Samburu County Semi Quantitative Evaluation on Access and Coverage (SQUEAC)

May 2017

Acknowledgement

Samburu County SQUEAC assessment was made successful through the contribution of a number of partners. The assessment was led by the County Department of Health.

The County is indebted by immense contribution by partners who tirelessly made this year's survey a success. The following partners are highly appreciated for their contribution.

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Acronyms and Abbreviations

CHMT	County Health Management Team
CHV	Community Health Volunteers
CMAM	Community Management of Acute Malnutrition
CMN	Coverage Monitoring Network
GAM	Global Acute Malnutrition
IEC	Information Education and Communication
IMAM	Integrated Management of Acute Malnutrition
KRC	Kenya Red Cross
LQAS	Lot Quality Assurance Sampling
MoH	Ministry of Health
NDMA	National Drought Management Authority
OTP	Outpatient Therapeutic Program
RUTF	Ready to Use Therapeutic Feeds
SAM	Severe Acute Malnutrition
SCHMT	Sub County Health Management Team
SFP	Supplementary Feeding Program
SMART	Standardized Monitoring Assessment on Relief and Transition
SQUEAC	Semi Quantitative Evaluation on Access and Coverage
TBAs	Traditional Birth Attendants
THPs	Traditional Health Practioners
UNICEF	United Nations Children's Fund

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Executive Summary

Introduction

Over the years, Samburu County has experienced both acute and chronic food insecurity. The County has therefore a poor nutrition status. A SMART survey conducted in June 2016, showed that the global acute malnutrition was 14.5%, with Severe acute malnutrition being 2.4%. Though there was a slight reduction in status of acute malnutrition (GAM), the reduction was not significant compared to June 2014 when a similar survey was done. Chronic malnutrition (Stunting) was equally high at 34.8%.

In October 2013, A SQUEAC assessment covering OTP revealed a single coverage of 51.6%. A number of program barriers were identified. These included; defaulting, long distance, migration, sharing of RUTF, alcoholism, health workers shortage, weak linkages of OTP to GFD programs, inadequate case finding as well as inadequate defaulter tracing among others. Key program boosters included; availability of RUTF in most of the health facilities, integrated outreaches, program awareness by the community, early admissions, good documentation, positive opinion about the program among the others.

In May 2017, the Samburu County department of health supported by international medical Corps and UNICEF carried a follow up SQUEAC assessment in the entire County. The objective of the assessment was to estimating the overall SAM coverage, identify boosters and barriers to the OTP program uptake and to make recommendations for coverage improvement. This assessment aimed to build the technical capacities of the ministry of health and partners technical persons on SQUEAC as a program coverage methodology.

Methodology and Key findings

SQUEAC is a 3 stage methodology that combines an array of qualitative information about access and the perception of CMAM program with small sample quantitative surveys. Stage one involved collection of quantitative (routine program data) as well as qualitative data using a number of methods and from several sources including; semi structured interviews which was administered to health workers in the health facilities, program staff (County nutrition coordinators, partners implementing staff, Health facility CHVs as well as carers of children in program), informal group discussions was administered to community leaders, THPs/TBAs, pastoralists and caregivers in the community. In-depth interviews were also done with caregivers of children in program and defaulting children.

Analysis of routine program data as well as qualitative information showed a number of program barriers and boosters. Some of the program boosters identified included; availability of RUTF at the County and sub county stores, technical capacity of health workers or CHVs to offer IMAM services, presence of IEC materials and documentation tools, knowledge and positive perception by the community, Early program admissions, partners presence among others. On the barriers side, the barriers identified included weak defaulter tracing mechanisms, inadequate outreaches and active case findings, lack of incentives to motivate community health volunteers, inaccessibility of OTP sites as a result of conflicts, distance, RUTF stocks at the remote health facilities among others.

Stage 2 involved formulation of hypothesis based on the information collected in stage 1. The hypothesis formulated was; Villages that are accessible to the health facilities have a higher coverage

compared to those are not accessible was formulated. This hypothesis was tested using the Simplified LQAS formula; d= In/2I in comparison with 50% SPHERE threshold for rural areas. Through a small area study, the hypothesis was confirmed.

Stage 3 involved likelihood (wide area) survey. Before this stage, prior mode was calculated using weighted barrier and boosters as well as concept map positive and negative linkages. Once the *prior mode* has been finalized and its shape parameters entered into the Bayes calculator (as s, a recommended sample size will be generated. This figure is the recommended *minimum* number of acutely malnourished children which need to be found during the *likelihood* survey to achieve the desired level of confidence in the *posterior,* or the overall coverage estimate. From the calculations a total of 29 children were to be actively searched in 41 villages.

Spatially Stratified Sampling method was used for sampling the villages. This was informed by the fact that there was no clear map of Samburu County with all villages or communities marked. An updated list of all the villages in Samburu County was made. Each village was linked to a health facility catchment. There were 464 villages in Samburu County. This was divided by the number of villages calculated in section 2.6.1. that is 41 villages to obtain a sampling interval of 11. The first village was randomly selected between 1 and 11. In this case the first village was village 6 (Lerata) from the list. The 2nd village was sampled as 11th village from village 6 and that continued until the 41st village was sampled. Data collection was done by 6 teams for 6 days. Each team had 3 members. Active case finding was used to search for SAM cases in the sampled villages.

Single coverage estimator was used to estimate the program coverage. Single coverage estimator includes both recovering cases that are admitted and those that are not in the program. Combining prior estimate and likelihood information in the calculator generated a posterior which showed the overall coverage for OTP in Samburu County as **45.2% (35.1- 55.4).**

Conclusion

Although, the coverage was arrived as a single coverage it was below 51.6% achieved during 2013 SQUEAC assessment which was a Point coverage. In this regard, the estimated coverage failed to meet the Standard SPHERE coverage for rural areas which is 50%.

The main reason for low OTP coverage included weak defaulter tracing coupled with inadequate community screening and active case findings. The main reasons for this was due to the fact that CHVs were not given incentives as they used to be given during the previous assessment. It was noted that during the assessment in few Community Units, the Community Health Volunteers were given incentives. The CHVs who were provided with incentives were attached to 4 Community Units (Lerata, Serolipi, Archers post and Lorubae) in Samburu East Sub County and were supported by Feed the Children. Lack of CHVs incentives lead to weak defaulter tracing strategies in the County as well as weak case findings. This can be attributed to early program defaulting as it was noted in program data analysis.

Community screening was minimal and inconsistent. The distribution of such outreached in space and time was not good. There was little support from the government meant for community outreaches. From the contingency plan (2016), the County government according to one of the program staff had promised to allocate Ksh 1.2million to support outreached. However, only Ksh. 0.6million was given.

The amount supported only few outreaches in the most affected parts of the County. Some of the partners that supported outreaches in the County included; KRC, Action Against Hunger and Feed the Children.

Food insecurity and poor OTP linkages was also cited as one cause of low coverage. As indicated by the health facility workers, community and health facility community health workers and program staff, there was noncompliance in the treatment of acute malnutrition due to household food insecurity where caregivers of children in the OTP program were forced to share the RUTF with other children in the household. Few households were linked to the cash transfer program in Samburu East and Samburu Central which made the situation worse.

Consumption of alcohol by caregivers especially for children in Samburu Central (around Maralal town) and Samburu North (around Baragoi town) was another program barrier noted through observation as well as semi structured interviews with health facility in charges as well as health facility based CHVs. Care givers of children who consumed alcohol failed to do their household roles including child care. A part from failing to take their children to the health facilities when they were supposed to do so thus leading to defaulting which is major challenge for the OTP program. Excess consumption of alcohol by the caregivers led to some of them sell the RUTF in a bid to have money to buy alcohol. Those who were beneficiary of cash transfer used their proceeds to buy alcohol instead of food for their children.

Migration as a result of drought, rainfall, domestic violence and conflicts also resulted to low program coverage where caregivers could not reach the service delivery sites when they were required to do so resulting to defaulting. Inaccessibility to the OTP sites as a result of distance, wild animals as well as conflicts also resulted to low program coverage.

Although there RUTF stocks were available at the County and sub county stores, there were notable gaps in the distribution. The County government had leveraged on the county government and partners vehicles to support in the distribution of RUTF but these efforts have not been sufficient. With gaps in documentation, affecting the ordering of stock there was notable stock outs in the OTP (remote health facilities).

Poor documentation was noted in a number of health facilities. This was attributed to inadequate workforce coupled with lack of incentives for health facilities CHVs, poor targeting of IMAM training whereby those health workers who are not involved in service delivery are not the once who participated in IMAM training. Inadequate IEC materials as well as beneficiary ration cards was also a reason for poor documentation.

