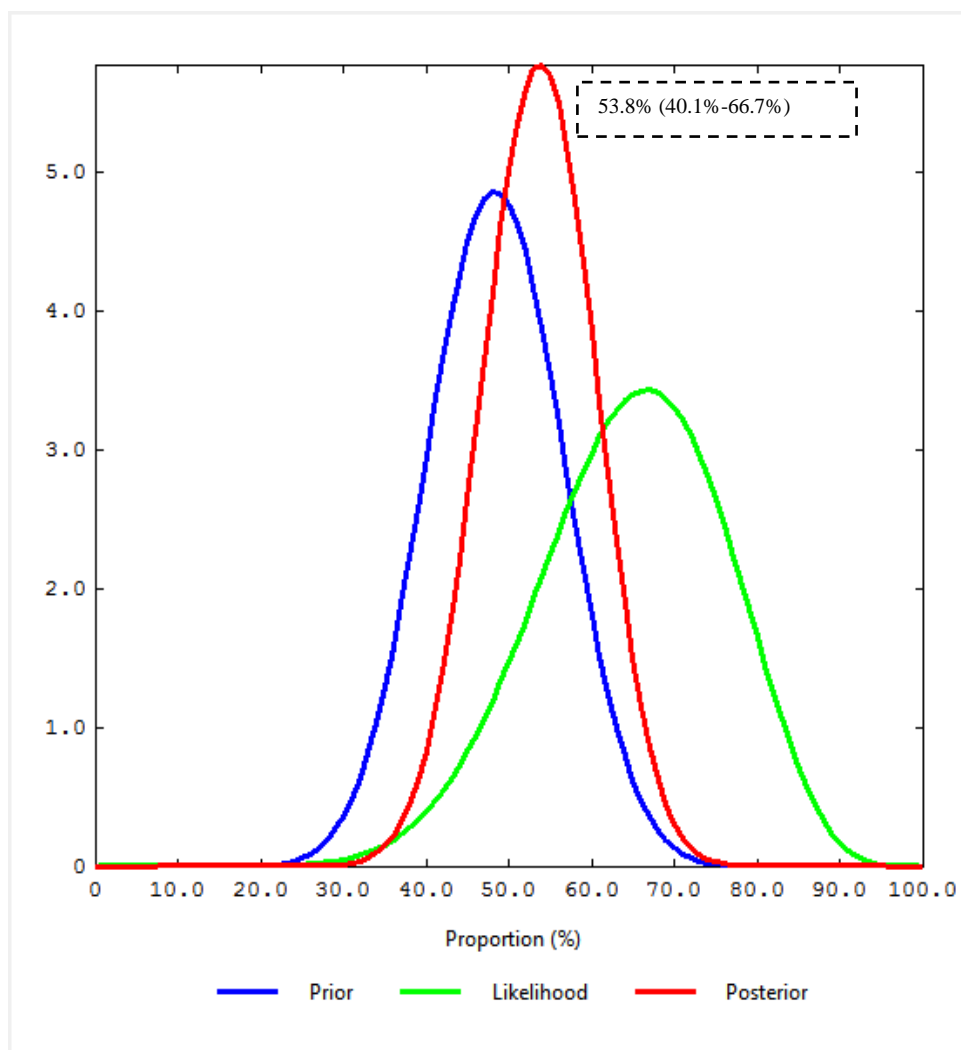


Figure 9: Posterior Coverage Estimate after wide area survey

The plot shows that there is considerable overlap between the Prior and the Likelihood; do not conflict. Posterior is narrower than Prior. The likelihood survey reduced uncertainty.



3.6 Reasons for Not Attending the Program

During the wide area survey, some of reasons given by the respondents of the DNAs are analyzed in Figure 8 below.