Recommendations

Based on the findings, the following key actions were recommended to address key program barriers;

Program Barrier	Recommendation
RUTF stock outs at the health facilities	Improve on documentation at the affected health facilities
	Scale up nutrition commodities requisition
Weak Defaulter tracing mechanisms	Strengthen defaulter tracing mechanism by actively involving community units and CHVs
	Incorporate Mother to mother support group/Mother and Father Care groups in defaulter tracing

	Involve local authorities and family members in defaulter tracing
	Advocate for recognition of community units and CHVs
Early Defaulting	Educate caregivers on the importance continuity of nutrition services to the clients at the OTP program sites
Weak Organization of OTP program	Improve program organization at the respective health facilities using the guidelines
Inadequate community screening and active case findings	Organize and execute more mass screening activities in the County
Household food insecurity and inadequate program linkages	Educate the community on food diversification and advocate for linkages of OTP to other programs
Inaccessibility to OTP programs due to distance wild animals and conflicts	Organize more outreaches in hard to reach areas and malnutrition hotspots
	County government to construct dispensaries in hard to reach areas
Migration due to drought, conflict and domestic violence	Organize integrated outreaches services to the areas the communities migrates
	Organize peace forums in conflict areas
Inadequate workforce	Increase the workforce by employing more health workers
Lack of knowledge on malnutrition signs	Educate the community on the early signs of malnutrition
Poor health seeking	Scale up health education in the communities
	Scale up advocacy to create awareness on child care through barazas, MTMSGs, and at the health facilities
Poor documentation	Continue capacity building to all health workers on documentation and good records keeping
Inadequate IEC materials and ration cards	Procure and dispatch IEC materials
Alcoholism	Establishment of mother care group and mother support groups within the child bearing age and health education
	Adopt direct observation of treatment (DOT) management
No incentives for CHVs	Give incentives to CHVs and absorb them to the County health system
Lack of proper targeting of IMAM training	Train nutrition program implementing health workers

1.0. Introduction

1.1. Background

Samburu County lies in the northern part of Kenya and covers an area of 21,022.1 sq. km (Samburu County CIDP 2013- 2017). It is situated in the northern part of Great Rift Valley. To the north west the County borders Turkana County. The County also borders the following Counties; Baringo to the Southwest, Marsabit to the Northeast, Isiolo to the East and Laikipia County to the South. The County lies between latitudes 0˚30' and 2˚35' N and between the longitudes 36˚15' and 38˚10' E. The County estimated population based on 2009, Kenya National Bureau of Statistics (KNBS) population census projection is 274,079 people with an under-five population of 51,884. Administratively, Samburu County is further divided in to 3 sub counties namely; Samburu North, Samburu East and Samburu Central. Samburu County is divided in to 3 livelihood zones namely pastoral, agro pastoral and formal employment/business/petty trade.

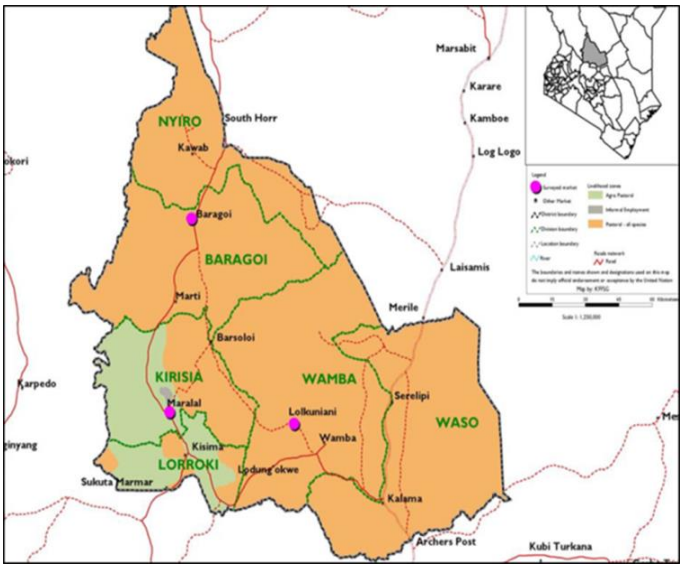


Figure 1: Samburu County Map

Approximately 85% of the County is lowland range land; the rest is highland where rain fed agriculture is practiced. According to a SMART survey carried out in Samburu County (June 2016), the global acute malnutrition was at serious state (14.5%) while SAM was 2.4%.

1.2. SQUEAC Assessment Rationale

Over the years, Samburu County has experienced both acute and chronic food insecurity. The County has therefore has a poor nutrition status. A SMART survey conducted in June 2016, showed that the global acute malnutrition was 14.5%, with Severe acute malnutrition being 2.4%. Though there was a slight reduction in status of acute malnutrition (GAM), the reduction was not significant compared to June 2014 when a similar survey was done. Chronic malnutrition (Stunting) was equally high at 34.8%.

In October 2013, A SQUEAC assessment covering OTP revealed a single coverage of 51.6%. A number of program barriers were identified. These included; defaulting, long distance, migration, sharing of RUTF, alcoholism, health workers shortage, weak linkages of OTP to GFD programs, inadequate case finding as well as inadequate defaulter tracing among others. Key program boosters included; availability of RUTF in most of the health facilities, integrated outreaches, program awareness by the community, early admissions, good documentation, positive opinion about the program among the others. Following the results, a number of recommendations were made as summarized in table 1 below.

Table 1: 2013 SQUEAC assessment recommendations

Program Barrier	Recommendation
Defaulting	• Strengthening defaulter tracing mechanism by supporting more integrated outreaches • Recruiting CHVs in the outreaches and giving them incentives to motivate them • Establishing more community units and strengthening the existing ones with training for CHVs on IMAM • Encouraging men to be involved in the OTP through the formation of more men care groups
Long Distances	• Integrated outreaches for villages more than 10km from the health facilities
Staff attitudes and shortages	• Recruitment of more staff to reduce the workload of few staff • The CHMT and SCHMTs to take disciplinary action to health workers who avoid duties
Noncompliance of IMAM protocols and alcoholism	• Continuous health education and counselling of caregivers on the importance of the programs
Competing activities	• Health education and counselling to mothers on the importance of IMAM program to the child health • Men involvement in the program to allow mothers time to take their children to the health facilities while carrying out other activities.
Sharing of RUTF	• Linkage of all OTP cases to GFD to avoid RUTF sharing • Improve program awareness to the community leaders
Poor linkage to GFD	• Review of GFD targets to have an allowance for including new OTP beneficiaries
No Active case finding /community screening	• Recruitment of more CHVs through community units and training them on IMAM • Supporting regular community screening through outreaches
Migration	• Initiating livelihood programs to encourage permanent settlements • Engaging communities in peace initiatives to avoid migration associated with insecurity • Initiating integrated outreaches in nomadic sites

This assessment will assist to establish whether the implementation of the recommendation has boosted the coverage of OTP program.

1.3. Objectives of SQUEAC Assessment

This assessment aimed to achieve the following key objectives

- Estimating the overall SAM coverage
- To identify boosters and barriers to the OTP program uptake
- To make recommendations for coverage improvement
- To build the capacities of MoH and partners technical persons on SQUEAC methodology

2.0. Methodology and Results

2.1. Introduction

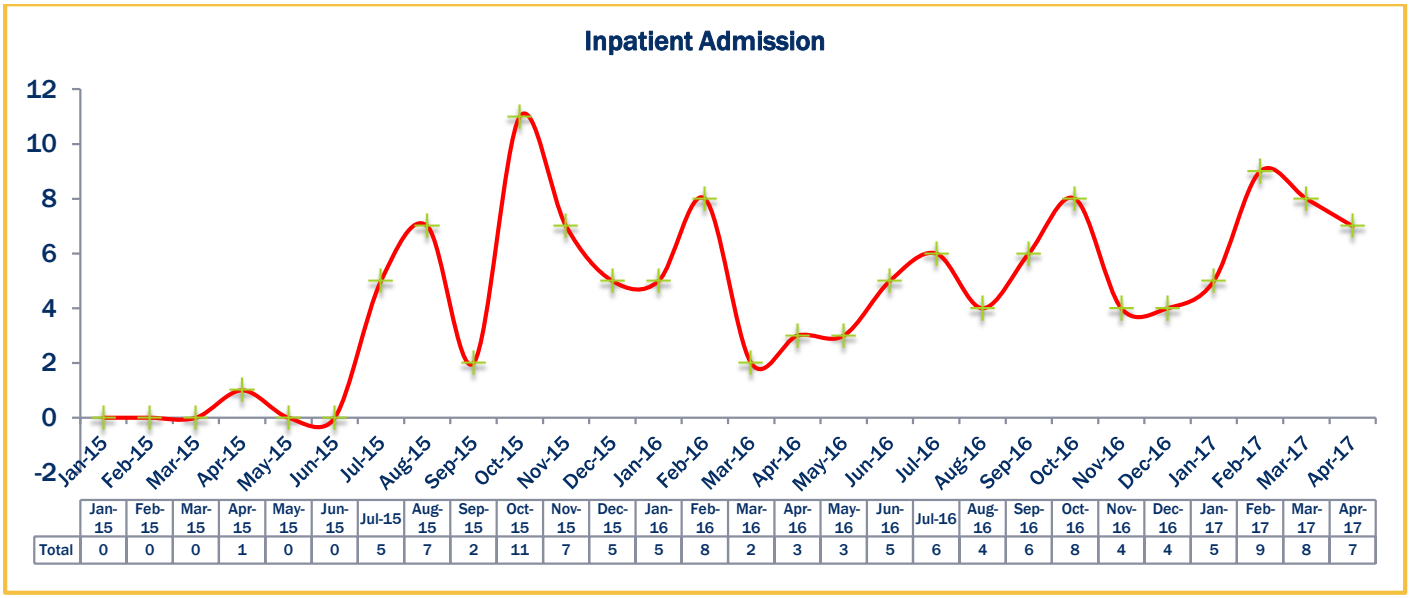
SQUEAC methodology was used in the assessment. SQUEAC method is a comprehensive, iterative tool to analyze the barriers and boosters to coverage and gives estimate coverage. SQUEAC also provides succinct actions for improving access and coverage (CMN). The method is a low resource 3 stage model. It combines an array of qualitative information about access and the perception of CMAM program with small sample quantitative surveys. These surveys test hypotheses generated during the qualitative work and establish levels of program coverage in key geographical areas. This combination both identifies key issues affecting presentation and program uptake real implementation whilst also establishing the actual levels of coverage attained. Vitally, all this can be done in time, allowing the tool to be of immediate practical use to tweak program design and in response to the information obtained (Mark Mayatt 2012).