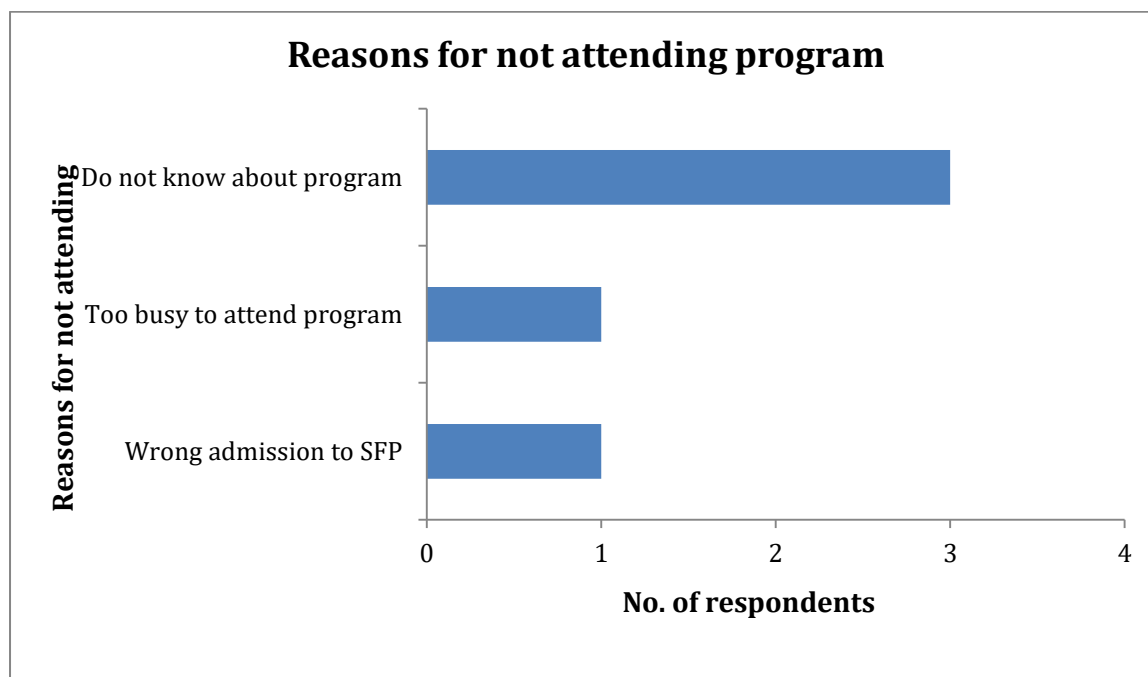


Figure 10: Reasons for not attending the OTP program

It was evident during the wide area survey that 3 out of the 5 cases did not know about existence of a program that could treat malnutrition while one was too busy to attend the distribution due to competing activities. Wrong admission was also cited that was linked to poor triage by health staff or Community health worker.



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4.0 CONCLUSION AND RECOMMENDATIONS



The first program coverage assessment in Merti Sub county was carried out in November 2012 with coverage estimate of **46.0% (32.0%-60.7%)** being unveiled. Some recommendations were made on how to overcome the barriers that negatively affect program access and coverage and the present situation is shown in *table 8*. The current coverage estimate for Merti Sub County **53.8% (40.1%-66.7%)** is above the minimum SPHERE standard of 50%. The improved coverage estimates were attributed to the action points on the recommendations made from the previous coverage assessment. However, during the investigation stage of qualitative data some barriers were also identified to affect service delivery in Merti Sub County. Some recommendations to the barriers were made by the survey team and Sub County health management team as shown in *table 9*.

Table 8: Recommendations from the previous SQUEAC survey and the present situation

Recommendation (Nov 2012)	Rationale	Evidence	Present situation (Nov 2013)
Strengthen existing Community Units	Nonexistence of community based CHVs leading to low coverage and awareness	Lack of awareness of OTP program in the community -Difficult in retaining CHVs -Lack of awareness on the causes of malnutrition	-Training of 2 CUs within the Sub County -CHV retention still a challenge as there is no incentives
Increase and strengthen outreach services	In hard to reach areas, there is little or no program awareness due to distance	-Late treatment seeking at health facility, lack of awareness of OTP program and causes of malnutrition -Periodic migration leads to defaulter, low case finding & delayed admission	-EPI integrated outreaches on regular basis (twice a month) with addition of one more site -Sensitization on the IMAM program during outreaches through HEDU