2.2. Stage 1: Identification of Areas of Low and High Coverage

In order to identify areas of high and low coverage analysis of routine program data was done. Data was collected in all 43 sites that offer OTP program in the entire county from October 2013 (the period which the program started to function) to April 2017. Data collected from the sites included; OTP admissions per month, admission MUAC, exits (cured, defaulters, deaths, non-responses) on monthly basis, defaulters based on their villages of residence and defaulting visits, disease calendar. Seasonal calendar was obtained from the county NDMA office since they have been monitoring the county seasons regularly over a period of time.

2.2.1. Admission over time

Analysis was done for the admissions of OTP and inpatient program from October 2013 to March 2017. Figure 2 below shows the number of children admitted in OTP from January 2015 to April 2017. There was a challenge in documentation of inpatient admissions.



	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Total	0	0	0	1	0	0	5	7	2	11	7	5	5	8	2	3	3	5	6	4	6	8	4	4	5	9	8	7

Figure 2: Inpatient admissions

The average length of stay recorded for in patient program was 4.3 days. From the analysis, documentation or Noncompliance in the management of children who were severely malnourished with complication was a barrier to coverage in all 3 management sites in Samburu County namely Mararal County Hospital, Baragoi Level 4 hospital as well as Wamba Catholic Hospital.

Analysis was also done for program admission for OTP program from October 2013, a month after the first SQUEAC was done to March 2017. This was plotted as indicated in figure 3 below. Due to considerable variations on monthly admissions, smoothening of the curve was done by moving averages. Admission trends were also compared to the County seasonal calendar in figure 4.

Notable spikes of admission were noted in the months of January due to the onset of drought resulting to low milk production among the pastoralists. Reduction in admissions in February could be attributed to the outmigration experienced in the County. High admissions were also realized in the months of November which is a peak of immigration as well as June and July which can also be classified as lean periods in the County especially in the pastoral livelihoods due to reduction in milk production.

Figure 3: Admission overtime

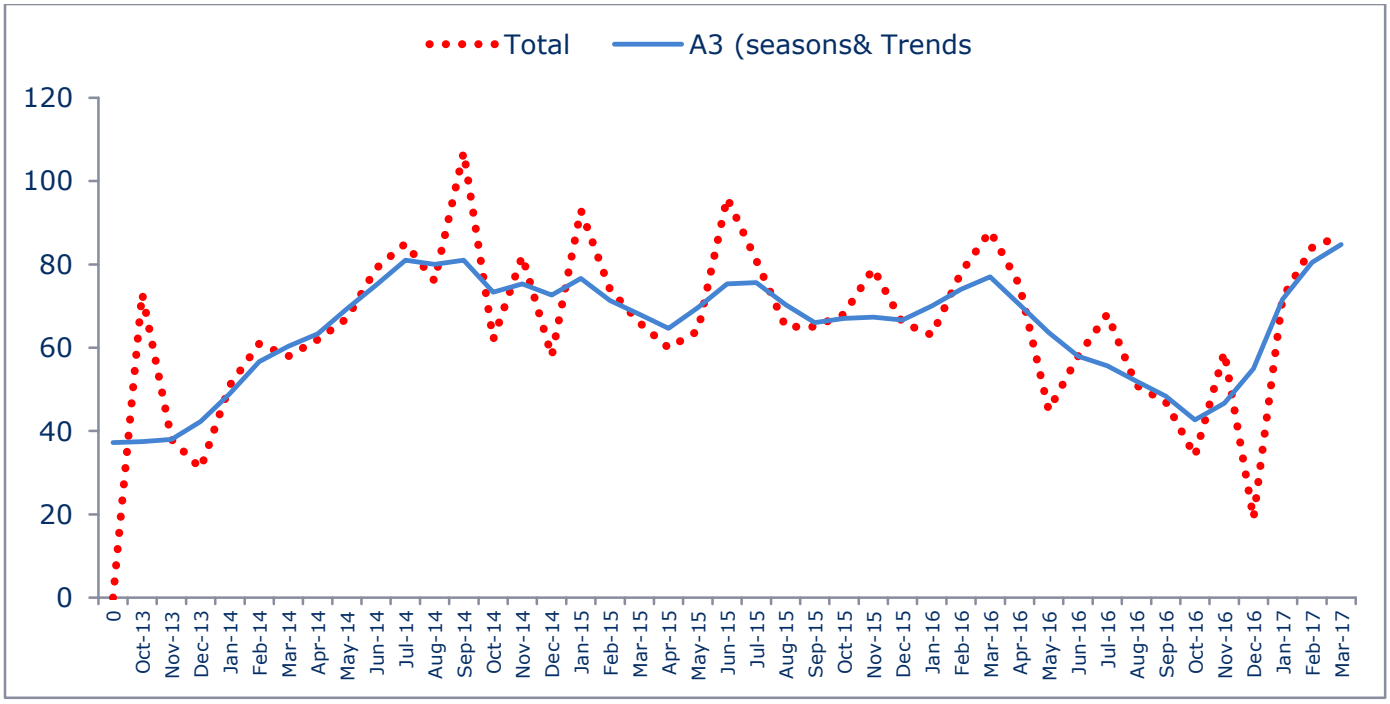


Figure 4: Samburu County Seasonal Calendar

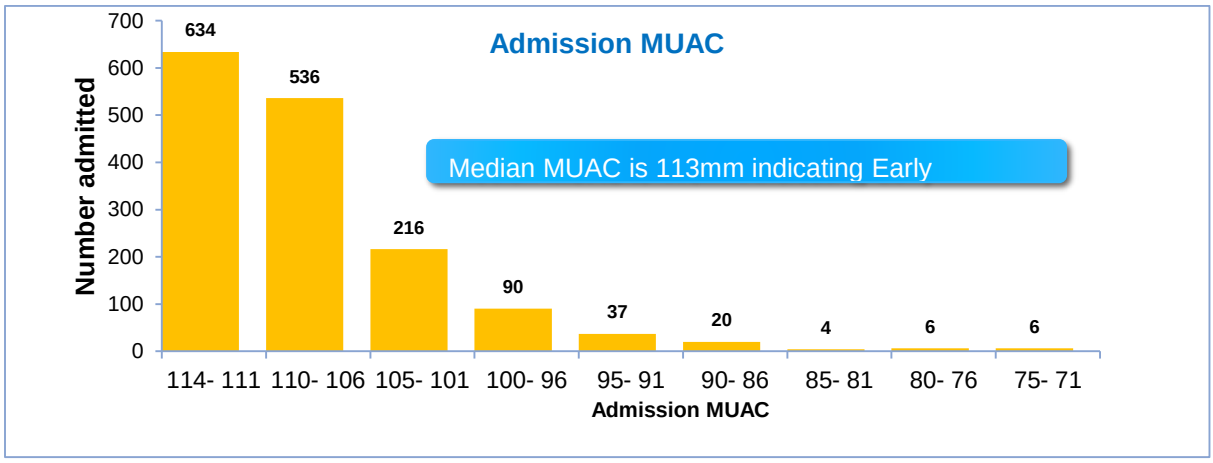
Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Season	Drought			Long rains		Continental rains			Short rains			
Agriculture	Harvesting	Land preparation		Cultivation & Planting		Harvesting			Land preparation & cultivation			Harvesting
Pastoralist	Livestock migration and low milk production			Livestock production increases (Breeding)		Low milk Production			Increased animal production			
Insecurity	Raids			Minor Livestock thefts		Raids				Minor thefts		
Migration	Out			In		Out			In			

2.2.2. Admission Time

Plotting admission overtime is useful but ignores the issue of timeliness of admission. Children with MUAC below the admission criteria (<11.5cm or 115mm), or with nutrition odema should be in the program. If many of these are not in program, then program coverage is low. Children who are admitted to the program after they have met program criteria after a considerable period of time are said to be late admissions. Late admission is associated with the need for inpatient care, longer treatment, defaulting and poor treatment out comes (including death). These can lead to poor program opinion by the host community leading to late presentation and program admission in a negative feedback cycle.

Analysis of admission time indicated that majority of children are admitted in OTP early with the mean median admission MUAC being 113mm. In this regard, children admitted in OTP program are likely to have good outcome (cure). They are also unlikely to develop complications, default and take a shorter period in the program. As such, the community is likely to have a positive program opinion and hence early presentation in the program. Early admission was therefore one of the program booster

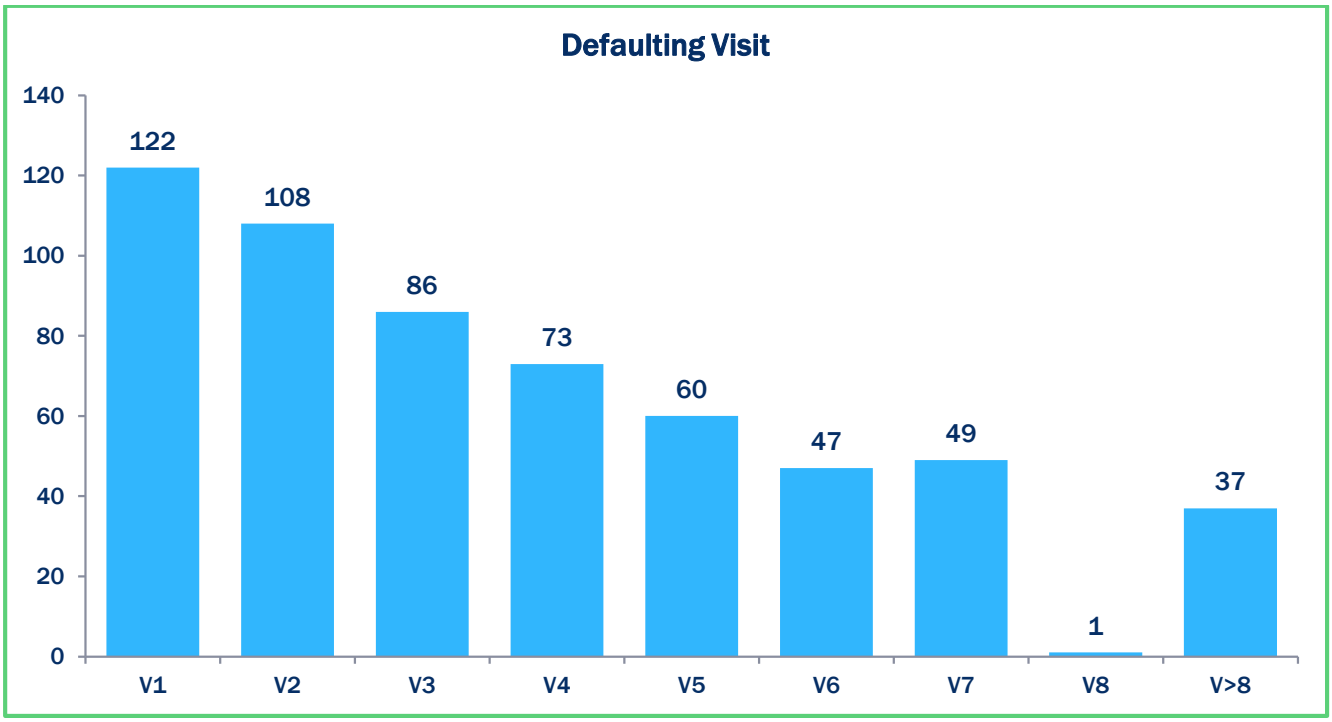
Figure 5: MUAC Admission



2.2.3. Defaulting Visit

Defaulting visit determines the coverage of program. If large number of children default in the first 2 visits, such children are likely to be current SAM cases. As shown in figure 6 below, majority of children defaulted in the first 3 weeks. The median defaulting visit was visit 4. Early defaulting was one of the notable program barriers.

Figure 6: Defaulting visit

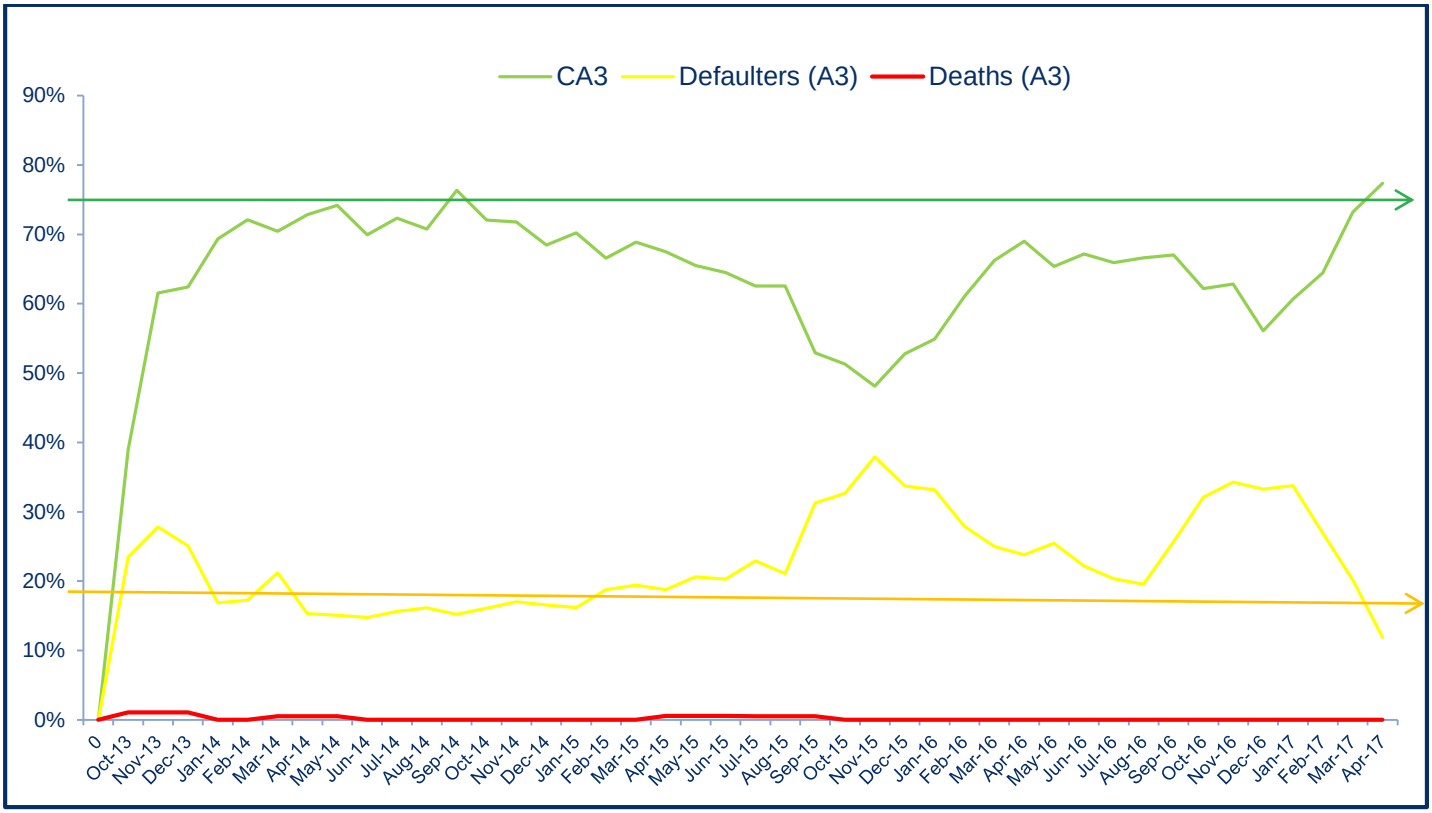


2.2.4. Exit Over Time

A high number of admissions does not guarantee a good coverage. Program coverage should be determined by examination of program exists. High defaulting rate is associated with low program coverage. When plotted overtime, a healthy program in which the sphere standards are being met have the cure line along the top of the graph while the defaulter and the death line at the bottom of the graph in a mirror image. In case the percentage of defaulters is more than 15%, then there is a cause of concern. Cure line should be above 75% while death line should be below 10%

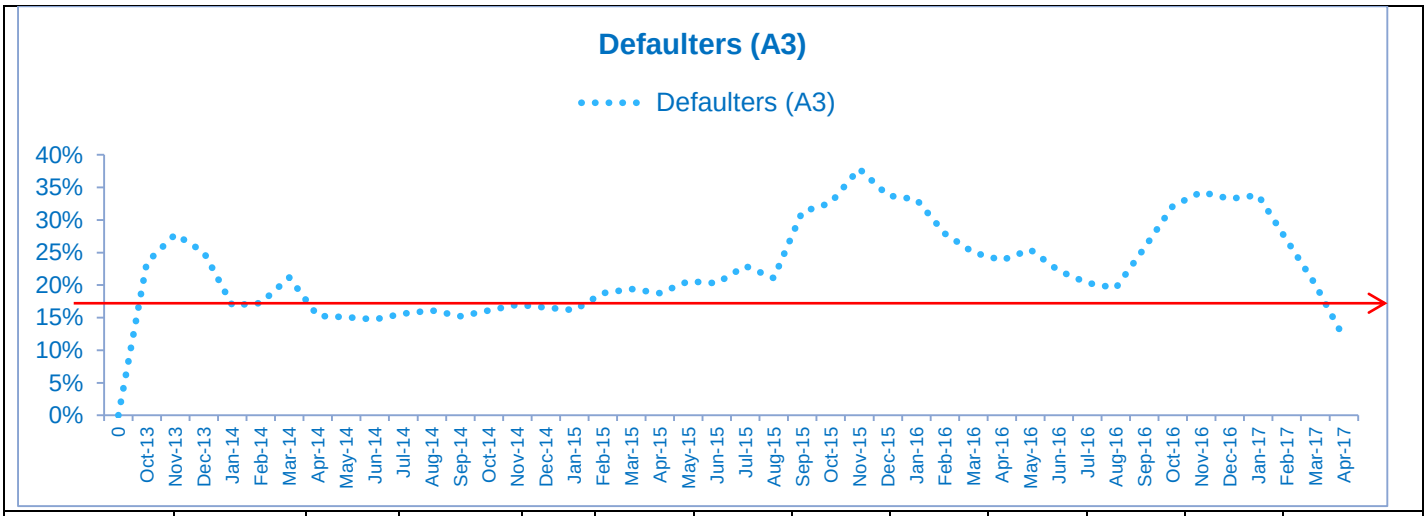
As shown in figure 7 below, Samburu County SAM cure line in almost all months was below 75%. Although death line remained below 10%, defaulter line was above 15% in most cases. This combined with the fact that majority of children defaulted between 1st and 4th visit was a concern as there could be "hidden deaths" in the community. Active case findings and defaulter tracing mechanism should be strengthened to ensure no such deaths are found in the community as well as to bring back the defaulting children to the program.

Figure 7: Exit over time



2.2.5. Defaulting Trend

Defaulting was a major barrier to the OTP program. Further analysis was done to establish the major causes of defaulting based on the seasonality, agricultural and livestock activities as well as migration patterns. As indicated in figure 8 below, defaulting spikes were realized in the months of November to January, this could be attributed to increased workload as well as well as migration by pastoralists as a result of drought.