Strengthen community sensitization	Inadequate sensitization on malnutrition management	community issues of and	RUTF not perceived as medicine but food, as evident by sharing among family members -Late treatment seeking at Health Facility	-Still a gap as the community perceives RUTF as food due to its availability in the Market -Still a gap as some people perceive a THP will do better than a clinician
Strengthen inter-program integration	Poor integration of program with other programs like EPI, FFA and GFD	of OTP	Lack of integration of OTP with EPI, FFA and GFD (no screening or referral)	-Strong linkage of IMAM to EPI -GFD/FFA not regular, thus increase in sharing
Improve program data	routine OTP program registers was quite unreliable	data from the	Inability to produce routine management statistics -Lack of reliable basic information for program implementation	Rapid data quality analysis on monthly basis, well completed registers in most facilities

Table 9: Recommendations from the current program coverage assessment

Barrier	Recommendation	Action plan	By who
Sharing of RUTF	Community sensitization on the content in the package and dangers of excessive use by an individual. Advocacy plan be in place for the county	Plan to have community profiling and sensitization by all partners and have advocacy plan for the county on behavior change.	MoH, facility health committee members, Partners
Distance	More outreach sites be established by MoH and agency supported outreach sites	MoH and partners	DHMT/CHMT
Stigma and cultural beliefs	Sensitization through HEDU in outreach sites and facilities on the benefit of modern treatment	MoH, CHWs and Program staff to do community sensitization	MoH, CHWs and program staff



Understaffing

Increase the number of MoH staff to offer nutrition and EPI(at least 2 staff per facility)

County health committee to see more nurses and nutritionist are posted in the sub county

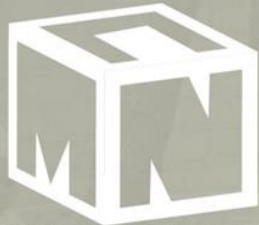
DHMT/CHMT

Poor documentation

Capacity enhancement through OJT by DHMT and partners to the few facilities facing the challenge and GAP assessment

Regular OJT and joint supervision by the C/ DHMT and documentation on best practices

DHMT/CHMT, Program staff



COVERAGE MONITORING NETWORK

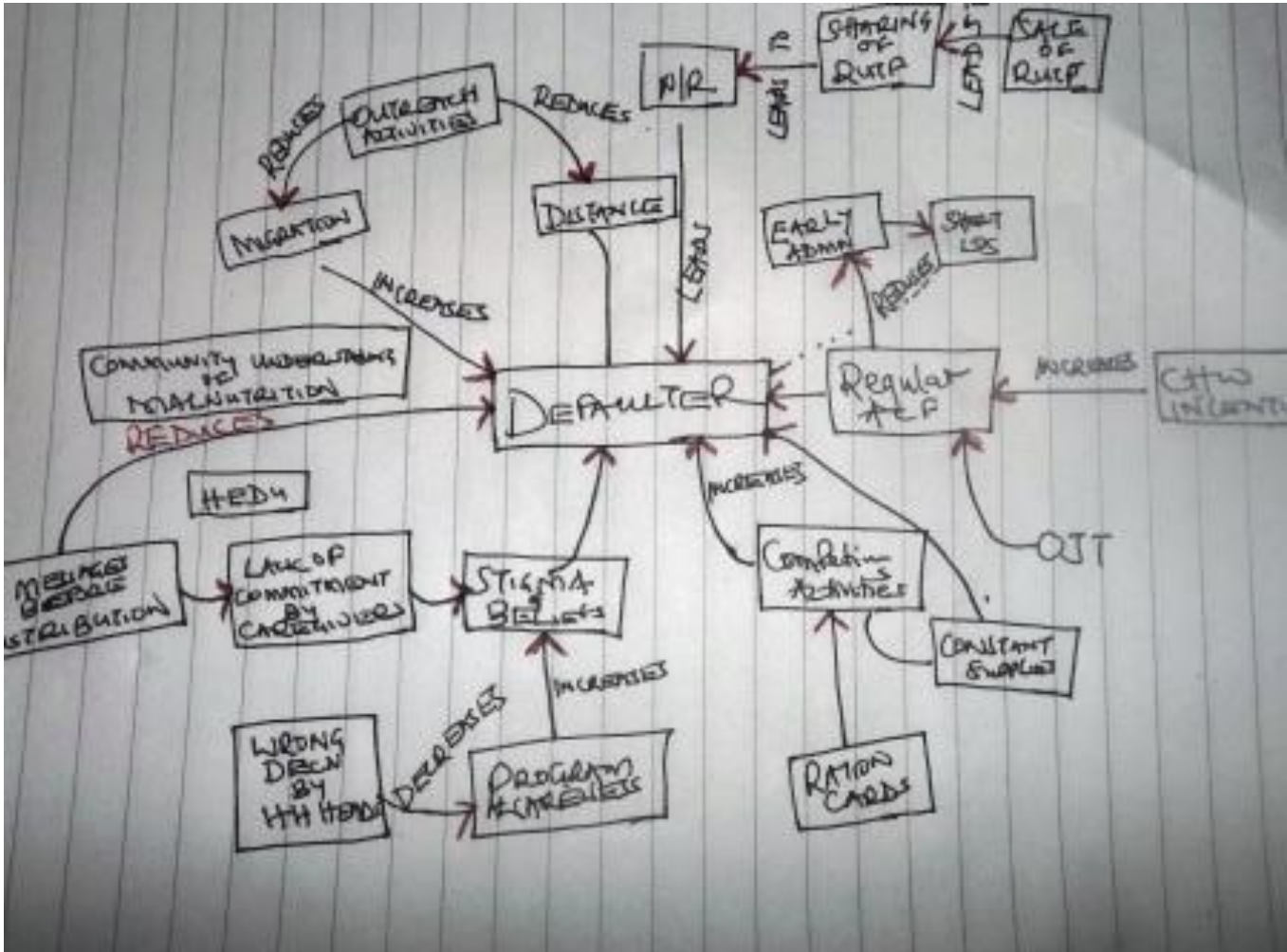
2013

COVERAGE ASSESSMENT

» SEMI-QUANTITATIVE EVALUATION OF ACCESS & COVERAGE

ANNEXES

ANNEX I: Merti Sub County Concept Map





COVERAGE ASSESSMENT

» SEMI-QUANTITATIVE EVALUATION OF ACCESS & COVERAGE



ANNEX II: Wide area survey results by sampled village

Table 10: Wide area survey results

Village	All SAM cases (MUAC <115mm)	SAM cases in Program	SAM not in Program	Recovering cases in Program
Goda A	1	0	1	0
Goda B	0	1	0	0
Awarsitu A&B	1	0	1	0
Saleti A	2	1	1	0
Malkagalla Central	0	0	0	0
Town B	2	0	0	0
Tasefayo	0	0	0	0
Fugicha	0	0	0	1
Taqwa 1	0	0	0	0
Badana	0	1	0	0
Bulesa box	1	0	1	0
Biliqo marara A	0	0	0	0
Rigga	0	0	0	0
Kambi juu	0	0	0	0
Lafe	0	0	0	0
Korbesa central B	0	0	0	0
Biliqi central (Korbesa)	0	0	0	0
Saleti Abukol Boru	0	0	0	0
Manyatta Funan	1	0	1	0
Malkagalla Town B	0	0	0	1
TOTAL	8	3	5	2



ANNEX III: List of participants

Table 11: List of Participants

NAME	SECTOR	DESIGNATION
Godfrey Mwiti	MOH	DHRIO
Safia Abdulkadir	ACF	HINI-O
Kioko Kiamba	ACF	PM ASST
Mwangi Peter	ACF	HINI-O
Patrick Musyoka	MOH	HRIO
Guyo Dabaso	ACF	HINI-O
Nuria Hassan	MOH	CHEW-NUTRITION
Gollo Mohamed	ACF	HNI-O
Lilian Mwikali	ACF	SURVEILLANCE
Salad Siad	MOH	CHEW-NURSE