Month	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Season	Drought season			Long rains		Continental rains			Short rains			
Agriculture	Harvestin g	Land Preparation		cultivation		Harvesting			Land preparation/cultivation			Harvesting
Pastoralists	Livestock migration and low milk production			Livestock production increases (breeding)		Low milk production			Increased animal production			
Insecurity	Raids			Minor livestock thefts		Raids					Minor Raids	
Migration	Outmigration			In migration		Outmigration			In migration			

2.2.6. Outreach Sites

A total of 15 outreach sites were mapped in Samburu County. There was no consistency in the Outreach. This was attributed to lack of financial support from the County government or development partners in the County. Lack of political will to support nutrition activities in the County has made the situation. As indicated in table 2 below, Samburu Central has only 2 outreach sites compared to Samburu North with 5 and Samburu East with 8 outreach sites. The County government committed to contribute 1.2 million to support outreach activities. However, only 0.6million was allocated. Partners supporting outreach activities in the County included Kenya Red Cross, Feed the children as well as the Action against hunger. There outreaches were not done regularly with some being held once in a month others once in three months and others only when funds were available. Since defaulting is a major issue in the management of acute malnutrition, there is need for the County department of health and partners to come together and mobilize funds to support outreaches.

Table 2: Mapped Outreach sites

Sub County	Outreach site	Name of the link Health facility	Distance from the link facility (Km)	Estimated population in the outreach site	Proposed Interventions (Outreach/ Mass screening)
Central	Lailelai/Nkipuruti	Muruangai Gok	10	910	Outreach
North	Parkati Area	Parkati Dispensary		790	Mass Screening
North	Loodua	Lesirikan H/C	22	770	Outreach
North	Uraa	Uraa Dispensay		1084	Mass Screening
North	Naiturkan/Nawapeto	Nachola Disp	10	1200	Outreach
North	Arsim	Arsim Lutheran		670	Mass Screening
East	Soitu A& B	Ndonyo Wasin	20	900	Outreach
East	Pareu	Pareu Disp		1291	Mass Screening
East	Reteti	Sereolipi H/C	20	1115	Outreach
East	Mugur	Lodungokwe Disp	25	770	Outreach
East	Leitemu	Sereolipi H/C	16	490	Outreach
East	Sirata	Sereolipi H/C	18	669	Outreach
East	Lesurua	Sereolipi H/C	50	509	Outreach
East	Laresoro	Archers Post	30	566	Outreach
Central	Losho	Lodekejeck Disp	15	670	OUTREACH

2.2.7. Program Documentation

In most of the health facilities (OTP sites), there were IEC materials to guide the health workers in service delivery. Such materials included acute malnutrition triage charts, WHZ charts, RUTF issuance charts as well as stock cards. A review of program registers revealed a few documentation challenges in some OTP sites, some of the challenges noted included; partly filled registers for example the average length of stay and exit outcome (not indicated). However, in some facilities the situation was different as all columns were well filled and legible. In such facilities it is easier to monitor the child progress. Finally it was noted that the OJT teams visited the facilities and made some correction which was a booster to the program. Lack of enough skilled staff in the county made the situation worse since the responsibility of handling OTP program was left in the hands of CHVs, without strict supervision, recording of information become a challenge. It became worse in situations where the health workers were absent due to a number of reasons.

2.3. Qualitative Information

Four survey teams were composed, comprising of 4 members per team, 1 MoH (Team leader) and 3 partner/Ministry of health staff. Three methods were used to collect qualitative information. Qualitative information collected was triangulated using different sources. The methods used to collect qualitative information included;

- **Semi structured interviews:** information was collected from health facility in charge/program staff and CHWs, carers of children in program
- **Informal group discussions**: by community leaders, TBAs/THPs, pastoralists and care givers in the community.
- **In-depth interviews:** with caregivers of children in program and defaulting children.

An observation checklist was also used to collect information regarding; the presence of IEC materials, RUTF stock, OTP registers and ration cards and also program organization. The information was analyzed to identify program barriers and boosters as well as areas of high and low coverage. Barriers and boosters were further organized in form of a concept map.

2.4. Concept Map

Concept-mapping is a graphical data-analysis technique that is useful for representing relationships between findings. Concept-maps show findings and the connections (relationships) between findings (Mark Mayyat 2011). Qualitative and quantitative data collected was further analyzed and organized in a concept map as shown in figure 9 below

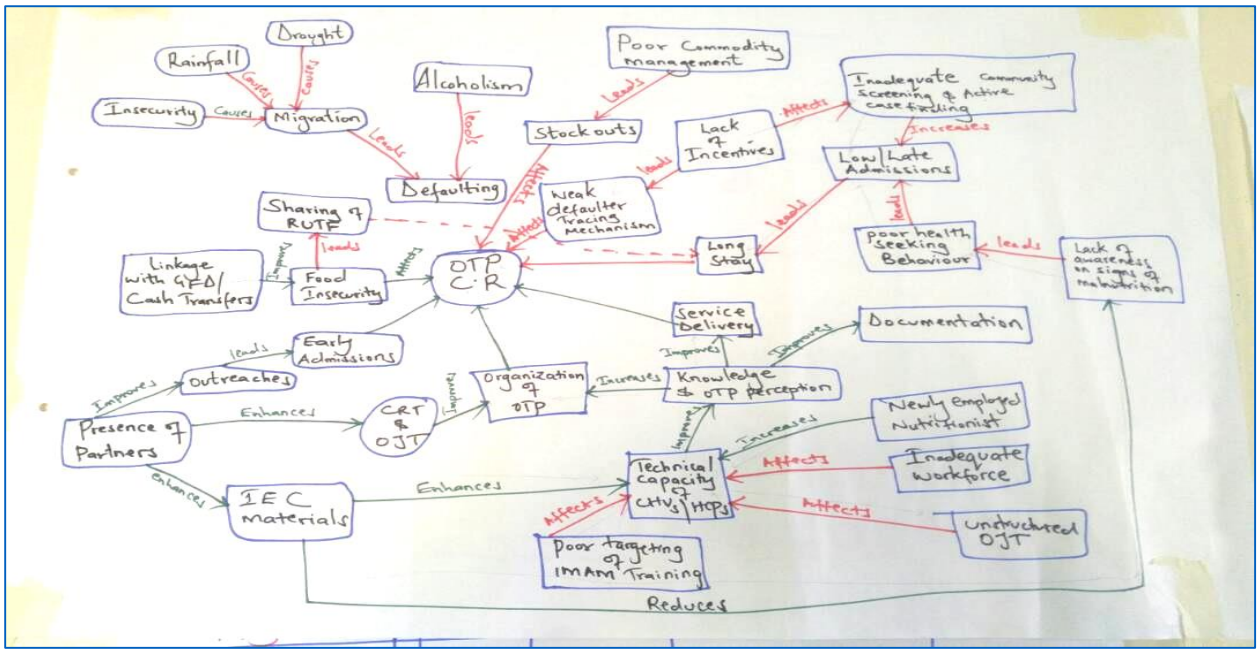


Figure 8: Concept map

2.5. Stage 2: Hypothesis Testing

The objective of this stage was to confirm areas of high and low coverage based on the data collected from stage 1. The hypothesis; Villages that are accessible to the health facilities have a higher coverage compared to those are not accessible was formulated.

Rationale:

- Defaulting was noted in villages away from the health facilities in comparison to those that were near the health facilities. Qualitative data showed that the main cause could be distance.
- There was weak defaulter tracing mechanism across the County
- RUTF stock outs was noted in health facilities even though the County/Sub county stores were well stocked.

This hypothesis was tested using the Simplified LQAS formula; d= In/2I in comparison with 50% SPHERE threshold for rural areas.

2.5.1. Small Area Study

The small area study was conducted in purposively selected villages both near and far away from the health facility. 4 teams (each with 3 members), were divided in to two, teams visited villages closer to a health facility and the other 2 visited villages far from the health facility. Each team was provided with a MUAC tape and a packet of RUTF. When they reached the village, they looked for a key informant who lead them to household of caregivers of children under five years of age where they asked whether they were aware of any program that treat malnutrition. They confirmed by showing them MUAC and RUTF.

Table 3: Small area study results

Purposively Sampled villages	Distance to OTP site	No of SAM cases in program	Number of SAM cases not in program	Total Cases
High Coverage (Ng'ari, Ntaduarai, Rangau, Loikas, Kijiji, Kirimon	< 5km	7	5	12
Low Coverage: Nkuroto, Soit Pus, Rabal, Mugur, Naibor Kenju	≥ 5km	4	8	12
High Coverage (Ng'ari, Ntaduarai, Rangau, Loikas, Kijiji, Kirimon	Program coverage standard (p)	50%	Number of SAM cases in program is 7 which is greater than 6 so the hypothesis is confirmed	
	Decision Rule (d)	d = I12/2I= I 6I		
	Number of SAM cases in program	7		
Low Coverage: Nkuroto, Soit Pus, Rabal, Mugur, Naibor Kenju	Program coverage standard (p)	50%	Number of SAM cases in program is 4 which is less than 6. The hypothesis was therefore confirmed.	
	Decision Rule (d)	d= I12/2I= I6I= 6		
	Number of SAM cases in program	4		

2.5.2. Prior Development

The analysis of routine program data (quantitative), qualitative data and the findings of small area survey provided a numerical representation of a belief about the program coverage (prior). Program barriers and boosters were organized and weighted based on the number of sources. Qualitative data was categorized as booster (positives) or a barrier (negatives) to the program. The prior mode was determined as an average of boosters (build up from 0%) and barriers (knock downs form 100%) as shown in the table below.

Summary of barriers and Boosters

Table 4: Summary of Program boosters

Boosters	Source	Score
RUTF was available at the County and Sub County store	Observations, Health facilities incharges, Health facilities CHVs, Program Staff	5
Technical capacity of health workers or CHVs to offer IMAM services	Health facility in charges, Health facility CHVs, Community CHVs, Program staff	3
Presence of IEC materials and documentation tools	Observations	2
Knowledge and positive perceptions by the community	Care givers of children not in program, care givers of children in program, TBAs/THPs, Health facility in charges, Health facilities CHVs, Nutritionists, Program staff	5
Malnutrition is treated in the health facilities	Community leaders, TBAs/THPs	4
Positive opinions on OJTs	Health facility in charges	2
Linkages of OTP with GFD and cash transfer programs	Health facility in charge, Health facility CHVs, Nutritionist and Program staff	2
Outreaches	Observation, Health facility in charges, Health facility CHVs	2
Partners presence	Health facility in charge, Observation, Nutritionist, Program staff	5
MoH vehicles are used to distribute RUTF	Program staff	1
Early Program admission	Program data	5
Total		**36**

Summary of Program Barriers

Table 5: Summary of Program barriers

Program barrier	Source	Score
Weak Organization of OTP program	Health facility incharge, Health facility CHVs, Program staff, Observation	- 4
Weak defaulter tracing mechanism	Health Facility incharge, Health facility CHVs, Program Staff	- 4
Inadequate screening and active case finding	Community leaders, community CHVs, Health facility incharge, Program staff and nutritionist	- 5
Food insecurity and inadequate program linkage	Health facility incharge, Community CHVs, Health facility CHVs, Program Staff and community leaders	- 4
Inaccessibility to OTP program (due to distance, wild animals and conflicts)	Health facility in charges and Pastoralists	- 4
Migration due to rainfall, drought, domestic violence and conflict	Health facility in charges and CHVs, caregivers of children in program, Program staff, nutritionists,	- 4
Stock outs of RUTF in the remote health facilities	Health facility in charges and CHVs, Observation, community leaders and program staff	- 2
Inadequate workforce	Health facility in charges, Nutritionists, Program staff, caregivers of defaulting children	- 5
Lack of awareness of malnutrition signs	Pastoralist and community leaders	- 2
Poor health seeking	Pastoralists, community leaders and caregivers of children in program	
Poor program documentation	Observation and Program staff	- 3
Inadequate IEC materials and beneficiary ration card	Observation and Health facility in charge	- 2
Alcoholism	Health facility in charge, Observation, Program staff	- 4
No incentives for CHVs	Health facility in charge	- 3
Poor targeting for IMAM training	Program Staff	- 2
Early Program defaulting	Program Data	- 4
Total		- **54**

Concept map Positive and Negative Links

From the Concept map, negative linkages added up to 25, while positive linkage added up to 22 as indicated in figures 9 and 10 below.

Figure 9: Concept map negative linkages

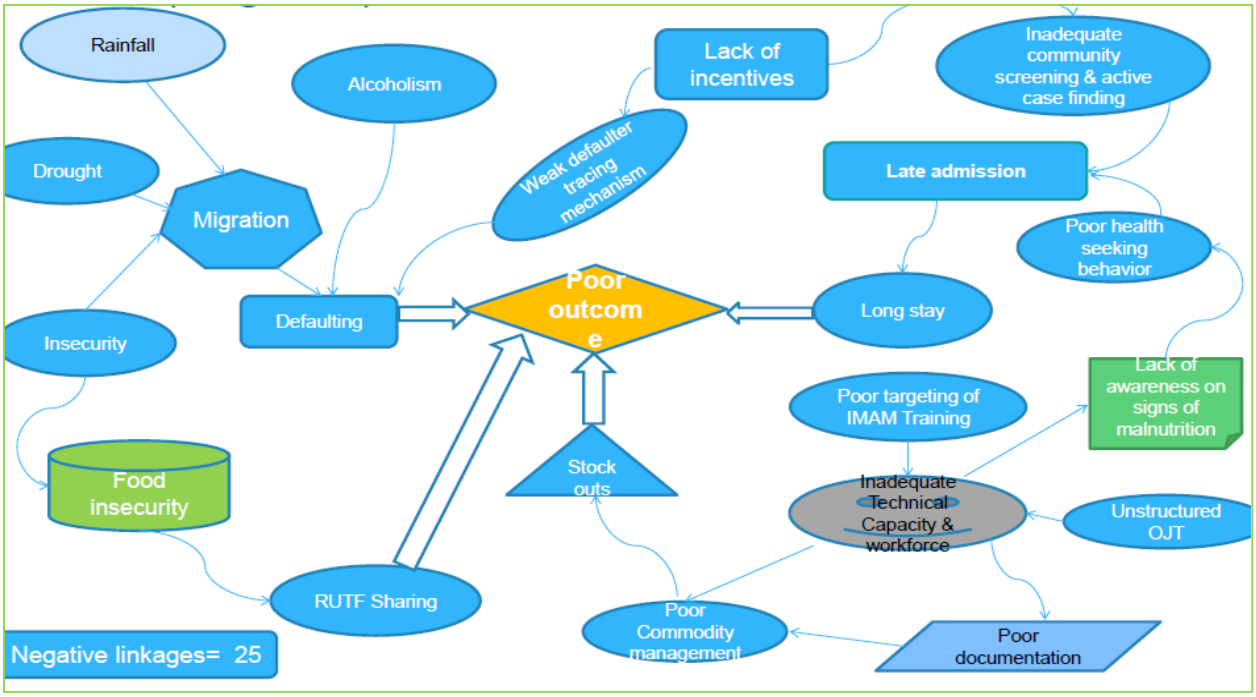
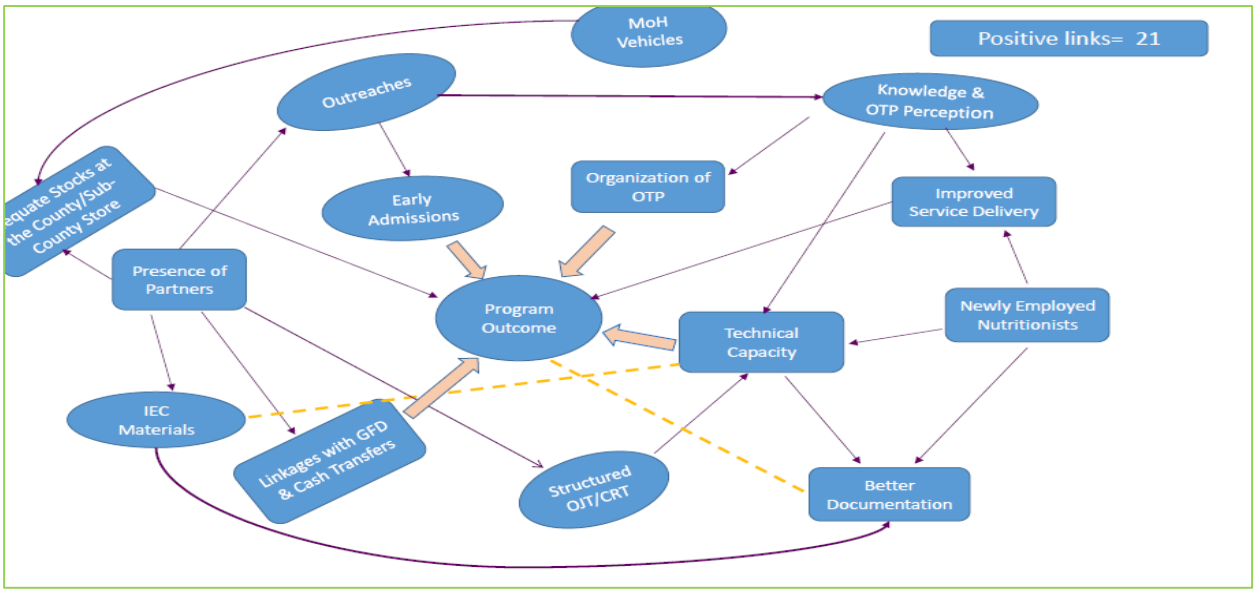


Figure 10: Positive Linkages



2.5.3. Prior Mode Development Using Weighted Barriers and Concept Map

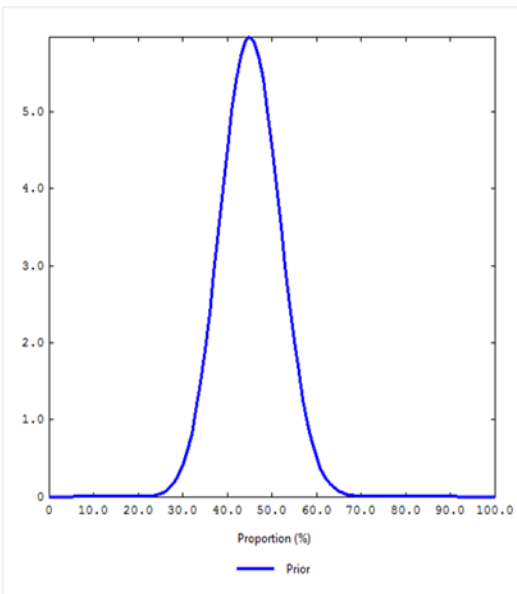
By weighting barriers and boosters and using the concept map positive and negative linkages as illustrated in figures 9 and 10, a prior mode of 44.5 was obtained as follows;

1. Weighted barriers and boosters = {36+ (100- 54)}/2 = {36+46}/2 = 82/2 = 41.

Note 36 is the sum of program boosters weighted while 54 was sum of weighted barriers (knock downs).

2. Using concept map; Positive links= 21 and negative links = 25.
   {21+(100- 25)}/2 = {21+ 75} /2 = 96/2 = 48
3. Average= (41+ 48)/2 = 89/2 = **44.5**

Using Bayes SQUEAC, coverage estimate calculator, while adjusting prior α and prior β until the mode (44.5) is obtained, the following prior plot was obtained.



The Prior α was 25.3 while the Prior β was 30.7

Figure 11: Bayes Plot

2.6. Wide Area (Likelihood) Survey

Once the *prior mode* has been finalized and its shape parameters entered into the Bayes calculator (as s, a recommended sample size will be generated. This figure is the recommended *minimum* number of acutely malnourished children which need to be found during the *likelihood* survey to achieve the desired level of confidence in the *posterior,* or the overall coverage estimate.

2.6.1. Sample Size Calculation

$$n = \left\{\frac{Mode(1 - Mode)}{(Precision/1.96)^2}\right\} - (\alpha - \beta - 1)$$

Where; **n= Sample size (number of children)**

Mode= 44.5%

Precision= 11.0%

α= 25.3

β= 30.7

Therefore;

$$n = \left\{\frac{0.445(1 - 0.445)}{(0.11/1.96)^2}\right\} - (25.3 - 30.7 - 1)$$

n= 29. Implying that the survey teams were required to find 29 children for the likelihood survey.

Since it was logistically impossible to search the cases in the entire County, it was prudent to randomly sample a number of villages where such cases will be found. The number of villages was depended on the number of cases, average population per village, proportion of children 6- 59 months in the population as well as the current estimate of SAM prevalence by MUAC as summarized in the formula below.

$$n\ villages = \frac{n}{\{Average\ village\ population * (\%\ children\ 6 - 59m) * \%\ SAM\ Prevalence\ (MUAC)}$$

Where nvillages= Number of villages to be randomly sampled

n= Number of children obtained in the previous section (29)

Average village population = 543

% children 6 – 59 months = 18.9%

% SAM prevalence by MUAC= 0.7%

$$n\ villages = \frac{29}{\{543 * (0.189) * 0.007)}$$

$$n\ villages = 40.8 \approx 41\ villages$$

Wide area (Likelihood) Survey was therefore carried out in 41 villages in Samburu County.

2.6.2. Sampling Method

Spatially Stratified Sampling method was used for sampling the villages. This was informed by the fact that there was no clear map of Samburu County with all villages or communities marked. An updated list of all the villages in Samburu County was made. Each village was linked to a health facility catchment. There were 464 villages in Samburu County. This was divided by the number of villages calculated in section 2.6.1. that is 41 villages to obtain a sampling interval of 11. The first village was randomly selected between 1 and 11. In this case the first village was village 6 (Lerata) from the list. The 2nd village was sampled as 11th village from village 6 and that continued until the 41st village was sampled.

2.7. Data Collection

Data collection was done by 6 teams for 6 days. Each team had 3 members. Active case finding was used to search for SAM cases in the sampled villages. Before data collection begin, the team sought authority from respective village leaders. After the permission was granted, the team with the assistance of village guide visited every household with children 6 to 59 months and measured their MUAC which was recorded in a tally sheet in case the child met the admission criteria (MUAC< 115mm). Each team had a questionnaire for capturing information for reasons of 'not in program cases as well as referral slip for all cases that met the admission criteria for both OTP and SFP program. A total of 31 children were met the admission criteria by MUAC as shown in table 6 below.

Table 6: Summary of Results

OTP cases	Number of Children
SAM Cases in Program (a) (covered cases)	13
SAM cases not in program (b) (Non Covered cases)	18
Total Active SAM Cases (a+ b)= C	31
Recovering cases in program	2
Recovering cases	0
Total Recovering Cases	2

2.8. Single Coverage Estimator)

Single coverage estimator was used to estimate the program coverage. Single coverage estimator includes both recovering cases that are admitted and those that are not in the program as illustrated below.

$$Single\ Coverage = \frac{Ci+Ri}{Ci+Ri+Cout+Rout}$$

Where;

Ci= Active cases in Program

Ri= Recovering cases in program

Cout= Active cases not in Program

Rout= Recovering cases not in program

Sum of Active and recovering cases in program was used as the numerator (15) while Active and recovering cases in and out of OTP program (33) was used as a denominator. This information was fed in a Bayes Coverage Estimator Calculator. Combining prior estimate and likelihood information in the calculator generated a posterior which showed the overall coverage for OTP in Samburu County as **45.2% (35.1- 55.4).** as illustrated in figure 12 below.

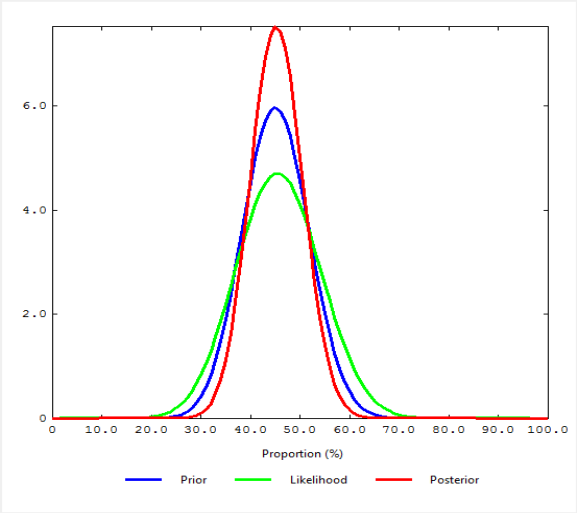


Figure 12: Coverage Estimate

Prior α = 25.3

Prior β= 30.7

Estimated Coverage= 45.2(35.1%- 55.4%)

2.9. Reasons for Non Attendance

For those children who were not admitted in the program, a questionnaire was administered to the caregivers to establish why they were not admitted in the program. Lack of awareness that their children was suffering from any illness was mentioned by a majority of the caregivers followed by lack of RUTF stocks in the health facilities. Other reasons are as illustrated in table 7 below.

Table 7: Reasons for non-enrollment to OTP program

	Reasons for Non Attendance	Number of Children
1.0	Lack of information that the child was ill	11
2.0	There were no RUTF stocks at the health facilities	5
3.0	Lack of information on a program that can treat malnutrition	3
4.0	Too far distances	2
5.0	Lack of conviction that the program can treat malnutrition	1
6.0	Non availability of financial resources for the journey	1
7.0	Non availability of financial resources for treatment	1
8.0	Too busy workload	1
9.0	Rejection of a known child	1
10.0	Child refused to consume RUTF	1
11.0	Non availability of means of transportation	1
12.0	Ashamed to be enrolled in OTP Program	1

3.0. Conclusion and Recommendations

3.1. Conclusion

The overall OTP Coverage in Samburu County was 45.2%. Although, this was arrived as a single coverage it was below 51.6% achieved during 2013 SQUEAC assessment which was a Point coverage. In this regard, the estimated coverage failed to meet the Standard SPHERE coverage for rural areas which is 50%.

The main reason for low OTP coverage included weak defaulter tracing coupled with inadequate community screening and active case findings. The main reasons for this was due to the fact that CHVs were not given incentives as they used to be given during the previous assessment. It was noted that during the assessment in few Community Units, the Community Health Volunteers were given incentives. The CHVs who were provided with incentives were attached to 4 Community Units (Lerata, Serolipi, Archers post and Lorubae) in Samburu East Sub County and were supported by Feed the Children. Lack of CHVs incentives lead to weak defaulter tracing strategies in the County as well as weak case findings. This can be attributed to early program defaulting as it was noted in program data analysis.

Community screening was minimal and inconsistent. The distribution of such outreached in space and time was not good. There was little support from the government meant for community outreaches. From the contingency plan (2016), the County government according to one of the program staff had promised to allocate Ksh 1.2million to support outreached. However, only Ksh. 0.6million was given. The amount supported only few outreaches in the most affected parts of the County. Some of the partners that supported outreaches in the County included; KRC, Action Against Hunger and Feed the Children.

Food insecurity and poor OTP linkages was also cited as one cause of low coverage. As indicated by the health facility workers, community and health facility community health workers and program staff, there was noncompliance in the treatment of acute malnutrition due to household food insecurity where caregivers of children in the OTP program were forced to share the RUTF with other children in the household. Few households were linked to the cash transfer program in Samburu East and Samburu Central which made the situation worse.

Consumption of alcohol by caregivers especially for children in Samburu Central (around Maralal town) and Samburu North (around Baragoi town) was another program barrier noted through observation as well as semi structured interviews with health facility in charges as well as health facility based CHVs. Care givers of children who consumed alcohol failed to do their household roles including child care. A part from failing to take their children to the health facilities when they were supposed to do so thus leading to defaulting which is major challenge for the OTP program. Excess consumption of alcohol by the caregivers led to some of them sell the RUTF in a bid to have money to buy alcohol. Those who were beneficiary of cash transfer used their proceeds to buy alcohol instead of food for their children.

Migration as a result of drought, rainfall, domestic violence and conflicts also resulted to low program coverage where caregivers could not reach the service delivery sites when they were required to do so resulting to defaulting. Inaccessibility to the OTP sites as a result of distance, wild animals as well as conflicts also resulted to low program coverage.

Although there RUTF stocks were available at the County and sub county stores, there were notable gaps in the distribution. The County government had leveraged on the county government and partners vehicles to support in the distribution of RUTF but these efforts have not been sufficient. With gaps in documentation, affecting the ordering of stock there was notable stock outs in the OTP (remote health facilities).

Poor documentation was noted in a number of health facilities. This was attributed to inadequate workforce coupled with lack of incentives for health facilities CHVs, poor targeting of IMAM training whereby those health workers who are not involved in service delivery are not the once who participated in IMAM training. Inadequate IEC materials as well as beneficiary ration cards was also a reason for poor documentation.

3.2. Recommendations

Program Barrier	Recommendation	By Who	Timeline
RUTF stock outs at the health facilities	Improve on documentation at the affected health facilities	Health workers, Sub County and County health management teams	July to October 2017
	Scale up nutrition commodities requisition	Health workers, Sub County and County health management teams	July to October 2017
Weak Defaulter tracing mechanisms	Strengthen defaulter tracing mechanism by actively involving community units and CHVs	County and Sub County Health Management Teams, Health workers and Partners	August to October 2017
	Incorporate Mother to mother support group/Mother and Father Care groups in defaulter tracing		
	Involve local authorities and family members in defaulter tracing		
	Advocate for recognition of community units and CHVs		
Early Defaulting	Educate caregivers on the importance continuity of nutrition services to the clients at the OTP program sites	Health workers, Community Health Volunteers, County and Sub County Health Management and Partners	July to October 2017
Weak Organization of OTP program	Improve program organization at the respective health facilities using the guidelines	Facility health workers, community health volunteers	July to September 2017
Inadequate community screening and active case findings	Organize and execute more mass screening activities in the County	County and Sub County Health Management teams, Partners	July to November 2017
Household food insecurity and inadequate program linkages	Educate the community on food diversification and advocate for linkages of OTP to other programs		
Inaccessibility to OTP programs due to	Organize more outreaches in hard to reach areas and malnutrition hotspots	County and Sub County Health Management Teams	July to October 2017

distance wild animals and conflicts	County government to construct dispensaries in hard to reach areas	County government of Samburu	July 2017- June 2018
Migration due to drought, conflict and domestic violence	Organize integrated outreaches services to the areas the communities migrates	County/Sub County Health Management and Partners	July to October 2017
	Organize peace forums in conflict areas	County government and partners	September 2017- June 2018
Inadequate workforce	Increase the workforce by employing more health workers	County government	July 2017- June 2018
Lack of knowledge on malnutrition signs	Educate the community on the early signs of malnutrition	Health workers, community health volunteers, CHMTs	July 2018
Poor health seeking	Scale up health education in the communities	CHMTs, Health workers and partners	June to December 2017
	Scale up advocacy to create awareness on child care through barazas, MTMSGs, and at the health facilities		
Poor documentation	Continue capacity building to all health workers on documentation and good records keeping	County and Sub County Health management teams and partners	June 2017
Inadequate IEC materials and ration cards	Procure and dispatch IEC materials	County and Sub County Health management teams and Partners	October 2017
Alcoholism	Establishment of mother care group and mother support groups within the child bearing age and health education	Health workers, community health volunteers, county and sub county health management teams	September 2017 to April 2018
	Adopt direct observation of treatment (DOT) management		
No incentives for CHVs	Give incentives to CHVs and absorb them to the County health system	County/sub County health management, partners and the County government	July 2017- June 2018
Lack of proper targeting of IMAM training	Train nutrition program implementing health workers	County/Sub County health management teams and partners	July 2017- June 2018

References

1. Myatt, Mark et al. 2012. Semi- Quantitative Evaluation of Access and Coverage (SQUEAC)/ Simplified Lot Quality Assurance Sampling Evaluation of Acess and Coverage (SLEAC) Technical Reference. Washington, DC: FHI 360/FANTA

2. Coverage Monitoring Network website; http://www.coverage-monitoring.org/

3. Ministry of Health Samburu County, International Medical Corps and UNICEF, 2013. Samburu County SQUEAC survey report 2013

Appendices

Appendix 1: Quantitative Data Collection Tools

Samburu SQUEA Assessment OTP Admissions		
Nane of the health facility		
Admission Criteria	**MUAC**	
	WHZ Score	
	Total	
Data Collectors Name		
Month	**Number of children Admitted**	
October-13		
Nov-13		
Dec-13		
Jan-14		
Feb-14		
Mar-14		
Apr-14		
May-14		
Jun-14		
Jul-14		
Aug-14		
Sep-14		
Oct-14		
Nov-14		
Dec-14		
Jan-15		
Feb-15		
Mar-15		
Apr-15		
May-15		
Jun-15		
Jul-15		
Aug-15		
Sep-15		
Oct-15		
Nov-15		
Dec-15		
Jan-16		

Samburu County SQUEAC Assessment- Defaulting Visit	
Sub County	
Health Facility	
Date	
Data Collector	

S.No	Village (Name)	1	2	3	4	5	6	7	>8	Total
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Samburu County SQUEAC Assessment MUAC admission tally sheet

Health Facility Name			
Date		Duration	
Data collector			
MUAC (mm)	**MUAC Admission Tally**	**Total**	
114- 111			
110- 106			
105- 101			
100- 96			
95- 91			
90- 86			
85- 81			
80- 76			
75- 71			
Total admission by MUAC			
Total admission by WHZ score			
Total Admissions			

Samburu County SQUEAC Assessment							
Year	Month	Diseases					
		Diarrhoea	Malaria	URTI	Skin Diseases	Intestinal Worms	Others
2013	October						
	November						
	December						
2014	January						
	February						
	March						
	April						
	May						
	June						
	July						
	August						
	September						
	October						
	November						
	December						
2015	January						
	February						
	March						
	April						
	May						
	June						
	July						
	August						
	September						
	October						
	November						
	December						
2016	January						
	February						
	March						
	April						
	May						
	June						
	July						
	August						
	September						
	October						
	November						
	December						
2017	January						
	February						
	March						
	April						

Samburu County SQUEAC Assessment Exits						
Facility						
Date						
Month	**Exits**					
	Cured	**Defauters**	**Deaths**	**Transfers**	**Non response**	**Totals**
Oct-13						
Nov-13						
Dec-13						
Jan-14						
Feb-14						
Mar-14						
Apr-14						
May-14						
Jun-14						
Jul-14						
Aug-14						
Sep-14						
Oct-14						
Nov-14						
Dec-14						
Jan-15						
Feb-15						
Mar-15						
Apr-15						
May-15						
Jun-15						
Jul-15						
Aug-15						
Sep-15						
Oct-15						
Nov-15						
Dec-15						
Jan-16						
Feb-16						
Mar-16						
Apr-16						
May-16						
Jun-16						
Jul-16						
Aug-16						
Sep-16						
Oct-16						
Nov-16						
Dec-16						
Jan-17						
Feb-17						
Mar-17						
Apr-17						

Appendix 2: Qualitative Data Collection Tools

Informal group discussion guide(TBAs, THPs, community leaders, pastoralists &caregivers of children not in the program)

Facility Name:_____District_____ Date:_____

1. Knowledge on malnutrition/ case definition/ aetiology

2. How do you identify malnutrition

3. How do you treat malnutrition

4. Do you know where malnutrition can be treated/ are you aware of a program which treats

5. malnutrition?

6. How far is the program site from the village?

7. In your opinion, how do you rank the distances

Distance in kms	Distance in time(hrs)	Perception of the distance

In- depth interview for caregivers (children in the program)

Facility Name:_____Sub. County_____ Date:_____

1. Do you know of malnutrition? Probe to get local terms

2. What do you think causes malnutrition? (use the local term for malnutrition)

3. When you child was sick, where did you seek treatment first?

4. How id you know about the program that treats malnutrition?(use the local term)

5. Has the program been beneficial to your child?

6. What would you like to be improved about the OTP program?

7. What would make you not to attend the OTP program promptly/on a weekly basis?(probr for any competing activity, find out if the mother has been attending on every visit)

In depth interview to caregivers of defaulting children

Facility Name:_____District_____ Date:_____

1. What were the reasons for defaulting?(probe for the reasons)

2. What would you like improved to avoid your child and others from defaulting?

Informal group discussions for community leaders, caregivers on community screening and active case finding

Facility Name:_____District_____ Date:_____

1. Show the MUAC tape and probe if they have seen it ,with who and where

2. When did you see it(MUAC) and what was it being used for?

3. Are there people in this village who wuse this(MUAC) on your children?

4. If yes, how often do they come to the village?

Semi structured interview for facility in charges/program staff and CHWs

Facility Name:_____ Sub County_____ Date:_____

1. In your opinion, what is the perception of the beneficiaries/community towards the OTP program?

2. How is defaulting a challenge to the program?

3. When does defaulting occur most and what are the probable reasons for defaulting?

4. How is the defaulter tracing mechanism in this facility?

5. How often do you conduct community screening/ active case finding? (probe when the last one was done)

6. Are there occasions when plumpy nuts is out of stock?

7. What other programs are linked to the OTP program?

8. Have you attended any IMAM training?

9. Do you find any challeges with documentation? (Specify)

10. How useful are the OJT sessions

11. Does the facility have enough human resource to deliver OTP services? (how many staff serve the OTP clients)

Facility Name: _____Sub. County_____ Date:_____

Observation checklist

Observe at the facility:

1. OTP stocks(if they are available)

2. Presence of IEC materials

3. OTP register(if well filled) and take snaps of the register

4. Beneficiary ration cards

5. Organization of the OTP program

6. Waiting time(from the time the client gets to the facility to the time she leave)

Appendix 3: Assessment Team

No	Name	Organization
1	Lesorgol Emmanuel	County government of Samburu Department of Health
2	Agnes Kamman	Samburu County government Department of Health services
3	Francis Lesiantam	County government of Samburu Department of Health Services
4	Steve Letipila	County government of Samburu, Department of Health Services
5	Lenaruti Joseph	County government of Samburu Department of Health Services
6	Abdullahi Ramadhani	County government of Samburu Department of Health Services
7	Christine Naitoti	County government of Samburu Department of Health Services
8	Njeri Lekartiwa	County government of Samburu Department of Health Services
9	Angelah Lolorua	County government of Samburu Department of Health Services
10	Magdaline Naisula	County government of Samburu Department of Health Services
11	Samwella Lemongi	County government of Samburu Department of Health Services
12	Maria Lodokiyaa	County government of Samburu Department of Health Services
13	Hellen Kariuki	County government of Samburu Department of Health Services
14	Delphina Kaaman	County government of Samburu Department of Health Services
14	Alex Louwa	International Medical Corps
14	Janet Gatimu	International Medical Corps
15	Yvonne Nganga	International Medical Corps
16	Mercy Mwikali	International Medical Corps
17	Irene Mugo	International Medical Corps
18	Lucy Waithaka	International Medical Corps
19	Benson Musau	United Nations Children Fund
20	Mark Murage	International Medical Corps